BOARD MEETING

Date: Wednesday, 25 May 2016

Time: 1.00pm

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

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

Apologies:

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

Board Administrator: Brenda Crene

Public Agenda

Item	Section 1 : Agenda Items	Ref #	Time (pm)
1.	Karakia		1.00
2.	Apologies		
3.	Interests Register		
4.	Minutes of Previous Meeting		
5.	Matters Arising - Review of Actions		
6.	Board Workplan		
7.	Chair's Report - verbal	-	
8.	Chief Executive Officer's Report	40	
9.	Financial Performance Report	41	
10.	Consumer Story (Kate Coley)	-	

	Section 2: Reports from Committee Chairs	Ref #	**Time (pm)**
11.	HB Health Consumer and Clinical Council (Graeme Norton & Chris McKenna)	42	1.50
12.	Reappointments to HB Health Consumer Council (Ken Foote)	43	
13.	Māori Relationship Board (Deputy Chair, Heather Skipworth)	44	
	Section 3: For Decision		
14.	Final Draft of HBDHB Annual Plan 16/17 *available 24 May* (Tim Evans/Carina Burgess)	45	2.20
15.	Best Start: Healthy Eating and Activity (Dr Caroline McElnay / Shari Tidswell)	46	2.30
16.	Budget Update and Investment Prioritisation – verbal (Dan Druzianic)	-	2.40
	Section 4: For Information / Discussion		
17.	Travel Plan update – verbal (Sharon Mason / Andrea Beattie)	47	3.10
18.	Customer Focused Booking (Sharon Mason / Carleine Receveur)	48	3.20
19.	Information Service Function Review (Tim Evans)	49	3.35
	Section 5: Monitoring		
20.	Transform and Sustain Strategic Dashboard Q3 Jan-Mar16 (Tim Evans)	50	3.45
21.	HBDHB Non-Financial Exceptions Report Q3 & MoH Dashboard Q2 (Tim Evans)	51	3.50
22.	Annual Maori Health Plan Q3 Dashboard (Tim Evans / Tracee TeHuia)	52	3.55
23.	Human Resource KPIs Q3 (John McKeefry)	53	4.00
24.	Te Ara Whakawaiora / Cardiovascular (John Gommans)	54	4.05
	Section 6: Recommendation to Exclude		
25.	Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	**Section 7: Agenda Items**	Ref #	**Time (pm)**
26.	Minutes of Previous Meeting		4.15
27.	Matters Arising – Review of Actions		
28.	Board Approval of Actions exceeding limits delegated by CEO	55	
29.	Chair's Report (verbal)		
	Section 8: Reports from Committee Chair		
30.	Finance Risk & Audit Committee (Dan Druzianic)	56	4.25
31.	HB Health Consumer and Clinical Council (Graeme Norton & Chris McKenna)	57	
32.	Māori Relationship Board (Heather Skipworth, Deputy Chair)	58	
	Section 9: General Business		

Next Meeting: 1.00 pm, Wednesday 29 June 2016
Te Waiora (Boardroom), HBDHB Corporate Administration Building

Tauwhiro Rāranga te tira He kauanuanu Ākina

Board "Interest Register" - 30 March 2016

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Kevin Atkinson (Chair)	Active	Chair of Unison Networks Limited	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair of FRAC	18.02.09
	Active	Director of Unison Fibre Limited	Non pecuniary interest. Unison is now a provider of high speed broadband to the District Health Board.	Will not take part in any decision or discussions in relation to the provision of high speed broadband to the District Health Board	The Chair of FRAC	17.11.10
	Active	Director of Hawke's Bay Rugby Football Union (HBRFU)	HBDHB has a sponsorship arrangement with HBRFU.	Will not take part in any decisions or discussion in relation to the sponsorship arrangement.	The Chair of FRAC	
	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussion in relation to the Trust	The Chair of FRAC	Mar-11
Ngahiwi Tomoana (Deputy Chair)	Active	Chair, Ngati Kahungunu Iwi Incorporated (NKII)	Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB: (i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department. (ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department.	Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB.	The Chair	01.05.08
	Active	Brother of Waiariki Davis	Perceived Conflict of Interest. Non-Pecuniary interest. Waiariki Davis is employed by HBDHB and is the Health Records Manager.	Will not take part in any decisions in relation to Health Records management. All employment matters in relation to Waiariki Davis are the responsibility of the CEO.	The Chair	01.05.08
	Active	Uncle of Tiwai Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Tiwai Tomoana is employed by HBDHB and is a Kitchen Assistant in the Food and Nutrition Department at Hawke's Bay Hospital.	All employment matters in relation to Tiwai Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Uncle of Iralee Tomoana	Iralee Tomoana is employed by HBDHB and works in the Radiology Department as a clerical assistant.	All employment matters in relation to Iralee Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Brother of Numia Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Numia Tomoana is employed by Cranford Hospice and works as a palliative care assistant and, in this role, works with chaplains at Hawke's Bay Hospital.	Will not take part in any decisions in relation to the Chaplain service at Hawke's Bay Hospital.	The Chair	01.05.08
Barbara Arnott	Active	Trustee of the Hawke's Bay Air Ambulance Trust	HBDHB has a partnership contract with Skyline Aviation who together operate the HB Air Ambulance Service which is supported by the Trust.	Declare this interest prior to any discussion on the HB Air Ambulance Services and Chair decides on appropriate mitigation action	The Chair	10.05.10
Helen Francis	Active	Alzheimer's Napier previously a Committee member Patron and Lifetime Member	Alzheimer's Society holds a contract with the HBDHB to provide dementia specific daycare and community services.	Will not take part in any decisions or discussion in relation to HBDHB contract with Alzheimer's Society	The Chair	08.06.10 21.06.14
	Active	Employee of Hastings Health Centre	Actual Conflict of Interest. Pecuniary Interest.	Will not take part in any decisions or discussions in relation to Hastings Health Centre.	The Chair	18.02.09
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.11
	Active	HB Medical Research Foundation	Trustee	Declare this interest prior to any discussion in relation to the Foundation, and an appropirate mitigation action is decided on.	The Chair	20.08.14
Diana Kirton	Active	Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB.	Perceived Conflict of Interest. Non-Pecuniary interest.	Will not take part in any decisions in relation to surgical services provided by or contracted by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO	The Chair	18.02.09
	Active	Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014	Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers.	Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on.	The Chair	16.01.14

