BOARD MEETING

Date: Wednesday 19 December 2018

Time: 1:30pm

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:
Chris Ash, Acting Chief Executive Officer
Executive Management Team members
John Gommans and Jules Arthur, Co-Chairs of Clinical Council
Rachel Ritchie, Chair HB Health Consumer Council
Members of the public and media

Mintute Taker: Brenda Crene

Public Agenda

Item	Section 1: Routine	Ref #	Time (pm)
1.	Welcome and Apologies		1:30
2.	Interests Register		
3.	Minutes of Previous Meeting		
4.	Matters Arising - Review of Actions		
5.	Board Workplan		
6.	Chair's Report (verbal)		
7.	Chief Executive Officer's Report – Chris Ash, Acting CEO	179	
8.	Financial Performance Report – Carriann Hall, ED Financial Services	180	
9.	Board Health & Safety Champion's Update – Board Safety Champion	181	
	Section 2: Governance / Committee Reports		
10.	Te Pitau Governance Group – Helen Francis	182	2:05
11.	Māori Relationship Board – Chair, Heather Skipworth	183	2:10
12.	HB Health Consumer Council – Chair, Rachel Ritchie	184	2:15
13.	HB Clinical Council – Co-Chairs, John Gommans and Jules Arthur	185	2:20
	Section 3: For Decision / Discussion		
14.	Health Equity Report – Dr Andy Phillips, Dr Nicholas Jones and Jess O'Sullivan	186	2:25
15.	Presentation: People Plan Progress – Kate Coley	187	2:40
	Section 4: For Information		
16.	A Musculoskeletal Service to address health inequities in HB – Dr Andy Phillips	188	2.55
	Section 5: General Business		
17.	**Section 6: Recommendation to Exclude the Public** Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	Section 7: Routine	Ref #	Time (pm)
18.	Minutes of Previous Meeting (public excluded)		3:00
19.	Matters Arising – Review of Actions		-
20.	Board Approval of Actions exceeding limits delegated by CEO	189	-
21.	Chair's Update (verbal)		
	Section 8: For Information		
22.	Māori Relationship Board – Chair, Heather Skipworth	190	3:10
23.	HB Health Consumer Council – Chair, Rachel Ritchie	191	3:15
24.	HB Clinical Council – Co-Chairs, John Gommans & Jules Arthur	192	3:20
25.	Finance Risk and Audit Committee – Chair, Dan Druzianic	193	3.25
	Meeting concludes		3:40

The next HBDHB Board Meeting will be held at
1.30pm on Wednesday 27 February 2018

Board "Interest Register" - 10 November 2018

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	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 where specific legal or fiduciary conflict identified.	The Chair of FRAC	22.02.17
	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 of FRAC	26.10.17
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	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
	Active	Involved with Waitangi Claim #2687 (involving Napier Hospital land) sold by the Government	Requested that this be noted on the Interest Register	Unlikely to be any conflict of Interest.	The Chair	28.03.18
Barbara Arnott	Active	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
	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	26.10.17
Dr Helen Francis	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
	Active	Independent Consultant	To a variety of health organisations.	Will declare at the beginning of meeting(s) if there are any projects that have anything to do with items on the agenda and will not be involved in those discussions	The Chair	26.02.18

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
	Active	Elected Board Member of the Federation of Primary Health Aotearoa New Zealand	Newly established sector wide multi-professional membership association, providing an inclusive platform for health and care integration with the people of New Zealand at the hear of the organisations objectives. No contracts held and have no financial interest in any of their work.	No conflict perceived	The Chair	10.11.18
Diana Kirton	Active	Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB.	Perceived Conflict of Interest. Non-Pecuniary interest.	Will not take part in any decisions in relation to surgical services provided by or contracted by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO	The Chair	18.02.09
	Active	Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014	Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers.	Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on.	The Chair	16.01.14
	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
	Active	Member, Hawke's Bay Law Society Standards Committee	Law Society	No conflict perceived	The Chair	20.06.17
	Active	RENEW Counselling Services	Counsellor	No conflict perceived	The Chair	17.07.17
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 Hastings 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
	Active	Shareholder Need a Nerd	IT support for home or business	No conflict perceived	The Chair	13.12.17
	Active	Shareholder of NZ Technologies	Technology and innovative support for businesses to grow	No conflict perceived	The Chair	13.12.17
Ana Apatu	Active	CEO of Whararíki Trust (a member of Takitimu Ora Whanau Collective)	A relationship which may be contractural from time to time	Will advise of any perceived or real conflict prior to discussion	PCDP Chair	5.12.16
	Active	Whakaraki Trust "HB Tamariki Health Housing fund"	Formed a relationship and MoU with HBDHB Child Health Team Community Women and Children's Directorate. The Trust created a "HB Tamariki Health Housing fund" to ensure warm dry homes for Hawke's Bay whanau.	Will advise at the outset of any discussions on this topic, and will not take part in any decisions / or financial discussions relating to this arrangement.	The Chair	8.08.18
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 28 NOVEMBER 2018, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.34PM

PUBLIC

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

Apologies: Board members leaving early as noted below.

In Attendance: Kevin Snee (Chief Executive Officer)
Members of the Executive Management Team
John Gommans (Chair, HB Clinical Council)
Malcolm Dixon (Deputy Chair, HB Health Consumer Council)
Members of the public and media
Brenda Crene

APOLOGY

Ngahiwi Tomoana left the meeting at 2.00pm and Diana Kirton at 4.30pm.

2. INTEREST REGISTER

No changes to the interests register were advised

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

3. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on 31 October 2018, were confirmed as a correct record of the meeting.

Moved: Dan Druzianic
Seconded: Peter Dunkerley
Carried

4. MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: **HR KPI's now People and Quality Dashboard –** provided Q1 (agenda item 18). Item closed

Item 2: **Addiction Services –** Addictions scoping paper provided to Committees in November. Consumer Council will further discuss at their December meeting.
Diana Kirton advised that a tour of addiction services had been undertaken. There is lot that will come together and currently this is work in progress. Remove action.

Item 3: **Working groups and a workshop in the New Year** with timing to be confirmed.

Item 4: **Consumer Service / Kiwi Host training for frontline staff in HB –** As Kate Coley was not present at the November meeting, this item would carry over to December.

5. BOARD WORK PLAN

The Board Work Plan was noted.

Advised a special FRAC meeting would take place at the end of January (likely 30th January 2019). An invitation would be issued. **Actioned.**

6. 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
Shona Richards	Dental Assistant	Communities Women & Children	11	25-Oct-18
Patricia Alexander	Social Worker	Older Persons & Mental Health	10	5-Oct-18

- A letter had been received regarding capital projects for the 2019/20 budget year and noted the HBDHB $45m upgrade advising this had been moved out to 2021, at the earliest. This signals there is significant pressure with funding now to be provided over the next two budgets.

  Carriann was not sure this would arise, as the basis of the estimate was a treasury submission. Did engage with MoH and there had been feedback from number of DHBs. Consider dialogue with them on high pressure costs. Carriann will come back to the Board with more detail. **Action**

- A letter had been received from CHB.

- Comment that communications with the MoH and other like organisations was not flowing as regularly as it had in prior years.

7. CHIEF EXECUTIVE OFFICER'S REPORT

The CEO provided an overview of his report with comments noted in addition to the report including:

- The Clinical Services Plan was well received within the sector and by clinicians. This is an integral part, together with the Health Equity Report which paves future health services within the HB.
- The Board had received detail around the Wairoa Integrated Care Demonstrator site exploring key strategies to improve health and wellbeing of the population of 6000 in northern HB.
- The Radiology Facilities Business Case proposed option provides certainty for radiology services and the respective equipment packages to address accreditation the standards we are currently failing. This option enables opportunity to reconfigure the layout/design of the department to allow for changes in the future, without overcapitalising.

Noted there had been a change with a number of acting roles which had become permanent.

An overview of targets was provided and discussed ie, Shorter stays in ED, Elective Performance. We now have a lot more acute surgery which has put pressure on ED workloads. Discharge planning initiatives were being worked though. ED is a whole of system measure – this month a

new model of care within the acute assessment unit was put in place. Also there is a very real focus on medicine with 37 patients through which had alleviated the system well.

Faster Cancer Treatment (the 31 day indicator, enables a better comparison between DHBs as patients are already in the system). Financial Performance for the month and YTD were below plan.

8. FINANCIAL PERFORMANCE REPORT

Carriann Hall (ED of Financial Services) spoke to the Financial Report for 31 October 2018, which showed a $748 thousand unfavourable variance to plan, with a year to date adverse variance of $726 thousand. The forecast is to achieve plan of a $5.0m deficit, however significant challenges prevail which are covered in the report.

There had been a lengthy discussion on the financials at the Finance Risk and Audit Committee Meeting held earlier in the day.

9. HEALTH & SAFETY BOARD CHAMPION'S UPDATE

Ana Apatu as Board Champion advise she had nothing to report. This was her last time as Board Champion which was not handed over to Hine Flood. Hine advised she was awaiting a time to review Wairoa Health Centre.

A copy of the roster to be issued to Board members (**actioned** 30 November 2018)

REPORT FROM COMMITTEE CHAIRS

10. PRIMARY CARE DEVELOPMENT PARTNERSHIP GOVERNANCE GROUP (PCDP)

As Helen had not been present at the prior PCDP meeting, Ana Apatu provided an update on activities.

Changes to the draft PCDP Agreement (appended to the report received) were noted.

The Agreement would be further modified to reflect appointing named alternates for members who were not able to attend. Ken Foote advised amended wording which Board members agreed would be incorporated into the agreement.

The amended wording would provide for:

- Should any core member from either the DHB or PHO be unable to attend, a Governance Group meeting they may nominate another member to act by proxy in relation to any decision to be made by the Governance Group.
- Should any core member from MRB, Clinical or Consumer Council's be unable to attend a Governance Group meeting, they may request that their appointed alternate attend in their place.
- Alternates shall be appointed in the same way as members.

It was proposed the final agreement be signed on 19 December 2018.

RESOLUTION

That the HBDHB Board:

1. Approve the attached Draft Hawke's Bay Primary Care Development Partnership Agreement as amended.

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

Remuneration for governance members on the HB PCDP: Currently we are unable to pay HBDHB board members as we are obliged to operate under the cabinet fees framework. Ken Foote has requested further advice from the MOH.

Ngahiwi Tomoana left the meeting.

11. PASIFIKA HEALTH LEADERSHIP GROUP (PHLG)

Barbara Arnott (Chair of CPHAC) who oversees the PHLG provided an overview of the meeting held 12 November 2018. Talalelei Taufale (Pasifika Health Development Manager) was in attendance for this item.

The Clinical Services Plan was reviewed however with limited time at the PHLG meeting to discuss, they advised a condition of approval to include: *"confidence that current plans are supported, the community voice is heard, and progress is to be shared back to this group as an ongoing action*".

Advised the group are in good heart and moving in the right direction with their voices being heard and work being acted on. However, there is still more work being done inside the hospital than outside the hospital (Navigators).

Data capture for Pasifika was being undertaken on an individual basis currently, with a plan to capture data for whanau. IT are looking at this.

Work around health literacy was being undertaken also, to ensure surveys in Pasifika communities are easy to understand. School principals and students have been met with to ascertain the best way to word these.

Currently working with communities to deliver services. Suggest the best place to tap into the largest groups was through the Churches.

12. MĀORI RELATIONSHIP BOARD (MRB)

Ana Apatu on behalf of Ngahiwi Tomoana (as Chair of MRB's prior meeting) advised that the Maternal Wellbeing Presentation received was an exemplar formed around the values of the organisation. MRB would like to see reports in future based around our values.

The Maori Health team have been undertaking a lot of work in the workforce development area.

A message from Ngahiwi Tomoana, that MRB would hold a Workshop on NUKA.

13. HAWKE'S BAY HEALTH CONSUMER COUNCIL

Malcolm Dixon, as Deputy Co-Chair of Consumer Council advised the outcomes of their meeting held on 14 November 2018 but opened commending Rachel Ritchie as an excellent Chair who is open, transparent, inclusive and very passionate about the consumer voice. He also noted that Graham Norton had recently received an award locally and nationally for his work with Consumer Council's and the voice of consumers.

Council had endorsed the Clinical Services plan and recommended that the Board approve the Final Draft. Consumer members who had attended the Nuka Conference were very appreciative and enthusiastic with learnings they took away which had been shared with Council at the prior meeting.

The Consumer Experience Facilitators have been working well – and a comprehensive report had been received from them around their achievements for the first month. They are DHB employees with the role split following the departure of Jeanette Rendell. On request Malcolm conveyed details form their report to Consumer Council.

Action: **The Board advised they would be interested in meeting and hearing from the Consumer Experience Facilitators, after they have been in their roles for six months. This would be scheduled on the Board Workplan (for May)**

14. HAWKE'S BAY CLINICAL COUNCIL

Co-Chair Dr John Gommans was in attendance and spoke to the report from the Council's meeting held on 15 November 2018. He advised that Council had elected Jules Arthur as co-chair, following advice that Andy Phillips would not be making himself available for re-election.

- Clinical Services Plan and recommend that the Board approve the Final Draft. The next steps are crucial and we must not underestimate the degree of change required (including within the workforce).
- Endorsed the local direction for Collaborative Pathways: following the loss of the map of medicine, Council recommended to park electronic pathways and continue with e-referrals in the interim.
- Discussed Advance Care Planning reporting to a sub-group of Council, which was work in progress.
- Radiology Business Case: Council provided their full support, as the equipment currently in operation is reaching the end of its life, together with the need to address accreditation issues and also to future proof the service, whilst continuing to provide services to our population.

FOR DISCUSSION / DECISION

15. WAIROA INTEGRATED CARE DEMONSTRATOR SITE – mini workshop

Chris Ash, Executive Director, Primary Care was joined by Emma Foster, Deputy ED of Primary Care who introduced Wietske Cloo, Service Director, Community, Women and Children and Lisa Jones Business Intelligence Team Leader.

- Remembering values in everything we do.
- It is about co-design Community ownership and leadership.
- We are a supporter and an enabler for Wairoa

The rural isolation of Wairoa together with high Māori ethnicity creates huge barriers for Wairoa. The area has a lower life expectancy rate than the rest of HB, with higher smoking rates, limited income, little or no access to transport. 8000 people live in Wairoa (mainly an older population).

The Wairoa District community has the opportunity to transform how services are designed, commissioned, delivered, and monitored. After many years of plans being developed, opportunities being missed and health outcomes ultimately not improving, now is the time to actively focus and move forward with the community in Wairoa to include:

1. Strong valued and authentic community ownership and governance
2. One health system for all Wairoa (regardless of the ownership structure)
3. Services that operate through strong outreach into the community
4. Consistent high quality care.

Initially worked on within the community by Te Pare Meihana (DHB employee) under the Social Localities umbrella, this work builds and expands on that work.

The **Wairoa Community Partnership Group** is led, owned and delivered in Wairoa, for Wairoa people, by Wairoa people. The purpose of this group is: United leadership is for a joined-up, community led and Government partnered approach to community design, investment and decision making'; and ensuring that 'all whānau across the Wairoa district are thriving'.

The Wairoa community decided - the group be truly representative of the people and not be bound by TLA legislation.

Hine explained and used diagrams to convey how the Community Partnership Group (CPG) operates; the structure, the make-up of representation on the group **, the focus areas; planning and implementation aspects (who the implementers are). Advised the implementers are from the community and already work within the community with whanau.

** The group is representative of the people and includes: Justice, Police, MSD, TPC, Health, MOE and TPE.

Following further explanation, questions and discussion the following recommendations were adopted:

RECOMMENDATION:

It is recommended that the Board:

1. **Note** the work completed to date in analysis and planning, in relation to integrated models of service and care for Wairoa District.
2. **Note** that work is underway to strengthen Clinical Governance in Wairoa to support improved communication, risk assessment and clinical processes improvement.
3. **Note** the significant investment, both financially and in human resources, required to maintain facilities in Wairoa to a standard that meets the needs of the community.
4. **Note** that this method of community relationships, value based decision making and strong local voice is in line with our organisational values.
5. **Discuss** whether we use this community led process as a model for engagement and negotiation with our most vulnerable populations.
6. **Agree** that increased focus needs to be included in future state delivery on customer/whānau relationships, open and proactive communication in response to clinical events.
7. **Approve** that the CPG and whānau voice is the vehicle for future model of engagement with the community and how we negotiate with this vulnerable community in relation to service allocation, design and delivery.
8. **Approve** that management can walk alongside the Wairoa community to progress the identified future state without compromise.
9. **Approve** that management continue to work with the primary and secondary care sector in Wairoa to progress towards one health system with shared leadership (clinical and management), pathways, processes and staff.

Adopted

Action: An update would be provided to the March Board Meeting.

16. RADIOLOGY FACILITY DEVELOPMENT BUSINESS CASE (SINGLE STAGE)

Colin Hutchison, Paula Jones and Janet Heinz who were joined by the team from Radiology supporting the business case.

The team were thanked sincerely for working tirelessly on this project to get this project to the place it is today.

This business case focuses on the need to: replace equipment; address quality accreditation issues; and future proof the service whilst continuing to provide services to consumers

The issues:
Replacement of MRI & Fluoroscopy units at Hawke's Bay Hospital:

- These units are diagnostic work-horses used to support acute and elective services
- Quality of images produced by units is diminishing
- Unscheduled maintenance (breakdown) time is increasing
- Outsourcing is costly and difficult for acute and frail patients

Failure to progress business case will result in withdrawal of IANZ accreditation

- 2012 – 2016 IANZ identified issues with radiology department layout and environment relating to **patient safety**, **patient privacy, environment** and **equipment replacement**
- 2017 these issues progressed to Corrective action requests (CARs) required monthly reporting on progress
- 2018 CARs maintained, quarterly reports required noting business case to address CARs in progress

Option three: (preferred option)

- Replacement of existing Fluoroscopy and MRI equipment and plan for replacement of other existing equipment
- Footprint increase for existing and planned services (e.g. PCI)
- All CARs issued by IANZ addressed
- Seismic strengthening works completed

The above option enables floor plan/footprint changes to occur, addresses accreditation issues and also future proofed the service, whilst continuing to provide services to our population and not overcapitalising.

IANZ would require a commitment from the HBDHB Board and even if a staged approach is approved and the build would be nearer 2023, this would satisfy IANZ that we are managing our way forward and progressing in the right directly.

For option 1 (do nothing): The DHB would be incur regrettable spend; would not allow for service continuity; the new scanner would require wider footprint area; the DHB cannot everything to private providers as they would not have the capacity to take all HB patients.

The HBDHB Board advised they would consider the discussion latter, when they consider the financials in the public excluded section of the November Board Meeting.

17. CLINICAL SERVICES PLAN

Ken Foote, Clinical Services Plan Project Sponsor and Company Secretary and Hayley Turner (Clinical Services Plan Project Manager, Planning and Strategic Projects) were in attendance.

- Advised that a full record of responses throughout the recent engagement process was available and would be on the website for viewing.

The tracked changed version of the document had been provided to the Board and had been through all Committees who had endorsed urging sign off by the HBDHB Board.

Chair, Kevin Atkinson agreed the changes reflected in the document provided, had enhanced the overall document.

David Moore of Sapere (contracted to facilitate the development of the CSP) was introduced to reflect. He noted this work had been progressing over an 18 month period, and gave a great deal of credit to the Project Sponsor, Ken Foote; Project Manager, Hayley Turner; Chris Ash ED Primary Care, Drs Gommans and Peterson credit for their respective roles.

On reflection over a 20 year time frame, this Clinical Service Plan compared very favourably too many others, focussing on addressing real concerns within society at large but keeping within the boundaries of what a health system can do. In the end you now have is a very powerful mandate for change.

These are difficult times with ever increasing medical costs. In developing a future strategy you have to turn existing systems on their head and put money into community and primary care services. This is the bravest CSP David has seen. He has an eye on the organisational implications as normal organisations may not be able to deliver. Really appreciated how the

Executive team came together. This was a rewarding and real experience. A fantastic job – but with significant change required.

Following further discussion, the Board approved the following Resolution:

RESOLUTION:

That the HBDHB Board:

1. **Reviewed** the summary of the engagement feedback
2. **Noted** the endorsement and recommendations from EMT and all four governance groups
3. **Approved** the final version of the Clinical Services Plan

Moved **Diana Kirton**
Seconded **Peter Dunkerley**
Carried

18. PEOPLE & QUALITY DASHBOARD

Jim Scott (HR's Business Analyst) was in attendance to speak to the newly designed dashboard. He advised this was an evolving paper, with the intention being to include data from the whole of sector and incorporate benchmarking and DHB comparisons. This will be placed online for managers at own levels to review and gather feedback with the goal to improve information over time. This is the first step in the change/development process.

It was noted there were excessive overdue leave hours and the Board were happy to see actions in place to address this.

"Excessive/ overdue leave hours 96,145 at average of 74.5 per employee. Compared to 83,093 at average of 71.6 per employee last year.
Employees to be encouraged to take more leave to rest and recharge over the coming summer months."

The board thanked Jim for the work undertaken.

FOR INFORMATION ONLY

19. BEST START HEALTHY EATING AND ACTIVITY PLAN UPDATE

No questions or discussion

20. TE ARA WHAKAWAIORA – ACCESS RATES 0-4 / 45-64

No questions or discussion

21. TE ARA WHAKAWAIORA- "SMOKEFREE UPDATE"

Page 291 of the report, it was noted there was inadequate data availability for pregnant Māori mums. In response, it was advised that LMC collect the data but it was not submitted (as a requirement) within their contract(s). The MoH are working to obtain this data (and change the respective contracts).

Made no sense as we set a target but are not able to monitor (through data capture). Shari had advised Patrick LeGeyt. Within Helen Francis's new role she may have an opportunity to raise this.

22. HBDHB PERFORMANCE FRAMEWORK EXCEPTIONS REPORT Q1

No questions or discussion

NON-FINANCIAL PERFORMANCE FRAMEWORK DASHBOARD Q1
No questions or discussion.

GENERAL BUSINESS

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

23. RECOMMENDATION TO EXCLUDE THE PUBLIC

RECOMMENDATION

That the Board

Exclude the public from the following items:

24. Confirmation of Minutes of Board Meeting - Public Excluded
25. Matters Arising from the Minutes of Board Meeting - Public Excluded
26. Board Approval of Actions exceeding limits delegated by CEO
27. Chair's Update
28 Radiology Facility Development Business Case Financials
29. Health Equity Report
30. Pasifika Health Leadership Group
31. Māori Relationship Board
32. HB Health Consumer Council
33. HB Clinical Council
34. Finance Risk and Audit Committee

Moved: **Heather Skipworth**
Seconded: **Peter Dunkerley**
Carried

The public section of the Board Meeting closed 4.03pm

Signed: _____
Chair

Date: _____

BOARD MEETING - MATTERS ARISING
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	29/9/18 10/10/18	The following process was agreed to move towards addressing the areas raised by MRB (in September's Board Report) around **Equity and Cultural Competency:** Kevin Atkinson Board Chair suggested the following process which was accepted at the MRB meeting: a) That a Working Group come together to study and focus on next year's planning. b) That a Workshop be set up in the New Year (including MRB members and other representatives as required), the result of which will be clear actions and targets we can aim for.	Kevin Snee	Timing Feb 19 TBC	
2	31/10/18	Kate Coley (HR) and primary care services should consider ongoing **training of frontline staff** (Consumer Service / kiwi host).	Kate Coley & Wayne Woolrich	Dec	Verbal update
3	28/11/18	**Funding of Capital Projects**: Carriann will come back to the Board with more detail. Raised under Chair's Report.	Carriann Hall	TBC	
4	28/11/18	Schedule **Consumer Experience Facilitator**s to attend the May 2019 Board meeting as members would like to hear about their work.	Kate Coley	May 19	
5	28/11/18	**Wairoa Integrated Care Demonstrator Site:** The Board requested an update at the March 2019 Board meeting.	Chris Ash / Emma Foster	Mar 19	Included on Workplan

Board Workplan as at 13 December 2018 (subject to change)	EMT Member	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Alcohol Harm Reduction Strategy (6 monthly update) **Feb**-Aug-Feb-Aug	Andy Phillips	29-Jan-19	13-Feb-19	13-Feb-19	14-Feb-19		27-Feb-19
Finance Report (Jan)	Carriann Hall	19-Feb-19				27-Feb-19	27-Feb-19
HBDHB Non-Financial Performance Framework Dashboard Q2 - **EMT/Board**	Chris Ash	19-Feb-19					27-Feb-19
HBDHB Performance Framework Exceptions Q2 Nov 18 **Feb 19** /May/Aug 19 (jit)	Chris Ash	5-Feb-19	13-Feb-19				27-Feb-19
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-Nov-**Feb**-May	Chris Ash	29-Jan-19	13-Feb-19	13-Feb-19	14-Feb-19		27-Feb-19
Ngatahi Vulnerable Children's Workforce Development - annual progress **Feb 19** (annual update)	Colin Hutchison	29-Jan-19	13-Feb-19	13-Feb-19	14-Feb-19		27-Feb-19
Te Ara Whakawaiora - Improving First Specialist Appointment Access (previously did not attend)	Colin Hutchison	22-Jan-19	13-Feb-19	13-Feb-19	14-Feb-19		27-Feb-19
Consumer Engagement Strategy Implementation Plan and presentation. Effectivenss of the strategy	Kate Coley	29-Jan-19			14-Feb-19		27-Feb-19
People Dashboard Q2 (Oct-Dec 18) **Feb**-May-Aug-Nov	Kate Coley	12-Feb-19					27-Feb-19
He Ngakau Aotea paper	Patrick LeGeyt	12-Feb-19					27-Feb-19
Te Ara Whakawaiora REVIEW	Patrick LeGeyt	22-Jan-19	13-Feb-19	13-Feb-19	14-Feb-19		27-Feb-19
Matariki Regional Development Strategy and Social Inclusion Strategy update (6 mthly) Sept-**Mar**	Andy Phillips	26-Feb-19	13-Mar-19	13-Mar-19	14-Mar-19		27-Mar-19
Finance Report (Feb)	Carriann Hall	19-Mar-19				27-Mar-19	27-Mar-19
Wairoa Integraed Care Demonstrator Site Update (Board action28/11)	Chris Ash	19-Mar-19					27-Mar-19
Violence Intervention Programme Presentation Committees reviewed in July - EMT Nov - TBC for March 19	Colin Hutchison	26-Feb-19	13-Mar-19	13-Mar-19	14-Mar-19		27-Mar-19
People Plan Progress Presentation (following Board in December)	Kate Coley	5-Mar-19	13-Mar-19	13-Mar-19	14-Mar-19		27-Mar-19
After Hours Urgent Care Service Update 6mthly (Sept-Mar-Sept)	Wayne Woolrich	26-Feb-19	13-Mar-19	13-Mar-19	13-Mar-19		27-Mar-19
Finance Report (Mar)	Carriann Hall	16-Apr-19				24-Apr-19	24-Apr-19
Hawke's Bay Health Awards Event - review Alcohol at this event annually	Kevin Snee						24-Apr-19
Finance Report (Apr)	Carriann Hall	14-May-19				29-May-19	29-May-19
HBDHB Non-Financial Performance Framework Dashboard Q3 - **EMT/Board**	Chris Ash	21-May-19					29-May-19
HBDHB Performance Framework Exceptions Q3 Feb19 /**May**/Aug/Nov (jit)	Chris Ash	7-May-19	8-May-19				29-May-19
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-Nov-Feb-**May**	Chris Ash	23-Apr-19	8-May-19	8-May-19	9-May-19		29-May-19
People Dashboard Q3 (Jan-Mar 19) Feb-**May**-Aug-Nov	Kate Coley	14-May-19					29-May-19
Finance Report (May)	Carriann Hall	18-Jun-19				26-Jun-19	26-Jun-19
Annual Plan 2019/20 SPEs to Board by end of June (include committees?)	Chris Ash	11-Jun-19	12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19
People Plan Progress Update Report (6 monthly - Dec, **Jun 19**)	Kate Coley	4-Jun-19	12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19
Finance Report (Jun)	Carriann Hall	16-Jul-19				31-Jul-19	31-Jul-19
Alcohol Harm Reduction Strategy (6 monthly update) Feb-**Aug**-Feb-Aug	Andy Phillips	30-Jul-19	14-Aug-19	14-Aug-19	15-Aug-19		28-Aug-19
Finance Report(July)	Carriann Hall	20-Aug-19				28-Aug-19	28-Aug-19
Annual Plan 2019/20 draft to the Board	Chris Ash	6-Aug-19	14-Aug-19	14-Aug-19	15-Aug-19		28-Aug-19
HBDHB Non-Financial Performance Framework Dashboard Q4 - **EMT/Board**	Chris Ash	20-Aug-19					28-Aug-19
HBDHB Performance Framework Exceptions Q4 Feb19 /May/**Aug**/Nov (jit)	Chris Ash	13-Aug-19	14-Aug-19				28-Aug-19
People Dashboard Q4 (Apr-Jun 19) Feb-May-**Aug**-Nov	Kate Coley	13-Aug-19					28-Aug-19
HB Health Awards - preparation for judging **2019**-2020	Kevin Snee	27-Aug-19		14-Aug-19	15-Aug-19		28-Aug-19

HAWKE'S BAY
District Health Board
Whakawāteatia

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** 179
	For the attention of: **HBDHB Board**
Document Owner:	Chris Ash, Acting Chief Executive Officer
Reviewed by:	Not applicable
Month as at	13 December 2018
Consideration:	For Information

RECOMMENDATION

That the Board

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

INTRODUCTION

This month's agenda is relatively light and includes the Health Equity Report. Board members will also receive a progress update on the People Plan priorities.

Following the Board meeting we will be joined by colleagues from Health Hawke's Bay to sign the revised Alliance Agreement, agreed by both Boards at their November meetings. "Te Pītau: The Hawke's Bay Health Alliance" sets out a renewed intent to work in full partnership with consumers, clinicians and local communities to design and implement a health system that is fit for the future. The report from the December meeting of Te Pītau is also included on this month's Board agenda.

PERFORMANCE

The key performance exceptions for November 2018 are:

- Emergency Department (ED): 'Shorter stays in ED (ED6)' has improved to 89% in November, giving a quarter-end result of 88%. This is still below the national average, which currently stands at just over 91%.

  In the last month, improvements have been seen because of a quieter hospital, allowing improved patient flow through the organisation. Additionally, the medical team has been trialling a new nurse-led model of care, which has resulted in more patients going through the Acute Assessment Unit (AAU) than before.

  Ongoing challenges for ED6 include high levels of acute surgical demand, which we are mitigating through improvements to our medical cover arrangements and model of care.

- Elective performance: The DHB continues to focus on actions to clear a backlog of cases to meet national elective services targets. The actions required to clear this backlog will necessitate significant system and process improvements within our Surgical Services. Many of these are already underway, including outsourcing to Royston and a plan to increase internal elective capacity. This will be enabled by measures including Saturday lists, (which will become regular operating practice by February 2019), and renting of 'wet theatre' space at local private hospitals. The DHB is also working with local primary care clinicians to appropriately manage demand.

- Faster Cancer Treatment for the month of November is not available at this time (as data is released on the 20th of each month).

Measure / Indicator	Target	Month of November	Qtr to end November	Trend For Qtr
Shorter stays in ED	≥95%	89%	88%	▲
Improved access to Elective Surgery (2018/19YTD)	100%	84%	89%	▲

Waiting list	Less than 3 months	3-4 months	4+ months
First Specialist Assessments (ESPI-2)	3,248	653	508
Patients given commitment to treat, but not yet treated (ESPI-5)	1,005	225	447

Faster cancer treatment – 62 day indicator* *(Patients who breach the 62 day target due to Capacity Constraint are still counted against target however patients who breach the target due to Clinical Decision or Patient Choice are now excluded).*	≥90%	100% October	82% 6m to October	▲
Faster cancer treatment - 31 day indicator	≥85%	81% October	85% 6m to October	▲
Increased immunisation at 8 months	≥95%	---	91% 3m to November	-
Better help for smokers to quit – Primary Care			81.8% 15m to November	
Raising healthy kids (New)			100% 6m to November	
Financial – month (in thousands of dollars)	(510)	(1,598)	---	---
Financial – year to date (in thousands of dollars)	(1,115)	(2,929)	---	---

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%*	*64/114 = 54%*

FINANCIAL PERFORMANCE

The result for the month of November is $1.1m unfavourable to plan, taking the year-to-date result to $1.8m adverse. Whilst still adverse, financial performance for Provider Services is significantly improved from previous months, reflecting management actions and reduced activity in the hospital.

HEALTH EQUITY REPORT

This report acknowledges that in Te Matau a Māui, Hawke's Bay, our people have pervasive and enduring differences in health that are not only avoidable, but unfair and unjust. Equity is defined as the absence of avoidable or remediable differences among groups of people. To achieve health equity, we must acknowledge that people with different levels of advantage will require different approaches and resources to achieve the same outcome. The inter-generational traumatic impact of colonisation has had long term impacts on Māori health, wellbeing and culture. Socio-economic factors account for almost half of all health inequity. Health care is responsible for a further 10%.

To achieve our commitment to equal outcomes, we will all need to work across sectors to overcome the barriers to equity - poverty, discrimination, powerlessness, lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare. We know that many in our community face barriers to accessing high quality health care services. These barriers include difficulties in navigating our complex systems, limited cultural competence of providers, lack of transport, out-of-pocket costs and co-payments for GP services.

PEOPLE PLAN PROGRESS (PRESENTATION)

Since Board approved the People Plan at their June meeting, a significant amount of work has been undertaken to begin to bring the five year plan, of work, to life. The People Plan was developed to support the organisation's ability to respond to the feedback that was received from The Big Listen, Kōrero Mai and the Clinical Services Plan. It will be a key enabler to support the achievement of our vision. The Board also endorsed both the Health and Safety Strategy and the Māori and Pacific workforce development action plans, which are two key components of the People Plan.

To ensure progress is made, the Executive Management Team (EMT) agreed the priorities for the first financial year and each key piece of work has either an EMT or operational lead to deliver the actions. The priorities for this year include:

- Work to support the challenging of unacceptable behaviours
- Development of a new personal and performance development framework
- A frontline leaders development programme
- Talent mapping all leaders across the Central region
- Annual leave planning
- Development of an annual wellbeing programme
- Implementation of a sick leave bank
- Values-based and culturally appropriate recruitment
- Refreshing our orientation to build on Southcentral Foundation's 'Core Concepts' philosophy.

CONCLUSION

Following a challenging 2018 for our Provider Services, November's results are showing early signs that management actions are starting to effect improvements within our financial and non-financial performance. There remains significant work, however, to consolidate on the back of the progress already made.

