BOARD MEETING

Date: Wednesday, 29 June 2016

Time: 1.00pm

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

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

Apologies: -

In Attendance: Dr Kevin Snee, Chief Executive Officer
Members of Executive Management Team

Board Administrator: Brenda Crene

Public Agenda

Item	Section 1 : Agenda Items	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	59	
9.	Financial Performance Report	60	
10.	Consumer Story (Kate Coley)	-	

	Section 2: For Information	Ref #	Time (pm)
11.	2016 Elections and briefing from Electoral Officer (Ken Foote and Warwick Lampp)	61	1.50
	Section 3: Reports from Committee Chairs		
12.	HB Clinical Council (Co-chairs Mark Peterson & Chris McKenna)	62	2.05
13.	HB Health Consumer Council (Graeme Norton)	63	
14.	Māori Relationship Board (Deputy Chair, Heather Skipworth)	64	
15.	Pacifica Health Leadership Group incl. Pacifica Dashboard (Dr Caroline McElnay)	65	
	Section 4: For Decision		
16.	Food Services Optimisation (Sharon Mason ,Gavin Carey-Smith & Deborah Chettleburg)	66	2.45
17.	Youth Health Strategy 2016-19 (Dr Caroline McElnay & Nicky Skerman)	67	2.55
	Section 5: For Discussion		
18.	Suicide Prevention and Postvention Plan (Dr Caroline McElnay & Penny Thompson)	68	3.05
19.	Health Equity Update Report 2016 (Dr Caroline McElnay)	69	3.10
	Section 6: Monitoring		
20.	Te Ara Whakawaiora / Oral Health (Sharon Mason & Dr Robin Whyman)	70	3.30
	Section 7: General Business		
	Section 8: Recommendation to Exclude		
21.	Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	Section 9: Agenda Items	Ref #	Time (pm)
22.	Minutes of Previous Meeting		3.35
23.	Matters Arising – Review of Actions		
24.	Board Approval of Actions exceeding limits delegated by CEO	71	
25.	Chair's Report (verbal)		
	Section 10: For Decision		
26.	Integrated Pharmacist Services in the Community (Mary Wills)	72	3.40
	Section 11: For Discussion		
27.	Regional Development Strategy Presentation (Kevin Snee and Wayne Jack NCC)	-	3.50
	Section 12: Reports from Committee Chair		
28.	Finance Risk & Audit Committee (Dan Druzianic)	73	

Next Meeting: 1.00 pm, Wednesday 27 July 2016
Te Waiora (Boardroom), HBDHB Corporate Administration Building

Tauwhiro Rāranga te tira He kauanuanu Ākina

Board "Interest Register" - 30 March 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 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 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	17.12.2015
	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	17.12.2015
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	The Trust has a lifestyle Contract with HBDHB signed 31 January 2015 Awarded a Green Prescription Contract with HBDHB 11 February 2015	Will not take part in any discussions or decisions relating to the Contract.	The Chair	04.02.14
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 25 MAY 2016, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.03PM

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

Apology Denise Eaglesome

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

Ngahiwi Tomoana opened the meeting with a Karakia.

APOLOGIES

An apology was noted from Denise Eaglesome.

INTEREST REGISTER

No changes to the interests register were advised.

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 27 April 2016, were confirmed as a correct record of the meeting.

Moved: Barbara Arnott
Seconded: Diana Kirton
Carried

MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: Budget Update and Investment Prioritisation was included on the board agenda for discussion (agenda item 16) – action item removed.

Item 2: Clinical Pathway for HepC – status update provided. Item can be removed

Item 3: Te Ara Whakawaiora – Breastfeeding – ongoing, detail expected in September.

Item 4: Workplan for May – amended following EMT discussion. Item can be removed

Item 5: Regional Health Improvement program – actioned. Item can be removed.

Item 6: MRB discussions – verbal update from Tracee TeHuia that the meeting had been delayed, pending a replacement within NKII's Health Portfolio. **Ongoing**

Item 7: Transform and Sustain refresh topics – actioned, item can be removed

Item 8: Living our Values / Behaviours presentation issued to board members, remove action.

BOARD WORK PLAN

The Board Work Plan was noted out to March 2017 with several additions as follows:

27 July	Consumer Story	Kate Coley
	Draft - Developing a Person Whanau Centred Culture	Kate Coley
	Annual Organisational Development Plan/Programme	John McKeefry
	Draft - HB Integrated Palliative Care	Tim Evans / Mary Wills
	HB Intersectoral Group Regional Plan TBC	Kevin Snee
	Health Equity Report	Caroline McElnay
	Transform and Sustain Refresh	Tim Evans
	Te Ara Whakawaiora / Oral Health	Robin Whyman

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 / Retires
Pauline Gordon	Care Associate	Surgical	16	3-Apr-16
Merehira Edwards	Registered Nurse	Surgical	35	2-May-16
Kathy Simmons	Health Records Associate	Facilities & Operational Support	22	18-May-16
Barbara Stewart	Receptionist - Outpatient	Facilities & Operational Support	15	31-May-16

- **Published statistics "How is my DHB performing?" for 3rd quarter of 2015/16:**

  The HB Today had published "How is my DHB performing?" with Hawke's Bay reflecting well for: Immunisation at 96% (cf target of 95%); Improved Access to Elective Surgery at 102% (which was above the 100% target); and on target at 90% for Better Heart and Diabetes Checks.

  Those below in Hawke's Bay included: Shorter stays in ED at 1% below target; Better help for smokers to quit (below for PHO enrolled patients); and Faster Cancer Treatment (FCT).

  FRAC had discussed the detail around the new FCT target, how it was measured, and anomalies around early detection.

  With added focus in this area, improvements were expected in the near future.

- **Smoke Free**:

  The Chair expressed his concern at the low target achieved for "Helping Smokers to Quit" (in the Primary Care setting). HB had achieved 78%, well below the 90% target. There had been a noticeable drop in this major MoH target and this needed to be turned around immediately. Management and the PHO were challenged to at least reach the middle of the pack in the very near future. The Board wanted to hear how this was going to be achieved.

Nicola Ehau (Manager Innovation & Development for Health Hawke's Bay Ltd) was in attendance and provided an overview on the areas of focus for smoke free which should see the target achieved by the end of June 2016. Resources within the PHO and DHB were working alongside each other to assist and encourage practices to achieve targets with their support.

A question was asked around how other PHOs (nationally) achieved the results they had. In most, if not all cases results were achieved by providing additional resources. Every PHO had a different approach, in Auckland there were active smoking champions out in the community. The concept was similar even though the structure was different.

The end goal is to have smoke free become part of "business as usual" for all general practices in Hawke's Bay.

Action CEO: HBDHB CEO would now include a smoke free update in his report monthly.

Action Clinical Council co-Chairs: Clinical Council will ensure added focus is placed on smoke free in primary care.

Dr Mark Peterson advised the real challenge was that this was a 15 month rolling target, with 2,000 being the base contacted consistently. Practices are not in that place yet.

- The Chair noted an extra $39m for **Pharmac** had been advised.
- The MoH had extended the term of the **Commissioner at Southern DHB**, until 2019.
- **MoH had announced a new role in Pharmacy**. A new technician will help free up pharmacists to spend more time with patients. Pharmacists will still be responsible clinically for correct prescriptions.
- Advised the **MoH had disestablished the National Health Committee** and the National Health Board and the Ministry of Health would take over the functions performed by these groups.
- Health Partnerships Limited (HPL) were asking DHBs to reconsider participation in the **Food Services Agreement**. This would be a key topic at following weeks Forum in Wellington.

  HPL seek to achieve the greatest level of participation as possible and the Chair wanted to be assured that HBDHB Board were still comfortable with the decision not to participate. Board members advised the Chair they were fully supportive and had no intention to review their decision.

  Action: HBDHB's CEO would advise that HBDHB Board remain strongly in favour of their past decision, and did not wish to reconsider HPLs Food Services Agreement.

CHIEF EXECUTIVE OFFICER'S REPORT

In presenting his report, the CEO noted in particular:

- Food Services Optimisation Review around quality and efficiency which has been undertaken and may require some capital investment. An update will be provided in June. Electronic ordering had been noted in an earlier review.
- Targets: a drop had been noted for shorter stays in ED for the month, as well as faster cancer treatment (further discussed later in the meeting). Better help for smokers to quit in the Hospital had dropped but was above target by 2.6%; with More heart and diabetes checks down .5% below the target of 90%.
- Hawkes Bay's financial performance is good, compared to the rest of the country.
- An overview of the papers included on the agenda was provided, noting good progress.

FINANCIAL PERFORMANCE REPORT

The financial result for April 2016, was an unfavourable variance of $173 thousand with a year to date a favourable result of $15 thousand cumulative. This included contingency of $250 thousand released to cover the rest of the elective surgery costs. As well as an additional $100 thousand transferred to Surgical Services and $90 thousand contributed to the corporate savings plan (3%). Overall this left $166 thousand of the contingency for the remaining two months of the financial year ended July 2016.

Not an easy month but believe HBDHB are still on track to reach year end surplus target.

CONSUMER STORY

Kate Coley (Director of QIPS) provided board members an insight into a patient's experience (in day surgery) as well as the experience of the patient's support person. The need for timely effectively communication with a stressed and anxious family member was noted, in contrast to the person receiving surgery who found the journey relaxed and comfortable.

The outcome of this story will see improvements made to internal processes in the day surgery area.

REPORT FROM COMMITTEE CHAIRS

Combined Hawke's Bay Clinical Council and HB Health Consumer Council Report

This follows the joint meeting held on 11 May 2016.

Clinical Council considered their own agenda for the first part of this meeting, with Consumer members joining thereafter. This was the second joint meeting held with a collaborative spirit evident which was reflected in the constructive discussions. Several more joint meetings were likely during 2016.

The Healthy Eating and Activity plan reflected good co-design with consumer members. The same process had been used for the Youth Health Strategy with very positive feedback on the work done to date. The final report on this strategy is expected in June.

Customer Focused Booking Programme was now planned to include a much wider focus as the customers don't just need a good booking system, they need more flexibility. Appointments are now often required outside normal working hours 8am to 5pm (5 days per week). A more holistic and flexible system will take more time to develop and implement.

Best Start: Healthy Eating and Activity was well received with strong support.

An update on the Travel Plan was provided with good progress being made. This will be a big culture change for staff.

Reappointments to HB Health Consumer Council

With approval noted by the CEO's of HBDHB and Health HB; and the associated background provided to board members, the following resolution was endorsed.

RESOLUTION

That the Board endorse the CEO's approval to reappoint the following members of Consumer Council for a further term of two years.

James Henry
Malcolm Dixon
Leona Karauria
Rosemary Marriott
Terry Kingston
Tessa Robin and
Heather Robertson

Moved **Helen Francis**
Seconded **Barbara Arnott**
Carried

Māori Relationship Board (MRB)

Heather Skipworth (Deputy Chair) provided an overview of the Meeting held on 12 May 2016 and noted the term "obesity" had already been largely been removed from the May reports which was very pleasing to see.

The following was put forward for the Board's consideration

RECOMMENDATION

That the Board

1. Note the content of this report, and
2. Consider MRBs advice and recommendations regarding the Best Start: Healthy Eating and Activity Plan Final, as follows:
    - The term 'Obesity' be removed where practical within the plan. MRB understands full exclusion may not be achievable because the plan is a public document and that 'obesity' is a clinical term
    - Refrain from using the term 'Obesity' within the community to eliminate the stigmatising of children and youth
    - Linking the Best Start: Healthy Eating and Activity Plan, Youth Health Strategy and Suicide Prevention Plan together to achieve an integrated approach. The strategies convey similar messages but are not connecting together.

Endorsed

Pasifika Health Leadership Group (PHLG)

Barbara Arnott provided an overview from the PHLG meeting held on Monday 9 May 2016.

Barbara advised it was very pleasing to see the bid for two Pasifica navigators was successful (pending board approval).

PHLG have come of age and it had taken a long time for them to understand how they could make a real difference. The Pasifika people have a range of cultures and language differences which at times has been overwhelming. Pacific people is the fastest growing area in our population in HB and accessing health services is paramount. Many have not been to, or lived in NZ before.

Pacific health has benefitted from the navigator/facilitation role(s) however two more Pasifica navigators will be very well received to ensure timely access to health services.

FOR DECISION

Final Draft HBDHB annual Plan 2016/17, and the Final Draft of the Central Region Regional Services Plan 2016/17

The final drafts were received and distributed to board member on 24 May, the day prior to the Board meeting for members to review.

The process for approval was a little cumbersome to ensure MoH timelines were met. The reports provided were not in final form however but do require approval subject to further changes which would be incorporated into the plan by 30th May.

Carina Burgess (the author) advised areas that could change, were clearly identified in the reports provided and outlined in the cover report.

Following discussion the recommendation was approved.

RESOLUTION

That the Board:

- **Approve** the Final HBDHB Annual Plan 2016/17 and Central Regional Services Plan 2016/17 subject to any minor changes that may occur from the final feedback received by MoH on 13th June.
- **Note** the HBDHB Māori Health Plan is incorporated into the HBDHB Annual Plan 2016/17.
- **Delegate(s)** Kevin Atkinson and one other board member to review and approve minor changes and sign the final documents prior to 17th June.

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

The process from here includes:

Any changes from EMT/Board incorporated into Final Draft Annual Plan, Māori Health Plan and Regional Services Plan, Submitted to MOH and loaded onto Diligent	*30th May*
Final Draft HBDHB Annual Plan to the Board	*2nd June*
Final Drafts to Māori Relationship Board (MRB)	*8th June*
Feedback on Final Draft of Annual Plan, Māori Health Plan and Regional Service Plan from MOH	*13th June*
Delegated Board Members to review, approve and sign Final Plans	*16th June*
Final Annual Plan and Regional Service Plan due to MOH	*17th June*
Final HBDHB Māori Health Plan 2016/17 due to MOH	*30th June*

Best Start: Healthy Eating and Activity

Shari Tidswell (Team Leader/Health Promotion Advisor) provided an overview to board members, acknowledging the feedback received from the committees during the month.

The Plan provided an evidenced-based approach to increasing healthy weights for children in Hawke's Bay which will be delivered with community partners (in order to support whānau engagement) and integration with existing programmes.

The Board noted the three advisory committees had recommended the Best Start: Healthy Eating and Activity plan be adopted.

Comments included:

- MRB's Deputy Chair Heather Skipworth was happy to see the term "obesity" used sparingly in the document presented to the Board, and was happy to hear the team were very clear about not over utilising the term obesity in the community.
- From personal experience, a member advised there appeared to be very little information available on maternal nutrition.

  Shari noted there was a referral pathway and midwives needed to be further reminded in this area.
- It was noted the biggest single influencing factor on a child's diet was their parent(s). There was very little reference in the document o parents/carers or to GPs (who support families and provide referrals). In response -
  - B4 school checks were in place and providers asked about what tools help.
  - Healthy first food discussions with mums.
  - For older aged children gaps occurred in accessing primary care. These are limited but want to develop other programs eg, through green prescription and active families, which is a referral pathway through Primary care.

The CEO advised HB has a role in leadership and will need to advocate for changes nationally and locally to develop an environment which supports healthy lifestyle changes.

HB will be reporting against the target B4 School checks as a measure against national target.

Action: A full review against plan for Best Start Healthy Eating and Activity was agreed to come back through the Committees to the Board in May 2017. This would be included on the detailed workplan.

RECOMMENDATION

That the Board:

1. Noted committee feedback.
2. Approved the Best Start: Healthy Eating and Activity Plan.
3. Agreed a full review against plan, would be provided in May 2017

Adopted

Budget Update and Investment Prioritisation

An update was provided by FRAC's Chair Dan Druzianic (who referred members to page 23 of the FRAC report) and put forward a FRAC Recommendation for Board approval.

Board members who had not attended the FRAC meeting were asked if there were any queries on any aspects of the proposed resolution they wished to discuss.

RESOLUTION

That the Board

1. **Approve** the budget to make annual savings of $13 million for the 2016/17 financial year ($10.3 million to balance expected unavoidable commitments and demands and $2.7 million for new investment)

2. **Approve** Option 2 (Net Expenditure – PBFF) be adopted in terms of moving and measuring strategic resource deployment and for savings allocations.
3. **Endorse** the process undertaken by Clinical Council to prioritise the requests for new investment.
4. **Note** the comments from the Māori Relationship Board
5. **Approve** Clinical Council's recommendations and savings options for new investments totalling $2m.

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

FOR INFORMATION / DISCUSSION

Travel Plan Update

Andrea Beattie provided a video outlining proposed travel options for staff. Parking has been an ongoing problem for a number of years (for the public) and a wide range of innovative ideas and options shown in the video related to staff hoping to reduce their travel to the hospital site. Options included: car-pooling, extra cycle stands, covered areas and extra showers, reconfiguring car parks, as well as the Regional Council altering and increasing bus transport options at peak times (including park and ride). Overall the plan is to encourage exercise and alternative means of travel to work, and to free up parking for the community.

The "Go Well" travel plan project formally kicks off from 1 July, with this promotional video initiating conversations with both internal and external stakeholders.

Discussion included:

- Had the Hastings District Council been approached suggesting the introduction of angle parking in McLeod Street? Advised this had not been taken any further at this time.
- Good communications need to be ensured for staff around showering facilities, bike parks etc.
- Benchmarking – how do we ensure we have made a difference (over time) following implementation?

  In response, we do have a mechanism to compare with a year later. A survey undertaken has provided a "base" snapshot (by those who filled it in). This would be re-done again in future.

The Chair was pleased with progress, and looked forward to the project formally commencing on 1 July 2016. The next Travel update would be provided in August.

Customer Focused Booking

Carleine Receveur the project lead introduced her paper and acknowledged the feedback to date from MRB and Clinical and Consumer Council.

This was about putting the customer at the heart of the booking process and changing the interaction we have with our customers. In the past we have disempowered our population and have appeared as dictatorial around appointments/bookings to suit the clinics rather than the customers. This project starts from the very beginning by re-defining bookings and re-engaging with staff and customers and co-designing a system that works for everyone.

Due to complexities uncovered during the course of the project, Customer Focussed Bookings has become a "programme of work" under which project(s) or work streams have been put in place. To this end a project entitled "Clinical Scheduling and Booking" is recommended to be put in place as a pre-requisite to ensure standardised processes are in place before implementing "UBook".

The following was summarised:

- Need to be careful with data security, with IS working to ensure this is not compromised.
- 80% of rescheduling has occurred for DHB related reasons. This is a priority area for the project and because of this timeframes are in 'amber'
- Booking staff need to interact well across specialties and some innovative training has been undertaken with favourable outcomes. Quality around bookings has improved and risks have since reduced.
- The work done on the DNA Project had raised issues and these have been noted and absorbed into the work being done. Work continues with Maori in co-designing systems/approaches that work.
- Presently plan to have the booking system in place and running by the end of 2016 with the Ophthamology area being first.

In discussion:

- Does "UBook" allow for early evening appointments? In response - if a speciality sets this up as such this will be achievable. The system will provide for whatever specific specialty booking times are.
- Are other DHBs looking at "UBook"? The MoH have supported Hutt Valley's "UBook" system as very innovative. Hutt are working with HBDHB first.
- What other software products have been looked at? There is presently nothing else on the market that is comparable.
- Can "UBook" be linked to the GO WELL travel times. It is well understood that those booking themselves take responsibility (to travel and attend times they have booked). This frees up the booking staff to focus on areas where they are most needed which may well include considering travel time details when booking for customers.

RECOMMENDATION

That the Board:

- Note the contents of this report.
- That due to the complexity and depth of work involved in clinic scheduling, Customer Focused Booking is shifting from a project to a programme. Under this umbrella programme a discreet project for Clinic Scheduling and Booking is being developed.

Adopted

Timelines Follow:

Activity	***Timeframe - 2016***
Download UBook files into test environment	*March - May*
Internal testing of UBook by bookers and administration staff	*June - July*
Further IT development (e.g. integration into Webpas)	*Aug - Sept*
Robust testing in the external environment	*Sept - Oct*
Further developments / testing / troubleshooting	*Oct - Nov*
Training, communications	*Nov*
Go Live (with speciality)	*Dec*

Information Service Function Review Update

Tim Evans (GM PIF) provided an update on progress following a presentation to the Board (which had including Davanti personnel) in March 2016.

The board were advised the Steering Group had been appointed and the Terms of Reference was with EMT.

Advice was being received from HR and the GM PIF had gone through the initial structure with everyone to obtain ideas on shape and issues aired. He advised the Davanti proposal milestones (as had been advised earlier) had been reset to meet the DHBs expectations and KPIs would be developed to show progress and improvements were being made which would come through the steering group. Technical support was being provided to the Project Sponsor.

The Board had reviewed progress and the next steps, understanding there was an expectation the project would take six months.

The Board were asked for their thoughts around the update and planning to date.

> Due to the sensitive nature of some of the issues to be discussed, the Board moved into Public Excluded (refer to Resolution to Exclude).
>
> The public board meeting then reconvened following the discussion.

MONITORING

Transform and Sustain Strategic Dashboard Q3 Jan-Mar 16

The framework is a tool to convey specific areas where poor performance and/or progress are indicated. Tim Evans advised he wished to handle this reporting in a different way and use the dashboard as a framework by taking subjects/projects and managing the workload to FRAC. He felt this would be a more powerful tool.

The Board were happy with this approach.

Actions GM PIF: As a result of the board's agreement, under-performing dashboard measures will be developed.

HBDHB Non-Financial Exceptions Report Q3; and MoH Dashboard Q2

Tim Evans drew attention to the Achievements, Areas of Progress and Areas of Focus. The latter being our focus to hit target: on better help for pregnant women to quit smoking; faster cancer treatment; and children without dental caries at five years of age.

The Chair referred to the comments included within the report and passed compliments on to those who do this work.

Action **Tim Evans to relay the board's thanks to the comment writers for the HBDHB Non-Financial Exceptions Report.**

Monitoring Dashboard for Quarter 2 (Oct-Dec 2015) provided by the MoH

HBDHB's only red highlight was for "under 19 year olds mental health waits" in spite of active work in this area.

Action: **Sharon Mason advised that more information on the under 19 Mental Health waits is expected and would be presented at the July Meeting.**

Annual Maori Health Plan Q3 Jan-March 2016 Dashboard

Tracee TeHuia (GM Maori Health) spoke to the dashboard provided.

The board were advised there had been a conversation around comparative reporting with the suggestion the Annual Maori Health Plan dashboard be presented in the same format/template as the Non-Financial Exceptions Report; but relay what was happening within the ethnicities. Need to provide a picture of the HB population to enable better understanding.

It was pleasing to note the good conversations around the proposed new UBook (customer booking) system due commence at the end of the calendar year.

Good responses had been received around change proposal for the DHB Māori Health Service.

Dr Gommans focus on clinicians attending the "engaging effectively with Maori" training was commended. Five of the doctors had commented the training has been beneficial to them.

Great to see an excellent result for quick access in angiograms in the last quarter.

The new Te Ara Whakawaiora programme for 2016/17 has now been signed off and reporting will be coming through the committees to the Board from the target champions.

Human Resource KPIs Q3

John McKeefry provided a brief overview of the report provided, with the main focus being on the Maori staff employed target. We do know that of all applicants, 9% are Māori with 15% of Maori being shortlisted which is encouraging. Of resignations received in the three months to 31 March 2016, only one person of 89 identified as Maori through the exit interview process.

This year our Māori staff employed target plateaued, despite active efforts. We cannot be complacent even though HB are doing better in this areas, than most DHBs.

Action: The following comments would be considered by HR and GM Maori Health

- HR are strongly recommending that Maori health services staff be included on interview panels, including Allied Health also.
- Can exit interviews by made compulsory for Maori staff who had resigned, to better understand their reasons for leaving (and apply the learnings gained). It was suggested such exit interviews may be undertaken by a Maori Health Service staff members by way of a chat. Privacy issues need to be considered.
- Do the DHB go out to various campuses to recruit (for Maori)? Other than sensitiveness around the Human Rights Act, it was acknowledged it could be an area of focus (outside of EIT and medical grads).

Deputy Chair Ngahiwi Tomoana advised there are a lot of Maori with transferable skills. Health is the biggest employer in HB. A lot of graduates ask how they can come back to help their people, however the focus is often not on health. Ngahiwi *personally* felt there were a several areas that could be focused on:

- Communication Strategy: Go out to the Maori communities, schools, iwi, community and conduct a drive to become a health professional, or health worker.
- Focus on present Māori employees and get their stories into the community. Drive this as the place to work.

We have passive recruitment presently. It was noted that Iwi have not been proactive in the area of health employment either – this can be done in partnership!

Action: **Te Ara Whakawaiora: Culturally Competent Workforce** is currently due through the committees in August 2016.

This is being reported in two parts a) HBDHB staff who are Maori; and b) HBDHB staff who have completed Treaty on-line training.

1. It was agreed the TAW Culturally Competent Workforce report would go to FRAC (in July) prior to going through the Committees (in August). This would be altered on the detailed workplan and TAW schedule.
2. As part of the Maori staff recruitment Campaign develop a "Communication Strategy" in partnership with Iwi to drive the employment of Maori. **HR and Comms.**

Te Ara Whakawaiora - Cardiovascular

Dr John Gommans spoke to the paper noting the indicator had been met locally and by ethnicity. Overall a good result. Regional data is included as HB is a long way from the tertiary centre (Wellington). HB do undertake procedures here but need to prioritise patients to Wellington.

A Cardiology Review TOR being drafted presently (Sharon), with no immediate change to the service in the very near future.

GENERAL BUSINESS

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

RESOLUTION TO EXCLUDE THE PUBLIC

RECOMENDATION

That the Board

Exclude the public from the following items:

19.	Information Service Function Review (part)
26.	Confirmation of Minutes of Board Meeting - Public Excluded
27.	Matters Arising from the Minutes of Board Meeting - Public Excluded
28.	Board Approval of Actions exceeding limits delegated by CEO
29.	Chair's Report
	Reports and Recommendations from Committee Chairs
30.	Finance Risk and Audit Committee
31.	HB Health Consumer Council and Clinical Council
32	Maori Relationship Board

The public section of the Board Meeting closed 4.12 pm

Signed: _____

Chair

Date: _____

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BOARD MEETING - MATTERS ARISING
(Public)

Action No	Date Issue first Entered	Action to be Taken	By Whom	By When	Status
1	30/3/16	**Te Ara Whakawaiora / Breastfeeding:** The Board wish to understand what other DHBs are doing and also to see where HB is benchmarked (including reasons and relative demographics). This will be included in the CEO's report when the information is available.	Caroline McElnay	Sept	
2	27/4/16 25/5/16	**Re MRB discussions:** Tracee TeHuia to arrange a discussion with NKII CEO Adele White, and invite Kevin Atkinson and Ngahiwi Tomoana to join in. Delayed due to pending replacement within NKII's Health Portfolio.	Tracee TeHuia		Work in Progress Update provided when available.
3	25/5/16	**Smoke Free in Primary Care:** a) Smoke Free update is to be included in HBDHB CEO's monthly report to the Board. b) Clinical Council to ensure added focus is placed on smoke free in Primary Care	Kevin Snee Chris McKenna and Mark Peterson		Actioned Included on Clinical Council's 8 June agenda.
4	25/5/16	**Health Partnerships – Food Services Agreement:** HBDHB's CEO would advise that HBDHB Board remain strongly in favour of their past decision, and did not wish to reconsider HPLs Food Services Agreement.	Kevin Snee	May	Actioned
5	25/5/16	**MRB's Recommendation:** Consider advice and recommendations, as follows: • The term 'Obesity' be removed where practical			Actioned prior to May Board

Action No	Date Issue first Entered	Action to be Taken	By Whom	By When	Status
		within the Best Start: Healthy Eating plan. • Refrain from using the term 'Obesity' within the community • Consider linking the Best Start: Healthy Eating and Activity Plan, Youth Health Strategy and Suicide Prevention Plan together to achieve an integrated approach.	Caroline McElnay		Meeting report being issued. Noted by Shari Tidswell in her presentation to the Board. For the Healthy populations team to consider.
6	25/5/16	**Best Start Healthy Eating and Activity:** A full review against plan was agreed to come back through the Committees to the Board in May 2017. This would be included on the detailed workplan.	Brenda Crene		Actioned
7	25/5/16	**Transform and Sustain Strategic Dashboard:** This reporting will be adopted as outlined in report to the Board. The board were happy with this approach. To be discussed with FRAC's Chair	Tim Evans		Work in progress
8	25/5/16	**HBDHB Non-Financial Exceptions Report Q3:** GM PIF to relay the board's thanks to the comment writers for this report	Tim Evans		Actioned
9	25/5/16	**MoH Dashboard for HBDHB Q2:** The COO advised more information on the under 19 Mental Health Waits is expected, and will be presented at the July Meeting.	Sharon Mason	July	

Action No	Date Issue first Entered	Action to be Taken	By Whom	By When	Status
10	25/5/16	**Maori staff employed:** Comments raised for further consideration include: The composition of Interview Panels for DHB and Allied staff; Exit Interviews and active campus recruitment (refer to page 11 of minutes) to be considered/ progressed. **Te Ara Whakawaiora: Culturally Competent Workforce** • It was agreed the TAW Culturally Competent Workforce report would go to **FRAC (in July**) prior to going through the Committees (in August). This would be altered on the detailed workplan and TAW schedule. • A "**Communication Strategy"** be developed in partnership with Iwi to drive employment.	John McKeefry and Tracee TeHuia Brenda Crene John McKeefry and Comms		In hand with a refreshed strategy going to FRAC in July and the Board in August noted on respective workplans. Actioned and staff advised accordingly.

HAWKE'S BAY DISTRICT HEALTH BOARD
WORKPLAN

Meetings 2016	Papers and Topics	Lead(s)
27 July	Consumer Story HB Integrated Palliative Care (Draft) Transform and Sustain Refresh Final HBDHB Annual Plan 16/17 SOI (on Diligent & Website) HB Intersectoral Group Regional Plan TBC Under 19 mental health wait target presentation	Kate Coley Tim Evans / Mary Wills Tim Evans Tim Evans Kevin Snee Sharon Mason
31 Aug	Consumer Story Draft Quality Accounts Orthopaedic Review Closure of phase one Travel Plan update – verbal Maori Staffing – Refreshed Strategy Annual Organisational Development Plan/Programme Community Pharmacy Strategy (board action 16/12/15) Urgent Care Service Change Proposal (in Aug or Sept) ***Monitoring*** HBDHB Non-Financial Exceptions Report Q4 Apr-Jun 16 plus MoH dashboard Annual Maori Health Plan Q4 Apr-Jun 2016 Transform and Sustain Strategic Dashboard Q4 Apr-Jun 16 Human Resource KPIs Q4 Te Ara Whakawaiora: Mental Health and AOD	Kate Coley Kate Coley Andy Phillips Sharon Mason John McKeefry John McKeefry Tim Evans/Billy Allan Liz Stockley Tim Evans Tim Evans / Tracee Tim Evans John McKeefry Sharon/Allison Stevenson
28 Sept	Consumer Story Orthopaedic Review – Phase 2 draft Family Violence – Strategy Effectivess – for noting Draft Developing a Person Whanau Centred Culture Final Quality Accounts NKII MoU Relationship Review Mental Health Consolidation / Benefits Realisation Final HB Integrated Palliative Care Long Term Investment Plan (Asset Management Plan) Annual Report (interim) Health and Social Care Networks update (6 monthly Sept-Mar17) ***Monitoring*** Te Ara Whakawaiora / Obesity (National Indicator)	Kate Coley Andy Phillips Caroline McElnay Kate Coley Kate Coley Ken Foote Sharon Mason / Allison Tim Evans / Mary Wills Tim Evans / Peter K Tim Evans Liz Stockley Caroline McElnay
	HB Health Sector Leadership Forum Date, Theme and Venue to be confirmed	**TBA**

Meetings 2016	Papers and Topics	Lead(s)
26 Oct	Consumer Story New Patient Safety and Experience Dashboard Alcohol Annual Report (Final) Final External Audit Report on agenda (P/excl) External Audit Engagement Arrangements ***Monitoring*** Tobacco - Annual Update on Progress against the Plan (for noting)	Kate Coley Kate Coley Caroline / Rachel Ayre Tim Evans Tim Evans Tim Evans Caroline McElnay
30 Nov	Consumer Story Final Developing a Person Whanau Centred Culture Travel Plan (quarterly update) – verbal Tobacco – Annual Update on progress against Plan ***Monitoring*** Te Ara Whakawaiora / Smoking (national Indicator) HBDHB Non-Financial Exceptions Report Q1 Jul-Sept 16 plus MoH dashboard Annual Maori Health Plan Q1 Jul-Sept 16 Transform and Sustain Strategic Dashboard Q1 Jul-Sept 16 Human Resource KPIs Q1 Staff Engagement Survey – any corrective actions	Kate Coley Kate Coley Sharon Mason / Andrea Caroline /Penny Caroline McElnay Tim Evans Tim Evans / Tracee Tim Evans John McKeefry John McKeefry
14 Dec	Consumer Story HB Workforce Plan – Discussion Document (Dec 16 – final March 17) Renal Stage 4 Final	Kate Coley John McKeefry Sharon Mason

Meetings 2017	Papers and Topics	Lead(s)
22 Feb	Consumer Story	Kate Coley
	Orthopaedic Review – phase 3 Draft	Andy Phillips
	Information Service Function Review (quarterly)	Tim Evans
	Monitoring	
	HBDHB Non-Financial Exceptions Report Q2 Oct-Dec16 plus MoH dashboard	Tim Evans
	Annual Maori Health Plan Q2 Oct-Dec16	Tim Evans
	Transform and Sustain Strategic Dashboard Q2 Oct-Dec166	Tim Evans
	Human Resource KPIs Q2	John McKeefry
	Te Ara Whakawaiora / Access (local indicator)	Mark Peterson
	Te Ara Whakawaiora / Cardiology (national indicator)	John Gommans
29 Mar	Consumer Story	Kate Coley
	HB Workforce Plan – Final for Endorsement	John McKeefry
	Travel Plan (quarterly update) - verbal	Sharon Mason / Andrea
	Health and Social Care Networks Update (6 monthly)	Liz Stockley
	Monitoring	
	Te Ara Whakawaiora /Breastfeeding (national indicator)	Caroline McElnay

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** 59
	For the attention of: **HBDHB Board**
Document Owner:	Dr Kevin Snee, Chief Executive Officer
Reviewed by:	Not applicable
Month: As at	22 June 2016
Consideration:	For Information

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Recommendations

That the Board
1) Note the contents of this report.

INTRODUCTION

There are a range of issues for discussion today. A number of those are key strategic issues: the health of our youth, suicide prevention, oral health, health inequity and economic development are all inter-related and critical to our health improvement goal. The development of our local pharmacist service is also a key strategic issue which relates to over 10 percent of our total spend on healthcare and offers the potential to think more radically about how we deliver pharmacy services locally. We will also consider how we report on the health of our Pasifika community so we can better meet their needs. Finally, we will consider how we take forward our food services so that we deliver good quality and value for money.

PERFORMANCE

Measure / Indicator	Target	Month of May	Qtr to end May	Trend For Qtr
Shorter stays in ED	≥95%	91.4%	92.5%	▼
Improved access to Elective Surgery (2015/16YTD)	100%	101.7%	-	▼
Waiting list	*Less than 3 months*	*3-4 months*	*4+ months*	
First Specialist Assessments (ESPI-2)	*2,706*	*354*	*4*	
Patients given commitment to treat, but not yet treated (ESPI-5)	*1,157*	*51*	*22*	
Faster Cancer Treatment*	≥85%	73.0% (Apr 2016)	61.8% (rolling 6m to Apr 2016)	▲
Increased immunisation at 8 months (3 months to May)	≥90%	---	95.1%	▼
Better help for smokers to quit – Hospital	≥95%	98.8%	98.5%	▲
Better help for smokers to quit – Primary Care	≥90%	77.6% (Quarter 3, 2015/16)	---	---

Measure / Indicator	Target	Month of May	Qtr to end May	Trend For Qtr
More heart and diabetes checks	≥90%	89.6% (Quarter 3, 2015/16)	---	---
Financial – month (in thousands of dollars)	($548)	($453)	---	---
Financial – year to date (in thousands of dollars)	($4,897)	($4,787)	---	---

**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%	*11/19 = 58 %*	*55/114 = 48.2%*

Note: The Ministry of Health minimum 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 has seen further deterioration in shorter stays in the Emergency Department (ED). We will bring a report updating the work that is in train and setting clear expectations about future progress to FRAC in July. Elective activity continues ahead of plan and numbers of patients waiting longer than four months continues to reduce.

Immunisation has continued above target. The quarter three figures for smoking cessation in primary care and heart and diabetes checks show little change, with a marginal improvement in the former and a marginal deterioration in the latter. The most recent preliminary data for smoking cessation we have is 78.8 percent with a projection of 83 percent for end of year which remains significantly below expectations. I have asked for further work to be done to improve our performance before year end.

This month sees a significant improvement in our monthly Faster Cancer Treatment performance, but a small deterioration in our six month rolling average. I am confident, as a result of improvements recently put in place and discussed last month, we will see improvement in our performance moving forward.

The financial result for May is a favourable variance of $95 thousand, making the year-to-date result $110 thousand favourable.

CONSUMER STORY

Organisational values are what shape our culture and define how consumers view us. This month's story highlights the positive impact that staff living our values had on the patient and whanau experience despite the unfortunate outcome of a beloved family member passing away in hospital.

PASIFIKA DATA AND REPORTING

The Ministry of Health's 'Ala Mo'ui - Pathways to Pacific Health and Wellbeing 2014-2018 is the Government's national plan for improving health outcomes for Pacific peoples in New Zealand. The Pasifika Health Leadership Group has adopted this dashboard as the foundation upon which we will measure and review improvements in Pacific health moving forward. This dashboard will be reported to the Board six monthly.

FOOD SERVICES OPTIMISATION REVIEW

Following the 2015 Heath Benefits Limited (HBL) Business Case and subsequent decision to retain in-house food services, the Board determined that HBDHB's Food Service be reviewed to identify opportunities to improve the current systems and processes. This optimisation review with recommendations has now been completed and covers multiple aspects of the Food Service including staff operations, processes, waste management, equipment, building layout, contracts and finances.

YOUTH HEALTH STRATEGY 2016-19

The Youth Health Strategy has been through a robust development process and has received extensive feedback. This has resulted in a strategy written in consultation with youth that conveys a shared vision. The strategy identifies a common set of youth outcomes and indicators that cut across the work of many organisations and services working with youth. This strategy is based on an internationally recognised Positive Youth Development Model. The hope is the framework will enhance organisations to communicate and develop strength-based models to ensure all youth in Hawke's Bay are thriving. A youth governance group will be set up to implement the strategy - this group will have youth members and will identify the immediate priorities for youth health and implement solutions to address these.

SUICIDE PREVENTION AND POSTVENTION PLAN

Since July 2015 HBDHB, in partnership with various agencies, has been implementing the Suicide Prevention and Postvention Plan. Today's report details the activity completed to date. There has been good interagency collaboration to date and we look forward to the continued suicide prevention work. The report will be submitted to the Ministry of Health in July. In addition, on 15 May Coroner Carla na Nagara released her inquest findings for the four youth suicides in Flaxmere 2013/2014. In response to Coroner na Nagara's recommendations, we will fully explore her recommendations over the next six months and identify next steps, working closely with the Flaxmere community and community providers.

HEALTH EQUITY UPDATE 2016: TACKLING HEALTH INEQUITIES

The Health Equity Update - tackling health inequities provides a snapshot of progress towards health equity. We are making progress. As a health care provider we can and must do more to ensure equitable access to services and to target appropriate health services to areas of greatest need. However, the powerful impact of social, economic and behavioural factors means that we can't achieve health equity through health services alone. This is why we are working closely with other sectors through the Intersectoral group, and in particular with MSD, to lift economic development and address social inclusion across Hawke's Bay. The Health Equity reports continue to challenge us to do more and provides pointers for where we need to focus our efforts.

TE ARA WHAKAWAIORA: ORAL HEALTH

Te Ara Whakawaiora (TAW) is an exception based report, drawn from Annual Maori Health Plan reporting. The intention of the programme is to improve the performance in Māori health. This report is from Sharon Mason, Champion for the Oral Health Indicators, with Dr Robin Whyman. It focuses on the key oral health indicators and activity to improve child oral health. While Maori 5-year-old oral health outcomes have improved over the past 10 years, a persistent significant inequity between Maori and the rest of our population remains. This report focuses on service level and population health activity that is endeavouring to change this inequity.

INTEGRATED PHARMACIST SERVICES IN THE COMMUNITY

The current Community Pharmacy Services Contract (CPSA 2012) has been extended until 30 June 2017 to allow time for the Ministry of Health (MoH) and DHBs to develop and implement a new approach to commissioning integrated pharmacist services in primary care.

All DHBs are asked to give agreement to proceed, so we can discuss the new contract with the sector from August. Further work will then proceed on governance arrangements, workstreams for contracting development and funding modelling and stakeholder communications for the transition to the new approach.

REGIONAL ECONOMIC DEVELOPMENT STRATEGY (REDS)

The DHB has been a key participant in the development of this plan as a member of the Intersectoral Group and the REDS Governance group. This is vital because we are not only the largest employer in Hawke's Bay, but the health sector drives around 10 percent of local Gross Domestic Product (GDP) through a range of activity. The board will be briefed on the strategy which will be formally launched next month.

SUMMARY

In summary, we have made good progress across a range of key strategic priorities whilst continuing to deliver sound performance across a range of indicators. There remains some room for improvement, however, across some indicators.

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report May 2016** 60
	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:	June 2016
Consideration:	For Information

RECOMMENDATION

That the Board and FRAC
Note the contents of this report

9

1. GM Planning Informatics & Finance comments

Financial performance

The result for May is a favourable variance of $95 thousand, making the year to date result $110 thousand favourable

Contingency of $266 thousand has been released to cover a higher estimate of the wash-up for IDF outflows to Mid Central DHB relating to cancer treatment. This is in addition to the $250 thousand released last month for elective surgery, and the year to date part of the $1.0 million transferred to Surgical Services and the $90 thousand contributed to the corporate 3% savings plan. This leaves $1.394 million of the contingency uncommitted with one month of the year remaining.

Forecast result

The forecast for the 30 June 2016 year remains at the $3.990 million budgeted surplus. Cover for medical vacancies and sick leave, likely costs to avoid ESPI breaches, and claw-back by MOH of PHARMAC hospital pharmacy price savings, will together be much higher than the remaining contingency. However, one off items are expected to offset the additional costs for this year, including:

- Reduced depreciation from lower cost and delayed implementation of Ngā Rau Rākau, and higher interest income and lower capital changes.
- Intermediate care beds for health of older people.
- Lower than expected growth in primary health care strategy costs and pharmacy payments, delayed under 13 access implementation, and unlikely expenditure of the primary mental health risk wash-up budget.

Efficiencies not achieved in the sustain programme, are expected to be offset by savings achieved elsewhere and delays in implementing new investments. IDF and elective services wash-ups, one high cost patient, and actuarial provisions relating to sabbatical leave contribute uncertainty to the forecast.

2. Resource Overview

	May				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)	(453)	(548)	95	17.4%	(4,787)	(4,897)	110	2.2%	3,990	3
Contingency utilised	91	250	159	63.7%	999	2,750	1,751	63.7%	3,000	8
Quality and financial improvement	430	787	(357)	-45.4%	6,960	8,288	(1,328)	-16.0%	10,200	11
Capital spend	1,098	1,892	(794)	-42.0%	15,657	19,466	(3,809)	-19.6%	21,358	16
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,228	2,177	(50)	-2.3%	2,145	2,174	29	1.3%	2,181	5 & 7
	CWD	CWD	CWD	%	CWD	CWD	CWD	%	CWD	
Case weighted discharges	2,458	2,404	54	2.2%	25,979	25,130	849	3.4%	27,407	5

The result for May is a favourable variance of $95 thousand, with $1.516 million of the contingency utilised ($917 thousand transferred to surgical, $83 thousand contributed to the corporate 3% savings plan, both year to date, $266 thousand for the Mid Central IDF wash-up and $250 thousand for Royston elective surgery).

Quality and Financial Improvement (QFI) programme savings continue below plan reflecting savings being made elsewhere. Efficiency budgets are being transferred to areas that have favourable variances. The implementation and monitoring of the remaining savings plans is ongoing. Realisation of IDF savings will not be known until the 2015/16 IDF wash-up process is complete.

Capital spend is well behind plan. The catch-up of Mental Health Inpatient Unit project payments budgeted last year, has been more than offset by low spend in IT, and later than planned purchase of some large clinical equipment items as they go through the trial process.

The FTE variance year to date reflects vacancies in allied health personnel, relating to new programmes or changes in the model of care.

Case weighted discharges are 2.2% ahead of plan in May, and 3.4% ahead of plan year to date. High acute general surgery, gastroenterology, and paediatric volumes are partly offset by low maternity, and internal medicine case-weights.

3. Financial Performance Summary

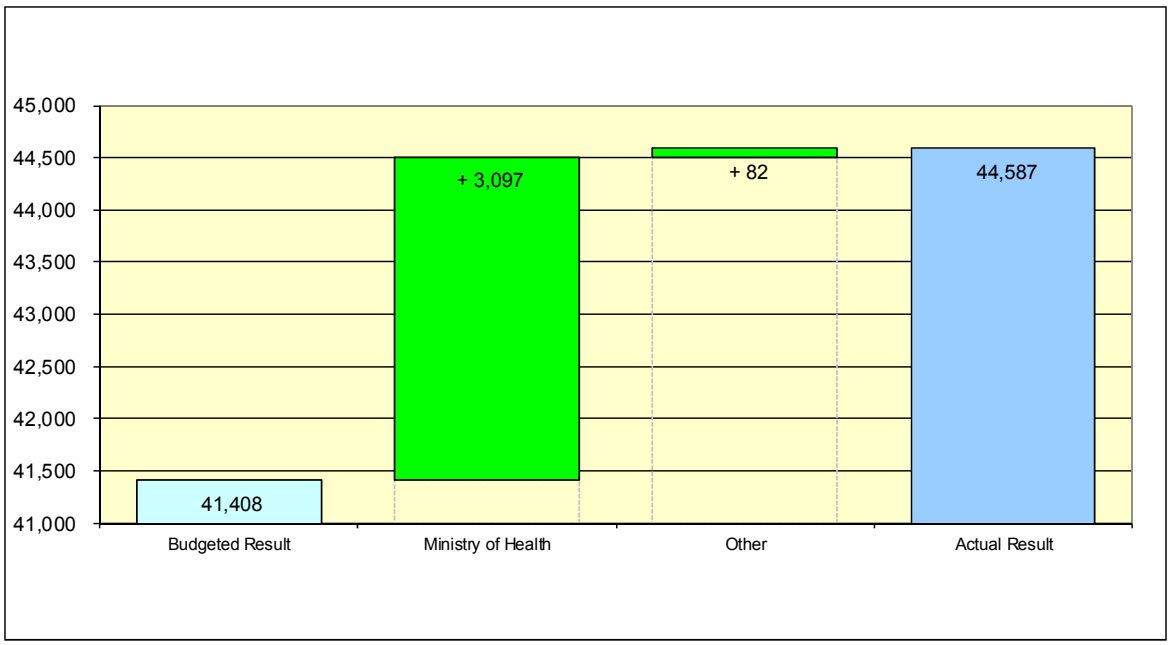
	May				Year to Date				Year End Forecast	Refer Section
$'000	Actual	Budget	Variance		Actual	Budget	Variance			
Income	44,587	41,408	3,179	7.7%	463,734	461,111	2,623	-0.6%	515,873	4
Less:										
Providing Health Services	20,418	19,552	(866)	-4.4%	220,133	217,252	(2,882)	-1.3%	241,346	5
Funding Other Providers	19,219	18,815	(404)	-2.1%	204,983	206,667	1,684	0.8%	222,530	6
Corporate Services	6,030	3,301	(2,729)	-82.7%	40,942	38,737	(2,205)	-5.7%	46,039	7
Reserves	(627)	288	915	317.3%	2,463	3,353	890	26.5%	1,968	8
	(453)	**(548)**	95	-17.4%	**(4,787)**	**(4,897)**	110	-2.2%	**3,990**	

Capital charge funding drives the income variance. The unfavourable providing health services variance is outsourcing to Royston, non-achievement of efficiencies, and locum cover, partly offset by allied health vacancies. Later than planned funding of new investments, lower cost access and medicine use reviews, more than offsets increasing costs in home care. Corporate services includes capital charge costs. Reserves are driven by lower depreciation and amortisation costs.

4. Income

$'000	May				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Ministry of Health	42,430	39,333	3,097	7.9%	441,331	438,090	3,240	0.7%	491,518
Inter District Flows	625	624	2	0.3%	6,866	6,859	6	0.1%	7,489
Other District Health Boards	204	339	(134)	-39.6%	3,060	3,983	(922)	-23.2%	3,393
Financing	115	86	29	33.3%	1,269	925	345	37.3%	1,351
ACC	599	506	93	18.4%	5,021	5,656	(635)	-11.2%	5,449
Other Government	22	35	(12)	-36.1%	339	380	(40)	-10.6%	366
Patient and Consumer Sourced	129	125	5	3.8%	1,147	1,396	(249)	-17.8%	1,267
Other Income	472	361	111	30.7%	4,645	3,824	821	21.5%	4,983
Abnormals	(11)	-	(11)	0.0%	57	-	57	0.0%	57
	44,587	**41,408**	3,179	7.7%	**463,734**	**461,111**	2,623	0.6%	**515,873**

May Income

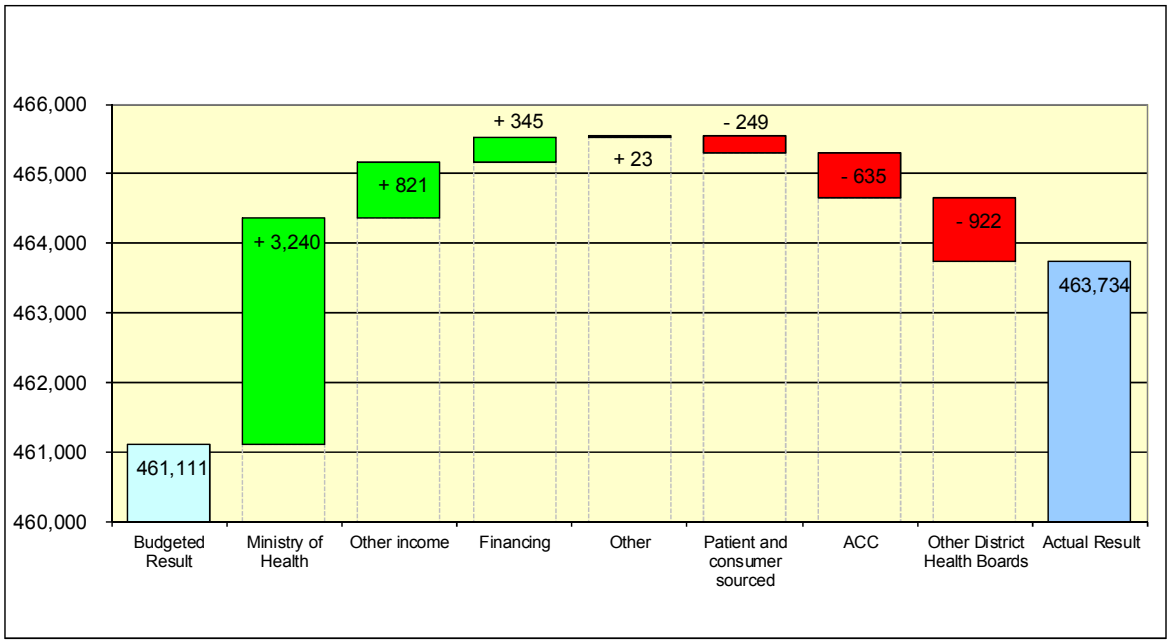


Note the scale does not begin at zero

Ministry of Health (favourable)
Includes the $2.996 million funding for additional capital charge relating to the 2014/15 land and building revaluations. The funding will be offset by the capital charge payments in December 2015 and June 2016.

