



Hawke's Bay Consumer Council Meeting

Combining with the Hawke's Bay Health Clinical Council

Date: Wednesday, 13 June 2018

Meeting: 2.00 pm to 5.00 pm

Venue: Magdalinos Room, Havelock North Function Centre, Te Mata Road, Havelock North

Council Members:

Rachel Ritchie (Chair)	Jenny Peters
Rosemary Marriott	Olive Tanielu
Heather Robertson	Jim Henry
Terry Kingston	Malcolm Dixon
Tessa Robin	Sarah Hansen
Leona Karauria	Dallas Adams
Sami McIntosh	Jemma Russell
Deborah Grace	Dr Diane Mara

Apology: Rosemary Marriott, Jenny Peters

In Attendance:

Kate Coley, Executive Director - People & Quality (ED P&Q)

Ken Foote, Company Secretary

Tracy Fricker, Council Administrator / EA to ED P&Q

Debs Higgins, Clinical Council Representative

Linda Dubbeldam, Health Hawke's Bay Representative

Public		
MONTHLY MEETING		
Item	Section 1 – Routine	Time (pm)
1.	Karakia Timatanga (Opening) / Reflection	2.00
2.	Apologies	
3.	Interests Register	
4.	Minutes of Previous Meeting	
5.	Matters Arising – Review Actions	
6.	Workplan	
	Section 2 – Discussion / Decision	
7.	Recognising Consumer Participation Policy – Kate Coley / Ken Foote	2.10
	Section 3 – Information Only (no presenters)	
8.	Te Ara Whakawaiaora – Oral Health (national indicator)	-
9.	HBDHB Youth Strategy Implementation Update (inclusive of Zero Fees 13-17)	-
	Section 4 – General Business	
10.	Topics of Interest – Member Issues / Updates	2.20

Public Excluded		
COMBINED MEETING WITH HB HEALTH CLINICAL COUNCIL		
Item	Section 5 – Combined Meeting / Workshop	
11.	Choosing Wisely & Making Prudent Decisions – Andy Phillips & John Gommans	2.30-3.30
<i>Afternoon Tea Break (10 minutes)</i>		
12.	Person & Whanau Centred Care – Rachel Ritchie & Kate Coley	3.40-4.40
13.	People Plan - Kate Coley	4.40-5.00
14.	Meeting closed	5.00

NEXT MEETING:

Thursday, 12 July 2018, Boardroom, 4.00 pm, HBDHB Corporate Office
Cnr Omaha Road & McLeod Street, Hastings

Interest Register**Hawke's Bay Health Consumer Council**

Mar-18

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
Rachel Ritchie (Chair)	Put the Patient First	Involved when group was active	Advocating for Diabetes Patients	Unsure	Real / potential / Perceived
Rosemary Marriott	YMCA of Hawke's Bay	Member	Youth Including health issues	No	
	Totara Health	Consumer Advisor	Health and wellbeing	No	
Heather Robertson	Restraints Committee of DHB	Committee Member	Representing Consumers on this Committee	No	
Terry Kingston	Interest in all health matters, in particular - Mental Health, Youth, Rural and Transport.			No	
	Age Concern Hawke's Bay	Board Member		No	
	Positive Aging Trust	Committee Member		No	
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	If contracted for service, there could be a perceived conflict of interest. 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.
	Simplistic Advanced Solutions Ltd	Shareholder / Director	Information Communications Technology services.	Yes	
	Wairoa Wireless Communications Ltd	Director/Owner	Wireless Internet Service Provider	Yes	
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
Malcolm Dixon	Hastings District Councillor	Elected Councillor		No	
	Scott Foundation	Allocation Committee		No	
	HB Medical Research Foundation Inc	Hastings District Council Rep		No	
James Henry	Health Hawke's Bay Ltd	Facilitator	Part-time role. Improving lifestyles for people with chronic illness.	No	

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Sarah de la Haye	Nil				
Sami McIntosh	Eastern Institute of Technology	Student Nurse	Practical placements	No	Perceived potential if applying for work.
Deborah Grace	Isect Ltd	Director	IT Security Awareness	No	
Dr Diane Mara	Napier Family Centre	Chair	Social Service Organisation	Yes	Perceived/possible conflict as NFC has a small contract for PND from HBDHB
	IHC Hawke's Bay Association	Chair	Disability Intellectual Stakeholder	No	
	Pacifica Women's Tiare Ahuriri Branch (Inc)	Branch Chair	Development Leadership for Pacific Women	No	

**MINUTES OF THE HAWKE'S BAY HEALTH CONSUMER COUNCIL
HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD
CORPORATE OFFICE ON THURSDAY, 10 MAY 2018 AT 4.00 PM**

PUBLIC

- Present:** Rachel Ritchie (Chair)
Rosemary Marriott
Heather Robertson
Terry Kingston
James Henry
Sarah Hansen
Olive Tanielu
Deborah Grace
Malcolm Dixon
Jenny Peters
Leona Karauria
Dallas Adams
Kylarni Tamaiva-Eria
Sami McIntosh
Terry Kingston
- In Attendance:** Ken Foote, Company Secretary
Kate Coley, Executive Director – People & Quality (ED P&Q)
Tracy Fricker, Council Administrator and EA to ED P&Q
- Guests:** Amber O'Callaghan, General Manager of Quality, Service Improvement and Innovation and Deirdre O'Connell, Quality Advisor, Hutt Valley District Health Board (HVDHB).
- Apologies:** Diane Mara and Tessa Robin

SECTION 1: ROUTINE

1. KARAKIA TIMATANGA (OPENING) / REFLECTION

Rachel Ritchie (Chair) welcomed everyone to the meeting. James Henry provided a karakia/reflection to open the meeting.

The two guests from HVDHB are here to see how our meetings work. HVDHB are in the process of setting up a consumer council. The Chair also welcomed Jemma Russell the new Youth Consumer Council representative who is replacing Kylarni Tamaiva-Eria. Roundtable introductions took place.

2. APOLOGIES

Apologies noted as above.

3. INTERESTS REGISTER

No conflicts of interest noted for items on today's agenda.

4. PREVIOUS MINUTES

The minutes of the Hawke's Bay Health Consumer Council meeting held on 12 April 2018 were confirmed as a correct record of the meeting.

Moved and Carried.

5. MATTERS ARISING AND ACTIONS

Item 1: IS Workshop

This item will be scheduled for a future meeting.

Item 2: Consumers on Projects

List of projects to be re-sent out to members with the meeting minutes.

Action: Members requested project report be re-sent to them.

Item 3: Workplan

Bowel Screening Programme - on agenda for today under item #12. Establishing Health & Social Care Localities – Te Pare Meihana will come to the July meeting. *Item can be closed.*

Item 4: Youth Consumer Council

Copy of proposal not yet sent through to members. Dallas Adams to provide.

Item 5: Framework for Developing the People Strategy

Feedback provided to Kate Coley. *Item can be closed.*

6. CONSUMER COUNCIL WORK PLAN

The work plan was provided in the meeting papers. There are a lot of items on the workplan for the June joint meeting. It was noted that some of the papers will be for information only.

7. CHAIR'S REPORT

The Chair provided a report on activities:

- A farewell for retiring members is to be held following the July Consumer Council meeting, when the new members will be present.
- An advertisement has been placed in HB today and community papers seeking nominations and letters have been sent to community groups explaining the nomination process and forms
- The joint meeting with Clinical Council is being held next month, 2-5 pm at the Havelock North Function Centre
- A list of member portfolios / committees has been collated and will be sent out to members with the meeting minutes
- Met with Di Vicary, Portfolio Manager – Referred Services who is involved with the national contact for Pharmacy re: consumer consultation
- Met with Kevin Snee, CEO and discussed ways for consumers to feel more welcome and encouraged to participate at leadership forum meetings
- Encouragement at the last Board meeting for work the Consumer Council is doing and our input to the papers going up to Board. The Chair commented that when the DHB engages with consumers that they create an expectation that they are listening and there will be action. If there is no action following feedback given, consumers will get annoyed and become cynical.

The Company Secretary commented that the Chair represents herself well at the Board and is pushing the consumer agenda and frustration at lack of progress in some areas. There is strong support from Board Members.

8. YOUTH CONSUMER COUNCIL REPORT

Dallas Adams, Chair of the Youth Consumer Council provided his report:

- Thank you to Jemma Russell for being a part of the Consumer Council, she is a key person on the Youth Consumer Council, is a hard worker and passionate with the rangatahi
- HDC funding proposal for the education project – an interview time has been received for next Thursday.

9. CONSUMER ENGAGEMENT UPDATE

Kate Coley, ED P&Q provided an update on activities:

- The Consumer Experience Manager and Consumer Experience Advisor positions will be advertised this week. These roles will be responsible for consumer experience, consumer engagement and health literacy
- The draft Consumer Engagement Strategy is on today's agenda – item #17
- Working with the Company Secretary on the Recognising Consumer Participation Policy and putting together all the pieces of work around health literacy, consumer engagement, consumer engagement.

SECTION 2: PRESENTATION / UPDATES

10. HEALTH & SOCIAL CARE LOCALITIES – WAIROA UPDATE

This item was a late removal from the agenda. Te Pare Meihana has been invited to attend the July Consumer Council meeting to provide an update.

Jenny Peters raised a concern that at the CSP Primary Care workshop there was a person from Wairoa who raised issues that she felt should have been discussed with Health & Social Care Localities group. Where should people in Wairoa go if they have issues in terms of planning? The Company Secretary advised that at the moment Health & Social Care Localities is about forming relationships and understanding and getting integration of services in Wairoa. In time there would be a local governance group for Wairoa issues.

11. MATERNAL WELLBEING MODEL OF HEALTH PRESENTATION

The Chair welcomed Patrick Le Geyt, Acting Maori General Manager, Charrissa Keenan, Health Gains Manager, Maori Health and Jules Arthur, Midwifery Director to the meeting. A copy of the paper "Plan to Develop a Kaupapa Māori Maternal Health Programme" was tabled at the meeting.

Patrick Le Geyt provided an overview of the programme developed from the SUDI (*previously known as cot death*) national rollout. The national programme has been modelled on the HBDHB safe sleep programme. HBDHB has been allocated additional resources to look at the social determinates of SUDI, bed sharing, smoking in pregnancy and alcohol. HBDHB currently offers education to mothers and safe sleep basinetts / wahakura or pepi-pods (flax or plastic). HBDHB is a high risk area for SUDI, and with the additional funds from the Ministry has seen this as an opportunity to do something different, to look at the issues from a wellbeing and holistic approach and to take services to culture.

Key points noted:

- Want to improve maternal and child health outcomes by coming up with an indigenous response which is culturally appropriate, culturally competent to give equitable outcomes
- Partnership approach with population health, maternity and Maori health

- Steering group of experts as the programme is developed
- Supporting the workforce to be culturally responsive

General discussion held re: low representation of Maori midwifery/nursing staff in Wairoa, cultural understanding and the criteria for who can receive pepi-pods; family violence and addictions factors being checked and standard of housing and poverty correlation to the increase in stats.

Any further feedback can be sent to Patrick.LeGeyt@hawkesbaydhb.govt.nz.

The Consumer Council **noted** the contents of the report and **approved** the development of a Kaupapa Māori Maternal Health Programme. Moved by Terry Kingston and seconded by Dallas Adams. **Moved and carried.**

12. NATIONAL BOWEL SCREENING ROLL-OUT UPDATE

The Chair welcomed, Dr Malcolm Arnold, Gastroenterologist and Lynda Mockett, Project Manager to the meeting.

Dr Arnold provided an overview of the programme, which will be rolled out in Hawke's Bay from 9 October 2018. It is the only screening programme that stops people from getting cancer. People aged between 60-74 years will receive an invitation letter and free test kit on their birthday starting in the first year with those with even numbered birth years. The screening programme can save lives by detecting potential cancer early and has considerable costs savings if polyps are caught early before they turn into cancer. It is important to get the word out that this is not a bad test, and is a safe procedure.

Working groups have been involved with all stages of the programme from primary care, information services, clinical treatment, diagnostics, equity and communications.

HBDHB is required to undertake a self-assessment by 27 July. The Ministry of Health will conduct a readiness assessment on 15 August and the "go live" date is 9 October. The new Endoscopy Suite will be completed before this date.

Questions / Feedback:

- Screening is done on people who have no symptoms or family history. If you have symptoms you go through your GP and are referred for a colonoscopy
- You should be tested earlier than 65 if you have a family history of bowel cancer to catch any polyps before they turn cancerous
- How will you use consumer feedback for continuous improvement of the programme? HBDHB is part of the National Endoscopy Quality Improvement Programme which uses a global rating scale on comfort, safety, appropriateness and privacy to ensure that a quality service is provided. This data is collected for all of endoscopy service. For the screening programme there may be a different system used
- It was noted that this screening programme ends at aged 74.

The Chair thanked Dr Arnold and Lynda Mockett for the update provided.

SECTION 3: DISCUSSION

13. THE PLACE OF ALCOHOL IN SCHOOLS - YOUNG PEOPLE AND UNDER-AGE EXPOSURE

The Company Secretary advised that this paper had been developed from concerns by the Medical Officer of Health who has ability to make submissions on any applications for alcohol licenses. There are a few schools that regularly apply for temporary licenses for functions on

school grounds where children are present. The approach being taken by the DHB is that this is inappropriate and is sending the wrong signal. The policy has been developed by Population Health that the DHB wants to advise principals and School Boards of Trustees that alcohol in schools is not appropriate.