As we enter our Planning Cycle for 2019/20, and the conclusion of work to develop a new Strategic Plan for the Hawke's Bay Health System, today's meeting gives an opportunity to consider two critical building blocks – the Health Equity Report and the People Plan.

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report November 2018** 180 For the attention of: **HBDHB Board**
Document Owner	Carriann Hall, Executive Director Financial Services
Document Author	Phil Lomax, Financial and Systems Accountant
Reviewed by	Executive Management Team
Month/Year	December, 2018
Purpose	For Information

8

RECOMMENDATION:

It is recommended that the HBDHB Board:

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

EXECUTIVE DIRECTOR FINANCIAL SERVICES COMMENTS

Financial Performance

As shown in the table below, the result for the month of November is $1.1m unfavourable to plan, taking the year-to-date (YTD) result to $1.8m adverse. The key drivers are summarised below.

Despite the overspend, we continue to forecast to achieve plan, although this is dependent on a number of factors, which are being closely monitored by management with the support of the Finance, Risk and Audit Committee (FRAC) through the FRAC Finance Sub-Committee, which met on the 6 December. There is another meeting scheduled for mid-January and an extended session in FRAC on 19 December.

	November				*Year to Date*				*Year End*	Refer
$'000	*Actual*	*Budget*	*Variance*		*Actual*	*Budget*	*Variance*		*Forecast*	Section
Income	48,527	48,278	250	0.5%	240,410	239,822	588	0.2%	574,614	3
Less:										
Providing Health Services	23,967	23,876	(91)	-0.4%	120,491	118,605	(1,886)	-1.6%	287,043	4
Funding Other Providers	22,142	20,788	**(1,354)**	**-6.5%**	103,943	100,926	(3,017)	-3.0%	242,667	5
Corporate Services	4,014	4,050	36	0.9%	21,018	21,060	42	0.2%	48,896	6
Reserves	2	74	**72**	**97.4%**	(2,114)	345	**2,459**	**712.1%**	1,008	7
	(1,598)	**(510)**	**(1,088)**	**-213.5%**	**(2,929)**	**(1,115)**	**(1,814)**	**-162.7%**	**(5,000)**	

Key Drivers

The detail of the variances are covered in the appendices to the report. The key drivers are:

- Providing Health Services (Appendix 2)
  Whilst this was $91k unfavourable in month ($1.9m adverse year-to-date), it was much improved from the prior months run rate of circa $450k adverse per month.

The improved results can be linked to actions the Provider Services teams have taken to control costs whilst the hospital has been in a less acute period. This includes close management of nursing rosters, patient watches and locum approvals. We anticipate annual leave management to start to impact from December.

- Funding Other Providers (Appendix 3)

  $1.4m adverse in month, a significant worsening of the position to $3m adverse YTD.

  Inter District Flow (IDF) outflows continue to be a significant challenge with $555k overspend in month, taking the YTD to $931k adverse. This is due to both a higher number of discharges and higher average Case Weighted Discharge (CWD) per discharge than experienced in 2017/18. Two particularly high case weights, discharged in October, were notified in November. The final case weight was much higher than estimated and these are the main contributor to the adverse variance in month.

  Health of Older People is $1.972m adverse YTD. This is attributed to residential care volumes and pay equity payments to external providers, although further analysis is being undertaken.

- Savings Plans (Appendix 8)

  Shortfall on savings plans of $2.0m YTD are included in the year-to-date position and discussed further below.

These are being partially offset by a number of favourable variances, including allied health personnel vacancies and outsourcing, some of which are timing differences.

Forecast

Whilst we are adverse year-to-date, we continue to forecast achievement of plan due to anticipated impacts from ongoing management actions, which were discussed in detail at FRAC last month and further explored in the FRAC Sub-Committee meeting of 6December. There is a further session on the FRAC agenda for 19 December meeting. Actions include:

- Programme of work, led by Executive Director Provider Services, commenced. This aims to get Provider Services on to a sustainable footing and includes focus on finance training, annual leave management, appropriate use of resources including review of nurse rosters and patient watches, as well as improved visibility and control around temporary resources. These are targeted schemes, with a focus on ensuring staff are flexed down and rested when the hospital status can accommodate it;
- Delivering identified savings plans of $13.2m;
- Housekeeping activities, including review of ACC revenue processes and a structured approach to reduce leave liability being implemented; and
- Progressing Primary Care prioritisation, which will be discussed further at the FRAC meeting of 19 December.

Other Performance Measures

	November				Year to Date				Year End Forecast	Refer Section
	Actual	Budget	Variance		Actual	Budget	Variance			
	$'000	$'000	$'000	%	$'000	$'000	$'000	%	$'000	
Savings plans	1,264	1,179	85	7.2%	2,705	5,897	(3,192)	-54.1%	14,152	10
Capital spend	1,381	1,157	224	19.4%	7,770	9,443	(1,673)	-17.7%	17,933	15
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,426	2,438	12	0.5%	2,395	2,439	44	1.8%	2,420	4 & 6
	CWD	CWD	CWD	%	CWD	CWD	CWD	%	CWD	
Case weighted discharges	2,872	2,488	384	15.5%	12,624	12,678	(55)	-0.4%	28,699	4

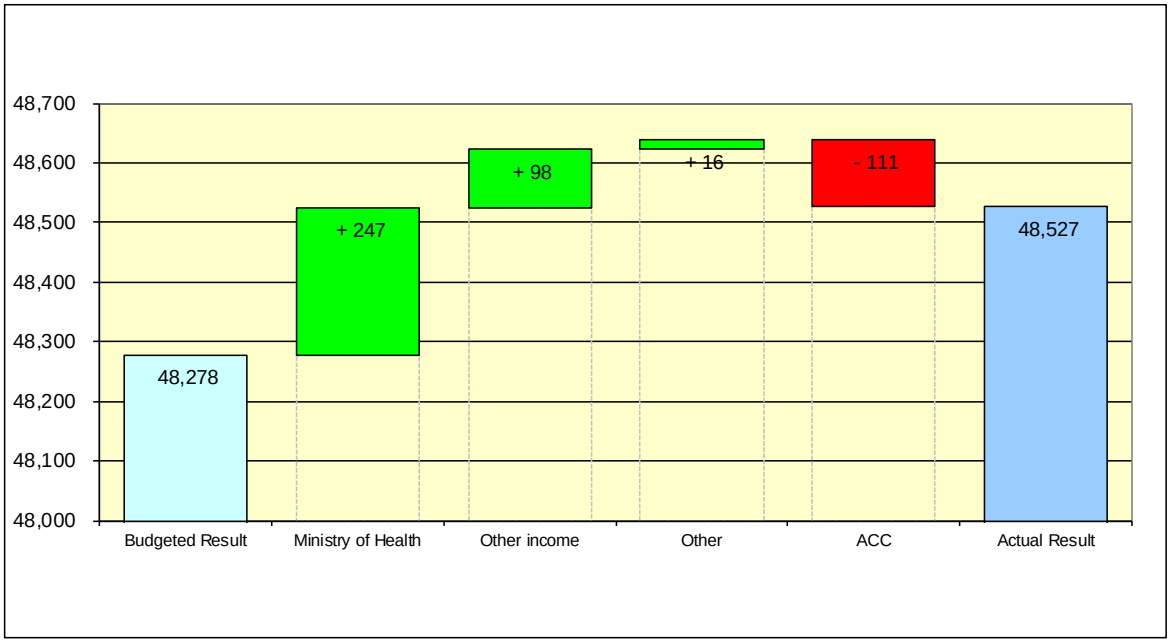
- Savings Plans (Appendix 8)
  - Achievement of the $14.2m saving plan is a significant factor in financial performance. Savings plans have been identified for $13.2m (93%) of the $14.2m required. Of the identified savings $6.7m has been removed from operational budgets.
  - On a straight line basis YTD savings of $5.9m should have been achieved by the end of November, and $2.7m has been made. To adjust for timing, a further $1.2m of the savings required has been accrued centrally. This is matched by assuming budgeted contingency of $542k and a further $667k relating to the new investments reserve, will not be spent. A further $485k adjustment has been made to better reflect the profile of likely Primary Care savings. The remaining $2.0m shortfall is in the year-to-date position.
- Capital spend (Appendix 12)
  - Capital spend is behind budget due to timing differences as a result of plant and equipment needs and procurement lead times in the block allocations.
- Cash (Appendices 11 & 13)
  - November's low point was a $10.8m overdraft at the end of the month with a forecast low of $13.6m overdrawn by the end of the year. These are within our current statutory limit of $27m. Interest is expected to come in $0.2m less than planned as a result.
- Employees (Appendices 2 & 4)
  - Employee numbers are favourable reflecting challenges filling vacancies in medical and allied health positions, partly offset by investment in additional role and high use of nursing resources.
- Activity (Appendix 2)
  - Year-to-date CWD are marginally lower than plan. Note that CWD numbers are counted only when patients are eventually discharged, and consequentially are not directly comparable with activity and acuity in Provider Services on a monthly basis. CWD's are reported as a proxy indicator of production, that increases in accuracy over longer periods.
  - The early cut of elective discharges show a shortfall on achieving the Ministry of Health target.

APPENDICES

1. INCOME

$'000	November				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Ministry of Health	46,304	46,057	247	0.5%	229,257	228,516	741	0.3%	547,480
Inter District Flows	724	762	(39)	-5.1%	3,285	3,811	(526)	-13.8%	9,146
Other District Health Boards	411	354	57	16.1%	1,941	1,748	193	11.1%	4,229
Financing	48	55	(7)	-12.6%	195	276	(81)	-29.5%	663
ACC	311	422	(111)	-26.3%	1,913	2,198	(285)	-13.0%	5,370
Other Government	42	43	(2)	-4.1%	192	293	(101)	-34.5%	673
Patient and Consumer Sourced	111	104	7	6.3%	448	520	(72)	-13.9%	1,261
Other Income	577	479	98	20.4%	2,610	2,442	167	6.8%	5,774
Abnormals	-	-	-	0.0%	570	17	553	3250.2%	17
	48,527	**48,278**	250	0.5%	**240,410**	**239,822**	588	0.2%	**574,614**

Month of November



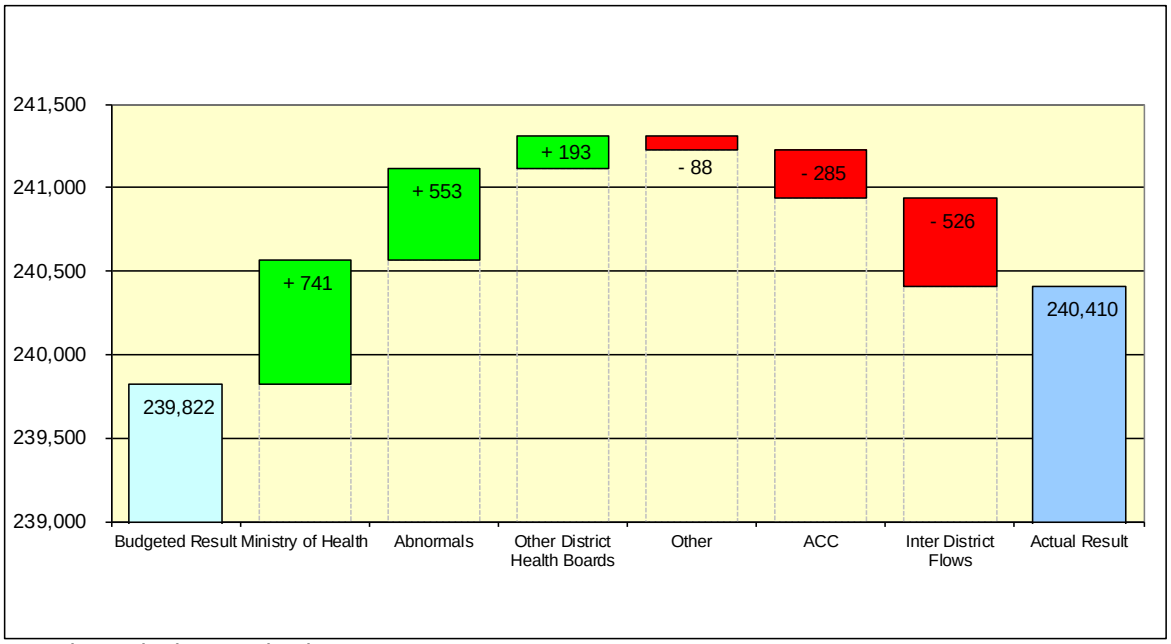
Note the scale does not begin at zero

Ministry of Health (favourable)
In-Between-Travel (home support), and pay equity(residential care).

Other income (favourable)
Unbudgeted GP Health Centre income in Wairoa, and income from other DHBs including for alcohol and drug residential services.

ACC (unfavourable)
Lower elective surgery income reflecting capacity constraints.

Year to Date



Note the scale does not begin at zero

Ministry of Health (favourable)
Pay equity and In-Between-Travel income offset in related expenditure (Appendix 4). Also immediate relief and CCDM funding (nurses agreement).

Abnormals (favourable)
Prior year wash-ups and accruals no longer required. All recognised in September.

Other District Health Boards (favourable)
Oncology and neurology clinics.

ACC (unfavourable)
Reduced elective surgery income due to capacity constraints, partly offset by increased rehabilitation income.

Inter District Flows (unfavourable)
Reduced income over the winter months, expected to increase going into summer.

2. PROVIDING HEALTH SERVICES

	November				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure by type $'000									
Medical personnel and locums	5,362	5,501	139	2.5%	26,734	27,000	266	1.0%	67,132
Nursing personnel	6,969	6,807	(162)	-2.4%	35,639	34,738	(901)	-2.6%	82,891
Allied health personnel	2,923	3,283	**360**	**11.0%**	14,950	16,246	**1,296**	**8.0%**	38,178
Other personnel	2,034	2,109	75	3.6%	10,390	10,387	(3)	0.0%	24,472
Outsourced services	788	984	**196**	**19.9%**	4,042	5,062	**1,020**	**20.2%**	12,166
Clinical supplies	3,923	3,373	**(550)**	**-16.3%**	19,135	16,014	**(3,121)**	**-19.5%**	40,068
Infrastructure and non clinical	1,967	1,819	**(148)**	**-8.1%**	9,602	9,159	(443)	-4.8%	22,136
	23,967	**23,876**	(91)	-0.4%	**120,491**	**118,605**	(1,886)	-1.6%	**287,043**
Expenditure by directorate $'000									
Medical	6,416	6,446	30	0.5%	33,642	31,987	**(1,656)**	**-5.2%**	77,910
Surgical	5,456	5,266	(190)	-3.6%	26,001	26,242	241	0.9%	64,006
Community, Women and Children	3,838	3,830	(8)	-0.2%	19,156	18,877	(279)	-1.5%	45,650
Older Persons, Options HB, Menta	2,925	3,028	103	3.4%	14,956	15,068	113	0.7%	36,282
Operations	3,578	3,432	(146)	-4.2%	17,563	17,055	(509)	-3.0%	40,720
Other	1,755	1,873	**119**	**6.3%**	9,173	9,376	204	2.2%	22,474
	23,967	**23,876**	(91)	-0.4%	**120,491**	**118,605**	(1,886)	-1.6%	**287,043**
Full Time Equivalents									
Medical personnel	354.5	369.6	15	4.1%	346	363	17	4.6%	365.7
Nursing personnel	994.5	956.9	(38)	-3.9%	990	976	(14)	-1.4%	966.9
Allied health personnel	471.8	501.9	**30**	**6.0%**	470	498	**28**	**5.6%**	492.5
Support personnel	143.0	139.9	(3)	-2.3%	141	138	(2)	-1.8%	137.1
Management and administration	282.5	283.1	1	0.2%	274	279	5	1.7%	276.5
	2,246.4	**2,251.4**	5	0.2%	**2,221**	**2,254**	33	1.5%	**2,238.7**
Case Weighted Discharges									
Acute	2,129	1,651	**479**	**29.0%**	9,257	8,679	**578**	**6.7%**	19,417
Elective	568	621	**(53)**	**-8.5%**	2,429	2,961	**(533)**	**-18.0%**	6,850
Maternity	153	180	(27)	-15.1%	852	851	1	0.1%	2,000
IDF Inflows	22	36	(14)	-38.9%	86	187	**(100)**	**-53.8%**	432
	2,872	**2,488**	**384**	**15.5%**	**12,624**	**12,678**	(55)	-0.4%	**28,699**

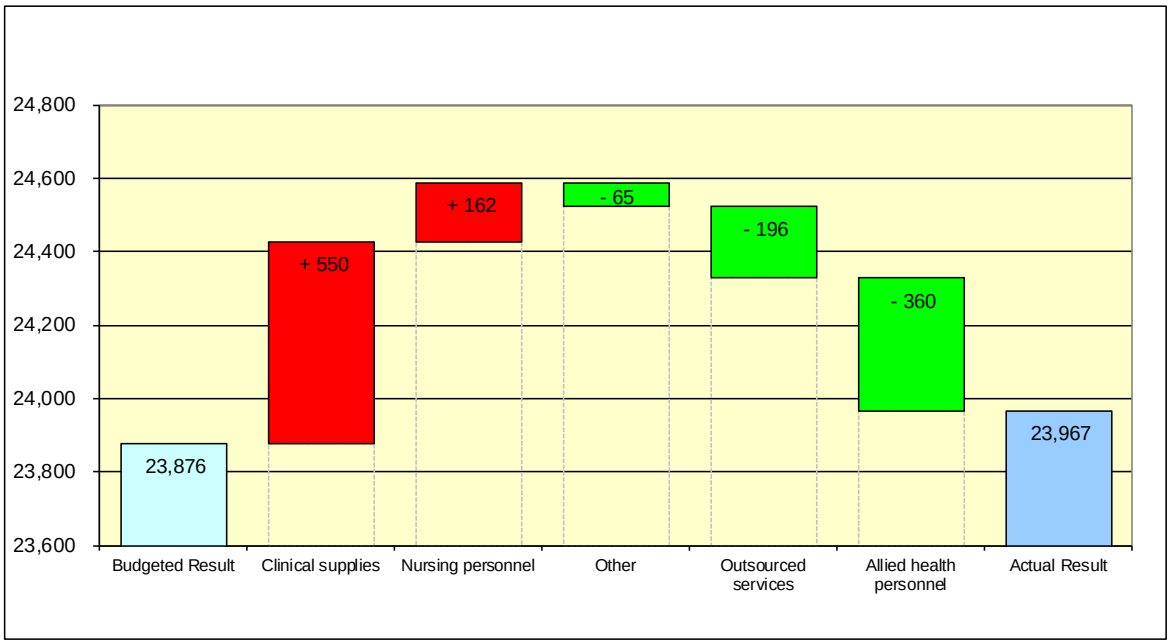
Directorates

- Medical (year-to-date) – challenges achieving planned efficiencies, nursing resource use, pharmaceutical costs (mainly biologics), medical staff vacancy cover, and radiology reads (radiologist vacancies).
- Operations (year-to-date) – vacancies in pharmacists, laboratory scientists, and technicians, more than offset by savings not yet achieved, unfavourable patient transport costs, and high blood costs.

Case Weighted Discharges

Acute discharges were significantly above plan both month and year-to-date, including general medicine, orthopaedics and general surgery. Electives are below plan in November, and remain well below plan year-to-date across all specialties. Elective surgery is expected to catch up to plan later in the year, and IDF inflow is likely to pick up over the summer.

Month of November



Note the scale does not begin at zero

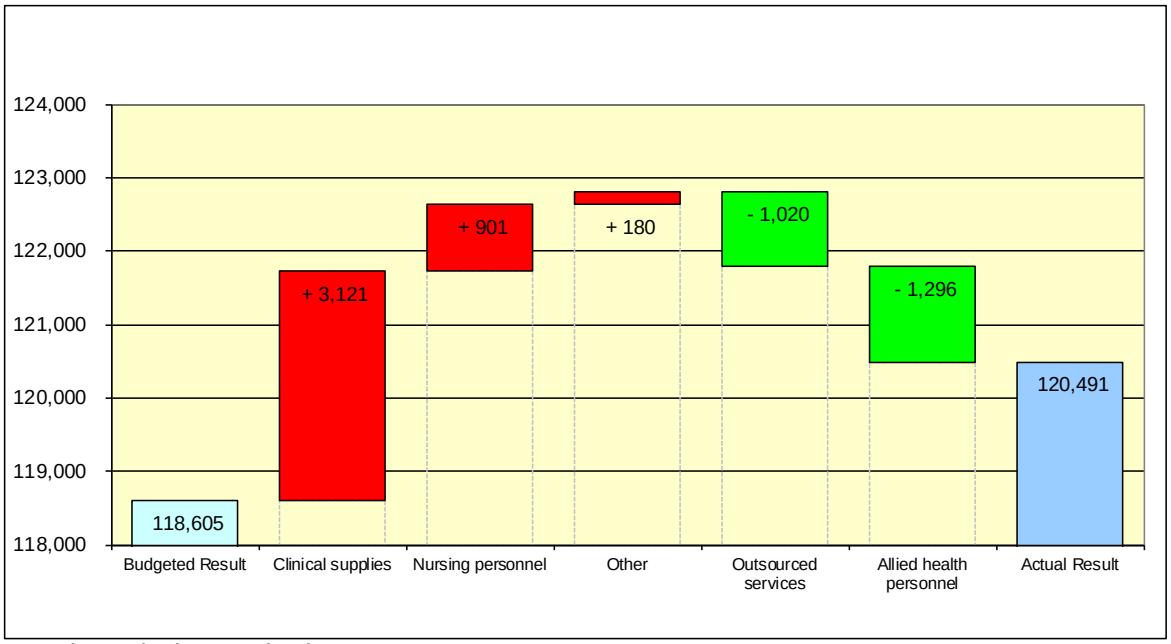
Clinical supplies (unfavourable)
Treatment disposables (mainly blood and blood intragam), difficulties achieving efficiencies phased evenly over the year, surgical implants and prostheses, cancer drugs, disposable instruments and monitoring equipment.

Nursing personnel (unfavourable)
High patient volumes in the wards.

Outsourced services (favourable)
Later than budgeted elective surgery (expected to occur from February), partly offset by after hours radiology reads caused by radiologist vacancies.

Allied health personnel (favourable)
Vacancies including MRTs, therapists, social workers, psychologists and pharmacists.

Year to Date



Note the scale does not begin at zero

Clinical supplies (unfavourable)
Challenges achieving evenly phased planned efficiencies, pharmaceuticals including biologics, treatment disposables including blood and blood intragam, and other clinical and client costs.

Nursing personnel (favourable)
Nursing costs reflect high patient volumes over the winter months.

Outsourced services (favourable)
Expected to be less favourable in future months as actions underway to manage elective surgery volumes start to impact.

Allied health personnel (favourable)
Continuing national issue with recruitment and retention.

Full Time Equivalents (FTE)

FTEs are 33 (1.5%) favourable year-to-date including:

Medical personnel (17 FTE / 4.6% favourable)

- Vacancies in radiology, Wairoa GPs, ED, psychiatrists, anaesthetists and registrars in the emergency department.

Nursing personnel (-14 FTE / -1.4% unfavourable)

- Impact of high patient volumes in the wards, Ata Rangi, ICU and ED.

Allied health personnel (28 FTE / 5.6% favourable)

- Vacancies including medical radiation technologists (MRTs), social workers, occupational therapists, psychologists, community support workers, pharmacists, health promotion workers and laboratory technicians.

MONTHLY ELECTIVE HEALTH TARGET REPORT
YTD To November 2018

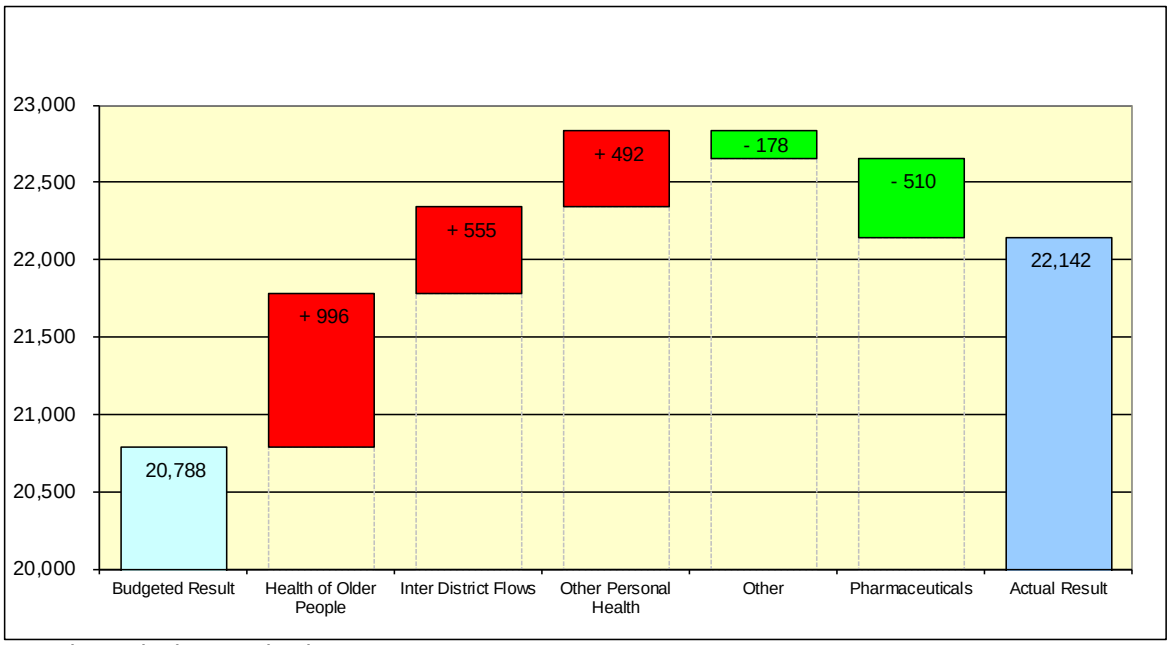
	November 2018				YTD November 2018				Full Year Plan
	Actual	Plan	Variance	%	Actual	Plan	Variance	%	
Anaesthetics	0	0	0	0.0%	**0**	**0**	**0**	**0.0%**	**4**
Cardiothoracic	2	10	-8	0.0%	**39**	**50**	**-11**	**0.0%**	**119**
Avastins	19	17	2	11.8%	**86**	**83**	**3**	**3.6%**	**201**
ENT	43	64	-21	-32.8%	**217**	**307**	**-90**	**-29.3%**	**740**
General Surgery	94	114	-20	-17.5%	**541**	**549**	**-8**	**-1.5%**	**1324**
Gynaecology	49	61	-12	-19.7%	**293**	**294**	**-1**	**-0.3%**	**708**
Maxillo-Facial	17	43	-26	-60.5%	**114**	**209**	**-95**	**-45.5%**	**507**
Neurosurgery	9	9	0	0.0%	**38**	**39**	**-1**	**0.0%**	**95**
Ophthalmology	121	115	6	5.2%	**512**	**552**	**-40**	**-7.2%**	**1328**
Orthopaedics	109	99	10	10.1%	**532**	**475**	**57**	**12.0%**	**1145**
Paediatric Surgery	5	7	-2	0.0%	**21**	**35**	**-14**	**0.0%**	**85**
Skin Lesions	23	22	1	4.5%	**76**	**105**	**-29**	**-27.6%**	**254**
Urology	38	53	-15	-28.3%	**192**	**255**	**-63**	**-24.7%**	**618**
Vascular	20	29	-9	-31.0%	**86**	**138**	**-52**	**-37.7%**	**333**
Non Surgical - Arranged	3	12	-9	-75.0%	**46**	**60**	**-14**	**-23.3%**	**144**
Non Surgical - Elective	11	13	-2	-15.4%	**56**	**62**	**-6**	**-9.7%**	**148**
TOTAL	**563**	**668**	**-105**	**-15.7%**	**2849**	**3213**	**-364**	**-11.3%**	**7753**

Please Note:This report was run on 6 December 2018
The volumes by specialty now include both Elecitve and Arranged discharges rolled into one.
Data is subject to change.

3. FUNDING OTHER PROVIDERS

$'000	November Actual	November Budget	November Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Payments to Other Providers									
Pharmaceuticals	3,097	3,607	510	14.1%	16,499	18,015	1,516	8.4%	43,284
Primary Health Organisations	3,454	3,402	(52)	-1.5%	15,733	15,528	(205)	-1.3%	36,660
Inter District Flows	5,352	4,797	(555)	-11.6%	24,916	23,985	(931)	-3.9%	57,564
Other Personal Health	2,325	1,833	(492)	-26.8%	9,764	8,591	(1,173)	-13.7%	21,580
Mental Health	876	1,058	182	17.2%	5,205	5,289	85	1.6%	12,699
Health of Older People	6,744	5,748	(996)	-17.3%	29,809	27,837	(1,972)	-7.1%	66,826
Other Funding Payments	294	342	48	14.1%	2,017	1,681	(336)	-20.0%	4,053
	22,142	20,788	(1,354)	-6.5%	**103,943**	**100,926**	(3,017)	-3.0%	242,667
Payments by Portfolio									
Strategic Services									
Secondary Care	4,974	4,233	(741)	-17.5%	22,761	21,210	(1,551)	-7.3%	50,902
Primary Care	8,235	8,338	103	1.2%	39,555	39,906	351	0.9%	96,074
Mental Health	1,204	1,526	322	21.1%	6,490	6,717	228	3.4%	16,127
Health of Older People	7,045	5,915	(1,130)	-19.1%	31,370	29,245	(2,125)	-7.3%	70,357
Other Health Funding	133	133	(0)	0.0%	667	666	(0)	0.0%	1,600
Maori Health	481	508	27	5.3%	2,456	2,541	86	3.4%	6,024
Population Health	70	134	64	47.9%	645	641	(4)	-0.6%	1,582
	22,142	20,788	(1,354)	-6.5%	**103,943**	**100,926**	(3,017)	-3.0%	242,667

Month of November



Note the scale does not begin at zero

Health of Older People (unfavourable)
Pay equity costs and In-Between-Travel partly offset in income.

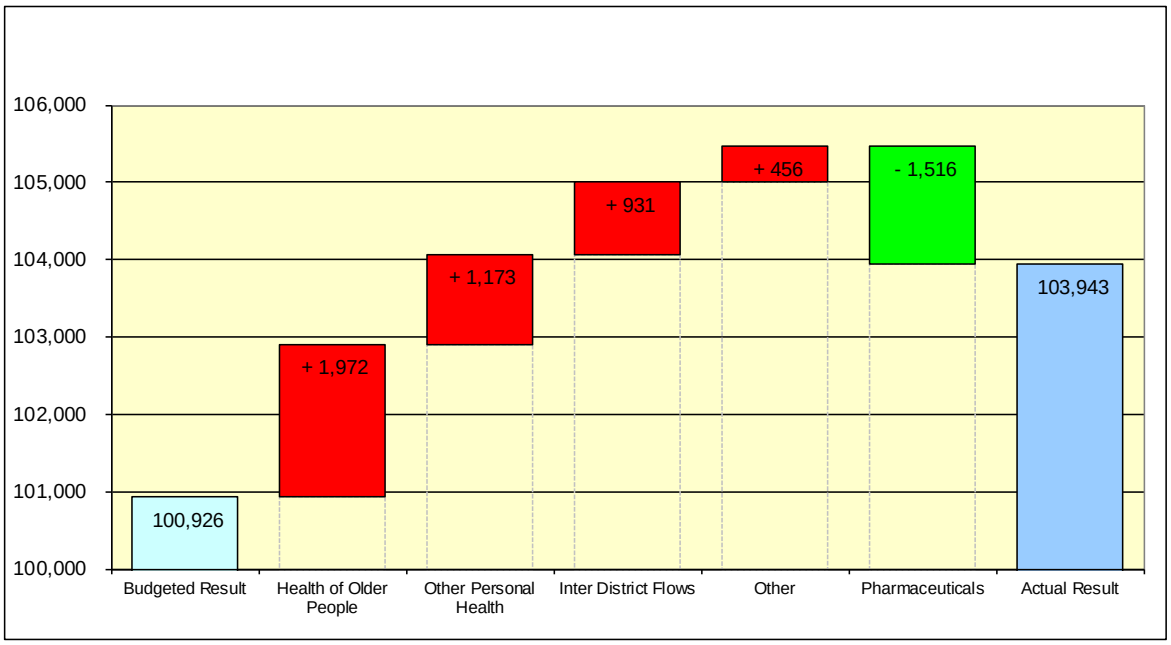
Inter District Flows (unfavourable)

Based on updated information indicating a couple of high case-weight neonatal discharges, and a high number of cardiology and plastics discharges in October.

Other Personal Health (unfavourable)
Efficiencies not yet achieved.

Pharmaceuticals (favourable)
Reduced pharmaceuticals and improvement in expected 2017/18 PHARMAC rebate.

Year to Date



Health of Older People (unfavourable)
Pay equity (residential care) and In-Between-Travel (home support) partly offset in income.

Other Personal Health (unfavourable)
Efficiencies not yet achieved.

Inter District Flows (unfavourable)
October updated discharge information, and higher volumes earlier in the year.

Pharmaceuticals (favourable)
Pharmaceutical rebates in line with PHARMAC forecasts.

4. CORPORATE SERVICES

$'000	November Actual	November Budget	November Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Operating Expenditure									
Personnel	1,519	1,520	0	0.0%	7,380	7,584	204	2.7%	17,495
Outsourced services	70	71	1	1.6%	359	361	2	0.5%	860
Clinical supplies	(2)	(20)	(19)	-92.5%	65	(136)	**(201)**	**-147.3%**	(278)
Infrastructure and non clinical	736	693	(44)	-6.3%	4,608	4,535	(73)	-1.6%	9,307
	2,324	2,263	(61)	-2.7%	12,412	12,344	(68)	-0.5%	27,384
Capital servicing									
Depreciation and amortisation	1,035	1,131	**96**	**8.5%**	5,331	5,441	109	2.0%	13,652
Capital charge	655	655	0	0.0%	3,275	3,275	(0)	0.0%	7,861
	1,690	1,786	**96**	**5.4%**	8,607	8,716	109	1.3%	21,513
	4,014	**4,050**	36	0.9%	**21,018**	**21,060**	42	0.2%	**48,896**
Full Time Equivalents									
Medical personnel	0.4	0.3	(0)	-27.8%	0	0	(0)	-8.3%	0.3
Nursing personnel	13.0	15.8	3	18.0%	14	16	2	13.6%	15.5
Allied health personnel	(0.3)	0.4	1	185.3%	0	0	0	47.1%	0.4
Support personnel	9.3	8.2	(1)	-12.8%	9	8	(1)	-15.8%	8.0
Management and administration	157.0	161.8	5	3.0%	150	160	**10**	**6.3%**	157.2
	179.3	**186.5**	7	3.9%	**174**	**185**	**11**	**6.0%**	**181.4**

The year-to-date clinical supplies variance is mainly planned efficiencies yet to be achieved.

