Hawke's Bay Health
Consumer Council Meeting

Date: **Thursday, 9 June 2016**

Meeting: **4.00pm to 6.00pm**

Venue: **Te Waiora Meeting Room, District Health Board Corporate Office, Cnr Omahu Road & McLeod Street, Hastings**

Council Members:

Graeme Norton (Chair)
Rosemary Marriott
Heather Robertson
Terry Kingston
Tessa Robin
Leona Karauria
Jim Morunga
Nicki Lishman
Jenny Peters
Olive Tanielu
Jim Henry
Malcolm Dixon
Rachel Ritchie
Sarah de la Haye

Apology:

In attendance:

Kate Coley, Director Quality Improvement & Patient Safety (DQIPS)
Tracy Fricker, Council Administrator and PA to DQIPS
Jeanette Rendle, Consumer Engagement Manager
Ken Foote, Company Secretary
Nicola Ehau, Head of Health Services for Health Hawke's Bay Ltd
Debs Higgins, Clinical Council Representative

HB Health Consumer Council
Agenda

PUBLIC

Item	Section 1 – Routine	Time (pm)
1.	Karakia Timatanga (Opening) / Reflection	**4.00**
2.	Apologies	
3.	Interests Register	
4.	Minutes of Joint Meeting with Clinical Council	
5.	Matters Arising - Review Actions (nil)	-
6.	Consumer Council Workplan	
7.	Chair's Update	
8.	Consumer Engagement Manager's Update	
	Section 2 – For Decision	
9.	Youth Health Strategy 2016-19 – Dr Caroline McElnay / Nicky Skerman	**4.20**
	Section 3 – For Discussion	
10.	Food Services Optimisation Review Gavin Carey-Smith, Deborah Chettleburgh & Jill	**4.25**
11.	Health Equity Update Report – Dr Caroline McElnay	**4.40**
12.	Suicide Prevention and Postvention Plan Report - Caroline & Penny Thompson	**4.55**
13.	Mobility Action Plan - Dr Andrew Phillips & Dr Tae Richardson	**5.10**
	Section 4 – For Information only	
14.	Te Ara Whakawaiora / Oral Health	**-**
	Section 5 – General	
15.	Topics of Interest - Member Issues / Updates	**5.40**
16.	**Section 6 – Recommendation to Exclude the Public**	

PUBLIC EXCLUDED

Item	Section 7 – Routine	
17.	Minutes of Previous Meeting (public excluded)	
18.	Matters Arising – Review Actions (nil)	
	Karakia Whakamutunga (Closing)	

NEXT MEETING Thursday 14 July 2016, commencing at 4.00pm
Te Waiora (Boardroom), HBDHB Corporate Administration Building

Tauwhiro Rāranga te tira He kauanuanu Ākina

Interest Register

Hawke's Bay Health Consumer Council

Feb-16

Name Consumer Council Member	Interest eg Organisation / Close Family Member	Nature of Interest eg Role / Relationship	Core Business Key Activity of Interest	Conflict of Interest Yes / No	If Yes, Nature of Conflict: - Real, potential, perceived - Pecuniary / Personal - Describe relationship of Interest to
Graeme Norton	3R Group Limited	Director/Shareholder	Product Stewardship	No	
	NZ Sustainable Business Council	Deputy Chair	Sustainable Development	No	
	HB Diabetes Leadership Team	Chair	Leadership group working to improve outcomes for people in HB with diabetes	No	Group is sponsored by HBDHB
	NZ Life Cycle Management Centre	Chair, Advisory Group	Advancing life cycle management thinking across NZ	No	
Rosemary Marriott	YMCA of Hawke's Bay	President	Youth Including health issues	No	
Heather Robertson	Restraints Committee of DHB	Committee Member	Representing Consumers on this Committee	No	
Terry Kingston	Central Hawke's Bay District Council	Elected Member	Local body	No	Will declare any perceived interests as they arise.
	Interest in all health matters, in particular - Mental Health, Youth, Rural and Transport.				
Tessa Robin	Te Kupenga Hauora - Ahuriri	Finance and Quality Manager	Responsible for overseeing QMS for organisation and financial accountability	No	Potential - Employer holds contracts with HBDHB
Leonna Karauria	NZ Maori Internet Society	Chairperson	Advocacy on Maori Communities	No	
	Computers in Homes HB Steering Committee	Member and Regional Co-ordinator	ICT Project Management through schools and communities	No	
	Computers in Homes, Wairoa Steering Committee	Member and Regional Co-ordinator	ICT Project Management through homes and communities	No	
	Maori Party Wairoa Branch	Chairperson	Supporting Policies at a local level	No	
	Simplistic Advanced Solutions Ltd	Director/Owner	Information Communications Technology services.	Yes	If contracted for service, there could be a perceived conflict of interest.
	Hastings District Council Digital Enablement Focus Group	Member	Advisory for digital literacy and internet access initiatives for communities	No	
	Wairoa Wireless Communications Ltd	Director/Owner	Wireless Internet Service Provider	Yes	Approached in early 2014 by HBDHB and contracted for service to provide wireless internet service to Wairoa Rural Health Learning Centre and Hallwright House. Could be a perceived conflict of interest.
Nicki Lishman	Employee of Ministry of Social Development	Regional Health Advisor	Liaising with health community and supporting Work and Income Staff.	Yes	Could be perceived/potential eg., situation where gaps identified regarding funding.
	Registered Social Worker, member of ANZASW	Professional body	Social work	No	
Jenny Peters	Nil				
Olive Tanielu	HB District Health Board	Employee	Work with Pacific Island children and families in hospital and in the community	Yes	Perceived/potential conflict between employee HBDHB and roles of Consumer
Jim Morunga	Nil				
Malcolm Dixon	Hastings District Councillor	Elected Councillor		No	
	Sport Hawke's Bay	Board of Trustees	Non paid role	No	
	Scott Foundation	Allocation Committee		No	
James Henry	Health Hawke's Bay Ltd	Facilitator	Part-time role. Improving lifestyles for people with chronic illness.	No	
Rachel Ritchie	Put the Patient First	Involved when group was active	Advocating for Diabetes Patients	Unsure	Real / potential / Perceived
Sarah de la Haye	Nil				

MINUTES OF MEETING FOR THE COMBINED HAWKE'S BAY CLINICAL COUNCIL AND HAWKE'S BAY HEALTH CONSUMER COUNCIL HELD IN THE "TAKARANGI" CONFERENCE ROOM, TE TAIWHENUA O HERETAUNGA, ORCHARD ROAD, HASTINGS ON WEDNESDAY, 11 MAY 2016 AT 4.00 PM

PUBLIC

Present:
Graeme Norton (Chair – Consumer Council and Meeting Chair)
Dr Mark Peterson (Co-Chair – Clinical Council)
Chris McKenna (Co-Chair) – Clinical Council)
Dr Tae Richardson
Dr David Rodgers
Dr Robin Whyman
Dr Caroline McElnay
Dr Andy Phillips
Debs Higgins
William Allan
David Warrington
Jules Arthur
Anne McLeod
Rachel Ritchie
James Henry
Jim Morunga
Heather Robertson
Rosemary Marriott
Tessa Robin
Jeanette Rendle
Nicki Lishman
Sarah de la Haye
Olive Tanielu
Lenora Karauria (5.00 pm)
Terry Kingston (5.05 pm)

In Attendance:
Dr Kevin Snee (Chief Executive Officer)
Ken Foote (Company Secretary)
Kate Coley (Director – Quality Improvement & Patient Safety)
Nicola Ehau, Head of Health Services for Health Hawke's Bay Limited
Tracy Fricker (PA to Director QIPS / Clinical Council Secretary)

WELCOME

Graeme Norton (Chair) welcomed everyone to the combined meeting of the Clinical and Consumer Councils.

Tessa Robin opened the combined meeting with a Karakia.

SECTION 6: FOR ENDORSEMENT

13. BEST START HEALTHY EATING PLAN (FINAL)

The Chair welcomed Shari Tidswell to the meeting.

The Chair advised that the Consumer Council has had considerable feedback into the plan over a significant period of time. This is the final draft of the plan and is for endorsement before going to the Board for approval next week.

The Best Start Healthy Easting Plan was endorsed by the Clinical Council and Consumer Council members.

SECTION 7: FOR INFORMATION

14. CUSTOMER FOCUSED BOOKING PROGRAMME UPDATE

The Chair welcomed Carleine Receiveur to the meeting. Carleine provided an update on the programme.

Since the last update in September 2015, the project, which due to its complexity and level of change required was changed into a programme of work, and it has made steady progress with the work streams:

- IS Solution
- Clinic Scheduling
- Customer Focused Booking Training
- Text to remind and demographics

Questions / feedback from Clinical and Consumer Council Members:

- When looking at clinic scheduling is clinical coding part of this? Carleine advised this will come through with national patient flow through visibility of patient journey

- It seems to focus on just the IS/booking side of things and not the whole picture of the needs of the consumer e.g. more flexibility of clinic hours, not just being 9.00-5.00 pm, Monday to Friday. Carleine advised all these are enablers to give consumers a choice to select the day and time for the appointment which suits them, within the constraints of what the service can provide. This is empowering the consumer to have a choice, rather than what currently happens i.e. an appointment card is sent out with a pre-determined date and time. The opening hours of clinics was not currently part of this programme, but may be considered in a subsequent project.

- The customer doesn't just need a booking system, they need flexibility.

- There needs to be a way to ensure that the demand is understood and translated across to the services which are being provided. Otherwise the individual is trying on their own to get the service at a time which is helpful for them.

- Hoping to see a reduction in the amount of DNA rates; and increased customer satisfaction in the ability to arrange their own appointment times.

- Is there going to be a linked system for other appointments e.g. appointments to see paediatrician/audiology etc on the same day? Yes that is in the process of being developed.

15. QUALITY ACCOUNTS – OVERVIEW OF PLAN AND CONTENT

Report taken as read. No issues raised.

David Warrington drew attention to the positive feedback HBDHB received from the Health Quality & Safety Commission for last year's Quality Accounts *(see Appendix 1 of the paper)*.

16. ENDOSCOPY SERVICE TRANSITION UPDATE

Report taken as read. No discussion or issues raised.

17. TRAVEL PLAN – VERBAL UPDATE

The Chair welcomed Andrea Beattie, Property and Service Contracts Manager to the meeting.

Andrea advised that the project does not officially start until 1 July but they have started to do some of the work early:

- A video has been produced which provides a summary of what we are doing and the views of staff on how they travel to work
- There has been discussion with the Regional Council re: bus service and reinstating an express service from Napier to the Hawke's Bay Hospital so it arrives on time for staff on the 7.00 am shift and also realigning some of the other bus routes. The Regional Council will announce the changes shortly.
- Discussions with car-pooling organisations e.g. Chariot, Waiapu Diocese etc
- Booked parking i.e. utilising our fleet car park when fleet cars are being used off site
- Awarded a tender for the review of our parking allocation on site which will include dedicated parks for car-pooling, drop off parks, reconfiguring of existing parks to see if we can get more parks in the existing footprint
- Cycling – review to have more stands and secure parking by the end of the year.

Questions / feedback from Clinical and Consumer Council Members:

- We get a lot of feedback from our consumers regarding the lack of parking, there is a lot of communications for and to staff, what is the plan to inform our community on what we are doing? We have a web page and did a survey last year, but that is only a small proportion of the community. The travel plan is about influencing staff behaviour so our consumers have more options

- It is crucial that patient focused booking and the travel plan are co-ordinated, transport has been identified as a barrier to care. It is important that people are advised of the public transport options and those who are utilising public transport have priority for appointment times to fit in with this

- There seems to be a focus on getting staff to work and car usage. A bigger part of the plan is also the health benefits of not running cars, not much talk about bike sharing and other options like that which can be used in urban areas. It would be good to see this as well as the public transport options. Andrea advised that Population Health are part of this team and they are looking at the active health side

- As above agree that a co-ordinated approach with patient focused booking is essential. The electronic system is the way to go, but aware that particularly the elderly and some of the lower socio-economic families don't have access to technology so there still needs to be some thought given to them

18. YOUTH HEALTH STRATEGY (DRAFT)

The Chair welcomed Nicky Skerman, Population Health Strategist, Women, Children & Youth to the meeting. He advised that some members of the Consumer Council have had a fair amount of input into this strategy, co-operating with Population Health. Dr Caroline McElnay advised that this is the first time that anyone has seen it written down as a strategy document.

Nicky Skerman provided an overview of the work undertaken to date to develop the Youth Health Strategy. There has been consultation with stakeholders and youth, asking them the same question "what made a healthy young person". The feedback from both groups was very similar, just different words. The stakeholders were also asked how they connected with other organisations to ensure their young people had access to services across the board. There have also been meetings with a broad range of groups including young people, councils, Maori, Pacific, Directions, and youth in employment and education. The draft document went out to the stakeholders last week for feedback.

Questions / feedback from Clinical Council and Consumer Council members:

- Has there been primary care involvement? Yes the PHO as part of the stakeholder consultation, but not individual GPs. The PHO has sent the draft strategy out to GPs
- A great document, a lot of hard work has gone into it. There is only one paragraph about violence and young people. Unfortunately statistics show that 50% of young people in New Zealand have been exposed to some sort of violence in the home, which is not adequately addressed. Can it be researched more and added in as a priority
- Like the statement "young people are a resource to be developed, not a problem to be fixed"
- Pleased to see acknowledgement given to learning for youth, a large portion who end up in prison are illiterate and a lot of other community difficulties for those who are not employable due to their inability to be literate
- Like the shared vision and strategy
- Well put together, holistic.

Positive feedback on the work to date. Any further feedback on the draft strategy can be directed to Nicky at nicky.skerman@hbdhb.govt.nz.

19. TE ARA WHAKAWAIORA / CARDIOVASCULAR

Report taken as read. No issues raised.

20. ANNUAL MAORI HEALTH PLAN Q3 JAN-MAR16 DASHBOARD

Report taken as read. No issues raised.

21. RECOMMENDATION TO MOVE TO PUBLIC EXCLUDED

The Chair recommended move to public excluded section of meeting.

Approved.

The meeting closed at 4.40 pm

Confirmed: _____
Chair

Date: _____

MATTERS ARISING

Nil

HB HEALTH CONSUMER COUNCIL WORKPLAN 2016-2017

Meetings 2016	Papers and Topics	Lead(s)
14 July	Alcohol – discussion Draft Developing a Person Whanau Centred Culture HB Integrated Palliative Care (discussion draft final in September) ***Monitoring*** Health and Social Care Networks Update	Caroline McElnay Kate Coley Mary Wills Liz Stockley
11 Aug	Draft Quality Accounts Travel Plan Update – verbal Orthopaedic Review – closure phase 1 ***Monitoring*** Annual Maori Plan Q4 15/16 Dashboard Te Ara Whakawaiora / Culturally Competent Workforce (local indicator) Te Ara Whakawaiora / Mental Health and AOD (national and local indicators)	Kate Coley Sharon Mason Andy Phillips Tracee TeHuia Chris and Andy Sharon, Alison S
8 Sept	• **HB Health Sector Leadership Forum – venue to be confirmed**	
15 Sept	Draft – Orthopaedic Review – phase 2 Draft – Family Violence – Strategy Effectiveness for noting Draft – Alcohol Final – Developing a Person Whanau Centred Culture Final – Quality Accounts (co-ord with Annual Report) Final – HB Integrated Palliative Care ***Monitoring*** Health and Social Care Networks Update Te Ara Whakawaiora / Obesity (national indicator)	Andy Phillips Caroline McElnay Caroline McElnay Kate Coley Kate Coley Mary Wills Liz Stockley Shari Tidswell
13 Oct	Final – Alcohol Draft – New Patient Safety and Experience Dashboard (reporting sequence to follow)	Caroline McElnay Kate Coley
10 Nov	Travel Plan – verbal Tobacco – Annual Update against the Plan (for noting) ** ***Monitoring*** Te Ara Whakawaiora / Smoking (national indicator) ** Annual Maori Plan Q1	Kate Coley Caroline McElnay Caroline McElnay Tracee TeHuia
8 Dec	Discussion - HB Workforce Plan ***Monitoring*** Health and Social Care Networks Update	John McKeefry Liz Stockley

CHAIR'S UPDATE

Verbal

CONSUMER ENGAGEMENT MANAGER'S UPDATE

Verbal

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

RECOMMENDATION

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

1. Note responses to committee feedback.
2. Endorse the Youth Health Strategy 2016-19 to go to the Board for final endorsement.

OVERVIEW

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

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

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

BACKGROUND

Consultation on the Youth Health Strategy commenced in October 2015. We met with members of HB Consumer Council to discuss the best approach in the development of a strategy for youth health that included both youth and stakeholder voices.

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

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

Consultation has taken place with stakeholders from various services such as; youth probation, Central Health, TTOH, NZ Police, YROA YNOT, Disability Services, and DHB staff from various specialities. Youth from across all age groups and ethnicities were also engaged as stakeholders. Recent youth health research for the Hawke's Bay region and nationally was also used in the development of the draft Strategy.

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

What did the stakeholder and community input say?

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

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

HOW HAVE WE RESPONDED TO COMMITTEE FEEDBACK?

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

Committee/s	Feedback	Response	Page reference
EMT	It reads very much like a DHB Strategy.	Noted. Implementation will be in collaboration with other sectors	--
	There needs to be greater linkages to other strategies,	Linkage to the Regional Economic Development Strategy and other strategies has been included.	P7
	What input has been received from GPs	Health Hawkes Bay attended the consultation process. Draft Strategy was put on the Health Hawkes Bay PHO portal for GPs to provide feedback.	--
	It would be helpful to include a definition for youth.	Definition added.	P4
	It would be good going forward to have some clear outcome measures that demonstrate it is working.	High level outcomes are listed on page 4. Performance measures have been developed using the result based accountability framework. They have not been included in the paper but are available on request.	--
Committee/s	**Feedback**	**Response**	**Page reference**
Clinical	Provide primary care more time to comment on the draft Strategy.	Feedback timeline was extended.	--
	Include links to other plans/ strategies (e.g. Healthy Eating Plan and Suicide Prevention/ Postvention Plan)	Linkages made to other strategies as suggested.	P7
	Make more reference/links to family violence	There is more information around family violence from the Hawkes Bay Youth 2000 series.	P7

		A link to the MOH National Family Violence Assessment and Intervention Guidelines 2002. Kahungunu Violence Free Iwi Strategy Action Plan "Te Wero A violence free Kahungunu".	P12
Consumer	Suggested data be included for youth with disabilities	To drill down via age is a possibility going forward.	--
	Meet with individual members from Consumer Council re youth issues	Met with Nicki Leishman (MSD) and Jim Morunga (Te Kupenga Hauora) to discuss their feedback.	--
Māori Relationship Board	Integrate the suicide strategy and what it means for youth to be healthy	What it means for youth to be healthy is addressed throughout the Strategy. References have been included on the Suicide Prevention and Postvention Plan, Best Start: Healthy Eating Plan.	P7
	The language of the young people should not be changed	Direct quotes by youth have been included throughout the Strategy.	--
	Link with Ngāti Kahungunu Inc. on what they may be undertaking re youth plans	Kahungunu Violence Free Iwi Strategy and Action Plan for a Violence Free Kahungunu is referenced. Ngāti Kahungunu Inc. does not have a youth strategy as such but does undertake many programmes with rangitahi. Met with Ngāti Kahungunu Inc. Requested meeting with Maunga Haruru Tangitu Trust. The Strategy has been sent for feedback.	--
	Set up governance across the sector including youth. Involve Māori Health Service.	Once the Strategy has been endorsed by HBDHB Board, a governance group will be formed and include membership from Māori Health Service.	--

NEXT STEPS

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

Creating Healthy Opportunities for Youth 2016 – 2019

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

OUR VISION

"HEALTHY HAWKES BAY"

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

OUR VALUES / BEHAVIOURS

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

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

CONTENTS

OUR GOALS FOR YOUTH

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

OUR OUTCOMES FOR YOUTH

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

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

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

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

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

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

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

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

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

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

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

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

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

Five Outcomes to achieve by age 15 for healthy development:

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

Youth in Hawke's Bay report healthy is

Feeling supported and accepted

Positive relationships with parents and connections with others

Good headspace

Positive influences

Independence

Taking responsibility

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

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

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

Case scenarios: 'everyday life for some teens'

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

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

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

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

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

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

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

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

"Support 100% and work together"

"Walk the Talk and Take Action"

Pacific Youth

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

The Hawke's Bay Health System - Transform and Sustain for 2013-2018:

The three broad aims are:

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

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

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

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

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

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

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

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

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

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

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

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

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

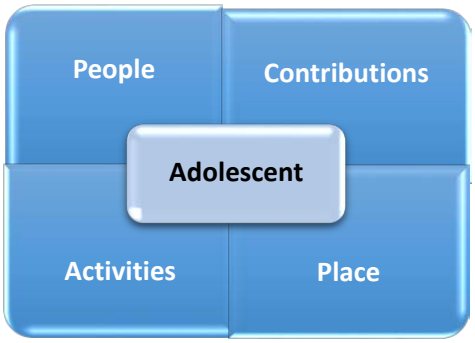
This shows the healthy opportunities could continue through into adulthood due to the synergy with the principles in all the strategic plans supporting "for the people by the people - mo te iwi i te iwi".