General discussion held. Differing views on the policy. Key points noted:

- The Alcohol Harm Reduction Strategy Group were all in favour of the policy. Schools are a place that healthy lifestyles should be promoted
- Does not have a problem with alcohol on school grounds. School is a place of education and older people can show case how to drink safely and responsibly
- The policy is appropriate in early child care/primary and intermediate school settings. High School age students will probably be drinking anyway, so this could be an opportunity for positive model modelling
- Picked on an easy target that will have minimal impact. Against children selling raffles for wine etc as for fundraising or auctioning of wine on school grounds. For jubilees in a marquee which come around once every 15 or 25 years that is going too far. Children see alcohol signage on their way to and from school on a daily basis, this would be a bigger target to focus on. An effective education programme will have a lot more consequences on alcohol abuse. Students at primary school spend 200 days per year in the buildings and secondary school 180 days, which is minimal.
- Target individual schools who apply for these licences, not a blanket rule
- You learn from peers and family drinking socially
- Supports the DHB policy and that schools need their own policies – alcohol has become too normalised
- Schools need to put in place their own policies. The intent of the policy is good but the process is not right
- The Ministry of Education need to tighten up on their policy on use of crown property, they set the guidelines for all schools to follow
- The application for licences are higher in primary schools and the policy is aimed at children not being exposed to bad habits. We need to look at why schools are applying for licenses. They fundraise as they don't have enough money to meet the needs of the children
- The Alcohol expo held in High Schools is amazing, and gives you the education you need to drink safely
- Supports the paper, the DHB needs to be a good role model. Look at the damage alcohol has been done to people and unborn children. Need to show and act on what we are preaching

The Company Secretary advised that this a DHB recommendation from a health perspective based on evidence and research that exposure to alcohol at an early age can be harmful later on. The intent is to meet with the Schools Association and Board of Trustees Association to try and influence them. By having this policy it allows the Medical Officer of Health a basis to object to licensing. At the moment they can object and the licencing tribunal can decide whether to grant the licence or not. The Medical Officer of Health and DHB does not have the right to ban. It is making a statement saying from a health perspective. The policy gives school information and evidence and strongly recommends to them that they seriously think about not allowing alcohol in the school environment. There has also been discussion within the DHB to be a stronger role model. The DHB is an alcohol free campus. The current debate is whether or not our health awards should be alcohol free. We need to be role modelling.

The Chair summarised support in general for the intent of the paper for the DHB to encourage schools to review their policies based on the evidence provided around alcohol consumption. The Council see this issue in a much wider context, and feel that this approach is a very narrow. However, they appreciate this policy has a direct and particular purpose in relation to the small number of primary schools where licence applications are numerous.

The Consumer Council **endorsed** the report. Moved by Leona Karauria and seconded by Rosemary Marriott. **Moved and Carried.**

14. CO-ORDINATED PRIMARY CARE OPTIONS PROGRAMME (CPO)

The Company Secretary advised the CPO is a package of services that GPs can refer their patients to keep them out of hospital.

Debs Higgins advised that the CPO programme was developed for a certain number of conditions that can be looked after in primary care that previously would have ended up in ED or hospital e.g. cellulitis, fluid re-hydration. Currently there are seven conditions that are regularly used/funded in Hawke's Bay. The idea is to look at expanding this programme out to other conditions in primary care which is more cost effective than providing the same service in hospital.

The Consumer Council **supported** the scoping for an expanded CPO Programme.

15. CLINICAL SERVICES PLAN - PLANNING FOR CONSULTATION

The Company Secretary provided an update. The for future options workshop have been held. The integrated workshop will be held on 31 May, the outcomes of which will form the basis of the draft CSP. The draft CSP will be completed by the end of June and governance groups will see the document in July. The wider consultation process to the community will occur August and September. Advice is now being sought from all governance groups on who and how do we engage with groups. How do we reach the general consumers?

Information will be on the website and there will be a précis document available that will identify the key issues.

Feedback:

- Use the Hastings District Council movable information container "your voice / your choice" – needs to be staffed
- Using TV screens in waiting rooms – hospital and GP
- Community newspapers
- Neighbourly website
- CHB – epic ministries operate "blue caravan"
- Libraries

Any other ideas can be provided to ken.foote@hbdhb.govt.nz.

16. CONSUMER COUNCIL REPRESENTATIVES - CLINICAL GOVERNANCE STRUCTURE

The Company Secretary provided a progress report on the clinical governance structure and committees. Apart from the Consumer Experience Committee (which are required to be current Clinical and consumer Council members), all other committees and advisory groups can have former Consumer Council members or people with experience at a governance level as consumer representatives. All consumer representatives will need to be appointed/approved by the Consumer Council.

Patient Experience Committee – with two members retiring replacements need to be appointed. Jenny Peters and Diane Mara where nominated. Moved by Dallas Adams and seconded by Rosemary Marriot. **Moved and Carried.**

The Consumer Council **endorsed** the policy. Moved by Kerry Kingston and seconded by Malcolm Dixon. **Moved and Carried.**

17. IMPLEMENTING THE CONSUMER ENGAGEMENT STRATEGY

Kate Coley, Executive Director – People & Quality advised that the document has had a minor refresh. The implementation approach was tabled at the meeting. Consumer engagement, consumer participation, patient experience and health literacy are to be amalgamated and will have connection up to the Consumer Experience Committee. Ken Foote, Company Secretary and Hayley Turner, Project Manager are working together to develop a project brief to bring the project together. The objectives of the strategy are included in the paper.

Brief discussion held. Council members were pleased to see that health literacy is now being termed as “making health easier to understand”. There needs to be an onus on the health service to ensure consumers understand the information they receive. An amendment was requested to describe it as “previously referred to as Health Literacy”.

The Consumer Council noted the report and **endorsed** the strategy. Moved by Deborah Grace and seconded by Heather Robertson. **Moved and Carried.**

SECTION 4: INFORMATION ONLY (No Presenters)

18. HB HEALTH SECTOR LEADERSHIP FORUM REPORT

Paper included in meeting papers for information only. No discussion held.

19. BEST START HEALTHY EATING & ACTIVITY PLAN (6 MONTH UPDATE)

Paper included in meeting papers for information only. No discussion held.

20. HBDHB PERFORMANCE FRAMEWORK EXCEPTIONS Q3 DASHBOARD

Paper included in meeting papers for information only. No discussion held.

21. TE ARA WHAKAWAIORA - DID NOT ATTEND (LOCAL INDICATOR)

Paper included in meeting papers for information only. No discussion held.

Pleased to see terminology DNA has changed – it better reflects what it is talking about.

SECTION 5: GENERAL

22. REPORTS BACK FROM CONSUMER REPRESENTATIVES

- **Urgent Care** – no update.
- **Disability Strategy** – information sent out via email prior to the meeting. Feedback received that the meetings held are too far apart. The Chair asked that members discuss this at the next opportunity.

23. TOPICS OF INTEREST – MEMBER ISSUES / UPDATES

- **Rosemary Marriott** – reflected as this is her last meeting. It had been a wonderful 5 years being involved in many projects and she had seen a lot of progress. However, raised concerns over the tender process used for youth health services. It was appalling and poorly managed in every respect. Also the loss Jeanette Rendle, Consumer Engagement Manager, and

Tracee Te Huia, General Manager – Maori Health was huge. They both had the best interests of consumers at heart and their abilities, experience, care and concern was valued. They truly understood what a consumer led health system is.

Action: *Rosemary Marriott to give specific feedback on tender process to Patrick Le Geyt, Acting General Manager, Maori Health.*

The meeting closed at 6.10 pm.

Confirmed: _____
Chair


Date: _____

Unconfirmed

HB HEALTH CONSUMER COUNCIL - MATTERS ARISING (Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	11/08/17	IS Workshop IS Workshop will be delayed as IS will receive output from the Big Listen and CSP workshops prior to enable a constructive workshop with Consumer Council at a future date.	Company Secretary	TBC	Request from IS Manager - latter part of 2018
2	12/09/17	Consumers on Projects List of projects requested by Consumer Members (spreadsheet).	Admin	May	First sent out 21/03/18. Resent 22/05/18
3	15/3/18	Youth Consumer Council Proposal for HDC funding to be sent out to Consumer Council Members for comment/endorsement (note: application due by 31 March)	Dallas Adams	April	Awaiting document
4	10/05/18	Member Issues <ul style="list-style-type: none"> Tender process for Youth Health Services – specific feedback on process to be sent to Patrick Le Geyt 	Rosemary Marriott	May	TBC

Consumer Council Workplan as at 7 June 2018 (subject to change)	EMT Member	Clinical Council Meeting Date	Consumer Council Meeting Date	BOARD Meeting date
Annual Plan 2018/19 Draft (June) (DRAFT DUE TO MoH 16 JULY)	Chris Ash	11-Jul-18	11-Jul-18	25-Jul-18
Alcohol Position Statement and Strategy	Kevin Snee	11-Jul-18	12-Jul-18	25-Jul-18
Clinical Services Plan verbal update (May June July)	Ken Foote	11-Jul-18	12-Jul-18	25-Jul-18
Consumer Council Annual Plan 2018/2018 Discussion	Kate / Ken and Rachel		12-Jul-18	
IS Presentation and Discussion (informed by CSP) moved to July 18	Kevin Snee	11-Jul-18	12-Jul-18	
Mobility Action Plan Update Presentation	Andy Phillips	11-Jul-18	12-Jul-18	
Policy on Consumer Stories	Kate Coley / John Gommans	11-Jul-18	12-Jul-18	25-Jul-18
Te Ara Whakapiri Next Steps (Last Days of Life) - MRB considered in April - moved to July for Council's and Board	Kevin Snee	11-Jul-18	12-Jul-18	25-Jul-18
Health and Social Care Localities - What has changed for consumers?	Chris Ash		12-Jul-18	25-Jul-18
Te Ara Whakawaiaora "Smokefree update"	Kevin Snee	11-Jul-18	12-Jul-18	27-Jun-18
Urgent Care Service Update	Wayne Woolrich	11-Jul-18	12-Jul-18	25-Jul-18
He Ngakau Aotea - Strategic Priorities for MRB (a courtesy preso)	Patrick LeGeyt	11-Jul-18	12-Jul-18	25-Jul-18
Annual Plan 2018/19 - approved Minister timing open	Chris Ash	12-Sep-18	13-Sep-18	26-Sep-18
Health Equity Report	Sharon Mason	12-Sep-18	13-Sep-18	26-Sep-18
Establishing Health and Social Care Localities in HB (Mar 18, Sept) - update on activity planned	Chris Ash	12-Sep-18	12-Sep-18	26-Sep-18
Te Ara Whakawaiaora - Breastfeeding (National Indicator)	Kevin Snee	12-Sep-18	13-Sep-18	26-Sep-18
Te Ara Whakawaiaora - Alcohol and other Drugs (National and Local Indicators)	Kevin Snee	10-Oct-18	11-Oct-18	31-Oct-18
Te Ara Whakawaiaora - Cardiovascular (National Indicator)	Kevin Snee	10-Oct-18	11-Oct-18	31-Oct-18
Te Ara Whakawaiaora - Did not Attend (local Indicator)	Kevin Snee	10-Oct-18	11-Oct-18	31-Oct-18
Best Start Healthy Eating & Activity Plan update (for information - 6 mthly Nov-May-Nov18)	Kevin Snee	14-Nov-18	15-Nov-18	28-Nov-18
HBDHB Performance Framework Exceptions Q1 Dashboard (from main report)	Kevin Snee	14-Nov-18	15-Nov-18	
Te Ara Whakawaiaora "Smokefree update" (6 monthly May-Nov) each year Board action Nov 17	Kevin Snee	14-Nov-18	15-Nov-18	28-Nov-18
People Plan (6 monthly - Dec, Jun)	Kate Coley	5-Dec-18	6-Dec-18	19-Dec-18
Urgent Care Service Update (6 monthly June Dec 18)	Wayne Woolrich	5-Dec-18	6-Dec-18	19-Dec-18
HBDHB Performance Framework Exceptions Q2 Dashboard	Kevin Snee	13-Feb-19	14-Feb-19	
Ngatahi Vulnerable Children's Workforce Development - annual progress Feb 19	Sharon Mason	13-Feb-19	14-Feb-19	27-Feb-19

 HAWKE'S BAY District Health Board Whakawāteatia	Policy - Recognising Consumer Participation
	For the attention of: Māori Relationship Board, Clinical & Consumer Councils
Document Owner/Author:	Ken Foote, Company Secretary
Reviewed by:	Kate Coley, Executive Director People & Quality and Executive Management Team
Month:	June 2018
Consideration:	For discussion and endorsement

RECOMMENDATION**That the Māori Relationship Board, Clinical & Consumer Council**

1. **Note** the contents of this paper and attached draft policy.
2. **Discuss** and provide comment and feedback.
3. **Endorse** in principle the process for implementation of the policy.

Note EMT have endorsed this paper and the attached policy

OVERVIEW

Engaging and partnering with consumers is an important part of ensuring that the Hawke's Bay Health Sector is meeting the needs of our community. Why and how we do this has been pulled together as part of the Consumer Engagement Strategy. One of the key issues to be addressed in this strategy is how we value and recognise consumer participation and engagement.

Currently the only formal policy on this issue is contained within the policy on 'Payment of Fees and Expenses' (HBDHB/OPM/108). Essentially this policy provides for the payment of fees to Consumer Council members only, and reimbursement of justifiable expenses to stakeholders and advisors (including consumer representatives) in exceptional circumstances. The policy does however include a number of principles that address other more intangible ways of recognising and valuing consumer input.

With the more recent heightened awareness and interest in engaging consumers, the appropriateness of this current 'narrow' policy has been raised as an issue by consumers and services alike. In lieu of a broader policy, discretionary ways of recognising consumer contribution are being employed. There is a risk that this could lead to potentially unsustainable precedents being set and unrealistic expectations being created.

CONSULTATION

Consultation with HB Health Consumer Council, and other initial feedback sought from MRB, other consumer groups (including Partnership Advisory Group (PAG), EMT, PMO and Finance confirmed that it was appropriate to establish an organisation wide policy that acknowledges this 'new' environment, and the desired level of engagement.

Through consultation it was agreed that the three Auckland District Health Boards “Recognising Community Participation” Policy (attached as Appendix 2) was a good starting point for how HBDHB might recognise consumer participation and the resulting implications.

Feedback received requested more detailed provisions for recognising consumer participation. Examples of these such as Manaaki, Koha/Gifts, vouchers, support with expenses, refreshments, payments and inclusion in flu vaccinations have been included in the new draft policy.

COST OF IMPLEMENTATION

EMT requested an indication of what the cost of implementation would be based on previous 12 months activity and/or future planned activity. Discussions with finance have resulted in an inability to accurately determine this based on not having a cost centre code that reflects consumer involvement. This deficiency has been addressed in the draft policy.

Discussions with Counties Manukau DHB has revealed that their internal systems and processes do not include being able to accurately reflect the cost of engagement. They do not have a budget for engagement. Teams build it into their project plan or use existing service budget.

In the absence of any evidence or objective assessment criteria, it is subjectively estimated that the total cost of implementation is likely to be around \$20k per annum, spread across a number of cost centres. The materiality of this is therefore very low, and the expectation is that all services and projects incurring such costs will absorb them within existing budgets.

