BOARD MEETING

Date: Wednesday, 30 November 2016

Time: 1.00pm

Venue: Te Waiora Room, DHB Administration Building,
Corner Omahu Road and McLeod Street, Hastings

Members:
Kevin Atkinson (Chair)
Ngahiwi Tomoana
Dan Druzianic
Barbara Arnott
Peter Dunkerley
Helen Francis
Diana Kirton
Denise Eaglesome
Jacoby Poulain
Heather Skipworth
Andrew Blair

Apologies: -

In Attendance:
Dr Kevin Snee, Chief Executive Officer
Members of Executive Management Team
Ana Apatu, Elected Boad Member (commencing December)
Members of the public and media

Board Administrator: Brenda Crene

Public Agenda

Item	Section 1 : Routine	Ref #	Time (pm)
1.	Karakia		1.00
2.	Apologies		
3.	Interests Register		
4.	Minutes of Previous Meeting		
5.	Matters Arising - Review of Actions		
6.	Board Workplan		
7.	Chair's Report - verbal	-	
8.	Chief Executive Officer's Report	127	
9.	Financial Performance Report	128	
10.	Board Health & Safety Champion's Update - Helen Francis	-	

11.	Consumer Story - Kate Coley	-	
	Section 2: Reports from Committee Chairs		
12.	Clinical and Consumer Council Report - Chris McKenna/Dr Mark Peterson/Graeme Norton	129	1.45
13.	Reappointment to HB Clinical Council - Ken Foote	130	1.55
14.	Māori Relationship Board - Chair, Ngahiwi Tomoana	131	2.00
15.	HBDHB Committee Structure - Ken Foote - Governance Structures and Proposed Meeting Schedule for 2017	132	2.10
	Section 3: For Decision		
16.	13-17 Year Old Primary Care Zero Rated Subsidy Project– Tim Evans / Patrick LeGeyte	133	2.15
17.	Position Statement on Reducing Alcohol-Related Harm – Caroline McElnay/ Rachel Eyre	134	2.30
	Section 4: Monitoring and Information		
18.	HBDHB Non-Financial Exceptions Q1 Jul-Sept16 - HBDHB Quarterly Performance Monitoring Dashboard Q4 Apr-Jun 16 (from MoH)	135	2.45
19.	HR KPIs Q1 Jul-September 2016 – Kate Coley / Jim Scott	136	2.55
20.	Annual Maori Plan Q1 Jul-Sep 2016 – Tracee TeHuia	137	3.05
21.	Te Ara Whakawaiora / Smoke Free – Caroline McElnay	138	2.55
22.	Regional Tobacco Strategy for HB (2015-2020) – Caroline McElnay	139	3.00
	Section 5: General Business		
23.	**Section 6: Recommendation to Exclude**		
	Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	Section 7: Agenda Items	Ref #	Time (pm)
24.	Minutes of Previous Meeting		
25.	Matters Arising – Review of Actions		
26.	Board Approval of Actions exceeding limits delegated by CEO	140	3.10
	Section 8: Reports from Committee Chair		
27.	Finance Risk & Audit Committee – Dan Druzianic	141	
28.	HB Clinical Council - Chris McKenna & Dr Mark Peterson	142	

Next Meeting:

Commencing with a Whakatau (to welcome the new Board) at 12.30pm on Wednesday 14 December 2016

The Board meeting will commence at 1.00pm.

Venue: Te Waiora (Boardroom)
HBDHB Corporate Office

Board "Interest Register" - 26 October 2016

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Kevin Atkinson (Chair)	Active	Chair of Unison Networks Limited	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB. Unison leases 3 generators which are located at Hawke's Bay Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	Chair of FRAC	18.02.09
	Active	Director of Unison Fibre Limited	Non pecuniary interest. Unison is now a provider of high speed broadband to the District Health Board.	Will not take part in any decision or discussions in relation to the provision of high speed broadband to the District Health Board	The Chair of FRAC	17.11.10
	Active	Director of Hawke's Bay Rugby Football Union (HBRFU)	HBDHB has a sponsorship arrangement with HBRFU.	Will not take part in any decisions or discussion in relation to the sponsorship arrangement.	The Chair of FRAC	
	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 discussion in relation to the Trust	The Chair of FRAC	Mar-11
Ngahiwi Tomoana (Deputy 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 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 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 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 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 Chair	01.05.08
Barbara Arnott	Active	Trustee of the Hawke's Bay Air Ambulance Trust	HBDHB has a partnership contract with Skyline Aviation who together operate the HB Air Ambulance Service which is supported by the Trust.	Declare this interest prior to any discussion on the HB Air Ambulance Services and Chair decides on appropriate mitigation action	The Chair	10.05.10
Helen Francis	Active	Alzheimer's Napier previously a Committee member Patron and Lifetime Member	Alzheimer's Society holds a contract with the HBDHB to provide dementia specific daycare and community services.	Will not take part in any decisions or discussion in relation to HBDHB contract with Alzheimer's Society	The Chair	08.06.10 21.06.14
	Active	Employee of Hastings Health Centre	Actual Conflict of Interest. Pecuniary Interest.	Will not take part in any decisions or discussions in relation to Hastings Health Centre.	The Chair	18.02.09
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.11
	Active	HB Medical Research Foundation	Trustee	Declare this interest prior to any discussion in relation to the Foundation, and an appropirate mitigation action is decided on.	The Chair	20.08.14
Diana Kirton	Active	Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB.	Perceived Conflict of Interest. Non-Pecuniary interest.	Will not take part in any decisions in relation to surgical services provided by or contracted by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO	The Chair	18.02.09
	Active	Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014	Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers.	Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on.	The Chair	16.01.14

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
	Active	Son, Chris Kirton, GP in Wairoa employed by HBDHB	Non-pecuniary interest: Will not take part in discussions around employment of GP's in Wairoa	All employment matters are the responsibility of the CEO.	The Chair	26.02.14
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.14
Dan Druzianic	Active	Director of Markhams Hawke's Bay Limited	Potential Conflict of Interest. Some clients may from time to time be employed by or have contracts with HBDHB	Declare an interest at any time an issue arises concerning a client, and take no further part in any decision or discussion on this matter.	The Chair	7.12.10
	Active	Director of Hawke's Bay Rugby Football Union (HBRFU)	HBDHB has a sponsorship arrangement with HBRFU.	Will not take part in any decisions or discussion in relation to the sponsorship arrangement.	The Chair	7.12.10
Denise Eaglesome	Active	Deputy Mayor of Wairoa District Council	Advocate as Deputy Mayor for Wairoa District, whereas HBDHB covers whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	28.02.11
	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	05.03.14
	Active	Coordinator for Health Contract for Rugby Academy in Wairoa	Health Contract with Wairoa Rugby Academy	Will not take part in any decisions or discussions in relation to this contract.	The Chair	25.05.15
Andrew Blair	Active	Owner of Andrew Blair Consulting Limited	Engaged from time to time to provide consultancy and advisory services to healthcare and other organisations.	Will not take part in decision relating to organistions to which he provide consultancy and advisory services.	The Chair	04.12.13
	Active	Advisor to Trustees and Management of Chelsea Hospital Trust	Engaged to provide advisory services to the Trust who own and operate the private hospital in Gisborne.	Will not take part in decisions relating to services HBDHB may from time to time engage.	The Chair	24.07.14
	Active	Advisor to Hawke's Bay Orthopaedic Group Ltd	Engaged to provide advisory services to the Group	Will not provide advice in relation to contracting, employment or relationship matters between the HBOG and HBDHB. Will not participate in any decisions made by HBDHB regarding orthopaedic services.	The Chair	19.09.15
	Active	Chair of Southern Partnership Group	Southern Partnership is to progress the facilities redevelopment of Dunedin Hospital.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	19.09.15
	Active	Director, Breastscreen Auckland Limited	Breast screening facility.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	17.12.15
	Active	Director, St Marks Womans Health (Remuera) Limited	Womans Health facility in Auckland	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	17.12.15
	Active	Director, Board of Safer Sleep Limited	Safer Sleep is an Anaesthetic IT company which provides peri-operative safety solutions to the healthcare industry.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair and withdraw from discussions/decisions.	The Chair	22.09.16
Jacoby Poulain	Active	Board Member of Eastern Institute of Technology (EIT)	Perceived conflict - HBDHB has a Memorandum of Understanding (MOU) with EIT relating to training and development in health related occupations	Will not take part in any decisions or discussions in relation to the MOU between HBDHB and EIT	The Chair	14.1.14
	Active	Councillor Hastings District Council	Potential conflict as potential advocate for Hastings District population whereas HBDHB coveres whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.1.14
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	Will not take part in any discussions or decisions relating to the Contract with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15
	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
Peter Dunkerley	Active	Trustee of Hawke's Bay Helicopter Rescue Trust	Actual conflict of interest. The Trust provides helicopter patient transfer services to HBDHB	Will not take part in any decision or discussion in relation to any contract or financial arrangement between HBHRT and HBDHB	The Chair	15.05.14

MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 26 OCTOBER 2016, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.00PM

Present:	Kevin Atkinson (Chair) Dan Druzianic Andrew Blair Peter Dunkerley Diana Kirton Barbara Arnott Helen Francis Heather Skipworth Denise Eaglesome (by video conference)
Apologies:	Ngahiwi Tomoana and Jacoby Poulain
In Attendance:	Kevin Snee (Chief Executive Officer) Members of the Executive Management Team Chris McKenna and Mark Peterson (Co-Chairs, HB Clinical Council) Graeme Norton (Chair, HB Health Consumer Council) Members of the public and media
Minutes	Brenda Crene

KARAKIA

Heather Skipworth opened the meeting with a Karakia.

APOLOGIES

Apologies were noted from Ngahiwi Tomoana and Jacoby Poulain.

COMMENT FROM THE CHAIR

The Chair congratulated the successful election candidates, and noted that Heather's profile may not have been as high as others however she was a very valuable board member and noted she was also a good Deputy Chair for the Maori Relationship Board. He was hopeful Heather could be retained as an appointed member of the Board.

INTEREST REGISTER

Heather Skipworth advised a new interest, that of Director of the Kahungunu Asset Holding Company. **Actioned**

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

CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on 28 September 2016, were confirmed as a correct record of the meeting.

Moved: Barbara Arnott
Seconded: Peter Dunkerley
Carried

MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: **Board Health & Safety Champion –** This has been placed on the agenda as a regular item.

Item 2: **Fracture Clinic / Orthopaedic Department near ED** – ongoing with a paper to EMT in November.

Item 3: **Home Dialysis** - Strategic Services have been investigating options to reduce the cost to those undertaking home dialysis. Numbers on home dialysis were included into the board minutes for 28 September and these numbers which were low, were confirmed as accurate. HBDHB were looking to our strategic partners to undertake a district review of renal services. The Chair asked for this item to remain.

Item 4: **"Social Inclusions Strategy"** – this item has been included on workplan. Remove action.

BOARD WORK PLAN

The Board Work Plan was noted.

CHAIR'S REPORT

- The Chair advised the following retirements, with a letter being sent conveying the Board's best wishes and thanks for their extended years of devoted service.

Name	Role	Service	Years of Service	Retired
Doug Knight	General Surgeon	Surgical	38	3-Oct-16
Ngaio Bell	Unit Receptionist	Facilities & Operational Support	11	6-Oct-16
Richard Nobbs	Purchasing Officer	Planning Informatics & Finance	33	28-Oct-16

- The Chair conveyed interesting stats around voter habits relating to the election of district health board members around the country. The HBDHB and HB Council election systems cause voter confusion. Currently they are STV and FPP systems with no immediate opportunities forseen to align or change.

  In the lead up to 2019 Elections, some consideration of the process/system should be undertaken to alleviate confusion (locally and nationally).
- The Chair requested a review of the Chaplaincy Service funding with a view to providing a larger contribution than at present. If this information was made available to Hastings District Council, they may contribute also.
- Court of Appeal ruled in favour of South Taranaki District Council regarding fluoridation of their water supply. Fluoride is not regarded as a medicine and therefore is not considered mass medication!
- The Ministry of Health had announced the release of a cataract surgery prioritisation tool which was now available, to ensure better clarity in the prioritisation of future surgery nationally.
- A draft MoU between the Community Fitness Trust & Hawke's Bay District Health Board had been prepared. EIT Hawke's Bay is very involved with AUT Millennium Hawke's Bay with the development of an important vehicle to make significant progress with healthy weight within our community. HBDHB would not be in a position to provide financial support, more the ability to provide support through clinical specialists and population health with research. It was noted that 31% of the adult community of HB are regarded as obese, with a further 35% considered as overweight.
- An approach had been received from a member of the Indian community living in HB to discuss forming a relationship around health. The CEO has a meeting schedule with this group.

CHIEF EXECUTIVE OFFICER'S REPORT

The CEO advised we had an "out of the ordinary" start to the year with power outages, the gastro outbreak and RMO strikes.

He provided an overview of his report highlighting that Faster Cancer Treatment work was progressing with a review of systems and processes. Financially the DHB are tracking off plan, with no contingency used for the first three months of the financial year. The Urgent Care Review has taken some time however is now showing signs of optimism even though it has some way to go.

FINANCIAL PERFORMANCE REPORT

The Financial report for September 2016, showed an adverse variance of $85 thousand for the month, with to date adverse variance of $203 thousand for the first three months of the year. Not alarming at this stage but is being monitored.

HEALTH & SAFETY BOARD CHAMPION'S UPDATE

Helen Francis provided a hand-out entitled "Communicating 'Health & Safety" to the Board which outlined the "Role of the Board Member Safety Champion".

In summary:

- Helen had met with Human Resource personnel to align communication on Health & Safety (H&S) matters with the Board.
- It was advised that some H&S detail would need to be provided to the full Board (in future) not just to FRAC.
- The monthly update for H&S would remain a standard Board Agenda item, to ensure nothing was missed that needs to be raised at Board level.
- The Chair thanked Helen for her update and advised a review should occur six monthly. This review would be placed on the workplan for April 2017. **Actioned**

CONSUMER STORY

Kate Coley provided a consumer story around an elderly person badly affected by the Havelock North gastro outbreak. An overview of the difficulties and the response was conveyed. The person was extremely appreciative of the excellent service(s) and communication provided by GP and district nurses who treated her either in or home, or took her to the GP. She was extremely grateful the excellent in house services provided by all during the outbreak.

REPORT FROM COMMITTEE CHAIRS

Hawke's Bay Clinical Council

The Council co-Chair spoke to the report from the Council's meeting held on 12 October 2016, advising the next extended meeting would include a "Workshop" around Palliative Care and Advanced Care Planning (joint with consumer council). MRB would be considering the paper also.

A good start had been made with the new "Quality Dashboard" with more work required. Some felt further work was required also on Clinical Council's Annual Plan which would be worked through with a sub-committee of Council (pending the availability of plans and structures).

A board member queried what was occurring with Laboratory specimen labelling and whether improvements had been made (following issues raised earlier). The co-Chair of Council advised there was a Laboratory Specimens meeting the following day. Board members wished to receive an update on Laboratory Specimen Labelling in the near future. **Action**

Hawke's Bay Health Consumer Council

The Council Chair advised the outcomes of the meeting held on 13 October 2016:

He provided a brief update on Consumer involvement in the Palliative Care paper which was to be further discussed at the combined Workshop in November. There were interesting conversations around the Tamariki presentation feedback. Consumer Council had signed off their Annual Plan which had been provided to the Board for their information.

There was some discussion around progress with a Consumer Council National Collective and the likelihood or otherwise of having one established. Currently there was a three year draft plan in circulation with 13 regions around the table to date, with more likely to join. The ideal outcome is to form a working group to help each other.

Māori Relationship Board (MRB)

Heather Skipworth (Deputy Chair) provided an overview of their meeting held on 12 October 2016 with two presentations received both of which were supported being Co-Designing Relationship Centred Practice (RCP) Framework and the Complementary Therapies Policy.

FOR DECISION

Annual Report 2016

The annual report was provided to FRAC for consideration earlier in the day. The Board were advised there had been some heading changes required in some areas which would be worked through. As the external report had not yet been finalised the "Annual Report 2016" as presented would be considered a "draft". The financials were correct and the bottom line would not change.

Considering the minor amendments would be made as noted at the FRAC meeting, the following resolution was put forward by the Board Chair.

RESOLUTION

That the HBDHB Board:

Approve the draft Annual Report 2016; and approve the Chair and one other Board member to sign on behalf, once finalised.

Moved **Dan Druzianic**
Seconded **Andrew Blair**
Carried

Central Regions Technical Advisory Services – AGM representative

As central region DHBs are shareholders of CTAS, appointment of a representative was required through the following Resolution:

RESOLUTION

That the Board

1. **Note** the draft Annual Report for TAS for the year ended 30 June 2016.
2. **Appoint** Kevin Atkinson as the HBDHB representative to attend the TAS Annual General Meeting to be held Tuesday 6 December 2016, with Kevin Snee appointed as his Alternate.

Moved **Barbara Arnott**
Seconded **Heather Skipworth**
Carried

Allied Laundry Ltd – AGM representative

Ken Foote as Chair of Allied Laundry provided an overview of the transition undertaken by Allied which doubled the size of the operation and remains work in progress. He advised the pressure is on to keep costs to a minimum. It was acknowledged the cost of Audit appeared high and that would be reviewed by directors and could well be an internal review in future.

RESOLUTION

That the Board

1. **Note** the Chairman's Report and the Financial Statements for Allied Laundry Services Ltd (Allied) for the year ended 30 June 2016.
2. **Appoint** Ken Foote as the HBDHB Shareholder representative to attend the Allied Annual General Meeting to be held on Tuesday 29 November 2016, with Peter Kennedy appointed as his Alternate.

Moved **Helen Francis**
Seconded **Dan Druzianic**
Carried

GENERAL BUSINESS

There being no further discussion, the Chair accepted a motion to move into Public Excluded.

RESOLUTION TO EXCLUDE THE PUBLIC

RESOLUTION

That the Board

Exclude the public from the following items:

19. Confirmation of Minutes of Board Meeting
    - Public Excluded

20. Matters Arising from the Minutes of Board Meeting
    - Public Excluded

21. Board Approval of Actions exceeding limits delegated by CEO

For Information /Discussion

22. Havelock North Gastroenteritis Outbreak Review – draft

23. Urgent Care Proposal

Reports and Recommendations from Committee Chairs

24. Finance Risk and Audit Committee Report

Moved: **Dan Druzianic**
Seconded: **Peter Dunkerley**
Carried

The public section of the Board Meeting closed at 1.50pm

Signed: _____

Chair

Date: _____

BOARD MEETING - MATTERS ARISING
(Public)

Action No	Date Issue first Entered	Action to be Taken	By Whom	By When	Status
1	31/8/16	**Fracture Clinic / Orthopaedic Dept near ED:** Investigating options and oportunities Progressing with verbal updates to the Board in the interim.	Sharon Mason		Ongoing.
2	28/9/16 26/10/16	**Home Dialysis:** Consideration of the impact on power accounts. HB Home Dialysis numbers provided by Sharon post Board meeting: 6 Napier 5 Hastings 0 Wairoa 0 Central HB. Strategic Services are investigating options to better support those who have dialysis treatment at home.T his will be going to EMT in November 2016. The Chair asked for this item to remain.	Sharon Mason		Ongoing.
3	26/10/16	**Interest Register** Update item for Heather Skipworth	Admin		Actioned.
4	26/10/16	**Laboratory Specimen Labelling** – update requested by the Board.	Andy Phillips	Nov	Refer to Clinical Council Report to the Board for November.

HAWKE'S BAY DISTRICT HEALTH BOARD
WORKPLAN

Mtg Date	Papers and Topics	Lead(s)
14 Dec	**The Board Meeting will commence with a Whakatau (to welcome the new Board) at 12.30pm in the Wairoa Room, followed by lunch.**	
	Consumer Story	Kate Coley
	Orthopaedic Review – Closure of phase one	Andy Phillips
	Orthopaedic Review – Phase 2 draft	Andy Phillips
	Travel Plan (quarterly update)	Sharon Mason
	Final External Audit Report (from Oct)	Tim Evans
	Transform and Sustain Refresh	Tracee TeHuia / Kate R
	Transform and Sustain Strategic Dashboard Q1 Jul-Sept 16	Tracee TeHuia
	Palliative Care in HB 2016-2026 Draft	Mary Wills
	Te Ara Whakawaiora – Healthy Weight	Caoline McElnay / Shari
	Pasifika Health Leadership Group Dashboard and members in attendance	Caroline McElnay
	Endoscopy Service – Facility Development	Sharon Mason / Trent
2017	Consumer Story	Kate Coley
22 Feb	Final Developing a Person Whanau Centred Culture	Kate Coley
	Orthopaedic Review – phase 3 Draft	Andy Phillips
	Review of Fracture Cliniic – Orthopaedic Dept near ED (board action)	Sharon Mason
	MRI Target Achievement (board action)	Sharon Mason / Mark
	Pacifika Health Leadership Group Qtly	Caroline McElnay
	Palliative Care in HB 2016-2026 Final	Mary Wills
	Social Inclusions Strategy (referred to in REDS)	Kevin Snee
	Monitoring	
	HBDHB Non-Financial Exceptions Report Q2 Oct-Dec16 plus MoH dashboard	Tim Evans
	Annual Maori Health Plan Q2 Oct-Dec16	Tracee TeHuia
	Transform and Sustain Strategic Dashboard Q2 Oct-Dec166	Tracee TeHuia
	Human Resource KPIs Q2	GM HR
	Te Ara Whakawaiora / Access (local indicator)	Mark Peterson
15 March	**Proposed HB Health Sector Leadership Forum (Venue TBA)**	
29 March	Consumer Story	Kate Coley
	Pasifika Health Leadership Group	Caroline McElnay
	HBDHB Workforce Plan – Final	GM HR
	Health and Social Care Networks (6 monthly update)	Tracee TeHuia
	Travel Plan Update	Sharon Mason
	External Audit Engagement Arrangements	Tim Evans
	Te Ara Whakawaiora / Breastfeeding (national indicator)	Caroline McElnay
	NKII MoU Relationship Review	Tracee TeHuia/Ken Foote

26 Apr	People and Culture Strategy (2016-2021) Mental Health Consolidation / Benefits Realisation (final) from Oct16 Board H&S responsibilities – agenda item review 6 monthly ***Monitoring*** Te Ara Whakawaiora / Cardiology (national indicator)	GM HR Sharon Mason Ken Foote John Gommans
31 May	Best Start Healthy Eating Plan (yearly review)	Caroline McElnay
29 June	Orthopaedic Review closure phase 2 Orthopaedic Review closure phase 3 Draft Equity Update Final Youth Health Strategy Final Suicide Prevention Postevention update against 2016 Plan. Pasifika Health Leadership Group incl Dashboard (6mthly) ***Monitoring*** Te Ara Whakawaiora / Oral Health (national indicator)	Andy Phillips Andy Phillips Caroline McElnay Caroline McElnay Caroline McElnay Caroline McElnay Sharon Mason / Robin W

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** 127
	For the attention of: **HBDHB Board**
Document Owner:	Dr Kevin Snee, Chief Executive Officer
Reviewed by:	Not applicable
Month as at	23 November 2016
Consideration:	For Information

8

Recommendations

That the Board

1. Note the contents of this report.

INTRODUCTION

This month is a fairly busy agenda with key papers on 13-17 Year Old Primary Care Zero Rated Subsidy and Alcohol Harm Reduction – the first vital for enabling improved access to primary care for deprived communities, the second being a first step on what is likely to be long road of reducing the enormous harm to our community as a consequence of excess alcohol intake. There are also a range of papers which relate to various aspects of performance which are discussed below.

This month saw the publication of the Ministerial Target quarter one performance figures for Hawke's Bay District Health Board (HBDHB) (attached) which were generally disappointing with the exception of immunisation. I anticipate our performance will improve throughout the course of the year.

PERFORMANCE

Measure / Indicator	Target	Month of October	Qtr to end October	Trend For Qtr
Shorter stays in ED	≥95%	94.6%	94.6%	▲
Improved access to Elective Surgery (2016/17YTD)	100%	-	96.1%	-
Faster cancer treatment*	≥85%	57.1% (October 2016)	62.4% (6m to October 2016)	▼
Increased immunisation at 8 months (3 months to end of October)	≥95%	---	95.6%	▲
Better help for smokers to quit – Primary Care	≥90%	81.4%		▲

Waiting list	*Less than 3 months*	*3-4 months*	*4+ months*
First Specialist Assessments (ESPI-2)	2,631	460	6
Patients given commitment to treat, but not yet treated (ESPI-5)	1,048	150	12

Measure / Indicator	Target	Month of October	Qtr to end October	Trend For Qtr
Better help for smokers to quit – Maternity	≥90%	91.2% (Quarter 1, 2016/17)	---	▲
Raising healthy kids (New)	≥95%	27% (Quarter 1 2016/17)	---	
More heart diabetes checks *(This indicator is no longer a Health Target)*	≥90%	88.1% (Quarter 1, 2016/17)	---	▼
Financial – month (in thousands of dollars)	$2,472	$2,424	---	---
Financial – year to date (in thousands of dollars)	$4,570	$4,319	---	---

***Based on the expected annual cancer registrations for the DHB supplied by the Ministry, the DHB is expected to identify at least 228 people a year (19 a month) as patients with a high suspicion of cancer.*

Faster Cancer Treatment Expected Volumes v Actual	*Target*	*Month Actual / Expected*	*Rolling 6m Actual / Expected*
	100%	*17/19 = 89.5%*	*125/114 = 109.6%*

Note: The Ministry of Health expectation for the number of people expected to be identified as high suspicion has been increased from 11.4 to 19 a month.

Performance this month shows an improvement in the ED six hour target which reflects good work done within the Emergency Department (ED) and Acute Assessment Unit (AAU) to improve performance. This will only be sustained if further work is undertaken to address flow through the hospital - this work is in train. Improved performance has been sustained into November. Elective activity remains below what we would want but I anticipate we will deliver our plan by year end. Faster Cancer Treatment performance remains unsatisfactory. Whilst it has improved for the month slightly compared to September, the six month rolling average has reduced.

Immunisation performance remains strong, however our smoking cessation performance is mixed with our figure for offering brief advice to pregnant women being above target, whereas the target for PHO enrolled patients' remains significantly below. Raising Healthy Kids is a new target where it is intended that by December 2017, 95 percent of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions. It is too soon to say whether this is an accurate representation of local performance.

The result for the month of September is an adverse variance of $48 thousand making a year-to-date adverse variance of $251 thousand. This is not a cause for concern at this stage but underlines the importance of delivering our savings plans. What is a cause for concern is a probable adverse variance in Inter District Flows (IDFs) which we will have a clearer understanding of by next month.

CONSUMER STORY

This month we share a daughter's story of her mother's referral to, and experience of, the engAGE intermediate care bed service. It highlights the positive impact this had as well as some suggestions for the service to consider to improve the patient and whanau experience.

SMOKING
Two papers presented today continue to highlight the impact of tobacco use in Hawke's Bay and the need to accelerate the change towards achieving smoking prevalence of less than five percent by 2025.

a) TE ARA WHAKAWAIORA - SMOKEFREE
The Te Ara Whakawaiora report highlights that HBDHB continues to exceed the Ministry of Health target relating to smokefree screening in secondary care. However, the primary care target has not yet been reached. The DHB and PHO have committed 1.7 FTE nursing and smokefree staff to work with practices, contacting patients direct, offering brief advice and support and updating records. The PHO has estimated the work required and anticipates that 90 percent will be reached by 31 December 2016.

b) REGIONAL TOBACCO STRATEGY FOR HAWKE'S BAY, 2015–2020 UPDATE
Māori, Pacific people and pregnant women are the priority groups for all tobacco control work, due to the higher prevalence and/or higher impact of smoking in these groups. The Regional Tobacco Strategy for Hawke's Bay 2015 – 2020 launched in November last year underpins the Tobacco Control Annual Plan. As a partner of Te Haa Matea Hawke's Bay, the Smokefree team provides leadership in smoking cessation training for practitioners, contributes to the national stop smoking target and supports new initiative developments. Te Haa Matea is in its infancy and will require our backing in the first instance. The Increasing Smokefree Pregnancy Programme (ISPP) has developed Wahine Hapu resources specifically for primary care settings to engage with pregnant women at time of confirmation of pregnancy. Maternity and Smokefree, working in collaboration, are visiting general practices to promote early engagement to ISPP. The outcome is to increase referrals to ISPP and therefore increase smokefree pregnancies.

13-17 YEAR OLD PRIMARY CARE ZERO RATED SUBSIDY
Cost is a barrier to accessing primary health care in New Zealand. The 13-17 Year Old Primary Care Zero Fees Subsidy builds on the national rollout of the zero fees policy for 6-12 year olds. It goes further than just removing cost by focusing on equity, requires changes to the model of primary care and identifies performance measures based on health indicators related to access. The proposal is estimated to cost around $583,235 per annum and will cover around 70 percent of the HBDHB 13-17 year old population from Wairoa to Central Hawke's Bay.

POSITION STATEMENT ON REDUCING ALCOHOL RELATED HARM
The DHB committees have unanimously supported a position put forward by Population Health, and supported by a wider group of stakeholders, that alcohol harm reduction be a priority issue for our DHB. A position statement has been drafted to this effect, which the committees have endorsed. This Position Statement essentially outlines the DHB's direction of travel over the next three to five years, consistent with the Ministry of Health's National Drug Policy. It advances HBDHB's high level commitment to making alcohol harm reduction a priority and to taking a leadership role on this issue both within our DHB as a service and across the community. The position statement also sets out what the next steps are for action. There are cogent reasons to address alcohol-related harm, based on the evidence that this is both a key driver of inequity and harm to our local community and with respect to having good evidence for what works.

HBDHB NON-FINANCIAL EXCEPTIONS QUARTER ONE
We continue to struggle to achieve 95 percent for under six hour waits in our emergency department. Performance dropped slightly in quarter four to 92.4 percent. For Faster Cancer Treatment we are consistently flagging enough patients for fast track monitoring but, at 65.6 percent, are not yet treating enough of them within 62 days of referral. Brief advice to quit smoking has seen a further deterioration to 80.9 percent against a target of 90 percent.

On the up side we have achieved the immunisation target for our total population, and achieved Mental Health utilisation targets across all age ranges. We also met target for fall assessments being carried out as well as fall prevention plans. Stroke service results are favourable for patients being admitted to an organised stroke unit as well as the number of patients being thrombolysed.

HUMAN RESOURCES KPIs

Annual Leave (2+ years) at 131 employees (five percent) has improved since the last quarter when it was 146 employees (5.63 percent). We are the second best performing of the mid-sized DHBs (and the fifth best of the 20 DHBs) for this measure. The total liability has reduced by $396 thousand since 30 June 2016 and is largely driven by a reduction in hours owed. Maori representation in the workforce has remained static in the last quarter and the gap to our target sits at 38 at 30 September 2016. Sick leave showed an increase in August due to the campylobacter outbreak but the year-to-date position is only slightly higher than this time last year. There are no concerns with staff turnover or Occupational Health and Safety KPI results.

ANNUAL MAORI HEALTH PLAN QUARTER ONE

The quarter one report demonstrates the continuation of good performance of Cervical Screening, Immunisations at eight weeks and ASH Rates for 0-4 year olds. However, whilst we have the third best result for all DHBs for ASH rates for this group, quarter one saw a rise of 13.1 percent from the previous quarter. There have been improvements in mental health compulsory treatment orders and acute hospitalisations for rheumatic fever. Areas of concern include child obesity, Māori workforce and Cultural Competency training of Medical staff.

SUMMARY

In summary, whilst the quarter one health target results are disappointing, there is evidence that there will be improvement in quarter two. In other areas we continue to perform well and make investments in our infrastructure and in improving access to primary care particularly for the most disadvantaged in our community.

How is My DHB performing?

MINISTRY OF HEALTH
MANATŪ HAUORA

2016/17 QUARTER ONE (JULY–SEPTEMBER 2016) RESULTS

www.health.govt.nz/healthtargets

This is the first time Raising Healthy Kids has been reported as a health target.

Shorter stays in Emergency Departments

		Quarter one performance (%)	95%	Change from previous quarter
1	West Coast	99		–
2	Waitemata	97		▲
3	South Canterbury	96		–
4	Wairarapa	96		–
5	Tairawhiti	96		–
6	Counties Manukau	96		–
7	Nelson Marlborough	96		–
8	Auckland	95		–
9	Whanganui	94		▲
10	Bay of Plenty	94		–
11	Taranaki	94		–
12	Hutt Valley	94		–
13	Canterbury	93		▼
14	Northland	93		–
15	Hawke's Bay	92		–
16	MidCentral	91		▼
17	Lakes	91		▲
18	Southern	90		▼
19	Waikato	89		▼
20	Capital & Coast	85		▼
	All DHBs	93		–

Shorter stays in Emergency Departments

The target is 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours. The target is a measure of the efficiency of flow of acute (urgent) patients through public hospitals, and home again.

Improved access to Elective Surgery

		Quarter one performance (%)	100%	Progress against plan (discharges)
1	Northland	125		▲
2	Tairawhiti	122		▲
3	Whanganui	121		▲
4	Taranaki	112		▲
5	MidCentral	112		▲
6	Counties Manukau	110		▲
7	Waikato	108		▲
8	Hutt Valley	108		▲
9	Nelson Marlborough	107		▲
10	Lakes	106		▲
11	Waitemata	105		▲
12	Southern	105		▲
13	West Coast	104		▲
14	Bay of Plenty	103		▲
15	Canterbury	99		▼
16	Capital & Coast	97		▼
17	Hawke's Bay	97		▼
18	Wairarapa	94		▼
19	Auckland	93		▼
20	South Canterbury	91		▼
	All DHBs	105		▲

Improved access to elective surgery

The target is an increase in the volume of elective surgery by an average of 4,000 discharges per year. DHBs planned to deliver 49,227 discharges for the year to date, and have delivered 2,395 more.

Faster Cancer Treatment

		Quarter one performance (%)	85%	Change from previous quarter
1	Waitemata	86		▲
2	Capital & Coast	84		–
3	Nelson Marlborough	83		▲
4	Bay of Plenty	82		▲
5	Waikato	81		▲
6	Southern	79		▲
7	Auckland	79		▲
8	Lakes	78		▲
9	Canterbury	78		▲
10	MidCentral	77		▲
11	South Canterbury	77		▲
12	Whanganui	76		▼
13	Northland	76		▲
14	Counties Manukau	75		▲
15	Taranaki	74		▼
16	Tairawhiti	74		▲
17	Wairarapa	73		▲
18	Hawke's Bay	66		▼
19	Hutt Valley	65		▼
20	West Coast	63		▼
	All DHBs	78		▲

Faster cancer treatment

The target is 85 percent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks, increasing to 90 percent by June 2017. Results cover those patients who received their first cancer treatment between 1 April 2016 and 30 September 2016.

Increased Immunisation

		Quarter one performance (%)	95%	Change from previous quarter
1	Hutt Valley	96		–
2	Hawke's Bay	95		–
3	South Canterbury	95		▲
4	Canterbury	95		–
5	MidCentral	95		–
6	Southern	95		▲
7	Whanganui	94		–
8	Capital & Coast	94		▲
9	Wairarapa	94		▼
10	Auckland	94		–
11	Counties Manukau	94		▼
12	Waitemata	94		▲
13	Waikato	92		▲
14	Taranaki	92		▼
15	Northland	91		▲
16	Tairawhiti	91		▲
17	Lakes	90		▼
18	Nelson Marlborough	89		▼
19	Bay of Plenty	86		–
20	West Coast	76		▼
	All DHBs	93		–

Increased immunisation

The national immunisation target is 95 percent of eight-month-olds have their primary course of immunisation at six weeks, three months and five months on time. This quarterly progress result includes children who turned eight-months between July and September 2016 and who were fully immunised at that stage.

Better help for Smokers to Quit

		Quarter one performance (%)	90%	Change from previous quarter
1	Lakes	90		–
2	Nelson Marlborough	89		–
3	Counties Manukau	89		▼
4	Tairawhiti	89		▼
5	Canterbury	89		–
6	Bay of Plenty	88		▲
7	Waitemata	87		▼
8	Waikato	87		▼
9	Auckland	87		▼
10	MidCentral	87		–
11	Wairarapa	87		–
12	South Canterbury	86		▼
13	Taranaki	86		▼
14	Capital & Coast	85		▲
15	Whanganui	85		▼
16	West Coast	84		▲
17	Northland	84		▼
18	Southern	83		▼
19	Hawke's Bay	81		–
20	Hutt Valley	80		▼
	All DHBs	87		▼

Better help for smokers to quit

The target is 90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.

The hospital target is no longer a health target, results will continue to be reported on the Ministry's website along with the maternity target results.

Raising Healthy Kids

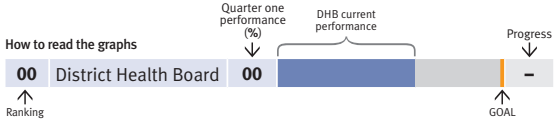
		Quarter one performance (%)	95%	Change from previous quarter*
1	Waitemata	83		NA
2	Auckland	79		NA
3	South Canterbury	71		NA
4	Northland	70		NA
5	MidCentral	66		NA
6	Lakes	62		NA
7	Tairawhiti	56		NA
8	Hutt Valley	53		NA
9	Southern	49		NA
10	Whanganui	47		NA
11	Waikato	47		NA
12	Canterbury	46		NA
13	West Coast	40		NA
14	Nelson Marlborough	33		NA
15	Counties Manukau	29		NA
16	Wairarapa	29		NA
17	Taranaki	28		NA
18	Hawke's Bay	27		NA
19	Capital & Coast	25		NA
20	Bay of Plenty	17		NA
	All DHBs	49		NA

Raising healthy kids

The target is that by December 2017, 95 percent of obese children identified in the Before School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions. Data is based on all acknowledged referrals for obese children up to the end of the quarter from Before School Checks occurring in the six months between 1 March and 31 August 2016.

*As this is the first time these results are being reported there is no comparison with the previous quarter.

How to read the graphs



Health target results are sourced from individual DHB reports, national collections systems and information provided by primary care organisations.

This information should be read in conjunction with the details on the website www.health.govt.nz/healthtargets

New Zealand Government

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report, October 2016** 128
	For the attention of: **HBDHB Board and the Finance Risk and Audit Committee (FRAC)**
Document Owner: Document Author(s):	Tim Evans, GM Planning, Informatics & Finance Finance Team
Reviewed by:	Executive Management Team
Month:	November 2016
Consideration:	For Information

9

RECOMMENDATION

That the Board and FRAC
Note the contents of this report

1. GM Planning Informatics & Finance comments

Financial performance

The result for the month of October is an adverse variance of $48 thousand making a year to date adverse variance of $251 thousand. A probable adverse Inter District Flow (IDF) has not been fully reflected below. Raw IDF information is being analysed and tested, and an update will be provided at the board meeting. Costs relating to the RMO strike have been included in corporate costs.

2. Resource Overview

	October				Year to Date				Year End Forecast	Refer Section
	Actual	Budget	Variance		Actual	Budget	Variance			
	$'000	$'000	$'000	%	$'000	$'000	$'000	%	$'000	
Net Result - surplus/(deficit)	2,424	2,472	(48)	-1.9%	4,319	4,570	(251)	-5.5%	5,000	3
Contingency utilised	-	250	250	100.0%	-	1,000	1,000	100.0%	3,000	8
Quality and financial improvement	397	1,076	(679)	-63.1%	2,661	4,333	(1,672)	-38.6%	13,000	11
Capital spend	1,032	1,753	(721)	-41.1%	2,902	7,012	(4,109)	-58.6%	22,042	16
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,175	2,125	(51)	-2.4%	2,188	2,178	(10)	-0.4%	2,202	5 & 7
	CWD	CWD	CWD	%	CWD	CWD	CWD	%	CWD	
Case weighted discharges	2,767	2,361	406	17.2%	10,303	9,838	465	4.7%	27,609	5

Low ACC and co-payment income, high medical vacancy and leave cover, the RMO strike, and unachieved efficiencies, were mostly offset in October by lower than planned mental health and health of older people payments and low new investment expenditure.

No contingency funds have been released. Revenue banking has been excluded from the contingency figure above. See Section 8 – Reserves for a reconciliation of the contingency and revenue banking.

Quality and Financial Improvement (QFI) programme savings are running behind plan due to timing differences with some plans expected to deliver their savings later in the year.

Capital continues behind plan. A number of projects have not started at the estimated times projected in the capital plan, and later than planned purchase of some large clinical equipment items going through the trial process has also impacted timing.

The FTE variance year to date reflects high patient volume in some areas, efficiencies not yet achieved, unbudgeted leave cover including long term sick leave, and cover for employees undergoing training.

Case weighted discharges (CWD) reflect high acute volumes year to date, including gastroenterology, paediatrics and surgery. Elective CWDs are lower than plan especially in orthopaedics and vascular surgery.

3. Financial Performance Summary

	October				***Year to Date***				***Year End Forecast***	Refer Section
$'000	***Actual***	***Budget***	***Variance***		***Actual***	***Budget***	***Variance***			
Income	43,543	43,653	(110)	-0.3%	176,508	175,651	857	-0.5%	532,441	4
Less:										
Providing Health Services	19,595	18,933	(662)	-3.5%	81,419	79,627	(1,792)	-2.3%	245,681	5
Funding Other Providers	18,542	18,931	389	2.1%	75,410	76,016	606	0.8%	228,008	6
Corporate Services	3,296	3,221	(75)	-2.3%	15,220	14,792	(428)	-2.9%	48,422	7
Reserves	(314)	97	**411**	**425.0%**	139	646	**507**	**78.4%**	5,330	8
	2,424	**2,472**	**(48)**	**-1.9%**	**4,319**	**4,570**	**(251)**	**-5.5%**	**5,000**	

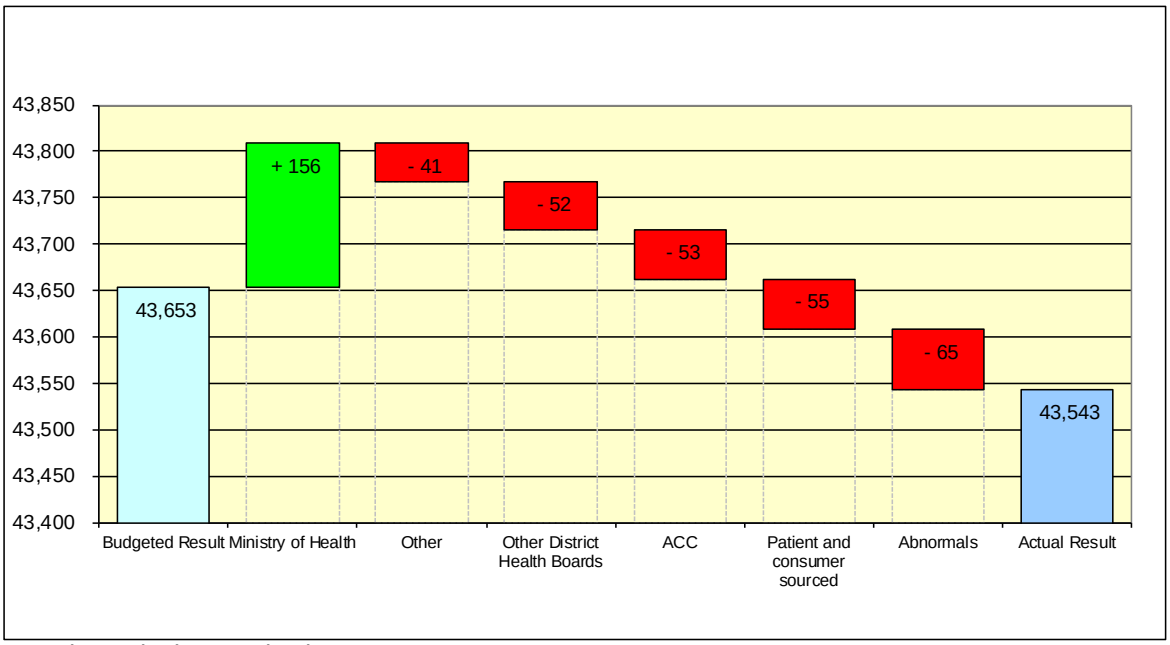
Provisions for new investment were released in October. This both recognises that later than planned implementation will reduce the cost in the current year, and also provides more time for the implementation of efficiencies.

