BOARD MEETING

Date: Wednesday, 28 June 2017

Time: 1.00pm

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

Members:
Kevin Atkinson (Chair)
Ngahiwi Tomoana
Dan Druzianic
Barbara Arnott
Peter Dunkerley
Dr Helen Francis
Diana Kirton
Jacoby Poulain
Heather Skipworth
Ana Apatu
Hine Flood

Apologies: -

In Attendance: Dr Kevin Snee, Chief Executive Officer
Members of Executive Management Team
Members of the public and media

Board Administrator: Brenda Crene

Public Agenda

Item	Section 1 : Routine	Ref #	Time (pm)
1.	Karakia		1.00
2.	Apologies		
3.	Interests Register		
4.	Minutes of Previous Meeting		
5.	Matters Arising - Review of Actions		
6.	Board Workplan		
7.	Chair's Report – verbal		

8.	Chief Executive Officer's Report	60	
9.	Financial Performance Report	61	
10.	Board Health & Safety Champion's - no update this month	-	
11.	365 Presentation on Safe 365 Tool - Kate Coley	-	
	Section 2: Reports from Committee Chairs		
12.	HB Clinical Council – Co-Chairs Chris McKenna & Dr Mark Peterson	62	1.50
13.	HB Health Consumer Council – Chair, Graeme Norton	63	2.00
14.	HB Health Consumer Council Appointments – Ken Foote	64	
15.	Māori Relationship Board – Chair, Ngahiwi Tomoana	65	2.10
	Section 3: Decision		
16.	Annual Plan, Regional Services Plan Report Final Draft HBDHB Annual Plan 2017/18 Final Draft Central Region Regional Service Plan 2017	66	2.20
	Section 4: Discussion / Information		
17.	Youth Health Strategy Update – Tracee TeHuia / Nicky Skerman	67	2.30
18.	Dementia Wing Glengarry House - verbal update – Tim Evans	-	
	Section 5: Monitoring		
19.	Consumer Experience Feedback Q3 - Presentation – Kate Coley	-	2.40
20.	Te Ara Whakawaiora / Oral Health – Dr Robin Whyman	68	2.55
21.	Annual Pacific Heatlh Plan Q3 – Tracee TeHuia / Talalelei Taufale	69	3.10
	Section 6: General Business		
22.	**Section 7: Recommendation to Exclude the Public**		
	Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	Section 8: Agenda Items	Ref #	Time (pm)
23.	Minutes of Previous Meeting		
24.	Matters Arising – Review of Actions		
25.	Board Approval of Actions exceeding limits delegated by CEO	70	-
26.	Chair's Update	-	
	Section 9: Discussion / Information		
27.	People Strategy Presentation – Kate Coley	-	3.25
28.	Cranford Hospice Autonomy Project Update – Ken Foote	71	3.45
29.	HB Health Alliance – Kevin Snee and Ken Foote	72	3.50
	Section 10: Reports from Committee Chairs		
30.	HB Clinical Council – Co-Chairs Chris McKenna & Dr Mark Peterson	73	4.00
31.	Finance Risk & Audit Committee – Chair Dan Druzianic - Final Budget 2017-18 (Decision)	74 75	4.05

The next HBDHB Board Meeting will be held at
1.00pm on Wednesday 26 July 2017

Board "Interest Register" - 9 May 2017

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Kevin Atkinson (Chair)	Active	Chair of Unison Networks Limited	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB. Unison leases 3 generators which are located at Hawke's Bay Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	Chair of FRAC	18.02.09
	Active	Director of Unison Fibre Limited	Non pecuniary interest. Unison is now a provider of high speed broadband to the District Health Board.	Will not take part in any decision or discussions in relation to the provision of high speed broadband to the District Health Board	The Chair of FRAC	17.11.10
	Active	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
	Active	Board Member of NZ Health Partnership Limited, *effective from 20 March 2017*	Lead, supported and owned by the 20 DHBs, NZ Health Partnerships creates efficiencies in the health sector that allow more to be spent on frontline services.	Will not take part in any decisions in relation to NZ Health Partnerships Limited	The Chair of FRAC	22.02.17
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
Dr 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

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
	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
	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
Jacoby Poulain	Active	Board Member of Eastern Institute of Technology (EIT)	Perceived conflict - HBDHB has a Memorandum of Understanding (MOU) with EIT relating to training and development in health related occupations	Will not take part in any decisions or discussions in relation to the MOU between HBDHB and EIT	The Chair	14.1.14
	Active	Councillor Hastings District Council	Potential conflict as potential advocate for Hastings District population whereas HBDHB coveres whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.1.14
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumatua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust (aligned to Iron Maori Limited)	The Trust has contracts with HBDHB including the Green Prescription Contract; and the Mobility Action Plan (Muscular Skeletal)	Will not take part in any discussions or decisions relating to any actions or contracts with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15 29.03.17
	Active	Director of Kahungunu Asset Holding Company Ltd	The asset portfolio of the company in no way relates to health, therefore there is no perceived conflict of interest.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	26.10.16
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
Ana Apatu	Active	CEO of U-Turn Trust (U Turn is a member of Takitimu Ora Whanau Collective)	Relationship and and may be contractural from time to time	No conflict	The Chair	5.12.16
	Active	Chair of Directions	Relationship and contractual	Potential Conflict as this group has a DHB Contract	The Chair	5.12.16
	Active	Chair, Health Promotion Forum	Relationship	No conflict	The Chair	5.12.16
Hine Flood	Active	Member, Health Hawkes Bay Priority Population Committee	Pecuniary interest - Oversight and advise on service delivery to HBH priority populations.	Will not take part in any conflict of interest that may arise or in relation to any contract or financial arrangement with the PPC and HBDHB	The Chair	14.02.17
	Active	Councillor for the Wairoa District Council	Perceived Conflict - advocate for the Wairoa District population and HBDHB covers the whole of the Hawkes Bay region.	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.02.17

MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 31 MAY 2017, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.00PM

Present:	Kevin Atkinson (Chair) Ngahiwi Tomoana (Deputy Chair) *Joined the meeting at 2.00pm* Dan Druzianic Dr Helen Francis Peter Dunkerley Diana Kirton Barbara Arnott Heather Skipworth Ana Apatu Hine Flood
Apology	Jacoby Poulain
In Attendance:	Kevin Snee (Chief Executive Officer) Members of the Executive Management Team Chris McKenna and Dr Mark Peterson (as co-Chairs, HB Clinical Council) Graeme Norton (Chair, HB Health Consumer Council) Members of the public and media Brenda Crene

KARAKIA

Ngahiwi Tomoana opened the meeting with a Karakia.

APOLOGIES

Jacoby Poulain's apology was conveyed by the Chair.

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 26 April 2017, were confirmed as a correct record of the meeting.

Moved: **Barbara Arnott**
Seconded: **Diana Kirton**
Carried

MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: **Chaplaincy Services –** Remains as an action. Unsure of the status, Kevin Atkinson to follow up on this.

Item 2: **NZHPL Letter** – Actioned

Item 3: **Communications re surpluses** – advised.

Item 4: **Board H&S Responsibilities / Rotational Schedule:** this was provided and updated at the Board meeting. Actioned

Item 5: **Maori Workforce** – Work in progress a paper to be provided to MRB in July. Included on workplan – Actioned

Item 6: **Te Ara Whakawaiora - Cardiology** – a status update was provided by Dr John Gommans – Actioned.

BOARD WORK PLAN

The Board Work Plan was noted for June:

- ✓ Consumer Experience Results Qtly
- ✓ People Strategy (2016-2021) first draft
- ✓ Youth Health Strategy update for Information
- ✓ Clinical Services Plan
- ✓ Renal Services Review *(since incorporated into the Clinical Services Plan)*

Monitoring

- ✓ Te Ara Whakawaiora / Oral Health (national indicator)

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
Francie Reed	Executive Assistant	COO Office	34	19-May-17
Jean Koorey	Clinical Nurse Educator	Surgical Directorate	13+	26-Apr-17
Pat Hildred	Clinical Nurse Specialist - Breast Cancer	Surgical Directorate	13+	26-May-17
Margaret Gudgeon	Registered Nurse	Medical Directorate	39	28-Apr-17
Lynne Faulkner	Registered Nurse	Medical Directorate	38	18-May-17
Anne Martin	NIR Co-ordinator	Population Health	12	6-Apr-17

- A "**Petition preventing Dementia Wing Closure at Glengarry House, Wairoa**" had been received from Susie Morunga on behalf of the Dementia Support Group Wairoa. This petition had been circulated to board members by the Chair prior to the Board Meeting.

  An update on the services at Glengarry House was provided. In summary the facility operated by BUPA consists of hospital level (14 beds), rest home (18 beds) and dementia facility (8 beds).

  At any one time the Dementia beds are not anywhere near to capacity. BUPA (who have been running the facility for 7-8 years) are seeking a subsidy (in the vicinity of $100k per year) to enable them to keep the dementia wing open. This sustainability subsidy would see the DHB fund the balance of the beds which remain empty.

  The potential closure of the wing would be a commercial decision by BUPA as there are specific staffing requirements associated with dementia.

  In summary the points raised at the meeting included:

  - $100k may be better spent provided services in the home.
  - Legitimate concern that some families cannot cope with deteriorating loved ones if the facility was closed, which could create health issues for the families.
  - Could day programmes be extended?
  - Likely see an upward trend in dementia in Wairoa, however also likely to see a drift of people out of town and nearer to health services in other centres, or for family reasons
  - The reality is that once a service is removed often they are not re-implemented.
  - Professional opinion advised there will be a very small number of patients currently, who would be classed as "difficult to manage'.
  - The Wairoa community need to be consulted.

  Action: The Board supported the consultation process around the Dementia Wing at Glengarry House and requested the following:

  a) A progress update at the June Board meeting.

  b) Considering consultation may take longer, a full update including recommendations at the July Board Meeting.

In the interim HBDHB will provide a subsidy to BUPA for the dementia wing at Glengarry House to remain open.
This is really a bigger issue than Dementia – it is about services as a whole and the Wairoa community need to be involved and part of the decision.

- **HBDHB had applied to the Ministry of Health for reimbursement of costs associated with the Campylobacter Outbreak in Havelock north in August 2016**. Despite best attempts the MoH advised they would not agree to this, but that they would accept HBDHB reducing its surplus because of this.

  In discussion the following points were raised:

  - The word "surplus" (especially for a DHB) carries negative connotations for many, and does not reflect what is being achieved.
  - Because of this general lack of understanding within the community (and within the MoH) it was felt a re-brand was necessary to ensure clarity.

    The rebranding of "surplus" to "investment income" was noted, and messaging could be personalised to enhance understanding by using "home improvements" as an example with the need to save, or find money to undertake this work.
  - An extensive list of achievements were listed by the Chair who advised that these had occurred because HBDHB had not fallen into deficit and strove to achieve "surpluses' which have gone straight back into buildings and services for the community.
  - The Board believed that this application was legitimate and appropriate, and that the Hawke's Bay community deserved to have these costs reimbursed, given the significance of this unique public health event, and the positive way in which HBDHB had responded to it.
  - There was also some concern that it appeared HBDHB was being 'penalised' because of the financial prudence shown through producing annual surpluses.

RESOLUTION

That the Board

- Request management to go back to the Ministry of Health with regard to the Board's concern and ask the Ministry to reconsider relief towards the $1.0m plus cost of the Campylobacter Crisis in August 2016.

Carried

- The recent Budget announcement would mean a lift in health funding for Hawke's Bay in the vicinity of an $18m compared to the 2016/17 financial year.
- A letter had been received from Hayley Anderson (Chair Cranford Hospice) seeking a HBDHB representative for the Cranford Trust Appointments Panel. Cranford Board members were provided with an opportunity to become trustees and six had taken this up, leaving an opportunity for up to 3 appointments to be made. Kevin Atkinson advised that he personally would be the initial HBDHB representative.
- Health targets, specifically Faster Cancer Treatment were showing signs of improvement. DHBs have differing ways to assess this target. Hawke's Bay did have a good month and we were one of six DHBs showing an improvement.

CHIEF EXECUTIVE OFFICER'S REPORT

The CEO commented mostly on the Campylobacter Outbreak:

- The Stage 1 Report of the Inquiry into the Campylobacter Outbreak in Havelock North had been released advising it was generally well handed by the DHB. An appendix to the CEO's report included a summary of the findings and the implications in particular for our DHB.

  The Report made reference to drinking water assessors who are paid for but not accountable to DHBs. He has written to the Director General advising these roles need to be directly accountable and managed by DHBs.

  IANZ accreditation applies independently to Drinking Water Assessors and should continue as it does for other DHB services already.

It was noted that Drinking Water Assessors do three years of training and there is currently a shortage nationally.

One important lesson from this outbreak is working collaboratively. This is about having good systems and processes and working hard and being open, honest and transparent. There is history in this province of organisations not working well together and this is not acceptable going forward!

The CEO felt DHBs were unique organisations being large in scale by critical mass and sitting between central and local Government. DHBs have a responsibility to fulfil a very real role.

- A Water Symposium was being held in Hawke's Bay on 1 and 2 June with 1000 people expected.
- Financially this month HBDHB have turned a corner and achieved reasonably positive performance with an upward trend.

Other areas covered in the CEO's report included: NZ Health Partnerships, Health Literacy, Best Start Healthy Eating and Activity Plan, HBDHB Non-Financial Exceptions Report Q3; Annual Maori Health Plan Q3; Human Resources KPIs Q3;Te Ara Whakawaiora / Access 45-65 years; Community Pharmacy Services Agreement.

The draft Annual Plan would be provided when available in early June.

FINANCIAL PERFORMANCE REPORT

The Financial report for April 2017, showed an adverse variance of $85k for the month, slightly increasing the cumulative adverse variance year to date to $1.9m. Contingency was utilised in April with $200k contingency remaining in reserve. The forecasted surplus currently sits at $3.5m following decline of the request to the MoH to contribute to the cost of the Campylobacter Outbreak.

The funding envelope was received on 26 May 2017, which would normally be received pre-Xmas 2016.

Ngahiwi Tomoana arrived at 2.00pm

HEALTH & SAFETY BOARD CHAMPION'S UPDATE

Dr Helen Francis provided a verbal update:

Continued meetings with Kate Coley and Gail Harris the Health and Safety Advisor (who is leaving the organisation shortly). Three site walks around the facility had been conducted during which Helen felt that practices and procedures worked well. She felt from the staff she had spoken to there was a willingness to raise issues. It was evident there people were experiencing stress which is a risk to the organisation.

Next month, Kate would provide a **365 presentation** – **action / note for the Agenda**

Ken Foote circulated the Board Health & Safety Champion Board member rotation sheet for completion and return to him during the meeting.

Action: **The Health and Safety Board Rotational Schedule will be issued to the Board and put into the Resource Centre on Diligent.**

During the first rotation, some guidelines would be formulated. Timing for individual board member activities (on site) during their rotation is their choice.

CONSUMER STORY

Dr John Gommans provided a presentation on a Health and Disability Commissioner complaint and the follow through resulting in changes within ED and including the family's response.

Good learnings and the resulting changes made from this tragic case.

REPORT FROM COMMITTEE CHAIRS

Hawke's Bay Clinical Council

Dr Mark Peterson co-Chair referred to the report from the Council's meeting held on 10 May 2017 and specifically summarised:

- A presentation from Sapere Consultants on the Clinical Services plan which is a major piece of work to guide health service planning for the next 30 years. Council supported the TOR and noted this will commence in the community and with primary care and kick off with a GP Forum.
- Health Literacy was received and noted it was more about the health literacy of the "system" rather than the patient. We can change the system.
- Congratulations re Hand Hygiene – reflects excellent work throughout the organisation.

Hawke's Bay Health Consumer Council

Graeme Norton Chair of Council spoke to their meeting held on 11 May 2017 advising:

- The Consumer Council Chair / Membership Appointment / Renewal Process was underway for members (in June) and the Chair (in August).
- Health literate organisations make health literacy a lot easier. Great to see Clinical Council agree with this.
- Consumer Council asked to meet with Sapere Consultants in June and also to speak with Anne Speden to understand where things are headed.
- Council farewelled Jim Morunga who passed away in May. A wonderful person and member of Council who summarised and got to the heart of issues quickly.

Maori Relationship Board

Ngahiwi Tomoana as Chair did not cover items at the MRB meeting but was delighted that the Chair and CEO have attended the MRB meetings which are now becoming shorter as questions are answered at the meeting.

Appointment of member to the Maori Relationship Board

A later paper had been received and circulated to the Board, regarding the resignation of Ahuriri District Health Trust member Des Ratima. Following consideration the board approved the following recommendation:

RECOMMENDATION

That the Board

- Appoint Fiona Cram as the Ahuriri District Health representative on the Maori Relationship Board (MRB).

Moved **Hine Flood**
Seconded **Helen Francis**

Carried

Action **A letter of thanks would be sent to Des Ratima (from the Chair) thanking him for his term on MRB and advising of Dr Cram's appointment.**

FOR DECISION

NZ Health Partnerships Ltd - Statement of Intent and Annual Plan

The Board received the papers which had been issued to the 20 DHBs for approval. In discussion the following was summarised:

- In the document, in summing up in the Statement of Responsibility NZHP want to be **"one voice"** for all the 20 DHBs – that did not appear practical. Best refer to as facilitating collaboration or helping DHBs achieve their aims/goals.
- Laundry and Food were provided as examples of "one voice" not suiting all. Being smart is about using business cases and success stories to develop a better service eg., Allied Laundry.
- Reframe NZHP's purpose to state "help DHBs to achieve their common goals" flips it to support us, not to tell us what to do!

RECOMMENDATION

That the HBDHB Board, as a shareholder in NZ Health Partnerships Ltd

1. **Approve** the NZHP Combined Statement of Intent 2017-2021 and Statement of Performance Expectations 2017/18

2. **Approve** NZ Health Partnerships Annual Plan 2017/18

Moved **Peter Dunkerley**
Seconded **Heather Skipworth**

FOR DISCUSSION / INFORMATION

Health Literacy Principles and Implementation Plan

The focus is to create a health literate Hawke's Bay health sector and an empowered and health literate population.

The focus of the report was conveyed as:

- Reducing literacy demands that the health system places on people to obtain, understand and use health services and information.
- Increasing the skills and abilities of people to access, navigate, understand and use the health system.

Health literacy needs to be part of everything we do, including our culture and core principles. It is all about making health easier to understand.

Kate Coley introduced Adam McDonald the Project Manager who provided a presentation to the board.

A summary of the discussion points follow:

- When considering the make-up of the Health Literacy Advisory Group and to obtain a simple objective balance, it was suggested half the members should be health literate and other half not so.
- It was conveyed that linkages with the PHO were not relayed in the report but do exist.
- The terminology "Health Literacy" is confusing to many! It was suggested this could be rephrased – for example "Making Health Care Easier to understand"
- Taking theory into simple practical solutions is paramount. This does not need to be complex Eg, 50% of people who receive their drugs from the pharmacy cannot understand how to take their pills. Discharge summaries and medications need to be well understood.
- If we model our behaviours on our report writing – we will not get health literacy within the institution. Concise with simple language is important.
- Engaging effectively with Maori relates to fixing health literacy also and we have that at our fingertips. A sense of frustration was expressed but the work that had gone into the report was acknowledged.

- Health Literacy has been in the radar for three years with no concrete actions to date.
- The Board wished to receive actions and a timetable, worked through in conjunction with the Advisory Group to inform the work that should be done.
- In conclusion the CEO suggested the following:
  - ✓ ID what needs to be fixed and focus on getting six things moving forward
  - ✓ Setting up some processes to ensure consistency across the organisation
  - ✓ Be active in co-design and do in parallel.

Action: **A progress/update with clear actions and timetable will be provided to the Board in July 2017**

Best Start Healthy Eating and Activity Plan update

Progress on the implementation plan was noted.

Shari was present for her progress report which the Board were pleased to receive and noted they were very happy with progress over the 12 month period. A well-presented report and easy to read.

Action: **The Board advised they would be happy to see an interim update in 6 months.**

FOR MONITORING

HBDHB Non-Financial Exceptions Report for Quarter Three (Jan-Mar 2017)

Tim Evans provided an overview of:

- Achievements: Stroke Services: Immunisation at 5 Years and Average Length of Stay Elective.
- Areas of Progress: Elective Surgery; Faster Cancer Treatment; Raising Healthy Kids: DNA (Did not attend); and Oral Health
- Areas of Focus being Acute Coronary Syndrome and Rheumatic Fever.

MoH Dashboard for Quarter Two (Sept-December 2016)

The report was tabled in A3. It was noted the MoH collate the information from all DHBs hence the report has been historically delayed.

Annual Maori Health Plan Dashboard Report for Quarter Three (Jan-Mar 2017)

Patrick LeGeyt spoke to the report provided:

- Achievements: Immunsation rates for 8 months old Māori
- Areas of progress: Māori children with BMI in 98th percentile at B4SC; Māori enrolled with HHB PHO; Cancer screening; cervical screening; Breast Screening; Access to referral services for Alcohol and Other Drugs; SUDI; and Māori Workforce within health
- Challenges: Acute hospitalization for Rheumatic Fever; Breastfeeding rates for Māori remain stagnant; Pre-school oral health enrolment rates for Māori The percentage of Māori women who are smoke free at two weeks postnatal; Māori under Mental Health Act compulsory treatment orders; and The Māori staff cultural competency training remained relatively stagnant.

  It was noted by Dr John Gommans that **Cultural Competency Training** has its biggest "participation" challenge amongst long term Senior Clinical Staff! The Medical Council will/have set requirements. However we do need to focus on junior doctors as they are shorter term (move around nationally).

A verbal update followed on where HBDHB was ranked with like DHBs Nationally, on key targets focused on in the Maori Health Plan for Q3.

The detail conveyed was taken from the following comparison table.

DHB	Breast Screening			Cervical Screening			PHO Enrolment			Immunisation		
Target	70% (50 - 69 Years)			80% (25 – 69 Years)			100%			95% (8 months)		
	Performance	Ranking - All DHBS	Ranking – **Comparative** DHBs	Performance	Ranking - All DHBS	Ranking – **Comparative** DHBs	Performance	Ranking - All DHBS	Ranking – **Comparative** DHBs	Performance	Ranking - All DHBS	Ranking – **Comparative** DHBs
Hawkes Bay	66.20%	6	**1**	73.30%	1	**1**	97.00%	5	**3**	95.40%	6	**1**
Mid Central	65.20%	7	**2**	60.90%	16	**5**	86.00%	11	**5**	92.00%	7	**2**
Lakes	62.00%	8	**3**	71.30%	4	**2**	101.00%	1	**1**	89.50%	8	**3**
Bay of Plenty	59.70%	19	**5**	68.30%	8	**4**	95.00%	7	**4**	81.30%	19	**5**
Northland	70.30%	13	**4**	68.50%	7	**3**	99.00%	3	**2**	88.90%	13	**4**

Human Resource Key Performance Indicators Q3

Staff turnover is slightly above the benchmark, looking at refreshing processes around exit interviews. There has been a slight improvement around annual leave.

Kate advised that over the next several months there will be a further refresh of the KPIs and bringing the quality dashboard together.

Those identifying as Maori employed by HBDHB:

- As of 31 May this now sits above the target at 14.1% (of our workforce).
- It was noted that historically job applications received from Maori was at 5%, this has now doubled to 10%. The pipeline approach: educate, recruit and retain. The challenge was suggested to be 25% in 5 years. A Workshop will take our learnings forward, refresh, broaden our views and perspectives. Our future workforce needs to reflect the diverseness of the HB community.
- Following the Workshop, detail will be brought back to the Board in July. This was already included on the workplan.