Other (favourable)
Includes donations, clinical trials income and ACC non-acute, partly offset by lower sales of cancer drugs to Tairawhiti DHB, and lower oncology clinic reimbursements from Mid Central DHB.

Year to date Income



Note the scale does not begin at zero

Ministry of Health (favourable)
Includes the $2.996 million funding for additional capital charge relating to the 2014/15 land and building revaluations.

Other income (favourable)
Includes clinical trial income and donations (unbudgeted).

Financing (favourable**)**
Higher cash balances than projected, and unbudgeted income on special fund and clinical trial balances.

Patient and consumer sourced (unfavourable**)**
Lower patient co-payments (audiology and Friendly landlord – both offset by reduced costs), and non-resident charges.

ACC (unfavourable)
Mainly prioritisation of elective surgery over ACC volumes earlier in the year.

Other District Health Boards (unfavourable**)**
Lower sales of cancer drugs to Tairawhiti DHB, offset in expenditure.

5. Providing Health Services

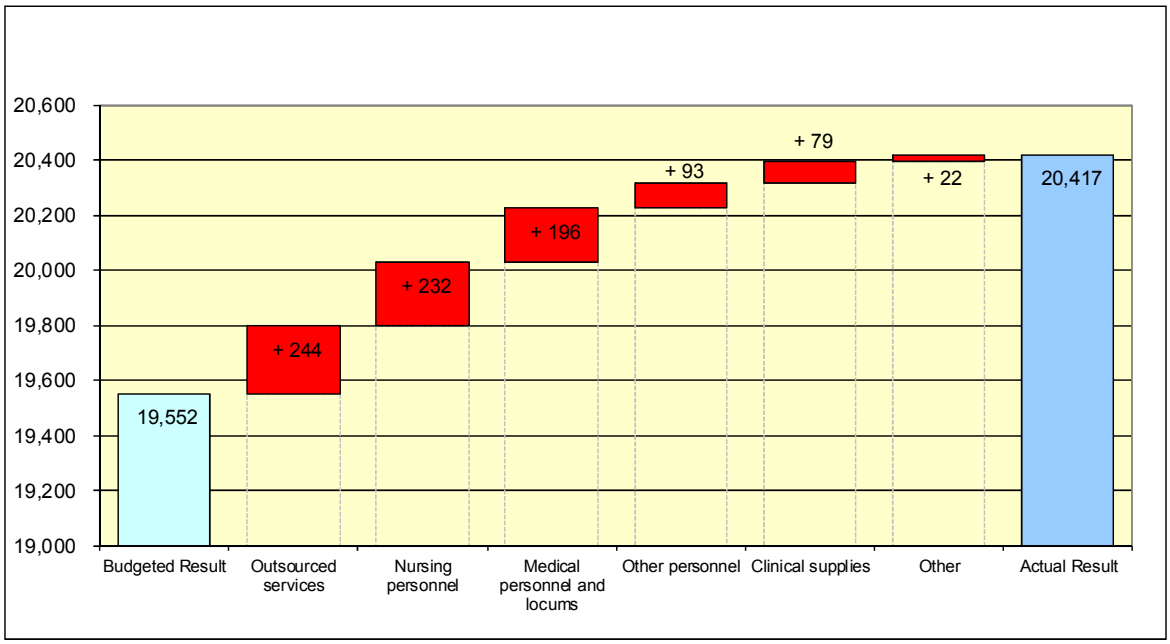
	May				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure by type $'000									
Medical personnel and locums	4,546	4,350	(196)	-4.5%	52,566	50,401	(2,164)	-4.3%	57,537
Nursing personnel	6,004	5,772	(232)	-4.0%	64,408	64,501	94	0.1%	70,258
Allied health personnel	2,664	2,717	53	2.0%	27,956	29,555	**1,598**	**5.4%**	30,499
Other personnel	1,788	1,695	**(93)**	**-5.5%**	18,636	18,532	(104)	-0.6%	20,314
Outsourced services	719	475	**(244)**	**-51.4%**	5,968	4,828	**(1,140)**	**-23.6%**	6,714
Clinical supplies	3,055	2,977	(79)	-2.6%	33,468	32,393	(1,075)	-3.3%	37,336
Infrastructure and non clinical	1,641	1,566	(76)	-4.8%	17,131	17,041	(91)	-0.5%	18,678
	20,418	**19,552**	(866)	-4.4%	**220,133**	**217,252**	(2,882)	-1.3%	**241,337**
Expenditure by directorate $'000									
Acute and Medical	5,648	5,127	**(520)**	**-10.2%**	60,240	58,428	(1,812)	-3.1%	65,999
Surgical Services	4,674	4,290	**(384)**	**-8.9%**	49,695	46,947	**(2,748)**	**-5.9%**	54,420
Women Children and Youth	1,622	1,623	1	0.1%	17,989	17,960	(30)	-0.2%	19,608
Older Persons & Mental Health	2,685	2,736	51	1.9%	29,915	30,591	676	2.2%	32,695
Rural, Oral and Communlty	1,907	1,850	(57)	-3.1%	19,897	20,213	316	1.6%	21,767
Other	3,882	3,925	42	1.1%	42,397	43,113	716	1.7%	46,847
	20,418	**19,552**	(866)	-4.4%	**220,133**	**217,252**	(2,882)	-1.3%	**241,337**
Full Time Equivalents									
Medical personnel	305.6	295.9	(10)	-3.3%	305	302	(3)	-0.9%	302.6
Nursing personnel	916.7	895.6	(21)	-2.3%	886	887	2	0.2%	890.3
Allied health personnel	436.5	444.2	8	1.7%	418	443	**25**	**5.5%**	443.9
Support personnel	140.9	128.6	**(12)**	**-9.6%**	132	129	(4)	-2.7%	128.9
Management and administration	256.8	245.4	(11)	-4.6%	248	246	(2)	-0.8%	246.2
	2,056.5	**2,009.8**	(47)	-2.3%	**1,988**	**2,007**	18	0.9%	**2,011.9**
Case Weighted Discharges									
Acute	1,655	1,623	32	2.0%	18,361	17,184	**1,177**	**6.9%**	18,824
Elective	549	584	(35)	-6.0%	5,882	5,752	130	2.3%	6,195
Maternity	232	167	**65**	**38.9%**	1,369	1,872	**(503)**	**-26.9%**	2,035
IDF Inflows	22	30	(8)	-25.5%	368	323	45	13.9%	353
	2,458	**2,404**	54	2.2%	**25,979**	**25,130**	849	3.4%	**27,407**

Directorates

The unfavourable result for May relates to:

- Acute and Medical – Includes nursing leave cover including leave buyouts, new investments, savings not achieved, and biologics.
- Surgical Services – major joint elective surgery outsourced to Royston, and leave cover (nursing personnel).

May Expenditure



Note the scale does not begin at zero

Outsourced services (unfavourable)
Outsourcing to Royston to meet the major joint target and ESPI compliance.

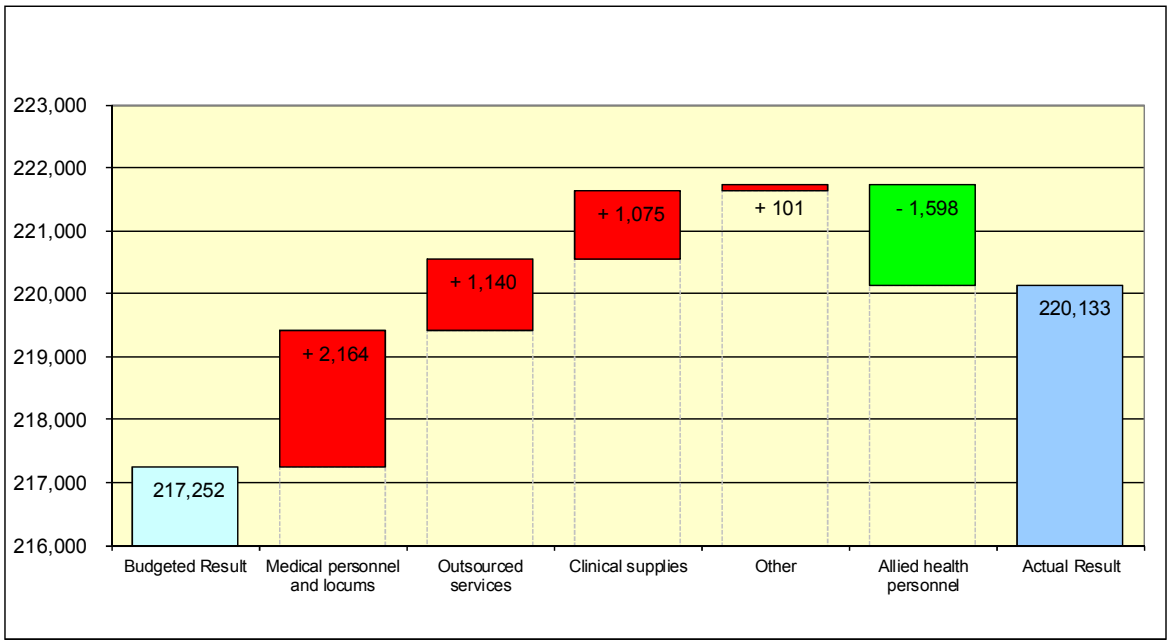
Nursing personnel (unfavourable)
Cover and additional staffing in ED and medical and surgical wards.

Medical personnel and locums (unfavourable)
Vacancy and leave cover.

Other personnel (unfavourable)
Higher staffing in addiction services, sterile services, food services, orderlies and administrative staff.

Clinical supplies (unfavourable)
Includes blood and renal supplies as the higher than estimated Pharmac rebate more than offset unachieved efficiencies.

Year to date Expenditure



Note the scale does not begin at zero

Medical personnel and locums (unfavourable)
Mainly vacancy and leave cover.

Outsourced services (unfavourable)
Outsourcing to Royston to meet the major joint target and ESPI compliance, mostly incurred since March.

Clinical supplies (unfavourable)
Savings targets not achieved.

Allied health personnel (favourable)
Vacancies mainly in mental health, but also across pharmacy, laboratory, and community dental.

Full time equivalents (FTE)

FTEs are 18 favourable year to date, including:

Allied health personnel (25 FTE / 5.5% favourable)

- Vacancies. Recruitment to positions for new models of care, low supply of applicants, delays in staged recruitment of pharmacy facilitators, and difficulty recruiting laboratory vacancies.

MONTHLY ELECTIVE HEALTH TARGET REPORT
YTD To May 2016

Plan for 2015/16	On-Site	Outsourced	IDF Outflow	TOTAL
Non Surgical - Arranged	70	0	0	**70**
Non Surgical - Elective	187	0	0	**187**
Surgical - Arranged	382	0	370	**752**
Surgical - Elective	4,682	768	650	**6,100**
TOTAL	**5,321**	**768**	**1,020**	**7,109**

		YTD May 2016			
		Actual	Plan	Var.	% Var.
On-Site	Avastins	164	182	-18	-9.9%
	ENT	432	391	41	10.5%
	General Surgery	879	977	-98	-10.0%
	Gynaecology	529	512	17	3.3%
	Maxillo-Facial	136	114	22	19.3%
	Ophthalmology	1066	628	438	69.7%
	Orthopaedics	792	868	-76	-8.8%
	Skin Lesions	166	164	2	1.2%
	Urology	400	419	-19	-4.5%
	Vascular	140	105	35	33.3%
	Surgical - Arranged	472	356	116	32.6%
	Non Surgical - Elective	78	174	-96	-55.2%
	Non Surgical - Arranged	31	65	-34	-52.3%
On-Site	**Total**	**5285**	**4955**	**330**	**6.7%**
Outsourced	Cardiothoracic	0	0	0	0.0%
	ENT	169	337	-168	-49.9%
	General Surgery	196	166	30	18.1%
	Gynaecology	10	54	-44	-81.5%
	Maxillo-Facial	43	104	-61	-58.7%
	Neurosurgery	0	0	0	0.0%
	Ophthalmology	54	0	54	0.0%
	Orthopaedics	30	24	6	25.0%
	Paediatric Surgery	0	0	0	0.0%
	Skin Lesions	3	0	3	0.0%
	Urology	39	24	15	62.5%
	Vascular	10	0	10	0.0%
	Surgical - Arranged	0	0	0	0.0%
	Non Surgical - Elective	0	0	0	0.0%
	Non Surgical - Arranged	0	0	0	0.0%
Outsourced	**Total**	**554**	**709**	**-155**	**-21.9%**
IDF Outflow	Cardiothoracic	66	78	-12	-15.4%
	ENT	39	39	0	0.0%
	General Surgery	45	50	-5	-10.0%
	Gynaecology	24	33	-9	-27.3%
	Maxillo-Facial	165	141	24	17.0%
	Neurosurgery	54	39	15	38.5%
	Ophthalmology	31	24	7	29.2%
	Orthopaedics	18	30	-12	-40.0%
	Paediatric Surgery	45	43	2	4.7%
	Skin Lesions	68	59	9	15.3%
	Urology	7	3	4	133.3%
	Vascular	13	57	-44	-77.2%
	Surgical - Arranged	141	341	-200	-58.7%
	Non Surgical - Elective	121	0	121	0.0%
	Non Surgical - Arranged	35	0	35	0.0%
IDF Outflow	**Total**	**872**	**937**	**-65**	**-6.9%**
		6711	**6601**	**110**	**1.7%**

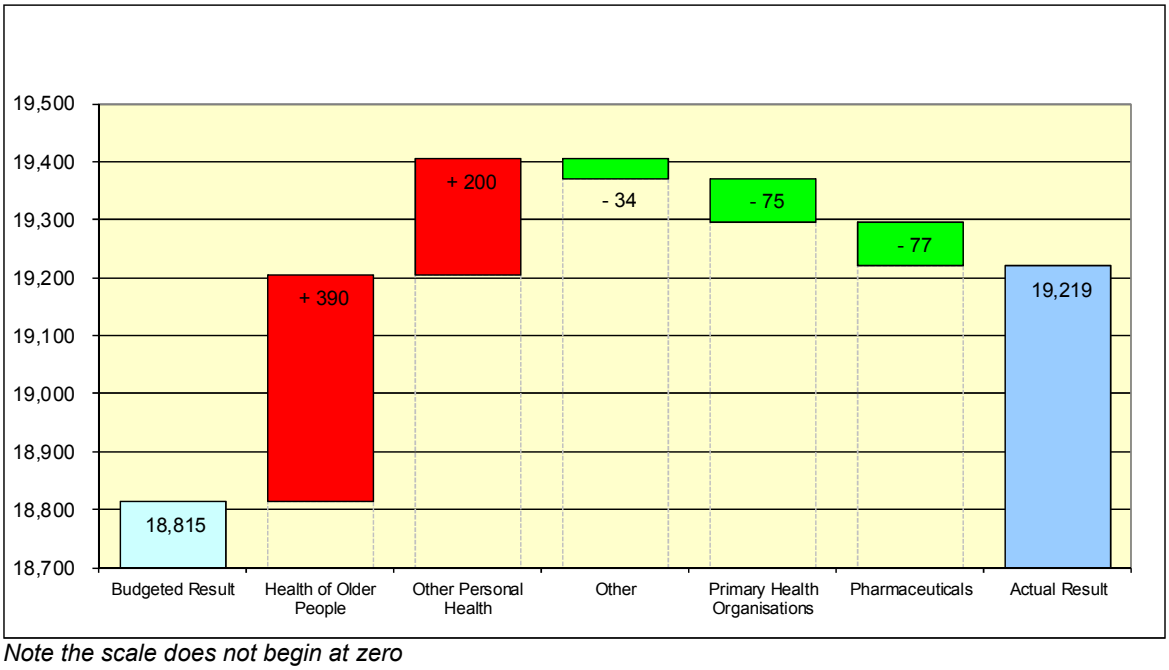
		May 2016			
		Actual	Plan	Var.	% Var.
On-Site	Avastins	0	18	-18	-100.0%
	ENT	52	39	13	33.3%
	General Surgery	76	98	-22	-22.4%
	Gynaecology	39	51	-12	-23.5%
	Maxillo-Facial	19	11	8	72.7%
	Ophthalmology	133	63	70	111.1%
	Orthopaedics	55	87	-32	-36.8%
	Skin Lesions	5	16	-11	-68.8%
	Urology	34	42	-8	-19.0%
	Vascular	15	11	4	36.4%
	Surgical - Arranged	43	36	7	19.4%
	Non Surgical - Elective	7	17	-10	-58.8%
	Non Surgical - Arranged	1	6	-5	-83.3%
On-Site	**Total**	**479**	**495**	**-16**	**-3.2%**
Outsourced	Cardiothoracic	0	0	0	0.0%
	ENT	17	39	-22	-56.4%
	General Surgery	23	19	4	21.1%
	Gynaecology	4	6	-2	-33.3%
	Maxillo-Facial	1	12	-11	-91.7%
	Neurosurgery	0	0	0	0.0%
	Ophthalmology	7	0	7	0.0%
	Orthopaedics	23	3	20	666.7%
	Paediatric Surgery	0	0	0	0.0%
	Skin Lesions	0	0	0	0.0%
	Urology	5	2	3	150.0%
	Vascular	3	0	3	0.0%
	Surgical - Arranged	0	0	0	0.0%
	Non Surgical - Elective	0	0	0	0.0%
	Non Surgical - Arranged	0	0	0	0.0%
Outsourced	**Total**	**83**	**81**	**2**	**2.5%**
IDF Outflow	Cardiothoracic	5	8	-3	-37.5%
	ENT	3	4	-1	-25.0%
	General Surgery	3	5	-2	-40.0%
	Gynaecology	0	4	-4	-100.0%
	Maxillo-Facial	2	15	-13	-86.7%
	Neurosurgery	3	4	-1	-25.0%
	Ophthalmology	2	3	-1	-33.3%
	Orthopaedics	0	3	-3	-100.0%
	Paediatric Surgery	8	4	4	100.0%
	Skin Lesions	2	6	-4	-66.7%
	Urology	1	0	1	0.0%
	Vascular	0	6	-6	-100.0%
	Surgical - Arranged	12	36	-24	-66.7%
	Non Surgical - Elective	10	0	10	0.0%
	Non Surgical - Arranged	3	0	3	0.0%
IDF Outflow	**Total**	**54**	**98**	**-44**	**-44.9%**
		616	**674**	**-58**	**-8.6%**

Please Note: The data displayed is as at 8th June 2016. IDF Events not yet captured in NMDS will not be reported above

6. Funding Other Providers

$'000	May Actual	May Budget	May Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Payments to Other Providers									
Pharmaceuticals	3,386	3,463	77	2.2%	38,405	38,715	310	0.8%	41,798
Primary Health Organisations	2,783	2,858	75	2.6%	30,871	31,545	674	2.1%	33,909
Inter District Flows	3,917	3,899	(19)	-0.5%	42,992	42,885	(107)	-0.2%	46,891
Other Personal Health	2,276	2,076	**(200)**	**-9.6%**	21,367	21,964	597	2.7%	21,747
Mental Health	1,075	1,116	41	3.6%	12,284	12,272	(12)	-0.1%	13,369
Health of Older People	5,339	4,949	**(390)**	**-7.9%**	54,761	54,437	(323)	-0.6%	60,028
Other Funding Payments	441	454	13	2.8%	4,302	4,848	**546**	**11.3%**	4,787
	19,219	18,815	(404)	-2.1%	**204,983**	**206,667**	1,684	0.8%	222,530
Payments by Portfolio									
Strategic Services									
Secondary Care	4,422	4,148	**(274)**	**-6.6%**	45,689	45,685	(4)	0.0%	48,274
Primary Care	7,179	7,380	201	2.7%	80,214	81,427	1,213	1.5%	87,607
Chronic Disease Management	382	376	(6)	-1.5%	3,637	3,844	**208**	**5.4%**	3,977
Mental Health	1,075	1,112	37	3.3%	12,281	12,230	(50)	-0.4%	13,365
Health of Older People	5,396	5,035	**(362)**	**-7.2%**	55,245	55,380	135	0.2%	60,565
Other Health Funding	(1)	(17)	(15)	-92.6%	(49)	(183)	**(134)**	**-73.3%**	(74)
Maori Health	535	526	(9)	-1.6%	5,675	5,790	114	2.0%	6,254
Population Health									
Women, Child and Youth	112	114	3	2.2%	1,243	1,193	(50)	-4.2%	1,375
Population Health	119	141	21	15.0%	1,050	1,301	252	19.3%	1,187
	19,219	18,815	(404)	-2.1%	**204,983**	**206,667**	1,684	0.8%	222,530

May Expenditure



Note the scale does not begin at zero

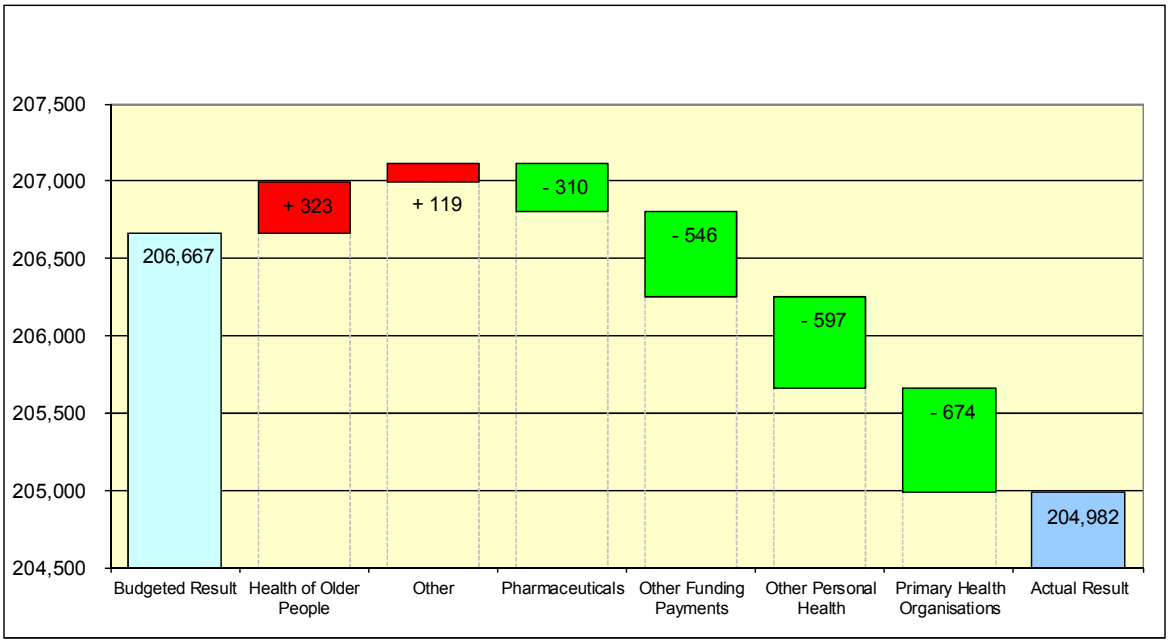
Health of Older People (unfavourable)
In between travel offset by additional MOH income.

Other Personal Health (unfavourable)
Includes provisioning for IDFs.

Primary Health Organisations (favourable)
Delayed implementation of lower cost access services and skin lesion removals.

Pharmaceuticals (favourable)
Slower than planned response from pharmacies relating to medicine use reviews (MUR).

Year to date Expenditure



Note the scale does not begin at zero

Health of Older People (unfavourable)
In between travel offset by additional MOH income.

Pharmaceuticals (favourable)
Slower than planned response from pharmacies relating to medicine use reviews (MUR).

Other Funding Payments (favourable)
Later than planned implementation of new investments, and delay of the Whanau Manaaki programme.

Other Personal Health (favourable)
Timing of new investment expenditure.

Primary Health Organisations (favourable)
Lower access payments (delayed implementation).

7. Corporate Services

$'000	May Actual	May Budget	May Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Operating Expenditure									
Personnel	1,320	1,243	**(77)**	**-6.2%**	13,523	13,576	53	0.4%	14,777
Outsourced services	104	86	(18)	-20.4%	1,048	951	**(97)**	**-10.2%**	1,142
Clinical supplies	1	0	(1)	-208.6%	131	5	**(126)**	**-2393.7%**	142
Infrastructure and non clinical	548	596	47	8.0%	7,594	7,677	82	1.1%	8,132
	1,974	1,926	(48)	-2.5%	22,296	22,209	(87)	-0.4%	24,193
Capital servicing									
Depreciation and amortisation	1,142	1,210	**68**	**5.6%**	12,119	12,660	541	4.3%	13,331
Financing	165	166	1	0.3%	1,791	1,796	5	0.3%	1,951
Capital charge	2,748	-	(2,748)	0.0%	4,736	2,071	**(2,665)**	**-128.6%**	6,565
	4,056	1,375	**(2,680)**	**-194.9%**	18,646	16,528	**(2,118)**	**-12.8%**	21,847
	6,030	**3,301**	**(2,729)**	**-82.7%**	**40,942**	**38,737**	**(2,205)**	**-5.7%**	**46,039**
Full Time Equivalents									
Medical personnel	-	-	-	0.0%	0	-	(0)	0.0%	-
Nursing personnel	12.3	16.4	4	25.1%	12	16	5	29.2%	16.5
Allied health personnel	0.1	-	(0)	0.0%	0	-	(0)	0.0%	-
Support personnel	9.5	9.4	(0)	-1.5%	9	9	(0)	-0.1%	9.4
Management and administration	149.2	141.6	**(8)**	**-5.4%**	136	142	6	4.4%	142.8
	171.1	**167.4**	(4)	-2.2%	**157**	**168**	**11**	**6.4%**	**168.7**

Funding for the additional capital charge relating to the 2014/15 land and building revaluation was received in May (see section 3). The provision for capital charge expenditure has been adjusted to offset the receipt of the funding. The net effect of the funding and expenditure is nil.

8. Reserves

$'000	May Actual	May Budget	May Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Expenditure									
Contingency	(266)	159	**425**	**267.0%**	1,159	1,751	**592**	**33.8%**	-
Transform and Sustain resource	28	41	13	32.4%	454	434	(20)	-4.6%	679
Other	(389)	88	**477**	**540.5%**	850	1,168	**318**	**27.2%**	1,289
	(627)	**288**	**915**	**317.3%**	**2,463**	**3,353**	**890**	**26.5%**	**1,968**

The Other category includes budget for one-off new investment and transform expenditure that has been spent mainly in Acute and Medical Services, partly offset by loss on disposal of assets and TAS audits relating to 2014/15.

9. Financial Performance by MOH Classification

$'000	May Actual	May Annual Plan	May Variance	Year to Date Actual	Year to Date Annual Plan	Year to Date Variance	End of Year Forecast	End of Year Annual Plan	End of Year Variance
Funding									
Income	42,839	39,767	3,073 F	444,284	441,293	2,991 F	491,587	491,789	(202) U
Less:									
Payments to Internal Providers	25,735	22,989	(2,745) U	243,800	241,054	(2,745) U	262,986	263,091	104 F
Payments to Other Providers	19,219	18,815	(404) U	204,983	206,667	1,684 F	221,164	224,184	3,020 F
Contribution	**(2,115)**	**(2,037)**	**(77) U**	**(4,498)**	**(6,428)**	**1,929 F**	**7,437**	**4,514**	**2,922 F**
Governance and Funding Admin.									
Funding	262	262	-	2,877	2,877	-	3,140	3,140	-
Other Income	3	3	-	38	28	10 F	40	30	10 F
Less:									
Expenditure	254	254	1 F	2,499	2,792	293 F	2,754	3,049	295 F
Contribution	**11**	**10**	**1 F**	**416**	**112**	**303 F**	**426**	**121**	**305 F**
Health Provision									
Funding	25,473	22,728	2,745 F	240,923	238,177	2,745 F	259,847	259,951	(104) U
Other Income	1,745	1,639	106 F	19,412	19,791	(378) U	20,987	21,479	(491) U
Less:									
Expenditure	25,567	22,887	(2,680) U	261,039	256,549	(4,490) U	284,707	282,076	(2,631) U
Contribution	**1,651**	**1,479**	**172 F**	**(704)**	**1,418**	**(2,122) U**	**(3,873)**	**(646)**	**(3,227) U**
Net Result	**(453)**	**(548)**	**95 F**	**(4,787)**	**(4,897)**	**110 F**	**3,990**	**3,990**	**0 F**

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 2015/16 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.

$'000	May Mgmt Budget	May Annual Plan	May Movement	Year to Date Mgmt Budget	Year to Date Annual Plan	Year to Date Movement	End of Year Mgmt Budget	End of Year Annual Plan	End of Year Movement
Funding									
Income	39,767	39,570	197 F	441,293	439,219	2,074 F	491,789	489,518	2,271 F
Less:									
Payments to Internal Providers	22,989	22,896	(93) U	241,054	240,843	(211) U	263,091	263,334	243 F
Payments to Other Providers	18,815	18,648	(167) U	206,667	204,844	(1,823) U	224,184	222,194	(1,990) U
Contribution	**(2,037)**	**(1,974)**	**(63) U**	**(6,428)**	**(6,468)**	**40 F**	**4,514**	**3,990**	**524 F**
Governance and Funding Admin.									
Funding	262	262	-	2,877	2,877	-	3,140	3,140	-
Other Income	3	3	-	28	28	-	30	30	-
Less:									
Expenditure	254	264	10 F	2,792	2,903	111 F	3,049	3,170	121 F
Contribution	**10**	**(0)**	**10 F**	**112**	**2**	**111 F**	**121**	**(0)**	**121 F**
Health Provision									
Funding	22,728	22,634	93 F	238,177	237,966	211 F	259,951	260,194	(243) U
Other Income	1,639	1,622	16 F	19,791	19,194	597 F	21,479	20,865	613 F
Less:									
Expenditure	22,887	22,831	(57) U	256,549	255,590	(959) U	282,076	281,060	(1,016) U
Contribution	**1,479**	**1,426**	**53 F**	**1,418**	**1,570**	**(151) U**	**(646)**	**0**	**(646) U**
Net Result	**(548)**	**(548)**	**(0) U**	**(4,897)**	**(4,897)**	**(0) U**	**3,990**	**3,990**	**(0) U**

11. Quality and Financial Improvement Programme

Row Labels	Sum of Planned Savings	Count of Planned Savings	Sum of ytd savings target	Sum of YTD actual Savings	Sum of monthly savings
CORPORATE	**1,360**	**14**	**1247**	**1247**	**113**
Green	1,360	14	1247	1247	113
Health Services	**7,000**	**69**	**6231**	**4903**	**493**
Amber	1,022	4	937	575	44
Green	5,638	60	4981	4328	449
Red	341	5	313	0	0
Maori Health	**82**	**1**	**76**	**76**	**7**
Green	82	1	76	76	7
POPULATION HEALTH	**70**	**2**	**64**	**64**	**1**
Green	70	2	64	64	1
STRATEGIC SERV	**1,688**	**2**	**671**	**671**	**61**
Green	1,688	2	671	671	61
Grand Total	**10,200**	**88**	**8288**	**6960**	**676**

The $1.328 million savings shortfall year to date is all in Health Services where we have achieved 79% of our year to date savings plan target. The gap in the savings plan for Health Services has largely been covered by additional savings made in other programmes not on the original savings plan. These include delayed staff appointments and intense management of all discretionary spend e.g travel.

Health Services

The five red programmes are (full year planned savings in brackets, and no savings have been achieved unless stated otherwise):

- Acute and Medical:
  - Radiology duplicate testing ($45 thousand)
  - Share of the additional $1million savings ($131 thousand)
- Chief Operating Officer:
  - Reduction in harm from falls ($50 thousand)
  - Reduction in pressure sores ($20 thousand)
- Older Persons Health:
  - Options Hawke's Bay ($95,000)

The four amber programmes are:

- Acute and Medical (2 projects):
  - Year to date savings of $471 thousand against a $695 thousand target, 68% attained.
- Chief Operating Officer:
  - Year to date savings of $40 thousand against a $146 thousand target, 27% achieved.
- Surgical:
  - Year to date savings of $64 thousand against a target of $105 thousand 61% achieved

Corporate, Maori Health, Population Health and Strategic Services

All green

12. Financial Position

30 June		*May*				*Annual*
2015	$'000	*Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2015*	*Budget*
	Equity					
120,014	Crown equity and reserves	102,965	108,540	5,574	(17,048)	108,183
(32,388)	Accumulated deficit	(20,126)	(25,307)	(5,181)	12,261	(16,420)
87,626		82,839	83,233	394	(4,787)	91,763
	Represented by:					
	Current Assets					
14,970	Bank	21,345	(3,506)	(24,852)	6,376	8,756
1,703	Bank deposits > 90 days	1,744	1,564	(181)	42	1,564
17,862	Prepayments and receivables	10,135	18,116	7,981	(7,727)	18,146
3,881	Inventory	3,972	3,802	(170)	91	3,845
1,220	Non current assets held for sale	1,220	-	(1,220)	-	-
39,635		38,417	19,976	(18,441)	(1,218)	32,310
	Non Current Assets					
148,434	Property, plant and equipment	152,162	165,441	13,279	3,728	166,016
2,298	Intangible assets	1,926	2,108	182	(372)	2,217
7,301	Investments	9,188	9,235	47	1,887	9,351
158,033		163,276	176,784	13,508	5,243	177,583
197,668	**Total Assets**	**201,693**	**196,759**	**(4,933)**	**4,025**	**209,894**
	Liabilities					
	Current Liabilities					
-	Bank overdraft	0	-	(0)	(0)	-
29,960	Payables	37,642	35,511	(2,130)	7,681	35,540
35,239	Employee entitlements	36,370	33,090	(3,279)	1,131	32,660
65,199		74,012	68,602	(5,410)	8,812	68,200
	Non Current Liabilities					
2,342	Employee entitlements	2,342	2,425	83	-	2,431
42,500	Term borrowing	42,500	42,500	-	-	47,500
44,842		44,842	44,925	83	-	49,931
110,042	**Total Liabilities**	**118,854**	**113,527**	**(5,327)**	**8,812**	**118,131**
87,626	**Net Assets**	**82,839**	**83,233**	**394**	**(4,787)**	**91,763**

The variance from budget for:

- Crown equity and reserves relates to the reversal of revaluation reserves for assets disposed of prior to 30 June 2015, to comply with Audit NZ's recommendations, and to a lower valuation of land and buildings than estimated at 30 June 2015;
- Bank reflects lower capital spend and the receipt of wash-ups and Pharmac rebates
- Prepayments and receivables reflect the accrual for wash-ups. This amount will continue to increase until wash-ups are received sometime after 30 June 2016.
- Property, plant and equipment relates to the revaluation and later payments for the MHIU over the project life;
- Employee entitlements – see below

13. Employee Entitlements

30 June 2015	$'000	May Actual	May Budget	May Variance from budget	May Movement from 30 June 2015	Annual Budget
7,916	Salaries & wages accrued	8,239	6,436	(1,803)	324	5,482
1,370	ACC levy provisions	1,995	1,107	(887)	625	1,176
4,951	Continuing medical education	5,515	5,059	(455)	564	4,860
19,383	Accrued leave	18,888	18,998	109	(494)	19,649
3,962	Long service leave & retirement grat.	4,075	3,915	(160)	113	3,925
37,582	**Total Employee Entitlements**	38,712	35,516	(3,197)	1,131	35,091

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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

2016 Annual Plan		Actual $'000	Year to Date Budget $'000	Variance $'000
	Source of Funds			
	Operating Sources			
13,872	Depreciation	12,119	12,660	541
3,990	Surplus/(Deficit)	(4,787)	(4,897)	(110)
(113)	Working Capital	10,031	12,978	2,947
17,749		17,363	20,741	3,378
	Other Sources			
-	Special funds and clinical trials	194	-	(194)
5,000	Borrowings	-	-	-
5,000		194	-	(194)
22,749	**Total funds sourced**	**17,557**	**20,741**	**3,184**
	Application of Funds:			
	Block Allocations			
3,856	Facilities	2,635	3,471	836
3,000	Information Services	869	2,627	1,758
5,200	Clinical Plant & Equipment	2,598	4,793	2,196
-	Minor Capital	26	27	1
12,056		6,128	10,918	4,790
	Local Strategic			
665	Renal Centralised Development	158	610	451
848	New Stand-alone Endoscopy Unit	309	714	405
5,654	New Mental Health Inpatient Unit Development	6,715	5,183	(1,532)
2,035	Maternity Services	2,022	1,937	(85)
100	Upgrade old MHIU	-	92	92
9,302		9,204	8,535	(669)
	Other			
-	Special funds and clinical trials	194	-	(194)
-	Transform and Sustain	3	-	(3)
-	Other	129	12	(116)
-		325	12	(313)
21,358	***Capital Spend***	***15,657***	***19,466***	***3,809***
	Regional Strategic			
1,391	RHIP (formerly CRISP)	1,900	1,275	(625)
1,391		1,900	1,275	(625)
22,749	**Total funds applied**	**17,557**	**20,741**	**3,184**

The year to date budget excludes any funding brought forward from last year, however the year to date actual column includes expenditure against that funding.

Monthly Project Board Report
May 2016

HAWKE'S BAY District Health Board

New Mental Health Unit Development

Project Director: G Carey-Smith

Overall Project Progress	Overall Status	Time Status	Financial Status
93%	G	G	G

Phase 3: Service & Facility Establishment

Formal approval of the Business Case was received in April 2013 from the Minister of Health for a replacement mental health facility. The project will provide four key deliverables:

1). Service redesign of acute mental health services to align with the HBDHB 2012 Mental Health Model of Care. Includes for investment in alternatives to inpatient care, with an increased focus on care provided in the community.
2). A replacement mental health inpatient unit on the Hawke's Bay Regional Hospital site.
3). A replacement mental health sub-acute facility, co-located with the inpatient unit.
4). A replacement of the Recovery Centres to move to some services within the community and a Day programme (co-located with the inpatient unit).

The project programme includes 3 Phases. Phase 1 'Service & Facility Planning, Design & Tendering' and Phase 2 'Service and Facility Implementation' have been completed on time and within budget. Phase 3 is now underway to complete the establishment of service elements that align with the Mental Health Service Model of Acute Care so the service can operate in an integrated manner, aligned to the cultural pathway; to ensure consumers and staff have successfully transitioned to the new services with new ways of operating.

Project Budget Status

Total Approved Project Budget	Total 15/16 Total Forecast Spend	$	7,272,000
Total Project Spend to Date	Total 15/16 Spend to Date	$	6,714,735
Percentage of Total Spend vs Budget	Percentage 15/16 Spend vs Forecast		92%

The tender process was completed and project approval at a total cost of $19.8M received on the 25 June 2014 Board Meeting. Continued value engineering and management during the porject has resulted in an overall saving of $1.5M resulting in the total project budget being reduced to $18.3M. The new figures are reflected in the graph below. The 2015/16 Total Forecast Spend against 15/16 Spend to Date is consistent with plan.

Deliverable Dates

Nga Rau Rakau Intensive Services Stabilisation	Oct-16	Documented End to End Integrated Pathway	Oct-16
Intensive Day Programme Stabilisation, Handover	Oct-16	IT System Changes	Oct-16
SPoE (Single Point of Entry Acute Coordination Function	Oct-16	Vision-Behaviour Statement & Oranga Ake Cultural Pathway	Oct-16
One Plan Assessment	Oct-16	Completion Evaluation	Nov-16
Electronic Discharge & GP Referal	Oct-16	Post Implementation Review & Post Occupancy Evaluations	Nov-16
Key Worker Function	Oct-16	As-Built Documentation & Defects Sign Off	Dec-16
Revised Procedures & Overarching Policies	Oct-16	Phase 3 Project Completion Documentation	Dec-16

Key Achievements this period

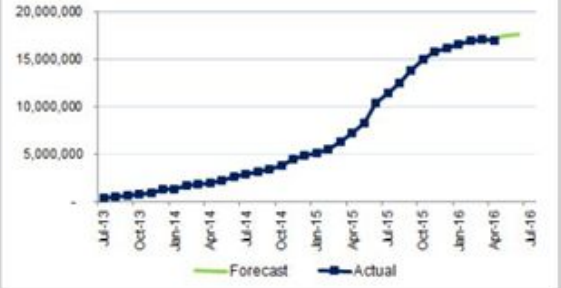
Ongoing development and implementation work for IDP and SPoE. Continue to work with vendor and internally to confirm the feasibility for IS developments needed to support the new model of care and implement SPoE and ensure IS systems necessary to support operations. Focus continues on integration across services, embedding Vision & Behaviour statement and strengthening community mental health. Review of Transition to Nga Rau Rakau commenced.

Planned Activities next period

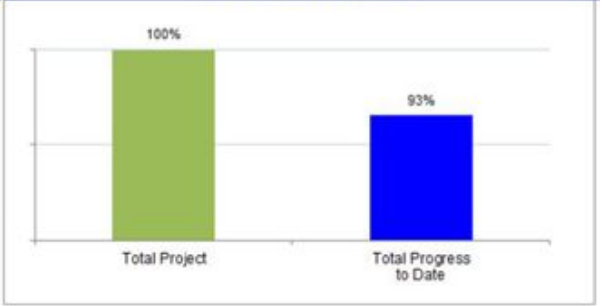
Ongoing embedding, integration & review of changes implemented; includes reporting, procedures, Vision & Behaviour statement, patient journey.
SPoE - progressing towards implementation.
IDP - Recruitment of lead priority. Working group ongoing and documenting Operating Model.
Implementation of 1 Assessment: 1 Plan.
Strengthen Community Mental Health; Case Load management, Key worker role, Review of meeting framework.
As-Built Documents are drafted for final reviewing.
Any building defects are being managed as required over the next 12 months.

Risks & Issues of Note	Mitigation & Resolutions
Ensure project costs remain safely within budget parameters	Regular assessments and tight control of project costs and contingency spend
Service delivery model not fully "owned" by service providers	Ongoing development and implementation of MoC. Staying true to MoC as founding document.
Timely alignment of changes to support service delivery	Service Re-design & Transition Management completed in timely manner
Engagement with wider consumers	Partnership Advisory Group ongoing.
Ability to secure & retain adequate human resources in timely manner	Dependent on availability within current market as well as freeing up & supporting capacity and capability internally.
Potential Inability of IS to deliver IT requirements & adequate resourcing to support implementation of Model of Care	Ongoing engagement with IS resource and potential provider to establish timeline & any funding requirements

Forecast vs Actual Spend



Total Project Progress



16. Rolling Cash Flow

	Actual	*May Forecast*	*Variance*	*Jun Forecast*	*Jul Budget*	*Aug Budget*	*Sep Budget*	*Oct Budget*	*Nov Budget*	*Dec Budget*	*Jan Budget*	*Feb Budget*	*Mar Budget*	*Apr Budget*	*May Budget*
Cash flows from operating activities															
Cash receipts from Crown agencies	44,949	40,751	4,198	42,638	42,917	41,398	53,415	42,775	41,398	41,449	42,855	44,486	41,430	42,677	41,398
Cash receipts from revenue banking	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from donations, bequests and clinical trials	44	-	44	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	564	423	141	443	396	415	407	472	412	419	408	428	435	427	435
Cash paid to suppliers	(24,762)	(23,636)	(1,125)	(24,118)	(26,591)	(25,841)	(26,281)	(24,506)	(24,657)	(25,142)	(24,284)	(21,292)	(25,121)	(24,787)	(23,716)
Cash paid to employees	(14,526)	(14,641)	115	(16,139)	(14,076)	(19,716)	(15,210)	(15,162)	(17,816)	(14,444)	(16,693)	(14,463)	(19,530)	(15,318)	(17,932)
Cash generated from operations	**6,268**	**2,897**	**3,371**	**2,825**	**2,646**	**(3,743)**	**12,330**	**3,579**	**(663)**	**2,281**	**2,286**	**9,160**	**(2,786)**	**2,999**	**185**
Interest received	115	86	29	82	81	80	67	66	80	72	75	68	75	73	75
Interest paid	(296)	(261)	(35)	(190)	(330)	(330)	(95)	(41)	(69)	(160)	(359)	(325)	(139)	(60)	(14)
Capital charge paid	(2,748)	-	(2,748)	(3,910)	-	-	-	-	-	(4,142)	-	-	-	-	-
Net cash inflow/(outflow) from operating activities	**3,339**	**2,721**	**618**	**(1,193)**	**2,396**	**(3,994)**	**12,302**	**3,604**	**(652)**	**(1,948)**	**2,002**	**8,903**	**(2,849)**	**3,012**	**246**
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	(1)	-	(1)	0	0	0	0	0	0	1,220	0	0	0	0	0
Acquisition of property, plant and equipment	(1,029)	(1,730)	701	(2,608)	(2,599)	(2,599)	(2,599)	(2,599)	(2,599)	(3,599)	(2,599)	(2,599)	(2,599)	(2,599)	(2,599)
Acquisition of intangible assets	(69)	-	(69)	-	-	-	-	-	-	-	-	-	-	-	-
Acquisition of investments	-	0	(0)	(348)	-	-	(285)	-	-	(285)	-	-	(285)	-	-
Net cash inflow/(outflow) from investing activities	**(1,099)**	**(1,730)**	**631**	**(2,956)**	**(2,599)**	**(2,599)**	**(2,884)**	**(2,599)**	**(2,599)**	**(2,664)**	**(2,599)**	**(2,599)**	**(2,884)**	**(2,599)**	**(2,599)**
Cash flows from financing activities															
Proceeds from equity injection	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Proceeds from borrowings	-	-	-	-	-	-	-	-	5,000	-	-	-	-	-	-
Repayment of finance leases	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Equity repayment to the Crown	-	-	-	(357)	-	-	-	-	-	-	-	-	-	-	-
Net cash inflow/(outflow) from financing activities	**-**	**-**	**-**	**(357)**	**-**	**-**	**-**	**-**	**5,000**	**-**	**-**	**-**	**-**	**-**	**-**
Net increase/(decrease) in cash or cash equivalents	2,239	991	1,248	(4,507)	(203)	(6,593)	9,418	1,005	1,749	(4,612)	(598)	6,304	(5,733)	413	(2,354)
Add:Opening cash	20,851	20,851	-	23,090	18,583	18,380	11,787	21,205	22,210	23,959	19,346	18,749	25,052	19,319	19,731
Cash and cash equivalents at end of year	**23,090**	**21,841**	**1,248**	**18,583**	**18,380**	**11,787**	**21,205**	**22,210**	**23,959**	**19,346**	**18,749**	**25,052**	**19,319**	**19,731**	**17,378**
Cash and cash equivalents															
Cash	7	7	0	7	7	7	7	7	7	7	7	7	7	7	7
Short term investments (excl. special funds/clinical trials)	19,985	18,748	1,237	15,478	15,278	8,685	18,103	19,108	20,857	16,244	15,646	21,950	16,217	16,629	14,276
Short term investments (special funds/clinical trials)	3,098	3,085	14	3,098	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095
Bank overdraft	(0)	2	(2)	(0)	-	-	-	-	-	-	-	-	-	-	-
	23,090	**21,841**	**1,249**	**18,583**	**18,380**	**11,787**	**21,205**	**22,210**	**23,959**	**19,346**	**18,748**	**25,052**	**19,319**	**19,731**	**17,378**

Draw-down of the revenue banking in 2015-16 is $0.8 million.

CONSUMER STORY

Verbal Presentation

HAWKE'S BAY District Health Board Whakawāteatia	**DHB Elections 2016 - Update** 61
	For the attention of: **HBDHB Board**
Document Owner:	Ken Foote, Company Secretary
Month:	June 2016
Consideration:	For Noting

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RECOMMENDATION

That the Board

Notes the contents of this report

PURPOSE

The purpose of this report is to provide an update on progress with issues associated with this year's DHB Elections.

HBDHB Electoral Officer, Warwick Lampp will be in attendance at the Board meeting, to both introduce himself and provide a verbal briefing on relevant issues.

KEY DATES

Key dates relating to the elections include:

13 July	First Public Notice of Election
15 July	Nominations Open / Roll Open for Inspection
12 August	Nominations Close / Electoral Roll Closes
19 August	Public Notice of Candidates
16 September	Delivery of Voting Documents
8 October	Election Day / Voting Closes at Noon
13 October	Official Result Declaration
5 December	New Board comes into office

CANDIDATE HANDBOOKS

This year there will be two Candidate Handbooks:

- District Health Board Elections 2016 – Information for Candidates.
  - Generic handbook prepared by the Ministry of Health
  - Focus on MoH, DHBs and the role of DHB Board members
- 2016 Local Government Elections Candidate Handbook – for HBDHB
  - Based on standard booklet produced by electionz.com
  - Personalised HBDHB cover and content
  - Focus on the election process.

CANDIDATES INFORMATION EVENINGS

With the decision made by the Board in April to conduct information evenings on a similar basis to 2013, arrangements are currently being made to hold these.

With nominations opening on 15 July 2016, arrangements are being made to conduct these as informal sessions to be held between 5.00 and 6.00pm on:

- Tuesday 19 July in Napier
- Wednesday 20 July in Hastings

Notices for these sessions will be distributed and placed on the website in early July.

BOARD DECISION MAKING DURING THE ELECTION PERIOD

Attached as **Appendix 1**, is a letter from the Office of the Director General of the Ministry of Health. This letter provides guidance on:

- Board Decision making
- Communications by DHB Board Members
- Communications by other DHBs
- Communications from DHB staff

It is recommended that Board Members note the contents of this letter.

ELECTION PROTOCOLS & POLICY

Also attached are:

- HBDHB Election Protocols – 2016 (refer to **Appendix 2)**
- HBDHB Election Protocols Policy – HBDHB Staff (refer to **Appendix 3**

It is important that Board members are aware of the contents and provisions included in these documents.

Appendix 1

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10 June 2016

Mr Kevin Atkinson
Chair
Hawke's Bay DHB
Private Bag 9014
HASTINGS 4156

Dear Kevin

Board decision-making and communications in the district health board election period

Further to our recent letter, the 2016 district health board (DHB) election period is almost upon us. As you will recall from the 2013 elections, the election period poses particular challenges for DHBs, boards and members, to ensure that policies which touch on election-related matters are being appropriately followed.

This letter provides general guidance around issues that often arise in the context of the elections. I would appreciate it if you could bring it to the attention of all board members.