New Zealand Research

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

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

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



PCAP – A Model for Promoting Youth Health & Development

Adolescents need to be connected to:

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

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

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

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

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

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

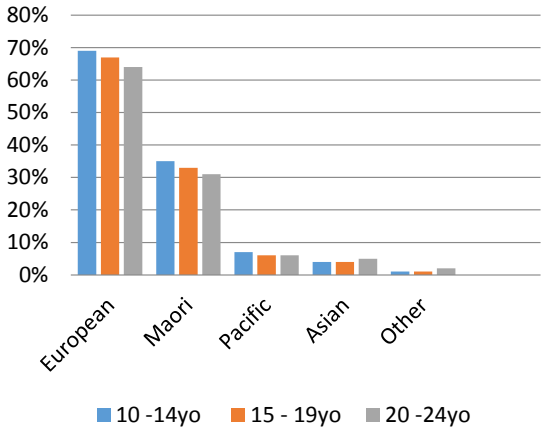
1. Hawke's Bay Region Census Data 2013:

Table 1: Demographics of Youth

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

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

Table 2: Ethnicity



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

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

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

Stakeholder's feedback

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

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

Implications for health services:

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

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

Young people report barriers to accessing services

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

Youth Focus Groups & Pacific Youth Survey 2016

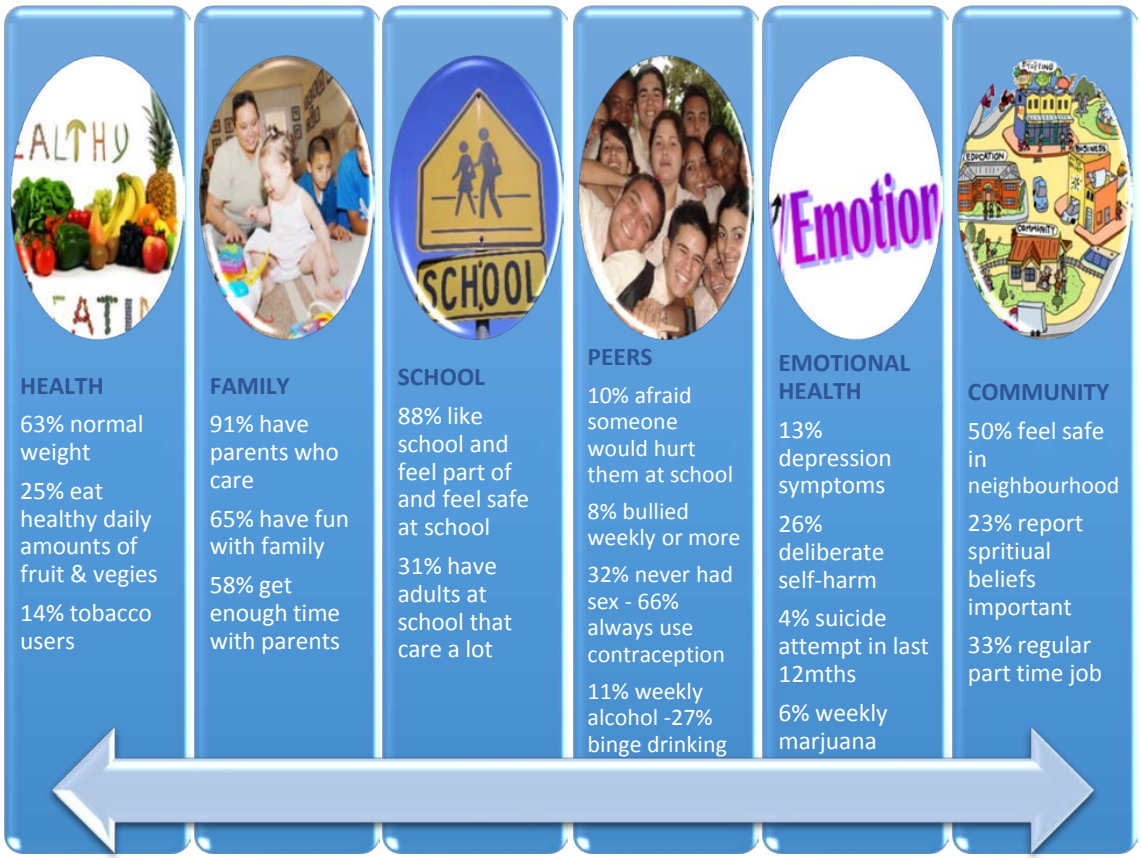
9.1

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

Implications for health services:

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

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

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

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

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

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

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

Professor Robert Blum recommends:

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

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

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

   (Barber and Stoltz, 2005)

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

   (Kirby & Cole)

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

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

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

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

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

   The framework outlines:

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

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

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

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

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

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

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

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

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

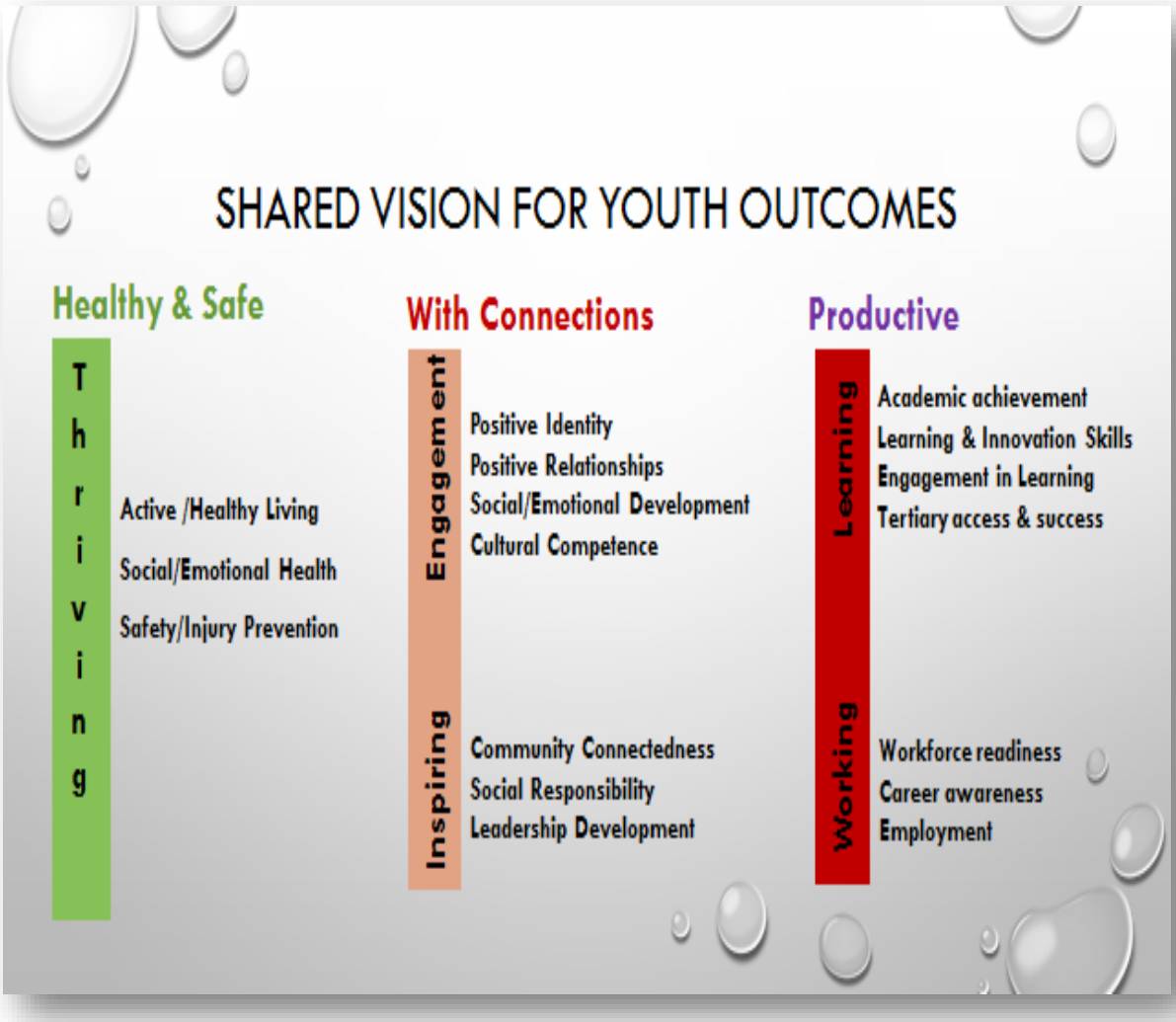
"Good habits formed at youth make all the difference" Aristotle

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

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

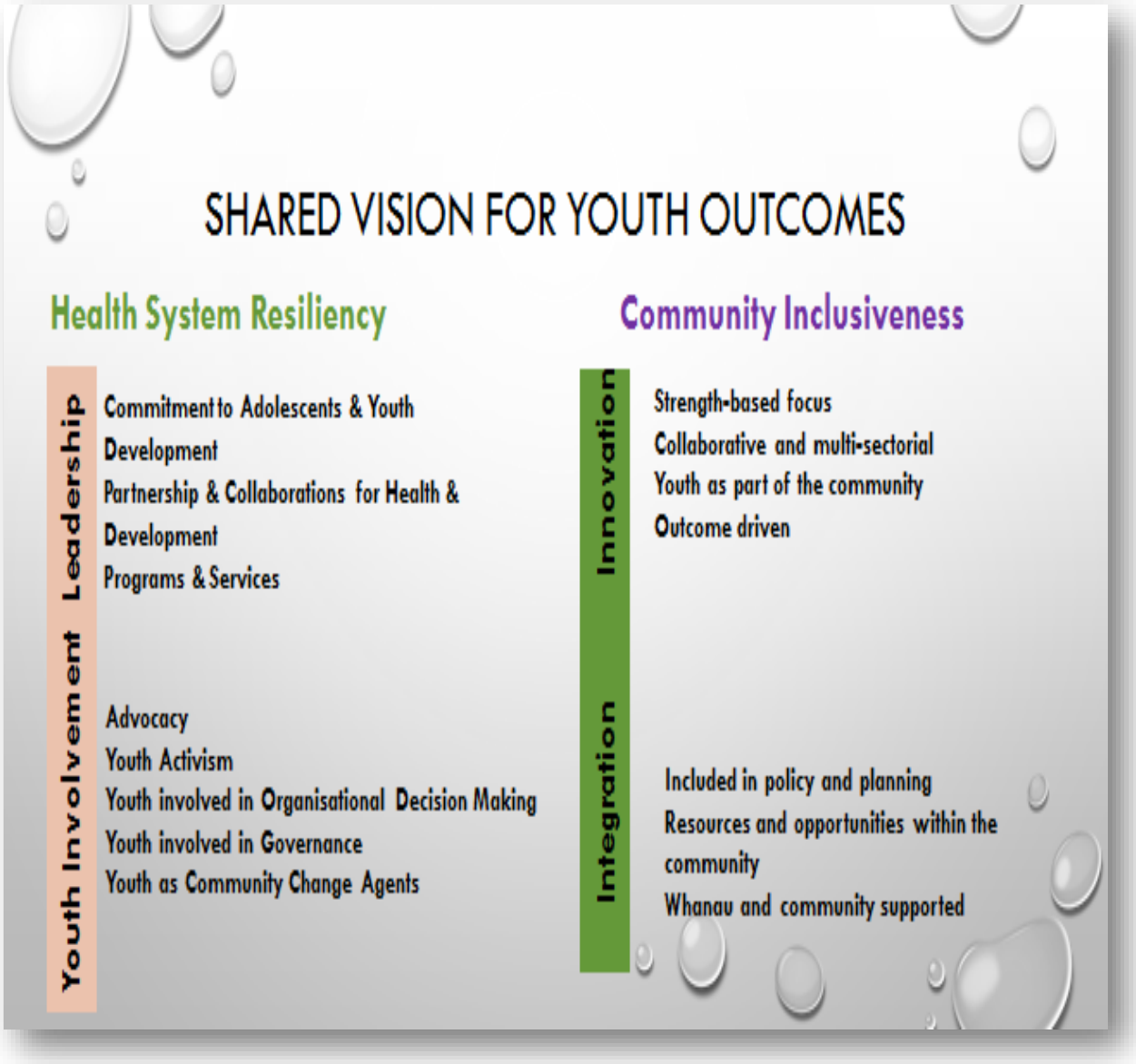
This Youth Strategy aims to convey a shared vision for young people by identifying a common set of youth outcomes and indicators that cuts across the work of many organisations/services working with youth. Though there are commonalities in how organisations/services talk about their goals and impact,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

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



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

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



Strategic Plan in Action

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

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

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

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

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

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

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

9.1

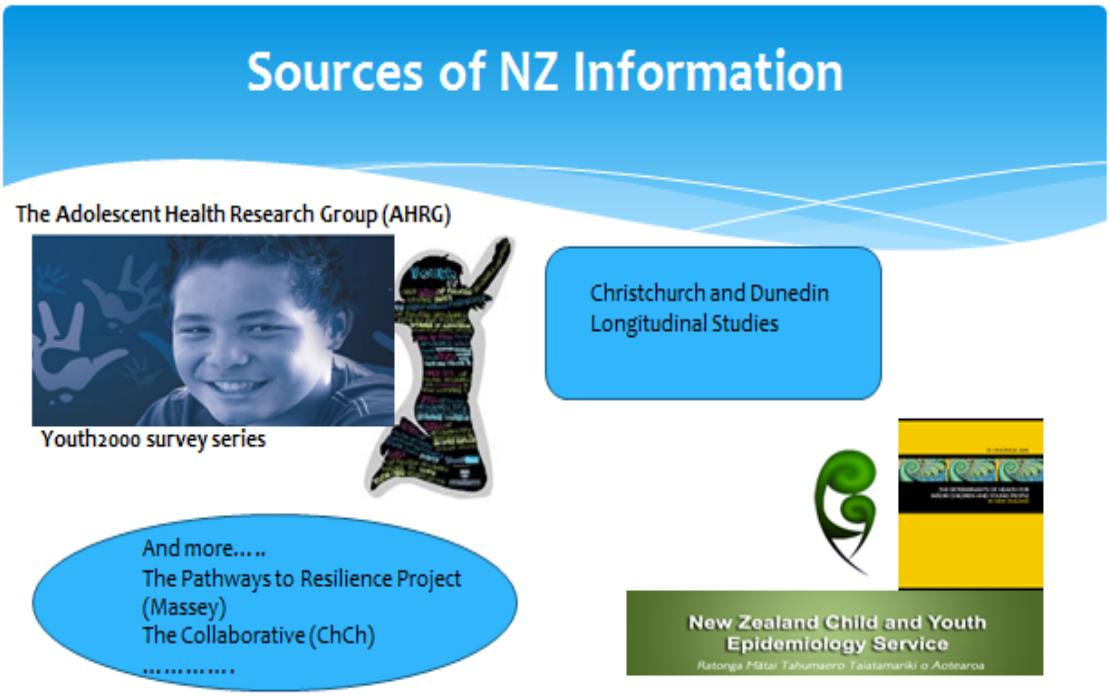
Goal 4: Health System Resiliency				
PRINCIPLE	**OUTCOME**	**INDICATORS**	**RECOMMENDATIONS**	**WORKFORCE DEVELOPMENT REQUIRED**
LEADERSHIP	**Commitment to Adolescents and Youth Development**	• YHD Governance Group • Positive Youth Health & Development Advisory/ Research Group for knowledge brokering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

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

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

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

References


Sources of NZ Information
The Adolescent Health Research Group (AHRG)
Youth2000 survey series
Christchurch and Dunedin Longitudinal Studies
And more.....
The Pathways to Resilience Project (Massey)
The Collaborative (ChCh)
.....
New Zealand Child and Youth Epidemiology Service
Ratonga Mātai Tahumaero Taiatamariki o Aotearoa


2002
along with Youth Health: A Guide to Action and E Tipu e rea
2011
Positive Youth Development in Aotearoa
Vulnerable/ high risk - 2013
YCAP TOOLKIT
Youth Health
A Resource Manual
A resource manual for Primary Care - 2014

Glossary

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

Consultation

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

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

10

RECOMMENDATION

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

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

OVERVIEW

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

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

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

OBJECTIVE

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

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

EXISTING FOOD SERVICE BACKGROUND

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

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

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

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

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

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

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

SUMMARY REPORT OUTCOME

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

1. Equipment planning and replacement plan

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

Recommendation:

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

2. Forecasting of meals

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

Recommendation:

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

3. Menu selection and processing

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

Recommendation:

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

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

4. Trendcare data

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

Recommendation:

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

5. Review current reporting structure and office space

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

Recommendation:

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

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

Recommendation:

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

6. Renew expired food service contracts

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

7. Zac's lounge area

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

Recommendation:

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

8. Clear signage for visitors in Zac's

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

Recommendation:

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

9. Relocation of the coffee machine

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

Recommendation:

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

10. Prepare bread products in Zac's café

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

Recommendation:

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

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

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

Recommendation:

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

12. Upgrading the till

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

Recommendation:

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

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

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

Recommendation:

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

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

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

Recommendation:

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

15. MOW service and meeting recipients needs

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

Recommendation:

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

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

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

Recommendation:

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

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

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

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

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

Recommendation:

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

18. Waste management & minimisation processes

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

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

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

Recommendation:

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

19. Wairoa and Central Hawke's Bay

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

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

FINANCIAL IMPLICATIONS

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

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

ATTACHMENTS

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

APPENDIX 1

Food Services Optimisation Action Plan

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

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

APPENDIX 2

Food Service Peer Review for Hawkes Bay DHB

Report compiled by:

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

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

EXECUTIVE SUMMARY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recommendation for Meals on Wheels:

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

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

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

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

Recommendations for Wairoa and Central Hawkes Bay Health Centre

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

REPORT

1. Hawke's Bay Fallen Soldiers Memorial Hospital

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

a) Food purchase, delivery, storage systems:

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

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


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

b) The method by which the food is prepared

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

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

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

c) The patient menu management system

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

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

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

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

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

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

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

d) Staff structure and operations

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

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

- Recommend that the service structure be reviewed.