Action **The Board noted the higher percentage of new management and administration staff within the workforce, although under the cap, Kate advised she would advise the reason for the increase at the June meeting.**

Te Ara Whakawaiora / Access 45-64 years

It was agreed the board would be provided with further detail (to that provided in February).

Reformatting of the report had been undertaken to ensure clarity as to where the problems are and the actions being taken which were highlighted in the tables.

GENERAL BUSINESS

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

RESOLUTION TO EXCLUDE THE PUBLIC

RESOLUTION

That the Board

Exclude the public from the following items:

23. Confirmation of Minutes of Board Meeting
    - Public Excluded

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

25. Board Approval of Actions exceeding limits delegated by CEO

26. Chair's Update

27. Cranford Hospice

28. Finance Risk and Audit Committee Report

Moved: **Barbara Arnott**
Seconded: **Hine Flood**
Carried

The public section of the Board Meeting closed 3.45pm

Signed: _____
Chair

Date: _____

5

BOARD MEETING - MATTERS ARISING
(Public)

Action No	Date Issue first Entered	Action to be Taken	By Whom	Month	Status
1	29 Mar 17 26 Apr 17	**Chaplaincy Services:** 1. Facilitate an opportunity for Rev Barbara Walker to speak to the HB Mayoral Forum. 2. Develop funding options for contributions to the $60k shortfall within the Chaplaincy service. Items remain as an action.	Board Chair Tim Evans		Mayor of Hastings to advise Board Chair of potential date(s)
2	26 Apr 17	**Maori Workforce:** Management agreed to consider: a) MRB's recommendation regarding Maori employed (currently at 13.75% of the total workforce) be lifted to 25% over next 5 years *ie., the 25% being based on the percentage of Maori within the HB population.* b) This discussion to include a review of comments from EXIT interviews of Maori Staff. c) Confirm timing for inclusion on the MRB agenda to discuss what is achievable.	Kate Coley	~~June~~ July	Paper and presentation to be developed for discussion at EMT and then to MRB in July. This item has been included on the workplan.
3	31 May 17	**Dementia Wing – Glengarry House, Wairoa:** The Board supported the consultation process around the Dementia Wing at Glengarry House and requested the following: d) A progress update at the June Board meeting. e) Considering consultation may take longer, a full update including recommendations at the July Board Meeting.	Tim Evans	 June July	

Action No	Date Issue first Entered	Action to be Taken	By Whom	Month	Status
4	31 May 17	**Request MoH to reconsider** relief towards the $1m cost of the Campylobacter Crisis in Havelock North.	Kevin Snee	June	
5	31 May 17	Formerly finalise and circulate the **Annual Plan** which was not available at the Board Meeting.	Tim Evans	June	Agenda Item 16
6	31 May 17	**Board Health and Safety Rotational Schedule** formerly issued and the Board provided with detail.	Ken Foote	June	Actioned
7	31 May 17	**365 Presentation** to the Board in June. Noted on workplan	Kate Coley	June	Agenda Item 11
8	31 May 17	**MRB Resignation & Reappointmen**t, letter to be sent to Des Ratima.	Ken Foote	June	Actioned
9	31 May 17	NZ Health Partnerships SOI and Annual plan approval - advise	Ken Foote	June	Actioned
10	31 May 17	**Health Literacy / Making Health Care easier to understand:** Interim: ✓ Identify what needs to be fixed and focus on getting <u>six</u> things moving forward ✓ Set up some processes to ensure consistency across the organisation ✓ Be active in co-design and do in parallel. Board Update in July: A progress/update with clear actions and timetable to be provided.	Kate Coley	July	
11	31 May 17	Best Start Healthy Eating and Activity Update – to be scheduled 6 monthly vs annually. Workplan update required.	Admin	Nov / May 18	Actioned
12	31 May 17	Human Resource KPIs for quarter 3: Higher percentage of new managers in the workforce noted. Response to the Board in June.	Kate Coley	June	

HAWKE'S BAY DISTRICT HEALTH BOARD – WORKPLAN

Mtg Date	Papers and Topics	Lead(s)
26 July	Consumer Engagement Strategy	Kate Coley
	Recognising Consumer Participation	Kate Coley
	Maori Workforce (Board action April)	Kate Coley
	Health Literacy priorities update and actions (Board action May)	Kate Coley
	Histology Laboratory and completion of the Education Centre (final approval of tender)	Sharon Mason
	Social Inclusion	Tracee TeHuia
	Alcohol Positon Statement Update (Board action Dec 17)	Tracee TeHuia
	Dementia Wing - Glengarry House	Tim Evans
30 Aug	Quality Accounts draft	Kate Coley
	Ngātahi Vulnerable Children Project (Board action Feb 17)	Tracee TeHuia
	Transform & Sustain Strategic Dashboard	Tracee TeHuia
	Travel Plan Report	Sharon Mason
	Monitoring	
	Annual Maori Health Plan Q4 – Dashboard	Tracee TeHuia
	HBDHB Non-Financial Exceptions Report Q4 Apr-Jun 17 + MoH	Tim Evans
	HR KPIs quarterly	Kate Coley
	Te Ara Whakawaiora / Culturally Competent Workforce (local ind)	Kate Coley
	Te Ara Whakawaiora / Mental Health and AOD (national / local)	Sharon Mason
6 Sept	**HB Health Sector Leadership Forum – East Pier, Napier**	
27 Sept	Orthopaedic Review – phase 3 draft	Andy Phillips
	Quality Accounts final	Kate Coley
	Consumer Experience Results Qtly	Kate Coley
	Annual Report (Interim)	Tim Evans
	Monitoring	
	Te Ara Whakawaiora – Healthy Weight Strategy (national Indicator)	Tracee TeHuia
25 Oct	Board H&S Champion - progress	Kate Coley
	People Strategy Update	Kate Coley
	Establishing Health and Social Care Localities Update	Tracee TeHuia
	Annual Report 2017 (Board and FRAC)	Tim Evans

Mtg Date	Papers and Topics	Lead(s)
25 Oct	Board H&S Champion - progress People Strategy Update Establishing Health and Social Care Localities Update Annual Report 2017 (Board and FRAC)	Kate Coley Kate Coley Tracee TeHuia Tim Evans
29 Nov	***Monitoring*** Travel Plan Update Report HR KPIs quarterly Te Ara Whakawaiora – smoking (national Indicator) Maori Annual Plan Q1 Dashboard HBDHB Non-Financial Exceptions Report Q1 Jul-Oct 17 + MoH dashboard Q4	 Sharon Mason Kate Coley Tracee TeHuia Tracee TeHuia Tracee TeHuia
13 Dec	Audit NZ Final Management Report on the audit of HBDHB for y/e June 2017 Consumer Experience Qtly feedback and Annual Review since inception Transform and Sustian Report (TBC as timelines very tight)	Tim Evans Kate Coley Tracee TeHuia
Jan 2018	**No meeting**	

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** 60
	For the attention of: **HBDHB Board**
Document Owner:	Dr Kevin Snee, Chief Executive Officer
Reviewed by:	Not applicable
Month as at	21 June 2017
Consideration:	For Information

8

Recommendations

That the Board

1. **Note** the contents of this report.

INTRODUCTION

As the year draws to a close we are seeing the general improvements in our performance continuing. This year has been a difficult year with a significant power outage, the largest recorded outbtreak of campylobacter worldwide, two RMO strikes and then, perhaps not surprisingly, a financial problem emerging in the last quarter of the year. So to end the year with generally improving picture of performance is a great credit to the staff of the DHB

I have appended a letter from the Target Champion for Shorter Stays in Emergency Departments (ED6), Dr Angela Pitchford, who visited earlier this year and made a series of recommendations. It was reassuring to note that the great majority of the recommendations related to known problems and the solutions proposed were ones that we were working on.

On this month's agenda we have a range of key topics. Our approach to investing in our staff and developing the right culture will be discussed. We will run a process over the next six months which will engage with staff and patients in the health system to discuss and agree what our culture should be, and how we will ensure we put it in place. This needs to be seen alongside the Clinical Services Plan which will describe the nature and structure of our health system's clinical services going forward.

Operational budget setting is basic technical exercise that is usually done without drama year-on-year. We could always spend more money, but at HBDHB we have prided ourselves on being fiscally prudent so that we could maximise our investment in patient care for the people of Hawke's Bay. The job of setting our budget has been made particularly difficult this year because rather than notifying DHBs of their funding envelope before Christmas, which has been the practice for many years, we were notified in May. This compresses the timescale to set and check the budget from months to days. Secondly, there was an error which overstated our budget of around $2m. We were not formally notified of our revised funding envelope until after 4pm on Friday 16 of June. The budgets now need to be reworked to provide the board with options about how resources will be spent and what the level of our savings programme will be. Clearly this has been a highly unsatisfactory process. The Executive Director of Corporate Services will present some options for the Board to consider.

PERFORMANCE

Measure / Indicator	Target	Month of May	Qtr to end May	Trend For Qtr
Shorter stays in ED	≥95%	94.2%	94.7%	▼
Improved access to Elective Surgery (2016/17YTD)	100%	-	98.8%	▼

Waiting list	*Less than 3 months*	*3-4 months*	*4+ months*
First Specialist Assessments (ESPI-2)	2,600	448	71
Patients given commitment to treat, but not yet treated (ESPI-5)	1,011	62	41

Faster cancer treatment*	≥85%	71.4% (April 2016)	72.1% (6m to April 2016)	▲
Increased immunisation at 8 months (3 months to end of April)	≥95%	---	94.3%	▼
Better help for smokers to quit – Primary Care	≥90%	88.7%%	---	▲
Better help for smokers to quit – Maternity	≥90%	---	92.8% (Quarter 3, 2016/17)	▲
Raising healthy kids (New)	≥95% (by Dec 2017)	---	91% (6m to May17)	▲
Financial – month (in thousands of dollars)	(1,882)	(1,568)	---	---
Financial – year to date (in thousands of dollars)	2,028	479	---	---

***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%	*14/19 = 74%*	*104/114 = 91.2%*

Ministerial Targets

Performance in this month shows small deterioration in our Shorter Stays in Emergency Departments (ED 6). At the time of writing we are on track to hit 95 percent target, but it will be a close call. Elective activity remains below plan, however we are getting closer to our planned delivery and we expect to meet the plan. Faster Cancer Treatment continues to improve but will not hit the end of year target of 85 percent. Raising healthy kids has seen a significant improvement and we are now close to delivering the target (which is not required until the end of December). Immunisation has seen a small drop, but we expect to deliver the target by year end – clearly some of the highly irresponsible anti-vaccination propaganda could be having an impact nationally.

Financial Performance

The result for the month of May (Month 11) is a favourable variance of $314 thousand making a year to date adverse variance of $1.5 million. This keeps us on track for our revised target surplus of $3.5 million.

HEALTH AND SAFETY

This month a presentation will be given showing all Board members the Safe365 tool. Safe365 has been developed by certified and experienced risk managers and aligns to best practices from a health and safety perspective. The online assessment tool has provided the DHB with an understanding of our capability and any gaps against best practice and the Health and Safety Act. The initial assessment identifies that the DHB has a safety index of 50 percent. This equates to the DHB being compliant with legislation and aligns to the old ACC Work Safe Management Practices (secondary level). In the long term it is the DHB's intent to achieve a safety index of 75 percent or above, which would equate to tertiary standard, and for this to be maintained on an annual basis. With the assessment completed, the DHB now has an agreed action plan to minimise the gaps and risks identified whilst enabling us to build the culture and capability of all our teams around health and safety.

CONSUMER FEEDBACK EXPERIENCE QUARTERLY REPORT

There are limitations and challenges to capturing, measuring and reporting on patient experience of care. This month we will provide a high level overview on these challenges and how we plan to address and resolve these issues. In addition we will present the themes and trends from consumer feedback in Quarter One 2017 (January – March). This incorporates results from the national inpatient experience survey, Marama real time mental health survey, Maternity survey and consumer feedback direct to HBDHB.

YOUTH HEALTH STRATEGY

The Youth Health Strategy 2016-19 was endorsed by the HBDHB Board in July 2016. Over the past year the strategy has been introduced across the health and social sectors as a strategic document with the hope of ensuring a shared vision, while setting youth focused outcomes and indicators. The strategy over the past year has helped raise the profile of youth health in Hawkes Bay. There has been interest in Hawke's Bay's Youth Strategy from the Ministry of Health and DHBs across the country. Key achievements are:

- Establishment of the Youth Consumer Council
- Redesign of youth health services (for tender) – informed by the Youth Health Strategy
- Increased profile of the youth sector

TE ARA WHAKAWAIORA / ORAL HEALTH

The Te Ara Whakawaiora report for oral health provides the 2016 results for proportion of pre-school children enrolled and the percentage dental decay free at five years. We have now achieved 89 percent of pre-school children enrolled. As this indicator reaches towards the national target of 95 percent, data integrity issues are becoming apparent. 0ver 100 percent of Other children are reported as enrolled, while Māori are at 73 percent and Pacific at 69 percent. The over reporting for Other suggests Māori and Pacific enrolment are under reported, but work is required to address the integrity of early childhood oral health enrolment data. Despite these issues, the proportion of children caries free in 2016 has increased to 59 percent, the proportion of Māori to 44 percent, the best result for the DHB to date, and for Other children to 74 percent. Māori caries free improved by eight percent in 2016.

A broad ranging and interdisciplinary work plan to address the continuing challenges of early childhood oral health inequities is described in the report. Concerningly, the report also describes the effects of loss of community water fluoridation in Central Hawke's Bay, particularly for 5-year-old Māori, where the proportion caries free has declined from 54 percent in 2013 to 24 percent in 2016. These results have been communicated to both the Central Hawke's Bay Mayor and to the Hastings District Council CEO. There are obvious implications in Hastings given the current cessation of fluoridation to enable chlorination of the water. The target champions have noted the key importance of collaborative work to increase the preventive focus of the model of care, to reduce exposure to sugar sweetened beverages in early childhood environments and to increase access to optimally fluoridated water in addressing the levels of caries in early childhood.

PASIFIKA HEALTH DASHBOARD QUARTER THREE

The Pasifika Health Dashboard was adopted by the HBDHB Board in 2016 with reporting to be six monthly. However, due to delays with Ministry of Health reporting, there were difficulties in meeting this timeline. As a result, the Pasifika Health dashboard has been aligned to the existing HBDHB quarterly reporting framework which will ensure regular and timely monitoring and reporting for Pacific

health. This is the final six-month Pasifika Health dashboard report and future reporting will be quarterly going forward.

The Pasifika Health Dashboard Quarter three demonstrates that Pacific health performs well in certain areas such as; Before School Checks, Raising Healthy Kids and Breastfeeding Rates (three months). There are a number of areas within 10 percent of achieving the target such as; Better Help for Smokers to Quit (Primary Care), More Heart and Diabetes Checks, Cervical Screening and Breast Screening, Increased Immunisation at eight months of age. Areas that are 20 percent plus from achieving the target include; Oral Health Pre-School Enrolment, Caries Free at five years, Mean Decayed or Filled Teeth at year eight (MDFT).

PEOPLE STRATEGY (2017-2022)

As part of the refresh of the Transform and Sustain programme we have agreed that a key enabler for a significant shift in our culture will be the development of the People Strategy. This, in conjunction with the development of the Clinical Services Plan, presents an opportunity to transform the delivery of healthcare services and the way in which we do this. The development of the strategy will be very much around engaging with all of our staff and patients in determining what this looks like and a presentation will be provided to Board outlining our approach and the key deliverables and milestones over the next six months.

FINAL DRAFT HBDHB ANNUAL PLAN 2017/18 AND REGIONAL SERVICE PLAN 2017/19

The Final Draft of the HBDHB Annual Plan and the Central Region Regional Service Plan 2017/18 are due to be submitted to the Ministry of Health on Friday 30 June. These are being presented for approval. Unfortunately, due to the change in timeline for the funding envelope this year, the financials were not approved in time to include in the Annual Plan Final Draft. A complete version will be shared with the Board following approval of the 2017/18 budget.

CRANFORD HOSPICE

The Cranford Hospice Autonomy Project is close to completion, with all issues associated with the establishment of the new Cranford Hospice Trust and the transfer of Cranford from Presbyterian Support East Coast on track for 30 June/1 July. Work on the development of a business case for a potential new Cranford facility is progressing, with an initial draft due to the steering group mid-July.

CONCLUSION

This month’s report represents continued performance improvement after what has been an unprecedented year for HBDHB. Underpinning this continued improvement is a growing capability and a steadily improving culture. As we head towards year end, we approach a new organisational year with key programmes in place to develop a step change in service delivery for our community in future years.

MINISTRY OF HEALTH
MANATŪ HAUORA

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8.1

12 June 2017

Kevin Snee
Chief Executive
Hawke's Bay District Health Board
Private Bag 9014
Hastings 4156

Dear Kevin,

Shorter Stays in emergency departments health target visit – 10 March 2017

I would like to thank you and your team for taking the time to speak with Sophia and I during our visit to Hastings Hospital on 10 March 2017, and apologise for the delay in sending out this letter to you. This was my first visit to Hastings Hospital, and as such it was great to learn more about your current models of care and the new initiatives that the DHB has put in place as well as some of the challenges that the DHB is facing in terms of managing its acute patient flow.

In particular, I was pleased to see the changes that the Emergency Departments had made at the front door and to hear about the work of the Whanau Wellness Programme and the Orbit team in reducing unnecessary ED presentations and hospital admissions. It was also good to hear that your Integrated Operations Centre is investing in its IT infrastructure. The combination of Trendcare and CaPlan should help the DHB to manage its day - to – day operations more effectively and to forecast future trends. I look forward to hearing more about the efficacy of the Three Phase Escalation Plan hat the Operation Centre has developed.

Lisa Jones' presentation titled 'Hawkes Bay Regional Hospital Emergency Department trends 2011 – 2016' was useful in helping me understand the demands on the Hawke's Bay DHB. This presentation led to a discussion on the need for Hastings to emulate the Urgent Care Facility that Napier has. In Hastings there are few medical care options after eight o'clock in the evening, or after six o'clock in the evening on the weekend. It would be useful for the DHB to establish a time frame for the Acute Care Alliance to engage with primary care on the possibility of opening an after-hours facility in Hastings.

I have listed a few opportunities for improvement below that you may wish to consider. Overall I think that Hawke's Bay DHB is making good progress and I look forward to seeing everyone's hard work reflected in the DHB's Shorter Stays in ED health target performance over the coming quarters.

Recommendations for improving flow in the ED

- It would be useful if your ED whiteboard could display real time performance against the Shorter Stays in EDs health target. It would reinforce the importance of providing timely care in the ED, and help the nurse coordinator identify opportunities for improving patient flow.
- It would be good to value stream map a few ED patients' journeys to understand where delays are occurring in the acute admission process. There will almost certainly be

opportunities for reducing duplication and speeding up patient transfers out of the ED. This would help to free up staff and treatment spaces so that new ED patients can be assessed.

Recommendations for improving flow in the hospital

- The DHB must improve its discharge planning processes. Ideally every patient should be given an estimated date of discharge shortly after admission, which should be monitored by both the service and the operations centre. You could also consider introducing criteria-based discharge processes for nursing staff and junior doctors, multi-disciplinary board rounds or rapid rounds, or restructuring your ward rounds so that patients who are likely to be discharged that day, are visited first.
- You may also wish to review the model of care for acute admissions. Having more inpatient specialists reviewing patients in the ED would help to speed up decision-making and have a positive impact on patient flow.

Recommendations for improving flow in general medicine:

- The model of care for the Acute Assessment Unit (AAU) should be reviewed. The AAU currently has a mixed function which is leading to inefficiencies, thus negating some of the benefits of having an AAU.
- You could consider extending the AAU's hours, so that it is open 24/7, in order to maximise its potential. In the interim, the DHB should put a process in place to ensure that patients who get admitted to the ward when the AAU is closed are still reviewed early by a senior medical officer (SMO). At the moment patients can wait on the ward for up to 24 hours before seeing an SMO, which is adding a lot of time to those patients' average length of stay.

If you have any questions, please feel free to contact the Ministry's ED and Acute Demand team. Sophia Faure can be contacted at sophia_faure@moh.govt.nz. I have now finished my tenure as the Shorter stays in EDs Target Champion, but I will ask the Ministry of Health to pass on my recommendations for Lakes DHB to the new Target Champion once they have been appointed

Yours sincerely,

A. M. Pitchford

Dr Angela Pitchford
Shorter stays in emergency departments Target Champion and National Clinical Director for Emergency Services

Cc Sharon Mason, Chief Operating Officer, Hawkes Bay DHB
Nicola Holden, DHB Relationship Manager, Ministry of Health

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report, May 2017** 61
	For the attention of: **HBDHB Board and the Finance Risk and Audit Committee (FRAC)**
Document Owner: Document Author(s):	Tim Evans, Executive Director Corporate Services Phil Lomax, Financial Accountant
Reviewed by:	Executive Management Team
Month:	June 2017
Consideration:	For Information

RECOMMENDATION

That the Board and the Finance Risk and Audit Committee

1 **Note** the contents of this report

1. Executive Director Corporate Services' comments

Financial performance

The result for the month of May (Month 11) is a favourable variance of $314 thousand making a year to date adverse variance of $1.5 million. This keeps us on track for our revised target surplus of $3.5 million.

Pressure on Health Service budgets returned as we move into winter levels of Emergency Department attendance and hospital activity. However some of this is factored into our year end forecasts, and there was an offset from technical gains on capital charges. This arose as a reduction in capital charge costs (recognised this month) caught up with reduced income (recognised in earlier months). This is partly offset by an adjustment to Continuing Medical Education balances, adding Goods and Services Tax (GST) to comply with the Senior Medical Officer collective agreement. A Capital report for the major Endoscopy scheme has been added to this report.

Elective Health Target

Elective discharges deteriorated from 0.3% under target (adjusted) in April to 1.2% under target year to date in May. However as we approach year end our more timely internal information is a better guide to performance because there is a lag in the validated Ministry of Health record. Internally we are projecting and tracking daily a 101% elective performance.

Forecast year end result

Our forecast surplus remains at $3.5 million, with the $1.5 million difference from budget reflecting the unfavourable result in February (mainly the RMO strike), and the MOH decision not to cover the costs of the Havelock North gastroenteritis outbreak. The close financial watch remains in

place in June, and thanks to much effort across the organisation appears to be keeping us on track.

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)	(1,568)	(1,882)	314	16.7%	479	2,028	(1,549)	-76.4%	3,500	3
Contingency utilised	-	250	250	100.0%	2,800	2,750	(50)	-1.8%	3,000	8
Quality and financial improvement	1,144	1,083	61	5.6%	9,291	11,917	(2,626)	-22.0%	13,000	11
Capital spend	2,503	1,753	750	42.8%	10,971	20,282	(9,311)	-45.9%	13,334	16
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,255	2,292	36	1.6%	2,221	2,207	(14)	-0.6%	2,214	5 & 7
	CWD	CWD	CWD	%	CWD	CWD	CWD	%	CWD	
Case weighted discharges	2,513	2,415	99	4.1%	27,829	25,328	2,501	9.9%	27,609	5

No contingency was released in May leaving $200 thousand in the reserve. The contingency released year to date is explained in reserves (see section 8).

The Quality and Financial Improvement (QFI) programme has achieved 77% of planned savings year-to-date.

Expenditure on the renal centralised development and the stand alone endoscopy unit has reduced the amount the capital programme is behind plan to $9.1 million, including:

- Replacement projects for the MRI and fluoroscopy for $3 million delayed into future years;
- $1.4 million of endoscopy project costs not incurred as early as expected;
- the process for procurement through NZ Health Partnerships (previously Health Alliance) has resulted in $2.9 million of clinical equipment on order or in the late stages of negotiation, that will be delivered early in the next financial year;
- $2.1 million for information technology that will not be used this year.