5. RESERVES

$'000	November Actual	November Budget	November Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Expenditure									
Contingency	29	39	10	24.9%	418	418	(0)	0.0%	700
Efficiencies	(182)	-	182	0.0%	(1,209)	-	1,209	0.0%	0
Other	155	35	**(120)**	**-344.6%**	(1,322)	(73)	1,250	**1721.5%**	308
	2	**74**	**72**	**97.4%**	**(2,114)**	**345**	**2,459**	**712.1%**	**1,008**

The contingency budget reduces when EMT approves expenditure where no source of funding has been identified. Contingency can still be released for unusual or unexpected events up to the remaining balance of the contingency, currently $700k.

Transfers out of the original $4m contingency year-to-date include:

- New nursing initiatives $1m;
- Executive Director Provider Services contingency $300k; and
- Cost pressure adjustments to budgets $2m.

The accrual for unachieved savings (recognising savings are more likely to increase incrementally rather than being achieved evenly over the year), appears as a negative expense amount in the efficiency line. Similar accruals to budget have been made (CEO contingency $418k, Executive Director Provider Services contingency $125k and new investments reserve $667k) that offset the unachieved savings accrual.

The “Other” category comprises the net impact of an ongoing review of accruals relating to the prior year. If the variance remains favourable it will be a one-off benefit.

6. FINANCIAL PERFORMANCE BY MOH CLASSIFICATION

	November			*Year to Date*			*End of Year*		
$'000	*Actual*	*Annual Plan*	*Variance*	*Actual*	*Annual Plan*	*Variance*	*Forecast*	*Annual Plan*	*Variance*
Funding									
Income	46,093	45,731	362	226,789	226,319	471	542,494	542,494	-
Less:									
Payments to Internal Providers	26,392	26,392	-	132,868	132,868	-	309,784	309,784	-
Payments to Other Providers	21,516	20,166	(1,349)	100,069	97,818	(2,250)	235,205	235,205	-
Contribution	**(1,815)**	**(827)**	**(988)**	**(6,147)**	**(4,367)**	**(1,780)**	**(2,495)**	**(2,495)**	**-**
Governance and Funding Admin.									
Funding	288	288	-	1,458	1,458	-	3,424	3,424	-
Other Income	9	3	7	13	13	-	30	30	-
Less:									
Expenditure	318	294	(24)	1,333	1,504	170	3,491	3,491	-
Contribution	**(20)**	**(3)**	**(17)**	**137**	**(33)**	**170**	**(37)**	**(37)**	**-**
Health Provision									
Funding	26,104	26,104	-	131,410	131,410	-	306,361	306,361	-
Other Income	2,432	2,448	(16)	13,140	13,010	130	30,937	30,937	-
Less:									
Expenditure	28,299	28,232	(67)	141,468	141,135	(333)	339,765	339,765	-
Contribution	**237**	**320**	**(83)**	**3,081**	**3,284**	**(203)**	**(2,467)**	**(2,467)**	**-**
Net Result	**(1,598)**	**(510)**	**(1,088)**	**(2,929)**	**(1,116)**	**(1,813)**	**(5,000)**	**(5,000)**	**-**

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

7. 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, or unbudgeted new funding received during the year and the associated expenditure.

$'000	November			Year to Date			End of Year		
	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement
Funding									
Income	45,731	45,131	600	226,319	224,195	2,123	542,494	537,477	5,017
Less:									
Payments to Internal Providers	26,392	26,336	(57)	132,868	132,551	(317)	309,784	309,025	(759)
Payments to Other Providers	20,166	19,802	(364)	97,818	97,182	(636)	235,205	233,452	(1,753)
Contribution	**(827)**	**(1,006)**	**179**	**(4,367)**	**(5,537)**	**1,170**	**(2,495)**	**(5,000)**	**2,505**
Governance and Funding Admin.									
Funding	288	290	(2)	1,458	1,450	8	3,424	3,383	40
Other Income	3	3	-	13	13	-	30	30	-
Less:									
Expenditure	294	285	(9)	1,504	1,432	(71)	3,491	3,413	(77)
Contribution	**(3)**	**8**	**(11)**	**(33)**	**31**	**(64)**	**(37)**	**-**	**(37)**
Health Provision									
Funding	26,104	26,037	67	131,410	131,059	351	306,361	305,542	819
Other Income	2,448	2,429	18	13,010	12,852	158	30,937	30,594	342
Less:									
Expenditure	28,232	27,978	(254)	141,135	139,521	(1,615)	339,765	336,136	(3,629)
Contribution	**320**	**488**	**(168)**	**3,284**	**4,390**	**(1,106)**	**(2,467)**	**-**	**(2,467)**
Net Result	**(510)**	**(510)**	**(0)**	**(1,116)**	**(1,116)**	**(0)**	**(5,000)**	**(5,000)**	**(0)**

8. QUALITY AND FINANCIAL IMPROVEMENT PROGRAMME

Savings plans are transferred to operational budgets as they are agreed. Living within budget will indicate that directorates are achieving their savings targets.

The table below shows $13.2m of savings targets have been identified. Of this amount, $6.7m was removed from operational budgets at the time this report was prepared.

Savings targets have been budgeted evenly through the year at directorate level. However, the savings are more likely to grow incrementally as schemes are identified and implemented. The mismatch between budget and likely achievement obscures the underlying operational performance of the DHB, and savings are being accrued at a consolidated level to overcome this. The amount accrued year-to-date is $1.2m. This is matched by reserves and contingency.

	Target	Current Year Identification					Savings Delivered / Forecast				Recurrency	
Division	2018/19 Savings Target $'000	2018/19 Identified Saving $'000	%	2018/19 Budget Adjusted	2018/19 Savings WIP	2018/19 Un-identified Savings	YTD Actual	YTD Plan	Var	2018/19 Forecast	2019/20 Identified Saving $'000	%
Strategic	-	-	- %	-	-	-	-	-	-	-	-	- %
Primary Care	4,673	4,735	101 %	716	4,019	(62)	968	1,947	(979)	3,285	4,634	99 %
Provider Services	6,544	5,675	87 %	4,716	959	869	1,092	2,727	(1,634)	4,454	3,230	49 %
HI&E	402	435	108 %	435	-	(33)	164	168	(3)	327	184	46 %
People & Quality	105	126	120 %	124	3	(21)	42	44	(2)	101	105	100 %
Information Services	254	272	107 %	18	254	(18)	108	106	2	270	254	100 %
Financial Services	1,430	1,263	88 %	37	1,226	167	68	596	(528)	174	1,150	80 %
Executive	112	28	25 %	28	-	84	-	47	(47)	25	-	- %
Capital Servicing	632	632	100 %	632	-	-	263	263	-	632	632	100 %
Timing Adjustments	-	-	- %	-	-	-	-	(1,209)	1,209	-	-	- %
Totals	**14,152**	**13,167**	**93 %**	**6,706**	**6,461**	**985**	**2,705**	**4,688**	**(1,982)**	**9,268**	**10,189**	**72 %**

9. FINANCIAL POSITION

30 June 2018	$'000	November Actual	November Budget	Variance from budget	Movement from 30 June 2018	Annual Budget
	Equity					
164,706	Crown equity and reserves	164,706	175,069	(10,363)	-	174,711
(15,982)	Accumulated deficit	(18,911)	(12,089)	(6,822)	(2,929)	(15,973)
148,723		145,795	162,979	(17,185)	(2,929)	158,738
	Represented by:					
	Current Assets					
7,444	Bank	820	9,283	(8,463)	(6,624)	2,313
1,885	Bank deposits > 90 days	1,895	1,901	(6)	10	1,901
25,474	Prepayments and receivables	31,833	24,792	7,041	6,359	25,045
3,907	Inventory	3,890	4,472	(582)	(18)	4,520
2,293	Investment in NZHP	2,638	-	2,638	345	-
-	Non current assets held for sale	-	625	(625)	-	625
41,003		41,075	41,074	2	72	34,404
	Non Current Assets					
175,460	Property, plant and equipment	177,871	181,230	(3,359)	2,411	185,018
1,479	Intangible assets	1,445	3,215	(1,770)	(35)	4,147
9,280	Investments	9,709	11,684	(1,975)	428	11,798
186,220		189,024	196,129	(7,104)	2,805	200,963
227,223	**Total Assets**	**230,100**	**237,202**	**(7,102)**	**2,877**	**235,368**
	Liabilities					
	Current Liabilities					
-	Bank overdraft	8,519	-	(8,519)	(8,519)	-
35,817	Payables	35,344	35,684	340	473	36,249
40,064	Employee entitlements	37,823	35,827	(1,996)	2,241	37,579
75,881		81,686	71,511	(10,175)	(5,805)	73,828
	Non Current Liabilities					
2,619	Employee entitlements	2,619	2,712	93	-	2,802
2,619		2,619	2,712	93	-	2,802
78,500	**Total Liabilities**	**84,305**	**74,223**	**(10,082)**	**(5,805)**	**76,629**
148,723	**Net Assets**	**145,795**	**162,979**	**(17,185)**	**(2,929)**	**158,738**

Crown equity and reserves includes changes in the 2017/18 result subsequent to the preparation of the 2018/19 budget. It also includes the $4m reduction to the 30 June 2018 revaluation reserve due to the seismic upgrades of the theatre block. Bank and bank deposits > 90 days reflects special funds and clinical trials, and the bank overdraft reflects the operating cash position at the end of the month. Prepayments and receivables include monies owing from Mid Cental Health for oncology services, and from Health Workforce NZ for RMO training. The investment in New Zealand Health Partnerships (NZHP) relates to a classification change separating the investment from property, plant and equipment.

10. EMPLOYEE ENTITLEMENTS

30 June 2018	$'000	November Actual	November Budget	Variance from budget	Movement from 30 June 2018	Annual Budget
10,004	Salaries & wages accrued	7,900	7,756	(144)	2,104	7,756
1,157	ACC levy provisions	1,417	561	(856)	(260)	532
5,945	Continuing medical education	4,412	4,807	395	1,532	6,456
21,348	Accrued leave	22,247	21,096	(1,151)	(899)	21,199
4,230	Long service leave & retirement grat.	4,467	4,319	(148)	(237)	4,438
42,683	**Total Employee Entitlements**	40,442	38,539	(1,904)	2,241	40,380

Accrued leave reflects the busy winter that reduced the opportunities for staff to take leave. Leave balances are expected to decline over the summer months and as management activities to reduce leave balances take effect.

11. TREASURY

Liquidity Management

The surplus cash of all DHBs is managed by NZHP under a sweep arrangement facilitated by BNZ. The DHB provides forecast cash flow information to NZHP to allow it 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.

The cash low point for each month is generally incurred immediately prior to receipt of MOH funding on the 4th of the month. However, November's low point was a $10.8m overdraft incurred on 30 November, and next month's low point is likely to be the $12.0m overdraft incurred on 3 December. The forecast low for the end of the financial year is $13.6m overdraft, which is within our statutory limit of $27m.

Debt Management

The DHB 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.

12. CAPITAL EXPENDITURE

Capital spend for the month is under budget, mainly in the block allocations to facilities, information services and clinical plant and equipment. The budget approved by the Board in June assumed even phasing across the year, whereas expenditure is likely to be more randomly spread reflecting immediate needs and procurement lead times.

See table on the next page.

2019 Updated Plan (Sep 18)		*Actual $'000*	*Year to Date Budget $'000*	*Variance $'000*
	Source of Funds			
	Operating Sources			
13,652	Depreciation	5,331	5,441	109
(5,000)	Surplus/(Deficit)	(2,929)	(1,116)	1,813
11,688	Working Capital	6,200	5,119	(1,082)
20,340		8,603	9,443	840
	Other Sources			
-	Special Funds and Clinical Trials	6	-	(6)
-	Funded Programmes	4	-	(4)
-		10	-	(10)
20,340	**Total funds sourced**	**8,613**	**9,443**	**831**
	Application of Funds:			
	Block Allocations			
3,430	Facilities	715	1,531	816
3,400	Information Services	810	1,426	616
3,225	Clinical Plant & Equipment	386	1,242	856
10,055		1,910	4,198	2,288
	Local Strategic			
100	Replacement Generators	-	-	-
26	Renal Centralised Development	24	13	(11)
2,872	Endoscopy Building	2,880	2,678	(202)
350	Travel Plan	100	146	46
1,180	Histology and Education Centre Upgrade	1,249	1,151	(98)
150	Radiology Extension	-	-	-
50	Fit out Corporate Building	-	-	-
500	High Voltage Electrical Supply	-	100	100
700	Seismic Upgrades	-	-	-
1,950	Surgical Expansion	1,443	1,157	(286)
7,878		5,696	5,245	(451)
	Other			
-	Special Funds and Clinical Trials	6	-	(6)
-	Funded Programmes	4	-	(4)
-	Other	154	-	(154)
-		164	-	(164)
17,933	***Capital Spend***	***7,770***	***9,443***	***1,673***
	Regional Strategic			
1,945	RHIP (formerly CRISP)	497	-	(497)
1,945		497	-	(497)
	National Strategic			
462	NOS (Class B shares in NZHPL)	345	-	(345)
462		345	-	(345)
20,340	**Total funds applied**	**8,613**	**9,443**	**831**

13. ROLLING CASH FLOW

	Actual	November Forecast	Variance	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast	Jul Forecast	Aug Forecast	Sep Forecast	Oct Forecast	Nov Forecast
Cash flows from operating activities															
Cash receipts from Crown agencies	45,021	47,042	(2,022)	46,768	46,885	46,632	46,886	46,963	46,631	46,984	46,875	46,174	53,627	46,947	47,270
Cash receipts from revenue banking	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from donations, bequests and clinical trials	56	-	56	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	(98)	5,138	(5,237)	5,889	492	498	492	492	498	492	495	501	502	529	495
Cash paid to suppliers	(29,547)	(27,688)	(1,858)	(27,012)	(26,555)	(24,937)	(27,952)	(27,996)	(26,297)	(28,615)	(28,715)	(26,504)	(28,613)	(27,131)	(28,218)
Cash paid to employees	(17,615)	(17,689)	74	(16,821)	(22,445)	(17,527)	(17,158)	(17,699)	(20,642)	(17,544)	(16,802)	(22,611)	(17,546)	(20,516)	(17,374)
Cash generated from operations	**(2,184)**	**6,803**	**(8,987)**	**8,824**	**(1,623)**	**4,667**	**2,269**	**1,760**	**190**	**1,318**	**1,853**	**(2,440)**	**7,969**	**(172)**	**2,173**
Interest received	48	25	23	20	15	10	5	0	0	0	(0)	(0)	0	0	0
Interest paid	-	-	-	-	-	-	-	-	5	10	15	20	25	30	35
Capital charge paid	(655)	(0)	(655)	(4,460)	(0)	(0)	(0)	(0)	(0)	(4,670)	(0)	(0)	0	(0)	(0)
Net cash inflow/(outflow) from operating activities	**(2,791)**	**6,828**	**(9,619)**	**4,384**	**(1,608)**	**4,677**	**2,274**	**1,760**	**196**	**(3,342)**	**1,867**	**(2,420)**	**7,994**	**(141)**	**2,208**
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	(1)	0	(1)	0	(0)	-	-	0	0	0	0	-	-	(0)	0
Acquisition of property, plant and equipment	(1,315)	(409)	(905)	(862)	(1,748)	(1,339)	(1,576)	(902)	(1,348)	(1,289)	(1,732)	(1,732)	(1,732)	(1,732)	(1,732)
Acquisition of intangible assets	(85)	(231)	146	(172)	(142)	(252)	(273)	(175)	(240)	(129)	(115)	(115)	(115)	(115)	(115)
Acquisition of investments	324	-	324	-	(129)	-	-	-	-	-	-	-	-	-	-
Net cash inflow/(outflow) from investing activities	**(1,077)**	**(640)**	**(436)**	**(1,034)**	**(2,020)**	**(1,591)**	**(1,849)**	**(1,077)**	**(1,588)**	**(1,418)**	**(1,847)**	**(1,847)**	**(1,847)**	**(1,847)**	**(1,847)**
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	(3,867)	6,188	(10,055)	3,349	(3,628)	3,086	424	683	(1,393)	(5,117)	20	(4,268)	6,147	(1,989)	361
Add:Opening cash	(4,238)	(4,238)	-	(8,105)	(4,756)	(8,383)	(5,298)	(4,873)	(4,191)	(5,583)	(10,701)	(10,681)	(14,948)	(8,802)	(10,790)
Cash and cash equivalents at end of period	**(8,105)**	**1,950**	**(10,055)**	**(4,756)**	**(8,383)**	**(5,298)**	**(4,873)**	**(4,191)**	**(5,583)**	**(10,701)**	**(10,681)**	**(14,948)**	**(8,802)**	**(10,790)**	**(10,430)**
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)	(10,820)	(932)	(9,888)	(7,637)	(11,265)	(8,180)	(7,755)	(7,073)	(8,465)	(13,583)	(13,563)	(17,830)	(11,683)	(13,672)	(13,311)
Short term investments (special funds/clinical trials)	2,710	2,877	(167)	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877
Bank overdraft	(0)	-	(0)	-	-	-	-	-	-	-	-	-	-	-	-
	(8,105)	**1,949**	**(10,055)**	**(4,756)**	**(8,384)**	**(5,298)**	**(4,873)**	**(4,191)**	**(5,583)**	**(10,701)**	**(10,681)**	**(14,948)**	**(8,801)**	**(10,790)**	**(10,429)**

Cash flow was impacted by the delay in collection of cancer clinic revenue from Mid Central Health, medical training reimbursements from Health Workforce NZ, now expected in December and the payment of the funding arising from the NZNO MECA settlement. Some stocking up of clinical supplies for the Christmas break also occurred but will reverse in January/February. The likelihood that the full capital budget will be spent by year end has pushed up the overdraft in June 2018. The forecast assumes achievement of the forecast result.

BOARD HEALTH & SAFETY CHAMPION'S UPDATE

Verbal

OURHEALTH HAWKE'S BAY Whakawateatia	**Te Pītau Governance Group (Formerly Primary Care Development Partnership Governance Group)**
	For the attention of: **HBDHB and Health Hawke's Bay Ltd Boards**
Document Owner:	Bayden Barber, Chair
Author:	Ken Foote, HBDHB Company Secretary
Month:	December, 2018
Consideration:	For Information

RECOMMENDATION

That the Boards:

1. **Note** the contents of this report
2. **Note** the name changes to 'TE PĪTAU Health Alliance (Hawkes Bay)' throughout the previously approved 'Primary Care Development Partnership' Agreement.

The Primary Care Development Partnership (PCDP) Governance Group met on Wednesday 12 December 2018.

NAME CHANGE

Following the previous meeting on 15 November 2018, the Chair had followed up initial discussions with HBDHB Kaumatua. The name suggested was Te Pītau, given its relevance to the kaupapa. Te Pītau is the figurehead of a waka taua (war canoe). The full term is Pītau Whakareia in which the head is forward and the arms are back (whakarei) indicating that the head/mind and thoughts are open as is the heart to the kaupapa at hand (open communications, relationships, transparency, etc). The arms back indicates that the kaupapa (primary care and wellness) is being carried forward with the Pītau at the head, breaking through the rough seas as it journeys forward.

Another relevant meaning for Pītau is the new young shoots of the harakeke plant (flax), wherein new life is given leading to growth and prosperity.

This new name had been circulated to all Governance Group members and had received unanimous support.

Following discussion, it was agreed that:

- The new full name would be 'TE PĪTAU Health Alliance (Hawkes Bay)'
- The alliance shall be known as 'Te Pītau'
- HBDHB Company Secretary will amend the PCDP Agreement (which had been approved by both the HBDHB and Health Hawke's Bay Boards) to reflect these new names
- The renamed Agreement be presented for signing on 19 December 2018
- A new brand will be developed to reflect the new name.

MENTAL HEALTH AND ADDICTIONS – INFORMING THE FUTURE

The Governance Group were presented with a paper that had been developed in preparation for the re-procurement of community-based Mental Health & Addictions (MH&A) services. This was very much a preliminary paper that brought together recent analysis of relevant information, analysis of current resource allocation in the context of some national, regional and local reviews and other research, and some preliminary findings.

Those leading the re-design were seeking initial feedback and input on both the issues raised in the paper and on the commissioning framework to be developed for the re-design.

Comments from the Governance Group included:

- Input will be required from all other health related governance groups, boards and councils
- 'Real' consumer/community engagement will be required
- Cultural advice will be essential
- Behavioural issues will need to be scoped
- Relationship building skills will be required
- Care will need to be taken with language/terminology 'to get it right'
- Needs a holistic approach
- Needs to consider the whole-of-patient journey
- Requires community and whānau integration.

The ring fencing of Mental Health services funding was explained and noted, as was the requirement for the programme of work to line up with the whole of the MH&A services model (including the Inpatient unit). Also noted was the issue of how non-specialist services adjust to the model of care.

Further information will be provided and discussions held as the re-design process gets under way.

MAURI COMPASS

Hine Flood briefly explained the Mauri Compass process used by the Wairoa Community Partnership Group to ensure that all activity/proposals for change add value and worth to the purpose that all whānau in Wairoa are thriving. Components of the process ensure that the whānau voices/stories are highlighted, outcome goals are set and performance measured, and projects are prioritised and good process is followed.

The Governance Group noted that this process could be much more widely used to assist the process of change envisaged for primary care in the Clinical Services Plan.

TE PĪTAU Health Alliance (Hawke's Bay) AGREEMENT

BETWEEN

HAWKE'S BAY DISTRICT HEALTH BOARD

AND

HEALTH HAWKE'S BAY LIMITED – TE ORANGA HAWKE'S BAY

DECEMBER 2018

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Our vision

HEALTHY
HAWKE'S BAY

TE HAUORA O
TE MATAU-Ā-MĀUI

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

Our values

Tauwhiro – delivering high quality care to patients and consumers

Rāranga te tira – working together in partnership across the community

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

Ākina – continuously improving everything we do

TE PĪTAU HEALTH ALLIANCE (HAWKE'S BAY) AGREEMENT

DATE: 19 DECEMBER 2018

1 THE PARTIES (each a **Party**) are:

Hawke's Bay District Health Board (DHB)

Health Hawke's Bay Limited – Te Oranga Hawke's Bay (PHO)

2 KEY INFORMATION

1. **Commencement Date: 1 July 2018**

2. **Te Pītau Governance Group Members**:

Core members will be:

- Three Directors of Health Hawke's Bay Ltd
  - Bayden Barber - Chair
  - Jeremy Harker
  - Jason Ward
- Three Members of Hawke's Bay District Health Board
  - Ana Apatu
  - Hine Flood
  - Helen Francis - Deputy Chair
- HBDHB Maori Relationship Board NKII representative
  - Beverly Te Huia
- Hawke's Bay Clinical Council representative
  - David Rodgers
- Hawke's Bay Health Consumer Council representative
  - Rachel Ritchie

As the Scope of our alliance activities expands to cover them, representatives from other parts of the Hawke's Bay health sector may be added, eg:

- Community Pharmacy
- Aged Care
- NGOs

3 OUR AGREEMENT

In consideration of the mutual promises given and received by each of us in this Agreement, we agree that we will be bound by and perform this alliance Agreement.

We agree that our alliance shall be known as 'Te Pītau'

Our Agreement comprises the following parts:

Part A: Our Commitment - is a statement of our background, our commitment to a whole-of-system decision making process, our purpose, principles and commitment to success. We agree that the remainder of this Agreement will be interpreted in accordance with the statements made in Part A.

Part B: How We Will Succeed – is a statement of how we will work together, in particular, to achieve success by completing our alliance activities and meeting and exceeding our objectives.

Part C: How We Will Work Together - details the processes that we have agreed to apply to how we will work together.

Part D: Term of Te Pītau - details how long we expect to work together for and, if or when necessary, how we will wind up our alliance.

Schedule 1 – includes the scope and annual activities of Te Pītau

PART A: OUR COMMITMENT

Part A of this Agreement is a statement of our background, our commitment to a whole-of-system decision making process, our purpose, principles, values and commitment to success.

1. Scope of Te Pītau

1.1 **Who We Are**: We, the Parties to Te Pītau, are the DHB and PHO for the Hawke's Bay district.

1.2 **Our Leaders**: We are led by our Te Pītau Governance Group, made up of those governance, management and clinical leaders and other key stakeholders, who can successfully lead Te Pītau to complete our alliance activities and achieve our objectives.

1.3 **Our Purpose**: We have formed Te Pītau to improve health outcomes for our populations, through:

1.3.1 transforming, developing, evolving and integrating primary and community healthcare services, consistent with commitments made within the 2018 Clinical Services Plan, i.e.:

- **achieve equity with a particular focus on those with unmet needs**
- **create a culture that is person and whanau centred**
- **co-design and prioritise services to meet the needs of populations with the poorest health and social outcomes**
- **make health easy to understand**

1.3.2 eliminating inequities in primary care access and health care delivery

1.3.3 making (and assisting the DHB to make) strategic health care decisions on a "whole-of-system" basis;

1.3.4 providing direction and building relationships within our primary and community health system;

1.3.5 assessing the primary and community health care needs of our populations;

1.3.6 planning health care delivery in our District that is amenable to primary and community settings, to make the best use of health resources;

1.3.7 balancing a focus on the highest priority needs areas in our communities, while ensuring appropriate care across all our populations;

1.3.8 determining models to be commissioned from delegated funding pools

1.3.9 establishing Service Level Alliances to advise on the development, delivery and monitoring of primary and community health services within the scope of our alliance;

1.3.10 monitoring the effectiveness and health outcomes of groups of services that fall within the scope of our alliance; and

1.3.11 informing our populations and other stakeholders of our performance in achieving our objectives.

1.4 **Te Pītau Activities**:

1.4.1 Our alliance activities are defined in the scope of Te Pītau. It is anticipated that this scope will be initially restricted to specific service areas, but will expand over time. Te Pītau, in carrying out its activities, may not be involved in all healthcare services in our District.

1.4.2 The scope and activities of Te Pītau (including objectives) are set out in Schedule 1.

1.5 **Our Conduct**: We will conduct our activities and achieve our objectives, by acting consistently with our Te Pītau Principles.

1.6 **What We Are Not**:

1.6.1 Te Pītau does not directly provide healthcare services although we will make decisions and recommendations on what services should be funded by the Parties.

1.6.2 Te Pītau does not have any authority over, nor responsibility for, any services provided directly by any employees of the Parties.

1.6.3 We work collaboratively but are not collectively established as a legal entity.

2. Overview of Decision Making

2.1 **Allocation of Decision Making**: At the core of this Agreement is a decision-making process that makes clear which decisions remain with the DHB, the PHO and the Government, and which decisions are devolved to us, the Parties.

2.2 **Clinician Input into Decision Making**: We recognise that clinical input is essential in all levels of decision making. At the alliance level, this will be achieved by ensuring all major Te Pītau activity decisions will involve input and support from the Hawke's Bay Clinical Council. At all other levels, this input will be provided through proactive involvement of appropriate clinicians.

2.3 **Māori Contribution to Decision Making**: We acknowledge our responsibilities under Te Tiriti o Waitangi and our desire to work with local Māori to enable them to contribute to Te Pītau decision making. Given the Memorandum of Understanding between HBDHB and Ngati Kahungunu Iwi Incorporated, this will be achieved through active engagement with HBDHB Māori Relationship Board (MRB) on all major Te Pītau decisions. At all other levels, we will ensure that a Māori perspective is present and/or represented in all decision making processes.

2.4 **Consumer Input into Decision Making**: We recognise that consumer input is essential in all levels of decision making. At the alliance level, this will be achieved by ensuring all major Te Pītau activity decisions will involve input and support from the Hawke's Bay Health Consumer Council. Consumer representatives will be involved in all co-design and decision making processes at all other levels.

2.5 **Other Input into Decision Making:** Where appropriate, we will work together with a wide range of different cultures, disadvantaged groups and communities to design the health services they need and engage them in our decision making processes.

2.6 **Decisions Made by Government**: The balancing side of the decision-making process is that it remains the role of the Government to determine the gross allocation of public funding, so as to achieve the best balance of outcomes for the population. Wherever possible this will involve discussion with clinicians, providers and/or the community through Te Pītau but we recognise that in some cases these decisions may be taken centrally.

2.7 **Decisions Made by the DHB**: We recognise that the DHB has two roles:

2.7.1 as a Party within Te Pītau, and

2.7.2 as the Government's agent, as the funder of health services in the District.

2.8 Te Pītau is intended, in part, to assist the DHB to fulfil its statutory objectives and functions as a funder of health services. The DHB will work within Te Pītau to fulfil those obligations where it is appropriate and practicable to do so.

2.9 However, we acknowledge that the DHB's statutory and other obligations will require it to make some decisions, which may affect Te Pītau, outside of this Agreement. Without limiting its ability to make those decisions, the DHB undertakes to make those decisions, insofar as is reasonably practicable, in good faith and having regard to Te Pītau's Principles. We agree that nothing in this Agreement limits the DHB's rights, powers, obligations or liabilities under any Law or other agreement.

2.10 **Decisions Made by the PHO**: Equally, we recognise that the PHO is subject to its own governance obligations. We also agree that nothing in this Agreement limits the PHO's rights or obligations, necessary to comply with its governance obligations under any Law or other agreement.

3. Te Pītau Principles

3.1 We will conduct ourselves and undertake our alliance activities in a manner consistent with the Hawke's Bay Health Sector Vision and Values, and our Te Pītau Principles and will take all reasonable steps to ensure that our employees, contractors and agents do likewise.

3.2 We agree that every part of this Agreement must be read in such a way as to be consistent with, and ensure the integrity of, our commitments to Te Pītau Principles.

3.3 **Te Pītau Principles**: Te Pītau is founded on the following principles:

3.3.1 we will adopt a person and whanau centred, integrated, whole-of-system approach, and make decisions on a 'Best for System' basis;

3.3.2 we will seek to make the best use of finite resources in planning and delivering health services to achieve improved health outcomes and equity for our populations;

3.3.3 we will apply the principles of Te Tiriti o Waitangi and incorporate kaupapa Māori practice and whanau ora approaches within our alliance activities;

3.3.4 we will conduct ourselves with honesty and integrity, and develop a high degree of trust;

3.3.5 we will support clinical leadership and, in particular, clinically informed service development;

3.3.6 we will promote an environment of high quality, performance and accountability, and low bureaucracy;

3.3.7 we will strive to resolve disagreements co-operatively and, wherever possible, achieve consensus;

3.3.8 we will adopt and foster an open and transparent approach to sharing information, subject only to statutory privacy principles;

3.3.9 we will monitor and report on our achievements, including public reporting;

3.3.10 we will be collectively responsible for all decisions and outcomes;

3.3.11 we will operate as a unified team providing mutual support, appreciation and encouragement;

3.3.12 we will conduct ourselves in accordance with best practice;

3.3.13 we will support professional behaviour and leadership;

3.3.14 we will remain flexible and responsive to support an evolving health environment;

3.3.15 we will develop, encourage and reward innovation and challenge our status quo;

3.3.16 we will actively support and build on our successes; and

3.3.17 we commit to fully exploring the collective sharing and management of the risks and benefits arising from our alliance activities. Where we cannot manage risk collectively, our principle is to allocate responsibility for each risk to those of us who can best manage it.

3.3.18 we will each accept our own costs of all participation in Te Pītau activities, and we agree that any third party costs directly incurred by Te Pītau, shall be shared equally.

PART B: HOW WE WILL SUCCEED

Part B of this Agreement is a statement of how we will work together, in particular, to achieve success by completing our alliance activities and meeting and exceeding our objectives.

4. Commitments

4.1 **Shared Decision Making**:

4.1.1 Each of us is fully committed to Te Pītau and carrying out our alliance activities to achieve our objectives. We acknowledge that this commitment is fundamental to Te Pītau's success.

4.1.2 We will work as one team, in a transparent, innovative and collaborative manner, to produce outstanding results.

4.2 **Shared Responsibility**:

4.2.1 We both take responsibility for Te Pītau's success and our failures.

4.2.2 We both take responsibility for achieving consensus decisions within Te Pītau.

4.2.3 We both take responsibility for addressing all potential disputes within Te Pītau.

4.2.4 We will establish and maintain an environment within Te Pītau that encourages open, honest and timely sharing of information.

4.3 **Shared Accountability**: We are both responsible collectively for identifying, managing and mitigating all risks associated with our alliance activities.

4.4 **Commitment to Good Faith**: We will, at all times:

4.4.1 act in good faith and be fair, honest and ethical in our dealings with each other;

4.4.2 make all decisions on a Best for System basis and when making such decisions, will give predominate weight to the interests of Te Pītau over our own self-interest;

4.4.3 do everything that is reasonably necessary to enable each of us to undertake our alliance activities and perform our obligations under this Agreement;

4.4.4 not act in a manner that impedes or restricts each other's performance of our alliance activities and the performance of our obligations under this Agreement; and

4.4.5 do all things that are, or may reasonably be, expected of us so as to give effect to the spirit and intent of this Agreement and Te Pītau.

4.5 **Commitment to Consultation**: We recognise that both of us may, in the course of undertaking our alliance activities and otherwise meeting our commitments under this Agreement, be required to consult with others who do not form part of Te Pītau. We will provide a reasonable opportunity to do so in a prudent and timely manner.

5. Service Level Alliances & Working Groups

5.1 **Service Development**: Where Te Pītau identifies a service within its scope that requires transformational change, we may establish a Service Level Alliance (SLA) to:

5.1.1 Collaboratively co-design and recommend how the service should be delivered within the scope of Te Pītau;

5.1.2 Monitor and report on the performance of a service within the scope of Te Pītau.

5.2 **Working Groups**: Clause 5.1 does not limit Te Pītau's ability to establish any other Working Groups that it considers necessary to advise it on any aspect of our alliance activities.

5.3 **Scope and Conditions**: A SLA or other Working Group will operate according to any directions, conditions or restrictions established by us. This will include the lines of accountability to the appropriate body within Te Pītau structures, and may include a direction to work collaboratively with others.

6. Services Planning

6.1 We will work together to decide how Te Pītau will carry out service planning for those services within its scope, which may include delegating decision making authority to our Te Pītau Governance Group.

6.2 Our Te Pītau Governance Group may, as a result of service model decisions or recommendations made, recommend to the DHB and/or PHO the method and form of contracting for the delivery of the service on a Best Practice basis.