Board decision-making

The general practice with the local body and DHB elections is to treat the three months before the elections as the 'pre-election period'. The pre-election period, and the weeks after the election before new board members take office, is a sensitive time when additional protocols are frequently required. In 2016, the pre-election period will start on 8 July, with new board members due to take office on 5 December (58 days after election day on 8 October).

The makeup of boards may change significantly once election and appointment processes have completed. Given this, binding long-term significant decisions – such as signing off new plans and making key appointments (for example, to the Chief Executive Officer position) – should be approached with additional caution during this time. However, because the pre- and post-election period is close to five months long, it would be impractical for boards to entirely restrict their decision-making to minor or non-controversial matters.

In the past, we have observed that it is helpful for new board members to be given observer status at board meetings from the time final results are announced until they take office on 5 December. While this is a decision for each individual board to make, it may allow for a smoother transition from the current membership to the new board.

Communications

The following guidance on communications is based on the Auditor-General's report, *Good Practice for Managing Public Communications by Local Authorities*, which is available on the Auditor-General's website at: http://www.oag.govt.nz/2004/public-communications. A copy is also attached for your reference. Although the report's main focus is on local bodies, it contains useful information that is also relevant to DHBs at election time. This includes a principles-based approach to looking at communicating with the public, which will be of interest if your DHB is planning communications around health topics such as fluoridation.

Comments from the Auditor-General's report on the 2014/15 local government audits are also useful.[5]

Communications by DHB board members

All communications by board members, acting in that capacity, should be guided by relevant DHB and board policies. The Auditor-General has suggested that local authorities look out for the following risks:

- the use of publicly-funded (or in the case of DHBs, board-funded) events as a platform for incumbent members to promote their achievements; In the pre-election period, board members may wish to consider actively reducing the number of major events they attend
- the use of newspaper columns and other communication channels, in case they change from being a useful vehicle for communicating ordinary business to something that could be seen as a vehicle for political campaigning.

Board members should be reminded that they are often aware of matters of high sensitivity or confidence, and that these confidences must be strictly maintained. Members have a legal duty under section 57 of the Crown Entities Act 2004 not to disclose information obtained in their capacity as board members that would not otherwise be available to them. Members should also be aware of their other individual duties under sections 53 to 56 of the Crown Entities Act (that is, to comply with the Crown Entities Act and the New Zealand Public Health and Disability Act 2000; to act with honesty and integrity; to act in good faith and not at the expense of the DHB's interests; and to act with reasonable care, diligence and skill).

Communications by DHBs

DHBs should not promote, or be perceived to be promoting, the re-election prospects of a sitting board member or any other candidate. Therefore, any use of DHB resources – such as stationery, postage, internet, email or phone – by members for re-election purposes – is unacceptable and a possible breach of the principles of the Local Electoral Act 2001.

A DHB's communications policy should also recognise the risk that communications by or about members (in any capacity as spokesperson for the DHB) during the pre-election period could result in the member achieving an electoral advantage at taxpayers' expense. The DHB's Chief Executive Officer should actively manage this risk.

Established DHB communication channels (for example, websites, newsletters, and 'advertorial' content in newspapers) may also present a risk during the pre-election period. This is because they could have the effect of raising a board member's personal profile in a manner that may appear to promote their re-election. For example, a photograph of a board member launching a DHB initiative in a board magazine may not be appropriate in the pre-election period because it could have the effect of raising that member's profile in the community.

This does not mean that a DHB should cease to publish news and information that is relevant to its activities. Rather, caution should be exercised over such matters. For example, while board member profiles should be removed from a DHB's website in the pre-election period, it would be appropriate to have the candidate profile statements of all candidates on the website once these are available to be published.

The Auditor-General has also cautioned local authorities about ensuring that their annual reports and annual report summaries do not have the effect of promoting or favouring existing members who are candidates for re-election. DHBs are asked to monitor any accountability documents that may be published in the pre-election period to ensure that they also meet these expectations.

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[5] http://www.oag.govt.nz/2016/local-govt/part5.htm – see Part 5, 'Local body elections'.

Communications from DHB staff

Chief Executives are advised to brief staff about the risks of inappropriate communications that may be perceived as a staff member contributing directly to the political debate and supporting a particular side. DHBs may wish to introduce special or temporary procedures in the pre-election period that cover such matters, and also set out protocols for dealing with media enquiries very clearly.

Another issue to manage is the contact between staff and those who are working on election campaigns. Candidates and their staff may ask for information about current activities, policies and costs. It is important that election candidates are treated equally in these circumstances and that the information they receive is neutral and factual. Protocols to ensure the equal treatment of requests from current members and candidates can provide important protection.

I trust that you find this information useful. Should you require clarification around any of the matters raised in this letter, Jonathan Morgan, Senior Advisor, Governance and Crown Entities, would be happy to assist. You can contact Jonathan on (04) 816 2678, or the team on vote2016@moh.govt.nz.

Yours sincerely

Jill Bond
Executive Director
Office of the Director-General

cc Dr Kevin Snee, CEO, Hawke's Bay DHB, kevin.snee@hawkesbaydhb.govt.nz
Ken Foote, ken.foote@hbdhb.govt.nz

Encl.

APPENDIX 2

Election protocols – 2016

11.1

Introduction

District health board elections will be held over a three week period leading up to **Saturday 8 October 2016.**

These protocols apply from Wednesday 13 July 2016 to all campaigning activities, whether before, during or after the election.

All candidates (including existing board members) and Hawke's Bay District Health Board staff are expected to follow these protocols.

1 Employees of district health boards may stand for election

District health board employees have a statutory right to be elected as a member of a district health board (Clause 7, Schedule 2, NZ Public Health and Disability Act 2000):

> "A person is not prevented from being elected as a member of a district health board simply because the person is an employee of the district health board."

There is a possibility that a conflict of interest could arise during the campaign period, so employees who offer themselves for election to public office must notify the chief executive immediately they do so, and be familiar with Hawke's Bay District Health Board's Policy

2 District health board staff must be politically neutral

It is important that staff remain politically neutral at all times in their dealings with board members, potential board members and the public in general.

It is not acceptable conduct for staff to obviously align themselves or publicly support any candidate. Any action that exposes staff to an allegation of bias could potentially cause serious problems for the individual employee and to the district health board as an organisation.

Staff should not take part in any activity related to the election campaign of a current or potential elected member (apart from their own, should they choose to stand). This includes:

- nominating or seconding a candidates nomination.
- attendance at private campaign strategy meetings
- taking part in any activity that could be seen to be a campaign activity (eg canvassing, social media comments, writing speeches, letters or media releases that could be linked to the candidate's campaign)
- involvement in public meetings (unless they are meetings where all candidates are invited to speak).

3 District health board resources should not be used for campaigning purposes

District health board resources (including time, computers, email, phones, faxes, stationery, photocopiers, stamps, business cards, notice boards, website or district health board premises) should not be used for campaigning purposes. Campaign photos must not be taken on district health board sites.

Candidates must not link their own facebook page and social media channels (if they are used for campaigning purposes) to HBDHB facebook page and social media channels.

Staff must not send or forward emails around the district health board seeking support for a particular candidate or candidates, or use any district health board forum or meeting as a platform for encouraging support (eg district health board public meetings).

4 District health board information

The district health board's website information includes details of current board members and these will be removed during the pre-election period. Following the close of nominations, the candidate profile statements of all candidates will be available through the Hawke's Bay DHB's website.

Care should be taken that district health board publications do not provide an inappropriate high profile for any current board member. This is a matter of judgement, taking into account the spokesperson role of the board chair and the ongoing activities of the district health board.

Where information is supplied by the district health board to a candidate for campaign purposes, it should be supplied to other candidates on request.

Where to go for further help

1 For general information regarding the district health board election processes: **www.health.govt.nz** and search on "DHB elections".

2 For further detail on communications in a pre-election period, see the website for the Report of the Controller and Auditor-General – *Good Practice for Managing Public Communications by Local Authorities:*
http://www.oag.govt.nz/2004/public-communications/part1.htm

3 If you are unsure whether or not particular requests or activities are in breach of these protocols, please discuss the matter with your manager or Hawke's Bay District Health Board's election contact, Ken Foote, Company Secretary extn 4527; 06 873 2159; **ken.foote@hbdhb.govt.nz** .

HAWKE'S BAY DISTRICT HEALTH BOARD	**Manual:**	Operational Policy Manual
	Doc No:	HBDHB/OPM/039
Election Protocols Policy - HBDHB Staff	**Issue Date:**	July 2004
	Reviewed Date:	May 2016
	Approved:	Chief Executive Officer
	Signature:	Dr Kevin Snee
	Page:	1 of 4

PURPOSE

APPENDIX 3

The purpose of this policy is three-fold:

- To provide guidance and support to staff who wish to stand for membership of Hawke's Bay District Health Board (HBDHB).
- To provide guidance to staff on the standard of behaviour required of them regarding the election of DHB Boards.
- To ensure HBDHB maintains the confidence of its communities and owners by acting professionally and impartially during the DHB Board election process.

SCOPE

This applies to all employees, include contracted or fixed term employees of HBDHB.

Employees shall be deemed to be representing the organisation when they are writing as a member of staff; are wearing the organisation's uniform and/or identification card; or can be associated with the organisation, e.g. are using a Board vehicle, presenting at meetings or conferences in their capacity as an HBHDB staff member.

OUT OF SCOPE

HBDHB Board, Advisory Committee or any other associated committee or council member. Members of these groups have policies, guidelines, Terms of Reference and codes of conduct and ethics specific to their function.

POLICY

HBDHB supports its population, including staff, to participate in the election of its governing Board as candidates and/or as voters.

People have the right to access HBDHB's services and facilities without harassment. This includes political harassment.

All HBDHB staff are required to remain politically neutral (apolitical) when carrying out their job. This includes interactions with patients/clients and their families, other staff, Board and Committee members.

HBDHB staff must do their job professionally and loyally, without letting their personal interests or views influence their advice or behaviour in the work place.

Employees of HBDHB may stand for DHB Elections:

- District Health Board employees have a statutory right to stand for election as a member of a DHB Board (clause 7, schedule 2, NZ Public Health and Disability Act 2000).

- If elected, Board Members who are also members of staff, will need to:

  - ensure they can do their primary job unhindered and without detriment to the public interest
  - ask for and take approved leave without pay to attend to any board business that occurs in their normal working hours
  - be especially diligent and transparent over potential conflicts of interest
  - are familiar with requirements of Board and committee members as detailed in HBDHB's the e-governance manual available on the DHB's website http://www.hawkesbay.health.nz

- HBDHB upholds the principles of being a good employer. In this context, good and reasonable employer means:

  - making reasonable efforts to enable staff elected as Board members to take leave without pay to attend board business, provided that this does not adversely affect the operation of the organisation
  - make arrangements to cover approved absence where practical

- As governor, HBDHB's Board should:

  - recognise the particular difficulties for DHB employees who are also members of the board
  - pay particular attention to ensuring that conflicts of interest of members who are also DHB employees are handled appropriately
  - avoid as far as possible placing the CEO or board member-employees in situations where any role tensions could develop or be exacerbated
  - not pressure CEOs to grant leave for board members, recognising that the CEO is the employer and that s/he has the responsibility for service provision and employees

- It is important to the reputation and probity of HBDHB that no individual candidates, including staff who are standing for election, are unfairly advantaged through access to DHB resources, including staff time and communication channels.

- HBDHB staff whose regular duties require writing media releases, letters, speeches and carrying out administrative tasks for current elected and appointed members are to exercise extreme care to ensure such activities cannot be linked in any way to a political campaign.

- Staff members involved in an election campaign (either their own or that of any candidate) should ensure that they identify and manage any conflict, or potential conflict of interest with their employment at HBDHB.

- DHB resources should not be used for campaigning purposes:

  - No DHB resources (including staff time, computers, e-mail, cell phones, faxes, stationery, photocopiers, stamps, cards and venues) should be used for campaigning purposes.
  - No DHB-provided forums or meetings (e.g. reference group meetings, DHB forums and public meetings) should be used for campaigning purposes.
  - This provision applies to all staff, board and committee members, including those who are standing, or considering standing, for election to a DHB Board.

- DHB information should be available to all candidates on an equal basis:

  - Where DHB information is supplied to a candidate for campaign purposes, it should be supplied to other candidates as a matter of course.

- HBDHB publications, website, social media and other communication vehicles (eg: DHB-funded radio spots) should not be used for campaign purposes:

  - Where communication platforms are provided by or through HBDHB, all candidates should have equal access to them.
  - Hawke's Bay DHB shall be guided by the Office of the Auditor-General's Guidelines for Advertising and Publicity by Local Authorities (also relevant to DHBs) which states: "*a local authority must not promote, nor be perceived to promote, the re-election prospects of a sitting member. Therefore, the use of Council resources for re-election purposes is unacceptable and possibly unlawful,*" and,

    "When the authority considers that information need not be presented as representing the corporate or collective position, the manner of its presentation should not create the appearance that what is being said represents the personal views of the people to whom the information is being attributed. Special care with presentation is required when attribution is to a spokesperson – commonly the Mayor or authority Chairperson or Chairperson of the associated committee – particularly during the pre-election period".

    The pre-election period is generally regarded as having started when the first public declarations of candidacy have been made.

- Board decision making during the election process:

  - During the election period (opening of nominations to the time the new Board takes office), the Board shall continue to carry out its duties.
  - The Board shall put in place arrangements as appropriate to ensure a smooth transition from the current to the newly elected Board.

RELATED HBDHB DOCUMENTS

House Rules
Media Relations Policy HBDHB/OPM/022
Leave Policy HBDHB/PPM/080

REFERENCES

"Good Practice for Managing Public Communications by Local Authorities", Controller and Auditor-General, April 2004.

FURTHER INFORMATION / ASSISTANCE

If you are unsure whether or not certain requests or activities are a breach of the preceding protocols, please discuss the matter with your manager or contact the Communications Service.

For general information regarding the DHB election processes: www.health.govt.nz

For further detail on communications in a pre-election period, see the website for the Report of the Controller and Auditor-General – Good practice for Managing Public Communications by Local Authorities: http://oag.govt.nz/2004/public-communications/part1.htm

Useful advice sheets from the State Services Commission:
See Understanding the code of conduct - Guidance for State servants: www.ssc.govt.nz/code-guidance-stateservants; and
Political Neutrality Fact Sheet No. 2 Political Views and Participation in Political Activity www.ssc.govt.nz/political-neutrality-guidance.

KEY WORDS

Board
Elections
Voting

For further information please contact the Company Secretary

	Hawke's Bay Clinical Council 62
	For the attention of: **HBDHB Board**
Document Owner:	Chris McKenna and Dr Mark Peterson as Co-Chairs
Reviewed by:	Not applicable
Month:	April, 2016
Consideration:	For Information

12

RECOMMENDATION

That the Board

- **Approve** $26,000 during 2016/17 (June-December 2016) from the new investment prioritisation contingency to investigate the recommendations of the Coroner's report into four suicides in Flaxmere.

Note that Clinical Council approved and supported the following:

- **Endorsed** the Youth Health Strategy 2016-19 "Creating Healthy Opportunities for Youth"
- **Supported** the Food Service team investigating and implementing the recommendations.
- **Supported** the Mobility Action Programme and RFP to MoH.
- **Supported** the Target Champions recommendations for Oral Health as follows:
  1. That Maori health provider contracts are changed to focus on engagement of hard to reach whanau with oral health services in the early pre-school years (by June 2017)
  2. That Community Oral Health Services achieve the preventative practice targets (by December 2017)
  3. To implement Maternal Nutrition Programme activities and implement healthy eating/sugar reduction programmes/policies as planned in the Best Start: Healthy Eating and Activity Plan (Reported annually until 2020)
  4. That Hawke's Bay DHB implements community water fluoridation as soon as necessary legislative changes enabling the DHB to act are in place. To be confirmed, dependent upon legislative changes.

Council met on 8 June 2016, an overview of issues discussed and/or agreed at the meeting are provided below.

The following papers were considered:

- ***Nurse Practitioner – Heart Failure (Business Case)***

Council endorsed the Business Plan provided to recruit for this role. At the time of prioritisation last year, this position was approved subject to the business case being provided. The funding allocation matched what was signed off for the 2015/16 year, however due to the delay in submitting this business case timelines were extended for recruitment (in July 2016).

- ***Request to Access Prioritisation Bids Contingency Fund***

The Investigating Coroners' Recommendations in relation to Youth Suicides in Flaxmere was received, with funds being sought to move forward and evaluate the recommendations. On the day Clinical Council met to discuss "prioritisation", the Coroner released her findings.

The proposal presented sought funding to employ the existing 0.5 FTE Suicide Prevention Coordinator for an additional six month period, to establish and lead a working group to investigate the Coroner's recommendations, and to develop a detailed proposal for future direction. The Council approved the recommendation.

If additional funding is required to implement that future direction, then a new funding bid would be presented to Council during the 2017 Prioritisation process.

Clinical Council Recommend that the Board approve $26,000 during 2016/17 (June-December 2016) to investigate the recommendations of the Coroner's report into four suicides in Flaxmere.

- ***Youth Health Strategy "Creating Healthy Opportunities for Youth 2016-10"***

With the comments received around input from Primary Care, and the future definition of youth, Council positively endorsed the Youth Health Strategy 2016-19 being provided to the Board for approval.

Others reports provided for information and discussion included:

- ***Food Service Optimisation Review***

The Food Services Optimisation Project Team in conjunction with other Food Service Experts undertook to work with the Nutrition and Food Service Department to determine opportunities for financial savings or opportunities to improve the current systems and processes.

The in-depth report was received with several suggestions made to the team which included viewing Hutt DHB's food service.

Following discussion Council supported the food service team investigating and implementing the recommendations, and noted the capital applications would require approval through the capital plan process.

- ***Action Plan – Learnings from the ICU Review 2013***

The Action Plan provided key recommendations with quarterly updates scheduled for Clinical Council and FRAC review until completion. Acute and medical directorate teams are comfortable with the timeframes and should see implementation by February 2017. The foundation document was not well articulated and as a consequence we need to get the TOR and governance structures right.

- ***Improved Endoscopy Services – Facility Development Update***

An overview was provided around preliminary design, geotechnical conditions, and capacity of the facility as well as procurement planning and the preliminary design estimates. Design was briefly discussed ensuring light reflection from the build being kept to a minimum.

- ***Suicide Prevention and Postvention Plan***

The report was received discussed and feedback provided.

- ***Health Equity Update Report***

The report and presentation by Dr Caroline McElnay was received noting that progress has definitely been made but not enough with 18 indicators updated, compared to 49 indicators previously.

There is not much difference in non-Māori life expectancy across NZ but there are significant variations for Maori. The differences appear to depend on where Maori live with economic factors being a huge driver.

We need to continue to focus on tackling "behaviour" and "risk" as well as "social and economic factors".

- ***Mobility Action Programme***

Musculoskeletal health conditions and lower back pain are a leading cause of disability and pain and have significant influence on health and quality of life. The aim of the proposed programme is to increase local community capacity to ensure sustainability. The proposal aligns to the Transform and Sustain which was endorsed by Clinical Council in May through the prioritisation process.

Dr Tae Richardson provided an enlightening overview of the background and funding request for submission to the MoH on 7 July. If successful a two year pilot is envisaged.

Council wholeheartedly support this RFP proceeding to the next stage.

- ***Te Ara Whakawaiora / Oral Health***

Dr Robin Whyman advised this was an area of significant challenge and a health equity issue where the gap was not closing. Inequity remains the same with Māori and Pacific children, and those living in socioeconomic disadvantage experiencing poorer outcomes for oral health.

Clinical Council supported the Target Champions recommendations below – the same as provided to the Board :

1. That Maori health provider contracts are changed to focus on engagement of hard to reach whanau with oral health services in the early pre-school years (by June 2017)
2. That Community Oral Health Services achieve the preventative practice targets (by December 2017)
3. To implement Maternal Nutrition Programme activities and implement healthy eating/sugar reduction programmes/policies as planned in the Best Start: Healthy Eating and Activity Plan (Reported annually until 2020)
4. That Hawke's Bay DHB implements community water fluoridation as soon as necessary legislative changes enabling the DHB to act are in place. To be confirmed, dependent upon legislative changes.

Committee Reports

The Clinical Council received reports on the following areas:

- ***HB Nursing Midwifery Leadership Council Update –*** report taken as read
- ***HB Clinical Research Committee Update –*** no concerns reported with members encouraged to view the Committees Annual Report available on the website.
- ***Urgent Care Alliance Update –*** Proposals are coming forward and aged Residential care are being involved in the process.

	HB Health Consumer Council 63
	For the attention of: **HBDHB Board**
Document Owner:	Graeme Norton, Chair
Reviewed by:	Not applicable
Month:	June 2016
Consideration:	For Information

13

RECOMMENDATION

That the Board

Note the contents of this report

Consumer Council met on 9 June 2016, an overview of issues discussed and/or agreed at the meeting is provided below.

YOUTH HEALTH STRATEGY 2016-19

Consumer Council endorses this strategy. Members believe that whilst the strategy is good the proof of effectiveness will be in how effective the services are on the ground. Some key points were made about that.

- We need to reach the youth who are not being served and want to receive assistance
- The entry point is to find where the highest trust is within groups and work from there. Allow for the possibility that the approach is different from health sector thinking.
- Please be joined up. Staretgies come to us separated; they cannot be acted on in silos as this is not the way that people live.

For its part Consumer Council is currently recruiting for youth membership on Council. There are likely to be two members to cover the position, supported by others already on Council. This signals our strong commitment to supporting youth services.

FOOD SERVICES OPTIMISATION REVIEW

Members made some suggestions for improvement and overall strongly supported the continuation of HBDHB supplied services. It was noted that we need to keep continuously on top of HBDHB Food Services, as we will continue to come under pressure to join the national service in spite of highly publicised criticisms of it in some regions. This means we need to have our facts well researched and close at hand.

HEALTH EQUITY UPDATE 2016

Whilst members appreciate that the framework to date has been around highlighting inequity and reducing or eliminating inequity they feel it is time to shift to the positive and frame the discussion and action around enabling equity – a wellness model. Members agreed to enter into an “online” dialogue with Dr McElnay to make recommendations on priority actions.

SUICIDE PREVENTION AND POSTVENTION PLAN REPORT

Members are highly engaged on this topic and provided feedback on engagement with schools, and linking this work with the youth strategy. It was acknowledged that in spite of substantial work to try to engage across agencies there was still frustration in the lack of cross sector engagement in some instances.

MOBILITY ACTION PROGRAMME (MAP) – PRESENTATION

Dr Tae Richardson and Dr Andy Phillips led a highly engaging presentation and workshop, looking for Council input into the design of a community based musculoskeletal programme. At this stage the MAP was subject to a funding bid nationally, having got through the first phase. Members, following a lively contribution session, were highly complementary on the approach including its targeted audience in the pilot phase.

This is the first presenter to have a spontaneous ovation from members – they want Dr Richardson to do all presentations from hereon! ☺

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board (MRB)** 64
	For the attention of: **HBDHB Board**
Document Owner:	Heather Skipworth (Deputy Chair)
Reviewed by:	Not applicable
Month:	June, 2016
Consideration:	For Information

14

RECOMMENDATION

That the Board

1. Note the contents of this report
2. Approve the following as priority actions required to further reduce health inequity in Hawke's Bay:
   a) Raise the target to Increase Māori Staff from 10% year-on-year to 25% over a five year period
   b) Present the strategy to Increase Māori staff to MRB before going to the Finance, Risk and Audit Committee (FRAC).
   c) Review the current HBDHB hiring protocols and processes
   d) Review the conviction policy for the HBDHB and whether a conviction that is old, is relevant now
   e) Broaden the scope of the target to all disciplines, not just medical, nursing and allied health
   f) Shift the responsibility of achieving the target to Hiring Managers setting KPIs for monitoring
   g) Senior Management monitor the progress of the target and provide monthly updates identifying why the target was achieved, or not achieved
   h) Train Hiring Managers to efficiently and effectively use the Managers Toolkit
   i) Māori Health Service involved in the recruitment processes from the development of position profiles, shortlisting and interview stages with a member of the team becoming a compulsory member of all hiring/selection panels
3. Do not approve recommendation number 4 of the Te Ara Whakawaiora: Oral Health paper but instead approve the following actions:
   a) Target Champion to present information about the benefits and side effects of Fluoridation to get a clearer understanding of Fluoridation
   b) HBDHB champion sugar free beverage events and challenge all other organisations to do the same.

PURPOSE

The purpose of this report is to provide an overview of the discussions undertaken at the MRB meeting held on the 8 June 2016.

Mobility Action Plan

Due to a conflict of interest I was unable to participate in the discussions about the Mobility Action Plan. However, I can report that Andrew Phillips (Director Allied Health) and Dr Tae Richardson (Board Member Clinical Council) provided an excellent presentation clearly demonstrating how inequities will be eliminated. MRB was in strong support of the Mobility Action Plan and was impressed by the following key points presented:

- The active partnership and involvement of local communities in the co-design of the new programme, Request for Proposal (RFP) and proposed model
- Improved access by not charging patients for the duration of intervention; a more streamlined referral pathway reducing the need for GP or secondary care intervention.
- Accessibility to a 'Core' Mobility Action Team (MAT) services that consists of three strands of healthcare; physiotherapy, the 'Stanford Programme', and the 'Māori Lifestyle Collective' comprising of community grassroots organisation Iron Māori and Patu; and non-Core MAT services (co-designed self management plan)
- Tailored 'Stanford Programmes', customised models of care targeting the cultural and social needs of Māori and Pacific customers
- Strengthening community capability and capacity by utilising local existing professionals
- Outcome/Exit Measures that support Whānau Ora Outcomes

Health Equity Update 2016: Tackling Health Inequities Presentation

MRB received the Health Equity Update 2016: Tackling Health Inequities.

There was considerable discussion about the NZ Territorial Authorities Statistics Gap in Years between Māori and non-Māori Life Expectancy by Gender and Region 2012-14. The presentation demonstrated the life expectancy gap for Māori who lived in Canterbury was higher in comparison to Māori who lived in Hawke's Bay. This highlighted that where you live has a significant impact on Māori life expectancy in comparison to non-Māori. Possible explanations for the causes of longer life expectancy were not known and Dr McElnay (Director Population Health/ Health Equity Champion) who stated that she had never seen this analysis result before. MRB asked Caroline to research the reasons for the longer life expectancy of Māori in the Canterbury region and requested Dr McElnay provide an update on the findings.

MRB provided the following advice on the Health Equity Update for Dr McElnay to consider:

- The power of Māori for Māori services should not be underestimated
- Good progress has been made in the health areas of 'access'. Where we are not making good progress is in areas where there are socio-economic issues. We need to do more around intersectoral collaboration to tackle these issues head on
- HBDHB need to celebrate the successes for Māori health better so that the community understands better where we are achieving
- Employment is a key contributor to better health and longevity. Employment provides more opportunities, builds self-confidence and better resilience, therefore this should be a HBDHB focus
- The living wage funding bid is a positive and more toward reducing inequity for our own staff. This is a great way for our organisation to role model the need to shift poverty

There was further discussion about employment being key to achieving equity. The following key points were highlighted:

- As the largest employer of the Hawke's Bay region we just need to get on with employing more Māori
- Māori make up 26% of the population in the Hawke's Bay region and around 46% of the hospital utilisation (as per the 2015 data). Increasing Māori staff has to be a priority action
- Views such as employing applicants with the highest grades such as nurses doesn't necessarily mean they are the right person for the job. Also we need to relook at the issue of not employing nurses with convictions. Teens grow up and mature, they shouldn't be black listed for a wrong doing in the past. Furthermore, life experience is of equal significance and value when caring for patients. A nurse who has had no trauma in their lives may not be as effective as a nurse who has
- Do Hiring Managers clearly understand the purpose of the target to Increase Māori staff and fully support the target to Increase Māori Staff.

MRB strongly felt that employment is a priority action required to further reduce health inequity in Hawke's Bay and request the HBDHB Board's approval of the above recommendations.

John McKeefry (GM Human Resources) is developing an action plan for increasing Māori staff to be presented to FRAC. It was requested the plan be presented to MRB first before going to FRAC.

While progress has been slow and gains are not significant, we still need to celebrate the successes. The Chair thanked Dr McElnay for bringing these achievements to the attention of MRB.

Youth Health Strategy 2016/19 FINAL

MRB noted the responses to the committee's previous feedback and endorsed the Youth Health Strategy 2016-19 to go to the Board for final endorsement.

HBDHB Annual Māori Health Plan 2016/17 FINAL DRAFT

MRB endorsed the Final Draft of the Annual Māori Health Plan subject to any minor changes that may occur from the final feedback received from the Ministry of Health on 13 June 2016, in addition the amendments below:

Māori Workforce and Cultural Competence

The new target of 25% for increasing Māori staff into DHB was proposed by MRB today. The GM Māori Health strongly advised that MRB keep with the 10% increase year on year until we reach population mix of 26% Māori. This will need to be approved by the Executive Management Team (EMT).

Obesity

Bariatric Surgery is to be added as an activity into the plan. Furthermore, the HBDHB are funded to provide seven surgeries per annum. MRB requested the surgeries be tracked by ethnicity and monitored on the AMHP dashboard.

Te Ara Whakawaiora: Oral Health

MRB noted the contents of the report and approved the Target Champions recommendations 1, 2 and 3. However, MRB *did not* approve recommendation number 4, but noted further discussion and research is required for MRB to get a clearer understanding of Fluoridation.

In addition, MRB provided the following advice for the Target Champion to consider:

- Include the safe consumption levels of sugar. Dr McElnay will also ensure this information is included in the Best Start: Healthy Eating and Activity Plan

- Apply the same emphasis on sugar as we do on Fluoride.

MRB requested the HBDHB champion sugar free beverage events and challenges all other organisations to do the same.

Food Services Optimisation Review

MRB noted the contents of the report. MRB provided the following feedback for consideration:

- Visual information about sugar levels both good and bad to be displayed in Zac's Café
- Food Wastage – leftovers to be donated to the homeless

MRB support 'Sugar Free' and requested the food provided for the meetings contain no more than 3gms per serving per person.

Suicide Prevention and Postvention Plan Report

MRB noted the contents of the report and supported the New Investment Funding Bid for a full time Suicide Prevention Coordinator to the Hawke's Bay Clinical Council, stating this is a priority particularly following the results of the Coroner's Report on the four suicides in Flaxmere.

MRB Representation on Hawke's Bay Clinical Council

The issue of payment is yet to be decided. MRB has received two Expressions of Interest to date. An email will be circulated to members requesting Expressions of Interest once the decision on payment is made.

HAWKE'S BAY District Health Board Whakawāteatia	**Pasifika Data and Reporting** **Ministry of Health- Ala Mo'ui Pathways to Pacific Health 2014 -2018** 65
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Caroline McElnay, Director Population Health Talalelei Taufale, Pacific Health Development Manager
Reviewed by:	n/a
Month:	June 2016
Consideration:	For Monitoring

15.1

RECOMMENDATION

That HBDHB Board:

1. Adopt the health priorities as per the Ministry of Health Ala Mo'ui Pathways to Pacific Health 2014-2018 as the Pasifika health priorities for HBDHB.
2. Report six monthly progress to the HBDHB using the Ala Mo'ui dashboard with local commentary provided.

OVERVIEW

As discussed with the Pasifika Health Leadership Group and EMT it is timely that we now develop our Pasifika Health Dashboard. This dashboard should mirror the health priorities outlined in Ala Mo'ui- Pathways to Pacific Health and Wellbeing 2014-2018, the Government's national plan for improving health outcomes for Pacific peoples in New Zealand.

PASIFIKA DATA AND REPORTING

Ministry of Health- Ala Mo'ui Pathways to Pacific Health 2014 -2018:
'Ala Mo'ui sets out the priority outcomes and actions for the next five years that will contribute towards achieving better health outcomes for Pacific people, families and communities.

'Ala Mo'ui can be used by the health and disability sector as a tool for planning and prioritising actions and developing new and innovative methods of delivering results and value for money.

'Ala Mo'ui replaces the Pacific Health and Disability Action Plan of 2002 the Pacific Health and Disability Workforce Development Plan 2004 and the Joint Action Plan for the Ministries of Health and Pacific Island Affairs 2008, as the key overarching document for improving Pacific health outcomes.

The dashboard of measures in the Ministry of Health publication "Ala Mo'ui" will be adopted as a Pacific Health Dashboard for the Hawke's Bay District Health Board. Reporting for Ala Mo'ui is six monthly and provides the following:

1. A comparison between DHBs with Pacific populations
2. Highlights the areas of progress - good performance
3. Highlights areas/health issues facing ongoing challenges

Benefits of using this dashboard include; sharing with HBDHB staff best practice in regards to what is working and discussing approaches from other areas for challenging health issues.

Furthermore, it opens up opportunities to work across DHBs to further explore ways to improve Pacific health.

PERFORMANCE HIGHLIGHTS

Achievements

1. The percentage of newborn infants enrolled with a general practice by three months reached 110% exceeding the 98% target as a result of GP facilitators performing monthly audits of practices for new births.
2. The percentage of Pacific infants who are exclusively or fully breastfed at three months of age trends is above the target at 62% (expected target 60%). HBDHB is the only DHB of the eight priority Pacific DHBs that has achieved this target.
3. Percentage of children with BMI >99.4th percentile referred to a GP or specialist services, Pacific peoples by priority DHBs remains at 100% above the target of 95.

Areas of Progress

1. Percentage of four year olds who received a B4SC for the first time fell below the target of 90% to 87.1%.
2. Percentage of children under 5 years old enrolled in DHB-funded dental services is improving, trending up to within 10% of the old 86% target, but short of the new 95% target.
3. Percentage of eligible adults who had cardiovascular risk assessed at 86.7% is trending towards the target of 90%.
4. The 89.5% immunisation coverage at six months of age is trending back up towards the target of 95%.
5. GP utilisation rate of 4.06 is higher than the 3.62 total New Zealand rate.
6. The nurse utilisation rate of 1.15 is higher than the 0.68 total New Zealand rate.

Challenges

1. Access to DHB alcohol and drug services has fallen 20% beyond the target. Other DHBs with Pacific services have improved access for families in the Auckland region.
2. Access rate to DHB Mental Health Services dropped from achieving the target in June to within 10% of achieving the target in December.
3. Percentage of children carries-free at age five sits at 38% well short of the 65% target.
4. Mean rate of DMFT at school year eight continues to fluctuate due to small Pacific numbers. The rate sits at 1.85 above the national rate of 1.02.
5. Percentage of smokers offered brief advice and support to quit in primary health care fell between 10-20% outside of the 90% target and sits at 74.6%.
6. Percentage of enrolled women aged 25-69 years who received a cervical smear in the past three years for Hawke's Bay has trended between 71% and 77% since 2013. It sits at 71.2% falling short of the 80% target.

Please note:

- Hawke's Bay data for children who are obese was not available at the time this report was prepared.
- The approximated gap to achieving target numbers stated may only be one of a range of possible values that could deliver the targeted level/result.

'Ala Mo'ui performance indicators progress for the priority DHBs, as at 31 December 2015

Indicator No	Counties Manukau DHB		Auckland DHB		Waitemata DHB		Capital & Coast DHB		Canterbury DHB		Hutt Valley DHB		Waikato DHB		Hawke's Bay DHB	
	Jun-15	Dec-15	Jun-15	Dec-15	Jun-15	Dec-15	Jun-15	Dec-15	Jun-15	Dec-15	Jun-15	Dec-15	Jun-15	Dec-15	Jun-15	Dec-15
1	↘		↘		↘		→		↘		↘		↗			
2	↗	↗	→	↗	→	↗	↗	→	↗	↗	→	↗	↗	→	↗	↗
3	→	↗	↗	↗	→	↗	↗	↘	↘	↗	↗	→	↗	↗	→	↘
4	↘	→	→	→	↘	→	↗	↗	→	↗	↗	↗	↘	↘	↗	↗
5	↘	↘	→	↘	↗	→	↘	↘	↗	↘	↗	↘	↗	↘	→	↘
6	↘	↗	↗	↗	↗	↗	↘	↗	↗	↘	↗	↗	↘	→	↗	→
7	↗	↗	→	↗	↘	→	↗	↘	↘	↘	↘	↘	↘	↗	↗	↗
8	→	→	↗	↘	→	→	→	→	→	↘	→	→			→	→
9	↗	↗	↗	↗	↗	↗	↗	↗	↘	↗	↗	↗			↗	↗
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11	↗	↘	→	↘	→	↘	↘	↘	↘	↗	↘	↘	↘	↘	↘	↘
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14	↗		↘		↗		↗						↘			
15	→	↗	→	↗	↗	↗	→	→	→	↗	↗	↗	↗	↘	↗	↘
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17	→	↘	↗	↗	↗	↗	→	↗	→	→	→	↗	↗	↗	→	→
18	↗	↘	↗	↗	↗	↗	↗	↗	↗	→	↗	↗	↗	→	↗	↗
19	↗		↗		↗		↗		↗		↗		↗		↗	
20	↗	↗	↗	↘	→	↗	↗	↘	↗	↗	↗	↘	↗	→	↗	↗

Indicator No.	Figure No.	Page No.	Indicator (timeline)	Health Target
1	2	2	ASH rates per 100,000 in 0–74-year-olds, (2001–2014)	no target
2	4	7	Access rate to DHB specialist mental health services, (2005/2006–2014/2015)	no target
3	6	9	Access to DHB alcohol and drug services, (2012/2013–2014/2015)	no target
4	8	12	Percentage of newborn infants enrolled with a general practice by three months, (2013–2015)	98%
5	10	15	Percentage of infants who received all WCTO core contacts in their first year of life, (2013–2015)	95%
6	12	17	Percentage of four-year-olds who received a B4SC, (2013–2015)	90%
7	14	19	Percentage of infants exclusively or fully breastfed at three months, (2013–2015)	60%
8	16	21	Percentage of children with BMI >99.4th percentile referred to a GP or specialist services, (2013–2015)	95%
9	18	23	Percentage of children under five years old enrolled in DHB-funded dental services, (2007–2014)	86%
10	20	25	Percentage of children caries-free at age five, (2007–2014)	65%
11	22	27	Mean rate of DMFT at school year eight, (2007–2014)	no target
12	24	32	Percentage of smokers offered brief advice and support to quit in primary health care, (2013–2015)	90%
13	26	34	Percentage of eligible adults who had cardiovascular risk assessed, (2013–2015)	90%
14	28	37	Percentage of children who are obese, (2006–2014)	no target
15	30	40	Percentage of enrolled women aged 25–69 years who received a cervical smear in the past three years, (2013–2015)	80%
16	32	45	GP utilisation rate (average visits per person), (2008–2015)	no target
17	34	47	Nurse utilisation rate in average visits per person, (2008–2015)	no target
18	36	49	Total GP and nurse utilisation rate in average visits per person, (2008–2015)	no target
19	38	56	Estimated percentage of people with diabetes, (2010–2014)	no target
20	41	60	Percentage of immunisation coverage at six months of age for three-month reporting, (2013–2015)	95%

Legend	
	Target achieved at last measure (data point). When 'no target' is set, a gap score is calculated (percent) when compared with the total New Zealand population at the last measure (data point).
	<10 percent away from achieving the target or compared with the total New Zealand population (if 'no target' was set).
	10 and above but less than 20 percent away from the target or compared with the total New Zealand population (if 'no target' was set).
	20 or more percent away from the target or compared with the total New Zealand population (if 'no target' was set).
↗	Increasing trend. Note this usually means good news except for Figure 2, 22, 28 and 38 where an increasing trend means not improving.
↘	Decreasing trend. Note this usually means bad news or is concerning except for Figure 2, 22, 28 and 38 where this is what one expects if this indicator was improving.
→	Flat-lining or plateauing.
	No data available (white box)

15.1

HAWKE'S BAY District Health Board Whakawāteatia	**Food Service Optimisation Review** 66
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Sharon Mason, COO Deborah Chettleburgh
Reviewed by:	Facilities & Operational Support Manager and Executive Management Team, HB Clinical Council, HB Health Consumer Council and the Māori Relationship Board
Month:	June 2016
Consideration:	For Discussion and Decision

RECOMMENDATION

That the Board:

1. Note the contents of this report.
2. Support the Food Service team in investigating and implementing the recommendations.
3. Note capital applications that arise from recommendations below will be put through the capital plan process for approval.

OVERVIEW

The HBDHB Nutrition and Food Service is an 'in-house' food service. Following the Heath Benefits Limited (HBL) Business Case the HBDHB Board determined that the Food Service be reviewed internally to see if there are opportunities for financial savings or opportunities to improve the current systems and processes. The review is to include the three sites, Hastings, Wairoa and Central Hawke's Bay. The menu management system is currently manual and it was of particular note to the Board that electronic menu management systems should be reviewed and considered.

The review includes bench marking and site visits to other food services. The review is looking for improvements within the NZ triple aim including:

1. Improved Quality/Safety/ experience of patient care
2. Improved Health & equity for all populations
3. Best Value for Public Health system resources

OBJECTIVE

The objective of the Food Services Optimisation Review is to review, analyse and make recommendations in a report to the HBDHB Board on the existing food service. It is expected the report will cover food service processes, management methods, staff utilisation, finances and state of the art processes, systems and equipment.

A Food Service Expert was employed to provide technical expertise & industry knowledge to assess efficiency of systems and processes, provide advice and recommendations on the processes used in Food Production at the three sites and to evaluate new ways of working to improve efficiency and cost effectiveness.

EXISTING FOOD SERVICE BACKGROUND

At Hawke's Bay Fallen Soldiers Memorial Hospital the food service uses a cook fresh model. The food service is responsible for meals to the kitchen door. Orderlies deliver meals in meal trolleys, cups, glasses and jugs are also delivered. The nursing staff are responsible for menu completion, getting the patient ready for their meals, assisting patients to eat or drink as necessary and the return of the patient's trays and dishes. The menu is planned to allow for choice. The standard menu offers a range of hot and cold items, minced and pureed textures. The menu and dishes offered reflect the principle of using food first to provide appropriate nutrition for the patients.

Meals on Wheels (MOW) meals are provided hot and frozen. This service supports people to live well in the community. Frozen meals are available for weekend meals/ statutory holidays and for people who prefer to eat their meal in the evening. The frozen meals are produced using blast chill techniques.

Zac's café operates a separate kitchen preparing 'short order' items as well as savoury dishes. Meal items are also provided from the main kitchen such as soups and the main dinner meal. Staff, some patients and visitors use the café. Staff are able to bring their own food into the café (it may include food purchased elsewhere). Microwaves are available for staff to heat food up, plates and cutlery are used by non-paying customers. The tea and coffee are free to staff and contractors working in the DHB.

The café has responded to the healthy food policy reducing and eliminating high sugar and high fat foods and beverages. The national DHB food and beverage environment guidelines are being developed. Further restrictions in food and beverages are included in the guidelines which will impact on Zac's.

The menu ordering is paper based, patients are required to complete the menu the day before the meals are served. The majority of patients receive the standard menu. The more common diets have a dedicated menu so that patients are offered food choices that are allowed in their diet.

A paper based menu ordering system means that meal selection is further away from the time of consumption, it also means that patients when admitted do not have the opportunity to choose the next meal, it is chosen for them.

HB Hospital has a high rate of plate consumption. The 2010 Australasian care study day showed we have a high number (72%) of patients eating 50% and more of their meal compared to the combined results of 58% eating 50% or more of the meal.

SUMMARY REPORT OUTCOME

The Food Services Optimisation Project Team in conjunction with other Food Service Experts has undertaken to work through the Nutrition and Food Service Department to determine opportunities for financial savings or opportunities to improve the current systems and processes.
The following items are of note.

1. Equipment planning and replacement plan

The kitchen is well equipped for a cook fresh system. A blast chiller was added four years ago to allow for better chilling of food and allow for frozen meals on wheels meals to be produced to a high quality. There is sufficient chiller capacity for receiving goods and the storeroom stock is tightly managed to be accommodated within the space. Dry storage space is tight with some boxes stacked stacked on the floor. The existing equipment will require replacing over the next few years. Assets lists with the estimated replacement dates are held by facilities. Capital requests will be made after reassessing the state of the equipment.

Recommendation:

- The addition of a small shelving rack on the far wall in the storeroom to accommodate the additional supply of Nutritional products. This would tidy up this area, raise the boxes off the floor and make the stock more easily accessible.
- Capital be allocated to keep the equipment up to date and in good operating condition.

2. Forecasting of meals

Current forecasting of meals is completed using previous production quantities and left over data from previous meals. Consideration is also given to weather and month/ statutory holidays. It is not possible to utilise bed management data because the data collected is not accurate.
The menu processors use Trendcare to ensure all patients admitted to the wards are provided with the appropriate meal. Additional meals are not provided unless it is matched with a patient. This tool has helped reduce the number of 'extra' meals provided, reducing waste and two meals being provided for the one patient.

Recommendation:

- That a spread sheet be developed that includes predicted meal numbers/ food ordered/ actual meals served/ left overs/ weather on the day.

3. Menu selection and processing

The menu management system is manual with menus being paper based. Any non-standard menus are manually checked, dishes are ordered using paper requests and given to the cooks and kitchen assistants for production. The time the menus are collected and filled in by patients' needs to be investigated to stream line the process. The food offered is of high quality and there is choice on the standard menu which maximises the opportunity for individual patients to eat and improve their intake. The standard menu includes different textured foods such as a minced and pureed. This is deliberate as a number of patients select a texture modified meal or dish at some stage of their hospital visit e.g. a minced main dish is selected with normal vegetables or a normal main dish is selected with pureed vegetables. This selection is made by patients who a fatigued and find these dishes easier to eat for a day or two without being identified by nursing staff. The menu allows patient choice.

Recommendation:

- Work with the care associates and RN's to determine if it is possible to have the menus completed by the patients at breakfast time. This would then mean patients are selecting for the lunch and dinner meals of that day and the following breakfast. It would mean patients discharged late afternoon/ early evening would not complete a menu.

- Investigate a menu management system that can interface with Trendcare. Understand the requirements and issues of the wards and kitchen. Determine the cost benefits a menu management system would add as well as the benefit for patients and meal consumption. Waikato DHB Food Service have just had approval for a project to investigate suitable menu management systems available. There is a possibility that HBDHB could require a similar menu management system.

4. Trendcare data

Trendcare data is used to ensure patient meals are sent to the right ward and that individual patient dietary requirements, for each meal, are met. Trendcare dietary information accuracy has improved over the past few months with wards advising the menu processors before each meal where patients are.
The Trendcare diet menu sheet is difficult to read and process menus from when there is a lot of dietary information attached to a particular patient. Trendcare is not formatted to be used as a menu management system, it does not have an easy to read format and there is limited space to enter data. A paper based system for diets is used with especially complex diets using an additional single sheet.

Recommendation:

- Further work is required to strengthen the Trendcare dietary information with ward staff requiring further training on the functionality of being able to note where and when patients are transferred from ED and theatre.
- Investigate if there is a way to stop using the paper based system and rely on Trendcare for processing diets or look at how best to continue with using the paper based system to process the menus but also utilise Trendcare to communicate diet changes/ ward changes.

5. Review current reporting structure and office space

The current structure of the department has a large number of direct reports reporting to the manager. It is suggested that the reporting lines be altered.

Recommendation:

- Discussions are planned with Human Resources to discuss options for reporting structure and determine the process for consultation.

The office space is very confined with the Food Service office being used for dual purpose. This office is used for Food Service management as well as for a clerical staff function. The sharing of office space by the three individuals with two distinctly different functions is difficult.
It is difficult for food service tasks to be completed/ impromptu staff meetings and queries and difficult for the clerical staff member who is taking phones calls around clinic bookings and when typing from the Dictaphone, where a quiet environment assists with accuracy and productivity. This issue is increased when Otago students are training each year.
Plans are being considered to enable the Food Service office to be used for food service functions moving the clerical staff member to another office space.

Recommendation:

- The clerical staff member needs to be re housed to another office space either a) reception area is rebuilt so that two work stations are built or b) the current bed storage area is converted to offices for the Nutrition & Food Service. The preferred option is the conversion of the current bed storage area to office space as this area adjoins the department and would provide more workable office space. Capital funding would be required and another space would need to be found for the bed storage

6. Renew expired food service contracts

A number of food contracts have or will expire this calendar year. HBDHB is taking immediate action with Health Alliance to ensure the following contracts are tendered, meat, poultry, groceries, thickened beverages, prepared fruit and vegetables and bread and dairy.

7. Zac's lounge area

A small lounge area in Zac's is used by staff. It has low chairs and located in a quieter space.
This slightly secluded area provides an opportunity to make this into an informal meeting area with lounge chairs and low tables. Although the current furniture is sparse it is used by staff. It is suggested that more appealing furniture would create a better environment for small groups to meet over coffee. This would require a small investment of capital to purchase appropriate furniture.

Recommendation:

Use survey monkey survey staff to determine if the current lounge area meets staff needs. Consider refurbishing area with 'softer' furnishing to create a more distinguishable lounge area and meeting area.

8. Clear signage for visitors in Zac's

Zac's has minimal signage and menu information making it difficult for visitors to navigate the café. The limited signage can make it difficult for staff and particularly visitors to make informed menu choices.

Recommendation:

- The installation of a new menu board, product pricing to be made clearer and signage installed for customers on the range of food and coffee. The signage for visitors to pay for tea and coffee has been made clearer but will be reassessed.

9. Relocation of the coffee machine

The coffee machine in Zac's is not in a prominent place – it is located for the convenience of the staff working rather than the customer wanting a takeaway coffee.
Waiting room for customers to stand while waiting for their takeaway coffee is not available with customers tending to feel 'in the way' of the queue of customers buying food items. Customers having coffee to drink in the café are well served.

Recommendation:

- Options are being considered to move the coffee machine to a more prominent position and create a space for customers to wait without interfering with customer flow. This is likely to encourage more customers purchasing coffee.

10. Prepare bread products in Zac's café

Bread products are made in the kitchen between 0630- 0815. The activity was moved from Zac's to the kitchen a number of years ago as it improved work flow, allowed for better use of the refrigeration space, allowed for quicker cooling of the bread products once filled. It also helped reduce the load on the limited refrigeration space in Zac's.
A disadvantage of having the bread products made in the kitchen is that the cost allocation between the two cost centres becomes blurred with these ingredients being sourced by the kitchen and the difficultly to calculate true costs of these ingredients used for an accurate budget transfer.
Zac's do not make more filled bread products if stock levels diminish at lunch time. With careful management of this line of food it is possible to make additional filled products if required later in the lunch service without generating additional food waste.

Recommendation:

- Order ingredients used for bread products under the Zac's cost centre rather than bundled in with the transfer change sum.
- Bread products continue to be made in the kitchen with some additional fillings and bread product taken to Zac's for the café to make additional filled bread products if needed.