Board Meeting 25 May 2016 - Interests Register

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
	Active	Son, Chris Kirton, GP in Wairoa employed by HBDHB	Non-pecuniary interest: Will not take part in discussions around employment of GP's in Wairoa	All employment matters are the responsibility of the CEO.	The Chair	26.02.14
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.14
Dan Druzianic	Active	Director of Markhams Hawke's Bay Limited	Potential Conflict of Interest. Some clients may from time to time be employed by or have contracts with HBDHB	Declare an interest at any time an issue arises concerning a client, and take no further part in any decision or discussion on this matter.	The Chair	7.12.10
	Active	Director of Hawke's Bay Rugby Football Union (HBRFU)	HBDHB has a sponsorship arrangement with HBRFU.	Will not take part in any decisions or discussion in relation to the sponsorship arrangement.	The Chair	7.12.10
Denise Eaglesome	Active	Deputy Mayor of Wairoa District Council	Advocate as Deputy Mayor for Wairoa District, whereas HBDHB covers whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	28.02.11
	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussions in relation to the Trust.	The Chair	05.03.14
	Active	Coordinator for Health Contract for Rugby Academy in Wairoa	Health Contract with Wairoa Rugby Academy	Will not take part in any decisions or discussions in relation to this contract.	The Chair	25.05.15
Andrew Blair	Active	Owner of Andrew Blair Consulting Limited	Engaged from time to time to provide consultancy and advisory services to healthcare and other organisations.	Will not take part in decision relating to organistions to which he provide consultancy and advisory services.	The Chair	04.12.13
	Active	Advisor to Trustees and Management of Chelsea Hospital Trust	Engaged to provide advisory services to the Trust who own and operate the private hospital in Gisborne.	Will not take part in decisions relating to services HBDHB may from time to time engage.	The Chair	24.07.14
	Active	Advisor to Hawke's Bay Orthopaedic Group Ltd	Engaged to provide advisory services to the Group	Will not provide advice in relation to contracting, employment or relationship matters between the HBOG and HBDHB. Will not participate in any decisions made by HBDHB regarding orthopaedic services.	The Chair	19.09.15
	Active	Chair of Southern Partnership Group	Southern Partnership is to progress the facilities redevelopment of Dunedin Hospital.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	19.09.15
	Active	Director, Breastscreen Auckland Limited	Breast screening facility.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	17.12.2015
	Active	Director, St Marks Womans Health (Remuera) Limited	Womans Health facility in Auckland	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	17.12.2015
Jacoby Poulain	Active	Board Member of Eastern Institute of Technology (EIT)	Perceived conflict - HBDHB has a Memorandum of Understanding (MOU) with EIT relating to training and development in health related occupations	Will not take part in any decisions or discussions in relation to the MOU between HBDHB and EIT	The Chair	14.1.14
	Active	Councillor Hastings District Council	Potential conflict as potential advocate for Hastings District population whereas HBDHB coveres whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.1.14
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumatua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust	The Trust has a lifestyle Contract with HBDHB signed 31 January 2015 Awarded a Green Prescription Contract with HBDHB 11 February 2015	Will not take part in any discussions or decisions relating to the Contract.	The Chair	04.02.14
Peter Dunkerley	Active	Trustee of Hawke's Bay Helicopter Rescue Trust	Actual conflict of interest. The Trust provides helicopter patient transfer services to HBDHB	Will not take part in any decision or discussion in relation to any contract or financial arrangement between HBHRT and HBDHB	The Chair	15.05.14

MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 27 APRIL 2016, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.05PM

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

Apologies Dan Druzianic

In Attendance: Kevin Snee (Chief Executive Officer)
Members of the Executive Management Team
Chris McKenna and Mark Peterson (Co-Chair, HB Clinical Council)
Graeme Norton (Chair, HB Health Consumer Council)
Members of the public and media

Minutes Brenda Crene

KARAKIA

Heather Skipworth opened the meeting with a Karakia.