6.3 The DHB and/or PHO will implement our Te Pītau Governance Group's decisions and recommendations, subject only to the provisions of clauses 2.9 and 2.10 respectively

6.4 In implementing our Te Pītau Governance Group's decisions or recommendation, the DHB and/or PHO (as appropriate) may:

6.4.1 undertake a procurement process based on the specification for the activity, work or service recommended by Te Pītau;

6.4.2 enter into agreements/contracts with relevant providers, which may include Parties and/or others; and/or

6.4.3 select from the Parties and other service providers those capable of providing the activity, work or service in accordance with the specification for the activity, work or service recommended by Te Pītau.

PART C: HOW WE WILL WORK TOGETHER

Part C of this Agreement details the structures and processes that apply to how we will work together.

7. Leadership Structure

7.1 **General Structure**:

7.1.1 Te Pītau will be directed and lead by our Te Pītau Governance Group.

7.1.2 The day-to-day affairs of Te Pītau will be co-ordinated by our Te Pītau Support Team (made up of relevant members of the management and clinical leadership teams of the DHB and PHO) and supported by the Clinical and Consumer Councils, and the MRB.

7.1.3 Our Te Pītau Support Team will be led by the HBDHB Executive Director Primary Care

7.2 **Service Developments**: Our SLAs will be led and directed by a Service Level Alliance Leadership Team, acting within a scope of authority, agreed by the Parties.

8. Te Pītau Governance Group Terms of Reference

8.1 **Te Pītau Governance Group**: We agree that we will have a Te Pītau Governance Group whose primary function will be to lead us with respect to our alliance activities and Te Pītau, in accordance with this Agreement.

8.2 **Duties of our Te Pītau Governance Group**: The duties of our Te Pītau Governance Group include:

8.2.1 promoting and supporting the vision, values and direction of Te Pītau;

8.2.2 facilitating development and implementation of commitments and service changes set out in the 2018 Clinical Services Plan, as they apply to primary and community care

8.2.3 role modelling Te Pītau Principles and setting challenging objectives;

8.2.4 facilitating, empowering and enabling the achievement of Te Pītau objectives/outcomes;

8.2.5 maintaining a coherent set of policies and procedures as necessary to undertake its duties;

8.2.6 agreeing with the DHB and PHO, in accordance with clause 6:

(a) our alliance activities and objectives, including the systems and key performance indicators for assessing achievement of these;

(b) the work, activity and services to be provided to meet our Te Pītau objectives;

8.2.7 establishing and/or supporting Service Level Alliances and other Working Groups as necessary to oversee the development and delivery of services that fall within the scope of Te Pītau;

8.2.8 providing high level support and stakeholder interface;

8.2.9 monitoring and encouraging inter-Party relationships and stakeholder engagement;

8.2.10 agreeing and adopting transparent governance and accountability structures for Te Pītau; and

8.2.11 mentoring and championing Te Pītau and its Parties as reasonably required.

8.2.12 approving the allocation of delegated/devolved funding pools

8.2.13 approving system and district level measures and related allocation of incentives, in conjunction with the Clinical Council.

8.3 **Membership of Te Pītau Governance Group**:

8.3.1 At the date of this Agreement the appointed core members of our Te Pītau Governance Group are set out in the Key Information on page 5 of our Agreement.

8.3.2 Alternates for appointed core members from the Māori Relationship Board, Clinical Council and Health Consumer Council shall also be appointed

8.3.3 Membership of our Te Pītau Governance Group shall be reviewed annually by an Appointments Panel made up of the Chair's and CEO's of the DHB and PHO, who shall consider the level of interest in membership, the benefits of some rotation balanced with retaining some experience, and the need to maintain a good mix of perspectives, skills and experience.

8.3.4 The Appointments Panel shall make recommendations to the DHB and PHO Boards.

8.3.5 The appointment of all core members (and alternates) requires the formal approval of both the DHB and PHO Boards.

8.3.6 Our Te Pītau Governance Group may, by agreement, add representatives from other parts of the Hawke's Bay health sector as members at any time, and may remove such members as necessary.

8.4 **Involvement**:

8.4.1 We agree that the members' regular involvement in and attendance at our Te Pītau Governance Group meetings is critical to Te Pītau's success.

8.4.2 Should any core member from either the DHB or PHO be unable to attend a Te Pītau Governance Group meeting, they may nominate another member to act by proxy in relation to any decision to be made by the Governance Group.

8.4.3 Should any core member from the Māori Relationship Board, Clinical Council or Health Consumer Council be unable to attend a Te Pītau Governance Group meeting, they may request that their appointed alternate attend in their place.

8.5 **Chair:** The Chair of our Te Pītau Governance Group shall be the Chair of the PHO.

8.6 **Deputy Chair:** The DHB shall appoint one of the three DHB Board members to be the Deputy Chair

8.7 **Decision Making**: When making a decision, determination or resolution, our Te Pītau Governance Group (together and individually) must:

8.7.1 have regard to its duties, specified at clause 8.2 of this Agreement;

8.7.2 have regard to the intent of Agreement;

8.7.3 consider the matter before them in good faith and use their best endeavours to facilitate a consensus decision;

8.7.4 not prevent a consensus decision being made for trivial or frivolous reasons;

8.7.5 use all relevant information in a timely fashion;

8.7.6 actively seek and facilitate a consensus decision, determination or resolution; and

8.7.7 where consensus cannot be reached, any decision, determination or resolution will require the support of at least 75% of those present and/or otherwise able to vote on the issue.

8.8 **Reporting**: Our Te Pītau Governance Group will provide a report to the Parties following each Te Pītau Governance Group meeting, and an Annual Report about its performance.

8.9 **Implementing Decisions**: We will implement all decisions and directions of our Te Pītau Governance Group concerning our alliance and this Agreement.

9. Service Level Alliance (SLA) Leadership Team

9.1 **SLA Leadership Team**: We agree that our Te Pītau Support Team may appoint a leadership team (SLA **Leadership Team**), whose primary function will be to direct and lead a SLA and provide guidance and leadership to us with respect to those of our alliance activities that are within the scope of that SLA

9.2 **Duties of a** SLA **Leadership Team**: The duties of a SLA Leadership Team may include:

9.2.1 providing a vision, strategic leadership and direction;

9.2.2 providing operational/project leadership and relationship management;

9.2.3 recommending the model via which services should be delivered in the District; and

9.2.4 monitoring and reporting on the performance of the service against its agreed outcomes;

9.3 **Consensus Decision-Making**: When making a decision, determination or resolution, a SLA Leadership Team (together and individually) must:

9.3.1 actively seek and facilitate a consensus decision, determination or resolution; and

9.3.2 where consensus cannot be reached, any decision, determination or resolution will require the support of at least 75% of those present and/or otherwise able to vote on the issue.

PART D: TERM OF TE PĪTAU

Part D of this Agreement details how long we expect to work together for and, if or when necessary, how we will wind up Te Pītau.

10. Term

This Agreement commences upon the Commencement Date specified in the Key Information and continues in effect until:

10.1 30 June 2028

10.2 The Parties may agree to renew this Agreement from this date, after following an agreed process having been initiated at least twelve months before this date.

11. Suspending Te Pītau Activities

11.1 **Suspension by our Te Pītau Governance Group**: Our Te Pītau Governance Group may suspend some or all of our alliance activities at any time.

11.2 **Suspension by the DHB or PHO**: The DHB or PHO may suspend some or all of our alliance activities, if it determines that it is necessary to do so to prevent a breach of a statutory, regulatory or contractual requirement (as acknowledged in clauses 2.9 and 2.10).

11.3 **Recommencement**: We will recommence the performance of our alliance activities only when directed to do so by our Te Pītau Governance Group.

12. Terminating Te Pītau

12.1 **Termination by the DHB or PHO**: We agree that the DHB or PHO may, in exceptional circumstances, terminate this Agreement if it determines that it is necessary to do so to prevent a breach of a statutory, regulatory or contractual requirement (as acknowledged in clauses 2.9 and 2.10).

12.2 **Termination by either Party**: We agree that either Party may terminate this Agreement due to ongoing Wilful Default by the other Party.

12.3 **Termination by Agreement**: We agree that this Agreement may be terminated by mutual agreement between the Parties.

Executed as an Agreement

Executed for Health Hawke's Bay Limited by:

in the presence of

Director/Authorised Signatory

Director/Authorised Signatory

Witness signature

Full name

Occupation

Address

Executed for Hawke's Bay District Health Board by:

in the presence of

Director/Authorised Signatory

Director/Authorised Signatory

Witness signature

Full name

Occupation

Address

Schedule 1 - Scope of Te Pītau

1 The ultimate scope of Te Pītau may include any/all those publically funded primary and community healthcare services and activities, within the Hawke's Bay Health Sector that are amenable to delivery in a primary and community healthcare setting.

2 On an ongoing basis, the scope of Te Pītau will generally be determined by agreement to establish specific Service Level Alliances or Working Groups. General issues may be included within the scope as agreed from time to time.

3 The initial scope of Te Pītau and our alliance activities for 2018/19 shall include the following:

Area of Focus	SLA	Whole Model Redesign	Description	Delegation Notes	Te Pītau Involvement 2018/19
Community Mental Health & Addictions	Yes	Yes	Multi-stage redesign and re-procurement of community based mental health and addictions services ahead of July 2020 go-live	• Total indicative operating envelope <$20m per annum (including DHB contracts and Primary Care directorate PVS transfers into provider arm) • PHO Mental Health packages of care (c$1m) in-scope • Will be informed by national Mental Health & Addictions Inquiry	Receive regular SLA updates on progress of service design and provide governance oversight of the process in line with Te Pītau Principles. Approve the work of the SLA as design authority, in order to progress proposed model of care into the procurement phase.

Area of Focus	SLA	Whole Model Redesign	Description	Delegation Notes	Te Pītau Involvement 2018/19
End of Life	Yes	Yes	Review of existing services supporting patients at the end of life, and redesign within existing resource envelope	• Operating envelope to be confirmed, but will include DHB contracts (most notably hospice services) and PHO discretionary funding • Likely to also include internal DHB provider PVS relating to hospital palliative care services	Receive regular SLA updates on progress of service design and provide governance oversight of the process in line with Te Pītau Principles Approve the work of the SLA as design authority, in order to progress proposed model of care into the procurement phase
Community Pharmacy	Yes	No	Development, review and prioritisation of developmental schemes within Schedule 3b of the new Integrated Community Pharmacy agreement	N/A	Receive regular SLA updates for discussion and incorporation into the wider strategic approach
Integrated Care Teams (ICT)	Yes	No	Phased programme of work to test, refine and implement the model for extended integrated care teams operating seamlessly around the enrolled patient list	• Year one activity likely to include District Nursing services (Primary Care directorate PVS transfers into provider arm)	Receive regular SLA updates on progress of service design pilots and provide governance oversight of the process in line with Te Pītau Principles Review recommendations and guide the prioritisation of work to further iterate ICT design

Area of Focus	SLA	Whole Model Redesign	Description	Delegation Notes	Te Pītau Involvement 2018/19
Youth Services	TBC	Yes	Potential fast-follower SLA, reviewing design and effectiveness of primary health and wellbeing services targeted at young people	TBC	Receive proposal around potential scope and configuration of this work stream. Endorse establishment of SLA
Urgent and On-Day Primary Care Access	TBC	Yes	Potential fast-follower SLA, reviewing design and effectiveness of primary care services meeting urgent and on-day healthcare needs	TBC	Receive proposal around potential scope and configuration of this work stream. Endorse establishment of SLA
Health of Older People	TBC	Yes	Potential fast-follower SLA, reviewing design and effectiveness of services to keep older people well and independent. Will build on internal strategic programme within HBDHB	TBC	Receive proposal around potential scope and configuration of this work stream. Endorse establishment of SLA
Rural Localities Model	No	No	Develop a framework for the development of sustainable rural services	N/A	Review intelligence relating to the development of rural services in line with the stated priorities of rural communities Commission focus work on underlying themes relating to sustainability (e.g. workforce, technology, clinical governance) Oversee development of a framework approach to the development of sustainable rural services

Area of Focus	SLA	Whole Model Redesign	Description	Delegation Notes	Te Pītau Involvement 2018/19
Primary Care Innovation & Development	No	No	Develop the framework for the evolution of primary healthcare in line with the Hawke's Bay CSP	N/A	Review intelligence relating to existing innovation and development of enrolment-based primary care, including structural considerations that impact the pace of change Review recommendations and guide the prioritisation of work to further iterate primary care innovation and development
System Level Measures	No	No	Ownership of the Hawke's Bay System Level Measures framework	N/A	Review and critically evaluate progress against the System Level Measures for Hawke's Bay Provide commentary to the Boards of HBDHB and HHB concerning delivery against these priorities Review recommendations and prioritise the development of measures within future iterations of the framework

Area of Focus	SLA	Whole Model Redesign	Description	Delegation Notes	Te Pītau Involvement 2018/19
Primary Healthcare KPI framework	No	No	Development and ownership of a set of key performance indicators by which to assess the quality of primary healthcare in Hawke's Bay	N/A	Review recommendations and prioritise the selection of measures for the framework Critically evaluate reported progress and plans to mitigate adverse variances against the agreed KPIs
Information Systems	TBC	No	Primary healthcare governance input to the development of the Information Systems strategy for Hawke's Bay	N/A	Receive regular updates on progress against the IS Strategy. Review recommendations and prioritise the development of primary healthcare priorities within the Strategy

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board**	183
	For the attention of: **HBDHB Board**	
Document Owner:	Heather Skipworth (Chair)	
Document Author:	Brenda Crene	
Month:	December 2018	
Consideration:	For Information	

RECOMMENDATION

That the Board

Note the contents of this report; and that the Māori Relationship Board:

1. **Received, discussed and provided feedback** on entitled "It's Hard to Ask" provided by Clinical Nurse Specialist Merryn Jones, and supported a Hui being held to promote discussion

2. **Discussed and provided feedback** on "A Musculoskeletal Service to Reduce Inequities in Hawke's Bay" with a resulting recommendation: that the Primary Care Development Parthership Governance Group:
   - **Consider** what role a Muscular Skeletal Service to reduce Health Inequities in HB (which ran as a pilot funded by MoH), may have in primary care delivery, as a preventative measure with an aim to reduce surgical procedures?

The Māori Relationship Boad met on 5 December 2018. An overview of matters discussed is provided below:

BOWEL SCREENING IN HAWKE'S BAY

In discussion around Bowel Screening, MRB felt there were two points to note here. It is understood there were other high health issue areas for Maori (as presented to MRB on 10 October 2018, that the main causes of premature death in Māori were Ischaemic Heart disease and Lung Cancer). However they felt that those areas already receive adequate focus. In light of the response from the MoH, following lobbying by DHBs to lower the Bowel Screening age for Māori, MRB feel the need to ensure the issues are not rolled in to one but kept separate.

This was discussed further when Chris Ash joined the meeting with the following recommendation made to clarify intent.

RECOMMENDATION

That MRB request the HBDHB Board:

1. **Implement** bowel screening from the age of 50 years for Maori within the Hawke's Bay region.

CHAIR'S REPORT

An update was provided to members on the recent Board meeting held on 28 November which included an update on the Wairoa Demonstrator site (including a brief overview of the Community partnership Group (CPG). An overview was provided around the likely new name for the Primary Care Development Parntership Group (PCDG) and it was agreed that this group should be included as a standard item on future MRB agendas.

PRESENTATION: IT'S HARD TO ASK

Merryn Jones (Clinical Nurse Specialist, Renal Transplant) and Nayda Heays (Registered Nurse) spoke to the report and provided a presentation.

The presentation was undertaken for information purposes and to gauge support for hosting a half-day regional transplant Hui to upskill and inform health providers about transplant – in particular, ways in which we can help raise the rates of transplant for Māori.

In Hawkes Bay 69% of the renal population identifies as Maori (ANZDATA 2014)

- 20 years ago we had a total of 6 renal patients.
- In 2018 we have 25 patients in two shifts

The Main focus now is to open a dialogue with Maori health providers about both "living" and "deceased" transplant donors and the better health outcomes a transplant delivers for eligible patients. To develop/foster champions and advocates within Maori health providers in hospital, primary healthcare and community health agency settings.

Kidney transplants:

2017/18 year: 13 transplants were conducted (included 5 deceased donors and 8 living donors) of the 13, one of the recipients was Maori.

2018/19 YTD: 6 transplants with 2 of the recipients being Māori.

MRB supported the proposed Hui as the best way forward to ignite discussion in the region. Suggested this be held on a local Marae in Easter 2019, with presentations provided by ODNZ, a nephrologist, intensivist, ICU nurse, transplant coordinator, a recipient and a donor.

It is felt that high profile speaker(s) would enthuse participants with the ability to change perceived attitudes and values around accepting a transplant. Other indigenous cultures are offering and receiving organs. It is perceived by many that Maori don't donate or receive .. but they do.

A MUSCULAR SKELETAL SERVICE TO REDUCE HEALTH INEQUITIES IN HB

Andy Phillips spoke to the programme which was designed to address muscular skeletal issues for Maori and Pasifika and quintile 5. Funding was from the MoH (through the previous Government) and that funding had now come to an end. This was taken to planning and funding at DHBs who are trying to work with other organisations locally as this is such a great initiative.

HB stood out in the area of focus, compared to other parts of the country as we addressed inequities in main stream health. Other DHB programs excluded those who are in the most need of help.

Ana Apatu asked how we can move this forward as we do not want to drop this preventative programme that has been proven to work. Following discussion it was suggested the PCDP be approached for a view on this.

RECOMMENDATION

That MRB request that the Board ask the PCDP to:

1. **Consider** what role a Muscular Skeletal Service to reduce Health Inequities in HB (which ran as a pilot funded by MoH), may have in primary care delivery as a preventative measure with an aim to reduce surgical procedures?

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Health Consumer Council** 184
	For the attention of: **HBDHB Board**
Document Owner:	Rachel Ritchie (Chair)
Month:	December 2018
Consideration:	For Information

12

RECOMMENDATION

That the Board

Note the contents of this report.

Council met on 6 December 2018. An overview of matters discussed is provided below:

CHAIR'S REPORT

Significant issues noted in the Chair's verbal report to Council included:

- Based on feedback from the Consumer Council representative on the Health Awards judging panel, the Chair intends to discuss with the CEO:
  - Enhanced Consumer Council involvement on the judging panel and/or in the shortlisting process (potentially in conjunction with Clinical Council).
  - Requirement that all nominations for awards indicate consistency with the aims and objectives of the new (CSP) approach to consumer engagement.
- A follow up meeting with the CIO to discuss a consumers view on priorities for ICT developments.
- Brief overview of PCDP Governance Group meeting held on 15 November 2018, including agreement for 'single' representative members (MRB, Clinical and Consumer Council's) to have appointed alternatives attend meetings where necessary."

COMMITTEE REPRESENTATIVE FEEDBACK

Updates were provided on:

- Disability Strategy Group
- HQSC Consumer Representatives Train the Trainer Workshops
  - Members who attended this training expressed some frustration and disappointment with aspects of this training. Feedback has been provided to HQSC.

DHB FUNDING OVERVIEW

Carriann Hall, Executive Director Financial Services, provided Council with a high-level presentation on funding arrangements for DHBs, and for HBDHB in particular.

Council members found the presentation useful in helping to understand better the HBDHB financial environment and funding constraints.

SCOPING REPORT - ADDICTIONS

Council received and discussed the report presented that provided current information about meth and the impacts on the user and their whanau, and current services available to support them. It was noted that the findings in this report were very similar to those in a very recently released Mental Health Inquiry Report.

From discussion, the overwhelming message was that people do not know where to go to get help/services. This issue will need to be addressed in the pending redesign of Hawke's Bay Mental Health and Addiction Services.

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Clinical Council** 185
	For the attention of: **HBDHB Board**
Document Owner:	Dr John Gommans (Co-Chair) Jules Arthur (Co-Chair)
Month:	December 2018
Consideration:	For Information

13

RECOMMENDATION

That the Board

Note the contents of this report.

HB Clinical Council met on 5 December 2018. A summary of matters discussed is provided below:

ADVANCE CARE PLANNING (ACP)

Council discussed and generally supported a request from ACP Advisory Group to report into the new clinical governance structure. Subject to agreement with Consumer Council, it was proposed that the most appropriate group would be the Clinical Experience Committee.

WORKPLAN

It was agreed that Clinical and Consumer Council's would have a joint meeting/workshop in March 2019, with the key theme being Person & Whanau Centred Care

A MUSCULAR SKELETAL SERVICE TO REDUCE HEALTH INEQUITIES IN HB

Council received this update.

Governance Report Overview

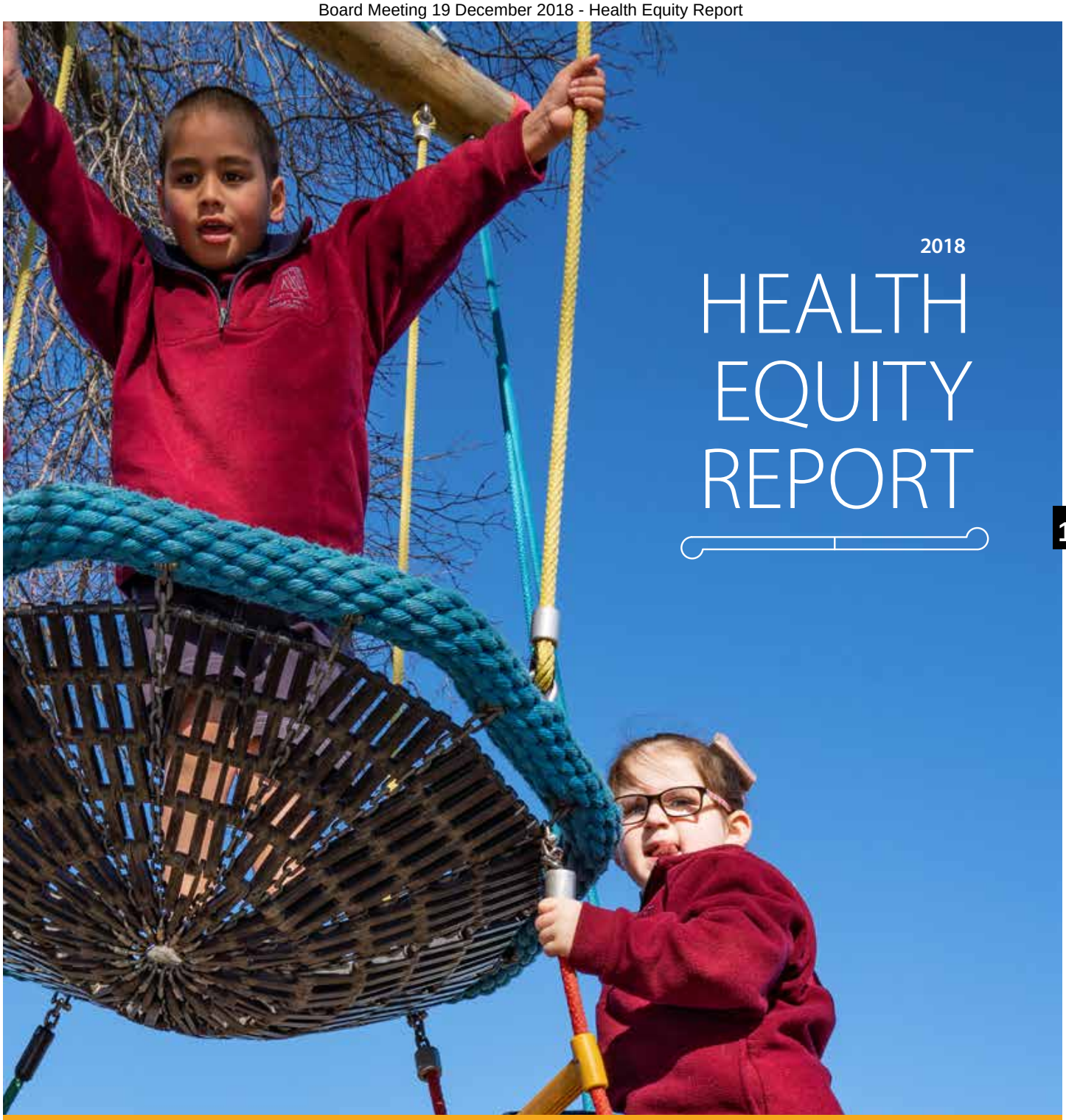
HAWKE'S BAY District Health Board Whakawāteatia	**Health Equity Report**
	For the attention of: **HBDHB Board**
Document Owner	Andy Phillips, Tumuaki O Te Puni Tūmatawhānui
Document Authors	Nick Jones, Jessica O'Sullivan, Andy Phillips, Patrick LeGeyt, Lisa Jones, Charrissa Keenan, Rachel Eyre, Rowan Manhire-Heath, Shari Tidswell
Reviewed by	Executive Management Team, HB Clinical Council, HB Health Consumer Council (in November) and the Māori Relationship Board reviewed in November and again in December)
Month/Year	December 2018
Purpose	Noting final version
Previous Consideration Discussions	N/A
Summary	This report acknowledges that in Te Matau a Māui, Hawke's Bay, our people have pervasive and enduring differences in health that are not only avoidable but unfair and unjust. Equity is defined as the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. *To achieve health equity we will need to acknowledge that different people with different levels of advantage will require different approaches and resources to get the same outcome.* The inter-generational traumatic impact of colonisation has had long term impacts on Māori health, wellbeing and culture. Socioeconomic factors account for almost half of all health inequity. Health care is responsible for a further 10%. To achieve our commitment to equal outcomes, we will all need to work across sectors to overcome the barriers to equity - poverty, discrimination, powerlessness, lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare. We know that many in our community face barriers to accessing high quality health care services. These barriers include difficulties in navigating our complex systems, limited cultural competence of providers, lack of transport, out-of-pocket costs and co-payments for GP services. We know that to address health inequities across the life span that we need to work across sectors and with communities to:

	• give all tamariki the best start in life • strengthen the role and impact of ill-health prevention • ensure that all tamariki and rangatahi experience few adverse childhood events, many positive childhood experiences and have an education that enables them to maximise their capabilities and have control over their lives • create fair employment and a healthy standard of living for all adults • create and develop healthy and sustainable places and communities • deliver excellent health services that produce the best outcomes for people with conditions such as cardiovascular disease, cancer, respiratory disease and diabetes • deliver excellent mental health and addictions services
Contribution to Goals and Strategic Implications	Improving Health and Equity for all populations
Impact on Reducing Inequities/Disparities	This report sets out actions required to reduce with the intent of eliminating health inequities
Consumer Engagement	A wide range of stakeholders have had input into this report No specific consumer engagement has been undertaken.
Other Consultation /Involvement	There is an intention for the report to undergo peer review prior to final publication.
Financial/Budget Impact	This paper signposts the need for reallocation of resource and investment priorities for any additional resource to achieve health equity
Timing Issues	Due to be presented at December 2018 Board meeting
Announcements/ Communications	This report is likely to have very significant media exposure and a communication plan will be developed

RECOMMENDATION:

It is recommended that the HBDHB Board

- **Note** the Health Equity Report in its final form.



2018

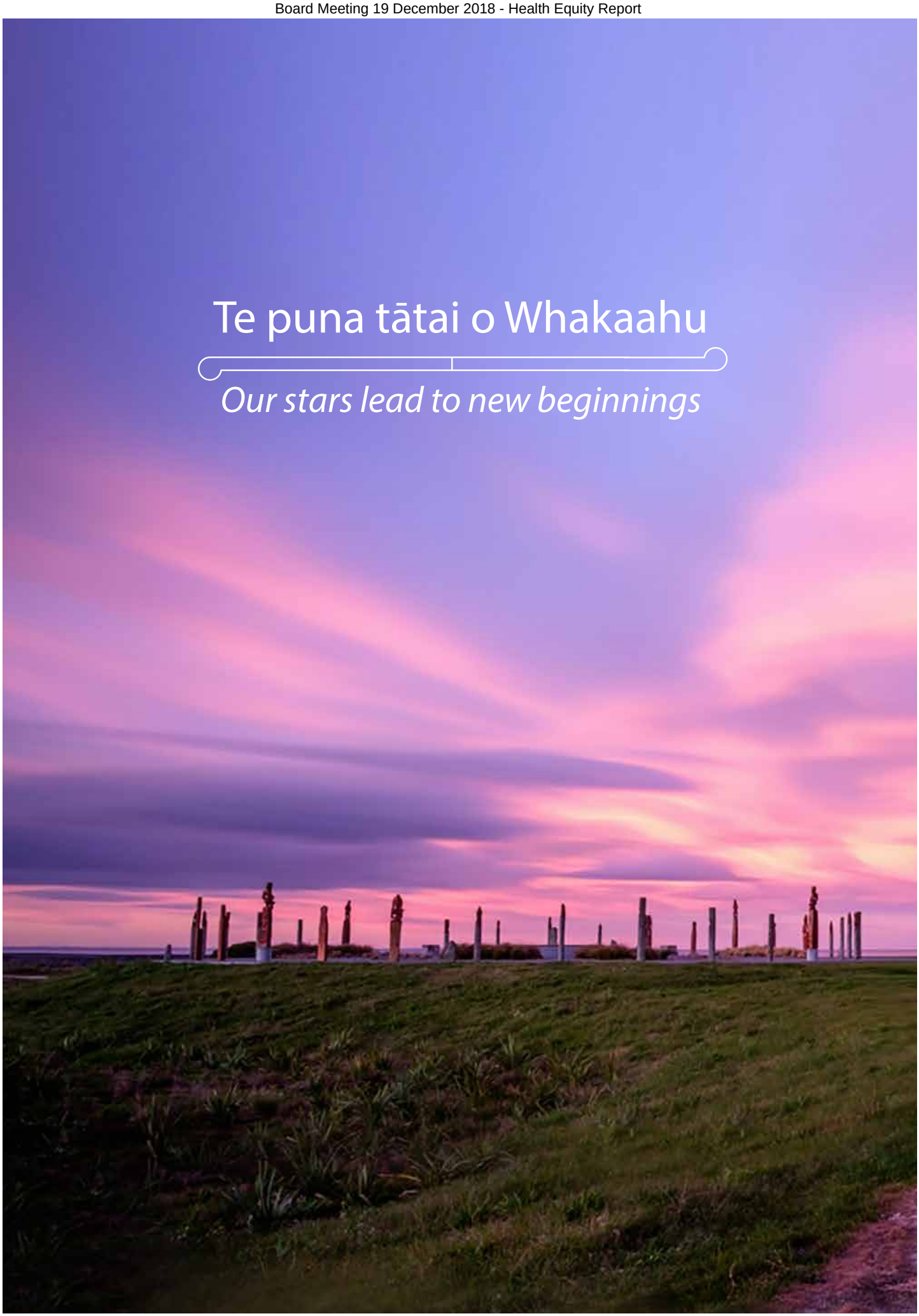
HEALTH EQUITY REPORT

14.1

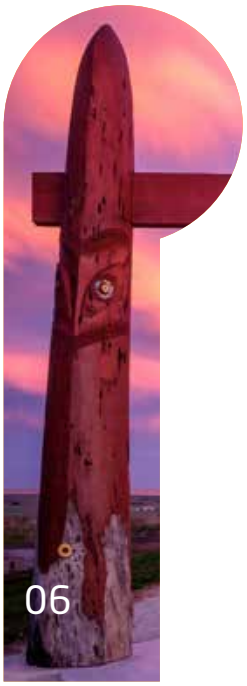
Kei tēnā, i tēnā, āna momo mahi

We've all got a role to play

www.ourhealthhb.nz


Te puna tātai o Whakaahu
Our stars lead to new beginnings

Ihirangi | Contents



INTERPRETATION GUIDE:

1.THE NEW ZEALAND HEALTH SURVEY: *A number of measures in this report are derived from the New Zealand Health Survey. The survey has a number of limitations to be kept in mind. Firstly, the survey is based on a sample of randomly selected households and the numbers of households sampled in Hawke's Bay is limited. The households chosen also change over time. This means that a break down of results into age or ethnic groups often requires information from several years to be combined to get a large enough sample. Secondly, the survey reports ethnicity in a different way to the rest of this report. People who identify as belonging to more than one ethnic group are counted in each group whereas other measures in this report use prioritised ethnicity so that people are counted in only one group. The measures published so far this year also do not contain any measures for NZ European/Other. This means measures for Māori and Pacific must be compared with the total Hawke's Bay population measure. These comparisons are likely to reduce the magnitude of true differences in the measure between Māori or Pacific and the NZ European/Other ethnic group.*

2. ETHNICITY: *In this report, we have used the term NZ European/Other to denote the non-Māori, non-Pacific population of Hawke's Bay. Due to small Pacific numbers, some graphs in this report show only Māori and NZ European/Other. It is therefore important to note that in these graphs, the NZ European/Other group does not include Pacific.*

3. AMENABLE MORTALITY: *In this 2018 Health Equity Report, a new definition for amenable mortality has been used. The new definition aligns Hawke's Bay's reporting to the national System Level Measure. This means that graphs for amenable mortality in this report cannot be compared with graphs in previous reports as the new definition includes some deaths that were not previously counted.*

Kei tēnā, i tēnā, āna momo mahi

We've all got a role to play

Spotlights

Early and avoidable deaths

Next steps

ACKNOWLEDGEMENTS:

EXECUTIVE DIRECTOR: **Dr Andy Phillips** LEAD AUTHOR: **Dr Nicholas Jones** PRINCIPAL ANALYST: **Lisa Jones with support from the Business Intelligence Team**
CONTRIBUTORS: **Margaret Alexander, Tiwana Aranui, Dr Rachel Eyre, Paul Faleono, Hawira Hape, Hastings District Council, Charrissa Keenan, Tania Kura, Patrick Le Geyt, Rowan Manhire-Heath, Jessica O'Sullivan (Editor), Talalelei Taufale, Laurie Te Nahu, Shari Tidswell, Mel West, Dr Bridget Wilson**

What is this report about?

Equity in health means that all groups have a fair opportunity to reach their full potential for a healthy life.

Inequities are differences in health that are not only unnecessary and avoidable but, in addition, are unfair and unjust. We cannot and must not allow these inequities to continue.

This is our third Health Equity Report.

What is the purpose of this report?

Continue monitoring progress against previously reported measures

By tracking progress we can hold ourselves to account, identify successful approaches and identify the greatest opportunities to eliminate health inequities.

As with the previous reports, we report on progress towards reducing early deaths (before the age of 75 years) that are avoidable through preventing disease or providing equitable health services.

These overarching measures provide a big picture view of health equity. They reflect our current services, the influence of service provision over many years, and our wider social and economic situation in Hawke's Bay.

We are mindful that death statistics are looking back in time. The process of collecting and checking information about why people die takes around three years and for the most part this report covers deaths up until the end of 2014. The number of deaths in any one year is affected by events or illnesses, health behaviours and services provided over a much longer period of time for many causes.