11. Clear operating model to be defined in terms of Zac's profitability

It has been previously understood that Zac's should operate to a break even position. Allowance must be made for the labour involved in cleaning the beverage area, tables and dishes used by non-paying customers as well as the cost of milk, tea, coffee, sugar, stirrers and disposable cups supplied for the free beverage service. Zac's provides an environment for staff to socialise and relax during their paid and non-paid breaks. It provides a venue for casual meetings.
Work is being undertaken to have clarity over actual food costs attributed to Zac's and ensure this is accurately calculated in the monthly budget transfer. Dishes made in the kitchen for patients are also sold in Zac's e.g. soup, evening desserts, suitable evening main dishes, potato etc. This is done to reduce duplication in cooking. Some items are made specifically in the kitchen for Zac's – such as salads and baked items. This operating model works well as the tasks are combined with patient cooking and extra catering tasks to make up the tasks for a cook position. The labour component cost for these specific dishes is not currently transferred to Zac's.
The new evening menu has been implemented and a new lunch menu is planned for later in the year. The new lunch menu makes less use of dishes cooked in the kitchen. This will make it easier to calculate the true costs of food transferred and should help attract more customers.

Recommendation:

- Continue to define the costing model used for Zac's to ensure it is accurate so true costs for the café and patients can be calculated. Look to reduce Zac's financial risk by providing excellent quality and increasing revenue.

12. Upgrading the till

A new point of sales till is being considered for Zac's café. Work is under way to consider the advantages of such a till and how the information generated will assist with the management of the café. A pay wave payment system and bar scanner are also being considered. Pay wave would speed up payment of goods.

Recommendation:

- Continue to evaluate the point of sales till, bar scanner and pay wave payment system before making recommendation to purchase.

13. Integration of the current hot and frozen MOW computer programme

There are two different computer programmes used for the MOW service, one for hot meals and one for frozen meals. The software system is cumbersome with the two programmes requiring a lot of manual data entering. The run sheets generated for the kitchen and the Red Cross drivers are difficult to read.

Recommendation:

- Investigate and apply for a replacement MOW software programme so that the frozen and hot meals service are integrated and the run sheets are easier for the Red Cross drivers to read and follow instructions.

14. Printing of Run Sheets in the morning of the MOW service

The current MOW system has the run sheets printed the day before the meals are produced and sent out. Any changes to these are communicated to the kitchen with a new run sheet being produced and sent to the kitchen the morning of the meal delivery.
After evaluating the benefits of printing the run sheets the day before the service versus printing the run sheets at 0815 hrs. On the morning of service it is considered not feasible to print on the day. The kitchen needs the production information at 0630hrs on the day in order to plan and produce the meals required.

Recommendation:

- Continue to print the run sheets the day before the MOW meal service.

15. MOW service and meeting recipients needs

The MOW service provides standard meals as per the menu, special diets and meals catering for the likes and dislikes of recipients. In an ideal world we should only provide standard meals and special diets and not cater for dislikes because it would reduce the need to cook different meal items, the need for individually labelled meals and notes on the run sheets. It would make the MOW process more stream lined but less responsive to customer needs. Since Nutrition & Food Service took over the administrative task of the MOW service we have been able to decrease the number of different meals produced that cater for likes and dislikes. The MOW service is supported from part government funding and by charging customers. It is imperative that HBDHBs MOW service continues to be sustainable.

Recommendation:

- Continue to provide for likes and dislikes for the MOW recipients and continue to manage expectations to minimise the number of 'special' meals produced as we want to maximise the opportunity for recipients to eat the meal and hence remain well-nourished in the community.
- Continuously monitor the financial aspects of providing this service. Benchmark against other DHBs and adjust meal charges to ensure they are in line with product increases. Continue providing a sustainable and high quality service.

16. Date stamp to be added to the lids of hot MOW meals

The hot MOW meals are not date stamped before they are delivered to the recipient's home as it is intended that the meals are eaten on delivery. Information is provided to the recipient when they start the MOW service to eat the hot meal on arrival and if they would rather have a hot evening meal they should order a frozen meal.
It is considered not necessary to date stamp the hot meals with the production date as it is not telling the recipient anything other than the production date – it does not advise when to eat the meal by, how to store it and for how long. We consider that the meal should be treated as is intended – to be eaten as soon as it is delivered much like a take away meal. The MOW service specification does not require a date stamp to be used for the hot meals.
The frozen meals are dated with a use by date. Production date records are kept. Instructions on how to reheat the frozen meals is included in the label.
A separate information sheet is sent when the recipient starts with the MOW service on how to reheat the frozen meal and on safe reheating of the hot meal.

Recommendation:

- Send out to recipients the recently developed information on safe reheating hot meals.

17. Protected meal times and 'out of hours' meal service

The 'Protected meal time' system has been introduced internationally and in NZ hospitals. Protected meal time draws attention to allowing time for the patient to have their meals when delivered – to not be interrupted by medical visits, tests or bed movement. It is intended to maximise the opportunity for patients to eat. As a result patients are more nourished and waste is reduced.

Out-of-hours meal service is increasingly needed as we see patients moved to wards after the meal service which can be after breakfast, lunch or dinner. The food service is responding to the demand for meals outside of meal service as required. A review of the requirements/ demands and response would ensure that the needs of the patients are being met and that the food choices have adequate energy and protein.

Out of hours meal service for staff is limited to vending. Most staff have access to refrigerators, toasters and sandwich making machines. Demand for alternative food which is available for purchase is unknown.

Recommendation:

- HBDHB explores protected meal times using a team of people led by nurses.
- Review the 'out-of hours' patient meal service with nursing staff.
- Survey staff working after hours to determine demand for food and beverage service

18. Waste management & minimisation processes

Patient meal service is recognised internationally to have a certain level of food waste regardless of the food service system in place. Managing the factors that contribute to food waste assist with controlling costs.

Facilities and Infection Control consider the disposal of patient waste using a disposal unit to be the preferred option as the food is potentially contaminated. The disposal unit has broken and we are waiting on options to replace the unit. The remaining kitchen and Café food waste is disposed of using a pig bin. Systems are in place to minimise food produced and serve patients high quality food in small portions that they will eat. Encouraging and assisting patients at meal and beverage time helps to reduce food waste.

Polystyrene cups are used in Zac's as well as for catering because they are a low cost option. It is preferred that we use disposable cups made from sustainable material. The café sells a high number of bottled beverages with around 50% being drunk in the café. The café staff sort dishes, rubbish and recyclable material efficiently and effectively in the dish room. A recycle station is used at various organisations which encourage customers to sort their waste.

Recommendation:

- Engage with staff to quantify food waste, identify contributing factors and processes, formulate and implement ways to reduce and minimise food waste
- Engage with staff to identify processes and staff time used, explore methods, timing and identify alternative processes that led to increased efficiency and quality while decreasing waste
- Explore systems used for patient menu selection and meal assistance with nursing staff
- Investigate the benefit of a recycling station for customers to sort waste to determine if it is more efficient
- Investigate the use of disposable ware replacing with more environmentally friendly ware or washable ware
- Look at replacing disposable ware in Zac's

19. Wairoa and Central Hawke's Bay

The two sites operate a cook fresh meal service for patients and MOW. Wairoa meals are produced in the hospital kitchen and CHB meals are supplied from the local café.
Wairoa HC makes use of the menu used at HB hospital with a hot meal served at lunch time.

Recommendation:
Introduce a six monthly visit by the Nutrition & Food Service Manager to review practices and the menu, look for improvements and make recommendations as appropriate.

FINANCIAL IMPLICATIONS

Capital costs for this Food Service Optimisation Review have not been determined. Likely items with costs associated are noted below. Final approval for capital will be made through the existing capital application process.

- Cost to modify office space
- Cost to relocate the coffee machine, improve furniture in lounge area and create a waiting space for coffees
- Cost for a point of sales till
- Cost of menu management system
- Cost of new MOW computer software

ATTACHMENTS

APPENDIX 1: Food Services Optimisation Action Plan
- Food Service Peer Review for Hawkes Bay DHB – Dec 2015

APPENDIX 1

Food Services Optimisation Action Plan

#	Recommendation	Responsible Person	Completion Date
1a	Alterations to Store Room	Jill Foley	Jul-16
1b	Capital Plan Updated	Christine McCutcheon	**Completed**
2	Meal forecast Spreadsheet	Sheryl & Dallas	Oct-16
3a	Reallocation of menu times	Deborah/ CNM/CA's	Nov-16
3b	Investigate the viability of a menu management system	Deborah	Apr-17
4a	Trendcare dietary information improved	Sally & CNM's	Dec-16
4b	Use Trendcare to improve the paper based system	Dallas	Dec-16
5	Review Food Service reporting structure	Deborah/ Bridget	Nov-16
6	Review office space options for improvements	Hannah/ Deborah	Jul-16
7	Investigate current Zac's lounge area functions and implement change where possible	Maureen	Dec-16
8	Improve signage in Zac's	Jill/ Maureen	Jul-16
9	Relocate coffee machine in Zac's	Hannah/Maureen	Nov-16
10a	Align product ordering to cost centres	Maureen/ Jill	Jul-16
10b	Production changes to bread products to better align with Zac's service	Maureen/ Jill	Aug-16
11a	Improve Zac's costing model	Barry/ Deborah	Feb-17
11b	Look at ways to reduce financial risks by increasing revenue	Maureen	Dec-16
12	Evaluate sales till, bar scanner and pay wave system options with the intention of upgrading to improve the service	Maureen/Gavin	Aug-16
13	Investigate options for MOW software replacement and improvements	Kylie/Deborah	Mar-17
14	Print the run sheets the day before the MOW meal service.	Deborah	**Completed**
15a	Manage MOW expectations to minimise 'special' meals but keep the community well nourished	Kylie	**Completed**
15b	Monitor and where feasible financially adjust MOW service to align with other DHBs product costs.	Deborah	Feb-17
16	Send out to recipients the recently developed information on safe reheating hot meals	Deborah	**Completed**
17a	HBDHB explores protected meal times using a team of people led by nurses.	Deborah/ CNM's	May-17
17b	Review the 'out-of hours' meal service and demand with nursing staff.	Deborah/ CNM's	Oct-16

#	Recommendation	Responsible Person	Completion Date
17c	Survey staff to determine demand for out of hours meal and beverage service	Maureen/ Deborah	Oct -16
18a	Quantify food waste & make recommendations with kitchen team	Deborah/Jill/team of staff	Dec-16
18b	Explore patient menu selection and meal assistance with nursing staff	Deborah/ CNM's	Dec-16
18c	Investigate the benefit of a recycling station for customers to sort waste to determine if it is more efficient	Maureen/ Jill	Jul-16
18d	Investigate the use of disposable ware replacing with more environmentally friendly ware or washable ware	Maureen/ Jill	Dec-16
18e	Look at replacing disposable ware in Zac's	Maureen/ Jill	Dec-16
19	6 monthly visits to Rural Food Services to review and improve systems and processes	Deborah	**Completed / Ongoing**

APPENDIX 2

Food Service Peer Review for Hawkes Bay DHB

Report compiled by:

Vicky Campbell
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December 2015

The objective of the Food Services Peer Review is review, analyse and make recommendations in a report to Hawkes Bay District Health Board on the existing food service. This is part of the Hawkes bay District Health Board Food Services Optimisation Project.

Thank you for offering me the opportunity to peer review the Hawkes Bay Food Service and I would be happy to be contacted to discuss further any item that I have reported on.

EXECUTIVE SUMMARY

Thank you for the opportunity to review the Hawkes Bay DHB "in-house' food service. Following the Heath Benefits Limited (HBL) Business Case the HBDHB Board determined that the Food Service be reviewed internally to see if there are opportunities to improve the current systems and processes or opportunities for financial savings. The review is to include the three sites, Hastings, Wairoa and Central Hawke's Bay.

Hawkes Bay Fallen Soldiers Memorial Hospital Food Service was designed in the late 1980's and as current patient meal numbers are still within the numbers that this facility was designed for the facility is fit for purpose and well laid out. The equipment is functional but due to the age of the equipment this is a high risk to the DHB so an equipment replacement plan for the next 10 years should be developed.

The forecasting of meal numbers could be reviewed to include the bed data information and collated into a spreadsheet.

Reviewing the most commonly used therapeutic diets and using more pre-printed menus for these would streamline this process and reduce time associated with this task.

The patient meal system should ideally be designed to minimise the time between menu selections and meal delivery as evidence has shown this can improve patient oral intake. Investigate the potential to move to breakfast, lunch dinner menus and processing the breakfast menus prior to the breakfast service to reduce ordering times for patients and to reduce waste of menus processed too far in advance.

Trendcare is being used for patient meal status but a manual system is also being used alongside of this. Recommend reviewing the currency of Trendcare data with a move to using only this data for ensuring that all patients on the ward receive the correct meal.

It is important to streamline current manual processes prior to implementing electronic systems as the use of Trendcare is an example where some manual processes have not changed. Recommend investigating menu management systems suitable for this size operation that are cover the basic requirements. This is a project by itself and a work stream should be set up to investigate the options available.

Recommend reviewing the current reporting structure of the service and office space. To strengthen the service by building on the expertise of the current staff and to allow the Manager time to focus on the direction of the service, the current structure could be reviewed to allow less direct reports.

Many of the contracts have expired and renewing contracts needs to be a priority with Health Alliance as this is a high risk area. Working with Health Alliance to develop joint contract pricing with Waikato DHB to maximise cost saving opportunities should be pursued.

Zacs cafeteria was observed to be a busy cafeteria which is well utilised by staff. The café seating provides a functional seating area with both seating inside and out. A lounge area could be created with comfortable seats where staff could meet out of busy times with a coffee.

The staff beverage area was clean and worked well for staff. Clear signage outlining that it is free for staff but welcoming visitors to access this facility after paying the cashier and informing them of the cost would enhance this service to visitors.

Staff report ventilation in the café servery, production and dishwash area as a concern. A temperature tracker would be able to scope the extent of this and then a solution can be investigated

Coffee is an important component of a cafeteria for customers and a good revenue stream. Investigate relocating the coffee machine to a more prominent location to promote this service and increase sales. Two options to investigate are suggested in this report. This would require an investment in capex so analysis of current coffee sales and projected sales would need to be evaluated to offset the capex expenditure.

Sandwiches and rolls are a popular menu item for lunch. As these are made by the café staff this would be more efficient to make in the cafeteria as costs would be more transparent and they could be prepared during the service if they run short. Recommend investigating solutions to enable sandwiches and rolls to be prepared in the cafeteria.

Currently Zacs sales are designed on a cost recovery basis. As the café currently utilises staff, ingredients and menu items from the main kitchen these costs are complex to calculate. This is a complex exercise but requires reviewing as it is important to ensure that the cafeteria is not subsidised by the main kitchen affecting patient meal costs.

A clear operating model also needs to be defined around whether the cafeteria is to be cost neutral or if it is to generate a profit, and how the costs associated with the free staff beverages are funded. An investment in upgrading the tills in the cafeteria to enable the sales data to be analysed would be a good investment as the data can assist with developing the café service and subsequently increasing revenue. An analysis of the two systems including reporting function, ease of use and costs will inform the decision.

Recommendation for Meals on Wheels:

Meals on Wheels forms a significant function within the Food Service as it produces approx 330 fresh MOW Monday to Friday and 100 frozen meals three days a week.

Investigate integration of the current administration system for both fresh and frozen meals to streamline this service and reduce workload and errors.

Recommend reviewing this system so that run sheets are only printed out on the morning of service and production is forecasted. Catering to special needs, including which vegetables they do not like, may need to be reviewed to streamline this service.

It is recommended the meal is eaten when it is delivered and not stored and reheated but it is known that this practice happens frequently. Presently there is no information about the meal on the container and I would recommend that at a minimum a date stamp be added to the lids of the hot MOW meals to inform recipients about the day that this meal was produced. Information should be provided to the client about safe reheating, even if it is not recommended, as it is known that clients do reheat the meal and it is better that this is done safely. This information could be either on the label or in the client information sheet.

Recommendations for Wairoa and Central Hawkes Bay Health Centre

Strengthen relationships and understanding of the processes with a 6 month site visit to review the service including a review of the menu, food safety practice of staff on site and café, quality of the meals, costing model and patient satisfaction surveys to ensure that the service is fit for purpose.

REPORT

1. Hawke's Bay Fallen Soldiers Memorial Hospital

Objective 1.1: Review the main hospital kitchen and patient food service operating process

a) Food purchase, delivery, storage systems:

There is a robust system in place to maintain minimal stock on site. This is managed through an impress system which informs the orders and regular deliveries. Food purchases are compiled against an impress once a stock take is done and according the menu cycle. This is a manual system and with the use of templates this works well.
An electronic menu management system that integrates with the current patient management system would streamline the current manual system, would assist in forecasting production numbers for each meal service, would provide easily accessible historical data to influence decision making

There is a robust system in place for receiving goods and for monitoring stock. There is sufficient chiller capacity for receiving goods and the storeroom stock is tightly managed to be accommodated within the space. Dry storage space is tight and boxes were observed stacked on the floor. Recommend the addition of a small shelving rack on the far wall in the storeroom to accommodate the additional supply of Nutritional products. This would tidy up this area, raise the boxes off the floor and make the stock more easily accessible.

Installation of shelving to have this stock neatly stacked and accessible.

b) The method by which the food is prepared

This is a cook fresh production kitchen with some cook freeze production currently in operation for the frozen Meals on Wheels meals. The kitchen is well set up to support both of these operations.
Sandwiches are a high risk item but one that is well received by patients. The temperatures need to be strictly monitored. The food service uses cold meat that is cooked on site. A review of the sandwich process would be recommended to ensure that the temperatures are managed within the safe limits throughout the process from making the sandwiches to the being served on the patient

tray. As summer progresses and the temperatures increase the time periods when sandwiches are not chilled increases the risk.
At the trayline all chilled foods including supplement drinks could either be available in a chilled cabinet or brought out from the chiller in smaller quantities.

Recommend temperatures of the items be tracked to evaluate the effectiveness of process changes before a chiller was investigated.

c) The patient menu management system

This is currently a manual system with the tasks completed daily by two menu co-ordinators.
Meal numbers are forecasted, based on actual meal numbers from the previous cycle, but there is no formula for this. A review of the forecasting of meal numbers to include the bed data information set out in a spreadsheet with the formula populated would be recommended.

The patient meal system should ideally be designed to minimise the time between menu selections and meal delivery as evidence has shown this can improve patient oral intake. The “Patient menu selection process” is one of the first steps in providing an opportunity for adequate consumption of food and fluids. It is one of many processes that work together to

Ensure that the right food and fluids are provided to the right person at the right time, whilst offering choice. This is a critical and complex part of patient care. Hence it is important for patients to be able to choose their meal as close to service as possible.

Patient meals are selected between 4-7pm today for tomorrow’s lunch, dinner and the following day’s breakfast. This can be very confusing for patients when they realise that they are choosing menu items for tomorrow and the following day. This is a time delay as patients menu requirements may change or they may be discharged. Hence there is significant processing of menus which are discarded before the meal. The menus currently return to the kitchen on the breakfast trolley. The process of patient menu selection is a key step in the execution of each patient’s nutrition care plan and supports overall nutrition care.

Recommend investigating whether the menus could be returned to the kitchen on the evening meal trolley and then these menus are used for the breakfast the following morning. This would require menus to the printed as breakfast, lunch and dinner (rather that the current lunch, dinner, breakfast) so patients would be choosing this afternoon for the following day breakfast, lunch and dinner. This would also require a change for the menu processors as they would potentially need to start earlier at 6am rather than the current 6.30am start. Processes would need to be investigated to see if the tasks associated with breakfast could be completed in this time period. This would improve the ordering time for patients and reduce the handling of menus.

There are currently only 8 pre-printed menus (standard, vegan, dairy free, gluten free, low residue, antenatal, child under 6, and a child over 6) and all other therapeutic menus require the menu processor to populate the therapeutic diet choices onto the menu prior to being given to the patient to select from. This is time consuming and could be reduced if the number of commonly used therapeutic menus were pre-printed. Pre-printed menus can offer a variety of choices within a pre-printed menu that are suitable for that diet type. An analysis of the most common therapeutic diets used from a review of the Trendcare data would show this. These could include soft, minced and puree diets with the thickened fluids printed on the bottom of the menu.

Patient information on meal requirements is entered into Trendcare by ward staff and is accessed prior to each meal service to ensure that all patients receive a meal. If Trendcare data is kept up to date by ward staff and Dietitians utilise this function for any special diet requests then the menu coordinators would not need to generate another ward list which they also update. Presently both an electronic system and a manual system is being used when in reality Trendcare does provide this data. Recommend reviewing this process to investigate rationale for current process and whether Trendcare could be the only ward reference list used. It is important to streamline current manual processes prior to implementing electronic systems. Recommend reviewing current menu management systems used in hospitals in New Zealand and then scoping the requirements for this facility to inform the decision making process.

d) Staff structure and operations

There is a flat structure within Nutrition and Food Services and the Manager has 17 direct reports including 7 Dietitians, 3 administration staff, 4 menu coordinators, Food Service Dietitian, Food Service Team leader, and Zac's cafeteria team leader, plus indirectly all the kitchen staff.
To strengthen the service by building on the expertise of the current staff and to allow the Manager time to focus on the direction of the service the current structure could be reviewed to allow less direct reports.

One concept could be that the service is divided into teams including Inpatient and MOW Food Service, Clinical Dietitians, and Zac's Cafeteria with a team leader for each area who reports through to the Manager Nutrition and Food Services. As there are currently 3 administrative staff who provide a diverse range of functions across the service from booking clinics to MOW administration it would be difficult for them to currently report to an administration team leader so this would be best to continue to report directly through to the manager. This would reduce the direct reports for the Manager down to 6 from the current extensive number which includes of the food service staff.

- Recommend that the service structure be reviewed.

To support this management change the following would need to be considered for each area;

Inpatient and MOW Food Service staff

This is currently happening to an extent within the production team as the manager builds capacity within the Food Service Dietitian role. But to enable this to occur fully the Food Service Dietitian requires a separate space where the kitchen staff are able to access her and this is currently limited by her shared office space. The current office is a Food service and administration office occupied by 3 staff members which is a busy space and less than ideal. Recommend that the Food Service has an office which is shared by the Food Service Dietitian and the afternoon Team Leader. The Food Service Dietitian would manage all of the meetings for this staff group. This would be an important change for the Food Service staff meeting as it would support the staff to see the Food Service Dietitian as the one to go to first. She currently works 4 days a week so the current strategy of the Manager covering would need to continue.

There could be some confusion as there is currently an afternoon supervisor who is a team leader so this position would need to be reviewed but appears to be more of a supervisor role. This would require further investigation and was outside the scope of this project.

Zacs Cafeteria

Currently Zacs is managed by the Team Leader for Zacs. This system works well with the oversight of the manager.

Clinical Dietitians:

Currently all 3 inpatient clinical Dietitians, 2 community Dietitians, and 2 Primary Care Dietitians report to the Manager. Plus the Manager provides supervision to the Mental Health Dietitian.

Recommend that a review of the current team structure with the potential of a Team Leader be appointed within this group of Dietitians so that all of these Dietitians report to a Team leader who then reports to the Manager.

Administrative staff:

All 3 administrative staff carry out such diverse roles that it may be simpler to have them all reporting directly to the Manager. There is a MOW administrator, a clinic booking administrator and a general administrator for the service. They could either report to an administrative coordinator or continue to report to the Manager as currently.

Office accommodation:

The current layout of staff offices would need to be reviewed to support any structure change. To facilitate the Food Service having a dedicated office, with the Food Service Dietitian and the afternoon Team Leader, the clinic administrator would need to be relocated. This office space is also used as a Hotdesk for the clinical dietitians in the morning.

The three administrative staff could occupy a shared space but they have a diverse range of responsibilities and have limited synergies that there is little perceived gain in collocating these positions. There is also limited space within the department to accommodate the three together without extensive building and subsequent costs. There is currently an allocated space in the Facilities block, at the request of the clinic administrator requesting a quiet space for dictation, so the clinic administrator could be relocated here. The MOW administrator currently occupies a space in this area. This would leave the current full time administrator in her current space within the department.

Recommend reviewing the current reporting structure within the service and this will then inform the necessary office changes.

e) The kitchen building layout and functionality

Hawkes Bay DHB are fortunate to have a kitchen that is still fit for purpose as the capacity is within what it was built for as there has not been any considerable growth in patient meal numbers just Meals on Wheels numbers.
The kitchen flows well from the loading dock through into the stores area where all stock is well managed. This then flows into the production and service area.
The dishwash area is limited but the main concern in this area would be the air temperature which should be investigated. There is also considerable soaking of large dishes which takes up space and is messy. This can be streamlined with the use of a pot wash machine and this is covered under the equipment section below.

Recommend investigating the air temperature and investigating the purchase of a pot wash machine.

f) Production process

The cook fresh process appears to be efficient for the current numbers. The number of cooks are minimised and trayline staff are utilised for preparation before the trayline begins and sorting dirty dishes after the meal service. The blast chiller is reported to be at capacity with limited opportunities to access this chiller outside of currently scheduled activities.

g) Waste management & minimisation processes

Waste management is an important element to consider in a Hospital Food Service as minimising waste has an effect on the budget and as there will always be an element of waste due to the nature of the service hence the importance of sustainable practices.

It was encouraging to see the sustainable practices around food waste direct from the kitchen utilising a “pig waste” system which is tightly monitored and guidelines adhered to.

The food waste that returns on a patients tray is processed in a different manner as it is considered by the Food Service as contaminated waste. This is currently disposed of via a waste master into the drainage system. This is not a sustainable practice and could be improved by investigating alternate waste solutions.

Recommend investigating sustainable practices to minimise or eliminate the use of the current waste master system. Canterbury DHB currently utilises the pig bins for all food waste, including patient meal tray food waste, as their pig bin operator is registered with Ministry of Primary Industries. Counties Maunkau DHB utilises a waste compactor which reduces the waste by up to 80% in volume which is a sustainable improvement and could also be investigated. Due to the current use of the pig bins the waste compactor may not be a necessary investment of capex due to the volume of waste.

Recommend investigating alternative waste management practices to ensure that all sustainable options are explored.

h) Equipment and automation utilisation

The Hospital Kitchen equipment is of an age where a replacement programme needs to be put in place to cover a staged replacement plan. Some of the equipment was transferred from Napier

Hospital when the Food Service was commissioned in 1988. All equipment is currently functioning well but this is a high risk area.

Recommend that a 10 year capex replacement plan be created to include a staged replacement for all large equipment items including the ovens, Steam Jacketed pans, Hobart mixers, blast chillers, and trayline hot holding equipment.

It was identified that there was pressure on the two blast chillers due to the volume of frozen MOW produced, so there was little capacity to use the blast chillers for other products. If the production of these frozen meals was to increase or it was identified that the blast chiller could be used for other products then an additional blast chiller would need to be investigated.

There is also an opportunity to review the dish wash area with the addition of a potwash machine. This would eliminate the need to soak and scrub gastronorm dishes as is currently done and would reduce the pressure on staff during the busy times. Recommend investigating the feasibility of a pot wash machine.

As all processes are currently done manually and there is limited automation this would require a large investment in capex. It can be beneficial to have automated equipment and this could be reviewed as equipment is replaced, e.g. ovens programmed to record food temperatures for HACCP plan. Having manual systems in place in a facility of this size can provide the benefit that staff are engaged in the process and regularly have to check temperatures.

i) Financial Budget (Revenue & Expenditure)

There is a process in place to compare the budget with actual expenditure and this can be benchmarked against the previous year for each line item. What is not clear is how this is benchmarked nationally or internationally as it is a diverse service encompassing Clinical Dietitians, Hospital Food Service, Meals on Wheels, meals for outlying sites like Springhill, patient and staff milk and beverages, and Zac's cafeteria. This would clearly need to be unbundled to be able to accurately benchmark with another service. This is a significant piece of work and I understand that there is a finance work stream dedicated to this.

j) Food Supplier Contracts / Standards

There are current processes in place for ordering from the various suppliers and these are ordered against impress orders and the cycle menu. Frequency of delivery depends on the nature of the item and the agreement with the supplier. This currently works well but many of the contracts have expired and renewing contracts needs to be a priority with Health Alliance as this is a high risk area. Working with Health Alliance to develop joint contract pricing with Waikato DHB to maximise cost saving opportunities.

k) Food Service Standards and Guidelines

The achievement of an accredited HACCP programme must be commended. This is a large undertaking and a great achievement to have an accredited Food Safety programme.
The nutrition standards for menus developed at the request by HBL for the provision of Food Services in all New Zealand DHB Hospitals has been consulted when reviewing the current menu. There are some variations and there is clear rationale for these.

l) Distribution processes – Springhill and MOW

There is a dedicated truck used only for food deliveries which provides a mid-day delivery to Springhill and the MOW to Napier and then again in the evening it delivers just the meals to Springhill. The meals for Springhill utilises the main patient menu and are packed and delivered in bulk to the unit where on site staff serve the meals. The MOW's are taken to a central area where the volunteer drivers collect them. This is an efficient delivery for the mid-day meal but as the truck does a special delivery in the evening for the Springhill meals so to ensure that it is economically viable the Springhill meal service would need to be costed.

Visiting Springhill and MOW collection points were outside the scope of this project so information was gathered by observations from the hospital kitchen site and discussions with staff.

This system is reported to be working well and as there is a truck available for the MOW delivery it is ideal to also deliver to Springhill.

There was no complaints from Springhill and it was reported that audits on food temperature, portion size, food quality have been done previously but no recent data was available. Recommend that this service is audited, minimum of 6 monthly, covering all aspects of the food service including meal quality, portion control, food temperature, customer satisfaction and staff feedback. This information would be used to review the service and inform any changes in the future.

Objective 1.2: Review the Zacs Cafeteria business model and operating process:

a) Café business model

Zacs cafeteria has two functions as it provides a location for staff to have their meal breaks and free access to tea, coffee and water. It also provides a café service providing the sale of food and beverages for staff and visitors to the hospital.
Currently Zacs sales are designed on a cost recovery basis. As the café currently utilises staff, ingredients and menu items from the main kitchen these costs are complex to calculate. This is a complex exercise but needs reviewing as it is important to ensure that the cafeteria is not subsidised by the main kitchen affecting patient meal costs.

b) The café building layout and functionality

The cafeteria has been well planned and the seating area is light with lots of windows and has access to outside seating. This is an asset for staff and this facility should be maximised to encourage staff to utilise this area. The seating area has recently been refurbished with new tables and chairs. There is an area on the far side of the cafeteria, before you exit into the corridor that has been converted into a seating area with chairs with soft furnishings. This slightly secluded area provides an opportunity to make this into an informal meeting area with lounge chairs and low tables. This would create an appealing meeting space and staff could be encouraged to use this while having a coffee for small groups to meet in quieter times of the day. This would require a small investment of capital to purchase appropriate furniture.

I must commend your staff on the cleanest and most orderly hospital staff beverage area that I have encountered. These are notoriously messy areas but this area has a good flow, items are clearly displayed and crockery cups are visible which discourages the use of disposable cups, and food service staff were frequently cleaning this area. It was a pleasure to use this facility. The signage for beverages use for visitors was not welcoming and did not specify the cost. This signage could be improved by clearly outlining that it is free for staff but welcoming visitors to access this facility after paying the cashier and informing them of the cost.

The servery area has reasonable flow but there are a few areas for consideration. The fruit bowls look attractive at the beginning of the servery but this is the ideal position for trays and plates rather than carrying trays and plates across from the soup table. There would be adequate room on the end of the servery to have one large bowl of mixed fruit as well as the plates and trays. The trays lend themselves nicely to this position as they can then go straight onto the tray rack in front of the servery and there is no balancing of trays across the centre of this busy area. A small amount of trays and plates could be kept beside the soup for those selecting soup.

The production area is restrained by the overall size of the cafeteria but this is managed by accessing the main kitchen area for the production of sandwiches, some hot menu items and the daily baked items. The difficulty with this arrangement is that if the sandwiches run low during the lunch service the staff are not able to produce any more and the costing model needs to be reviewed to ensure that the patient meal service is not subsidising the café sandwiches. There is a designated cold prep area for sandwiches to be prepared in the café and recommend that making them back onsite be investigated to minimise waste of over production of sandwiches but to also enable sandwiches to be made at short notice.

The coffee machine is situated in a secluded space close to the cashier which is a busy area. There is a system in place to inform patrons when their coffee is ready but if you wanted a takeaway coffee there is limited area to wait. Currently, during busy times, you would have to wait in the seating area. The coffee shop in comparison is set up to drop in and order your take out coffee as it is visually appealing, has good signage and a welcoming area to wait. Currently the coffee is not well advertised and promoted due to its location. Coffee is a great revenue stream and this could be increased with relocating the coffee machine to a new location. There are two options to explore to relocate the coffee machine and revenue, available staffing and capex will influence this decision.

Option1: A coffee station could be developed where the current water cooler is. This would promote coffee sales as it would be visually appealing and would provide a specialist coffee service and a waiting area for coffee could be developed. The current table talkers would still be utilised for informing customers when their coffee was ready for collection. This would require separate staffing during the hours that it is operated. A review of current sales would confirm current trends to confirm the minimum staffing hours required.

Option 2: Currently where the second till is located this could be converted into a coffee station and the till could be utilised as a second till during busy times. This would occupy a larger space than is currently occupied by the second till and would increase the congestion around the staff beverage station while customers wait for their takeaway coffees. The current table talkers would still be utilised for informing customers when their coffee was ready for collection. Recommend investigating both options to see where it is most viable to have the coffee machine located as there will be compromises with both locations. This would require an investment in capex so analysis of current coffee sales and projected sales would need to be evaluated to offset the capex expenditure.

c) Till system

Currently there are 2 tills used in the café but they are standalone machines and are not connected by any software. Sales data is only available from the printed till tape so it is difficult to analyse sales data. I understand that one of the tills is near the end of its life and needs replacing.

The RMO's currently write the total cost of their meal and sign their name on a list. With the current system it is difficult to readily access the data on the items selected and the information on total spend per visit would need to be manually entered into a spreadsheet if it was to be evaluated. As the RMO meal cost is a DHB expense improved reporting on expenditure would enable the DHB to manage this.

To enable the cafeteria manager to analyse sales data to improve sales and be able to monitor trends and forecast production an electronic till system should be investigated. There are two options available:

Option 1: to replace one till and purchase a software package which links the data. This is assuming that the current till can be linked to this software. A quote would need to be sourced for this but should be the cheapest option as it involves only the replacement of one till.

Option 2: to purchase the Point of Sale System which proposes to replace both tills, a software package and software licence.

When comparing the two options it is important to compare their functionality, the ease of producing reports, and ideally separate out the RMO sales data. An analysis of the two systems including reporting function, ease of use and costs will inform the recommendations. This is a good investment as the data can assist with developing the café service and subsequently increasing revenue.

When considering the most viable option consideration needs to be given to the development of the coffee area as this may involve an additional till.

d) Production process

Space is at a premium in this kitchen. It is a compact kitchen which is well designed but has little capacity for expansion. This affects the capacity for production and storage space in the cafeteria kitchen hence the main kitchen facility is used for the production of baked items, sandwiches and rolls, and some of the hot patient menu items.

There is limited space for 2 staff to work in the hot production area which is a hot area with an oven, gas hobs and a hot grill all producing heat and limited air flow.

The kitchen is well equipped for short order items, toasted sandwiches and burgers, which are reported to be popular.

Due to the sandwiches being prepared in the main kitchen there is limited ability in the cafe kitchen to prepare sandwiches during the meal service if stock is running low, as the ingredients are not stocked here. It has also been difficult to accurately cost the sandwiches as they utilise fillings and labour from the main kitchen which can be seen as efficient but from a pure costing perspective is complex to analyse. If sandwiches were prepared on site this would be the flexibility to prepare short order sandwiches as necessary, reducing waste with over production, and costs would be transparent. The current reported concerns from staff for preparing them on site are chiller space and bench space. If chiller space was the concern and an additional chiller was required then the area that currently is used to store drinks could be investigated as a suitable location for a chiller. There is a cold preparation area and if the number of sandwich fillings each day was minimised this may streamline this production and enable it to be prepared onsite. Recommend that the process and location for making sandwiches be explored further.

The cafeteria utilises hot menu items produced in the main kitchen for the inpatient meal service. This is a good use of resources in the main kitchen utilising menu items that are already being prepared but the costing model could be reviewed to ensure that it accurately reflects the true cost.

On the day that I visited the cafeteria the work spaces behind the servery was hot and staff were commenting on this as their main concern. I would recommend that the temperature of this area be monitored by using a temperature logger to evaluate the extent of this problem. Once the extent of the problem is known then a solution can be investigated.

e) Financial Budget (Revenue & Expenditure)

The budget for Nutrition and Food Service has a division for Zacs cafeteria. To ensure that all costs are included a review of the costing model, especially for items produced in the main kitchen for the cafeteria, needs to be undertaken. A clear operating model also needs to be defined around whether the cafeteria is to be cost neutral or if it is to generate a profit, and how the costs associated with the free staff beverages are funded (staff, crockery and consumables cost).

Due to time constraints this was out of the scope of this project.

f) Waste management & minimisation processes

The return of dirty dishes to the kitchen on the trayline into the dish wash area was observed to work well as staff was available at busy times to clear the dirty dishes. Pig bins were in use for food waste and general rubbish was recycled where possible by the café staff.

To ensure sustainable practices a review of the rubbish system in the café providing staff and visitors with the ability to separate out food waste from general waste and recycling. Having a rubbish bin

system with 3 or 4 options for waste would be recommended to separate the waste as shown in the photo below. This would also reduce the time taken for Food Service staff to sort all waste from the conveyor belt.

Current system in Zac's for waste.

Photo of suggested waste management station for Zac's cafeteria. This photo is of Christchurch Hospital cafeteria and was supplied by Canterbury DHB.

At the lunch service there were numerous ready prepared menu items which were heated in the combi oven and then hot held in the hot cabinet. Small numbers were heated at one time to minimise waste at the end of the service. The quantity of the hot main menu item which was produced in the main kitchen is requested based on forecasted numbers. This does fluctuate but staff reported minimal left at the end of the meal service. This is reported to be monitored and orders altered accordingly.

g) General observations

All chilled cabinet food should be clearly labelled with the name of the item. Any item requiring heating should have a label with heating instructions. On the day that I was in the cafeteria for lunch I purchased a "stack" which did not have a label identifying the contents or any heating instructions. The process for this needs to be reviewed.

At 1.30pm on both days that I visited the cafeteria there was limited sandwiches available in the cabinet. This would be improved if the sandwiches were produced on site.

Objective 1.3: Review the MOW management process

a) The type of foods selected and how they are used

There is a 4 week cycle menu for the hot MOW and 10 choices of frozen meals. This provides adequate variety and the frozen meals are a great service for clients creating flexibility for weekends and evening meal options. The menu is suitable for the expected customer group with a roast meal on once every week.

When conducting the annual patient survey enquiring about whether the menu is acceptable and identify any difficulties with reheating the frozen meals. MOW recipients are generally very good at providing feedback when they are unhappy and according the MOW administrator there is seldom any negative feedback.

b) Food purchase, delivery, storage systems

The food purchases for MOW are the same as the main kitchen and this works well.

c) The method by which the food is prepared

All meals are produced fresh on site with the use of fresh, chilled and frozen foods.

d) Kitchen production of frozen meals for MOW

The frozen Meals on Wheels are made utilising the correct modified starch suitable for freezing. The meals are served using chilled and frozen menu items, which are then sealed and put in the blast freezer. The frozen meals are well presented with the clear seals and labels informing clients of the name of the meal, where the meal was produced, storage and heating instructions and a use by date.

These are well presented and have a professional appearance to them.

e) MOW management systems

The MOW administrator is responsible for setting up the clients in the system, producing the daily run sheets with any dietary requirements and is the central person for the clients, accounts payables, Red Cross deliveries and the food service. Accounts payable are responsible for the payments and the MOW supervisor in the kitchen is responsible for production and packaging of the meals.

Currently the MOW administrator works off two different systems, one for the hot MOW and another for the frozen MOW, which do not interface. If a client is ordering both hot and frozen meals this needs to be entered into both systems which is time consuming and can result in errors. An integrated system for both meals would streamline this service.

Personal preferences are catered for and this is printed out the day prior to service to enable the MOW supervisor to highlight special requests and to produce a production sheet. An updated list is printed out again on the day of service to account for changes that may have occurred over the past 24 hours. Recommend reviewing this system so that sheets are only printed out on the morning of service and production is forecasted. Catering to special needs, including which vegetables they do not like, may need to be reviewed to streamline this service.

f) General comments

Recommend that the MOW administrator visit the kitchen to observe a meal and to discuss the menu items to enable her to answer the queries from MOW recipient's queries.

The hot meals are packaged in the foil containers without labels. It assumes that the client has the information sheet about MOW readily available with the menu on it. This is common practice and recipients seem to **manage** with this. A date stamp on the lid would be recommended as it confirms when the meal was produced and would assist clients when these meals are stored in the fridge at home.

The only information provided to the client about food safety is the following statement written in the information pamphlet "It is expected that the hot meals are eaten at the time of delivery." But it also

states “Please provide a suitable container if you are out when delivery is expected”. These statements conflict as if they are not home the meal cannot be eaten when it is delivered therefore the meal does require some information about when it needs to be consumed by and safe reheating instructions. At a minimum the label should have the date. Information should be provided to the client about safe reheating, even if it is not recommended, as it is known that clients do reheat the meal and it is better that this is done safely. This information could be either on the label or in the client information sheet.

Currently the costing for MOW includes the supervisor and the cook but needs to be reviewed to include the labour of the kitchen assistants serving at trayline and purchasing and receiving costs. MOW produces a significant number of meals which forms a significant role within the Food Service and the true costs need to be reflected in the costing model.

2. Wairoa Medical Centre & Central Hawke’s Bay Health Centre

Objective 2.1: Review the External Area business model and operating process including but not limited to:

As I was unable to visit either site due to the limitation of this project the responses below are based on discussions with the Nutrition and Food Services Manager. These discussion on the current known processes and rationale for these services, and potential opportunities for the future are reflected in the section below.

a) Central Hawkes Bay Food Services and systems

The Central Hawkes Bay Healthcare Centre is based in Waipukurau and is a relatively new building with limited cooking facilities. The local café, Zinc, has the contract to provide the lunch and dinner service, and the MOW’s with a 2 week cycle menu.

The breakfast for the inpatient meals is prepared by the Health Centre staff which consists of stewed fruit, cereal and toast. There is a domestic dishwasher on site for the breakfast dishes and the beverage cups. Lunch and dinner meals are delivered on insulated trays and after the meal service the trays and dishes are returned to the café for washing. This contract is managed by the Charge Nurse for the Health Centres and earlier this year there was a complaint raised about the quality of the meals and the Nutrition and Food Service Manager was contacted. There is a system in place for monitoring the meals and there is a relationship between the Health Centre Charge Nurse and the Manager Nutrition and Food Services.

Due to the small number of meals, the location and limited on site kitchen facilities this may be the best way to manage this service. Without seeing the Health Centre facility, the cafe and the meals this is difficult to comment on but I can identify opportunities for the future.

This is a small centre with a small number of meals but it remains a service under the Hawkes Bay DHB and warrants further input to ensure that the meals are of a required standard and quality. It would be recommended that this be proactively monitored rather than responding to complaints.

Working together with the Charge Nurse it would be recommended that there is a 6 month site visit to monitor the service including a review of the menu, food safety practice of staff on site and café, quality of the meals, costing model and patient satisfaction surveys to ensure that the service is fit for purpose. This will need to be developed over time.

b) Wairoa Food Services and systems

The Wairoa Health Centre is an integrated GP centre with inpatient hospital beds attached to this facility. This is an older facility with a relatively large kitchen which was used previously for producing a larger number of meals.

In this facility ward staff serve the breakfast of stewed fruit, cereal and toast which is provided by the kitchen. The facility employs one cook who is rostered to work 8 hours per day to prepare the lunch and dinner for up to 8 beds daily and approximately 25 MOW 5 days a week.

Working together with the site manager to visit the site 6 monthly monitor the service including review of the menu, food safety practice, purchasing practices, quality of the meals, costing model and patient satisfaction surveys to ensure that the service is fit for purpose. This would also be good for developing relationships between the facility and the Manager Nutrition and Food Services to enable them to work together in the future to ensure that the foods service is of a high standard, meets the clients' needs and is value for money. MOW numbers are reported to have been static for some time, while numbers are growing in Hastings and Napier area, so it would be ideal to review this service to see if it currently meets the clients' needs and whether there is any capacity to increase this service.

This food service is reported to be a large kitchen facility which is currently underutilised with the current meal numbers. Recommend that this facility be reviewed to explore options for expanding this service, if the current equipment is functional, to potentially include a staff café facility or provide function catering to the neighbouring businesses. If expansion is not viable is it possible to reduce the kitchen footprint as a large area requires more cleaning and there may be energy efficiencies to be gained. The excess space could also be used for other purposes.

HAWKE'S BAY District Health Board Whakawāteatia	**Youth Health Strategy 2016-19**	67
	For the attention of: **HBDHB Board**	
Document Owner: Document Author(s):	Caroline McElnay, Director Population Health Nicky Skerman, Population Health Strategist Women, Children and Youth	
Reviewed by:	Executive Management Team, Māori Relationship Board (MRB), Clinical and Consumer Council	
Month:	June 2016	
Consideration:	For endorsement	

RECOMMENDATION

That the Board:

Endorse the Youth Health Strategy 2016-19.

17

OVERVIEW

The Hawke's Bay community is invested in youth across multiple levels and sectors, frequently sharing common population groups and mutual visions. Hawke's Bay DHB funds the most contracts locally for youth services alongside other funding sources such as; Ministry of Health, Ministry of Social Development, Ministry of Education, Ministry of Youth Development and Councils.

This Strategy has the potential to create opportunities across the Hawke's Bay region to improve the responsiveness of services for youth. It aims to convey a shared vision from both Hawke's Bay youth and stakeholders by identifying a common set of youth outcomes and indicators that cut across the work of many organisations/services working with youth.

Though there are many commonalities in how organisations/services talk about their goals and impact, the lack of shared knowledge can lead to missed opportunities for collaboration and collective impact.

BACKGROUND

Consultation on the Youth Health Strategy commenced in October 2015. Members of HB Consumer Council were consulted around the best approach for the development of a strategy for youth health that included both youth and stakeholder voices.

Youth health specialists Dr Vicky Shaw and Anita Balhorn were contracted to assist with the writing of the Strategy utilising their expertise in the area of positive youth development. We asked stakeholders and youth what their view was of a healthy young person.

Consultation has taken place with stakeholders from various services such as; youth probation, Central Health, TTOH, NZ Police, YROA YNOT, Disability Services, and DHB staff from various

specialities. Youth from across all age groups and ethnicities were also engaged as stakeholders. Recent youth health research for the Hawke's Bay region and nationally was also used in the development of the draft Strategy.

The concept of the Strategy was discussed at HB Consumer Council, MRB and the Pasifika Health Leadership Group in March with feedback and recommendations noted in developing the draft.

Further stakeholder meetings were held in early May to seek feedback on the draft strategy and the draft Strategy was presented to HB Consumer Council, Clinical Council and MRB in May for discussion and feedback.

This Youth Health Strategy has now been endorsed by the commitees and comes to the Board for final endorsement.

What did the stakeholder and community input say?

The input received from these groups and people reinforced the evidence, with the following themes:

- A shorter document to engage decision-makers key points read in 5-10 minutes
- A more visual document
- Recommendations rather than a plan
- Clarification around youth representation on governance group going forward
- Positive feedback around the emphasis on developing collaborations and linkages
- Pleased to see consultation with youth

HOW HAVE WE RESPONDED TO COMMITTEE FEEDBACK?

The HBDHB committees represent a diverse range of interests and have provided a wealth of insight and feedback in the development of this Strategy. Below is a summary of feedback requesting changes and responses from the plan authors.

Committee/s	Feedback	Response	Page reference
EMT	It reads very much like a DHB Strategy.	Noted. Implementation will be in collaboration with other sectors	--
	There needs to be greater linkages to other strategies,	Linkage to the Regional Economic Development Strategy and other strategies has been included.	P7
	What input has been received from GPs	Health Hawkes Bay attended the consultation process. Draft Strategy was put on the Health Hawkes Bay PHO portal for GPs to provide feedback.	--
	It would be helpful to include a definition for youth.	Definition added.	P4
	It would be good going forward to have some clear outcome measures that demonstrate it is working.	High level outcomes are listed on page 4. Performance measures have been developed using the result based accountability framework. They have not been included in the paper but are available on request.	--

Committee/s	Feedback	Response	Page reference
Clinical	Provide primary care more time to comment on the draft Strategy.	Feedback timeline was extended.	--
	Include links to other plans/ strategies (e.g. Healthy Eating Plan and Suicide Prevention/ Postvention Plan)	Linkages made to other strategies as suggested.	P7
	Make more reference/links to family violence	There is more information around family violence from the Hawkes Bay Youth 2000 series. A link to the MOH National Family Violence Assessment and Intervention Guidelines 2002. Kahungunu Violence Free Iwi Strategy Action Plan "Te Wero A violence free Kahungunu".	P7 P12
Consumer	Suggested data be included for youth with disabilities	To drill down via age is a possibility going forward.	--
	Meet with individual members from Consumer Council re youth issues	Met with Nicki Leishman (MSD) and Jim Morunga (Te Kupenga Hauora) to discuss their feedback.	--
Māori Relationship Board	Integrate the suicide strategy and what it means for youth to be healthy	What it means for youth to be healthy is addressed throughout the Strategy. References have been included on the Suicide Prevention and Postvention Plan, Best Start: Healthy Eating Plan.	P7
	The language of the young people should not be changed	Direct quotes by youth have been included throughout the Strategy.	--
	Link with Ngāti Kahungunu Inc. on what they may be undertaking re youth plans	Kahungunu Violence Free Iwi Strategy and Action Plan for a Violence Free Kahungunu is referenced. Ngāti Kahungunu Inc. does not have a youth strategy as such but does undertake many programmes with rangitahi. Met with Ngāti Kahungunu Inc. Requested meeting with Maunga Haruru Tangitu Trust. The Strategy has been sent for feedback.	--
	Set up governance across the sector including youth. Involve Māori Health Service.	Once the Strategy has been endorsed by HBDHB Board, a governance group will be formed and include membership from Māori Health Service.	--

NEXT STEPS

Once the Youth Health Strategy has been endorsed by HBDHB Board, a governance group will be established that includes youth membership. The recommendations listed in Appendix One will be considered by this group and a prioritised action plan developed. Operational teams will then implement the action plan. Regular reporting against this plan and outcome measures will be established. We will report to the Board on progress against this Strategy in July 2017.

Youth Health Strategy 2016-2019

Creating Healthy Opportunities for Youth 2016 – 2019

"Strong leadership to commit to what young people want"
17year old Hawke's Bay youth

Hawke's Bay District Health Board

OUR VISION

"HEALTHY HAWKES BAY"

"TE HAUORA O TE MATAU-A-MAUI"
Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community.