Lower ACC and co-payment income due to resource constraints, higher than budgeted medical vacancy and leave cover, and RMO strike costs, were mostly offset in October by lower than planned mental health and health of older people payments.

4. Income

$'000	October Actual	October Budget	October Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Ministry of Health	41,694	41,538	156	0.4%	168,587	167,438	1,149	0.7%	507,930
Inter District Flows	629	629	(0)	0.0%	2,681	2,515	166	6.6%	7,545
Other District Health Boards	281	334	(52)	-15.7%	1,163	1,334	(171)	-12.8%	4,004
Financing	84	66	18	26.5%	254	294	(40)	-13.7%	885
ACC	440	493	(53)	-10.8%	1,855	2,003	(148)	-7.4%	5,980
Other Government	40	76	(35)	-46.7%	141	179	(38)	-21.4%	444
Patient and Consumer Sourced	64	119	(55)	-46.0%	330	481	(151)	-31.5%	1,447
Other Income	311	334	(23)	-6.9%	1,506	1,340	166	12.4%	4,140
Abnormals	-	65	(65)	-100.0%	(10)	66	(76)	-115.8%	67
	43,543	**43,653**	(110)	-0.3%	**176,508**	**175,651**	857	0.5%	**532,441**

October Income



Note the scale does not begin at zero

Ministry of Health (favourable)
Recognition of Health Promoting Schools funding, and DSS income for the Child Development Unit.

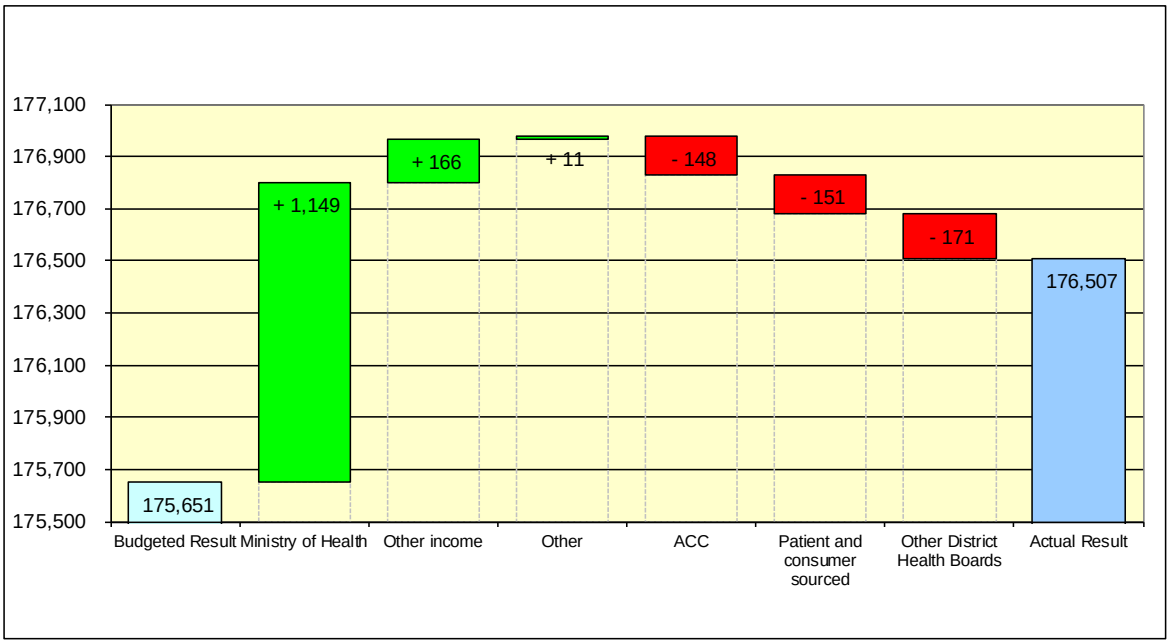
Other District Health Boards (unfavourable)
Lower than budgeted cancer drug sales to Tairawhiti DHB.

ACC (unfavourable)
Lower ACC elective volumes due to capacity constraints.

Patient and consumer sourced (unfavourable)
Lower than budgeted non-resident, dental and audiology co-payments.

Abnormals (unfavourable)
Income for the national patients flow project received and recognised earlier than budgeted.

October YTD



Ministry Of Health (favourable)
Funding a high cost patient and child development funding.

Other income (favourable)
Unbudgeted donations and clinical trial income.

ACC (unfavourable)
Lower ACC elective volumes due to capacity constraints.

Patient and Consumer Sourced (unfavourable)
Lower than budgeted non-resident, audiology and NASC recoveries.

Other District Health Boards (unfavourable)
Lower than budgeted cancer drug sales to Tairawhiti DHB, marginally offset by patient transport recoveries from a number of DHBs.

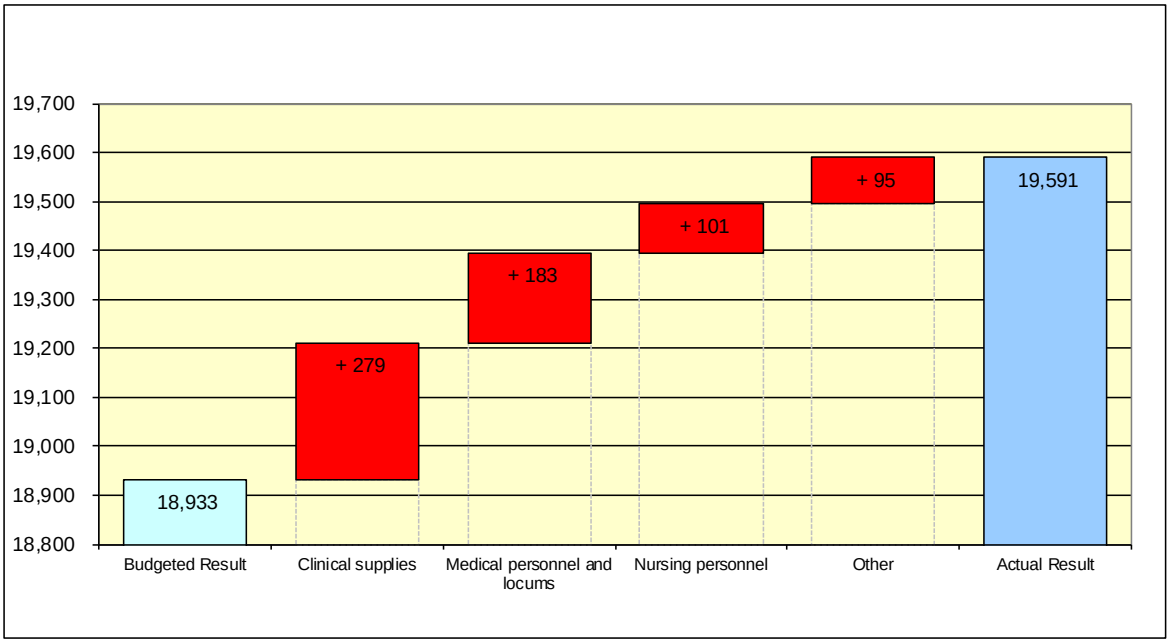
5. Providing Health Services

	October				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure by type $'000									
Medical personnel and locums	4,475	4,291	(183)	-4.3%	17,888	18,272	385	2.1%	58,566
Nursing personnel	5,760	5,659	(101)	-1.8%	23,736	23,225	(511)	-2.2%	72,813
Allied health personnel	2,589	2,634	45	1.7%	10,607	10,979	372	3.4%	33,107
Other personnel	1,649	1,625	(25)	-1.5%	7,246	6,920	(326)	-4.7%	20,984
Outsourced services	717	653	**(64)**	**-9.8%**	2,871	2,795	(76)	-2.7%	8,017
Clinical supplies	2,712	2,433	**(279)**	**-11.5%**	12,228	10,893	**(1,334)**	**-12.2%**	32,849
Infrastructure and non clinical	1,689	1,638	(52)	-3.2%	6,841	6,543	(298)	-4.6%	19,347
	19,591	**18,933**	**(658)**	**-3.5%**	**81,416**	**79,627**	**(1,788)**	**-2.2%**	**245,681**
Expenditure by directorate $'000									
Acute and Medical	5,453	5,111	**(342)**	**-6.7%**	22,078	21,057	(1,021)	-4.8%	66,170
Surgical Services	4,275	4,150	(126)	-3.0%	18,191	17,479	(713)	-4.1%	54,219
Women Children and Youth	1,601	1,520	**(80)**	**-5.3%**	6,573	6,338	(235)	-3.7%	19,594
Older Persons & Mental Health	2,641	2,545	(96)	-3.8%	10,868	10,753	(115)	-1.1%	33,269
Rural, Oral and Communlty	1,737	1,735	(2)	-0.1%	7,440	7,178	(262)	-3.7%	21,852
Other	3,884	3,871	(13)	-0.3%	16,265	16,823	558	3.3%	50,577
	19,591	**18,933**	**(658)**	**-3.5%**	**81,416**	**79,627**	**(1,788)**	**-2.2%**	**245,681**
Full Time Equivalents									
Medical personnel	296.3	289.7	(7)	-2.3%	306	305	(1)	-0.4%	313.8
Nursing personnel	897.5	871.9	(26)	-2.9%	894	876	(18)	-2.0%	891.3
Allied health personnel	431.7	438.1	6	1.5%	434	451	17	3.8%	449.5
Support personnel	133.1	122.6	**(10)**	**-8.5%**	131	126	(5)	-3.8%	127.5
Management and administration	250.2	232.5	**(18)**	**-7.6%**	254	244	(10)	-4.0%	244.7
	2,008.8	**1,954.8**	**(54)**	**-2.8%**	**2,018**	**2,002**	**(16)**	**-0.8%**	**2,026.8**
Case Weighted Discharges									
Acute	1,717	1,659	58	3.5%	7,328	6,790	**538**	**7.9%**	18,713
Elective	456	516	**(60)**	**-11.6%**	2,073	2,228	**(155)**	**-7.0%**	6,451
Maternity	520	147	**373**	**254.7%**	691	671	19	2.9%	2,000
IDF Inflows	74	39	35	89.5%	211	149	**62**	**41.5%**	445
	2,767	**2,361**	**406**	**17.2%**	**10,303**	**9,838**	**465**	**4.7%**	**27,609**

Directorates

- Acute and Medical includes vacancy and leave cover for medical staff, efficiencies not achieved, oncology and gastrointestinal pharmaceutical costs, and respiratory and renal, and ED nursing personnel.
- Women Children and Youth relates to additional medical personnel and nursing costs in Ata Rangi and SCBU.

October Expenditure



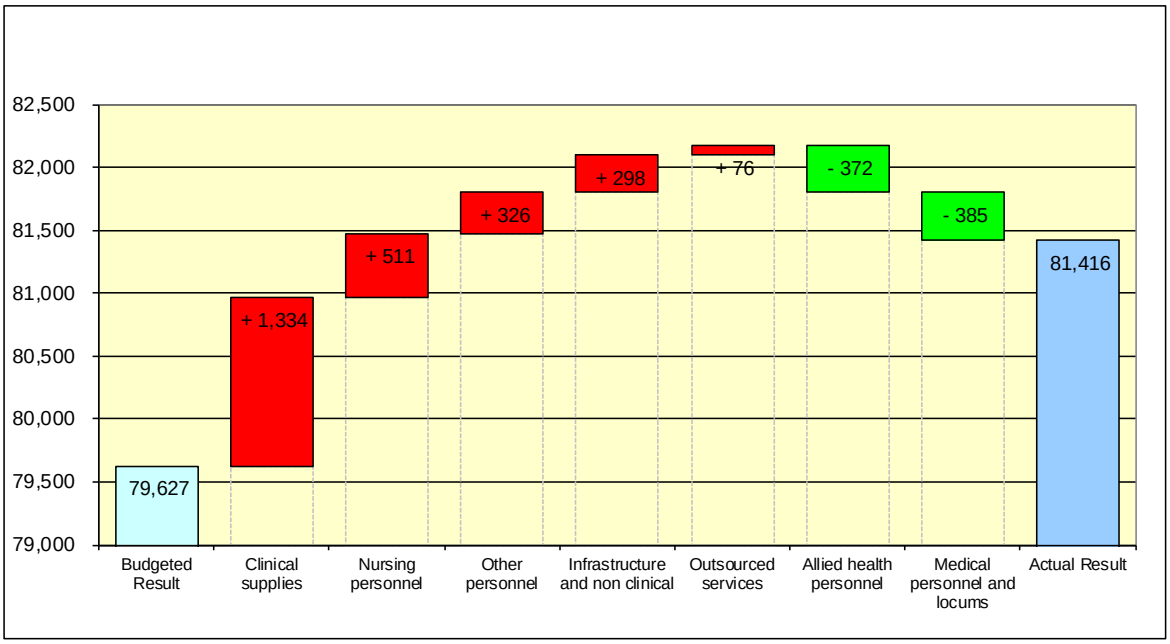
Note the scale does not begin at zero

Clinical supplies (unfavourable)
Efficiencies not achieved partly offset by lower than budgeted implant and prostheses costs.

Medical personnel and locums (unfavourable)
Strike costs are excluded from this section (see section 7 – Corporate). Vacancies, leave and retirements reduced medical personnel costs, but were significantly offset by SMO locum cover costs.

Nursing personnel (unfavourable)
Higher than budgeted annual leave and study leave costs, higher duties allowances, penal payments mainly in ED, overtime payments mainly in Haemodialysis.

October YTD Expenditure



Clinical supplies (unfavourable)
Efficiencies not yet achieved.

Nursing personnel (unfavourable)
Leave provisioning, overtime, higher than budgeted penal and higher duties allowances, and extra staffing (mainly in July).

Other personnel (unfavourable)
Payments to retiring staff, administration efficiencies not being achieved, and sick leave, long service leave and training costs.

Infrastructure and non-clinical (unfavourable)
Mental health efficiencies to be achieved elsewhere, hostel renovations in Wairoa, maintenance costs.

Outsourced services (unfavourable)
Respite beds and child health income treated as costs for consolidation purposes, partly offset by lower laboratory send-away costs.

Allied Health personnel (favourable)
Mental health vacancies including psychologists and community support. These positions have been steadily being filled since the start of the year.

Medical personnel and locums (favourable)
Release of 2015/16 unpaid allowances accrual

Full time equivalents (FTE)

FTEs are 16 unfavourable year to date including:

Nursing personnel (18 FTE / 2.0% unfavourable)

- Higher than budgeted staffing in certain areas including: ED, rural and community services, A1 and B2 medical wards, and Ata Rangi, partly offset by the low use of the surgical overflow ward.

Support personnel (5 FTE / 3.8% unfavourable)

- Leave cover, long term sick leave, and training, mainly impacting on orderlies and kitchen assistants.

Management and administration personnel (10 FTE 4.0% unfavourable)

- Minimal leave cover not coping with high workloads and long term sick leave. Hours related retirement payments.

mostly offset by:

Allied Health Personnel (17 FTE / 3.8% favourable)

- Vacancies mainly in psychologists and social workers, community support, pharmacists and pharmacy technicians, and MRTs

Medical FTEs are marginally unfavourable for the month, as unbudgeted positions offset vacancies and leave cover. The impact of the unbudgeted positions is consequently reflected in outsourced medical costs rather than FTE numbers.

MONTHLY ELECTIVE HEALTH TARGET REPORT
YTD To October 2016

Plan for 2016/17	On-Site	Outsourced	IDF Outflow	TOTAL
Non Surgical - Arranged	70		0	**70**
Non Surgical - Elective	187		0	**187**
Surgical - Arranged	390		307	**697**
Surgical - Elective	5,003	788	629	**6,420**
TOTAL	**5,650**	**788**	**936**	**7,374**

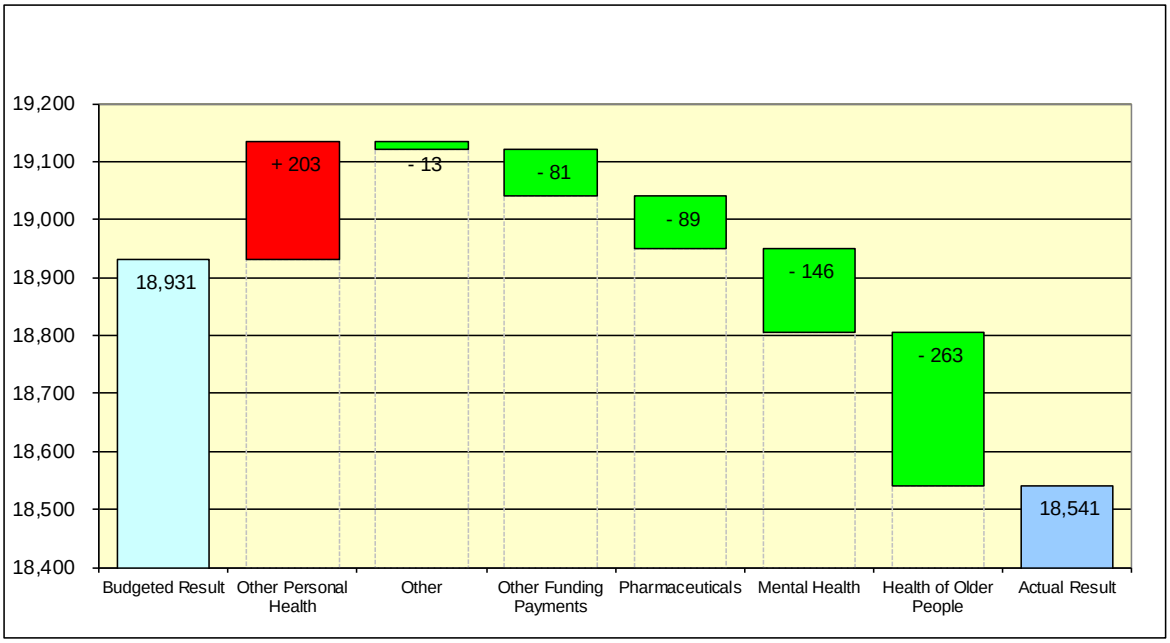
		YTD October 2016				Oct-16				
		Actual	Plan	Var.	%Var.		Actual	Plan	Var.	%Var.
On-Site	Avastins	68	68	0	0.0%	On-Site	16	16	0	0.0%
	ENT	169	195	-26	-13.3%		34	44	-10	-22.7%
	General Surgery	267	305	-38	-12.5%		52	69	-17	-24.6%
	Gynaecology	212	172	40	23.3%		44	39	5	12.8%
	Maxillo-Facial	60	63	-3	-4.8%		14	14	0	0.0%
	Ophthalmology	291	362	-71	-19.6%		84	84	0	0.0%
	Orthopaedics	272	303	-31	-10.2%		42	68	-26	-38.2%
	Skin Lesions	60	60	0	0.0%		14	14	0	0.0%
	Urology	162	147	15	10.2%		39	33	6	18.2%
	Vascular	62	47	15	31.9%		12	11	1	9.1%
	Surgical - Arranged	192	163	29	17.8%		51	51	0	0.0%
	Non Surgical - Elective	25	64	-39	-60.9%		1	15	-14	-93.3%
	Non Surgical - Arranged	9	23	-14	-60.9%		2	7	-5	-71.4%
On-Site	**Total**	**1849**	**1972**	**-123**	**-6.2%**	**On-Site**	**405**	**465**	**-60**	**-12.9%**
Outsourced	Cardiothoracic	0	15	-15	-100.0%	Outsourced	0	3	-3	-100.0%
	ENT	69	46	23	50.0%		18	13	5	38.5%
	General Surgery	84	87	-3	-3.4%		21	23	-2	-8.7%
	Gynaecology	10	10	0	0.0%		2	4	-2	-50.0%
	Maxillo-Facial	11	21	-10	-47.6%		6	7	-1	-14.3%
	Neurosurgery	0	6	-6	-100.0%		0	2	-2	-100.0%
	Ophthalmology	44	12	32	266.7%		33	4	29	725.0%
	Orthopaedics	15	30	-15	-50.0%		13	10	3	30.0%
	Paediatric Surgery	0	2	-2	-100.0%		0	0	0	0.0%
	Urology	34	26	8	30.8%		14	7	7	100.0%
	Vascular	10	14	-4	-28.6%		2	3	-1	-33.3%
	Surgical - Arranged	0	0	0	0.0%		0	0	0	0.0%
	Non Surgical - Elective	0	0	0	0.0%		0	0	0	0.0%
	Non Surgical - Arranged	0	0	0	0.0%		0	0	0	0.0%
Outsourced	**Total**	**277**	**269**	**8**	**3.0%**	**Outsourced**	**109**	**76**	**33**	**43.4%**
IDF Outflow	Cardiothoracic	22	25	-3	-12.0%	IDF Outflow	3	6	-3	-50.0%
	ENT	10	15	-5	-33.3%		1	3	-2	-66.7%
	General Surgery	11	16	-5	-31.3%		4	4	0	0.0%
	Gynaecology	15	8	7	87.5%		5	2	3	150.0%
	Maxillo-Facial	62	66	-4	-6.1%		9	15	-6	-40.0%
	Neurosurgery	28	14	14	100.0%		4	3	1	33.3%
	Ophthalmology	7	10	-3	-30.0%		1	2	-1	-50.0%
	Orthopaedics	11	6	5	83.3%		0	2	-2	-100.0%
	Paediatric Surgery	21	16	5	31.3%		9	4	5	125.0%
	Skin Lesions	13	25	-12	-48.0%		0	6	-6	-100.0%
	Urology	8	2	6	300.0%		2	1	1	0.0%
	Vascular	4	5	-1	-20.0%		2	1	1	100.0%
	Surgical - Arranged	56	99	-43	-43.4%		10	23	-13	-56.5%
	Non Surgical - Elective	43	0	43	0.0%		11	0	11	0.0%
	Non Surgical - Arranged	12	0	12	0.0%		2	0	2	0.0%
IDF Outflow	**Total**	**323**	**307**	**16**	**5.2%**	**IDF Outflow**	**63**	**72**	**-9**	**-12.5%**
TOTAL		**2449**	**2548**	**-99**	**-3.9%**	**TOTAL**	**577**	**613**	**-36**	**-5.9%**

Please Note: This report was run on 7th November 2016. Skin Lesions and Avastins have been adjusted to plan.

6. Funding Other Providers

$'000	October Actual	October Budget	October Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Payments to Other Providers									
Pharmaceuticals	3,567	3,656	89	2.4%	14,743	14,880	136	0.9%	43,351
Primary Health Organisations	2,831	2,859	28	1.0%	11,458	11,655	197	1.7%	35,401
Inter District Flows	3,791	3,776	(15)	-0.4%	15,314	15,106	(208)	-1.4%	45,317
Other Personal Health	2,074	1,871	**(203)**	**-10.9%**	8,074	7,304	**(771)**	**-10.5%**	22,651
Mental Health	1,002	1,148	**146**	**12.7%**	4,314	4,574	**260**	**5.7%**	13,761
Health of Older People	4,895	5,159	**263**	**5.1%**	19,921	20,635	714	3.5%	61,928
Other Funding Payments	381	462	**81**	**17.6%**	1,585	1,862	**277**	**14.9%**	5,599
	18,542	18,931	389	2.1%	**75,410**	**76,016**	606	0.8%	228,008
Payments by Portfolio									
Strategic Services									
Secondary Care	4,045	3,898	(147)	-3.8%	16,292	15,592	(700)	-4.5%	46,778
Primary Care	7,698	7,758	60	0.8%	31,522	31,627	105	0.3%	94,684
Mental Health	1,137	1,131	(6)	-0.6%	4,449	4,523	74	1.6%	13,574
Health of Older People	4,932	5,215	**282**	**5.4%**	20,178	20,841	663	3.2%	62,582
Other Health Funding	(37)	89	**125**	**141.7%**	234	354	**120**	**34.0%**	1,063
Maori Health	443	529	**86**	**16.3%**	1,873	2,129	**257**	**12.1%**	6,403
Population Health									
Women, Child and Youth	226	208	(17)	-8.4%	449	522	**73**	**13.9%**	1,669
Population Health	98	104	5	5.1%	412	426	14	3.3%	1,255
	18,542	18,931	389	2.1%	**75,410**	**76,016**	606	0.8%	228,008

October Expenditure



Note the scale does not begin at zero

Other Personal Health (unfavourable)
IDF wash-up provisions for 2016/17.

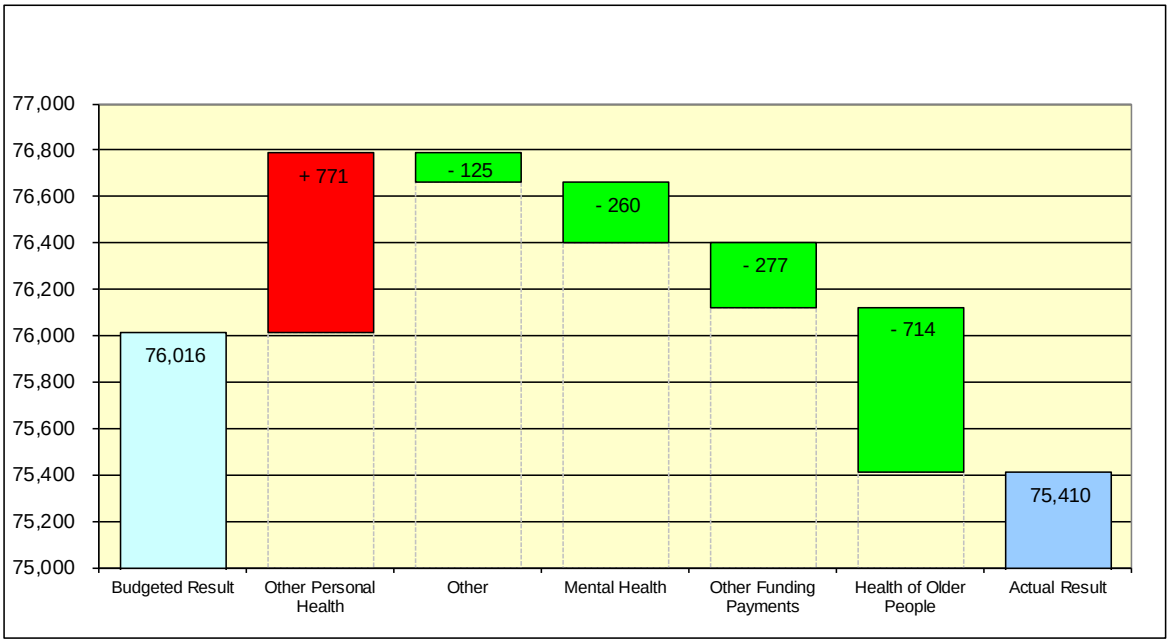
Other Funding Payments (favourable)
Reduced payments for Maori primary health services

Pharmaceuticals (favourable)
Volatile demand driven expenditure, close to budget year to date.

Mental Health (favourable)
Lower crisis respite and community residential costs.

Health of Older People (favourable)
Lower than planned home support, residential care, and aging in place costs.

October YTD Expenditure



Other Personal Health (unfavourable)
High cost patient treatment, IDF wash-up provisions for 2016/17, and .

Mental Health (favourable)
Lower crisis respite and community residential costs.

Other Funding Payments (favourable)
Lower costs in Maori primary health

Health of Older People (favourable)
Lower residential care costs partly offset by higher home support.

7. Corporate Services

$'000	October Actual	October Budget	October Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Operating Expenditure									
Personnel	1,400	1,188	(211)	-17.8%	5,615	5,080	(535)	-10.5%	15,136
Outsourced services	121	94	(27)	-29.1%	423	376	(47)	-12.4%	1,092
Clinical supplies	9	9	0	1.0%	48	38	(10)	-27.1%	114
Infrastructure and non clinical	465	620	155	24.9%	3,908	4,085	176	4.3%	8,956
	1,996	1,912	(84)	-4.4%	9,994	9,578	(415)	-4.3%	25,298
Capital servicing									
Depreciation and amortisation	1,158	1,144	(14)	-1.2%	4,567	4,558	(10)	-0.2%	13,887
Financing	142	165	23	13.9%	659	656	(3)	-0.5%	2,052
Capital charge	-	-	-	0.0%	-	-	-	0.0%	7,186
	1,300	1,309	9	0.7%	5,226	5,213	(13)	-0.2%	23,125
	3,296	**3,221**	(75)	-2.3%	**15,220**	**14,792**	(428)	-2.9%	**48,422**
Full Time Equivalents									
Medical personnel	1.8	0.3	(1)	-546.2%	1	0	(0)	-74.6%	0.3
Nursing personnel	14.2	15.4	1	7.8%	12	16	3	20.8%	15.5
Allied health personnel	0.5	4.3	4	89.0%	0	4	4	89.8%	4.4
Support personnel	10.1	9.1	(1)	-12.1%	9	9	(0)	-0.6%	9.4
Management and administration	139.8	140.8	1	0.7%	147	146	(0)	-0.2%	146.0
	166.4	**169.7**	3	2.0%	**170**	**176**	7	3.7%	**175.6**

Personnel costs includes the cost of strike cover and management training. Infrastructure and non-clinical reflects a reduction in the provision for the Regional Health Informatics Programme (RHIP).

8. Reserves

$'000	October Actual	October Budget	October Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Expenditure									
Contingency	(30)	(30)	0	0.0%	66	66	0	0.0%	3,863
Transform and Sustain resource	24	59	35	59.3%	89	252	163	64.6%	593
Other	(308)	68	376	554.6%	(16)	328	344	105.0%	874
	(314)	**97**	411	425.0%	**139**	**646**	507	78.4%	**5,330**

Contingency budgets transferred to operational costs reconcile as follows:

	$'000
Original contingency budget	3,000
Plus:	
Revenue banking	4,200
Less:	
Additional surplus agreed with MOH	-500
Feasibility studies	-600
Elective surgery delivery costs	-1,942
Melanoma and oncology treatments	-295
Remaining contingency budget (per above table)	3,863

The provision for new investment projects was removed in October, reflecting expenses unlikely to be incurred in 2016/17 due to later than planned implementation. Similarly some transformational projects are starting later than planned.

9. Financial Performance by MOH Classification

	October			Year to Date			End of Year		
$'000	Actual	Annual Plan	Variance	Actual	Annual Plan	Variance	Forecast	Annual Plan	Variance
Funding									
Income	41,752	41,609	143 F	169,650	168,470	1,180 F	511,773	511,773	-
Less:									
Payments to Internal Providers	22,154	22,049	(106) U	94,839	94,554	(285) U	278,344	278,344	-
Payments to Other Providers	18,542	18,931	389 F	75,410	76,016	606 F	228,008	228,008	-
Contribution	**1,056**	**629**	**427 F**	**(599)**	**(2,100)**	**1,501 F**	**5,422**	**5,422**	**-**
Governance and Funding Admin.									
Funding	268	266	2 F	1,067	1,065	2 F	3,197	3,197	-
Other Income	3	3	-	10	10	-	30	30	-
Less:									
Expenditure	226	269	43 F	985	1,075	90 F	3,227	3,227	-
Contribution	**45**	**0**	**45 F**	**92**	**(0)**	**92 F**	**0**	**0**	**-**
Health Provision									
Funding	21,886	21,782	104 F	93,772	93,489	283 F	275,147	275,147	-
Other Income	1,788	2,042	(254) U	6,848	7,171	(323) U	20,638	20,638	-
Less:									
Expenditure	22,351	21,982	(370) U	95,794	93,990	(1,803) U	296,207	296,207	-
Contribution	**1,323**	**1,842**	**(520) U**	**4,826**	**6,669**	**(1,843) U**	**(422)**	**(422)**	**-**
Net Result	**2,424**	**2,472**	**(48) U**	**4,319**	**4,570**	**(251) U**	**5,000**	**5,000**	**-**

The table above reports the result in the classifications used by the Ministry of Health, and against the projections in the Annual Plan. Those projections differ from the budgets used elsewhere in this report as outlined in the table below.

10. Management Budget Movements

Changes are made to Annual Plan projections so that managers are accountable for budgets that are relevant and up-to-date. The Management budget is used for internal reporting and the annual plan is used for MOH and statutory reporting. The net result is the same in both budgets.

The major changes between revenue and expense lines are usually due to health provision savings programmes. As these numbers have firmed up some savings programmes are around growing revenue rather than reducing costs. In 2016/17 changes to the operation of the price volume schedule (payments by the funder to the provider arm) will also create movements between the annual plan and the management budget.

	October			*Year to Date*			*End of Year*		
$'000	*Mgmt Budget*	*Annual Plan*	*Movement*	*Mgmt Budget*	*Annual Plan*	*Movement*	*Mgmt Budget*	*Annual Plan*	*Movement*
Funding									
Income	41,609	41,759	(150) U	168,470	168,739	(269) U	511,773	511,803	(30) U
Less:									
Payments to Internal Providers	22,049	21,937	(112) U	94,554	93,459	(1,095) U	278,344	275,461	(2,882) U
Payments to Other Providers	18,931	19,204	273 F	76,016	77,142	1,126 F	228,008	231,341	3,334 F
Contribution	**629**	**619**	**11 F**	**(2,100)**	**(1,861)**	**(238) U**	**5,422**	**5,000**	**422 F**
Governance and Funding Admin.									
Funding	266	268	(2) U	1,065	1,073	(8) U	3,197	3,220	(23) U
Other Income	3	3	-	10	10	-	30	30	-
Less:									
Expenditure	269	271	2 F	1,075	1,083	8 F	3,227	3,250	23 F
Contribution	**0**	**-**	**0 F**	**(0)**	**-**	**(0) U**	**0**	**-**	**0 F**
Health Provision									
Funding	21,782	21,668	114 F	93,489	92,386	1,103 F	275,147	272,241	2,905 F
Other Income	2,042	2,014	28 F	7,171	7,082	88 F	20,638	20,366	272 F
Less:									
Expenditure	21,982	21,830	(152) U	93,990	93,037	(953) U	296,207	292,608	(3,599) U
Contribution	**1,842**	**1,853**	**(11) U**	**6,669**	**6,431**	**238 F**	**(422)**	**(0)**	**(422) U**
Net Result	**2,472**	**2,472**	**-**	**4,570**	**4,570**	**-**	**5,000**	**5,000**	**-**

11. Quality and Financial Improvement Programme

Row Labels	Sum of Planned Savings	Sum of ytd savings target	Sum of YTD actual Savings	%age Savings Achieved
Corporate	1,526,792	508,931	385,371	76%
Health Services	8,292,086	2,764,029	1,600,585	58%
Population Hea	26,166	8,722	8,722	100%
Maori	148,195	49,398	49,398	100%
Health Funding	3,006,808	1,002,269	617,375	62%
Grand Total	**13,000,047**	**4,333,349**	**2,661,451**	**61%**

Health Services

Year to date health services are achieving 58% of their savings target.

Row Labels	Sum of Planned Savings	Sum of ytd savings target	Sum of YTD actual Savings	%age Savings Achieved
Acute Medical	2,407,323	802,441	466,256	58%
COO	158,496	52,832	26,416	50%
FAC	793,458	264,486	47,030	18%
Lab	460,566	153,522	153,522	100%
Mental	444,579	148,193	148,193	100%
OPRS	600,850	200,283	97,733	49%
Pharm	77,638	25,879	25,879	100%
ROC	533,349	177,783	177,783	100%
Surgical	2,092,648	697,549	357,563	51%
WCY	723,180	241,060	100,209	42%
Grand Total	**8,292,086**	**2,764,029**	**1,600,585**	**58%**

Most of the YTD shortfall is due to timing of the savings plans. These plans are phased 1/12th mainly to avoid back-loading of savings plans into the second half of the year. Some of the savings plans will deliver higher levels of savings over the summer months as activity levels reduce.

Facilities and Operational Support savings are impacted by administration and patient transport workloads that are making realisation of savings difficult.

Corporate

Row Labels	Sum of Planned Savings	Sum of ytd savings target	Sum of YTD actual Savings	%age Savings Achieved
Business Intelli	32,892	10,964	7,960	73%
CEO	159,640	53,213	39,935	75%
Contracts	14,527	4,842	4,842	100%
DAHST	2,142	714	714	100%
Depreciation	517,008	172,336	129,219	75%
DON	10,587	3,529	3,529	100%
Finance	184,195	61,398	58,313	95%
Governance	78,148	26,049	6,296	24%
Human Resourc	123,967	41,322	-	0%
Information Se	344,360	114,787	114,787	100%
Quality	59,326	19,775	19,775	100%
Grand Total	**1,526,792**	**508,931**	**385,371**	**76%**

CEO savings are affected by retirement payments, whose impact will reduce and be offset steadily throughout the year.

Governance savings are affected by legal fees, whose impact will also reduce progressively over the year.

Human resources savings are affected by additional resources applied to management restructuring.

12. Financial Position

30 June		*October*				*Annual*
2016	$'000	*Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2016*	*Budget*
	Equity					
102,608	Crown equity and reserves	102,608	105,733	3,125	-	105,376
(10,973)	Accumulated deficit	(6,654)	(11,699)	(5,045)	4,319	(11,268)
91,635		95,954	94,034	(1,920)	4,319	94,108
	Represented by:					
	Current Assets					
15,552	Bank	22,843	5,843	(17,000)	7,291	8,523
1,724	Bank deposits > 90 days	1,732	1,741	9	8	1,741
22,433	Prepayments and receivables	15,189	18,362	3,173	(7,244)	18,618
4,293	Inventory	4,202	3,989	(214)	(91)	4,044
1,220	Non current assets held for sale	1,220	1,220	-	-	-
45,222		45,187	31,155	(14,032)	(35)	32,927
	Non Current Assets					
151,944	Property, plant and equipment	150,419	160,451	10,032	(1,525)	166,159
2,037	Intangible assets	1,868	1,041	(826)	(170)	665
9,777	Investments	10,430	8,635	(1,795)	653	9,476
163,758		162,716	170,127	7,411	(1,042)	176,299
208,980	**Total Assets**	**207,904**	**201,283**	**(6,621)**	**(1,077)**	**209,226**
	Liabilities					
	Current Liabilities					
-	Bank overdraft	-	-	-	-	-
38,137	Payables	32,362	30,651	(1,711)	(5,775)	30,697
34,070	Employee entitlements	34,449	31,703	(2,747)	379	34,484
-	Current portion of borrowings	-	-	-	-	6,000
72,208		66,812	62,354	(4,458)	(5,396)	71,180
	Non Current Liabilities					
2,638	Employee entitlements	2,638	2,394	(244)	-	2,438
42,500	Term borrowing	42,500	42,500	-	-	41,500
45,138		45,138	44,894	(244)	-	43,938
117,345	**Total Liabilities**	**111,949**	**107,248**	**(4,701)**	**(5,396)**	**115,118**
91,635	**Net Assets**	**95,954**	**94,034**	**(1,920)**	**4,319**	**94,108**

The variance from budget for:

- Bank reflects lower capital spend, higher payables and employee entitlement balances, and higher prepayments and receivables;
- Property, plant and equipment relates to slower than planned expenditure on capital projects;
- Employee entitlements – see below

13. Employee Entitlements

30 June		*October*				*Annual*
2016	$'000	*Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2016*	*Budget*
7,466	Salaries & wages accrued	9,109	6,184	(2,925)	1,643	6,559
482	ACC levy provisions	805	552	(253)	323	851
5,348	Continuing medical education	4,354	4,074	(280)	(994)	5,131
19,149	Accrued leave	18,632	19,230	598	(516)	20,249
4,263	Long service leave & retirement grat.	4,187	4,056	(130)	(76)	4,131
36,708	**Total Employee Entitlements**	37,087	34,097	(2,990)	379	36,922

14. Treasury

Liquidity management

The surplus cash of all DHBs is managed by NZ Health Partnerships Limited under a sweep arrangement facilitated by Westpac. The DHB provides forecast cash flow information to NZHPL, to allow them to invest the funds at the most advantageous rates, and uses the same information to ensure the DHB has the funds to meet its obligations as they fall due.

Debt management

The term debt facility with MOH is for $42.5 million, and is fully drawn. A further $5 million relating to the disposal of the Napier site, is available for the mental health build, and is likely to be drawn down in the last quarter of calendar 2016. The DHBs interest exposure is managed through a spread of maturity dates, rather than the use of derivative financial instruments, and the average cost of borrowing is currently 4.58%. No debt will become current until the 2017/18 financial year, and $25 million is for terms longer than five years.

The drawdown of $6.5 million in June 2012 increased the amount maturing in March 2019 to $11.5 million. This was done to take advantage of the low interest rate applying to that maturity, but it also puts the balance for that year above the $10 million limit set in the Treasury Management Policy.

Foreign exchange risk management

No material transactions occurred during the month. No transactions met the criteria that would trigger the requirement to arrange foreign exchange rate cover.

15. Capital Expenditure

See next page.

2017 Annual Plan		*Actual $'000*	*Year to Date Budget $'000*	*Variance $'000*
	Source of Funds			
	Operating Sources			
14,440	Depreciation	4,567	4,558	(10)
5,000	Surplus/(Deficit)	4,319	4,570	251
(2,479)	Working Capital	(5,653)	(1,831)	3,822
16,961		3,233	7,297	4,063
	Other Sources			
-	Special funds and clinical trials	28	-	(28)
1,220	Sale of assets	-	-	-
5,000	Borrowings	-	-	-
6,220		28	-	(28)
23,181	**Total funds sourced**	**3,262**	**7,297**	**4,035**
	Application of Funds:			
	Block Allocations			
3,183	Facilities	710	1,061	351
3,125	Information Services	69	1,042	972
5,464	Clinical Plant & Equipment	914	1,821	907
11,772		1,693	3,923	2,230
	Local Strategic			
2,460	MRI	-	820	820
500	Renal Centralised Development	39	167	127
3,000	New Stand-alone Endoscopy Unit	416	1,000	584
710	New Mental Health Inpatient Unit Development	248	237	(11)
100	Maternity Services	126	33	(93)
400	Upgrade old MHIU	319	452	133
400	Travel Plan	13	133	120
400	Histology Upgrade	-	14	14
1,100	Fluoroscopy Unit	-	367	367
200	Education Centre Upgrade	-	(133)	(133)
9,270		1,161	3,089	1,928
	Other			
-	Special funds and clinical trials	28	-	(28)
1,000	New Technologies/Investments	-	-	-
-	Other	19	-	(19)
1,000		48	-	(48)
22,042	***Capital Spend***	***2,902***	***7,012***	***4,109***
	Regional Strategic			
1,139	RHIP (formerly CRISP)	360	285	(75)
1,139		360	285	(75)
23,181	**Total funds applied**	**3,262**	**7,297**	**4,035**

16. Rolling Cash Flow

	Actual	October Forecast	Variance	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast	Jul Budget	Aug Budget	Sep Budget	Oct Budget
Cash flows from operating activities															
Cash receipts from Crown agencies	43,302	52,018	(8,716)	45,123	42,029	43,288	45,233	42,011	43,230	38,306	53,213	43,210	41,712	45,478	52,018
Cash receipts from revenue banking	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from donations, bequests and clinical trials	4	-	4	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	6,762	492	6,271	432	439	428	448	455	447	455	451	426	425	427	492
Cash paid to suppliers	(26,043)	(24,932)	(1,111)	(28,245)	(25,817)	(25,670)	(23,015)	(25,798)	(25,452)	(24,172)	(29,745)	(27,144)	(25,118)	(27,069)	(24,932)
Cash paid to employees	(15,013)	(15,100)	87	(17,754)	(14,438)	(16,693)	(14,472)	(19,536)	(15,263)	(17,897)	(15,594)	(13,909)	(19,483)	(15,098)	(15,100)
Cash generated from operations	**9,012**	**12,478**	**(3,466)**	**(444)**	**2,213**	**1,354**	**8,194**	**(2,868)**	**2,961**	**(3,309)**	**8,325**	**2,582**	**(2,463)**	**3,738**	**12,478**
Interest received	84	66	18	80	72	75	68	75	73	75	73	81	80	67	66
Interest paid	(292)	(41)	(251)	(69)	(160)	(359)	(325)	(139)	(60)	(14)	(150)	(330)	(330)	(95)	(41)
Capital charge paid	-	-	-	-	(3,636)	-	-	-	-	-	(3,576)	-	-	-	-
Net cash inflow/(outflow) from operating activities	**8,804**	**12,503**	**(3,699)**	**(433)**	**(1,511)**	**1,069**	**7,937**	**(2,931)**	**2,974**	**(3,248)**	**4,672**	**2,332**	**(2,713)**	**3,709**	**12,503**
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	-	0	(0)	0	625	0	0	0	0	0	0	0	0	0	0
Acquisition of property, plant and equipment	(1,032)	(1,568)	536	(1,648)	(1,638)	(1,632)	(1,972)	(2,107)	(2,006)	(1,875)	(2,193)	(2,511)	(2,511)	(2,511)	(2,511)
Acquisition of intangible assets	-	(20)	20	(286)	(200)	(265)	(295)	(340)	(265)	(115)	(70)	(85)	(85)	(85)	(85)
Acquisition of investments	(181)	-	(181)	(652)	(301)	(8)	-	(1,075)	-	-	(284)	-	-	(285)	-
Net cash inflow/(outflow) from investing activities	**(1,213)**	**(1,588)**	**375**	**(2,586)**	**(1,514)**	**(1,905)**	**(2,267)**	**(3,522)**	**(2,271)**	**(1,990)**	**(2,547)**	**(2,596)**	**(2,596)**	**(2,881)**	**(2,596)**
Cash flows from financing activities															
Proceeds from equity injection	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Proceeds from borrowings	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Repayment of finance leases	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Equity repayment to the Crown	-	-	-	-	-	-	-	-	-	-	(357)	-	-	-	-
Net cash inflow/(outflow) from financing activities	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**(357)**	**-**	**-**	**-**	**-**
Net increase/(decrease) in cash or cash equivalents	7,591	10,915	(3,324)	(3,019)	(3,025)	(836)	5,670	(6,454)	703	(5,238)	1,767	(264)	(5,309)	828	9,907
Add:Opening cash	16,984	16,984	-	24,575	21,555	18,530	17,694	23,364	16,911	17,613	12,375	14,143	13,879	8,569	9,398
Cash and cash equivalents at end of year	**24,575**	**27,899**	**(3,324)**	**21,555**	**18,530**	**17,694**	**23,364**	**16,911**	**17,613**	**12,375**	**14,143**	**13,879**	**8,569**	**9,398**	**19,305**
Cash and cash equivalents															
Cash	4	7	(3)	7	7	7	7	7	7	7	7	7	7	7	7
Short term investments (excl. special funds/clinical trials)	21,373	24,797	(3,424)	18,453	15,428	14,592	20,262	13,808	14,511	9,273	11,040	10,777	5,467	6,295	16,203
Short term investments (special funds/clinical trials)	2,972	3,095	(123)	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095
Bank overdraft	226	-	226	-	-	-	-	-	-	-	-	-	-	-	-
	24,576	**12,004**	**(3,324)**	**21,555**	**18,530**	**17,694**	**23,364**	**16,910**	**17,613**	**12,375**	**14,142**	**13,879**	**8,569**	**9,397**	**19,305**

10

BOARD HEALTH & SAFETY CHAMPION'S UPDATE

Verbal

HAWKE'S BAY
District Health Board
Whakawāteatia

CONSUMER STORY

11

Verbal Presentation

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Clinical Council joined by HB Health Consumer Council** 129
	For the attention of: **HBDHB Board**
Document Owner:	Chris McKenna, Dr Mark Peterson as Co-Chairs of Clinical Council; and Graeme Norton as Chair of Consumer Council
Document Author:	Brenda Crene, Board Administrator
Reviewed by:	Not applicable
Month:	November, 2016
Consideration:	For Information

RECOMMENDATION

That the Board

Review the contents of this report.