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

Inpatient and MOW Food Service staff

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

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

Zacs Cafeteria

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

Clinical Dietitians:

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

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

Administrative staff:

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

Office accommodation:

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

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

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

e) The kitchen building layout and functionality

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

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

f) Production process

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

g) Waste management & minimisation processes

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

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

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

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

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

h) Equipment and automation utilisation

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

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

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

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

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

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

i) Financial Budget (Revenue & Expenditure)

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

j) Food Supplier Contracts / Standards

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

k) Food Service Standards and Guidelines

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

l) Distribution processes – Springhill and MOW

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

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

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

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

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

a) Café business model

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

b) The café building layout and functionality

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

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

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

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

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

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

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

c) Till system

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

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

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

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

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

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

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

d) Production process

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

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

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

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

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

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

e) Financial Budget (Revenue & Expenditure)

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

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

f) Waste management & minimisation processes

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

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

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

Current system in Zac's for waste.

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

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

g) General observations

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

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

Objective 1.3: Review the MOW management process

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

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

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

b) Food purchase, delivery, storage systems

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

c) The method by which the food is prepared

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

d) Kitchen production of frozen meals for MOW

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

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

e) MOW management systems

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

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

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

f) General comments

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

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

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

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

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

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

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

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

a) Central Hawkes Bay Food Services and systems

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

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

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

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

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

b) Wairoa Food Services and systems

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

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

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

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

HAWKE'S BAY District Health Board Whakawāteatia	**Health Equity Update 2016: Tackling Health Inequities**
	For the attention of: **Maori Relationship Board (MRB), Clinical and Consumer Council**
Document Owner: Document Author(s):	Caroline McElnay, Director Population Health -
Reviewed by:	N/A
Month:	June 2016
Consideration:	Seeking recommendations

RECOMMENDATION

That MRB and Consumer & Clinical Councils :

1. Receive the report.
2. Make recommendation to the HBDHB Board on priority actions required to further reduce health inequity in Hawke's Bay.

OVERVIEW

A summary of the key findings of the Health Equity Update 2016 will be presented. The document is currently in production and a copy of the report will be tabled.

BACKGROUND

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

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

PURPOSE OF HEALTH EQUITY REPORT

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

Tackling Health Inequities

Health Equity Update 2016

To tackle:

To deal with a difficult or complex problem

To lead the initiative and go on the offensive

Contents

Summary

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

This "Tackling Health Inequities" report is a mixture of good news and bad news. 13 of the 18 indicators reviewed show improvements with a reduction in inequity and we are seeing progress in areas where effective and targeted health services can make a difference.

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

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

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

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

Tackling social and economic factors – work together to focus on better economic development and social inclusion across Hawkes Bay, support increases in minimum wage towards a living wage, tackle housing issues,

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

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

Marmot 2015

Key Findings

Inequity gap in avoidable deaths nearly gone:

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

Avoidable hospital admissions for under- four year olds are reducing.

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

Teenage pregnancy rates decreasing

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

At least 50 years before equity in life expectancy between Māori and non-Māori is achieved if current trends continue.

We predict it will be at least 50 years before equity in life expectancy between Māori and non-Māori is achieved if current trends continue. The variation in life expectancy for Māori across New Zealand highlights the effect of geography on this measure – Māori in Hawkes Bay can expect to live on average 6 years less than Māori in Otago. This variation is likely to be due to underlying social and economic living conditions and inequalities rather than any significant variation in health services. It matters more where you live if you are Māori than if you are non-Māori.

Of great concern are the areas where health inequity appears to be worsening or static.

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

- Acute bronchiolitis admissions amongst children are increasing and are associated with poor housing conditions;
- Tobacco use amongst Māori women remains high. 43% of all Māori women giving birth in the past year were smokers – at the current slow rate of decrease it will be another 15 years before rates are the same as non-Māori. Helping women to stop smoking remains a priority.
- Obesity in 4 year olds has increased since 2009 with significant variation across communities – nearly 12% of children living in places like Camberley and Tamatea are obese compared to less than 1% of 4 year olds living in places like Havelock North Central and Poraite

- There has been no improvement in the oral health of 5 year olds with Māori or Pasifika children or children living in less affluent communities having significantly more dental decay.
- The widening gap and increase in violent crime in Hawke's Bay compared to the rest of New Zealand is a marker of underlying community and social issues. Research tells us that more unequal societies are more likely to experience higher rates of crime.

Health equity achieved or on track to be achieved in 1-2 years
Amenable mortality
Good progress in reducing health inequity
Avoidable mortality Ambulatory sensitive admissions 0-4 year olds Teenage (<18 year old) pregnancies
Health equity reducing but still significant inequity
Life expectancy Premature deaths Potential years of life lost Children living in households receiving benefits Youth not in employment, education or training Unemployment Hospital admissions due to medical conditions with a social gradient Tobacco use year 10 students Ambulatory sensitive admissions 45-64 year olds
Health equity unchanged or worsening
Acute bronchiolitis admissions Violent crime Tobacco use during pregnancy Obesity amongst 4 year olds Oral health of 5 year olds

Introduction

Hawke's Bay is a great place to live. But not everyone in Hawke's Bay has the same opportunity to be healthy. Stark health inequities exist in some parts of our community with some groups having better health outcomes than others. For Hawke's Bay to have the brightest future possible we need to collectively eliminate these health inequities.

So started my last report released in October 2014. This update gives us a chance to see how we are progressing on some of the key areas of health inequity. The reception to the 2014 report was mostly positive with great interest shown by community groups, health professionals, our local government and central government agencies and the media.

However not everyone was receptive or positive about the report. The feedback I received varied:

"This isn't health equity – most of these diseases are due to poor lifestyle choices made by some"

Health inequities are differences in health outcomes which are avoidable or remediable – in other words they are not inevitable. Not all differences in health outcome are avoidable, but when avoidable differences are seen consistently between different groups of people, no matter how those groups are defined then those differences are inequitable.

Many lifestyle choices such as smoking, drinking alcohol, lack of exercise or poor eating are strongly linked with socioeconomic status and income. While ultimately people are responsible for the choices they make, many of those choices are influenced by factors outside that person's control. We need to dig deeper into what those influencers are and help to make a difference. We cannot assume that if only people knew what to do to improve their health they would do it – and if they didn't then they must be lazy, disinterested and deserve all that befalls them consequently. I explore this in more detail in the next chapter.

"Why are you focusing so much on deaths and length of life – surely it's the quality of life that's important? "

Quality of life is important but when there are still significant differences in the length of life by ethnicity that tells us that we need to do something about this major health inequity. A quarter of all deaths among Māori in Hawke's Bay occur before the age of 50, mostly from preventable or treatable causes.

"You haven't told me anything I don't already know – I live and work in communities where health inequities are stark."

Many community groups told me that my report wasn't news to them – and my response was that my report wasn't directed at them – but at the many others in our community who don't know about

health inequities, and who don't realise the contribution that they too can make to improving health and well-being in Hawke's Bay. They may be business owners generating employment, teachers working with young Māori and Pasifika who may be struggling to achieve qualifications, philanthropists keen to give back to their community. We all have a role in reducing health inequity and the solutions lie amongst us all collectively.

"Your report missed many aspects of health such as mental well-being and domestic violence – they have a powerful impact on health in our community and there must be inequities there"

One of the biggest problems in trying to describe health equity and its drivers is the lack of good population health data in areas such as mental health, domestic violence, and whānau focused data. We need to develop better measures of well-being in our community including how to better describe the health of whānau and communities in a more holistic way. Also some data sources are not updated annually for example the Census and the New Zealand Health Survey. There is also often a delay in some data releases – mortality data can be three years old by the time the DHB receives it thereby limiting our ability to be up to date. Any health equity report can only ever be a snapshot of what is happening in the community. Future reports will look in more detail at these other areas.

"What is the DHB going to do about this? This shows your services aren't up to scratch with the rest of the country"

If people think that the poor health in Hawke's Bay compared to the rest of the country is solely the responsibility of health services and reflects a failure to deliver quality health services then my last report failed to communicate that health is the result of many factors, of which health care is only one aspect. This DHB should of course aim and strive to provide the best quality health services that it can and ensure equitable access to that health care – so that health needs are met in a timely, and high quality way. I highlighted in my 2014 report the particular issues around access to primary care, especially amongst 45-64 year olds and the barriers that cost of going to a general practice can create. However addressing many of the causes of ill-health lie outside the direct control of the DHB. This is why the Hawke's Bay DHB is working closely with other agencies across Hawke's Bay, including businesses and the economic sector, to develop ways of tackling these issues together.

My last report was very much about defining the issues with health inequity and setting out a challenge to the whole community to address health inequity – its by-line was "we all have a role to play". This update tracks the progress we are making in some areas and highlights ongoing areas of concern.

Ways of tackling health inequities - changing behaviour

There are many factors which influence health and therefore many ways of addressing health inequities. These factors can be categorised into 4 main areas:

Health behaviours – such as use of tobacco, nutrition, physical activity, alcohol

Health care – both access to care and receipt of high quality health care

Social and economic factors, whereby education and income are two of the biggest determinants of health

Physical environment – the quality of our air, water and other environmental factors that can directly influence our health and well-being

Itemising and describing the issues is important but tackling health inequities requires a combination of approaches and broad community effort and leadership. Solely focusing on one area will not get the better health equity that we seek.

In this update I want to explore tackling health behaviours in more detail.

When we look at the variation in healthy behaviours within a community we often see less healthy behaviours amongst communities which are less well off. There have been many attempts to explain why this is so. It's clearer when the risk factor is linked to the unaffordability of essentials such as housing and heating. It's more complicated when we look at risk factors such as smoking, obesity or alcohol. How much of this is due to informed personal choice to continue their behaviours and how much due to other factors (linked in some way to social disadvantage) which actually stop people from making more healthy choices?

Most people know that smoking harms health and about the importance of good food and regular exercise. The reasons that people continue to smoke and that obesity continues to increase do not stem from ignorance. Advice is useful but it is not how much people know that determines whether they behave as the advice suggests. What we fail to understand are the barriers that are stopping people from taking up those healthy behaviours.

Empowerment is about knowing you have control over many aspects of your health, about valuing the changes you can make and about then making those changes. Research has shown that this empowerment is often absent in less well-off communities often then resulting in a belief that change isn't possible or that they can't make changes to their health. This may help explain some of the variation we see in patterns in healthy behaviour.

Tackling health inequities and helping to change behaviours therefore requires both a supportive environment framework and empowerment frameworks. First by making healthy choices the easy choices (e.g. knowledge, availability, cost, a supportive environment) and secondly by empowering people to make decisions that will positively influence their health and well-being.

A local example of an empowerment model is Iron Māori. I spoke to Heather Skipworth and Lee Grace about Iron Māori and its Kaupapa:

Iron Māori was first established in 2009. It offers triathlon-style swim, run, and cycle events in a variety of distance ranges for both individuals and for teams and is very popular both within Hawke's Bay and across New Zealand. For many of its participants it has proved to be life changing with many going on to achieve other personal goals in education, employment and improved health and mental wellbeing.

Heather's original concept for Iron Māori came out of her own sense of achievement she experienced on completing her first Iron Man event. At the time she was working with some clients with weight problems and she wanted to help them get that same sense of achievement and accomplishment in reaching their goals.

> *"When you complete something that's hard and arduous and takes a lot of tenacity, and it's something that people don't expect you to be able to do, you grow from that. That transcends an event and ends up in other aspects of your life – how you think about yourself and how you expect more of yourself. There is a shift in peoples thinking from "I can't do this ", "this is the mould I'm in …this is how life has been" towards realising that all of those are changeable. "*

Iron Māori does this by creating an accepting and supportive environment for those who register for one of their events. This starts right from the very first meeting where people share their stories and "you are surrounded by a lot of people who can accept you for your whole person ".

This non-judgemental aspect is emphasised:

> *"You can go to doctors and even if he's not judgemental he's going to say you are overweight – you need to lose some weight. We never tell people they are obese ….We never concentrate on their health issues. We just include them and the health issues slowly slip away without even having talked about them"*

Empathy and trust are not just words on a mission statement - Lee says that Iron Māori is real -

> *"People stand up at the info evenings and talk about their life story - this resonates with people who are in that position. They may be living with drugs and violence and alcohol at the moment but they see someone who was doing that two years ago talking about how their lives changed. This openness and vulnerability is really powerful. "*

Whanaungatanga and the inclusiveness of Iron Māori is an essential part of the physical training

> *"Even with the practical training side of things there are barriers that individuals have to overcome to feel included. For some people simply wearing togs for the first time in front of a bunch of people is hard. But with a lot of laughter and humour it doesn't take long for people to come in and they are comfortable."*

Trust, being inclusive and having a lot of empathy are key to Iron Māori's strength. But so too is the belief in people –

"We say we can take you and we will have you swimming… we believe you - you can do it and we keep believing in them even when they don't. Someone else believes in them enough that they keep doing it and when they do it they feel great!"

The health benefits are side benefits that come about as people realise that smoking or too much alcohol doesn't fit into an active lifestyle. But the change comes from them – no-one is telling them to stop – they want to change and Iron Māori gives them a belief in themselves to change the things they thought they couldn't.

"I can kick that habit because I don't want it. "

Heather and Lee have also seen people going back into study and getting into training or employment.

"This is not about rules – or saying you can't smoke or drink - it's a positive drive as opposed to reducing the negative. They have a reason to want to change and they are supported by others who are doing the same."

By accomplishing a goal in a supportive way and feeling really good …opens up a whole world of "I can do that " – it's about confidence to go and do things. "

Role models are important – and what Iron Māori provides is for people who are achieving their personal goals, not drinking and spending more time with their families to be positive role models for others - and in so doing redefining what a role model is.

"We don't get bogged down in the why or the theory or the latest study on motivation to change. We just do it and we try to understand people. We know that what's really powerful is when you hear someone speak and they are telling your story, and the time is right - then that's your motivation...

"We never tell anyone they are on a programme – because programmes begin and end. This is a Kaupapa – this is your life, this is part of your lifestyle and a way of living. We never say it's a programme – even if you leave Iron Māori your journey still continues – it has no end. "

There are other models of empowerment operating in different ways throughout our community. Whilst they vary in detail the central theme is about giving back control to people to make changes in their lives and the lives of their whānau. These models in themselves will not solve all the health inequity issues in Hawke's Bay. But together with a resolve to provide an environment to support healthy choices they will have a positive impact on behaviours and the choices that people make.

In addition the importance of whānau and on whānau ora has long been identified as an important component and a key driver of Māori development. Health equity for Māori therefore needs to consider whānau health equity.

"Culturally grounded and holistic approaches focus on improving the wellbeing of whānau as a group, as well as individuals within the whānau. Whānau ora

recognises that whānau wellbeing is closely linked to Maori cultural values, alongside social and economic priorities. It aims to increase whānau wellbeing, including whānau participation in Te Ao Maori, sport and exercise, financial literacy, and higher education."

Tracee TeHuia, GM Māori Health

Health Outcome Indicators

Life Expectancy (how long we live)

At the current rate of change in life expectancy equity for Māori won't be reached for another nearly 50 years.

There is no updated life expectancy data by District Health Board since the last Health Equity 2014 report - that was for the period 2008-2010. However recent analysis by Statistics New Zealand calculates life expectancy by territorial authority regions for 2012-14 and also compares the results with 2005-07. The Hawke's Bay territorial region is very similar to the Hawke's Bay DHB boundaries and this analysis provides us for the first time a comparison of how we do in relation to other parts of New Zealand and how life expectancy has changed over this 7 year period.

Life expectancy at birth has increased in all regions in New Zealand since 2005–07, with Hawke's Bay increasing the most - by 1.5 years for males and 1.2 years for females. Hawke's Bay however remains in the bottom quartile of the 16 regions.

Life Expectancy in Hawke's Bay region, by ethnicity and gender, 2012-14, years

	Hawke's Bay Region	Life Expectancy Gap	New Zealand	Life Expectancy Gap
Males	78.6 years	3.8 years	79.5 years	3.7 years
Females	82.4 years		83.2 years	
Māori male	71.7 years	8.2 years	73.0 years	7.3 years
Non-Māori Male	79.9 years		80.3 years	
Māori Female	75.9 years	7.7 years	77.1 years	6.8 years
Non-Māori female	83.6 years		83.9 years	

Source: Stats NZ

Can we draw a picture of men and women?

Maori

72 years

76 years

Non-Maori


80 years


84 years

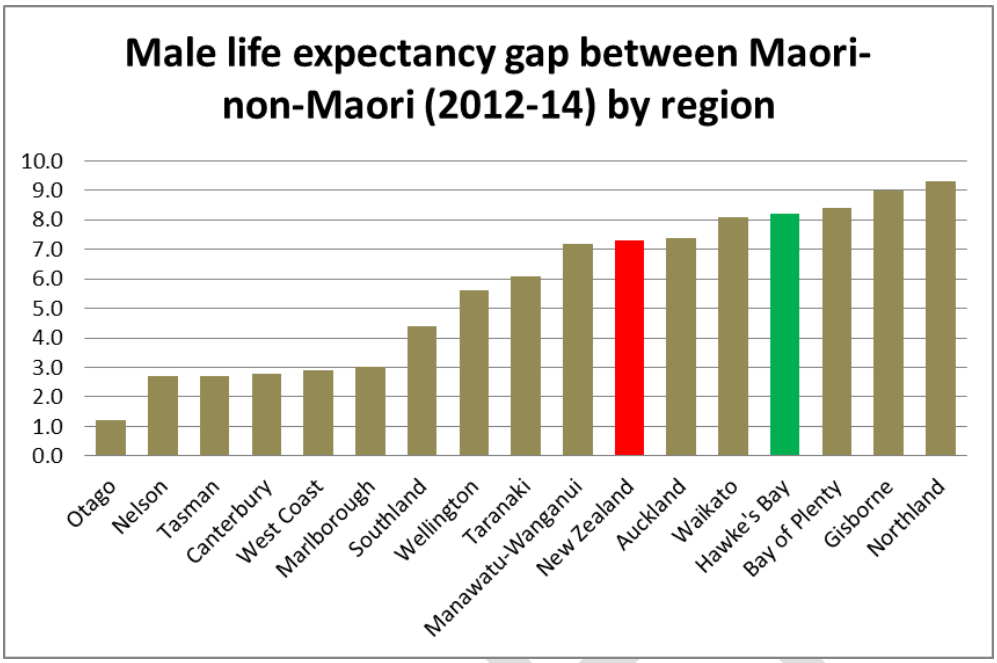
The gap in life expectancy in Hawkes Bay between Māori and non-Māori is 8.2 years for males and 7.7 years for females. **This is one of the largest gaps in life expectancy across New Zealand, which varies from one year in Otago to 9 years in Northland. This variation in gap is due to the variation in life expectancy for Māori across the country, rather than any variation in life expectancy for non- Māori.** Māori in Hawkes Bay can expect to live on average 6 years less than Māori in Otago. This variation in life expectancy for Māori across New Zealand will be heavily influenced by social and economic factors rather than health behaviours and local health service provision.