APOLOGIES

Nil

INTEREST REGISTER

No changes to the interests register were advised

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

CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on 30 March 2016, were confirmed as a correct record of the meeting.

Moved: Barbara Arnott
Seconded: Peter Dunkerley
Carried

MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: Budget Update following the Prioritisation Process – Verbal update to the Board in May

Item 2: Hepatitis C Clinical Pathway timing: Ongoing update in May

Item 3: Meeting with MRB Members: The CEO attended MRB's workshop and discussions were captured in the report from MRB for April.

Item 4: NZ Health Partnerships recommendations were conveyed accordingly: remove action

Item 5 TAW / Breastfeeding demographics information in CEOs report: Ongoing - with update expected in September 2016

BOARD WORK PLAN

The Board Work Plan was noted and would be updated at least to calendar year end.

The Board Chair noted the large number of agenda items listed for the May Board meeting.

Action: EMT will review the workplan.

CHAIR'S REPORT

- The Chair advised the following retirements, with a letter being sent conveying the Board's best wishes and thanks for their extended years of devoted service.

Name	Role	Service	Years of Service	Retires
Jennie Butler	Dental Therapist	Oral Rural & Community	47	14-Apr-16
Jane Harding	Registered Nurse	Surgical	19	29-Apr-16

- The NZ Health Strategy was launched (over 2 days) in mid April. Attendees found it interesting from an innovation point of view. Advised there were adverse childhood experiences and childhood development ideas to follow up on.

  There appeared to be a very close similarlarity to the HBDHB's Transform and Sustain. It would appear that HBDHB's strategy is three years ahead of the Ministry.

CHIEF EXECUTIVE OFFICER'S REPORT

The CEO's had recently received news that HBDHB were top nationally for 'hand hygiene'. The target was now 80% with Hawke's Bay achieving 89%. Well done to all those who have supported in achieving this milestone.

Regional Health Information Programme (RHIP)

The CEO's report contained a recommendation for the Board's consideration. Detail around the topic had been discussed extensively at the Regional Governance Group Meeting and it was time to move forward with certainty and implement the programme.

While financial detail is still being refined the population based funding formula share of an additional spend of $8.3m for the region to complete the programme, would mean $1.7m over three years programme for Hawke's Bay (which can be funded).

Barbara Arnott requested that HBDHB's contribution of $1.7m (as was included in the report) be noted in the resolution. This was agreed.

RESOLUTION

That the Board

1) Note the contents of this report.

In relation to Regional Health Information Programme (RHIP):

2) **That the Chairs and CEs** reconfirm the commitment of the RHIP Programme vision as per their commitment on 15 October 2015.
3) **Agree** to Deploy (build, implement and operate), the RIS, Clinical Portal (Core and Enhanced), Healthcare Practitioner Index, Regional WAN and Infrastructure to all 6 DHBs.
4) **Agree** that the Programme of deployment to other DHBs, following Whanganui's deployment,

will be subject to:
   a) The successful implementation and go live of the current planned phase of the Programme (recommendation 2 above) within the current allocated Programme budget.
   b) That there is a Post Implementation review of the Clinical Portal Implementation to ensure it is a sound base upon which to build the Enhanced Portal
   c) That there is a review of the proposed Enhanced Portal design and functionality against the existing Portal functionality as a reference to ensure it will provide additional value
   d) That there is continued independent review of the Programme.
5) **Agree** to deploy the Interim Regional Operating Model as agreed to support the Whanganui deployment as above.
6) **Note** that the Interim Service Model will need to be developed to meet the regional needs as other DHBs come onto the regional solution.
7) **Agree** to have WebPAS build and available for local implementation / uptake, initially by first Whanganui in 2016, followed by MidCentral / Wairarapa and then the remaining DHBs (timing and sequence to be advised).
8) **Agree** to the commitment of funding of up to $8.3M (in addition to the $56.2M already committed) to support the above recommendations, noting that any additional funds to be invested will be accompanied by a revised cash flow, accommodating where possible each DHB's funding availability and constraint
9) **Note** that some Chairs and CEs will need to seek Board approval for this additional funding and will do so before 30 April 2016.
10) **Note** that HBDHB's contribution would be $1.7 (as noted in the report).

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

Action Admin: **Ensure the Resolution is provided to CTAS.**

Flouridation

The governments intention for DHBs to now make decisions around fluoridation was agreed a sensible move, as DHBs are far better placed than council's to make decisions on oral health.

Indications are that since Central Hawke's Bay had removed fluoride from their water supply, their dental statistics have detrioriated.

The balance of the CEO's report was taken as read, noting the positive financial result.

FINANCIAL PERFORMANCE REPORT

The Financial report for March 2016, was reviewed showing a favourable variance of $52 thousand with a year to date result of $187 thousand favourable. Only the year to date part of the $1.0 million was transferred to Surgical Services and the $90 thousand contributed to the corporate 3% savings plan, have been released from contingency. Members were advised the $2m contingency was still available.