Note that **Clinical and Consumer Council** endorsed the following for board Approval:

- **Approved** the 13-17 Year Old Primary Care Zero Rated subsidy selecting Option One.
- **Endorsed** the System Level Measures report pending consideration of the feedback provided, prior to being issued to the Board for approval with submission to MoH by due date.
- **Endorsed** Alcohol Related Harm Reduction Position statement to go to the Board for adoption
- **Endorsed** Transform and Sustain Refresh and the proposed 19 refreshed projects.

Clinical Council met on 9 November 2016 for an extended afternoon meeting. Clinical Council considered their specific agenda initially and were then joined by Consumer Council members for discussion around topics of mutual interest.

This was followed by a Combined Palliative Care and Advanced Care Planning workshop with a number of additional participants joining the meeting at that time.

The Clinical Council specific topics discussed included:

- ***RMO Strike Update***

  An update was received on the strike action taken in October 2016 which overall was managed well. 200 outpatient appointments and 43 operations had to be cancelled; with no real reduction in attendance at ED, or referrals in from primary care. Further RMO strike action had been issued for 23-25 November. Leave approvals for clinical staff to attend professional development conferences would pose a problem should this action take place.

- ***Learnings from the ICU Review 2013***

  The CMO advised the processes for reviews had changed with improved oversight of report recommendations and action plans. Regular updates will continue to be received by Clinical Council until all recommendations are complete.

- ***Clinical Governance Structure Update***

  This remains work in progress and once finalised, the framework would provide added assurance to HBDHB Board around governance. Meetings with chairs of the advisory groups had taken place with several Clinical Council members already involved in these advisory groups. Further Council participation in the other three groups was required with expressions of interest sought.

- ***Allied Professions Forum***

  An overview was provided on the areas Allied had been working on which included staffing, training and support of current staff, developing new staff and new service models. The Co-Chair noted a challenge was the ability to free up study time and funding that. The CAHPO commented that they are working on developing a training hub as part of the workforce development strategy. Part of this included some funding initiatives and the ability to back fill with allied health professionals.

- ***Laboratory Specimens Labelling Improvement Initiative***

  The Board requested an update on laboratory errors at their October meeting. Council subsequently received an evaluation report at their November meeting. It was advised a review group meet bi-monthly to look at new learnings and support for staff. A "consequences process" were implemented, resulting in some real and sustainable changes being observed in an historically "hard to achieve" area. There are also synergies within Pharmacy and Radiology being focused on. We are now seeing some positive change in the trends.

Updates were received from the following Committees who report to Clinical Council:

- ***HB Clinical Research Committee:*** The Term of Reference for the Committee together with membership would be reviewed at the next meeting.

- ***Laboratory Services Committee:*** A quarterly update was received, with a number of resignations noted. An accreditation visit occurred in mid October with no new corrective actions advised from this visit. Work is continuing on building a new histology lab with Board approval received for the provision of clinical pathology expertise to the Laboratory. Plan also to review microbiology.

Consumer members joined the meeting at 2.00pm with the following items discussed, all of which have be provided in November or December

- ***13-17 Year Old Primary Care Zero Rated Subsidy (November Board Agenda)***

  This proposition evolved from a Health Sector Leadership Forum originally, following which a number of options had been presented following which it was noted that a universal approach to all of the population was just not affordable and to focus on Wairoa and other depravation 8, 9 and 10 areas.

  During consultation with GP practices, the PHO and some groups of young people from deprived areas - the feedback received was noted as being very similar. GPs acknowledged that cost was a factor and that the current model of care was not always responsive to young people. Youth advised the same. This proposition removes cost as a barrier but also asks primary care practices to change their model of care to be more "youth friendly".

  Primary Care had advised they preferred Option 1. The cost to implement this is quoted as being just over $60,000 more than Clinical Council had allocated, however all practices would not participate, therefore it was highly likely to come in under budget.

  Following discussion Clinical and Consumer Council approved the content of the report and supported recommendation Option 1.

- ***System Level Measures (November FRAC Agenda for Information)***

  An overview of what system level measures were and the collaborative effort between the hospital (secondary care) and primary care to work together and what needed to be achieved, in summary:

  1. Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0–4 year olds (i.e. Keeping children out of the hospital)
  2. Acute hospital bed days per capita (i.e. Using health resources effectively)
  3. Patient experience of care (i.e. Person centred care)
  4. Amenable Mortality rates (i.e. Prevention and early detection)

  Two joint primary and secondary care workshops had been held to brainstorm ideas and subsequent meetings held to refine the plan. The plan was then submitted to the Ministry of Health for review and some changes were required.

  This was a great opportunity to develop a framework for Hawke's Bay that was more valuable and meaningful for our population. Year one would be around educating primary and secondary on what system level measures are. The Ministry have provided a framework and they want to see primary and secondary working together developing the plan for Hawke's Bay. The PHO proposed in their payment structure to general practice in year one, that they monitor attendance and incentivise general practice to get around the table.

  Following active discussion the Clinical and Consumer Council members endorsed the content of the report and supported the recommendations.

- ***Alcohol Harm Reduction Position Statement (November Board Agenda)***

  Since Clinical and Consumer Council's had reviewed a draft in July 2016, this draft position statement had been prepared for endorsement by Council's for adoption by the Board.

  It was noted there had been unanimous support for a position statement on reducing alcohol related harm. There was a desire for the statement to be "punchy and positive", the vision was whanau and community oriented and it was an opportunity for engagement and further collaboration. This was about working in partnership with the community via iwi lead strategies, consistent messaging and integrating with other work being undertaken including fetal alcohol, youth strategy, family violence and the with councils around the alcohol strategy. It was acknowledged this was a societal issue and there will be no quick fixes!

  This is an opportunity for the DHB to take the lead and be part of the solution to move forward on this issue.

  The Clinical and Consumer Councils fully endorsed the position statement and the recommendation for the Board to adopt the position statement.

- ***Transform & Sustain Refresh (December Board Agenda)***

  The paper articulated the outputs of the projects from the transform and sustain refresh process which had been brought together in a series of work streams.

  Feedback received included the need to have leadership, partnership and integration a lot stronger. It was noted there were signs of organisational fatigue with staff who had project work as part of their roles, having competing priorities with project work being de-prioritised.

  Endorsement was approved by Clinical and Consumer Councils for the 19 projects proposed.

- ***Urgent Care (brief provided to the Board in October)***

  The current status was conveyed with a Request for Proposal (RFP) in abeyance, at the request of the parties that were working together, to come up with a proposal to co-locate a GP after hours service in Hastings close to the Emergency Department as a priority. The timeframe for the GP after hours to be in place is April 2017.

  The remaining were two work streams being the advanced practitioner workforce and aged residential care have options identified in the paper for approval.

There is a lot of work being done around training and staffing and this includes the involvement of the Allied Health workforce (as there is a lot of synergy between Allied Health and Nursing).

The Business Case is due to the Board in December 2016.

The following papers have been provided to the Board in November but were not discussed by Council at their November meeting:

- *Travel Plan Update*
- *Regional Tobacco Strategy for HB (2015-2020)*
- *Te Ara Whakawaiora / Smoke Free*
- *The Annual Maori Plan Q1 was not available at the time of the meeting and would be received by Council's and MRB in December.*

The following paper was provided to Council's for information with no discussion and will be provided to the Board in February 2017, together with the Orthopaedic phase 2 draft.

- *Orthopaedic Review – closure of phase 1*

WORKSHOP ON PALLIATIVE CARE and ADVANCED CARE PLANNING

Feedback was captured from Clinical and Consumer Council, however with further consultation planned with stakeholders, a final report will be brought back in early 2017 for Board consideration.

OURHEALTH HAWKE'S BAY Whakawateatia	**Reappointment to HB Clinical Council** 130 For the attention of: **HBDHB Board and Health Hawke's Bay Ltd Board**
Document Owner:	Ken Foote, Company Secretary
Reviewed by:	Not applicable
Month:	November 2016
Consideration:	For Endorsement

13

RECOMMENDATION

That the Board endorse the CEO's approval to reappoint David Warrington for a second term, expiring September 2019.

The attached memo to the Chief Executives of HBDHB and Health Hawke's Bay Ltd has been prepared and submitted in accordance with the Terms of Reference of the Hawke's Bay Clinical Council. The memo provides some background to the recommendation, and the CEO's approval.

It is now recommended that both Boards endorse this reappointment.

HAWKE'S BAY
District Health Board
Whakawāteatia

Memo

To:	**Kevin Snee, CEO HBDHB** **Nicola Ehau, Acting CEO Health Hawke's Bay**
From:	Ken Foote, HBDHB Company Secretary
Date:	29 September 2015
Subject:	**Reappointment to Clinical Council – David Warrington**

In accordance with the Clinical Council Terms of Reference and tenure of appointed members, David Warrington's first term on Council expires this month. Given this, last month Council co-Chairs issued an "Expression of Interest" request for a potential replacement / reappointment. A selection process was then followed for those who responded to this EOI.

From this process, David Warrington has now been recommended for re-appointment for a second term. In making this recommendation, the panel noted "David has the requisite skills for Council and additionally his participation has been excellent during his current tenure."

RECOMMENDATION

That David Warrington be reappointed for a second term on Clinical Council, expiring September 2019.

APPROVAL

We approve the above recommendation

Kevin Snee
CEO HBDHB

3/10/16
Date

Nicola Ehau
Acting CEO, Health Hawke's Bay Ltd

4/10/16
Date

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board (MRB)** 131
	For the attention of: **HBDHB Board**
Document Owner:	Heather Skipworth (Chair)
Reviewed by:	Not applicable
Month:	November, 2016
Consideration:	For Information

14

RECOMMENDATION

That the Board

Review the contents of this report; and

Note that MRB:

- **Endorsed** the proposed new projects of Transform and Sustain Programme Refresh **pending consideration** of their feedback
- **Endorsed the HEAT tool being embedded into Project methodology**
- **Endorsed** the Clinical Council recommendations for the 13-17 Year Old Primary Care Zero Fees Subsidy Project for the Board, **pending** the inclusion of the Implementation Plan and Evaluation Framework to be incorporated
- **Endorsed** the Alcohol Related Harm Reduction Position Statement for adoption by the Board **pending** consideration of their feedback
- **Noted that** further consultation with the community on the Palliative Care in Hawke's Bay Draft Plan is underway. MRB provided feedback for inclusion into the plan.

MRB met on 9 November 2016, an overview of issues discussed and/or agreed at the meeting are provided below.

The following papers were considered:

- ***Transform And Sustain Refresh***

MRB noted the contents of the report and **endorsed** the proposed new projects in consideration of the following feedback.

- Demonstrate how whānau, hapu and Iwi will be measured and illustrate how whānau would provide feedback. The current the measures are for individuals only?
- Demonstrate how whānau capability will be assessed and measured to ensure their ability to take care of their whānau is achievable and sustainable. In addition, ensure any service change does not impact on the whānau
- Endorsed the proposal for the Health Equity Assessment Tool (HEAT) to be embedded into project methodology

- Identify the links between what success looks like for Kahungunu, Toiora and Transform and Sustain and add to the Transform and Sustain programme

- ***13-17 Year Old Primary Care Zero Fees Subsidy Project***

MRB **endorsed** the Clinical Council recommendations pending the inclusion of an Implementation Plan and the Evaluation Framework for the Board.

MRB felt it would have been helpful if the following was included into the paper:

- Who and how cultural competency was incorporated into the implementation of the subsidy
- The changes that will be made by general practices
- An indigenous wellness approach be included into the delivery
- A project implementation plan be developed from the ground up
- Clear high level principles be included in the project.

The Whānau Wellness Card ending this year, covers all whānau. D Ratima was concerned that only youth will now receive free services instead of the entire whānau.

Tim Evans (General Manager Planning, Informatics and Finance) and Patrick LeGeyt (Programme Manager Māori Health) were congratulated for their efforts on this project. Patrick reciprocated the acknowledgement adding that this project is an example of one of the strategic proposals that MRB has driven that has now come to fruition.

- ***Alcohol Harm Reduction Position Statement***

MRB noted the contents and **endorsed** the Position Statement for adoption by the Board pending the following feedback:

- The vision was too narrow on alcohol and should incorporate substance abuse and how whānau actively participate in the community so that the vision overlays all strategies.
- Knowing what the end game looks like would be valuable, what success would look like
- Identify what the health sector and community are currently doing to reduce alcohol harm e.g. Health Hawke's Bay PHO, District Health Board (DHB) and Ngāti Kahungunu Iwi Inc. (NKII).
- Bearing in mind the drinking culture of gang whānau warrants this group should be included as champions in their community to shift behaviour.
- Target the right people in the communities that have a huge drinking culture e.g. gang whānau
- DHB to take leadership and be advocates
- Align the Alcohol Strategy with the Youth Strategy.

- ***Palliative in Hawke's Bay Draft Plan***

MRB noted further consultation with the community will follow and provided the following feedback on the draft plan below:

- The quote by Dame Cicely Saunders in the Executive Summary does not encompass the Māori world view of death as death in Māoridom is not the end.
- Aged Care Services is not necessarily the right facility to place palliative patients.
- Acknowledge the work and services of caregivers and taking into consideration the challenges of their work.
- Education around pain management is key for whānau.
- Having good navigation for support and services is essential for whānau.

Other discussions included:

- ***Fluoridation The Key Facts***

Dr Robin Whyman (Clinical Director Oral Health) and co-presenters Dr Bethany Jones (Neurologist) and Dr Kate Robertshaw (Neurodevelopmental Paediatrician) presented 'Fluoridation the Key Facts' and highlighted the following key points:

- The combination of oral health education, regular cleaning, lifestyle including nutrition i.e. reducing sugar and fluoridation are imperative to improving oral health. Without fluoridation teeth will become chalky and enamel damage will increase.
- Research about the side effects of fluoridation is inconclusive. There needs to be more robust research.
- Data information of low levels of fluoridation is negligible in terms of the impact of fluoridation on a child's brain development.

Dr Whyman and co-presenters were thanked for an informative presentation that was very helpful and valuable. MRB were not able to endorse the Te Ara Whakawaiora: Oral Health report presented earlier in June because more information was required to make an informed decision. The presentation was to be circulated to members to review the information provided. Any further feedback was to be emailed and collated to make a decision on the paper by February 2017 when MRB next meet.

Chrissie Hape (Iwi/CYF Partnership Advisor, NKII) asked to note that NKIIs current focus is Ngā Wai Māori (Natural Water) and good quality water so from an Iwi perspective they are very interested in Fluoridation and the impacts on Wai Māori. Dr Adele Whyte (CEO, NKII) was interested in the demographic groups of the stats presented.

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Committee Structure and Meeting Schedule for 2017** 132
	For the attention of: **HBDHB Board**
Document Owner:	Ken Foote, Company Secretary
Reviewed by:	Executive Management Team
Month:	November 2016
Consideration:	For Decision

RECOMMENDATION

That the Board

1. Confirm the current governance committee structures and processes
2. Approve the attached Meeting Schedule for 2017.

GOVERNANCE COMMITTEE STRUCTURES

It is appropriate to at least once a year to review the governance committee structures operating within the DHB. These current structures are diagrammatically shown entitled "Governance Structures" on the following page.

Given that there appears to be general satisfaction with the existing structures, a review this year could be as simple as answering three key questions:

1. Is the current structure meeting the Board's needs?
2. If so, can the structures / processes be further improved?
3. If not, what needs to change?

It is acknowledged that there are some discussions going on with Ngati Kahungunu Iwi Inc about potentially enhancing the level and scope of HBDHB engaging with Maori. This could have a flow on impact on the role and function of MRB.

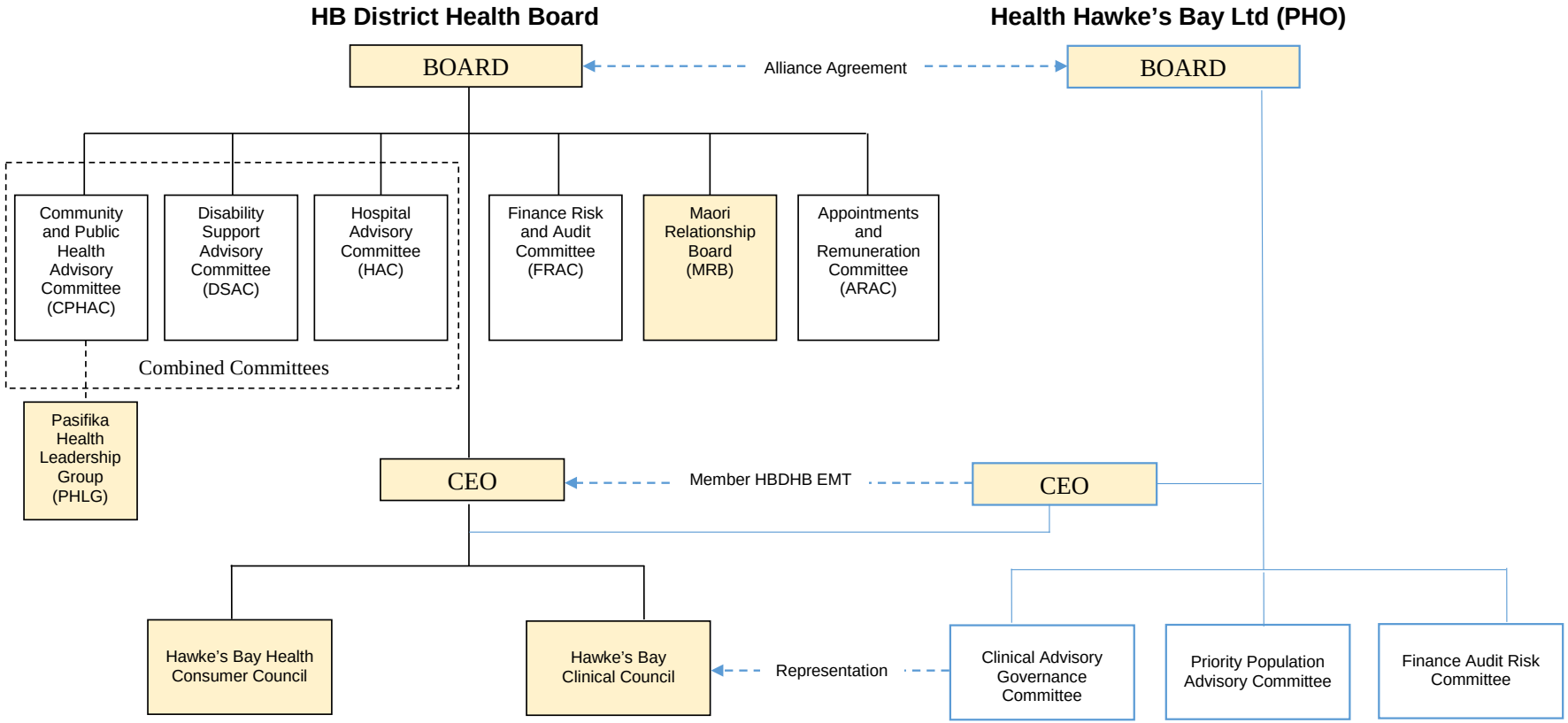
It is currently too early to anticipate this, so for planning purposes it has been assumed that MRB will continue to meet through 2017 under current arrangements. A similar assumption has been applied to all other committees on the basis that no changes will be made following the suggested review.

MEETING SCHEDULE 2017

This schedule attached (in calendar and monthly meeting form) reflects the same meeting structure / processes as in 2016.

Once approved, the intention will be to incorporate other regional and local health governance meetings into this schedule to provide a full overview, together with further formulation of indicative work plans.

HAWKE'S BAY HEALTH SECTOR GOVERNANCE STRUCTURES



- Hawke's Bay Heatlh Sector Leadership Forum
- Representation on Alliance Leadership Team (other than Pasifika Health Leadership Group)

Hawke's Bay District Health Board 2017

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Sun	1 NEW YEARS DAY									1		
Mon	2 Holiday				1					2		
Tue	3 Holiday				2			1		3		
Wed	4	1	1		3			2		4	1	
Thu	5	2	2		4	1		3		5	2	
Fri	6	3	3		5	2		4	1	6	3	1
Sat	7	4	4	1	6	3	1	5	2	7	4	2
Sun	8	5	5	2	7	4	2	6	3	8	5	3
Mon	9	6 WAITANGI DAY	6	3	8	5 QUEENS BIRTHDAY	3	7	4	9	6	4
Tue	10	7	7	4	9	6	4	8	5	10	7	5
Wed	11	8 MRB Clinical Council Consumer Council	8 Clinical Council Consumer Council	5	10 MRB Qtly Clinical Consumer Council	7	5	9 MRB Annual Clinical Consumer Council	6 Leadership Forum	11 MRB Clinical Council Consumer Council	8 MRB Qtly Clinical Consumer Council	6 Clinical Council Consumer Council
Thu	12	9	9	6	11	8	6	10	7	12	9	7
Fri	13	10	10	7	12	9	7	11	8	13	10	8
Sat	14	11	11	8	13	10	8	12	9	14	11	9
Sun	15	12	12	9	14	11	9	13	10	15	12	10
Mon	16	13	13	10	15	12	10	14	11	16	13	11
Tue	17	14	14	11	16	13	11	15	12	17	14	12
Wed	18	15	15 Leadership Forum	12 MRB Clinical Council Consumer Council	17	14 MRB Clinical Council Consumer Council	12 MRB Clinical Council Consumer Council	16	13 Clinical Council Consumer Council	18	15	13 FRAC BOARD
Thu	19	16	16	13	18	15	13	17	14	19	16	14
Fri	20	17	17	14 GOOD FRIDAY	19	16	14	18	15	20 HB ANNIVERSARY	17	15
Sat	21	18	18	15	20	17	15	19	16	21	18	16
Sun	22	19	19	16	21	18	16	20	17	22	19	17
Mon	23	20	20	17 EASTER MONDAY	22	19	17	21	18	23 LABOUR DAY	20	18
Tue	24	21	21	18	23	20	18	22	19	24	21	19
Wed	25	22 FRAC BOARD	22	19	24	21	19	23	20	25 FRAC BOARD	22	20
Thu	26	23	23	20	25	22	20	24	21	26	23	21
Fri	27	24	24	21	26	23	21	25	22	27	24	22
Sat	28	25	25	22	27	24	22	26	23	28	25	23
Sun	29	26	26	23	28	25	23	27	24	29	26	24
Mon	30	27	27	24	29	26	24	28	25	30	27	25 CHRISTMAS DAY
Tue	31	28	28	25 ANZAC DAY	30	27	25	29	26	31	28	26 BOXING DAY
Wed			29 FRAC BOARD	26 FRAC BOARD	31 FRAC BOARD	28 FRAC BOARD	26 FRAC BOARD	30 FRAC BOARD	27 FRAC BOARD		29 FRAC BOARD	27
Thu			30	27		29	27	31	28		30	28
Fri			31	28		30	28		29			29
Sat				29			29		30			30
Sun				30			30					31
Mon							31					
Tue												

15.1

HBDHB Meeting Schedule for 2017

Date	Meeting	Time(s)	Venue
February			
8 February 2017	Hawke's Bay Clinical Council	3.00-5.30pm	HBDHB Board Room
8 February 2017	Maori Relationship Board Meeting (MRB)	9.00am-noon	HBDHB Board Room
9 February 2017	HB Health Consumer Council	4.00-6.00pm	HBDHB Board Room
22 February 2017	Finance Risk & Audit Committee (FRAC)	10.00am-12.30pm	HBDHB Board Room
22 February 2017	HBDHB Board Meeting	1.00-4.00pm	HBDHB Board Room
March			
8 March 2017	Hawke's Bay Clinical Council	3.00-5.30pm	HBDHB Board Room
9 March 2017	HB Health Consumer Council	4.00-6.00pm	HBDHB Board Room
15 March 2017	***HB Health Sector Leadership Forum***	*8.30-3.00pm*	*Venue to be confirmed*
29 March 2017	Finance Risk & Audit Committee (FRAC)	10.00am-12.30pm	HBDHB Board Room
29 March 2017	HBDHB Board Meeting	1.00-4.00pm	HBDHB Board Room
April			
12 April 2017	Maori Relationship Board Meeting (MRB)	9.00am-noon	HBDHB Board Room
12 April 2017	Hawke's Bay Clinical Council	3.00-5.30pm	HBDHB Board Room
13 April 2017	HB Health Consumer Council	4.00-6.00pm	HBDHB Board Room
26 April 2017	Finance Risk & Audit Committee (FRAC)	10.00am-12.30pm	HBDHB Board Room
26 April 2017	HBDHB Board Meeting	1.00-4.00pm	HBDHB Board Room
May			
10 May 2017	Maori Relationship Board Meeting (MRB)	9.00am-noon	HBDHB Board Room
10 May 2017	HB Clinical Council – **Quarterly Meeting** part with Consumer Council	12.30pm-5.30pm	HBDHB Education Centre
31 May 2017	Finance Risk & Audit Committee (FRAC)	10.00am-12.30pm	HBDHB Board Room
31 May 2017	HBDHB Board Meeting	1.00-4.00pm	HBDHB Board Room
June			
14 June 2017	Maori Relationship Board Meeting (MRB)	9.00am-noon	HBDHB Board Room
14 June 2017	Hawke's Bay Clinical Council	3.00-5.30pm	HBDHB Board Room
15 June 2017	HB Health Consumer Council	4.00-6.00pm	HBDHB Board Room
28 June 2017	Finance Risk & Audit Committee (FRAC)	10.00am-12.30pm	HBDHB Board Room
28 June 2017	HBDHB Board Meeting	1.00-4.00pm	HBDHB Board Room
July			
12 July 2017	Maori Relationship Board Meeting (MRB)	9.00am-noon	HBDHB Board Room
12 July 2017	Hawke's Bay Clinical Council	3.00-5.30pm	HBDHB Board Room
13 July 2017	HB Health Consumer Council	4.00-6.00pm	HBDHB Board Room
26 July 2017	Finance Risk & Audit Committee (FRAC)	10.00am-12.30pm	HBDHB Board Room
26 July 2017	HBDHB Board Meeting	1.00-4.00pm	HBDHB Board Room
August			
9 August 2017	HB Clinical Council – **Annual Meeting**	12.30pm-5.30pm	*Venue to be confirmed*
10 August 2017	HB Health Consumer Council	4.00-6.00pm	HBDHB Board Room
30 August 2017	Finance Risk & Audit Committee (FRAC)	10.00am-12.30pm	HBDHB Board Room
30 August 2017	HBDHB Board Meeting	1.00-4.00pm	HBDHB Board Room
September			
6 September 2017	***HB Health Sector Leadership Forum***	*8.30-3.00pm*	*Venue to be confirmed*
13 September 2017	Maori Relationship Board Meeting (MRB)	9.00am-noon	HBDHB Board Room
13 September 2017	Hawke's Bay Clinical Council	3.00-5.30pm	HBDHB Board Room
14 September 2017	HB Health Consumer Council	4.00-6.00pm	HBDHB Board Room
27 September 2017	Finance Risk & Audit Committee (FRAC)	10.00am-12.30pm	HBDHB Board Room
27 September 2017	HBDHB Board Meeting	1.00-4.00pm	HBDHB Board Room
October			
11 October 2017	Maori Relationship Board Meeting (MRB)	9.00am-noon	HBDHB Board Room
11 October 2017	Hawke's Bay Clinical Council	3.00-5.30pm	HBDHB Board Room
12 October 2017	HB Health Consumer Council	4.00-6.00pm	HBDHB Board Room
25 October 2017	Finance Risk & Audit Committee (FRAC)	10.00am-12.30pm	HBDHB Board Room
25 October 2017	HBDHB Board Meeting	1.00-4.00pm	HBDHB Board Room
November			
8 November 2017	Maori Relationship Board Meeting (MRB)	9.00am-noon	HBDHB Board Room
8 November 2017	HB Clinical Council – **Quarterly Meeting** part with Consumer Council	12.30pm-5.30pm	*Venue to be confirmed*
29 November 2017	Finance Risk & Audit Committee (FRAC)	10.00am-12.30pm	HBDHB Board Room
29 November 2017	HBDHB Board Meeting	1.00-4.00pm	HBDHB Board Room
December			
6 December 2017	Hawke's Bay Clinical Council	3.00-5.30pm	HBDHB Board Room
7 December 2017	HB Health Consumer Council	4.00-6.00pm	HBDHB Board Room
13 December 2017	Finance Risk & Audit Committee (FRAC)	10.00am-12.30pm	HBDHB Board Room
13 December 2017	HBDHB Board Meeting	1.00-4.00pm	HBDHB Board Room
TBC	Pasifika Health Leadership Group (PHLG)	4.30-6.30pm	HBDHB Board Room
TBC	Pasifika Health Leadership Group (PHLG)	4.30-6.30pm	HBDHB Board Room
TBC	Pasifika Health Leadership Group (PHLG)	4.30-6.30pm	HBDHB Board Room
TBC	Pasifika Health Leadership Group (PHLG)	4.30-6.30pm	HBDHB Board Room

HAWKE'S BAY District Health Board Whakawāteatia	**13-17 Year Old Primary Care Zero Fees Subsidy Project** 133
	For the attention of: **Finance Risk and Audit Committee & HBDHB Board**
Document Owner: Document Author):	Tim Evans, GM Performance, Informatics & Finance Patrick LeGeyt, Programme Manager - Māori Health
Reviewed by:	Executive Management Team, Clinical & Consumer Council and the Māori Relationship Board
Month:	November, 2016
Consideration:	For Approval by HB Clinical Council For Discussion by MRB and HB Health Consumer Council For Consideration by FRAC For Decision by HBDHB Board

16

RECOMMENDATION

That HBDHB Board:

1. **Approve** funding Eligible General Practices within the geographical area of Wairoa, Napier, Hastings and CHB to provide zero fees to their 13-17yr old population.
   - Eligible practices include those with high enrolled Māori (84.5%) and Pacific (89.6%) 13-17 year olds; and
   - cover 67.7% of all enrolled 13-17 year olds
   - costs $583,235 ($63,235 over budget)
3. **Approve** the requirement of general practices within programme to make 'youth friendly' changes to the model of primary care;
4. **Approve** the Programme Level Measures;
5. **Endorse** the content of this report and acknowledge that further work is required to develop an implementation plan, outcomes and evaluation framework to reach a go live date of 1 January 2017.

BACKGROUND

In May 2015 a budget investment paper, containing three investment options, was submitted to HBDHB Clinical Council for consideration. The following options were supported:

- Extend Free Primary Care for all 13-17 years olds in Hawke's Bay
  a. Ring Fence the funding for targeted access to Decile 4 & 5 to Primary Care.
  b. Reduce the amount to $500,000 per annum; proposition to come back to Clinical Council.
- Extend Free Primary Care for all 13-17 year olds in Wairoa
  a. An estimated $20,000 per annum was approved

Consultation: Following consultation with ten general practices as well as Directions Youth Health service, HHB Priority Population Committee and HHB Clinical Advisory Group; as well as targeted groups of youth from Hastings, (Camberley, Flaxmere) and Wairoa, it was agreed that a programme be introduced that addressed zero fees and changes to the model of care with associated programme performance measures.
Barriers to access: Cost is recognised as the most significant barrier to access but other areas were also identified by youth as needing to be included in the model of care.

"What Youth have told us they want"

- No cost primary health services
- Integrated (health services) with youth social services and offer 'practical' support and not just 'quick advice'
- Telehealth and preappointment options needs to offered more fully
- Walk in clinic options
- Self-selection menu of services (electronic or tick box) should be offered at reception
- Consultation times need to be more generous
- Clinic locations closer to where they live
- Staff that specialise in youth health, are younger and from a variety of cultural backgrounds
- Staff need training to be more friendly, responsive and accommodating for youth

PROGRAMME APPROACH

1. Removal of Cost
Directly fund general practices with co-payment subsidy based on a utilisation rate of 2.15 per annum costed at $25.00 per consult, inclusive of a 25% buffer for potential increases.[1]

After hours consultation subsidy is also included and will be slightly higher at $40.00 per visit (utilization rate of 0.26 visits per annum per person) as well as a pharmacy subsidy of $5.00 per item, per GP consultation (see attached paper for breakdown of funding formula calculations, options and analysis).

2. Target high need – Māori and Pacific Population Groups
Practices with the above demographic have been consulted and their feedback on model of care sought. Currently it is anticipated that 14 practices will be included in the programme, which includes two practices aligned to The Doctors Hastings.

[1] Table 1.0 provides 'indicative' funding to practices identified that fit the criteria. However it is not certain that all practices identified will participate as it is a voluntary scheme. This could reduce the overall expenditure and/or provide for a redistribution of allocated funds. Furthermore, there is a funding differentiation between VLCA practices and non VLCA practices, and reducing the co-payment subsidy to $15 per consultation for VLCA practices would reduce the overall funding request to within budget.

3. Changes to Model of Care

General practices that agree to enter the zero fees subsidy programme will be expected to adopt changes to their model of care.

The overarching principles for the model are:

- Provide a range of 'youth friendly' clinical health services, staffed by health professionals who are well trained, skilled and knowledgeable in youth health.
- Provide comprehensive and 'joined up' youth friendly care.
- Work across sectors to encourage population, community, school and family level interventions that will improve the health of young people.

4. Implementation:

- There are currently fourteen practices[2] that have indicated an interest in being part of the program of work.
- To qualify for funding each practice will need to demonstrate a commitment to improving youth health outcomes through an agreed plan – developed with each of the practices.
- The funding received by the practices is a nominal figure of $25 per consultation calculated against their enrolled 13-17 year old population, and multiplied against a utilisation rate of 2.15 visits per annum.
- Within a number of practices the following services are current and will provide a further platform to develop the model of care
    - Sexual health contract provided free of charge to the person in Napier , Hastings and Central Hawke's Bay for youth up to and including 20 year olds, and in Wairoa for youth up to and including age 24 years.
    - Whanau wellness programme provided free of charge to the person and their whanau which includes pharmacy scripts.
    - PC/ED copperative which includes an intensive case management approach
    - A number of practices have also been supported to employ social work services and kaiawhina

Where these services are in place the implementation process will ensure alignment to the best use of funding or augments what's in place as appropriate.

The sum per practice ranges from $11,933 to $83,958 per annum. (Refer Table 1.0 below)

5. Programme Outcome Measures:[3]

Reduction in acute Emergency Department presentations and admissions for -

- Self -referred but not admitted Emergency Department attendance rate (in and out of hours)
- Serious Skin Infections
- Asthma
- Mental Health (presentations & admissions)

[2] Table 1.0 – lists practices identified that meet the criteria of the programme. Shaded practices are VLCA practices (Very Low Cost Access). Many of which offer low or no fees for the 0-18/20 age group

[3] The higher level programme outcome measures provide a challenge to ensure performance indicators included in the provider contract have a clear line of sight to what's intended. This will require utlising a broad base line with practices who are not recipients of the funding and would be part of the establishmnent stage.

Individual Practice Plans - Each practice plan will:

- be co designed with the practice staff and PHO practice development team and youth
- include baseline expectations that involve changes to model of care and zero fees.[4]
- include tailored measures that will contribute to the achievement of the program outcomes.

Tailored practice measures - would be specific to individual general practices and negotiated with each practice. Options would include but are not limited to;

- Increased utilisation of primary care (> 25%) over current utilisation rates
- Youth Friendly General Practices
- Engagement in youth specific training
- Alignment of practice to recognised Youth Health Standards[5]
- Inclusion of findings from practice specific Youth Health Satisfaction Surveys in model of care design

Funding - would dictate the scope of each practice plan, however all practices will be guided to address all items listed above. (The funding formula is provided in section: 'Removal of Cost' above. Table 1.0 below illustrates funding allocations per practice based on the formula).

Resources - used to guide Best Practice for the model would include the RNZGP Measures against the Youth Friendly General Practice Audit, and the Youth Health Standards developed in Counties Manukau DHB.

6. Alignment to the HBDHB Youth Health Strategy

This proposal, through its network of providers, development of practice plans and alignment to program outcomes, supports the HBDHB Youth Health Strategy implementation The four key outcomes identified internationally and within the youth strategy aligned to creating positive youth development are:

- Healthy and Safe thriving youth engaged in healthy active lives
- Engaged and inspired youth engaged in positive relationships with peers and seniors
- Productive learning and working environments where youth can achieve as participants and leaders
- Communities that encourage inclusiveness supported through adequate resources in strength based environments.

FINANCIAL IMPACT

Although the theoretical costing of this recommended option is $63,235 over this years budget, this potential overspend is not specifically addressed in this paper because:

- Costing is based on 100% uptake by all qualifying practices – which may not be the case.
- Implementation from 1 January 2017 will have only a 50% cost impact on this financial year.
- Data gathered over the first 3-4 months of implementation will assist with the practical calculation of the budget required for 2017-18.
- Any potential 'shortfall' in 2017-18 budget can be addressed through various optons at that time.

[4] It is important to note that a number of the practices already provide zero fees.
[5] 2006 (Draft) Youth Health Standards Commissioned by Counties Manukau

Table 1.0 – Funding Allocation

Napier	Existing Fees	Total	% MPI	General consult funding	Urgent care consult	Pharmacy funding (based on $5.00 per consult)	Full Utilisation costs
The Doctors - Napier	$27.00	1400	42%	$75,250	$14,560	$16,870	$106,680
Tamatea Medical	$28.00	453	32%	$24,349	$4,711	$5,459	$34,519
Maraenui Medical (VLCA)	$11.50	417	74%	$22,414	$4,337	$5,025	$31,775
						$0	
Wairoa	Fees	Total				$0	
Wairoa Medical (VLCA)	$12.00	106	66%	$5,698	$1,102	$1,277	$8,077
Queen St Medical (VLCA)	$11.50	222	84%	$11,933	$2,309	$2,675	$16,916
Health Care Centre Ltd (VLCA)	$11.50	245	79%	$13,169	$2,548	$2,952	$18,669
						$0	
Central Hawkes Bay	Fees	Total				$0	
The Doctors – Waipawa*	$24.00					$0	
Tuki Tuki Medical	$24.00	503	29%	$27,036	$5,231	$6,061	$38,329
						$0	
Hastings	Fees	Total				$0	
Totara Health (VLCA)	$0.00	1214	65%	$65,253	$12,626	$14,629	$92,507
Medical & Injury (VLCA)	$0.00	278	65%	$14,943	$2,891	$3,350	$21,184
Hauora Heretaunga (VLCA)	$0.00	590	93%	$31,713	$6,136	$7,110	$44,958
The Doctors - Hastings	$16.00	664	36%	$35,690	$6,906	$8,001	$50,597
The Doctors - Gascoigne St* (VLCA)	$11.00					$0	
Hastings Health Centre	$18.00	1562	25%	$83,958	$16,245	$18,822	$119,024
	Total Program funding p.a.			$411,403	$79,602	$92,231	$583,235
						Total funding available	$520,000
Urgent Care - based on $40.00 per consult at 0.26 consults p.a.						Variance	$63,235
Pharmacy - based on $5.00 per consult @2.41 consults (0.26 + 2.15 (UC+Genral conslut rate)) p.a.							

16

Appendix One

(Contains all background and appendices for the initial and subsequent papers)

1. Cost as a Barrier to Access to Primary Health Care

In New Zealand primary health care is heavily subsidised and the out of pocket expense of primary health care for consumers is relatively low. NZ is in the top quartile for government funded health care in the OECD countries with just over 80% of health costs funded by general government revenues.[6] Whilst the level of out-of-pocket contributions for health care in New Zealand is bottom quartile and, despite increased funding of primary health care, cost remains the most significant barrier of access for some population groups to primary health care in NZ.

The NZ Health Survey 2013-2014 found that cost is the most significant barrier to accessing primary care service in New Zealand. Those in the more highly deprived areas, on low-medium incomes, young people aged under 25 years of age, Māori and Pacific peoples, those who use more services, and those in poorer health, are more also likely than other New Zealanders to forego visits as a result of the cost of primary health care[7]. In Hawkes Bay, the survey found that youth (15-24 years) have higher rates of unmet need for primary care than NZ national average (34% compared to 23%).

NZ research has consistently shown significant inequities in access to, and use of, services. A number of studies have particularly focused on differences between Māori and non-Māori utilisation of health services.[8] Overall, the results suggest that in many cases Māori have less access to primary health care, relative to the whole population, particularly when proxies for need (e.g., mortality, hospital discharges) are taken into account. Poor access to primary health care for Māori is considered a key factor in higher rates of illness and hospitalisations, in generating poorer health outcomes and inequalities in health. Similarly, research available on Pacific peoples' experiences of health services shows that Pacific peoples living in New Zealand generally have poorer health status than other New Zealanders; are more exposed to risk factors for poor health, and experience barriers in accessing health services.[9]

Cost also contributes to some groups seeking out free health care from HBDHB Emergency Department (ED). This can be evidenced by a significant increase in ED presentations of 17.6% over the last 5 years. ED presentations grew by 5.6% in 2015 alone. Attendances by children (5-14 years) and youth (15-24 years), increased by 10.5% and 9.7% respectfully.[10] The high utilisation rates and low conversion rate to inpatient admissions suggest ED is being used as a first level primary care health service, especially for those in close proximity to the hospital and also impoverished populations.