OUR VALUES / BEHAVIOURS

- **TAUWHIRO** - delivering high quality care to patients and Consumers
- **RARANGA TE TIRA** – working together in partnership across the Community
- **HE KAUANUANU** – showing respect for each other, our staff, patients and consumers
- **AKINA** – continuously improving everything we do

VISION Hawke's Bay Health	**"Healthy Hawke's Bay" "Te hauora o te matau-a-maui"** Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community.	**Mai Māori Health Strategy 2014 - 2019** Māori taking responsibility for their own health at a whānau, hapū and iwi level.	**Pasifika Health Action Plan 2014 - 2018** Healthy and strong Hawke's Bay Pacific community that is informed, empowered and supported to improve the management of their health and the health of their families.
AIMS	**The Hawke's Bay Health System - Transform and Sustain for 2013-2018:** The three broad aims are: 1. Responding to our population. 2. Delivering consistent high-quality health care. 3. Being more efficient at what we do.	**Mai Māori Health Strategy 2014 - 2019** Focuses on engaging better with whānau, delivering consistent high quality care and more efficient use of resources. Mai seeks to work toward an integrated health sector that takes responsibility for responding to the needs of Māori in the way they prefer services and care.	**Pasifika Health Action Plan 2014 -2018** Better health service response to Pacific health needs through a collaborative approach with Pacific communities that will lead to improvements in health and wellbeing.

17.1

CONTENTS

Executive Summary

OUR GOALS FOR YOUTH

This Strategic plan for youth aims to convey a shared vision for young people by identifying a common set of youth outcomes and indicators that cuts across the work of many organisations/services working with youth. Though there are commonalities in how organisations/services talk about their goals and impact, the lack of shared language across the services can lead to missed opportunities for collaboration, alignment and collective impact. Our vision is that this framework enhances organisations/services individual and/or collective ability to define, communicate about, develop, and implement strength-based models to influence outcomes that ensure all youth are thriving in New Zealand.

OUR OUTCOMES FOR YOUTH

The youth development approach calls for a balance between services designed to prevent, intervene or treat health problems and efforts that promote development through preparation, participation and leadership experiences with youth. Creating synergy to meet the needs of youth in the full context of their lives will result in healthy opportunities for youth and sustainable benefits for the community overall.

This framework is intended to provide a basic listing of outcomes and corresponding indicators. It does not capture complex relationships among outcomes and indicators or developmental differences.

17.1

GOALS What do youth need for healthy development	Healthy & Safe	With Connections	Productive	Health System Resiliency	Community Inclusiveness
OUTCOMES How will we know youth have achieved healthy development	**Thriving** ▪ Healthy/active living ▪ Social/emotional health ▪ Safety/injury prevention	**Engagement & Inspiring** ▪ Positive identity and relationships ▪ Social/emotional development ▪ Cultural competence ▪ Community connectedness ▪ Social responsibility and leadership development	**Learning & Working** ▪ Engagement in learning ▪ Learning and innovation skills ▪ Academic achievement ▪ Tertiary access and success ▪ Career awareness ▪ Workforce readiness ▪ Employment	**Leadership & Youth Involvement** ▪ Commitment to adolescents and youth development ▪ Partnerships and collaborations for health and development ▪ Programs and services ▪ Advocacy ▪ Youth involved in governance and leadership ▪ Youth as community change agents	**Innovation & Integration** ▪ Whānau and community supported ▪ Resources and opportunities ▪ Strength based focus ▪ Youth as part of the community ▪ Collaborative and multi-sectoral ▪ Outcome driven

Definition of Youth: Ministry of Youth Development Strategy Aotearoa (2002) defines youth 12-24 years.

Overview

"Young People are a resource to be developed not a problem to be fixed". (Joy G Dryfoos 1998)

This statement began a journey of discovery in the 1990s to advocate for adolescent development and collaborative service models for ensuring that children are healthy and ready to learn. Two decades on and this emphasis on positive development for the wellbeing of the 'whole young person' is strongly echoed today and by youth in Hawke's Bay.

The World Health Organisation's Global Strategy[1] emphasis is to transform societies to create opportunities for thriving children and adolescents, which in turn, will deliver enormous social, demographic and economic benefits.

Creating healthy opportunities and working together in communities will enable the rights of youth to wellbeing. Our goals have the enduring theme and commitment to:

- Youth are thriving in Hawke's Bay
- Youth are fully prepared, fully engaged and actively participating in communities

Hawke's Bay District Health Board (HBDHB) is investing in a Youth Health Strategy 2016 -2019. This Strategy seeks to improve the responsiveness of Hawke's Bay health services for youth. In order to achieve this outcome research indicates strengths based models utilising Positive Youth Development are proven to be most successful.

'Shift the paradigm from preventing and "fixing" behaviour deficits to building and nurturing "all the beliefs, behaviours, knowledge, attributes, and skills that result in a healthy and productive adolescence and adulthood"[2]

The Positive Youth Development approach, calls for a focus on young people's capacities, strengths and developmental needs and not solely on their problems, risks or health compromising behaviours. It recognizes the need to broaden beyond crisis management and problem reduction to strategies that increase young peoples' connections to positive, supportive relationships and challenging, meaningful experiences. While health problems must be addressed and prevented, youth must also be prepared for the responsibilities of adulthood.[3]

Professor Robert Blum (United Nations Advisor)[4] recommends: A Framework for Healthy Adolescence *or what young people need for healthy development:*

Five Outcomes to achieve by age 15 for healthy development:

- Academic engagement
- Emotional and physical safety
- Positive sense of self/self-efficacy
- Life and decision-making skills
- Physical and mental health

Youth in Hawke's Bay report healthy is

Feeling supported and accepted

Positive relationships with parents and connections with others

Good headspace

Positive influences

Independence

Taking responsibility

Research continues to inform us of the sustainable benefits and high returns from investing in women's, children's and adolescents' health. 70% of preventable adult deaths from non-communicable diseases are linked to risk factors that start in adolescence.

[1] United Nations Secretary General. Global Strategy for Women's, Children's and Adolescents Health 2016 - 2030
[2] Dr Karen Pittman. The Forum for Youth Investment, Ready by 21
[3] Becky Judd. The Forum for Youth Investment, Incorporating Youth Development Principles into Adolescent Health Programs 2006
[4] United Nations Advisor Professor Robert Blum. A Framework for Healthy Adolescence *or what young people need for healthy development. MSD Jan 2016*

Snapshot of Today 2016

If we take a snapshot of where we are today with our responsiveness to youth, we know the Hawke's Bay community is multicultural and invested in youth across multiple levels and sectors. However, youth report they are uncertain around understanding and navigating access and utilisation of multiple services.

Case scenarios: 'everyday life for some teens'

14year old male living in a blended family, attending school with no learning difficulties, has reliable friendships and plays sport regularly for his school and a club. He has just broken up with his girlfriend of the last 9 months.

16year old female living in a single parent family with six siblings (oldest child), irregularly attending school – recently saw school counsellor for low mood due to bullying; smokes, has few friends, mostly spends time at home to help out with siblings.

One of these young people would be considered to be well supported and the other not. However the negative outcome for both could be the same. Currently there are funded services to meet the needs described. Both young people have access to services in the community such as:

- Schools e.g. teachers, deans, school counsellors, social workers in schools (SWIS)
- School Based Health Services (SBHS)
- Youth One Stop Shop (YOSS)
- Primary Care Provider (PCP – GP practices)
- Primary Healthcare Organisation (PHO) Packages of Care (PCP and/or NGO)
- Non-Government Organisation (NGO) Youth Services
- Iwi wraparound Services
- Pacific Health Promotion Service
- Child Adolescent & Family Service (CAFS)
- Community programs e.g. sports, after school, cultural groups
- Church support/programs/groups
- Accident & Medical

However, young people report barriers to accessing and utilising services. Many services work in isolation of each other; services use separate client databases (e.g. limited ability for timely information sharing), differing eligibility criteria, and differing standards for quality services and/or service requirements.

Returning to our two young people; in accessing services the young person may have:

- potentially told their story seven or more times
- engaged via the same/different/no screening tool with different services with same/differing results
- problems identified and fixed, yet normal daily functioning still declining
- engaged with multiple providers but young person indecisive/unmotivated about care plan led by services
- received counselling from three different counsellors and possibly three different therapeutic interventions,
- been put off by the negative stigma of needing help or perceived by peers to be needy/damaged therefore unwilling to access services
- been put off due to lack of youth friendly service
- peers as the only source of information relating to chosen service – young person is misinformed or may be perceived lack of confidentiality
- not accessed any services as uncertain of what support they need or will receive

The only way to change the odds for all youth is to **work together** differently to **create healthy opportunities** for youth to thrive.

"Support 100% and work together"

"Walk the Talk and Take Action"

Pacific Youth

17.1

Introduction

Over the last few years HBDHB have reviewed the needs of our multicultural community and acknowledge the future population projections indicate this will increase. The HBDHB strategic plans reflect the health system in partnership with Māori and Pacific. It is important to promote the synergy of all the strategic plans which the Youth Health Strategy is aligned to. The underlying principles are weaved throughout the goals and outcomes that all youth in Hawke's Bay are thriving with healthy and productive adolescence and adulthood.

The Hawke's Bay Health System - Transform and Sustain for 2013-2018:
The three broad aims are:

1. Responding to our population.
2. Delivering consistent high-quality health care.
3. Being more efficient at what we do.

The strategy acknowledges "organisations need to work together with a focus on prevention, recognizing that good health begins in places where we live, learn, work and play long before medical assistance is required".

Mai - Māori Health Strategy 2014–2019: This strategy 'Mai' means 'To bring forth' and relates to Māori taking responsibility for their own health at a whānau, hapū and iwi level. Mai focuses on engaging better with whānau, delivering consistent high quality care and more efficient use of resources. Finally, Mai seeks to work toward an integrated health sector that takes responsibility for responding to the needs of Māori in the way they prefer services and care. (HBDHB MAI)

The Pasifika Health Action Plan is a four year building block: At the core of improving Pacific health is the need for families, community groups and services to do things differently. The six key priority areas are:

1. Pacific workforce supply meets service demand.
2. Systems and services meet the needs of Pacific people.
3. Every dollar is spent in the best way to improve health outcomes.
4. More services delivered locally in the community and in primary care.
5. Pacific people are better supported to be healthy.
6. Pacific people experience improved broader determinants of health.

It is important to acknowledge other strategic plans that are fundamental to the wellbeing of Youth. We know there are increasing rates of obesity and suicide amongst Youth. Other strategies that align with the Youth Health Strategy are listed below:

- HBDHB - Best Start: Healthy Eating and Activity Plan (2016 -2020) aims to improve healthy eating and active lives for Hawke's Bay children.
- HBDHB - Suicide Prevention and Postvention Plan 2015-2017 aims to ensure Hawke's Bay has a clear pathway to:
  - Reduce suicides
  - Minimise presence of suicidal behaviour
  - Access appropriate care
  - Build community/workplace resilience
- MOH Family Violence Assessment & Intervention Guidelines "Child Abuse and Intimate Partner Violence 2002"
- Te Wero "A Violence Free Kahungunu" (Kahungunu Violence Free Strategy Action Plan)
- HBRC - Regional Economic Development Strategy 2011

This Youth Strategy aims to determine how to get the best outcomes for youth to thrive in Hawke's Bay, determine how it will be achievable, and how we will know if it has been achieved.

The Positive Youth Development provides a framework for examining thriving in youth and has been useful in promoting positive outcomes for all youth.

This perspective sees youth as resources to be nurtured and focuses on the alignment between the strengths of youth and resources in the settings that surround them as the key means of promoting positive outcomes.[5]

Successful youth outcomes include the development of attributes such as competence, confidence, character, connection, caring, and contribution. The development of these positive attributes is thought to foster positive outcomes during adolescence such as:

- improved self-care
- greater academic achievement
- higher quality interpersonal relationships
- overall improved wellbeing

These attributes are also believed to be critical in promoting successful adult development and improved health outcomes.[6]

This shows the healthy opportunities could continue through into adulthood due to the synergy with the principles in all the strategic plans supporting "for the people by the people - mo te iwi i te iwi".

New Zealand Research

During the 1990s New Zealand youth had high incidences of morbidity and mortality but little local research to help define what the needs were and therefore enable appropriate health provision to improve health outcomes. Two significant research groups have been key contributors to the evolvement of youth health over the last two decades.

1. The Christchurch Health and Development Study (CHDS) has been in existence for over 35 years. CHDS followed the health, education and life progress of a group of 1,265 children born in the Christchurch urban region during mid-1977. The cohort has now been studied from infancy into childhood, adolescence and adulthood resulting in many reports reflecting the life course.
2. Adolescent Health Research Group (AHRG) was established in the late 1990s to undertake the Youth 2000 National Youth Health and Wellbeing Survey series. Over 27,000 young people have participated in 2001, 2007 and 2012. The samples of New Zealand secondary school students completed an anonymous comprehensive health and wellbeing survey. The results from these surveys provide comprehensive and up to date information about issues facing young people in New Zealand.

This research, along with other New Zealand and international evidence, continues to significantly transform developments for youth in policy, funding and provision of services, intersectoral partnerships and collaboration, programs, community integration, and workforce development.

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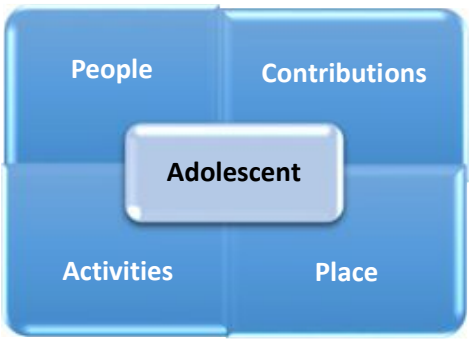


PCAP – A Model for Promoting Youth Health & Development

Adolescents need to be connected to:

- People – an adult who cares, who is connected, a network of adults
- Contribution – opportunities to contribute
- Activities – school/ community to develop a sense of connection/ belonging
- Place – safe places for youth

[5] Krauss,SM. Pittman,K J. Johnson, C. Ready By Design The Science of Youth Readiness Mar 2016

[6] Gary R. Maslow, Richard J. Chung

What Do We Know about Youth in Hawke's Bay?

It is important to acknowledge what we know in order to plan for the future of our youth:

- How healthy are young people in Hawke's Bay?
- How well do we respond to their needs?
- In what areas do young people need us to improve?

World Health Organisation defines youth as 10-24 years old. The latest census in 2013 provides data on age and ethnicity breakdown of youth 10–24 years old in Hawke's Bay.

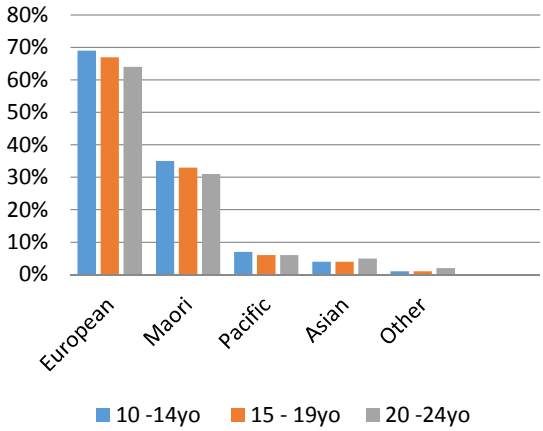
1. Hawke's Bay Region Census Data 2013:

Table 1: Demographics of Youth

	Total Population	**151,179**	
	Total Youth Population	29,199	19%
Gender	Male	14,016	48%
	Females	15,183	52%
Age Groups	10 -14yo	11,178	7%
	15 – 19yo	10,089	7%
	20 – 24yo	7,932	5%
District	Hastings	14,016	48%
	Napier	11,388	39%
	Wairoa	1,460	5%
	Central Hawke's Bay	2,336	8%

Nearly 20% of the population in Hawke's Bay are aged between 10-24 years old. There are slightly more females than males. Most of the youth are between 10-19 years old e.g. predominantly school aged. Most of the youth tend to live in the urban areas of Hastings 48% and Napier 39% with 8% living in Central Hawke's Bay and 5% in Wairoa.

Table 2: Ethnicity



The 2013 census data presents a multicultural society in Hawke's Bay. Two-thirds of youth are European, nearly one-third are Māori, nearly 10% are Pacific, and Asian and other ethnicities make up 5% of the remaining youth. The ethnicity make-up is consistent across the current youth age groups. Projections for the next 10 years show an increasing proportion of youth will be Māori, Pacific or Asian.

The Hawke's Bay census data collated by the HBDHB highlighted the needs of our youth. In Hawke's Bay our youth show some health trends and risk factors higher than the New Zealand average:

- Teenage pregnancy
- Sexually transmitted diseases
- Suicide rate
- Diagnosed mental health disorders e.g. anxiety, depression
- Smoking prevalence
- Sole parents benefits for under 25
- Unemployed
- Involvement with justice e.g. apprehension

Stakeholder's feedback

"We need to resource the family needs alongside the young persons to ensure positive outcomes can be sustainable"

This is consistent with information provided from NZ Epidemiology Group and Adolescent Health Research Group.

Implications for health services:

Hawke's Bay youth clearly identify barriers to access and utilisation of services which may contribute to the higher rates of risk factors around behaviour or lifestyle choices that are preventable. While some barriers lie outside the health system, such as financial barriers due to inequities e.g. income inequalities, ethnicity, age, sexual orientation, others are more directly the responsibility of health services.

"Developing and implementing standards for quality youth health and development services is a way to minimize variability and ensure a minimal required level of quality to protect adolescents' rights in health care". [7]

Young people report barriers to accessing services

- "Agencies need to be more approachable – people too bossy"
- Lack "Supportive and non-judgemental helpers"
- "Better PI Programmes that are relevant to youth"
- Workforce able to relate to their needs – "REAL" – life experience
- Re-brand from negative – ('problem focused') to normalised access for positive wellbeing – "remove stigma of being broken or damaged"
- Unable to get to services
- Later hours and longer hours for clinics
- Want access to knowledge – "ask them, not assume"

Youth Focus Groups & Pacific Youth Survey 2016

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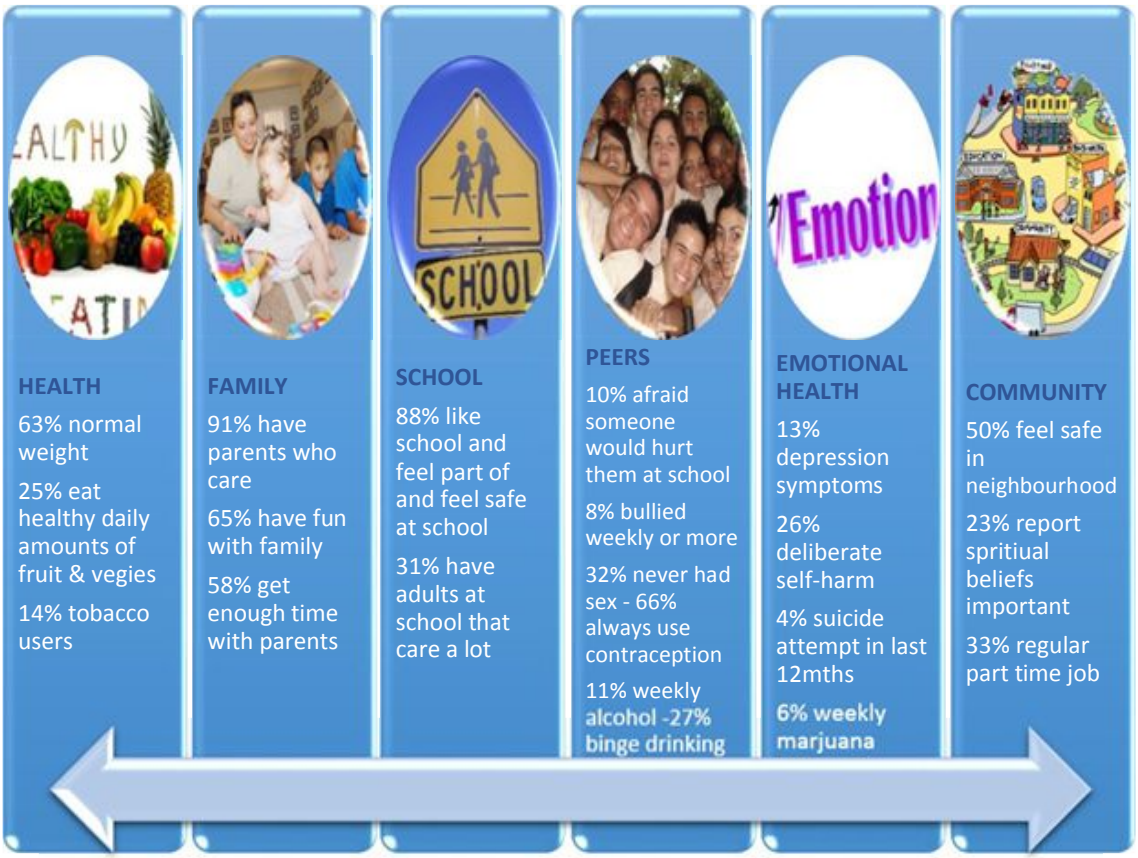
[7] World Health Organisation. Policy Brief: A standards-driven approach to improve the quality of health-care services for adolescents 2014

2. Youth 2012 (Adolescent Health Research Group - AHRG): Hawke's Bay Youth report

Hawke's Bay youth (aged 12 – 18 years old) were surveyed in 2012 at school (482 students) as part of a national youth survey. A broad range of schools participated and were well represented across the decile school system for Hawke's Bay. Dr Simon Denny has provided an overview of Hawke's Bay data alongside national trends.

Figure 1: 'How a teen views the context of their lives' – trends from Youth 2000 survey series



In 2012 the questionnaire asked diverse questions about areas that affect young peoples' wellbeing; from languages spoken, to home and school life, employment, community contributions, and health behaviours.

The Youth survey series indicates physical activity and eating fruit and vegetables have changed very little since 2007 nationally. In Hawke's Bay where it would be expected there is more access to fresh fruit and vegetables our youth report low healthy daily amounts. Over a third of Hawke's Bay youth do not rate themselves within a normal weight. This is a large percentage of youth who consider they are not healthy with the likely impact affecting behaviours/choices, and/or normal functioning, and therefore increasing/adding to their risks or potential for vulnerability. The youth survey series reports nationally that the high proportion of students who are classified as overweight or obese by BMI has not improved over time. In fact, nutrition and obesity is one of the areas where AHRG have seen things worsen for specific groups of young people.

Family relationships are incredibly important for young people to be healthy, safe and happy. The youth survey series showed over the past decade Hawke's Bay young people are well connected to their families. They know they have parents who care about them and are happier with 'how their family gets along'.

What hasn't improved for Hawke's Bay young people is their perception of getting enough time with their parents. Over 40% of young people feel they do not get enough time with their families.

We know that students who feel safe and supported by their schools are likely to stay longer and do better academically. The findings show that Hawke's Bay students feel connected to school environment. However only a third feel that they have an adult at school who cares about them. This is slightly better than the national average. At this stage of their development and the need to nurture their skills, beliefs, and attitudes it would appear there is momentum for further improvement collectively.

Substance use is one of the most dramatic and exciting changes in the past decade. Nationally, smoking regularly has reduced 56% since 2001. Regular marijuana use has reduced 60% and binge drinking has reduced 43%. However, Hawke's Bay young people report higher trends with substance and tobacco use.

New Zealand has very high rates of suicide. The Youth 2000 survey series shows that suicide attempts have decreased since 2001, but have remained stable since 2007. Hawke's Bay young people report significant depressive symptoms that will affect their ability to function in everyday life. The suicide rates for young people in Hawke's Bay is above the national average. These rates are still unacceptably high.

If we consider how young people want services to work with them in relation to the 'context of their life' Hawke's Bay youth report the need for more caring adults in their lives and more time spent with them. Does this need reflect our higher trends with health risk factors (e.g. substance use and depressive symptoms) and reinforce strength based approaches for future health gains for youth in Hawke's Bay?

Contrary to popular belief most young people in secondary schools are not sexually active. 75% of young people in 2012 in New Zealand secondary schools have not had sex. The survey data shows that the use of condoms and contraception however has not improved over time – it remains remarkably similar over the past 10 years. Hawke's Bay young people report one third of those having sex do not use contraception/condoms. This also is supported by our higher rates of teen pregnancy. This suggests that we still need to make significant improvements to access to health services for health literacy and contraception/condoms.

The major cause of death and injury among New Zealand young people is motor vehicle crashes. In Hawke's Bay nearly one-third of young people surveyed report binge drinking. This would indicate we still have young people at risk of poor decision making resulting in high risk behaviours.

Violence is distressing for young people - and it is very heartening to see nationally that fewer young people are being hit or harmed on purpose, been in physical fights and had been sexually abused. In Hawke's Bay 15% of young people are witnessing adults at home hitting or physically hurting a child in the last 12 months. There is still considerable work to be done in this area.

Two of the issues that have worsened over the past decade are related to the socio-economic environments of young people. There has been a 38% decrease in young people who have paid part-time employment and a 50% increase in the number of young people who say their families worry about not having enough food.

Both of these things affects a young person's ability to function well in society and can impact on their future.

Implications for health services:

- New morbidities will drive future health service need (nutrition, behaviour, mental health, co-morbidities)
- Prevalence of new morbidities is high – determining where service provision can be more pro-active for Youth access and utilisation e.g. primary care or specialist or secondary care or interdisciplinary to the needs
- Young peoples' worlds are on-line and self-directed - information is everywhere secondary care or interdisciplinary to the needs

The above implications can affect a young person's ability to function well in society and can impact on their future.

These implications will require a renewed look at workforce development to meet the changing needs and wider scope of professionals' involvement in health care for adolescents at the primary and referral levels. The workforce may need to be more multidisciplinary to minimize addressing needs in silos.

Training programmes need to be influenced by the changing nature of developmental needs driving outcomes. This may require more emphasis on chronic and preventive care models. This shift highlights the need for designing competency-based educational programmes that emphasize the developmental and contextual aspects of adolescent health, and enhance competencies in consultation, interpersonal communication and interdisciplinary care.[8]

[8] WHO. Core Competencies in Adolescent Health and Development For Primary Care Providers 2015

Journey of Discovery

Research continues to inform us of the sustainable benefits and high returns from investing in women's, children's and adolescents' health. 70% of preventable adult deaths from non-communicable diseases are linked to risk factors that start in adolescence.

A visiting global expert on teenage health gave New Zealand a glowing report card, with one exception – our high youth suicide rate. UN Advisor Professor Robert Blum, says "fewer Kiwi teens are drink driving and smoking, but parents and teachers need to make them feel better connected. New Zealand's poverty levels too need attention."

Professor Robert Blum recommends:

A Framework for Healthy Adolescence *or what young people need for healthy development:*

I. **Five Outcomes to achieve by age 15 for healthy development**
   - Academic engagement
   - Emotional and physical safety
   - Positive sense of self/self-efficacy
   - Life and decision-making skills
   - Physical and mental health

II. **Three Parental Behaviours Critical for Healthy Adolescent Development**
   - Connection
   - Encouraging autonomy
   - Behavioural regulation

   (Barber and Stoltz, 2005)

III. **Positive Communities create**
   - Safety and structure;
   - Belonging and group membership;
   - Personal empowerment;
   - Control over one's life;
   - Competence;
   - Closeness with peers and nurturing adults.

   (Kirby & Cole)

[9] Wayne Francis Charitable Trust –Youth Advisory Group 2011 Positive Youth Development in Aotearoa "Weaving connections - Tuhonohono rangatahi"

Our youth in Hawke's Bay reinforce what global experts tell us about what is important for their resiliency and healthy development.

We can work together to increase opportunities for young people to thrive such as improve responsiveness of services, ensure safer neighbourhoods and ensure access to high quality education and resilient health system. The journey is more successful when the young people own it, have the sense of identity, and abilities to be pro-active and seek out supports and opportunities to meet their needs.

We are very fortunate to have New Zealand based literature and evidence to support models of Positive Youth Development including Māori and Pacific. Below is a brief outline of each to highlight the common theme and principles to support the paradigm shift from "fixing to nurturing" and recognise the full context of wellbeing for youth.

1. **Positive Youth Development in Aotearoa NZ[9]**

   In essence this framework suggests that both informal and formal initiatives, activities and programmes intentionally weave connections by integrating two key focuses and adopting three key approaches. This model supports creating key partnerships and systematic change.

   The framework outlines:

   1. Key outcomes:
      - Developing the whole person
      - Developing connected communities

   2. Key approaches
      - Strength based
      - Respectful relationships
      - Building ownership and empowerment

2. **Whānau Ora (Māori Health Strategy MAI)**
   The philosophy and policy of Whānau Ora begins with acknowledgement of whānau as the tahuhu (backbone) of Māori society. A key principle of our transformation is that consumers and whānau are at the centre of care rather than any provider or care setting.

   Whānau Ora embodies six key outcomes:
   - Whānau self-management
   - Healthy whānau lifestyles
   - Full whānau participation in society
   - Confident whānau participation in Te Ao Māori
   - Economic security, and successful involvement in wealth creation
   - Whānau cohesion

3. **Kautaha**
   A strengths-based approach to building health and wellbeing. Kautaha is a model for working together towards a common goal. It is underpinned by a set of related and coherent principles that takes a unified approach and focuses on strengths, potential, and solutions rather than on accentuating problems and deficits. For these reasons the Kautaha approach has been highly effective across history and could be successfully adapted to collective endeavours such as Fanau Ola, socio-economic and community development. *(Health Promotion)*

All the models presented endorse the underlying principles of strength-based approaches. These models' successes relies on the young person/rangatahi in the centre with strong connections to family/whānau for nurturing, and areas that enable and empower the young person to developmentally mature, filling their kete with skills, knowledge, and abilities to cope with life experiences through connections with family/whānau, school, work, peers, and community. This is particularly voiced by the young people as what 'matters for their wellbeing'.

This is even more critical when we focus on vulnerable youth. Because "problem-free is not fully prepared, and fully prepared is not fully engaged"[10]. Positive Youth Development ensures we focus on all aspects of their lives rather than only reduce risk or fix problems. It is dangerous to be caught in the "fix then develop" fallacy. This argument holds that we must address problems facing young people who are vulnerable, involved in risky behaviours, or experiencing adversity before they can take advantage of any opportunities focused on their growth. This approach is not supported by research.[11] This has led to an over-emphasis on problem reduction as an acceptable goal for some sub-populations of young people. This has often resulted in service dependency and lack of control for one's own wellbeing by youth and/or whanau, or practices that do not match positive youth development for positive outcomes. In some cases, problem focus approach explicitly runs counter-productive to positive outcomes; e.g. the need to fix problems far outweighs the capacity and capability to build strengths.

This is an opportunity for services to encourage:
- the development and evaluation of consistent/universal standards of quality care for youth
- promote excellence and innovation in the education and training of child and youth health professionals e.g. incorporate WHO core competencies for working with youth
- stimulate and promote the development of new knowledge
- promote the uptake and implementation of evidence-based practice and policy that can lead to improvement in child and youth health outcomes

"Good habits formed at youth make all the difference" Aristotle

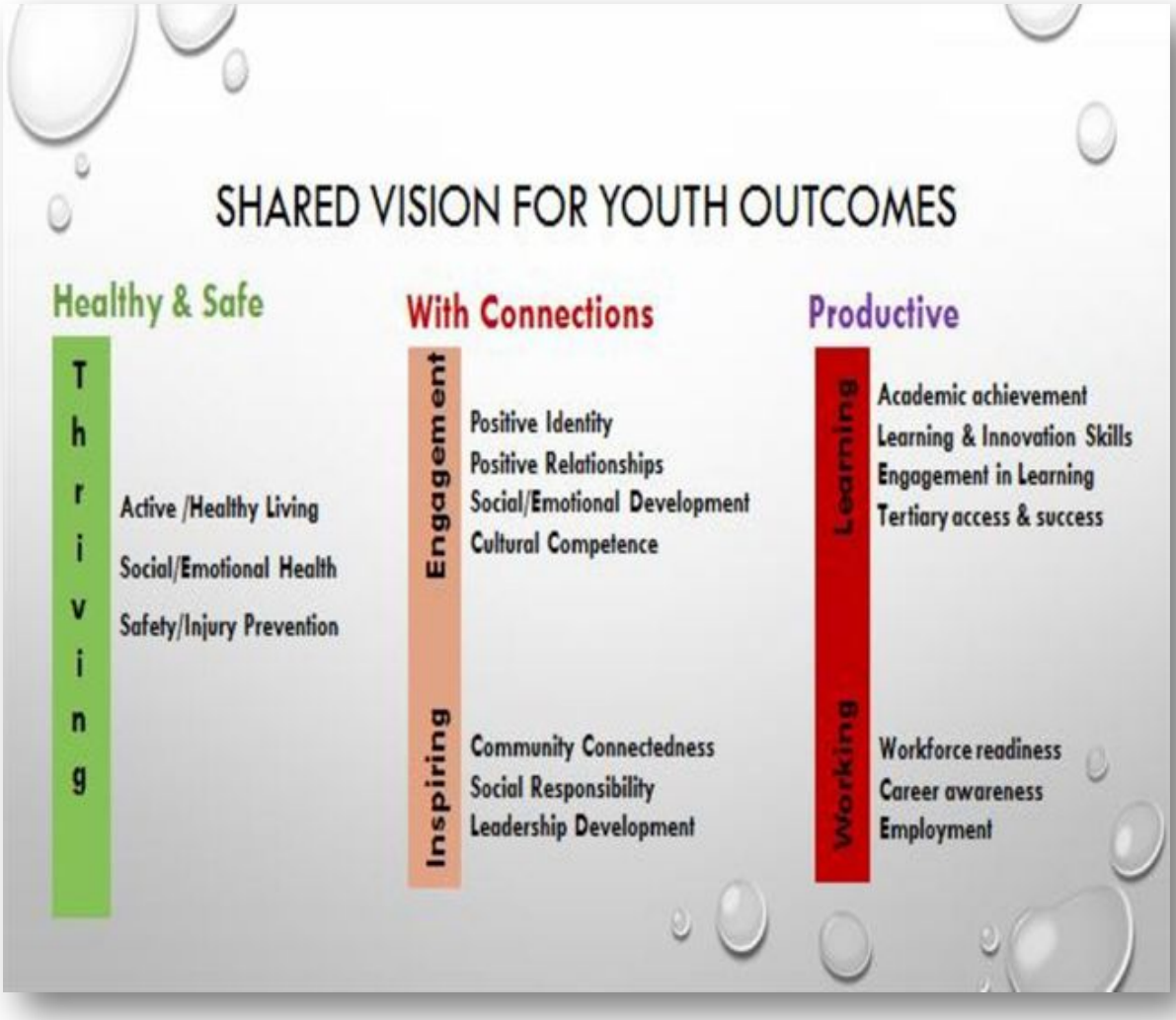
[10] Dr Karen Pittman. The Forum for Youth Investment, Ready by 21.

[11] Krauss,SM. Pittman,K J. Johnson, C. Ready By Design The Science of Youth Readiness Mar 2016

Youth's Vision or "Brighter Future"

This Youth Strategy aims to convey a shared vision for young people by identifying a common set of youth outcomes and indicators that cuts across the work of many organisations/services working with youth. Though there are commonalities in how organisations/services talk about their goals and impact, the lack of shared language across the services can lead to missed opportunities for collaboration, alignment and collective impact.

Our vision is that this framework enhances organisations/services, individual and/or collective ability to define, communicate about, develop, and implement strength-based models to influence outcomes that ensure all youth are thriving in New Zealand.



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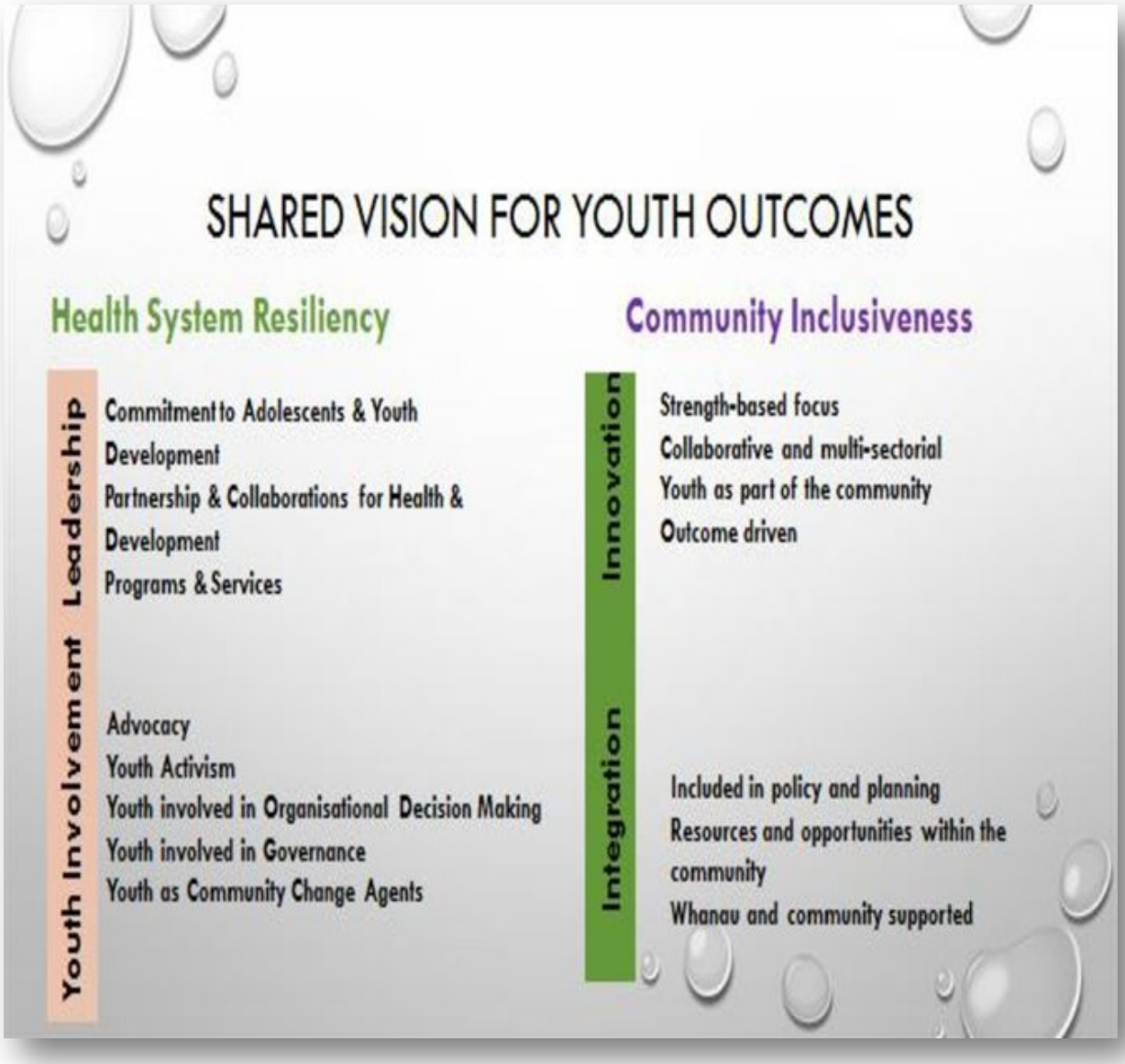
Working Together for 'Healthy Youth, Healthy Whānau, Healthy Community'

The youth development approach calls for a balance between services designed to prevent, intervene or treat health problems and efforts that promote development through preparation, participation and leadership experiences with youth.

Creating synergy to meet the needs of youth in the full context of their lives will result in healthy opportunities for youth and sustainable social and economic benefits for the community for generations to come.



Appendix One

Strategic Plan in Action

Goal 1: Healthy and Safe				
Principle	**Outcome**	**Indicator**	**Recommendations**	**Workforce Development Required**
Thriving	**Active/ Healthy Living**	• Youth live in maintained dry, clean, and safe housing • Youth develop and maintain healthy eating habits • Youth develop and maintain regular exercise habits • Youth participate in scheduled wellness checks/screens/ assessments • Youth develop health literacy • Youth participate in preventive care • Youth with chronic conditions or disability participate in their care and are included in the community	1. Increase access and utilisation by: • Normalise access to general services by promoting positive strength based access and utilisation such as 'Healthy Choices' (holistic not silo e.g. sexual health focus) • Implement wellness screens for all young people 11-13 years old through PCP or SBHS. • Provide health education promoting youth development and planned support for developmental milestones. Utilise incentive based frameworks to positively influence self-management of preventive care • Develop youth friendly facilities and services through engagement with youth clientele through relevant surveys via social media tools 2. Improve communication tools relevant to youth • Coordinate youth developed campaigns to embrace healthy choices, healthy lives, healthy community that enable same message across all sectors for young people and families e.g. partnerships between health, education, and City Councils	• Te Tiriti o Waitangi • Ottawa Charter • Health Promoting Schools • Core competencies (WHO Guidelines) • Youth screening tools • Special issues • ASK model • FPA certificates and life skill courses • Collaborative processes • Community workshops

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Goal 1: Healthy and Safe				
Principle	**Outcome**	**Indicator**	**Recommendations**	**Workforce Development Required**
Thriving	**Social/ Emotional Health**	• Youth identify, manage and appropriately express emotions and behaviours. • Youth make positive decisions and access external supports. • Youth prevent, manage and resolve interpersonal conflicts in constructive ways. • Youth develop healthy relationships.	1. Improve access and utilisation by: • Develop key relationships/partnerships within matching areas to streamline ease of access • Build consistency of strength-based models • Develop transparency and fluidity of progressive support from one service to another (e.g. transition, shared care, transfer) 2. Improve communication tools relevant to youth: • Provide a licence card for young people to own that shows all service available with ability to stamp a service to show it has been used/active e.g. like coffee cards • Develop an app that shows map of services – e.g. AOD Collaborative, Napier City Council • Advertise services through social media promoting positive influence and support	
Thriving	**Safety/ Injury Prevention**	• Youth avoid risky behaviours. • Youth avoid bullying behaviours. • Youth use refusal skills. • Youth avoid using illegal substances.	1. Improve access and utilisation by: • Consistent, timely, and reliable information sharing processes • Planning is focused on the needs of the young person and includes active participation of young person • Provide screening, consultation and liaison by youth health services in GP practices with high percentage of Māori and Pacific youth or high percentage of truancy identified in youth • Provide consultation and liaison by youth mental health services and AOD in GP practices and schools with high percentage of Māori and Pacific youth or high percentage of depression identified in youth • Provide transition planning and promote relationship building when changing to shared/transfer of care. Include whānau or supportive caring adult in this planning • Provide appropriate screening training to all services for youth to build consistency and increased anticipatory opportunities	

Goal 1: Healthy and Safe				
Principle	**Outcome**	**Indicator**	**Recommendations**	**Workforce Development Required**
			• Promote health and development opportunities for youth and separately for families/whānau – build consistent messages and support 2. Increase communication tools relevant to youth by: • Utilisation of social media to promote and normalise access to services	

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Goal 2: With Connections				
PRINCIPLE	**OUTCOME**	**INDICATORS**	**RECOMMENDATIONS**	**WORKFORCE DEVELOPMENT REQUIRED**
ENGAGEMENT	**Positive Identity**	• Youth develop a strong sense of self. • Youth develop positive values.	• Develop strength based models to support positive influence of life skills • Coordinate programs consistency with principles of PYD • Utilise workforce youth are able to consider 'REAL' and relevant with appropriate life experiences • Promote non-judgemental and acceptance for diverse cultures significant to youth • Support developments across sector partnerships for activities and facilities for youth to do and be • Support development and training of peer supports • Health partner with education to deliver health curriculum in schools – increase health literacy • Support development and provision of parenting programs for 'parenting teens' • Provide opportunities for youth to volunteer • Provide opportunities for youth to use cultural skills and promote cultural inclusiveness	• Cultural competency • Hart Ladder • Peer to Peer Support • Motivational interviewing • Brief interventions • Solutions Focus Brief Therapy • Werry Centre E-Learning • Undergraduate/ Postgraduate Study – youth health, mental health, psychology, youth work, social work, speech language • Diversity training e.g. transgender, values • Whānau Ora • COPMIA • Social media training and development
	Positive Relationships	• Youth develop positive, sustained relationships with caring adults. • Youth develop positive relationships with peers. • Youth affiliate with peers who abstain from negative behaviours.		
	Social /Emotional Development	• Youth develop social skills • Youth demonstrate pro-social behaviour. • Youth develop friendship skills. • Youth develop coping skills		
	Cultural Competence	• Youth develop cultural competence. • Youth advance diversity in a multicultural world. • Youth respect diversity		

Goal 2: With Connections				
PRINCIPLE	**OUTCOME**	**INDICATORS**	**RECOMMENDATIONS**	**WORKFORCE DEVELOPMENT REQUIRED**
INSPIRING	**Community Connectedness**	• Youth feel a sense of belonging. • Youth participate in community programs.	• Provide opportunities to develop and train youth as teachers in health settings • Provide opportunities for youth guides in hospitals • Provide opportunities for youth as peers supports • Provide opportunities for youth to develop leadership abilities and utilise these skills • Provide opportunities for youth involvement in governance and advisory groups	• Youth development in chronic illness and development • Leadership development
	Social Responsibility	• Youth demonstrate civic participation skills • Youth feel empowered to contribute to positive change in their communities. • Youth volunteer/participate in community service. • Youth consider the implications of their actions on others, their community, and the environment.		
	Leadership Development	• Youth educate and inspire others to act. • Youth demonstrate leadership skills • Youth model positive behaviours for peers. • Youth communicate their opinions and ideas to others.		

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Goal 3: Productive				
PRINCIPLE	**OUTCOME**	**INDICATORS**	**RECOMMENDATIONS**	**WORKFORCE DEVELOPMENT REQUIRED**
LEARNING	**Academic Achievement**	• Youth are on track for high school graduation. • Youth graduate from high school. • Youth perform at or above age level. • Youth improve education achievement.	• Annual Youth Health & Development review linked to School Pastoral Services (e.g. holistic support for individualised learning pathways) • Upskill workforce to screen for anxiety around normal daily functioning and provide brief interventions to increase coping skills without needing secondary intervention • Coordinate and prioritise transition programs for chronic illness, vulnerable, or disability to all areas relevant to development needs at an early stage for pro-active planning. Enable youth to participate and lead their plan supported by family/whānau as able • Implement support programs that youth have responsibility in setting end timeframes	• Disability • FASD • Health literacy • Oral language • Life skills development • Emotional wellbeing screening/assessment • Motivational interviewing • CBT
	Learning and Innovation Skills	• Youth demonstrate critical thinking skills (e.g. reasoning, analysis). • Youth solve problems. • Youth work in groups to accomplish learning goals. • Youth think creatively		
	Engagement in Learning	• Youth express curiosity about topics learned in and out of school. • School attendance improves. • Youth spend time studying. • Youth spend time reading. • Motivation to learn.		
	Tertiary Access/ Success	• Youth plan to attend Tertiary education. • Youth enrol in Tertiary education. • Youth complete some type of Tertiary qualification		

Goal 3: Productive				
PRINCIPLE	**OUTCOME**	**INDICATORS**	**RECOMMENDATIONS**	**WORKFORCE DEVELOPMENT REQUIRED**
WORKING	**Workforce Readiness**	• Youth develop communication skills. • Youth work effectively in groups. • Youth develop critical thinking and decision-making skills. • Youth develop positive work habits.	• Youth with disabilities have support while at school to plan/ enable independent lives suitable to their needs as future goals	
	Career Awareness	• Youth develop knowledge about occupations. • Youth are aware of their interests and abilities (passion and strengths).		
	Employment	• Youth are employed at wages that meet their basic needs. • Youth established in employment/career within five years of graduating from high school.		

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Goal 4: Health System Resiliency				
PRINCIPLE	**OUTCOME**	**INDICATORS**	**RECOMMENDATIONS**	**WORKFORCE DEVELOPMENT REQUIRED**
LEADERSHIP	**Commitment to Adolescents and Youth Development**	• YHD Governance Group • Positive Youth Health & Development Advisory/ Research Group for knowledge brokering	1. To improve leadership and sustainability of Positive Youth Health and Development • Develop and support Population Trends Advisory Groups • Develop MOUs to support key partnerships to support leadership, responsiveness, research, quality improvement, IT support • Develop collaborative partnerships with key agencies invested in long term gains for youth e.g. YOSS, SBHS, PHO, CDU, CAFS, Māori, Pacific, and youth involvement to support model of Excellence of YHD • Develop YHD Review Panel for complex cases including YOSS, SBHS, CAFS, Paediatrics (including Gateway), Children's Team, CYF, Police, HNZ, WINZ, MOE, to guide sectors on collaborative processes and best practice to support development needs • Support resourcing capacity and capability for development of YHD Leadership for a Centre/Model of Excellence across the region • Develop national links to support establishment of Centre/Model of Excellence e.g. Collaborative (Christchurch), Centre for Youth Health (Auckland), SYHPANZ (National) • Development of outcome measures across sectors 2. To improve outcomes for youth when accessing multiple providers by enabling information to travel with the young person from service to service in a timely manner • Develop portals to support and enable improved information sharing e.g. a single PMS for community services with access to public health database	• SLAT Development and ongoing support • Management and understanding of PYD • Collaborative workshops
	Partnerships and Collaborations for Health and Youth Development	• Establishment of Centre/Collaborative Model of Excellence to support EBBP and Workforce Development for Youth Health and Development • Establishment of Interagency Accountability Framework (Act, Monitor, Review)		
	• **Programs and Services (including program assessment, planning and evaluation)** • **Education and Technical Assistance** • **Collective Data Collection and Surveillance**	• Youth understand and know all services available and how to access the right service at the right time with services they trust and respect • Youth are appropriately matched to their developmental stages for managing chronic illness and disability • Programs provide critical supports, services and opportunities • Programs(and/with partners) address related interdisciplinary adolescent issues		

Goal 4: Health System Resiliency				
PRINCIPLE	**OUTCOME**	**INDICATORS**	**RECOMMENDATIONS**	**WORKFORCE DEVELOPMENT REQUIRED**
		• Programs go beyond a focus on individual behaviour change, creating positive environments in family • Collective data management and reporting	• Develop collective reporting tools to match broader partnerships and mutual outcomes/results • Develop collective data management across the sectors to match strategic vision to capture healthy youth, healthy whānau, healthy community – holistic and strength-based	

17.1

Goal 4: Health System Resiliency				
PRINCIPLE	**OUTCOME**	**INDICATORS**	**RECOMMENDATIONS**	**WORKFORCE DEVELOPMENT REQUIRED**
YOUTH INVOLVEMENT	• **Youth involved in Organisational Decision Making** • **Youth involved in Governance** • **Youth as Community Change Agents**	• Youth hold governance positions • Youth hold leadership positions in health services • Youth designed programs are implemented • Youth are involved in training workforce • Youth lead developments with social media communication • Youth involved in evaluation programs	• Youth and families participate in designing and delivery of expos, Health Promotion forums, Family/Parenting workshops • Provide opportunities of leadership for families • Provide support to families/whānau to encourage and support their children's involvement in leadership roles • Provide opportunities to celebrate youth and family success or appropriate avenues to share learnings that will grow positive development for youth and families/whānau • Negotiate with EIT around involvement of youth students (e.g. nursing, teaching, social work, disability) are able to have course requirements incorporated into involvement in research or youth projects relevant to youth health and development	

Goal 5: Community Inclusiveness				
PRINCIPLE	**OUTCOME**	**INDICATORS**	**RECOMMENDATIONS**	**WORKFORCE DEVELOPMENT REQUIRED**
INNOVATION INTEGRATION	**Strengths-Based Approaches**			
	Development Focused			
	Developing the 'Whole' Young Person			
	Social Connectedness	Supporting the whānau and the community		
	Independence and Empowerment			

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Appendix Two

References

Appendix Three

Glossary

ABBREVIATION	DEFINITION
AHRG	Adolescent Health Research Group
AOD	Alcohol & Other Drugs
BMI	Body Mass Index
CAFS	Child Adolescent & Family Service
CDU	Child Development Unit
CYF	Child, Youth, & Family
COPMIA	Supporting Parents, Healthy Children
CHDS	Christchurch Health and Development Study
CBT	Cognitive Behavioural Therapy
EIT	Eastern Institute of Technology
EBBP	Evidence Based Best Practice
FPA	Family Planning Association
FASD	Fetal Alcohol Spectrum Disorder
GP	General Practitioner
HBDHB	Hawke's Bay District Health Board
HNZ	Housing NZ
MOE	Ministry of Education
MOH	Ministry of Health
NGO	Non-Government Organisation
PI	Pacific Island
PMS	Patient Management System
PCAP	People Contribution Activities Place
PCP	Primary Care Provider
PHO	Primary Health Organisation
PYD	Positive Youth Development
SBHS	School Based Health Services
SLAT	Service Level Alliance Team
SWIS	Social Worker In School
SYHPANZ	Society of Youth Health Professionals Aotearoa NZ
TTOH	Te Taiwhenua O Heretaunga
UN	United Nations
WINZ	Work & Income NZ
WHO	World Health Organisation
YHD	Youth Health & Development
YOSS	Youth One Stop Shop

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Appendix Four

Consultation

STAKEHOLDERS INPUT FROM	

• Directions (Youth One Stop Shop)
• Hayseed Trust
• Central Health
• Hastings City Council
• Napier City Council
• Wairoa Health Centre
• YROA YNOT
• Women Child and Youth Directorate
• Ministry Social Development Youth Services Team Leader
• Probation Services
• Te Taiwhenua O Heretaunga Youth Services
• School Based Health Services, HBDHB
• Health Hawkes Bay Team
• Police Youth Officer
• Disability Services
• Takatimu Ora
• U-Turn Trust
• Consumer Council members
• Māori Relationship Board member
• Suicide Prevention Coordinator, HBDHB
• Women Child and Youth Service Director, HBDHB
• Health Promotion Advisor, HBDHB
• Paediatrician, HBDHB
• Children's Commissioner
	• Secondary schools:
	  ○ Hastings Girls High School
	  ○ William Colenso High School
	  ○ Tamatea High School
	  ○ Flaxmere College
	• Youth Probation Officer
	• Ministry of Social Development
	• Te Kupenga
	• Teenage Parent Group Te Taiwhenua O Heretaunga and William Colenso
	• Land based training participants
	• Hastings Junior Youth Council 2015
	• Hastings Senior Youth Council 2015
	• Hastings Senior Youth Council 2016
	• Youth Advisory Group (YAH) - Directions
	• Pacific Hui (February 2016)
	• Pasifika Health Leadership Group
	• Programme Manager, Māori Health HBDHB
	• TukiTuki Medical Centre
	• Health Care Centre, Wairoa

HAWKE'S BAY District Health Board Whakawāteatia	**Suicide Prevention and Postvention Plan Report** 68
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Caroline McElnay, Director Population Health Penny Thompson, Suicide Prevention Coordinator
Reviewed by:	Executive Management Team, Maori Relationship Board (MRB), Clinical and Consumer Councils
Month:	June 2016
Consideration:	For information and discussion

RECOMMENDATION

That the Board:

Note the contents of this report and provide feedback.