Although we do not yet have information on what has happened since 2014 for deaths, we do have access to current hospital stay information and information about changes in behaviours that we know are linked to health.

These measures provide a more forward-facing view that helps us to determine whether any recent changes are likely to have already impacted on numbers of deaths.

Explore key issues such as family violence and mental health in more depth

More in-depth analysis allows us to begin to understand some of the root causes of inequity and some of the pathways by which social position contributes to inequity in Hawke's Bay.

Introduce a greater focus on the life course journey

The introduction of a life course framework recognises the profound impact that events and illnesses, that occur early in life, have on health as we age.

The underlying principle for health equity is that there is no fair justification for a person's social position (for example their socioeconomic status, gender, educational attainment, disability, sexual orientation or ethnicity) **to determine their level of health or length of life.**

This report focuses more on ethnicity than other aspects of social position, such as socioeconomic status.

First and foremost, this reflects our obligations under Te Tiriti o Waitangi to ensure Māori achieve the level of health necessary to fully participate in society and to retain autonomy over the systems and resources needed for health.

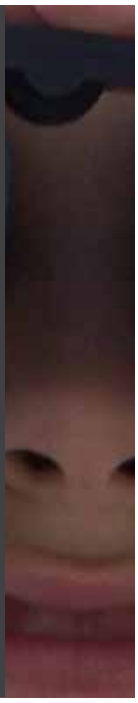
We have reported on inequities according to socio-economic status where possible, but changes to the New Zealand Deprivation Index since our last Health Equity Report made this more challenging.

However, as ethnicity and other measures of social position are highly inter-related, it is reasonable to assume that many of the findings in this report would also apply for people living in greater socio-economic deprivation.

What did we find?

The starkest message is that Māori, Pacific people, and people living in greater socio-economic deprivation are still more likely to die early from avoidable causes.

This message provides a central focus for this report as we look closely into how deaths from avoidable causes can be prevented.



A recent study showed that Hawke's Bay DHB was one of New Zealand's most successful DHBs in improving life expectancy for Māori for the period 2006 to 2013[1]. This success was noted in previous reports along with other positive trends including a closing of the equity gap for early and avoidable deaths. The news this time is less positive with most measures of early and avoidable deaths showing no further progress has been made over the last two years of available data (2012-2014).

The findings in this report provide direction for actions to address health inequity:

- For Māori nearly a quarter of all avoidable deaths can be prevented if we can **improve heart health**
- Another quarter will be prevented when we prevent **lung cancer deaths** through smokefree living (and early detection and more effective treatment) and when we address the underlying causes of **suicide** and **vehicle crashes**
- For Pacific people we also need to focus on preventing and managing **diabetes** and preventing **stroke**
- Pacific pre-schoolers are experiencing higher rates of avoidable hospital stays, particularly for **skin infections**, and have the highest rates of **dental decay** by the time they reach school
- Avoidable hospital stays for Māori and Pacific adults aged 45-64 years are increasing. This is driven by increases in hospital stays for **heart attacks, chronic lung disease** and **skin infection.**

The role of health services in eliminating inequity

The potential for health services to eliminate health inequity is clearly demonstrated by the continuing progress in immunisation and screening.

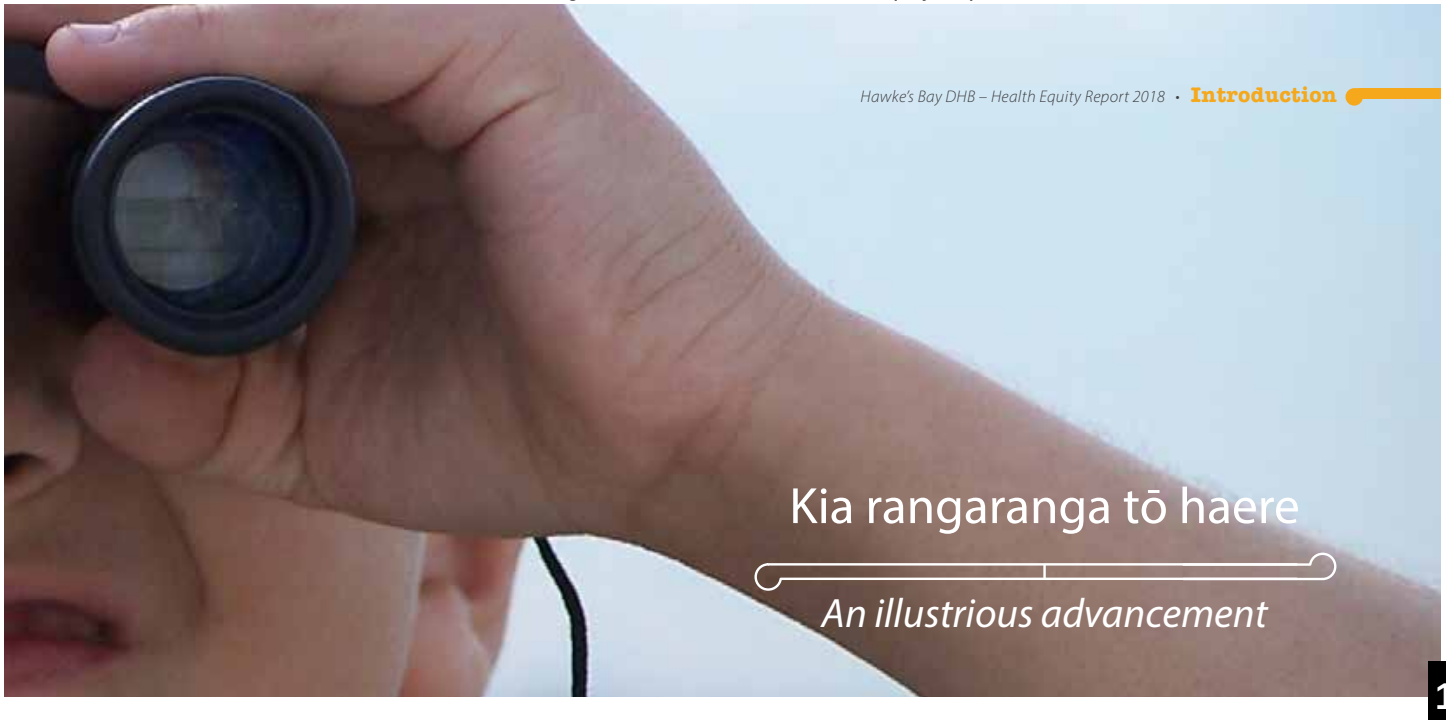
Successes in delivering these preventive services show what can be achieved when we purposefully set out to understand the needs of our community and deliver our services in a way that meets the needs of whānau. We need to learn from these successes to address other inequities such as those in sexually transmitted infection.

A focus on mental health

This report provides a new focus on mental health and well-being.

The report describes important inequities in mental health such as the higher rate of hospital stays for mental illness and the higher rate of hospital stays resulting from self-harm for Māori and for women. The picture of higher psychological distress in Hawke's Bay, along with persisting levels of family violence, reinforce the need for more work to address these issues that in turn influence so many other aspects of health.

[1]Sandiford P, Consuelo DJJV, Rouse P. How efficient are New Zealand's District Health Boards at producing life expectancy gains for Māori and Europeans? Australia and New Zealand Journal of Public Health. 41(2) 2017.



The role of social and economic factors in eliminating inequity

This report finds that large disparities in socio-economic conditions that affect health persist for Māori and Pacific people in Hawke's Bay.

As a measure of housing related illness we are still seeing a significant difference between Māori, Pacific and NZ European/Other rates for bronchiolitis.

The influences of the social, economic and physical environment are also linked to the way we live. It is not surprising that persisting inequities in socio-economic factors are accompanied by trends in behaviours that increase health risk.

New Zealand Health Survey data is used to measure trends in key risks such as obesity, nutrition, tobacco and alcohol use. Recent survey data show worsening trends in many of these measures. Reductions in physical activity and increased harmful alcohol use are prevalent across society and we need to strengthen our collaborative efforts if we are to increase wellbeing.

We need to act on these findings. We can't afford to wait and see if more positive trends are around the corner.

Some of these issues of inequity are clearly linked to deterioration in socioeconomic conditions. For example, we know the housing situation for many whānau in Hawke's Bay has deteriorated. We will work across sectors with our partners locally and nationally on these issues.

In order to reduce avoidable hospital stays for adults, we will listen to our communities to understand what services they need and take action. This is particularly true for services to Māori and Pacific whānau and also for other groups such as people with disability. We need to understand better the biases that have been built into our systems that result in poorer quality of service for these groups.

We know from successful programmes both in Hawke's Bay and elsewhere that tackling inequity requires system and culture change, deliberate and sustained focus, realistic resourcing, accountability at all levels, and real community partnership.

Ko te Pae tata, whakamāua ki tina

Furthest horizons are achieved, step by step

Summary of findings

Health equity ACHIEVED

Immunisations

GOOD PROGRESS *towards health equity*

Breast screening

Cervical screening

Pregnancy - under 18s

Youth not in employment education or training

SOME PROGRESS *towards equity but slowing or stalled*

Premature mortality

Avoidable mortality

Amenable mortality

Years of Life Lost

Acute bronchiolitis

Ambulatory Sensitive Hospitalisations (0-4 year olds)

Oral health – 5 year olds

Breastfeeding

Childhood obesity

NO PROGRESS *or inequity worsening*

Fruit and vegetable intake

Physical activity

Adult obesity

Hazardous drinking

Maternal smoking

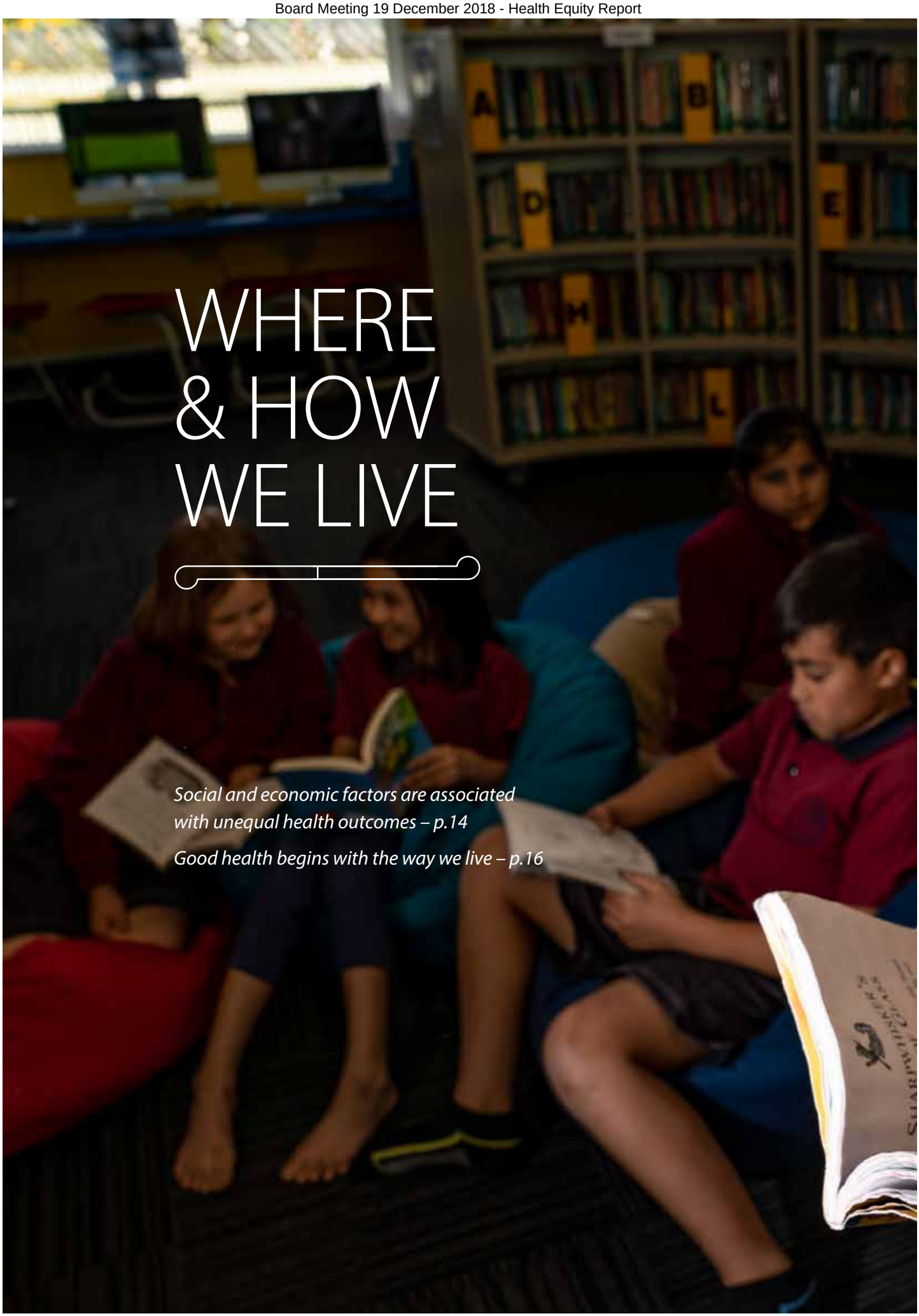
Sexually transmitted infections

Mental health

Female hospital stays for assault

Diabetes

Ambulatory Sensitive Hospitalisations (45-64 year olds)



WHERE & HOW WE LIVE

Social and economic factors are associated with unequal health outcomes – p.14

Good health begins with the way we live – p.16


Nāu te rourou, nāku te rourou, ka piki te ora
With your basket and my basket the people will thrive

Social and economic factors are associated with unequal health outcomes

The social and economic conditions that people are born into and live in have a profound impact on health outcomes.

These factors include housing, education, income, social support and connection and they are closely linked. For example, education will impact on income, and income will subsequently impact on housing. These links lead to an accumulation of disadvantage among some people and an accumulation of privilege among others.

The health of Māori whānau is deeply rooted in the impacts of colonisation. Epidemics brought by European settlers decimated Māori communities and losses of land, languages, traditions and economic livelihood followed. These ordeals and accumulated trauma have induced further illnesses present in Māori today. Medical research suggests that molecular changes resulting from social trauma and illness may be passed on from one generation to the next.

Social and economic factors also underpin health behaviours: people living in poverty have fewer choices available to them, greater stress and poorer access to opportunities such as education, and all of these experiences can lead to higher levels of unhealthy behaviours.

25% *of Hawke's Bay 0-4 year olds live in a household* **receiving a main benefit**

Compared with **18%** nationally.

40% *of Hawke's Bay tamariki Māori aged 0-4 years live in a household* **receiving a main benefit**

Compared to **19%** of Pacific children and **14.5%** of NZ European children.

61% *of total* **food grants** *are to Māori*

Compared with **27%** to NZ European.

One in three *Māori school leavers* **do not have** *an* **NCEA Level 2** *qualification or equivalent*

Compared with **one in four** Pacific leavers and **one in seven** NZ European leavers.

22% *of young Māori are* **not in employment, education** *or* **training**

Down from 30% in the 2014 Health Equity Report.

CASE STUDY:

MAKING HEALTH A CORE BUSINESS OBJECTIVE

On average, adults spend at least one third of their life at work. This makes the workplace an ideal environment to promote health and wellbeing.

Tumu Timbers in Hastings is an example of a local business which has made workplace wellbeing a core business objective. The company manufactures timber bins, crates and pallets, beehive wood ware and packaging. Most of its 150 employees are men, and around half identify as Māori and/or Pacific.

The Tumu Timbers workplace health and wellbeing programme, now in its fourth year, aims to promote and improve the health and wellbeing of all Tumu Timbers employees and their whānau, resulting in a healthier workforce. The programme has been driven by staff who initiated a health and wellbeing committee. One of the first tasks of the committee was to conduct a health and wellbeing survey to find out what the staff wanted Tumu to focus on and what barriers exist for some.

Early initiatives focussed on making the healthy choice easier. This meant simple changes like switching to non-sugary drinks in the vending machine and providing fruit bowls with free fruit in lunch rooms. Other initiatives supporting nutrition, physical activity and smoking cessation have since been added. Employees are also offered subsidised health insurance.

A programme called "Mates in Manufacturing", renamed from "Mates in Construction", has been introduced which aims to create a culture that encourages talking about mental health issues and personal feelings, and to ensure staff know how to support each other and where to get help.

Hawke's Bay DHB's Population Health Advisory Team supported Tumu Timbers in the development of its wellness programme and continues to provide ongoing advice and support.

Superintendent Tania Kura, Eastern Police District Commander

CASE STUDY:

PARTNERING FOR COMMUNITY GAINS

Superintendent Tania Kura, Eastern Police District Commander, speaks on the importance of community partnerships.

"As Eastern Police District Commander, I believe in taking an open approach to developing partnerships within our communities. After six years here in Hawke's Bay, I've seen first-hand the strong, well-established relationships our officers have strived to build and maintain.

Real differences come when leaders collaborate with a common purpose. We're very fortunate to have a number of like-minded agency leaders across the Eastern District who are very willing to take a pragmatic approach to making things happen for the good of our communities.

An example of this is the positive approach we're taking to encourage truants back to school with the support of parents, the Ministry of Education, truancy services and schools. One key benefit of this initiative is a reduction in the number of young people going to Youth Court.

Our focus on crime prevention means thinking differently about how we solve problems as we aim to reduce both reoffending and re-victimisation. We can't be the safest country in the world unless we work with others. I'm grateful for the support extended to Police from other agencies, non-government organisations and iwi groups.
I'm also heartened by the willingness of others to invite us to the table to help create coordinated solutions."

Good health begins with the way we live

The environment we live in influences our day-to-day behaviours, including nutrition and obesity, smoking, alcohol and other drug use. Health behaviours have a large impact on our health and wellbeing.

Tama tu tama ora, tama noho tama mate

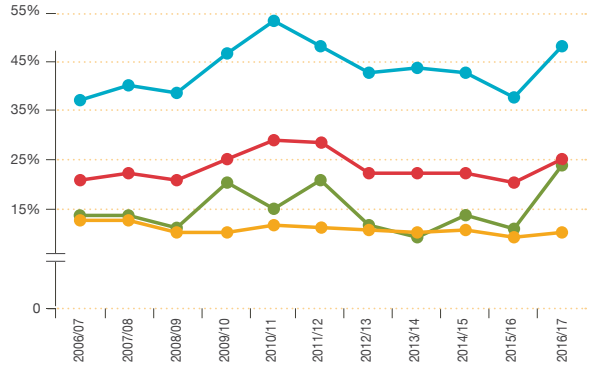
An active person will remain healthy while a lazy one will become sick

Little change in reducing maternal smoking since 2007

Maternal smoking is still of great concern with little change in the overall trend for maternal smoking since 2007.

Maternal smoking is more likely among women living in more deprived areas. Helping women, and Māori women in particular, to stop smoking must remain a priority.

HAWKE'S BAY PERCENTAGE OF SMOKER STATUS OF WOMEN DELIVERING IN HBDHB FACILITIES BY ETHNICITY



Source: HBDHB Data Warehouse

KEY:

Total · Māori · Pacific · NZ European/Other

Fewer youth are smoking but more Hawke's Bay adults smoke than nationally

A growing proportion of young people in Hawke's Bay are choosing not to smoke.

However one in five Hawke's Bay adults still smoke daily compared with one in six nationally. Māori have the highest smoking rates at 40 percent and Māori women are three times more likely to smoke than non-Māori women. Efforts to achieve the 2025 smokefree target (of less than 5 percent) must focus on supporting Māori to quit and on preventing uptake amongst rangatahi Māori.

Hawke's Bay people are drinking more harmfully than New Zealanders as a whole

29 percent of Hawke's Bay adults drink at harmful levels compared with 21 percent nationally, and harmful drinking is rising over time. Alcohol-related hospital admission rates have doubled since 2009.

Recent age and ethnicity break-downs are not available for Hawke's Bay, but past and national patterns show:

- 15-24 year olds drink the most hazardously, although 25-44 year olds are not far behind
- fewer Māori drink alcohol than non-Māori (Pacific and Asian also lower) but Māori experience more harm overall than non-Māori.

In New Zealand, hazardous drinking is higher in more deprived areas, and there is a strong association with increased alcohol outlet density in these areas.

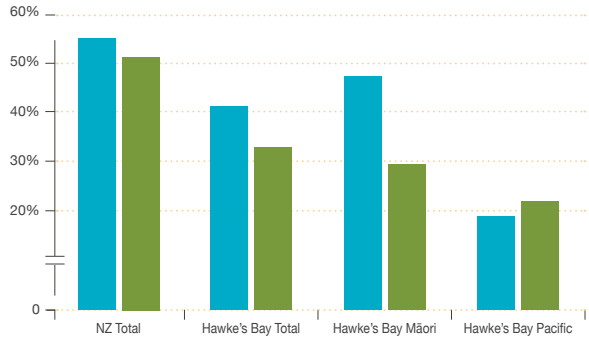
Fewer adults and children are eating enough fruit and vegetables

Just one third of Hawke's Bay adults and children meet the recommended guidelines for daily fruit and vegetable intake (3+ serves of vegetables and 2+ serves of fruit).

This trend has worsened over the past three years. Adults living in the most deprived areas consume less fruit and vegetables than the least deprived areas. This finding is particularly troubling given the plentiful supply of locally grown produce in our region.

Our food environment influences our food choices. As shown in the table on the right, people living in our most deprived areas have more dairies and fast food outlets in their neighbourhoods than those in the least deprived areas. On the other hand there is little difference in the density of supermarkets and fruit and vegetable stores.

PERCENTAGE OF NEW ZEALAND & HAWKE'S BAY CHILDREN MEETING FRUIT & VEGETABLE INTAKE GUIDELINES (AGE STANDARDISED)



Source: New Zealand Health Survey

KEY:

2011-14 2014-17

INDICATOR	MOST DEPRIVED	LEAST DEPRIVED
Average density of convenience stores per 10,000 people in Hawke's Bay census areas	10.2	3.4
Average density of fast food and takeaway outlets per 10,000 people in Hawke's Bay census areas	10.4	4.9
Average density of supermarkets and fruit and vegetable stores per 10,000 people in Hawke's Bay census areas	4.2	3.4

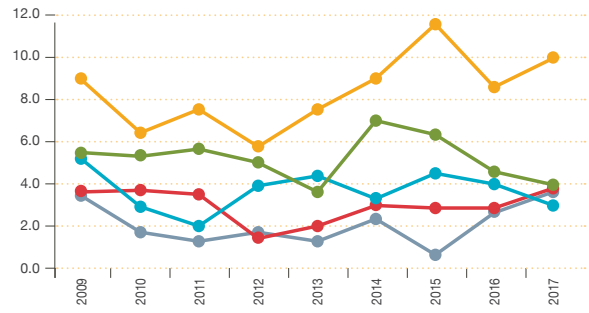
Based on/adapted from: INFORMAS (University of Auckland)

Childhood obesity remains more common in our most deprived communities

Children living in Quintile five (highest deprivation) remain more likely to be obese at their B4 School Check compared with children living in other Quintiles.

Māori children are less likely to have a healthy weight than non-Māori children and an even smaller proportion of Pacific children have a healthy weight. Only 54 percent of Māori and 45 percent of Pacific children are at a healthy weight at their B4 School Check compared with 67 percent of NZ European/Other children.

PERCENTAGE OF OBESITY IN HAWKE'S BAY 4 YEAR OLDS AT B4 SCHOOL CHECK BY QUINTILE



Source: B4 School Check database extract provided by Health Hawke's Bay

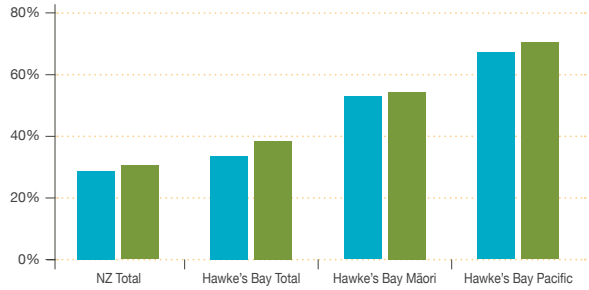
KEY:

Quintile 1 Quintile 2 Quintile 3 Quintile 4 Quintile 5

Adult obesity is increasing across all ethnic groups

Over a third (37.5 percent) of Hawke's Bay adults are obese compared with just under a third nationally (30.5 percent). Over the last three years, obesity rates in Hawke's Bay have worsened across all ethnic groups. Māori (53 percent) and Pacific people (70 percent) experience higher levels of obesity in Hawke's Bay. Adults who live in more deprived areas are more likely to be obese than those living in less deprived areas.

PERCENTAGE OF OBESITY IN NEW ZEALAND AND HAWKE'S BAY ADULTS (AGE STANDARDISED)



Source: New Zealand Health Survey

KEY:

2011-14 2014-17

14.1

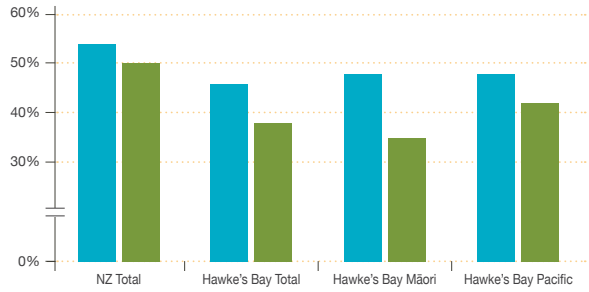
Physical activity levels for Māori and Pacific have fallen

Hawke's Bay adults are less active than their New Zealand average counterparts.

Only 38 percent of Hawke's Bay adults meet physical activity guidelines compared with 50 percent nationally, a decline of 5 percent since the first Health Equity Report in 2014. The percentage of Māori meeting the guidelines has dropped from 48 percent to 35 percent in the period between 2011-14 and 2014-17 and the percentage of Pacific people has dropped from 47 percent to 42 percent.

Over recent years we have seen increasing participation in programmes such as Iron Māori but we need to work harder to ensure that activity gains from these programmes are carried over into daily life.

PERCENTAGE OF NEW ZEALAND AND HAWKE'S BAY ADULTS MEETING PHYSICAL ACTIVITY GUIDELINES (AGE STANDARDISED)



Source: New Zealand Health Survey

KEY:

2011-14 2014-17

EQUITY FOR LIFE

Health is a resource for everyday living. It provides us with a capacity to participate in society and contributes to quality and length of life.

Our "health capacity" accumulates over our life. If our health capacity grows, so does our resilience and ability to recover from health threats that occur later in life. But if our health capacity is depleted, our health becomes more vulnerable.

14.1

Te Pae tawhiti, whaiā kia tata

Discover life's fortunes

Our Health Capacity

This chart shows how health related events, social, economic and physical environments, and behaviours can either grow or deplete our health capacity.

This is not intended to be a complete picture of all relevant factors. Its purpose is to illustrate how life experiences can contribute to inequities in illness and death.

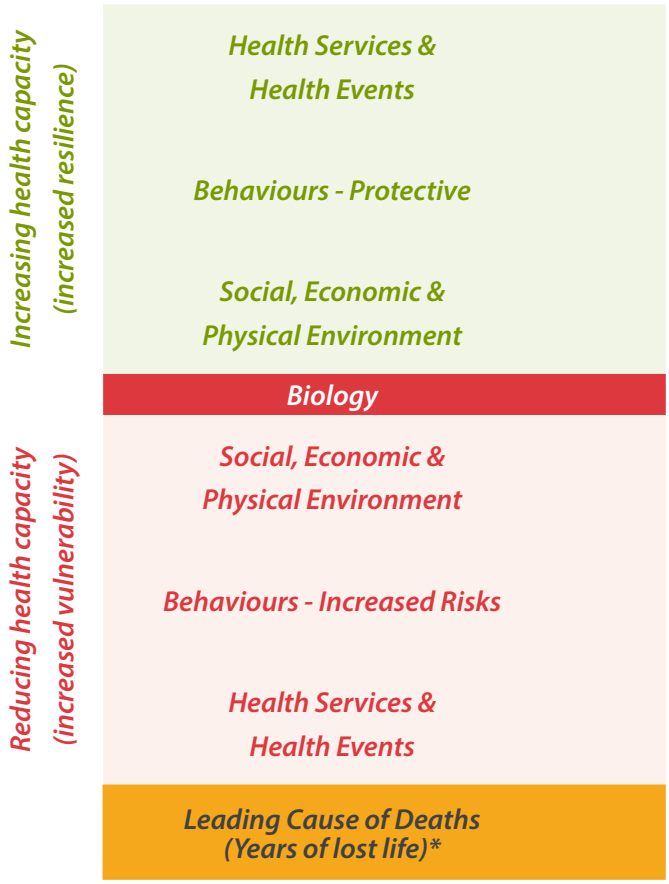
The dotted lines illustrate changes in health capacity for two hypothetical people. For one person their health capacity grows over their life, becoming depleted as death approaches late in life. For the other person their health capacity becomes depleted earlier in life ultimately resulting in a premature death. The lines also illustrate the difference in quality of life between the two life courses.

The chart illustrates the importance of building our health capacity early in life. But it also shows the potential for positive factors to increase our health capacity even after negative influences early in life.

In the middle of the chart is a line representing biology. Our genes are fixed but our biology can change and interact with other factors as we age.

The first 1000 days of life have the biggest impact.

Fold out page to reveal factors affecting health capacity →



* Adapted from: Ministry of Health 2018. Health and Independence Report 2017

Kotahi te hā tā te mokopuna
ki tā te kaumātua

An elder's life exemplifies the child's wellness

Me mate ūruroa,
koi mate wheke

Endless toil garners rich reward

Ahakoa he tupu
mātāngerengere, me ū

Although there are difficult phases of development, remain committed







HE PĒPI preconception, pregnancy and infancy	**NOHINOHI** (0-1 year old) pre-school	**TAMARIKI TAIŌHI** (1-11 year old) middle childhood	**TAITAMARIKI** (12-18 year old) adolescence	**RANGATAHI** (19-40 year old) early adulthood	**RANGATAKAKAU** (40-60 year old) middle adulthood	**RANGATIRA/PĀKEKE** (60+ year old) late adulthood
Access to sexual health services, safe from environmental toxins, supportive post natal care, Well Child checks and immunisation	Immunisation and Well Child checks, oral health care	Connected to primary care, oral health services	Access to sexual health and adolescent health services	Maternity services	Screening on time	Good access to primary care and support services
Good nutrition and health for mother at conception and during pregnancy, no alcohol and tobacco in pregnancy, breastfeeding	Good family nutrition, regular adequate sleep	Educational achievement, regular sleep, physical activity,	Engaged in school and community, culturally connected	Low or no alcohol use, active lifestyle	Low or no alcohol use, active lifestyle	Maintain social connection
Safe, warm and dry smoke free home; loving, emotionally stable violence free home; safe from environmental toxins	Material wealth; safe, warm and dry smoke free home; loving, emotionally stable violence free home; early childhood education	Material wealth; safe, warm and dry smoke free home; loving, emotionally stable violence free home; safe connected urban environment; healthy nutritional environment	Mentoring; supportive relationships and whānau; whānau provides structure limits, rules and predictability	Healthy and safe work environment	Healthy and safe work environment	Safe home environment
Interaction with Capacity Factors						
Unsafe cold damp smoking home, emotional distress, family violence	Poverty, unsafe cold, damp, smoking home, emotional distress, family violence, neighbourhood violence	Poor nutritional environment, poorly connected unsafe urban environment, poor quality or transient housing	Low self-esteem, lack of cultural connection, parental substance use or mental illness, family violence or other traumatic event	Criminal conviction or prison unhealthy or unsafe work environment	Unhealthy or unsafe work environment	Unsafe home environment
Poor nutrition and health for mother at conception and during pregnancy, alcohol and tobacco in pregnancy, no breastfeeding	Poor nutrition e.g. sugar sweetened beverages, irregular or inadequate sleep	Educational achievement limited, limited physical activity	Early substance use, lack of social engagement e.g. no sport, lack of parental supervision and support	Harmful alcohol and other substance use	Harmful alcohol use, poor nutrition, inactivity	Poor social connection and loneliness
Poor access to sexual health services, late or no antenatal care, not connected to post natal care, Well Child checks or immunisation	Lack of access to immunisation, Well Child checks, oral health care, developmental or behavioural disorder	Not connected to primary care or oral health services, chronic disease or disability, developmental disorder, rheumatic fever	Depression or anxiety	Late maternity services	Late or no access to screening services	Poor access to primary care and support services, increased frailty, dementia
Other accidents, SUDI, cancer, vehicle crashes, diarrhoea & pneumonia		***Suicide, vehicle crashes, other injuries, cancer, neurological disorders***			***Cancers, cardiovascular (heart disease & stroke), suicide, vehicle crashes, diabetes***	***Cardiovascular (heart disease & stroke), cancers, neurological, chronic lung, diabetes***

14.1

Health across the life course

In this part of the report we have grouped some measures into life stage to show the importance of equity across the life course and to tell the story of how events earlier in life can influence our health as we age.

HEALTH ACROSS THE LIFE COURSE:

Childhood

"Many challenges in adult society have their roots in the early years of life, including major public health problems such as obesity, heart disease and mental health problems."

– WHO, 2008

Kotahi te hā tā te mokopuna ki tā te kaumātua

An elder's life exemplifies the child's wellness

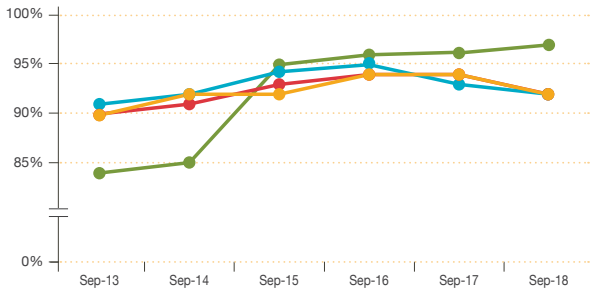
Immunisation shows equity is possible

Equity has been achieved in eight month immunisation rates for both Māori and Pacific infants. 97 percent of Pacific eight month olds are immunised. This is an increase of 12 percent since 2013.

Hawke's Bay continues to achieve good immunisation coverage at 24 months of age with 94.6 percent of two year olds fully immunised (just under the Ministry of Health target of 95 percent). As at September 2018, 94 percent of NZ European/Other, 93 percent of Māori and 92 percent of Pacific children were fully immunised at 24 months of age.

The school based Human Papilloma Virus (HPV) programme, that prevents cervical and other cancers, has achieved greater coverage among Māori and Pacific adolescents than for NZ European/Other. This shows the pro-equity value of delivering programmes through schools by removing barriers to service.