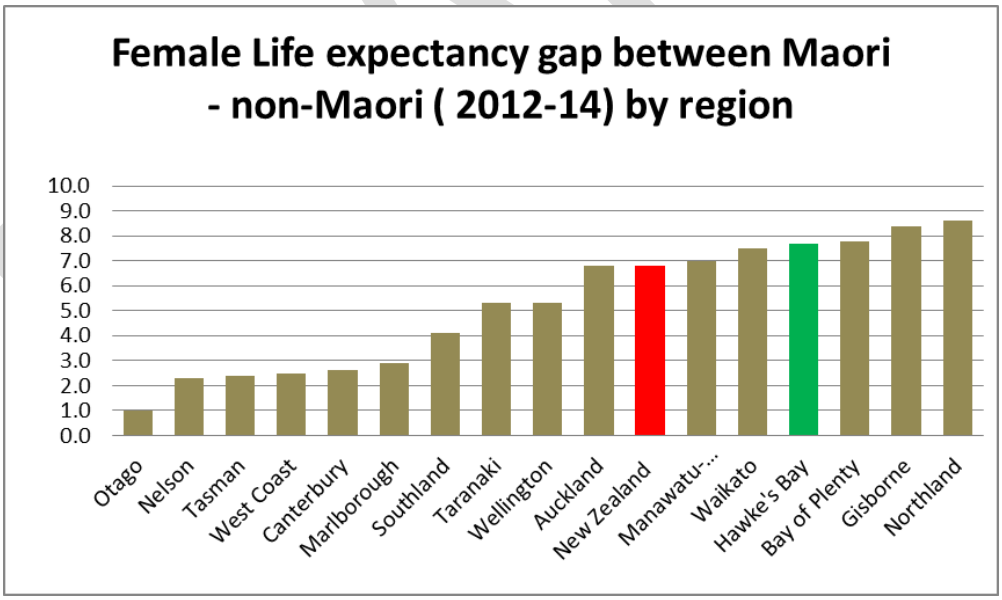
Analysis of trends in life expectancy between 2005-07 and 2012-14 by ethnicity and gender shows that the **biggest gains in life expectancy across New Zealand were for Māori males in Hawke's Bay and for Māori females in Hawke's Bay**, along with Taranaki, Tasman and West Coast regions.

The 1.4 years reduction in life expectancy gap between Māori and non- Māori males in Hawkes Bay is also the largest reduction observed across the regions in New Zealand.

Good progress appears to have been made in Hawke's Bay over the past 7 years, especially compared to other regions. **However at the current rate of change in life expectancy equity for Māori won't be reached for another nearly 50 years.**

Maybe map the following charts??





Premature Deaths

Premature deaths are deaths before the age of 75 years. In Heath Equity 2014 I highlighted the inequity in the proportion of premature deaths before 75 years but also, more shockingly, in deaths before the age of 50 years for both Māori and Pasifika in Hawke's Bay. The latest figures for 2008-12 show improvements with a small decrease in the percentage of Māori dying before the age of 50

years but an increase for Pasifika people (numbers are very small). A quarter of the deaths in our Māori communities occur before the age of 50 compared to only 5% in our non- Māori non-Pasifika communities. Most of these deaths are avoidable.

Comparison of Premature deaths in Hawke's Bay between 2006-10 and 2008-2012

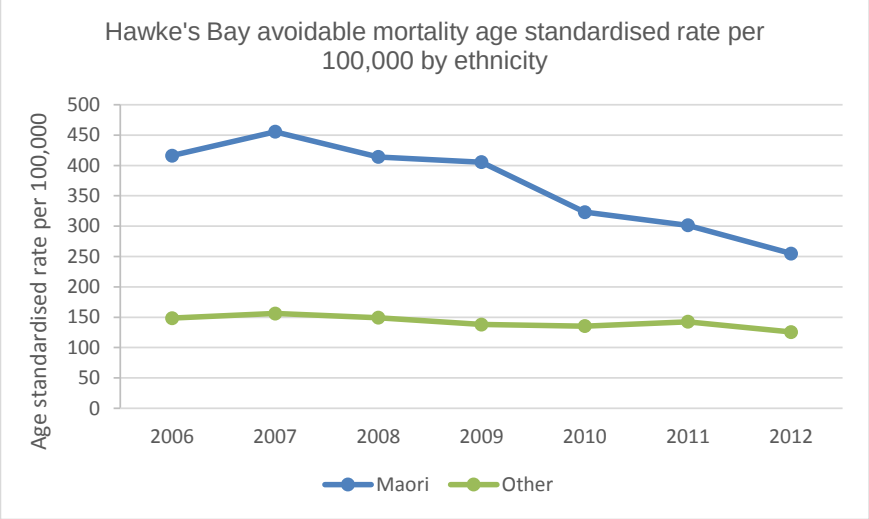
	Deaths under 75 years		*Deaths under 50 years*	
	2006-2010	*2008-2012*	*2006-2010*	*2008-2012*
Māori	77.0%	73.2%	26.3%	24.8%
Pasifika	52.4%	63.4%	23.8%	29.0%
Other	31.9%	31.3%	5.1%	5.2%
Quintile 5	56.5%	54.5%	16.1%	14.8%
Quintile 1	20.6%	20.8%	4.4%	3.9%
HB Total	38.7%	38.0%	9.2%	8.5%

Avoidable Deaths

Nearly three-quarters of all deaths before the age of 75 years are avoidable either because of disease prevention or because of effective treatment and health care. Deaths due to these diseases or conditions can be counted and expressed as a rate. Any difference in these rates by ethnicity or by area of residence can therefore be considered to be a health inequity.

The equity gap in avoidable deaths is reducing and should close by 2017 if current trends continue. Avoidable death rates are still 2 times higher amongst Māori and amongst people living in Quintile 5 areas in Hawke's Bay

The top cause of avoidable deaths across all ethnic groups remains ischaemic heart disease (heart attacks), accounting for about one-fifth of all avoidable deaths. The top cause of avoidable deaths for Māori women is lung cancer, followed by ischaemic heart disease. The top cause of death for non-Māori women remains breast cancer. Road traffic injuries and diabetes continue to be significant causes of death amongst Māori. Suicide is a significant cause of death for all ethnicities.



Top causes of avoidable deaths	Māori Males	Other Males	Māori Females	Other Females
Ischaemic Heart disease	26.6 % (1)	22.3 % (1)	15.6 % (2)	12.3 % (3)
Road traffic injuries	12.5 % (2)	4.5 % (6)	3.9 % (8)	-
Lung cancer	10.3 % (3)	17.7% (2)	22.4 % (1)	13.6 % (2)
Diabetes	8.2 % (4)	3.5 % (9)	8.3 % (4)	2.8 % (9)
Suicide & self-inflicted injuries	6.0% (5)	8.3 % (3)	5.4 % (6)	3.2 % (8)
Complications perinatal period	4.1 %(6)	-	-	-
Cerebrovascular disease	3.8 % (7)	5.7 % (5)	5.4% (6)	7.8 % (5)
COPD	3.4% (8)	4.1 %(8)	5.9 % (5)	6.9 % (6)
Breast cancer	-	-	8.3 % (3)	14.1 % (1)
Colorectal cancer	3.1 % (9)	7.9 % (4)	-	11.9 % (4)
Melanoma Skin	-	4.2% (7)	-	4.5% (7)
Stomach cancer	2.5 % (10)		-	-

Potential Years of Life Lost (PYLL)

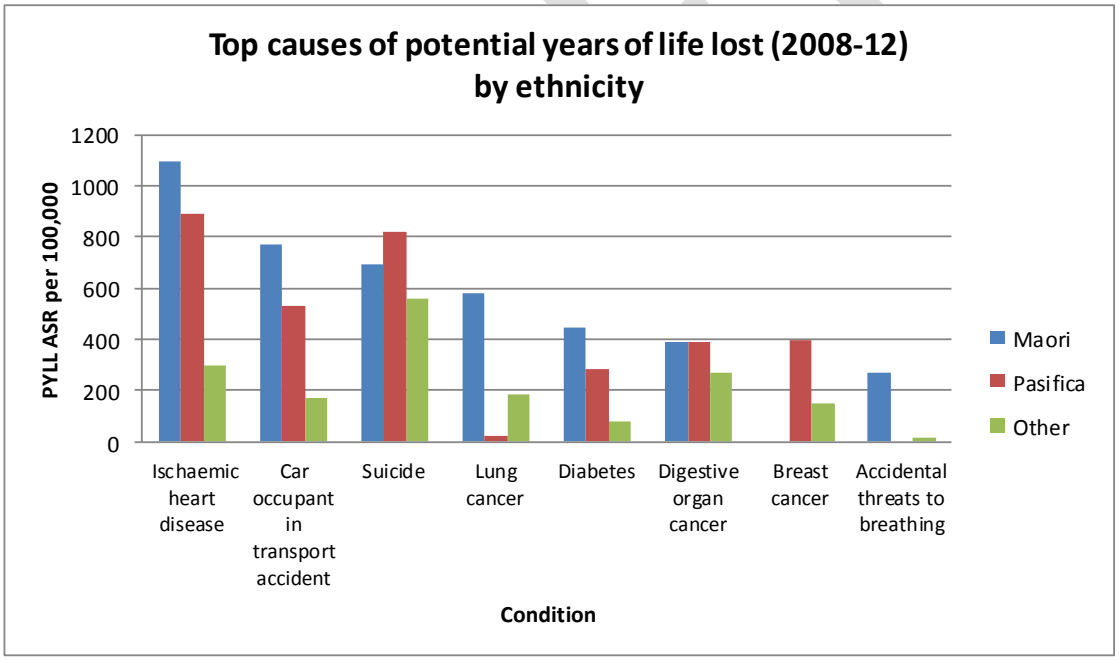
Another way of looking at premature deaths is to calculate the average years a person would have lived if he or she had not died prematurely. This method emphasises the importance of causes of death which occur at earlier ages because there are more potential years of life lost.

The most recent time period studied (2008-2012) shows that there have been **reductions in PYLL and a reduction in inequity for Maori and people living in Quintile 5 areas**. However Māori rates are still 2.0 times, Pasifika rates 2.9 times and people living in Quintile 5 1.8 times higher than the rest of Hawke's Bay.

The top conditions to target to reduce health inequity continue to be

- ischaemic heart disease (heart attacks) (Māori 4 times and Pasifika 3 times higher),
- being in a car involved in a transport accident (Māori 4.6 times and Pasifika 3 times higher)
- lung cancer (Māori 3 times higher)
- diabetes (Māori 5 times and Pasifika 3.5 times higher)

In the time period 2008-12 a set of conditions coded as "Other Accidental threats to breathing" emerged as a top cause of PYLL for Māori (Māori -17 times higher). This latter grouping includes Sudden Unexplained Death in infancy (SUDI). A small number of deaths at an early age (these deaths all occurred in the first year of life) will result in large numbers of potential years of life lost. SUDI rates in Hawke's Bay have been falling but a spike was seen in 2010/11. This spike was noticed and led to local maternity and early child care services implementing a Safe Sleep programme focused on the prevention of SUDI.

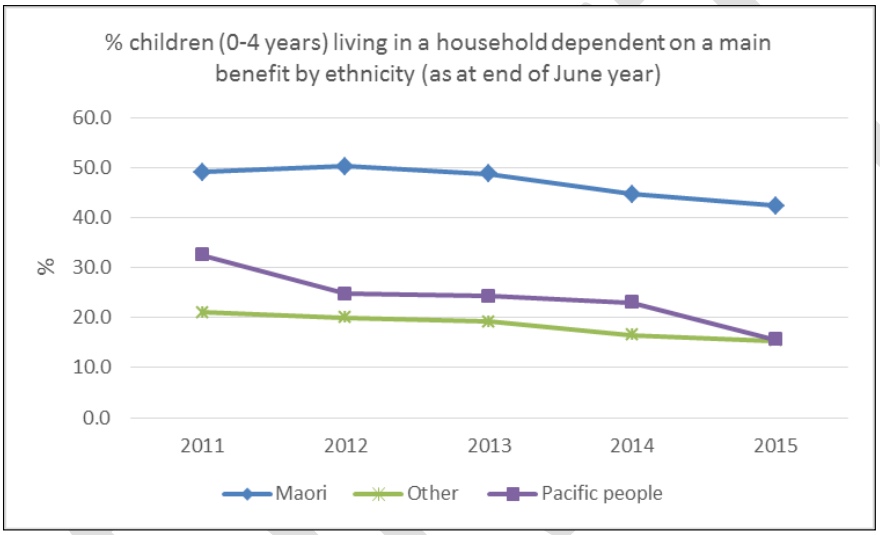


Social and Economic Factors

Children Living In Households Receiving Benefits

There has been a decrease in the percentage of children in Hawke's Bay living in households receiving a working age main benefit although these figures are still higher than for New Zealand as a whole - 28% of 0-4 year olds live in households receiving a working age benefit compared with 21% for New Zealand and 23% of 0-14 year olds in Hawke's Bay compared to 18% in New Zealand (at end June 2015)

There are however still clear disparities by ethnicity, particularly for Māori, with the most recent figures for 2015 showing **42% of Māori children aged 0-4 years** living in such households compared to 15.3% of non- Māori non-Pasifika children.



% children living in households dependent on a main benefit, by ethnicity, 2015.

Ethnicity	HB 0-4 years	NZ 0-4 years	HB 0-14 years	NZ 0-14 years
Māori	42.4%	36.9%	36.4%	25.4%
Pacific	15.6%	18.5%	15.2%	14.5%
Other	15.3%	11.9%	13.0%	9.0%
Total	28.3%	20.6%	22.8%	17.8%

Source: Ministry of Social Development

Young people not in education, employment or training (NEET)

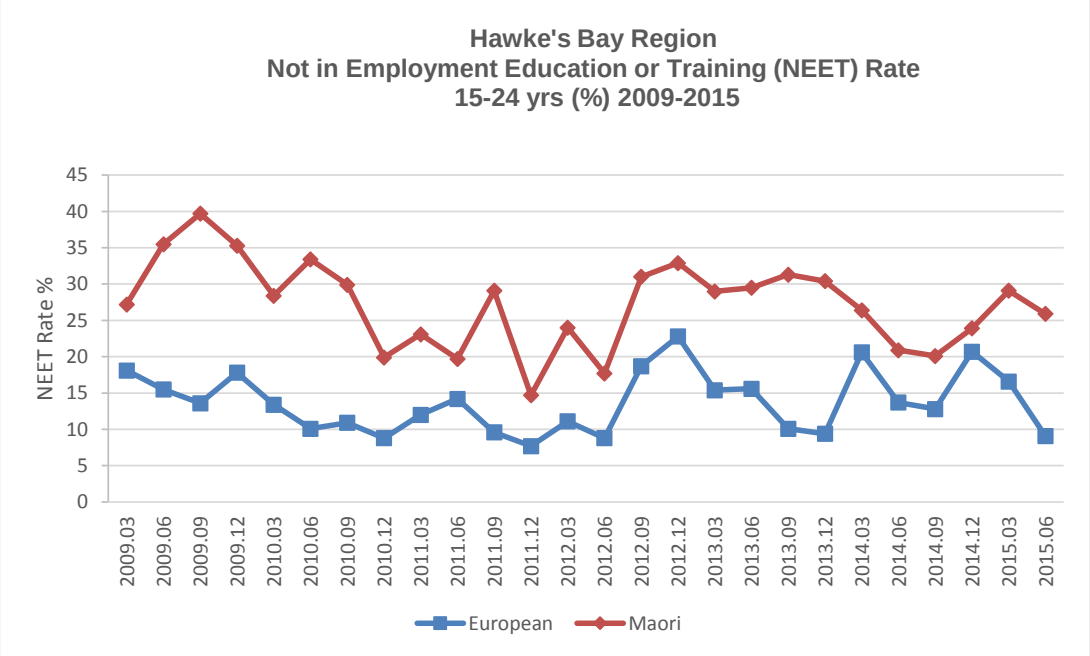
Young people not in employment, education, or training (NEET) are young people aged 15–24 years who are unemployed (part of the labour force)and not engaged in education or training, and those not in the labour force and not engaged in education or training for many reasons. These young people are at greater risk of a range of negative outcomes including poorer health, depression, or early parenthood. This is an indicator where there have been consistent differences in the rates of NEET by ethnicity, with Māori rates often between 2-3 times higher than non- Māori rates.

The proportions of young people who are NEET in Hawke's Bay fluctuate, as do the national rates.

The most recent figures show that **25.9% of young Māori are not in education, employment or training compared to 9.1% European young people.**

It is hard to determine what is happening re closing of the gap due to fluctuation of data.

Hawke's Bay region - not in employment education or training (NEET) rate 15-24 years (%) 2009-2015



Source: Household Labour Force Survey – Statistics NZ

Unemployment

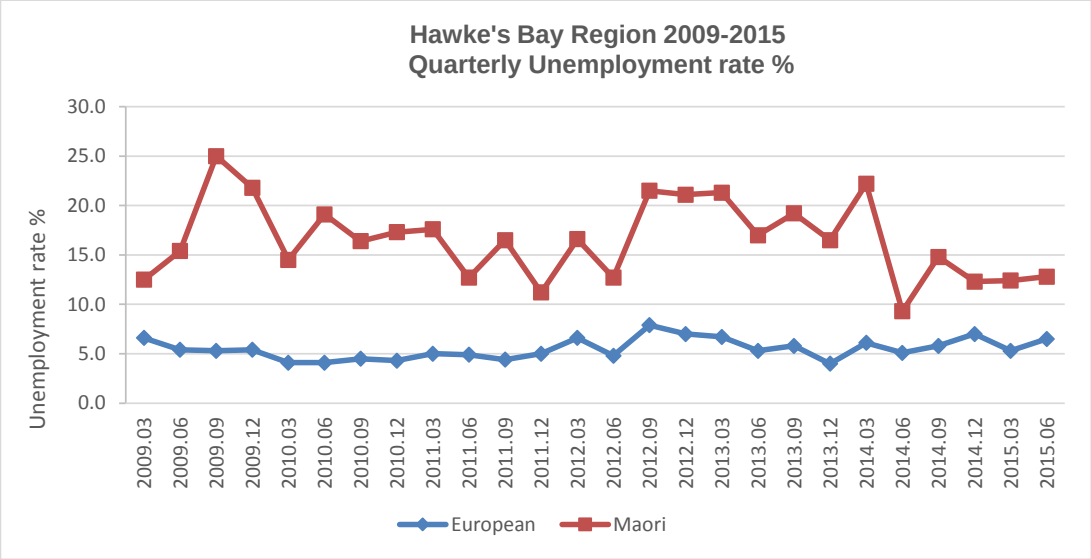
There is good evidence to show that work is generally good for physical and mental health and well-being and being unemployed does tend to be associated with poorer physical and mental health.

Being unemployed is defined as all people in the working-age population who during the reference week were without a paid job, available for work, and had either actively sought work in the past four weeks ending with the reference week, or had a new job to start within the next four weeks.

Unemployment rates in Hawke's Bay have fluctuated over the period March 2009 to June 2015 and both locally and nationally do seem to have decreased since September 2012. At 7.2% in June 2015 Hawke's Bay rates are just higher than the New Zealand average of 5.7%.