For clarification the $3.990million budgeted surplus includes $.99m funding provided to HBDHB by the MoH.

Clarification around Pharmac may see a claw back by Ministry of our savings.

Other areas of the report were summarised as follows:

- Good and bad offsetting each other does show a certain amount of volatility. Need to get budget work finished to enable spending in targeted areas to commence/continue.
- IDFs remain uncertain at this time.

- Strategic resource redeployment. We are now investing more resource into population health and community care and not as much into the hospital. With quarter 3 of the financial year behind us, it shows there has been a signficiant shift equating to nearly $1m.
- The quality and financial improvement plan is sitting 13% below target. Movement in budgets is taking effect in this area.
- No HR issues.

Overall we are close enough to the end of the financial year to feel confident of reaching the financial target at year end.

CONSUMER STORY

Kate Coley provided feedback on changes made in-house to date and an update on stories shared:

Services out of villa 6: A small project has been looking at accommodation pressures (ie, variety of services run out of the villa). Separation of "oncology" cancer patients in particular, due to their immunity issues has always been supported by the board.

ED front of house structural changes had been delayed, with work commencing at the end April 2016. Already, processes around triage have been changed/adapted. The EngAGEe Orbit team has been in place since February with a huge impact on reducing the number of frail elderly that would normally have been admitted through ED. Support in ED with wrap around services being provided to get them back home as soon as practical, has seen a 50% reduction in admissions.

Complaints in ED had dropped by 50%, with several complimentary stories shared at the meeting.

Customer service training has been provided to an array of staff, with complaints around the first interaction dropping considerably. This is being rolled out to Primary Care as well.

REPORT FROM COMMITTEE CHAIRS

Hawke's Bay Clinical Council

Dr Mark Peterson spoke to the report to the Board from Council's meeting held on 13 April 2016:

- Clinical Council considered Business Cases for Investment in 2015/16. All three were endorsed. These proposals had been previously approved pending the provision of the business cases.
- Best Start Healthy Eating (Draft): Council endorsed and were very supportive of the direction of travel and looked forward to reviewing the final document.

  A discussion around changing the paper to Healthy Lifestyles as opposed to Healthy Eating was raised. However it was noted the focus was healthy eating and more benefits come from this as opposed to exercise.
- The "Prioritisation Process" was underway with individual Council members already reviewing the detail (of the cases put forward). The extended Council meeting on 11 May will incorporate the prioritisation process and the Board will be updated accordingly (at their 25 May meeting).

  MRB will have the opportunity to review the prioritisation detail at their meeting on 12 May, and provide their comments to the Board.
- There will be an MRB representative attending Clinical Council meetings in the same capacity as the Chair of Consumer Council. No name had been put forward as yet.
- Asked whether Clinical Council had considered or discussed Faster Cancer Treatment, the response was they had not. It was advised this was being monitored closely and there will be action.

Hawke's Bay Health Consumer Council

Graeme Norton advised the outcomes of their meeting held on 14 April 2016.

- *Older Persons Panel* – a self-elected sub group of six (of Consumer Council) was now working with Mental Health, Older Persons and Options to establish a working panel to provide consumer engagement on various aspects of service development and delivery.
- *Health and Social Care Networks* – a sub group will work with GM Primary Care to ensure robust engagement of consumers in network development.

  Following on from presentation in February – had a meeting and a subgroup was put in place.
- *Draft Best Start Healthy Eating* (Obesity Strategy) was reviewed and felt the strategy had received good community engagement – essential as the community need to own this. The final is scheduled to come to the Board in May. This has been a very healthy process with valuable in depth contribution by consumer members.
- *Consumer Engagement Principles and Framework*: the work done to date can now be used as the basis for a discussion with Clinical Council.

Māori Relationship Board (MRB)

Ngahiwi Tomoana (Chair) provided an overview of the Workshop held on 13 April 2016:

The content included in the MRB report to the Board was noted.

MRB had reflected on their performance and were delighted with the results shared at the workshop, noting teen pregnancies were down, and there was in increase in systemic heart disease and smoking checks. MRB discussed how they could make further improvements resulting in even more success.

Members examined the Maori Health Service Review. Want to take a leadership role and determine if the whanau health service was to the whole whanau, rather than individuals.

- The Obesity strategy was an example of how this can be modelled. Pilot testing a whanau based model of service delivery.
- Now seeing behavioural changes in dealing with Maori, starting to show results.
- Asked whether MRB was fit for purpose? Was MRB the best model? Some felt they should be more analytical.

  Kevin Atkinson advised there was a good relationship between MRB, HBDHB and Iwi. The number of HBDHB board members on MRB had increased over recent years. Did MRB think it should be just a Māori advisory board?

  Ngahiwi advised he was unsure but felt that what was likely required, was a change in "focus".

  HBDHB Board members on MRB relayed the following comments:

  - Certainly have a better understanding of the issues and feel enlightened to a different perspective.
  - Felt some areas get to the board a little late. Māori like to discuss things in more depth so timing is an issue.
  - Relayed that MRB members feel advice in some cases was not implemented.