PERCENTAGE OF HAWKE'S BAY 8 MONTHS OLDS IMMUNISED



Source: National Immunisation Register

KEY:

Total · Māori · Pacific · NZ European/Other

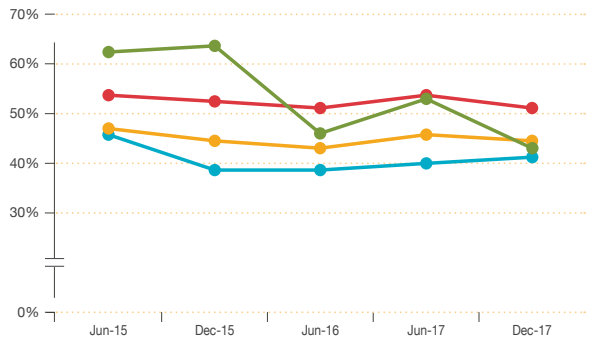
14.1

Breastfeeding rates for Māori and Pacific are lower than in 2015

Breastfeeding rates in Hawke's Bay at six weeks, three months and six months are persistently below the national average and show consistent inequity for Māori, Pacific and people living in areas of high deprivation. Breastfeeding rates at three months are lower than in 2015 for all ethnic groups.

We have however seen some improvements in the percentage of women (including for Māori and Pacific) breastfeeding at two weeks after discharge. The challenge is to support women in maintaining these higher rates of breastfeeding for longer.

PERCENTAGE OF HAWKE'S BAY INFANTS BREASTFEEDING (FULLY OR EXCLUSIVELY) AT THREE MONTHS



Source: Wellchild Tamariki Ora dataset

KEY:

Total · Māori · Pacific · High Deprivation Area

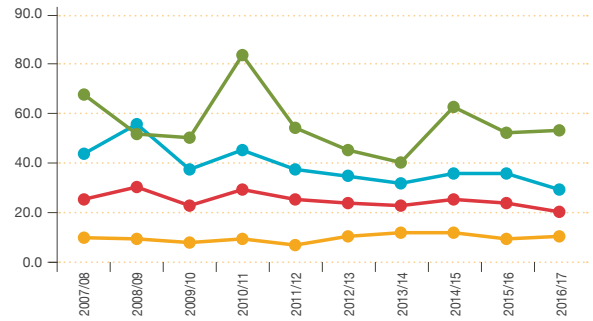
The gap in housing-related childhood illness stopped closing in 2013

Bronchiolitis (an acute respiratory illness which affects infants) is linked to housing conditions and other environmental factors such as smoking in the home.

The gap between Māori and NZ European/Other for bronchiolitis hospital stays reduced between 2009 and 2013. There has been little or no decline for Māori infants since that time and rates for Māori infants remain significantly higher than NZ European/Other. Pacific infant hospital stays for bronchiolitis remain significantly higher than Māori and NZ European/Other infants.

Over the same period, housing demand has increased and demand for social housing has tripled over the last three years. Families are forced to share housing and to accept unhealthy living conditions.

HAWKE'S BAY ACUTE BROCHIOLITIS HOSPITALISATION RATE PER 1000 POPULATION (0-4 YEARS)



Source: National Minimum Dataset

KEY:

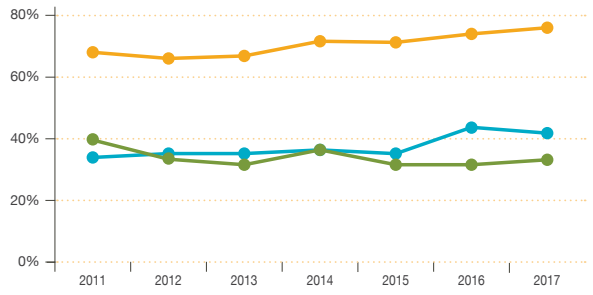
HB Total · Māori · Pacific · NZ European/Other

Māori five year olds have less dental decay, but a large and persistent equity gap remains for Māori and Pacific children

There has been a small improvement in the percentage of Māori children who are free of dental decay since 2015.

However a large inequity persists which is partly due to the improvements for NZ European/Other children. There has been no improvement in dental health for Pacific children and rates are worse now than they were in 2011.

HAWKE'S BAY PERCENTAGE OF FIVE YEAR OLDS FREE OF DENTAL DECAY BY ETHNICITY



Source: HBDHB Oral Health Information System

KEY:

Māori · Pacific · NZ European/Other

Progress stalled in reducing Māori and Pacific children's hospital stays for conditions that could be prevented by better community care

Ambulatory Sensitive Hospitalisations (ASH) are hospital stays for conditions that could be avoided through better community care. ASH rates provide a useful gauge for primary care access and quality.

Overall, Hawke's Bay ASH rates for 0-4 year olds remain lower than New Zealand and Hawke's Bay DHB is ranked 6th lowest out of all DHBs.

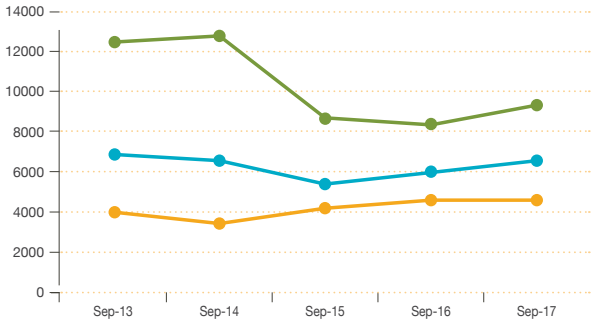
Between 2013 and 2015, considerable progress was made towards closing the equity gap for Māori and Pacific children. However since 2015 this trend has stalled, with ASH rates increasing for Māori, Pacific and NZ European/Other children.

Despite the fact that Hawke's Bay ASH rates for Pacific children are amongst the lowest of all eight DHBs with high Pacific populations, Pacific children living in Hawke's Bay have the highest ASH rates of all ethnic groups.

Good progress continues in reducing avoidable hospital stays for asthma and oral health problems.

Progress on reducing ASH rates for cellulitis (skin infections) in Pacific children has been reversed over the last 12 months.

HAWKE'S BAY AMBULATORY SENSITIVE HOSPITALISATION RATE PER 100,000 POPULATION BY ETHNICITY (0-4 YEARS)

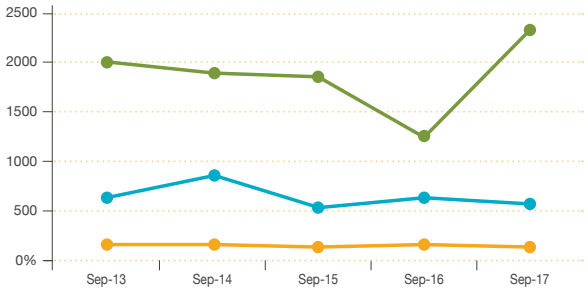


Source: National Minimum Dataset

KEY:

Māori · Pacific · NZ European/Other

HAWKE'S BAY AMBULATORY SENSITIVE HOSPITALISATION RATE PER 100,000 POPULATION FOR CELLULITIS BY ETHNICITY (0-4 YEARS)



Source: National Minimum Dataset

KEY:

Māori · Pacific · NZ European/Other

14.1

HEALTH ACROSS THE LIFE COURSE:

Youth

Pregnancy (under 18s) and sexually transmitted infections are two key measures where there are significant and persistent inequities for our young people.

These measures provide an indication of the quality and adequacy of our youth health services.

Iti rearea, kahikateā, ka tāeā

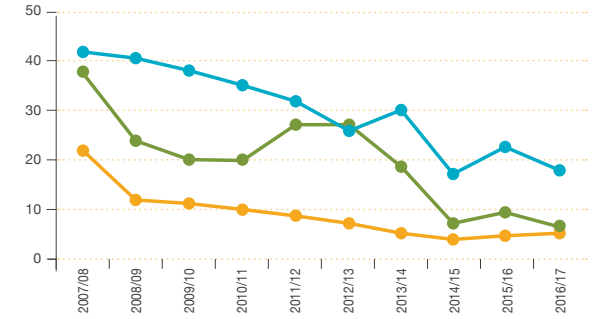
Lofty heights are surmountable

Significant progress made in reducing pregnancy in under 18 year olds but access to services remains an issue

Since 2007/08 the Māori rate of pregnancy for under 18 year olds has decreased by more than half from 41.4 per 1000 to 18.5 per 1000. Rates for Pacific under 18 year olds are now similar to NZ European/Other.

Despite these health gains, persistent equity gaps for Māori remain and Hawke's Bay rates remain higher than New Zealand overall. In 2016/17, Māori under 18 year olds were almost four times more likely to have a pregnancy than NZ European/Other. Adolescent pregnancy can have negative health, social and economic effects on girls, their families/whānau and communities, which makes access to appropriate health care for young men and women even more important.

HAWKE'S BAY CONCEPTION (BIRTHS AND TERMINATIONS)
RATE PER 1000 POPULATION FOR UNDER 18 YEAR OLDS BY ETHNICITY



Source: National Minimum Dataset

KEY:

Māori Pacific NZ European/Other

14.1

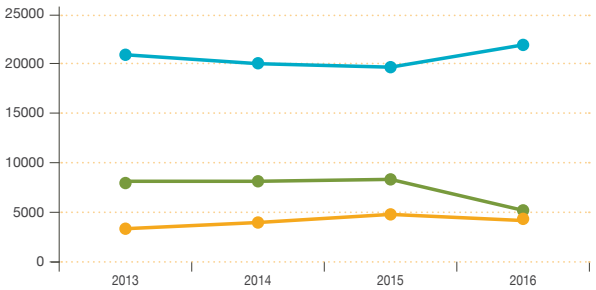
Large inequities continue in sexually transmitted infections (STIs) and some STIs are increasing

Large equity gaps exist across most STIs, with young Māori (male and female) most vulnerable to undetected and untreated STIs.

Chlamydia and gonorrhoea levels are higher in Hawke's Bay than nationally and syphilis is on the increase.

Improving access to youth-friendly and culturally appropriate care is critical to reduce the harmful effect on individuals and prevent wider STI spread in the community. This will also help to protect the health of future generations, given the harmful impact of STIs on reproductive health and fertility.

HAWKE'S BAY LABORATORY-CONFIRMED CHLAMYDIA RATE PER 100,000
POPULATION FOR 15-19 YEAR OLD FEMALES BY ETHNICITY



Source: Institute of Environmental Science & Research (ESR)

KEY:

Māori Pacific NZ European/Other

HEALTH ACROSS THE LIFE COURSE:

Adulthood

Long-term conditions are the leading cause of poor health and early death for adults in Hawke's Bay.

This section describes trends for some of the key conditions that contribute most to health loss: cancer, cardiovascular disease, respiratory conditions and diabetes.

Me mate ūruroa,
koi mate wheke

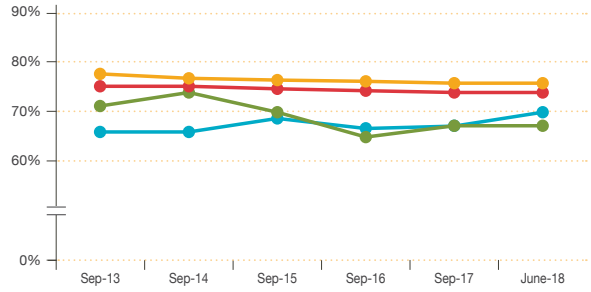
Endless toil garners rich reward

Breast screening target for wahine Māori achieved this year for the first time

In June 2018, Hawke's Bay reached the Ministry of Health target for breast screening for wahine Māori of 70 percent. This is the first time this target has been achieved.

However, rates for Pacific women have decreased, creating an increasing inequity for Pacific women.

HAWKE'S BAY PERCENTAGE OF WOMEN RECEIVING BREAST SCREENING IN THE PREVIOUS TWO YEARS BY ETHNICITY (50-69 YEARS)



Source: BreastScreen Aotearoa

KEY:

Total · Māori · Pacific · NZ European/Other

14.1

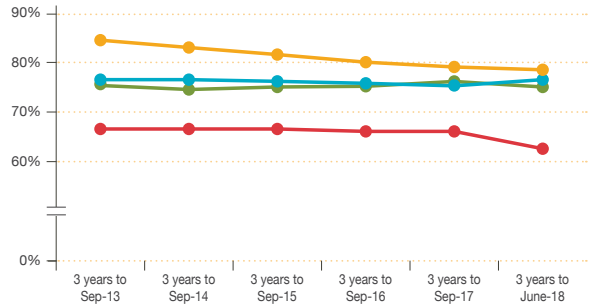
Māori and Pacific cervical screening rates are holding despite an overall decline

At a national level, cervical screening rates are in decline and this trend is also reflected in Hawke's Bay.

However in Hawke's Bay, Māori and Pacific screening rates are remaining constant, and this is most likely due to the increased efforts of outreach services for Māori and Pacific women (refer page 52).

Of concern is that Asian screening rates are persistently lower than other ethnic groups and have declined further in the most recent period to June 2018.

HAWKE'S BAY PERCENTAGE OF WOMEN RECEIVING CERVICAL SCREENING IN THE PREVIOUS THREE YEARS BY ETHNICITY (25-69 YEARS)



Source: National Cervical Screening Programme

KEY:

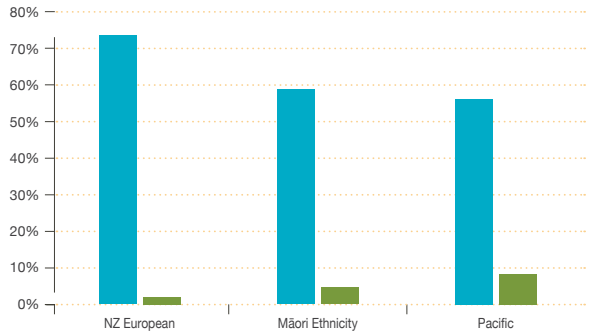
Asian · Māori · Pacific · NZ European/Other

Diabetes remains more common among Pacific and Māori and is less likely to be well controlled

Diabetes is responsible for a significant burden of ill health including cardiovascular disease, kidney disease, and blindness. This is especially the case for Māori and Pacific people who have the highest prevalence of diabetes but are also less likely to have had an annual diabetes check or have their diabetes under good control (HbA1c <65). This is a significant area of mismatch between health need and health service provision.

Furthermore, equity between Māori and Pacific and NZ European[2] populations does not appear to have improved between 2015 and 2018.

HAWKE'S BAY DIABETIC CONTROL BY ETHNICITY (2017/18)



Source: Health Hawke's Bay

KEY:

Well controlled (HbA1c <65) Very poorly controlled (Hba1c >100)

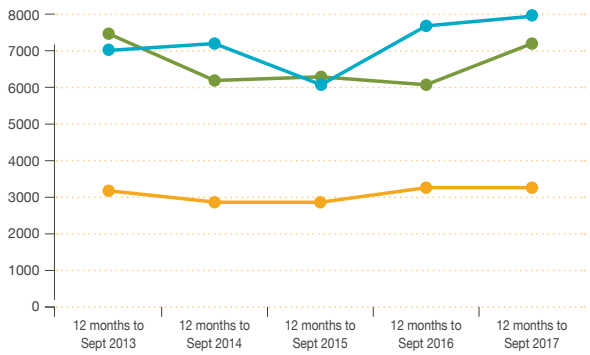
Hospital stays for Māori and Pacific adults (45-64 years) for conditions that could be prevented by better community care are increasing

Ambulatory Sensitive Hospitalisations (ASH) are hospital stays for conditions that could be avoided through better community care. ASH rates provide a useful gauge for primary care access and quality.

Māori and Pacific ASH rates for 45-64 year olds were reducing between 2013 and 2015 but now appear to be increasing. ASH rates for 45-64 year olds in Hawke's Bay are now significantly higher than New Zealand.

The increase in the overall ASH rate for 45-64 year olds is driven by growth in ASH rates for heart attacks, skin infections and chronic bronchitis and emphysema (COPD).

HAWKE'S BAY AMBULATORY SENSITIVE HOSPITALISATION RATE PER 100,000 POPULATION BY ETHNICITY (45-64 YEARS)



Source: National Minimum Dataset

KEY:

Māori Pacific NZ European/Other

[2]NZ European only. Does not include Asian/Other

Hospital stays for Māori and Pacific adults (45-64 years) for conditions that could be prevented by better community care are increasing

HEALTH ACROSS THE LIFE COURSE:

The end of life

We have stopped making progress towards equity in early avoidable deaths.

Ahakoa he tupu mātāngerengere, me ū

Although there are difficult phases of development, remain committed

Premature deaths

An increasing gap in premature death rates for Māori due to lung cancer, suicide and heart disease has resulted in an overall stalling of the previous trend towards reducing inequity. Not all deaths prior to 75 years are considered avoidable.

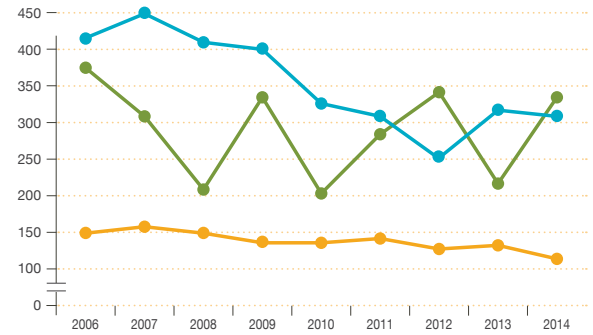
In this report, **premature** *deaths are deaths that occur* **before** *the age of* **75 years**

Avoidable deaths

Avoidable deaths are deaths before the age of 75 years that could have been avoided either by disease prevention or effective treatment and health care

Avoidable death rates for Māori improved considerably from 2006 to 2012 but there have been no further improvements since that time. For Pacific people, there has been no discernible decline in avoidable deaths since 2006/2007. Avoidable death rates for NZ European/Other have been in slow decline since 2006. The result is an increasing equity gap in avoidable deaths for Māori and Pacific people.

HAWKE'S BAY AVOIDABLE DEATHS AGE STANDARDISED RATE PER 100,000 POPULATION BY ETHNICITY (0-74 YEARS)



Source: National Mortality Collection 2018

KEY:

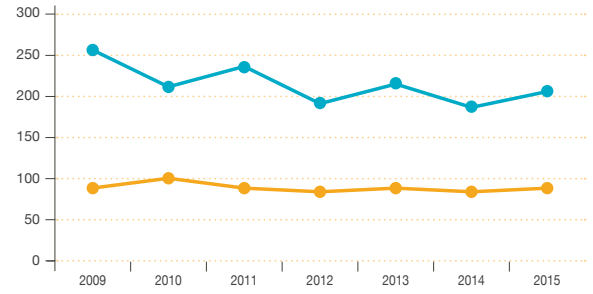
Māori Pacific NZ European/Other

Amenable deaths

Amenable deaths (a sub-set of avoidable deaths) are deaths which could have been avoided through access to quality health care. Amenable deaths are therefore a good "big picture" indicator of how the health system is performing.

Between 2009 and 2012, amenable deaths for Māori were in decline but in the last three years of available data (2012-2015) that positive trend has stalled.

HAWKE'S BAY AMENABLE DEATHS AGE STANDARDISED RATE PER 100,000 POPULATION BY ETHNICITY (0-74 YEARS)



Source: National Mortality Collection 2018

KEY:

Māori NZ European/Other

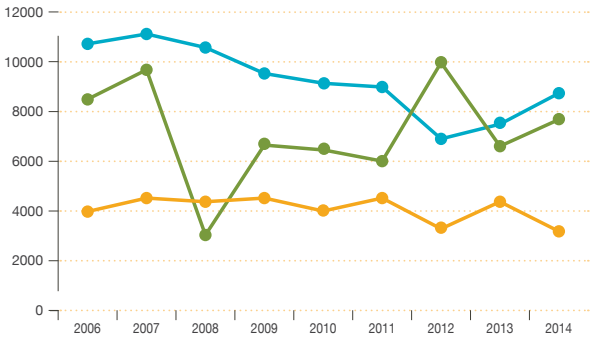
Years of Life Lost

Another way of looking at premature deaths is to calculate the average years a person would have lived if they had not died early.

This method, known as Years of Life Lost (YLL), emphasises the importance of deaths which occur at earlier ages because there are more years of life lost. The equity gap in YLL between Māori and NZ European/Other reduced between 2007 and 2012 but in the last two years of available data (2012-2014), progress has stalled. YLL is also increasing for Pacific people.

Top causes of Years of Life Lost for Māori are coronary heart disease, suicide, lung cancer and road traffic crashes.

HAWKE'S BAY YEARS OF LIFE LOST AGE STANDARDISED RATE PER 100,000 POPULATION BY ETHNICITY (0-74 YEARS)

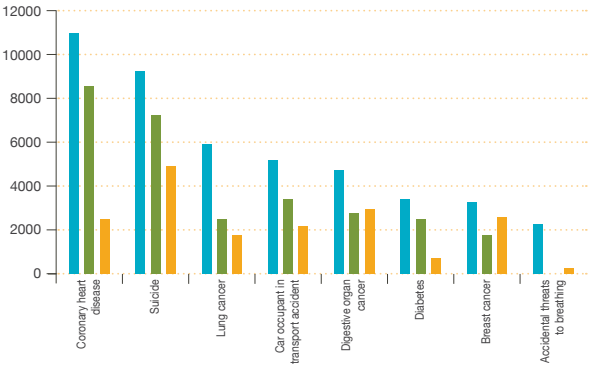


Source: National Mortality Collection 2018

KEY:

Māori Pacific NZ European/Other

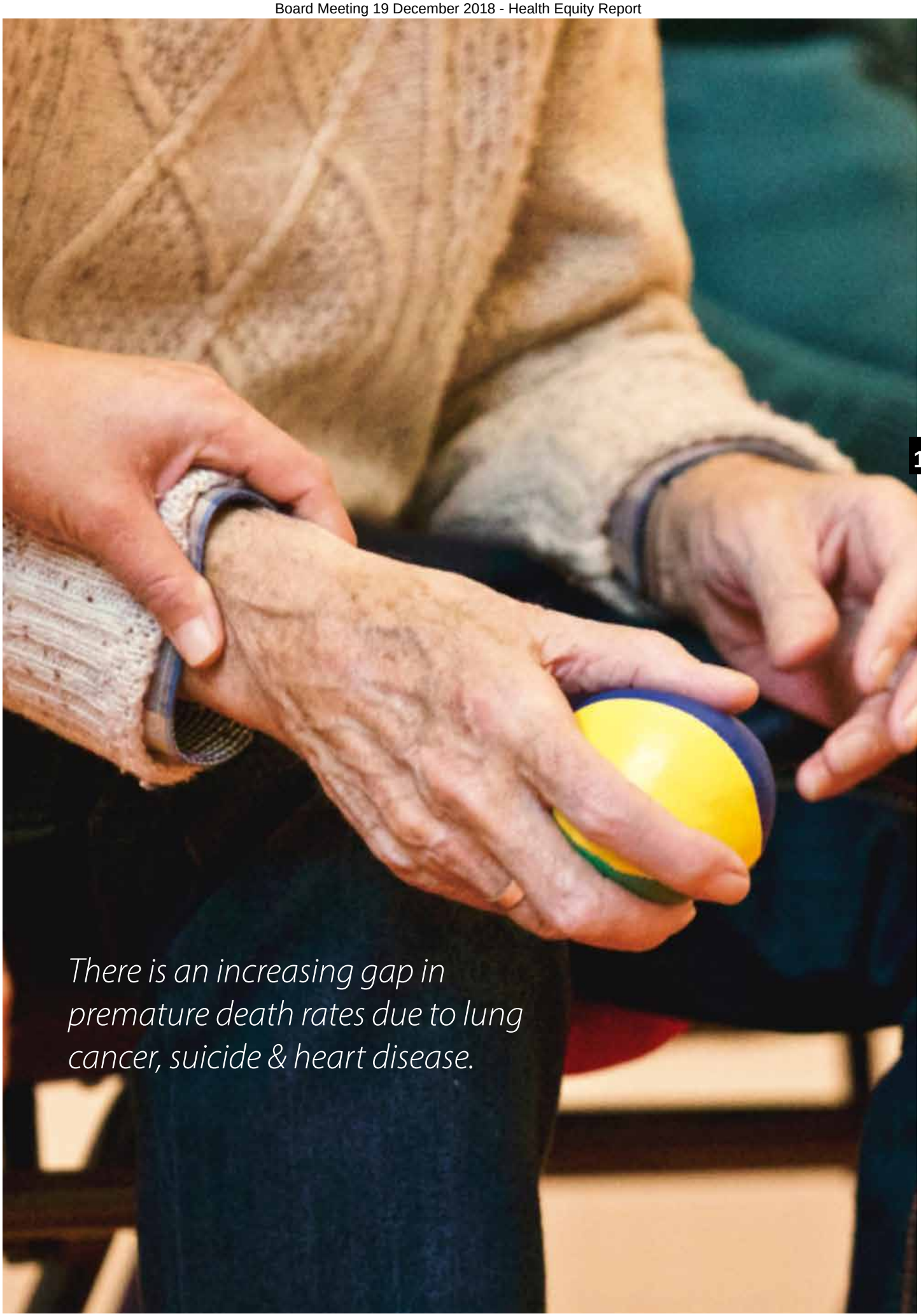
TOP CAUSES OF YEARS OF LIFE LOST AGE STANDARDISED RATE PER 100,000 POPULATION BY ETHNICITY (2010-2014)



Source: National Mortality Collection 2018

KEY:

Māori Pacific NZ European/Other


There is an increasing gap in premature death rates due to lung cancer, suicide & heart disease.

SPOTLIGHTS

Mahia te mahi

The work is ready to do

A SPOTLIGHT ON:

Pacific health in Hawke's Bay

Talalelei Taufale, Hawke's Bay DHB's Pacific Health Manager

It is important to acknowledge that Pacific people want to live healthy, strong lives.

But many Pacific families struggle with socio economic pressures, as well as the demands of balancing Pacific values, culture, language, family and church expectations with societal norms and expectations.

Pacific communities are made up of separate and unique ethnic groups, and approaches may need to vary between them. Also, Pacific and Māori are often addressed as one group.

Our current health system presents obstacles for the Pacific community such as language barriers, cost, transport and hours of opening. The local Pacific community would benefit from a health system that is culturally responsive to Pacific people; and from a greater understanding of what quality care for Pacific people looks like.

Some health services serve the local Pacific community very well, for example breast and cervical screening. These services have made an effort to understand the Pacific world view and to orient their services to work better for Pacific people.

The Hawke's Bay DHB's Pasifika health service was established in 2017 and includes a team of outreach navigators (further detail in the story over the page). **It is the only dedicated Pacific health team in the Hawke's Bay DHB; and is culturally responsive, delivering a whānau-centred service that is making a difference. One Pacific family described our navigators as "angels from heaven".**

Pacific five year olds have the **highest rates of tooth decay**

Pacific children have the **highest rates** *of* **avoidable hospital stays**

The Pasifika health service works closely with other health services on how to provide the best service for Pacific people but this takes time. The willingness of services to be involved and undertake this journey of learning is encouraging and will create some real shifts in the way we work with the Pacific community and the outcomes we achieve.

What are the building blocks for improving Pacific health?

1
We need to cement a "turangawaewae" - a place to stand and a sense of belonging for Pacific health at all layers and levels of the Hawke's Bay DHB. Having a place to stand and a voice to effect change will give assurance to the community that Pacific health is a priority - not an afterthought or an add on.

2
Growing the Pacific health workforce is a priority, especially in the services that Pacific people are using most frequently. We need to create working environments where Pacific staff and patients feel welcomed and supported.

3
We need to reshape the way our health services work with Pacific communities and we need to deliver services in Pacific community settings including established church networks, family and other social and sporting settings.

4
The traditional approach of working with individuals does not work for Pacific families. A flexible, whole-of-family approach is a lot more effective. This way we can capture other health conditions and outstanding health checks, as well as improve community understanding of how and when to use services. In working with families we are also more likely to gain buy in from our Pacific clients and to build genuine relationships that support effective service provision.

Back row: Paul Faleono, Talalelei Taufale
Front row: Silia Momoisea, Olive Tanielu, Amataga Iuli

CASE STUDY:

WORKING WITH FAMILIES, PACIFIC STYLE

Paul Faleono is a Pacific Health Navigator with the Hawke's Bay DHB's Pasifika Health Service and shared this story of how a Pacific-based, whānau centred approach works.

"The Kaotira family migrated from Kiribati to Hawke's Bay in early 2017 to work on a Patoka dairy farm with their five children. Their house was an hour's drive from the nearest doctor. They were isolated geographically and culturally, and they spoke little English.

When we first visited the family, we greeted them in Kiribati and Samoan then sat on the floor and began to talk. We spoke about their family, their village, their island and the reasons they had migrated. From there we were able to talk about health and other issues. We then went away and connected with other health and social services as well as the Healthy Homes team to get the Kaotira family the support they needed.

During the following school holidays we visited the family again, accompanied by a public health nurse. In just one visit, all the children received health checks, were shown how to brush their teeth, skin and ear infections were addressed, and the family was shown how to use their unopened asthma medication. We also provided the father with some patches and gum to help him quit smoking.

The Kaotira family emerged from this visit with more knowledge about the health issues affecting their family and a greater connection with the services that can help them. We visit the Kaotira family at regular intervals and continue to support them on their health journey."

A SPOTLIGHT ON:

Mental health in Hawke's Bay

A strong sense of mental wellbeing is vital to enable people to live life to the fullest and engage actively in their family or whānau, in employment, hobbies and the wider community.

Data on self-rated health, psychological distress, alcohol and other drug use and mood/anxiety disorders are sourced from the New Zealand Health Survey.

E tipu, e rea, hei ōranga

Grow o tender shoot

Self-rated health

Self-rated health is an important measure of both physical and mental wellbeing. Rather than simply capturing physical disease, it provides an insight into a person's lived health experience.

- 87 percent of Hawke's Bay adults describe their health as excellent, very good, or good.
- However only 81 percent of Māori report excellent, very good or good health.
- People living in our least affluent communities also rate their health lower.

Psychological distress

Psychological distress is where someone is significantly affected by feelings of anxiety, confused emotions, depression or rage.

- Levels of self-reported distress slowly increased in New Zealand between 2011 and 2017. For the 2014 to 2017 period Hawke's Bay DHB was among the DHBs with the highest levels of self-reported distress and Hawke's Bay's rate was significantly above the rate for New Zealand.
- Psychological distress is highest for Māori and Pacific people[3].

[3] Based on national findings as the Hawke's Bay survey size was too small to reach statistical significance.

Alcohol and other drugs

- 29 percent of Hawke's Bay adults are hazardous drinkers. This means they are likely to be harming their own health or harming others through their drinking. Young people are particularly vulnerable as earlier initiation and heavier drinking sessions are more likely to lead to the development of a harmful drinking pattern later in life.
- Amphetamine use in Hawke's Bay appears to be slowly decreasing and is now in line with the rest of New Zealand (having previously been much higher).
- Cannabis use remains significantly higher than the rest of New Zealand. Māori men are the highest users of cannabis in Hawke's Bay. Unfortunately, the New Zealand Health Survey data do not include synthetic substances which are a serious concern for many whānau.

29%** of Hawke's Bay **adults** are **hazardous drinkers

***Cannabis use** remains significantly **higher** than the rest of New Zealand*

***Synthetic substances** are a serious concern for many whānau*

14.1

Mood/anxiety disorders

Mood/anxiety disorders include depression, bipolar disorder, panic attacks, phobia, post-traumatic stress and obsessive compulsive disorders.

- Almost one in five Hawke's Bay adults report being diagnosed with a mood or anxiety disorder during their lifetime.
- Women's rates are double those of men.
- People living in our most deprived communities have higher rates than those living in least deprived areas.

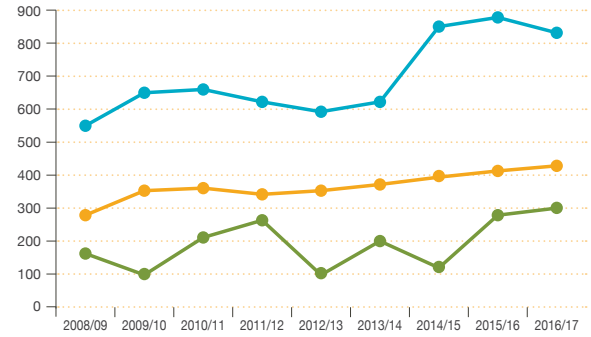
*Almost **1 in 5** Hawke's Bay **adults** report being diagnosed with a **mood** or **anxiety disorder** during their lifetime*

Mental Health Inpatient Services and Compulsory Treatment Orders

Mental health inpatient services and compulsory treatment orders provide for the most severely ill patients.
A compulsory treatment order is a court order requiring a person to receive treatment for up to six months.

- While mental health inpatient hospital stays have been slowly increasing since 2008/9, the more rapid increase following 2013/14 has likely been influenced by the way clinical services have been delivered with less respite care available in the community, rather than being driven by a significant increase in community need.
- Māori are 2.5 times more likely to be admitted to mental health inpatient services than non-Māori.
- Compulsory treatment orders for Māori are three times those of non-Māori.

MENTAL HEALTH INPATIENT HOSPITALISATIONS (HAWKE'S BAY DHB FACILITIES & HAWKE'S BAY RESIDENTS) AGE STANDARDISED RATE PER 100,000 POPULATION BY ETHNICITY



Source: HBDHB Data Warehouse

KEY:

Māori Pacific[4] NZ European/Other

Intentional self harm

Intentional self-harm is a deliberate act which may not be done with the intention of ending life but nevertheless reflects extreme emotional distress. Traumatic life experiences and a lack of secure relationships increases the risk of self harm.

- The rate of Hawke's Bay self-harm hospital stays has increased by 30 percent between 2013/14 and 2016/17. While the overall numbers are not large (180 admissions in 2013/14 increasing to 241 admissions in 2016/17) it is a concerning marker of suffering for both individuals and whānau. This is not solely a Hawke's Bay phenomenon with a similar increase in self-harm hospital stays occurring for New Zealand over the same time period.
- Women's hospitalisation rates for self-harm are double those of men and Māori are more likely to self harm than non-Māori.

The rate of **self-harm** *hospital stays has* **increased** *by* **30%** *between 2013/14 and 2016/17*

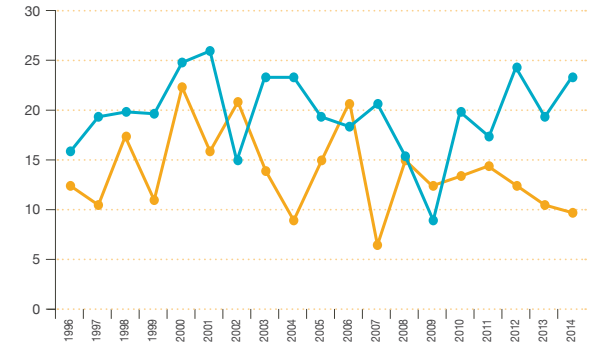
Women's *hospitalisation rates for* **self-harm** *are* **double** *those of men*

[4] Pacific numbers are very small and below NZ European/Other. Further investigation is needed to establish whether this reflects less need for inpatient services or barriers to access.