LEARNING FROM COUNTIES MANUKAU DHB

Counties Manukau have shared their learnings with HBDHB. These include:

1. Set cost centre codes up in advance of implementation.
2. Associated costs of consumer engagement should be the responsibility of the budget holder of the service or project, as opposed to being centralised. When services take responsibility for the costs of engagement they take better ownership of the relationship with the consumer representative.
3. Costs should be estimated and approved by the budget holder in advance of the project or engaging with consumer representatives. Have a process in place for this.
4. Provide certificates for consumers to acknowledge receipt of travel expenses and vouchers
5. Implement a transparent process that includes an attendance register when accounting for vouchers/taxi chits/reimbursements.
6. Be clear about who administers the process within services.
7. Rates are at the discretion of the budget holder but should be based on the level of the project, not the skill brought (for example, the Chair of Consumer Council is not paid a Chairs rate if involved in a project steering group).

RECOMMENDATIONS

It is recommended that the following process be implemented for this proposed policy:

1. EMT and Consumer Council feedback regarding this draft policy be incorporated.
2. As per policy guidelines, the draft policy should then be distributed more widely for organisational comment.
3. Policy is finalised and approved through governance process.
4. Review and amend existing ‘Payment of Fees and Expenses’ (HBDHB/OPM/108) Policy in light of this policy.

5. Make consequential changes to the 'Sensitive Expenditure Policy' (HBDHB/OPM/015) supported by Maori Health Services. (The definition of Koha to include cash equivalents).
6. Processes to support the policy, including learnings from Counties Manukau DHB to be confirmed in conjunction with the finance team.
7. Policy and processes to be rolled out with training to support.

ATTACHMENT

Draft policy on 'Recognising Consumer Participation'

HAWKE'S BAY DISTRICT HEALTH BOARD	Manual:	Operational Policy Manual
	Doc No:	HBDHB/OPM/120
	Date Issued:	May 2018
	Date Reviewed:	
	Approved:	To be confirmed
	Signature:	
	Page:	1 of 15

PURPOSE

Engaging and partnering with consumers is an important part of ensuring that Hawke's Bay District Health Board (the DHB) is meeting the needs of the community.

The DHB values and wishes to encourage consumers, whānau and community input and participation in HBDHB work. It is important that this contribution is recognised.

This policy explains how consumer participation can be recognised in a way that is fair, simple, consistent and compliant with financial and other imperatives.

PRINCIPLES

The fundamental intent of this policy is to clearly set out HBDHB's position on how we recognise consumer input.

Principles on which the policy is based include:

1. Engaging with consumers adds value by improving decision making, services and outcomes and fosters a culture of person and whanau centred care.
2. The DHB will invite consumers to participate in one off events, focus groups and to join project groups.
3. Consumers who participate by invitation in DHB activities should be offered reimbursement for reasonable expenses incurred in such participation
4. The DHB will ensure that the time and effort of consumers contributing and participating in DHB initiatives will be appropriately acknowledged and recognised. Such recognition may be in tangible and/or intangible form.
5. Expenditure decisions in recognition of consumer participation in DHB activities will be made with integrity and transparency.
6. Costs associated with recognising consumer participation are not centralised. The responsibility lies with the budget holder of the service or project and will be coded to the appropriate cost centre.
7. All consumers participating will be considered equal, irrespective of their employment status, profession, qualifications, experience or background.
8. Genuine appreciation for consumer input will be expressed through consideration of meeting times and venues, timely communication, feedback, follow up and an expression of appreciation.
9. Engaging with consumers is aligned with the vision and values of the Hawke's Bay Health sector; in particular Rāanga te tira – partnership and He Kauanuanu – respect.

SCOPE

This policy will apply to all consumers who are invited to participate in DHB work as a consumer representative.

This policy is applicable to all HBDHB employees who engage consumers in project, planning, improvement and decision making processes.

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This policy excludes Consumer Representatives who are paid for their involvement through specific external funding mechanisms.

This policy does not apply to engaging contractors or consultants providing professional services or Consumer Council members attending governance meetings.

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ROLES AND RESPONSIBILITIES

The Executive Director People & Quality has overall responsibility for the application of this policy.

Executive Directors, Senior Clinical Leaders, Service Directors, Project Managers and other budget holders, are responsible for engaging and appropriately recognising consumer representatives involved in their respective areas.

The Consumer Experience Manager is responsible for providing management and administrative support related to consumer representation.

The Executive Director Corporate Services has overall responsibility for the development and maintenance of systems and processes, including internal controls and financial monitoring of payments and vouchers.

The HBDHB Company Secretary shall independently monitor all costs associated with the application of this policy.

POLICY

The 8 principles above shall be applied as part of this policy.

In relation to the recognition of consumer participation the DHB will provide:

Manaakitanga (host responsibility)

Manaaki can be defined as “to look after, care for, show respect or kindness to”. Manaakitanga can be loosely translated to “hospitality”. Being hospitable, looking after visitors and caring about how others are treated is very important.

Recognition of people invited to participate in DHB activities requires that they are positively valued and shown respect. It requires sensitivity to people’s cultural and social diversity and an awareness of people with disabilities. It means that people assisting the DHB should be provided with sufficient resources to enable and support effective contribution. It includes the provision of sufficient information (in a format that is easy to understand), support with transport and other needs as required, ensuring the venue and information are fully accessible, providing refreshments, formally acknowledging people for their participation and providing feedback on their input. There should be no barriers to participation.

When offering hospitality, reference should be made to the ‘Sensitive Expenditure Policy’ (HBDHB/OPM/015).

Verbal and/or written acknowledgements, and expressions of appreciation, should be provided in all cases.

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Koha/Gifts

A koha or gift may be presented as a token of appreciation for contributions made to DHB activities, but should not be an expectation of the recipient. Koha/gifts may be in the form of petrol or supermarket vouchers or other tokens of appreciation (not cash or cheque). The value of a koha/gift for a person involved in any one project should not exceed \$50.00.

Vouchers should not be given regularly to the same person, as they may constitute taxable income.

People already on a salary or a contract, which covers their participation, should not receive a koha/gift.

Refreshments

It is appropriate to provide light refreshments for those who inform or advise the DHB through participation in a public consultation e.g. Hui, fono, discussion group. Reference should be made to the DHB's Healthy Eating Policy (HBDHB/OPM/115)

Reimbursements and Payments

Consumer representatives who participate in DHB activities by invitation should be offered reimbursement for reasonable expenses associated with their participation and may be offered payment for the time and value of their input.

Table 1 below provides a guide to the kind and level of reimbursements and monetary recognition payable. It is based on activities that are attended in person but payments can also be made when people participate in other ways, for example teleconferences or work done by individuals at home.

In all cases, the amount and type of on-going expenses and payments must be approved by the budget holder i.e. Service Director, Executive Director, Project Sponsor (or other role with the relevant delegated authority) in advance of the project, with the upper limit set.

For ongoing activities there must be a letter of agreement sent to the participant and the terms of reference agreed for the project/committee activity with the appropriate sign off. The agreement should include an outline of expectations of the consumer representative's contribution. If, for example a consumer representative is required to chair a meeting, or is expected to seek wider community views on a topic, then consider what additional time would be required to fulfil this function well. The agreement should outline any process for compensation, including a process for compensating expenses for last minute changes to meeting dates or times.

Reimbursements:

Consumer representatives seeking reimbursement of out of pocket expenses should complete a **Consumer Expenses Claim Form**, and provide:

- bank account number;
- receipts or invoices for items less than \$50 (incl. GST) or incurred overseas;
- GST tax invoices for items greater than \$50 (incl. GST) and incurred in New Zealand.

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Consumer representatives receiving vouchers to cover their expenses should also acknowledge receipt of payment by signing a **Voucher Acknowledgement of Receipt Register** and this should be kept on record.

Consumer representatives already on a salary or a contract which covers their participation should be reimbursed for out of pocket expenses using the usual employee expense claim process, or in accordance with their contract.

The DHB will not fully compensate people for taking time off work or for loss of income as a result of providing input into DHB work or projects. The levels of recognition set out below should be regarded as partial compensation.

Payments:

Consumer representatives offered 'remuneration' compensation for the time they have given, should be asked to complete a **HBDHB Joining Form** and an **IR330C Form**, and will be added to payroll and have withholding tax deducted from any payment.

Consumer representatives should not be compensated with vouchers for any time they have given, due to the complications and cost of complying with taxation obligations.

Consumer representatives providing appropriate tax invoices for their time, will be required to complete a **New Supplier Request Form**. Once approved, payments will be made into the verified bank account number provided.

Table 1: Reimbursement and recognition details

Type of activity	Type and extent of financial support or recognition the DHB can provide	Paid by
1. General invitation to a public hui/meeting Participation in a public consultation e.g.: attending a public meeting, hui, fono or discussion group	<ul style="list-style-type: none"> No honorarium or koha Assistance for people who would not otherwise be able to attend, e.g. mobility taxi service Assistance if requested with interpreters, or other supports that are essential for participation 	<ul style="list-style-type: none"> Taxi vouchers or bus passes provided prior to the meeting if possible Carpark pass if meeting is on hospital grounds.
2. Personalised invitation to one-off event Participation in focus group, forum, workshop or meeting	<ul style="list-style-type: none"> A koha or gift may be appropriate (up to the value of \$50.00) Assistance, if requested, with taxis/transport for people who would otherwise be unable to attend Reimbursement of reasonable out of pocket expenses up to \$125.00 per meeting (see travel expenses) Expenses may include travel, childcare and special aids for participation 	<ul style="list-style-type: none"> Koha/gift in the form of petrol or supermarket voucher (it is helpful to provide a choice as not everyone drives) Taxi vouchers or bus passes provided prior to the meeting if possible Carpark pass if meeting is on hospital grounds.

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Type of activity	Type and extent of financial support or recognition the DHB can provide	Paid by
3. Invitation to ongoing group membership, partnership or collaboration	<ul style="list-style-type: none"> Reimbursement of reasonable out of pocket expenses (see travel expenses) Expenses may include travel, childcare and special aids for participation Inclusion, if requested, in annual influenza vaccination <p>Consumer Representative working at a Project level</p> <ul style="list-style-type: none"> May be paid a meeting fee of up to \$50.00* for each meeting attended. <p>Consumer Representative working at a governance level (i.e. Consumer Council member)</p> <ul style="list-style-type: none"> Payment as per 'Payment of Fees and expenses' Policy (HBDHB/OPM/108) 	<ul style="list-style-type: none"> An honorarium is paid in recognition of time made as tax deducted payment Expenses reimbursed are tax exempt. Paid retrospectively on receipt. Carpark pass if meeting is on hospital grounds.

* this policy does not preclude paying a lesser amount.

Travel expenses (private vehicle)

Use of a private vehicle will be reimbursed on a distance travelled basis using IRD mileage rates (available on-line by typing "IRD mileage rates" into a search engine). Some common travel distances are provided below.

Return Trip distance
43km (i.e. Napier to Hastings)
14km (i.e. Flaxmere to Hastings)
22km (i.e. Bay View to Napier)
40km (i.e. Te Awanga to Napier)
72km (i.e. Waimarama to Hastings)
99km (i.e. CHB to Hastings)
233km (i.e. Wairoa to Napier)

MEASUREMENT CRITERIA

This Policy will be reviewed annually along with a full summary of costs incurred within the 12 months previous. To facilitate the capture of costs under this policy, expenses should be coded to Community Consultation Costs (currently account code 583500) within the appropriate cost centre.

As an appropriate independent control measure, HBDHB Company Secretary will periodically review all transactions charged against this code

An annual survey will be sent to Service and Project leaders, Consumer Council members and Consumer Representatives regarding feedback on how the policy is working in practise.

DEFINITIONS

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“Consumer”

Refers to patients and their families / whānau / caregivers / personal support persons, who have had personal experiences in the health and disability system. The term also includes those who might use services in the future and members of the public generally, given they are the targeted recipients of health promotion and public health messaging and services.

“Consumer Engagement”

Consumer engagement refers to the wide range of strategies in which consumers are involved in the planning, service delivery and evaluation of healthcare. Informing consumers does not, in itself, constitute engagement. Engagement requires dialogue and building relationships.

“Consumer Representative”

A consumer representative is a person with healthcare experiences relevant to the project or management group. A consumer representative provides advice based on their own personal experiences of services or care, and/or on behalf of others.

“On-going”

For the purposes of this policy, and in the context of activities, ongoing means predictable. If a meeting is scheduled to occur regularly with the same group of people as part of business as usual, or a specified project, that activity is classed as “on-going”.

REFERENCES

Health Quality and Safety Commission - Engaging with Consumers: A guide for District Health Boards.

RELATED DOCUMENTS

‘Payment of Fees and expenses’ (HBDHB/OPM/108)
‘Sensitive Expenditure Policy’ (HBDHB/OPM/015)
‘Healthy Eating Policy’ (HBDHB/OPM/115)

FORMS

All relevant forms applicable to this policy may be found on HBDHB intranet – Our Hub.

For illustrative purposes only, copies of such forms current at the time this policy was first approved, are attached:

- Appendix 1: Consumer Expenses Claim Form
- Appendix 2: Voucher Acknowledgement of Receipt Register
- Appendix 3: HBDHB Joining Form
- Appendix 4: HBDHB New/Updated Supplier Form
- Appendix 5: IR330C – Tax Rate Notification for Contractors

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KEYWORDS

Consumer
Consumer Engagement
Consumer Representative
Expenditure
Gift
Koha
Participation
Payment
Project
Recognition
Refreshments
Reimbursement
Travel expenses
Vouchers

For further information please contact the Consumer Experience Manager.

**Appendix 2****Voucher Acknowledgement of Receipt Register**

This form is to be used in accordance with the Recognising Consumer Participation Policy. Its purpose is to account for and maintain a record of the issue of vouchers.

Type of Voucher e.g. petrol, super market	Voucher Issuer e.g. MTA, Countdown	Voucher Number	Name of Recipient	Recipients Signature

Staff responsible for the use of vouchers, should ensure this form is completed whenever vouchers are issued, and be able to present the completed form on request.