In October 2013, HBDHB and HHBPHO performed a survey of consumers and/or their whānau/support people, who presented at the Emergency Department, HB Hospital, between 9am

[6] Treasury Report: Improving the targeting of co-payments in primary care. June 2012
[7] Ministry of Health. NZ Health Survey 2013-2014.
[8] Evaluation of the Primary Health Care Strategy: Practice Data Analysis 2001-2005. Gribben & Cumming. 2007
[9] Ibid.
[10] HBDHB Information Services. Hawke's Bay Regional Emergency Department Trends 2011-2015

to 7pm over the period 09 September 2013 to 13 September 2013[11]. The purpose of the survey was to find out from consumers who access ED:

1. What they knew of available health services in the community
2. their experience of primary care services
3. their preference for options in accessing primary care services in the future

A total of 67 surveys were initiated with 63 being fully completed. Forty-two or 67% of respondents that answered the demographic questions identified Māori as an ethnicity. Eleven or 18% of respondents identified as Pacific and of these, six were Cook Island, four Samoan and one Tongan. Fourteen identified as New Zealander or European only. When asked what barriers prevented the respondents from accessing primary care services the majority indicated cost as a barrier, followed by transport, outstanding debts with their GP and availability of appointments.

Ambulatory sensitive hospitalisations (ASH) can be considered an indicator of reduced access to primary care. ASH related hospitalisations are potentially avoidable through preventive interventions or treatments deliverable in a primary care setting and account for around 1/5 of acute and arranged medical and surgical discharges. ASH rates amongst 0-4 years show disparities with Māori rates 1.6 times those of non-Māori rates. However this disparity has decreased as ASH rates have declined faster for Māori which coincides with the implementation of free primary care for children aged under 6. Theoretically the ASH rates for other groups of children and young people would be impacted in a similar way if access to primary care was improved.

Improved access to primary health helps prevent the early onset of long term conditions. There is growing evidence that prevention and intervention strategies applied early in life are more effective in altering outcomes, and reap more economic returns over the life course, than do strategies applied later in life. [12] Health research also confirms that risk factors for long term health conditions often present during childhood and adolescence and that targeted investment in earlier intervention at the primary care level is cost effective and has the potential to reduce some of this burden.

Improved resourcing of primary care improves population health outcomes and lowers the overall long term cost on the health system. International research also supports the focus on providing additional resources to encourage greater use of primary health care services. International research finds that primary health care in countries with stronger primary health care systems with lower costs have better health outcomes (most notably in infancy and childhood) [13].

This paper proposes a primary care zero fees approach for 13-17 year olds in Hawkes Bay that builds upon the national rollout of zero fees for under 13 year olds but is targeted towards those populations where cost is known to be a barrier to access.

2. Targeted Primary Care Funding

Over the last 15 years, primary health care funding has undergone a transformation. The Primary Health Care Strategy 2001 signalled a move away from the targeted funding approach to a universal approach, where all New Zealanders are eligible for government funding for primary health care. The PHCS emphasised capitation based funding payments based on community health and health prevention. The result has been health expenditure increase for higher income deciles more quickly than spending on lower income deciles.[14]

[11] HBDHB, Māori Health Services: Internal Report. Māori and Pacific Access to Health Services Survey. 3 October 2013.
[12] Improving the Transition Reducing Social and Psychological Morbidity During Adolescence: A report from the Prime Minister's Chief Science Advisor, May 2011
[13] Treasury Report: Improving the targeting of co-payments in primary care. June 2012
[14] Treasury Report: Improving the targeting of co-payments in primary care. June 2012

Primary health funding capitation formula and associated allocation methodologies has also been heavily criticised. It's argued that the co-payments a consumer pays to see a GP are unrelated to that consumer's ability or inability to pay, but rather to the make-up of that practice's population as a whole and to the pricing policy of the individual medical centre.

In 2015, the Primary Care Working Group (PCWG) on General Practice Sustainability provided a report to the Minister of Health detailing recommendations to improve the equitable access to affordable primary health care, workforce sustainability and shifting services closer to the community. The PCWG reviewed current targeted funding mechanisms including Community Services Cards (CSC), Working for Families Tax Credits (WFTC), deprivation and ethnicity. It found that CSC as a sole targeting mechanism had a low income threshold below the minimum wage, had a low uptake by consumers and were administratively burdensome for providers to manage. Similarly, WFTC required active application by individuals and did not cover low income individuals without children. However, PCWG found that deprivation had a strong correlation to Māori and Pacific ethnicity and therefore served as a proxy for targeting for Māori and Pacific ethnicity. The group recommended primary health funding be targeted towards a combination of CSC, deprivation and ethnicity. However, most of the components related to the recommendations, such as CSC income thresholds and primary care funding formulas, required central government policy level changes and the funding formula remains unchanged.

Given the findings of the PCWG Report require major policy changes at central government level, this paper proposes using a targeting approach focused on general practices with high Māori, Pacific and Quintile 4 & 5 enrolled populations.

3. Hawkes Bay 13-17 Year Old Population Information

HB Population 13-17 Year Olds
Hawke's Bay has proportionally more people in the more deprived sections of the population than the national average (40%) with 47% of the population living in Quintile 4 and 5 areas.[15] Of 13-17 year olds living in the HBDHB region, 5,755 (52.7%) live in Quintile 4 and 5 areas.[16]

There are approximately 11,096 children aged 13-17 years enrolled with Health Hawke's Bay PHO general practices.

- Hastings has the highest number of 13-17 year olds enrolled in general practice (5,428 or 49%).
- Māori (35.8%) and Pacific (4.9%) make up a combined 41% of 13-17 year olds within the enrolled population of Health Hawke's Bay PHO general practices.
- VLCA[17] practices make up 30% (3,248) of 13-17 year olds within the enrolled population of Health Hawke's Bay PHO general practices.

Māori and Pacific enrolled populations are concentrated in under half of the general practices in HB.

- Just twelve general practices in HB have 85% of the total enrolled Māori and Pacific 13-17 year olds.
- High needs areas, such as Wairoa, Māori make up 77.3% of the enrolled population of general practices.

[15] Ministry of Health website: Population of Hawkes Bay DHB 2015/16
[16] Ministry of Health website: PHO Enrolment Demographics 2016
[17] Very Low Cost Access (VLCA) practices receive higher capitation rates in return for lower zero fees capped levels for standard consultations (zero fees for children 0–5 years, $11.50 maximum for children 6–17 years, $17.50 maximum for adults 18 years and over). A general practice must have at least 50% "High Needs" people (Māori, Pacific, or Quintile 5) enrolled to qualify for VLCA funding.

- In Hastings, Māori and Pacific 13-17 year olds make up 42% of the total enrolled population with 76% enrolled in just three general practices (Totara Health, Hastings Health Centre and Hauora Heretaunga[18]).
- Napier only has 13% of the HB Māori and Pacific 13-17 year olds. However, 73% of Napier Māori and Pacific population are enrolled in only three general practices (The Doctors Napier, Maraenui Medical Centre and Tamatea Medical Centre).
- General Practices with the largest 13 to 17 year old Māori and Pacific populations include Totara Health, The Doctors Napier, Hauora Heretaunga, Hastings Health Centre, The Doctors Hastings (includes Gascoigne St, Waipawa), Wairoa Health Centre, Queen Street Medical and Medical and Injury.

53% of Hawkes Bay 13-17 year olds live in Quintile 4 & 5 areas

85% of the total Māori and Pacific 13-17 year olds are enrolled in only 12 GP practices

76% of Māori and Pacific 13-17 year olds living in Hastings are enrolled in only three general practices

73% of Māori and Pacific 13-17 year olds living in Napier are enrolled in only three general practices

(See Appendix for greater breakdown of HB Population 13-17 Year Olds)

16

4. Primary Care Utilisation Rates

In 2015, the average GP consultations for 13-17 year olds was 1.72 consults per annum. There is very little difference between VLCA and Non-VLCA average GP consultation rates at 1.70 and 1.73 per annum respectfully. Combined GP and Nurse Consultations for 13-17 year olds is 2.15 consults per annum.

In 2015, Māori and Pacific received less average GP consultations than Asian and Other NZers. Māori and Pacific received 1.56 and 1.28 average GP consultations per annum in comparison with Asian and Other NZers which had 1.75 and 1.86 per annum. However, Māori received higher Nurse Consultations than any other ethnic group with 0.58 per annum. This increased the combined GP and Nurse average consultations for Māori to 2.13 per annum in comparison to Non-Māori 2.21, Asian 1.75 and Pacific 1.62 per annum.

The average GP consultations for 13-17 year olds was only 1.72 consults per annum

(See Appendix for further information on GP and Nurse Consultation Rates)

Utilisation Ratio Equation

When the zero fees for Under-6s and Under-13s scheme were introduced throughout New Zealand, practices experienced an initial increase of 10% in utilisation rates, which then levelled off. Experience in HBDHB which introduced consultation fees for Under-13s indicates that visits to general practice have reportedly increased on average 23 percent in the 6-12 age group in the first six months of the scheme.

The average GP consultation utilisation for 13-17 year olds is 1.72 consults per annum. This will need to have a 25% buffer included for any potential increases in utilisation. Therefore the HBDHB consultation fees subsidy for 13-17 year olds will be based on a rate of 2.15 visits per annum. The funding formula mechanism will need to be monitored to ensure utilisation do not exceed an average of 2.15 visits per year. Agreements will need to allow a review of utilisation rates annually.

[18] Hastings Health Centre, Totara Health, Hauora Heretaunga make 62% of the total 13-17 year old enrolled population of Hastings general practices

HBDHB zero fees subsidy for 13-17 year olds will be based on a rate of 2.15 visits per annum (inclusive of 25% buffer)

5. Primary Care Consultation Fees

In Hawkes Bay, consultation fees for 13 to 17 year olds range from $0 to $39. Where After Hours services are in place, the charges are usually approximately $5 more expensive per visit. Pharmacies charge a flat fee of $5 per item dispensed and may charge $1-2 extra per item after hours.

There is a geographical distinction in consultation fees costs in HB. Although the average consultation fee per person is only $17.69, there is a clear distinction between Napier and CHB with Hastings and Wairoa. In Hastings and Wairoa there are eight no cost and very low cost consultation fees practices charging between $0 – $18 per consultation. Whereas Napier has only two low cost consultation fees practice charging between $11.50 - $18 and fourteen practices charging between $20 - $39 consultation fees. In CHB the consultation fees are $24.

(See Appendix for HHBPHO GP Practice Consultation Fees)

Consultation Fees Subsidy Rate[19]

The average consultation fees for the General Practice above is only $14.70. This is impacted by VLCA practice capped consultation fees of $12.00 with three practice charging consultation fees. However in order to capture a significant section of the Māori and Pacific community, as well as Napier and CHB, General Practices, such as The Doctors Napier, Hastings Health Centre and Tuki Tuki Medical need to be included. Therefore the consultation fees subsidy must be attractive enough to include them. Therefore a consultation fees of $25.00 (GST Excl) per visit is recommended.

There is variability in the afterhours charges to people aged 13 to 17. At a price offer of $40.00 per visit and a current utilization rate of 0.26 visits per annum per person.

It is assumed all pharmacies would accept an offer of $5.00 per item, per GP consultation (2.41 per person).

HBDHB zero fees subsidy will be $25.00 per visit

After hours fees subsidy will be $40.00 per visit

Pharmacy subsidy will be $5.00 per item

6. Option Analysis

The HBDHB Clinical Council approved funding investment for:

- All of Wairoa enrolled 13-17 year olds (estimated $20,000 per annum)
- 60% of the rest of HB enrolled 13-17 year olds (estimated $500,000)
    - Focus should be on Decile 4 & 5 populations

To achieve the Clinical Council's targeted funding allocation, three options have been developed.

Option One – Targeted Approach

[19] There is a funding differentiation between VLCA practices and non VLCA practices, and reducing the co-payment subsidy to $15 per consultation for VLCA practices would reduce the overall funding request to within budget.

- Option One provides a targeted approach towards general practices with the largest Māori and Pacific population groups (13-17 year olds).

Māori (35.8%) and Pacific (4.9%) make up a combined 41% of 13-17 year olds within the enrolled population of Health Hawke's Bay PHO general practices. VLCA practices make up 30% of 13-17 year olds within the enrolled population of Health Hawke's Bay PHO general practices. In Wairoa, Māori make up 77.3% of the enrolled population of General Practices. Other General Practices with significant Māori and Pacific populations include The Doctors Napier, The Doctors Hastings, Hastings Health Centre, Tamatea Medical Centre and Tuki Tuki Medical Centre with an additional 34.9% of the Māori and 26.0% of the Pacific enrolled population.

Therefore a selection criteria of General Practices with at least 30% enrolled 13-17 year old Māori patients and with over 100 enrolled 13-17 year old Māori patients has been applied. This will provide for a wider geographical coverage and ensure a capture of both high needs communities and the majority priority populations. (See Appendix for list of GP Practices)

Population Coverage
Option One provides for 84.5% of the total enrolled Māori population, 89.6% of Pacific and 67.7% of the total enrolled Health Hawke's Bay PHO population.

Option One zero fees subsidy will cover the following population and geographical areas:

- **67.7% of HBDHB for 13-17 year olds;**
- **Wairoa, Napier, Hastings and CHB,**
- **High needs communities of Wairoa, Maraenui and Flaxmere; and**
- **84.5% of Māori and 89.6% of Pacific populations**

Cost Analysis
Option One would be over the budget by $63,235 per annum and would cost an estimated $583,235 per annum.

Using local information on utilization rates in this age group, consultation fees at the different practices and the numbers of young people enrolled at each practice it is estimated that around 68% of people aged 13 to 17 years would be able to access free primary care visits during daytime hours at a price offer of $25 per visit. At the current utilization rate of 2.15 visits per person per annum the cost to the DHB to achieve 68% coverage is estimated at $411,408 per annum.

Afterhours costs based on a price offer of $40.00 per visit and a current utilization rate of 0.26 visits per annum per person is estimated to cost the DHB of $79,602 per annum.

Pharmacy costs based on $5.00 per item, per GP consultation (2.41 per person), is estimated to cost the DHB approximately $92,231 per annum.

The total cost of implementing zero fees and prescriptions for 68% coverage of HB population between aged 13 to 17 years is estimated at $583,235 (GST Excl).

- **Daytime GP consultations: $411,408**
- **After Hours GP consultations: $79,602**
- **Prescription Charges: $92,231**
- **TOTAL COST: $583,235**

These costings include the estimated cost for standard general practice consultations for enrolled patients, visits to general practice by casual (non-enrolled) patients, after hours visits primary care visits, pharmacy dispensing fees but exclude ACC consultation fees and any after hour's premium levied by pharmacies.

Option Two – Generic Approach

Option Two provides a different approach where HBDHB simply set the consultation fees at $25 per consult and generically offer it to all General Practices in HBDHB region. This approach is consistent with the MOH zero fees 6-13 year old subsidy.

The rationale for Option Two is to make the zero fees subsidy for 13-17 year olds a fair offer to all General Practices and let market forces determine the uptake of the offer. The offer still needs to be attractive enough to ensure those uptake of those General Practices serving population groups where cost is a barrier to accessing primary care and who experience unequal health outcomes. If the consultation fees subsidy is $25.00 per consultation the following General Practices may accept the HBDHB offer consultation fees subsidy for 13-17 year olds.

Population Coverage
Option Two this would cover 100% of the total enrolled 13-17 year olds HB population.

Option Two zero fees subsidy will cover the total population and HBDHB geographical areas:

- **100% of HBDHB for 13-17 year olds;**
- **Wairoa, Napier, Hastings and CHB,**
- **High needs communities of Wairoa, Maraenui and Flaxmere**

Cost Analysis
Option Two would not be within budget and would cost an estimated $845,514 per annum.

Option Two provides for 100% of people aged 13 to 17 years to access free primary care visits during daytime hours. At a price offer of $25.00 per visit, with a utilization rate of 2.15 visits per person per annum, the cost to the DHB to achieve 100% coverage for daytime GP consultations is estimated at $596,410 per annum.

Afterhours costs based on a price offer of $40.00 per visit and a current utilization rate of 0.26 visits per annum per person is estimated to cost the DHB of $115,398 per annum.

Pharmacy costs based on $5.00 per item, per GP consultation (2.41 per person), is estimated to cost the DHB approximately $133,706 per annum.

The total cost of implementing zero fees and prescriptions for 82% coverage of HB population between aged 13 to 17 years is estimated at $845,514

- **Daytime GP consultations: $596,410**
- **After Hours GP consultations: $115,398**
- **Prescription Charges: $133,706**
- **TOTAL COST: $845,514**

Option Two is not within budget and therefore a lower consultation fee subsidy rate should be considered.

Option Three – Generic Approach of Lower Subsidy

Option Three provides for a set zero fees subsidy offer of $20.00 per GP consultation to all General Practices in HBDHB region. A lower subsidy offer could reduce the uptake of GP practices that may accept the offer:

Population Coverage
Based on GP practices that currently charge equal or around $20 per consultation, approximately only 56.8% of the total enrolled 13-17 year olds would be covered, including 66.7% of the total

enrolled Māori population, 81.2% of Pacific and 48.2% of Other of the total enrolled Health Hawke's Bay PHO population. (See Appendix for List of GP Practices likely to accept offer).

Option Three zero fees subsidy will cover the following population and geographical areas:

- **56.8% of HBDHB for 13-17 year olds;**
- **Wairoa, Napier, and Hastings (not CHB),**
- **High needs communities of Wairoa, Maraenui and Flaxmere; and**
- **66.7% of Māori and 81.2% of Pacific populations**

Cost Analysis
Option Three would be within budget and would cost an estimated $412,662 per annum.

Option Three provides for 56.8% of people aged 13 to 17 years to access free primary care visits during daytime hours. At a price offer of $20.00 per visit, with a utilization rate of 2.15 visits per person per annum, the cost to the DHB to achieve 56.8% coverage for daytime GP consultations is estimated at $271,115.00 per annum.

Afterhours costs based on a price offer of $40.00 per visit and a current utilization rate of 0.26 visits per annum per person is estimated to cost the DHB of $65,572.00 per annum.

Pharmacy costs based on $5.00 per item, per GP consultation (2.41 per person), is estimated to cost the DHB approximately $75,975 per annum.

The total cost of implementing free primary care visits and prescriptions for 56.8% coverage of HB population between aged 13 to 17 years is estimated at $412,662

- **Daytime GP consultations: $271,115.00**
- **After Hours GP consultations: $65,572.00**
- **Prescription Charges: $75,975**
- **TOTAL COST: $412,662**

Comparative Analysis

Options	Population Coverage (Percentage)					Cost	+/- Budget $520,000
	Māori	Pacific	Other	Asian	Total		
One	84.5	89.6	57.4	26.4	67.7	$583,235	+$ 63,235
Two	100	100	100	100	100	$845,514	+$325,514
Three	66.7	81.2	48.2	67.8	56.8	$412,662	- $107,338

Option One
Option One provides for:

- targeted approach towards General Practices with high enrolled Māori and Pacific 13-17 year olds
- $25.00 consultation fees subsidy
- covers 67.7% of all enrolled 13-17 year olds
- contains a high percentage of Māori (84.5%) and Pacific (89.6%) enrolled population
- wide geographical coverage Wairoa, Napier, Hastings and CHB
- Includes all VLCA practices

Option One does not provide for:

- 'fairness' with an open offer to all General Practices
- A cost structure close to budget
    - is $63,235 over budget

Option Two

Option Two provides for:

- an ‘opt in’ fair market approach to all General Practices
    - is consistent with consultation fees 6-13 year old approach
- $25 consultation fees subsidy
- covers 100% of all enrolled 13-17 year olds
- contains the highest percentage of Māori and Pacific enrolled population
- wide geographical coverage Wairoa, Napier, Hastings and CHB
- includes all VLCA practices

Option Two does not provide:

- a cost structure within budget
    - is $325,514 over budget

Option Two should not be considered due to the total cost being considerably outside the funding parameters.

Option Three

Option Three provides for:

- an ‘opt in’ fair market approach to all General Practices
    - is consistent with consultation fees 6-13 year old approach
- affordable costs structure
    - $115,534.25 under budget
- $20 consultation fees subsidy
- covers 56.8% of all enrolled 13-17 year olds
- includes all VLCA practices
- includes Clive and Havelock North

Option Three does not provide for:

- less geographical coverage
    - limited in Napier and does not include CHB
- less Māori population coverage (66.7%)
- sole focus on decile 4 & 5
    - potential inclusion of Havelock North

7. Feedback

Primary Care

Ten general practices as well as Directions Youth Health service, HHB Priority Population Committee and HHB Clinical Advisory Group were consulted over the zero fees proposition. The overwhelming majority favoured reducing costs for general practices services and a targeted approach of Māori, Pacific and Quintile 4 & 5.

Common themes from general practice included:

- Cost was a barrier to accessing primary care
- A targeted approach to Māori, Pacific and Quintile 4 & 5 was favoured
- Attitudes and behaviours of staff was a barrier for youth access
- Multidisciplinary approaches and partnerships with youth social services and youth specialist services would best suit youth health issues
- Youth health networks in each district that were accessible to all youth would improve access to youth health services

Local Consumer Feedback

HBDHB consulted with two groups of 13-17 year olds in Hastings (Camberley, Flaxmere) and Wairoa (Wairoa College) regarding the zero fees proposition. The groups were asked a range of questions related to primary care access and appropriateness.

Both groups stated that cost was the major issue and agreed that zero fees subsidy for 13-17 year olds was a good proposition. However, both groups also suggested that non-financial barriers also impacted on accessing general practice. The groups stated that the attitudes and behaviours of primary care staff were one of the most significant barriers faced in accessing services. They stated the barriers were that significant that they do not use general practice until they are extremely unwell. Furthermore they stated that school health services were difficult to access due to their limited availability and lack of privacy.

The groups of youth had many innovative suggestions for primary care to improve youth friendly services. They suggested that primary care needs:

- integrated with youth social services and offer ‘practical’ support and not just ‘quick advice’
- Telehealth and preappointment options needs to offered more fully
- Walk in clinic options
- Self-selection menu of services (electronic or tick box) should be offered at reception
- Consultation times need to be more generous
- Clinic locations closer to where they live
- Staff that specialise in youth health, are younger and from a variety of cultural backgrounds
- Staff need training to be more friendly, responsive and accommodating for youth

Youth Experience of General Practice

Most young people in New Zealand see the GP or family doctor as the main place they get health care. However, many young people report barriers or problems (such as cost, embarrassment, not wanting to be bothered or concerns regarding confidentially) to seeking health care. Often barriers are found to be particularly high for Māori, Pacific and sometimes Asian or other migrant groups; young people in higher deprivation communities and same sex attracted young people. Additionally

when young people do see GP's this is often for short term illnesses or difficulties (especially respiratory or skin care issues) not for issues that represent the main burden of disease in this age group (such as mental health and behavioural issues).

There is little research regarding the impact of General Practice care for young people. However, available evidence[20] suggests:

- Most New Zealand high school students have seen a General Practitioner (GP) within the last year.
- The majority of New Zealand high school students say GPs or family doctors are the main place that they seek health care.
- Where young people do see GPs this is often for short term illnesses and not for issues such as mental health or health risk behaviours. This is the case even when young people do have mental health difficulties and even when they would like help for them.
- GP's often report difficulties in providing youth friendly care (such as lack of training or time).
- Where young people are more familiar with their GP they report fewer barriers to accessing health care.
- GP's who have received high quality training in adolescent health have been shown to be more likely to offer high quality adolescent health care.
- There are a range of actions (such as increased utilization of trained practice nurses, routine psychosocial screening and continuity of care approaches) that may be taken to enhance General Practice care for young people; however few of these approaches have been evaluated.

8. Key Considerations for A 'Youth Friendly' Primary Model Of Care

Research, literature reviews and consultation feedback all pointed towards the need to change the model of primary care for youth to address non-financial barriers to access.[21] A systematic review[22] of factors that young people perceived to make health care youth-friendly found that:

- accessibility,
- staff attitude (respectful and supportive, honest, trustworthy and friendly),
- communication (clarity of information and listening skills of the clinician),
- medical competency, guideline driven care (confidentiality, autonomy, and well-managed transition to adult health care),
- age appropriate environments,
- youth involvement
- appropriate health outcomes were central to young people's positive experience of care.

The literature reviewed in this document suggests that to improve young people's health the health sector should:

- Provide a range of 'youth friendly' clinical health services, staffed by health professionals who are well trained, skilled and knowledgeable in youth health.

[20] Assessment of youth-friendly health care: a systematic review of indicators drawn from young people's perspectives. 2013. Ambresin AE, Bennett K, Patton GC, Sanci LA & Sawyer SM. *J Adolesc Health* 52(6) 670-81.

[21] Fleming & Elvidge. Youth Health Services Literature Review. 2010.
Craig E, Jackson C, Han DY, NZCYES Steering Committee. *Monitoring the Health of New Zealand Children and Young People: Indicator Handbook*. 2007. Auckland: Paediatric Society of New Zealand, New Zealand Child and Youth Epidemiology Service.
The Health Status of Children and Young People in the Hawke's Bay 2015. Dunedin: New Zealand Child and Youth Epidemiology Service, University of Otago; 2016.

[22] Assessment of youth-friendly health care: a systematic review of indicators drawn from young people's perspectives. 2013. Ambresin AE, Bennett K, Patton GC, Sanci LA & Sawyer SM. *J Adolesc Health* 52(6) 670-81.

- These should provide comprehensive and 'joined up' youth friendly care.
- Work across sectors to encourage population, community, school and family level interventions that will improve the health of young people.

9. Best Practice Models and Standards

Provider Training

A transformation towards a youth friendly model of care will require specific training package for general practice. A comprehensive adolescent health training package for GP's was tested in a robust trial in Melbourne, Australia[23]. The educational programme (2.5 hours per week for 6 weeks) in the principles of adolescent health care, followed 6 weeks later by a 2-hour session of case discussion and debriefing was developed and evaluated. General Practice care for young people knowledge, attitudes and self-reported behaviours were improved following the training and were maintained at a five year follow up. A training package should be developed by Health Hawkes Bay PHO, in collaboration with general practice and youth health and social service providers, for participating general practices in the zero fees proposition.

Standards for Youth Health Care

Accreditation to standards or frameworks for youth health care can also support the hardwiring of a youth primary care model. Standards have been developed for Primary Care and other providers in numerous settings. In New Zealand the College of General Practitioners published a guide for GP's in working with young people (RACGP, 2006). This has been developed and reviewed by New Zealand practitioners and provides practical guidance for communication, screening, managing key adolescent health issues. Additionally there are local draft standards for youth health services (Kidz First Centre for Youth Health and the Youth Health Expert Working Group 2006). Other frameworks include the WHO Principles for Adolescent Friendly Care and the New South Wales Centre for the Advancement of Adolescent Health Youth Health Better Practice Framework (2005).[24] Either established standards and frameworks or the development of localised standards, in partnership with Directions Youth Health Centre, should be adopted as a baseline expectation for participating general practices in the zero fees proposition.

Viewing youth as new users of health services

The UK Royal College for Paediatrics and Child Health paper on Health Care for Adolescents (Royal College for Paediatrics and Child Health 2003) suggests that young people should be regarded as new users of health services and offered a specific appointment to meet their GP and discuss and negotiate their general practice service. This could include a discussion regarding confidentiality; the range of issues addressed by the GP and other professionals in the practice and having an opportunity to decide whether to continue with their parents GP or chose their own. If this is offered as a routine process to young people as they grow up and is explained to parents and young people in advance, such an introduction appointment could potentially address many of the identified barriers to high quality GP care for young people.

Integrated health and social services with General Practice

Research identified that school based health services, youth health centres and youth social service providers often provided more satisfactory care and support to young people than general practices do. The former services are typically provided by youth health trained nurses or social workers, youth workers or peer supporters in the first instance. It is widely acknowledged that general practice alone cannot solely address youth health related issues. Ideally, youth friendly general practice would

[23] Fleming & Elvidge. Youth Health Services Literature Review. 2010.
[24] Fleming & Elvidge. Youth Health Services Literature Review. 2010.

collaborate with other youth specific providers and offer a multidisciplinary, holistic approach, including primary care, reproductive and sexual health care, substance abuse treatment, mental health care, and education and counselling. Establishing and hardwiring collaborative relationships with local school health, youth health and youth social services should be a baseline expectation for participating general practices in the zero fees proposition.

Youth Friendly Environments

Studies demonstrate that youth want health service environments to be more youth appropriate. Youth prefer livelier décor, youth orientated reading material, and music. Youth also reported that clinic-sponsored incentives (e.g., gift certificates) would increase the likelihood that they would attend appointments. It will be recommended that participating general practices consider youth friendly environments as part of their youth friendly model of care.

Free appointments

All appointments being free or a schedule of free appointments (e.g. for an annual visit) might increase young people's use of health care. This approach has been effective for a HB sexual health clinics initiative. It is critical that people know that the appointments are free. Free appointments is a key baseline component for participating general practices in the zero fees proposition.

Flexible Appointments

Youth friendly models of care should also involve flexibility around consultations. General practices should consider walk-in clinics and telehealth appointments. Furthermore, general practice should use text reminders so young people are prompted about their appointment. It will be recommended that participating general practices consider flexible appointments as part of their youth friendly model of care.

Extended appointment times

Extended appointment times are suggested as part of providing youth friendly health services by the World Health Organisation (2002) and others. Extended appointments can allow time for explaining confidentiality, relationship building, screening and following up sensitive heath issues. This might be done by funded appointments and or by utilising non-medical health staff. Extended appointments maybe considered appropriate by participating general practices in the zero fees proposition.

Health Screening

There is considerable advocacy for routine screening for sensitive health issues among young people. This is on the basis that young people do not typically proactively disclose sensitive behaviours to health providers and yet they are often willing to, or indeed want to discuss them. Further many of these behaviours can have significant health consequence or interact with other health problems, for which the young person may be being treated. In New Zealand the year 9 assessments and opportunistic youth health screens when young people return to school clinics have been reported as a key part of the success of the HEADS Assessments. Research estimates that for every dollar spent on screening in adolescence long term health costs are reduced by a greater amount.[25] It will be recommended that participating general practices consider a health screening and assessment approach as part of their youth friendly model of care.

A baseline requirement of general practices within the Zero Fees 13-17 Year Old programme will be to make 'youth friendly' changes to their model of primary care

[25] Fleming & Elvidge. Youth Health Services Literature Review. 2010.

10. Measuring Benefits

Successful implementation of the project will show significant improvements within the NZ Triple Aim as follows:

Triple Aim Outcome Profile

Dimension	Measure
1. Improved Quality/Safety / experience of Patient Care	• Improved access to primary care including better information to Manage my own health (Health Literacy) • Early detection of health risks and access to treatment
2. Improved Health & equity for all populations	• Decreased burden of disease across the population • Increased equity of health status including Māori, Pacific, Low deprivation populations
3. Best Value for Public Health system resources	• Decreased cost of disease management associated with Long term conditions across the system

Population Health Measures

The Zero Fees Proposition for 13-17 Year Olds will implement a set of Programme Measures as well as Individual Tailored Measures for participating general practices.

The New Zealand Child and Youth Epidemiology Service provide a set of "Top 20" Indicators of Child and Youth Health indicators (see Appendix Four). [26] Most relevant to the zero fees proposition are:

- Most Frequent Causes of Hospital Admission and Mortality
- Primary Health Care Provision and Utilisation
- Exposure to Cigarette Smoke in the Home

Furthermore, the Otago University and New Zealand Child and Youth Epidemiology Service Health Status of Children and Young People in the Hawke's Bay 2015 Report provides Ambulatory Sensitive Hospitalisation (ASH) rate indicators and relevant, in terms of significant incidences, attributable to access to primary health care for 13-17 year olds.

Programme Measures

Therefore the health indicators within the Programme Measures for the Zero Fees 13-17 Year Old proposition include a reduction in acute Emergency Department presentations and admissions[27] for:

- Self -referred but not admitted Emergency Department attendance rate (in hours and out of hours)
- Serious Skin Infections
- Asthma
- Mental Health (presentations & admissions)

Non-clinical indicators for the Programme Measures for the Zero Fees 13-17 Year Old proposition include:

[26] Craig E, Jackson C, Han DY, NZCYES Steering Committee. *Monitoring the Health of New Zealand Children and Young People: Indicator Handbook*. 2007. Auckland: Paediatric Society of New Zealand, New Zealand Child and Youth Epidemiology Service

[27] ASH Rates and ED Presentation baseline data yet to be determined by HBDHB

- Increased utilisation of primary care (≥ 25%) over current utilisation rates
- Youth Friendly General Practices
    - Free consultations, Youth specific training, Accredited to Youth Health Standards, Flexible consultations, Youth Health Satisfaction Surveys

Individual Tailored Measures
Individual tailored indicators would be general practice specific related to the clinical and non-clinical programme indicators. These would require breakdown of HBDHB and PHO data to determine specific health indicators directly attributable to access to primary care. The tailored measures would be negotiated with each practice and the scope of the plans would be based on the level of funding they are likely to receive. However there would be baseline expectations that include changes to model of care and zero fees.

Health Hawkes Bay and HBDHB will develop 0-18 year old population profiles for each general practice that opts in for the 13-17 year old primary care zero fees subsidy. Each general practice will be asked to provide a plan on how they will improve their responsiveness to their youth population. Depending on the general practice population profile they could be asked for a population health plan on how they will respond to health issues.

11. Risks

Unintended Consequences

The following potential unintended consequences have been identified:

1. Patient Flight – Some patients and their whanau could leave their General Practice to enrol in a practice with consultation fees.
2. Lack of Capacity - General Practices providing consultation fees could be inundated with enrolment requests impacting on their capacity to deliver quality health care.
3. Funding Sustainability - funding could be compromised if General Practices that have opted into the consultation fees subsidy grow their enrolled population beyond the ability of the funding parameters.

Risk Analysis

Risk	Likelihood Hi/Med/Lo	Impact Hi/Med/Lo	Planned Response
Activity increase leads to reluctance of General Practices to participate	Med	Hi	Identify optimal practices and also Work with consider existing VLCA (very low cost access practices)
Ability of selected practices to provide an optimal 13- 17 year old service as per requirements identified.	Med	Hi	Work with selected practices to find optimal ways to meet the requirements

12. Implementation

Project Approach
The 13-17 year old primary care zero fees subsidy is being implemented under the formal HBDHB project management methodology. The project has a terms of reference with a project manager, governance committee and project team.

Implementation by Health Hawkes Bay
The implementation of the13-17 year old primary care zero fees subsidy project will be a partnership between HBDHB Strategic Services and Health Hawkes Bay. HBDHB and Health Hawkes Bay will visit each eligible general practice and discuss the programme detailing the 13-17 year old primary care zero fees subsidy and model of care expectations. HBDHB will contract Health Hawkes Bay to contract with general practice. It will build upon current transformation work with general practice being carried out by Health Hawkes Bay.

Procurement
HBDHB Contracts will manage the procurement process. A letter of offer will be sent to the targeted general practices detailing the zero fees subsidy including criteria and expectations.

HBDHB and Health Hawkes Bay will provide a population profile for each general practice including significant health issues for 13-17 year olds. Each general practice will be asked to submit a proposal on what new services or service model they intend to implement to improve access to primary care services for 13-17 year olds. The service plan should cover objectives, targets and measures for areas such as addressing significant health needs, reducing ASH rates and ED admissions as well as detailing the provision of any additional 'youth friendly' services.

HBDHB Māori Health, Strategic Services and Health Hawkes Bay must approve and sign off the service plan before funding is released.

Timeline:

High Level Milestone	**Date of Completion**
EMT paper - Preapproval SG - EMT / Clinical Council	October 2016
Implementation	
Preparation for Go Live _ systems/ processes as per plan completed – Contracts developed and agreed	October – December 2016
Go Live	1 January 2017

Appendix Two

Implementation of 'Zero Fees' For Children Under 13 Years

In July 2015 the Government invested $90 million nationally over three years to make doctors' visits and prescriptions free for children aged under 13 years at any time of the day or night. The intent is to remove cost as a barrier to access to primary care services by replacing the zero fees made by patients to general practices, Accident and Medical centres and pharmacies with government funding.

The zero-fee visits for children under 13 policy was an 'opt in' approach where general practices could choose whether or not to provide 'zero fees' to under-13s. Those that opt in receive an additional subsidy of around $45 per annum from the Government. (The General Medical Subsidy (GMS) rate for casual visits for 6–12 year olds remains unchanged, helping to incentivize enrolment with a regular practice and continuity of care). Nationally, 96% of general practices with enrolled children aged 6 - 12 have opted in to the zero-fees for under-13s scheme, and 98% of practices with enrolled under-sixes offer zero-fee visits.

Utilization rates for zero fees for under-13s have been modelled on existing average utilization rates of an average of 2.2 visits per year. The Government subsidises an additional $44 - $45 for 'Zero Fees Under 13 year olds' over and above the $94.28 - $99.48 (non-Access Practices) and $117.31 - $125.33 (Access Practices) first contact non-high user card subsidy.

In Hawke's Bay practices, Health Hawkes Bay report an increase of 23% in utilization rates for the 6-12 year old group.

Appendix Three:

HEALTH HAWKES BAY ENROLLED POPULATION 13-17 YEARS

There are approximately 11,096 children aged thirteen to seventeen enrolled with Health Hawke's Bay PHO general practices. Māori and Pacific make up 35.2% and 4.8% of 13-17 year olds within the enrolled population of Health Hawke's Bay PHO general practices.

Health Hawkes Bay - 2015 Calendar Year 13-17 Enrolled Population by Ethnicity

Ethnicity	HEALTH HAWKES BAY Patients
Asian	292
Māori	3,905
Other	6,362
Pacific	538
Total	**11,096**

Around 3,215 of those are registered with one of the eight Very Low Cost Access practices (VLCA)[28] with Health Hawke's Bay PHO general practices.

Health Hawkes Bay - 2015 Calendar Year 13-17 Enrolled Population by Age and VLCA/Non-VLCA

Age	HEALTH HAWKES BAY Patients	VLCA Practices	Non-VLCA Practices
13	2,205	685	1,521
14	2,221	674	1,547
15	2,272	659	1,613
16	2,168	604	1,564
17	2,230	594	1,637
Total	**11,096**	**3,215**	**7,881**

16

Primary Care Utilisation Rates

In 2015, the average GP consultations for 13-17 year olds was 1.72 consults per annum. There is very little difference between VLCA and Non-VLCA average GP consultation rates at 1.70 and 1.73 per annum respectfully. Combined GP and Nurse Consultations for 13-17 year olds is 2.15 consults per annum.

Health Hawkes Bay - 2015 Calendar Year 13-17 Year Old Enrolled Population & Total Consultations

Age	HEALTH HAWKES BAY Patients	Average GP & Nurse Consults	Average GP Consults	Average Nurse Consults
13	2,205	1.68	1.40	0.28
14	2,221	1.89	1.50	0.39
15	2,272	2.05	1.66	0.39
16	2,168	2.42	1.92	0.50
17	2,230	2.70	2.13	0.57
Total	**11,096**	**2.15**	**1.72**	**0.43**

[28] *Very Low Cost Access (VLCA) practices receive higher capitation rates in return for lower zero fees capped levels for standard consultations (zero fees for children 0–5 years, $11.50 maximum for children 6–17 years, $17.50 maximum for adults 18 years and over). A general practice must have at least 50% "High Needs" people (Māori, Pacific, or Quintile 5) enrolled to qualify for VLCA funding.*

Health Hawkes Bay - 2015 Calendar Year 13-17 Year Old Enrolled Population & Total Consultations Non-VLCA Practices

Age	Average Patients	Average GP & Nurse Consults	Average GP Consults	Average Nurse Consults
13	1,521	1.57	1.38	0.19
14	1,547	1.77	1.49	0.28
15	1,613	1.97	1.68	0.29
16	1,564	2.22	1.88	0.35
17	1,637	2.61	2.17	0.44
Total	**7,881**	**2.04**	**1.73**	**0.31**

For VLCA the average combined GP and Nurse Consultations were slightly higher at 2.42 per annum than Non-VLCA practices 2.04 per annum. This is primarily due to VLCA practices having a higher nurse consultation average rate of 0.71 in comparison to Non-VLCA average rate of 0.31.

Health Hawkes Bay - 2015 Calendar Year 13-17 Year Old Enrolled Population & Total Consultations VLCA Practices

Age	Average Patients	Average GP & Nurse Consults	Average GP Consults	Average Nurse Consults
13	685	1.93	1.43	0.50
14	674	2.16	1.51	0.65
15	659	2.24	1.61	0.64
16	604	2.93	2.03	0.91
17	594	2.94	2.01	0.93
Total	**3,215**	**2.42**	**1.70**	**0.71**

In 2015, Māori and Pacific received less average GP consultations than Asian and Other NZers. Māori and Pacific received 1.56 and 1.28 average GP consultations per annum in comparison with Asian and Other NZers which had 1.75 and 1.86 per annum. However, Māori received higher Nurse Consultations than any other ethnic group with 0.58 per annum. This increased the combined GP and Nurse average consultations for Māori to 2.13 per annum in comparison to Non-Māori 2.21, Asian 1.75 and Pacific 1.62 per annum.

Health Hawkes Bay - 2015 Calendar Year 13-17 Year Old Average Consultations of Enrolled Population by Ethnicity

Ethnicity	Average Patients	Average GP & Nurse Consults	Average GP Consults	Average Nurse Consults
Asian	292	2.01	1.75	0.26
Māori	3,905	2.13	1.56	0.58
Other	6,362	2.21	1.86	0.35
Pacific	538	1.62	1.28	0.34

Appendix Four

Primary Care Subsidy and Zero Fees Structures

Primary Care Subsidies

The Government currently subsidises first contact primary care for 13 - 17 year olds between:

- Access Practices
  - $63.65 - $117.31 for Males
  - $115.65 - $125.33 for Females
- Non-Access Practices
  - $63.65 - $94.28 for Males
  - $99.48 - $115.65 for Females

Primary Care Subsidy Rates by Age – High User Card, Access Practices, VLCA, Under 14 Yrs & Under 6 Yrs

Age Group	Gender	First Contact				Vlca	Free Under Sixes	Free Under 13s
		Access Practices		Non Access Practices				
		Huhc	Non Huhc	Huhc	Non Huhc			
5 - 14	Female	$379.5048	$125.3340	$379.5048	$99.4860	$52.2740	$2.4168	$45.0256
	Male	$379.5048	$117.3144	$379.5048	$94.2880	$51.6556	$2.2616	$44.8704
15 - 24	Female	$365.5776	$115.6512	$365.5776	$115.6512	$29.6752	N/A	N/A
	Male	$365.5776	$63.6512	$365.5776	$63.6512	$16.3328	N/A	N/A

16

Primary Care Consultation Fees

In Hawkes Bay, consultation fees for 13 to 17 year olds range from $0 to $42 (GST Incl). Where After Hours services are in place, the charges are usually approximately $5 more expensive per visit. Pharmacies charge a flat fee of $5 per item dispensed and may charge $1-2 extra per item after hours.

There is a geographical distinction in consultation fees costs between Napier and CHB with Hastings and Wairoa. In Hastings and Wairoa there are eight no cost and very low cost consultation fees practices charging between $0 – $18 per consultation. Whereas Napier has only two low cost consultation fees practice charging between $11.50 - $18 and fourteen practices charging between $20 - $39 consultation fees. In CHB the consultation fees are $24.

General Practices with the largest 13 to 17 year old Māori and Pacific populations include Totara Health, The Doctors Napier, Hauora Heretaunga, Hastings Health Centre, The Doctors Hastings (includes Gascoigne St, Waipawa), Wairoa Health Centre, Queen Street Medical and Medical and Injury.