"European' unemployment rates have been relatively stable at around 6% since September 2012. **Māori rates have decreased substantially since March 2014 averaging out at around 12.5 % for the past 3 quarters (December 2014- June 2015) with a reduction in the equity gap.**

Hawke's Bay region 2009-13 - Quarterly unemployment rate %



Source: Household Labour Force Survey – Statistics NZ

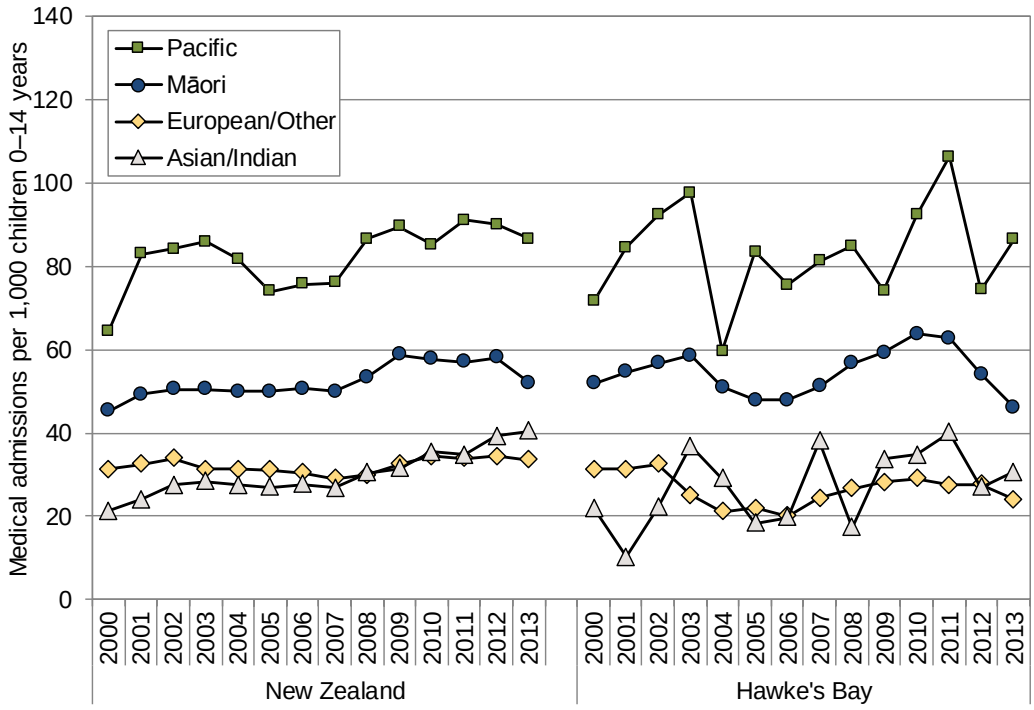
Childhood Disease linked with socioeconomic conditions

There are many childhood diseases that are known to be sensitive to socioeconomic conditions with much higher rates or worse outcomes seen in those children living in the most socioeconomically deprived areas. Most of these conditions are infectious and respiratory diseases and many can be directly linked to cold damp houses and overcrowding. The Health Equity report 2014 highlighted that admission rates for these conditions had increased in Hawkes Bay since 2006 for all ethnic groups but particularly for Pasifika children with a widening in health equity gap for both Pasifika and Māori.

Updated data from the NZ Child and Youth Epidemiology service show that In Hawke's Bay for the period 2009-2013 t**he overall rate of admissions for all conditions with a social gradient in Hawke's Bay was significantly lower than the New Zealand rate.**

There has been a reduction locally in the admission rates for Māori and Asian / Indian with fluctuation in Pasifika rates. **There remains a marked disparity in admission rate by ethnicity but substantial closing of the gap in admission rates between Māori and European / other children.**

Hospital admissions for medical conditions with a social gradient, per 1000, 0-14 years old, by ethnicity, Hawke's Bay vs New Zealand, 2000-2013



Source: New Zealand Child & Youth Epidemiology Service

Unfortunately the NZCYES have not provided data on trends in admissions for the individual diseases in this category.

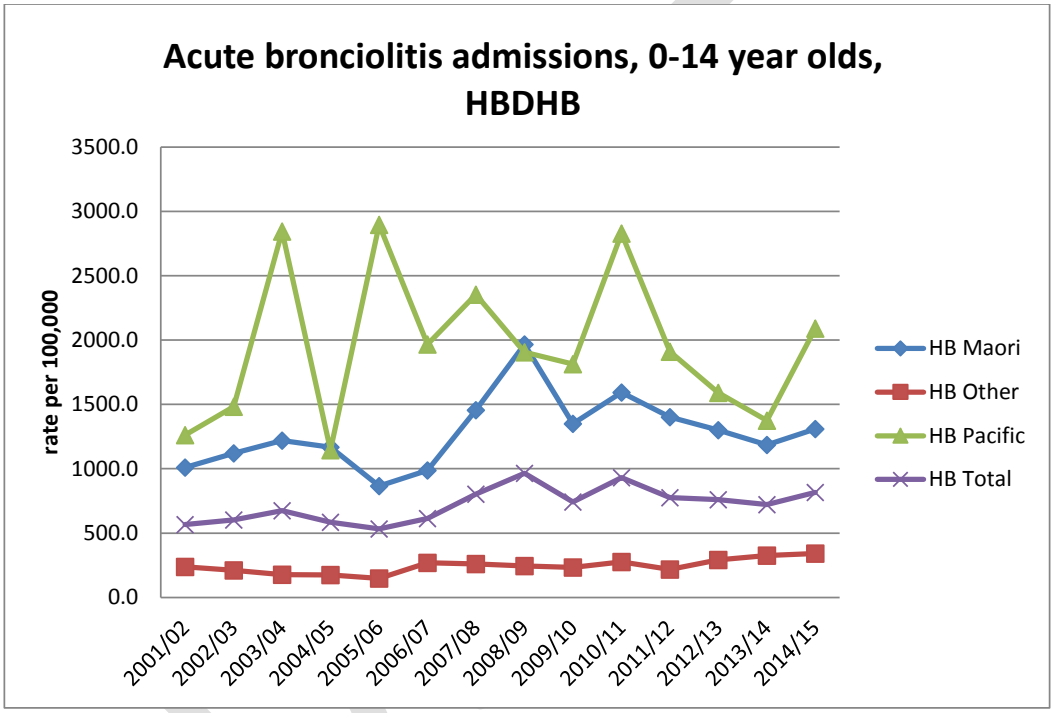
It is not clear if this decrease in admissions is due to an improvement in living conditions or due to other programmes such as vaccination programmes and earlier treatment in primary care.

Acute bronchiolitis

Acute bronchiolitis is a one of the diseases in the list of medical conditions with a social gradient for admissions to hospital. It a viral infection of the airways and occurs mainly amongst infants under one year old. It is the most common cause of hospital admission in this age group and tends to occur most frequently in late winter. In 2014/15 there were 283 child admissions with this condition in Hawke's Bay, of whom 180 were Maori, 65 Other and 38 Pasifika.

There are a number of risk factors which increase the likelihood of infection such as prematurity, congenital heart disease, immune deficiency, household overcrowding, poverty, lack of breastfeeding, maternal smoking during pregnancy and exposure to tobacco smoke in the home.

Over the period 2010-2014 Hawkes Bay had **higher** rates of bronchiolitis admissions than the New Zealand average (111.1 per 1000 compared to 84.6 per 1000, a relative rate of 1.3 times higher). Admission rates have been generally **increasing** since 2001 but have decreased for Maori and Pasifika children over the past 5-6 years (with an increase for Pasifika children in 2014/15). **However there continues to be inequity with higher rates of bronchiolitis amongst Maori (3 times) and Pasifika (4 times) children and amongst children from quintile 5 areas (4 times) – these are all statistically significantly higher rates.**



Prevalence of Violent crime

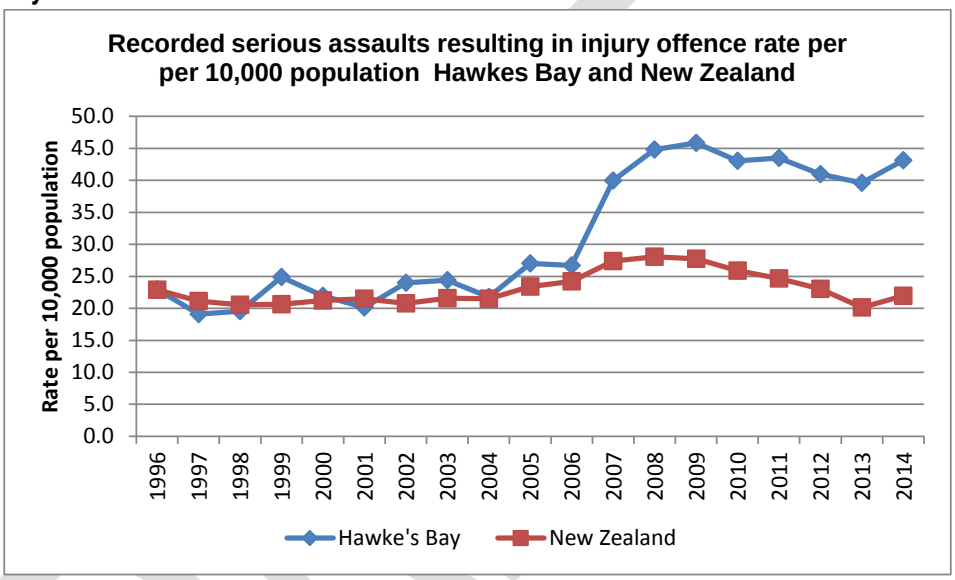
The links between crime and health are complex. Violent crime may result in temporary or permanent disability and in some cases death. Some victims of crime may suffer psychological distress and subsequent mental health problems. Crime and fear of crime can also alter people's lifestyles and impact on their physical and psychological health. There is also concern about homicide and suicide by people with mental illness.

NZ Police data has been analysed to try to ascertain the prevalence of violent crime in Hawke's Bay. The data only includes violent offences which are reported to the police and is susceptible to

changes in police crime reporting procedures. It is also only available at a Hawke's Bay level, not by ethnicity or socioeconomic decile.

Hawke's Bay rates continue to be higher than the New Zealand average and are twice the rate for New Zealand. Over the last 5 years there has been a slight increase in the rates of assault resulting in injury in Hawke's Bay with a reduction nationally resulting in a **widening of the gap in equity between Hawkes Bay and New Zealand as a whole.**

Recorded serious assault resulting in injury offence rate per 10,000 population Hawke's Bay and NZ



Health Behaviours

Tobacco use amongst young people

In the Health Equity report 2014 tobacco use was highlighted as the single biggest underlying cause of inequity of death rates and ill-health in Hawke's Bay. In particular the high rate of smoking amongst Maori women giving birth was highlighted and declared a public health crisis, given the effects that smoking has both for the mother and on the health of her infant with lasting impacts into adulthood.

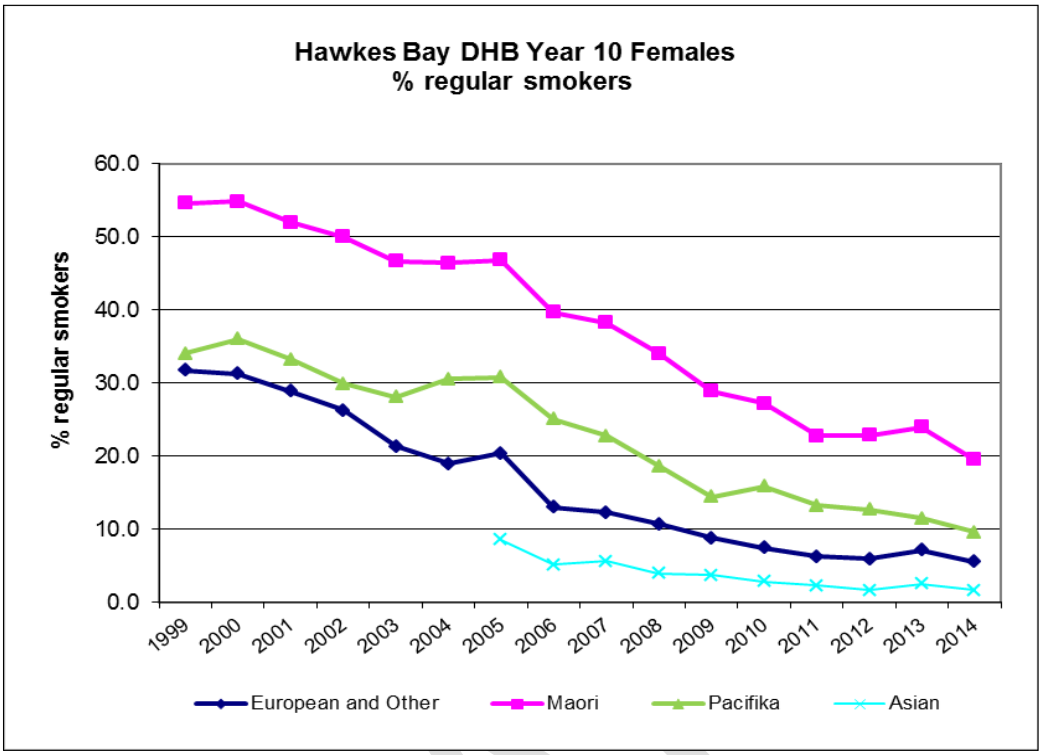
The main source of information on smoking rates comes from the census but this will not be updated until 2018. However the latest ASH (Action on Smoking and Health) Year 10 survey results are available (2014). This survey is an annual questionnaire of around 30 000 students across New Zealand and funded by the Ministry of Health. It is conducted in schools throughout the country and is one of the biggest surveys of its kind. It has been going for 16 years and gives us a valuable and robust insight into rates of youth smoking.

Smoking is an addiction largely taken up in childhood and adolescence, so it is crucial to reduce the number of young people taking up smoking in the first place. Most current and ex-smokers say that they started smoking regularly before they were 18 with many smoking regularly before the age of 16.

The percentage of year 10 students who are regular smokers has been **dropping consistently** since the first survey in 1999 when 28.6% of students across New Zealand were regular smokers compared to only 6 % in 2014. The latest survey indicates that 8.7% of year 10 students in Hawke's Bay are regular smokers - this is statistically higher than the 6 % for New Zealand.

This decrease has been seen across all ethnic groups with a narrowing of the gap in prevalence noticeable since 2006. Māori continue to have higher rates of regular smokers (17%) with the lowest rates seen amongst Asian students (2%) and 5% European.

Year 10 girls are more likely to be regular smokers than year 10 boys. **Nearly 20% of Māori girls aged 15 years are regular smokers - this is 6 times the rates of smoking amongst European / Pakeha girls and twice the rate amongst Māori males (11%).** Pasifika girls are also more likely to be regular smokers but the rate is 1.7 times that of European / Pakeha girls



Source: Action on Smoking and Health (ASH)

Improvements continue to be seen and the gap in smoking rates for both boys and girls by ethnicity is closing. Tackling smoking rates amongst young Māori women remains a key health priority and is an area where more innovative and whānau inclusive approaches will be required.

Tobacco use in pregnancy

Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. These include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy.

Encouraging pregnant women to stop smoking during pregnancy may also help them kick the habit for good, and thus provide health benefits for the mother and reduce exposure to second-hand smoke by the infant.

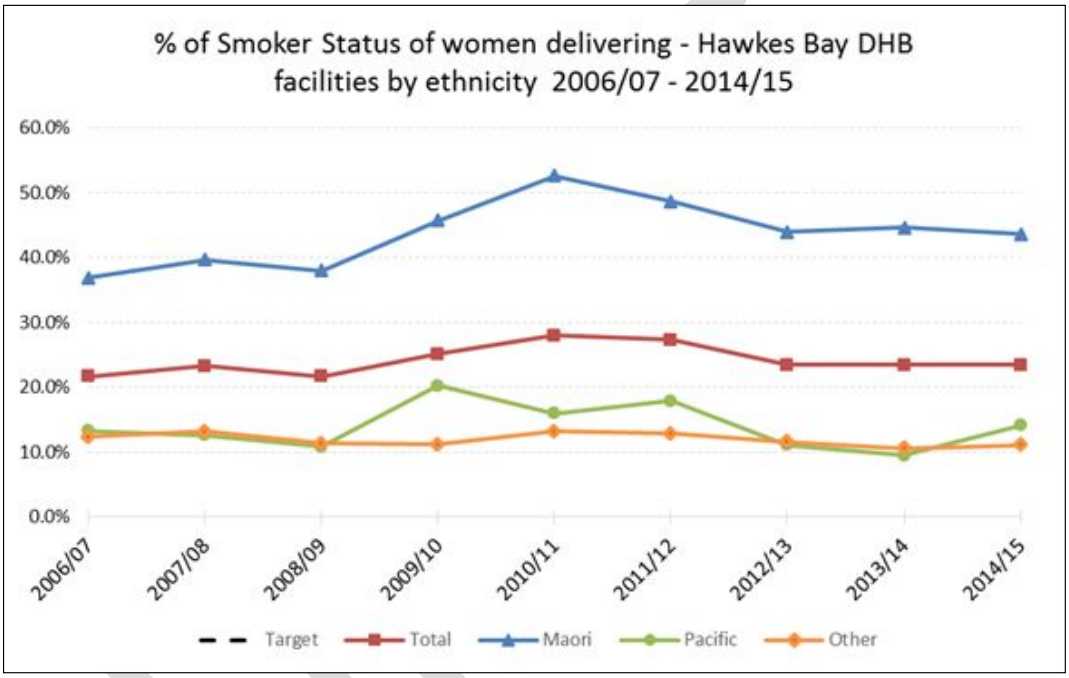
23% of all women who had a baby at one of the Hawke's Bay DHB facilities during 2014/5 were current smokers with big differences seen both by ethnicity and by deprivation**. Pregnant women who are Māori or who live in a quintile 5 area are 5 times more likely to be smokers than non-Māori or women living in a Quintile 1 area.**

43% of all Māori women giving birth were smokers compared to 8.6% of non-Māori non-Pacific women; 32% of women living in Quintile 5 compared to 6% living in quintile 1.

Rates of smoking amongst pregnant women peaked in 2010/11 and have been **very** slowly decreasing since then. If the percentage of Māori women who are regular smokers or the percentage of women living in Quintile 5 areas declines at the same rate as it has since 2010/11 (nearly 10% reduction over 5 years) **equity won't be achieved for at least 15 years**.

Reducing smoking rates amongst Māori women must remain a key health equity target.