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Appendix 3



JOINING FORM

Please complete all detail in FULL and return to the Recruitment Team

SURNAME: Dr / Mr / Mrs / Miss / Ms	FIRST NAME (S) (in full):
PREVIOUS NAME(S):	DATE OF BIRTH: / /
ADDRESS:	PHONE NUMBER(S):
GENDER: Male / Female	Have you previously been employed by HBDHB? Yes / No
NEXT OF KIN: Name: Phone Number(s): Address: Relationship:	
EQUAL EMPLOYMENT OPPORTUNITY INFORMATION: The following information will be used for reporting and statistical purposes only. Which ethnic groups do you identify with? (please indicate more than one if applicable):	
NZ Maori <input type="checkbox"/>	British or Irish <input type="checkbox"/> Other European <input type="checkbox"/>
NZ European / Pakeha <input type="checkbox"/>	Asian <input type="checkbox"/> Other Ethnic Group (or further detail): <input type="checkbox"/>
Pacific Islander <input type="checkbox"/>	Indian <input type="checkbox"/>
BANK ACCOUNT DETAILS (Please attach deposit slip) Name of Bank: Account No: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Bank Code Bank/Branch Account Number Suffix	
PAYROLL USE ONLY: Employee Number: Cost Centre: Applicant Number: Salary: Commencement Date: Increment Date: Position: Phone Allowance: Yes / No Roster Group:	

Signature:

Date:

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Appendix 4

HBDHB New/Updated Supplier Form



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Part A – Your information (* Denotes a mandatory field. If you are updating the information we hold on you, only complete the boxes you want us to change)

Payment details		
* Name/department of the person at the DHB who asked you to complete this form		
Supplier number if an existing supplier		
*Trading name that will appear on your invoices		
*Legal name (if different)		
*Legal status (e.g. registered company, partnership, sole trader, Crown entity etc.)		
*Company No. / NZBN (include certificate)		
*e-mail address (for purchase orders)		
*Physical address (for supplier returns)		
*Postal address - if different from physical address:		
*Type of goods or services you will provide:		
*DHB Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	Employee number:	
*Independent contractor? <input type="checkbox"/> Yes <input type="checkbox"/> No	IRD number:	
*GST registered? <input type="checkbox"/> Yes <input type="checkbox"/> No	GST number:	
If registered you must provide compliant tax invoices, see: http://www.ird.govt.nz/gst/work-out/work-out-records/records-tax/tax-info/		
Who should we contact at your business		
*Contact name:		
*Phone number:	Mobile number:	*e-mail address:
Purchasing contact person, if different from above		
*Contact name:		
*Phone number:	Mobile number:	*e-mail address:
Payments contact person – for remittance advices		
*Contact name:		
*Phone number:	Mobile number:	*e-mail address:

If you are a contractor receiving scheduler payments, you must also include a completed Tax rate notification for contractors IR330C form (available on the IRD website), or a copy of any Certificate of exemption (COE). Otherwise tax will be deducted at the no-notification rate.

HBDHB New/Updated Supplier Form**Part B – Bank Account detail and declaration**

2. Bank Account details	
*We accept any of the following as evidence of your Bank Account:	Document attached
A pre-printed deposit slip which includes the full bank account number (bank, branch, account number and suffix) and the account holders name :	<input type="checkbox"/>
A bank statement which includes the full bank account number (bank, branch, account number and suffix) and the account holder's name:	<input type="checkbox"/>
A letter from the bank which includes the full bank account number (bank, branch, account number and suffix) and the account holder's name. This must be signed and stamped by the bank.	<input type="checkbox"/>
An internet printout which includes the full bank account number (bank, branch, account number and suffix) and the account holder's name and the web address along the top or bottom of the page. This does not need to be signed and stamped by the bank unless all of the above is not provided on the printout.	<input type="checkbox"/>
ATM printout must show the bank logo and the full bank account number (bank, branch, account number and suffix) and the account holder's full name.	<input type="checkbox"/>
Hand-written bank account evidence as long as it includes the full bank account number (bank, branch, account number and suffix) and the account holder's name. This must be signed and stamped by the bank.	<input type="checkbox"/>

3. Supplier Declaration	
*I declare that:	
<ul style="list-style-type: none"> the information given in this application is true and correct I am authorised to make this request on behalf of the organisation. 	
Full name:	Job title:
Signature:	Date:


Payments will be made on the 20th of the month following date of invoice as per HBDHB terms and conditions. (T&C available on the HBDHB website)

Return this form to the Contracts Team e-mail:
contracts@hawkesbaydhb.govt.nz

With subject line "New Supplier Request" (Supplier Name)

4. OFFICE USE ONLY		
Contracts approval:	Name & Signature:	Date:
Purchasing approval:	Name & Signature:	Date:
Creditor number :	Name & Signature:	Date:
WHT loaded :	Name & Signature:	Date:

Appendix 5



Inland Revenue
Te Tari Taake

Tax rate notification for contractors

IR330C
March 2017

Use this form if you're a contractor receiving schedular payments.

Don't use this form if you're receiving salary or wages as an employee, you'll need to use the *Tax code declaration (IR330)* form.

Once completed:

Contractor Give this form to the person paying you.

Payer Don't send this form to Inland Revenue. You must keep this completed IR330C with your business records for seven years following the last schedular payment you make to the person or entity.

1. Your details

Full Name

IRD number (8 digit numbers start in the second box. 1 2 3 4 5 6 7 8)

If you don't have:

- your IRD number you can find it on your myIR Secure Online Services account or on letters or statements from us.
- an IRD number go to www.ird.govt.nz (search keywords: IRD number) to find out how to apply for one.

2. Your tax rate

You must complete a separate *Tax rate notification for contractors (IR330C)* for each source of contracting income.

Refer to the flowchart on page 2 and enter your tax rate to one decimal point here. %

Refer to the table on page 3 and enter your schedular payment activity number here.

Your tax code will always be: WT

3. Declaration

Name

Designation or title (if applicable)
For example, director, partner, executive office holder, manager, duly authorised person

Signature

Day Month Year

Please give this completed form to your payer. If you don't complete sections 1 and 3 your payer must deduct tax from your pay at the no-notification rate of 45%, except for non-resident contractor companies where it's 20%.

Privacy RESET FORM

Meeting your tax obligations means giving us accurate information so we can assess your liabilities or your entitlements under the Acts we administer. We may charge penalties if you don't.

We may also exchange information about you with:

- some government agencies
- another country, if we have an information supply agreement with them
- Statistics New Zealand (for statistical purposes only).

If you ask to see the personal information we hold about you, we'll show you and correct any errors, unless we have a lawful reason not to. Call us on 0800 377 774 for more information. For full details of our privacy policy go to www.ird.govt.nz (keyword: privacy).

1

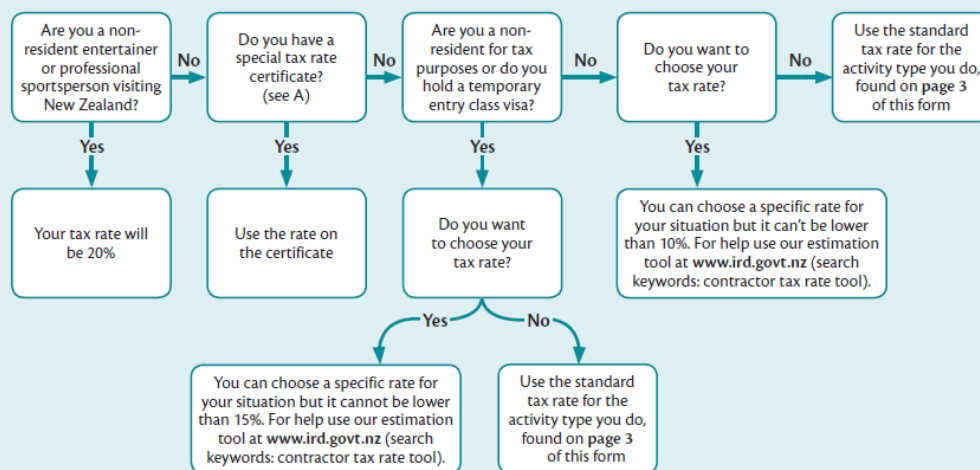
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Schedular payments are payments made to people who are not employees but are contractors. This includes independent contractors, labour-only contractors and self-employed contractors. You're receiving schedular payments if you're not an employee and the type of work you're receiving a payment for is an activity listed on page 3.

If you aren't ordinarily required to have tax deducted from payments you receive you can choose to have tax deducted from them, they'll be treated as schedular payments, if the person paying you agrees. You will need to get their agreement in writing.

Use the flow chart below to work out what tax rate to use



- A** If you have a special tax rate (STR) certificate enter your special tax rate on page 1 and show your original STR certificate to your payer. An STR is a tax rate worked out to suit your individual circumstances. You may want an STR if the minimum tax rate that applies to you will result in you paying too much tax. For example, if you have business expenses that will lower the amount of tax you need to pay on your income. You can apply for an STR certificate by downloading a *Special tax code application (IR23BS)* from our website or by calling 0800 257 773. Please have your IRD number handy.
- If you're a non-resident contractor the application process is different. For more information go to www.ird.govt.nz (search keywords: NRCT special rate).
- B** If you don't want tax deducted from your schedular payments, you may be able to apply for a Certificate of exemption (COE) online using the *Request for PAYE exemption on schedular payments (IR332)* form on our website.
- If you're a resident contractor paid by a labour hire business under a labour hire arrangement you cannot use a COE for these payments. You may be able to apply for a 0% special tax rate instead by completing an IR23BS.
- For more information about COEs go to www.ird.govt.nz (search keywords: schedular coe).

Non-residents

Applications for non-resident contractor certificates of exemption or enquiries about non-resident contractors should be sent to:

Post:	Email: Nr.contractors@ird.govt.nz
Team Leader	Phone: 64 4 890 3056
Non-resident Contractors Team	Fax: 64 4 890 4502
Large Enterprises Services	
PO Box 2198	
Wellington 6140	
New Zealand	

Additionally, the following may be entitled to an exemption from tax:

- non-resident entertainers taking part in a cultural programme sponsored by a government or promoted by an overseas non-profit cultural organisation
- non-resident sports people officially representing an overseas national sports body.

Post:	Email: Nr.entertainers@ird.govt.nz
Team Leader	Phone: 64 9 984 4329
Non-resident Entertainers Unit	Fax: 64 9 984 3081
Large Enterprises Services	
PO Box 76198	
Manukau City	
Auckland 2214	
New Zealand	

Schedular payment tax rates

If you are receiving payment for any of the types of work listed below, enter the activity number in the box at section 2 on page 1.

The description of activities covered may not be exhaustive. For a more detailed description see schedule 4 of the Income Tax Act 2007.

You'll generally be required to file an income tax return at the end of the tax year.


If you receive schedular payments you will receive an invoice for your ACC levies directly from ACC.

Activity number	Activity description	Standard tax rate – %	No-notification rate – %
1	ACC personal service rehabilitation payments (attendant care, home help, childcare, attendant care services related to training for independence and attendant care services related to transport for independence) paid under the Injury Prevention and Rehabilitation Compensation Act 2001	10.5	45
2	Agricultural contracts for maintenance, development, or other work on farming or agricultural land (not to be used where CAE code applies)	15	45
3	Agricultural, horticultural or viticultural contracts by any type of contractor (individual, partnership, trust or company) for work or services rendered under contract or arrangement for the supply of labour, or substantially for the supply of labour on land in connection with fruit crops, orchards, vegetables or vineyards	15	45
4	Apprentice jockeys or drivers	15	45
5	Cleaning office, business, institution, or other premises (except residential) or cleaning or laundering plant, vehicle, furniture etc	20	45
6	Commissions to insurance agents and sub-agents and salespeople	20	45
7	Company directors' (fees)	33	45
8	Contracts wholly or substantially for labour only in the building industry	20	45
9	Demonstrating goods or appliances	25	45
10	Entertainers (New Zealand resident only) such as lecturers, presenters, participants in sporting events, and radio, television, stage and film performers	20	45
11	Examiners (fees payable)	33	45
12	Fishing boat work for profit-share (supply of labour only)	20	45
13	Forestry or bush work of all kinds, or flax planting or cutting	15	45
14	Freelance contributions to newspapers, journals (eg, articles, photographs, cartoons) or for radio, television or stage productions	25	45
15	Gardening, grass or hedge cutting, or weed or vermin destruction (for an office, business or institution)	20	45
16	Honoraria	33	45
17	Modelling	20	45
18	Non-resident entertainers and professional sportspeople visiting New Zealand	20	N/A
19	Payment by a labour hire business to any person (eg individual, partnership, trust or company) performing work or services directly for a client of the labour hire business or a client of another person, under a labour hire arrangement	20	45
20	Payments for: – caretaking or acting as a guard – mail contracting – milk delivery – refuse removal, street or road cleaning – transport of school children	15	45
21	Proceeds from sales of: – eels (not retail sales) – greenstone (not retail sales) – sphagnum moss (not retail sales) – whitebait (not retail sales) – wild deer, pigs or goats or parts of these animals	25	45
22	Public office holders (fees)	33	45
23	Shearing or droving (not to be used where CAE code applies)	15	45
24	Television, video or film: on-set and off-set production processes (New Zealand residents only)	20	45
25	Voluntary schedular payments	20	45
	If you are a non-resident contractor receiving a contract payment for a contract activity or service and none of the above activities are applicable, then:		
26	Non-resident contractor (and not a company)	15	45
27	Non-resident contractor (and a company)	15	20

Note: If you need help choosing your tax rate use the estimation tool at www.ird.govt.nz (search keywords: contractor tax rate tool)

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 <p>HAWKE'S BAY District Health Board Whakawāteatia</p>	Te Ara Whakawaiaora: Oral Health
	<p>For the attention of:</p> <p>Māori Relationship Board, HB Clinical Council, HB Health Consumer Council and the HBDHB Board</p>
Document Owner	Sharon Mason, Executive Director Health Services
Document Author	Robin Whyman, Clinical Director for Oral Health Services and Communities, Women and Children Directorate
Reviewed by	Charrissa Keenan, Health Gains Advisor, Māori Health; Wietske Cloo, Deputy Service Director for Communities, Women and Children Directorate; Claire Caddie, Service Director for Communities, Women and Children Directorate and the Executive Management Team
Month / Year	June 2018
Purpose	For monitoring
Previous Consideration Discussions	This report is provided annually.
Summary	<p>Inequity in dental caries levels has multiple causes that are continually developing and changing and there is no universal solution.</p> <p>A wide ranging programme of work of is developing around early childhood oral health with partners across, and external to, the DHB including activity in service change, population health activities and healthy environments</p>
Contribution to Goals and Strategic Implications	<ul style="list-style-type: none"> • Improving experience of care. • Improving Health and Equity for all populations; • Improving Value from public health system resources.
Impact on Reducing Inequalities / Disparities	Improved equity and reduction of oral disease in Māori , Pacific and young children living in poverty.
Consumer Engagement	Te Roopu Matua – Māori Oral Health Advisory Group established and partners at the table of the project Steering Group for improving equity in oral health for children under 5 years.
Other Consultation / Involvement	Not applicable for this report
Financial / Budget Impact	Not applicable for this report
Timing Issues	Not applicable for this report
Announcements / Communications	Nil

RECOMMENDATION:

That the Executive Management Team, Māori Relationship Board HB Clinical Council, HB Health Consumer Council, and HBDHB Board

1. **Note** the content of this report
2. **Endorse** the recommendations and identified areas for improvement



Te Ara Whakawaiaora: Oral Health

8

Author:	Robin Whyman,
Designation:	Clinical Director for Oral Health Services and Communities, Women and Children Directorate
Date:	18 May 2018

OVERVIEW

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

UPCOMING REPORTS

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

Priority	Indicator	Measure	Champion	Reporting Month
Oral Health <i>National Indicator</i>	1. % of eligible pre-school enrolments in DHB-funded oral health services. 2. % of children who are caries free at 5 years of age	≥95% ≥67%	Robin Whyman	MAY 2018

MĀORI HEALTH PLAN INDICATOR: Oral Health

Oral health, general health and quality of life

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

Severe early childhood caries affects the child's first (primary) teeth and 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.