Health Hawkes Bay Practices - Enrolled Population Consultation Fees for 13-17 Year Olds

Napier	Fees	Māori	Pacific	Other	Asian	Total
The Doctors - Napier	$27.00	546	40	773	41	1400
Carlyle Medical	$27.00	76	8	355	6	445
Central Medical	$28.00	50	1	151	2	204
Shakespeare Road Medical	$20.00	29	2	31	3	65
Greendale Medical	$30.00	43	1	241	8	293
HB Wellness Centre	$27.00	14	2	35	6	57
Tamatea Medical	$28.00	133	10	307	3	453
Taradale Medical Centre	$39.00	93	8	640	28	769
Dr Luft	$30.00	24	0	26	1	51
Dr Craig	$25.00	16	1	59	0	76
Dr Hendy	$25.00	6	1	26	3	36
Dr Harris	$18.00	15	1	3	0	19
Maraenui Medical	$11.50	249	60	107	1	417

Wairoa	Fees	Māori	Pacific	Other	Asian	Total
Wairoa Medical	$12.00	70	0	36	0	106
Queen St Medical	$11.50	184	3	31	4	222
Health Care Centre Ltd	$11.50	189	4	49	3	245

Central Hawkes Bay	Fees	Māori	Pacific	Other	Asian	Total
The Doctors – Waipawa*	$24.00					
Tuki Tuki Medical	$24.00	141	3	354	5	503

Hastings	Fees	Māori	Pacific	Other	Asian	Total
Totara Health	$0.00	616	175	399	24	1214
Medical & Injury	$0.00	147	33	66	32	278
Hauora Heretaunga	$0.00	485	64	33	8	590
The Doctors - Hastings	$16.00	206	31	394	33	664
The Doctors - Gascoigne St*	$11.00					
Hastings Health Centre	$18.00	336	59	1102	65	1562
Te Mata Medical	$15.00	51	5	718	20	794
Mahora Medical	$27.00	8	3	67	2	80
Dr Jolly	$24.00	16	0	50	1	67
Dr Wakefield	$24.00	8	1	41	0	50
Clive Medical Centre Ltd	$21.00	27	0	97	5	129

VLCA Practices

***** Enrolled population included in The Doctors Hastings total population

Appendix Five

Recommended "Top 20" Indicators of Child and Youth Health[29]

Individual and Whanau Health and Wellbeing	Socioeconomic and Cultural Determinants	Risk and Protective Factors
Most Frequent Causes of Hospital Admission and Mortality	Children in Families with Restricted Socioeconomic Resources	Breastfeeding
Low Birth Weight: Small for Gestational Age, Preterm Birth	Household Crowding	Overweight and Obesity
Infant Mortality	Educational Attainment at School Leaving	Exposure to Cigarette Smoke in the Home
Oral Health	Primary Health Care Provision and Utilisation	Immunisation
Injuries Arising from Assault in Children		
Total and Unintentional Injuries		
Serious Bacterial Infections		
Lower Respiratory Morbidity and Mortality In Children		
Selected Chronic Conditions: Diabetes and Epilepsy		
Disability Prevalence		
Self-Harm and Suicide		
Teenage Pregnancy		

Appendix Six

[29] Craig E, Jackson C, Han DY, NZCYES Steering Committee. *Monitoring the Health of New Zealand Children and Young People: Indicator Handbook*. 2007. Auckland: Paediatric Society of New Zealand, New Zealand Child and Youth Epidemiology Service

Consumer and Primary Care Consultation

Consumer Consultation – Youth Questions

Youth Questions

1. If you had to look after the health of young people, what would a good health service look like?
    a. What are the key features?
    b. Where, when, who and how?
2. What is working well at the moment? Why?
    a. What isn't working well?
    b. What would you change?
    c. What would you keep?
    d. What would you stop?

Primary Care Consultation - Questions

- Proposition of zero fees for 13-17 Year Olds (Decile 4-5)

Questions:

1. What do you think would improve access to primary care for young people Dep 8-10
2. What else other than financial barriers would enhance young people engaging proactively with general practice?
3. Do you think general practice is the best place for young people to access health services?
4. If you had to look after the health of young people, what would a good health service look like?
    a. What are the key features?
    b. Where, when, who and how?

HAWKE'S BAY District Health Board Whakawāteatia	**Position Statement on Reducing Alcohol-Related Harm** 134
	For the attention of: **HBDHB Board**
Document Owner: **Document Author(s):**	Dr Caroline McElnay, Director Population Health Dr Rachel Eyre, Medical Officer of Health
Reviewed by:	Executive Management Team, Māori Relationship Board, Clinical and Consumer Councils
Month:	November 2016
Consideration:	For Decision

RECOMMENDATION

That the HBDHB Board:

1. Adopt the Position Statement on Reducing Alcohol-related Harm.

17

PURPOSE OF REPORT

To adopt the Position Statement on Reducing Alcohol-related Harm.

BACKGROUND SUMMARY

An initial discussion paper (refer Appendix One) was presented to the committees during July 2016 proposing that a position statement on alcohol-related harms be drafted for the Board to adopt. The discussion paper explained why alcohol-related harm is a priority for the Hawke's Bay DHB region and what future actions our DHB could take. A short film was locally produced and shown to highlight the key issues http://www.ourhealthhb.nz/healthy-communities/supporting-healthy-communities/promoting-responsible-alcohol-use/ and a position statement from the Wellington region was provided by way of example.

CONCLUSION

The committees unanimously supported that alcohol harm reduction be a priority issue for our DHB and for the development of a position statement. Subsequently, a position statement was drafted based on committee feedback and presented back through the committees in October. The committees universally endorsed the draft position statement with minimal changes.

In essence, this Position Statement outlines the DHB's 'statement of intent' over the next three to five years (this timeframe being consistent with the National Drug Policy). It demonstrates the Hawke's Bay DHB's high level commitment to making alcohol harm reduction a priority. It also commits the DHB to taking a leadership role and to help build a a common agenda on alcohol harms both within our DHB as a service and across the community. Next steps for action are also described.

This final position paper is presented to be adopted by the HBDHB Board.

POSITION STATEMENT ON REDUCING ALCOHOL-RELATED HARM

Hawke's Bay District Health Board Position

Harmful alcohol consumption is a major risk factor which contributes to the physical, mental and social ill-health in our community and to Māori: non-Māori health inequities in Hawke's Bay. This health and social burden is borne not just by drinkers but often by others.

The Hawke's Bay District Health Board recognises that the widespread promotion of and accessibility to alcohol has a significant role to play in people's drinking behaviour. Similarly, the DHB understands that the strongest measures to reduce alcohol-related harm operate at a policy level and include increasing price, reducing availability and reducing advertising.

Hawke's Bay District Health Board commits to taking a leadership role in reducing alcohol-related harm in our community. The first steps involve the DHB developing a high-level Strategy and a more detailed Implementation (and Communication) Plan to take action in collaboration with our stakeholders and community.

OUR VISION

"Healthy communities, family and whānau living free from alcohol-related harm and inequity"

The Core DHB Values that underpin the *process* for developing the DHB's Strategy and plans to address alcohol-related harm are:

Rāranga te tira -Working in partnership across the community

- The improvement of Māori outcomes will require Iwi defined and led strategies
- Community engagement & ownership will be critical to change attitudes to alcohol – related harm

Tauwhiro - High quality care

- Effective strategies need to be evidence informed
- Population-based prevention strategies are the most effective and efficient, where possible to deliver at the local level
- Improving early intervention support & treatment has an important role

He kauanuanu - Showing respect to staff, patients and community

- A harm minimisation approach is realistic for many people, accepting that target groups need tailored advice and strategies
- Systems thinking is critical to develop strategies which work synergistically

Akina - Continuous improvement

- DHB leadership entails being a role model, e.g. holding alcohol-free events within our health system and thus leading the way towards moderation in the community
- Relies on strengthened intelligence through improving health system data collection

The Hawke's Bay District Health Board is committed to supporting our government's National Drug Policy 2015-2020[1] to:

- reduce excessive drinking by adults and young people
- protect the most vulnerable members of our community when it comes to alcohol-related harm e.g. children and young people, pregnant women and babies (Foetal Alcohol Spectrum Disorder)
- reduce the harm caused by alcohol use including crime, disorder, public nuisance and negative public health outcomes
- support the safe and responsible sale, supply and consumption of alcohol
- improve community input into local alcohol licensing decisions
- improve the operation of the alcohol licensing system.

Further to the above, the Hawke's Bay District Health Board is committed to:

- reduce and eliminate alcohol and other drug-related harm inequities – particularly for Māori, young people, pregnant women and others who experience disproportionate alcohol-related harm in our community.

NEXT STEPS

The Hawke's Bay District Health Board will undertake the following next steps as a priority.

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

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

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

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.

5. Establish the best method to engage the relevant departments across our 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.

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.

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, consistent health messaging (such as no drinking in pregnancy).

[1] http://www.health.govt.nz/system/files/documents/publications/national-drug-policy-2015-2020-aug15.pdf

KEY OUTCOMES

Consistent with the National Drug Policy the key outcomes our District Health Board is striving for, include:

- Reduced hazardous drinking of alcohol
- Delayed uptake of alcohol by young people
- Reduced illness and injury from alcohol
- Changed attitudes towards alcohol and reduced tolerance for alcohol-related harms

October 2016
Position Statement Review date: October 2017 and on a 3 year cycle thereafter.

LINKAGES

National Drug Policy Framework (2015-2020) (Inter-Agency Committee on Drugs, 2015)

Rising to the Challenge - The Mental Health and Addiction Service Development Plan (2012-2017)

Hawke's Bay District Health Board: Health Equity in Hawke's Bay (McElnay C 2014), *Health Equity in Hawke's Bay Update* (McElnay C 2016) *Youth Health Strategy* (2016-2019), *FASD Discussion Document* (December 2015), *Intimate Partner Violence Intervention* (Reviewed September 2016) *Mai, Māori Health Strategy* (2014-2019), *Māori Health Annual Plan* (2016 – 2017).

APPENDIX 1

HAWKE'S BAY District Health Board Whakawāteatia	**Discussion paper on Reducing Alcohol-Related Harm**
	For the attention of: **HB Clinical Council, HB Health Consumer Council and the Māori Relationship Board**
Document Owner: Document Author(s):	Dr Caroline McElnay, Director Population Health Dr Rachel Eyre, Medical Officer of Health
Reviewed by:	Executive Management Team
Month:	July 2016
Consideration:	For endorsement

RECOMMENDATION

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

2. Note the contents of this report.
3. Feedback on the questions.
4. Endorse the proposed approach of developing a HBDHB Position Statement.

OVERVIEW

The purpose of this paper is to facilitate discussion amongst HBDHB committees on alcohol-related harm. Alcohol-related harm is a critical issue for our DHB, creating a significant burden of harm to individuals, to communities and to our health system.

Following a first round of discussions among the committees, it is proposed that a Position Statement on alcohol-related harms be drafted for the second round. The Position Statement would outline the DHB's priorities to reduce alcohol-related health harms in the next three to five (3-5) years (this timeframe being consistent with the National Drug Policy). This would be the DHB's opportunity to develop a common agenda on alcohol harms and to outline actions to address them. A final Position Statement would be put forward to be endorsed by the HBDHB Board.

An example of a Position Statement from the combined Wellington region of three district health boards is attached.

A short film has been produced and will be presented to the committees with this discussion paper.

BACKGROUND

Why we need to take alcohol-related harm seriously

- There are a high number of hazardous drinkers[2] in New Zealand and Hawke's Bay is no exception
- Every year around 1000 New Zealanders die from alcohol-related causes
- Alcohol-related harm in New Zealand is estimated to cost an overall $6.5 billion per year
- Alcohol is a toxin, an intoxicant, a carcinogen and an addictive psychotropic drug
- Hazardous drinking patterns can create both acute and chronic health problems
- Alcohol not only affects the individual but also those around them. It has detrimental effects e.g. lifelong brain damage to young people and to the foetus when a woman drinks whilst being pregnant
- Lack of systematically collected data on 'alcohol-related harm' including 'harm to others' limits our ability to estimate the true cost to communities and prevents adequate resources and effective strategies being assigned

What alcohol-related harm looks like in Hawke's Bay (based on current health data[3])

Alcohol related harm in our DHB region is demonstrated by:

- Rates of hazardous drinking in Hawke's Bay are higher than the national average (by 60%)
- Increasing rates of hazardous drinking over time (by almost 10% from 2006/07 to 2011/14)
- Highest rates of hazardous drinking among young people (41% in the 15-24 year age group)
- Higher rates of hazardous drinking and increased hospitalisations among Māori
- Increased hospitalisation rates for alcohol-related conditions among women
- Slight increase in women exceeding the alcohol and other substance legal limits while driving
- Hawke's Bay has slightly higher rates than New Zealand for alcohol related crashes resulting in non-fatal injuries but the percentage of alcohol-related crashes resulting in fatal injuries have dropped below national average

In 2015, a Hawke's Bay community survey[4] showed wide-spread recognition of alcohol harm and some pointers for change in the alcohol environment, as follows:

- Two-thirds feel the drinking of alcohol has a negative impact in their community
- Nearly 90% of people agree that alcohol affects family violence in the community and over 80% agree it affects community safety
- The majority of respondents want fewer bottle stores. Bottle stores and supermarkets selling alcohol are the most commonly identified as having the greatest impact on alcohol harm in communities
- Almost 80% want more alcohol-free entertainment options

What works to reduce alcohol related harm (based on the evidence) and what opportunities do we have:

Policy:

- The strongest measures to reduce alcohol-related harm are at the policy level and involve increasing price, reducing availability and reduced advertising. The Sale and Supply of Alcohol Act (2012) requires Medical Officer of Health input and enables more community say to reduce alcohol availability at a local level e.g. via the Local Alcohol Policy (LAP) process and licensing decisions.

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2 Hazardous drinkers are defined as adults who obtained an Alcohol Use Disorders Identification Test (a validated tool) score of 8 or more representing an established pattern of drinking that carries a high risk of future damage to physical or mental health.

3 Includes latest NZ Health Survey (Ministry of Health) results, HBDHB hospitalisation data and Massey data (Environmental Health Indicators NZ programme).

4 This 2015 HBDHB led survey involved 1000 adult respondents from across Hawke's Bay.

Community:

- The next most effective and cost-effective measures at a DHB level include a range of community-level interventions that aim to delay drinking in young people, reduce harm to Māori, pregnant women, and Pasifika, encourage moderation in older adults and seek to reduce availability (limiting both demand and supply)
- Interventions need to be whānau and community focussed and not just focussed on individual choice
- A focus on settings where target groups are found allows for integrated approaches
- Community-level interventions need to be community-led but communities often lack resources to do this and to focus on alcohol harm
- It is critical to find ways to delay drinking as long as possible, especially under 18s, to prevent alcohol's harmful effects on growing brains (up to the age of 25 years old)
- The message that there is no safe amount of alcohol which can be drunk in pregnancy needs to be widely understood - including by health professionals
- Reducing the exposure of young people to alcohol promotion, marketing and sponsored events particularly associated with sport is important

Screening:

- Screening and brief intervention approaches in hospital (ED), primary care, with pregnant or reproductive age women, and in settings with a wider community reach is a proven cost-effective strategy
- A screening/data collection initiative in ED may be able to gain support from other funders, (such as from the Health Promotion Agency and ACC), to inform a business case for the DHB to undertake the next phase (brief intervention and referral)
- There is scope for improving screening and brief intervention in primary care and wider settings, to include midwives (currently being looked at under Foetal Alcohol Spectrum Disorder), and others (Police, aged care sector, etc.). Achieving the buy-in from primary care around the importance of screening and brief intervention is key

Collaboration:

- There are a range of opportunities to build on and strengthen existing initiatives in the community, for example as led by Safer Communities Networks
- The DHB is a signatory to the Joint Alcohol Strategy (by Napier City Council and Hastings District Council) and is involved in the review
- There is an opportunity to support partnerships with local Iwi to better meet Māori needs. Māori often take more notice of whānau and friends' messages and support than health professionals
- A range of frameworks and plans can help guide our actions. Our DHB's Position Statement can be used as our platform to promote our common agenda with other groups

How can our DHB improve what it does – future actions?

Suggested areas for future investment include:

- Enable screening (initially) and brief intervention in ED (with possible external funding)
- Improve uptake of brief intervention in primary care, encouraging greater buy-in by primary care health professionals (e.g. use of incentives)
- Investigate brief intervention training opportunities in wider community settings, including midwives
- Develop a process for communication/community engagement to facilitate conversation on alcohol health impacts and to inspire and support community action
- Enhance support for Safer Communities projects, ensuring those projects which reduce inequity are prioritised and adequately resourced (which target for example, delayed drinking/reducing social supply for Māori youth)
- Develop more Iwi partnership approaches to reducing alcohol-related harm
- Provide health leadership by being alcohol-free at health sector events such as award ceremonies and other health events

- Collaborate with other agencies, particularly councils, during development of LAPs. The DHB is working alongside Napier City and Hastings District Councils to implement their Joint Alcohol Strategy - an opportunity exists to become a signatory to the revised strategy
- Establish usefulness of a review of current Mental Health and Addiction Services and whether they are accessible, appropriate and sufficient to meet the needs of target groups
- Align alcohol strategies with other work in the area of social needs, as alcohol harm is often connected with poverty and stress e.g. vulnerable children and CYF review
- Establish a dedicated Alcohol Harm Minimisation Coordinator role to: help identify champions to promote key messages and counter resistance; develop a supportive structure including a high level steering group; write and co-ordinate a three to five (3-5) year plan with an associated monitoring framework to report back to Board level.

(Please note that the data, evidence for what works and rationale for improvement suggestions are detailed in a background report (currently in draft) available on request from the author).

QUESTIONS FOR THE COMMITTEES

Your feedback is sought on the following questions to help guide the next steps.

1. Is there an appetite to tackle this issue of alcohol related harms?

2. What are your ideas about how we go about this e.g. the process for getting buy-in and commitment to actions from across our DHB, how we engage intersectorally and how we work with communities to bring about the necessary social change?

ATTACHMENT

Position statement on reducing alcohol related harm from Waiarapa DHB, Hutt Valley DHB, Capital and Coast DHB, Regional Public Health (2012-13) provided as an example.

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Performance Framework Exceptions Quarter 1 2016/17** 135 **HBDHB Quarterly Performance Monitoring Dashboard Quarter 4 2015/16**
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Tim Evans, Director of Finance and Information Peter Mackenzie, Operational Performance Analyst
Reviewed by:	Executive Management Team
Month:	November 2016
Consideration:	Monitoring

RECOMMENDATION

That the Board:

Note the contents of this report.

18

OVERVIEW

The purpose of this paper is to provide the Board with exception reporting on the Hawke's Bay District Health Board's performance on the Statement of Intent (SOI) and the District Annual Plan (DAP). A quick reference summary dashboard will be supplied prior to the meeting and shows our position as at the end of this quarter for all indicators. The dashboard uses traffic light methodology (as described on page 4) to represent this. Detailed information is included for all indictors where the variance to target was greater than 0.5% (indicated on the dashboard as a red cell with a 'U' symbol).

As this report ends September 2016, the results in some instances may vary to those presented in other reports.

BACKGROUND

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

ANNUAL PLAN (AP) 2016/2017

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

STATEMENT OF PERFORMANCE EXPECTATIONS (SPE) 2016/17

The SPE is produced annually within the context of the four-year Statement of Intent (SOI) 2014-18. The SPE informs the House of Representatives of the performance expectations agreed between a Minister and a Crown Entity. Formal agreement is gained annually through the AP process and actual performance is assessed and reported through the audited HBDHB Annual Report.

HAWKE'S BAY DISTRICT HEALTH BOARD (HBDHB) PERFORMANCE FRAMEWORK

The four dimensions of the non-financial monitoring framework, which was developed by the Ministry as a mandatory framework, will reflect DHB's functions as owners, funders and providers of health and disability services.

The 4 dimensions of DHB performance are:

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

KEY FOR DETAILED REPORT AND DASHBOARD

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

CONTENTS

PERFORMANCE HIGHLIGHTS

Achievements

- Immunisation at 8 months. We have achieved target for Maori and Pacific as well as the total population at 95.2%.
- Secondary mental health service utilisation target was achieved for Total and Maori across all age groups (0-19, 20-64 and 65+)
- Fall Assesments. We have achieved the target for the number of fall assessments carried out and the number of patients at risk who have been given a fall prevention plan.

Areas of Progress

- Faster Cancer Treatment. The result for patients treated within 62 day has increased to 65.6% this quarter from 62.5% in the previous quarter. The number of patients identified as at high risk has also increase over the quarter with the last month dropping off slightly. (page 7).
- Cervical Screening. There has been a small increase for the total, Pacific and other populations. Maori has remained the same as the previous quarter (page 16)
- Mental Health – Transition Plans. The result has increased from 44.8% to 53.2% and is expected to carry on improving based on local data. There is still a long way to go in order to achieve target of 95% (page 10)

Areas of Focus

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

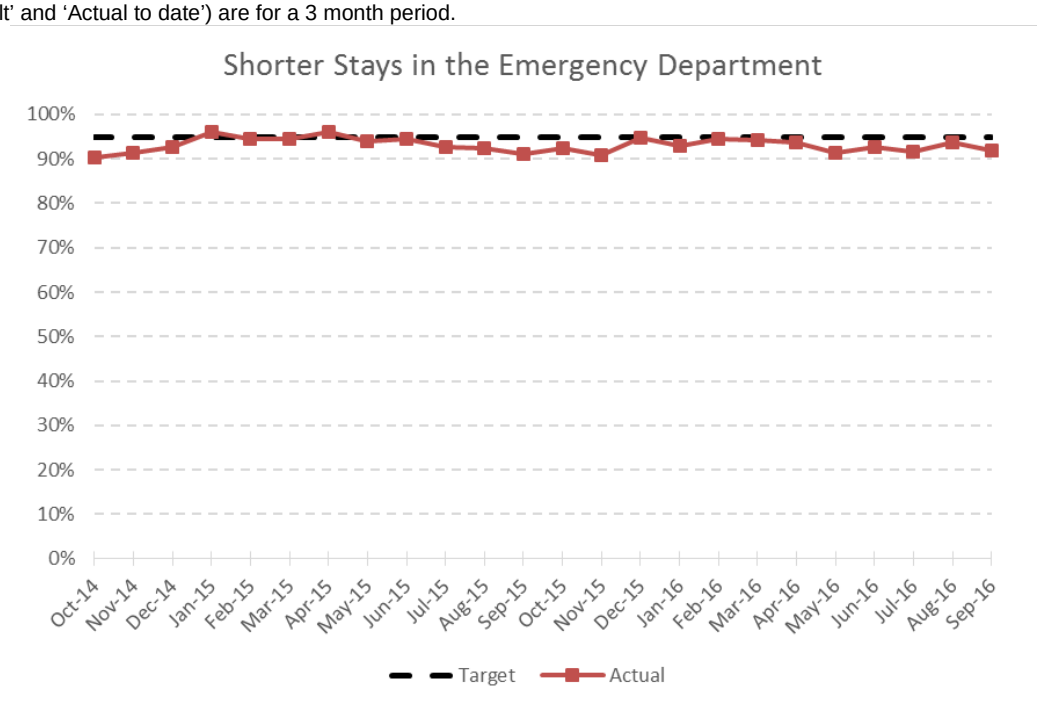
- Shorter Stays in ED. Patients waiting less than 6 hours in ED has decreased slightly from 92.5% to 92.4%, and remains below the target of 95% (page 5)
- Better Help for Smoker to Quit – Primary Care. A further decrease this quarter from 81.3% to 80.9% this quarter, this is below the target of 90% (page 8)
- Raising Health Kids. This is a new Health Target set by the Ministry of Health for 2016/17. We are currently at 21% against a target of 95%. (page 9)
- Improving Diagnostic Waiting Times – MRI and CT (waiting to confirm results)

DIMENSION 1 – ACHIEVING GOVERNMENT PRIORITIES AND TARGETS

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

Ethnicity	Baseline [1]	Previous result [2]	Actual to Date [3]	Target 2015/16	Progress against Previous Result
Total	94.7%	92.5% (U)	92.4% (U)	≥95%	▼
Maori	94.8%	94.2% (U)	94.6% (F)	≥95%	▲
Pacific	94.8%	95.6% (F)	95.3% (F)	≥95%	▼
Other	91.6%	91.1% (U)	91% (U)	≥95%	▼

Please note: Data presented in the graph are monthly results, whilst the data in the result section above ('Previous result' and 'Actual to date') are for a 3 month period.

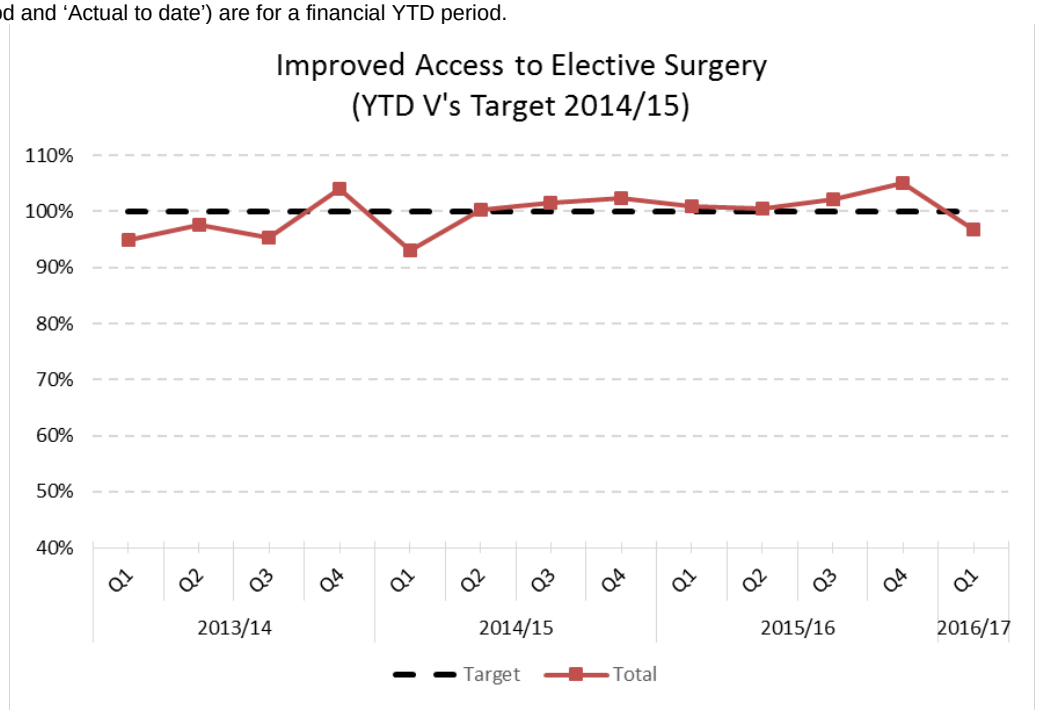


Comments:
In order to support the shorter stays in ED health target there has been a redesign of ED 'Front of House' to increase number of assessment areas and improve triage, initial assessment and fast-track processes. There has been a strong focus on relationship building between ED and Primary care, with work being done collaboratively to implement initiatives and manage frequent presenters to ED through multi-disciplinary approach and development of care pathways for this patient group.
Next quarter we intend to work on 'Optimising acute patient flow' along general medicine services in order to make flow process into, through and around ED more efficient.

1 *October to December 2015*
2 *April to June 2016*
3 *July to September 2016*

Health Target: Improved access to elective surgery (discharges)				
Key Performance Measures	**Baseline** [4]	**Actual to Date** [5]	**Period Target**[6]	**Target 2016/17** [7]
Discharges	1,823	1,874 (U)	≥1,935	≥6,012
Result to Target	100.9%	96.8% (U)	≥100%	≥100%

Please note: Data presented in the graph are monthly results, whilst the data in the result section above ('Previous period and 'Actual to date') are for a financial YTD period.



Comments:
There are several factors that have affected the result for quarter 1. Resource issues led to short term cancellations and outsourcing, as well as more complex operations taking place this quarter using up more theatre time. A recovery plan has been discussed with the Ministry, extra sessions have been rostered and with resource issues in hand we expect to see an improvement in Q2 progress.

4 July to September 2015

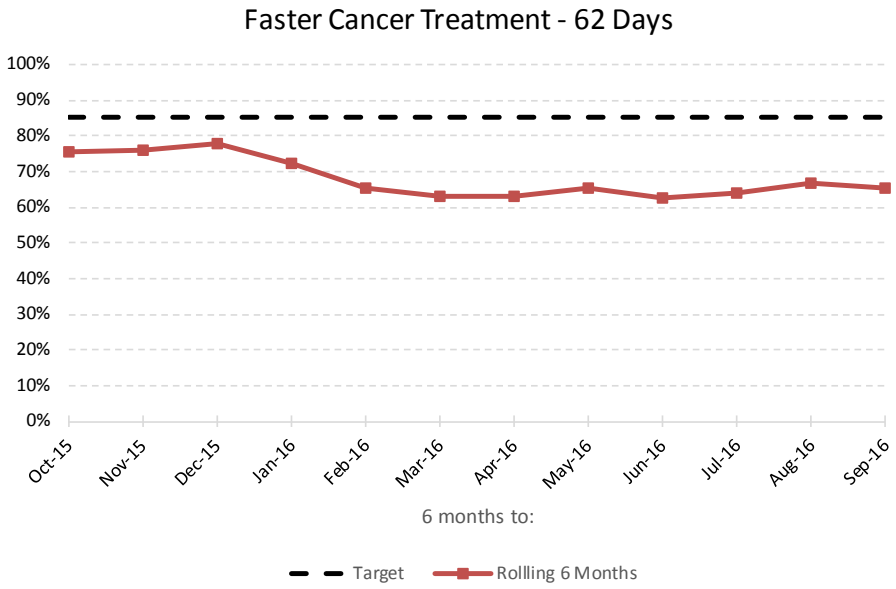
5 July to September 2016

6 *July to September 2016*

7 July 2016 to June 2017

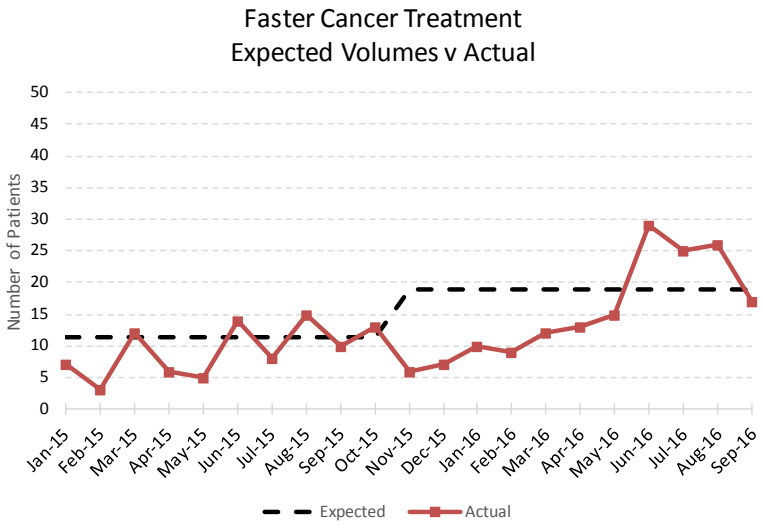
Health Target: Faster Cancer Treatment
Patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer

Key Performance Measures	Baseline [8]	Previous result [9]	Actual to Date [10]	Target 2015/16	Trend direction
Total	77.6%	62.5% (U)	65.6% (U)	≥85%	▲



Comments:
There have been multiple discussion with FCT (faster cancer treatment) Governance group and clinical teams for implementation of internal standards, such as referral to MDM (mulit disciplinary meeting) < 28 days, and referral for urgent CT (computer tomography) within 10 days.
The IT team have developed a module in the PMS (patient management system), that will support the capture of patient information in an electronic format. The value of this development ensures all the data for the patients, identified for the 62 day target and the 31 day indicator to be held in an electronic database.

Based on the expected annual cancer registrations for the DHB supplied by the Ministry, the DHB is expected to identify at least 228 people a year (19 a month) as patients with a high suspicion of cancer.



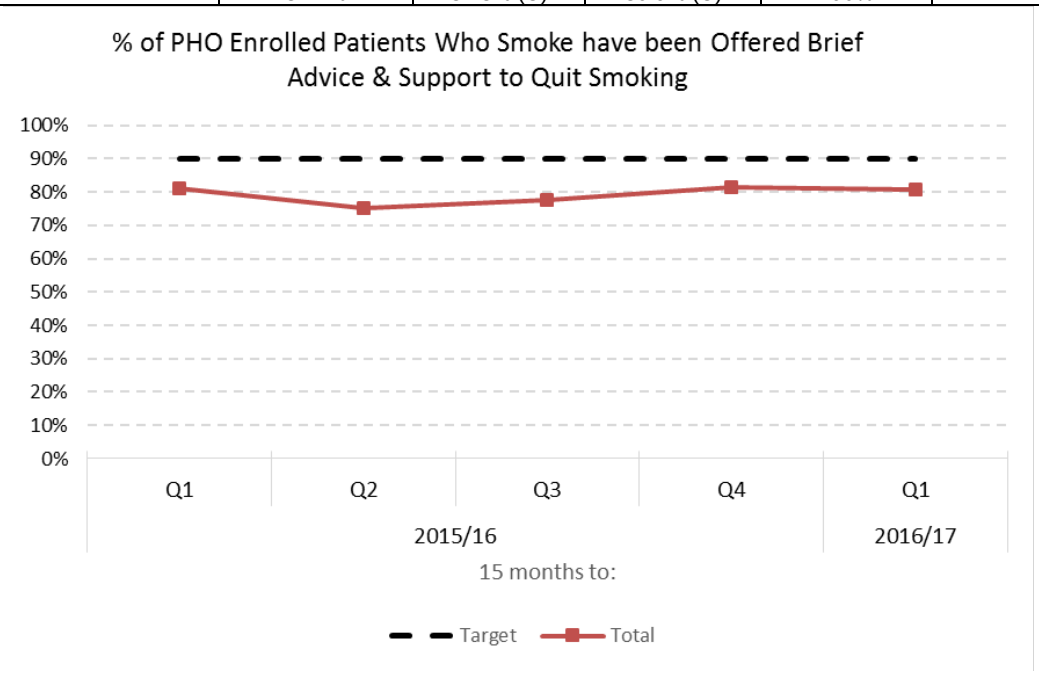
8 *6 months to December 2015*

9 *6 months to June 2016*

10 *6 months to September 2016*

Health Target: Better help for smokers to quit – Primary Care
90% of patients who smoke are seen by a health practitioner in primary care are offered brief advice and support to quit smoking

Key Performance Measures	Baseline [11]	Previous result [12]	Actual to Date [13]	Target 2015/16	Trend direction
Total	81.2%	81.3% (U)	80.9% (U)	≥90%	▼



Source: Ministry of Health

Comments:
Health Hawke's Bay continues to fund 28 general practices access to monthly Karo reporting which provides lists of patients who do not have a smoking status recorded in the past 12 months, and if identified as a current smoker do not have a record of smoking brief advice being offered in the past 12 months. Karo also provides a three-month projection so practices can contact patients who have not visited the practice in the past 12 months and therefore opportunistic screening has not been possible.

Practices with high enrolled populations in low quintile areas have extremely transient populations. This results in a large number of patients being non-engaged for a number of years and non-contactable. This is a growing barrier for meeting target.

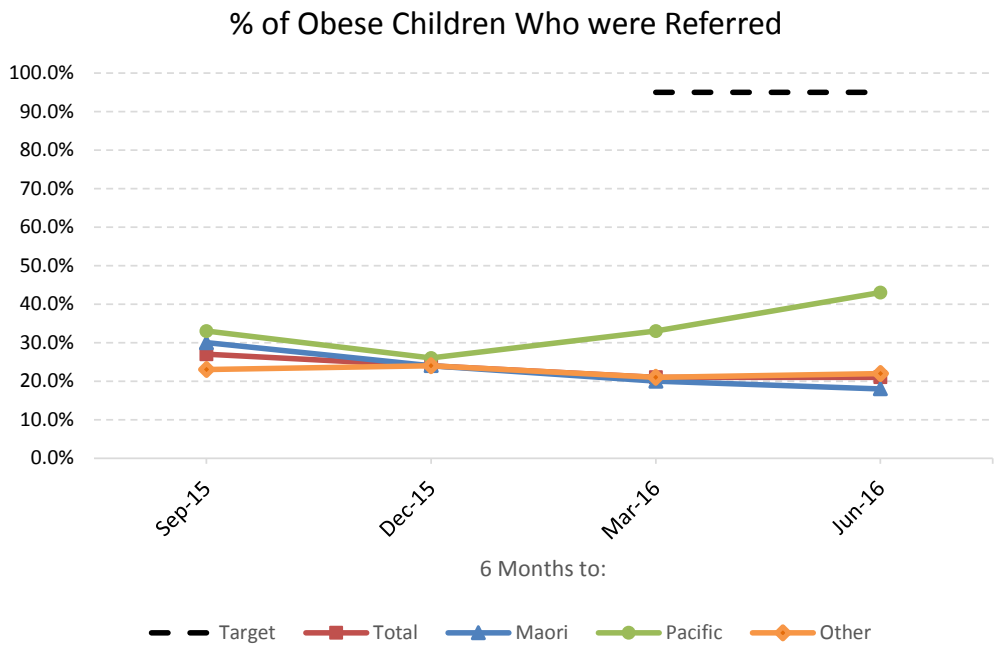
11 *October to December 2015. Source: DHB Shared Services*

12 *April to June 2016. Source: DHB Shared Services*

13 *July to September 2016. Source: DHB Shared Services*

Health Target: Raising Healthy Kids
95 percent of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

Key Performance Measures	Baseline [14]	Previous result [15]	Actual to Date [16]	Target 2015/16	Trend direction
Total	27.0%	21% (U)	21% (U)	≥95%	▬
Māori	30.0%	20% (U)	18% (U)	≥95%	▼
Pacific	33.0%	33% (U)	43% (U)	≥95%	▲
Other	23.0%	21% (U)	22% (U)	≥95%	▲



Source: Ministry of Health

This is a new Health Target introduced by the Ministry of Health for the 2016/17 year. The targer is 95% by June 2017 and has been included in the excpetions report as a way of minoriting progress over the financial year.

Comments:
Clinicians attended a Dietition facilitated professional development on the practical application of the new tool, launch of the HB tool utilising Be Smarter was also presented. Paediatrician presented the referral pathway back into the GP practice for children identified at the B4SC with a BMI >98th percentile and HB has also developed a clinical assessment tool for this referral screen. Training has also been delivered to Te Taiwhenua O Heretaunga (iwi provider) and wider WC/TO nursing group at Hauora Heretaunga on the new Raising Healthy Kids Targets, resources and referral pathways. Training will be delivered in Wairoa to B4SC clinicians and Kahungungu Exceutive by the end of October/16. (Health equity for Maori and Pacific)

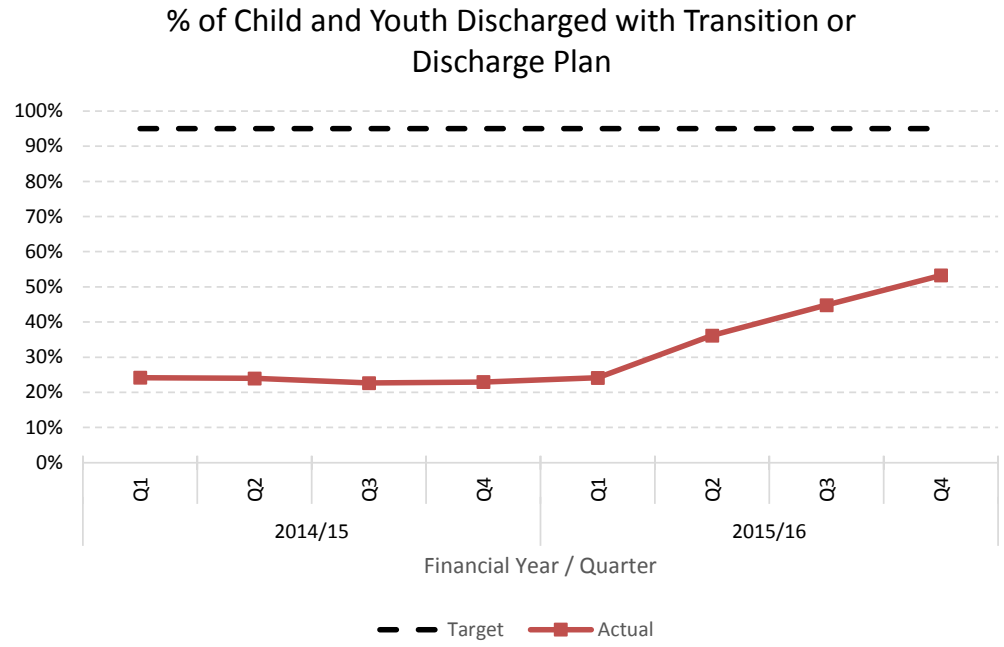
We have had the training in service and provided the resources that will support the B4SC clinicians to engage with families and discuss the referral pathways available

14 *October to December 2013. Source: DHB Shared Services*

15 *January to March 2016. Source: DHB Shared Services*

16 *April to June 2016. Source: DHB Shared Services*

Improving mental health services using transition (discharge) planning (PP7)					
Key Performance Measures	**Baseline** [17]	**Previous result** [18]	**Actual to Date** [19]	**Target 2015/16**	**Trend direction**
Total	36.2%	44.83% (U)	53.2% (U)	≥95%	▲



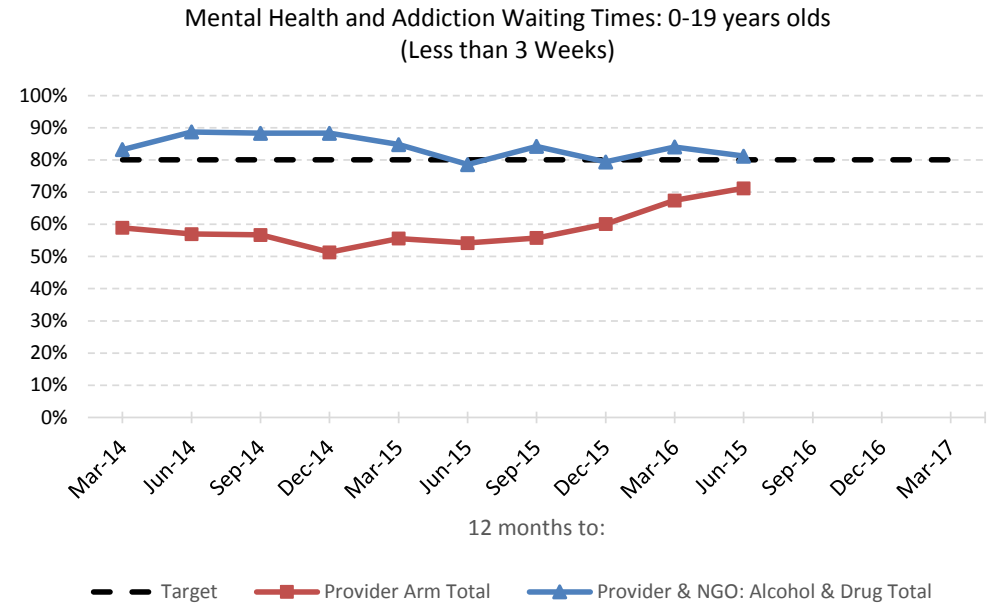
Comments:
The transition plan KPI has been given considerable attention over the past nine months, and this has been reflected in improvements in performance. As the data represents the last 12 months to July, the data is will have some lag in showing this improvement. Our own data indicates significant improvement over time:
April 2016 91%
May 2016 100%
June 2016 100%
July 2016 100%
August 2016 96.4%
We anticipate that the 12month data will begin to reflect the significant improvement over time, and anticipate further improvement. Improvements have been achieved through: (a) increased awareness and focus on KPI by staff and (b) ability to generate report on this KPI which can be used to prompt improved performance.