Suicide

- Suicide is a major cause of premature, avoidable death in Hawke's Bay, especially for Māori. Suicide is the second highest cause of years of life lost (YLL) for Māori and Pacific people (refer page 36).
- The rate of suicide deaths appears to have been reducing for NZ European/Other while Māori suicide rates appear to have increased. Suicide data does need to be interpreted with caution given the small number of deaths that occur each year.
- Provisional coronial data (which haven't been adjusted to account for population growth) indicate that suicide deaths are increasing over time.
- Alcohol intoxication or a history of alcohol abuse are often associated with youth suicide[5].

HAWKE'S BAY SUICIDE AGE STANDARDISED RATE PER 100,000 POPULATION BY ETHNICITY (0-74 YEARS)



Source: National Mortality Collection 2018

KEY:

Māori NZ European/Other

Suicide *is a* **major cause** *of premature, avoidable death in* **Hawke's Bay**

[5] Sir Peter Gluckman. Youth suicide in New Zealand – a discussion paper.

CASE STUDY:

PARTNERING TO SUPPORT YOUNG PEOPLE WITH MENTAL HEALTH ISSUES

For Luke, detail is very important so a job researching and digitising historic cemetery records at Hastings District Council was ideal. Luke was employed for six months to get Hastings' old hand-written burial records into an easily searchable on-line format. During this time, Luke built up his computer and research skills while growing his confidence. His completed proposal to Council identified further work – he proposed a 12 month contract and is now the official 'cemetery intern'.

Luke's initial job with Hastings District Council was created as part of the Rangatahi mā Kia eke programme - a programme designed to support young people who are experiencing mental health issues (or other health and disability conditions) to overcome barriers to employment. Sponsor organisations identify a project which delivers community or environmental good. A young person is recommended and both the sponsor and young person are supported to deliver the project by the partner agencies.

Over the past 12 months, Rangatahi mā Kia eke has delivered some really positive outcomes including re-engaging young people with education, career direction and experience and employment opportunities. The young people have also made a positive contribution to the sponsor organisations they worked for.

The programme is a great example of collaboration in action. The programme is delivered by Hastings District Council and funded by the Ministry of Social Development, who also provide Work Broker support and links to other Work and Income services. EIT, Oranga Tamariki, Te Puni Kokiri and Hawke's Bay DHB provide expert information, links to services and advisory group membership.

Engagement in society including employment is an effective tool in supporting wellbeing and for rangatahi on this programme experiencing mental health issues, it has been life changing.

A SPOTLIGHT ON:

Family Violence

"Family violence is a long-standing and complex problem. It has contributing factors from multiple levels of society. Family violence is preventable, but it will require long-term commitment and sustained action across many sectors. Along the way, we will continue to need high quality responses to those who have experienced violence, and those who have perpetrated it."

– New Zealand Family Violence Clearinghouse

Ka whati te kupenga, ka hao te rangatahi

A tattered net signifies change is on the horizon

There is no monitoring framework for family violence in Hawke's Bay and there is no straight forward way of measuring the prevalence of family violence in our community.

For this report, we look first at a snapshot of key national statistics and we then present two indicators at the Hawke's Bay level.

The first is female hospital stays due to assault and the second is the relationship of offenders of serious assaults to their victims. Both of these indicators capture only the most serious cases of assault and therefore are no measure of the prevalence of family violence in our community.

While society-wide efforts are essential if we are to address family violence, health services have an important role to play in effective screening and early intervention.

The National Picture in Family Violence[6]

47% *of all homicide* **deaths** *in New Zealand are* **family related**

Almost a **third** *of all family violence* **deaths** *in New Zealand are* **children**, *who have died as a result of* **abuse** *&* **neglect**

1 in 3 *New Zealand* **women** *experience* **physical** *and/or* **sexual abuse** *from a* **partner** *in their lifetime*

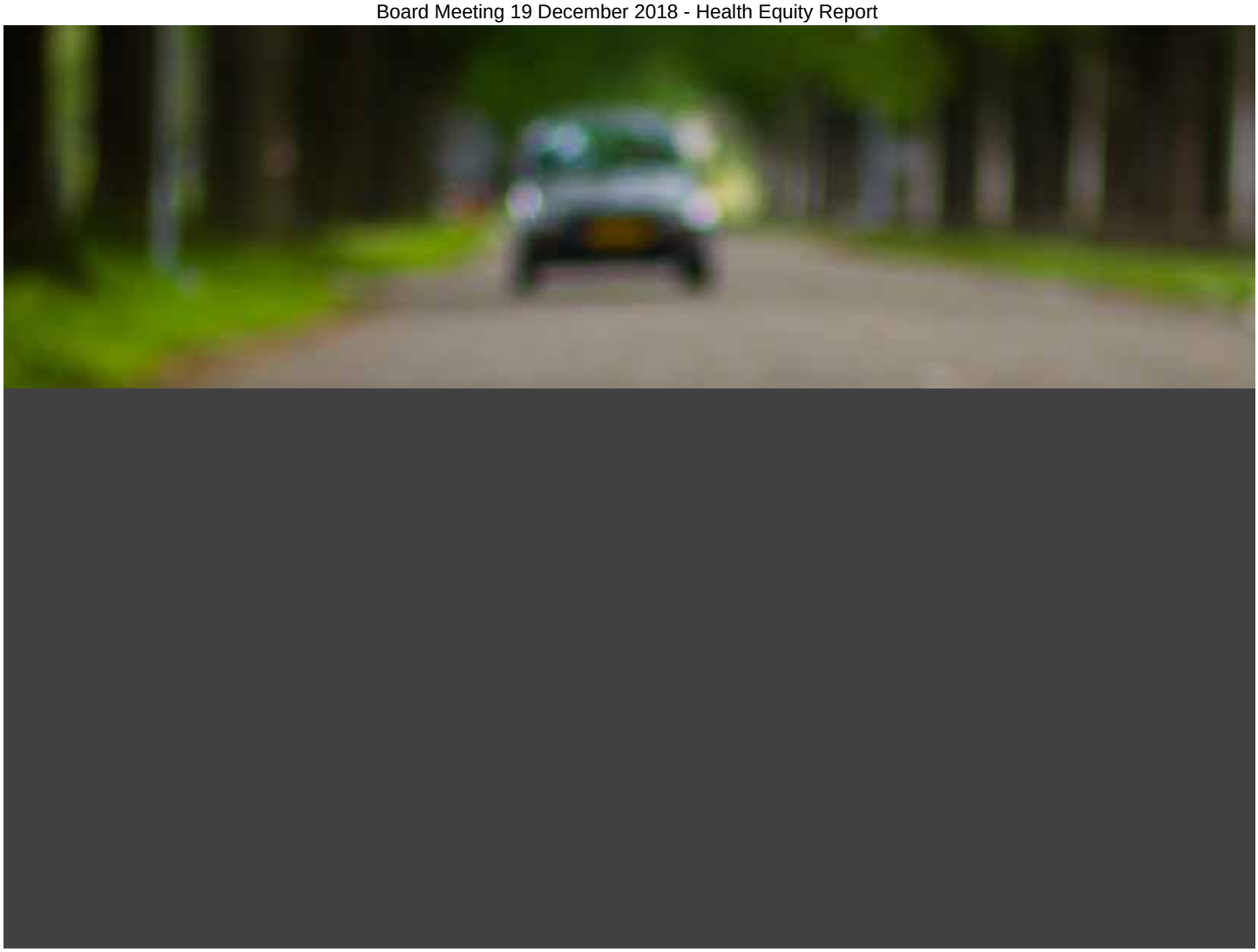
3/4 *of intimate* **partner violence** *is perpetrated by* **men** *and* **1/4 by women**

3/4 *of interpersonal* **offences** *by a family member are* **not reported** *to Police*

Pacific young people are **3 times more likely** *to be exposed to* **family violence** *than NZ European young people*

Māori **children** *are* **6 times more likely** *to* **die** *from* **child abuse** *or* **neglect**

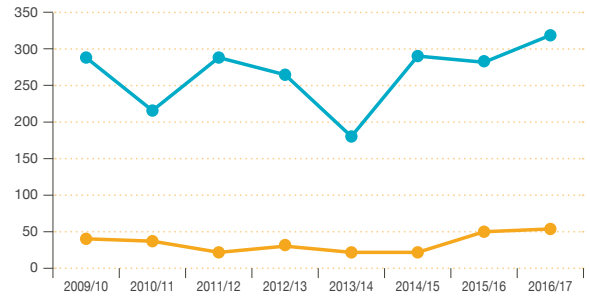
[6] Family Violence Clearinghouse



Female hospital stays for assault in Hawke's Bay[7]

- Hawke's Bay female hospital stays due to assault include assaults by any person, not just family members. They are not, therefore, a direct measure of family violence but they do provide part of the picture.
- Female rates of hospital stays for assault are increasing over time and, in 2016/17, Hawke's Bay female rates were higher than New Zealand females (reaching statistical significance). Hawke's Bay Māori female rates of hospital stays due to assault are six times those of NZ European/Other.

HAWKE'S BAY FEMALE ASSAULT HOSPITALISATION RATE AGE STANDARDISED PER 100,000 POPULATION BY ETHNICITY



Source: National Minimum Dataset

KEY:

Māori NZ European/Other

[7] Includes females of all ages but predominantly adult females

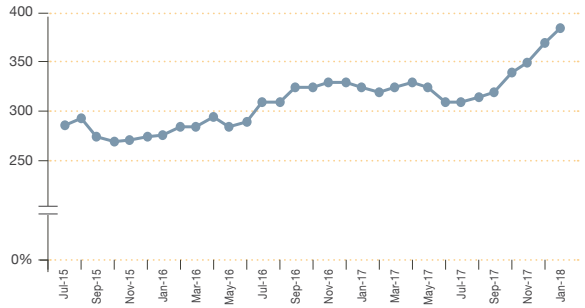
Serious assault causing injury

Police data records serious assaults causing injury and the relationship of the offender and victim. Over half of the victims of serious assault causing injury are a current or past partner of the offender. A further 16 percent are other family members.

Over **half** *of the* **victims** *of serious* **assault** *causing injury are a current or past* **partner** *of the* **offender**

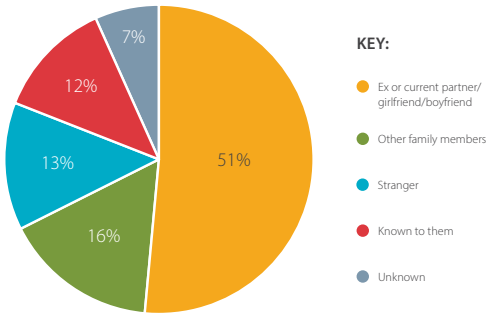
16% *of the* **victims** *of serious* **assault** *causing injury are non-partner family members of the* **offender**

NUMBER OF OFFENDERS FOR SERIOUS ASSAULTS RESULTING IN INJURY - HAWKE'S BAY POLICE AREA BY ROLLING 12 MONTH PERIOD



Source: New Zealand Police

HAWKE'S BAY OFFENDERS FOR SERIOUS ASSAULT CAUSING INJURY IN 12 MONTHS TO JANUARY 2018 - % BY RELATIONSHIP OF VICTIM



Source: New Zealand Police

Mahia te mahi

The work is ready to do

A SPOTLIGHT ON:

Housing and Health

Poor housing causes poor health. Cold and damp housing coupled with household crowding continues to affect the health and wellbeing of many Hawke's Bay families.

E kore au e ngaro he kākano i ruia mai

As a seedling, my growth is maintained

Poor housing conditions are regularly linked to presentations of young children suffering from acute bronchiolitis – a viral infection of the airways.

Māori children are three times and Pacific children five times more likely to need to stay in hospital for bronchiolitis than NZ European/Other children. Acute bronchiolitis is not easily treated by a visit to the doctor, but there is clear evidence it can be reduced with warm, dry, smokefree and uncrowded housing.

Household crowding is also an important risk factor for a range of infectious diseases including pneumonia, bronchiolitis, gastroenteritis, rheumatic fever, tuberculosis and skin infections.

Pacific children are more likely to be admitted to hospital for a skin infection while acute rheumatic fever and tuberculosis continue to impact Māori and Pacific people at much higher rates than NZ European.

Hawke's Bay's challenges

- Demand for social housing has tripled over the last three years
- Two thirds of people on the social housing register are Māori
- There are many rental homes in the private rental market in substandard condition adding to poor health outcomes for tenants.

Turning health outcomes around for Māori and Pacific families requires addressing these challenging housing situations. Hawke's Bay DHB has responded to this need with a Child Healthy Housing Programme where there are many initiatives making a positive impact on the health and wellbeing of families. Complementing this work is a Ready to Rent programme, supported by the Hawke's Bay Housing Coalition and wider networks.

These programmes are a step in the right direction to achieving healthier homes and a healthier population but there is much work to be done to address the lack of housing and unacceptable housing situation faced by many.

CASE STUDY:

HOME IS WHERE THE HEALTH IS

Mel West is a kaiāwhina for the Hawke's Bay DHB's Child Healthy Housing Programme and shares a story about the work it does to support families in need.

"A grandmother and her five grandchildren were referred to Hawke's Bay DHB's Child Healthy Housing team after one child got pneumonia. All six of the family had respiratory issues and one child was in a wheelchair with high health needs.

The rental property the family were in was uninsulated and draughty. Weatherboards and flashings were missing and black mould was growing in the bedrooms. The ceiling was sagging in parts and falling down in others. Mouse droppings and other debris would fall into the house through holes in the ceiling. There was not a single smoke alarm in the house.

The Child Healthy Housing team helped this family to find a long term rental which was dry, insulated, had new carpets and curtains as well as a compliant fireplace. The team arranged for wheelchair modifications and donated bunks and bedding. This family are feeling very happy and secure in their new home thanks to the instant health benefits. They enjoyed a warm winter with no hospital admissions."

The Child Healthy Housing Programme has helped over 800 families to improve the health of their homes.

CASE STUDY:

READY TO RENT

Ready to Rent (R2R) began as a small idea which is fast growing into a local gem, receiving nationwide attention.

This local initiative is aimed at up-skilling tenants who are struggling to find a rental property and providing them with a 'support letter' they can use when applying for tenancies in the future.

The brainchild of the Hawke's Bay Housing Coalition, a group of local organisations who joined forces to improve access to quality housing, R2R is led by Hawke's Bay DHB, supported by the Hawke's Bay Property Investor's Association, Te Taiwhenua o Heretaunga, WINZ, Budget First and others.

Since its launch in 2017, 140 people have attended R2R, of which 75 percent have been Māori.

The programme has assisted attendees to successfully enter a competitive private rental market by building their skills and knowledge around renting. The programme includes sessions on the rights and responsibilities of tenants, what landlords want in a tenant, how to keep your home warm, dry and healthy as well as managing money and debts.

The New Zealand Property Investors' Federation (NZPIF) has praised the initiative saying that combined with compulsory insulation, the Ready to Rent programme was a cost-effective solution that would see the living standards of renters improve considerably.

"The New Zealand Property Investors' Federation (NZPIF) fully supports the Hawke's Bay DHB's Ready to Rent Programme," *it stated in a press release.*
"A study of local landlords showed that 85 percent would use this scheme to find the best candidate for their property."

Ready to Rent is a great example of local people with local relationships, ready and willing to address a local issue.

A SPOTLIGHT ON:

Screening

A new pathway implemented in 2017 has resulted in the most successful breast screening year yet in Hawke's Bay.

Te kekēte te āra mai i te āra

Many veins direct my paths

Reaching Out

A new pathway implemented in 2017 has resulted in the most successful breast screening year yet in Hawke's Bay, with record numbers of wahine (female) Māori receiving their mammogram in 2018 and the region achieving national Ministry of Health targets for wahine Māori of 70 percent for the first time.

The new pathway was implemented to prioritise women (Māori and Pacific) who were due or overdue for breast screening. The women were invited to attend a mobile screening facility, offered incentives to attend their appointment, and were well supported through their journey. The initiative's success came down to a collaboration between the Hawke's Bay DHB's population health screening team, BreastScreen Coast to Coast, general practices and Māori health providers.

In cervical screening, an increased focus on Māori and Pacific women has seen their screening rates hold constant, despite overall declines both in Hawke's Bay and nationally.

An **increased focus** *on Māori and Pacific women has seen their* **cervical screening rates** *hold* **constant, despite overall declines** *both in Hawke's Bay and* **nationally**

Many of the women we screen tell us that they wouldn't have done it if we hadn't come to them. So we know we are saving lives.

CASE STUDY:

CERVICAL SCREENING OUTREACH SERVICE

Margaret Alexander is a kaiāwhina working with Hawke's Bay DHB's cervical screening outreach service and shares her insights.

"Our service reaches out to Māori and Pacific women in high need communities by visiting them in their own homes and offering a smear service within their home environment. The women we reach out to do not typically engage with their doctor or respond to recalls because the system hasn't met their needs. The first thing we do is be accessible and gain trust and understanding of their situation. We also educate these women about the positive health benefits of screening. If you can engage positively you're half way towards meeting their needs.

We will often visit hesitant women a number of times, but we don't give up. In a culturally sensitive way, and in their own time and space, we get to the bottom of why someone may be unsure about having a smear.

We know our approach is working because most women will re-engage with their general practice at the end of our time with them. New relationships are also made with other women in the whānau who express a desire to connect with the service.

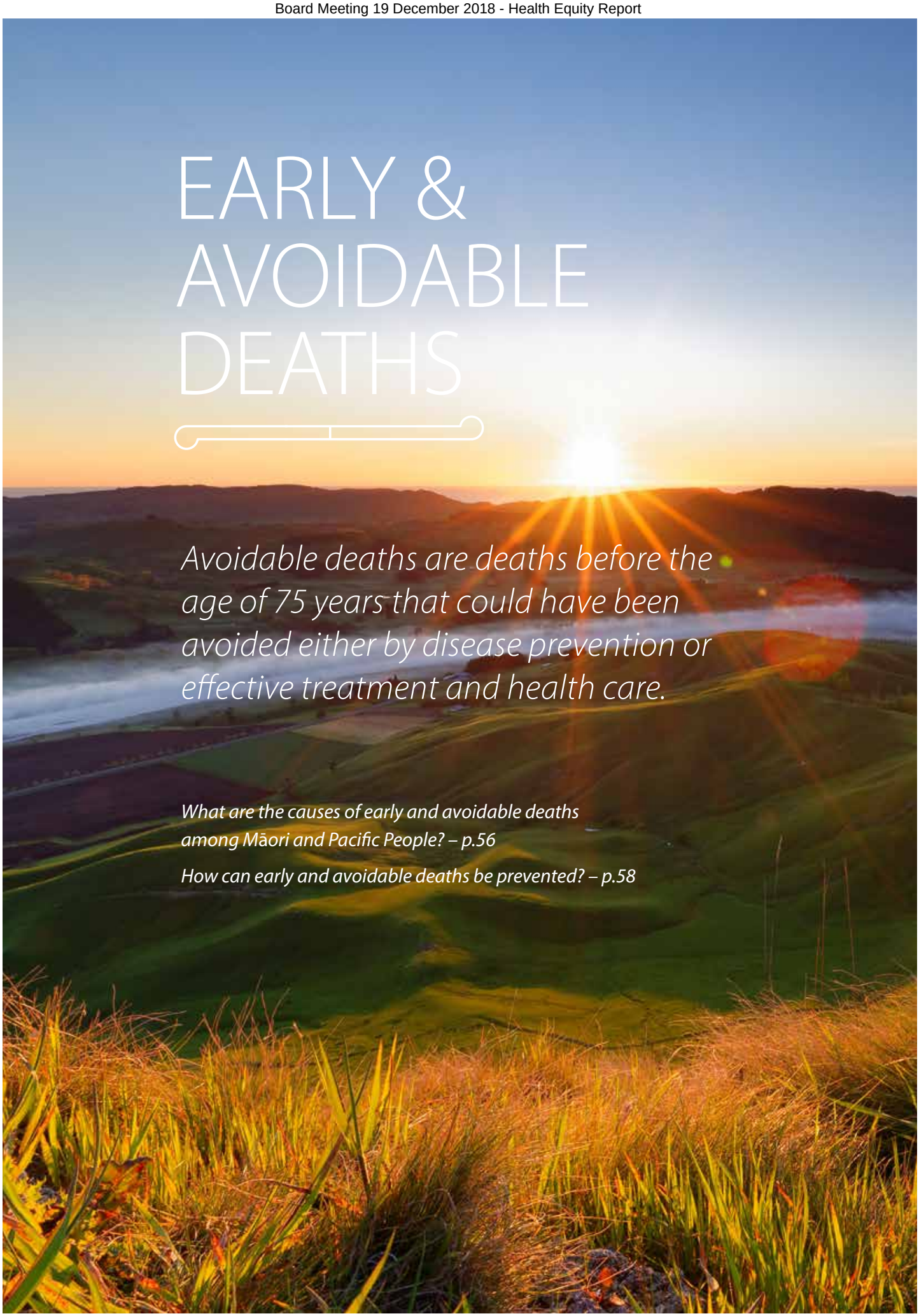
The outcomes

Cervical cancer is one of the easiest cancers to prevent, so long as cell changes are detected early. Many of the women we screen tell us that they wouldn't have done it if we hadn't come to them. So we know we are saving lives.

We support women to come together and recognise their worth as individuals, get aboard the waka and tautoko (support) each other to address their health needs and complete their smear as whānau. The benefits of having three generations of women in the same room giving each other awhi is so rewarding.

Benefits beyond screening

The nature of our service means that once kaiāwhina are in the homes, other health needs can also be discussed and guidance or referrals given."



EARLY & AVOIDABLE DEATHS

Avoidable deaths are deaths before the age of 75 years that could have been avoided either by disease prevention or effective treatment and health care.

What are the causes of early and avoidable deaths among Māori and Pacific People? – p.56

How can early and avoidable deaths be prevented? – p.58


Mēna, ka huu te ringahora, ka ora te rangi, ka ora te iwi
If it resounds from the east, the skies clear, the iwi thrives

What are the causes of early and avoidable deaths among Māori and Pacific people?

In Hawke's Bay, the gap in life expectancy between Māori and non-Māori is 8.2 years for males and 7.7 years for females[8].

This shorter life expectancy is because Māori, along with Pacific and people living in the least affluent parts of Hawke's Bay, are more likely to die at younger ages from conditions which are preventable or treatable. We call these "avoidable" deaths.

After a long period of improvement, avoidable death rates for Māori have stopped declining. For Pacific people, there has been no discernible change in avoidable deaths since 2006/2007. Meanwhile, the long term picture for NZ European/Other is one of steady improvement, resulting in a widening of the equity gap.

Māori and Pacific people also live less years in good health. Living with long-term conditions such as diabetes, cancers, cardiovascular diseases, respiratory diseases and mental illness are part of the modern Māori and Pacific health story.

Avoidable death *rates for Māori have* **stopped declining**

There has been **no discernible change** *in avoidable deaths for* **Pacific people** *since 2006/2007*

[8] Based on life expectancy analysis by Statistics NZ for 2012-14. Updated life expectancy data expected in 2020.

Mēna, ka huu te ringahora, ka ora te rangi, ka ora te iwi

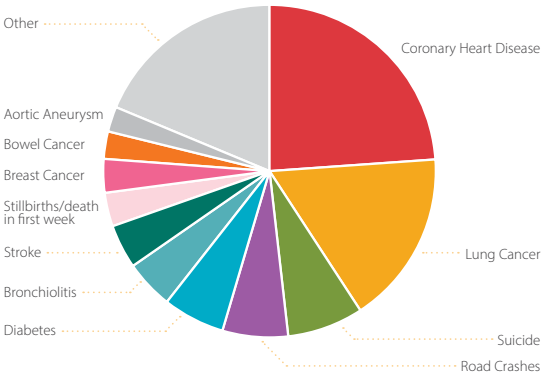
If it resounds from the east, the skies clear, the iwi thrives

Top causes of avoidable deaths

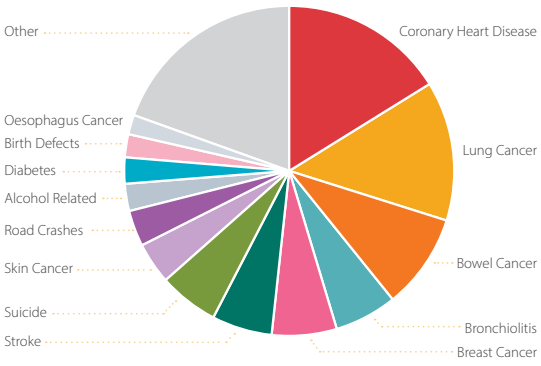
Coronary heart disease is the biggest cause of avoidable death across all ethnic groups.

For Māori, lung cancer is the second biggest, followed by suicide and road crashes. For Pacific people, coronary heart disease is followed by diabetes, suicide and stroke. For NZ European/Other, coronary heart and lung cancer are also top causes, alongside bowel and breast cancer.

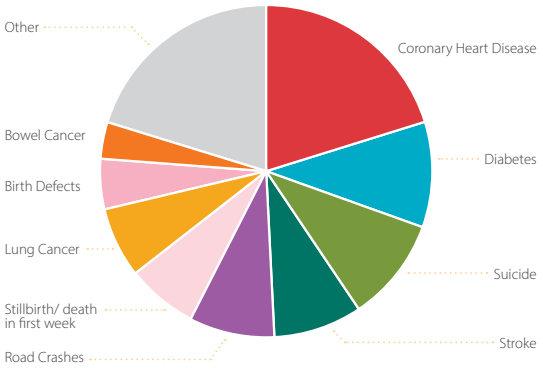
MĀORI



NZ EUROPEAN/OTHER



PACIFIC



How could these early deaths be prevented?

Prevention

Most of the top causes of early avoidable deaths are underpinned by behavioural factors including smoking, poor nutrition, insufficient physical activity and hazardous drinking.

However, the solution is not as simple as saying people need to change their behaviour. Health behaviours are linked to underlying social conditions, emotional trauma early in life, inter-generational disadvantage and the effects of colonisation, feelings of empowerment (which are lower in more deprived communities) and the ease of healthy choices in the surrounding environment. An example of this is the higher density of fast food and alcohol outlets in low income communities, making the healthy choice much harder.

A recent New Zealand study[9] found that socioeconomic factors are responsible for 42-46 percent of inequities. This tells us that reducing socioeconomic disparities would greatly reduce the equity gap in deaths over the long term.

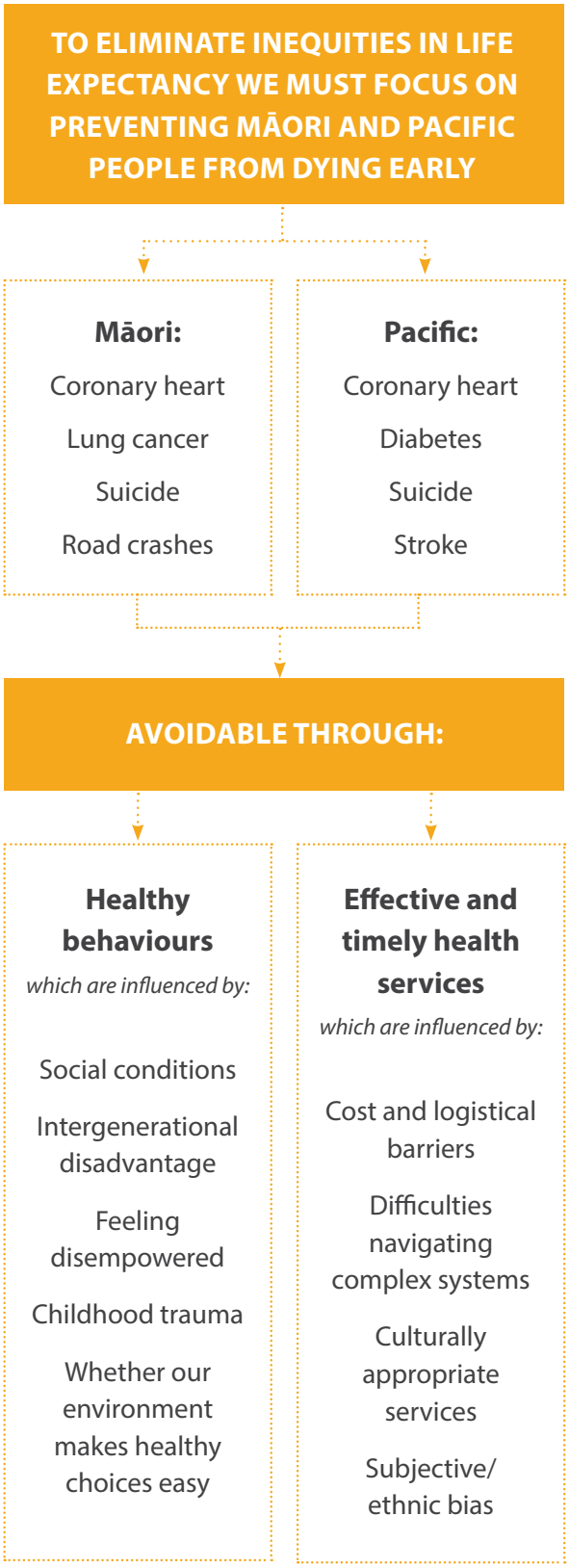
Providing equitable and timely health care services

Māori are more likely to die early from a condition which was potentially avoidable through the effective and timely use of health services than NZ European/Other. Coronary heart disease is by far the largest of these causes of death.

Why are Māori and Pacific people not using the health services that will help them to live longer? What is preventing them from entering the system at the right time, and what is happening on their journey through the system? Key factors include opening hours, transport and cost, difficulties navigating a complex health system, cultural responsiveness of the services they use and subjective/ethnic bias within the system.

The key elements to be considered in our plan to address the inequity in life expectancy are summarised in the table opposite.

[9] Blakely, T, Disney, G et al (2018). Socioeconomic and Tobacco Mediation of Ethnic Inequalities in Mortality over Time. Repeated Census-mortality Cohort Studies, 1981 to 2011. *Epidemiology* 2018;29: 506–516.



CULTURE COUNTS: THE SIGNIFICANCE OF AGE IN MĀORI SOCIETY

As a society everyone values a long and healthy life. Yet for Māori, Pacific and people living in greater deprivation, the reality is one of a shorter, less healthy life.

Premature mortality (earlier death) and living with long term conditions takes a huge toll on Māori leadership, whānau, hapū and iwi and it erodes Māori culture or "cultural capital".

What is cultural capital?

"Cultural capital" is the fabric that holds a society together. For Māori it is about holding fast to the treasures of your ancestors. Acquiring cultural capital takes a life-long dedication to its practice, recital and song. It is also the expected behaviour under the leadership of kaumātua, koroua and kuia. The marae, or centre for cultural and traditional activities, remains the most enduring Māori institution.

Age, mana and tribal integrity

A flourishing community and culture depends on the transfer of tradition, roles and responsibilities, and language down through the generations. With age comes mana. It is the older generation who carry the status, tradition and integrity of their people. Elders are recognised for their life experiences and the knowledge they have accumulated over the years. Without leadership at that level, a Māori community will be the poorer and, at least in other Māori eyes, unable to function effectively or to fulfil its obligations.

Yet many are not surviving long enough to take up the challenge and to play their role in ensuring the continuation of Māori culture.

It is well established that a strong sense of "cultural identity" has benefits for physical, mental and spiritual health for Māori and Pacific people. The loss of culture through premature mortality, therefore, has important implications for younger generations.

Mauri ora!

NEXT STEPS

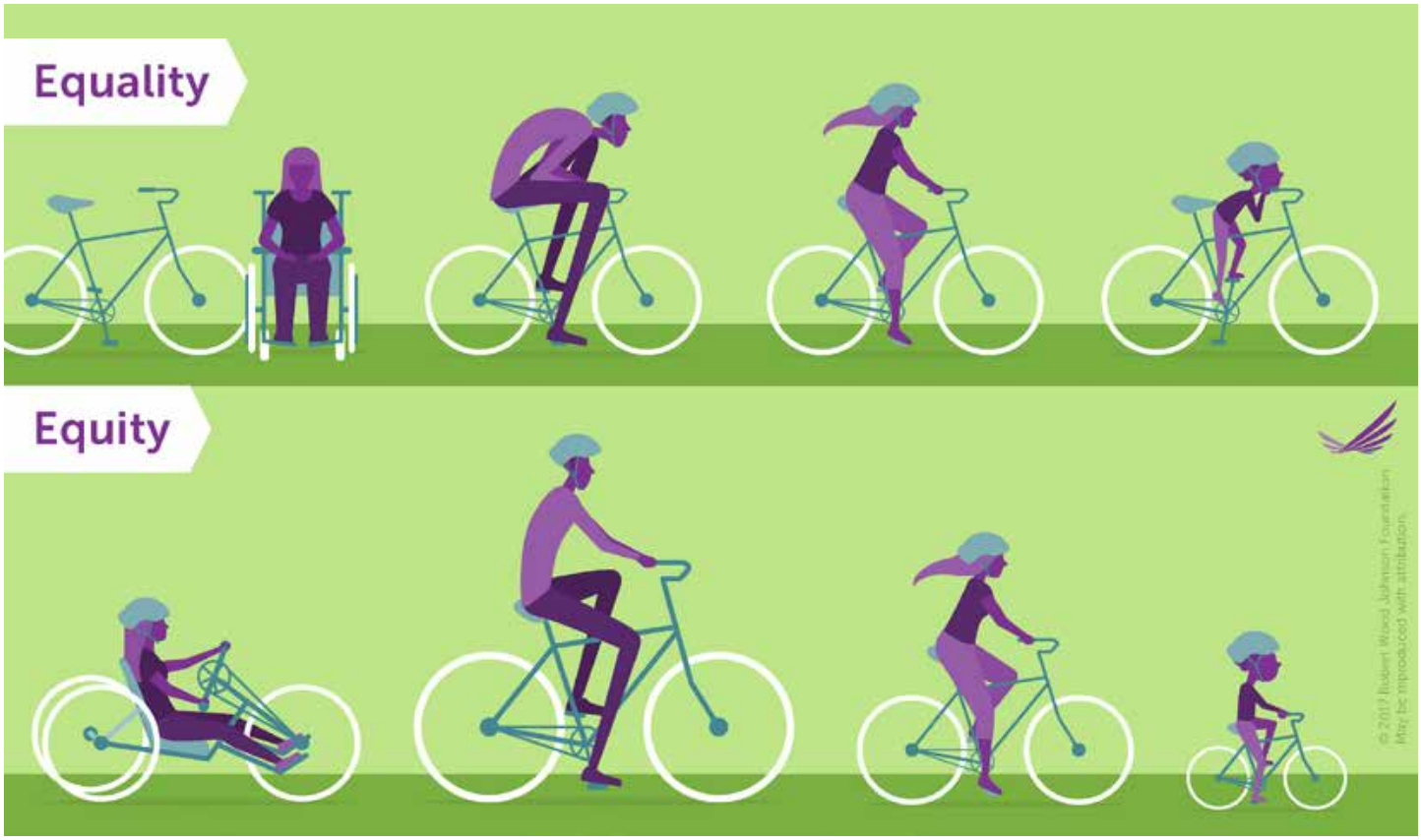
In the same way as providing equal educational opportunities for all children requires different approaches and resources for different groups, achieving health equity in Hawke's Bay will require different approaches and resources for different groups to get the same health outcomes.