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OVERVIEW

Hawke's Bay District Health Board approved a two year Suicide Prevention and Postvention Plan (SPP Plan) in June 2015. Since this date, the network of agencies participating in suicide prevention have worked together to; link consumers to agencies and agencies to agencies, improve information sharing processes, review the support model to include prevention, provide access to training and maintain interagency commitment to suicide prevention. The various agencies within the support model continue to be actively engaged with suicide prevention activities and are delighted by the combined effort and commitment to date. Going forward, the support model is focused on; community engagement, building community resilience, supporting local initiatives, working with youth and looking for opportunities to expand suicide prevention activities in Hawke's Bay.

BACKGROUND

In December 2013, HBDHB adopted a three tier model shared by Northland DHB. The three tiers consisted of a Governance group, Manager's group and Local Response Teams. Terms of reference for each tier were created in early 2014. The suicide prevention work in Hawke's Bay has been driven by the agencies represented within the support model which includes the implementation of the SPP Plan. The SPP Plan has four key areas with various activities and outcomes to ultimately reduce the rates of suicide in Hawke's Bay.

A. Resilience building activities in the region – activities to respond to early risks, promote mental health and wellbeing and help prevent suicide.
B. Information on workforce development for health workers and key community gatekeepers to respond to distressed people in the community.
C. Approaches specific to at risk groups includes mental health users, male, youth and Māori.
D. Multi-agency postvention response in cluster and contagion situation and postvention approaches for in-cluster situations.

PROGRESS REPORT

A. Resilience building activities in the region – activities to respond to early risks, promote mental health and wellbeing and help prevent suicide.

- In the past 10 months we have supported, led and promoted wellbeing/suicide prevention events in Flaxmere, Napier and Flaxmere College including John Kirwan's and Mike King's community presentations. One of the events we supported was AZONE "Own Your Life" event in Napier where Che Fu performed. Our role on the day was to hand out "its ok to ask for help" wallet cards with a conversation on what the card means, provide Master of Ceremonies key messages and for services to be given the opportunity to share information about their services
- Ministry of Education regional office facilitated a Preventing and Responding to Suicide resources kit workshop for schools
- Suicide Bereavement Group facilitated by families affected by suicide
- HBDHB has been chosen by the MOH to utilise the Suicide Prevention Outcomes Framework to better understand the activities and interventions that will reduce suicides

B. Information on workforce development for health workers and key community gatekeepers to respond to distressed people in the community.

- Three Question, Persuade and Refer (QPR) Gatekeeper Suicide Prevention training sessions were held in Wairoa, Central Hawkes Bay and Flaxmere. Attendees were social workers, youth workers, community champions, education services, community groups, youth/students, local businesses, ACC, Police, NGOs, public health nurses

C. Approaches specific to at risk groups includes mental health users, male, youth and, Māori.

- Mental Health Services (MHS) developed a MHS Follow-up After Attempted Suicide Policy
- Rural Health Alliance Suicide Prevention workshops completed in Wairoa and Central Hawke's Bay. Overall, 35 people attended the interactive workshops
- Tumu Timbers Hastings supported their senior management team to attend a presentation to identify risk, protective factors and where to go for assistance. Four Tumu Timber staff members attended QPR Gatekeeper training
- Premiere Hairdressing youth workshop co-facilitated and attended by various agencies
- Wonby1 workshop for Pacific focusing on Le Va message of HOPE – the workshop was well attended
- Mindfulness workshops facilitated by HBDHB MHS staff at Flaxmere College with students was well received

D. Multi-agency postvention response in cluster and contagion situation and Postvention approaches in for in-cluster situations.

- The agencies represented in the three tier model (support model) have completed a template highlighting what they consider to be their roles and responsibilities within the LRT and Fusion group tiers. We intend to workshop the completed templates to determine if agencies perception of other agencies is accurate
- With the support of Clinical Advisory Services Aotearoa we evaluated the support model and a report was tabled complete with recommendations. We are currently implementing the recommendations
- Te Taiwhenua O Heretaunga initially established a youth academy, identified a leadership ambassador and intends to establish a youth guide health promotion relating to suicide and bullying
- Le Va facilitated a FLO Talanoa train the trainer workshop with 15 people in attendance
- Information sharing process reviewed and changes implemented to ensure as many precautions are taken to maintain confidentiality

IDENTIFIED OUTCOMES

- 57 people attended QPR Gatekeeper training. 51 completed evaluations. 49 out of 51 of participants answered "yes" to feeling more competent and confident speaking to people about suicide
- Central Hawke's Bay training focused on rural and farming communities were given the opportunity to be involved in the next phase of learning - this was well received by attendees
- Clear guideline for MHS staff on follow-up procedures following a serious suicide attempt
- Community groups are actively engaging in suicide prevention promotion, events and training/workshops
- Guided by rangatahi on what messages to utilise and mediums to talk through
- Activities target various groups such as rural, Māori, pacific and youth
- Consistency of utilising evidence based messages such as Le Va and Mental Health Foundation
- Members of the support model continue to enhance the way we work together, improve processes and maintain commitment
- Schools increased awareness and understanding of process and pathways

IDENTIFIED RISKS

- The lack of a specific budget limits the ability to plan suicide prevention activities, provide training and support initiatives
- Increased capacity demands on the Suicide Prevention Coordinator following the release of the Coroners Joint Findings. The HBDHB and Governance Group interagency members agreed that we need a six month project to establish and coordinate a working group to investigate the coroner's recommendationsThis requires additional FTE resource.

PRIORITIES FOR 2016/2017

- Community engagement is a key focus for the coming year. We wish to engage with key community groups and representatives to identify how we can strengthen their involvement in collaborative suicide prevention work, decrease communities fear regarding suicide, increase communities awareness of signs and symptoms of suicide and services available
- Building resilience - ongoing training opportunities are made available to community and whanau to increase their capability to ask "if someone is suicidal", "if they have a plan", "persuade them to go for help" and "take them to the most appropriate service". In addition identifying what does that whānau or community need to build their resilience
- Supporting local initiatives - Supporting Te Taiwhenua O Heretaunga to continue their youth academy. Working with youth, utilising their voice to influence others around resilience factors for mental health and suicide
- Continue to seek opportunities to expand suicide prevention within the community


GRATITUDE JAR
What are you grateful for today?

HAWKE'S BAY District Health Board Whakawāteatia	**Health Equity Update 2016: Tackling Health Inequities** 69
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Caroline McElnay, Director Population Health -
Reviewed by:	Executive Management Team, MRB, Clinical Council and Consumer Council
Month:	June 2016
Consideration:	For discussion

RECOMMENDATION

That HBDHB Board :

1. Receive the report.
2. Discuss findings and recommendations.

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OVERVIEW

The Health Equity Update 2016 "Tackling Health Inequities" is a snapshot of progress towards health equity in Hawke's Bay.

BACKGROUND

The Health Equity Champion role was established in 2013 and one of the key expectations of this role is the production of an annual independent report on health equity in Hawke's Bay. The first Health Equity report was presented to the Board in October 2014 and provided an overview of existing health inequities, provided an understanding of how the various factors influencing health interact and identified opportunities for specific action that the district health board and other agencies could take to improve health equity.

The Health Equity Update 2016 highlights the progress that has been made in some key areas of inequity to date and outlines ongoing challenges.

PURPOSE OF HEALTH EQUITY REPORT

1. To contribute to improving the health and wellbeing of local populations and reduce health inequities.
2. To promote action for better health.
3. To promote partnerships for health.

KEY FINDINGS

Thirteen of the 18 indicators reviewed show improvements with a reduction in health inequity.

In particular we are seeing progress in areas where effective, appropriate and targeted health services are making a difference.

- There has been significant and continued closure of the gap in deaths rates by ethnicity and for people living in our most deprived communities (quintile 4 and quintile 5) for deaths which are known to be linked to access to good health care.
- There has been a reduction in hospital admissions for our children under 5 for conditions which are preventable, mainly because of high immunisation rates against rotavirus, a common cause of gastroenteritis in children, and better earlier management of skin infections.
- There has also been a reduction in the difference in rates of teenage pregnancies by ethnicity, due to better access to health education and sexual health services.

However, there are a number of areas where heath equity is improving but significant inequity remains. The pace of change is such that for some indicators (e.g. life expectancy) it may be another 50 years before health equity is reached. The variation in life expectancy gap between Māori and non-Māori across New Zealand illustrates the challenge for us in Hawke's Bay.

Of particular concern are those indicators where there is no progress towards health equity or where inequity seems to be worsening. These indicators are:

- hospital admissions for children with viral chest infections
- obesity among 4 year olds
- oral health of 5 year olds
- tobacco use during pregnancy
- violent crime

Whilst these 18 indicators are only a snapshot of health in our communities, this update suggests that more progress is being seen in those areas more directly influenced by health care, such as prevention programmes and better access to consumer appropriate health services. This is encouraging and tells us that health care provision can make a difference. It also emphasises that we need to keep on doing so.

However, the powerful impact of social, economic and behaviour on the indicators showing less or no progress reminds us of the ongoing need to continue to address the underlying causes of health inequity. The profile on Iron Māori shows how behaviour change is possible when people and whānau are supported appropriately to make changes in their own lives. But we all have a role to play in addressing social, economic and living conditions across our community.

RECOMMENDATIONS

We need a game plan to tackle the multiple determinants of health in order to eliminate health inequities in Hawke's Bay.

Tackling unhealthy behaviours

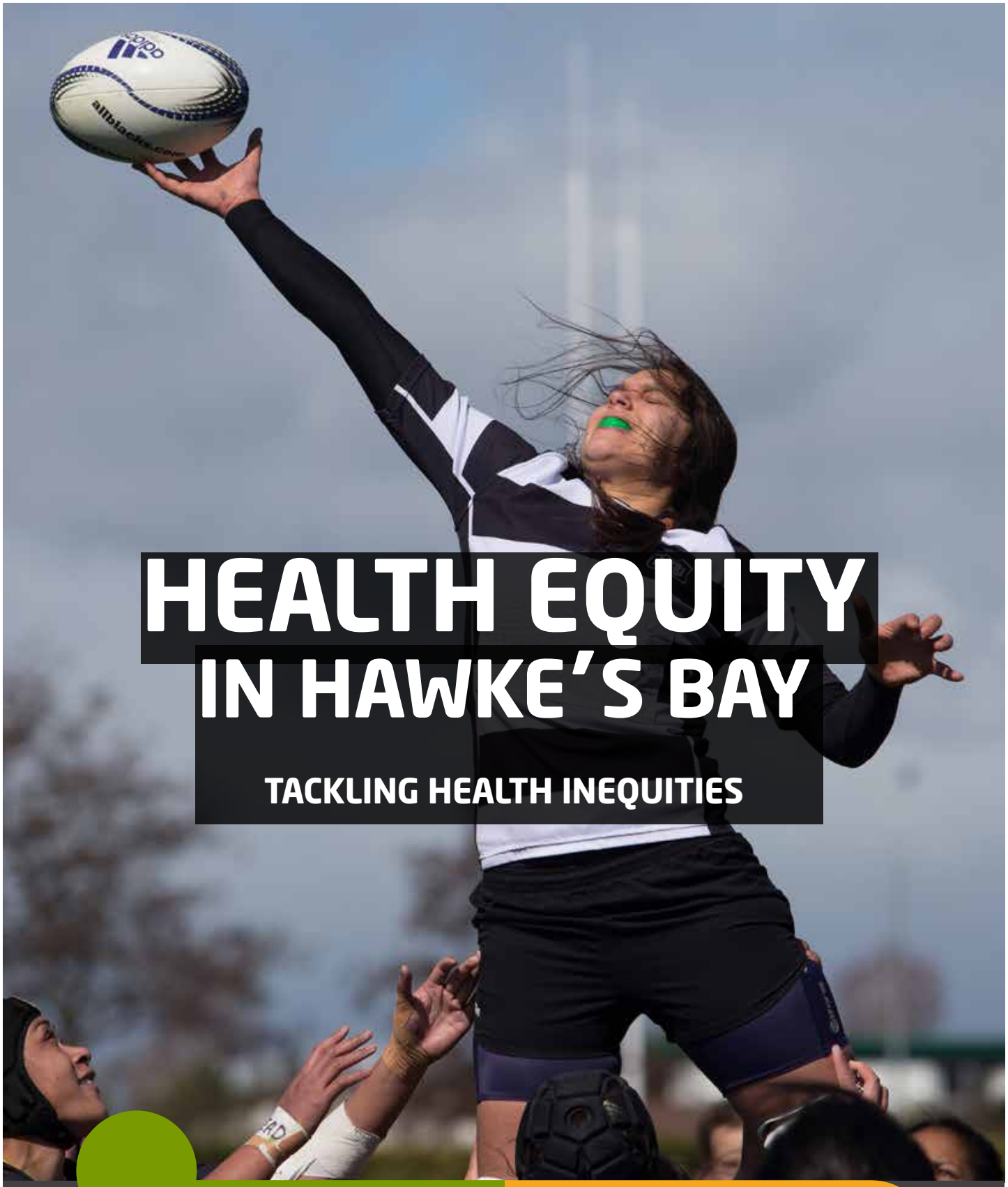
1. Support people, whānau and communities to live healthier lives e.g. Support programmes which engage and motivate people and whānau to make healthier choices.
2. Work with communities to improve availability of healthier food and have more opportunities for physical activity.
3. Help people become smoke-free.
4. Ensure our communities are safer by working with communities and other agencies to address alcohol and drug use and family violence.

Tackling social, economic and living conditions

1. Work with the Hawke's Bay Intersectoral group and others to help grow economic development across the region.
2. Provide training and employment opportunities for Māori and Pasifika within the DHB.
3. Ensure our employees are paid fairly and receive a "living wage".
4. Use our purchasing power to support the local economy.
5. Tackle housing issues by supporting the Hawke's Bay Housing Coalition and continue to provide insulation and housing improvements for families with housing-related health needs.

Tackling health care

1. Continue to assess our health services and programmes and by using the health equity assessment tool, identify where inequity exists and target interventions or changes accordingly.
2. Ask about social conditions and make sure people are supported with referrals to agencies that can help with income and social support, housing improvements etc.
3. Provide health care that is easy to reach and in the community.



HEALTH EQUITY IN HAWKE'S BAY

TACKLING HEALTH INEQUITIES

WE HAVE ALL GOT A ROLE TO PLAY

UPDATE 2016

www.ourhealthhb.nz

McElnay C 2016, Health Equity in Hawke's Bay, Hawke's Bay District Health Board.
Acknowledgements: Lisa Jones
Photography www.ankh.co.nz

SUMMARY

TO TACKLE:
To deal with a difficult or complex problem, to lead the initiative and go on the offensive

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"Should we look for technical solutions and educate people and patients about healthy behaviour? Or should we… seek to create the conditions for people to lead fulfilling lives, free from poverty and drudgery? In my view we should do both."

Marmot 2015

Health Inequities are differences in health outcomes that are avoidable or preventable – and therefore unfair. But they are not inevitable. We can make a difference with a determined and focused effort that addresses underlying causes, and through better and closer to home, provide more available health services. This means working across the whole community to make sure living conditions that support health are distributed fairly. It requires "tackling" and "going on the offensive".

This "Tackling Health Inequities" report is a mixture of good news and bad news. Thirteen of the 18 indicators reviewed show improvements. Inequity has decreased and we are seeing progress in areas where effective and targeted health services are making a difference.

However the powerful impact of social and economic factors on health means for many other areas either progress is slow or worsening.

We still don't fully understand the relationship between health promoting behaviours and disadvantage, but this report profiles one local initiative, Iron Māori, which demonstrates that behaviour change is possible if it's supported appropriately.

This sets out an on-going challenge for us all if we are serious about eliminating health inequity. It re-emphasises the need to work closely with people, whānau, communities and other agencies, as a team, to build healthier and fairer communities. We need a game plan to tackle the multiple determinants of health:

Tackling behaviours – support people, whānau and communities to live healthier lives – this includes supporting programmes which engage and motivate people and whānau, as well as working with communities to help make healthy choices easier and more accessible.

Tackling social and economic factors – work together to focus on better economic development and social inclusion across Hawke's Bay; support increases in minimum wage towards a living wage; tackle housing issues.

Tackling healthcare – assess the impact on health equity when designing health programmes or service changes, provide care that's easy to reach and in the community, ask about social conditions and make sure people are supported with referrals to agencies that can help with income, social support and housing improvements.

Dr Caroline McElnay,
Health Equity Champion
Director of Population Health

June 2016

KEY FINDINGS

If the current trends continue there will be no difference in health care preventable death rates between Māori and non-Māori in the next one to two years.

19.1

KEY FINDINGS

INEQUITY GAP IN DEATHS THAT COULD HAVE BEEN PREVENTED (AVOIDABLE DEATHS) NEARLY GONE

We have seen significant and continued reduction in deaths, which could have been prevented by either prevention or early treatment programmes or better access to medical care. Known as avoidable mortality and amenable mortality indicators if the current trends continue there will be no difference in health care preventable death rates between Māori and non-Māori in the next one to two years.

HOSPITAL ADMISSIONS FOR 0-4 YEAR OLDS, THAT COULD HAVE BEEN AVOIDED, ARE REDUCING

Ambulatory sensitive admissions for 0-4 year olds are the number of hospital admissions which could have been avoided by prevention programmes in primary care or better access to treatment in primary care in this age group. We are seeing less of these admissions and good progress in reduction of inequity. This is mostly due to specific health programmes such as the introduction of the rotavirus (a virus which causes diarrhoea and dehydration in infants and young children) vaccine into the childhood immunisation schedule and a local management programme for skin infections.

TEENAGE PREGNANCY RATES DECREASING

Teenage pregnancy rates have also decreased. This is largely due to improved access to primary care contraceptive and sexual health services. This is due to more general practices able to offer free services for young people and a social media awareness raising and education campaign.

AT LEAST 50 YEARS BEFORE EQUITY IN LIFE EXPECTANCY BETWEEN MĀORI AND NON-MĀORI IS ACHIEVED IF CURRENT TRENDS CONTINUE

We predict it will take at least 50 years before equity in life expectancy between Māori and non-Māori is achieved if current trends continue. The variation in life expectancy for Māori across New Zealand highlights the effect of geography on this measure – Māori in Hawke's Bay can expect to live on average six years less than Māori in Otago. This variation is likely to be due to underlying social and economic living conditions and inequalities rather than any significant variation in health services. It matters more where you live if you are Māori than if you are non-Māori

OF GREAT CONCERN ARE THE AREAS WHERE HEALTH INEQUITY APPEARS TO BE WORSENING OR STATIC

All five areas highlighted in this report have strong social and economic links.

- **ACUTE RESPIRATORY (BRONCHIOLITIS)** Admissions amongst children are increasing and are associated with poor housing conditions;
- **SMOKING AMONGST MĀORI WOMEN REMAINS HIGH**. Of all Māori women giving birth in the past year 43 percent were smokers – at the current slow rate of decrease it will be another 15 years before rates are the same as non-Māori. Helping women to stop smoking remains a priority
- **OBESITY IN FOUR YEAR OLDS** has increased since 2009 with significant variation across communities. Nearly 12 percent of children living in places like Camberley and Tamatea are obese compared to less than 1 percent of four year olds living in places like Havelock North Central and Poraiti.
- There has been no improvement in the **ORAL HEALTH OF FIVE YEAR OLDS** with Māori or Pasifika children, or children living in less affluent communities, having significantly more dental decay.
- The widening gap and increase in **VIOLENT CRIME** in Hawke's Bay compared to the rest of New Zealand is a marker of underlying community and social issues. Research tells us that the more unequal societies are the more likely they are to experience higher rates of violent crime.

Hawke's Bay is a great place to live. But not everyone in Hawke's Bay has the same opportunity to be healthy.

INTRODUCTION

Hawke's Bay is a great place to live. But not everyone in Hawke's Bay has the same opportunity to be healthy. Stark health inequities exist in some parts of our community with some groups having better health outcomes than others. For Hawke's Bay to have the brightest future possible we need to collectively eliminate these health inequities.

So started my last report released in October 2014. This update gives us a chance to see how we are progressing on some of the key areas of health inequity.

The response to the 2014 report was mostly positive with many community groups, health professionals, local government and central government agencies and media showing interest.

However not everyone was receptive or positive about the report. The feedback I received varied:

"This isn't health equity – most of these diseases are due to poor lifestyle choices made by some."

Health inequities are differences in health outcomes which are avoidable or remediable – in other words they are not inevitable. Not all differences in health outcome are avoidable, but when avoidable differences are seen consistently between different groups of people, no matter how those groups are defined then those differences are inequitable.

Many lifestyle choices such as smoking, drinking alcohol, lack of exercise or poor eating are strongly linked with socioeconomic status and income. While ultimately people are responsible for the choices they make, many of those choices are influenced by factors outside that person's control. We need to dig deeper into what those influences are and help to make a difference. We cannot assume that if only people knew what to do to improve their health they would do it – and if they didn't then they must be lazy, disinterested and deserve all that befalls them consequently. I explore this in more detail in the next chapter.

"Why are you focusing so much on deaths and length of life – surely it's the quality of life that's important?"

Quality of life is important but when there are still significant differences in the length of life by ethnicity that tells us that we need to do something about this major health inequity. A quarter of all deaths among Māori in Hawke's Bay occur before the age of 50, mostly from preventable or treatable causes.

"You haven't told me anything I don't already know – I live and work in communities where health inequities are stark."

Many community groups told me that my report wasn't news to them – and my response was that my report wasn't directed at them – but at the many others in our community who don't know about health inequities, and who don't realise the contribution that they too can make to improving health and well-being in Hawke's Bay. They may be business owners generating employment, teachers working with young Māori and Pasifika who may be struggling to achieve qualifications, philanthropists keen to give back to their community. We all have a role in reducing health inequity and the solutions lie amongst us all collectively.

"Your report missed many aspects of health such as mental well-being and domestic violence – they have a powerful impact on health in our community and there must be inequities there."

One of the biggest problems in trying to describe health equity and its drivers is the lack of good population health data in areas such as mental health, domestic violence, and whānau focused data. We need to develop better measures of well-being in our community including how to better describe the health of whānau and communities in a more holistic way. Also some data sources are not updated annually for example the Census and the New Zealand Health Survey. There is also often a delay in some data releases – mortality data can be three years old by the time the DHB receives it, thereby limiting our ability to be up-to-date. Any health equity report can only ever be a snapshot of what is happening in the community.

"Your report missed many aspects of health such as mental well-being and domestic violence – they have a powerful impact on health in our community and there must be inequities there."

Future reports will look in more detail at these other areas. In addition the importance of whānau and on whānau ora has long been identified as an important component and a key driver of Māori development. Health equity for Māori therefore needs to consider whānau health equity.

"What is the DHB going to do about this? This shows your services aren't up to scratch with the rest of the country."

This DHB should of course aim and strive to provide the best quality health services that it can and ensure equitable access to that health care – so that health needs are met in a timely, and high quality way. I highlighted in my 2014 report the particular issues around access to primary care, especially amongst 45-64 year olds and the barriers that the cost of going to a general practice can create. However addressing many of the causes of ill-health lie outside the direct control of the DHB. This is why Hawke's Bay DHB is working closely with other agencies across Hawke's Bay, including businesses and the economic sector, to develop ways of tackling these issues together.

TACKLING HEALTH INEQUITIES: CHANGING BEHAVIOUR

There are many factors which influence health and therefore many ways of addressing health inequities. These factors can be categorised into four main areas:

Health behaviours – such as use of tobacco, nutrition, physical activity, alcohol

Health care – both access to care and receipt of high quality health care

Social and economic factors – where education and income are two of the biggest determinants of health

Physical environment – the quality of our air, water and other environmental factors that can directly influence our health and well-being.

Tackling health inequities requires a combination of approaches and broad community effort and leadership. Solely focusing on one area will not get us the health equity we want.

In this update I want to explore tackling health behaviours in more detail.

When we look at the difference in healthy behaviours within a community we often see less healthy behaviours amongst communities which are less well off. There have been many attempts to explain why this is so. It's clearer when risk factors are linked to the unaffordability of essentials such as housing and heating. It's more complicated when we look at risk factors such as smoking, obesity or alcohol. How much of this is due to informed personal choice and how much due to other factors (linked in some way to social disadvantage) which actually stops people from making more healthy choices?

Most people know smoking harms health and about the importance of good food and regular exercise. The reasons people continue to smoke and that obesity continues to increase do not stem from ignorance. Advice is useful but it is not how much people know that determines whether they behave as the advice suggests. What we fail to understand are the barriers that are stopping people from taking up those healthy behaviours.

Empowerment is about knowing you have control over many aspects of your health, about valuing the changes you can make and about then making those changes. Research has shown that empowerment is often absent in less well-off communities often then resulting in a belief that change isn't possible or they can't make changes to their health. This may help explain some of the variation we see in patterns in healthy behaviour.

Tackling health inequities and helping to change behaviours therefore requires both a supportive environment and empowerment framework.

- First by making healthy choices the easy choices (for example: knowledge, availability and cost, supportive environment)
- Secondly by empowering people to make decisions that will positively influence their health and well-being.

IRON MĀORI

A local example of an empowerment model is Iron Māori. I spoke to Heather Skipworth the founder of Iron Māori and fellow trustee Lee Grace about Iron Māori and its Kaupapa.

Iron Māori was first established in 2009. It offers triathlon-style swim, run, and cycle events in a variety of distance ranges for both individuals and for teams. It's very popular both within Hawke's Bay and across New Zealand.

For many of its participants it has proved to be life changing with many going on to achieve other personal goals in education, employment and improved health and mental wellbeing.

Heather's original concept for Iron Māori came out of her own sense of achievement she experienced on completing her first Iron Man event. At the time she was working with some clients with weight problems and she wanted to help them get that same sense of achievement and accomplishment in reaching their goals.

"When you complete something that's hard, arduous, takes a lot of tenacity and it's something that people don't expect you to be able to do, you grow from that. That transcends an event and ends up in other aspects of your life – how you think about yourself and how you expect more of yourself. There is a shift in peoples thinking from 'I can't do this', 'this is the mould I'm in' '…this is how life has been' towards realising that all of those are changeable."

Iron Māori does this by creating an accepting and supportive environment for those who register for one of their events. This starts right from the very first meeting where people share their stories and 'you are surrounded by a lot of people who can accept you for your whole person'.

This non-judgemental aspect is emphasised:

"You can go to doctors and even if he's not judgemental he's going to say you are overweight – you need to lose some weight. We never tell people they are obese. We never concentrate on their health issues. We just include them and the health issues slowly slip away without even having talked about them."

Empathy and trust are not just words on a mission statement; Lee says that Iron Māori is real .

"People stand up at the info evenings and talk about their life story - this resonates with people who are in that position. They may be living with drugs and violence and alcohol at the moment but they see someone who was doing that two years ago talking about how their lives changed. This openness and vulnerability is really powerful."

Whanaungatanga and the inclusiveness of Iron Māori is an essential part of the physical training

"Even with the practical training side of things there are barriers that individuals have to overcome to feel included. For some people simply wearing togs for the first time in front of a bunch of people is hard. But with a lot of laughter and humour it doesn't take long for people to come in and they are comfortable."

Trust, being inclusive and having a lot of empathy are key to Iron Māori's strength. But so too is the belief in people.

"We say we can take you and we will have you swimming… we believe you - you can do it and we keep believing in them even when they don't. Someone else believes in them enough that they keep doing it and when they do it they feel great!"

The health benefits are side benefits that come about as people realise smoking or too much alcohol doesn't fit into an active lifestyle. But the change comes from them – no-one is telling them to stop – they want to change and Iron Māori gives them a belief in themselves to change the things they thought they couldn't.

"I can kick that habit because I don't want it."

Heather and Lee have also seen people going back into study and getting into training or employment.

"This is not about rules – or saying you can't smoke or drink - it's a positive drive as opposed to reducing the negative. They have a reason to want to change and they are supported by others who are doing the same."

"By accomplishing a goal in a supportive way and feeling really good …opens up a whole world of 'I can do that' – it's about confidence to go and do things."

Role models are important – and what Iron Māori provides is for people who are achieving their personal goals, not drinking and spending more time with their families to be positive role models for others.

"We don't get bogged down in the why or the theory or the latest study on motivation to change. We just do it and we try to understand people. We know what's really powerful is when you hear someone speak and they are telling your story, and the time is right - then that's your motivation.

"We never tell anyone they are on a programme – because programmes begin and end. This is a Kaupapa – this is your life, this is part of your lifestyle and a way of living. We never say it's a programme – even if you leave Iron Māori your journey still continues – it has no end. "

There are other programmes in our community which support empowerment and motivation to change. They vary in detail but the central theme is about giving back control to people to make changes in their lives and the lives of their whānau. These types of programmes and a resolve to provide an environment to support healthy choices will have a positive impact on behaviours and the choices that people make.

Photo courtesy HB Today

CHAPTER 1.0 HEALTH OUTCOMES

At the current rate of change in life expectancy equity for Māori won't be reached for another nearly 50 years.

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LIFE EXPECTANCY – *HOW LONG WE LIVE*

There is no updated life expectancy data, by District Health Board, since the last Health Equity 2014 report - that was for the period 2008-10. However recent analysis by Statistics New Zealand calculates life expectancy by territorial authority regions for 2012-14 and also compares the results with 2005-07. The Hawke's Bay territorial region is very similar to the Hawke's Bay DHB boundaries and this analysis provides us for the first time a comparison of how we do in relation to other parts of New Zealand and how life expectancy has changed over this seven year period.

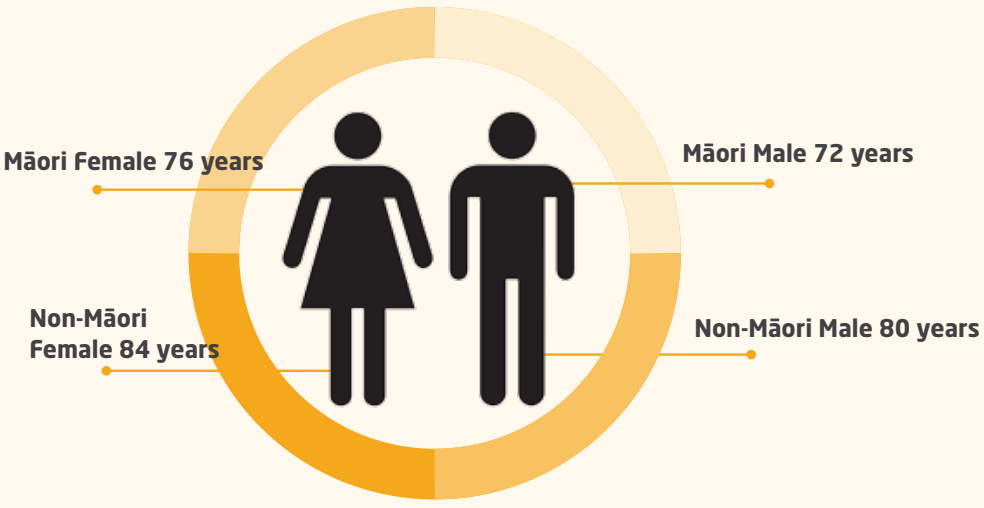
Life expectancy at birth has increased in all regions in New Zealand since 2005–07, with Hawke's Bay increasing the most - by 1.5 years for males and 1.2 years for females. Hawke's Bay however remains in the bottom quartile of the 16 territorial authority regions.

The gap in life expectancy in Hawke's Bay between Māori and non-Māori is 8.2 years for males and 7.7 years for females. **This is one of the largest gaps in life expectancy across New Zealand, which varies from one year in Otago to nine years in Northland. This variation in gap is due to the variation in life expectancy for Māori across the country, rather than any variation in life expectancy for non-Māori.** Māori in Hawke's Bay can expect to live on average six years less than Māori in Otago. This variation in life expectancy for Māori across New Zealand will be heavily influenced by social and economic factors rather than health behaviours and local health service provision.

Analysis of trends in life expectancy between 2005-07 and 2012-14 by ethnicity and gender shows that the **biggest gains in life expectancy across New Zealand were for Māori males in Hawke's Bay and for Māori females in Hawke's Bay,** along with gains in the Taranaki, Tasman and West Coast regions.

LIFE EXPECTANCY IN HAWKE'S BAY REGION, BY ETHNICITY AND GENDER, 2012-14, YEARS

	HAWKE'S BAY	LIFE EXPECTANCY GAP	NEW ZEALAND	LIFE EXPECTANCY GAP
Males	78.6 years	3.8 years	79.5 years	3.7 years
Females	82.4 years		83.2 years	
Māori Male	71.7 years	8.2 years	73.0 years	7.3 years
Non - Māori Male	79.9 years		80.3 years	
Māori Female	75.9 years	7.7 years	77.1 years	6.8 years
Non - Māori Female	83.6 years		83.9 years	



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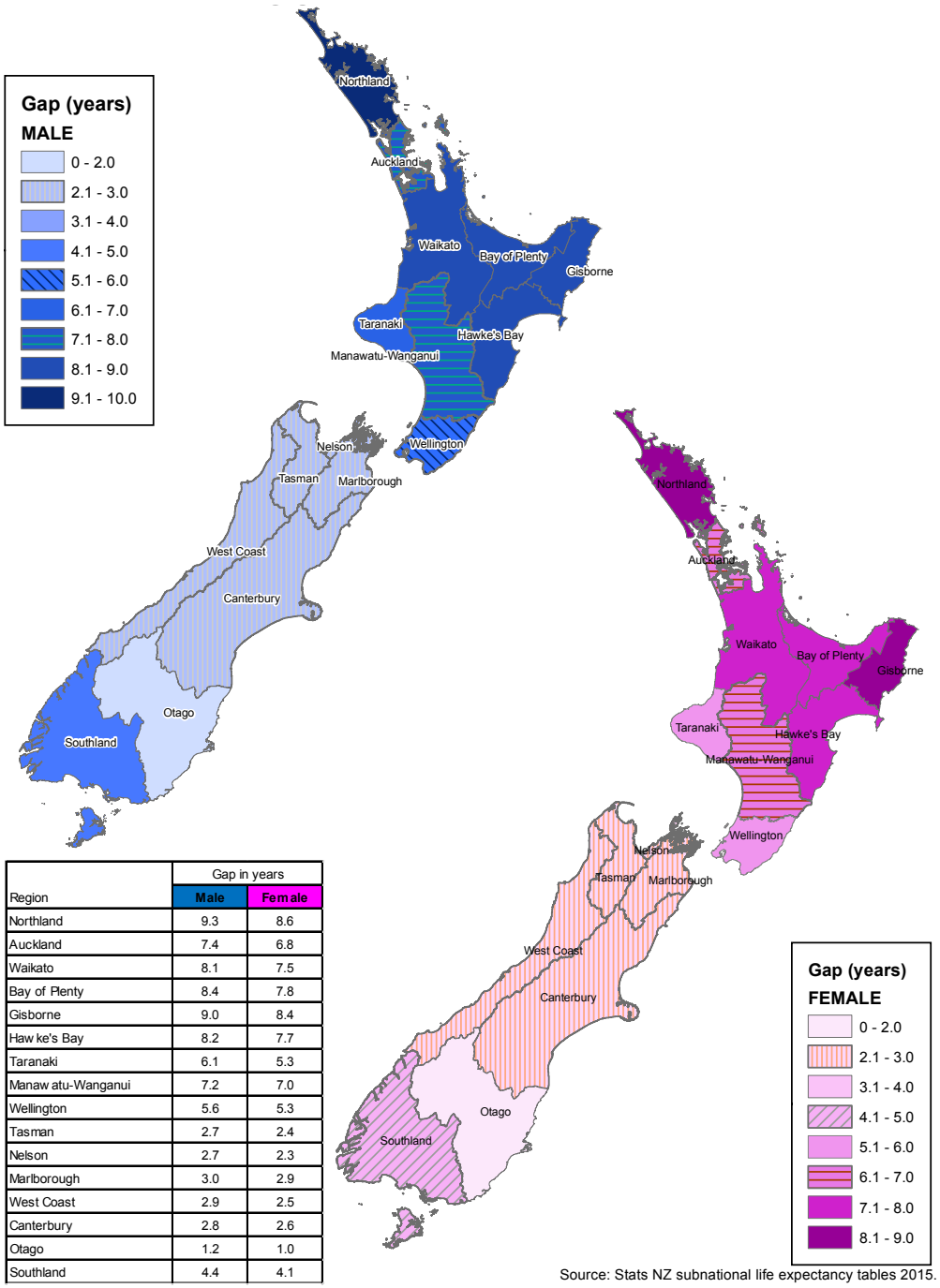
1.0 HEALTH OUTCOMES

The 1.4 years reduction in life expectancy gap between Māori and non-Māori males in Hawke's Bay is also the largest reduction observed across the regions in New Zealand.

Good progress appears to have been made in Hawke's Bay over the past seven years, especially compared to other regions. **However at the current rate of change in life expectancy equity for Māori won't be reached for another nearly 50 years.**

GAP IN YEARS BETWEEN MĀORI AND NON-MĀORI LIFE EXPECTANCY BY GENDER AND REGION 2012-14



Region	Gap in years	
	Male	Female
Northland	9.3	8.6
Auckland	7.4	6.8
Waikato	8.1	7.5
Bay of Plenty	8.4	7.8
Gisborne	9.0	8.4
Hawke's Bay	8.2	7.7
Taranaki	6.1	5.3
Manawatu-Wanganui	7.2	7.0
Wellington	5.6	5.3
Tasman	2.7	2.4
Nelson	2.7	2.3
Marlborough	3.0	2.9
West Coast	2.9	2.5
Canterbury	2.8	2.6
Otago	1.2	1.0
Southland	4.4	4.1

Source: Stats NZ subnational life expectancy tables 2015.

19.1

COMPARISON OF PREMATURE DEATHS IN HAWKE'S BAY BETWEEN 2006-10 AND 2008-12

	DEATHS UNDER 75 YEARS		DEATHS UNDER 50 YEARS	
	2006-2010	2008-2012	2006-2010	2008-2012
Māori	77.0%	73.2%	26.3%	24.8%
Pasifika	52.4%	63.4%	23.8%	29.0%
Other	31.9%	31.3%	5.1%	5.2%
Quintile 5	56.5%	54.5%	16.1%	14.8%
Quintile 1	20.6%	20.8%	4.4%	3.9%
HB Total	38.7%	38.0%	9.2%	8.5%

PREMATURE DEATHS

Premature deaths are deaths before the age of 75 years. In Heath Equity 2014 I highlighted the inequity in the proportion of premature deaths before 75 years but also, more shockingly, in deaths before the age of 50 years for both Māori and Pasifika in Hawke's Bay. The latest figures for 2008-12 show improvements with a small decrease in the percentage of Māori dying before the age of 50 years but an increase for Pasifika people (numbers are very small).

A quarter of the deaths in our Māori communities occur before the age of 50 compared to only 5 percent in our non-Māori non-Pasifika communities. Most of these deaths are avoidable.

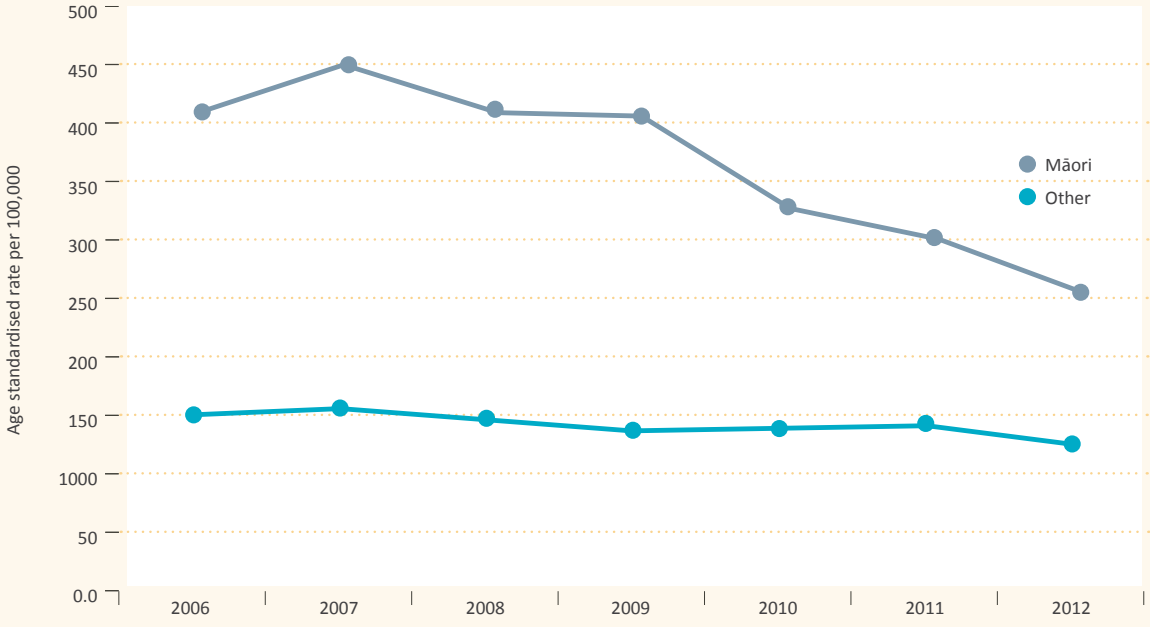
AVOIDABLE DEATHS

Nearly three-quarters of all deaths before the age of 75 years are avoidable either because of disease prevention or because of effective treatment and health care. Deaths due to these diseases or conditions can be counted and expressed as a rate. Any difference in these rates by ethnicity or by area of residence can therefore be considered to be a health inequity.

The equity gap in avoidable deaths is reducing and should close by 2017 if current trends continue. Avoidable death rates are still two times higher amongst Māori and amongst people living in Quintile 5 areas in Hawke's Bay.

The top cause of avoidable death across all ethnic groups remains ischaemic heart disease (heart attacks), accounting for about 20 percent of all avoidable deaths. The top cause of avoidable death for Māori women is lung cancer, followed by ischaemic heart disease. The top cause of death for non-Māori women remains breast cancer. Road traffic injuries and diabetes continue to be significant causes of death amongst Māori. Suicide is a significant cause of death for all ethnicities.

HAWKE'S BAY AVOIDABLE MORTALITY AGE STANDARDISED RATE PER 100,000 BY ETHNICITY



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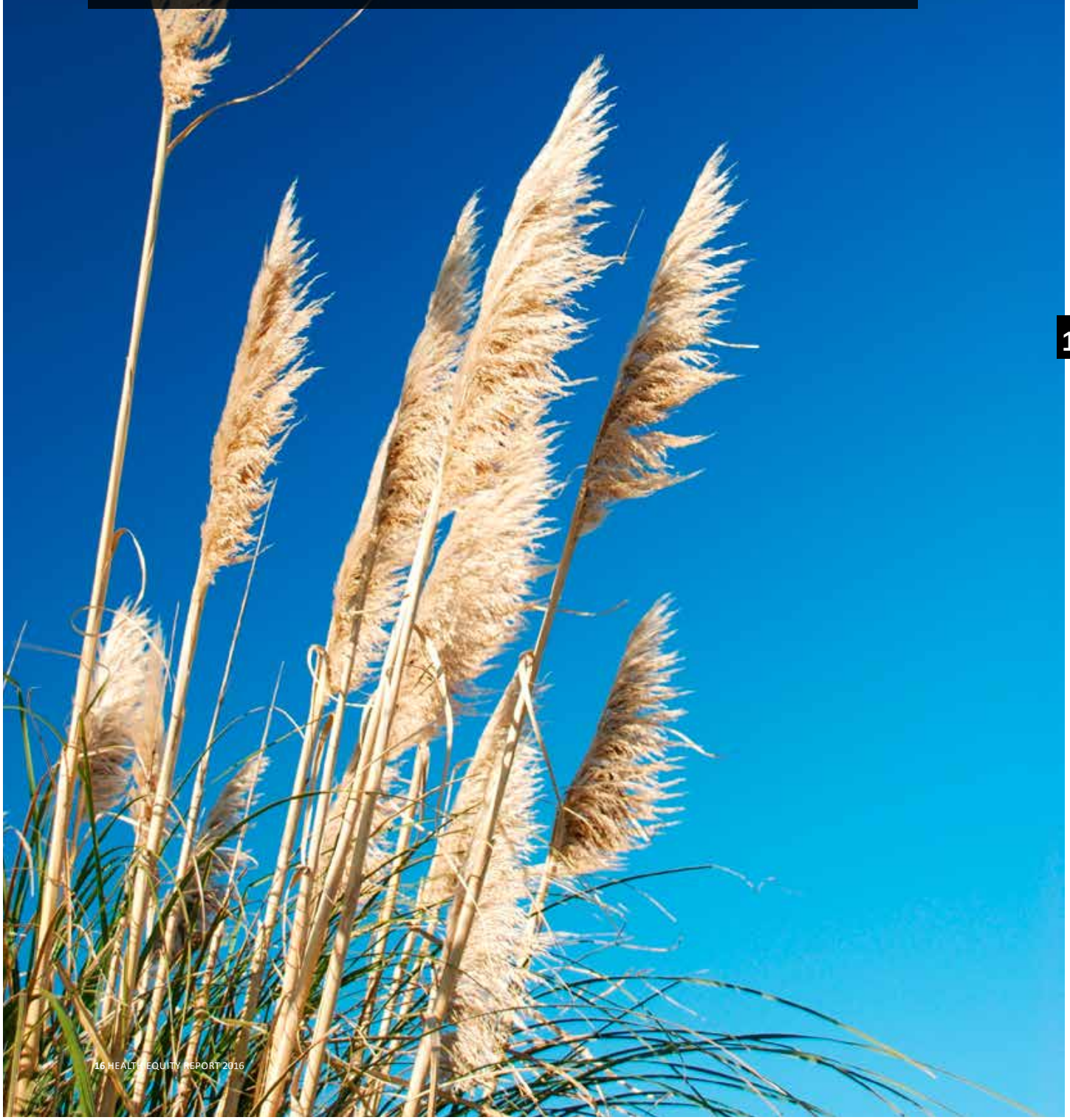
1.0 HEALTH OUTCOMES

The equity gap in avoidable deaths is reducing and should close by 2017 if current trends continue.



19.1

TOP CAUSES OF AVOIDABLE DEATHS	MĀORI MALES	OTHER MALES	MĀORI FEMALES	OTHER FEMALES
Ischaemic heart disease	26.6% (1)	22.3% (1)	15.6% (2)	12.3% (3)
Road traffic injuries	12.5% (2)	4.5% (6)	3.9% (8)	–
Lung cancer	10.3% (3)	17.7% (2)	22.4% (1)	13.6% (2)
Diabetes	8.2% (4)	3.5% (9)	8.3% (4)	2.8% (9)
Suicide & self-inflicted injuries	6.0% (5)	8.3% (3)	5.4% (6)	3.2% (8)
Complications infant perinatal period	4.1% (6)	–	–	–
Cerebrovascular disease	3.8% (7)	5.7% (5)	5.4% (6)	7.8% (5)
COPD (respiratory disease)	3.4% (8)	4.1% (8)	5.9% (5)	6.9% (6)
Breast cancer	–	–	8.3% (3)	14.1% (1)
Colorectal cancer	3.1% (9)	7.9% (4)	–	11.9% (4)
Melanoma skin	–	4.2% (7)	–	4.5% (7)
Stomach cancer	2.5% (10)		–	–

POTENTIAL YEARS OF LIFE LOST (PYLL)

Another way of looking at premature deaths is to calculate the average years a person would have lived if they had not died prematurely. This method emphasises the importance of causes of death which occur at earlier ages because there are more potential years of life lost (PYLL).