Smoker status of women delivering in HBDHB facilities by ethnicity (2007-2013)



Source: HBDHB Data Warehouse

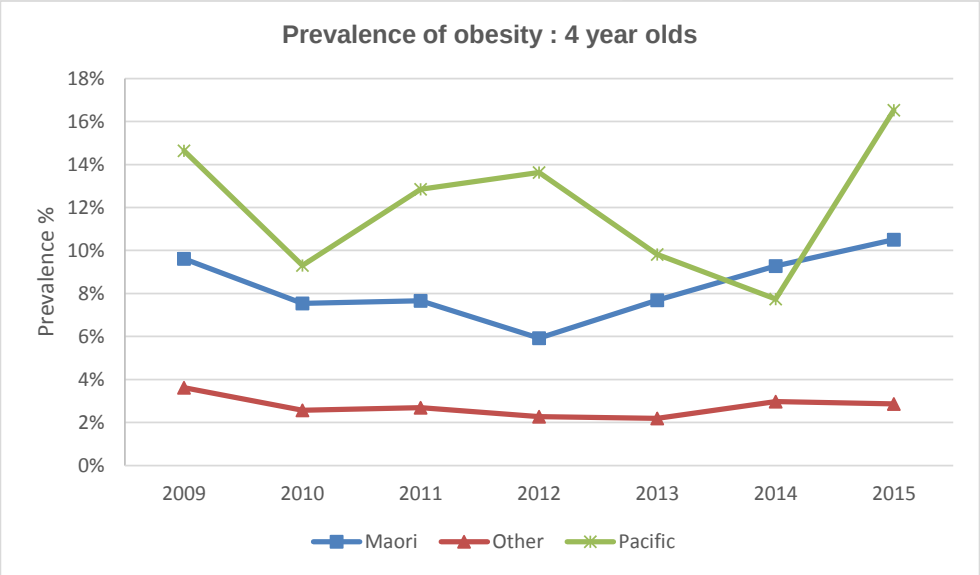
Obesity in 4 year old children

There has been an increase in the prevalence of obesity in 4 year olds since 2009 (5.8%) and a widening in inequities.

The World Health Organization (WHO) regards childhood obesity as one of the most serious global public health challenges for the 21st century. Obese children and adolescents are at an increased risk of developing various health problems, and are also more likely to become obese adults and have a higher risk of morbidity, disability and premature mortality in adulthood.

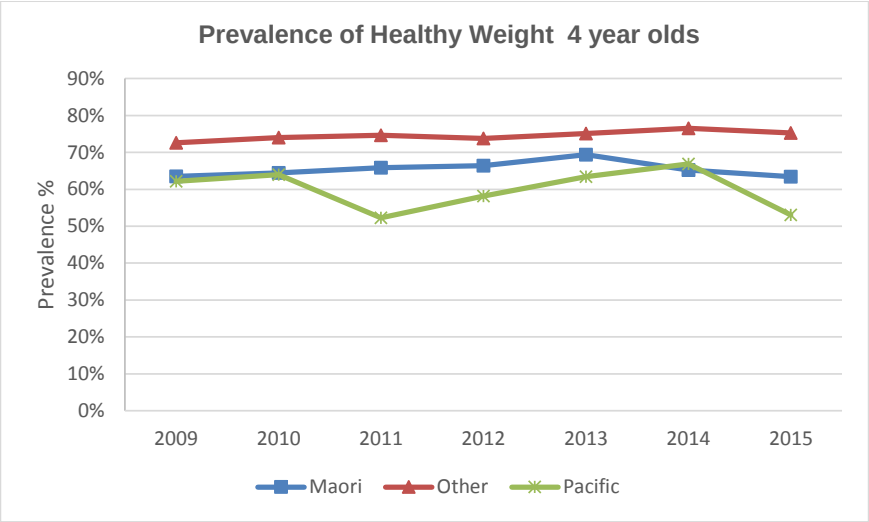
The B4 school check is part of the Well Child schedule of childhood milestone checks. It generally occurs just before the child begins school when the child is aged 4 years old. Height and weight are collected at the time of the check and this provides an opportunity to assess if the child has a healthy weight.

In 2015 6.5% children who had a B4 school check were assessed as being obese (1 in 16). Of the 143 children assessed as obese, 89 were Maori, 19 Pasifika and 35 other. Obesity prevalence was three times higher amongst Māori children (10.5%) and nearly 6 times higher amongst Pasifika children (16.5%) compared to Other children (2.9%). There is a clear socio-economic gradient in prevalence with 11.6% of 4 year olds in quintile 5 obese compared to 0.4% in quintile 1 (four times higher).



Healthy weight Prevalence rates

Using healthy weight data is an alternative to focusing on obesity. Children with a healthy weight are children who are not overweight, obese nor underweight. Our aim is to increase this proportion and reduce inequities. In 2015 approximately 70% of 4 year olds had a healthy weight, with **no improvement** since 2009. 63% of Maori children and 53% of Pasifika children assessed had a healthy weight.



Source: B4school data base. Health Hawkes Bay

Oral health of 5 year olds

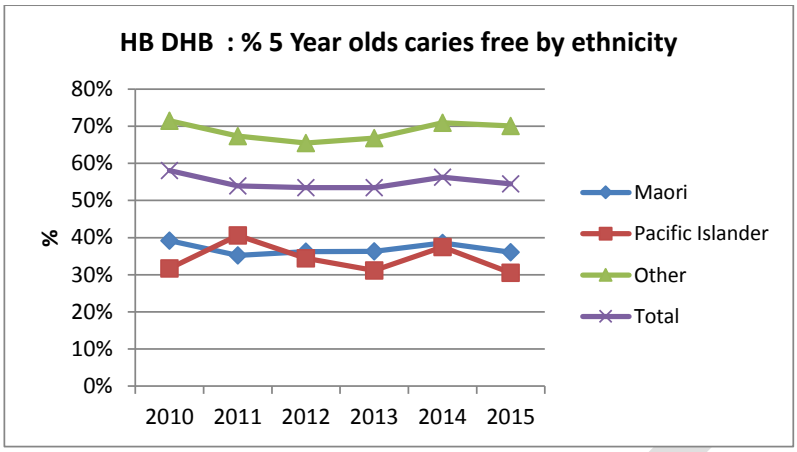
There has been no improvement in the past 5 years for any ethnicity and a widening of inequity

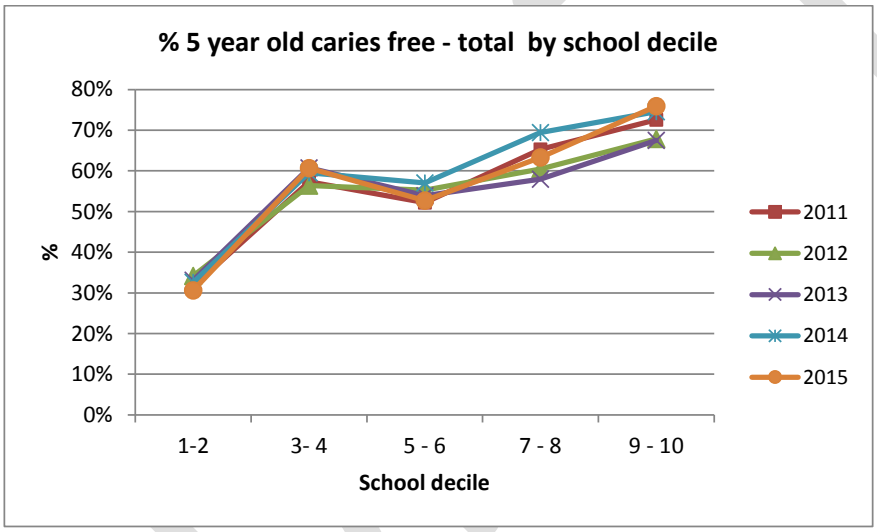
The risk of dental decay begins as soon as the teeth begin to appear in the mouth (at around 6 months of age). Good oral hygiene (regular tooth brushing) and healthy food are both needed to prevent dental decay. The increasing consumption of sugars and in particular sugary drinks affects the health of teeth as well as contributing to the increasing numbers of children who are overweight or obese. Dental decay in 5 year olds will have probably started 3-4 years previously and may reflect eating patterns which go on to become established eating habits later in life.

One of the indicators used to assess the oral health of children is the proportion of children at age 5 who are caries free (no sign of dental decay).

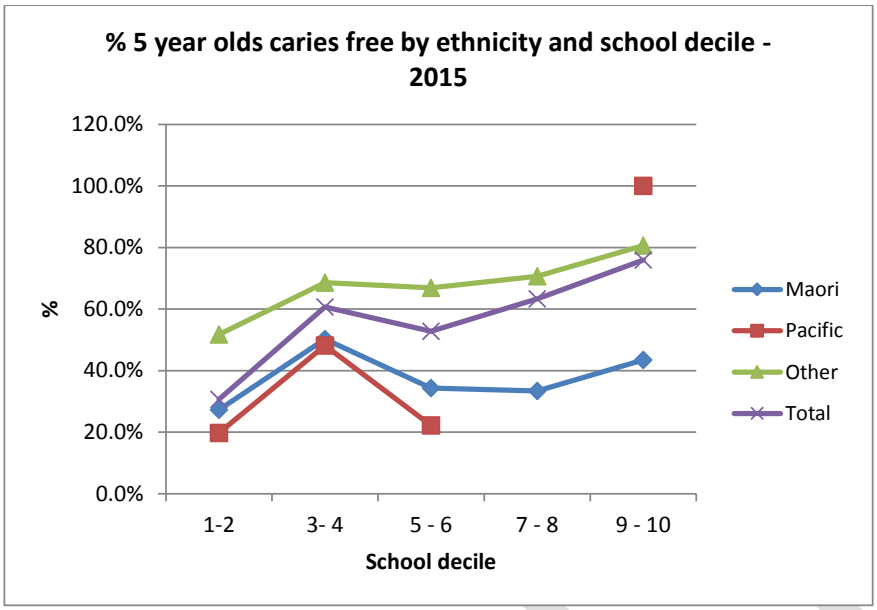
There are significant and widening inequities in children's oral health. Twice as many European / Other children aged 5 in Hawkes Bay (70%) are caries free compared to Maori (36%) and Pasifika children (30%). There is also a clear socioeconomic gradient with children attending decile 9-10 schools (more advantaged schools) 2.5 times more likely to have no dental caries than children attending decile 1-2 schools.

Urgent attention is needed to reduce inequity in this area.. Healthy nutrition needs to be supported all the way from during pregnancy though to infants and children.





This school decile gradient is less for Maori children and may in part reflect the smaller numbers of Maori children attending higher decile schools. In 2015 81% of European / other children in decile 9-10 schools were caries free, compared to 44% of Maori children in those schools


% 5 year olds caries free by ethnicity and school decile - 2015
120.0%
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
%
1-2
3- 4
5 - 6
7 - 8
9 - 10
School decile
Maori
Pacific
Other
Total

Health Care

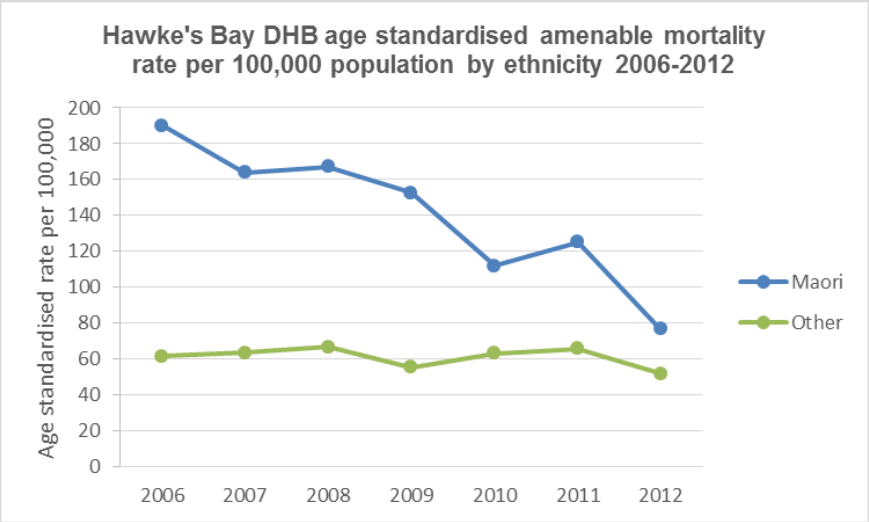
Amenable mortality

Amenable deaths (mortality) are a specific group of deaths which could have been avoided through access to quality healthcare and is a very useful indicator of equity in healthcare. In New Zealand, the proportion of all avoidable deaths considered to be amenable is approximately 40%.

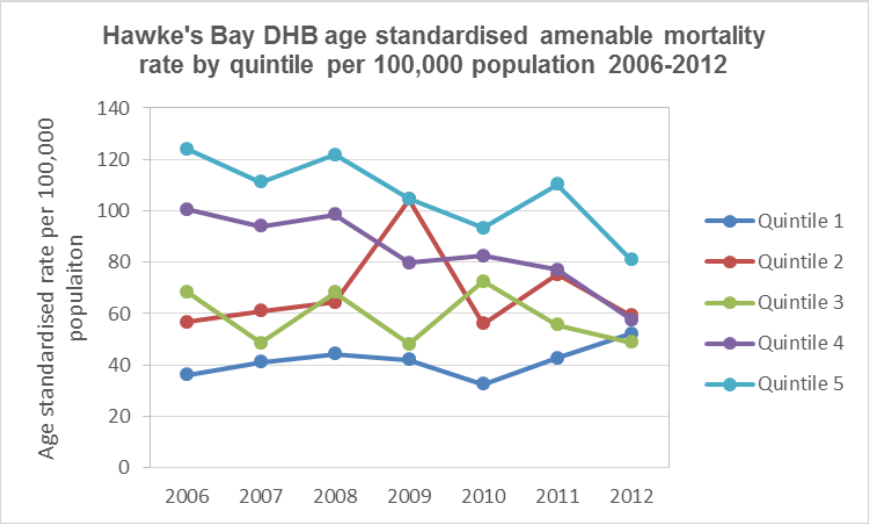
In a truly equitable healthcare system there should be no difference in amenable mortality rates by ethnicity or by place of residence.

Māori amenable mortality rates have been reducing consistently since 2006 and are now not statistically different to non- Māori non –Pasifika rates in Hawke's Bay. Caution should be taken though as the actual numbers of death each year are small and cause the rates to fluctuate. Never the less rates have been reducing and in 2012 were 1.5 times higher than non-Māori / non-Pacific people and 1.6 times higher amongst people living in Quintile 5 areas. Pasifika data for Hawke's Bay are too small for robust analysis.

This indicator is the best evidence yet of equitable access and treatment for conditions categorised as fully treatable. The biggest driver of this reduction is the better management of ischaemic heart disease, diabetes and cancers.



Source: Ministry of Health National Mortality Collection



Source: Ministry of Health National Mortality Collection

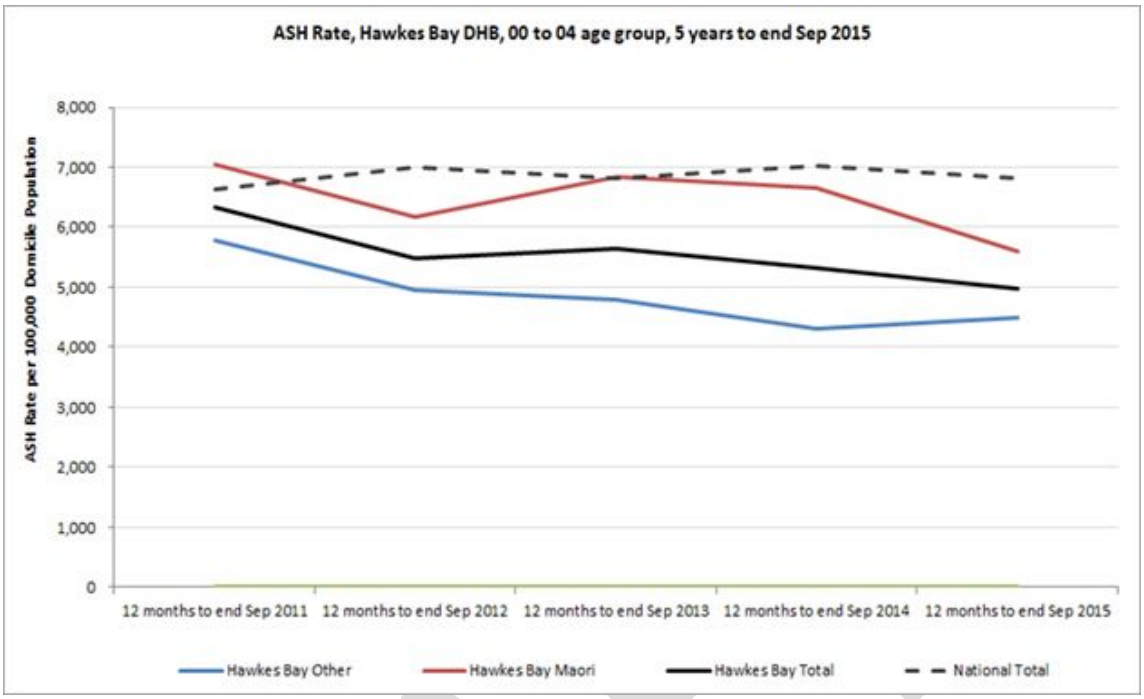
Ambulatory Sensitive Hospitalisations 0-4 year olds

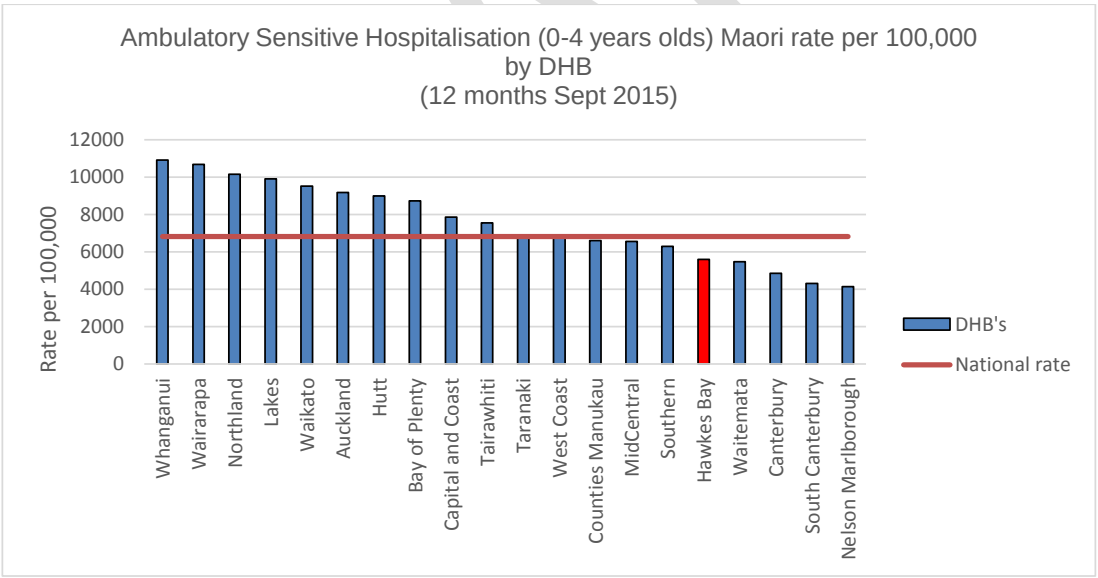
Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through preventive interventions or treatments deliverable in a primary care setting. They are often used as proxy markers for primary care access and quality.

The Ministry of Health ASH definition and methodology has been revised from quarter one of the 15/16 year and data are only available for the 5 years to end September 2015.

ASH rates for 0-4 year olds in Hawke's Bay have been decreasing and rates are now consistently lower than New Zealand. Māori rates have been declining since September 2013 and the gap between Māori and non- Māori rates has been closing. Māori rates of ASH are still higher (1.2 times) than non- Māori rates.