What does this all mean? – p.62

What are our next steps? – p.66

Rūia taitea kia tū ko taikaka ānake

Discard the sapwood to uncover the heartwood



What does this all mean?

This report demonstrates that in Te Matau a Māui/ Hawke's Bay, different groups within our population experience differences in health outcomes that are not only avoidable or preventable, but are also unfair and unjust.

As New Zealanders we have a strong sense of fairness. We understand that life can provide more challenges to some than to others but we don't accept that disadvantage should prevent any of us from participating fully in society.

We believe everyone should have enough nutritious food to eat, safe and healthy housing and that all children should have the opportunity to enjoy educational success.

This report reflects the view that social and economic disadvantage should not prevent any of us from enjoying a full and healthy life. In fact, health is one of the most important resources each of us needs to achieve the goal of full participation.

The priority health issues

All of the findings in this report are important but when we consider the picture overall some common themes emerge.

- Rates of early and avoidable deaths for Māori and Pacific people have stopped declining while decline has continued for NZ European/Other. Reducing inequity will require focusing on heart disease, lung cancer, suicide and vehicle crashes for Māori and heart disease, diabetes, suicide and stroke for Pacific people. The analysis of deaths by life years lost highlights the particular importance of suicide and vehicle crashes. The deaths due to these causes occur at a higher rate among young people, making these issues a particular priority.
- Similar patterns of inequity are also evident in hospital stays that can be avoided through better community care. For adults aged 45-64 years, inequity for Māori and Pacific people is increasing and the biggest inequities are in avoidable hospital stays for heart attacks, chronic lung disease and skin infections.
- For preschool children good progress continues in reducing avoidable hospital stays for asthma and oral health problems, but skin infection hospital stays are increasing for Pacific children.
- There is more to health than hospital stays and dying. Other measures of health service performance such as those linked to sexual health show persisting inequities reflecting the need for an increased focus on youth health services. This report also highlights the importance of mental health and family violence as key issues.

The underlying causes

The health issues identified above are influenced by inequities in behavioural and other known risk factors. These factors operate over a lifetime so trends in deaths will be linked to behaviours over many years. However, it is also concerning to find that alcohol use is increasing, tobacco use remains much higher in Hawke's Bay, and smoking among hapū (pregnant) wahine Māori is not declining. An adequate intake of fruit and vegetables is still not being achieved by many despite the horticultural resources of our district and physical inactivity is increasing despite pro-activity initiatives such as the iWay cycle programme and Iron Māori.

Our reviews of mental health and family violence highlight key health issues that can also be seen as a symptom of more fundamental causes.

Inequities for Māori in; hospital stays for mental illness, self-harm and assault, and suicide rates all point to more fundamental and persisting inequities in socioeconomic determinants of health within our society. Differences in socioeconomic determinants can in turn be linked to the inter-generational, traumatic and long term impacts that colonisation has had on Māori health, wellbeing and culture in Hawke's Bay.

Learning from our successes

The successes in immunisation, screening programmes, reductions in teenage pregnancy and youth not in employment, education or training (NEET) all demonstrate that equity can be achieved.

When we deliberately focus on eliminating inequity and provide culturally appropriate services to whānau at a time and place that meets their needs, we can succeed. Other successes, such as the reductions in some ASH rates for children, demonstrate the potential for achieving equity with whānau centred and integrated approaches to healthcare or, in the case of the NEET rates, through concerted multi-agency action. We need to take the lessons from these successes and incorporate them into our social and organisational structures so we create health sector and society-wide equity promoting systems. Our Clinical Services Plan makes it clear that we must go beyond providing navigators to help families find their way through a "foreign" system to more fundamental change that makes the system itself navigable by all, with the whānau at its centre.

Learning from world best practice

The Nuka System of Care is a holistic healthcare system owned, created, and implemented by Alaska Native people to maximise physical, mental, emotional, and spiritual well-being.

There is much that we can learn from Nuka which is recognised internationally for its success. Relationship is at the core of the Nuka model. Nuka is particularly skilled in fostering relationships between providers and clients, and at asking communities about their health priorities and negotiating with them around delivering these services. They use real time feedback from the communities they serve, as well as clinical data to rapidly improve services to meet desired outcomes. In Hawke's Bay, this will mean changing the nature of our relationships with Māori to one where Māori led approaches gain greater attention and relevance.

This will also mean challenging non-Māori, non-Pacific world views of health care systems, funding, and power. Partnering with people and whānau in meaningful, participatory ways where power is shared is critical if we are going to understand the root causes of inequities and design successful solutions.

Wider opportunities to achieve equity

We know that health care is responsible for between 10 and 20 percent of health inequities. This is something that is within our control as a sector, and we can make immediate progress on this. Barriers to high quality health care include: difficulties in navigating our complex systems, the cultural competence of providers, limited knowledge of how and when to use services, lack of transport, out-of-pocket costs and co-payments for GP services.

The Nuka example can help guide us as we address these issues.

Almost half of inequities would be eliminated by addressing disparities in socio-economic conditions.

We all know that this is not simple, nor is it something we can resolve quickly. But we must work together as a whole community to find ways to increase the pace of change. Current government priorities align well with increased focus on issues such as: reducing child poverty, increasing housing supply, and improving mental health. Locally we have already established the Mātariki partnership. As this partnership moves to focus more on equitable outcomes as a key priority there will be more opportunity for local system change to achieve health equity.

Meeting our treaty obligations remains critical to achieving health equity. As treaty settlement groups move into their post settlement phase there is much cause for optimism. Post treaty settlement groups will not only assist in addressing economic disadvantage for Māori but will become key partners in eliminating health inequities.

What are our next steps?

01

Listen to our communities most impacted by health inequities and act to change services

This report identifies some priority health issues and determinants but this is just a starting point. Our next step must be to go to our communities and ask 'what matters to them' and 'how they can inform service responses to meet their needs'.

02

Partner with Māori and Pacific leaders to deliver on the commitments made in our Clinical Services Plan that are focused on eliminating health inequities

This report discusses some of the ingredients of success, and our Clinical Services Plan identifies commitments to take us forward. However, the detail about how we will implement those strategies remains for us to decide. Many of the solutions to the issues identified in this report will come from the communities most affected.
A next step must be to establish an equity action planning process with Māori and Pacific communities that sets out a pathway for the rebalancing of service provision to more kaupapa Māori and Pacific based models.

03

Invest in whānau ora approaches to community needs

Better understanding of specific issues such as heart health inequity will assist in designing issue specific responses. However, we also need to ensure we take a system wide perspective that focuses on total system and cultural change based on whānau ora approaches.

04

Establish an equity promoting system and explicitly tackle structural ethnic bias

In order for us to achieve equity we must establish equity as core property of the health system in Hawke's Bay. This means changing the way we do things across the system and making sure that everything we do will reduce inequity. Part of that process will involve dealing with ethnic bias within our system. The existence of bias or disadvantage based on ethnicity and socioeconomic status are well established in New Zealand and elsewhere. Even when we account for socioeconomic factors inequities based on ethnicity remain. This bias, sometimes known as institutional or structural racism, remains an important cause of inequity and we will engage in fearless, honest and respectful discussions about this so that we can work together to address it.

Kei tua i te awe māpara, he tangata kē

Behind the tattooed face, a different man appears

Kei tēnā, i tēnā, āna momo mahi

We've all got a role to play

"Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members."

– Ottawa Charter (WHO 1986)

OURHEALTH HAWKE'S BAY
Whakawateatia

Te Puni Tūmatawhānui | Health Improvement & Equity Directorate | Hawke's Bay District Health Board

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HAWKE'S BAY
District Health Board
Whakawāteatia

PEOPLE PLAN PROGRESS

Presentation

15

A MUSCULOSKELETAL SERVICE TO REDUCE HEALTH INEQUITIES IN HAWKE'S BAY

Provided for Information

16

A Musculoskeletal Service to Reduce Health Inequities in Hawkes Bay

Health Inequity

In Hawke's Bay, our people experience pervasive and enduring differences in health that are not only avoidable or preventable, but they are also unfair and unjust.

Equity is defined as the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically.

To achieve health equity we need to acknowledge that different people with different levels of advantage will require different approaches and resources to get the same health outcomes

We also need to acknowledge the inter-generational, traumatic and long term impact that colonisation has had on Māori health, wellbeing and culture

Addressing Inequity

- Almost half of inequities could be eliminated by addressing disparities in socio-economic conditions.
- We all know that this is not as simple, nor is it something that we can address quickly.
- But we must work together as a whole community to find ways to increase the pace of change.
- To achieve our commitment to equal outcomes, we will all need to work across sectors to overcome the barriers to equity - poverty, discrimination, powerlessness, lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare.
- We also know that health care is responsible for around 10% of health inequities.
- This is something that is within our control as a sector and we can make immediate progress on this.
- Barriers to high quality health care include difficulties in navigating our complex systems, limited cultural competence of providers, limited knowledge of how and when to use services, lack of transport, out-of-pocket costs and co-payments for GP services.

Background

- Musculoskeletal health conditions such as osteoarthritis, rheumatoid arthritis and lower back pain are **the leading cause of disability** in Hawke's Bay and have a significant influence on health and quality of life.

- They affect one in four adults in our community and Māori & Pacific adults are **1.3 times more likely** to have arthritis than NM/NP (New Zealand Health Survey 2013/14)

- Comprise at least 25% of total annual health spend

Drivers for Change

- Historical and current service pathway inequitable
- Evidence of unmet need and unresponsiveness to goals of early intervention
    - 17% Māori (cf total HB population of 26% Māori),
    - 32% lived in quintile 5 (cf total HB population 35% at 2013 census),
    - Subjective and objective scoring at clinic shows that Māori and those from areas of high deprivation have a higher severity of disease at first presentation (greater pain and poorer function)

	Leadership Championing the provision of high-quality health care that delivers equity of health outcomes for Māori	Knowledge Developing knowledge about ways to effectively deliver and monitor high-quality health care for Māori	Commitment Being committed to providing high-quality health care that meets the health care needs and aspirations of Māori
Health System	**Health system leadership is about setting an expectation that all New Zealanders will have equity of health outcomes.** In order to achieve equity of health outcomes, disparities in health care must be eliminated. Government legislative and strategic approaches are important in setting the scene for committing to the elimination of health disparities and achieving health equity. Health system leadership is expressed in: health policies and strategies; setting the expectation that equity is an integral component of quality; setting health targets; developing funding formulas for service procurement; and building and maintaining a health workforce that is responsive to the health care needs and aspirations of Māori. Services must be organised around the needs of individuals and whānau. To achieve this, Government must focus on removing infrastructural, financial, physical and other barriers to delivering high-quality health care for Māori that exist between health and other sectors.	**The health system requires knowledge to monitor progress in achieving health equity for Māori.** Knowledge encompasses high-quality health information that includes: research – quantitative and qualitative and/or informed by Māori methodologies; high-quality population health data with complete and consistent ethnicity data; cultural competency and health literacy; Māori models of health and wellbeing; clinical care pathways, guidelines and tools; and health innovation. Knowledge of what improves health equity for Māori should be developed and built upon to inform health policy and strategy. The use of high-quality health information, and the use of equity parameters to measure and monitor progress toward achieving health equity, is integral to this process. Further to this, the health system performance improvement and monitoring frameworks should include specific health equity measures.	**The health system is committed to reconfiguring services to deliver high-quality health care that meets the health care needs and aspirations of Māori.** Health system commitment is expressed in: incentivising and rewarding the delivery of equitable health outcomes for Māori; requiring performance data to be analysed by ethnicity, deprivation, age, gender, disability and location; measuring and monitoring progress toward achieving health equity for Māori; developing frameworks that focus on protecting the health rights of Māori; and investing in the development of organisational health equity expertise. Health system commitment requires regulatory authorities to ensure that all vocational training and continuing professional development activities have a robust health equity, cultural competency and health literacy focus.
Health Organisations	**Health organisation leadership is about making an explicit organisational commitment to delivering high-quality health care that ensures health equity for Māori.** Organisational leadership is expressed in well aligned policies, strategies and plans that are responsive to the health care needs and aspirations of Māori. The organisation sets and monitors equity and other quality improvement targets; ensures that structural arrangements do not prevent individuals and their whānau accessing health services and actively invests in building and maintaining Māori health workforce capacity and capability. The organisation actively partners with providers beyond the health sector to allow for better service integration, planning and support for Māori.	**Health organisations must establish environments that encourage learning and the sharing of high-quality health information.** To inform decision-making, health organisations should focus on developing and building their knowledge of evidence-based initiatives that have: 1. undergone equity analyses before they are implemented 2. been monitored for their effectiveness in achieving health equity for Māori. Health organisations should also endorse the use of health equity and quality improvement tools that support the delivery of high-quality health care that is responsive to the needs and aspirations of Māori.	**Health organisations are committed to reconfiguring services to deliver high-quality health care that meets the health care needs and aspirations of Māori.** Health organisations are committed to building relationships with Māori to collaboratively design, implement and evaluate initiatives that ensure delivery of high-quality health care that meets their needs and aspirations. Investment in initiatives that are successful in achieving health equity for Māori should be matched by divesting from initiatives that are unable to progress this goal. To make good decisions on which initiatives to support, health organisations must use high-quality health information, for example, complete and consistent ethnicity datasets, to monitor services against agreed indicators. Health organisations are also committed to supporting community initiatives that meet the health needs and aspirations of Māori.
Health Practitioners	**Health practitioner leadership is pivotal in ensuring that health care is focused on achieving health equity for Māori.** Leadership requires health practitioners to: review their own clinical practice and those of their peers, through a health equity and quality lens; ensure that their organisation collects high-quality ethnicity data; audit, monitor and evaluate health impact and outcome data to improve the delivery of high-quality health care for Māori; and provide critical analysis of those organisational practices that maintain disparities in health care. Leadership involves active partnership with providers beyond the health sector to allow for better service integration, planning and support for Māori individuals and whānau.	**Health practitioners strengthen their capacity and capability to deliver high-quality health care for Māori by learning and sharing high-quality health information.** Routine use of clinical guidelines and tools is important in high-quality health care decision-making, as is building knowledge in the use of quality health equity improvement tools. Health practitioners should develop their skills in routinely examining data collected by their organisations to monitor the impact of their own work and the work of their colleagues on achieving health equity for Māori. Health practitioners must build their own knowledge of how they can provide health information effectively to ensure Māori individuals and whānau understand them.	**Health practitioners must be committed to continuous quality improvement processes that focus on achieving health equity.** Health practitioners express their commitment by: routinely using and analysing administrative data to inform their practice; using evidence-based innovations that achieve health equity for Māori; and tailoring continuing professional development to build their capacity/capability in delivering equitable health care. Health practitioners should also understand their role in supporting Māori individuals and whānau to develop their health literacy. Health practitioners are committed to supporting community initiatives that meet the health needs and aspirations of Māori individuals and whānau.

Equity of Healthcare for Māori: A Framework

NZ Ministry of Health (June 2014)

http://www.health.govt.nz/system/files/documents/publications/equity-of-health-care-for-maori-a-framework-jun14.pdf

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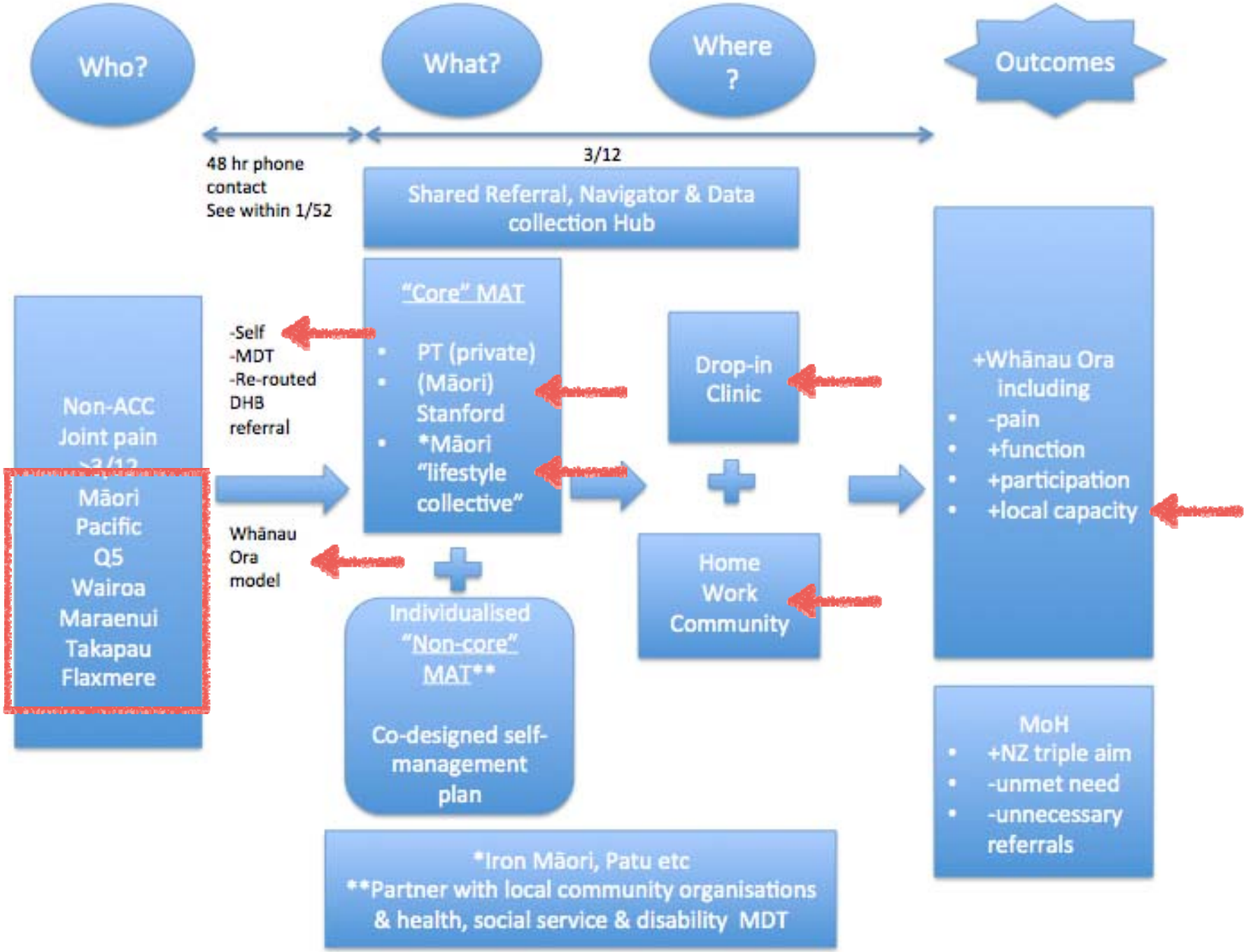
The Mobility Action Programme for Hawke's Bay

- Intentionally delivered to quintile 5 populations in urban centres of Flaxmere and Maraenui and rural centres of Wairoa and Takapau
- Partnerships with WINZ and major employers of disadvantaged workers
- Care is relationship centred. Consumers have access to the education and support needed to make decisions and participate in their own care, including self-care
- Provides access close to home of early, multidisciplinary, evidence informed care by appropriately qualified practitioners with appropriate values and behaviours.
- Models of care that are **relevant, customised to the local environment and develop capacity and capability of communities.**
- Care is well coordinated.
- **Disparities in access to care and health outcomes identified and reduced**.
- Information collected and analysed by Iron Maori to enable assessment of patient experience, clinical outcomes and value for money of the services that have been delivered.


Who?
What?
Where ?
Outcomes
48 hr phone contact
See within 1/52
3/12
Shared Referral, Navigator & Data collection Hub
"Core" MAT
PT (private)
(Māori) Stanford
*Māori "lifestyle collective"
-Self
-MDT
-Re-routed DHB referral
Non-ACC Joint pain
Māori
Pacific
Q5
Wairoa
Maraenui
Takapau
Flaxmere
Whānau Ora model
Drop-in Clinic
Home
Work
Community
Individualised "Non-core" MAT**
Co-designed self-management plan
+Whānau Ora including
-pain
+function
+participation
+local capacity
MoH
+NZ triple aim
-unmet need
-unnecessary referrals
*Iron Māori, Patu etc
**Partner with local community organisations & health, social service & disability MDT

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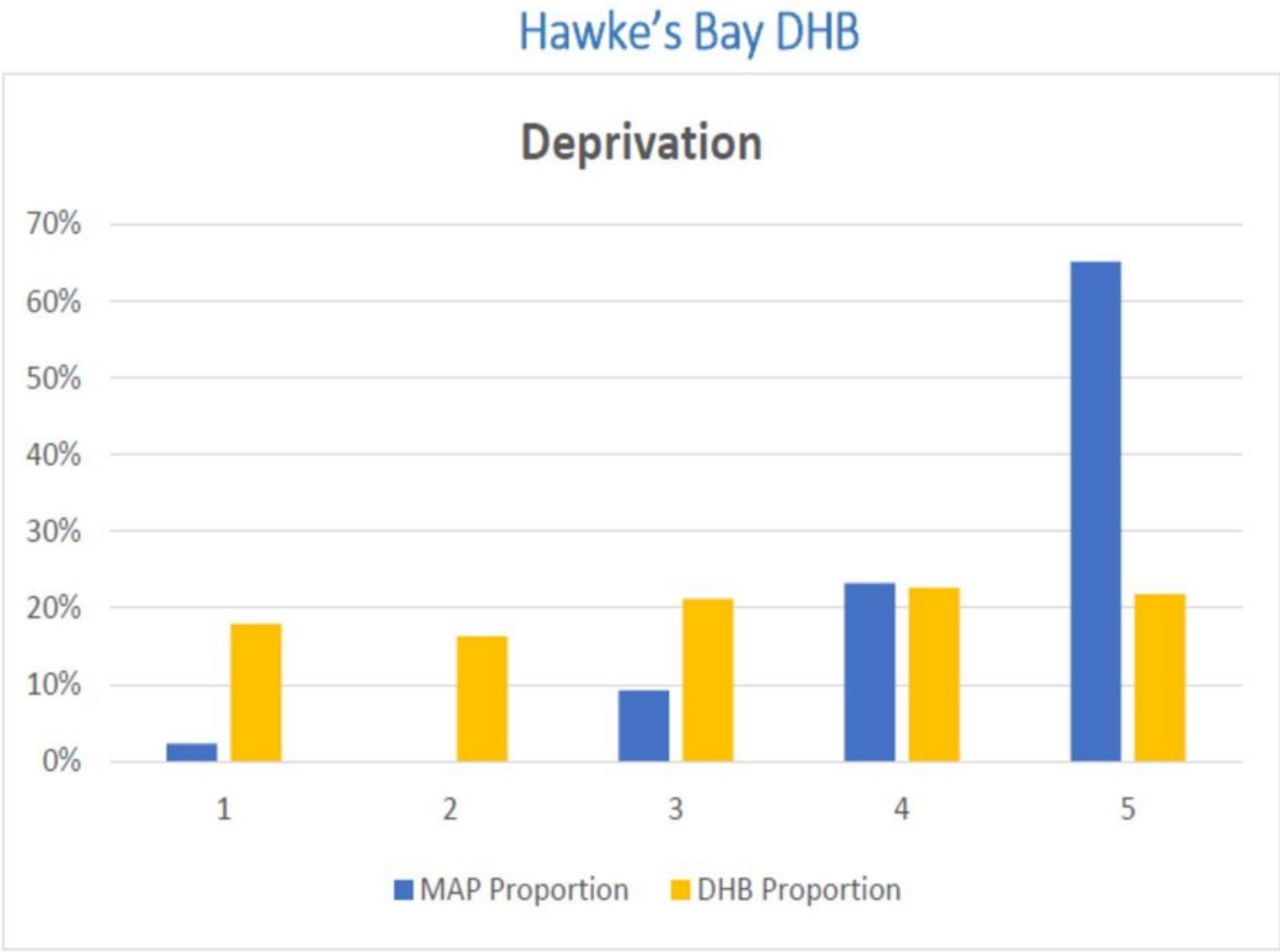
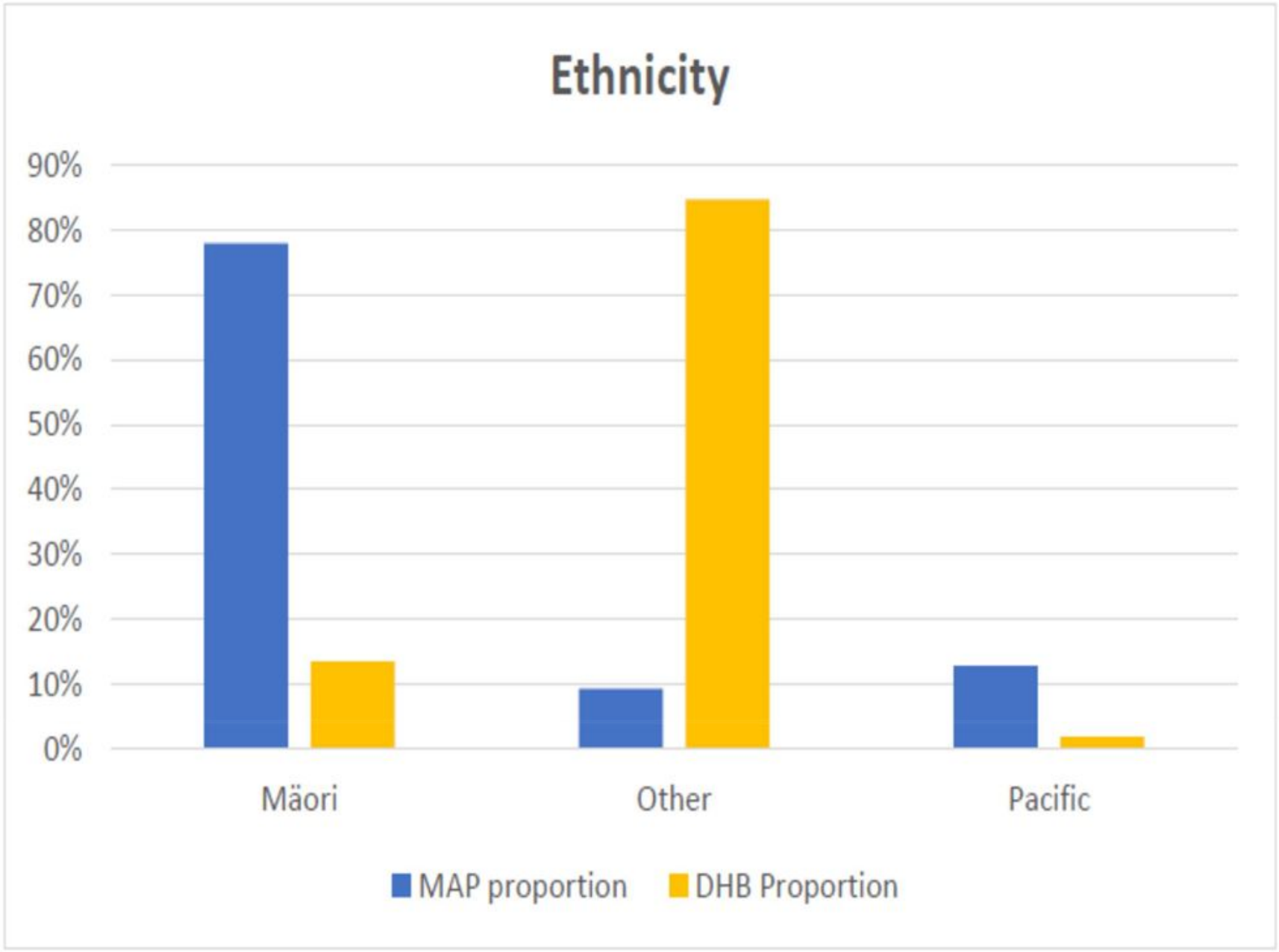
Opportunities to Inform System Change

- Intentional service design to abolish inequity
- Self management support programmes
- Use of patient outcome and experience knowledge
- Shared record - Whānau Tahi
- “Virtual” GP consult
- Relationship Centred Practice


Hawke's Bay DHB
Deprivation
70%
60%
50%
40%
30%
20%
10%
0%
1
2
3
4
5
MAP Proportion
DHB Proportion


Ethnicity
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Mäori
Other
Pacific
MAP proportion
DHB Proportion

Deprivation by ethnicity						
DHB proportion	Maori		Pacific		Other	
Deprivation quintile	DHB proportion	MAP proportion	DHB proportion	MAP proportion	DHB proportion	Map proportion
1 (least deprived)	5%	3%	2%	0%	20%	0%
2	7%	0%	4%	0%	18%	0%
3	15%	4%	10%	27%	22%	25%
4	25%	27%	18%	0%	22%	25%
5 (most deprived)	47%	66%	66%	73%	17%	50%
Total:		67		11		8

What was life like for you prior to the Mobility Action Plan?

- I was in a lot of pain, couldn't raise my arm.
- I was up and down, trying to keep moving, trying to go to the gym, but it was difficult and painful.
- When I broke my ankle, I found I couldn't do all things I loved to do, like running and playing golf. I got a bit down but was then told about the MAP programme.
- I had a bit of arthritis in my knee and wanted to learn more about what I could do to help myself and reduce the pain and increase movement.
- I was going through a bad time.
- I used to be able to run every day but the pain got so bad I could hardly even walk.
- I stayed in bed a lot.
- I was relying on family to bring meals to me in bed.
- I didn't hold out much hope to have anything done or getting any help.

How have you found the experience?

- I really appreciate being able to take part, the support, care and advice of knowledgeable people was fantastic.
- It was a really good experience.
- The physio and massage therapy was really helpful.
- Aqua aerobics was awesome, I had considered trying it before but could not believe how beneficial it was when I got to try it.
- I loved it, I got to go to the gym and had a personal trainer.
- Excellent, I learnt a lot about other people.
- I could see there were a lot of people that are worse off than me.
- It gave me the motivation to help others in need, instead of getting down about my own injury and health conditions.
- It was very interesting, I have learnt lots of bits and pieces, lots of conversations with other people in similar situations or with worse conditions than mine.
- I wondered if I was actually bad enough to be on the programme when I saw how bad some people were, I really appreciated that I was able to take part t
- I was so pleased that the woman at WINZ said I could go on the Mobility Action Plan. It has been a big positive for me and given me hope.

What were the positive aspects?

- Having the support of co-ordinators and others participating in the programme.
- Knowing that I was not the only one in pain – I didn't feel alone.
- The 7 week "Living with pain" course was hugely beneficial, it taught me about mind body and soul and how to look after my needs- not just my physical pain.
- It made me realise how grumpy I had been.
- It gave me good strategies to deal with my emotions.
- The breathing techniques have helped to control my pain which has increased with the cold weather.
- I did a course about how to manage clinical pain and conditions- that was really good.
- Everyone shared their experiences.
- We all got 1-1 time and time to talk in a group, I felt listened to.
- I got to exercise again, at the gym and at the pool. I find the pool is really good exercise and it doesn't hurt my ankle, which has been fused.
- The people that ran the dealing with chronic pain at the Heretaunga Hotel were great.
- Going to the gym is very beneficial.
- The personal trainer gets us to do the things we can manage and also makes us think about things we can do for ourselves to keep us well.
- One chappie was using a stick to walk when he started but now I see him walking without a stick- it's just great!
- The tutors on the pain management workshop were fantastic and very supportive.
- Getting assessments and help at last.
- When I saw the physio for the first time, she said I should be in hospital already. She understood the pain I was in.
- I saw another physio and have been referred to see a specialist.
- The support from the people from MAP was great. They were always calling me to see how I was going.

What is life like now?

- Not too bad, winter has been a bit of a struggle but I feel I have had more tools to deal with my pain having had all of this help. I feel more able to cope with pain.
- It makes me realise how pain can impact your life and make it feel really stressful. I am now able to use the skills I have learnt and not be grumpy with my whanau.
- I don’t know if there is a solution other than dealing with the pain.
- I am not allowed to work and I still have to use crutches, but I am happier and always like to keep busy. I do things around the house to help out and it helps keep me feeling useful.
- I am still in a lot of pain and have been going for massage with a lady through a guy at the gym. She is also putting me in touch with a naturopath to see if they can help with my pain.
- I try to manage my pain by taking herbal products rather than pain medications from the pharmacy.
- I am still going to the gym and find this a positive way of keeping active but also enjoy that I am always learning different things from the people that go with me.
- I am so grateful that I am getting help, I won’t be in extreme pain for a change. There is a light in front of me.

Conclusion

We must not tolerate inequities in health outcomes. They are unfair and they are unjust. It is time to challenge traditional views and "ways of doing things" and begin to overhaul the system that is clearly working for some better than others.

To address health inequities we need to:

- Ensure that decisions about the allocation of resources are increasingly taken by communities
- Increase investment in prevention and screening programmes that reduce the burden of disease and ill health on our community
- Partner with communities, funders and providers to design quality health services and funding policies with the express purpose of achieving equity, holding ourselves accountable through public monitoring and evaluation
- Work across sectors to address determinants of health for individuals and communities with coordinated approaches, integrated funding streams, and shared accountability across agencies
- Use person and whānau centred care to share power authentically and champion self-determination.

Tē tōia, tē haumatia
Nothing can be achieved without a plan, a workforce and a way of doing things

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:

18. Confirmation of Minutes of Board Meeting - Public Excluded
19. Matters Arising from the Minutes of Board Meeting - Public Excluded
20. Board Approval of Actions exceeding limits delegated by CEO
21. Chair's Update
22. Māori Relationship Board
23. HB Health Consumer Council
24. HB Clinical Council
25. Finance Risk and Audit Committee

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).