  Questioning a group effectiveness? MRB are not alone in this review, as PHLG and the HBDHB Board look inwardly and wonder if they make a difference also. MRB are going through a questioning period at present.

  From Barbara Arnott's experience this is all to do with "focus".

  Maybe Tracee TeHuia and Adele White (CEO NKII) could have a discussion.

Action: Kevin Atkinson asked that he and Ngahiwi Tomoana be included in the discussion with Tracee and Adele.

- Everyone is trying hard to work together. The CEO felt the discussion at MRB was a really constructive and very worthwhile. We have come a long way and there is a lot of good information available and we can now benchmark ourselves against other DHBs. We have the best relationship throughout the 20 DHBs nationally, and this was acknowledged at the Workshop.
- Consumer Council had consciously shifted how it worked as they felt constantly burdened. They now focus intently on their pre-meeting agendas and only discuss where they can make the biggest impact. Need to get a good quality of depth to be able to give good advice.
- Talk about things - then get the discussion into a form that will ensure there are workable actions helps!
- It was suggested the HEAT tool be applied to all papers, not just for MRB. Otherwise we will not know whether the recommendaitons are worthwhile. This would help improve efficiencies around meetings and would put the committees in a better position to review the strategy.

FOR INFORMATION AND DISCUSSION

Transform and Sustain Refresh Draft

Tim Evans took the Board through the paper provided.

- As we have moved through the Transform and Sustain process over the past three years or so, it has progressed and we are now seeing a reduction in projects. Therefore priorities have been worked through the executive team (in line with the triple aim) to bring forward project work that will ensure further required change continues to occur
- Following are the topics of focus agreed to by the Executive team:
  - ⇒ Person and Whānau Centred Care (people as partners in their healthcare)
  - ⇒ Health and Social Care Networks (creating strong primary and community care clusters)
  - ⇒ Whole of Public Sector delivery (delivering effectively with public sector partners)
  - ⇒ Information System connectivity (and improved outpatient process)
  - ⇒ Financial Flows and models (incentivising and funding the right behaviours)
  - ⇒ Organisational Development Investing in Staff and changing culture (equipping our staff for a changing world)

  Now is the time for consultation and discussion with wider stakeholders and this was presently planned to occur in fairly tight timelines.
- Those attending the HB Health Sector Leadership Forum Workshop will be exposed to this detail to enable discussion/feedback on 17 May 2016. The draft paper had already been through Consumer, MRB and Clinical Council.
- The Board noted the reasoning and process thus far and again, the Chair noted the HBDHB Transform and Sustain detail to date, contained a lot of similarities with the National Plan ie, the NZ Health Strategy.

It was noted that work had already commenced in some of these 'new' priority areas, particularly Person & Whanau Centred Care and Heatlh and Social Care Networks.

Barbara Arnott advised that the Pasifika Health Leadership Team were meeting on 9 May, and were grappling as to where they could make a significant difference. Barbara provide detail to PHLG and expect PHLG them to feed questions into the process.

Timelines: The Leadership Forum Workshop detail will feed into the final Transform and Sustain document which will come through the advisory committees through to the Board for their 29 June Meeting Note: this was already included on the respective work plans.

From the timeline provided in the report, it appears the projects were to be co-design documented and agreed by 30 June 2016.

DHB Elections 2016

Pre-election resolutions required with detail provided in the report prepared by Ken Foote. The only change to the resolution below as approved in 2013, is the change in Electoral Officer

RESOLUTION

That the Board

- Appoints Warwick Lampp from Electionz.com as the HBDHB Electoral Officer.
- Resolves that the names of candidates on the voting documents be arranged in alphabetic order of surname.
- Requests the DHB elections communications programme includes the promotion of nominations as well as encouragement to vote.
- Advertise and conducts "information evenings" for potential candidates (in Hastings and Napier) prior to nominations being opened.

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

Key dates relating to the elections include:

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

Electronic Papers Post Implementation Report

Electronic Board papers were introduced in July 2015 through the use of Diligent Boards application on Surface Pro devices. Given the number of issues that have arisen, a post implementation review was initiated and recently completed. The report, an independent assessment, was provided.

Following receipt of the report the Steering Group consisting of Ken Foote, Gina McEwen and Brenda Crene, considered the contents with Steering Group comments now included against the recommendations on pages 14 –17 of the report.

A range of comments on the device and application were relayed at the meeting which mirrored feedback within the report.

The biggest downfall with the device for users of the DHB surface pro devices was the short battery life, however an independent using his own surface pro for work purposes within the DHB advised there was no issue (from his perspective) and found the device very good.

Diligent initially was set up for iPad use (Internationally) and more recently developed the app for Windows 8.1 (the DHB opted to wait for). The diligent app for iPads is very easy to download onto owned devices for user log in, as usual.

Several agreed the device provided had more functionality than desired, for others not enough (as the device had been stripped and was not fully functional). This set up (within the DHB network) had caused a lot of problems for some.