The FTE variance year-to-date reflects offsetting factors including high patient volume in some areas, efficiencies not yet achieved, and unbudgeted leave cover, partly offset by vacancies.

Acute case weighted discharges (CWD) were close to plan in May, with electives 61 case-weights (10%) ahead of plan, and IDFs 31 case-weights ahead of plan. Year to date acute volumes are ahead of plan in general internal medicine, gastroenterology, general surgery and paediatrics.

3. Financial Performance Summary

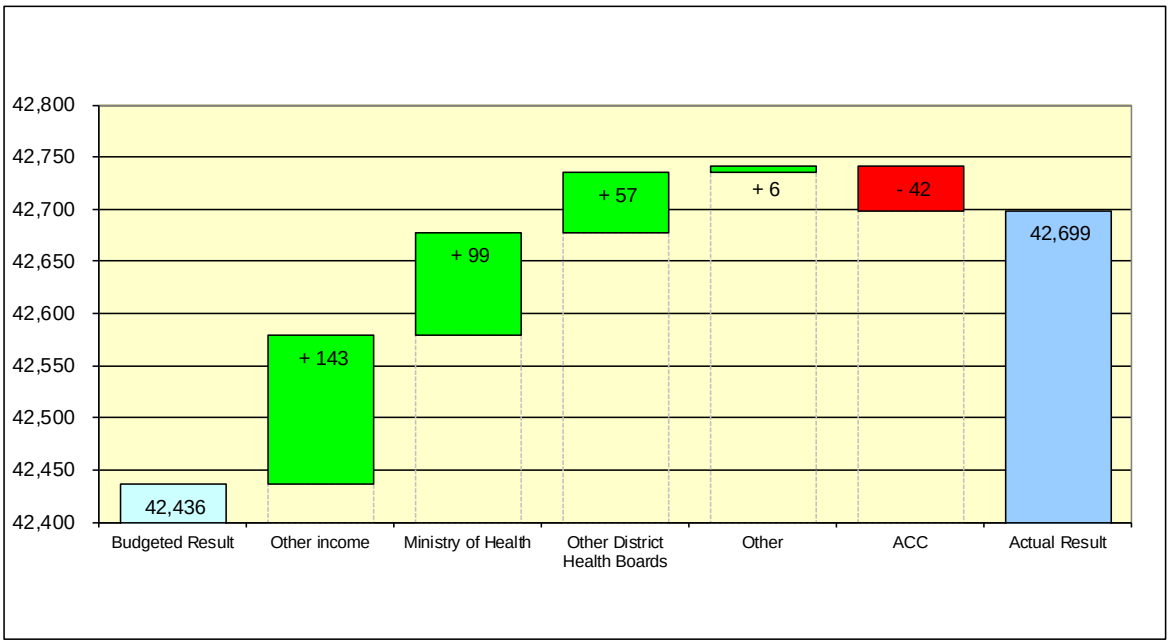
	May				Year to Date				Year End Forecast	Refer Section
$'000	Actual	Budget	Variance		Actual	Budget	Variance			
Income	42,699	42,436	263	0.6%	480,985	479,241	1,744	-0.4%	534,177	4
Less:										
Providing Health Services	22,699	22,052	(647)	-2.9%	234,579	226,576	(8,002)	-3.5%	256,209	5
Funding Other Providers	18,643	18,771	128	0.7%	208,639	208,240	(399)	-0.2%	227,588	6
Corporate Services	2,894	3,433	539	15.7%	40,514	41,527	1,013	2.4%	46,746	7
Reserves	31	63	31	50.3%	(3,226)	869	4,095	471.0%	134	8
	(1,568)	**(1,882)**	314	-16.7%	**479**	**2,028**	(1,549)	-76.4%	**3,500**	

Efficiencies not achieved and an adjustment to CME entitlements, are more than offset by reduced capital charges and interest costs, additional income from the Wairoa GP centre, In Between Travel (IBT) and donations, and reduced costs in residential care and aging in place, and PHARMAC estimates.

4. Income

$'000	May				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Ministry of Health	40,458	40,359	99	0.2%	458,498	456,669	1,829	0.4%	509,541
Inter District Flows	631	629	2	0.3%	7,101	6,916	185	2.7%	7,727
Other District Health Boards	390	334	**57**	**17.1%**	3,542	3,669	(126)	-3.4%	3,872
Financing	105	75	30	40.3%	838	812	27	3.3%	911
ACC	498	541	(42)	-7.8%	5,131	5,580	**(449)**	**-8.1%**	5,680
Other Government	17	18	(1)	-5.0%	374	419	(45)	-10.7%	483
Patient and Consumer Sourced	93	123	(30)	-24.3%	1,125	1,325	**(200)**	**-15.1%**	1,232
Other Income	502	359	**143**	**39.9%**	4,375	3,784	**591**	**15.6%**	4,730
Abnormals	5	0	5	2577.4%	1	67	**(66)**	**-98.5%**	1
	42,699	**42,436**	263	0.6%	**480,985**	**479,241**	1,744	0.4%	**534,177**

May Income



Note the scale does not begin at zero

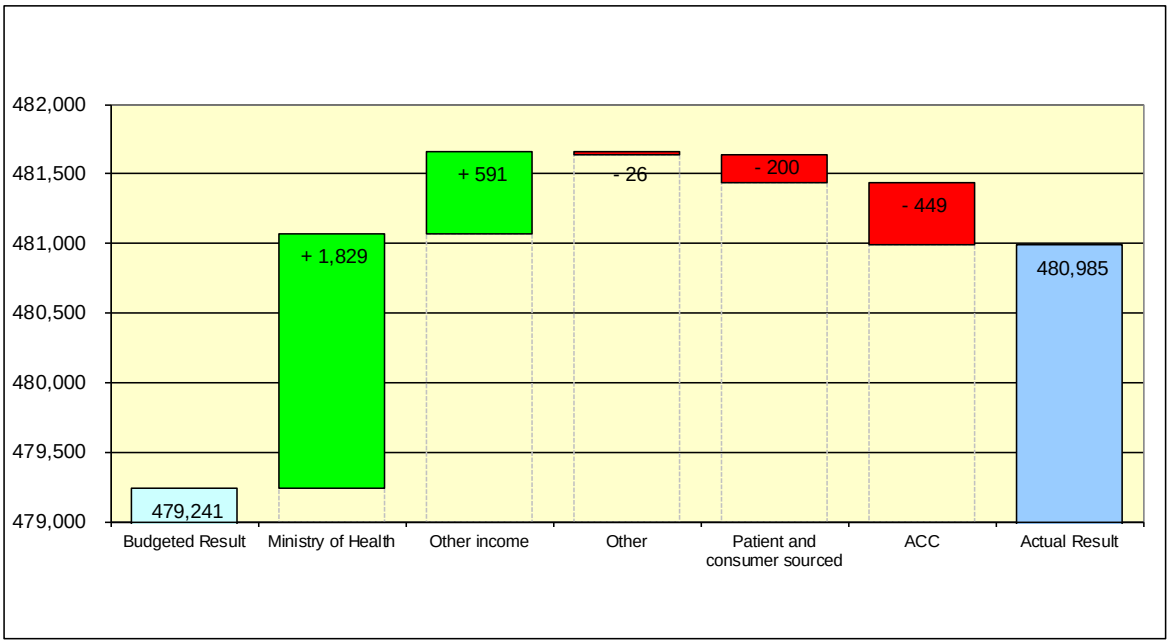
Other Income (favourable)
Wairoa GP Centre and donations.

Ministry of Health (unfavourable)
In Between Travel funding.

Other District Health Boards (unfavourable)
Lower oncology income.

ACC (unfavourable)
Lower elective surgery and rehabilitation income.

Year to Date Income



Ministry Of Health (favourable)
Additional funding for first contact services, In Between Travel, and high cost treatment, partly offset by funding adjustments relating to capital charges that are cost neutral and offset in reserves (see section 8).

Other income (favourable)
Unbudgeted donations and clinical trial income, and a wide variety of sundry income.

Patient and Consumer Sourced (unfavourable)
Lower than budgeted non-resident charges, audiology sales, and meals on wheels.

ACC (unfavourable)
Lower ACC elective volumes due to capacity constraints. Lower ACC rehabilitation income due to lower demand.

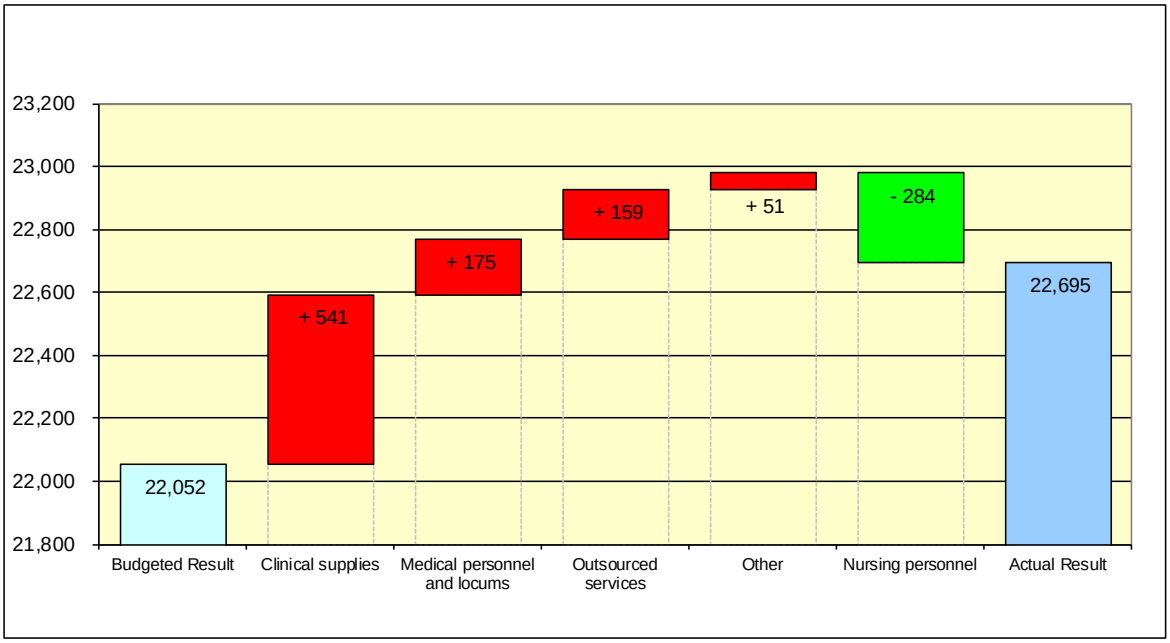
5. Providing Health Services

	May				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure by type $'000									
Medical personnel and locums	5,115	4,940	(175)	-3.5%	55,401	53,900	(1,501)	-2.8%	60,466
Nursing personnel	6,566	6,850	284	4.1%	67,456	66,653	(803)	-1.2%	73,895
Allied health personnel	2,934	3,030	96	3.2%	29,378	30,760	1,381	4.5%	32,228
Other personnel	2,015	1,969	(46)	-2.3%	20,318	19,640	(678)	-3.5%	22,197
Outsourced services	954	795	**(159)**	**-20.0%**	9,023	7,747	**(1,276)**	**-16.5%**	9,876
Clinical supplies	3,338	2,796	**(541)**	**-19.4%**	34,694	30,090	**(4,604)**	**-15.3%**	37,627
Infrastructure and non clinical	1,773	1,673	**(101)**	**-6.0%**	18,305	17,787	(518)	-2.9%	19,915
	22,695	**22,052**	(643)	-2.9%	**234,575**	**226,576**	(7,998)	-3.5%	**256,205**
Expenditure by directorate $'000									
Medical	5,989	5,791	(198)	-3.4%	62,691	59,784	(2,907)	-4.9%	68,388
Surgical	5,312	5,037	**(275)**	**-5.5%**	53,327	49,679	**(3,649)**	**-7.3%**	58,195
Community, Women and Children	3,806	3,752	(54)	-1.4%	39,623	38,597	(1,026)	-2.7%	43,099
Older Persons, Options HB, Menta	2,899	3,082	**183**	**5.9%**	30,987	31,167	179	0.6%	33,893
Operations	3,185	3,172	(13)	-0.4%	33,580	33,415	(165)	-0.5%	36,790
Other	1,505	1,218	**(287)**	**-23.6%**	14,366	13,935	(431)	-3.1%	15,840
	22,695	**22,052**	(643)	-2.9%	**234,575**	**226,576**	(7,998)	-3.5%	**256,205**
Full Time Equivalents									
Medical personnel	323.9	317.8	(6)	-1.9%	319	315	(4)	-1.2%	315.5
Nursing personnel	914.1	934.2	20	2.1%	911	890	(21)	-2.4%	892.9
Allied health personnel	450.7	470.0	19	4.1%	436	455	19	4.1%	455.8
Support personnel	133.7	130.6	(3)	-2.4%	133	127	(6)	-4.8%	127.5
Management and administration	264.5	266.5	2	0.7%	258	251	(8)	-3.1%	251.7
	2,087.0	**2,119.0**	32	1.5%	**2,058**	**2,037**	(21)	-1.0%	**2,043.4**
Case Weighted Discharges									
Acute	1,594	1,602	(8)	-0.5%	18,923	17,084	**1,839**	**10.8%**	18,713
Elective	672	611	**61**	**9.9%**	6,091	6,001	90	1.5%	6,451
Maternity	179	164	15	9.3%	1,956	1,839	**117**	**6.4%**	2,000
IDF Inflows	68	37	31	82.2%	859	404	**454**	**112.4%**	445
	2,513	**2,415**	99	4.1%	**27,829**	**25,328**	2,501	9.9%	**27,609**

Directorates

- Surgical includes efficiencies not achieved, locum vacancy and leave cover, and fee for service payments for additional surgery sessions.
- Medical includes vacancy and leave cover for medical staff, efficiencies not achieved yet, gastrointestinal pharmaceuticals and biologics.
- Community, Women and Children is mostly efficiencies not achieved, increased paediatric and maternity volumes, additional junior medical staff, and locums for sabbatical and parental leave cover.

May Expenditure



Note the scale does not begin at zero

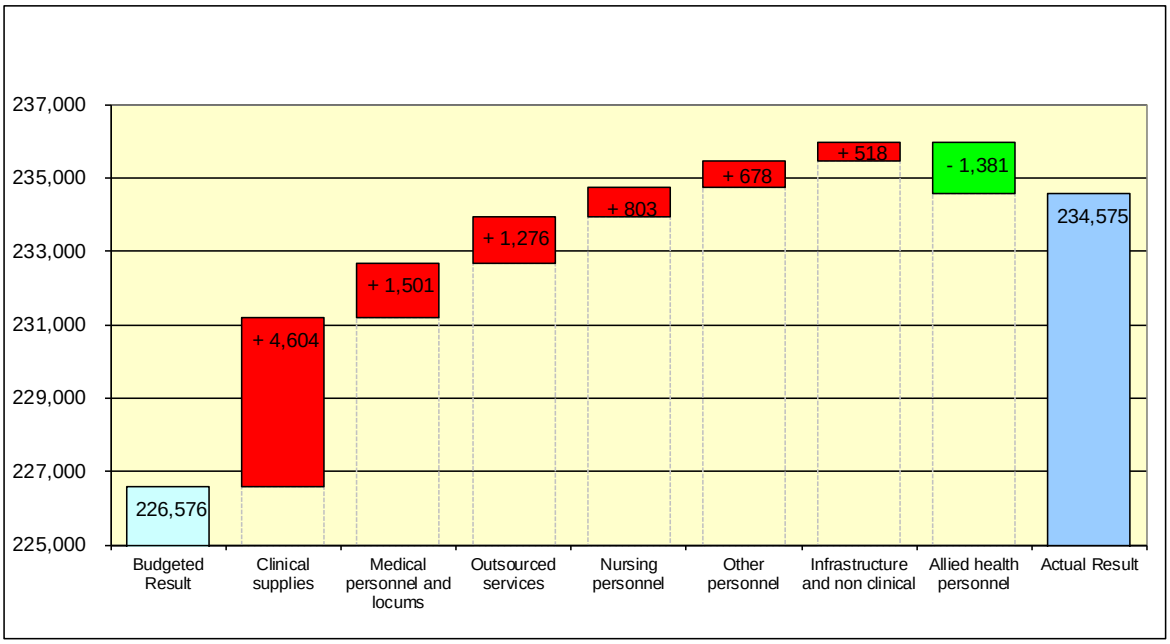
Clinical supplies (unfavourable)
Predominantly efficiencies not yet achieved or achieved elsewhere, and oncology pharmaceuticals.

Medical personnel and locums (unfavourable)
Adjustment to the calculation of CME entitlements to comply with the SMO collective agreement.

Outsourced services (unfavourable)
Clinical services, Royston and Radiology procedures.

Nursing personnel (favourable)
Vacancies

Year to Date Expenditure



Clinical supplies (unfavourable)
Mostly efficiencies not yet achieved or achieved elsewhere. Also includes patient transport costs.

Medical personnel and locums (unfavourable)
Locums for vacancy and leave cover, leave not taken, additional sessions to meet targets, adjustment to CME entitlements, additional radiology SMO costs and some additional RMO positions.

Outsourced services (unfavourable)
Outsourced elective surgery to meet discharge targets, higher use of outsourced mental health beds, the acute flow management refresh, and CT teleradiology reads.

Nursing personnel (unfavourable)
Additional time worked including some additional staffing, greater use of part-timers and overtime. Mainly ED, and the wards.

Other personnel (unfavourable)
Maori Health vacancies, management restructuring costs, and additional administration staffing to provide cover.

Infrastructure and non-clinical (unfavourable)
Efficiencies not yet achieved, and legal costs relating to the gastroenterology outbreak.

Allied Health personnel (favourable)
Mainly mental health vacancies including psychologists, therapies and community support staff. Also includes vacancies in health promotion officers, laboratory technicians, and pharmacists.

Full time equivalents (FTE)

FTEs are 21 unfavourable year to date including:

Nursing personnel (21 FTE / 2.4% unfavourable)

- Higher than budgeted staffing in ED, the medical wards, and maternity. Some planned efficiencies have not been achieved or have been achieved elsewhere.

Management and administration personnel (8 FTE 3.1% unfavourable)

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

Support personnel (6 FTE / 4.8% unfavourable)

- Cover for leave, long term sick leave, and training, mainly impacting on orderlies and kitchen assistants.

Medical personnel (4 FTE / 1.2% unfavourable)

- Usually medical FTEs will be favourable because vacancy and leave cover is often provided by locums who do not generate an FTE. However year to date reductions caused by vacancies and staff on leave have been offset by leave not taken and new positions.

partly offset by:

Allied Health Personnel (19 FTE / 4.1% favourable)

- Vacancies mainly in health promotion, social workers, laboratory technicians, community support workers, and occupational therapists.

MONTHLY ELECTIVE HEALTH TARGET REPORT
YTD To May 2017

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

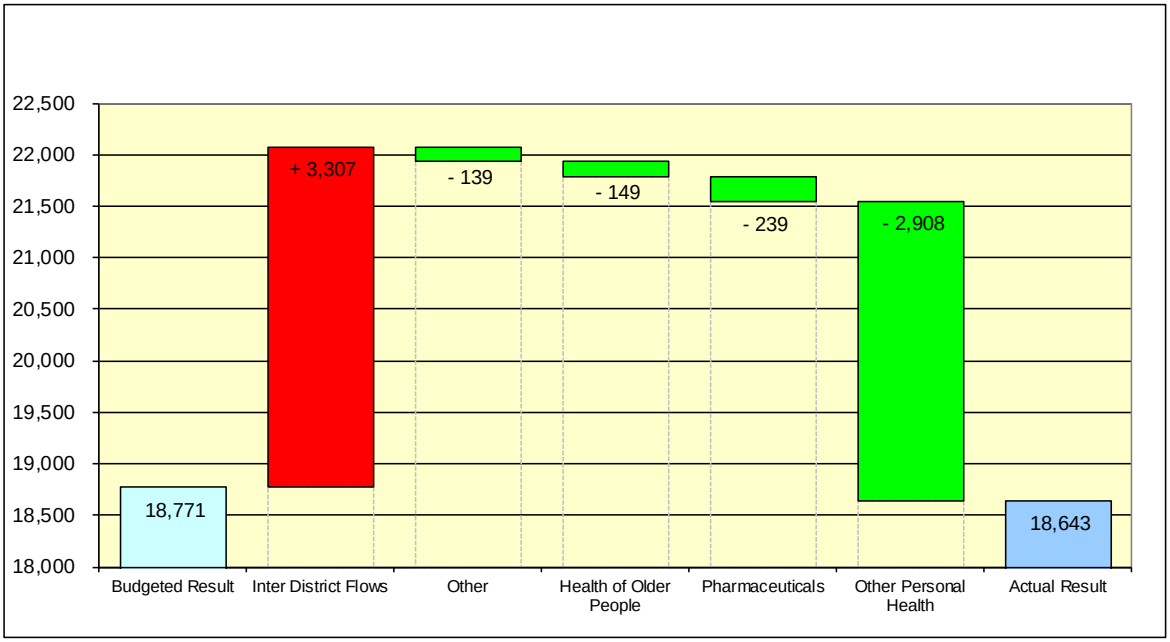
		YTD May-17						May-17			
		Actual	Plan	Var.	%Var.			Actual	Plan	Var.	%Var.
On-Site	Avastins	183	183	0	0.0%	On-Site	Avastins	19	19	0	0.0%
	ENT	478	519	-41	-7.9%		ENT	36	55	-19	-34.5%
	General Surgery	782	813	-31	-3.8%		General Surgery	92	85	7	8.2%
	Gynaecology	509	457	52	11.4%		Gynaecology	43	48	-5	-10.4%
	Maxillo-Facial	150	166	-16	-9.6%		Maxillo-Facial	23	17	6	35.3%
	Ophthalmology	886	994	-108	-10.9%		Ophthalmology	95	107	-12	-11.2%
	Orthopaedics	765	851	-86	-10.1%		Orthopaedics	98	96	2	2.1%
	Skin Lesions	160	160	0	0.0%		Skin Lesions	17	17	0	0.0%
	Urology	446	392	54	13.8%		Urology	45	41	4	9.8%
	Vascular	161	125	36	28.8%		Vascular	16	13	3	23.1%
	Surgical - Arranged	489	378	111	29.4%		Surgical - Arranged	49	37	12	32.4%
	Non Surgical - Elective	74	174	-100	-57.5%		Non Surgical - Elective	6	19	-13	-68.4%
	Non Surgical - Arranged	25	64	-39	-60.9%		Non Surgical - Arranged	2	6	-4	-66.7%
On-Site	**Total**	**5108**	**5276**	**-168**	**-3.2%**	**On-Site**	**Total**	**541**	**560**	**-19**	**-3.4%**
Outsourced	Cardiothoracic	0	40	-40	-100.0%	Outsourced	Cardiothoracic	0	5	-5	-100.0%
	ENT	134	135	-1	-0.7%		ENT	12	15	-3	-20.0%
	General Surgery	307	249	58	23.3%		General Surgery	32	29	3	10.3%
	Gynaecology	11	37	-26	-70.3%		Gynaecology	0	5	-5	-100.0%
	Maxillo-Facial	40	68	-28	-41.2%		Maxillo-Facial	5	9	-4	-44.4%
	Neurosurgery	0	17	-17	-100.0%		Neurosurgery	0	1	-1	-100.0%
	Ophthalmology	123	18	105	583.3%		Ophthalmology	0	0	0	0.0%
	Orthopaedics	87	51	36	70.6%		Orthopaedics	9	0	9	0.0%
	Paediatric Surgery	0	2	-2	-100.0%		Paediatric Surgery	0	0	0	0.0%
	Skin Lesions	3	0	3	0.0%		Skin Lesions	0	0	0	100.0%
	Urology	60	76	-16	-21.1%		Urology	7	9	-2	-22.2%
	Vascular	2	41	-39	-95.1%		Vascular	0	5	-5	-100.0%
	Surgical - Arranged	0	0	0	0.0%		Surgical - Arranged	0	0	0	0.0%
	Non Surgical - Elective	0	0	0	0.0%		Non Surgical - Elective	0	0	0	0.0%
	Non Surgical - Arranged	0	0	0	0.0%		Non Surgical - Arranged	0	0	0	0.0%
Outsourced	**Total**	**767**	**734**	**33**	**4.5%**	**Outsourced**	**Total**	**65**	**78**	**-13**	**-16.7%**
IDF Outflow	Avastins	1	0	1		IDF Outflow	Avastins	0	0	0	0.0%
	Cardiothoracic	59	71	-12	-16.9%		Cardiothoracic	4	7	-3	-42.9%
	ENT	36	43	-7	-16.3%		ENT	2	4	-2	-50.0%
	General Surgery	50	44	6	13.6%		General Surgery	1	4	-3	-75.0%
	Gynaecology	33	22	11	50.0%		Gynaecology	3	2	1	50.0%
	Maxillo-Facial	135	175	-40	-22.9%		Maxillo-Facial	5	18	-13	-72.2%
	Neurosurgery	64	40	24	60.0%		Neurosurgery	1	5	-4	-80.0%
	Ophthalmology	31	30	1	3.3%		Ophthalmology	2	3	-1	-33.3%
	Orthopaedics	33	18	15	83.3%		Orthopaedics	3	2	1	50.0%
	Paediatric Surgery	72	47	25	53.2%		Paediatric Surgery	7	4	3	75.0%
	Skin Lesions	68	69	-1	-1.4%		Skin Lesions	7	7	0	0.0%
	Urology	19	6	13	216.7%		Urology	0	1	-1	-100.0%
	Vascular	14	14	0	0.0%		Vascular	0	1	-1	-100.0%
	Surgical - Arranged	141	278	-137	-49.3%		Surgical - Arranged	9	27	-18	-66.7%
	Non Surgical - Elective	105	0	105			Non Surgical - Elective	7	0	7	0.0%
	Non Surgical - Arranged	51	0	51			Non Surgical - Arranged	4	0	4	0.0%
IDF Outflow	**Total**	**912**	**857**	**55**	**6.4%**	**IDF Outflow**	**Total**	**55**	**85**	**-30**	**-35.3%**
TOTAL		**6787**	**6867**	**-80**	**-1.2%**	**TOTAL**		**661**	**723**	**-62**	**-8.6%**

Please Note:This report was run on 7th June 2017. Skin Lesions and Avastins have been adjusted to plan. Data is subject to change.