A second opportunity to measure the impact of early investment in prevention of dental caries occurs at Year 8 when the number of adult decayed, missing and filled (DMF) teeth are measured and reported.

Management of dental caries occupies considerable DHB resources to treat children and adolescents and private resources to manage the effects in adulthood. Untreated acute and chronic

infections lead to a higher risk of hospitalisation and loss of school days and work days which has implications for a child's ability to learn and an adult's ability to work.

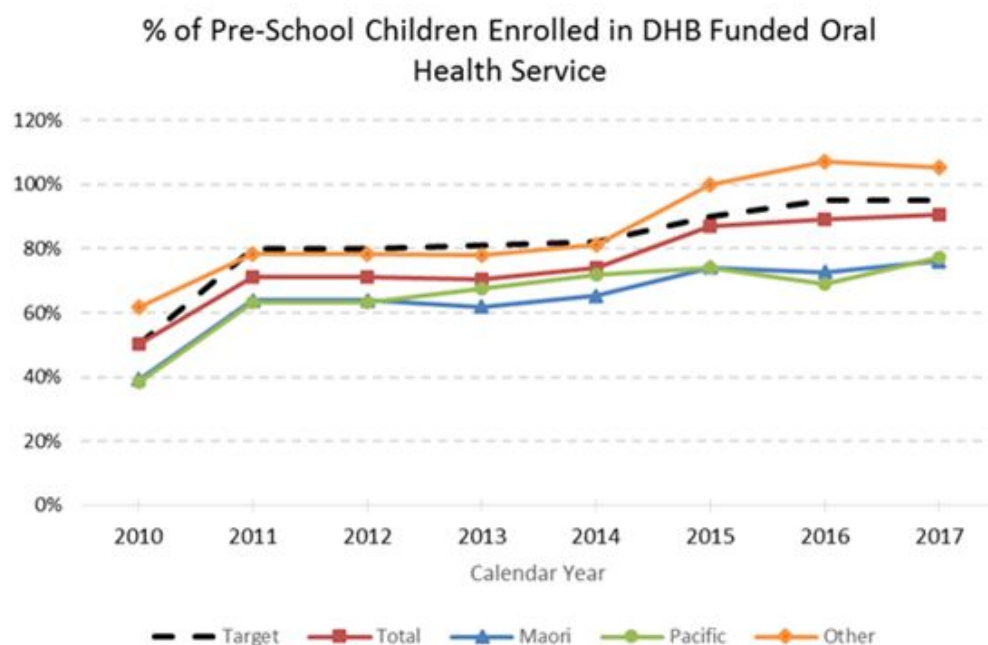
The determinants of dental caries are known — the risk factors include diet (sugar consumption) and poor oral hygiene. Poverty is also an identified risk factor for dental caries, but the how and why aspects of this relationship are less understood. Effective population health strategies and clinical 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, these improvements are not equitable across all population groups, and barriers to access and substantial inequities in oral health outcomes remain.

Inequality in outcomes in oral health status for Māori

Tamariki Māori and Pacifica, and those children living in socioeconomic disadvantage experience poorer outcomes in oral health status (National Health Committee, 2003). These tamariki also tend to enrol and use oral health services later compared to non-Māori children, highlighting the need to explore in greater detail an appropriate and responsive model of oral health care services for this population group.

WHY IS THIS INDICATOR IMPORTANT?

Percentage of preschool children enrolled in DHB Funded Oral Health Service



	Target	Total	Maori	Pacific	Other
2010	50%	50.4%	39.2%	38.3%	61.9%
2011	80%	71.1%	63.8%	63.3%	78.4%
2012	80%	71.1%	63.8%	63.3%	78.4%
2013	81%	70.4%	61.9%	67.4%	78.0%
2014	82%	73.9%	65.3%	71.7%	81.3%
2015	90%	87.1%	74.1%	74.2%	99.8%
2016	95%	89.2%	72.7%	69.1%	107.0%
2017	95%	90.5%	76.1%	77.1%	105.2%

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

Preschool children enrolled in DHB oral health services have increased rapidly as the DHB has focused on the national priority of earlier preschool enrolment in oral health services. However, the 2016 results raised concerns about the quality of the ethnicity coding.

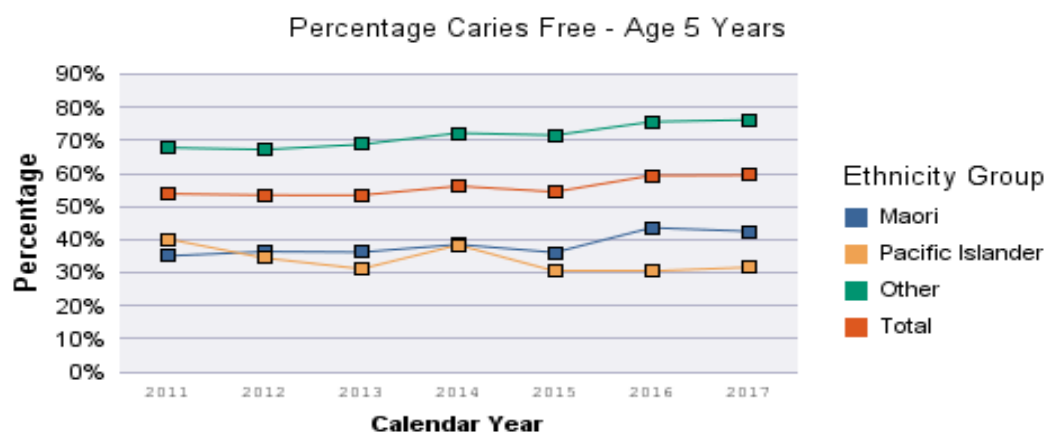
The 2017 results reflect pleasing increases in the proportion of Maori preschool children enrolled, but more importantly the absolute numbers enrolled has increased by a further 234 children. Māori enrolled has increased by 192 children, and Pacific by 56 children. Other children have decreased by 14 children and remain at over 100%.

Considerable work has been put into checking the ethnicity of children enrolled in the Titanium oral health patient management system and comparison with the ethnicity recorded in ECA from the national databases. Data cleansing, along with an absolute increase in numbers enrolled is responsible for the improved result as enrolments primarily occur from the quadruple enrolment process at birth to primary care, immunisation services, Well Child/Tamariki Oral and oral health at birth.

However, a discrepancy exists as we remain reporting 105.2% Other children are enrolled. Our conclusion after discussion with other DHBs and other services reporting preschool data is that this reflects discrepancies in the denominator figures used to report this indicator, which are provided by the Ministry of Health, but based on census projections from the Department of Statistics.

The overall level of preschool enrolment and the continued improvement for tamariki Māori and Pacifica is encouraging and our focus will be to ensure these gains do not level off.. However, the challenge is to engage all of these tamariki/children and their whānau/families with Oral Health Services. Improvements in oral health status will be maximised when tamariki/children are engaged and seen by the Oral Health Services. Our efforts are focused on achieving this goal via the Equity <5 years project. . Ongoing attention to data quality is required. Updated denominator figures may move this indicator after the 2018 census data are available.

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



	Target	Total	Maori	Pacific	Other
2010	58%	58.4%	38.1%	34.2%	72.5%
2011	54%	54.0%	35.1%	39.8%	67.5%
2012	54%	54.1%	36.9%	39.2%	65.5%
2013	64%	54.2%	36.7%	31.2%	66.3%
2014	65%	56.5%	38.7%	38.0%	71.2%
2015	65%	54.4%	36.0%	30.5%	70.1%
2016	67%	59.0%	44.0%	31.0%	74.0%
2017	67%	59.5%	42.5%	31.6%	75.1%

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

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

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

2017 results represent Minimal changes. There was a small decline for Maori and a small gain for Pacific children, who experience the worst oral health among Hawke's Bay groups. Importantly the substantial gain reported in 2016, against the previous trend, has largely been held. The improvement to the proportion of Other children decay free means the inequality in this indicator has not improved in 2017.

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

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

Activity planned to support these indicators has been

- 1 *Quadruple enrolment in the oral health service from birth, alongside enrolment for primary care, Well Child/Tamariki Oral and immunisation services.*
Ethnicity coding and data accuracy in the Titanium database was reviewed and updated in early 2018. Ongoing work is checking the accuracy of the database for double enrolments
- 2 *Improve whānau engagement with early childhood oral health services*
A Kaiawhina employed in the Community Oral Health Service started in July 2017 and was able to bring 282 children back into the service in the first 6 months. The Hastings Central team have adjusted their booking and appointment systems to be able to accommodate Kaiawhina appointments for families. Changes to ensure a flexible and responsive model of care for tamariki/children under 5 years are being explored to avoid losing these children in the first place.

3 *Changing the relationships with Māori health providers*

Changes to incorporate additional visits for high risk whanau through the Well Child Tamariki Ora providers contracts between Te Taiwhenua o Heretaunga, Kahungunu Executive, Plunket NZ and Māori Health and were implemented in late 2017. The emphasis of this work is to engage tamariki/children and their whānau with the Oral Health Service by age 1 year, and subsequent annual visits.

Changes to the operation of the Titanium database operated by the Community Oral Health Service were put in place for the start of the 2017 calendar year to enable Well Child/ Tamariki Ora providers to select and place appointments for tamariki and whanau directly in the system.

4 *Audit of the clinical pathway and patient experience for preschool children receiving dental care under general anaesthetic*

During 2017 and early 2018 an audit of preschool children who received dental care under general anaesthetic was undertaken including data review and whanau interviews. A series of recommendations are being finalised with the Steering Group for the project improving equity in oral health for children under 5 years.

5 *Improving preventive practice in the Community Oral Health Service*

Work with the clinical teams of dental therapists to improve the utilisation of fluoride varnish, bite wing radiography and fissure sealants to prevent dental decay is ongoing. All of the indicators show improvement and work is currently focussed on reducing variation between clinical teams across the service.

6 *Training in Relationship Centred Practice*

Training for the clinical teams in relationship centred practice was undertaken during 2017 by the Director of Allied Health as part of the service's ongoing programme of in-service education.

7 *Community water fluoridation*

Community water fluoridation remains an ongoing and serious concern as it has been absent from the Hastings District Council supply since August 2016 and no clear timeframe for its reinstatement has been announced by Hastings District Council.

A submission to Select Committee supporting the Health (Fluoridation of Drinking Water) Amendment Bill, by the DHB, was made in January 2017 and an oral submission made, on behalf of the DHB in March 2017. A conversation with the Central Hawke's Bay water team was held in October 2017. Further progress on extension of community water fluoridation (beyond Hastings) is now awaiting progress on the Bill by the government.

8 *Population health strategies*

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

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

- 1) Increasing healthy eating and activity environments – Working with Sport Clubs and Code via Sport HB to introduce healthy food choices and Water is the Best Drink". Work continues with Schools to promote 'Water is the Best Drink' and supporting water only schools. Work has started with early childhood centres to support healthy weight and oral health. Key HB events are delivering "Water is the Best Drink" messaging. A church with 2000 members in Flaxmere adopted a water only policy in November 2017. All events and activities held at or outside the church facilities are water only. Recent report back has indicated successful implementation with minimal disruption.

- 2) Develop and deliver prevention programmes - “Healthy Foods- Healthy Teeth and eating for under 5’s” is now finalised and distributed to B4SC nurses and other health professionals – the information on oral health has been enhanced as part of this process.
- 3) Intervention to support children to have healthy weight – Raising Healthy Kids Health Target is supporting referral to lifestyle change programme which include healthy eating, water only and oral health -the BESMARTER Goal Setting Tool has been adapted to include oral health activity.
- 4) Provide leadership in healthy eating - HBDHB Board has endorsed the reviewed Healthy Eating Policy and this now aligns with the MoH’s guideline. The DHB is sugar sweetened beverage free and soon will be mostly confectionary free.

The DHB enhanced this in March 2018 when a “Water for Kids” programme and policy was introduced in the Paediatric Ward and SCBU at Hawke’s Bay Hospital.

Breastfeeding

The March 2017 Te Ara Whakawaiaora: Breastfeeding report acknowledged that currently challenges exist meeting the 6 week target and that a drop off occurs between 6 weeks and 3 months. Initiatives to improve and sustain early breastfeeding are important to early childhood oral health. Recent literature (Gussy et al 2016) has demonstrated that early introduction of sugary beverages (before 18 months) is significantly associated with early development of dental caries. Initiatives associated with breastfeeding have been reported in the Te Ara Whakawaiaora: Breastfeeding report identifying a new 6 week to 6 month programme initiative run by TTOH, Plunket HB and Kahungunu Executive to provide in home breastfeeding support. The emphasis of this contract is to provide appropriate advice and support for Māori and Pacific mothers and their whānau. From discharge to 6 weeks recent sign off has agreed an LMC incentive package to increase postnatal visits during the first two weeks post birth and a consistent messaging community based campaign.

Oral health promotion

The intermittent national campaign and TV advertisement run by the Ministry of Health and Health Promotion Agency “Baby Teeth Matter” and brushing teeth with fluoride toothpaste 2x a day are being supported locally with posters and repeated on the HBDHB Facebook page. Evaluation of the national programme by the Health Promotion Agency reported strong recognition and resonance with the programme particularly for Māori and Pacific whānau.