There is now an option to restore full functionality to the surface pro devices and have the Diligent App easily accessible by the normal user password, (without DHB network password access).

NOTE: If training is an issue, it was advised that Diligent Training is easy to access through the 0800 number 24/7/365. Ken Foote undertook his training via this method and uses most aspects of functionality extensively. He is happy to sit with anyone and provide assistance, if requested.

If retaining the Surface Pro device we must ensure members have the Diligent App easily accessible (if the device is re-set to original).

The Chair advised he is keen to have the Central Region on Diligent.

PRESENTATION

Living our Values/Behaviours

The presentation by John McKeefry was received by the Board who requested a copy of the slides. **Actioned.**

Areas covered in the presentation included: What does success look like? Current Status; Values and Behaviours as well as a number of Actions to be undertaken; including the Promotional approach – rebranding.

GENERAL BUSINESS

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

RESOLUTION TO EXCLUDE THE PUBLIC

RESOLUTION

That the Board

Exclude the public from the following items:

19. Confirmation of Minutes of Board Meeting
    - Public Excluded

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

21. Board Approval of Actions exceeding limits delegated by CEO

22. Chair's Report

    Reports and Recommendations from Committee Chairs

23. Finance Risk and Audit Committee

24. HB Clinical Council

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

The public section of the Board Meeting closed 3.16pm

Signed: _____

Chair

Date: _____

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BOARD MEETING - MATTERS ARISING
(Public)

Action No	Date Issue first Entered	Action to be Taken	By Whom	By When	Status
1	30/3/16	**Agenda item for May – budget update,** around the effect of spends by category would follow the prioritisation process (with Clinical Council)	Tim Evans	May	Agenda Item public excluded
2	30/3/16	Clinical Council requested to enquire about **timing for the Clinical Pathway for Hepatitis C.**	Mark Peterson	May	A Clinical Pathway is being developed by Mid Central. Once available HB will formalise a process to localise for our region. Timing is unsure, given the recent Pharmac decision to fund a new Hep C medication.
3	30/3/16	**Te Ara Whakawaiora / Breastfeeding:** The Board wish to understand what other DHBs are doing and also to see where HB is benchmarked (including reasons and relative demographics). This will be included in the CEO's report when the information is available.	Caroline McElnay	Sept	
4	27/4/16	**Board workplan**: EMT to review.	EMT	May	Issues addressed – Workplan updated.
5	27/4/16	**Regional Health Improvement Programme (RHIP):** Suggested to include item 10, that HBDHB's contribution of $1.7m was included in the report. Advise CTAS of the outcome and provide Sadie with a copy of the Resolution.	Admin Admin	May May	Actioned Actioned

Action No	Date Issue first Entered	Action to be Taken	By Whom	By When	Status
6	27/4/16	**Re MRB discussions:** Tracee TeHuia to arrange a discussion with NKII CEO Adele White and invite Kevin Atkinson and Ngahiwi Tomoana to join in.	Tracee TeHuia	May	Verbal update
7	27/4/16	**Transform and Sustain Refresh:** Tim Evans to be brought up to speed on what is already occurring with: • Person and Whānau Centred Care; and • Health and Social Care Networks.	Tim Evans	May	Actioned
8	27/4/16	**Living our Values / Behaviours Presentation** Issue the presentation to board members.	Admin	May	Actioned

HAWKE'S BAY DISTRICT HEALTH BOARD
WORKPLAN

Meetings 2016	Papers and Topics	Lead(s)
29 June	Consumer Story Orthopaedic Review Closure of phase 1 HB Intersectoral Group Regional Plan Suicide Prevention Plan Update Youth Health Strategy (final) Health Equity Update Food Services Internal Review Health and Social Care Networks update (rqstd by board) Transform and Sustain Refresh ***Monitoring*** Te Ara Whakawaiora / Oral Health	Kate Coley Andy Phillips Kevin Snee Caroline McElnay Caroline McElnay Caroline McElnay Sharon Mason Liz Stockley Tim Evans Sharon Mason
27 July	Consumer Story Developing a Person Whanau Centred Culture (draft) Annual Organisational Development Plan/Programme Transform and Sustain Refreshed HB Integrated Palliative Care (Draft) HB Intersectoral Group Regional Plan TBC	Kate Coley Kate Coley John McKeefry Tim Evans Tim Evans / Mary Wills Kevin Snee
31 Aug	Consumer Story Draft Quality Accounts Travel Plan update - verbal Community Pharmacy Strategy (board action 16/12/15) Information Service Function Review (quarterly) Urgent Care Service Change Proposal (in Aug or Sept) ***Monitoring*** HBDHB Non-Financial Exceptions Report Q4 Apr-Jun 16 plus MoH dashboard Annual Maori Health Plan Q4 Apr-Jun 2016 Transform and Sustain Strategic Dashboard Q4 Apr-Jun 16 Human Resource KPIs Q4	Kate Coley Kate Coley Sharon Mason Tim Evans/Billy Allan Tim Evans Liz Stockley Tim Evans Tim Evans Tim Evans John McKeefry
7 Sept	**HB Health Sector Leadership Forum – venue to be confirmed**	