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	3,379	3,618	239	6.6%	39,686	39,722	36	0.1%	43,440
Primary Health Organisations	2,785	2,882	98	3.4%	31,919	32,525	606	1.9%	34,795
Inter District Flows	7,084	3,776	(3,307)	-87.6%	45,249	41,541	(3,708)	-8.9%	48,775
Other Personal Health	(1,141)	1,767	2,908	164.6%	19,922	20,261	340	1.7%	21,975
Mental Health	1,155	1,148	(7)	-0.6%	12,432	12,609	177	1.4%	13,597
Health of Older People	5,010	5,159	149	2.9%	55,703	56,746	1,043	1.8%	60,787
Other Funding Payments	372	421	49	11.6%	3,730	4,837	1,107	22.9%	4,219
	18,643	18,771	128	0.7%	**208,639**	**208,240**	(399)	-0.2%	227,588
Payments by Portfolio									
Strategic Services									
Secondary Care	4,054	3,898	(156)	-4.0%	46,734	42,878	(3,856)	-9.0%	50,737
Primary Care	7,802	7,891	89	1.1%	86,522	86,939	417	0.5%	94,300
Chronic Disease Management	-	-	-	0.0%	-	-	-	0.0%	-
Mental Health	1,155	1,148	(7)	-0.6%	12,567	12,609	42	0.3%	13,732
Health of Older People	5,117	5,198	80	1.5%	56,242	57,174	931	1.6%	61,363
Other Health Funding	(110)	(46)	63	136.6%	(2)	651	652	100.3%	(20)
Maori Health	513	498	(15)	-3.1%	4,798	5,510	712	12.9%	5,389
Population Health									
Women, Child and Youth	91	98	7	7.5%	1,247	1,391	143	10.3%	1,456
Population Health	21	87	66	75.9%	530	1,089	559	51.3%	631
	18,643	18,771	128	0.7%	**208,639**	**208,240**	(399)	-0.2%	227,588

May Expenditure



Note the scale does not begin at zero

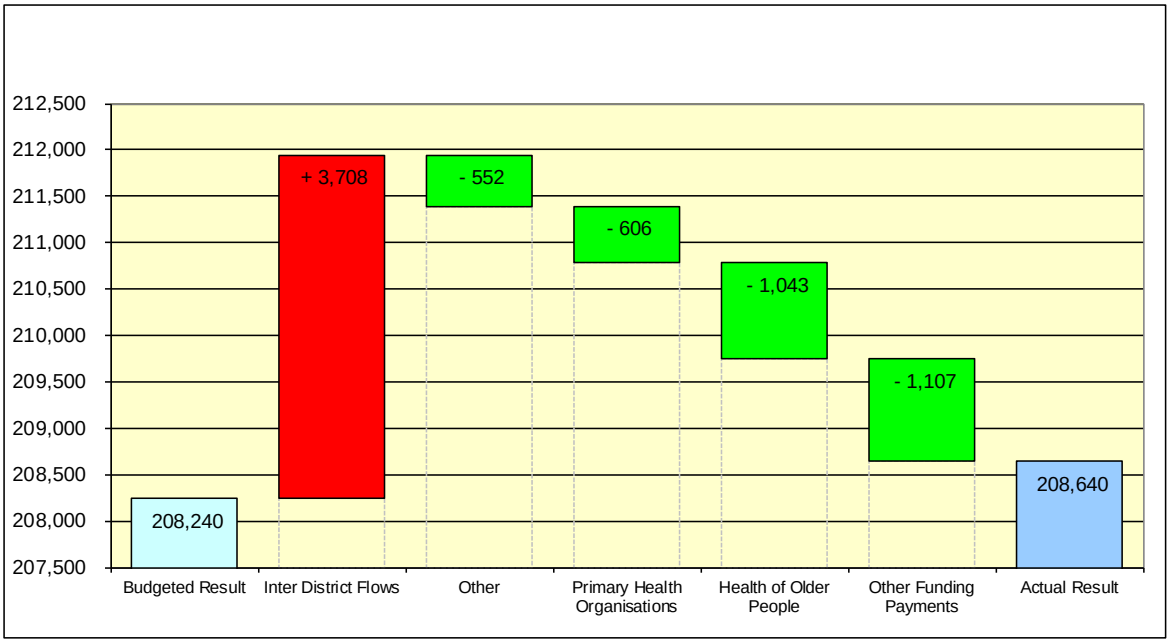
Inter District Flows (unfavourable)
Reflects a change in treatment. The provision for IDF wash-up has been transferred from other personal health. The previous treatment reduced consolidation problems for MOH in combining DHB results, and is no longer considered necessary.

Health of Older persons (favourable)
Residential care and aging in place.

Pharmaceuticals (favourable)
There is some uncertainty regarding PHARMAC estimates, and the costs incurred by the DHB. Until this is resolved a significant cost provision has been allowed for. The provision is marginally less than necessary to align with PHARMAC forecasts.

Other personal health (favourable)
$3.1 million has been transferred to Inter District Flows – see above. Also includes National Haemophilia payments.

Year to Date Expenditure



Inter district flows (unfavourable)
Overspend largely in acute activity related to cardiothoracic, cardiology, general medicine, haematology, oncology and plastics.

Primary Health Organisations (favourable)
Reducing volume.

Health of Older People (favourable)
Lower residential care costs partly offset by higher home support. Slower than budgeted aging in place costs.

Other Funding Payments (favourable)
Release of Maori primary health accruals from 2015/16, and reduced public health expenditure.

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	1,411	1,373	(38)	-2.8%	14,704	14,078	(626)	-4.4%	16,033
Outsourced services	101	92	(9)	-9.9%	1,183	1,046	**(136)**	**-13.0%**	1,299
Clinical supplies	10	9	(1)	-7.8%	131	104	(27)	-25.8%	117
Infrastructure and non clinical	683	601	**(82)**	**-13.6%**	8,070	8,601	**531**	**6.2%**	8,726
	2,206	2,076	**(129)**	**-6.2%**	24,087	23,830	(258)	-1.1%	26,175
Capital servicing									
Depreciation and amortisation	1,151	1,177	26	2.2%	12,465	12,682	217	1.7%	13,887
Financing	-	180	**180**	**100.0%**	777	1,878	**1,100**	**58.6%**	362
Capital charge	(462)	-	462	0.0%	3,184	3,138	(46)	-1.5%	6,322
	688	1,357	**668**	**49.3%**	16,426	17,698	**1,271**	**7.2%**	20,571
	2,894	**3,433**	**539**	**15.7%**	**40,514**	**41,527**	1,013	2.4%	**46,746**
Full Time Equivalents									
Medical personnel	0.4	0.3	(0)	-28.1%	0	0	(0)	-34.3%	0.3
Nursing personnel	13.0	14.7	2	11.5%	13	15	2	12.9%	14.5
Allied health personnel	1.1	0.4	(1)	-165.9%	1	0	(0)	-48.3%	0.4
Support personnel	9.8	9.5	(0)	-3.0%	9	9	(0)	-0.7%	9.4
Management and administration	143.9	147.7	4	2.6%	141	146	5	3.5%	145.9
	168.2	**172.6**	**4**	**2.6%**	**164**	**170**	**7**	**3.9%**	**170.5**

Personnel relates to the RMO strike. Infrastructure and non-clinical includes NZ Health Partnerships, RHIP, corporate training, Insurance, and community consultation. Financing and capital charges reflect the debt to equity swap. The swap is cost neutral with the variance from budget offset in income (see section 4).

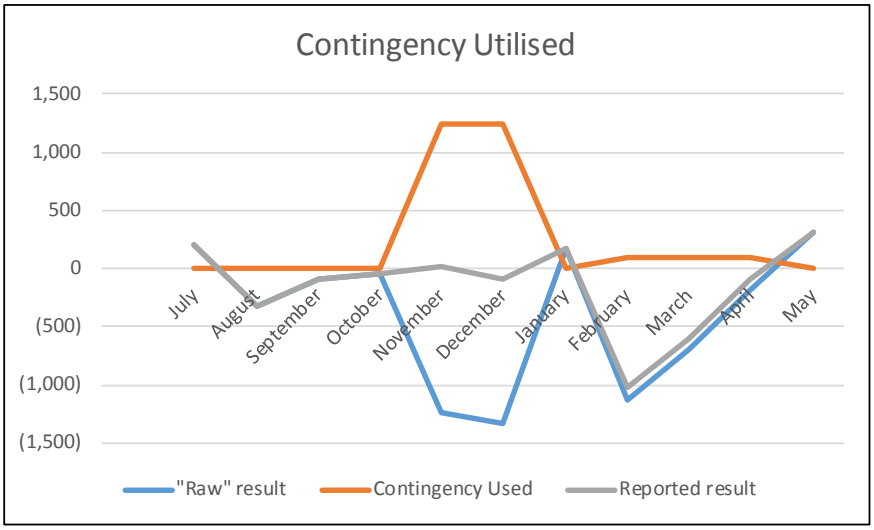
8. Reserves

$'000	May Actual	May Budget	May Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Expenditure									
Contingency	17	17	0	0.0%	(3,285)	76	**3,362**	**4402.8%**	444
Transform and Sustain resource	4	8	4	55.5%	55	207	**152**	**73.4%**	55
Other	11	38	27	71.1%	4	586	**581**	**99.2%**	(365)
	31	**63**	**31**	**50.3%**	**(3,226)**	**869**	**4,095**	**471.0%**	**134**

Contingency usage year to date includes:

- $1.4 million to offset IDF provisioning
- $1.0 million for costs relating to the gastroenteritis outbreak
- $0.3 million for costs relating to the RMO strike.
- $0.1 million to release a pro rata portion of the remaining contingency

The impact of contingency utilisation on the reported result over the financial year is graphed below.



Contingency budgets transferred to operational costs reconcile as follows:

	$'000
Original contingency budget	3,000
Plus:	
Revenue banking	4,200
Less:	
Additional surplus agreed with MOH	-500
Feasibility studies	-600
Elective surgery delivery costs	-1,942
Melanoma and oncology treatments	-295
Additional resource for payroll and health records	-61
Remaining contingency budget ($3.0 million of general contingency, and $0.8 million T&S)	3,802

All of the contingency has been released for the forecast.

The remaining favourable variance relates to new investments that will not proceed this year.

9. Financial Performance by MOH Classification

	May			Year to Date			End of Year		
$'000	Actual	Annual Plan	Variance	Actual	Annual Plan	Variance	Forecast	Annual Plan	Variance
Funding									
Income	40,759	40,720	38 F	461,195	459,534	1,661 F	512,680	511,288	1,392 F
Less:									
Payments to Internal Providers	24,071	24,071	(0) U	253,819	252,773	(1,046) U	280,694	279,687	(1,007) U
Payments to Other Providers	18,643	18,771	128 F	208,639	208,240	(399) U	227,588	227,178	(410) U
Contribution	**(1,955)**	**(2,121)**	**166 F**	**(1,264)**	**(1,479)**	**215 F**	**4,398**	**4,423**	**(25) U**
Governance and Funding Admin.									
Funding	266	266	-	2,929	2,929	-	3,197	3,197	-
Other Income	3	3	-	27	28	(1) U	29	30	(1) U
Less:									
Expenditure	332	300	(32) U	2,875	3,271	396 F	3,218	3,573	355 F
Contribution	**(63)**	**(31)**	**(32) U**	**81**	**(314)**	**395 F**	**8**	**(346)**	**354 F**
Health Provision									
Funding	23,805	23,805	0 F	250,890	249,844	1,046 F	277,497	276,490	1,007 F
Other Income	1,938	1,713	225 F	19,764	19,679	84 F	21,468	21,398	70 F
Less:									
Expenditure	25,292	25,248	(45) U	268,991	265,702	(3,289) U	299,871	296,965	(2,906) U
Contribution	**451**	**270**	**180 F**	**1,662**	**3,821**	**(2,159) U**	**(906)**	**923**	**(1,829) U**
Net Result	**(1,568)**	**(1,882)**	**314 F**	**479**	**2,028**	**(1,549) U**	**3,500**	**5,000**	**(1,500) U**

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

10. Management Budget Movements

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

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

	May			Year to Date			End of Year		
$'000	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement
Funding									
Income	40,720	40,806	(86) U	459,534	459,841	(307) U	511,288	511,803	(515) U
Less:									
Payments to Internal Providers	24,071	23,704	(367) U	252,773	248,888	(3,885) U	279,687	275,461	(4,226) U
Payments to Other Providers	18,771	19,233	462 F	208,240	212,040	3,800 F	227,178	231,341	4,163 F
Contribution	**(2,121)**	**(2,131)**	**9 F**	**(1,479)**	**(1,087)**	**(392) U**	**4,423**	**5,000**	**(577) U**
Governance and Funding Admin.									
Funding	266	268	(2) U	2,929	2,950	(21) U	3,197	3,220	(23) U
Other Income	3	3	-	28	28	-	30	30	-
Less:									
Expenditure	300	271	(29) U	3,271	2,978	(293) U	3,573	3,250	(323) U
Contribution	**(31)**	**-**	**(31) U**	**(314)**	**-**	**(314) U**	**(346)**	**-**	**(346) U**
Health Provision									
Funding	23,805	23,436	369 F	249,844	245,938	3,906 F	276,490	272,241	4,249 F
Other Income	1,713	1,562	151 F	19,679	18,806	873 F	21,398	20,366	1,032 F
Less:									
Expenditure	25,248	24,749	(498) U	265,702	261,629	(4,073) U	296,965	292,608	(4,358) U
Contribution	**270**	**249**	**22 F**	**3,821**	**3,115**	**706 F**	**923**	**(0)**	**923 F**
Net Result	**(1,882)**	**(1,882)**	**0 F**	**2,028**	**2,028**	**0 F**	**5,000**	**5,000**	**0 F**

11. Quality and Financial Improvement Programme

The purpose of this report is to give Finance, Risk and Audit Committee (FRAC) a monthly update on the identified quality and financial improvement savings (QFI) and progress year-to-date.

At the end of April we have achieved 75% of our year-to-date savings target (unchanged from March).

Row Labels	Sum of Planned Savings	Sum of ytd savings target	Sum of YTD actual Savings	%age Savings Achieved
Corporate	1,526,792	1,399,559	1,253,566	90%
Health Services	8,292,287	7,601,263	5,972,939	79%
Population Health	26,166	23,986	23,986	100%
Maori	148,195	135,845	135,845	100%
Health Funding	3,006,808	2,756,241	1,904,833	69%
Grand Total	**13,000,248**	**11,916,894**	**9,291,170**	**78%**

Row Labels	Sum of Planned Savings	Sum of ytd savings target	Sum of YTD actual Savings
AMBER	**5,211,497**	**4,777,206**	**3,471,484**
Acute Medical	2,407,523	2,206,896	1,771,342
Business Intelligence	23,880	21,890	10,038
DON	10,587	9,705	1,729
FAC	34,114	31,271	13,957
Information Services	326,304	299,112	182,713
OPE	553,717	507,574	336,735
Surgical	1,474,734	1,351,840	895,732
WCY	380,638	348,918	259,238
RED	**1,712,667**	**1,569,945**	**269,292**
Business Intelligence	9,012	8,261	-
FAC	17,563	16,100	16,100
OPE	47,619	43,650	-
Strategic Services	1,153,808	1,057,657	206,250
Surgical	484,665	444,276	46,942
Grand Total	**6,924,164**	**6,347,151**	**3,740,775**

12. Financial Position

30 June		*May*				*Annual*
2016	$'000	*Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2016*	*Budget*
	Equity					
102,608	Crown equity and reserves	150,108	105,733	(44,375)	47,500	105,376
(10,973)	Accumulated deficit	(10,494)	(14,241)	(3,747)	479	(11,268)
91,635		139,614	91,492	(48,122)	47,979	94,108
	Represented by:					
	Current Assets					
15,552	Bank	21,060	5,927	(15,133)	5,508	8,523
1,724	Bank deposits > 90 days	1,690	1,741	52	(34)	1,741
22,433	Prepayments and receivables	17,226	18,586	1,361	(5,208)	18,618
4,293	Inventory	4,519	4,037	(481)	226	4,044
1,220	Non current assets held for sale	625	-	(625)	(595)	-
45,222		45,119	30,292	(14,827)	(103)	32,927
	Non Current Assets					
151,944	Property, plant and equipment	151,267	165,604	14,337	(677)	166,159
2,037	Intangible assets	1,677	714	(963)	(360)	665
9,777	Investments	10,879	9,192	(1,687)	1,102	9,476
163,758		163,823	175,509	11,686	65	176,299
208,980	**Total Assets**	**208,943**	**205,802**	**(3,141)**	**(38)**	**209,226**
	Liabilities					
	Current Liabilities					
-	Bank overdraft	-	-	-	-	-
38,137	Payables	31,865	31,118	(747)	(6,273)	30,697
34,070	Employee entitlements	34,826	33,259	(1,568)	756	34,484
-	Current portion of borrowings	-	6,000	6,000	-	6,000
72,208		66,691	70,377	3,685	(5,516)	71,180
	Non Current Liabilities					
2,638	Employee entitlements	2,638	2,433	(205)	-	2,438
42,500	Term borrowing	-	41,500	41,500	(42,500)	41,500
45,138		2,638	43,933	41,295	(42,500)	43,938
117,345	**Total Liabilities**	**69,329**	**114,309**	**44,980**	**(48,016)**	**115,118**
91,635	**Net Assets**	**139,614**	**91,492**	**(48,122)**	**47,979**	**94,108**

The variance from budget for:

- Equity reflects the amount the budgeted opening balance differs from the 2015/16 result and the variance in the 2016/17 result year-to-date, the swap of the DHB's debt into equity on 15 February, and the $5 million equity injection for the mental health build;
- Bank and property, plant and equipment mainly reflect the lower capital spend;
- Non-current assets held for sale was adjusted for the reclassification of 307 Omahu Road to property, plant and equipment in November;
- Borrowing, both term and current, reflect the debt to equity swap.
- Employee entitlements – see below

13. Employee Entitlements

30 June		*May*				*Annual*
2016	$'000	*Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2016*	*Budget*
7,466	Salaries & wages accrued	11,931	5,216	(6,715)	4,465	6,559
482	ACC levy provisions	1,592	820	(772)	1,110	851
5,348	Continuing medical education	619	5,373	4,754	(4,729)	5,131
19,149	Accrued leave	19,306	20,161	855	157	20,249
4,263	Long service leave & retirement grat.	4,016	4,122	106	(247)	4,131
36,708	**Total Employee Entitlements**	37,464	35,691	(1,773)	756	36,922

14. Treasury

Liquidity management

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

Debt management

The $42.5 million term debt facility with MOH was swapped into equity on 15 February 2017. The $5 million equity injection for the mental health build, was received in March. The DHB now has no interest rate exposure relating to debt.

Foreign exchange risk management

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

15. Capital Expenditure

See next page.

Monthly Project Board Report
May 2017

HAWKE'S BAY District Health Board

Improving Endoscopy Services. Phase 3
Service transition and Facilities Development.

Project Manager Facilities Development: Trent Fairey

Overall Project Progress	Quality & Safety Risk Status	Time Status	Financial Status
16%	G	Y	G

Phase 3: Service transition & Facility Development

Formal approval of the Business Case was received in December 2016 from the Hawke's Bay District Health Board for the construction of a stand -alone Gastroenterology Service building (improving Endoscopy services).
Phase 1 Service & Facility Planning, and Phase 2 Design & Tendering of service facility have been completed on time and within budget.
Phase 3 Service Transition and Facility construction is now underway. This phase concentrates on the construction of the facility to enable the service transition in late 2018.
A fourth and final phase of the project will complete the Improving Endoscopy Services programme, focusing on the development of the service and delivery of the bowel screening programme.

Project Budget Status

Total Approved for Capital Budget	$ 11,670,000	Total 16/17 Forecast Spend	$ 2,240,000
Total Project Spend to Date	$ 1,891,472	Total 16/17 Spend to Date	$ 1,448,472
Percentage of Total Spend vs Budget	16%	Percentage 16/17 Spend vs Forecast	65%

The tender process was completed in November 2016, total project cost was approved in the December 2016 Board Meeting at a total of $11.67M. MOH approval for the project programme of works was received in late December 2016. Project start date was delayed until February 2017 to allow for further geotechnical testing and structural design developments. Project initiation was completed on the 27th February 2017 on approval of the site specific safety plan.

Deliverable Dates

Geotechnical design and Testing	Complete	Internal construction - Building Services	Apr-18
Site specific safety plan review and approval	Complete	Furniture , Fittings and Equipment installation	Jun-18
Earthworks and Excavation	Complete	Building services commissioning	Jul-18
Foundation construction	May-17	Facility Sign off & Certificate of Public Use	Aug-18
Structural Steelwork installation	Oct-17	Service Training and Transition to Staged start up	Sep-18
Concrete floor structures	Nov-17	Full operational capacity available and Service Go Live	Oct-18
Exterior and Roof Cladding	Dec-17	Post Implementation Review & Post Occupancy Evaluations	Feb-19

Key Achievements this period

Approval of the site specific safety plan.
Certified geotechnical solution for uplift anchors and foundation design.
Construction of foundation raft, including the installation of geotextile grid and the majority of the screw pile solutions.
Approval and sign off for structural design, including the BRB seismic braces.
No accidents recorded on site to date, 1st Quarter H&S Audit pass mark of 97%.