In addition to these initiatives, other population health activities that reduce the effects of poverty and improve living standards for whānau are linked to improvements in health, including oral health. An example of these initiatives is the Child Healthy Housing programme.

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

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

1 Under 5 years equity project-

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

The project is aiming to:

- strengthen consumer engagement and participation with Oral Health and to substantially improve consumer input to Oral Health Services and to oral health strategies to improve child oral health.
- coordinate consistent messaging and health promotion activity focussing on improving equity in early childhood oral health.
- improve whānau engagement with early childhood oral health services commenced in the Hastings Central community clinic hub.
- spread innovation that is successful within the service.
- work in collaboration with other providers for early childhood such as B4SC, Health Hawkes Bay, Well Child Tamariki Ora providers, Child Health Team, Early Childhood Education & Kohanga Reo and Outreach Immunisation teams to reduce the siloed nature of oral health services delivery.
- Lead improvement to ensure culturally appropriate and responsive oral health services
- influence policy change, particularly for water only environments
- review practice and implement change, or advocate for change, where appropriate

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

2 *Workforce change and kaiawhina engagement*

Community Oral Health Services have changed the service's workforce mix by redeploying a clinical vacancy within the service to employ a kaiawhina to support the service's engagement with the community and other providers. This initiative commenced at the Hastings Central hub clinic and the preschool attendance rate has improved from 72.8% to 76.7% at the clinic. The Kaiawhina is expanding her work to Mahora and Flaxmere, and assisting the wider service and further work to investigate the role of kaiawhina in the model of service and workforce mix within the Community Oral Health Service.

3 *Clinical quality indicators*

Community Oral Health Services are continuing to monitor the implementation of a greater preventive focus in the clinical activity of the service. This involves monitoring 3 quality indicators (fluoride varnish, bitewing radiography and fissure sealants). Levels of use of fissure sealant use are satisfactory. Fluoride varnish use requires better targeting and work is ongoing to ensure that children at greatest clinical risk are receiving 6-monthly applications of fluoride varnish.

Use of bitewing radiography remains lower than optimal as it represents a significant clinical practice change, but levels have continue to improve throughout 2017. Six-monthly reporting to the service and peer discussion is being used to effect these changes to clinical practice.

RECOMMENDATIONS FROM TARGET CHAMPION

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

1 *Enrolment data quality*

Work needs to continue to ensure that Māori and Pacific 5-year-old children are enrolled for oral health services and are as correctly reported as the denominator data allows. That work will continue by checking the Titanium oral health database has the status of children correctly reported. Further change may occur once the 2018 census becomes available with updated denominator data for preschool child numbers.

2 *Accelerating equity in caries free status Māori and Pacific children*

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

3 *Community water fluoridation*

An ongoing conversation is required with Hastings District Council regarding the reinstatement of community water fluoridation as water plant improvements are made following the Havelock North gastro illness. Reinstatement is a high priority for Maori and Pacific oral health, particularly when the decline in Maori 5-year-old oral health in CHB is considered as reported in this report in 2016.

Work on community water fluoridation is primarily awaiting further progress on the Health (Fluoridation of Drinking Water) Amendment Bill. However, in the meantime meetings with drinking water staff of the Councils are held where appropriate to discuss the proposed changes under the Bill. It is appropriate to wait until the outcomes of the Bill are clear before making wider recommendations for community water fluoridation in Hawke's Bay.

4 *Model of care improvements.*

Both the audit of the clinical pathway and patient experience for preschool children receiving dental care under general anaesthetic and the demands of an aging workforce are strong drivers for continued attention to the model of care. Issues are being identified both within the Community Oral Health Service and across the DHB and the Hawke's Bay health system. The Community Oral Health Service is embarking on review of the model of care and will develop a paper recommending the mix of clinical, administration and Kaiawhina staffing that best supports the contemporary needs of the population group. It is also important that recommendations from the audit are finalised and confirmed by the Steering Group of the project group focussed on equity in oral health for children under 5 years and that an action plan is then developed to work through the recommendations.

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

Description	Responsible	Timeframe
Continue quality control of the ethnicity coding and patient status accuracy within the oral health patient management system (Titanium)	Unit Manager Oral Health Clinical Director for Oral Health Children, Women and Communities Deputy Service Director	June 2019
Under 5 years of age caries free equity project		Phase 2 Jan – Dec 2018 and Total project 2017-2019
Consumer engagement, participation and feedback. Te Roopu Matua is established and their guidance and advice assists in project delivery and prioritisation.	Project Manager and Project Steering Group Unit Manager Oral Health	Total project 2017-2019 throughout the project

<p>Healthy Foods - Healthy Teeth and eating for under 5s prevention programme Specific tools for ECE, Kohanga Reo and Pacific Island Language nests are being developed with the sector</p> <p>Environmental scanning of water only policies and decisions about next steps,</p> <p>Water for kids in Paediatric ward and SCBU evaluation July 2018 and decisions about widening of the scope</p> <p>Early intervention in general practice in conjunction with Systems Level Measures work.</p> <p>Heath HB to trial the “lift the lip” at 15 month immunisation with 2 high needs practices (2018-2019)</p> <p>Agree recommendations from preschool child general anaesthetic audit and develop action plan</p>	Population Health	March 2019
	Oral Health Population Health Advisor	March 2019
		July 2018
	Project Manager and SLM group	July 2018
		December 2018
Community Oral Health Service Model of Care review and decisions	Project Manager	July 2018
	Deputy Service Director CWC Directorate	September 2018
	Unit Manager Oral Health Clinical Director for Oral Health	
Well Child Tamariki Ora provider outreach services	Māori Health Services Unit Manager Oral Health	Ongoing June 2019
TTOH , KE and Plunket continue regular collaborative meetings with COHS to improve systems	Clinical Director for Oral Health	Ongoing June 2019
Continue to transition clinical service delivery towards a preventive care focus using clinical quality indicators to monitor service performance	Unit Manager Oral Health	
Community water fluoridation	Clinical Director for Oral Health	
Ongoing discussion with Hastings DC to establish the process and timeframe for reinstatement of community water fluoridation.		December 2018
Monitor legislative change timetable		Legislative timeframe uncertain
Build relationships with communities of interest		2017-2019

Breastfeeding initiatives to improve and sustain early breastfeeding	Breastfeeding Champion	July 2019
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CONCLUSION

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

However, significant steps to control early childhood dental caries would be made with region-wide access to optimally fluoridated water and removal of sugar sweetened beverages from all early childhood environments. Improvement in both of these indicators will require focus on collaborative activities to improve social and economic environments, including community water fluoridation and sugar-free environments,

A very wide ranging programme of work of is developing around early childhood oral health with partners across, and external to, the DHB. There also remains willingness by Oral Health Services to continue to question the best model of care for delivery of preschool oral health while also maintaining positive outcomes for the primary school child population.

Data quality issues, particularly related to enrolment, have improved but continue to challenge the reporting of the enrolment indicator. Some of these issues are out of the direct control of the DHB.

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

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

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

RECOMMENDATION:

That the Executive Management Team, Māori Relationship Board HB Clinical Council, HB Health Consumer Council, and HBDHB Board

3. **Note** the content of this report
4. **Endorse** the recommendations and identified areas for improvement

 <p>HAWKE'S BAY District Health Board Whakawāteatia</p>	HBDHB Youth Strategy Implementation update inclusive of Zero Fees 13-17
	For the attention of: Māori Relationship Board, HB Clinical Council & HB Health Consumer Council and HBDHB Board
Document Owner	Chris Ash – Executive Director Primary Care
Document Author(s)	Jill Garrett, Strategic Services Manager – Primary Care; and Marie Beattie, Portfolio Manager Integration
Reviewed by	Emma Foster- GM Totara Health/Directions; Julia Ebbett- GM Te Taiwhenua O Heretaunga; Stacey Tito – Directions Youth Social Worker; Ruth Fa'afuata – Rangatahi Youth Services TToH and Executive Management Team
Month/Year	June 2018
Purpose	Information update Progress against outcomes report
Previous Consideration Discussions	Regular update for monitoring
Summary	This paper outlines: <ul style="list-style-type: none"> • Background to the strategy and commencement overview • Progress to goals • Stakeholder engagement • Highlights and Challenges <ul style="list-style-type: none"> - Implementing the strategy - Zero fees 13-17yrs update • Recommendations and next steps
Contribution to Goals and Strategic Implications	HBDHB Youth Strategy Goals
Impact on Reducing Inequities/Disparities	Addressing high need youth health through a mechanism of positive youth development
Consumer Engagement	Directions Youth Health Services Youth Consumer Council Zero Fees 13-17 clusters Public health and school based health services (SBHS)
RECOMMENDATION That MRB, Clinical and Consumer Council: 1. Note the contents of this report	



Update on implementation of the HBDHB Youth Health Strategy

Author(s):	Marie Beattie
Reviewers:	Jill Garrett – Strategic Services Manager – Primary Care
Designations:	Portfolio Manager - Integration
Date:	May 2018

RECOMMENDATION

That the Executive Management Team, Māori Relationship Board, Clinical Council and Consumer Council

- **For information and consideration**

1.0 Background information:

In line with The World Health Organisation's Global Strategy¹, the Hawke's Bay District Health Board (HBDHB) have made a commitment to ensure there is opportunity for the children and youth of their region to thrive. This support to the region's children and youth will realise enormous social, demographic and economic benefits. Working on a strengths based model for positive development the view looks beyond crisis management and problem reduction. It incorporates strategies that increase young people's connection to positive supportive relationships and challenging meaningful experiences²

2.0 Progress to Goals (Refer Appendix one below for detailed 2018-19 action plan)

Goal 1: Youth Report Healthy and Safe

HEADSS assessments continue to be completed for all Year 9 students in Decile 1-3 high schools. Youth friendly audits for general practice teams has been completed as part of the Zero fees for 13- 17 year olds. This program is now in operation in 13:14 practices offered. It is an assessment tool used across multi agencies that needs to be supported in its use across a range of health services to effectuate appropriate referrals and support.

Goal 2: Youth Report they Feel Connected

An updated youth services directory is to be created and made available via social media which is an appropriate medium for youth in regard to independent access. It currently includes community and health services and will be expanded based on information gathered from the youth council. More work is underway relating to this goal (see Appendix One for details) Providers report a greater level of connectedness with the strengthening of the management

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

of Directions. Confidence in the multidisciplinary team that operates from this provider is growing. Its strength is in providing service support to the population of Hastings. Areas for development is extending this to the population of Napier.

Goal 3: Productive:

Local councils operate youth projects aimed at preparing youth for a life of productivity and academic success. Rangatahi services support connecting youth to programmes that ensure they have Levels 1-2-3 NCEA in readiness for the workplace and or training. HBDHB contributes to this by operating the incubator programme and participation in the annual careers expo designed to give youth a taste of the varying careers available in health.

Goal 4: Health System Resiliency:

Supporting transgender issues is at the fore in regard to the 'sense of belonging that youth feel when engaging and connecting with services. Work in this area will continue to be a focus in 2018-19 as we prepare the workforce to be more ably suited to work with rangatahi and specifically LGBTI. The Use of HEADSS across all of sector agencies is a means of supporting positive youth relationships. Work is underway to ensure the health workforce take up the training being provided locally.

Goal 5: Community Inclusiveness

Investing in youth to participate in decisions that affect them is a powerful motivator for change. Establishing a governance group by youth for youth meant that rangatahi have influence on planning that impacts on their peers. The work of the youth consumer council is ongoing and connecting this council with youth governance groups within Hawke's Bay is part of the mahi of this strategy.

3.0 Stakeholder engagement

- 3.1 The Youth Strategy and Zero fees for 13-17yrs has built a strong consumer and stakeholder network that are consulted to inform planning and reporting. The list of stakeholder involvement includes; Youth Consumer Council, Local body Youth Councils (representative of our Local Territorial Authorities), Directions Youth Health Centre, HBDHB School Based Health Services and the PHNs within that service, General Practice Teams, Prima Volta Charitable Trust, PHO, YCON, and YMCA/YWCA.

4.0 Highlights (and challenges)

- 4.1 The Youth Consumer Council has been sustained over a period of 2 yrs since its establishment. Representatives from the council are frequently requested for their input in many forum both in health and across sector. Links between the HBDHB consumer council and local body councils.
- 4.2 SBHS enhanced (nurse hours) has seen positive results. There was some disquiet with the reduction of GP hours within schools, however this coincided with the introduction of the zero fees for 13-17yrs and funding made available for access to a GP for any presenting student to have access to GP services.
- 4.3 Increased utilisation of the Directions Youth Health service has been observed and this trend is encouraging. This increase is thought to be attributable to the relocation of the service closer to the city centre. Growing the multidisciplinary team within this service is positive as we move to creating opportunities for rangatahi to access services through normalising health seeking behaviours
- 4.4 Zero fees for 13- 17 year olds at general practices has now been fully implemented in 13 of the 14 eligible practices. This initiative provides free consultation with members of the general practice team. An additional benefit of the initiative is that it provides early opportunity to engage and foster therapeutic relationships with the young people and members of the practice team. (Appendix Two) Consultation rates have met the projected forecast of 2.15 visits per annum,

however there are still youth registered with a general practice who have no contact with this service. Work is underway to determine if they have been able to access services elsewhere (Directions, SBHS etc) or have utilised ED as a primary care provider.

- 4.5 The zero fees funding was provided to the practice team in order to enhance the utilisation of the full general practice team, not solely GPs. This has been a positive step in models of care change that see multidisciplinary teams included in general practice; e.g. social worker, counsellors, health care assistants, navigator's et.al.

Challenges

- 4.6 There is currently a review being carried out at Ministry of Health level of all Mental Health Services (nationally). Hawke's Bay is hosting the ministry panel of enquiry in the week 4-8 June. The findings from this review will highlight the areas of strength and development for Hawke's Bay. Preliminary local findings is that mental health is an area that needs strengthening.
- 4.7 There still exists low consultation rates for 13-17yr olds within general practice; 56% have 0-1 consults per annum when registered with a practice. Investigation into this is underway (see para 4.4 above)
- 4.8 Sexual Health Services in Hawkes Bay continue to see an equity gap in our rangatahi accessing this service particularly our tane. Further implementation of the Youth Health Strategy and development of a regional Sexual Health Strategy will set a clear direction for this service in the future.