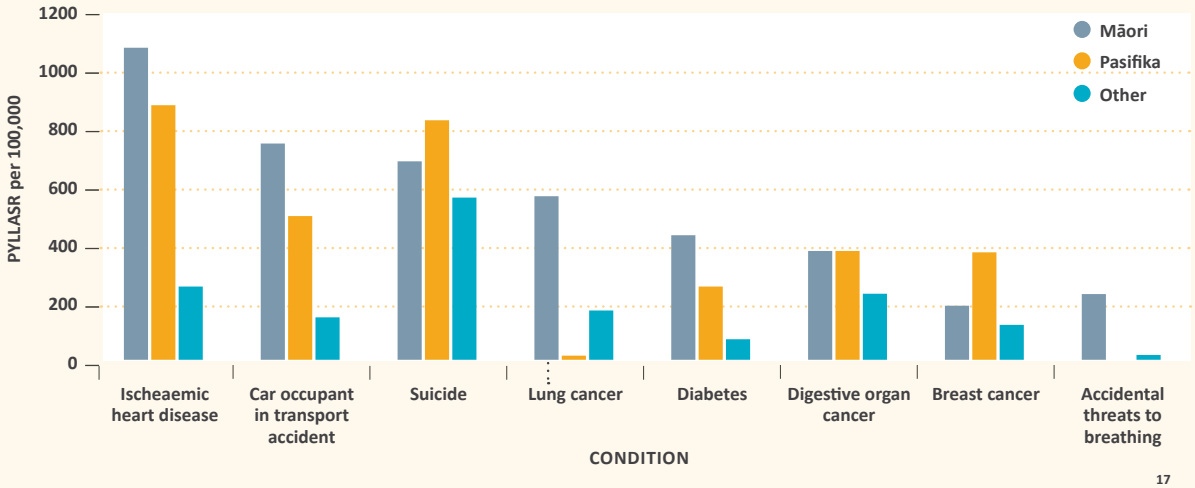
The most recent time period studied (2008-12) shows that there have been **reductions in PYLL and a reduction in inequity for Māori and people living in Quintile 5 areas.** However Māori rates are still 2.0 times, Pasifika rates 2.9 times and people living in Quintile 5 1.8 times higher than the rest of Hawke's Bay.

The top conditions to target to reduce health inequity continue to be:

- ischaemic heart disease (heart attacks) (Māori 4 times and Pasifika 3 times higher),
- being in a car involved in a transport accident (Māori 4.6 times and Pasifika 3 times higher)
- lung cancer (Māori 3 times higher)
- diabetes (Māori 5 times and Pasifika 3.5 times higher)

In the time period 2008-12 a set of conditions coded as "Other accidental threats to breathing" emerged as a top cause of PYLL for Māori (Māori 17 times higher). This latter grouping includes Sudden Unexplained Death in infancy (SUDI). A small number of deaths at an early age (these deaths all occurred in the first year of life) will result in large numbers of potential years of life lost. SUDI rates in Hawke's Bay have been falling but a spike was seen in 2010-11. This spike was noticed and led to local maternity and early child care services implementing a Safe Sleep programme focused on the prevention of SUDI.

TOP CAUSES OF POTENTIAL YEAR OF LIFE LOST (2008-12) BY ETHNICITY



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CHAPTER 2.0 SOCIAL AND ECONOMIC FACTORS

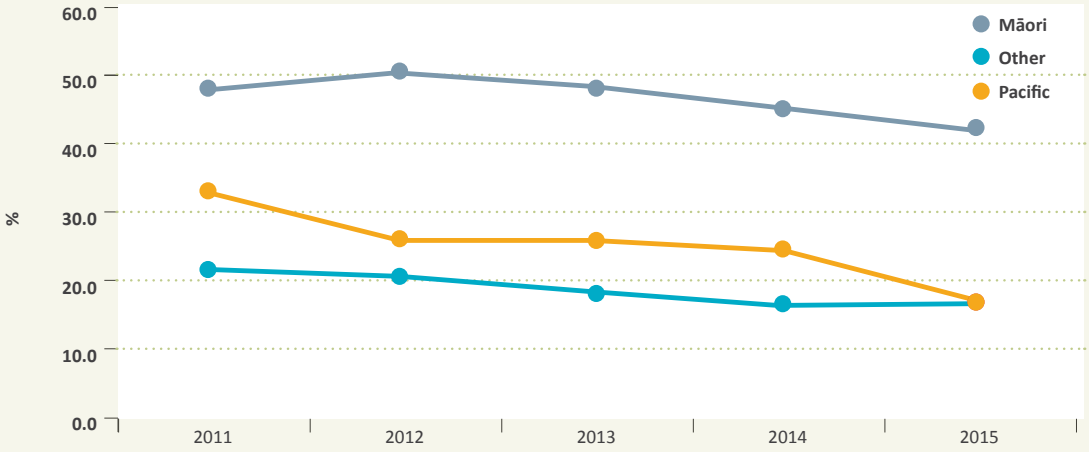
This section looks at some social and economic factors which can influence health and where possible looks at the distribution of those across the community.

CHILDREN LIVING IN HOUSEHOLDS RECEIVING BENEFITS

There has been a decrease in the percentage of children in Hawke's Bay living in households receiving a working age main benefit although these figures are still higher than for New Zealand as a whole. Twenty eight percent of 0-4 year olds live in households receiving a working age benefit compared with 21 percent for New Zealand and 23 percent of 0-14 year olds in Hawke's Bay compared to 18 percent in New Zealand (at end June 2015).

There are however still clear disparities by ethnicity, particularly for Māori, with the most recent figures for 2015 showing **42 percent of Māori children aged 0-4 years** living in such households compared to 15.3 percent of non- Māori non-Pasifika children.

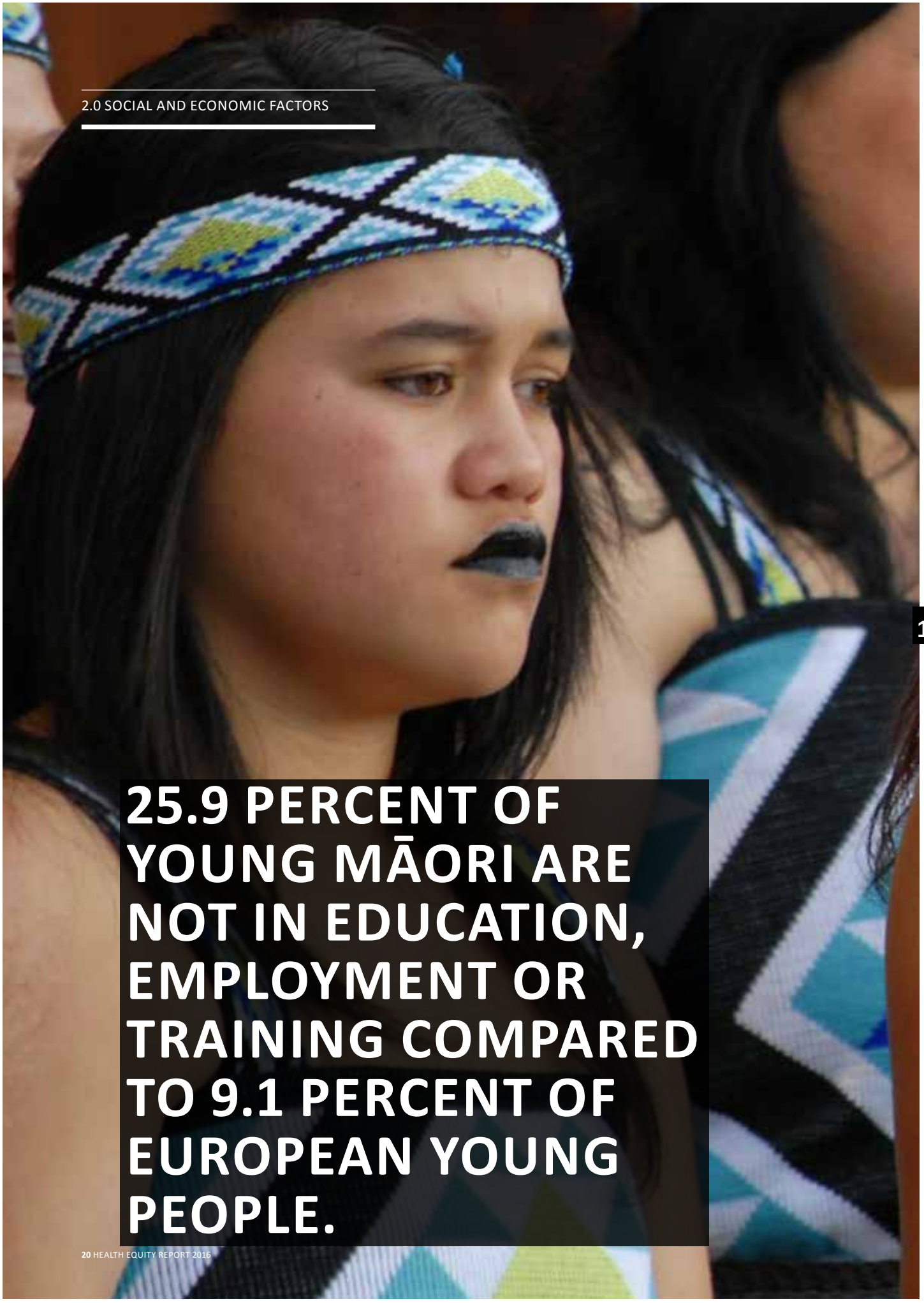
PERCENT OF CHILDREN (0-4 YEARS) LIVING IN A HOUSEHOLD DEPENDENT ON A MAIN BENEFIT BY ETHNICITY
(AS AT END OF JUNE YEAR)



PERCENT OF CHILDREN LIVING IN HOUSEHOLDS DEPENDENT ON A MAIN BENEFIT BY ETHNICITY 2015.

ETHNICITY	HB 0-4 YEARS	NZ 0-4 YEARS	HB 0-14 YEARS	NZ 0-14 YEARS
Māori	42.4%	36.9%	36.4%	25.4%
Pacifika	15.6%	18.5%	15.2%	14.5%
Other	15.3%	11.9%	13.0%	9.0%
TOTAL	28.3%	20.6%	22.8%	17.8%

Source: Ministry of Social Development



19.1

25.9 PERCENT OF YOUNG MĀORI ARE NOT IN EDUCATION, EMPLOYMENT OR TRAINING COMPARED TO 9.1 PERCENT OF EUROPEAN YOUNG PEOPLE.

YOUNG PEOPLE NOT IN EDUCATION, EMPLOYMENT OR TRAINING (NEET)

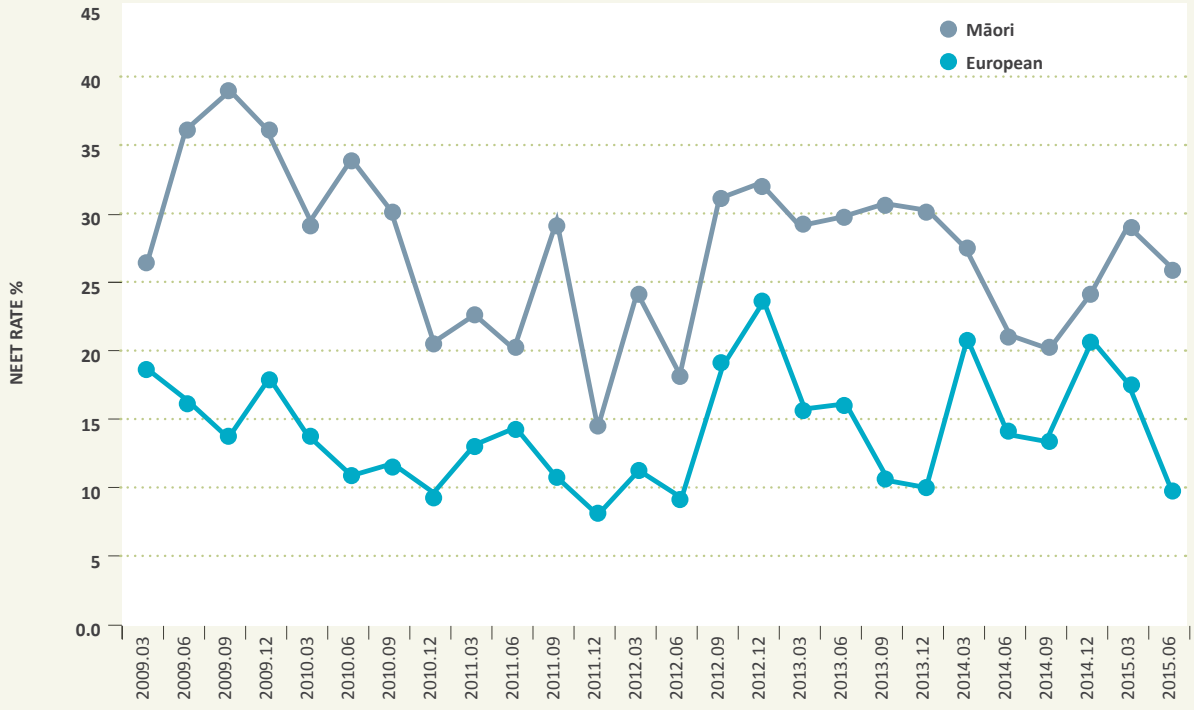
Young people not in employment, education, or training (NEET) are young people aged 15–24 years who are unemployed (not part of the labour force) and not engaged in education or training. These young people are at greater risk of a range of negative outcomes including poorer health, depression, or early parenthood. This is an indicator where there have been consistent differences in the rates of NEET by ethnicity, with Māori rates often between 2-3 times higher than non- Māori rates.

The proportions of young people who are NEET in Hawke's Bay fluctuate, as do the national rates.

The most recent figures show that **25.9 percent of young Māori are not in education, employment or training compared to 9.1 percent European young people.**

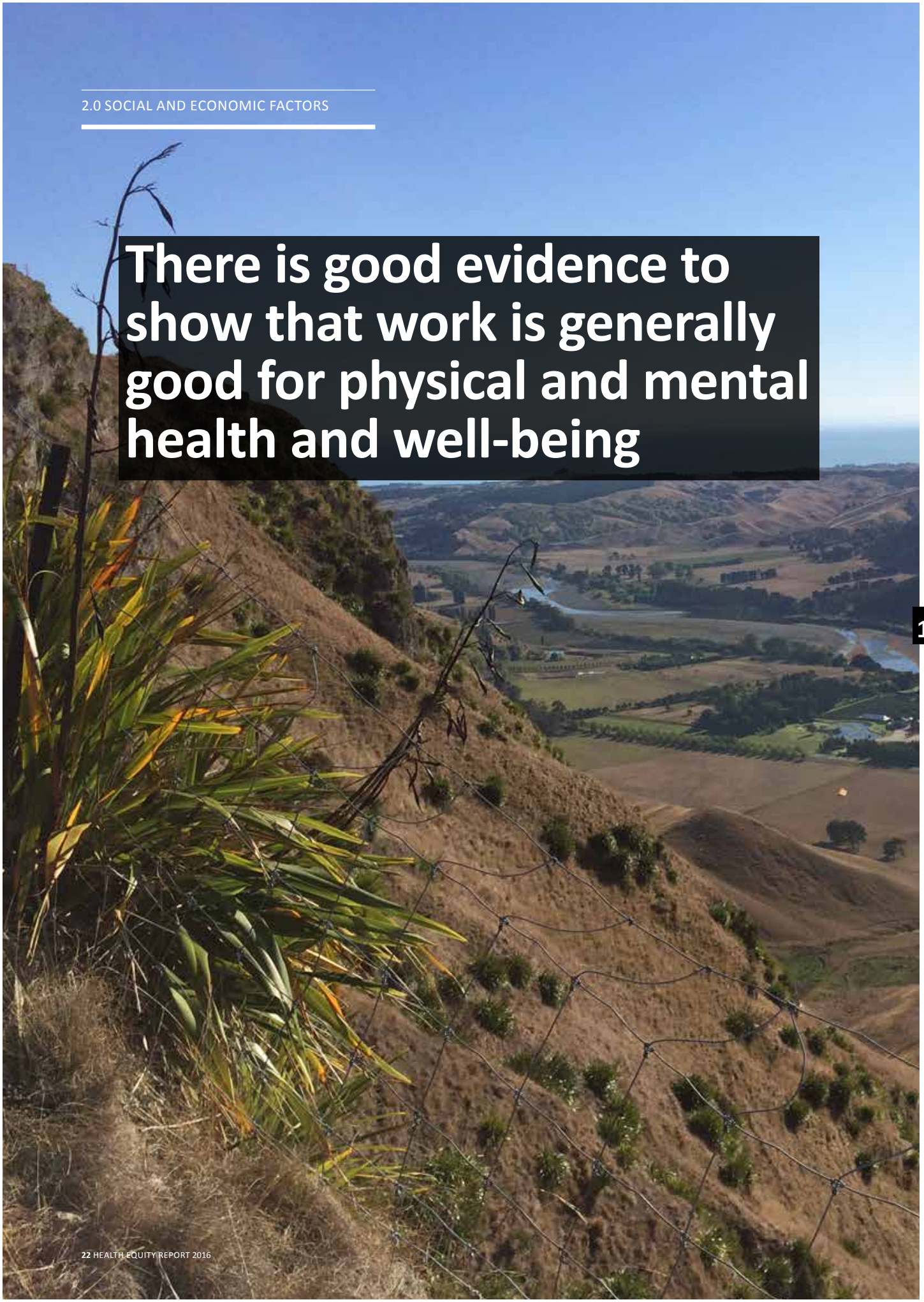
Given the fluctuating data it is difficult to determine whether this gap is closing or not.

HAWKE'S BAY REGION NOT IN EMPLOYMENT EDUCATION OR TRAINING (NEET) RATE 15-24YRS (PERCENT) 2009-15



Source: Household Labour Force Survey – Statistics NZ

There is good evidence to show that work is generally good for physical and mental health and well-being



19.1

UNEMPLOYMENT

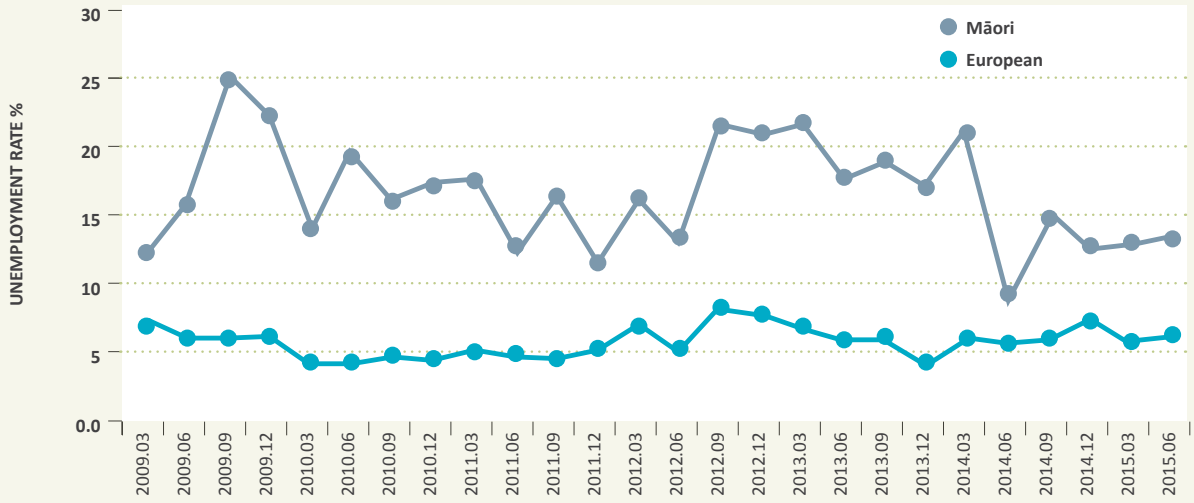
There is good evidence to show that work is generally good for physical and mental health and well-being and being unemployed does tend to be associated with poorer physical and mental health.

Being unemployed is defined as all people in the working-age population who during the reference week were without a paid job, available for work, and had either actively sought work in the prior four week period, or had a new job to start within the next four weeks.

Unemployment rates in Hawke's Bay have fluctuated over the period March 2009 to June 2015 and both locally and nationally do seem to have decreased since September 2012. At 7.2 percent in June 2015 Hawke's Bay rates are just higher than the New Zealand average of 5.7 percent.

European unemployment rates have been relatively stable at around 6 percent since September 2012. **Māori rates have decreased substantially since March 2014 averaging out at around 12.5 percent for the past period December 2014 to June 2015 with a reduction in the equity gap.**

HAWKE'S BAY REGION 2009-2015 - QUARTERLY UNEMPLOYMENT RATE PERCENTY



Source: Household Labour Force Survey – Statistics NZ

CHILDHOOD DISEASE LINKED WITH SOCIOECONOMIC CONDITIONS

There are many childhood diseases that are known to be linked to socioeconomic conditions with much higher rates or worse outcomes seen in those children living in the most socioeconomically deprived areas. Most of these conditions are infectious and respiratory diseases and many can be directly linked to cold damp houses and overcrowding. The Health Equity report 2014 highlighted that admission rates for these conditions had increased in Hawke's Bay since 2006 for all ethnic groups but particularly for Pasifika children with a widening in health equity gap for both Pasifika and Māori.

Updated data from the NZ Child and Youth Epidemiology service (NZCYES) show that In Hawke's Bay for the period 2009-13 **the overall rate of admissions for all conditions with a social gradient in Hawke's Bay was significantly lower than the New Zealand rate.**

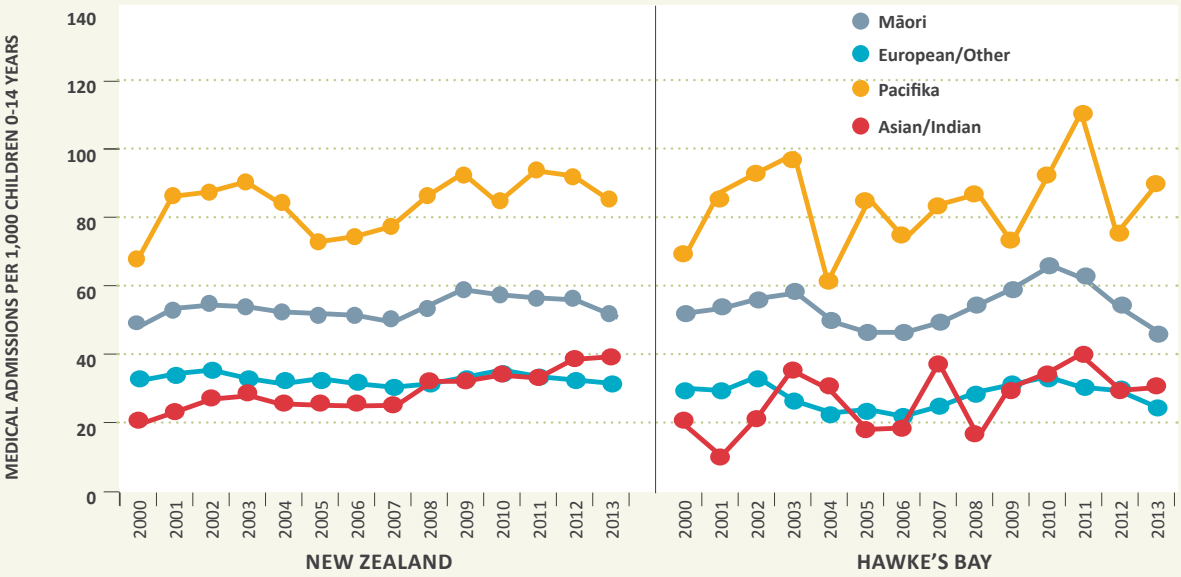
There has been a reduction locally in the admission rates for Māori and Asian / Indian with fluctuation in Pasifika rates. **There remains a marked disparity in admission rate by ethnicity but substantial closing of the gap in admission rates between Māori and European / other children.**

Unfortunately NZCYES have not provided data on trends in admissions for the individual diseases in this category.

It is not clear if this decrease in admissions is due to an improvement in living conditions or due to other factors such as vaccination programmes and earlier treatment in primary care.

19.1

HOSPITAL ADMISSIONS FOR MEDICAL CONDITIONS WITH A SOCIAL GRADIENT, PER 1000, 0-14 YEARS OLD, BY ETHNICITY, HAWKE'S BAY VS NEW ZEALAND, 2000-13



Source: New Zealand Child & Youth Epidemiology Service

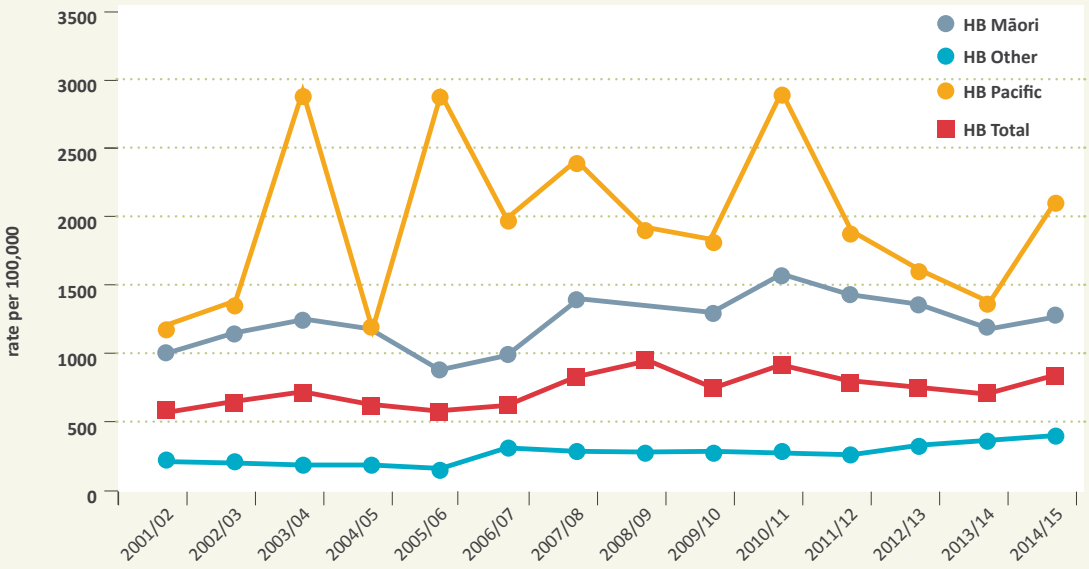
ACUTE BRONCHIOLITIS

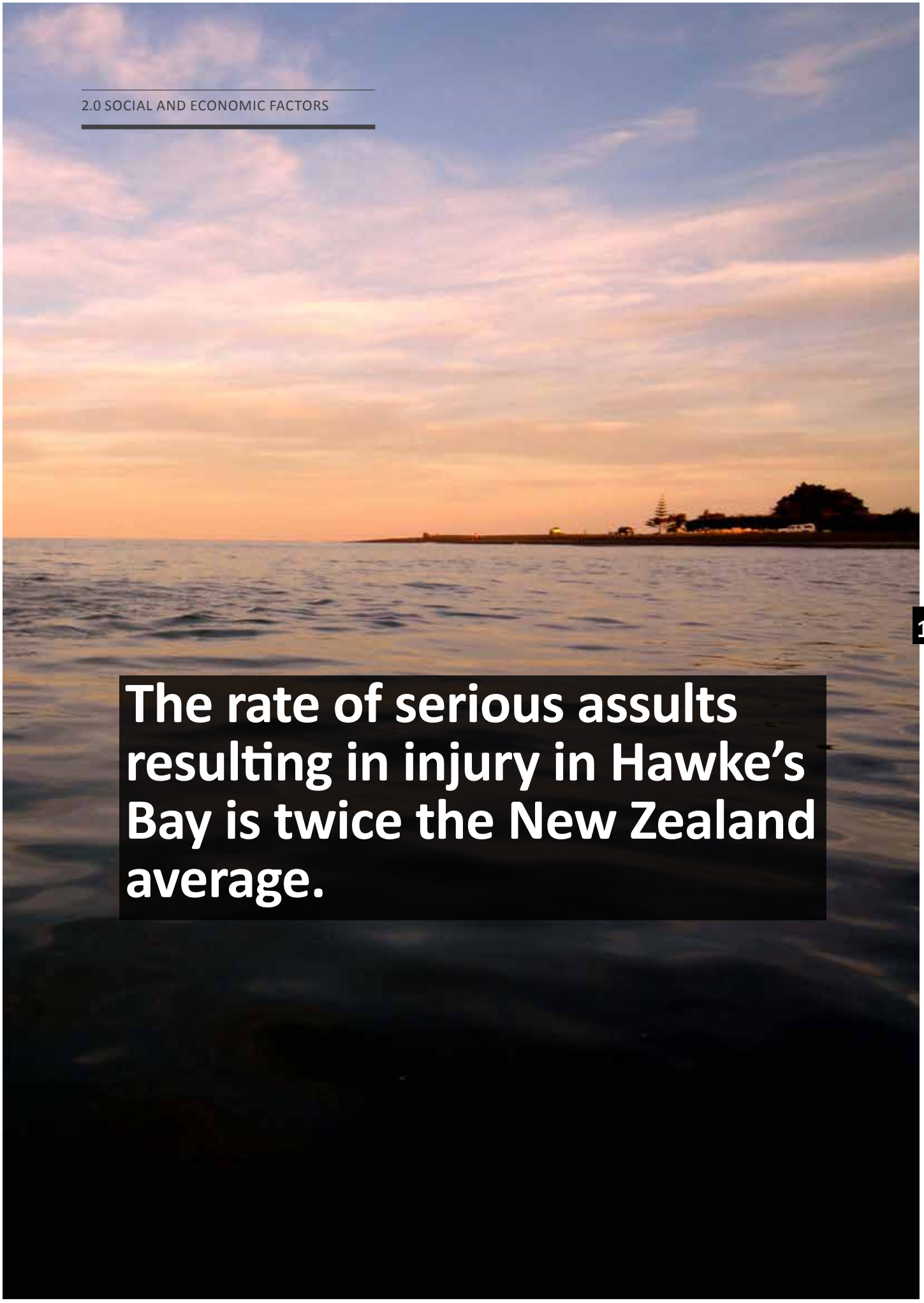
Acute bronchiolitis is a one of the diseases in the list of medical conditions with a social gradient for admissions to hospital. It is a viral infection of the airways and occurs mainly amongst infants under one year old. It is the most common cause of hospital admission in this age group and tends to occur most frequently in late winter. In 2014-15 there were 283 children admitted to hospital with this condition in Hawke's Bay, of whom 180 were Māori, 65 Other ethnicity and 38 Pasifika.

There are a number of risk factors which increase the likelihood of infection such as prematurity, congenital heart disease, immune deficiency, household overcrowding, poverty, lack of breastfeeding, maternal smoking during pregnancy and exposure to tobacco smoke in the home.

Over the period 2010-14 Hawke's Bay had **higher rates of bronchiolitis admissions** than the New Zealand average (111.1 per 1000 compared to 84.6 per 1000, a relative rate of 1.3 times higher). Admission rates have been generally increasing since 2001 but have decreased for Māori and Pasifika children over the past 5-6 years (with an increase for Pasifika children in 2014-15). **However there continues to be inequity with higher rates of bronchiolitis amongst Māori (3 times) and Pasifika (4 times) children and amongst children from quintile 5 areas (4 times) – these are all statistically significantly higher rates.**

ACUTE BRONCIOLITIS ADMISSIONS 0-14 YEAR OLDS HBDHB




2.0 SOCIAL AND ECONOMIC FACTORS
19.1
The rate of serious assults resulting in injury in Hawke's Bay is twice the New Zealand average.

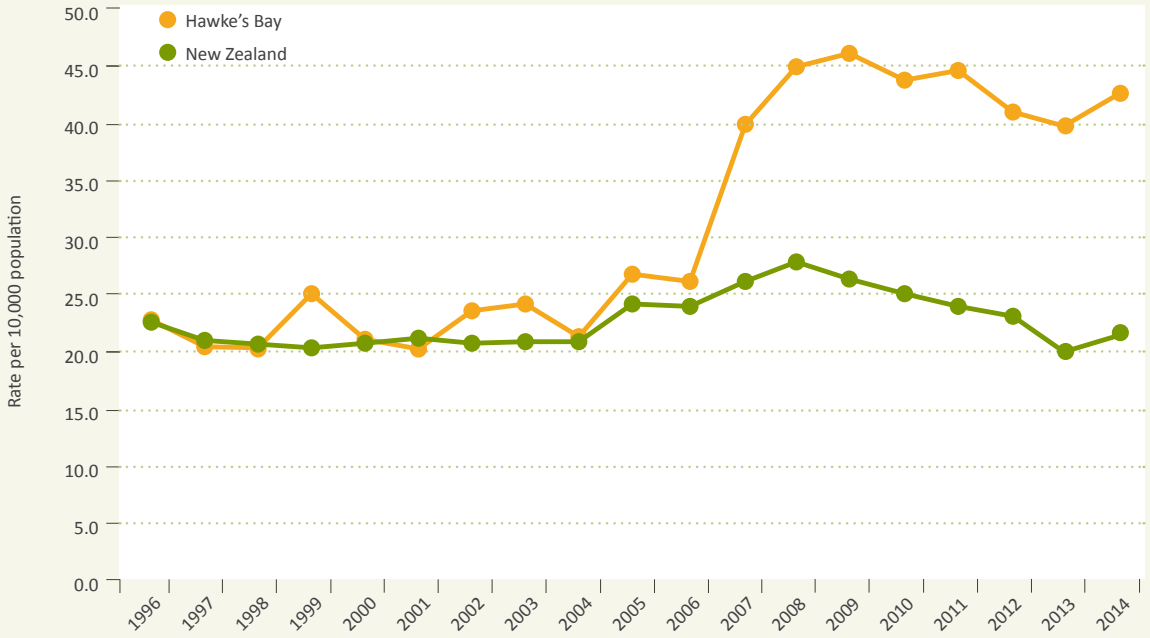
PREVALENCE OF VIOLENT CRIME

The links between crime and health are complex. Violent crime may result in temporary or permanent disability and in some cases death. Some victims of crime may suffer psychological distress and subsequent mental health problems. Crime and fear of crime can also alter people's lifestyles and impact on their physical and psychological health. There is also concern about homicide and suicide by people with mental illness.

NZ Police data has been analysed to try to ascertain the prevalence of violent crime in Hawke's Bay. The data only includes violent offences which are reported to the police and is may vary due to changes in police crime reporting procedures. It is also only available at a Hawke's Bay level, not by ethnicity or socioeconomic decile.

Hawke's Bay rates of violent crime continue to be higher than the New Zealand average and are twice the rate for New Zealand as a whole. Over the lfivast five years there has been a slight increase in the rates of assault resulting in injury in Hawke's Bay with a reduction nationally resulting in a **widening of the gap in equity between Hawke's Bay and New Zealand as a whole.**

RECORDED SERIOUS ASSAULT RESULTING IN INJURY OFFENCE RATE PER 10,000 POPULATION HAWKE'S BAY AND NZ



CHAPTER 3.0 HEALTH BEHAVIOURS

The measures in this section look at health behaviours. These are known risk factors which have a direct influence on health and can change through changes in behaviour.

TOBACCO USE AMONGST YOUNG PEOPLE

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. In particular the high rate of smoking amongst Māori women giving birth was highlighted and declared a public health crisis, given the effects that smoking has both for the mother and on the health of her infant with lasting impacts into adulthood.

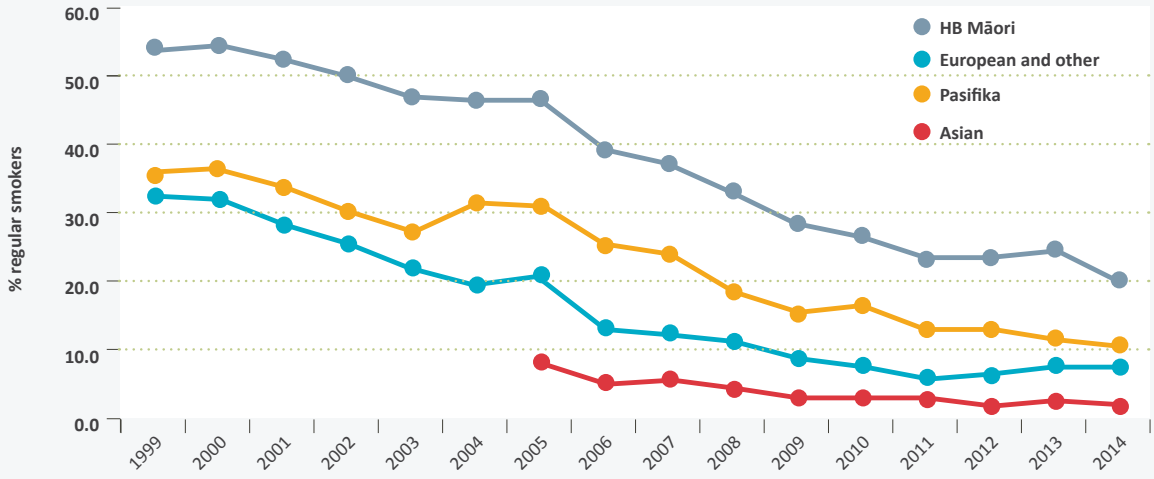
The main source of information on smoking rates comes from the census but this will not be updated until 2018. However the latest Ministry of Health funded ASH (Action on Smoking and Health) Year 10 survey results are available (2014). This survey is an annual questionnaire of around 30,000 students across New Zealand. It is conducted in schools throughout the country and is one of the biggest surveys of its kind. It has been going for 16 years and gives us a valuable and robust insight into rates of youth smoking.

Smoking is an addiction largely taken up in childhood and adolescence, so it is crucial to reduce the number of young people taking up smoking in the first place. Most current and ex-smokers say that they started smoking regularly before they were 18 with many smoking regularly before the age of 16.

The percentage of year 10 students who are regular smokers has been **dropping consistently** since the first survey in 1999 when 28.6 percent of students across New Zealand were regular smokers compared to only 6 percent in 2014. The latest survey indicates that 8.7 percent of year 10 students in Hawke's Bay are regular smokers. This is statistically higher than the 6 percent for New Zealand.

This decrease has been seen across all ethnic groups with a narrowing of the gap in prevalence noticeable since 2006. Māori continue to have higher rates of regular smokers (17 percent) with the lowest rates seen amongst Asian students (2 percent) and 5 percent European.

HAWKE'S BAY DHB YEAR 10 FEMALES PERCENT REGULAR SMOKERS



Source: Action on Smoking and Health (ASH)

Reducing smoking rates amongst Māori women must remain a key health equity target.

Year 10 girls are more likely to be regular smokers than year 10 boys. **Nearly 20 percent of Māori girls aged 15 years are regular smokers this is 6 times the rates of smoking amongst European girls and twice the rate amongst Māori males (11 percent).** Pasifika girls are also more likely to be regular smokers but the rate is 1.7 times that of European girls.

Improvements continue to be seen and the gap in smoking rates for both boys and girls by ethnicity is closing. Tackling smoking rates amongst young Māori women remains a key health priority and is an area where more innovative and whānau-inclusive approaches will be required.

Tobacco use in pregnancy

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 in infancy.

Encouraging pregnant women to stop smoking during pregnancy may also help them kick the habit for good, and thus provide health benefits for the mother and reduce exposure to second-hand smoke by the infant.

Twenty three percent of all women who had a baby at a Hawke's Bay DHB facility during 2014-15 were current smokers with big differences seen both by ethnicity and by deprivation.

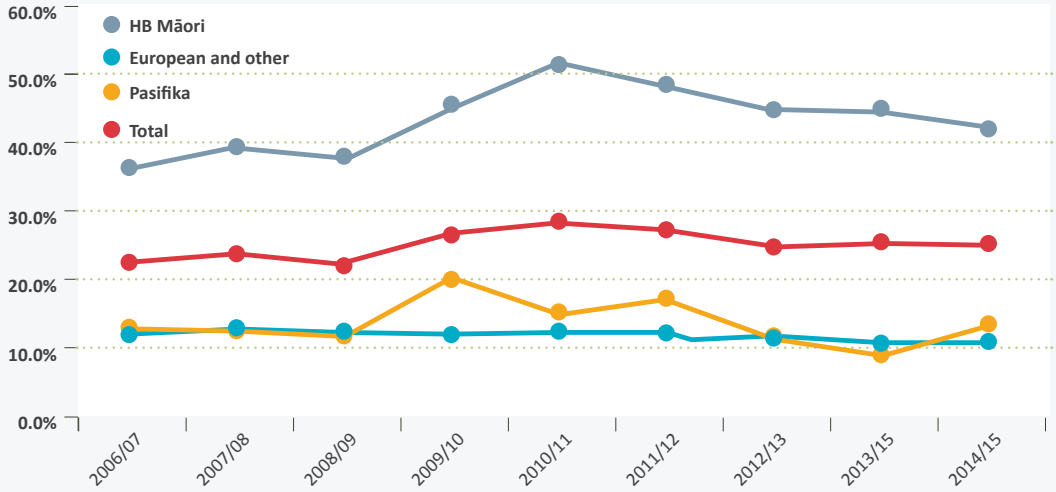
Pregnant women who are Māori or who live in a quintile 5 area are five times more likely to be smokers than non-Māori or women living in a Quintile 1 area.

Forty three percent of all Māori women giving birth were smokers compared to 8.6 percent of non-Māori non-Pacific women; 32 percent of women living in Quintile 5 compared to 6 percent living in Quintile 1.

Rates of smoking amongst pregnant women peaked in 2010-11 and have been very slowly decreasing since then. If the percentage of Māori women who are regular smokers, or the percentage of women living in Quintile 5 areas, declines at the same rate as it has since 2010-11 (nearly 10 percent reduction over 5 years) **equity won't be achieved for at least 15 years.**

Reducing smoking rates amongst Māori women must remain a key health equity target.

PERCENT OF SMOKER STATUS OF WOMEN DELIVERING IN HBDHB FACILITIES BY ETHNICITY 2006-07 TO 2014-15



Source: HBDHB Data Warehouse

OBESITY IN FOUR YEAR OLD CHILDREN

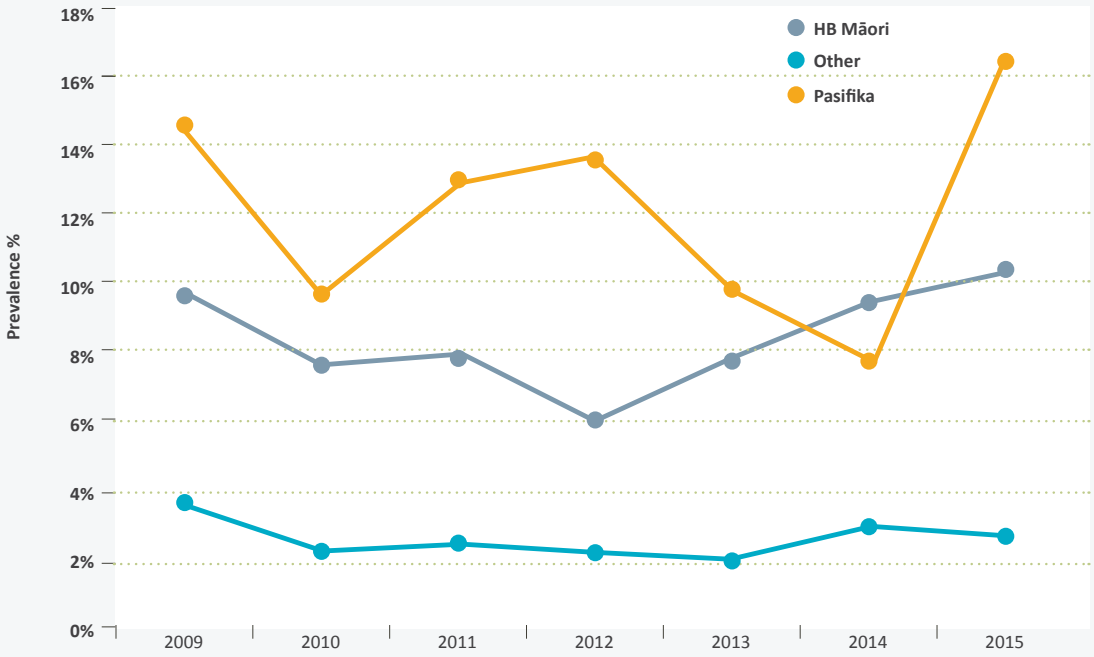
There has been an increase in the prevalence of obesity in four year olds since 2009 (5.8 percent) and a widening in inequities.

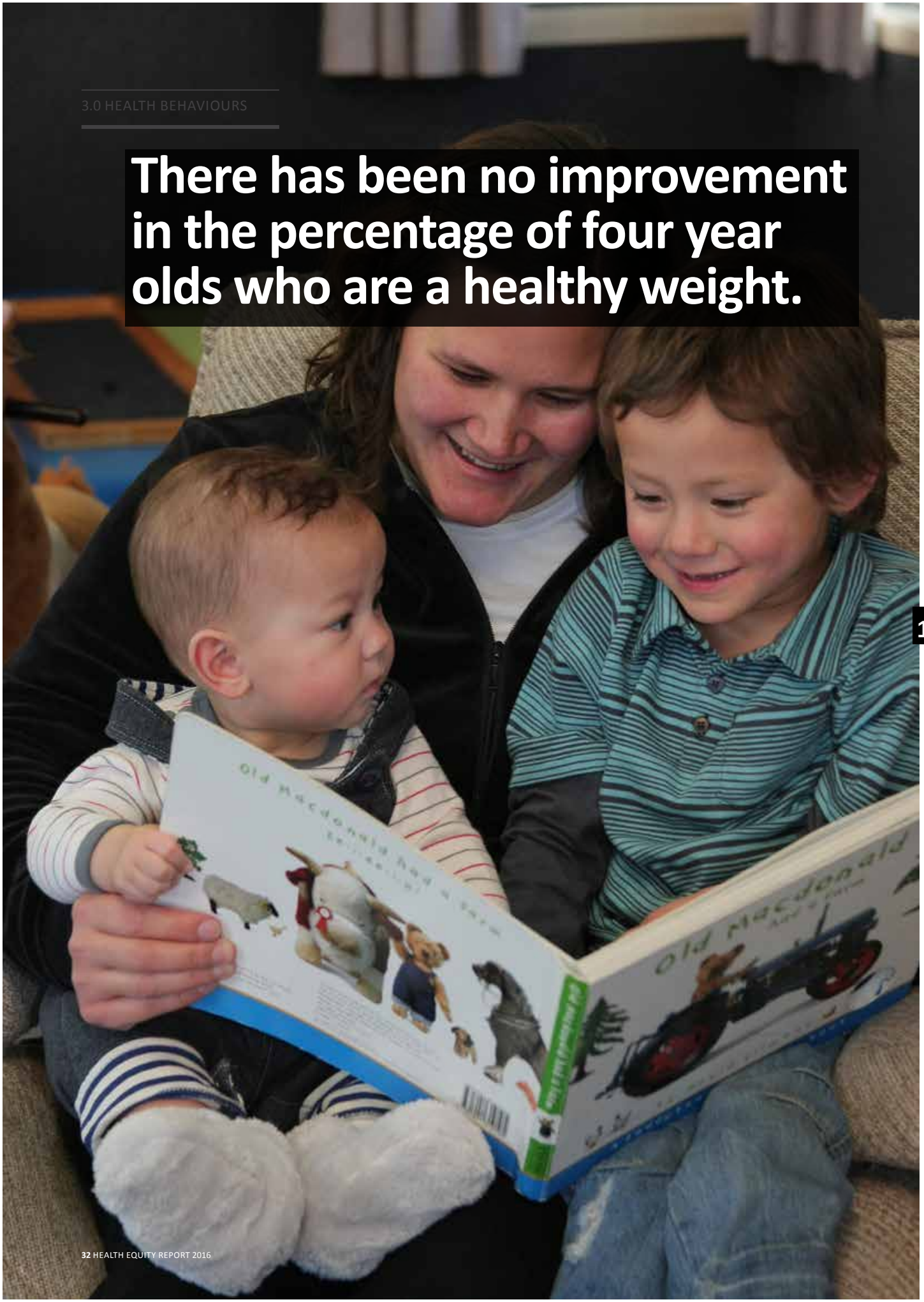
The World Health Organization (WHO) regards childhood obesity as one of the most serious global public health challenges for the 21st century. Obese children and adolescents are at an increased risk of developing various health problems, and are also more likely to become obese adults and have a higher risk of morbidity, disability and premature mortality in adulthood.

The B4 school check is part of the Well Child schedule of childhood milestone checks. It generally occurs just before the child begins school when the child is aged four years old. Height and weight are collected at the time of the check and this provides an opportunity to assess if the child has a healthy weight.

In 2015 6.5 percent children who had a B4 school check were assessed as being obese (1 in 16). Of the 143 children assessed as obese, 89 were Māori, 35 other and 19 Pasifika. Obesity prevalence was three times higher amongst Māori children (10.5 percent) and nearly six times higher amongst Pasifika children (16.5 percent) compared to Other children (2.9 percent). There is a clear socio-economic gradient in prevalence with 11.6 percent of four year olds in quintile 5 obese compared to 0.4 percent in quintile 1 (four times higher).'

PREVALENCE OF OBESITY : FOUR YEAR OLDS



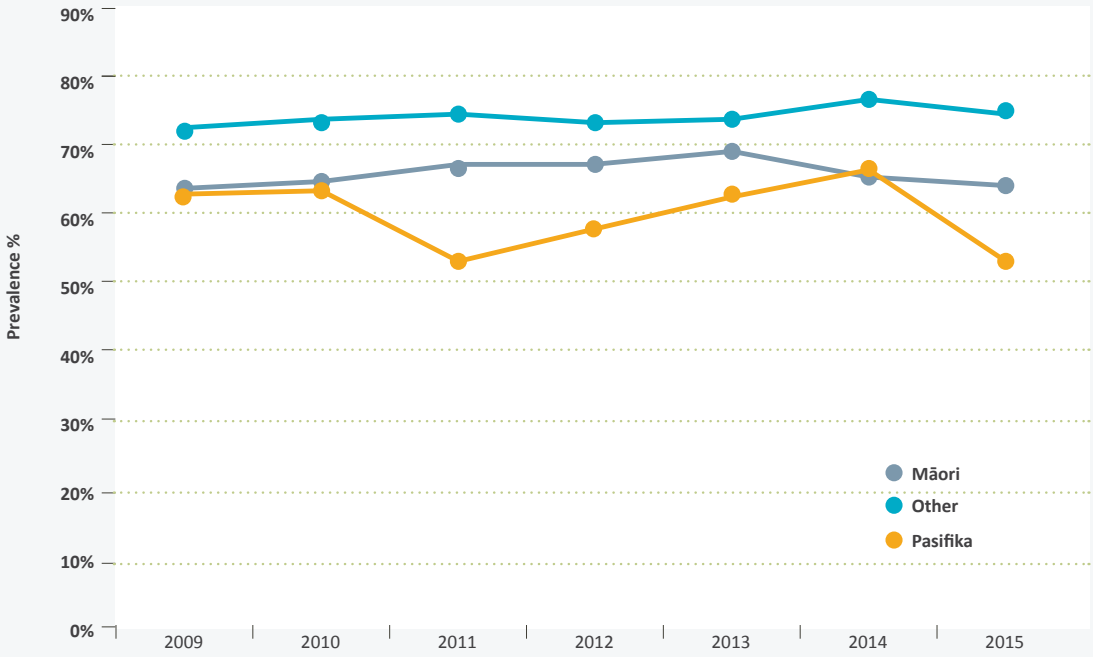

3.0 HEALTH BEHAVIOURS
There has been no improvement in the percentage of four year olds who are a healthy weight.
Old Macdonald had a farm
Old Macdonald

19.1

Healthy weight prevalence rates

Using healthy weight data is an alternative to focusing on obesity. Children with a healthy weight are children who are not overweight, obese nor underweight. Our aim is to increase this proportion and reduce inequities. In 2015 approximately 70 percent of four year olds had a healthy weight, with **no improvement** since 2009. 63 percent of Māori children and 53 percent of Pasifika children assessed had a healthy weight.