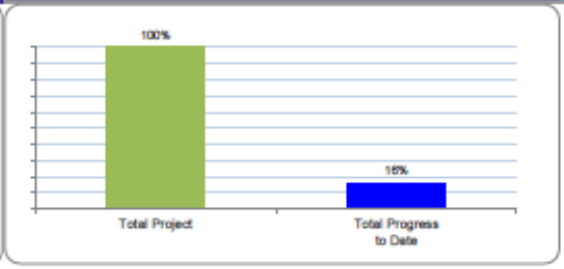
Planned Activities next period

Completion of foundation raft to southern section and final installation of screw piles.
Construction of service tunnel between theatre block and Endoscopy building.
2nd Quarter Health and Safety audit of construction.

Risks & Issues of Note	Mitigation & Resolutions
Redesign of the Endoscopy Units Level 1 to support the theatre expension project.	Prompt decision making and design approvals allowing variations to the current contract in a timely manner.
Continued wet weather further delaying the completion of the foundation raft.	Project timeline flex on the HBDHB programme will allow for possible wet weather extensions. Project contract allows for standard wet weather delays, however events like cyclones and unusual weather patterns are genuine extensions of time.
Installation of screw piles to last southern section of site.	Dependent on results of installation, an alternative plan has been developed from the failure of piles 23, 24, 25 & 26. This should allow remedial works that do not require further extensions of time.
Re-calibration of construction programme to recover for lost construction time. Late start up due to unresolved geotechnical conditions , cyclone weather issues and screw pile installation failures.	Ongoing management with GEMCO construction. Review of the original programme has indicated a delay of 15 working days, until the foundation stage of the project is complete we will not now the full extent that these weather events have affected the programme, risk around these dates remain. It should be noted that the project programme allows for construction delays,construction completion in late August 2018 is still viable. Staged start up and go live of the facility is planned for spring 2018.

Actual Spend

Total Project Progress



2017 Annual Plan		*Actual $'000*	*Year to Date Budget $'000*	*Variance $'000*
	Source of Funds			
	Operating Sources			
14,440	Depreciation	12,465	12,682	217
5,000	Surplus/(Deficit)	479	2,028	1,549
(2,479)	Working Capital	41,475	207	56,172
16,961		54,419	14,917	57,938
	Other Sources			
-	Special funds and clinical trials	167	-	(167)
1,220	Sale of assets	-	1,220	(1,220)
5,000	Borrowings	(42,500)	5,000	(47,500)
6,220		(42,333)	6,220	(48,887)
23,181	**Total funds sourced**	**12,086**	**21,137**	**9,051**
	Application of Funds:			
	Block Allocations			
3,183	Facilities	2,939	3,093	154
3,125	Information Services	652	2,789	2,137
5,464	Clinical Plant & Equipment	2,157	4,956	2,799
11,772		5,748	10,838	5,089
	Local Strategic			
2,460	MRI	-	2,254	2,254
500	Renal Centralised Development	1,170	458	(712)
3,000	New Stand-alone Endoscopy Unit	1,701	2,749	1,047
710	New Mental Health Inpatient Unit Development	369	651	282
100	Maternity Services	136	42	(94)
400	Upgrade old MHIU	1,328	686	(643)
400	Travel Plan	198	367	169
400	Histology and Education Centre Upgrade	95	248	153
1,100	Fluoroscopy Unit	-	1,008	1,008
200	Education Centre Upgrade	-	(17)	(17)
9,270		4,997	8,444	3,447
	Other			
-	Special funds and clinical trials	167	-	(167)
1,000	New Technologies/Investments	-	1,000	1,000
-	Other	58	-	(58)
1,000		225	1,000	775
22,042	***Capital Spend***	***10,971***	***20,282***	***9,311***
	Regional Strategic			
1,139	RHIP (formerly CRISP)	1,115	855	(260)
1,139		1,115	855	(260)
23,181	**Total funds applied**	**12,086**	**21,137**	**9,051**

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	41,436	41,705	(269)	52,759	44,097	43,377	43,621	52,709	47,119	43,737	43,776	46,758	43,834	43,759	46,693
Cash receipts from revenue banking	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from donations, bequests and clinical trials	59	-	59	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	1,632	446	1,187	441	436	442	436	501	443	441	449	455	449	449	455
Cash paid to suppliers	(29,619)	(24,663)	(4,956)	(30,193)	(27,164)	(25,792)	(26,744)	(26,026)	(26,392)	(26,902)	(25,489)	(23,314)	(26,461)	(26,350)	(25,106)
Cash paid to employees	(17,622)	(18,048)	426	(15,743)	(15,482)	(20,672)	(15,549)	(15,731)	(18,680)	(15,147)	(23,127)	(15,969)	(15,808)	(16,118)	(18,824)
Cash generated from operations	**(4,114)**	**(561)**	**(3,553)**	**7,264**	**1,888**	**(2,645)**	**1,764**	**11,453**	**2,489**	**2,129**	**(4,392)**	**7,930**	**2,015**	**1,741**	**3,219**
Interest received	105	75	30	73	74	74	74	74	74	74	74	74	74	74	74
Interest paid	-	544	(544)	0	-	-	-	-	-	-	-	-	-	-	-
Capital charge paid	462	-	462	(5,906)	(0)	(0)	(0)	(0)	(0)	(8,537)	(0)	(0)	(0)	(0)	(0)
Net cash inflow/(outflow) from operating activities	**(3,546)**	**58**	**(3,604)**	**1,431**	**1,962**	**(2,572)**	**1,838**	**11,527**	**2,563**	**(6,335)**	**(4,318)**	**8,003**	**2,088**	**1,814**	**3,292**
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	8	0	8	0	-	-	-	-	-	625	-	-	-	-	-
Acquisition of property, plant and equipment	(2,482)	(2,284)	(198)	(2,588)	(1,749)	(1,749)	(1,749)	(1,749)	(1,749)	(1,749)	(1,749)	(1,749)	(1,749)	(1,749)	(1,749)
Acquisition of intangible assets	(21)	(20)	(1)	(135)	(338)	(338)	(338)	(338)	(338)	(338)	(338)	(338)	(338)	(338)	(338)
Acquisition of investments	(217)	-	(217)	(245)	-	-	(249)	-	-	(249)	-	-	(249)	-	-
Net cash inflow/(outflow) from investing activities	**(2,712)**	**(2,304)**	**(408)**	**(2,968)**	**(2,087)**	**(2,087)**	**(2,336)**	**(2,087)**	**(2,087)**	**(1,711)**	**(2,087)**	**(2,087)**	**(2,336)**	**(2,087)**	**(2,087)**
Cash flows from financing activities															
Proceeds from equity injection	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Proceeds from borrowings	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Repayment of finance leases	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Equity repayment to the Crown	-	-	-	(357)	-	-	-	-	-	-	-	-	-	-	-
Net cash inflow/(outflow) from financing activities	**-**	**-**	**-**	**(357)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Net increase/(decrease) in cash or cash equivalents	(6,257)	(2,246)	(4,012)	(1,895)	(126)	(4,659)	(498)	9,439	475	(8,046)	(6,406)	5,915	(248)	(273)	1,205
Add:Opening cash	29,008	24,014	4,994	22,756	20,862	20,736	16,077	15,578	25,018	25,493	17,447	11,041	16,956	16,708	16,435
Cash and cash equivalents at end of year	**22,750**	**21,768**	**982**	**20,862**	**20,736**	**16,077**	**15,578**	**25,018**	**25,493**	**17,447**	**11,041**	**16,956**	**16,708**	**16,435**	**17,640**
Cash and cash equivalents															
Cash	4	4	-	4	4	4	4	4	4	4	4	4	4	4	4
Short term investments (excl. special funds/clinical trials)	19,772	18,741	1,031	17,835	17,705	13,046	12,548	21,987	22,462	14,416	8,010	13,926	13,678	13,404	14,609
Short term investments (special funds/clinical trials)	2,973	3,015	(42)	3,015	3,026	3,026	3,026	3,026	3,026	3,026	3,026	3,026	3,026	3,026	3,026
Bank overdraft	1	8	(6)	8	-	-	-	-	-	-	-	-	-	-	-
	22,750	**21,768**	**982**	**20,862**	**20,736**	**16,077**	**15,579**	**25,018**	**25,493**	**17,447**	**11,041**	**16,957**	**16,709**	**16,435**	**17,640**

The operating forecasts for 2017/18 year are based on the draft budget. The capital forecasts are based on the capital plan presented to the Board in June 2017, and the unspent portion of the 2016/17 capital plan has not been carried forward to 2017/18, both improving the cash position in the above table. Committed expenditure at the end of June 2017 will require the deferral or removal of items in the 2017/18 plan.

BOARD HEALTH & SAFETY CHAMPION'S UPDATE

No report this month

365 PRESENTATION ON SAFE 365 TOOL

11

Kate Coley

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Clinical Council** 62
	For the attention of: **HBDHB Board**
Document Owner:	Chris McKenna and Dr Mark Peterson as Co-Chairs
Document Author:	Brenda Crene
Reviewed by:	Not applicable
Month:	June, 2017
Consideration:	For Information

12

RECOMMENDATION

That the Board note that Clinical Council reviewed and commented on the following:

- Collaborative Pathways
- Consumer Experience Feedback Q3 Jan-Mar 2017
- Health System Performance Insights – Presentation
- Health Round Table Data (HRT) – Presentation
- Youth Health Strategy
- Te Ara Whakawairoa – Oral Health

Council met on 14 June 2017, an overview of issues discussed and/or agreed at the meeting are provided below.

The following papers were received:

Collaborative Pathways

Collaborative pathways work has been progressing well with complications being experienced due to the inflexibility of the Map of Medicine. An example of two system(s) were provided on-line to Council members (Map of Medicine [MoM] and Nexxt). Currently two GP practices were trialling and feedback was being sought on functionality.

In summary:

- Gains have been made with users now including AAU, ED and Central HB.
- Advised some pathways have been changed/adapted to better reflect what was actually happening e.g., hips and knees.
- Map of Medicine is still being used with progress being made with "Nexxt" to develop the dynamic process.
- It was noted that the Map of Medicine contract had been extended to the end of December 2017. MoM, cannot provide a dynamic pathway and do not deal with secondary pathways.
  We have to the end of October to work with Nexxt when we will present to Clinical Council the results of the trial in the two pilot practices. Both Map of Medicine and Nexxt are aware of this.
- Auckland DHB went to Canterbury system after considering Nexxt. It is not known exactly why this occurred but local politics in Auckland is complex.

- It is likely that HBDHB will investigate Canterbury Pathways again, as part of the review later this year.
- "Health One" was moving out around the country with a consumer portal as well, which we are keeping an eye on.

Consumer Experience Feedback Q3 Jan-Mar 2017

Council were advised we are now experiencing a significantly lower than usual response rates to surveys from consumers/patients, who have been in hospital. The data captured was not an adequate reflection of our community with an inability to breakdown by age for this quarter. Maori feature poorly in the response rate. A MoH requirement, most if not all DHBs struggle to acquire the required survey data.

This work is being taken into Project under Transform and Sustain.

Health System Performance Insights - Presentation

Council received a programme overview of a piece of work about to be undertaken around high levels goals which ultimately focus on delivering better outcomes for more people, for the same or less overall system cost and the ways that may be achieved nationally. This work in conjunction with DHB Shared Services and has taken 6 months to get to this point, with buy in agreed by the various stakeholders. The Chair for this work is HBDHB's Chief Allied Professions Officer, Dr Andy Phillips. Funding to date had been provided by TAS.

Health Round Table Data (HRT) - Presentation

Medical Director, Dr Russell Wills reported on data matters, more specifically the lack of good reliable data (ultimately through the lack of Clinical Coding expertise). The range of results relayed for this hospital are higher than the norm in most areas and could well be attributed to the lack of clinical coding expertise here in HB. The appointment of an experienced coder has since been made (19 June 2017).

Youth Health Strategy

Council received an update on this Strategy approved by the Board a year ago. Council were very pleased with the progress made especially in regard to the Youth Council and their affiliation to HB Consumer Council. This group provide their services free of charge, however a nominal amount is provided to the HB Youth Consumer Council monthly. Rewarding volunteers is the topic being discussed the Council's jointly in July. This report was received by Council and the next steps were noted.

Te Ara Whakawairoa – Oral Health

The percentage of preschool children enrolled in DHB funded health services has risen rapidly, sitting at 12% above target in 2016. It was noted that the quality of ethnicity coding was of concern. The percentage of children who are caries free at the age of five has also risen by 8% above target. HB sit in the *top half* of DHBs nationally.

There is still and equity problem in accessing oral health in Hawke's Bay. There was also a denominator problem resulting from the census and work on this will be undertaken over the next six months.
ASH and ACCESS rates – caries free at 5 years. ASH was at the very low end. We are talking about the very young with oral disease or difficult to manage children. Focused on ACCESS outcome not the ASH outcome, however both are important.

OURHEALTH HAWKE'S BAY Whakawateatia	**HB Health Consumer Council** 63
	For the attention of: **HBDHB Board**
Document Owner:	Graeme Norton, Chair
Reviewed by:	Not applicable
Month:	June 2017
Consideration:	For Information

13

RECOMMENDATION

That the Board

Review the contents of this report

Council met on 15th June 2017, an overview of issues discussed and/or agreed at the meeting are provided below.

The following papers/matters were considered:

- ***Clinical Services Plan – Consumer/Community Engagement***
- ***Youth Health Strategy – Update***
- ***Consumer Experience – Quarterly Presentation of Feedback***
- ***Consumer Council Annual Plan – Review***
- ***People Strategy – Principles for Development***

Rather than talk about each of these in isolation in this report I will try to bring them together (they are all linked) in what turned out to be a wide ranging and robust conversation amongst members on key themes to be addressed; how far have we got and what should happen next.

Our "sister" Clinical Council has in its annual plan some key directions which it has set for us both and which we strongly support. They are to

"Work in partnership with the Hawke's Bay Health Consumer Council to ensure that Hawke's Bay health services are organised around the needs of people.

- Develop and promote a "Person and Whānau Centred Care" approach to health care delivery.
- Facilitate service integrations across / within the sector.
- Ensure systems support the effective transition of consumers between/within services.
- Promote and facilitate effective consumer engagement and patient feedback at all levels.
- Ensure consumers are readily able to access and navigate through the health system."

To this list we would add that partnering with consumers means valuing the skills and experience we can bring; empowering and allowing consumers to participate in their own wellness – a strengths based model of care.

Are we there yet? In spite of good intentions and some great projects and examples we are yet to experience systemic change towards the outcomes we are seeking. The Clinical Services Plan

represents yet another opportunity to “be brave” acorss the health sector in Hawke’s Bay and actively drive towards a health service which will meet the needs of our community.

At a governance level we acknowledge that 80+% of healthcare spend is on chronic or long term conditions and their consequences and for which the drivers are social, economic and behavioural. So this is a complex problem to solve that requires more than just the health sector alone. What we can influence/control ourselves is how we work.

Services are still, for the most part, operating in persistently siloed ways and consumers persistently report being done to instead of done with. We can and must change that. The way services are structured, coupled with behaviours that are engrained still leads to us doing “dumb stuff”. Business models that are not fit for purpose or which have financial drivers around activity instead of outcomes mean we are busy but are we doing the right things?

The Consumer Council strongly endorses the direction of travel as typified in the Transform and Sustain Strategic Plan as recently refreshed. Acknowledging that sometimes priorities that are imposed centrally work against local priorities, we need to continue to be transformative if we are to do the best for our people.

OURHEALTH HAWKE'S BAY Whakawateatia	**Appointments to HB Health Consumer Council** 64
	For the attention of: **HBDHB Board and Health Hawke's Bay Ltd Board**
Document Owner:	Ken Foote, Company Secretary
Reviewed by:	Not applicable
Month:	June 2017
Consideration:	For Endorsement

14

RECOMMENDATION

That the Board endorse the CEO's approval to appoint:

- The following members of Consumer Council for a further term of two years:
  - Rachel Ritchie
  - Sarah Hansen
  - Jenny Peters
  - Olive Tanielu
- The following new members to vacant positions on Consumer Council for a term of two years:
  - Diane Mora
  - Deboara Grace

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

It is now recommended that both Board endorse these reappointments.

HAWKE'S BAY
District Health Board

MEMO

To: Kevin Snee, Chief Executive HBDHB
Wayne Woolrich, General Manager, Health Hawke's Bay Ltd

From: Ken Foote, Company Secretary HBDHB

Subject: **APPOINTMENT TO HAWKE'S BAY HEALTH CONSUMER COUNCIL**

Date: 7 June, 2017

The Consumer Council Membership Schedule shows four members retiring by rotation, and two vacancies:

Rachel Ritchie	1st	June 17
Sarah Hansen	1st	June 17
Jenny Peters	2nd	June 17
Olive Tanielu	2nd	June 17
Vacancy		
Vacancy		

An extensive and transparent process has been conducted (involving direct mail to all known health related community groups, advertisements in local newspapers, website and Facebook messages), to attract nominations for the six positions. 15 nominations were received, including nominations for reappointment from all four existing Council members.

A selection panel was convened under the Chairmanship of Graeme Norton, and interviews conducted with shortlisted candidates where appropriate.

RECOMMENDATIONS

The election panel recommend that:

- The four 'retiring members' all be reappointed for a further two years, ie
  - Rachel Ritchie
  - Sarah Hansen
  - Jenny Peters
  - Olive Tanielu

- **Diane Mora** be appointed to fill one vacancy:
  - Significant skills and experience as an educator and health advocate within community
  - Local and national leadership roles with PACIFICA INC (Pacific Women's Council)
  - Chair Napier Family Centre
  - Chair IHC (Hawke's Bay) Association
  - PHD in Education (Pacific Women Achievements in Tertiary Education)
  - MNZM in 2009.

Deborah Grace be appointed to fill the other vacancy:

- Now strong advocate for 'consumer voice' being heard and promoting networking for consumers
- Chair of Mental Health Partnership Advisory Group for last 2 years
- Significant input into redesign of Mental Health Services and inpatient unit.
- PAG received awards in two categories in HB Health Awards in 2015

APPROVAL

We approve the above recommendations for appointment

Kevin Snee, CEO HBDHB — Date 6/6/17

Wayne Woolrich, GM Health Hawke's Bay Ltd — Date 12/6/17

Following your approval, these appointments will be forwarded to the Boards of HBDHB and Health Hawke's Bay Ltd for endorsement.

14

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board (MRB)**	65
	For the attention of: **HBDHB Board**	
Document Owner:	Na Raihania (Proxy Chair)	
Reviewed by:	Not applicable	
Month:	June 2017	
Consideration:	For Information	

RECOMMENDATION

That the HBDHB Board

Note the contents of this report.

MRB met on 14 June 2017, an overview of issues discussed and recommendations at the meeting are provided below.

The following reports and papers were discussed and considered:

HEALTH LITERACY

The Health Literacy Principles paper was presented to MRB at the May meeting. MRB **recommend** HBDHB merge their efforts, and collaborate, with Health Hawke's Bay concerning health literarcy planned activities.

RESIGNATION OF NGĀTI KAHUNGUNU IWI INCORPORATED CEO

On behalf of NKII, Chrissie Hape (GM) confirmed the resignation of Dr Adele Whyte and further confirmed the NKII review of MRB has been put on hold.

TE ARA WHAKAWAIORA / ORAL HEALTH (NATIONAL INDICATOR)

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

The MRB are supportive in the efforts to address barriers for tamariki accessing oral health but also stressed the importance of providing solutions for vulnerable families. The Acting GM Māori Health advised that an oral health treatment programme is being considered for young mothers as well.

MRB commend the newly established kaiāwhina role in one hub in Hastings. However they provided a caution that the kaiāwhina will need support given the likely workload.

CONSUMER EXPERIENCE FEEDBACK QUARTERLY REPORT

MRB noted the contents of Jeanette Rendle (Consumer Engagement Manager) presentation. They acknowledged the current survey mechanism is ineffective in capturing meaningful Māori consumer feedback. They stressed the importance of Māori co-design and culturally appropriate feedback mechanisms that capture Māori consumer experiences. Jeanette Rendle requested MRB representation on the project group. However MRB recommended that representation would be more appropriate from the Māori Health Improvement Team. The Acting GM Māori Health will appoint the respective staff to the project team.

MRB **request** reviewing the ethnicity breakdown of the patient experience survey related to; Adult inpatient experience survey (81), Consumer feedback direct to HBDHB (284), Marama Real-time feedback (30) and Maternity Services Survey (174).

YOUTH HEALTH STRATEGY UPDATE

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

HEALTH HAWKE'S BAY CULTURAL COMPETENCY FRAMEWORK

MRB noted the contents of the report.

PEOPLE STRATEGY (2016-2021) FIRST DRAFT

MRB noted the contents of the report and agreed the organisation's philosophy should reflect the organisation's values.

MRB discussed the strategy title and recommend the title *Our People, One Team*, is renamed as it sounds too monocultural. They stressed the importance of a people strategy that values and encourages all ethnicities, and Māori in particular, to express themselves culturally within the scope of their work.

HAWKE'S BAY District Health Board Whakawāteatia	**FINAL DRAFT Hawke's Bay District Health Board Annual Plan 2017/18 and Regional Service Plan 2017/18** 66 For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Tracee Te Huia, Executive Director, Strategy and Health Improvement Carina Burgess, Head of Planning Robyn Richardson, Health Services Planner
Reviewed by:	n/a
Month:	June, 2017
Consideration:	For Approval

16

RECOMMENDATION

That HBDHB Board

- Approve the Final Draft Regional Services Plan 2017/18 and give permission for Central TAS to use the CEO and Chair's signatures in the Final.
- Approve the Final Draft Annual Plan and delegate two signatories to sign off the Final Plan once the financials are completed and Ministry of Health (MOH) approval has been received.

OVERVIEW

The Draft HBDHB Annual Plan 2017/18 and Central Region Regional Service Plan 2017/18 was submitted to the Ministry of Health (MOH) in March 2017. Since then we have received guidance on additional priorities to include in the plans and feedback on the drafts that were submitted.

A number of delays in information received from the MOH has led to ongoing delays in the planning process. The Regional Service Plan 2017 is attached in its final draft form, however the Annual Plan will be evolving right up until the due date of the 30th June. Due to the late delivery of the funding envelope, the financial section of the Annual Plan has not been included as the budget has not been approved in time to include in the paper. This will be made available to the Board as soon as possible following approval of 2017/18 budget.

Final Draft Regional Services Plan

The Regional Service Plan has been developed through the Regional Networks in each of the priority areas. The priority areas have remained similar to last year with the addition of a new emerging priority added late in May– Sudden Unexpected Death in Infancy National Prevention Programme in response to the Minister's new programme to be implemented from July 2017. The plan also includes refreshed Central Regional vision, values, priorities and governance.

Approval:

It is recommended that the Board approve the Regional Service Plan 2017/18 and give permission for Central TAS to use the CEO and Chair's signatures in the Final Plan.

Final Draft Annual Plan

The Final Draft Annual Plan is being submitted as a late paper and still requires more work prior to submitting to the MOH on 30th June.

The guidance on the two new Better Public Service targets to include in the 2017/18 plan was not received from the MOH until mid-June. These targets are:

- Healthy Mums and Babies: 'By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups'
- Keeping Kids Healthy: 'By 2021, a 25% reduction in the rate of hospitalisations for avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019'

Feedback from the MOH on the draft was centred around being more explicit about equity actions for Elective Health Target, Raising Health Kids Health Target, Mental Health and Primary Care Integration.