5.0 Recommendations and next steps

- 5.1 Monitor access of young people 13-17 years to their general practice teams and the Emergency Department and respond to trends and/or equity gaps.
- 5.2 Provide comparative general practice consult and utilisation data between practices in the program and those outside of the program to fully demonstrate its impact on rangatahi health seeking behaviours.
- 5.3 Promote the zero fees for 13-17 year olds widely and at touch points where these young people are known to come together or access ie secondary schools, career expos, Kapa Haka competitions and on social media via the youth consumer council Facebook page.
- 5.4 Strengthen the cluster plans in the zero fees 13-17 to ensure collaboration and coordination of services and referral pathways for rangatahi are in effective in meeting their needs.
- 5.5 Supporting primary care to include 'behaviourist type roles' as part of model of care development.
- 5.6 Implement the transgender pathway for young people in Hawke's Bay who are seeking support with gender issues.

**Appendix One – HBDHB Youth Health Strategy
2018-19 Action Plan**

Goals	Outcome relates to	Objective	Activities	Who ...
Goal 1: Youth report that they are healthy & safe	Social connectedness	<p>System wide use of HEADDs assessment across primary care services to support an appropriate referral process if required.</p> <p>Proactively address absenteeism / behaviour issues due to health or social issues.</p>	<p>HEADDs -90% coverage rate in SBHS environment. Appropriate follow up completed with consent and actioned this includes connecting to whanau for relevant support.</p> <p>HEADDs assessment training is being offered locally by the SYPHANZ group. It is open to anyone who works with young people.</p> <p>Facilitate up skilling of ED staff in their interactions, assessment and treatment of youth.</p>	<p>PHNs GP clinical teams. Youth Workers DYS ED Staff</p>
	Emotional wellbeing	<p>Maintain the services currently provided by Directions.</p> <p>Ensure workforce development around mental health is ongoing for youth workers.</p> <p>Use utilisation data to inform the mental health inquiry currently in play</p>	<p>Nurses from participating 13-17year old free fees practices have participated in a mental health credentialing process. Youth are accessing this service in the general practice they are enrolled in.</p> <p>SBHS nurses are regularly being up skilled and credentialed in the area of mental health. There are currently 12 nurses completing this process.</p> <p>Wellington Youth Workers Collective have delivered in HB a free workshop on gender diverse youth.</p> <p>School nurses are screening young people's mental health status in the school environment. Brief interventions occur or referrals to the school counsellors or one of the providers of mental health services locally are actioned.</p> <p>Additional new Ministry of Health funding will see the SBHS service provision grow across more secondary schools.</p>	<p>DYS MoE Practice Nurses SBHS Peers CAFS SWIS Te Kupenga O Ahuriri. NEETS</p>

	Avoidance of risky behaviours	Minimise the possibility of youth engaging in behaviours that put their wellbeing at risk.	<p>YMCA are working with Oranga Tamariki to transition young people back to school who have disengaged.</p> <p>Promote the free health and social services of the SBHS, Directions and 13-17 year olds general practice access.</p> <p>13-17 year old free GP access has been promoted through social media and increased utilisation of the general practice teams has been observed.</p> <p>Plans are in progress to advertise SBHS and Directions services via the same mechanism.</p>	YCC General Practice SBHS DYS YMCA
Goals	Outcome relates to	Objective	Activities	Who ...
Goal 2: Youth report they feel connected	Community Connectedness	An up to date directory of youth services is available via various mediums and widely distributed so that youth are aware of services available.	<p>An audit has been undertaken of the current youth services directory as a result local councils, MSD MoE, HBDHB and youth are working together to update and maintain this resource.</p> <p>The resource will be available at the touch points where there are youth connections. Additionally, the resource will be available and advertised online.</p> <p>Whanau Tahi is an electronic universal mechanism by which young people can be referred to a variety of services within the sector.</p>	HBRC HDC NDC MSD MoE HBDHB YCC

Goals	Outcome relates to	Objective	Activities	Who ...
Goal 2 (cont.)	Positive Relationships	Youth experience positive relationships	<p>Directions youth services currently provide informal peer support as well as a place to “be” for the young people of the region. Young people can engage in a variety of physical activities and sharing of food.</p> <p>Resilience building workshops for youth have been occurring in decile 1-3 secondary schools these have been well received and there has been very positive feedback from participants and the schools.</p> <p>Suicide prevention workshops have been held by Te Tai Timu these have been well attended.</p> <p>YMCA holiday programme targets older participants to mentor younger ones and in doing so creates an opportunity for youth to be role models.</p>	DYS PHO Te Tai Timu YMCA
	Leadership Development	Youth are provided with an opportunity to be leaders	<p>Establishment of a formal peer mentor group within Directions is underway. Within this group there will be youth who will assume leadership roles within the group.</p> <p>The YMCA encourages the older group attending their school holiday programmes to assume leadership roles and run parts of the programme.</p>	DYS HBDHB YMCA

Goals	Outcome relates to	Objective	Activities	Who ...
Goal 3: Productive	Workforce Readiness	Young people are assisted to develop the skills and attitudes they need to take a positive part in society, now and in the future.	HDC currently run a programme called “Youth Connector” Working with service providers or youth to assist with training, interviewing skills and preparations of CVs in readiness for the workforce. Each repetition of this cycle sees approx. 12 young people through the programme. NEETS (Not in employment education or training) support youth to complete academic national standards then transition to the workforce.	HDC Te Taiwhenua O Heretaunga YCON
	Career Awareness	Youth are aware of career opportunities and have a thorough knowledge of what is required to pursue their chosen career pathway.	Every year the careers expo is held in conjunction with EIT and MoE in Hawkes Bay. Youth from secondary schools and alternative education institutions arrange for youth to attend this.	HB Secondary Schools NZ Army NZ Navy HBDHB EIT Massey University

Goals	Outcome relates to	Objective	Activities	Who ...
Goal 4: Health System Resiliency	Commitment to Adolescents and Youth Development	There are well established programmes within the community where the focus is early intervention/prevention to divert young people away from criminal activity.	<p>Collaboration and consultation around youth development and programmes have occurred with both the Hastings District and Napier City council this quarter.</p> <p>Efforts to create protective environments in a wider context has seen the HBDHB recently endorse a report outlining the evidence showing that underage exposure to alcohol causes harm. A particular focus is on events held on school grounds where children are present. As a result of this endorsement, schools in HB will be encouraged to develop a school alcohol policy. A public statement and alcohol-free fundraising guide is being developed.</p>	HBDHB NCC HCC MoE
	Partnerships and Collaborations for Youth Health Development	All sectors of the community will co-design youth development with the young people at the forefront.	Refer to Leadership development in Goal 2	
	Data Collection collation and analysis	To use health system data to inform program decisions that have a positive impact on youth. Use utilisation data to inform the mental health inquiry currently in play	Utilisation of the zero fees for 13-17yr olds has shown an increase in access to the general practice teams. Equity for Maori and Pacific remains a challenge. Work to address this includes promoting the service in secondary schools, emergency departments, urgent care facilities and	General Practice HBDHB

Goals	Outcome relates to	Objective	Activities	Who ...
Goal 5: Community Inclusiveness	Youth as community change agents	Youth are involved with local iwi to work with young people.	The youth consumer council have submitted a proposal to the Hastings District Council for funding to work with local iwi and youth around exam readiness and life skills that include budgeting, food preparation and culinary skills.	YCC TTOH HDC
	Youth Involved in Governance	Youth have the mandate to lead and support themselves as a group to achieve what youth need/want.	A youth governance group is currently being established to support the Mahi of Directions youth services. Two high profile community members and a counsellor from William Colenso secondary school have volunteered to guide the group to ensure good governance and a commitment to youth during this process.	Directions HBDHB Ben Evans Ken Foote
	Youth involved in Organisational Decision Making	Youth are provided with the forum to have their voice heard around proposed health service delivery.	Representatives from the Youth consumer council have contributed to the CSP at every community consultation evening.	HBDHB Directions

Abbreviations

DYS	Directions Youth Services	NCC	Napier City Council
GP	General Practice	NEETS	Not in Education Employment or Training.
HBDHB	Hawkes Bay District Health Board	PHN	Public Health Nurses
HBRC	Hawkes Bay Regional Council	PHO	Primary Health Organisation
HCC	Hastings City Council	SBHS	School Based Health Service
MoE	Ministry of Education	SWIS	Social Worker in Schools
MoH	Ministry of Health	YCC	Youth Consumer Council
MSD	Ministry of Social Development	YCON	Youth Council of Napier



Update on Implementation of the HBDHB Zero fees 13-17yrs

Author(s):	Jill Garrett
Designations:	Strategic Services Manager – Primary Care
Date:	June 2018

RECOMMENDATION

That Māori Relationship Board, Clinical Council and Consumer Council

- Note the contents of this report

Definitions:

Consultation rate	Consultation rates show the number of times on average that consumers within this age bracket will access the primary health care team where they are enrolled ³ . The programme is funded on an average consult rate of 2.15 per annum
Utilisation rates	Utilisation rates illustrate what percentage of the enrolled population access services where they are enrolled.

1.0 BACKGROUND INFORMATION

- 1.1 **The aim of the zero fees for 13 -17 is to provide free access to our high needs youth population and in so doing promote confidence in the use of the health care system to support proactive health seeking behaviours.**
- 1.2 In 2016 proposals were presented to HBDHB committees for the funding of zero fees for 13-17year olds by the HBDHB. It was agreed that coverage of 67% of our Maori and Pasifika populations could be provided for through the funding that was made available (\$563,000). Practice eligibility was determined by registered population within this age band of ≥30% or ≥100. This resulted in fourteen practices being eligible for the program.
- 1.3 Approval by the board was granted in November 2016, Preparation for programme implementation started in January 2017. Rolling start dates began from 1 July, with a number of practices already offering zero fees for this cohort of enrolled patients. (See table 1.0 below). Tukituki Medical was the 14th practice offered the programme but to date they have declined.
- 1.4 Prerequisites to being eligible for the programme is completion of the RNZGP Primary Care Youth Friendly Audit. Quarterly reporting is a prerequisite of the programme and consists of;
 - a. Progress against actions identified from the RNZGP Youth Friendly audit⁴
 - b. ED presentations and admissions: Skin, Respiratory, AoD, Sexual Health, and Mental Health (*pertaining to practices within the programme*)

³ Note the programme provides for free access to 13-17yr olds when they access the practice where they are enrolled.

⁴ Examples of cluster plans attached.

- c. Consultation and utilisation rates of General Practice demonstrating access by eligible population and to the health care team so as to meet the needs of the rangatahi presenting.
- 1.5 Practices were invited to be part of a cluster according to geographical location. This was well received by the practices and recognised as a means of sharing resources and ideas. Two practices have chosen to opt out of this structure, one to work independently and the other to not engage in the programme.
- 1.6 Programme wide comparable reporting commenced in Q3 due to the rolling start date of the clusters / practices. Tukituki medical is the only practice to opt out of the programme, citing reporting requirements as the reason. Table 1.0 below lists the practices in the programme and their respective start dates.

Table 1.0 – Rolling start date – zero fees 13-17yrs

General Practices offering zero fees 13-17yrs	Start dates
Hauora Heretaunga ⁵	Pre 1 July
Hastings Cluster	
Totara Health, Medical and Injury,	Pre 1 July
Doctors Hastings (Inclusive of Gascoigne and Waipawa)	1 October
Hastings Health Centre	1 November
Wairoa Cluster	
Wairoa Medical, Queen Street Medical, Health Care Centre Ltd	1 July
Napier Cluster	
Maraenui Medical	1 July
The Doctors Napier, Tamatea Medical,	1 December

*Drs Hastings Group

Reporting against evaluation framework

Evaluation of the programme is based on the evaluation framework established at programme outset. (See Appendix One).

2.0 CLUSTER PLANS

- 2.1 Each cluster was required to complete recognised audit based around being youth friendly. Two options were provided that of the RNZGP network and that of recognised leader within adolescent health for New Zealand Dr Sue Bagshaw. All practices within the programme have completed this and used the findings to generate their own action plan.
- 2.2 Key items within the plans include, training of staff in supporting rangatahi to utilise services available, linkages with other youth based services for ease of referral and follow up, employment of youth workers within the team, identifying youth champions within the team advertising of the programme to raise awareness, promoting the use of manage my health – patient portal by youth, improved communication developed by rangatahi to promote what services are available and the confidentiality they can have faith in when engaging with the services.
- 2.3 The cluster plans include three activities that are common to all members for economy of resourcing and one individual activity. As we move towards the commencement of the new financial year and contracting, the cluster will be encouraged to revisit the audit and evaluate against progress made to date.
- 2.4 Included in those activities will need to be a focus on how to engage rangatahi in health promoting, and normal health seeking behaviours, as we now have the data that tells us that

⁵ Hauora Heretaunga is operating separately to the cluster currently as they had wanted to consolidate internal processes and systems for meeting the needs of youth before joining a cluster.

56% of consumers in this cohort only have 0-1 contacts with their health care team within a 12 month period. Research tells us that early engagement in health seeking behaviours lead to better health outcomes in adulthood.

3.0 CONSULTATION AND UTILISATION RATES:

- 3.1 Rates at which youth access primary care has now been broken down into two dimensions for evaluation purposes. Initially consultation and utilisation rates were terms used interchangeably. They are now distinguished as outlined under definitions above.
- 3.2 Currently the funding buys out-patient co-payments.⁶ The rates are \$53.75 p.a. per registered patient (VLCA practice) and \$63.43 p.a. (non VLCA practice) for an anticipated consultation rate of 2.15 p.a.
- 3.3 Consultation rates for the programme (See Appendix Two for full summary)

Consult rate ⁷	Māori	Pasifika	Other
2014 – 2016 ⁸	1.61	1.23	1.80
2017 - 2018 ⁹	2.21	1.97	2.50

3.4 Consultation rates per cluster

	Equity Gap ¹⁰	Māori	Pasifika	Other
Napier	-0.65	2.18	1.75	2.83
Wairoa	-0.49	2.65	*	3.14
Hastings	-0.26	2.15	2.08	2.41

*Insufficient numbers

- 3.5 Whilst the consult rate has met expectations and is predominantly over the threshold of the 2.15 funded rate, an equity gap still exists and the utilisation data provides a different narrative.
- 3.6 Utilisation has been made available to the clusters for the first time in quarter three. On consultation with the clusters, the focus needs to be on the 0-1 consults p.a. cohort rather than the 4 and 6+ who are known to the practice due to their health needs warranting this level of contact.