Meetings 2016	Papers and Topics	Lead(s)
28 Sept	Consumer Story Orthopaedic Review – Phase 2 draft Family Violence – Strategy Effectivess – for noting Final Developing a Person Whanau Centred Culture Final Quality Accounts NKII MoU Relationship Review Mental Health Consolidation / Benefits Realisation Final HB Integrated Palliative Care Long Term Investment Plan (Asset Management Plan) Annual Report (interim) Health and Social Care Networks Update (rqstd by Board)	Kate Coley Andy Phillips Caroline McElnay Kate Coley Kate Coley Ken Foote Sharon Mason / Allison Tim Evans / Mary Wills Tim Evans / Peter K Tim Evans Liz Stockley
26 Oct	Consumer Story Alcohol Annual Report (Final) Final External Audit Report on agenda (P/excl) External Audit Engagement Arrangements	Kate Coley Caroline / Rachel Ayre Tim Tim Tim
30 Nov	Consumer Story Tobacco – Annual Update on progress against Plan Travel Plan (quarterly update) – verbal Information Service Function Review (quarterly) ***Monitoring*** HBDHB Non-Financial Exceptions Report Q1 Jul-Sept 16 plus MoH dashboard Annual Maori Health Plan Q1 Jul-Sept 16 Transform and Sustain Strategic Dashboard Q1 Jul-Sept 16 Human Resource KPIs Q1 Staff Engagement Survey – any corrective actions	Kate Coley Caroline /Penny Sharon Mason / Andrea Tim Evans Tim Evans Tim Evans / Tracee John McKeefry John McKeefry
14 Dec	Consumer Story HB Workforce Plan – Discussion Document (Dec 16 – final March 17) Renal Stage 4 – final for Endorsement Health and Social Care Networks Update	Kate Coley John McKeefry Sharon Mason Liz Stockely

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

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** 40
	For the attention of: **HBDHB Board**
Document Owner:	Dr Kevin Snee, Chief Executive Officer
Reviewed by:	Not applicable
Month: As at	16 May 2016
Consideration:	For Information

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Recommendations

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

INTRODUCTION

There are a range of issues for discussion today. Firstly, our approach to addressing the crisis of malnutrition and sedentary nature of our modern life leading to the high prevalence of overweight and obesity in our community will be discussed. Our travel plan is also on the agenda; one of the intentions of this plan is to encourage people to leave their cars at home and use other modes of transport thereby increasing their activity. There are a number of quarterly performance reports highlighting good progress and areas where we need to improve. We also bring to the board updates on our plans for next year and the results of our prioritisation process for the relatively modest investments that we are in a position to make.

In this month's Board report I will also comment on our performance. The key problem in April was our Faster Cancer Treatment performance. We also saw an adverse variance in our financial performance.

PERFORMANCE

Measure / Indicator	Target	Month of April	Qtr to end April	Trend For Qtr
Shorter stays in ED	≥95%	93.7%	93.7%	▼
Improved access to Elective Surgery (2015/16YTD)	100%	102.6%	-	▲
Waiting list	*Less than 3 months*	*3-4 months*	*4+ months*	
First Specialist Assessments (ESPI-2)	*2,642*	*328*	*23*	
Patients given commitment to treat, but not yet treated (ESPI-5)	*1,077*	*131*	*26*	
Faster Cancer Treatment*	≥85%	58.3% (Mar 2016)	63.2% (rolling 6m to Mar 2016)	▼
Increased immunisation at 8 months (3 months to March)	≥90%	---	96.0%	▲
Better help for smokers to quit – Hospital	≥95%	97.6%	97.6%	▼

Measure / Indicator	Target	Month of April	Qtr to end April	Trend For Qtr
Better help for smokers to quit – Primary Care *there was a change in definition at the start of 2015/16 which has an impact on the results	≥90%	77.6% (Quarter 2, 2015/16)	---	▲
More heart and diabetes checks	≥90%	89.6% (Quarter 3, 2015/16)	---	▼
Financial – month (in thousands of dollars)	($50)	($223)	---	---
Financial – year to date (in thousands of dollars)	($4,349)	($4,334)	---	---

**Based on the expected annual cancer registrations for the DHB supplied by the Ministry, the DHB is expected to identify at least 76 people a year (11.4 a month) as patients with a high suspicion of cancer.*

Faster Cancer Treatment Expected Volumes v Actual	*Target*	*Month Actual / Expected*	*Rolling 6m Actual / Expected*
	100%	*12/11 = 105 %*	*57/68 = 83.3%*

Performance this month has seen a slight deterioration in shorter stays in the Emergency Department (ED). This deterioration has continued into May and work is ongoing to return to the previously favourable trajectory.

Elective activity continues ahead of plan and numbers of patients waiting is greater than we would wish; this is partly explained by the good work ongoing in National Patient Flow, which is tracking the patient journey for elective activity from referral through to treatment.

Immunisation has continued to improve and remains above target. There are no updates for heart and diabetes checks and smoking in primary care.