Due to the change in timeline this year for the funding envelope, the financials have not been confirmed in time to submit with these papers as they will be presented at the same Board meeting and therefore are not included in the Final Draft presented to you. Once approved, the financials will be slotted into the Annual Plan.

Approval:

It is recommended that the Board approve the Final Draft Annual Plan 2017/18 and delegate two signatories (in addition to the Chair) to sign off the plan once it is complete. It will be shared with the Board in its final state, prior to sign off.

ATTACHMENTS ARE AVAILABLE SEPARATELY ON THE WEBSITE

Central Region Regional Service Plan 2017/18

Late Paper – Hawke's Bay District Health Board Annual Plan 2017/18

HAWKE'S BAY District Health Board Whakawāteatia	**Youth Health Strategy 2016-19 Update** 67
	For the attention of: **HBDHB Board**
Document Owner:	Tim Evans, Executive Director Corporate Services
Document Author:	Nicky Skerman, Population Health Strategist; Women, Children and Youth
Reviewed by:	Executive Management Team, Māori Relationship Board, Clinical and Consumer Councils
Month:	June 2017
Consideration:	For information

RECOMMENDATION

HBDHB Board

- **Note** the contents of this report.

17

OVERVIEW

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

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

Though there are many commonalities in how organisations and 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. The final version was endorsed by the HBDHB Board after going through the committees in June 2016.

Youth Strategy Update

Over the last year, the Youth Health Strategy has been presented in many forums within the district health board and to some community groups. These include the; Woman Child and Youth Strategic group, paediatric study days, the Suicide Prevention Fusion group and the Child Adolescent and Family Service (CAFS).

As a strategic document we are ensuring a shared vision whilst setting youth focused outcomes and indicators. The document also encourages an increase in profile around this age group and promotes some common principles about how services are provided.

Feedback from CAFS

> "I think that it has highlighted themes we are seeing, around the complexity and co-morbidity. In the front of our minds and energy are the needs to work together with other agencies (e.g., Directions, Oranga Tamariki, School Guidance Counsellors) to create a more cohesive approach across the sector."

Feedback from Paediatric Study day

> Good ideas & strategies hearing the voice of youth
> Interesting to know strategy. Valuable info
> Interesting discussion, more info in adolescent secondary health needed/identified.

Model of Youth Health

In October 2016, HBDHB began a two phase competitive procurement process.

The first phase was a call for "Registrations of Interest" (ROI). As part of that process there were two stakeholder and youth consultation meetings with forty people in attendance from across the sector. The purpose of the meetings was to consider different models for delivering youth health services in Hawke's Bay. These meetings were supported with a panel of representatives from general practice, mental health, personal health services, Ministry of Social Development and Māori Health Services.

The second phase is a competitive "Request for Proposals" (RFP) that will be open to those suppliers who responded to the ROI. The RFP, aimed at procuring several youth services to commence January 2018, was launched on the Government Electronic Tender Service (GETS) in April.

Youth Consumer Council

At the end of 2016, HBDHB formed a Youth Consumer Council following a nomination process across the district. There are currently eight members representing mixed age and ethnicity and areas of interest covering; mental health, suicide prevention, education, Hauora Māori, alcohol and drugs, rural health, cultural health and disability.

The Youth Consumer Council is a committee of HBDHB consumer council supported by HBDHB, Directions Youth Trust and Te Taiwhenuia O Heretaunga. The Youth Consumer Council have developed a terms of reference that has been signed off by HBDHB Consumer Council. The group meets monthly and have been approached to be participate in many projects and initiatives across Hawke's Bay. During March, two of the group attended the Hawke's Bay Health Sector Leadership Forum.

We are in the process of developing a pathway for access to Youth Consumer Council. Support from HBDHB is being provided by Jeanette Rendle (Consumer Engagement Manager) and Nicky Skerman (Strategic Services).

Various HBDHB staff and other youth representatives from around the country have attended Youth Consumer Council meetings to provide support to the group, such as the communication team who are supporting the group in the area of social media. The group have set up a Facebook page to support connection with other Hawke's Bay youth.

The group were also profiled in the HBDHB March CEO newsletter and have produced their own brochure promoting themselves , stating their three priorities:

- Teen Suicide Awareness
- Drugs and Alcohol Culture
- Mental Health

A meeting was held with the Chief Information Officer around the vision youth have given for the digital future of some youth services. This will be a future project that will potentially change the way youth access services and receive information. During our consultation, the youth voice raised digital media as an important area for development.

Free under 18s Primary Care

The Youth Strategy's vision around positive youth development, increase and early access to services and no door is the wrong door (connection of youth services) has been integral as part of the free under 18 services in general practice. This service is expected to be in place in 2017.

NEXT STEPS

- Youth services stakeholder group: To be set up in 2018 once all youth services are in place
- Continue to support the Youth Consumer Council
- Continue to work with the Ministry of Health helping to share with other DHBs the work we are engaged withinin the youth space.
- Develop a dashboard looking at outcome measures when data from June 2016 becomes available. e.g. teenage pregnancy and suicides rates.

DEMENTIA WING GLENGARRY HOUSE WAIROA

Verbal Update

HAWKE'S BAY
District Health Board
Whakawāteatia

CONSUMER EXPERIENCE FEEDBACK Q3

Presentation

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Oral Health** 68
	For the attention of: **HBDHB Board**
Document Owner: Document Author:	Sharon Mason, Executive Director Health Services Dr Robin Whyman, Clinical Director Oral Health
Reviewed by:	Executive Management Team, Māori Relationship Board, HB Clinical Council and HB Health Consumer Council
Month:	June 2017
Consideration:	For Monitoring

RECOMMENDATION

That the HBDHB Board

- **Note** the contents of this report.

OVERVIEW

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

UPCOMING REPORTS

The following are the indicators of concern, allocated EMT champion and reporting month for each.

Priority	Indicator	Measure	Champion	Reporting Month
Oral Health *National Indicator*	1. % of eligible pre-school enrolments in DHB-funded oral health services. 2. % of children who are caries free at 5 years of age	≥95% ≥67%	Robin Whyman	**JUN 2017**

MĀORI HEALTH PLAN INDICATOR: Oral Health

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 DHB resources to treat children and adolescents and private resources to manage the effects in adulthood. Untreated acute and chronic infections lead to a higher risk of hospitalisation and loss of school days and work days which may impact of a child's ability to learn and adult's ability to work.

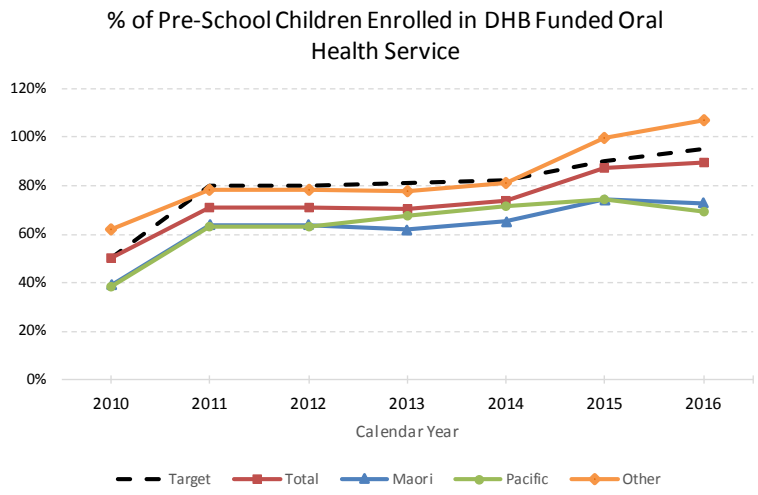
The determinants of dental caries are known — the risk factors include diet (sugar consumption) and poor oral hygiene. Effective population health strategies and clinical prevention methods have substantially reduced the amount of dental caries in the child population and reduced the impact of dental 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 (National Health Committee, 2003). They have also tended to enrol for oral health services, and utilise services later, when compared to non-Māori.

WHY IS THIS INDICATOR IMPORTANT?

Percentage of preschool children enrolled in DHB Funded Oral Health Service



	Target	Total	Māori	Pacific	Other
2010	50%	50.4%	39.2%	38.3%	61.9%
2011	80%	71.1%	63.8%	63.3%	78.4%
2012	80%	71.1%	63.8%	63.3%	78.4%
2013	81%	70.4%	61.9%	67.4%	78.0%
2014	82%	73.9%	65.3%	71.7%	81.3%
2015	90%	87.1%	74.1%	74.2%	99.8%
2016	95%	89.2%	72.7%	69.1%	107.0%

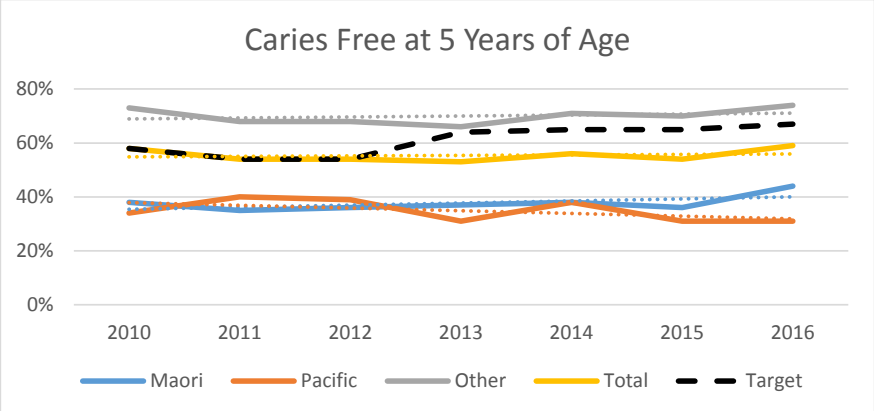
Early preschool enrolment and engagement with Oral Health Services is considered a key preventive strategy to improve preschool oral health. Earlier engagement raises the profile of good oral health for whanau, enables a relationship to develop between whanau and the Community Oral Health Service teams,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

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

These data are obtained from the Community Oral Health Service's Titanium clinical record database. Enrolment data is now populated by parental self-declared ethnicity data obtained through a quadruple enrolment alongside enrolment for primary care, Well Child Tamariki Ora and Immunisation. However, this has operated for only 2 years. It is likely that the discrepancy is in part a legacy issue that relates to the older (3-4 years) preschool children and will improve as quadruple enrolment has been the basis of data for all age groups, in a further 2 years time. The denominator for the numbers in each ethnicity group are based on Statistics New Zealand data provided through the Ministry of Health and based on census projections. It is also possible that the denominators are providing misleading percentages.

The overall level of preschool enrolment and improvement is very pleasing. The discrepancy with Māori and Pacific enrolment is concerning and will require ongoing attention to data quality and checking the system/ quadruple enrolment.

Percentage of children who are caries free at 5 years of age



	Target	Total	Maori	Pacific	Other
2010	58%	58.4%	38.1%	34.2%	72.5%
2011	54%	54.0%	35.1%	39.8%	67.5%
2012	54%	54.1%	36.9%	39.2%	65.5%
2013	64%	54.2%	36.7%	31.2%	66.3%
2014	65%	56.5%	38.7%	38.0%	71.2%
2015	65%	54.4%	36.0%	30.5%	70.1%
2016	67%	59.0%	44.0%	31.0%	74.0%

The percentage of children caries free (decay free) at 5 years measures the proportion of children that are 5 years of age, and commencing school education, without dental decay severe enough to have caused cavitation (holes) to develop in the primary teeth.

Caries free at 5 years is an important indicator as longitudinal studies indicate that children with good early childhood oral health have improved Year 8, adolescent and adult oral health. Children that are free of dental decay in the preschool and early primary school years are also less disrupted with education, eating and sleeping and have better general health.

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

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

However, the target of 67% caries free has not yet been achieved for Māori or Pacific children, and results for Pacific children remain particularly concerning.

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

Activity planned to support these indicators has been

1 *Quadruple enrolment in the oral health service from birth, alongside enrolment for primary care, Well Child/Tamariki Ora and immunisation services.*
This initiative has now been operating since early 2016 and is now business as usual for lead maternity carers (LMCs) and oral health services. The strong flow of information from the quadruple enrolment process to oral health services is believed to be the primary reason behind the ongoing increases in the first indicator in this report (percentage of preschool children enrolled in DHB Funded Oral Health Service).

2 *Changing the relationships with Māori health providers*
With the advent of quadruple enrolment the focus of activity for the Māori health provider services working with oral health is changing. Traditionally these services have helped to engage with enrolment, and focus is now changing to supporting hard to reach whanau and Oral Health Services to connect.

Changes to the operation of the Titanium database operated by the Community Oral Health Service were put in place for the start of the 2017 calendar year.

Changes to incorporate additional visits for high risk whanau through the Well Child Tamariki Ora providers are currently being made to contracts between Te Taiwhenua o Heretaunga, Kahungunu Executive, Plunket NZ and Māori Health and will be finalised by 1 July 2017.

3 *Improving preventive practice in the Community Oral Health Service*
Work with the clinical teams of dental therapists to improve the utilisation of fluoride varnish, bite wing radiography and fissure sealants to prevent dental decay is ongoing. All of the indicators show improvement and work is currently focussed on reducing variation between clinical teams across the service.

4 *Community water fluoridation*
The DHB noted in 2016 that the government has signalled legislation to provide decision making ability to district health boards. The benefits of community water fluoridation to reducing dental caries were also noted from the Te Ara Whakawaiora report in 2016.

4

The Bill to make the decision making change was introduced in late 2016 and a submission supporting the Bill was made by the DHB, after consideration and approval of the Board. A verbal submission was made to the Select Committee by Dr Whyman in March 2017 and it is understood the Select Committee is due to report back in June 2017.

5 *Population health strategies*

Population health strategies are an important contributor to improving child oral health, and in particular:

HBDHB's *Best Start Healthy Eating and Activity: A Plan (2016-2020),* with 4 interlinking objectives:

1) Increasing healthy eating and activity environments – Collection of data is underway to provide benchmarks to measure change in healthy eating environments. All HB primary schools have been contacted re status of 'water only policies' and a 500m zone mapped around each school (via Auckland University INFORMAS study) to provide a baseline of unhealthy food and drink advertising sites.

2) Develop and deliver prevention programmes - "Healthy Foods- Healthy Teeth and eating for under 5's" was launched in March for use in the B4SC. Initial feedback from this design will be sought in July and then will be tailored for use in WCTO visits and ECE settings.

3) Intervention to support children to have healthy weight – Raising Healthy Kids is the new Health Target linked to the BMI measure at the B4SC which support referrals for overweight and obesity to primary care and Pre School Active Families where oral health messages are linked.

4) Provide leadership in healthy eating - HBDHB Board has endorsed the reviewed Healthy Eating Policy and this now aligns with the MoH's guideline – we are sugar sweetened beverage free and soon will be mostly confectionary free.

Healthy Housing

The Child Health Housing Programme is fully operational and aims to reduce preventable illness among low income families/whanau who are living in cold, damp and unhealthy homes. Eligible families typically live in sub-standard housing and have a history of health issues associated with cold damp housing and overcrowding. Homes are assessed by the team and an intervention plan is implemented to improve the quality of the house and to address structural and functional crowding.

Breastfeeding

The March 2017 Te Ara Whakawaiora: Breastfeeding report acknowledged that currently challenges exist meeting the 6 week target and that a drop off occurs between 6 weeks and 3 months. Initiatives to improve and sustain early breastfeeding are important to early childhood oral health. Recent literature (Gussy et al 2016) has demonstrated that early introduction of sugary beverages (before 18 months) is significantly associated with early development of dental caries. Initiatives associated with breastfeeding have been reported in the Te Ara Whakawaiora: Breastfeeding report.

Oral health promotion

The national campaign and TV advertisement run by the Ministry of Health and Health Promtion Agency "Baby Teeth Matter" and brushing teeth with fluoride toothpaste 2x a day are being supported locally with posters and repeated on the HBDHB Facebook page.

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

Māori and Pacific preschool enrolment and engagement with Oral Health Services and improvements in the proportion of Māori and Pacific children caries free at 5 years represent a complex interplay of societal, environmental and service delivery factors.

1 Under 5 years equity project

In late 2016 the Communities, Women and Children directorate commenced a project focussing on delivering equity in oral health outcomes for 5 year-olds with a 5 year time frame.

The project is aiming to

- strengthen consumer engagement and participation with Oral Health and to substantially improve consumer input to Oral Health Services and to oral health strategies to improve child oral health.
- Coordinate consistent messaging and health promotion activity focussing on improving equity in early childhood oral health.
- trial initiatives to improve whanau engagement with early childhood oral health services commencing in the Hastings Central community clinic hub.
- spread innovation that is successful within the service.
- work in collaboration with other providers for early childhood such as B4SC, Health Hawkes Bay, Well Child Tamariki Ora providers, Child Health Team, Early Childhood Education & Kohanga Reo and Outreach Immunisation teams to reduce the siloed nature of oral health services delivery
- Influence policy change, particularly for water only enviornments

The project sponsors are the Service Director Communities Women and Children and Clinical Director for Oral Health, the Project Manager is the Communities Women and Children Deputy Service Director and a Project Steering Group with broad representation from services, Māori Health, PHO and consumer has been established.

2 Workforce change and kaiawhina engagement

Community Oral Health Services have changed the service's workforce mix by redeploying a clinical vacancy within the service to employ a kaiawhina to support the service's engagement with the community and other providers. This initiative will commence at the Hastings Central hub clinic and will be monitored for effectiveness.

3 Clinical quality indicators

Community Oral Health Services are continuing to monitor the implementation of a greater preventive focus in the clinical activity of the service. This involves monitoring 3 quality indicators (fluoride varnish, bitewing radiography and fissure sealants). Levels of use of fluoride varnish and fissure sealants are satisfactory but clinical variation remain. Focussing on improvements to utilisation with appropriate children is the current priority. Use of bitewing radiography remains lower than optimal as it represents a significant clinical practice change. Six-monthly reporting to the service and peer discussion is being used to effect these changes to clinical practice.

RECOMMENDATIONS FROM TARGET CHAMPION

The primary concerns associated with these preschool oral health outcomes relate to

1 Enrolment data quality

Work needs to continue to improve the proportion of Māori and Pacific 5-year-old children enrolled for oral health services. That work also needs to further understand the reasons underlying the over representation of non-Māori and non-Pacific children in the enrolled numbers. This will start with comparsion with services also using quadruple enrolment, particularly national immunisation register

(NIR), checking enrolments for ethnicity against ECA data and evaluation of denominators being used to calculate the percentages.

2 Accelerating equity in caries free status Māori and Pacific children

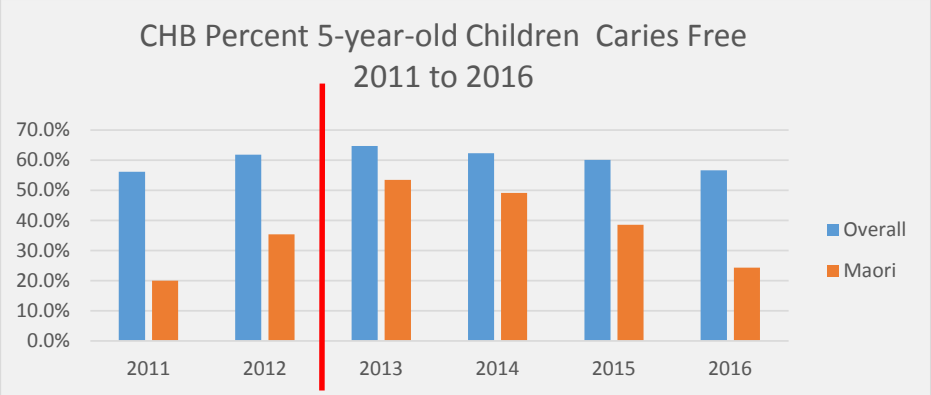
The project to improve equity in 5-year-old caries free status is ambitious and aims to take a cross sector focus. It will require ongoing support over 3-4 years to achieve the planned outcomes.

3 Community water fluoridation

A substantial risk exists with achieving the indicator of improved 5-years-olds caries free as a result of the loss of community water fluoridation in Hastings in August 2016 following the campylobacter outbreak in Havelock North.

Hastings District Council infrastructure used to deliver community water fluoridation is currently being used to chlorinate the water. A timeframe to return to fluoridation, which can be in conjunction with chlorination, has not been provided by the Hastings District Council at this time.

Community water fluoridation was lost in Central Hawke's Bay (CHB) in late 2012 and monitoring of the 5-year-old caries free rates is ongoing. The 2016 data confirms that loss of community water fluoridation in CHB has been particularly detrimental to Māori 5-year-old caries free outcomes in CHB, as the following graph indicates.



Dr Snee wrote to the Central Hawke's Bay and the Hastings District Councils in March 2017 expressing the DHB's concerns at the CHB outcomes, and the potential outcomes in Hastings. He also met with the CHB Mayor in April 2017.

Action on fluoridation will not completely remove the oral health inequities outlined in this paper, but it is important that the DHB continues to act on this issue both within the current legislative framework and the potential framework outlined in the earlier section.

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

Description	Responsible	Timeframe
Review the ethnicity coding and accuracy within the oral health patient management system (Titanium)	Team Leader Oral Health Clinical Director for Oral Health Children, Women and Communities Deputy Service Director	June 2018

Under 5 years of age caries free equity project		Phase 1 Feb – Nov 2017 and Total project 2017-2019
Consumer engagement, participation and feedback. Te Roopu Matua.	Project Manager and Project Steering Group	April – Nov 2017 and ongoing
Relationship Centre Practice training for all Community Oral Health Staff	Team Leader Oral Health	Jul- Aug 2017
Seek feedback on the Healthy Foods - Healthy Teeth and eating for under 5s prevention programme and tailor it for use in WCTO and ECE settings	Population Health	July 2018
Environmental scanning of water only policies and decisions about next steps	Oral Health Population Health Advisor	July 2018
Early intervention in general practice in conjunction with Systems Level Measures work.	Project Manager and SLM group	Dec 2017
Well Child Tamariki Ora provider outreach services	Māori Health Services	July 2017
Continue to transition clinical service delivery towards a preventive care focus using clinical quality indicators to monitor service perfomance	Clinical Director for Oral Health Team Leader Oral Health	June 2018
Community water fluoridation Monitor legislative change timetable Build relationships with communities of interest	Clinical Director for Oral Health	2017-2018 Legislative change 2017-2019 Relationship development communities of interest
Breastfeeding initiatives to improve and sustain early breastfeeding	Breastfeeding Champion	July 2018

CONCLUSION

Improving early childhood oral health eliminating inequity in dental caries levels has been described as a “wicked problem” (Thomson 2017) because it is difficult to solve, has multiple causes, is continually developing and changing and has no universal solution. It represents the outcome of complex societal inequities in social conditions and health services.

However, significant steps to control early childhood dental caries would be made with region-wide access to optimally fluoridated water and removal of sugar sweetened beverages from all early childhood environments.

Improvement in both of these indicators will require focus on collaborative activities to improve social and economic environments, including community water fluoridation and sugar-free environments,

a greater understanding of data quality and corrections to data quality issues, particularly related to enrolment, a continued to move to a preventive clinical focus for the Oral Health Services and a willingness by Oral Health Services to continue to question the best model of care for delivery of preschool oral health while maintaining very positive outcomes that are being achieved for oral health outcomes in the primary school child population.

Dr Robin Whyman
Target Champion for Oral Health
Clinical Director Oral Health

REFERENCES

National Health Committee. *Improving Child Oral Health and Reducing Child Oral Health Inequalities*. 2003. National Advisory Committee of Health and Disability. Wellington. P 1-28.