3.7 Utilisation rates for the programme (See Appendix Two for full summary)

Utilisation rates - programme	Number	0-1 Consults	2-3 Consults	4-5 Consults	6+ Consults
Maori	3418	57%	21%	10%	12%
Pasifika	505	65%	19%	9%	9%
Other	4,140	54%	22%	11%	13%

3.8 Utilisation rates per cluster (See Appendix Two for full summary)

Utilisation rates	Number	0-1 Consults	2-3 Consults	4-5 Consults	6+ Consults
Napier Cluster					
Maori	989	60%	18%	10%	12%

⁶ Alternatives to how the funding could be allocated was discussed at length with practices prior to programme start. Options discussed were packages of care being allocated to only those youth in need, identified by the practice.

⁷ Consultation rates includes GP and Nurses, recognising the use of the general practice team support and management of this cohort

⁸ Pre implementation

⁹ 1 May 2017-30 April 2018, reflects the rolling start dates of the practices involved. Napier cluster were the last to come on board in Dec 2017.

¹⁰ Equity gap between Māori and Other

Pasifika	122	66%	24%	5%	6%
Other	1229	54%	21%	10%	15%

Utilisation rates	Number	0-1 Consults	2-3 Consults	4-5 Consults	6+ Consults
Hastings cluster					
Maori	1,844	57%	22%	9%	12%
Pasifika	379	63%	17%	11%	9%
Other	2,437	53%	23%	12%	12%

Utilisation rates	Number	0-1 Consults	2-3 Consults	4-5 Consults	6+ Consults
Wairoa Cluster					
Maori	459	54%	20%	12%	15%
Pasifika	4				
Other	109	53%	17%	13%	17%

- 3.9 Work will commence in quarter 4 to analyse the NHIs for this cohort against ED data and to determine if there is engagement with ED instead of primary care and if so what work can be done to reengage these consumers.
- 3.10 All practices within the programme recognise there is work to be done to normalise health seeking behaviours with this cohort and promoting proactive engagement for education and advice as the first step. Group appointments where rangatahi bring friends with them to their appointments is openly encouraged as one mechanism for achieving this.

4.0 ED PRESENTATIONS AND ADMISSIONS:

- 4.1 The evaluation framework identifies that proactive use of primary care may have an impact on ED presentations and admissions.

ED Utilisation for top 4 conditions¹¹ by programme

ED Utilisation for top 4 conditions¹² by cluster 12 months to 30 April 2017

ED utilisation data 13-17yrs¹³	AoD	Mental Health	Respiratory	Skin
Hastings cluster	29	22	91	62
Napier	8	12	13	7
Wairoa ¹⁴	1	1		1

ED Utilisation for top 4 conditions¹⁵ by cluster 12 months to 30 April 2018

ED utilisation data 13-17yrs¹⁶	AoD	Mental Health	Respiratory	Skin
Hastings cluster	51	48	100	44
Napier	9	21	17	12
Wairoa ¹⁷	3		1	2

¹¹ Sexual Health non identifiable within list of event reason groupings. This will be addressed in Q4 reporting

¹² Sexual Health non identifiable within list of event reason groupings. This will be addressed in Q4 reporting

¹³ Cohort of consumers registered with eligible practices

¹⁴ Wairoa ED Hastings presentations only

¹⁵ Sexual Health non identifiable within list of event reason groupings. This will be addressed in Q4 reporting

¹⁶ Cohort of consumers registered with eligible practices

¹⁷ Wairoa ED Hastings presentations only

- 4.2 Next steps is the matching of ED and Practice utilisation data for those with a practice utilisation rate of 0-1 to determine if ED is being utilised as the primary care provider. The cluster plan would then be used to identify targeted actions to engage those rangatahi in normalising health seeking behaviours using the primary care team as their health care home.

5.0 GENERAL COMMENTARY

- 5.1 There has been open sharing of data and cluster plans across the programme. Now that all practices have been fully engaged in the programme for one quarter opportunities to meet at programme level will be created to compare data (anecdotal, quantitative and qualitative) to inform next steps.

- 5.2 Questions have been asked as to the reporting requirement for this funding when U13s (and soon to be U14s) has no expectations attached.

- 5.2.1 Cluster plans: The programme lead sees it as important to continue this expectation as the cluster plan provides the mechanism to evaluate against a recognised youth friendly audit tool

- 5.2.2 The consultation, utilisation and ED presentation data provided by the PHO and DHB provides valued data that the clusters are now beginning to utilise purposefully.

- 5.3 Sexual health service provision is funded via the Coordinated Primary Options (CPO) Programme (sexual health contract) and it is also an expectation that consults relating to sexual health will be covered with the zero fees 13-17 contract. Analysis of any overlap and potential double funding is underway. Contracts for both programmes now make it the prioritisation of funding to be used explicit.

- 5.4 Appreciation of the zero fees is illustrated by comments made by practice managers involved in the programme as listed below;

“Group consults are common where rangatahi bring a friend or refer a friend does indeed promote normalising of health seeking behaviours.”

“This programme has been a journey of severe joy, being able to provide care free.”

“One young woman was so sick she had no idea and would not have come in if she had had to pay”

- 5.5 Advertising of the programme is limited. It is advertised within the practices involved, in the school based health services, Directions and pharmacies. The zero fees programme was launched with limited media coverage outside of the providers. Re advertising and alternative advertising needs to be considered as one means of improving utilisation by enrolled populations.

6.0 PHARMACY

- 6.1 There is high levels of good will with the pharmacies to provide this service
- 6.2 Currently the pharmacy software does not enable automatic identification of these patients for ease of system recording. The scripts are identified at practice level but the volume of scripts processed without an automatic system is creating issues in reporting and claiming. If this cannot be resolved within the two year pilot alternative actions may need to be put in place to facilitate an automated system.
- 6.3 Pharmacy funding was provided based on anticipated volumes measured against the 2.15 consultation rates and previous quarterly pharmacy warehouse data. Current data is showing that actual pharmacy utilisation is lower than anticipated. 2108-19 funding levels to individual pharmacies will be guided by the current consultation rates.

7.0 NEXT STEPS FOR CONSIDERATION

- 7.1 The introduction of the U14 MoH funded initiative shifts the potential costing of the programme with its current practice participation from \$451,300 to \$355,266 a per annum saving of 96,034. U14s is flagged to commence in Dec 2108 giving a potential saving of \$64,022.¹⁸
- 7.2 Clusters have indicated they would like the opportunity to explore options for utilising the savings to improve service provision and connectedness. This needs to be balanced with the recognition that up to 56% of enrolled populations are currently not utilising their capitation funding.
- 7.3 NHI data matching for ED presentations and Practice Utilisation rates needs to inform activities within the 2018-19 cluster plans
- 7.4 Training of front of house staff is recognised by all clusters as an area that needs focus as illustrated in findings from the youth friendly audits. Work is underway to identify training opportunities locally and at low cost. HEADSS assessments is a priority.
- 7.5 Strengthening links with youth related services and an extended primary care team such as social workers, youth health workers, AoD support, mental health counsellors will be discussed at the zero fees 13(14) -17 forum being planned.
- 7.6 Strengthening links with the education sector and Ministry of Social Development to socialise the programme and strategy to foster a multisectorial approach to support the intentions.
- 7.7 Pharmaceutical (script) claiming will be closely monitored in lieu of the currently experienced low pharmacy utilisation rates.
- 7.8 Provide comparative data from a regional control group.

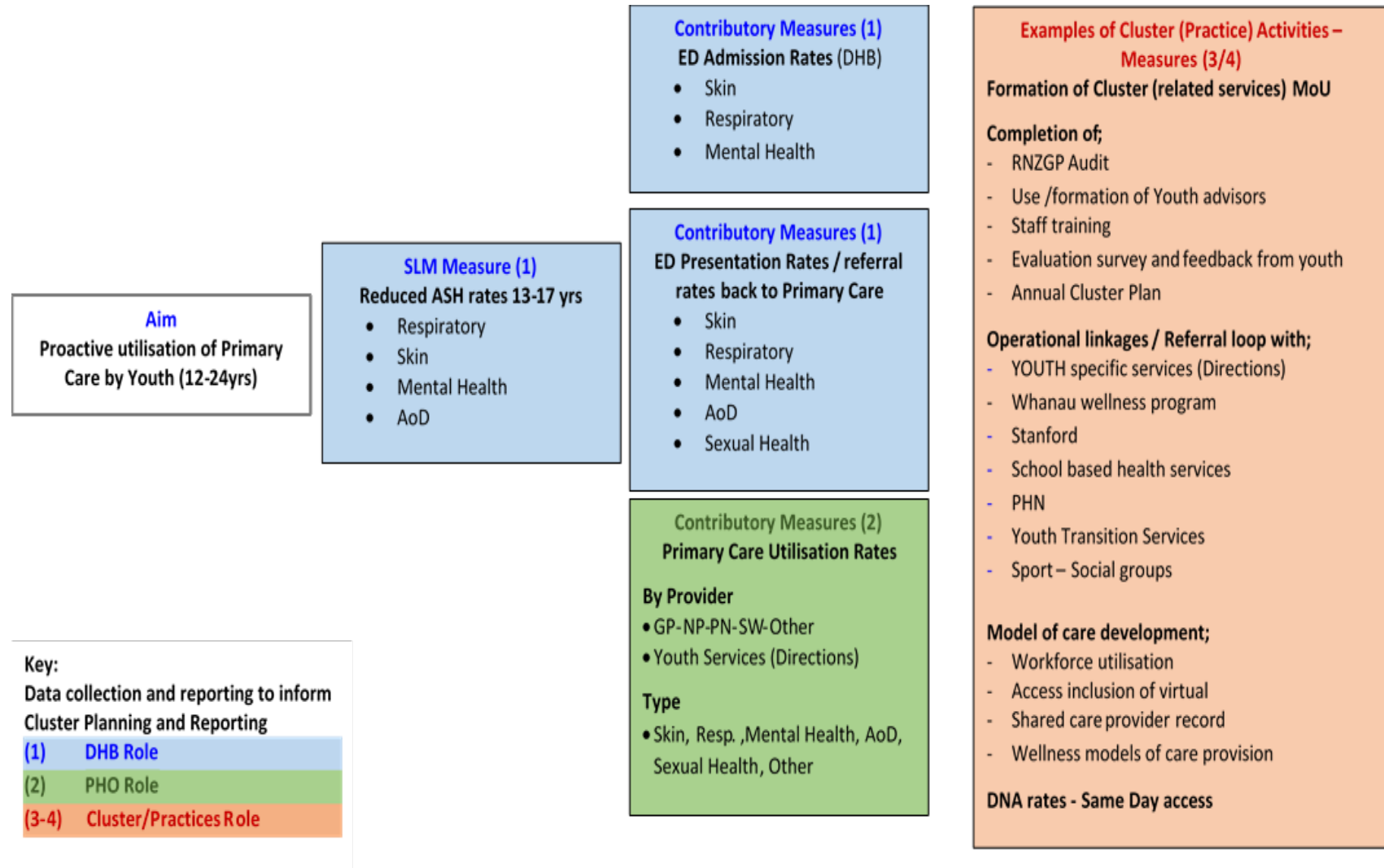
ATTACHMENTS:

Appendix One: Evaluation Framework – zero fees 13-17yrs

Appendix Two: Consultation and Utilisation Rates (Primary Care)

¹⁸ Eight months of savings.

Appendix One: Evaluation Framework – zero fees 13-17yrs



Appendix Two: Consultation and Utilisation Rates (Primary Care)

13-17 Year Olds 12 Month To 30 April 2018 Capitation Consultations											
Age as at 31 March 2018											
Programme Average Consultations - Total						Programme Average Consultations - Maori					
12 Months to 30 April 2018						12 Months to 30 April 2018					
Practice	Total Patients	Ave GP Consults	Ave Nurse Consults	Ave Total Visits	Nurse to GP Ratio	Practice	Total Patients	Ave GP Consults	Ave Nurse Consults	Ave Total Visits	Nurse to GP Ratio
CHB Cluster	497	1.43	0.36	1.79	20%	CHB Cluster	126	1.47	0.35	1.82	19%
Hastings cluster	4,660	1.82	0.46	2.28	20%	Hastings cluster	1,844	1.62	0.53	2.15	25%
Napier cluster	2,340	1.88	0.62	2.50	25%	Napier cluster	989	1.57	0.61	2.18	28%
Wairoa Cluster	572	1.22	1.51	2.73	55%	Wairoa Cluster	459	1.20	1.45	2.65	55%
Grand Total	8,069	1.77	0.57	2.35	24%	Grand Total	3,418	1.54	0.67	2.21	30%
Programme Average Consultations - Pasifika						Programme Average Consultations - Other					
12 Months to 30 April 2018						12 Months to 30 April 2018					
Practice	Total Patients	Ave GP Consults	Ave Nurse Consults	Ave Total Visits	Nurse to GP Ratio	Practice	Total Patients	Ave GP Consults	Ave Nurse Consults	Ave Total Visits	Nurse to GP Ratio
CHB Cluster	6				0%	CHB Cluster	365	1.44	0.37	1.81	20%
Hastings cluster	379	1.54	0.55	2.08	26%	Hastings cluster	2,437	2.02	0.40	2.41	16%
Napier cluster	122	1.26	0.48	1.75	28%	Napier cluster	1,229	2.19	0.63	2.83	22%
Wairoa Cluster	4				67%	Wairoa Cluster	109	1.36	1.78	3.14	57%
Grand Total	511	1.45	0.53	1.97	27%	Grand Total	4,140	2.00	0.50	2.50	20%

Programme utilisation - Pasifika						Programme utilisation - Other					
12 Months To 30 April 2018						12 Months To 30 April 2018					
Practice	Total Patients	0-1 Consu Its	2-3 Consu Its	4-5 Consu Its	6+ Consu Its	Practice	Total Patients	0-1 Consu Its	2-3 Consu Its	4-5 Consu Its	6+ Consu Its
CHB Cluster	6					CHB Cluster	365	59%	25%	7%	8%
Hastings cluster	379	63%	17%	11%	9%	Hastings cluster	2,437	53%	23%	12%	12%
Napier cluster	122	66%	24%	5%	6%	Napier cluster	1,229	54%	21%	10%	15%
Wairoa Cluster	4					Wairoa Cluster	109	53%	17%	13%	17%
Grand Total	505	65%	19%	9%	9%	Grand Total	122	54%	22%	11%	13%