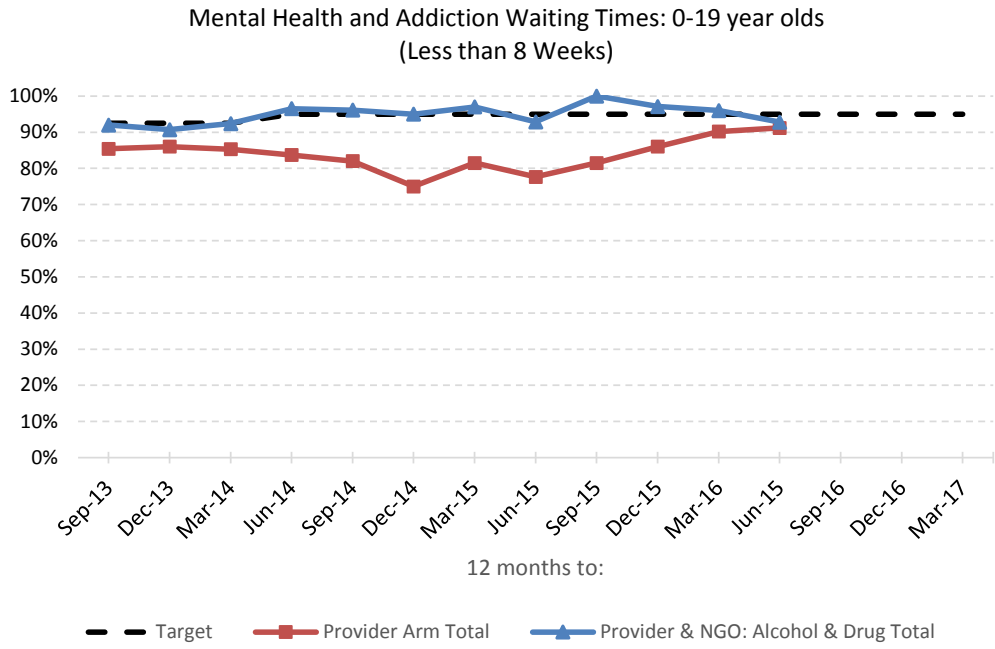
17 January 2015 to December 2015.

18 April 2015 to March 2016.

19 July 2015 to June 2016..

Shorter waits for non-urgent mental health and addiction services (PP8): Mental Health Provider Arm					
Key Performance Measures	**Baseline [20]**	**Previous result [21]**	**Actual to Date [22]**	**Target 2015/16**	**Trend direction**
Mental Health Provider Arm: Age 0-19					
<3 weeks	60.1%	67.4% (U)	71.2% (U)	≥80%	▲
<8 weeks	81.5%	90.2% (U)	91.2% (U)	≥95%	▲
Addictions (Provider Arm & NGO): Age 0-19					
<3 weeks	84.2%	84% (F)	81.2% (F)	≥80%	▼
<8 weeks	99.5%	96% (F)	92.8% (U)	≥95%	▼





2012 months to December 2015

21 12 months to March 2016

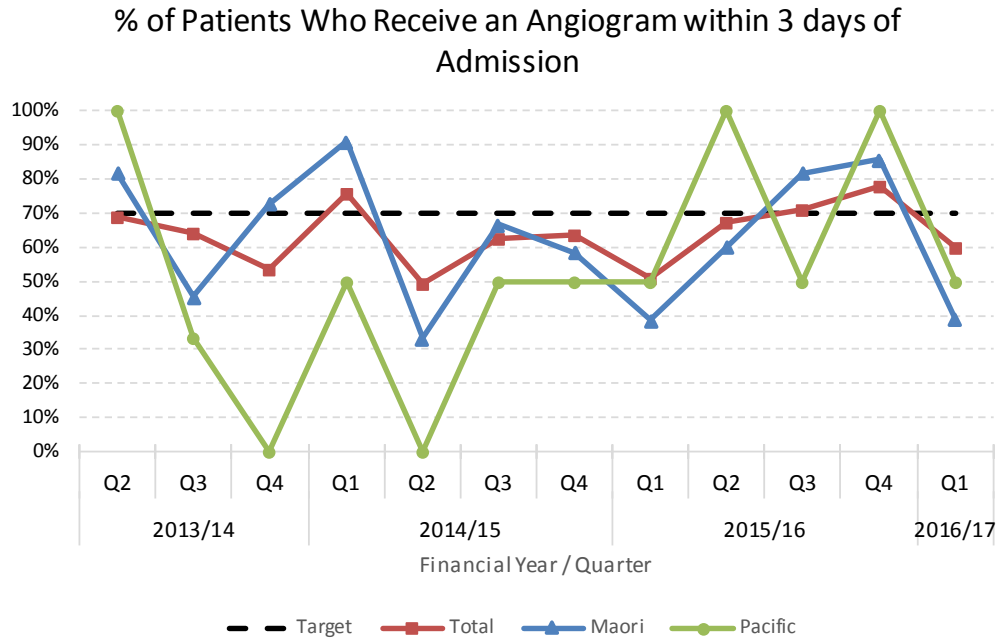
22 12 months to June 2016

18

Source: Ministry of Health
Comments: Some of the Steps currently undertaken to reduce wait times are, referral meeting's 3 times a week designated clinician phone referrer or parent that morning of receiving the referral, have the appointment calendar in front of you so you can arrange a time then and there and finally email CAPA and Clinician so they are aware of referral and a letter can be sent out of confirmation immediately although if the appointment is for the next few days we don't send a letter. Ongoing review of wait times is also occurring via regular reporting, which is informing further strategies.

Improvement management for long term conditions (PP20) Cardiovascular Disease: 70% of high-risk patients will receive an angiogram within 3 days of admission

Key Performance Measures	Baseline [23]	Previous result [24]	Actual to Date [25]	Target 2015/16	Trend direction
Total	68.7%	77.6% (F)	60% (U)	≥70%	▼
Māori	60.0%	84.6% (F)	38.9% (U)	≥70%	▼
Pacific	100.0%	100% (F)	50% (U)	≥70%	▼



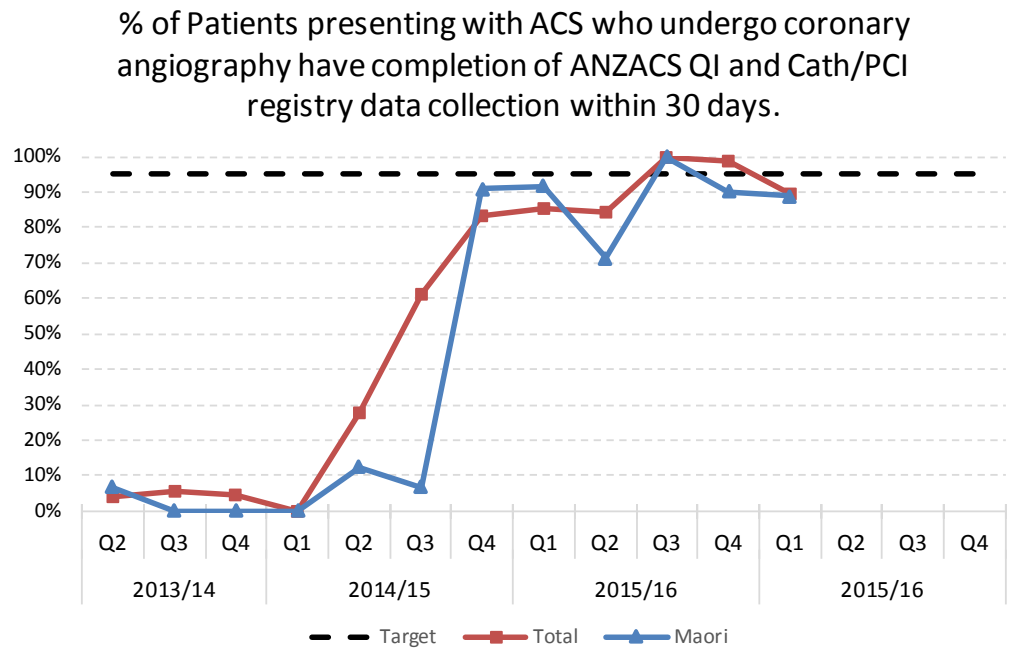
Comments:
It was commented during a teleconference with the Ministry of Health that there are challenges in accessing beds at Capital & Coast. A report has been created and was discussed as it shows the waiting time along the patients journey. We are going to follow this up and distribute latest report during the next quarter. It was discussed with the MoH that there is not good visibility of patients who are waiting six days and longer. This is a potential risk as it would be good to understand if this is an issue.

23 *January to March 2015*

24 *April to June 2016*

25 *July to September 2016*

Improvement management for long term conditions (PP20) Cardiovascular Disease: Over 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days					
Key Performance Measures	**Baseline [26]**	**Previous result [27]**	**Actual to Date [28]**	**Target 2015/16**	**Trend direction**
Total	84.1%	96.6% (F)	89.7% (U)	≥95%	▼
Māori	71.4%	90.0% (U)	88.9% (U)	≥95%	▼
Pacific	50.0%	-	100% (F)	≥95%	*



Key Performance Measures	Baseline [29]	Previous result [30]	Actual to Date [31]	Target 2015/16	Trend direction
Reducing Rheumatic fever (PP28)					
Total	0.6	1.87 (U)	1.86 (U)	≤1.5	▲
Maori	2.48	7.99 (U)	4.82 (U)	≤1.5	▲
Pacific	-	-	16.47 (U)	≤1.5	*

Comments:

Within the last quarter a small baseline survey within the Flaxmere school communities undertaken, this shows good understanding of throat swabbing for sore throats but not the link to rheumatic fever. The Action plan from survey and anecdotal evidence is multifaceted and includes engaging with throat swabbing schools and close-by ECEC Facebook pages, local performers, national health promotion materials, etc. Kaiawhina's find children more likely to report incomplete adherence than caregivers and a 5 day reminder useful.

26 *January to March 2014*

27 *January to March 2016*

28 *April to June 2016*

29 *October to December 2012.*

30 *July 2015 to June 2016 (12 month data)*

31 *July to September 2016 (3 month data)*

Key Performance Measures	Baseline [32]	Previous result [33]	Actual to Date[34]	Target 2015/16	Trend direction
Improving waiting time for diagnostic services (PP29)					
Coronary Angiography	69%	100% (F)	100% (F)	≥95%	▬
Computed Tomography (CT)	84.4%	94.6% (F)	87.4% (U)	≥95%	▼
Magnetic Resonance Imaging (MRI)	31.0%	44.7% (U)	52.8% (U)	≥85%	▲
Diagnostic Colonoscopy: Urgent	82.4%	93.5% (F)	93% (F)	≥85%	▼
Diagnostic Colonoscopy: Non-Urgent	87.1%	80.4% (U)	97.6% (F)	≥85%	▲
Surveillance Colonoscopy	79.3%	93.5% (F)	94.6% (F)	≥70%	▲
Comments: Currently the DHB is utilising several strategies to manage demand in CT/MRI such as continuing with vetting and justification of all CT/MRI requests, developing hospital wide imaging guidelines and adopting the NCAR community guidelines. We have realised some extra capacity in our hybrid CT/NM scanner by establishing a dedicated CT weekly list and the department is also participating in both an external review of its services and an MRT roster review that will inform the organisation of both current and future capacity/demand and the associated required staffing.					

32 December 2015.

33 June 2016.

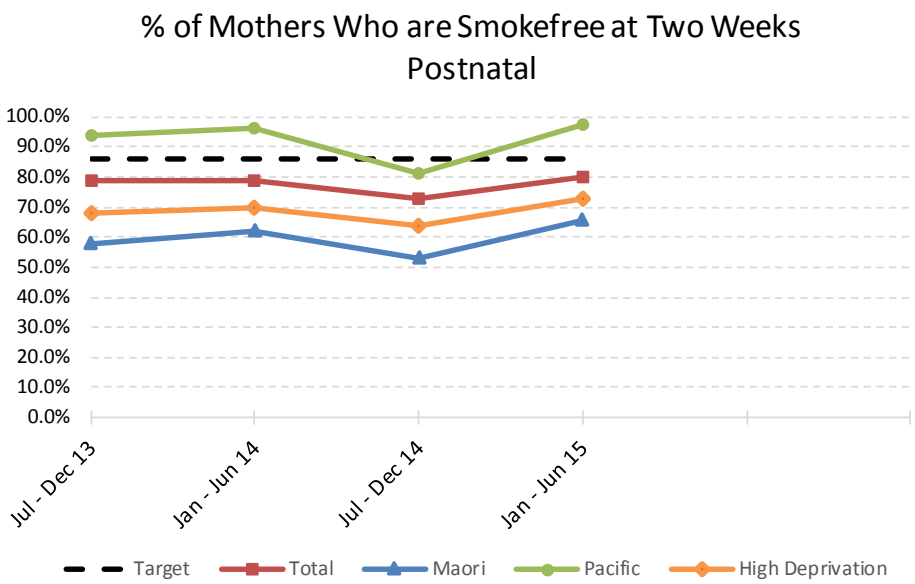
34 September 2016

DIMENSION 4 – SERVICE PERFORMANCE

PREVENTION SERVICES

Percentage of Pregnant Māori woman that are Smokefree at 2 weeks postnatal

Ethnicity	Baseline [35]	Previous result [36]	Actual to Date [37]	Target 2015/16	Trend direction
Total	0.0%	73% (U)	79.9% (U)	≥86%	▲
Māori	58.0%	53% (U)	65.6% (U)	≥86%	▲
Pacific	0.0%	81% (U)	97.7% (F)	≥86%	▲



Comments:

There is ongoing work in this area making sure all data entry people responsible for maternity data entry are familiar with the smokefree information on booking forms and Healthware in order to complete fields accordingly.

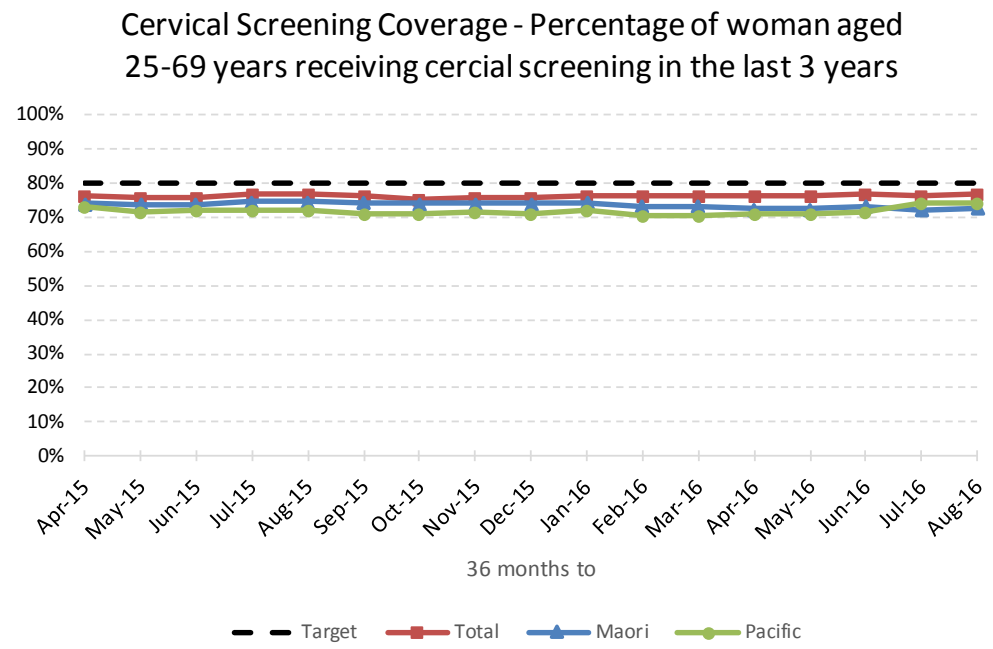
The Early Engagement Project is a combined effort between Ata Rangi Maternity and the Smokefree Team planned to be launched in November. This project is developed for all GP practices and other primary care health care providers to make as many practitioners as possible aware of the five essentials in the first 10 weeks of pregnancy (find a midwife, screening, iodine & folic acid, diet & exercise and smokefree , alcohol and other drug abuse education).
The smokefree team has developed smokefree resources for all health care providers as well as for women and their whānau. This is expected to increase early smokefree intervention with increased rate of early antenatal smoking cessation referrals.

35 July to December 2013

36 July to December 2014

37 January to June 2015

Percentage of women aged 25-69 years receiving cervical screening in the last 3 years					
Key Performance Measures	**Baseline** [38]	**Previous result** [39]	**Actual to Date** [40]	**Target 2015/16**	**Trend direction**
Total	75.8%	76.6% (U)	76.9% (U)	≥80%	▲
Māori	74.1%	73.2% (U)	72.7% (U)	≥80%	▼
Pacific	71.2%	71.4% (U)	74.2% (U)	≥80%	▲
Other	76.5%	77.8% (U)	78.2% (U)	≥80%	▲



Source: National Screening Unit

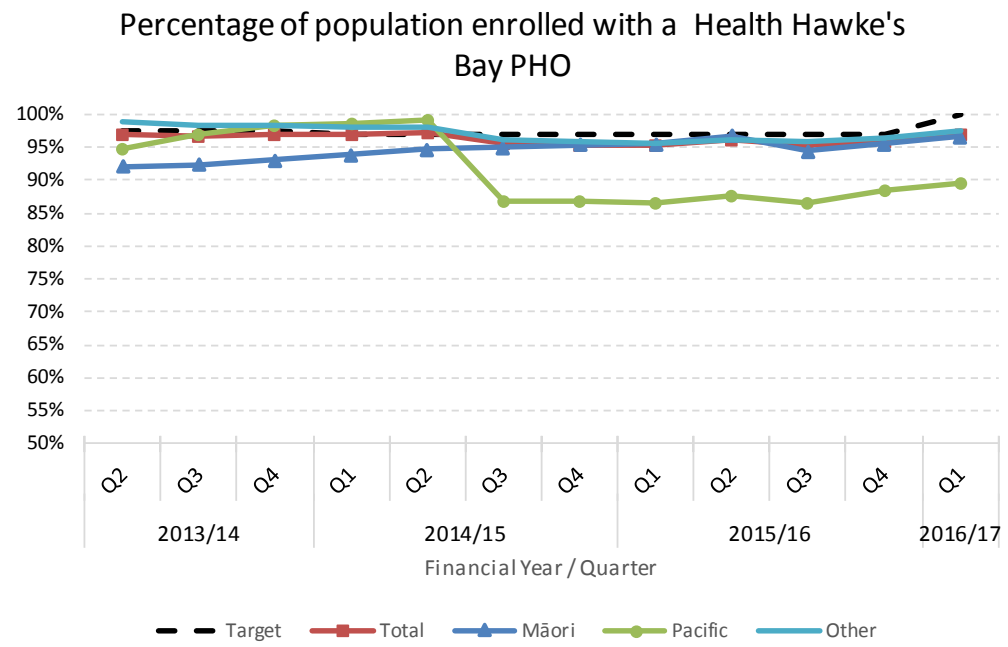
We are continuing to work with GP practices to improve participation of NCSP priority group women in screening e.g. Best Practice in Primary Care project and data-matching. In addition, contacting Maori and Pacific women who have never had a cervical smear or have not had one for over five years by phone or home visits, and offering outreach smears, to which the the uptake has been positive. We are continuing to ensure accuracy of participant ethnicity data held on National Cervical Screening Programme Register and ethnicity data on NHI. Recent population projections released by the National Screening Unit show that in the next five years (2016-2021) Hawke's Bay's NCSP eligible Maori and Pacific populations will increase by 7% and the Asian population will increase by 16% we anticipate this being a challenge to the sector.

38 36 months to 31 December 2015. Source: National Screening Unit

39 36 months to 31 June 2016. Source: National Screening Unit

40 36 months to 31 August 2016. Source: National Screening Unit

Proportion of the population enrolled in the PHO					
Key Performance Measures	**Baseline** [41]	**Previous result** [42]	**Actual to Date** [43]	**Target 2015/16**	**Trend direction**
Total	96.4%	95.9% (U)	96.9% (U)	≥100%	▲
Māori	97.2%	95.6% (U)	96.6% (U)	≥100%	▲
Pacific	88.7%	88.4% (U)	89.6% (U)	≥100%	▲
Other	96.5%	96.5% (U)	97.4% (U)	≥100%	▲



Source: Ministry of Health

Comments:
Practices were audited in September 2016 and some issues with information being sent through secure network. PHO Performance Manager is in the process of identifying practice New Born Enrolment champions and a link to the MOH website has been circulated which includes 10 minute video. There is also a review taking place to confirm data recoding and processes.

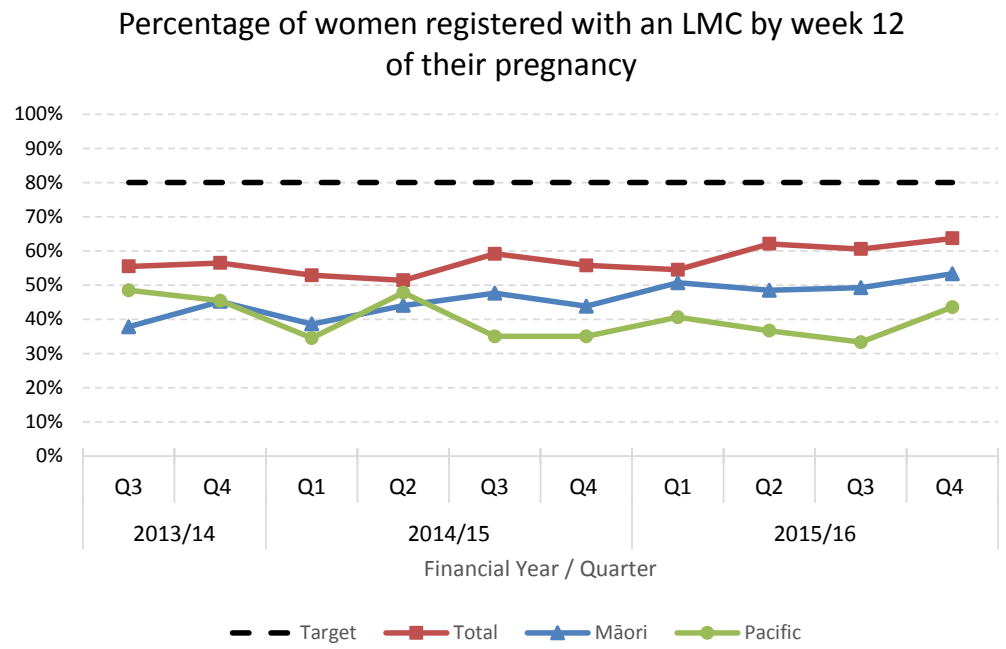
18

41 October to December 2014.

42 April to June 2016.

43 July to September 2016.

Percentage of women registered with an LMC by week 12 of their pregnancy					
Key Performance Measures	**Baseline** [44]	**Previous result** [45]	**Actual to Date** [46]	**Target 2015/16**	**Trend direction**
Total	54.5%	60.6% (U)	63.7% (U)	≥80%	▲
Māori	50.7%	49.2% (U)	53.3% (U)	≥80%	▲
Pacific	40.6%	33.3% (U)	43.6% (U)	≥80%	▲
Other	58.5%	73.4% (U)	72.8% (U)	≥80%	▼



Comments:
Whilst the result remains unfavourable and demonstrates ethnic inequity it is encouraging to see the trend moving in the right direction and improved from the last quarter. Current actions going on in this space are: Napier Maternity resource centre continues to grow as a women's health hub for pregnancy related matters in Napier on Kennedy road with continued positive results in access by Maori and young pregnant women. A new Early engagement programme "My Baby, My midwife and me" is just about to be launched officially with a roll out programme across GP practices in Hawke's Bay with the Midwifery Director meeting planned to go to all GP practices with the key messages and support increase in early bookings with a midwife.

A recent media release has occurred in Wairoa community to raise awareness and support women who are Hapu to access a midwife. There is also a planned media release and launch for the rest of Hawke's Bay in December. The Find Your Midwife website link is on all our webpages, is regularly posted on our facebook pages and is on all posters across the community.

44 October to December 2014.

45 January to March 2016.

46 April to June 2016.

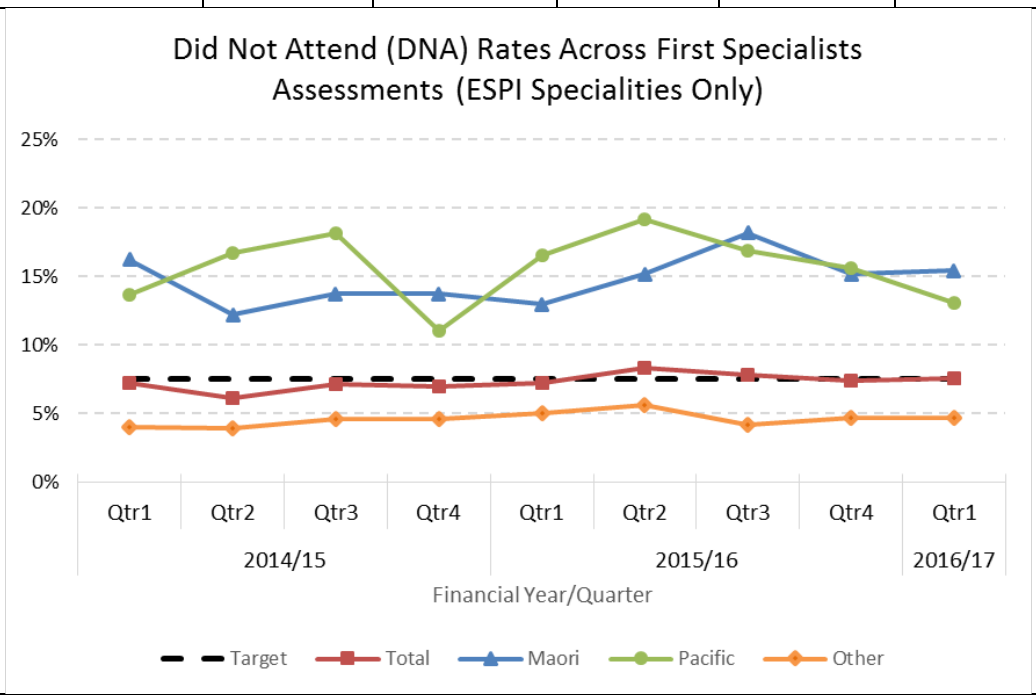
High intensive users of hospital services (High flyers to ED) – 4 attendances of more in a 12 month period					
Key Performance Measures	**Baseline** [47]	**Previous result** [48]	**Actual to Date** [49]	**Target 2015/16**	**Trend direction**
Total	5.6%	5.4% (F)	5.18% (F)	≤5.4%	▲
Māori	6.1%	6.1% (U)	5.76% (U)	≤5.4%	▲
Pacific	6.9%	6.2% (U)	5.92% (U)	≤5.4%	▲
Other	5.3%	4.9% (F)	4.81% (F)	≤5.4%	▲
Comments: A pilot has commenced between ED and Primary Care to identify and case manage "frequent flyers" to ED through re-engagement with General Practice and the development of integrated care plans for the patient group. Hawkes Bay DHB has engaged the Francis Group and Dr Ian Sturgess to work with the ED, AAU and General Medicine to assist with optimising acute patient flow work stream.					

47 October to December 2014.

48 January to March 2016.

49 April to June 2016.

Did not attend (DNA) rate across first specialist assessments[50]					
Key Performance Measures	**Baseline** [51]	**Previous result** [52]	**Actual to Date** [53]	**Target 2015/16**	**Trend direction**
Total	8.1%	7.4% (F)	7.5% (F)	≤7.5%	▼
Māori	14.9%	15.2% (U)	15.4% (U)	≤7.5%	▼
Pacific	18.3%	15.6% (U)	13% (U)	≤7.5%	▲
Other	5.3%	4.7% (F)	4.7% (F)	≤7.5%	—



Comments:
Although the overall DNA result is favourable against the target of 7.5% and although the gap has narrowed in the last quarter there remains persistent disparities for our Maori and Pacific populations. Through the Customer Focused Booking project recent changes have been made to the internal reporting of DNA. The new reports are user friendly and provide an "at a glance state of DNA" (including ethnicity breakdown) for the ESPI specialities, the project will use these reports to monitor and track DNA performance. The project recognises that a number of initiatives that are being developed have not yet translated to this key performance indicator. A new initiative focusing on the three specialities with the highest DNA rates for Maori has been instigated within the project.

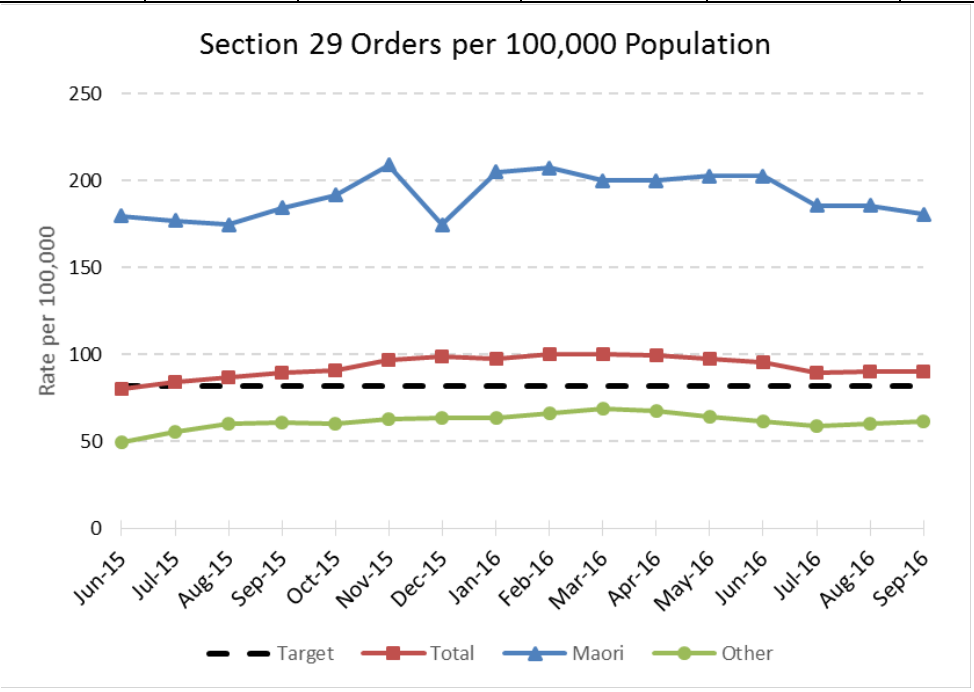
50 ESPI specialities only

51 October to December 2014

52 January to March 2016

53 April to June 2016

Rate of Section 29 orders per 100,000					
Ethnicity	**Baseline [54]**	**Previous result [55]**	**Actual to Date [56]**	**Target 2015/16**	**Trend direction**
Total	97	97.3 (U)	89.7 (U)	≤81.5	▲
Māori	196	201.6 (U)	183.9 (U)	≤81.5	▲
Other	93.4	64.5 (U)	60.1 (U)	≤81.5	▲



Comments:
Some recent trending down for Maori CTO rates is positive but more work is needed to reduce in this in the longer term. There are activities ongoing to better understand complexities of this issue and greater connection with our communities and whānau, which is imperative. Community Mental Health vision is to have a greater Whanau Ora type approach to our treatment and service provision with a more holistic approach to needs, including social and economic factors, to support whanau aspirations for improved wellness and lifestyle. Supporting Parents Healthy Children (was COPMIA) and Pregnancy Parenting Support initiatives are examples of how and where we will be resourcing this work.
A Te Ara Whakawaiora paper was presented and discussed at MRB in August. Subsequently, the Mental Health directorate and Maori Health Services have organised a wananga that will be held in Q2 with a wide group of stakeholders to discuss the complexities of compulsory treatment orders.

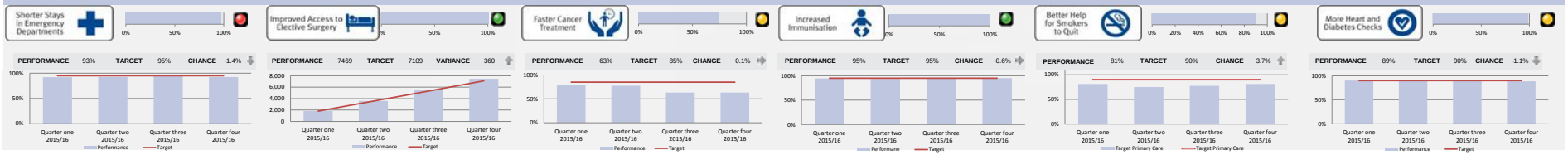
54 *October to December 2015*
55 *April to June 2016*
56 *July to September 2016*

MINISTRY OF HEALTH
MANATŪ HAUORA

Hawke's Bay DHB performance monitoring report quarter four 2015/16

Monitoring Status Standard Monitoring

HEALTH TARGETS

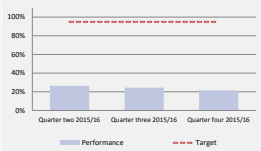


SERVICE RECONFIGURATION - SHIFTING SERVICES
(IMPROVING SYSTEM INTEGRATION)

The DHB provided a comprehensive report which clearly outlined their commitment to reconfigure and shift services and their investment strategy.

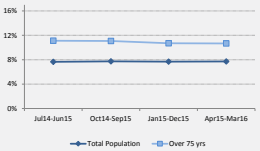
Raising Healthy Kids

Percentage of Obese Children Who Were Referred

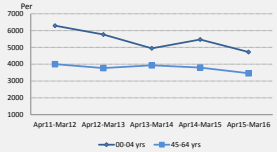


OVERALL INDICATORS ACROSS DHBs

ACUTE READMISSIONS RATES (standardised)



AMBULATORY SENSITIVE HOSPITALISATION RATES



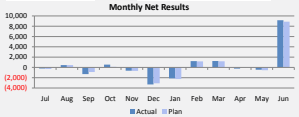
FINANCIAL MANAGEMENT

Financial Performance Rating: Good

NET RESULT

	YTD-Jun 2016 Actual	Plan	Variance
YTD Net Result:	4,366	3,990	376

Monthly Net Results



MAIN FINANCIAL CATEGORIES

$'000	YTD-Jun 2016 Actual	Plan	Variance
Personnel Costs	(187,322)	(188,426)	1,104
Outsourced Services	(15,116)	(10,654)	(4,461)
Clinical Supplies	(44,463)	(43,432)	(1,031)
Infrastructure/Other Supplies	(45,989)	(41,717)	(4,273)

PROGRESS AGAINST LOCAL ACTIONS AS DEFINED IN THE DHB ANNUAL PLAN

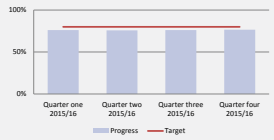
IMPROVED MANAGEMENT FOR LONG TERM CONDITIONS (CVD, DIABETES AND STROKE)

IMPROVING WRAP AROUND SERVICES – HEALTH OF OLDER PEOPLE

Immunisation Coverage

	Goal	Performance
Immunisation coverage at 2 and 5 years of age		
Immunisation coverage at 2 years of age	95%	95%
Immunisation coverage at 5 years of age	90%	93%
Human papillomavirus immunisation	65%	68%

Cervical Screening Coverage



REGIONAL SERVICE DELIVERY

Quarter four 2015/16

Overall Performance

National Priorities		Information Technology Critical Priorities	
Cancer Services		eMedicines Reconciliation	
Cardiac Services		Clinical Workstation (CWS) and Clinical Data Repository (CDR)	
Health of Older People		Replacement of legacy Patient Administration Systems (PAS)	
Elective Services		National Infrastructure Platform (NIP)	
Stroke Services		Patient Portal	
Mental Health and Addictions		National Patient Flow	
Major Trauma			
Hepatitis C			

Health Workforce Regional Actions against Workforce Plan

CROSS-AGENCY PRIORITIES

Prime Minister's youth mental health project	Reducing Rheumatic fever	Delivery of the children's action plan
On track	On track	On track

Quality and Safety Markers

	Goal	Performance	
Falls risk assessment (Jan-Mar16)	90%	97%	
Hand hygiene (Jan-Mar16)	80%	90%	

	Goal	Performance	
Surgical site infections (Oct-Dec 2015):			
Antibiotic administered in the right time	100%	98%	
Patients receive cefazolin or cefuroxime	95%	94%	

Regional Performance Highlights

The Central region received achieved ratings for six out of ten of its national priorities, a slight improvement in overall performance since the last quarter.

There is good progress in Mental Health and Addiction services with 14 out of the 20 actions now complete and the remaining to be continued in 2016/17.

The Central region has successfully inputted data to the national Major Trauma Registry. While some actions are still partially achieved, there is an expectation of further progress in 2016/17.

For IT services, there is steady progress on the regional programme with a number of activities and it is expected that there will be greater momentum in the next 12 months.

Regional Performance Issues

For Cancer Services, progress has been made for the Upper GI and Head and Neck Tumour Standard Reviews, and the region has made good efforts in assisting the DHBs. However, the health target was not achieved by the DHBs, therefore a partially achieved rating was given.

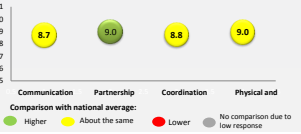
The region successfully achieved both Cardiac ACS indicators across all DHBs this quarter and there is ongoing progress for the Heart Failure initiatives. A partially achieved rating was given due to intervention rates across the suite of cardiac procedures in Secondary Services remaining low. The region continues to make considerable effort in addressing the barriers to access.

For Elective services, the partially achieved rating is due to the waiting times performance in April and May. There is an improvement from the previous quarter however, and work has been completed on the ESPWP Final Report.

There was insufficient data provided for Stroke Services in the region's report. More information is expected in the next quarter.

Full capability of the NIP is not ready and the programme is still revising its timeframes. A revised contract framework with IBM is on track to be signed by the end of this month.

Patient Experience



WAITING TIMES

Diagnostic waiting times

	Goal	Performance
Coronary angiography (<90 days)	95%	100.0%
Radiology		
CT Scan (<42 days)	95%	94.6%
MRI Scan (<42 days)	85%	44.7%

	Goal	Performance
Colonoscopy		
Urgent colonoscopy (<14 days)	75%	93.5%
Non-urgent colonoscopy (<42 days)	65%	80.4%
Surveillance colonoscopy (<84 days)	65%	93.5%

Patients Waiting For FSA and Treatment

PATIENTS WAITING FOR FSA

	Apr	May	Jun	last mnth	3 mnths
ESPI 2	23	4	45	41	22
ESPI 2 %	0.8%	0.1%	1.8%	1.4%	0.8%

PATIENTS WAITING FOR TREATMENT

	Apr	May	Jun	last mnth	3 mnths
ESPI 5	21	18	7	-11	-14
ESPI 5 %	1.8%	1.5%	0.6%	-0.9%	-1.1%

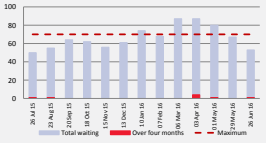
Regional Provision Cardiac Surgery Delivery

REGIONAL DELIVERY - CAPITAL & COAST DHB OF SERVICE

PERFORMANCE AGAINST PLAN	90%	VARIANCE	-67

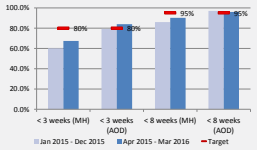
WAITING LIST - CAPITAL & COAST DHB OF SERVICE

TOTAL REGIONAL WAITING LIST	53
% OF NATIONAL WAITING LIST	21%



Mental Health

Mental health and addictions waiting times: Child and Youth aged 0-19 years



SERVICE COVERAGE DELIVERY

This quarter the DHB provided:

- an update on its pharmaceutical waste collection and disposal processes
- confirmation of delivery of the spinal cord impairment actions identified in the Annual Plan
- a report on delivery of key actions from its suicide prevention plan
- an update on occupational therapy services for people with low vision

PERFORMANCE HIGHLIGHTS

The DHB reached the immunisation targets for all milestone ages at 8 months, 2 years and 5 years, and for HPV immunisation.

Good financial performance.

PERFORMANCE ISSUES

Faster cancer treatment health target: Performance in this target dropped in the second half of 2015/16 and Hawke's Bay now sits second to bottom of the DHB rankings. With the 85% target now due to be achieved, sustained performance improvement is required in 2016/17.

Further work is needed to achieve the goals for the better help for smokers to quit and the more heart and diabetes checks health targets.

Further work is also needed to meet the expectations for Improved management for long term conditions of stroke services.

How to read this dashboard

This dashboard shows a summary of most aspects of DHB performance. It combines indicators of DHB performance, as agreed in the 2015/16 Annual Plan, as well as complementary information such as financial net results, hospital indicators and other priorities. The structure has been designed to display DHB information using an 'at-a-glance' approach. It is not to be used for general publication. It groups information according to the following areas:

Health targets	Shows the progress made by the DHB against the health targets. The top bar chart show relative performance to target for each measure, while the time series charts absolute performance throughout the year.
Service Reconfiguration	This area displays information related to the progress DHBs are achieving in the implementation of the System Integration Programme.
Waiting Times	This area summarises an array of indicators that show DHB progress towards reducing waiting times.
Other Priorities	Emerging priorities such as the Prime Minister's youth mental health initiative.
Service coverage	Self-reported confirmation & exception report. DHBs must ensure service coverage expectations are met, or demonstrate resolution of service coverage gaps by providing an appropriate resolution plan, and adequate progress is being made against the resolution plan.
Financial Management	Overview of the financial performance of the DHB based on data provided by the DHBs in monthly financial templates.
Highlights and Lowlights	High level description of particular issues in which a DHB exceeded agreed performance expectations or has not met agreed performance expectation and does not have an appropriate resolution plan in place, or needs to progress further.

Each area includes one or more indicators. Definitions for those are as follow: (Definitions for health target indicators are shown in the health target summary table and therefore are not repeated here.)

Acute readmissions rates *	Acute readmission rates are defined as the number of unplanned acute readmissions to hospital within 28 days of a previous inpatient discharge that occurred within the 12 months to the end of the quarter, as a proportion of inpatient discharges in the 12 months to the end of the quarter. The rates are standardised by patient population characteristics, deprivation, rurality, patient health conditions, comorbidity and surgery, using national patient population as a 'standard'. Indirect standardisation using logistic regression method is applied to derive the rates.
Ambulatory sensitive hospitalisations (ASH) *	Ambulatory Sensitive Hospitalisations (ASH) result from diseases and conditions sensitive to prophylactic or therapeutic interventions deliverable through primary care and are, therefore, avoidable. The ASH rates are derived by the total number of 12-month ASH for DHB patients aged 0-4 and 45-64 as the numerators and the same age population of the DHB as the denominators respectively. Rates for 45-64 age group are age standardised using national population as a standard.
Improved management for long term conditions	DHBs are expected to report on delivery of the actions and milestones as identified in the 2015/16 annual plans for long term conditions (LTC), diabetes care improvement packages (DCIP), acute coronary syndrome (ACS) services, and stroke services.
Improving wrap around services -Health of Older People	DHBs are expected to report on delivery of the actions and milestones as identified in the 2015/16 annual plans for health of older people services including home and community support services, InterRAI, dementia care pathways, HOP specialists and fracture liaison services.
Immunisation coverage at 2 and 5 years of age	The percentage of children who have completed their age-appropriate immunisations by the age of 2 years and by the age of 5 years. The rating - indicated by the traffic light colour - is based on performance for both the 2- and 5-year-old milestones.
Human papillomavirus immunisation	Percentage of eligible girls fully immunised with human papillomavirous (HPV) vaccine. For 2015/16 the measure is the 2002 birth cohort measured at 30 June 2016.
Cervical screening coverage	The number of eligible women (aged 25-69 years) screened in the three years to end of quarter being reported as a proportion of the hysterectomy adjusted female population.
Regional delivery - cardiac	Regional cardiac provider delivery against plan. DHBs submit four-weekly reports.
Waiting list - cardiac	Regional cardiac provider total waiting list against the waiting list target including those waiting over four months. Proportion of regional to national waiting list. DHBs submit four-weekly reports.
Patients waiting for FSA (ESPI 2)	The total number on the waiting list waiting longer than four months for a first specialist assessment (FSA) for the last three months, and the number waiting as a % of the total list. ESPI is referred to elective services patient flow indicators.
Patients waiting for treatment (ESPI 5)	The total number on the waiting list waiting longer than four months for treatment for the last three months, and the number waiting as a % of the total list. ESPI is referred to elective services patient flow indicators.
Alcohol and drugs waiting times: * Child and Youth aged 0-19 years	Waiting times are measured from the time of referral for treatment to the first date the client is admitted to treatment, following assessment in any service whether it be NGO or provider arm.
Prime Minister youth mental health initiative	Reporting on service delivery and quality improvement in School Based Health Services, progress against local youth SLAT action plan to implement improvements in primary care responsiveness to youth, and youth primary mental health services (reported under PP26).
Reducing rheumatic fever *	A progress report against the DHB's rheumatic fever prevention plan (the regional plan for the South Island), plus hospitalisation rates per 100,000 DHB total population for acute rheumatic fever are 40% reduction from baseline (2009/10-2011/12).
Delivery of the children's action plan	Progress on delivery of the actions and milestones identified in DHB Annual Plans support the implementation of the Children's Action Plan and reduce child assaults.
Raising healthy kids	The percentage of children who were referred from the B4SC to a relevant service and acknowledged by the service provider or were already under care of service or the parent/caregiver declined the referral, among the total number of children who had a B4SC and were identified as obese (BMI>98th percentile).
Regional service delivery	A qualitative and quantitative assessment of a progress report on behalf of the region agreed by all DHBs within that region. The report focuses on the actions agreed by each region as detailed in its RSP implementation plan.
Quality and Safety Markers	Progress toward the markers set by the Health Quality and Safety Commission. These include older patients receiving a falls assessment, compliance with good hand hygiene practice, and two surgical site infection measures: hip and knee replacement patients receiving 2g or more of cephazolin and antibiotic administered in the right time.
Patient Experience	Average rating out of 10 for inpatient experience across the four domains of communication, partnership, coordination of their care, and having physical and emotional needs met, based on results from the national patient experience survey.
Diagnostic waiting times	Performance against the waiting time indicators for Coronary Angiography, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), and Colonoscopy.
Performance highlights	Brief analysis of areas where a DHB is performing above expectations by achieving/exceeding a performance expectation, making significant progress from their base position, or implementing/leading an innovation process that will lead to performance improvement.
Performance issues	Brief analysis of areas where a DHB is performing below expectations, and actions being taken to resolve the issue(s)

*** Data for these measures covers a period prior to the current quarter to ensure complete coding of data.**

Some indicators are for information only. Some, on the other hand, are accompanied by a traffic light colour.
This colour represents the perceived risk to a DHB achieving their target for the year.