Gussy M et al. Natural history of dental caries in very young Australian children. *International Journal of Paediatric Dentistry*. 2016: 26: 173-183.

Thomson WM. *Oral Health and NZ Children*. Presentation to the University of Otago Public Health Summer School. Wellington. 2017.

HAWKE'S BAY District Health Board Whakawāteatia	**Annual Pacific Health Plan Q3 (Jan-Mar 2017)** 69
	For the attention of: **HBDHB Board**
Document Owner:	Tracee Te Huia, Executive Director, Strategy & Health Improvement
Document Author(s):	Talalelei Taufale, Pacific Health Development Manager Peter Mackenzie, Business Intelligence Analyst
Reviewed by:	Executive Management Team
Month:	June 2017
Consideration:	For Monitoring

RECOMMENDATION

That the Board:

Note the contents of this report.

CONTENTS OF THE REPORT

The original intention when the Pasifika Health dashboard was adopted by the HBDHB Board was for the Pasifika Health dashboard reporting to be 6 monthly. However, due to delays with MOH reporting, presenting a regular 6 month report would be problematic.

Moving forward we have aligned Pasifika Health reporting to the existing HBDHB Quarterly reporting framework. This will remove our dependency on MOH and ensure regular and timely monitoring and reporting for Pacific health. As a result, this will be the final 6 month Pasifika Health dashboard report. Future Pasifika Health dashboard reports will now be quarterly.

2016-2017 ANNUAL PACIFIC HEALTH PLAN QUARTER 3 PERFORMANCE HIGHLIGHTS

Achievements

1. The B4SC rate for Q3 is 75% a good increase of 13% from Q2. This is 6% above equity of 69% and meets the ≥ 75% target.

2. Raising Healthy Kids saw a significant increase of 57% from 43% in Q2 to 100% in Q3. This rate is above the target of ≥95%

Areas of progress

1. Caries Free at 5 years had a slight improvement from 30.5% Q2 to 31%. There is a significant disparity gap of 43% between Pacific and non-Pacific. The gap towards achieving the target of ≥ 67% is 36%

2. More Heart and Diabetes Checks slightly improved from 84% in Q2 to 84.3%. To achieve equity of 90% the gap is 5.7%. The target is ≥ 90%.

3. Breast Screening rates had a slight improvement from 65.4% in Q2 to 65.8%. The disparity gap is 9.1%. The national target is ≥70%

Challenges

4. Breast Feeding rates (3 months) dropped significantly from achieving above the ≥ 60% target at 63% to 46%. The disparity gap between Pacific and non Pacific was 5%.

5. Oral Health Pre-school Enrolment rates dropped from 74.2% in Q2 to 69.1%. Performance previously has trended towards bridging the equity gap towards the target 95%. The disparity gap is now 37.9% towards achieving equity between Pacific and non Pacific. The gap towards achieving the target is 20.9%

6. MDFT Score at Year 8 for the 2016 Calendar year is 1.43 against the target of <0.92, the result is also an increase of 0.37 from 2015. There is a disparity gap of 0.8 between Pacific and the best performing ethnicity of Other.

7. Better help for Smokers to Quit saw a slight drop from 82.2% Q2 to 81.4%. The disparity gap is 7.7. The gap towards achieving the target of ≥ 90% is 8.6%

8. Increased Immunisation rates saw a drop from achieving the target with 100% in Q2 to 94.6%. This sits above equity rate of 93.5% by 1.1%. The gap towards achieving the target of ≥ 95% is now 0.4%

9. Cervical screening for 25-69 year old Pacific women for Q3 is 73.6% down slightly from 74.8% in Q2 with a disparity gap of 6.4% between Pacific and non- Pacific. The target is ≥ 80%

10. Pacific Workforce is 1% of the HBDHB workforce. A target for Pacific Workforce will be set following consultation with stakeholders in July.

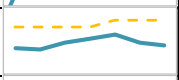
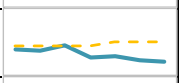
Please note:

- Unless otherwise stated, the results presented in this dashboard are for Pacific.
- Pacific Workforce is a new target
- *Update in Q4 : Data is received from the Ministry 6 monthly

Contents

2016-2017 ANNUAL PACIFIC HEALTH PLAN QUARTER 3 PERFORMANCE HIGHLIGHTS 2
Achievements 2
Areas of progress 2
Challenges 2
Ambulatory Sensitive Hospitalization 0-4 5
Ambulatory Sensitive Hospitalization 45-64 6
Mental Health 7
B4SC 8
Breastfeeding 10
Obesity – Raising Healthy Kids 11
Oral Health Enrolment 12
Oral Health Caries Free 14
Oral Health DMFT 16
Smoking: Brief Advice and Support to Quit 17
Cardiovascular Risk 18
Cervical Screening 19
Breast Screening 20
Immunisation 21
Pacific Workforce 22

Pacific Health Dashboard

Indicator	Baseline	Prior period	Actual to date Pacific	Actual to date Other	Period target	Individual Numbers	Time Series Trend (12 months)	Desired Trend	
ASH Rates (0-4 yrs)	8,182	8,088 (U)	(*)	(*)	-			↓	Update in Q4
ASH Rates (45-64 yrs)	5636	5823 (U)	(*)	(*)	-			↓	Update in Q4
Mental Health Access (0-19)	3.0%	2.14% (U)	(*)	(*)	≥4%			↑	Update in Q4
Mental Health Access (20-64)	3.0%	2.14% (U)	(*)	(*)	≥5%			↑	Update in Q4
Mental Health Access (65+)	1.0%	1% (F)	(*)	(*)	≥1.15%			↑	Update in Q4
B4 School Check	31.0%	62% (U)	75% (F)	69% (U)	≥75%			↑	
Breast Feeding Rates (3 months)	62.0%	63% (F)	46% (U)	51% (U)	≥60%			↑	
Raising Health Kids	33.0%	43% (U)	100% (F)	73% (U)	≥95%	+1		↑	
Oral Health Pre-School Enrollment	71.7%	74.2% (U)	69.1% (U)	107% (F)	≥95%	-181		↑	
Caries free at 5 years	30.5%	30.5% (U)	31% (U)	74% (F)	≥67%	-43		↑	
MDFT Score at year 8	1.04	1.04 (U)	1.43 (U)	0.63 (F)	≤0.92			↓	
Better Help for Smokers to Quit (Primary Care)	75.7%	82.2% (U)	81.4% (U)	89.1% (U)	≥90%			↑	
More Heart and Diabetes Checks	87.0%	84% (U)	84.3% (U)	90% (F)	≥90%	-85.3		↑	
Cervical Screening	71.2%	74.8% (U)	73.6% (U)	77.8% (U)	≥80%	-72		↑	
Breast Screening	66.5%	65.4% (U)	65.8% (U)	74.9% (F)	≥70%	-27		↑	
Increased Immunisation	100.0%	100% (F)	94.6% (F)	93.5% (U)	≥95%	0		↑	
Pacific Workforce	1.2%	1.2%	1.0%	-	-			↑	

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

Ambulatory Sensitive Hospitalization 0-4

Ambulatory Sensitive Hospitalization (ASH)

	Baseline [1]	Previous result[2]	Actual to Date[3]	Target 16-17	Trend direction
Pacific	8,182	8,088 (U)	-	-	-
Māori	5,336	5,755 (U)	-	≤5,610	-
Other	3,768	4,469 (F)	-	-	-
Total	4,725	5,272 (F)	-	-	-

Comments:

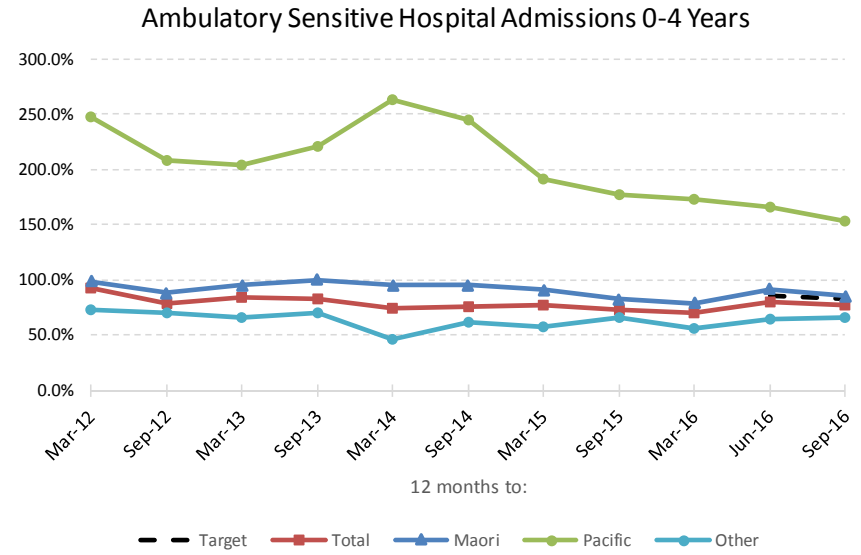
As at September 2016 Hawke's Bay Pacific children have significantly higher rates of ASH compared to the rest of the population.
Each ASH band for total population is divided into; Māori, Pacific, Other[4]. The base line rates for the DHB will be compared with national total population rates and targets set accordingly. These are expressed in rates per 100,000.

To September 2016, the Top Three ASH conditions for Pacific in the 0-4 year age group were

- Upper and ENT repiratory infections.
- Asthma
- Gastroenteritis/dehydration

As part of the ASH O-4 work there is a multidisplinary group looking at the current pathways for children with respiratory conditions.They will use learnings form the successful adult repiratory programme,designed to reduce hospital admissions to tailor a pathway for 0-4.

Time series



Source: Ministry of Health

1 12 months to September 2015

2 12 months to March2016

3 12 months to September 2016

[4] MoH-System Integration SI1: Ambulatory sensitive hospitalisations.

Ambulatory Sensitive Hospitalization 45-64

Ambulatory Sensitive Hospitalization (ASH)

Key Performance Measures	Baseline [5]	Previous result[6]	Actual to Date[7]	Target 16-17	Trend direction
Pacific	5,636	5,823 (U)	-	-	-
Māori	6,310	7,801 (U)	-	≤3,510	-
Other	2,812	3,167 (F)	-	-	-
Total	3,510	4,063 (U)	-	-	-

Comments:

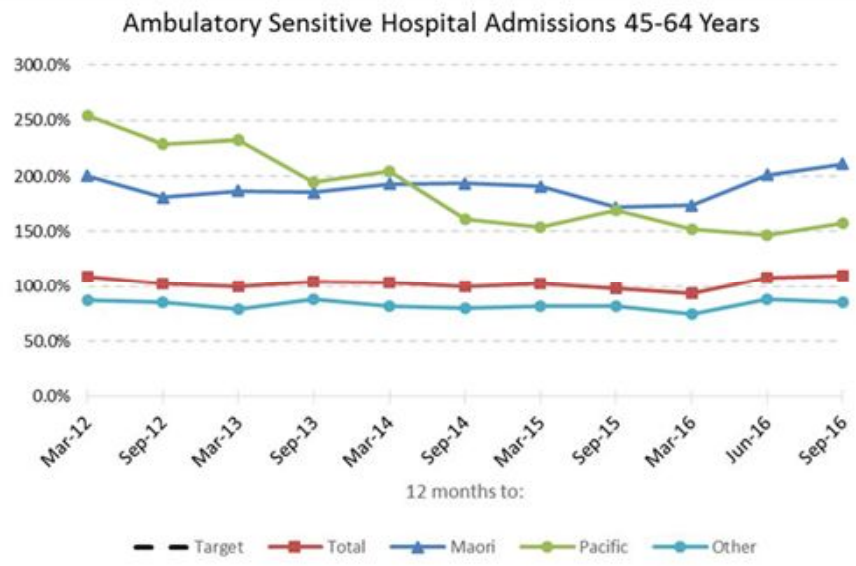
The ASH results for Pasifica have shown a recent rise but overall are trending down. Work done in the area of respiratory and cellulitis are proving efficacious in addressing hospitalisations.

Cardiovascular management inclusive of congestive heart failure is an area that requires attention and has been included in the focus of contributory measures within the System Level Measures framework.

CVDRA forms part of this work from a screening perspective, as does smoking and brief advice. Both areas are showing increments towards achieving target.

Management post diagnosis is the area of focus.

Time series



Source: Ministry of Health

5 12 months to September 2015

6 12 months to March2016

7 12 months to September 2016

Mental Health						
Access rate to DHB specialist mental health services						
Key Performance Measures	Baseline [8]	Previous result[9]	Actual to Date[10]	Target 16-17	Trend direction	Time series
Ages 0-19						
Pacific	3.0%	2.14% (U)	-	≥4%	-	
Māori	4.6%	4.92% (F)	-	≥4%	-	
Other	3.7%	3.79% (F)	-	≥4%	-	
Total	4.1%	4.26% (F)	-	≥4%	-	
Ages 20-64						
Pacific	3.0%	2.14% (U)	-	≥5%	-	
Māori	8.8%	9.26% (F)	-	≥5%	-	
Other	3.8%	3.83% (U)	-	≥5%	-	
Total	4.9%	5.11% (F)	-	≥5%	-	
Ages 65+						
Pacific	1.0%	1% (F)	-	≥1.15%	-	
Māori	1.0%	1.19% (F)	-	≥1.15%	-	
Other	1.1%	1.1% (F)	-	≥1.15%	-	
Total	1.0%	1.12% (F)	-	≥1.15%	-	

8 12 months to September 2015

9 12 months to March2016

10 12 months to September 2016

Comments: Previous results to March 2016 indicate some work needed to lift Pacific access rate to specialist mental health services to meet and/or exceed target, however actual to date figure is not recorded. Improvement needed in data availability to allow analysis of gaps and opportunities to lift Pacific performance.	

B4SC

Percentage of four-year-olds who received a B4SC

Key Performance Measures	Baseline [11]	Previous result[12]	Actual to Date[13]	Target 16-17*	Trend direction	Time series
Pacific	101%	62% (U)	75% (F)	≥75%	▲	
Māori	101%	55% (U)	69% (U)	≥75%	▲	
Other	113%	54% (U)	69% (U)	≥75%	▲	
Total	107%	68% (U)	81% (F)	≥75%	▲	

**The target for this indicator is cumulative for the financial year, Target for the quarters are follows: Q1 25%, Q2 50%, Q3 75%, Q4 100%.*

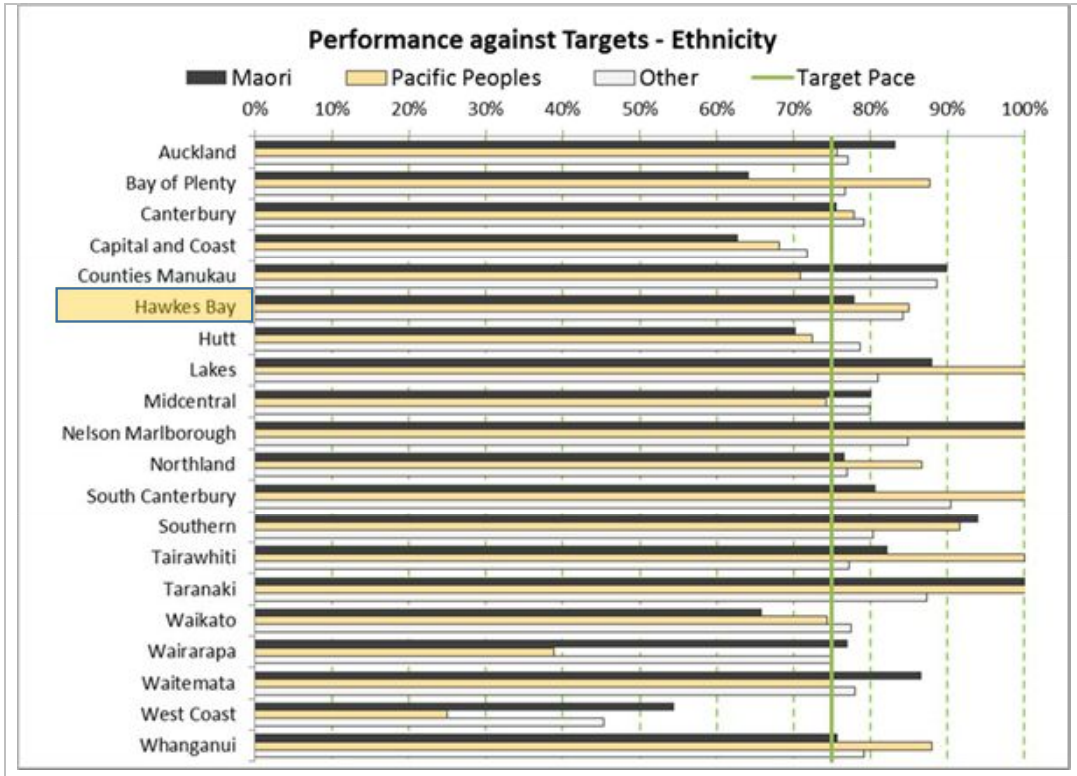
Comments:

As its culmulative target per quarter we are on target to achive a 100% referral rate by Q4 for Pacific.

11 July 2015 to June 2016

12 July 2016 to December 2016

13 July 2016 to March 2017


Performance against Targets - Ethnicity
Maori
Pacific Peoples
Other
Target Pace
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Auckland
Bay of Plenty
Canterbury
Capital and Coast
Counties Manukau
Hawkes Bay
Hutt
Lakes
Midcentral
Nelson Marlborough
Northland
South Canterbury
Southern
Tairawhiti
Taranaki
Waikato
Wairarapa
Waitemata
West Coast
Whanganui

Breastfeeding

Percentage of infants exclusively or fully breastfed (at three months)

Key Performance Measures	Baseline [14]	Previous result[15]	Actual to Date[16]	Target 16-17	Trend direction
Pacific	62.0%	63% (F)	46% (U)	≥60%	▼
Māori	46.0%	39% (U)	39% (U)	≥60%	—
Total	54.0%	53% (U)	51% (U)	≥60%	▼

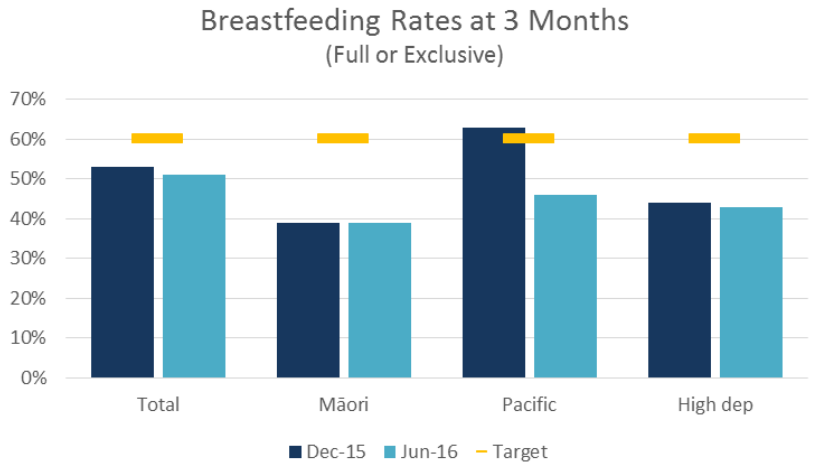
Comments:

Pacific Breastfeeding rates at 3 months have dropped over the past 6 month period however note the dataset is small but compared to a previous rate of 63% indicates a rate significantly below the target of 60%.

Te Ara Whakawaiora indicator report tabled in March 2017 to the Board for breastfeeding contains a set of recommendations to review the current breastfeeding service to better support Māori and Pacific whānau post discharge from Maternity Services and consider options for disinvestment to reinvest.

New investment is also under contract via Māori Health to provide lactation consultation community support to address identified equity issues.

Time series



Source: Ministry of Health

14 3 months to June 2015

15 3 months to December 2015

16 3 months to June 2016

Obesity – Raising Healthy Kids

Obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

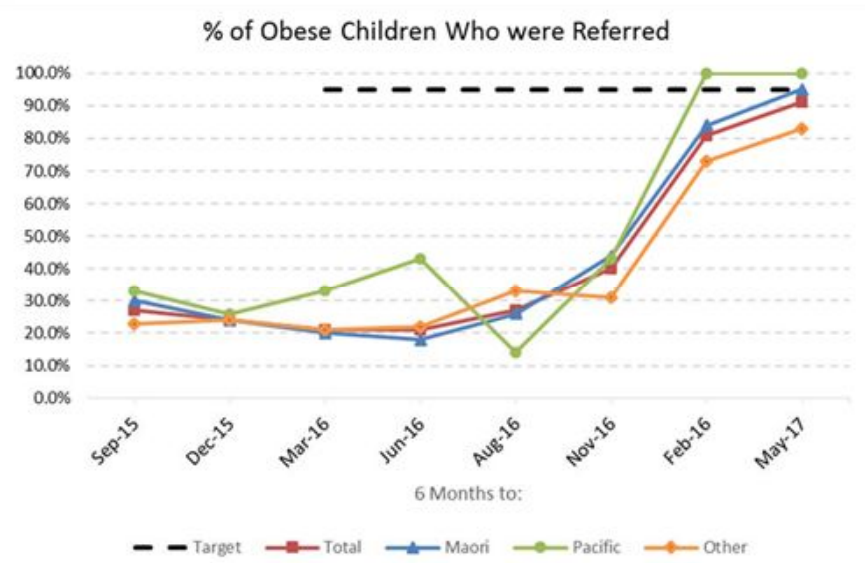
Key Performance Measures	Baseline [17]	Previous result[18]	Actual to Date[19]	Target 16-17	Trend direction
Pacific	33.0%	43% (U)	100% (F)	≥95%	▲
Maori	30.0%	44% (U)	84% (U)	≥95%	▲
Other	23.0%	31% (U)	73% (U)	≥95%	▲
Total	27.0%	40% (U)	81% (U)	≥95%	▲

Comments:

This is a new target, beginning in 1 July 2017. Prior to 1 July, child and their families were referred directly to a family lifestyle programme, with a smaller number referred to their GP. From 1 July B4 School Check nurses have been making referrals to both family lifestyle intervention and their GP. To support this process we have developed a Healthy Conversation Tool, adapted a family lifestyle plan and provided training for general practice staff. Alongside this, we have set up a supporting system for recording and providing individual support for practice nurses.

The impact of this work is shown in the continued progress toward the target. With Pasifika children having met and exceeded the target.