Compared to New Zealand in the 12 months to Sept 2015 the Hawkes Bay Māori rate was 82 % of the national Māori rate and Hawkes Bay DHB was the 5th best performer of all DHBs





ASH rates for Māori 0-4 year olds have decreased for gastroenteritis, dental conditions, cellulitis, and upper respiratory infections and ENT conditions. Gastroenteritis/dehydration admission rates for Māori 0-4 year olds in Hawke's Bay are half the national Māori rate.

However ASH rates have increased for Māori 0-4 year olds for asthma, and lower respiratory infections. **The largest equity gap is for dental conditions where rates of ASH for Māori 0-4 years olds is three times that on non- Māori 0-4 years olds.**

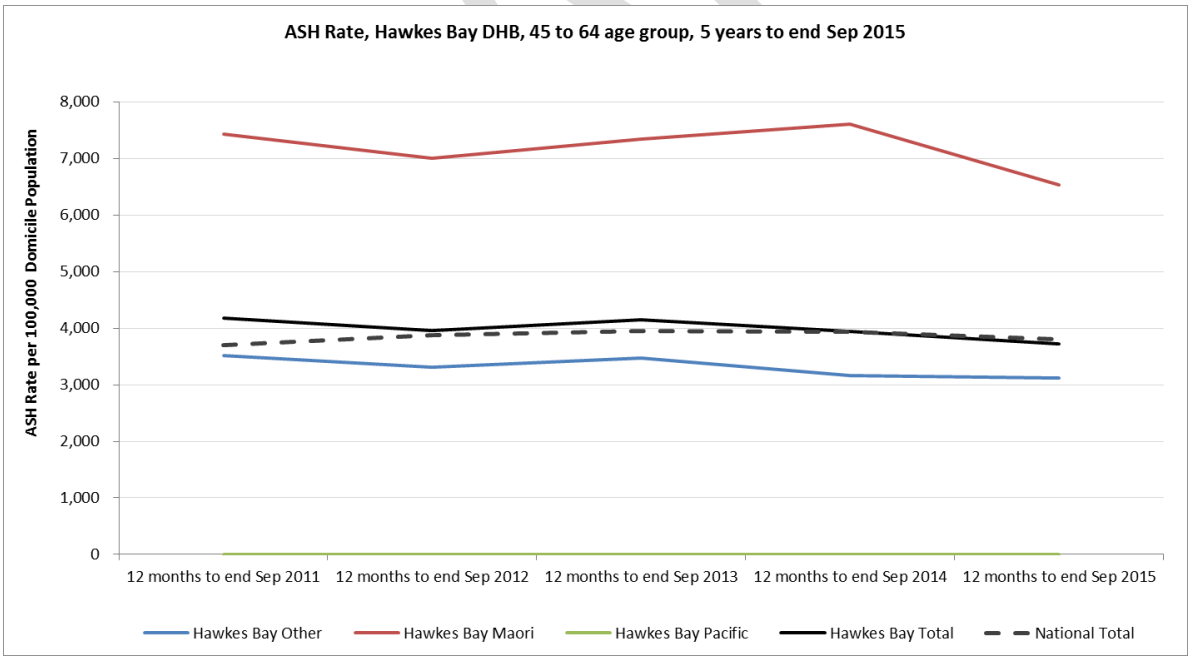
For some conditions specific programmes are being effective at preventing hospitalisations e.g. the infant rotavirus vaccination programme prevents hospitalisations with gastroenteritis, skin care programmes in Kohanga reo, and the healthy housing programme as well as free primary care visits ensure that conditions are managed earlier and better. **Asthma and dental conditions remain significant areas of inequity for Māori 0-4 year olds.**

Ambulatory Sensitive Hospitalisations 45- 64 years

By contrast there has been little change in rates for 45-64 year olds and Hawkes Bay rates are similar to NZ. Rates of ASH for Māori remain higher than non-Māori (twice) with little change over this period. The disparity between Māori and non-Māori has closed slightly.

ASH rates have increased for cellulitis and congestive heart failure.

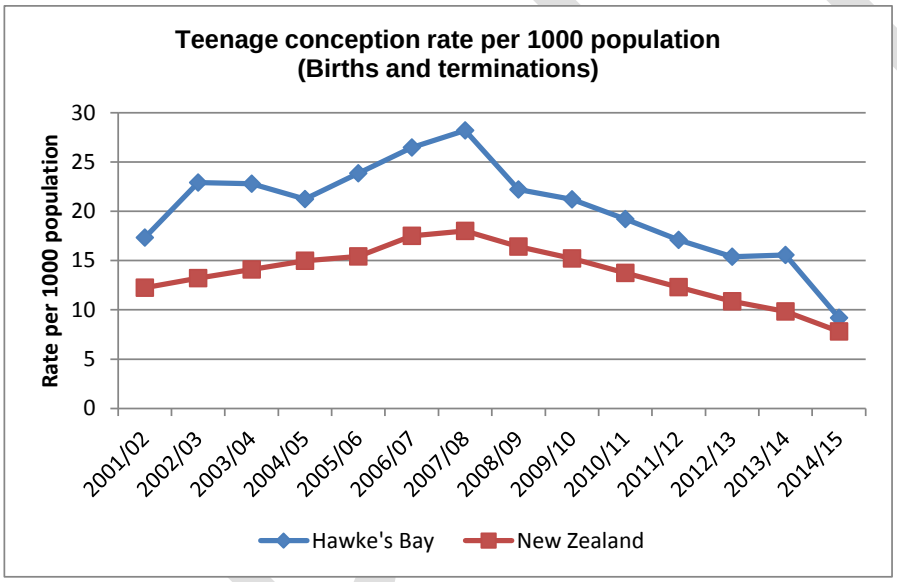
Heart disease, skin infections, and respiratory infections all feature highly as causes of the disparity in ASH rates for this age group. Much more needs to be done to improve access and treatment for Māori adults with these conditions.



Teenage pregnancies (under 18 yrs)

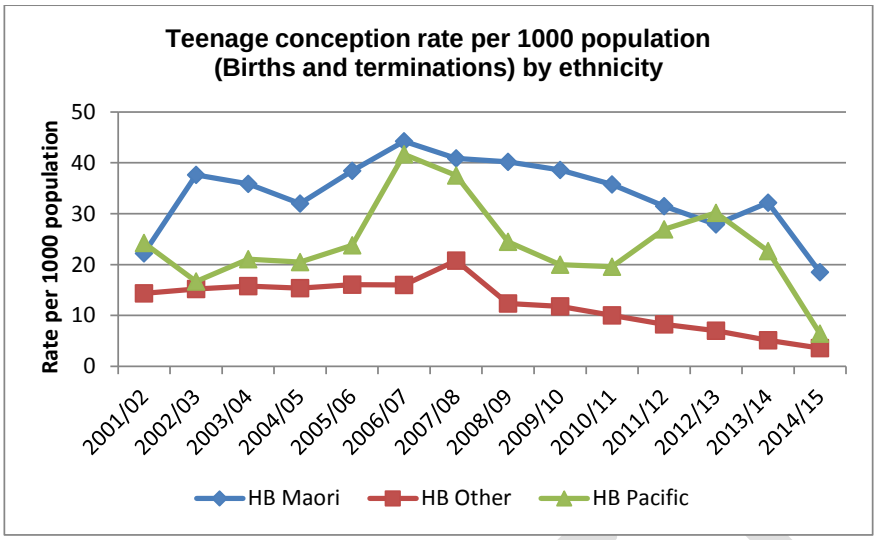
Most teenage pregnancies under 18 years are unplanned and around 40% end in abortion. While for some young women having a child when young can be a positive experience for many more teenagers bringing up a baby can be difficult and often results in poor outcomes for both the teenage parent and the child - in terms of the baby's health, the mothers emotional health and well-being and the likelihood of both the parent and child living in long term poverty. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers.

In 2014/15 there were 33 births to girls aged 13-17 years and 20 terminations giving a total number of conceptions of 53. **This gives a "conception rate" of 9.2 per 1000 girls in this age group – a large decrease since 07/08 when there were 28 conceptions per 1000 13-17 year olds**. Hawke's Bay has had generally higher conception rates in this age group than the New Zealand average but the gap has been reducing since 07/08.



Source: Ministry of Health NMDS

There are still higher rates of conceptions for Māori and Pasifika teenagers, although actual numbers of Pasifika conceptions are very low. Māori conception rates have been declining since 2006/07 but still remain higher than non-Māori teenagers – three year averages show that rates for Māori are 4 times that of non-Māori 13-17 year olds.



Due to small numbers analysis by deprivation has been done for births and terminations under 20 years. **This shows a very strong relationship with deprivation with rates of births in quintile 5 being 12 times the rate in quintile 1**. There is a less strong relationship with terminations of pregnancy.

These trends are very encouraging. Research reviews[1] have shown that a combination of education and improved access to contraception reduces unintended pregnancy amongst adolescents. These local results suggest that recent changes to the delivery and availability of free sexual health services for young people and a social media awareness raising and educational campaign have been effective in improving equitable access and utilisation.

[1] The Cochrane Collaboration 2016: Interventions for preventing unintended pregnancies amongst adolescents

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

12

RECOMMENDATION

That MRB and Consumer & Clinical Councils:

Note the contents of this report and provide feedback.

OVERVIEW

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

BACKGROUND

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

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

PROGRESS REPORT

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

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

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

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

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

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

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

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

IDENTIFIED OUTCOMES

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

IDENTIFIED RISKS

- The lack of a specific budget limits the ability to plan suicide prevention activities, provide training and support initiatives
- Increased capacity demands on the Suicide Prevention Coordinator following the release of the Coroners Joint Findings. The HBDHB and Governance Group interagency members agreed that we need a six month project to establish and coordinate a working group to investigate the coroner's recommendations, this requires additional FTE resource.
- Due to capacity staff issues Te Kupenga Hauora Ahuriri cannot deliver on their activity of creating a marae resource.

PRIORITIES FOR 2016/2017

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


GRATITUDE JAR
What are you grateful for today?

MOBILITY ACTION PROGRAMME

13

"A Musculoskeletal Service to Reduce Health Inequities"
Paper provided by Dr Tae Richardson

A Musculoskeletal Service to Reduce Health Inequities

Purpose

This session has been arranged for members of the Hawkes Bay DHB Consumer Council to discuss and contribute to the design of a community musculoskeletal programme. It is intended that this is submitted to the Ministry of Health For funding under a Request for Proposal (RFP) within the Mobility Action Programme.

Background

Current service:

We are working in partnership with local communities to co-design a new programme because we are concerned by the inequities in the current service. For example, of the 160 referrals received in the first quarter of 2016 by the orthopaedic outpatient clinic for hip or knee pain:

- 17% were Māori (compared with a total HB population of 26% Māori),
- 32% lived in quintile 5 residential addresses (compared with a 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) suggesting our service is currently unresponsive to goals of early intervention.

These lower referral rates suggest an unmet need given the knowledge that Māori and other under-served populations have a higher incidence of disease.

While quality improvements to the existing service have been made, we feel that solutions outside of the existing service need to be sought if we are to eliminate inequities, improve patient experience of care and patient outcomes in a value for money way.

Opportunity:

In the 2015 Budget, the Government invested money in a Mobility Action Programme with the aim that,

"…people with musculoskeletal health conditions fulfill their health potential and increase independence. This will be achieved through improved access to high quality advice, assessment diagnosis and treatment including education and rehabilitation."

HBDHB and Health Hawkes Bay have already jointly submitted a successful Registration of Interest (ROI) and are working with communities to prepare a Request for Proposal (RFP) from the Ministry of Health.

Proposed Model for the RFP:

We would like members of consumer council to have input into the design of a Whānau Ora model of care targeted at Māori, Pacific and quintile 5 patients who have experienced joint pain for more than 3 months and who are not eligible for ACC funding. The service will meet the needs of both the working age and elderly population. We plan in particular to improve access to services for people with previous or current employment in heavy labouring jobs and those with barriers to paid work, training or caring for partners or children due to musculoskeletal conditions.

Our pilot sites will be located within our most under-served Hawkes Bay communities of highest deprivation (deprivation index 10) and highest Māori and Pasifika populations: namely rural sites of Wairoa and Takapau and urban sites of the suburbs Flaxmere and Camberley (in Hastings) and Maraenui (in Napier).

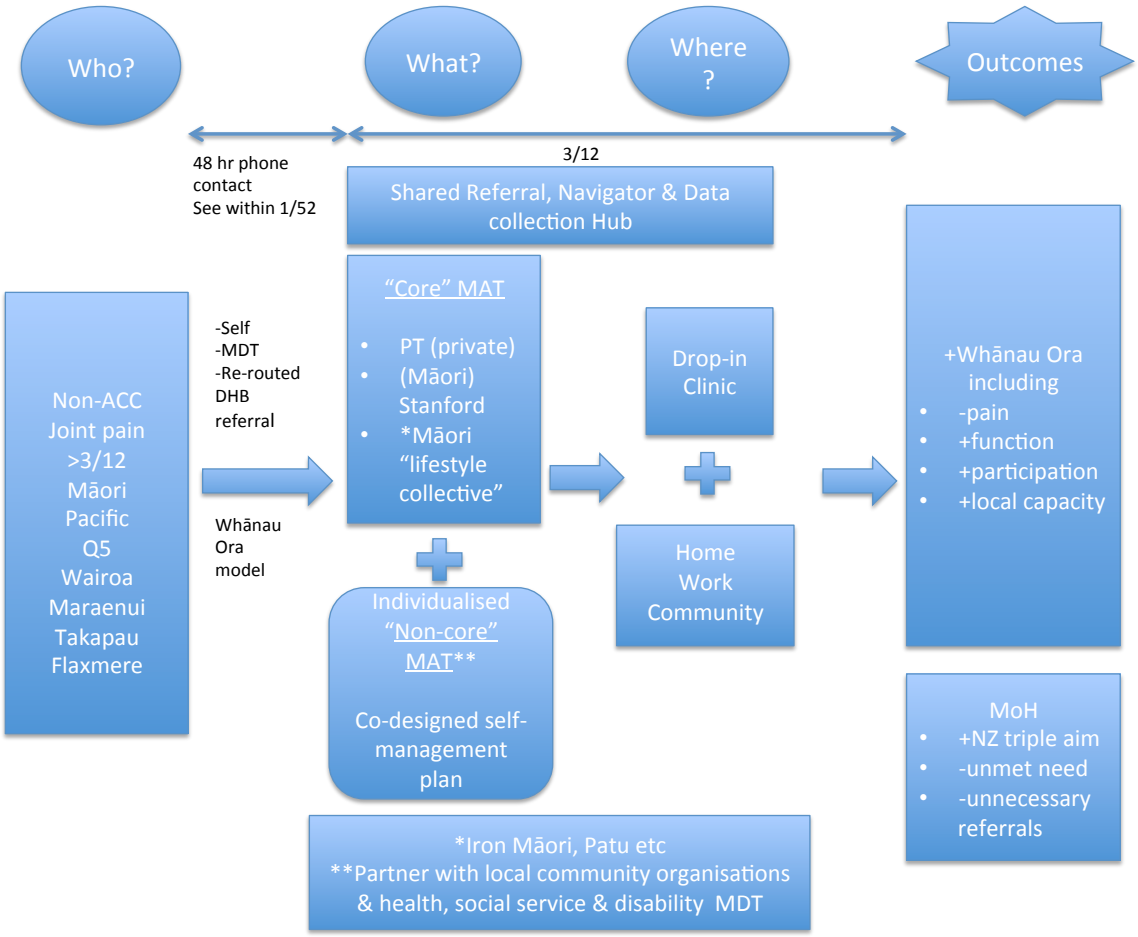
Through this programme, services will be provided without cost to patients for the duration of their intervention. Referral modes are self-referral (including walk in), referral by any member of the MDT ("core" or "non-core") and re-routing from the current DHB hip/knee referral pathway (see diagram).

The service, which will be co-designed with input from patients and providers, will compromise a "core" MAT of physiotherapy, Māori Stanford self-management programme and a Māori Lifestyle Collective (a suite of kaupapa Māori healthy lifestyle services including Iron Māori and Patu programmes). In addition a range of "non-core" MAT options will allow an individualised, co-designed self-management programme. The non-core MAT options include all existing publically funded health, social service and disability multidisciplinary team members as well a local community organisations. Both the 'core' and 'Non-Core' team members will be drawn from professionals currently living and working within these communities, the majority of whom will be local private physiotherapy providers. From a community perspective this will create community-specific programmes which deliberately build local capacity and capability. Together this team will deliver assessment, diagnostic, treatment and education services.

This team will be supported by a referral, navigation and data collection hub. The programme will be delivered at a community-based drop-in clinic, at home, work and in other community venues.

Each patient's intervention programme will be up to 3 months in duration. Outcome/exit measures will support Whānau Ora outcomes including reduced pain, improved function, increased social and cultural participation and increased local capacity. We will tailor the programme specifically to address NZ triple aim outcomes with particular emphasis placed on a reduction in unmet need, reducing the need for GP consultations and unnecessary referral to secondary care.

A pictorial overview:



Our proposed model has been developed in partnership with community leaders and primary care clinicians in partnership to build on the strengths of existing programmes and to remove access barriers specifically for people in our targeted populations. Referral for these services will not be required, walk-ins are encouraged and core services will be provided with no cost to the patient. They will be delivered in local communities therefore reducing the need for transport. Services will be culturally responsive and flexible around people's lifestyle e.g. work and training commitments, child care etc. Of particular note we plan to hold workplace clinics for Hawke's Bay's key unskilled labour employers such as horticulture, food processing, meatworks, forestry and shearing.

A specific focus of the programme is to increase local community capacity to ensure sustainability with appropriate ongoing PHO and DHB support. The proposal is fully aligned with Hawke's Bay Health Sector's *Transform and Sustain* strategic framework and has been endorsed by the Hawke's Bay Clinical Council who prioritise all new investment funding across the sector.

Next step

Building on the ROI, in a process of co-design, in partnership with groups including Consumer Council, MRB, EMT, Health Hawkes Bay, Community Leaders and others, we will put together an RFP for submission to the Ministry of Health by 07/07/16.

If this is successful then we hope to receive funding sufficient for a 2 year pilot.

Thank you in advance for your help. We are looking forward to getting your insights at your meeting on 09/06/16.

Dr Tae Richardson.
Patrick LeGeyt
Dr Andy Phillips

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Oral Health**
	For the attention of: **Maori Health Board (MRB), HB Clinical Council, HB Health Consumer Council**
Document Owner:	Sharon Mason, Chief Operating Officer (Target Champion)
Document Authors:	James Dawson, Portfolio Manager Hospital Services Dr Robin Whyman, Clinical Director Oral Health Services
Reviewed by:	Wietske Cloo, Service Director for Oral, Rural and Community; Ruth O'Rourke, Team Leader for Oral Health; and Executive Management Team
Month:	June, 2016
Consideration:	Monitoring / For Information

RECOMMENDATION

That MRB, Clinical and Consumer Council:

1. Note the contents of this report
2. Approve the Target Champions recommendations on page 9 of this report.

OVERVIEW

Te Ara Whakawaiora (TAW) is an exception based report, drawn from Annual Maori Health Plan quarterly reporting, and led by TAW Champions. Specific non-performing indicators are identified by the Māori Health Service which are then scheduled for reporting on progress from committees through to Board.

The intention of the programme is to gain traction on performance and for the Board to get visibility on what is being done to accelerate the performance against Māori health targets.