The DHB is on track to achieve target	
Some aspects still need development / or the DHB is not tracking to target but has an appropriate resolution plan.	
The information available suggests the DHB is not on track to meet the target and does not have an appropriate resolution plan.	
To date, the DHB has provided no report.	NR
Not Applicable	NA

The Quality and Safety markers use a different traffic light scheme, to mimic that used by the Health Quality and Safety Commission.

Performance at or above the goal level	
Performance within 10/15% of the goal level (depending on the marker)	
Performance more than 10%/15% below the goal level (depending on the marker)	

18.1

HAWKE'S BAY District Health Board Whakawāteatia	**Human Resource KPIs (Q1 July-Sept 2016)** 136
	For the attention of: **HBDHB Board**
Document Owner: Document Author:	Kate Coley, Acting GM Human Resources Jim Scott, Workforce Analyst
Reviewed by:	Executive Management Team
Month:	November 2016
Consideration:	Monitoring

RECOMMENDATION

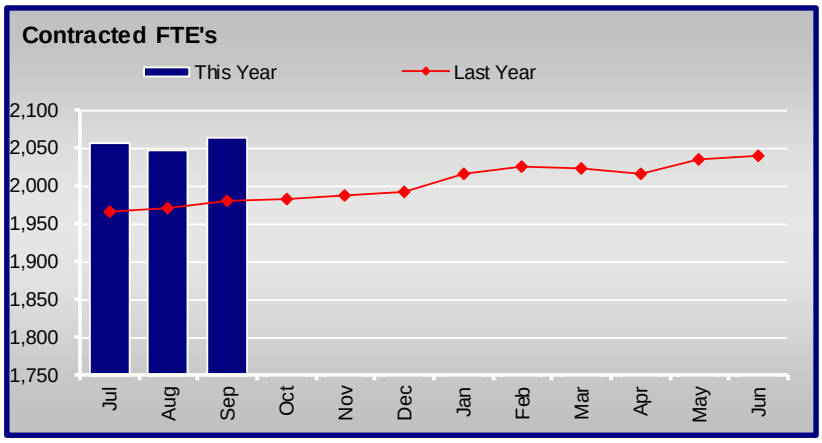
That the HBDHB Board:

Note the contents of this report.

19

Headcount and positions

Reporting on headcount/ positions is a snapshot in time rather than an average for the month or year.



Contracted FTEs
2063.1 at 30 Sep. 2016
1980.9 at 30 Sep. 2015
= 4.2% increase

Overall increases/ (decreases)

	FTE	
Medical	14.0	6.1%
Nursing	35.7	4.3%
Allied Health	20.1	4.9%
Support	(0.3)	(0.2%)
Mge. & Admin	12.7	3.4%
Total	**82.2**	**4.2%**

Accrued FTE:

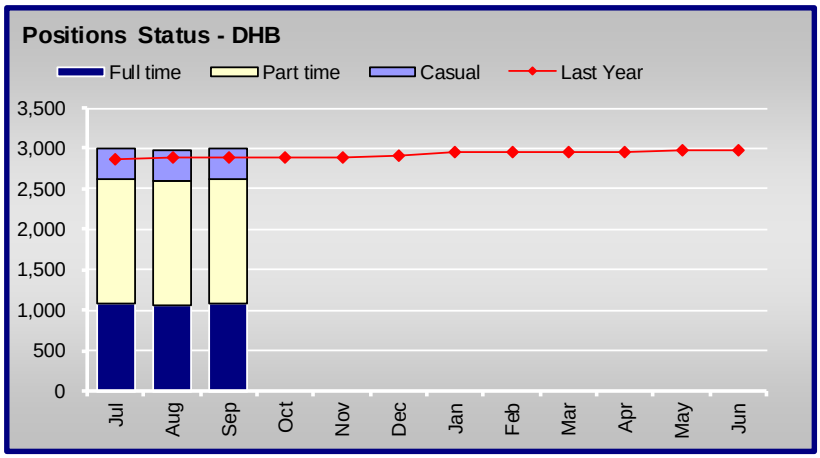
	Budget	**Actual**	**Variance**	**% Variance**
Month of Sep. 2016	2234	2223	11	0.5%
Year to date to Sep. 2016	2202	2199	3	0.1%

Accrued FTE has a year to date favourable variance to September of 3 or 0.1%. Details are in the Finance Report and include:

	FTE	Comments
Allied Health Personnel	20	Vacancies mainly in psychologists, social workers, community support, pharmacists, pharmacy technicians and MRTs.
Nursing Personnel	(15)	Partly driven by efficiencies not yet achieved (savings budgeted from July however the actual realization of savings may be more gradual). High workloads in certain areas including ED, A1 and B2 Medical wards and Ata Rangi.

New Position Requests to Recruit approved by EMT in July to September 2016 quarter:

Position	**FTE**
Administrator	0.5
Registered Nurse (Surgical Sub-Specialties)	0.8
Registered Nurse (Villa 4 Urology & Gynaecology)	0.6
Laboratory Technician	1.0
Care Associate	0.6
Health Records Associate (fixed-term)	1.0
Project Manager (Oncology Services)	1.0
Medical Epidemiologist	1.0



Positions filled:
3005 at 30 Sep. 2016
2892 at 30 Sep. 2015
= 3.9% increase (113 positions)

Of the 3005 positions (last year in brackets):
36% are full-time (36%)
51% are part-time (52%)
13% are casual (12%)

Overall increases/ (decreases) – breakdown of 3.9% increase

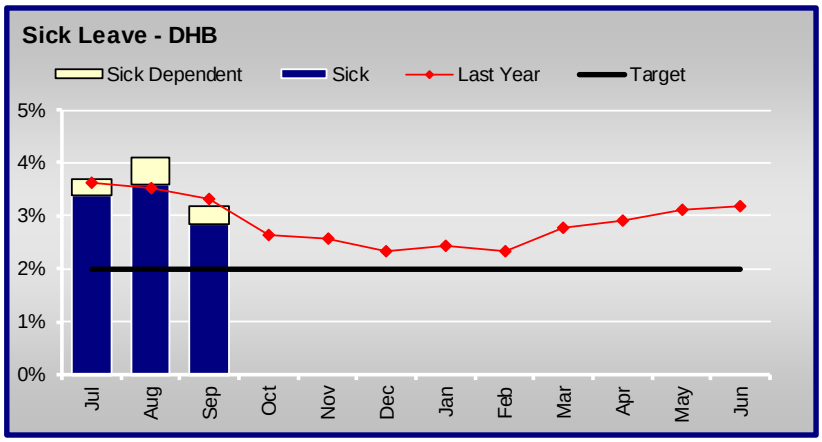
	Full time	Part time	Casual	Total	% change
Medical	13	2	9	24	9.3%
Nursing	4	40	(2)	42	2.9%
Allied Health	19	0	3	22	4.2%
Support	(1)	0	6	5	2.8%
Management & Admin	11	1	8	20	4.5%
Totals	**46**	**43**	**24**	**113**	**3.9%**

Sick Leave

The percentage of sick leave taken hours (paid and unpaid) to accrued FTE hours.

Note: as this KPI is reported early in the month, not all sick leave for the previous month has been recorded as yet. Figures and the graph will be adjusted in the following month.

Target is 2.00%



Sep 2016 = 3.17%
Sep 2015 = 3.32%

YTD Sep '16 = 3.65%
YTD Sep '15 = 3.49%

The sick leave taken for the month of August 2016 was higher than normal due largely to the Havelock North campylobacter outbreak.

HBDHB is currently ranked the lowest of the mid-sized DHBs.

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

30 Sept. 2016 – 9th lowest out of 20 DHBs (12 months ended Sept. 2016 ranked 7th lowest)

30 Sept. 2016 – the lowest out of 6 mid-sized DHBs (12 months ended Sept. 2016 ranked the lowest)

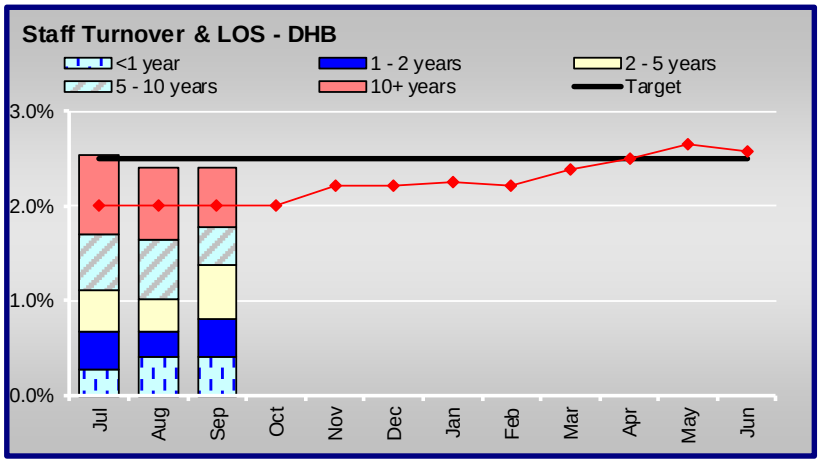
Staff Turnover

Incidence of staff resignations in an organisation. #Voluntary resignations ÷ Total headcount at the beginning of the period. Period is a rolling 3 Months

Note: Junior Doctors (RMOs), Temporary (fixed term) employees and casual employees are excluded from this measure. Employment terminations due to redundancy, death, dismissal and medical grounds are excluded.

A table has been included in the notes for each section to show total headcount at the beginning of the period, new starts, resignations, transfer and changes of status to reconcile to total headcount at the end of the quarter.

Target is 2.50% per quarter.



3 months ended Sep '16 = 2.40% which is below the target of 2.50%

12 months to Sep '16 = 9.66% which is below the 10% annual target.

2246	Staff at 1 July '16
58	New Staff
(63)	Staff resignations
22	Change of status – mostly fixed term to permanent
2263	Staff at 30 Sep '16

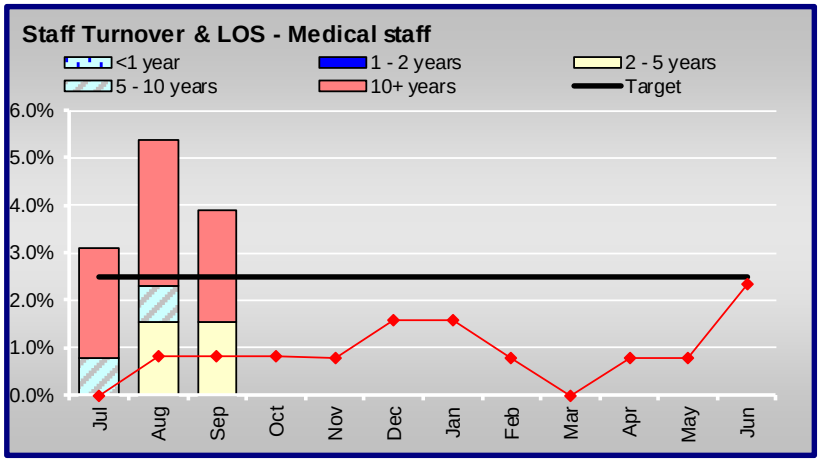
Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

30 Sept. 2016 – 8th lowest out of 20 DHBs (12 months ended Sept. 2016 ranked 8th lowest)

30 Sept. 2016 – 3rd lowest out of 6 mid-sized DHBs (12 months ended Sept. 2016 ranked 3rd lowest)

19

Staff Turnover – Medical Staff



3 months ended Sep '16 = 3.88% which is above the 2.50% target.

This 3.88% represents 5 resignations in the quarter:

- 2 retired
- 1 moving to a position outside HBDHB
- 1 personal reasons
- 1 other reason

The July and August quarterly figures were also above target and featured a number of retirements.

12 months to Sep '16 = 7.94% which is below the 10% annual target.

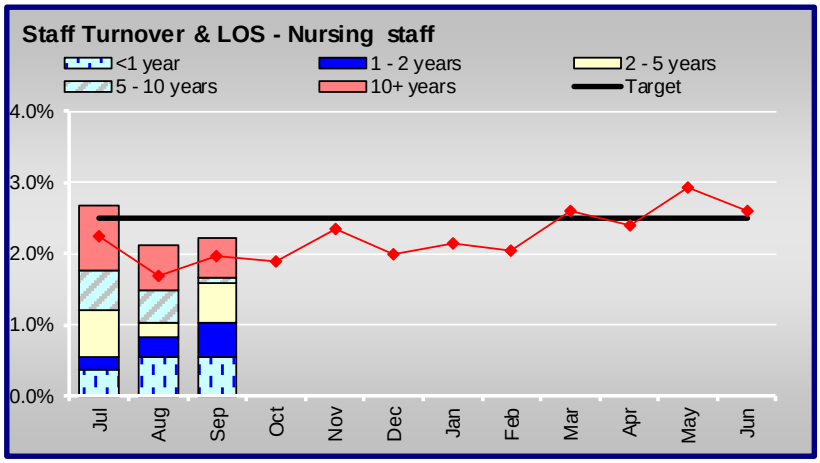
129	Staff at 1 July '16
2	New Staff
(6)	Staff resignations
2	Change of status – fixed term to permanent
(1)	Trf other staff group
126	Staff at 30 Sep '16

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

30 Sept. 2016 – 18th lowest out of 20 DHBs (12 months ended Sept. 2016 ranked 13th lowest)

30 Sept. 2016 – 6th lowest out of 6 mid-sized DHBs (12 months ended Sept. 2016 6th the lowest)

Staff Turnover – Nursing Staff



3 months ended Sep '16 = 2.22% which is below the target of 2.50%

12 months to Sep '16 = 9.51% which is below the 10% annual target.

No significant trends.

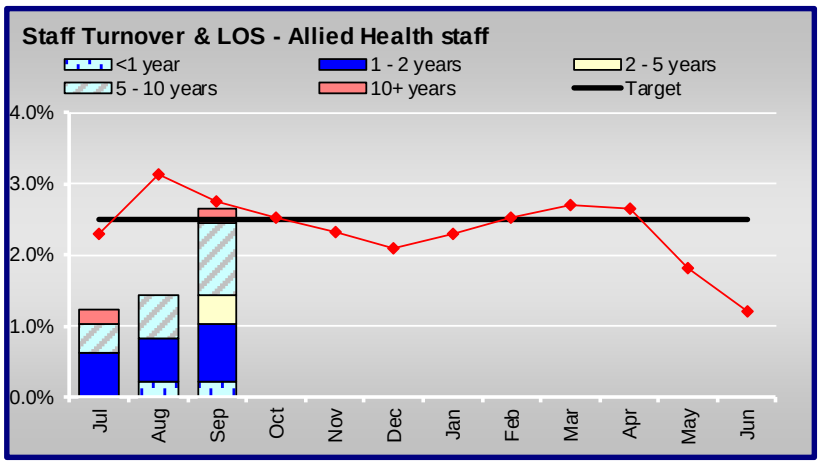
1081	Staff at 1 July '16
25	New Staff
(27)	Staff resignations
15	Change of status – mostly fixed term to permanent
2	Trf other staff group
1096	Staff at 30 Sep '16

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

30 Sept. 2016 – 10th lowest out of 20 DHBs (12 months ended Sept. 2016 ranked 10th lowest)

30 Sept. 2016 – 4th lowest out of 6 mid-sized DHBs (12 months ended Sept. 2016 ranked 4th lowest)

Staff Turnover – Allied Health Staff



3 months ended Sep '16 = 2.65% which is slightly above the 2.50% target.

This 2.65% represents 13 resignations in the quarter:

- 3 moving to positions outside HBDHB
- 2 family reasons
- 2 relocating outside HB
- 2 terminating multi-job positions
- 1 not returning from parental leave
- 3 other reasons

12 months to Sep '16 = 8.79% which is below the 10% annual target.

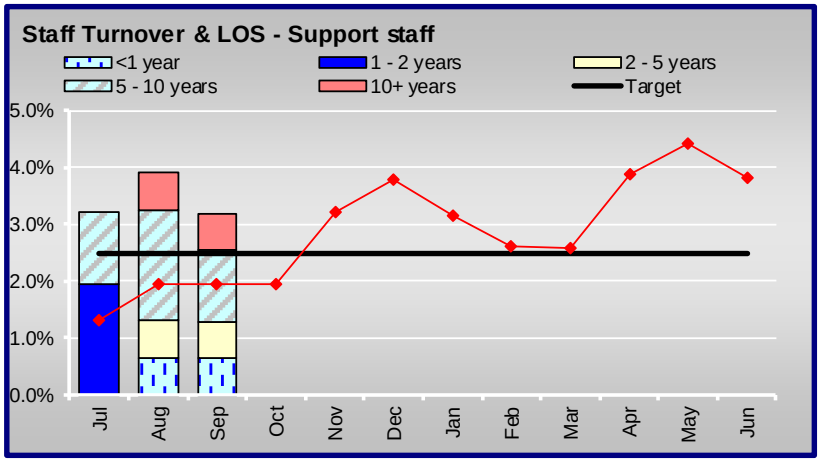
490	Staff at 1 July '16
16	New Staff
(15)	Staff resignations
4	Change of status – fixed term or casual to permanent
(3)	Trf other staff group
492	Staff at 30 Sep '16

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

30 Sept. 2016 – 11th lowest out of 20 DHBs (12 months ended Sept. 2016 ranked 3rd lowest)

30 Sept. 2016 – 4th lowest out of 6 mid-sized DHBs (12 months ended Sept. 2016 ranked the lowest)

Staff Turnover – Support Staff



3 months ended Sep '16 = 3.18% which is above the 2.50% target.

This 3.18% represents 5 resignations in the quarter:

- 3 moving to positions outside HDBHB
- 1 family reason
- 1 retired

12 months to Sep '16 = 13.29% which is above the 10% annual target.
This 13.29% represents 21 resignations in the year:

- 3 relocating outside HB
- 5 moving to position outside HBDHB
- 4 retired
- 2 further education
- 1 personal reasons
- 1 family reasons
- 1 not returning maternity leave
- 1 other
- 3 unknown

157	Staff at 1 July '16
4	New Staff
(6)	Staff resignations
2	Change of status – casual to permanent
(1)	Trf. other staff group
156	Staff at 30 Sep '16

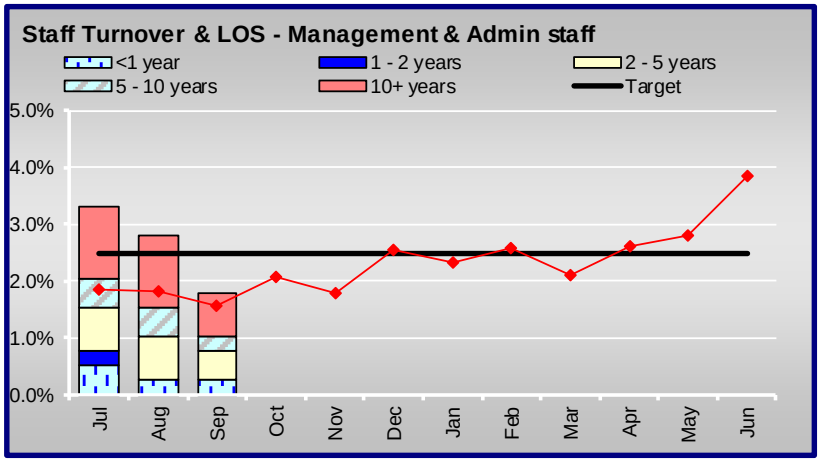
Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

30 Sept. 2016 – 15th lowest out of 20 DHBs (12 months ended Sept. 2016 ranked 15th lowest)

30 Sept. 2016 – 5th lowest out of 6 mid-sized DHBs (12 months ended Sept. 2016 ranked 5th lowest)

Note a number of other DHBs outsource much of their Support staff which can impact on their Turnover rate.

Staff Turnover – Management & Administration Staff



3 months ended Sep '16 = 1.80% which is below the 2.50% target.

12 months to Sep '16 = 10.20% which is slightly above the 10% annual target.

This 10.20% represents 40 resignations in the year:

- 13 retired
- 6 relocating outside HB
- 8 moving to position outside HBDHB
- 2 family reasons
- 1 personal reasons
- 2 other reason
- 8 unknown reasons

389	Staff at 1 July '16
11	New Staff
(9)	Staff resignations
(1)	Change of status – mostly fixed term to permanent
3	Trf from staff groups
393	Staff at 30 Sep '16

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

30 Sept. 2016 – 5th lowest out of 20 DHBs (12 months ended Sept. 2016 ranked 9th lowest)

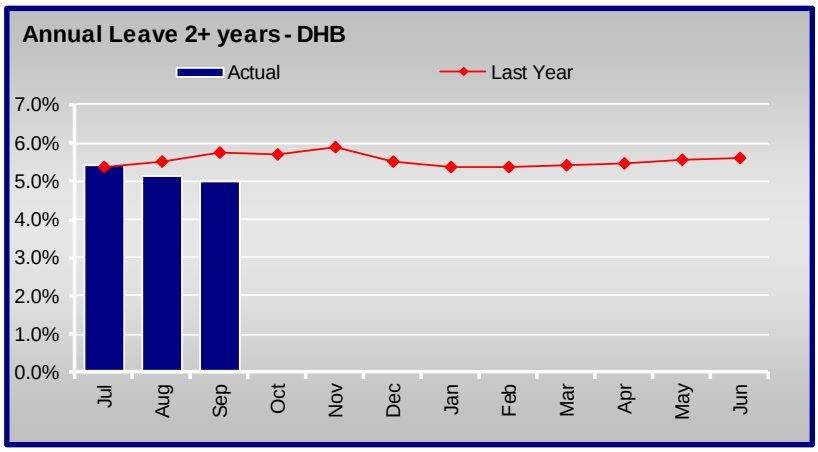
30 Sept. 2016 – 2nd lowest out of 6 mid-sized DHBs (12 months ended Sept. 2016 ranked 5th lowest)

19

Accrued Annual Leave (2+ years)

The percentage of employees where accrued annual leave balance is greater than 2 years annual leave entitlement.

Target is 0%.



Sep '15 = 5.73% (145 staff)
Sep '16 = 5.00% (131 staff)
Decreased by 14.

We are the second best performed mid-sized DHB for this KPI and the 5th best of the 20 DHBs.

The total liability at 30 September 2016 was $18.380m compared to $18.776m at 30 June 2016. This $396k improvement is made up of:

1. $344k favourable driven by a decrease in the hours owing.
2. $52k favourable driven by a decrease in the average rates.

Note that the average AL balance has increased slightly over the last 5 years but that staff with 5 weeks (or more) annual entitlements increasing from 52.0% in September 2011 to 64.3% in September 2016.

	Average AL balance (hours)	% staff with an annual entitlement of 5 or more weeks Annual Leave
Sep. 2016	122.63	64.3%
Sep. 2011	120.03	52.0%

Note also that the total leave hours owed (includes statutory lieu leave etc.) and average leave balance is less than this time last year:

	Total Hours Owed	Employees with leave balance	Average Leave balance (hours)
Sep. 2016	438,251	2623	167.08
Sep. 2015	445,949	2535	175.92

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

30 Sept. 2016 – 5th lowest out of 20 DHBs (Sept. 2015 – 7th lowest)

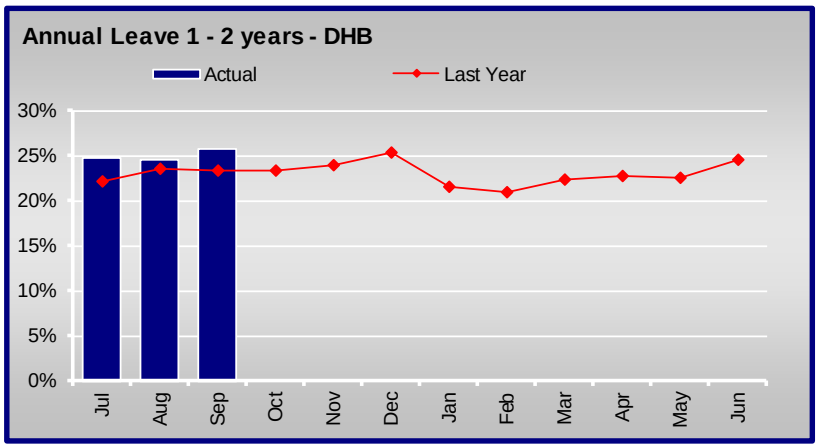
30 Sept. 2016 – 2nd lowest out of 6 mid-sized DHBs (Sept. 2015 – 3rd lowest)

30 Sept. 2016 – 2nd lowest of the central Region DHBs (Sept. 2015 – 3rd lowest)

Accrued Annual Leave (1 – 2 years)

The percentage of employees where accrued annual leave balance is between 1 and 2 years annual leave entitlement.

Target is 15%.



Sep '15 = 23.35% (591 staff)
Sep '16 = 25.60% (671 staff)
Increased by 80

An increase in the number and percentage of staff with 1 to 2 years of annual leave owing.

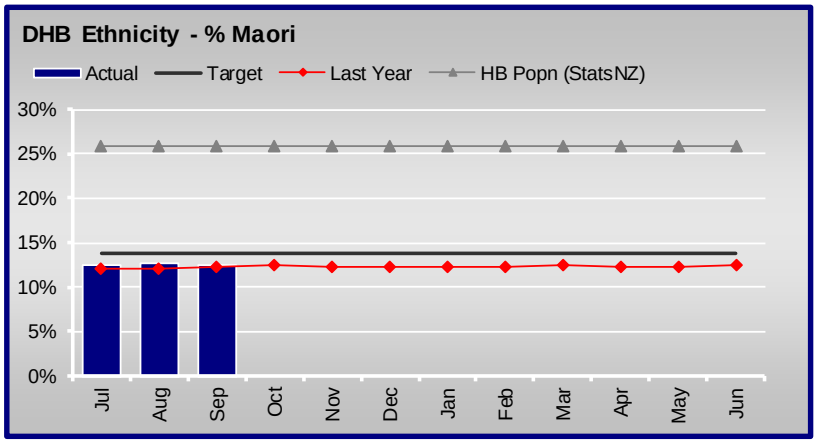
This is a cause for concern especially if the number of staff with 1 – 2 years accrued annual leave begin to spill over into the 2+. Services will need to continue to monitor annual leave balances closely and optimise opportunities to have annual leave taken.

Staff Ethnicity

Measure the number of positions at HBDHB where the incumbents identify themselves as Māori

Target is set at 10% improvement on previous year. 2016/17 target = 13.75%. The Māori population for HB is 25.9%

Note - We generally report on positions so we can break our numbers down for reporting purposes by Occupational Group, Service, and Department etc. Some employees have more than one position in more than one Department, Service or occupational group



Note – at 30 June 2011 the percentage of Māori staff was 8.9% compared to 12.5% at 30 June 2016.

Māori staff representation in the Workforce:

	People	Positions
Sep. '16	13.08%	12.48%
Sep. '15	12.62%	12.28%

September 2016 breakdown:

	Positions filled	% of Total
NZ & European	2268	75.47%
Maori	375	12.48%
Pacific Islands	35	1.17%
Other	257	8.55%
Not known	70	2.33%
Total	**3005**	

Support staff (27.37%) and Management & Admin staff (16.52%) exceed the DHB target.

Allied Health (13.20%) Medical (3.42%) and Nursing staff (10.84%) are below the target.

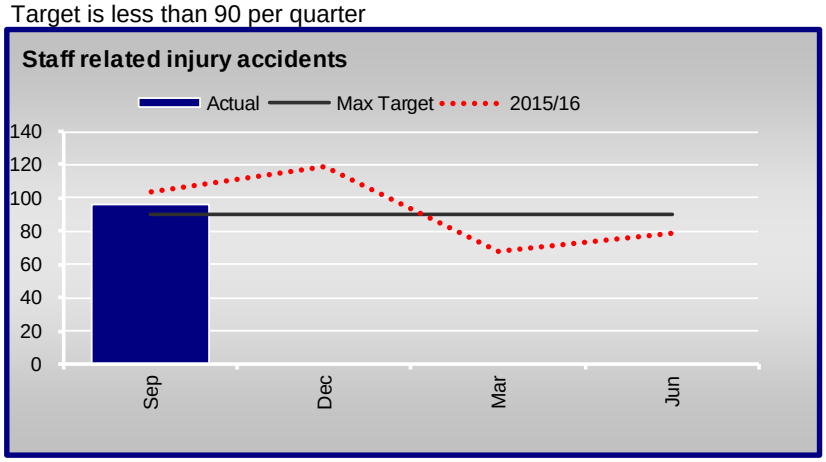
The gap to our target sits at 38 at 30 September 2016.

372	Maori Staff - 1 July 2016
24	New Staff
(23)	Staff resignations
2	Changes to ethnicity
375	Maori Staff – 30 Sep. '16

Occupational Health & Safety KPIs

Staff related injury accidents reported

Workplace injuries reported.
Target is less than 90 per quarter



Total for the quarter = 96
July = 33
August = 33
September = 30

Percentage of total staff by quarter:

Sept. '16	3.2%
Compared to: Sept. '15	3.6%

Of the 96 for the June quarter:

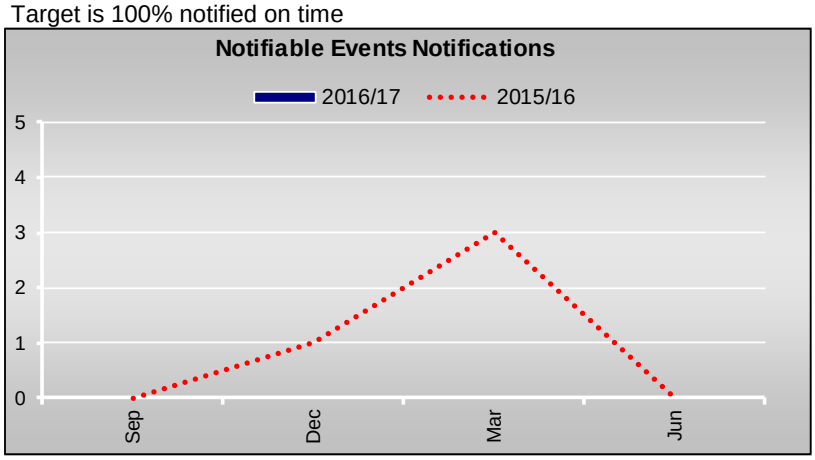
- 29 back injuries/ sprain/ strain
- 23 cuts/ bruises/ lacerations/ burns
- 19 needlestick injuries and exposure to blood and body fluids
- 25 remaining included fracture/ possible fracture, gradual onset discomfort, graze, abrasion.

None of the above were notified to Work Safe NZ as a notifiable event.

Notifiable Events

Accidents notified to the Ministry of Business Innovation and Employment (MoBIE) as soon as possible'. Measured against next working day.

Target is 100% notified on time



There were no notifiable events reported for the quarter.

HAWKE'S BAY District Health Board Whakawāteatia	**Annual Māori Health Plan Q1 (July-Sept 2016) Non-Financial Exceptions Report** 137
	For the attention of: **HBDHB Board**
Document Owners:	Tracee Te Huia, General Manager Māori Health
Document Author(s):	Patrick Le Geyt, Programme Manager Māori Health; Justin Nguma, Senior Health & Social Policy Advisor; and Peter Mackenzie, Operational Performance Analyst
Reviewed by:	Executive Management Team; Māori Relationship Board, HB Clinical Council and HB Health Consumer Council
Month:	November 2016
Consideration:	Monitoring

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report.

OVERVIEW

The purpose of this paper is to provide MRB, HB Clinical Council, HB Health Consumer Council and the HBDHB Board with exception report for Quarter 1 on the implementation of the 2016 – 2017 Annual Māori Health Plan. A quick reference summary dashboard will be supplied prior to the meeting and shows our position as at the end of Quarter 1 for all indicators. The dashboard uses traffic light methodology with detailed information and symbols for all indictors. For example, in a situation where the performance of the indicator for the current quarter is higher than the previous quarter this symbol '▲' will be used to show an upward trend while an opposite symbol '▼' will be used to show a downward trend. In cases where the variance to the annual target for the indicator is greater than 0.5% this symbol **'U'** *(indicated on the dashboard in red)* will be used to indicate unfavourable trend and **'**F' for favourable trend *(indicated on the dashboard in green colour)* toward the annual target *(see the table below).*

KEY FOR DETAILED REPORT AND DASHBOARD

Baseline	Latest available data for planning purpose
Target 2015/16	Target 2016/17
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target
U (Unfavourable)	Actual to date is unfavourable to target
Trend direction ▲	Performance is improving against the previous reporting period or baseline
Trend direction ▼	Performance is declining
Trend direction -	Performance is unchanged

Table of Contents

2017-2017 ANNUAL MĀORI HEALTH PLAN PERFORMANCE HIGHLIGHTS

Achievements

1. Cervical screening

Cervical Screening for 25-69 year old Māori women (72.7%) for this quarter is slightly lower than the 73.2% in the last 2015-2016 quarter (Page 5). However, HBDHB continues to be on the top list on Cervical Screening performance in New Zealand. This performance also narrows the disparity gap between Māori and non- Māori by 5.5%.

The performance is attributed to the HBDHB integrated service approach across the screening pathways in working together towards a common goal of attaining the national target for Māori women and addressing inequity. Māori women have access to free cervical smear tests and support services across the district. We have been working closely with GP practices to improve participation of NCSP priority group women in screening e.g. Best Practice in Primary Care project and data-matching. In addition, we have been contacting Māori and Pacific women who have never had a cervical smear or have not had one for over five years by phone or home visits, and offering outreach smears. The uptake has been positive.

Recent population projections released by the National Screening Unit show that in the next five years (2016-2021) Hawke's Bay's NCSP eligible Māori and Pacific populations will increase by 7% and the Asian population will increase by 16%. This is a challenge our sector need to prepare for.

2. Immunisation

HBDHB ranks 3rd nationally for immunisation rates for 8 months old Māori and has remained above or very near the target of ≥ 95% with a 94.4% in Quarter 1 (Page 6).

This success is attributable to a number of factors ranging from having a champion in the executive management team; a committed, appropriate, experienced workforce; and an action plan with sound tracking and tracing processes with NIR to ensure that children are referred to outreach if needed in sufficient time to locate them. Attempts are made to contact all families with overdue children to offer immunisation and information / resources if hesitant.

Efforts will be focused on fostering collaborative relationships with all immunisation providers to promote immunisation within the community at antenatal sessions monthly and PEPE groups (first time parents) run through Plunket.

Areas of progress

1. Mental Health and Addictions

Māori under Mental Health Act compulsory treatment orders has decreased from 201.6 per 100,000 population in Quarter 4 of 2015/16 to 183.9 per 100,000 population in Q1 2016/17. There still remains a significant inequality between Māori and non-Māori of 94.2 per 100,000 population down from 104.9 per 100,000 population in Quarter 4 (Page 7).

2. Access to Care

The number of Māori enrolled in the Health Hawke's Bay PHO increased slightly by 1% from 95.6% in Quarter 4 of 2015-2016 to 96.6% in Quarter 1 in 2016-2017 and remains slightly below the expected performance target of 97% (Page 8). Currently HBDHB ranks 4th among all DHBs in the country for Māori PHO enrolments.

3. Rheumatic Fever

Acute Hospitalisation for Rheumatic Fever has decreased from 7.33 in Quarter 3 of 2015-2016 to 4.82 in Quarter 1 of 2016-2017 (6 monthly data) (Page 9).

4. Alcohol and Other Drugs

Access to services for 0-19 Year Olds within 3 weeks of referral increased by 4.2% from 66.4% in Quarter 4 of 2015-2016 to 70.6% in Quarter 1 of 2016-2017 but still below the expected target of 80%. Similarly, 0-19 Year Olds seen within 8 weeks of referral increased slightly from 91.4% to 91.7% but less than the target of 95% (Page 10).

The decreased wait times has been a focus over 2016 and is a product of collaborative work with referrer (e.g., schools, CYF) in ensuring that we provide most seamless service possible for Māori.

Areas of focus

The above achievements notwithstanding, we are challenged to put more efforts in the following areas to gain traction towards targets:

1. Ambulatory Sensitive Hospitalisations

ASH Rates in 2015/16 and presented a significant narrowing of disparity gap for 0-4 year old group between Māori and Other and HBDHB has 3rd best results for all DHBs for 0-4 year old group. However in Quarter 1 of 2016/17 they have risen 13.1% to from 78.6% in Quarter 4 to 91.7% in Quarter 1. Similarly, ASH Rates for 45-64 year old group have increased from 170% in Quarter 4 to 196.0% in Quarter 1 presenting a significant inequality between Māori and non- Māori of 87% (Page 11).

2. Breast Screening

Breast screening services for (50-69yrs) has decreased slightly from 67.9% in Quarter 4 of 2015-2016 to 67.1% in Quarter 1 of 2016-2017 and remains just below the expected target of ≥70% (Page 12).

3. Workforce Development

Staff completed cultural training is making slow progress from 77.5% in Quarter 4 to 78.8% in Q1. Medical staff (39.9%) and Support staff (63.3%) have progressed the slowest of all occupational groupings. Medical staff, despite a 25.6% increase in 2015/16, have only increased 0.3% from Quarter 4 to 39.9% in Quarter 1 (Page 13).

Māori Workforce did not grow in Quarter 1 and remained static at 12.5%; the same result noted in Quarter 4 of 2015-2016 (Page 14). Whilst the 2016-2017 annual target of 13.8% is only an additional 10% on 2015-2016 result, it remains a significant challenge.

4. Obesity

The B4SC data for Quarter 1 of 2016-2017 (6 monthly data) shows that only 18% of Māori Children with BMI in 98th percentile were referred to a health professional for nutritional advice, which is a 2% decrease from 20% reported in Quarter 3 of 2015-2016 (Page 15).

QUARTERLY PERFORMANCE AND PROGRESS UPDATE

Cancer Screening

Outcome: Achieve the National Cervical Screening Programme (NCSP) national – Target: 80% of 25-69 years

Key Performance Measures	Baseline[1]	Previous result[2]	Actual to Date[3]	Target 16-17	Trend direction
Māori	74.1%	73.2% (U)	72.7% (U)	≥80%	▼
Pacific	71.2%	71.4% (U)	74.2% (U)	≥80%	▲
Other	76.5%	77.8% (U)	78.2% (U)	≥80%	▲
Total	75.8%	76.6% (U)	76.9% (U)	≥80%	▲

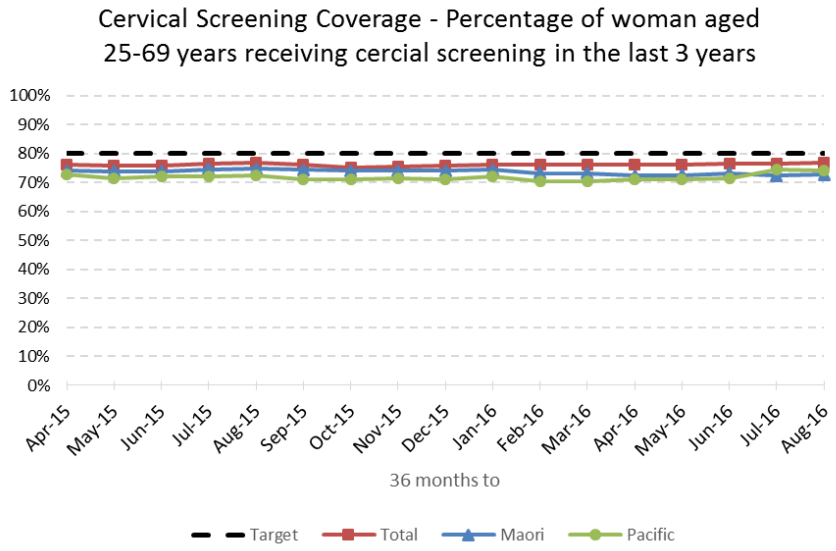
Comments:

Continuing to work with GP practices to improve participation of NCSP priority group women in screening e.g. Best Practice in Primary Care project and data-matching. In addition, contacting Māori and Pacific women who have never had a cervical smear or have not had one for over five years by phone or home visits, and offering outreach smears. The uptake has been positive.

Continuing to ensure accuracy of participant ethnicity data held on National Cervical Screening Programme Register and ethnicity data on NHI

Recent population projections released by the National Screening Unit show that in the next five years (2016-2021) Hawke's Bay's NCSP eligible Māori and Pacific populations will increase by 7% and the Asian population will increase by 16%. A challenge to the sector.

Time series



Source: National Screening Unit

20

13 years to December 2015

23 years to June 2015

33 years to August 2016

Increasing Immunisation

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

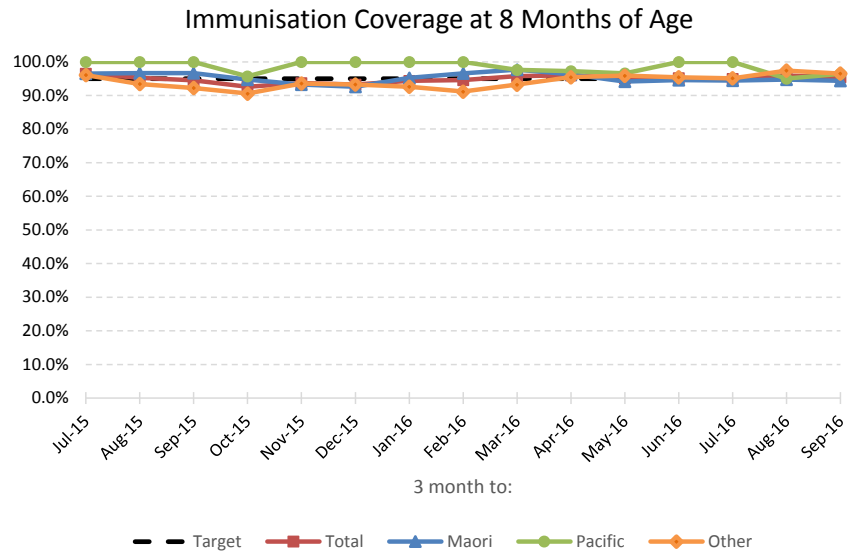
Key Performance Measures	Baseline[4]	Previous result[5]	Actual to Date[6]	Target 16-17	Trend direction
Māori	92.6%	94.6% (F)	94.4% (U)	≥95%	▼
Pacific	100.0%	100% (F)	96.4% (F)	≥95%	▼
Other	93.3%	95.4% (F)	96.5% (F)	≥95%	▲
Total	93.3%	95.2% (F)	95.4% (F)	≥95%	▲

Comments:

Implementing the Immunisation Action Plan and continuing to be systematic in our approach. Sound tracking and tracing processes in place with NIR to ensure that children are referred to outreach if needed in sufficient time to locate them. Attempts are made to contact all families with overdue children to offer immunisation and information / resources if hesitant.