PREVALENCE OF HEALTHY WEIGHT : FOUR YEAR OLDS



Source: B4school data base. Health Hawke's Bay

3.0 HEALTH BEHAVIOURS

Urgent attention is needed to reduce inequity in this area. Healthy nutrition needs to be supported all the way from during pregnancy though to infants and children.

ORAL HEALTH OF FIVE YEAR OLDS

There has been no improvement in the past five years for any ethnicity and a widening of inequity.

The risk of dental decay begins as soon as the teeth begin to appear in the mouth (at around six months of age). Good oral hygiene (regular tooth brushing) and healthy food are both needed to prevent dental decay. The increasing consumption of sugars, and in particular sugary drinks, affects the health of teeth as well as contributing to the increasing number of children who are overweight or obese. Dental decay in five year olds will have probably started three to four years previously and may reflect eating patterns which go on to become established eating habits later in life.

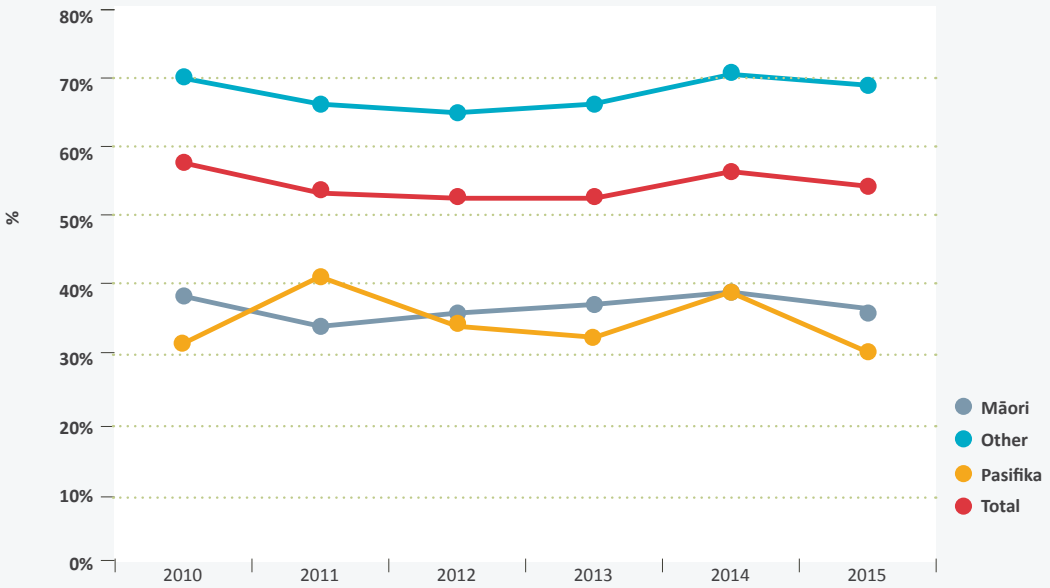
One of the indicators used to assess the oral health of children is the proportion of children at age five who are caries free (no sign of dental decay).

There are significant and widening inequities in children's oral health. Twice as many Other children aged five in Hawke's Bay (70 percent) are caries free compared to Māori (36 percent) and Pasifika children (30 percent). There is also a clear socioeconomic gradient with children attending decile 9-10 schools (more advantaged schools) 2.5 times more likely to have no dental caries than children attending decile 1-2 schools.

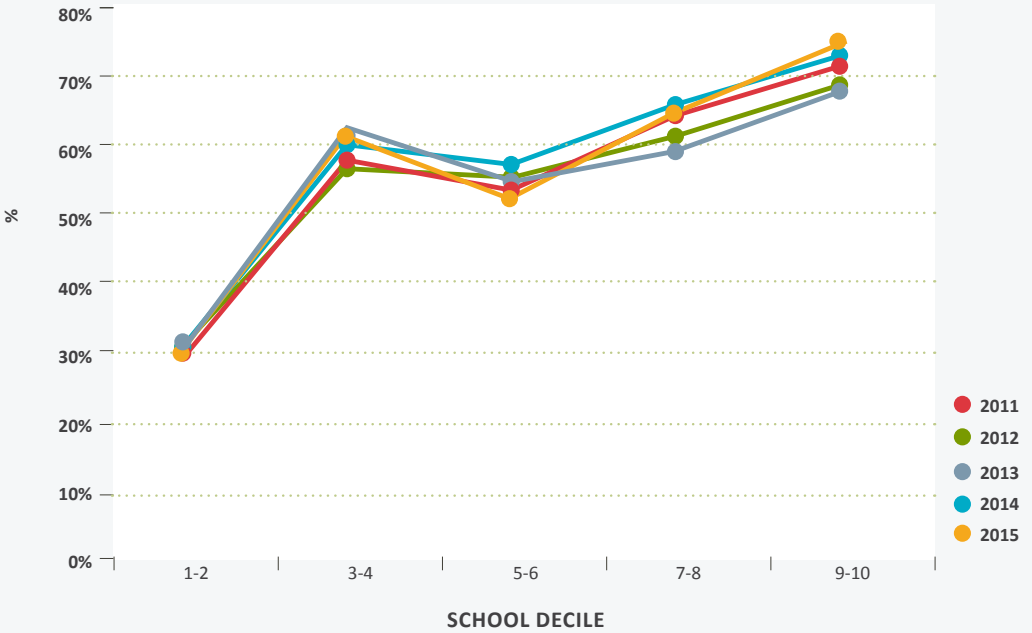
Urgent attention is needed to reduce inequity in this area. Healthy nutrition needs to be supported all the way from during pregnancy though to infants and children.

19.1

HAWKE'S BAY DHB : PERCENT FIVE YEAR OLDS CARIES FREE BY ETHNICITY

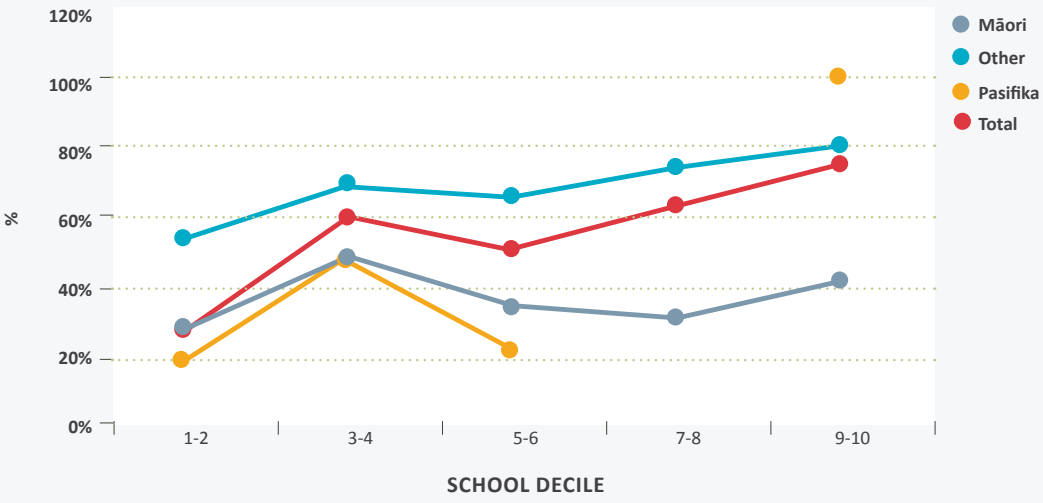


PERCENT FIVE YEAR OLDS CARIES FREE - TOTAL BY SCHOOL DECILE



This school decile gradient is less for Māori children and may in part reflect the smaller number of Māori children attending higher decile schools. In 2015 81 percent of Other children in decile 9-10 schools were caries free, compared to 44 percent of Māori children in those schools.

PERCENT FIVE YEAR OLDS CARIES FREE BY ETHNICITY AND SCHOOL DECILE 2015



CHAPTER 4.0
HEALTH CARE

The measures in this section look at access to healthcare and quality of healthcare received.

This indicator is the best evidence yet of equitable access and treatment for conditions categorised as fully treatable. The biggest driver of this reduction is the better management of ischaemic heart disease, diabetes and cancers.

AMENABLE MORTALITY

Amenable deaths (mortality) are a specific group of deaths which could have been avoided through access to quality healthcare and is a very useful indicator of equity in healthcare. In New Zealand, the proportion of all avoidable deaths considered to be amenable is approximately 40 percent.

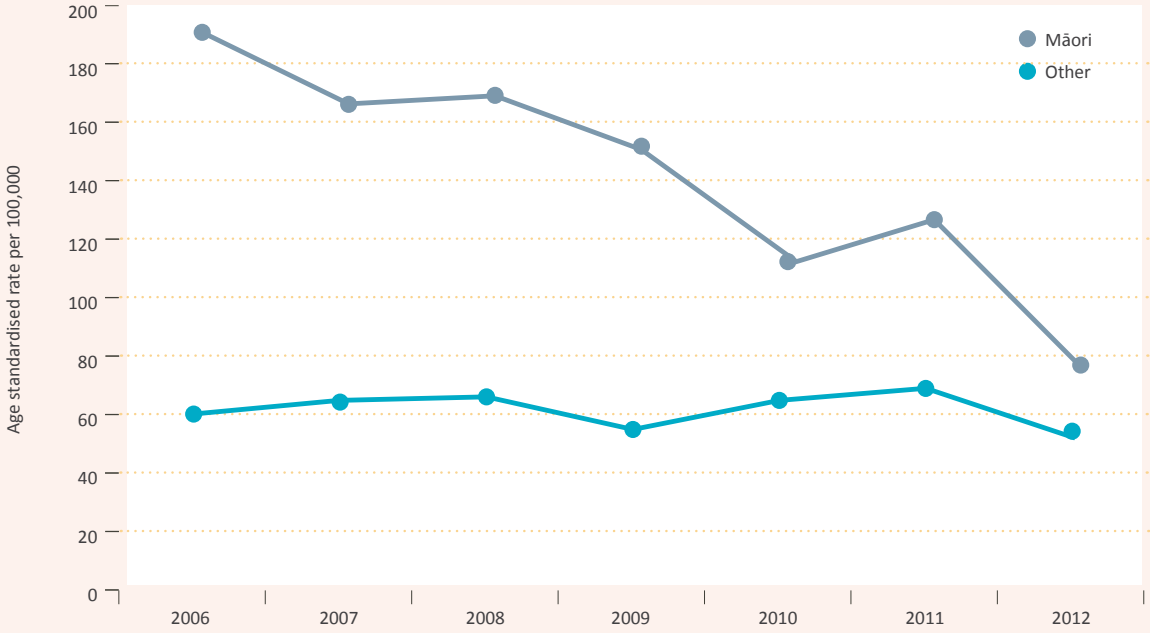
In a truly equitable healthcare system there should be no difference in amenable mortality rates by ethnicity or by place of residence.

Māori amenable mortality rates have been reducing consistently since 2006 and are now not statistically different to non- Māori non-Pasifika rates in Hawke's Bay as the actual number of deaths each year are small and cause the rates to fluctuate.

Never-the-less rates have been reducing and in 2012 rates for Other were 1.5 times higher than non-Māori / non-Pacific people and 1.6 times higher amongst people living in Quintile 5 areas. Pasifika data for Hawke's Bay are too small for robust analysis.

This indicator is the best evidence yet of equitable access and treatment for conditions categorised as fully treatable. The biggest driver of this reduction is the better management of ischaemic heart disease, diabetes and cancers.

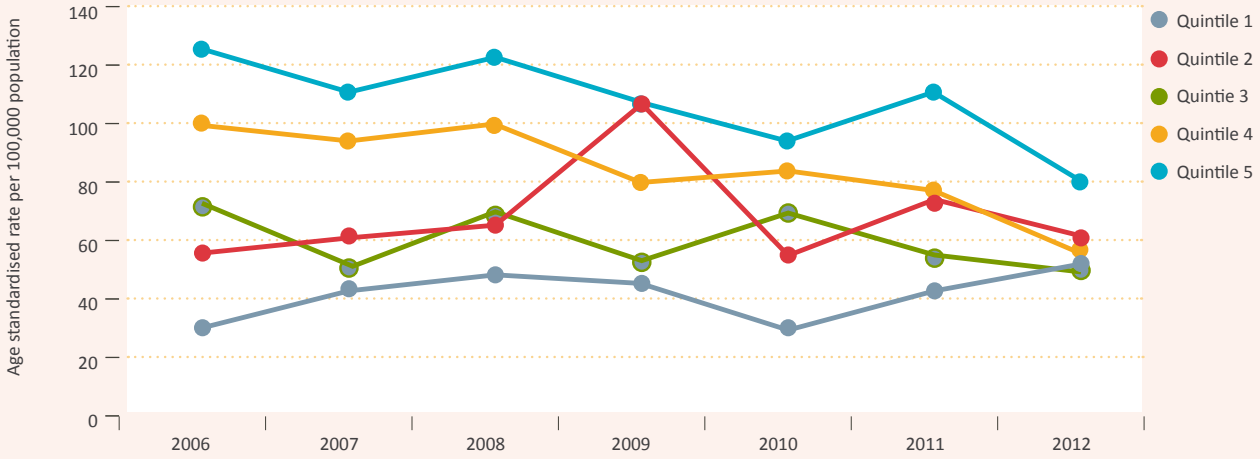
HAWKE'S BAY DHB AGE STANDARDISED AMENABLE MORTALITY RATE PER 100,000 POPULATION BY ETHNICITY 2006-12



Source: Ministry of Health National Mortality Collection

4.0 HEALTH CARE

HBDHB AGE STANDARDISED AMENDABLE MORTALITY RATE BY QUINTILE PER 100,000 POPULATION 2006-12



Source: Ministry of Health National Mortality Collection

AMBULATORY SENSITIVE HOSPITALISATIONS 0-4 YEAR OLDS

Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through preventive interventions or treatments deliverable in a primary care setting. They are often used as proxy markers for primary care access and quality.

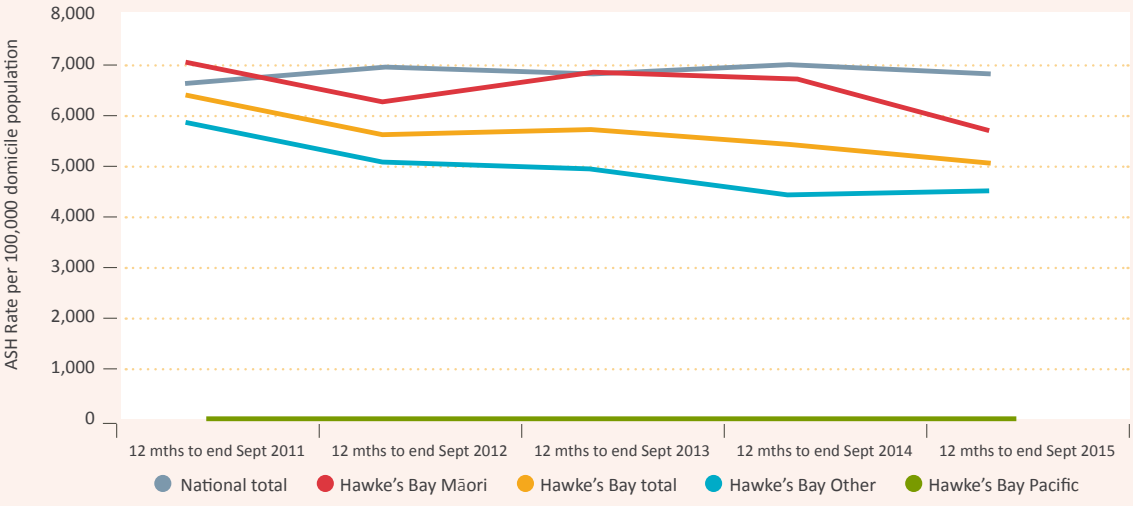
The Ministry of Health ASH definition and methodology has been revised from quarter one of the 15/16 year and data are only available for the 5 years to end September 2015.

ASH rates for 0-4 year olds in Hawke's Bay have been decreasing and rates are now consistently lower than New Zealand. Māori rates have been declining since September 2013 and the gap between Māori and non-Māori rates has been closing. Māori rates of ASH are still higher (1.2 times) than non-Māori rates.

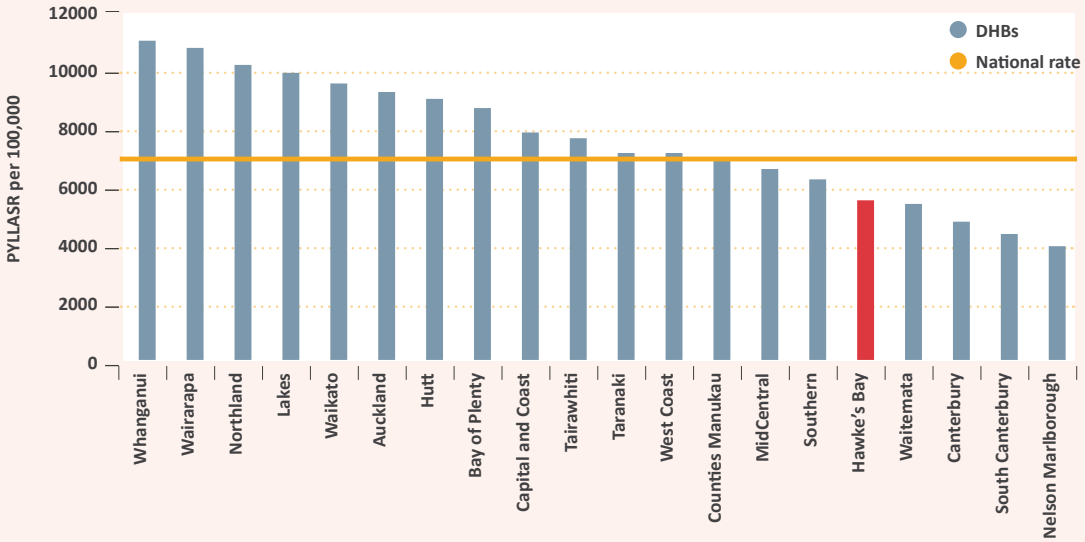
Compared to the rest of New Zealand in the 12 months to September 2015 the Hawke's Bay Māori rate was 82 percent of the national Māori rate and Hawke's Bay DHB was the fifth best performer of all DHBs.

ASH rates for Māori 0-4 year olds have decreased for gastroenteritis, dental conditions, cellulitis, upper respiratory infections and ENT conditions. Gastroenteritis/dehydration admission rates for Māori

ASH RATE HBDHB 0 TO FOUR YEAR OLDS FOR THE FIVE YEARS TO END SEPTEMBER 2015



AMBULATORY SENSITIVE HOSPITALISATION (ZERO TO FOUR YEARS OLD) MĀORI RATE PER 100,000 BY DHB
(12 MONTHS SEPT 2015)



0-4 year olds in Hawke's Bay are half the national Māori rate.

However ASH rates have increased for Māori 0-4 year olds for asthma, and lower respiratory infections. **The largest equity gap is for dental conditions where rates of ASH for Māori 0-4 years olds is three times that of non-Māori 0-4 years olds.**

For some conditions specific programmes are being effective at preventing hospitalisations for example the infant rotavirus vaccination programme prevents hospitalisations with gastroenteritis, skin care programmes in Kohanga Reo, the healthy housing programme and free primary care visits ensure that conditions are managed earlier and better. **Asthma and dental conditions remain significant areas of inequity for Māori 0-4 year olds**.

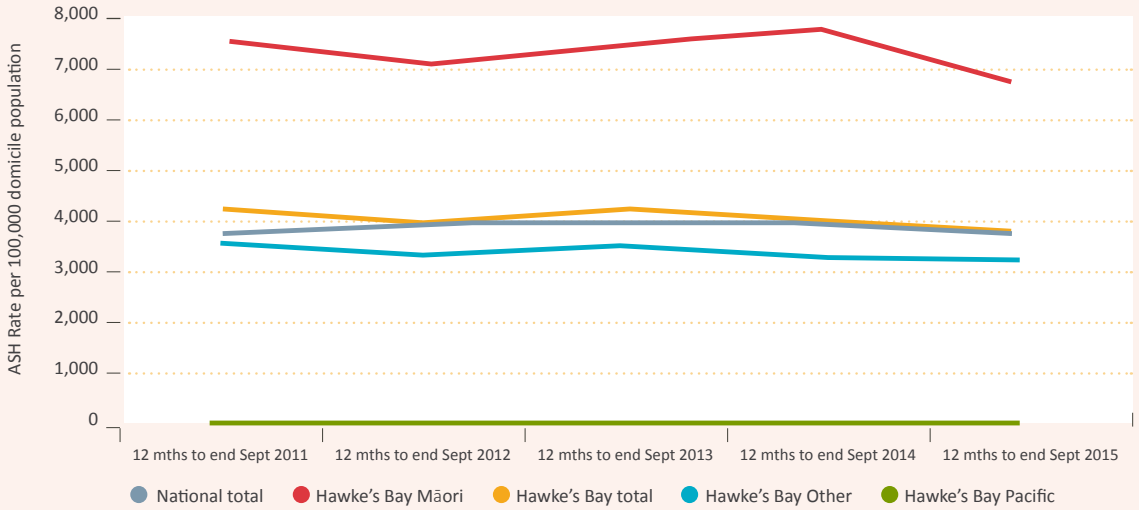
AMBULATORY SENSITIVE HOSPITALISATIONS 45-64 YEARS

By contrast there has been little change in rates for 45-64 year olds and Hawke's Bay rates are similar to NZ. Rates of ASH for Māori remain higher than non-Māori (two times higher) with little change over this period. The disparity between Māori and non-Māori has closed slightly.

ASH rates for 45-64 year olds have increased for cellulitis and congestive heart failure.

Heart disease, skin infections, and respiratory infections all feature highly as causes of the disparity in ASH rates for 45-64 year olds. Much more needs to be done to improve access and treatment for Māori adults with these conditions.

ASH RATE, HAWKE'S BAY DHB, 45 TO 64 YEAR OLDS, FIVE YEARS TO END SEPTEMBER 2015

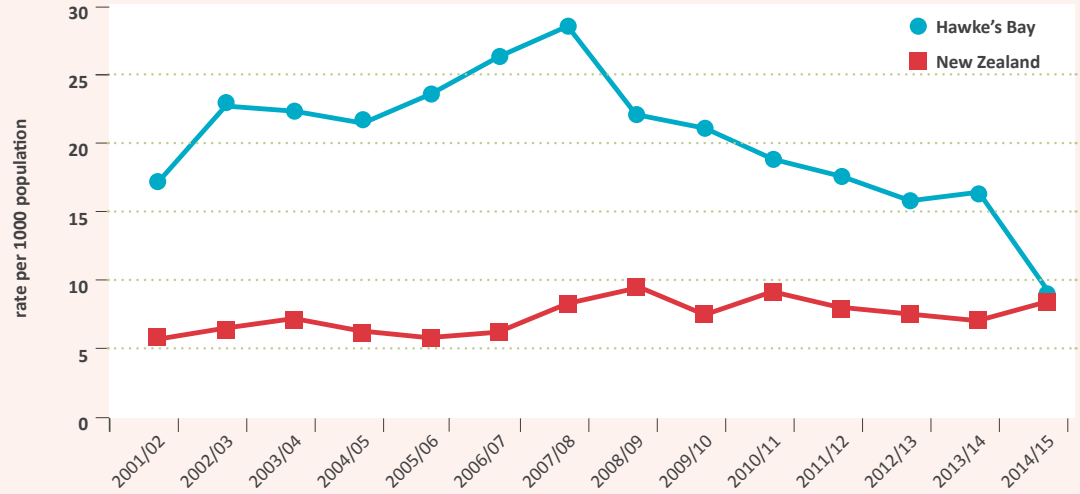


TEENAGE PREGNANCIES (UNDER 18 YEARS)

Most teenage pregnancies under 18 years are unplanned and around 40 percent end in abortion. While for some young women having a child when young can be a positive experience for many more teenagers bringing up a baby can be difficult. The result is poor outcomes for both the teenage parent and the child in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long term poverty. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty, and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60 percent higher than for babies born to older mothers.

In 2014-15 there were 33 births to girls aged 13-17 years and 20 terminations giving a total number of conceptions of 53. **This gives a "conception rate" of 9.2 per 1000 girls in this age group – a large decrease since 2007-08 when there were 28 conceptions per 1000 13-17 year olds.** Hawke's Bay has had generally higher conception rates in this age group than the New Zealand average but the gap has been reducing since 2007-08.

TEENAGE CONCEPTION RATE PER 1000 POPULATION (BIRTHS AND TERMINATIONS)



Source: Ministry of Health NMDS

"Conception rate" of 9.2 per 1000 girls in this age group – a large decrease since 2007-08 when there were 28 conceptions per 1000 13-17 year olds.

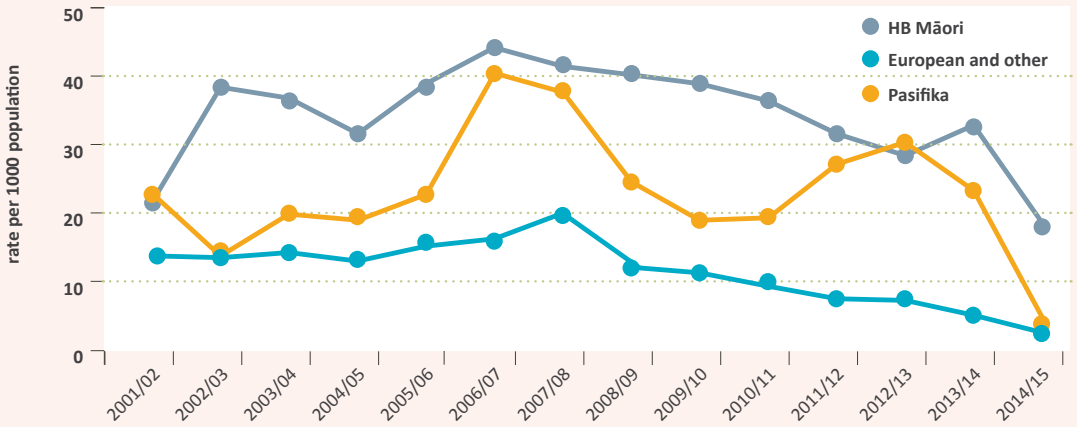
There are still higher rates of conceptions for Māori and Pasifika teenagers, although actual numbers of Pasifika conceptions are very low. Māori conception rates have been declining since 2006-07 but still remain higher than non-Māori teenagers. Three year averages show that rates for Māori are four times that of non-Māori 13-17 year olds.

Due to small numbers, analysis by deprivation has been done for births and terminations under 20 years. **This shows a very strong relationship with deprivation with rates of births in quintile 5 being 12 times the rate in quintile 1.** There is a less strong relationship with terminations of pregnancy.

These trends are very encouraging. Research reviews[1] have shown that a combination of education and improved access to contraception reduces unintended pregnancy amongst adolescents. These local results suggest that recent changes to the delivery and availability of free sexual health services for young people and a social media awareness raising and educational campaign have been effective in improving equitable access and utilisation.

[1]The Cochrane Collaboration 2016: Interventions for preventing unintended pregnancies amongst adolescents

TEENAGE CONCEPTION RATE PER 1000 POPULATION (BIRTHS AND TERMINATIONS) BY ETHNICITY



Source: Ministry of Health NMDS

SUMMARY OF FINDINGS

HEALTH EQUITY ACHIEVED OR ON TRACK TO BE ACHIEVED IN 1-2 YEARS:	CATEGORY
Amenable mortality	Health care
GOOD PROGRESS TOWARDS HEALTH EQUITY:	
Avoidable mortality	Health outcome
Ambulatory sensitive admissions 0-4 year olds	Health care
Teenage (<18 year old) pregnancies	Health care
HEALTH EQUITY IMPROVING BUT STILL SIGNIFICANT INEQUITY:	
Life expectancy	Health outcome
Premature deaths	Health outcome
Potential years of life lost	Health outcome
Children living in households receiving benefits	Social and economic
Youth not in employment, education or training	Social and economic
Unemployment	Social and economic
Hospital admissions due to medical conditions with a social gradient	Social and economic
Tobacco use year 10 students	Healthy behaviours
Ambulatory sensitive admissions 45-64 year olds	Health care
HEALTH EQUITY UNCHANGED OR WORSENING:	
Acute respiratory (bronchiolitis) admissions	Social and economic
Obesity amongst 4 year olds	Healthy behaviours
Oral health of 5 year olds	Healthy behaviours
Tobacco use during pregnancy	Healthy behaviours
Violent crime	Social and economic

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HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Oral Health** 70
	For the attention of: **HBDHB Board**
Document Owner:	Sharon Mason, Chief Operating Officer (Target Champion)
Document Authors:	James Dawson, Portfolio Manager Hospital Services Dr Robin Whyman, Clinical Director Oral Health Services
Reviewed by:	Wietske Cloo, Service Director for Oral, Rural and Community; Ruth O'Rourke, Team Leader for Oral Health; and Executive Management Team, Maori Relationship Board, HB Clinical Council, HB Health Consumer Council
Month:	June, 2016
Consideration:	Monitoring / For Information

RECOMMENDATION

That the Board:

1. Note the contents of this report
2. Approve the Target Champions recommendations on page 9 of this report.

20

OVERVIEW

Te Ara Whakawaiora (TAW) is an exception based report, drawn from Annual Maori Health Plan 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.

This report is from Sharon Mason Champion for the Oral Health Indicators. It focuses on the key oral health indicators and activity to improve child oral health

UPCOMING REPORTS

The following are the indicators of concern, allocated EMT champion and reporting month in 2015/16.

Priority	Indicator	Measure	Champion	Responsible Manager	Reporting Month
Oral Health *National Indicator*	The total number (%) of children are caries free at first examination after the child has turned five years, but before their sixth birthday	>66%	Sharon Mason	James Dawson	Jun 2016

WHY IS THIS INDICATOR IMPORTANT?

Oral health, general health and quality of life
Dental decay (dental caries) is one of the most common preventable chronic diseases. It is an important public health problem because of its prevalence, impact on individuals, society, and the public health system.

Severe early childhood caries reduces a child's quality of life: causing pain and discomfort, it affects eating and sleeping, prevents healthy growth and weight gain and reduces immunity to disease. Dental caries in early childhood is strongly predictive of an ongoing childhood and adulthood risk of dental caries.

Management of dental caries occupies considerable resources in our Community Oral Health Service and untreated acute and chronic infections lead to a higher risk of hospitalization and loss of school days which may impact of a child's ability to learn.

The determinants of dental caries are known — the risk factors include diet (sugar consumption) and poor oral hygiene. Effective population health strategies and clinical prevention methods have substantially reduced the amount of dental caries in the child population and reduced the impact of dental caries for the community. However, substantial inequities in oral health outcomes remain.

Inequality in outcomes in oral health status for Māori
Māori and Pacific children, and those living in socioeconomic disadvantage experience poorer outcomes in oral health status. [1.]. They have also tended to enrol for oral health services, and utilise services, later when compared to non-Māori.

MĀORI HEALTH PLAN INDICATOR: Oral Health Caries Free (National Indicator)

The total number (%) of children who are caries (tooth decay) free at first examination after the child has turned five years, but before their sixth birthday.

In addition the Ministry of Health require reporting of:
- enrolment in oral health services of all populations aged 0 – 4yrs
- Mean decayed, missing or filled scores (DMF) at Year 8 (approximately 12 years).

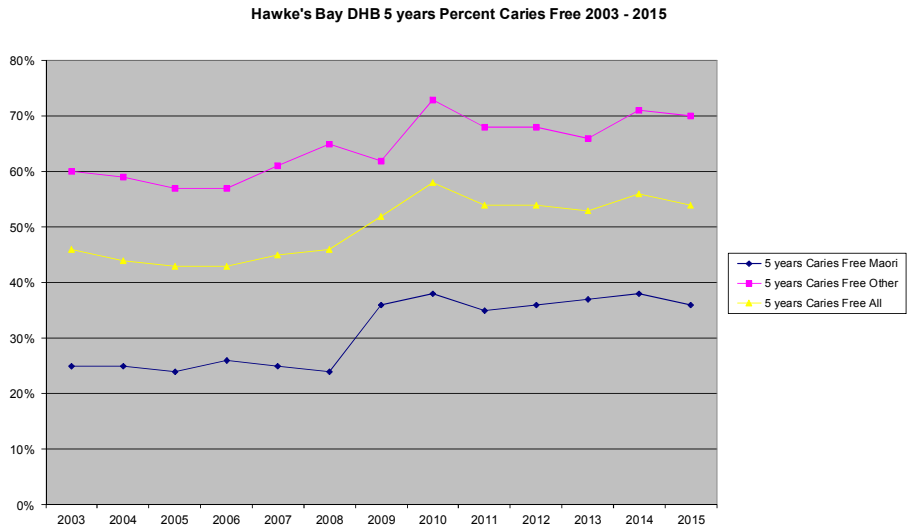
We are required to report as on overall mean based on ethnicity in three categories:
- Māori,
- Pacific
- Non-Māori

Maori 5 year old caries free (target >66%)

2015	54% Overall
	36% Maori
	70% Other
2014	56% Overall
	38% Maori
	71% Other

The result for Maori 5-year-old children caries free in 2015 is 36%, which is a slight decrease from 2014. This is also consistent with a slight decrease Overall. The 2003 to 2015 trend is shown in Figure 1.

Figure 1 Hawke's Bay DHB 5-year-old caries free by ethnicity 2003 – 2015



It is disappointing that in 2015 we have not moved closer to the target of 66% of 5-year-old children caries free. However, several factors may have contributed to this result.

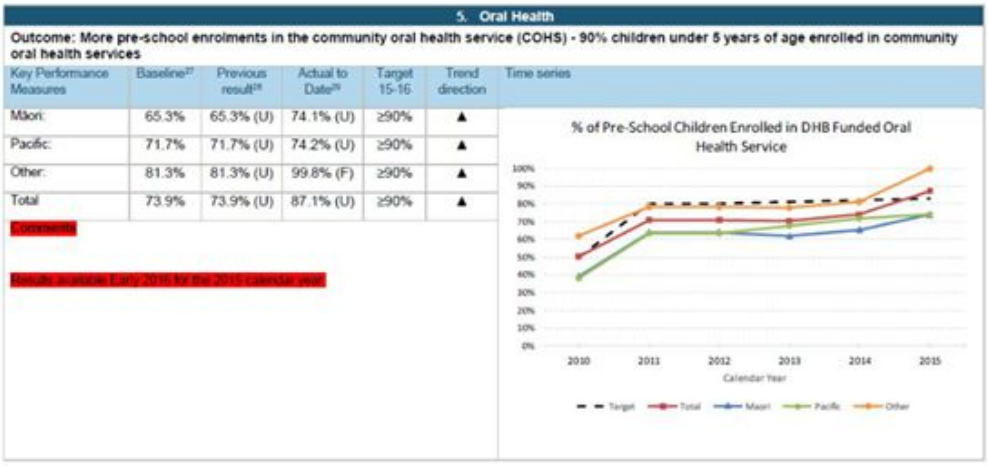
1. Significant data cleansing within the Titanium database. While we cannot be sure of the effect that this has had we believe it does mean we are reporting a more accurate result in 2015 and would explain all groups moving back by 1-2%.
2. Actively increasing our preschool enrolment with a focus on high need children (see below). This does mean that we see and report on more of the children who have dental caries earlier and it is likely to have contributed to an apparent lack of improvement for this result.
3. Changing clinical practice. The service is providing an earlier intervention for dental caries involving the use of stainless steel crowns on teeth with early dental caries. Previously these teeth may have had later treatment (post 5-years-old) but the crowns do elevate the children showing as having experienced dental caries (lowers the caries free rate).

Maori 0 – 4 enrolment status for 2015

The results of enrolment status for Maori preschool children in 2015 aged 0-4 years is 74.1%. The growth in Maori preschool enrolment is a very pleasing indication that strategies described below to increase early engagement with community oral health services is taking effect. Early enrolment and engagement are believed to be key strategies to commencing early preventive strategies for dental caries and ultimately improving the indicator discussed above (5-year-old children caries free).

These results are described in Figure 2.

Figure 2 Hawke's Bay DHB Preschool enrolment in community oral health services



5. Oral Health

Outcome: More pre-school enrolments in the community oral health service (COHS) - 90% children under 5 years of age enrolled in community oral health services

Key Performance Measures	Baseline[27]	Previous result[28]	Actual to Date[29]	Target 15-16	Trend direction
Māori:	65.3%	65.3% (U)	74.1% (U)	≥90%	▲
Pacific:	71.7%	71.7% (U)	74.2% (U)	≥90%	▲
Other:	81.3%	81.3% (U)	99.8% (F)	≥90%	▲
Total	73.9%	73.9% (U)	87.1% (U)	≥90%	▲

Comments

Results available Early 2016 for the 2015 calendar year

Time series

Maori decayed, missing and filled teeth (DMFT) at Year 8

Year 8 Maori children had 1.43 DMF teeth in 2015. This remains above our target of 0.88 and indicates a continued challenge for the DHB to improve Maori child oral health throughout the primary years.

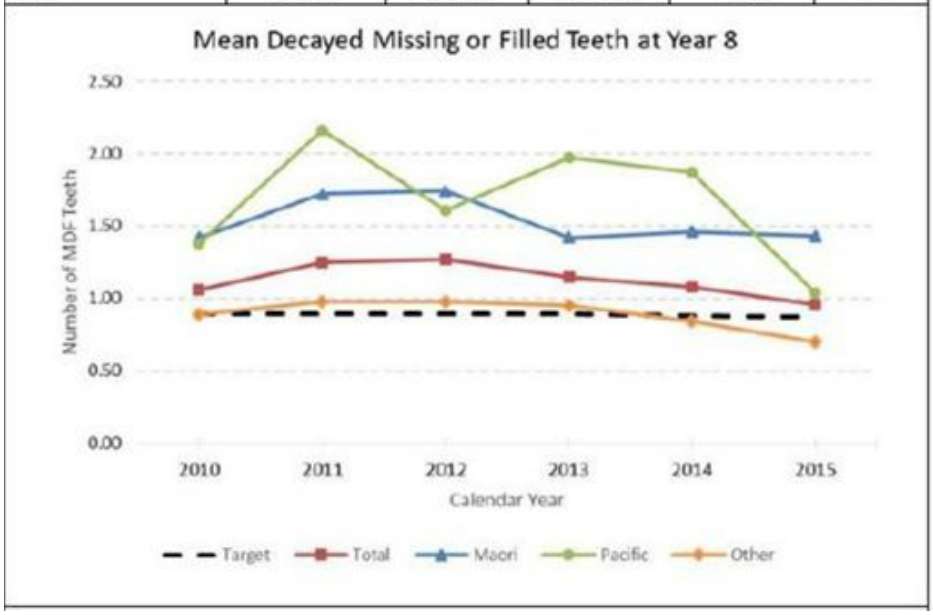
However, NZ and international evidence is that improvement in preschool oral health will provide a flow on legacy to improved Year 8, adolescent and adult oral health.

Focussing nationally 1.43 DMF teeth for Maori Year 8 children places Hawke's Bay DHB 10th out of 20 DHBs compared with the 2013 national data (latest available). The range nationally for Maori is 0.97 (CCDHB) to 2.81 (BOPDHB).

The Community Oral Health Service is now putting effort into an increased preventive focus in their clinical activity. This would also be expected to further improve the caries free 5-year-old and Year 8 DMF rates in time.

Figure 3 Hawke's Bay DHB Year 8 DMF teeth 2010 – 2015

Oral Health MDFT score at year 8 (PP10)					
Key Performance Measures	**Baseline [18]**	**Previous result [19]**	**Actual to Date[20]**	**Target 2015/16**	**Trend direction**
Total	108.0%	1.08 (U)	0.96 (U)	≤0.88	▲
Māori	145.0%	1.46 (U)	1.43 (U)	≤0.88	▲
Pacific	185.0%	1.87 (U)	1.04 (U)	≤0.88	▲
Other	83.0%	0.84 (F)	0.70 (F)	≤0.88	▲



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

Service Coverage
The HBDHB is actively working to increase early enrolment and engagement with the Community Oral Health Service. The target is to have children enrolled at birth and all children seen by the Community Oral Health Service by 12 months.

The service coverage target is >= 90% of preschool children enrolled with the service.

The service has historically high levels (>95%) of engagement with primary school aged children and the aim is to continue these high levels but enable a greater focus on preventive dental care.

Quadruple enrolment from birth
In 2014 the HBDHB commenced a process of quadruple enrolment where the Lead Maternity Carer facilitates the parent/caregiver signing up for GP, immunisation and Well Child/Tamariki Ora and Oral Health Services enrolment. This process has gone into full operation from the start of 2015.

Quadruple enrolment ensures that all children born in Hawke's Bay are enrolled at birth into Oral Health Services, which results in a significant increase in enrolled status of 0-4 year olds. Historically the oral health service has needed to put substantial effort into finding and enrolling preschool children. The change means that greater effort can be put on attendance and actual engagement with the service, enabling preventive advice and care to be provided, especially for whanau at greatest risk of dental caries.

Relationships with Māori health providers
HBDHB has historically invested in oral health educators within Maori health provider services, and in oral health services as a whole, to follow up hard to enrol children.

Oral Health Services have a strong relationship with four Māori health providers, as well as Plunket. Our current Māori provider partners are:

- Choices
- Te Taiwhenua o Heretaunga
- Ngati Kahungungu Executive
- Te Kupenga Hauora

With the advent of quadruple enrolment the focus of activity for the Māori health provider services in oral health is being reviewed. It is anticipated, the focus will move towards helping to engage enrolled, but hard to reach whanau.

Improving access to Community Oral Health Services for Māori Tamariki (0-5 years) Project
The Service is engaged in a project with Maori Health and the population health advisor for oral health addressing barriers to preschool attendance and engagement, with the aim of a resulting decrease in dental caries for children under 5 years.

The project goals are:

- Improve access to Oral Health Service Hubs for Māori tamariki for under 5yrs
- Improve engagement of whānau and tamariki
- Reduction in 'Did Not Attend'/DNA rates to community dental services for Maori tamariki under 5 years of age to <15%
- Improving community dental service utilisation by >20%

This project is currently analysing DNA data to better understand patterns of DNA within the service and how to configure services best to engage hard to reach whanau.

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

There will continue to be a strong focus of action on enhanced early enrolment and engagement with the Community Oral Health Service. The aim is to have enrolment at over 90% for all ethnicities and for all children to have been seen within the service by 12 months. Early contact facilitates anticipatory guidance about oral health and provides a clinical risk assessment for elevated dental caries risk. Strong risk assessment then enables an appropriate clinical preventive programme to be put in place to support home care.

Changes are planned to the focus of the Maori health provider's contracts to assist with supporting engagement with the oral health service, and not the historical focus on enrolment.

Preventative practice

The Community Oral Health Service is focussing within its clinical teams on a stronger preventive approach, rather than an historical approach focussed on treatment of dental caries.

A stronger preventive approach, aims to use clinical visits to assist in the avoidance of the initiation, progression and recurrence of dental disease.

The service is measuring improved clinical risk assessment and response by monitoring levels of preventive activity within clinician's clinical work.

Three preventive care indicators have been developed and are being assessed and reported back to staff on a 6-monthly basis. This work will continue in the next 2-3 years.

Intervention	Description	Target (%)
Fluoride varnish by 4yrs	prevention of decay and remineralisation of the tooth surface	40
Bitewing radiographs by 6yrs	x-rays for the early detection of tooth decay	95
Fissure sealants by 8yrs	application of protective resin to prevent tooth decay	85

Audits to date have shown

1. There are notable variations in practice between clinicians / treatment hubs,
2. Overall the interventions above are provided for a greater proportion of Maori children than non-Maori, consistent with the increased caries risk
3. Clinical practice is closest to the target for application of fluoride varnish and furthest from target in the use of bitewing radiographs

A peer support and open reporting of information approach is being used in the service improve the levels of preventive practice.

It is anticipated fluoride varnish and fissure sealant targets can be met within 12-18 months.

Figures 4, 5 and 6 report the outcomes of clinical quality indicators bitewing radiographs, fluoride varnish application and fissure sealants to December 2015.

Figure 4

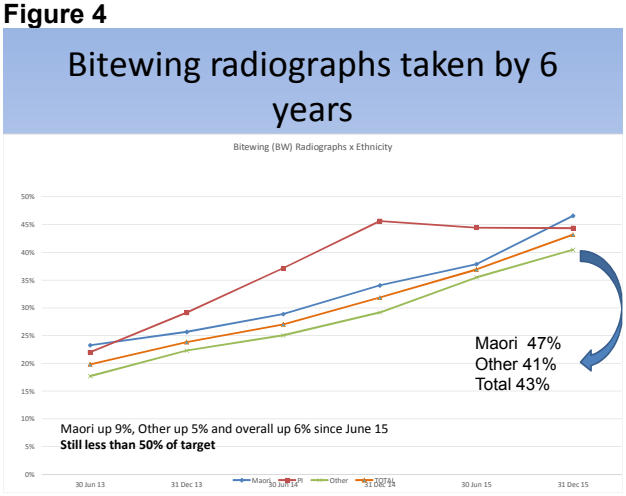


Figure 5

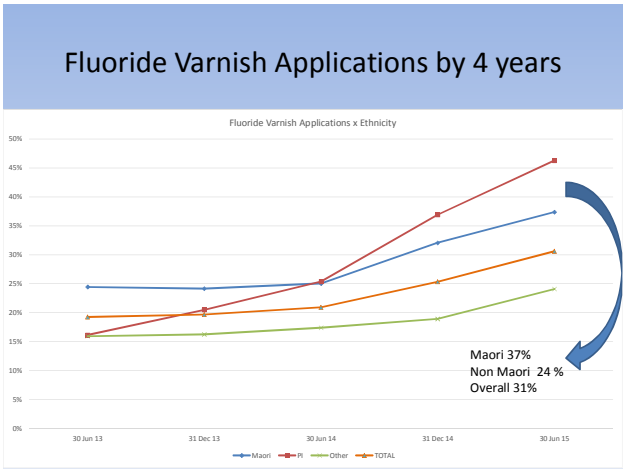
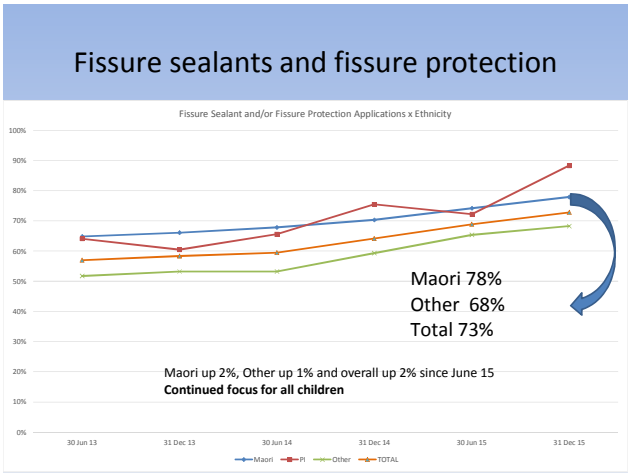


Figure 6



RECOMMENDATIONS FROM TARGET CHAMPION

Population Health Initiatives

While early enrolment and engagement with clinical services, and a greater preventive focus within clinical services are important to reducing level of early childhood dental caries.

However, dental caries in our Hawke's Bay communities is also a symptom of the overall health of our communities and will be importantly influenced by population health strategies.

The DHB's population health initiatives, especially Best Start: Healthy Eating and Activity and reduction of early childhood sugar consumption will provide important population health support to improving early childhood oral disease levels.

In particular child oral health will be influenced by

- Best Start Healthy Eating and Activity
- Healthy Housing
- Breastfeeding
- Smoking cessation
- Water Policy and community water fluoridation

Community water fluoridation has been shown to reduce dental caries by between 20 and 40%, and to be particularly effective in reducing socioeconomic and ethnic disparities in dental caries, [2.]. Over half of Hawke's Bay preschool children live in areas without reticulated optimally fluoridated water (Napier, Wairoa and central Hawke's Bay). Only children receiving water from the Hastings reticulated supply receive optimally fluoridated water. The government has recently signalled a move of the decision making process for community water fluoridation to DHBs following necessary legislative changes.

Community water fluoridation could be expected to improve caries free rates by at least 20%, and to reduce inequities in oral health. Increased coverage should be pursued as opportunities arise.

A watching brief on government's moves regarding community water fluoridation decision making and submissions to the process when the opportunities arise to ensure a workable framework is developed.

Specific actions recommended		Timeframe
1	Maori health provider contracts are changed to focus on engagement of hard to reach whanau with oral health services in the early pre-school years	By June 2017
2	Community Oral Health Services achieve the preventative practice targets	By December 2017
3	Implement Maternal Nutrition Programme activities and implement healthy eating/sugar reduction programmes/policies as planned in the Best Start: Healthy Eating and Activity Plan	Reported annually until 2020
4	Hawke's Bay DHB implements community water fluoridation as soon as necessary legislative changes enabling the DHB to act are in place	To be confirmed, dependent upon legislative changes

CONCLUSION

While the 2015 caries free Maori 5-year-old proportion has slightly decreased strong strategies at a service engagement, clinical activity and population health level are in place and are developing.

These initiatives are expected to result in gradual improvement to the indicator based on current international advice, and strategies in place in other jurisdictions.

Sharon Mason
Target Champion for Oral Health /Chief Operating Officer

REFERENCES

[1.] National Health Committee, Improving Child Oral Health and Reducing Child Oral Health Inequalities. 2003, National Advisory Committee on Health and Disability: Wellington. p. 1-28.

[2.] Thomson, W., K. Ayers, and J. Broughton, Child Oral Health Inequalities in New Zealand: A Background Paper to the Public Health Advisory Committee. 2003, National Health Committee: Wellington. p. 1-63.

[3] NZ National Child Oral Health Services Clinical Guideline for Bitewing Radiography (2010)

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:

22. Confirmation of Minutes of Board Meeting
- Public Excluded

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

24. Board Approval of Actions exceeding limits delegated by CEO

25. Chair's Report

26. Integrated Pharmacist Services in the Community

27. Regional Development Strategy

Reports and Recommendations from Committee Chairs

28. Finance Risk and Audit Committee Report

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).