This report is from Sharon Mason Champion for the Oral Health Indicators. It focuses on the key oral health indicators and activity to improve child oral health

UPCOMING REPORTS

The following are the indicators of concern, allocated EMT champion and reporting month in 2015/16.

Priority	Indicator	Measure	Champion	Responsible Manager	Reporting Month
Oral Health *National Indicator*	The total number (%) of children are caries free at first examination after the child has turned five years, but before their sixth birthday	>66%	Sharon Mason	James Dawson	Jun 2016

WHY IS THIS INDICATOR IMPORTANT?

Oral health, general health and quality of life
Dental decay (dental caries) is one of the most common preventable chronic diseases. It is an important public health problem because of its prevalence, impact on individuals, society, and the public health system.

Severe early childhood caries reduces a child's quality of life: causing pain and discomfort, it affects eating and sleeping, prevents healthy growth and weight gain and reduces immunity to disease. Dental caries in early childhood is strongly predictive of an ongoing childhood and adulthood risk of dental caries.

Management of dental caries occupies considerable resources in our Community Oral Health Service and untreated acute and chronic infections lead to a higher risk of hospitalization and loss of school days which may impact of a child's ability to learn.

The determinants of dental caries are known — the risk factors include diet (sugar consumption) and poor oral hygiene. Effective population health strategies and clinical prevention methods have substantially reduced the amount of dental caries in the child population and reduced the impact of dental caries for the community. However, substantial inequities in oral health outcomes remain.

Inequality in outcomes in oral health status for Māori
Māori and Pacific children, and those living in socioeconomic disadvantage experience poorer outcomes in oral health status. [1.]. They have also tended to enrol for oral health services, and utilise services, later when compared to non-Māori.

MĀORI HEALTH PLAN INDICATOR: Oral Health Caries Free (National Indicator)

The total number (%) of children who are caries (tooth decay) free at first examination after the child has turned five years, but before their sixth birthday.

In addition the Ministry of Health require reporting of:
- enrolment in oral health services of all populations aged 0 – 4yrs
- Mean decayed, missing or filled scores (DMF) at Year 8 (approximately 12 years).

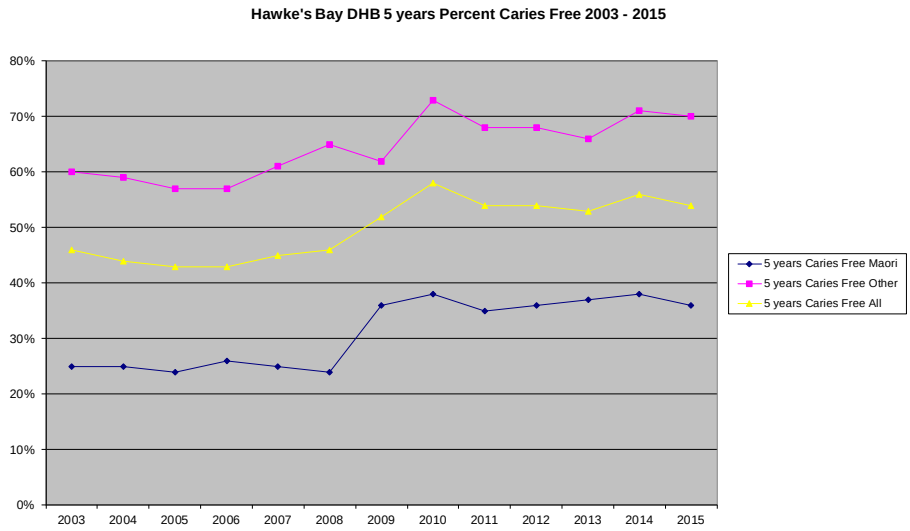
We are required to report as on overall mean based on ethnicity in three categories:
- Māori,
- Pacific
- Non-Māori

Maori 5 year old caries free (target >66%)

2015	54% Overall
	36% Maori
	70% Other
2014	56% Overall
	38% Maori
	71% Other

The result for Maori 5-year-old children caries free in 2015 is 36%, which is a slight decrease from 2014. This is also consistent with a slight decrease Overall. The 2003 to 2015 trend is shown in Figure 1.

Figure 1 Hawke's Bay DHB 5-year-old caries free by ethnicity 2003 – 2015



It is disappointing that in 2015 we have not moved closer to the target of 66% of 5-year-old children caries free. However, several factors may have contributed to this result.

1. Significant data cleansing within the Titanium database. While we cannot be sure of the effect that this has had we believe it does mean we are reporting a more accurate result in 2015 and would explain all groups moving back by 1-2%.
2. Actively increasing our preschool enrolment with a focus on high need children (see below). This does mean that we see and report on more of the children who have dental caries earlier and it is likely to have contributed to an apparent lack of improvement for this result.
3. Changing clinical practice. The service is providing an earlier intervention for dental caries involving the use of stainless steel crowns on teeth with early dental caries. Previously these teeth may have had later treatment (post 5-years-old) but the crowns do elevate the children showing as having experienced dental caries (lowers the caries free rate).

Maori 0 – 4 enrolment status for 2015

The results of enrolment status for Maori preschool children in 2015 aged 0-4 years is 74.1%. The growth in Maori preschool enrolment is a very pleasing indication that strategies described below to increase early engagement with community oral health services is taking effect. Early enrolment and engagement are believed to be key strategies to commencing early preventive strategies for dental caries and ultimately improving the indicator discussed above (5-year-old children caries free).

These results are described in Figure 2.

Figure 2 Hawke's Bay DHB Preschool enrolment in community oral health services

5. Oral Health

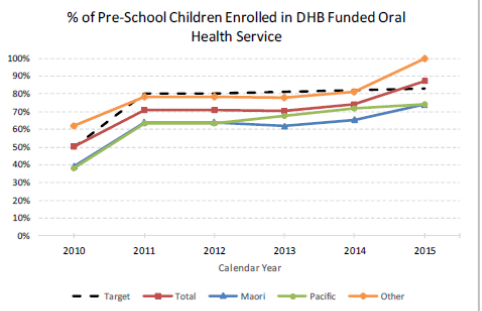
Outcome: More pre-school enrolments in the community oral health service (COHS) - 90% children under 5 years of age enrolled in community oral health services

Key Performance Measures	Baseline[27]	Previous result[28]	Actual to Date[29]	Target 15-16	Trend direction
Māori:	65.3%	65.3% (U)	74.1% (U)	≥90%	▲
Pacific:	71.7%	71.7% (U)	74.2% (U)	≥90%	▲
Other:	81.3%	81.3% (U)	99.8% (F)	≥90%	▲
Total	73.9%	73.9% (U)	87.1% (U)	≥90%	▲

Comments

Results available Early 2016 for the 2015 calendar year

Time series



Maori decayed, missing and filled teeth (DMFT) at Year 8

Year 8 Maori children had 1.43 DMF teeth in 2015. This remains above our target of 0.88 and indicates a continued challenge for the DHB to improve Maori child oral health throughout the primary years.

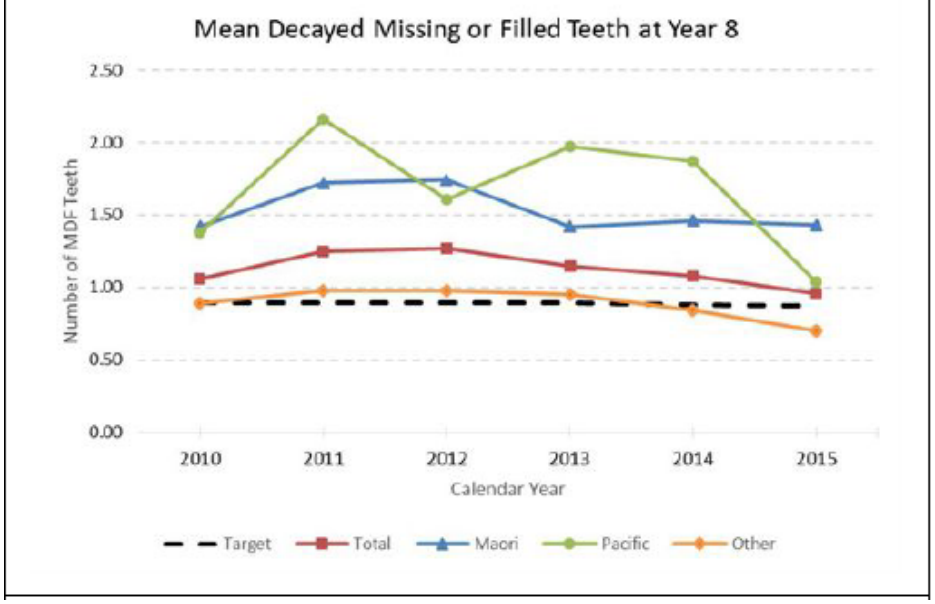
However, NZ and international evidence is that improvement in preschool oral health will provide a flow on legacy to improved Year 8, adolescent and adult oral health.

Focussing nationally 1.43 DMF teeth for Maori Year 8 children places Hawke's Bay DHB 10th out of 20 DHBs compared with the 2013 national data (latest available). The range nationally for Maori is 0.97 (CCDHB) to 2.81 (BOPDHB).

The Community Oral Health Service is now putting effort into an increased preventive focus in their clinical activity. This would also be expected to further improve the caries free 5-year-old and Year 8 DMF rates in time.

Figure 3 Hawke's Bay DHB Year 8 DMF teeth 2010 – 2015

Oral Health MDFT score at year 8 (PP10)					
Key Performance Measures	**Baseline [18]**	**Previous result [19]**	**Actual to Date[20]**	**Target 2015/16**	**Trend direction**
Total	108.0%	1.08 (U)	0.96 (U)	≤0.88	▲
Māori	145.0%	1.46 (U)	1.43 (U)	≤0.88	▲
Pacific	185.0%	1.87 (U)	1.04 (U)	≤0.88	▲
Other	83.0%	0.84 (F)	0.70 (F)	≤0.88	▲



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

Service Coverage

The HBDHB is actively working to increase early enrolment and engagement with the Community Oral Health Service. The target is to have children enrolled at birth and all children seen by the Community Oral Health Service by 12 months.

The service coverage target is >= 90% of preschool children enrolled with the service.

The service has historically high levels (>95%) of engagement with primary school aged children and the aim is to continue these high levels but enable a greater focus on preventive dental care.

Quadruple enrolment from birth

In 2014 the HBDHB commenced a process of quadruple enrolment where the Lead Maternity Carer facilitates the parent/caregiver signing up for GP, immunisation and Well Child/Tamariki Ora and Oral Health Services enrolment. This process has gone into full operation from the start of 2015.

Quadruple enrolment ensures that all children born in Hawke's Bay are enrolled at birth into Oral Health Services, which results in a significant increase in enrolled status of 0-4 year olds. Historically the oral health service has needed to put substantial effort into finding and enrolling preschool children. The change means that greater effort can be put on attendance and actual engagement with the service, enabling preventive advice and care to be provided, especially for whanau at greatest risk of dental caries.

Relationships with Māori health providers
HBDHB has historically invested in oral health educators within Maori health provider services, and in oral health services as a whole, to follow up hard to enrol children.

Oral Health Services have a strong relationship with four Māori health providers, as well as Plunket. Our current Māori provider partners are:

- Choices
- Te Taiwhenua o Heretaunga
- Ngati Kahungungu Executive
- Te Kupenga Hauora

With the advent of quadruple enrolment the focus of activity for the Māori health provider services in oral health is being reviewed. It is anticipated, the focus will move towards helping to engage enrolled, but hard to reach whanau.

Improving access to Community Oral Health Services for Māori Tamariki (0-5 years) Project
The Service is engaged in a project with Maori Health and the population health advisor for oral health addressing barriers to preschool attendance and engagement, with the aim of a resulting decrease in dental caries for children under 5 years.

The project goals are:

- Improve access to Oral Health Service Hubs for Māori tamariki for under 5yrs
- Improve engagement of whānau and tamariki
- Reduction in 'Did Not Attend'/DNA rates to community dental services for Maori tamariki under 5 years of age to <15%
- Improving community dental service utilisation by >20%

This project is currently analysing DNA data to better understand patterns of DNA within the service and how to configure services best to engage hard to reach whanau.

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

There will continue to be a strong focus of action on enhanced early enrolment and engagement with the Community Oral Health Service. The aim is to have enrolment at over 90% for all ethnicities and for all children to have been seen within the service by 12 months. Early contact facilitates anticipatory guidance about oral health and provides a clinical risk assessment for elevated dental caries risk. Strong risk assessment then enables an appropriate clinical preventive programme to be put in place to support home care.

Changes are planned to the focus of the Maori health provider's contracts to assist with supporting engagement with the oral health service, and not the historical focus on enrolment.

Preventative practice

The Community Oral Health Service is focussing within its clinical teams on a stronger preventive approach, rather than an historical approach focussed on treatment of dental caries.

A stronger preventive approach, aims to use clinical visits to assist in the avoidance of the initiation, progression and recurrence of dental disease.

The service is measuring improved clinical risk assessment and response by monitoring levels of preventive activity within clinician's clinical work.

Three preventive care indicators have been developed and are being assessed and reported back to staff on a 6-monthly basis. This work will continue in the next 2-3 years.

Intervention	Description	Target (%)
Fluoride varnish by 4yrs	prevention of decay and remineralisation of the tooth surface	40
Bitewing radiographs by 6yrs	x-rays for the early detection of tooth decay	95
Fissure sealants by 8yrs	application of protective resin to prevent tooth decay	85

Audits to date have shown

1. There are notable variations in practice between clinicians / treatment hubs,
2. Overall the interventions above are provided for a greater proportion of Maori children than non-Maori, consistent with the increased caries risk
3. Clinical practice is closest to the target for application of fluoride varnish and furthest from target in the use of bitewing radiographs

A peer support and open reporting of information approach is being used in the service improve the levels of preventive practice.

It is anticipated fluoride varnish and fissure sealant targets can be met within 12-18 months.

Figures 4, 5 and 6 report the outcomes of clinical quality indicators bitewing radiographs, fluoride varnish application and fissure sealants to December 2015.

Figure 4

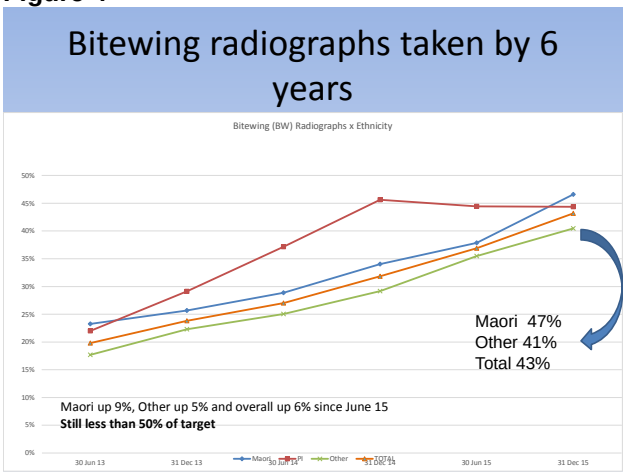


Figure 5

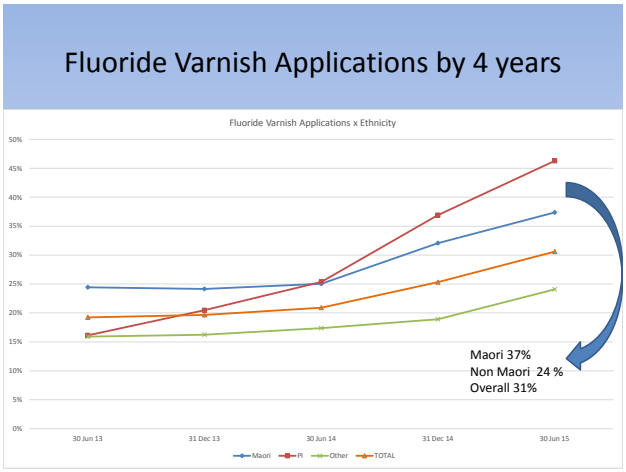
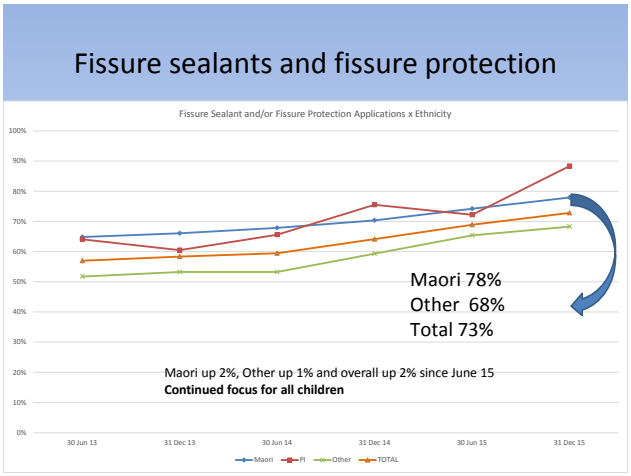


Figure 6



RECOMMENDATIONS FROM TARGET CHAMPION

Population Health Initiatives

While early enrolment and engagement with clinical services, and a greater preventive focus within clinical services are important to reducing level of early childhood dental caries.

However, dental caries in our Hawke's Bay communities is also a symptom of the overall health of our communities and will be importantly influenced by population health strategies.

The DHB's population health initiatives, especially Best Start: Healthy Eating and Activity and reduction of early childhood sugar consumption will provide important population health support to improving early childhood oral disease levels.

In particular child oral health will be influenced by

- Best Start Healthy Eating and Activity
- Healthy Housing
- Breastfeeding
- Smoking cessation
- Water Policy and community water fluoridation

Community water fluoridation has been shown to reduce dental caries by between 20 and 40%, and to be particularly effective in reducing socioeconomic and ethnic disparities in dental caries, [2.]. Over half of Hawke's Bay preschool children live in areas without reticulated optimally fluoridated water (Napier, Wairoa and central Hawke's Bay). Only children receiving water from the Hastings reticulated supply receive optimally fluoridated water. The government has recently signalled a move of the decision making process for community water fluoridation to DHBs following necessary legislative changes.

Community water fluoridation could be expected to improve caries free rates by at least 20%, and to reduce inequities in oral health. Increased coverage should be pursued as opportunities arise.

A watching brief on government's moves regarding community water fluoridation decision making and submissions to the process when the opportunities arise to ensure a workable framework is developed.

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

CONCLUSION

While the 2015 caries free Maori 5-year-old proportion has slightly decreased strong strategies at a service engagement, clinical activity and population health level are in place and are developing.

These initiatives are expected to result in gradual improvement to the indicator based on current international advice, and strategies in place in other jurisdictions.

Sharon Mason
Target Champion for Oral Health /Chief Operating Officer

REFERENCES

[1.] National Health Committee, Improving Child Oral Health and Reducing Child Oral Health Inequalities. 2003, National Advisory Committee on Health and Disability: Wellington. p. 1-28.

[2.] Thomson, W., K. Ayers, and J. Broughton, Child Oral Health Inequalities in New Zealand: A Background Paper to the Public Health Advisory Committee. 2003, National Health Committee: Wellington. p. 1-63.

[3] NZ National Child Oral Health Services Clinical Guideline for Bitewing Radiography (2010)

TOPICS OF INTEREST – MEMBER ISSUES / UPDATES

Verbal

15

OURHEALTH
HAWKE'S BAY
Whakawateatia

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:

17. Minutes of Previous Meeting
- Public Excluded

18. Matters Arising – Review of Actions (nil)
- Public Excluded

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).