Time series



Source: Ministry of Health

**data has only been correctly collected from 01/07/2016*

21

17 6 months to June 2016

18 6 months to December 2016

19 6 months to March 2017

Oral Health Enrolment

Percentage of children under five years old enrolled in DHB-funded dental services

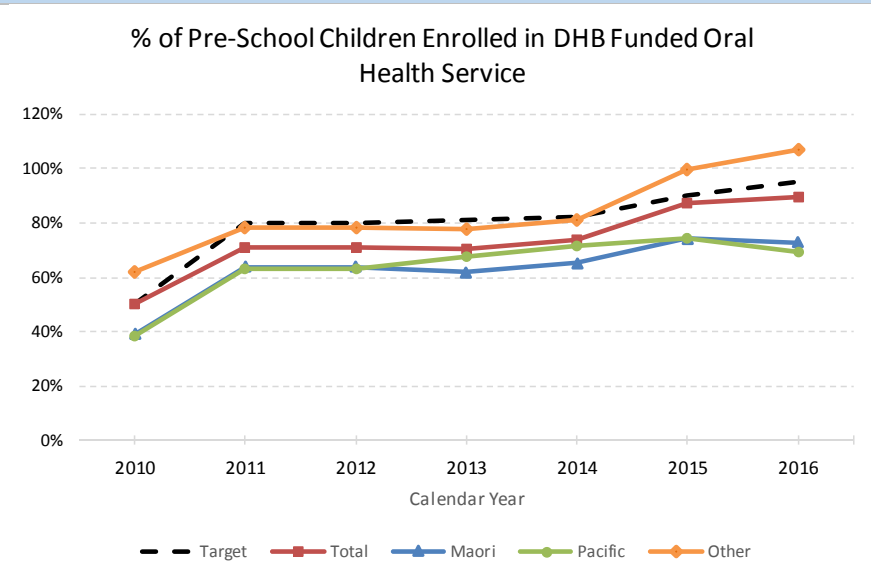
Key Performance Measures	Baseline [20]	Previous result[21]	Actual to Date[22]	Target 16-17	Trend direction
Pacific	71.7%	74.2% (U)	69.1% (U)	≥95%	▼
Māori	65.3%	74.1% (U)	72.7% (U)	≥95%	▼
Other	81.3%	99.8% (F)	107% (F)	≥95%	▲
Total	73.9%	87.1% (U)	89.2% (U)	≥95%	▲

Comments:

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

These data are obtained from the Community Oral Health Service's Titanium clinical record database. Enrolment data is now populated by parental self-declared ethnicity data obtained through a quadruple enrolment alongside enrolment for primary care, Well Child Tamariki Ora and Immunisation. However, this has operated for only 2 years. It is likely that the discrepancy is in part a legacy issue that relates to the older (3-4 years) preschool children and will improve as quadruple enrolment has been the basis of data for all age groups, in a further 2 years time. The denominator for the numbers in each ethnicity group are based on Statistics New Zealand data provided through the Ministry of Health and based on census projections. It is also possible that the denominators are providing misleading percentages.

Time series



Source: Ministry of Health

20 2015 Calendar Year

21 2015 Calendar Year

22 2016 Calendar Year

The overall level of preschool enrolment and improvement is very pleasing. The discrepancy with Māori and Pacific enrolment is concerning and will require ongoing attention to data quality and checking the system/ quadruple enrolment.	

Oral Health Caries Free

Percentage of children caries-free at age five

Key Performance Measures	Baseline [23]	Previous result[24]	Actual to Date[25]	Target 16-17	Trend direction
Pacific	30.5%	30.5% (U)	31% (U)	≥67%	▲
Māori	36.0%	36% (U)	44% (U)	≥67%	▲
Other	70.1%	70.1% (F)	74% (F)	≥67%	▲
Total	54.4%	54.4% (U)	59% (U)	≥67%	▲

Comments:

The percentage of children caries free (decay free) at 5 years measures the proportion of children that are 5 years of age, and commencing school education, without dental decay severe enough to have caused cavitation (holes) to develop in the primary teeth.

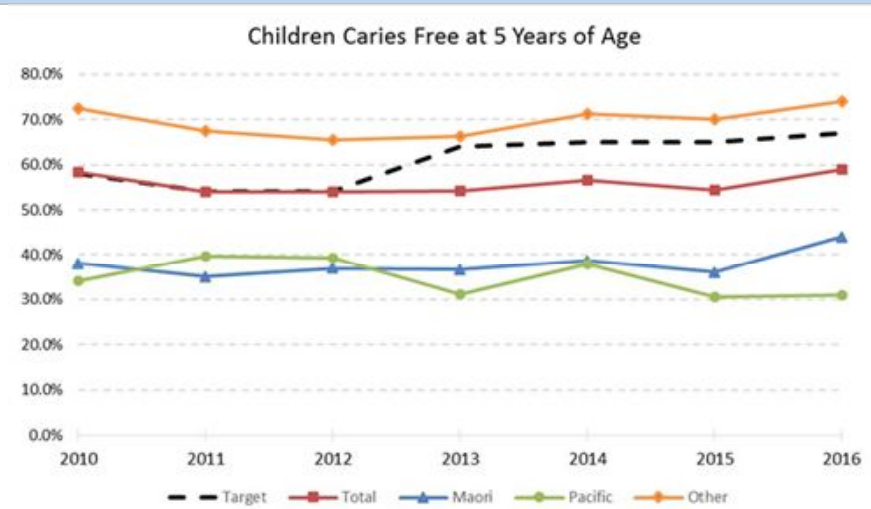
Caries free at 5 years is an important indicator as longitudinal studies indicate that children with good early childhood oral health have improved Year 8, adolescent and adult oral health. Children that are free of dental decay in the preschool and early primary school years are also less disrupted with education, eating and sleeping and have better general health.

The 2016 results represent a substantial improvement in outcomes for all groups except Pacific where only a small improvement is noted.

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

However, the target of 67% caries free has not yet been achieved for Māori or Pacific children, and results for Pacific children remain particularly concerning.

Time series



Source: Ministry of Health

23 2015 Calendar Year

24 2015 Calendar Year

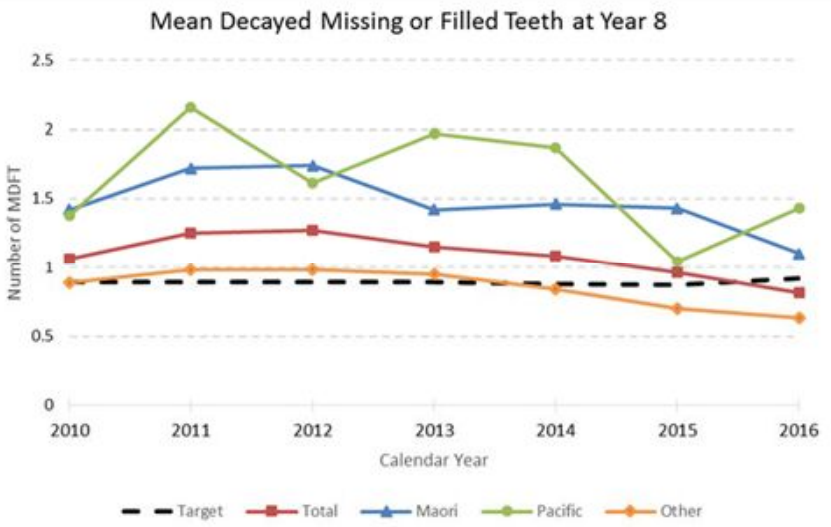
25 2016 Calendar Year

In late 2016 the Communities, Women and Children directorate commenced a project focussing on delivering equity in oral health outcomes for 5 year-olds with a 5 year time frame. The project is aiming to • strengthen consumer engagement and participation with Oral Health and to substantially improve consumer input to Oral Health Services and to oral health strategies to improve child oral health. • Coordinate consistent messaging and health promotion activity focussing on improving equity in early childhood oral health. • trial initiatives to improve whanau engagement with early childhood oral health services commencing in the Hastings Central community clinic hub. • spread innovation that is successful within the service. • work in collaboration with other providers for early childhood such as B4SC, Health Hawkes Bay, Well Child Tamariki Ora providers, Child Health Team, Early Childhood Education & Kohanga Reo and Outreach Immunisation teams to reduce the siloed nature of oral health services delivery • Influence policy change, particularly for water only enviornments The project sponsors are the Service Director Communities Women and Children and Clinical Director for Oral Health, the Project Manager is the Communities Women and Children Deputy Service Director and a Project Steering Group with broad representation from services, Māori Health, PHO and consumer has been established. Pacific Health engagement with this project will be actively sought as improved outcomes for Pacific 5-year-olds are essential to closure of the equity gap	

Oral Health DMFT						
Mean rate of DMFT at school year eight						
Key Performance Measures	Baseline [26]	Previous result[27]	Actual to Date[28]	Target 16-17	Trend direction	Time series
Pacific	1.04	1.04 (U)	1.43 (U)	≤0.92	▼	
Māori	1.43	1.43 (U)	1.1 (U)	≤0.92	▲	
Other	0.7	0.7 (F)	0.63 (F)	≤0.92	▲	
Total	0.96	0.96 (U)	0.81 (F)	≤0.92	▲	

Comments:

While overall the DHB is favourable to target our result for Pacific children was 1.43 and a deterioration from 1.04 in 2015, but still substantially improved from 1.87 in 2014. Two challenges exists for Pacific child results in HBDHB - small numbers meaning a great deal of movement in the results, but more substantially a difficutly identifying a trend towards improvement. The oral health service is strongly focussed on correct risk identification and use of quality indicators with the clinical staff to ensure at risk primary school aged children are receiving fluoride varnish, bitewing films and fissure sealants appropriately. We will also be monitoring the effects of the under 5 years equity project for longer terms effects on Year 8 outcomes especially for Pacfiic children.



Source: Ministry of Health

26 2015 Calendar Year

27 2015 Calendar Year

28 2016 Calendar Year

Smoking: Brief Advice and Support to Quit						
Percentage of smokers offered brief advice and support to quit in primary health care						
Key Performance Measures	Baseline [29]	Previous result[30]	Actual to Date[31]	Target 16-17	Trend direction	Time series
Pacific	75.7%	82.2% (U)	81.4% (U)	≥90%	▼	*Source: Ministry of Health*
Māori	80.8%	85.1% (U)	83.9% (U)	≥90%	▼	
Other	75.7%	89.8% (F)	89.1% (U)	≥90%	▼	
Total	81.2%	87.4% (U)	86.4% (U)	≥90%	▼	
Comments: During the quarter Pacific had a .8% decrease, which is in line with the overall decrease of that quarter. However over the financial year Pacific is up to 81.4% from 75.7%. PHO continue to work with general practices to ensure patients are offered a choice of smoking cessation support via the general practice smoking cessation clinics, Te Haa Matea (HB Stop Smoking Services) and Quitline referrals.						

29 3 months to December 2015

30 3 months to December 2016

31 3 months to March 2017

Cardiovascular Risk

Percentage of eligible adults who had cardiovascular risk assessed

Key Performance Measures	Baseline [32]	Previous result[33]	Actual to Date[34]	Target 16-17	Trend direction
Pacific	87.0%	84% (U)	84.3% (U)	≥90%	▲
Māori	86.3%	84.5% (U)	85.3% (U)	≥90%	▲
Other	91.7%	88.9% (U)	90.0% (F)	≥90%	▲
Total	90.3%	87.8% (U)	88.7% (U)	≥90%	▲

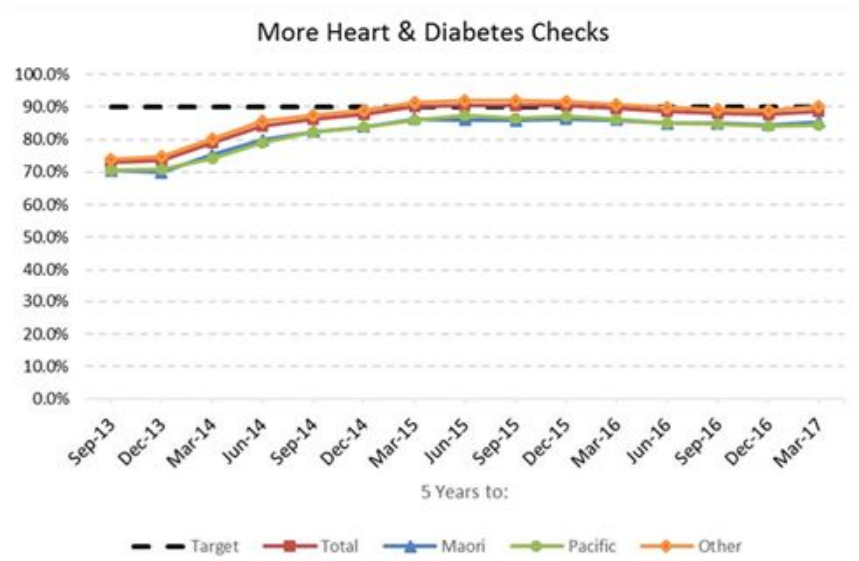
Comments:

Since February we have been running a CVDRA promotion for all eligible patients who meet the Ministry of Health recommended criteria. Practices are funded $20 to provide free CVDRA screening to their patients.

To date, 14 Pacific patients have received a free CVDRA as a result of this campaign, please note not all practices have submitted their invoices, and therefore the data is incomplete.

We will be happy to provide a summary of the campaign once all data is available.

Time series



Source: Ministry of Health

32 12 months to September 2015

33 12 months to March2016

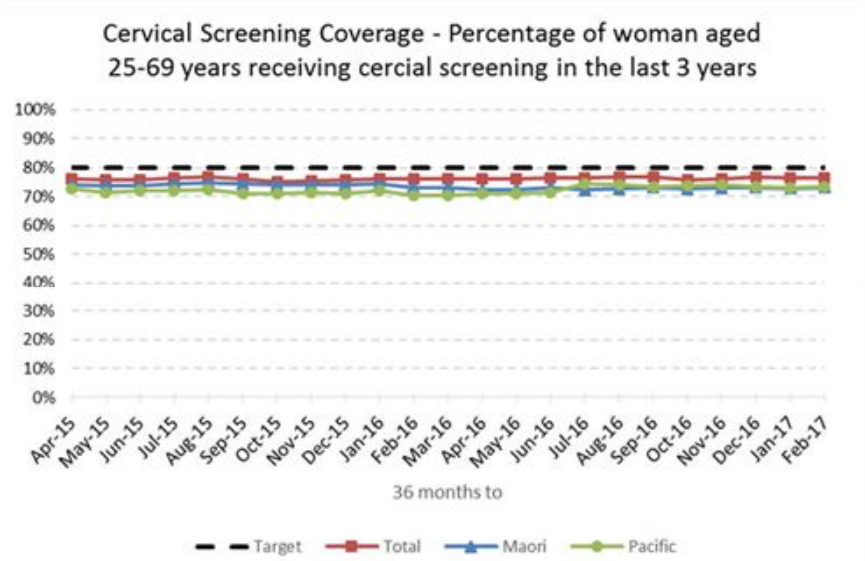
34 12 months to September 2016

Cervical Screening

Percentage of enrolled women aged 25–69 years who received a cervical smear in the past three years

Key Performance Measures	Baseline [35]	Previous result[36]	Actual to Date[37]	Target 16-17	Trend direction
Pacific	71.2%	74.8% (U)	73.6% (U)	≥80%	▼
Māori	74.1%	72.8% (U)	73.1% (U)	≥80%	▲
Other	76.5%	78.9% (U)	77.8% (U)	≥80%	▼
Total	75.8%	76.7% (U)	76.6% (U)	≥80%	▼

Time series



Comments:

We have improved our ranking for Pacific women from 1oth place in December 2016 to 9th. To achieve 80% coverage we need to screen another 70 Pacific women. Equity is 5.1%.

We continue working with both The Doctors – Napier and Totara Health Nurse smeartakers offering smears to Maori and Pacifc women in their homes or supporting them to a clinic.

We have employed a Pacific Community Support worker who will be supporting Nurse smeartakers in the Community and working with Community groups to encourage women to participate in both Breast and Cervical Screening.

Providing smears in the community is intensive and requires significant time to engage and encourage the women to been screened, but we are encouraged with the feedback received from the women who tell us 'they have only had the smear because it was offered to them in the home'. Kanohi ki te Kanohi enables one on one health education to explain the importance of screening.

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

21

35 36 months to December 2015

36 36 months to December 2016

37 36 months to February 2017

Breast Screening

Percentage of enrolled women aged 50–69 years who received a Breast Screening in the past two years

Key Performance Measures	Baseline [38]	Previous result[39]	Actual to Date[40]	Target 16-17	Trend direction
Pacific	66.5%	65.4% (U)	65.8% (U)	≥70%	▲
Māori	68.4%	64.7% (U)	66.7% (U)	≥70%	▲
Other	76.0%	75% (F)	74.9% (F)	≥70%	▼
Total	74.7%	73.6% (F)	73.4% (F)	≥70%	▼

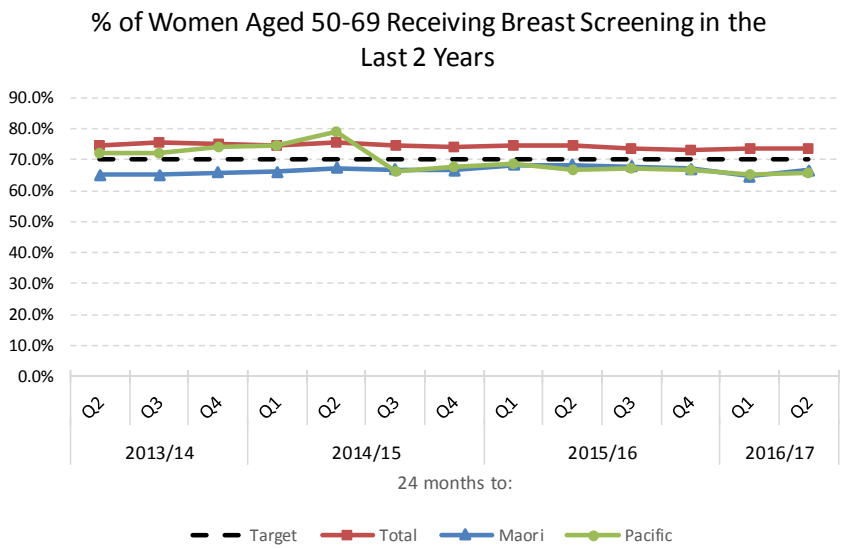
Comments:

To achieve coverage an additional 15 Pacific women need to be screened. The Breast Screen Mobile has recently visited Wairoa.

This visit was successful, with a reduction in the overall DNA rate to 7% for the visit. We believe it was due to a new process that was agreed with Breast Screening Coast to Coast, all priority women who do not respond to recall when receiving an appointment for the BSA mobile will be referred to an ISP. This was trialled for the visit mobile visit to Wairoa and due to its success will be implemented in other regions that Breast Screen Coast to Coast support and work with.

A Breast Screen campaign will be launched in the next Quarter. At this stage 12 Health Centres have agreed to release information on women 45-69 who are registered patients and are Maori and Pacific. The lists will be sent to BSCC for data matching and sent directly to us. Women identified as not screened or underscreened will be invited to have a mammogram, contact information for support to services is provided also. When the woman has her mammogram she will receive a $20 Pak n Save gift card.

Time series



Source: Breast Screening

38 24 months to December 2015

39 24 months to September 2016

40 24 months to December 2016

Immunisation

8 month olds completing primary course of immunisation

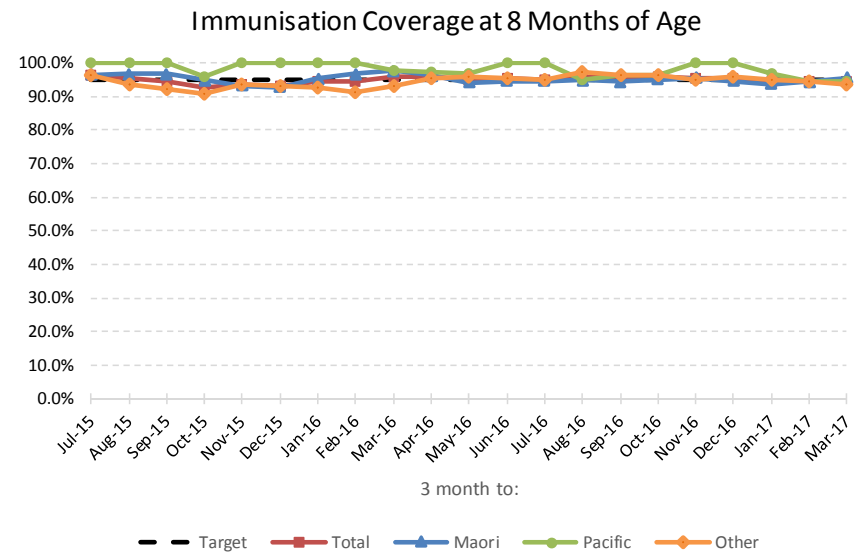
Key Performance Measures	Baseline [41]	Previous result[42]	Actual to Date[43]	Target 16-17	Trend direction
Pacific	100.0%	100% (F)	94.6% (F)	≥95%	▼
Māori	92.6%	94.4% (U)	95.4% (F)	≥95%	▲
Other	93.3%	96.2% (F)	93.5% (U)	≥95%	▼
Total	93.3%	95.3% (F)	94.4% (U)	≥95%	▼

Comments:

Although the Pacific rate appears to be trending down this quarter there were only 37 Pacific infants in this cohort of which 35 are up to date with immunisation. One child equates to 2.7% coverage. Because of small numbers of children in the Pacific cohort coverage rates can have sizeable swings. In future quarters I will be able to report on the reason why the precise child has not been immunised, whether declined by parent or medically unable to be immunised etc.

Overall coverage sits at 94.4% for the quarter.This is attributed to effective use of the NIR database in tracking down children that are due for immunisation and the efforts of our staff and collaborators to contact all families to get children in on time. We will continue to foster these collaborative efforts with our partners in promoting immunisation services in the community.

Time series



Source: National Immunisation Register, Ministry of Health

21

41 October to December 2015

42 October to December 2016

43 January to March 2017

Pacific Workforce

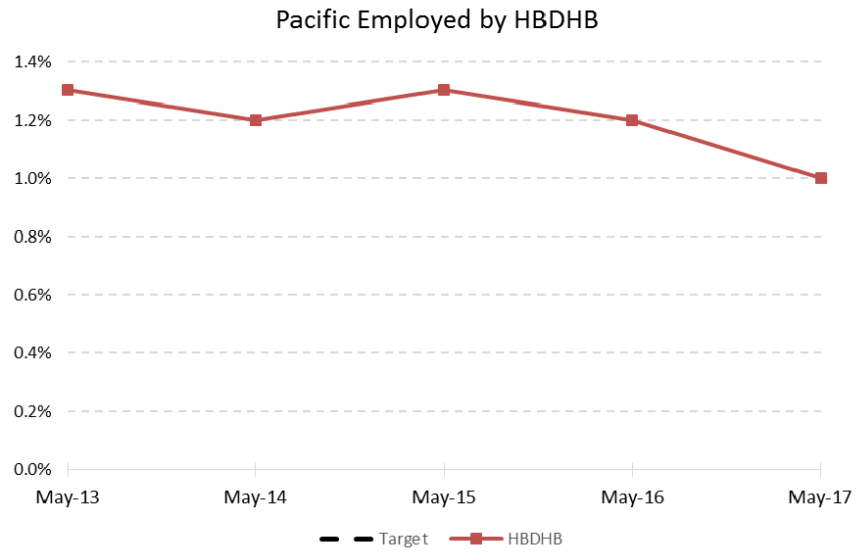
Pacific Workforce Employed by the DHB

Key Performance Measures	Baseline [44]	Previous result[45]	Actual to Date[46]	Target 16-17	Trend direction
HBDHB	1.3%	1.2%	1.0%		▼
Medical	2.3%	1.1%	0.7%		▼
Management & Administration	1.6%	1.5%	1.7%		▲
Nursing	1.0%	1.1%	1.0%		▼
Allied Health	0.8%	0.7%	0.4%		▼
Support	3.3%	2.7%	1.6%		▼

Comments:

At the end of June 2017, a diversity workshop will be run to identify the successes and learnings from the work we have undertaken to increase Maori representation in our workforce, and how we can apply these learnings to increasing the Pacific workforce. This diversity workshop will identify mechanisms for developing a pipeline, recruiting, retaining and developing our Pacific workforce. Once this has been completed then we can consider a target for future increases.

Time series



44 May 2015

45 May 2016

46 May 2017

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:

23. Confirmation of Minutes of Board Meeting
24. Matters Arising from the Minutes of Board Meeting
25. Board Approval of Actions exceeding limits delegated by CEO
26. Chair's Update
27. People Strategy Presentation
28. Cranford Hospice Autonomy Project Update
29. HB Health Alliance
30. Hawke's Bay Clinical Council
31. Finance Risk and Audit Committee Report
    - Final Budget 2017-18

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).