Continue to foster collaborative relationships with all immunisation providers and promote immunisation within the community at antenatal sessions monthly and PEPE groups (first time parents) run through Plunket.

Time series



Source: National Immunisation Register, Ministry of Health

4 October to December 2015

5 April to June2016

6 July to September 2016

Mental Health

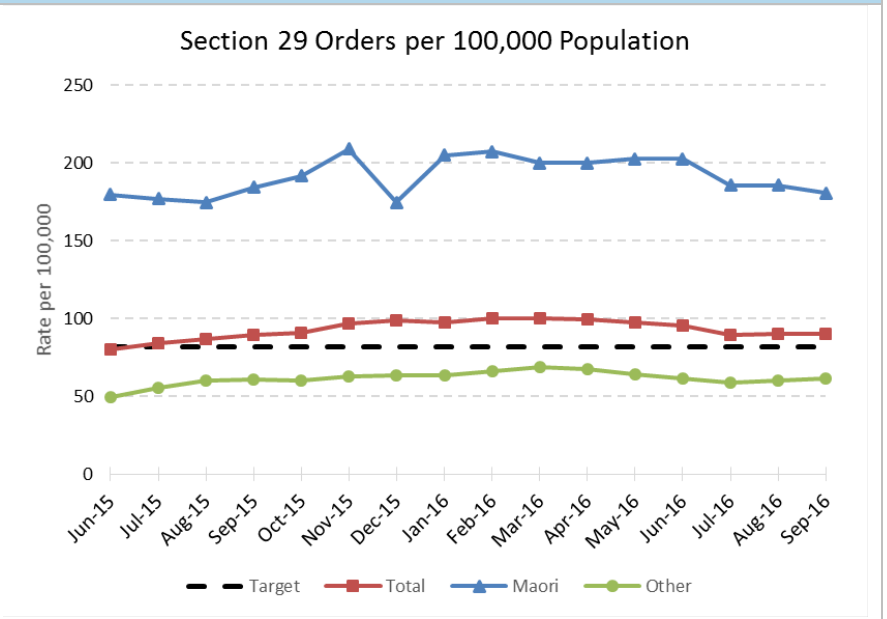
Outcome: Reduced rate of Māori under compulsory treatment orders to < 81.5 per 100,000 (total population)

Key Performance Measures	Baseline[7]	Previous result[8]	Actual to Date[9]	Target 15-16	Trend direction
Māori (per 100,000)	196	201.6 (U)	183.9 (U)	≤81.5	▲
Other (per 100,000)	93.4	64.5 (F)	60.1 (F)	≤81.5	▲
Total (per 100,000)	97	97.3 (U)	89.7 (U)	≤81.5	▲

Comments:

Some recent trending down for Māori CTO rates is positive but more work needed to reduce in longer term. Activity in the table below indicate moves to better understand complexities of this issue and greater connection with our communities and whānau, which is imperative. Community Mental Health vision is to have a greater Whānau Ora type approach to our treatment and service provision with a more holistic approach to needs, including social and economic factors, to support whānau aspirations for improved wellness and lifestyle. Supporting Parents Healthy Children (was COPMIA) and Pregnancy Parenting Support initiatives are examples of how and where we will be resourcing this work.

A Te Ara Whakawaiora paper was presented and discussed at MRB in August. Subsequently, the Mental Health directorate and Māori Health Services have organised a wananga that will be held in Q2 with a wide group of stakeholders to discuss the complexities of compulsory treatment orders.



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7

8*April to June 2016*

9*July to September 2016*

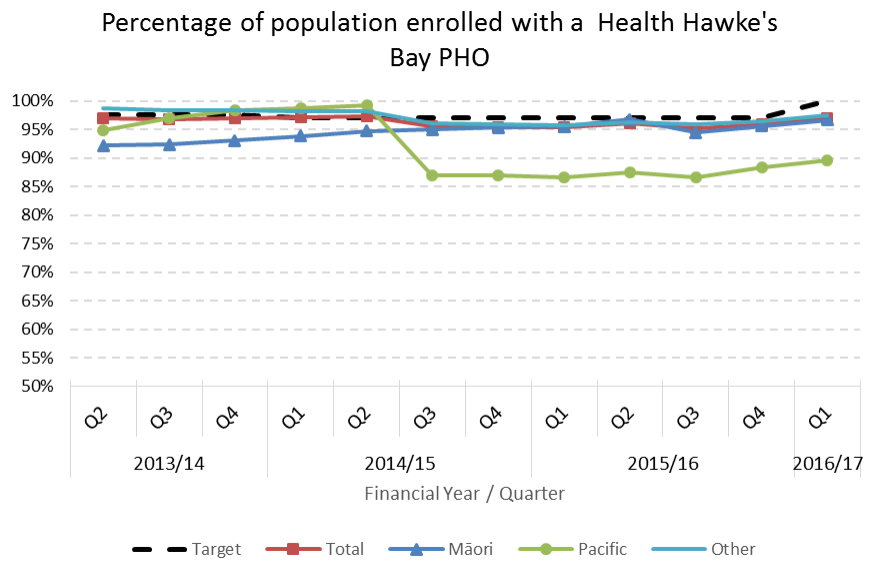
Access to Care

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

Key Performance Measures	Baseline [10]	Previous result[11]	Actual to Date[12]	Target 16-17	Trend direction
Māori	97.2%	95.6% (U)	96.6% (U)	≥100%	▲
Pacific	88.7%	88.4% (U)	89.6% (U)	≥100%	▲
Other	96.5%	96.5% (U)	97.4% (U)	≥100%	▲
Total	96.4%	95.9% (U)	96.9% (U)	≥100%	▲

Comment:

Time series



10 October 2015

11 April 2015

12 July 2016

Reducing Rheumatic Fever						
Outcome: Reduced incidence of first episode Rheumatic Fever						
Key Performance Measures	Baseline [13]	Previous result [14]	Actual to Date[15]	Target 16-17	Trend direction	
Māori	2.48	7.99 (U)	4.82 (U)	≤1.5	▲	**Comments:** Work continues on refreshed rheumatic fever plan
Pacific	-	-	16.47 (U)	≤1.5	*	
Total	0.6	1.87 (U)	1.86 (U)	≤1.5	▲	

13 July 2014 – June 2015

14 July 2015 – June 2016

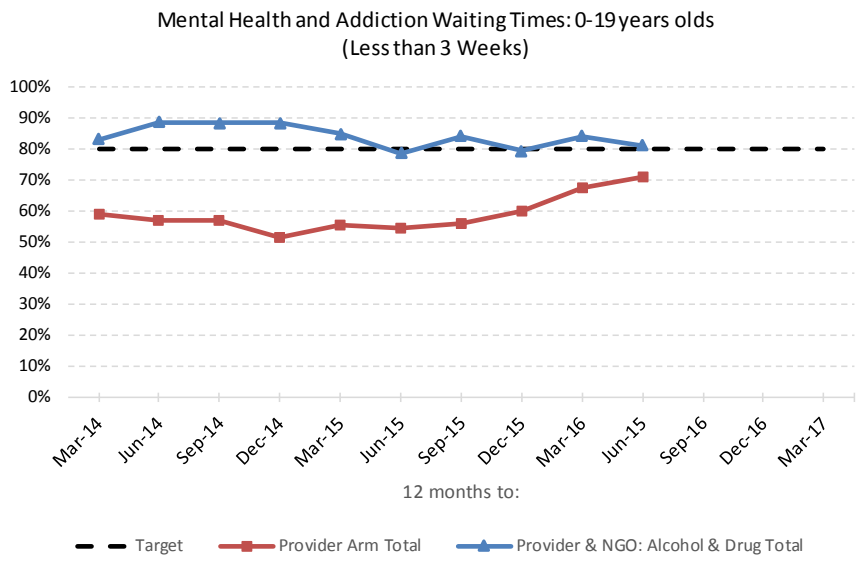
15 July 2016 – September 2016

Alcohol and Other Drugs

Outcome: % of 0-19 year olds seen within 3 weeks of referral

Key Performance Measures	Baseline [16]	Previous result[17]	Actual to Date[18]	Target 16-17	Trend direction
Mental Health Provider Arm: Seen within 3 weeks Ages 0-19					
Māori	63.2%	66.4% (U)	70.6% (U)	≥80%	▲
Pacific	75.0%	71.4% (U)	72.7% (U)	≥80%	▲
Other	56.9%	68% (U)	71.3% (U)	≥80%	▲
Total	60.1%	67.4% (U)	71.2% (U)	≥80%	▲
Decreased wait times has been a focus over 2016 and is trending positively, although there has been an increase in referrals over time.					
Provider Arm and NGO: Seen within 3 weeks Ages 0-19					
Māori	90.5%	88% (F)	81.6% (F)	≥80%	▼
Pacific	-	-	-	≥80%	*
Other	61.5%	80% (F)	80% (F)	≥80%	—
Total	84.2%	84% (F)	81.2% (F)	≥80%	▼

Time series



16 January 2015 to December 2015

17 April 2015 to March 2016

18 July 2015 to June 2016

Ambulatory Sensitive Hospitalization (ASH)

Outcome: Reduction in Ambulatory Sensitive Hospitalisation (ASH) rates in 0-4 year olds.

Key Performance Measures	Baseline [19]	Previous result[20]	Actual to Date[21]	Target 16-17	Trend direction
Māori	82.1%	78.6% (F)	91.7% (U)	≤85.3%*	▼
Other	66.1%	55.5% (U)	63.8% (U)	-	▼
Total	73.0%	69.6% (U)	80.3% (U)	-	▼

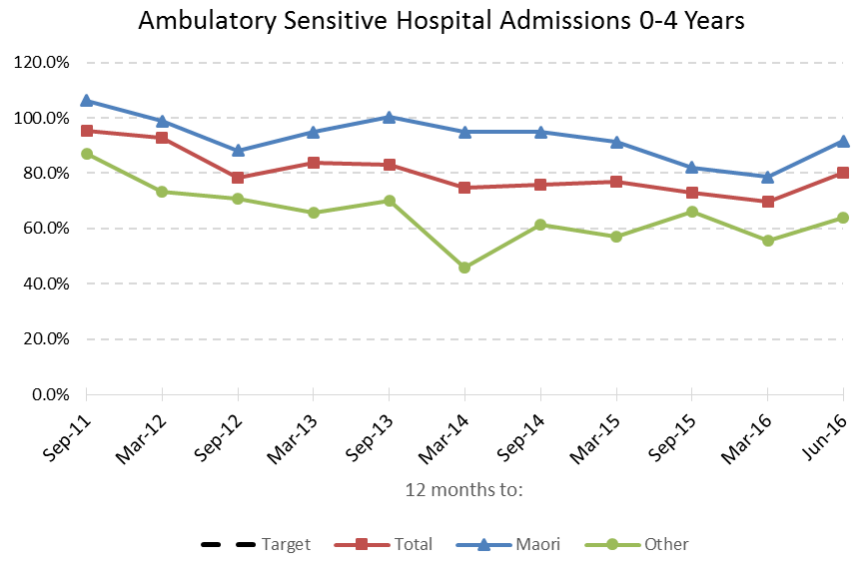
** To focus on equity the Māori target has been set at 'within 5% of the Total'*

Planning is underway to employ a Kaiawhina, as part of the HBDHB Public Health team as part of the skin programme, within local Te Kohanga Reo. This role will support the Te reo skin resources developed and rolled out into ECE and Te Kohanga reo in 2015, which focus on preventing skin infections.

The Māori health Programme manager is working with Plunket to provide a facilitation and advocacy role initiating oral health appointments and attendance by whānau who may have barriers to accessing services. WCTO services as well placed to perform this role as they have established relationships with whānau, as well as WCTO checks aligning with key oral health checks.

The HBDHB Respiratory programme has been extended to cover children, work is being planned to up skill Primary care staff around child specific respiratory conditions and pathways. Other opportunities being scoped are; development of clinical pathways; flu injections for children with respiratory conditions; looking at support post discharge for children presenting to ED with respiratory conditions. Activities focus on improving management of respiratory conditions and follow up at primary care/community level to reduce the possibility of hospital admissions.

Time series



Source: Ministry of Health

20

1912 months to September 2015

2012 months to September 2015

2112 months to March2016

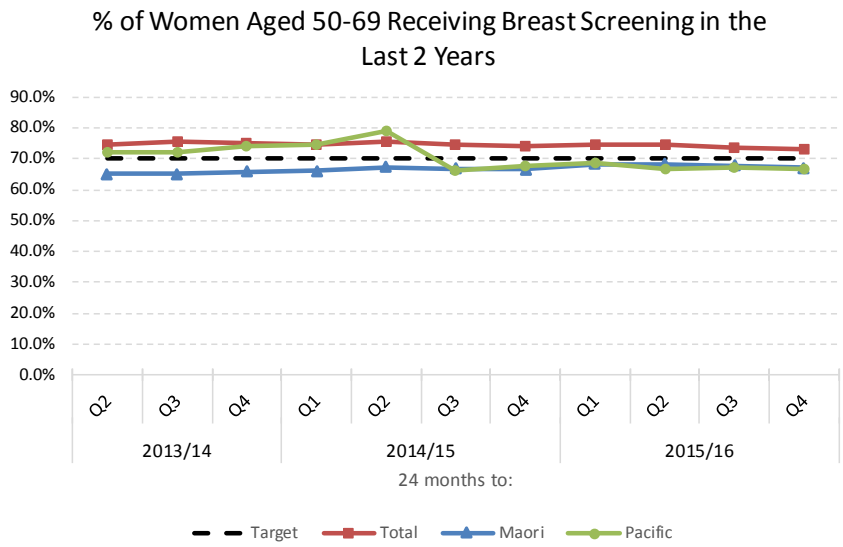
Breast Screening

Outcome: Achieve the National Breast Screen Aotearoa (BSA) national – Target: 70% of 50-69 years

Key Performance Measures	Baseline [22]	Previous result[23]	Actual to Date[24]	Target 16-17	Trend direction
Māori	68.4%	67.9% (U)	67.1% (U)	≥70%	▼
Pacific	66.5%	67.2% (U)	66.6% (U)	≥70%	▼
Other	76.0%	74.5% (F)	74.5% (F)	≥70%	—
Total	74.7%	73.4% (F)	73.2% (F)	≥70%	▼

Comments:

Time series



Source: National Screening Unit

2224 months to December 2015

23 24 months to March 2016

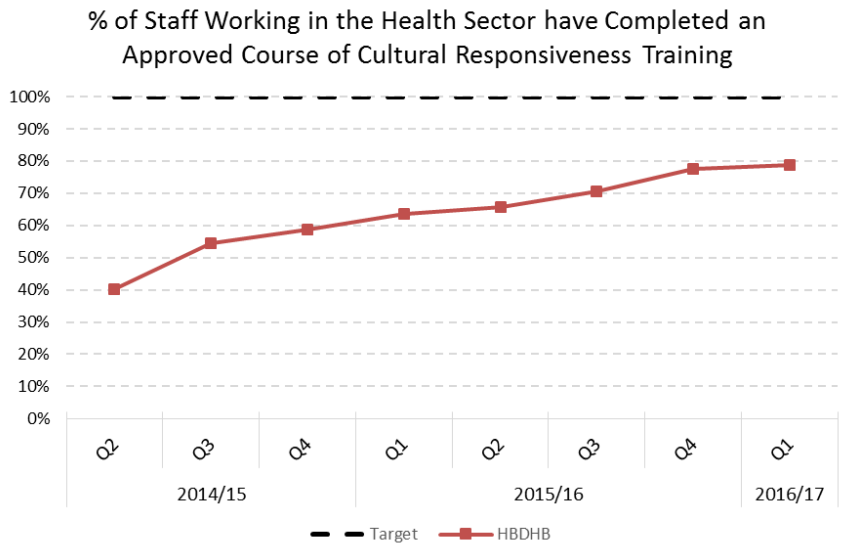
24 24 months to June 2016

Māori Workforce and Cultural Competency

Outcome: All staff working in the health sector have completed an approved course of cultural responsiveness training.

Key Performance Measures	Baseline [25]	Previous result[26]	Actual to Date[27]	Target 16-17	Trend direction
Medical	19.20%	39.6% (U)	39.9% (U)	-	▲
Management & Administration	79.10%	85.6% (U)	87% (U)	-	▲
Nursing	70.00%	81.4% (U)	82.9% (U)	-	▲
Allied Health	77.30%	85.2% (U)	86.2% (U)	-	▲
Support Staff	35.60%	60.1% (U)	63.3% (U)	-	▲
HBDHB	65.60%	77.5% (U)	78.8% (U)	≥100%	▲

Time series



Comments:

Current report shows DHB staff who have completed EEWM training or other cultural training.

Managers now have access to reports within PAL$ to monitor staff completion rates of EEWM and Treaty of Waitangi.

25 December 2014

26March 2016

27June 2016

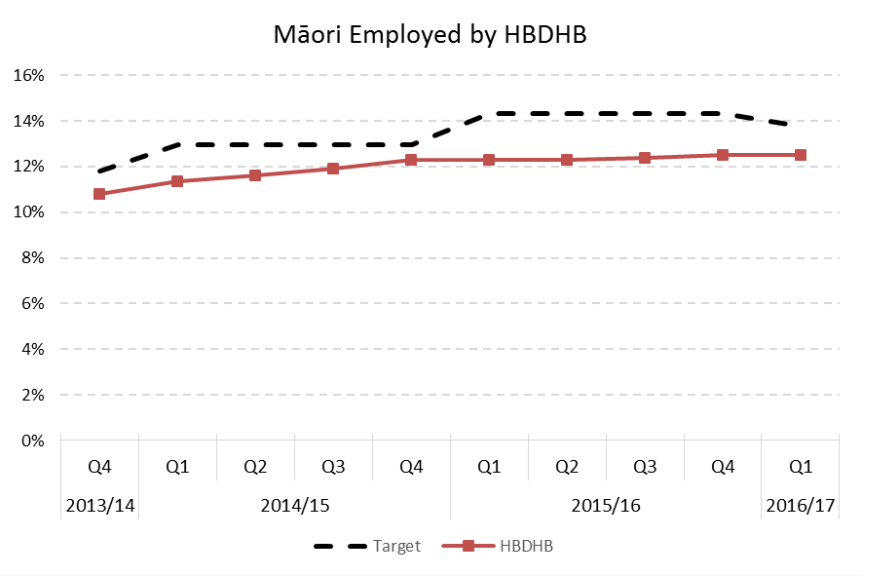
Māori Workforce and Cultural Competency

Outcome: Increased proportion of Māori employed by 10% yearly across HBDHB. Target 16/17 year 13.75%

Key Performance Measures	Baseline [28]	Previous result[29]	Actual to Date[30]	Target 16-17	Trend Direction
Medical	2.90%	3.2% (U)	3.4% (U)	-	▲
Management & Administration	16.50%	16% (F)	16.5% (F)	-	▲
Nursing	10.60%	10.8% (U)	10.8% (U)	-	—
Allied Health	12.60%	13.2% (U)	13.2% (U)	-	—
Support Staff	28.20%	29.3% (F)	27.4% (F)	-	▼
HBDHB	12.30%	12.5% (U)	12.5% (U)	≥13.75%	—

Comments:
Gap to 30 September is 38 made up as follows:
30 Medical
44 Nursing
3 Allied Health
(26) Support
(13) Management and Admin

Time series



28 December 2014

29March2016

30June2016

Obesity						
Outcome: Reduce the incidence of Obesity in Hawke's Bay – Target: 95 percent of children with BMI ≥98th percentile identified in the Before School Check (B4SC) programme will be referred on for nutrition, activity and lifestyle interventions.						
Key Performance Measures	Baseline [31]	Previous result [32]	Actual to Date [33]	Target 15-16	Trend direction	Comments
Māori	30.0%	20% (U)	18% (U)	≥95%	▼	We currently do not have this data as this is a new target and the first quarter are only just completed – data checking is underway. It will come from the B4 School Check programme
Other	23.0%	21% (U)	22% (U)	≥95%	▲	
Total	27.0%	21% (U)	21% (U)	≥95%	—	

31 6 months to September 2015

32 6 months to March 2016

33 6 months to June 2016

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora – Smokefree** 138
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Caroline McElnay, Director Population Health Johanna Wilson, Acting Smokefree Programme Manager
Reviewed by:	Executive Management Team, Māori Relationship Board, HB Clinical and HB Health Consumer Council
Month:	November 2016
Consideration:	Monitoring

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report.

OVERVIEW

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

21

MĀORI HEALTH PLAN INDICATOR: Smokefree

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

WHY ARE THESE INDICATORS IMPORTANT?

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

These targets are designed to prompt doctors, nurses and other health professionals to routinely ask the people they see whether they smoke. The health professional is then able to provide brief advice and to offer quit support to smokers. There is strong evidence that brief advice from a health professional is highly effective at encouraging people to try to quit smoking, and to stay smokefree. Research shows that one in every forty smokers will make a quit attempt simply as a result of receiving brief advice. In the Health Equity Report 2014, tobacco use was highlighted as the single biggest underlying cause of inequity of death rates and ill health in Hawke's Bay.

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

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

During the period 28/5/2015 to 25/06/2016, 98% of patients aged 15 years and over coded as given brief advice and help to stop smoking. The Smokefree team continue to provide ABC, Helping People Stop Smoking, Nicotine Replacement Therapy (NRT) educational support to clinical staff ward by ward, in the hospital. It is important that patients who smoke within the hospital setting are:

- Charted NRT to manage their addiction
- Offered a referral for cessation and behavioural support on discharge

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

		Target	Total	Maori	Pacific	Other	Non Maori
2015/16	Q1	90.0%	81.2%	80.8%	75.7%	75.8%	81.5%
	Q2	90.0%	75.0%	74.5%	70.7%	75.8%	75.4%
	Q3	90.0%	77.6%	76.4%	71.9%	79.1%	77.6%
	Q4	90.0%	81.3%	80.3%	75.3%	83.1%	81.3%

During the period 1 July 2015 – 30 June 2016, 81% PHO enrolled smokers were given brief advice and help to quit. The likely reasons for not achieving this target are:

- Incorrect patient contact details
- Timeliness of ABC conversations. Due to workloads and/or patient priorities, the ABC is not done
- ABC completed verbally, ABC documentation not completed
- No confidence in carrying out ABC
- Few clinical staff have completed the "Helping People Stop Smoking" MoH training

The Smokefree Community Systems Coordinator 0.7 FTE supports the PHO and General Practices in finding solutions to achieve the 90% PHO enrolled smokers; provided with brief advice and help to quit target. There had been a three month period whilst this role was recruited to which left a gap in support to the PHO and General Practices. However, this position has now been filled and will work closely with both the PHO and General Practices to provide sustainable solutions for our whānau and communities.

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

	Month (3 months to)	Target	Total	Maori
2013/14	Q1	90.0%	93.2%	0.0%
	Q2	90.0%	96.3%	94.3%
	Q3	90.0%	87.9%	85.4%
	Q4	90.0%	94.5%	95.2%
2014/15	Q1	90.0%	100.0%	100.0%
	Q2	90.0%	98.1%	100.0%
	Q3	90.0%	98.6%	97.9%
	Q4	90.0%	96.9%	95.2%
2015/16	Q1	90.0%	90.3%	87.7%
	Q2	90.0%	96.5%	95.2%
	Q3	90.0%	88.6%	86.2%
	Q4	90.0%	89.0%	81.1%

Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. These include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death at infancy.

Encouraging pregnant women to stop smoking during pregnancy may also help them to kick the habit for good and provide health benefits for the mother and reduce exposure to second-hand smoke by the infant.

91.1% of all pregnant women in Hawke's Bay who identified as smokers were offered smoking brief advice and support to quit (1 July 2015 – 30 June 2016). In the same period, pregnant Māori women who identified as smokers passed the target in one quarter and were below 90% in three quarters. Therefore, overall in the year for Māori, 87.55% were offered smoking brief advice and support to quit.

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

There is no specific data on referrals of young Māori women to cessation support other than what is collected in (3) above HBDHB and Choices Kahungunu Health Services continue to support Wāhine Hapū and their whānau to be smokefree in the Increasing Smokefree Pregnancy Programme (ISSP). ISPP newly named Wāhine Hapū results for January to December 2015 were:

- There were 502 not smokefree pregnant women booked to HBDHB service, 69% were Māori, 28% European, 2% Pacific island and 1% other.
- Total of 318 stop smoking referrals were made for antenatal women (238), postnatal women (34) and whānau (46). 212 (67%) identified as Māori.
- Of the 318 referrals received to stop smoking services, 103 opted on to a three month stop smoking programme. 63 identified as Māori. 31 (30%) of those who opted on to the programme were smokefree at 4 weeks and 27 (26%) remained smokefree at 12 weeks.

As noted above the ISPP now has incentives to encourage whānau members of the pregnant, postnatal women to increase the chances of the women to be smokefree and to improve the health outcomes of foetus and baby. In conjunction, opportunistic peer to peer support is provided to midwives and lead maternity carers on the ward to increase their confidence with smoking cessation. House Officer and Registrar smokefree training occurs twice a year.

In addition, the Smokefree Māori Support Worker is working with young people to encourage smokefree lifestyles before pregnancy.

95% of Māori women who are smokefree at 2 weeks post-natal

	Target	Total	Maori	Pacific	High Deprivation
Jul - Dec 13	86%	79.0%	58.0%	94.0%	68.0%
Jan - Jun 14	86%	79.0%	62.0%	96.0%	70.0%
Jul - Dec 14	86%	73.0%	53.0%	81.0%	64.0%
Jan - Jun 15	86%	79.9%	65.6%	97.7%	72.6%

Data for Māori women smokefree at 2 weeks is sourced from. To ensure considerable opportunity is given to women to be smokefree, the ISPP includes postnatal women and their whānau. Although most women referred to the ISSP are pregnant, 11% of women are postnatal.

CHAMPION'S REPORT OF ACTIVITY THAT WILL OCCUR TO INCREASE PERFORMANCE OF THESE INDICATORS?

The tobacco control realignment saw the end of 32 Aukati Kai Paipa in New Zealand on 30 June 2016. Hawke's Bay was successful in the bid to be one of the new Stop Smoking Services in New Zealand. Te Haa Matea is a partnership between Te Taiwhenua o Heretaunga (Lead), Te Kupenga Hauora o Ahuriri, Choices Kahungunu Health Services and HBDHB. It is estimated Hawke's Bay has approximately 23,000 smokers in the region. To be able to achieve less than 5% of smokers by 2025, Hawke's Bay needs to help 1,337 people stop smoking each year. This is the goal of Te Haa Matea – to enrol 1,337 people per year and encourage and support as many as possible to be smokefree in 4 weeks.

Te Haa Matea is committed to working together to achieve this goal by:

- Hospital referrals to the Te Haa Matea Hub for follow-up.
- Support PHO and General Practices.
  - Working with the PHO to add a Te Haa Matea referral pathway to Med Tech. (Quitline currently is the only referral pathway).
  - Te Kupenga Hauora is working with Maraenui Medical Centre in helping patients to stop smoking. Te Haa Matea wants to work with other General Practices.
- Expanding the ISPP from an initiative between Choices Kahungunu Health Services and HBDHB to Te Haa Matea partners. This means all partners can work with Wāhine Hapū and her whānau to create a smokefree home environment and better health outcomes for all. The ISPP provides incentives at 1, 4, 8 and 12 weeks validation smokefree of nappies for the Wāhine Hapū and food vouchers for her whānau. By expanding ISPP to Te Haa Matea, we want to achieve a wider coverage of smokefree whānau.
- Te Haa Matea Stop Smoking Practitioners are holding smokefree clinics in youth training establishments e.g. Trade and Commerce, Hastings.

HBDHB along with various stakeholders continues to implement the Regional Tobacco Strategy with particular focus on young Māori women smoking rates and looking at opportunities to work better together with hauora providers.

RECOMMENDATIONS FROM TARGET CHAMPION

There needs to be ongoing focus on achieving the targets for PHO enrolled smokers and Māori pregnant women. The Smokefree Systems Coordinator role that had been vacant for three months has now been filled and this role needs to continue to work closely with the PHO and general practices to support practices to achieve this target.

Ongoing work with LMCs and general practices needs to ensure that there is equity in referring pregnant women to cessation services.

More work is required to define the target group of "young Māori pregnant women" and ensure appropriate services. The expansion of the Increasing Smokefree Pregnancy Programme has potential to be effective but this needs to be evaluated and other programmes considered as required.

Most of the indicators for this area are process indicators – the exception being the percentage of Māori women postnatal who are smokefree. These process indicators are based on the assumption that by inquiring about smokefree status and making referrals to cessation services there will be a reduction in smoking rates. We must ensure that these process targets are being met but also that a wide population health approach is also being taken to reduce smoking rates in our priority groups. This approach is outlined in the Regional Tobacco Control Plan.

CONCLUSION

Achieving these targets continue to be challenging. However I am excited with the development of Te Haa Matea in Hawke's Bay and note the increased focus on working together and support for primary care and smokefree pregnancies. Working collaboratively in all settings will help us achieve the Aotearoa Smokefree 2025 goal.

HAWKE'S BAY District Health Board Whakawāteatia	**Regional Tobacco Strategy for Hawke's Bay, 2015–2020 update** 139
	For the attention of: **HBDHB Board**
Document Owner:	Caroline McElnay, Director Population Health
Document Author(s):	Shari Tidswell, Team Leader/Population Health Advisor; and Johanna Wilson, Acting Smokefree Programme Manager
Reviewed by:	Exeuctive Management Team, Māori Relationship Board, HB Clinical and HB Health Consumer Council
Month:	November 2016
Consideration:	For information

RECOMMENDATION:

That the HBDHB Board

Note the contents of this report.

OVERVIEW

In November 2015 the Regional Tobacco Strategy for Hawke's Bay, 2015–2020 was endorsed by the HBDHB Board with a yearly report to be provided to the Board and Committees. This is the first annual update of the Strategy with particular focus on progress towards the three objectives through monitoring of the six key indicators:

22

Indicator 1a: Smoking prevalence (particularly Māori)
Indicator 1b: Smoking prevalence in pregnant women (particularly Māori women)
Indicator 1c: Lung Cancer Incidence
Indicator 2a: Prevalence of Year 10 students who have never smoking (particularly Māori students)
Indicator 2b: Prevalence of Year 10 students living with one or more parent who smokes (particularly Māori students
Indicator 3a: Number of tobacco free retailers

BACKGROUND

The Health Equity Report 2014 identified tobacco use as the single biggest underlying cause of inequity of death rates and ill-health in Hawke's Bay[1]. Smoking is still more prevalent for Māori than any other ethnic group in New Zealand[2] and is more common in areas with a significant Māori population and in areas of deprivation. Pregnant women who are Māori or who live in a Quintile 5 area are five more times more likely to be smokers than non-Māori or women living in a Quintile 1 area[3].

[1] McElnay C 2014. Health inEquity in Hawke's Bay. Hawke's Bay District Health Board.
[2] Ministry of Health. 2011. Māori Smoking and Tobacco Use 2011. Wellington. Ministry of Health.
[3] McElnay C 2016. Health Equity in Hawke's Bay. Hawke's Bay District Health Board

While rates of tobacco use have declined over the years, the decrease for Māori in particular is not sufficient to reach equity nor to reach the national 2025 Smokefree target of smoking prevalence being less than 5%.

The Regional Tobacco Strategy for Hawke's Bay 2015-2020 goal is for communities in Hawke's Bay to be smokefree/auahi kore – with Hawke's Bay whānau enjoying a tobacco free life. The Strategy has a strong commitment to reducing the social and health inequities associated with tobacco use and has three objectives:

- Cessation – help people stop smoking
- Prevention – preventing smoking uptake by creating an environment where young people choose not to smoke
- Protection - creating smokefree environments

The main source of information on smoking rates comes from the NZ Census but this will not be updated until 2018. The Ministry of Health funded ASH (Action on Smoking and Health) year 10 tobacco use survey and we have preliminary results for 2015. This survey is an annual questionnaire of approximately 30,000 students from across New Zealand. It is conducted in schools throughout the country and is one of the biggest surveys of its kind. It provides valuable and robust insight into rates of youth smoking. HBDHB also collect smoking data on pregnant women engaging with our services, this included over 90% of women giving birth. We are able to report the data quarterly.

WHAT'S HAPPENED IN ONE YEAR?

OBJECTIVE 1: HELPING PEOPLE TO STOP SMOKING

Te Haa Matea (Stop Smoking Services, Hawke's Bay)

At the same time HBDHB adopted the Tobacco Strategy, the Ministry of Health announced the end of 32 Aukāti Kai Paipa services and six national smokefree advocacy groups at 30 June 2016. The formation of 16 regional Stop Smoking Services and one national smokefree advocacy group commenced on 1 July 2016. Hawke's Bay is fortunate to have one of the regional Stop Smoking Services. Te Haa Matea is a partnership between Te Taiwhenua o Heretaunga (Lead), Te Kupenga Hauora o Ahuriri, Choices Kahungunu Health Services and HBDHB. Te Haa Matea's mission is to help whānau stop smoking and 'breathe easy'. One of the goals of Te Haa Matea is to support and encourage 1,337 Hawke's Bay residents to stop smoking (and stay stopped) each year until 2025. Of these, 39% (516 per annum) will need to be Māori[4].

HBDHB are contributing specifically to Te Haa Matea outcomes by providing project management for the development of the new service, cessation services in Wairoa, providing cessation programmes for pregnant women and providing support for workplace cessation programmes. HBDHB also provides leadership for the Smokefree Coalition which coordinates and delivers health promotion activity.

Choices Kahungunu Health Services and HBDHB have been running a successful Increasing Smokefree Pregnancy Programme (ISSP) with Wāhine Hapū since 2014. ISSP is set to expand to all partners of Te Haa Matea, providing wider coverage with more resources and greater access for pregnant women. The resources include nappy incentives to Wāhine Hapu who can validate being smokefree at weeks 1, 4, 8 and 12. Whānau who live in the same household will receive food vouchers to the value of $30.00 if they can validate being smokefree at weeks 1, 4, 8, and 12. This is creating a smokefree environment for the new baby and whānau.

Te Haa Matea cessation support has expanded to include smokefree clinics in workplaces i.e. Trade and Commerce (Rangatahi and Young Adults), Silver Fern Farms in Central Hawke's Bay, Tumu Timbers in Hastings and Lighthouse / Wit in both Napier and Hastings.

[4] HBDHB. Tobacco Control Plan 2015 – 2018.

Rates of Smoking for Māori Women Remain High

Assisting women to stop smoking remains a priority. For Māori women giving birth this year, 37.6% were smokers (2016 data for women giving birth in HBDHB services). A review of the Smokefree Pregnancy Programme in 2015 recommended early engagement at confirmation of pregnancy is necessary to give brief advice and offer cessation support. Most Wāhine Hapū get confirmation of pregnancy from their general practitioner. A suite of Wāhine Hapū resources has been developed to remind GPs to conduct ABC with Wāhine Hapū and refer her onto ISPP as soon as possible. The distribution of Wāhine Hapū resources will occur at the same time as the Maternity "Early Engagement" project, whereby a collaboration approach between Maternity and the Smokefree Team will talk with all GPs in the Hawke's Bay region over the next six months.

HBDHB have funded Directions Youth Health Service to develop and deliver a programme to support young Māori wāhine to remain smokefree, working with year 8, 9 and 10 students to co-design the programme. In addition the Smokefree Team's Māori Support Worker is using a range of support tools including FaceBook to promote smokefree lifestyle before pregnancy. Having smokefree wāhine is critical in reducing smoking during pregnancy and reducing smoking rates.

Smokefree Education, Training, Cessation Support

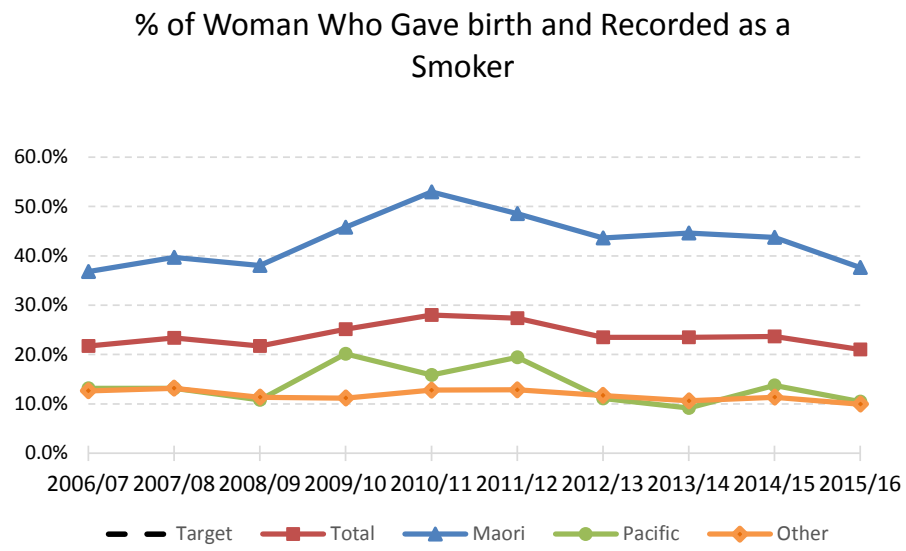
The Smokefree Team continues to support primary and secondary care clinicians with: -

- Understanding Nicotine Replacement Therapy (NRT) medicines
- How to chart NRT for patients
- How to complete Quit Cards
- Confidence in NRT conversations and
- Completing the "Helping People Stop Smoking" Ministry of Health training.

This year, the above mentioned training was extended to clinical staff at Royston Hospital and Te Taiwhenua o Heretaunga. We will continue to provide smokefree education and training in clinical and community settings.

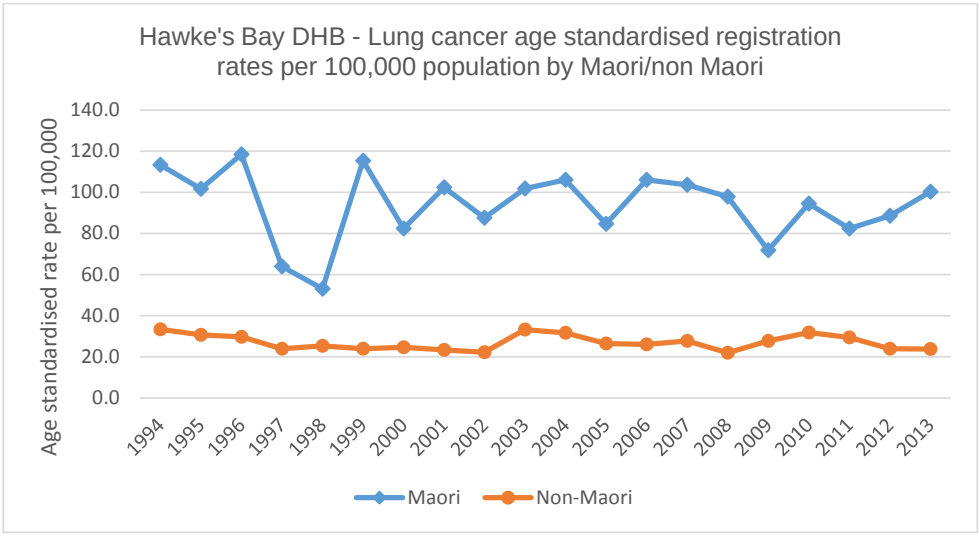
Indicator 1a: Smoking prevalence (particularly Maori)
No update on prevalence until 2018 census. Current data has smoking rates at 18% for non-Māori and 47.4% for Māori in Hawke's Bay. Please refer to the HB Tobacco Strategy for details.

Indicator 1b: Smoking prevalence in pregnant women (particularly Maori women)
The data below provides a time series from 2007 to June 2016 and illustrates a decrease in smoking rates for pregnant women from 2011. There is a significant reduction between 2015 to 2016 from 23.7% to 21% with the reduction of Māori women even greater from 43.7% to 37.6%. The delivery of the ISPP, greater engagement in healthy lifestyles programme (i.e. Maternal Nutrition), increases in the price of cigarettes and increased education/awareness have all contributed to this improvement.



Indicator 1c: Lung Cancer Incidence

Overall rates for lung cancer continues to decline slowly from 54 per 100,000 in 2004 to 31 in 2013, reflecting the reduction in the smoking population. However, the gap between Māori and non-Māori remains. This reflects the higher prevalence of smoking for Māori in Hawke's Bay.



OBJECTIVE 2: PREVENTING SMOKING UPTAKE

Young people who smoke may acquire the habit and become addicted before reaching adulthood, making them less able to quit smoking and more likely to have a tobacco-related health problem.

Te Haa Matea provide smokefree clinics and education in workplace settings, trade training establishments and teen parent units to target young people. These include Tumu Timbers, Silver Fern Farms (CHB), Wit/Lighthouse, EIT Hawke's Bay, Trade and Commerce and both Teen Parent Schools. The Smokefree Team's Māori Support Worker is working with rangitahi as outlined above.

Indicator 2a: Prevalence of Year 10 students who have never smoked (particularly Maori students)
The annual ASH survey shows that there has been a gradual increase in the number of Māori students who have never smoked. The percentage of all Māori year 10 students across New Zealand who never smoked was 16.2% in 2000 increasing to 59.2% in 2015. In 2015, Hawke's Bay noted 73% of year 10s, 54.33% of Māori year 10s and 50.95% of Māori wahine year 10s have never smoked.

This is a significant improvement. Anecdotally we are told that price increases were a major contributor with "family and friends not supplying young people due to the cost". This social supply remains the leading source of tobacco for this age group.

Indicator 2b: Prevalence of Year 10 students living with one or more parent who smokes
This information is sourced from the census so will not be available until 2018.

OBJECTIVE 3: CREATING SMOKEFREE ENVIRONMENTS

Hawke's Bay DHB continues to visit all retailers at least once a year to deliver reminders on the legislative requirements, encourage a smokefree policy and check compliance. A review of the Controlled Purchase Operations was completed this year and retailer education increased with the delivery of national resources.

A second visit by a Population Health Advisor or Smokefree Health Promoter is to encourage retailers to not sell tobacco. Three retailers located in Napier, Putorino and Wairoa become tobacco-free in the past year. Two articles were published in local newspapers that promoted retailers becoming tobacco free; "Hawke's Bay Retailers Care about Our Kids and Whānau".

An increase in burglaries at dairies and retail outlets has become a concern with cigarettes and cash targeted. Visits to all retailers located in Napier and Hastings during August and September 2016 confirmed this but did not provoke any retailer to not sell tobacco. Comments below are from three dairies who were burgled.

Support Legislation and Policy Change for Smokefree Environment

As a member of the HB Smokefree Coalition, HBDHB supported a coordinated submission to the joint Council Smokefree Policy (Napier and Hastings). Feedback from the joint committee reviewing submissions was that the information and constructive approach used in the submission was instrumental in achieving the changes to the policy. The new policy has extended smokefree environments to include bus stops, frontages of Council building, cafes and wider coverage in parks. HBDHB have supported awareness raising for these changes including signage and advertising.

Submissions on plain packaging and e-cigarettes aim to influence law change to further discourage smoking by reducing advertising and brand power, also providing other cessation support opportunities.

Indicator 3a: Number of Tobacco Free Retailers
In the past year, three retailers have stopped selling tobacco, which is a reduction. HBDHB has a process of visiting tobacco retailers to ensure compliance with the law and discuss becoming a tobacco free retailer. The decision to continue to sell is an economic one.

CONCLUSION

- It is exciting to have HBDHB involved in the development of Te Haa Matea in Hawke's Bay. All Smoking Cessation Services working collaboratively in all settings will help us achieve the Aotearoa Smokefree 2025 goal.

- Programmes led by and contributed to by HBDHB are seeing successes in supporting the reduction in smoking especially for Māori wāhine, as noted in the smoking data for pregnant women and improvement in never smoked for year 10 Māori wahine.

- The passing of legislation requiring tobacco products to have plain packaging this month is expected to further reduce smoking intiation. Tobacco products will no longer look attractive; as design and appearance has been a powerful marketing tool to initiate smoking for young people and encourage smokers to continue smoking.

HAWKE'S BAY
District Health Board
Whakawāteatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

24. Confirmation of Minutes of Board Meeting
- Public Excluded

25. Matters Arising from the Minutes of Board Meeting
- Public Excluded

26. Board Approval of Actions exceeding limits delegated by CEO

Reports and Recommendations from Committee Chairs

27. Finance Risk and Audit Committee Report

28. HB Clinical Council

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

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