In last month's report I provided a brief update on our performance for the Faster Cancer Treatment health target and indicated that a detailed update would be prepared for the May board. A presentation on this target will now be provided to the May FRAC meeting. Quarterly results (for six months to March 2016) were 63.2 percent (36 compliant cases from a total of 57) against the expected 85 percent compliance for the 62 day health target. There was an improvement from February (42.9%) to March (58.3%) for the 62 day target. March 2016 results for the 31 day indicator were 84.2 percent (48 compliant cases from a total of 57). The presentation to FRAC will focus on three key areas to improve the patient journey; governance, clinical co-ordination and access to diagnostics. A teleconference will be will held with the Ministry of Health champions to seek support for further strategies to improve HBDHB performance.

The financial result for April is an unfavourable variance of $173 thousand, making the year-to-date result $15 thousand favourable.

CONSUMER STORY

This month's consumer story highlights the patient experience and journey through the Day Surgery Unit. It highlights the issue of timely and effective communication and the perspective of an anxious family member waiting for news from behind closed doors. At our meeting we will share the work that is underway in Day Surgery to improve not only our internal processes but also enhance the patient experience.

ANNUAL PLANS
Feedback from the Ministry of Health (MoH) on the First Drafts of the Annual Plan, Māori Health Plan and the Regional Services Plan has been received. The majority of the feedback was regarding technical issues such as timeframes and measurable activities requiring minimal changes for the Final Draft, which is due back to the MoH by 30 May 2016. The Final Draft is being shared with the Board with the chance to comment by 30 May. The Board is being asked to delegate two members to review and sign off the Final Annual Plan prior to 17 June.

BEST START: HEALTHY EATING AND ACTIVITY
A plan for improving healthy eating and active lives for children in Hawke's Bay 2016-2020
The plan has been through a robust development process and has received extensive feedback. This has resulted in a comprehensive plan to improve healthy eating and support active lives for Hawke's Bay children. The plan supports healthy environments, will deliver prevention programmes and interventions, and highlights the role of leadership across the sectors and community. Activities are designed and delivered with whānau and communities to gain the greatest impact.

Recently the Ministries of Health and Education released a request to schools to become "water only". HBDHB's Best Start: Healthy Eating and Activity Plan provides the vehicle to lead and implement this and other changes that may be required to support healthy weights in Hawke's Bay.

2016-17 BUDGET UPDATE AND INVESTMENT PRIORITISATION
The Board will receive, as part of today's agenda, a recommendation from FRAC on the 2016-17 budget and the Clinical Council recommendations for new investments. The Māori Relationship Board also considered these recommendations and will provide their feedback to the Board as part of today's discussion.

TRAVEL PLAN
The "Go Well" travel plan project formally kicks off from 1 July, however this month we have been busy developing and releasing a promotional video, and starting conversations with both internal and external stakeholders. Hawke's Bay Regional Council has recently announced that an express bus service from Napier to the hospital will start from 1 August 2016 arriving in time for the 7am shift. Discussions have also been held with car-pooling and car park booking organisations such as Chariot and Parkable. A review of the car parking layout and allocation, cycle parking and associated signage will be completed in June, with remarking, new cycle stands and signage updates occurring before the year end. Work is also happening in the background in developing a simplified, user-friendly version of the site and visitor brochure map as well as developing content for both Nettie and Our Health travel plan pages.

CUSTOMER FOCUSED BOOKING
This project is making steady progress. High level achievements include the project identifying and supporting a Customer Focused Booking training programme for booking staff and the progression of UBook as an IS enabler for on line customer clinic booking. It is anticipated that UBook implementation will commence in December 2016 on a specialty by specialty basis.

For the organisation to utilise the functionality of the UBook, a separate project has been established to design clinic scheduling specifically standardising business processes and templates.

DAVANTI REVIEW IMPLEMENTATION
The first steps are being taken to implement the recommendations of the Davanti review of our Information Systems function. The first quarterly update on progress is on the agenda.

TRANSFORM AND SUSTAIN STRATEGIC DASHBOARD
The Transform and Sustain Strategic Dashboard for quarter three is also on the agenda. We are moving into new territory in considering the impact of our strategy rather than the process for implementing it. While some targets are not being met, most are in line with expectation or better. The suggestion is that the Board use the dashboard as a framework to prompt deeper investigation. That would mean systematically lining up the topics of least progress for discussion. This could perhaps best be done in the existing FRAC framework where discussion items allow the opportunity for broad discussion and clinical involvement.

HBDHB NON-FINANCIAL EXCEPTIONS REPORT
We have a number of quarterly non-financial performance reports this month.

The Non-Financial Exceptions Report for Quarter 3 (to the end of March 2016) is a familiar format. This quarter it shows that we are achieving heart and diabetes checks, improved access to elective surgery, immunisation at eight months, and before school checks. However we are struggling to hit target on better help for pregnant women to quit smoking, faster cancer treatment, and children without dental caries at five years of age.

We are now relaying to Board the Ministry of Health's quarterly scorecard on the DHB. This replaces our previous reporting of the internal DHB view of our performance. Board members should note that this means a longer lead time and the report is therefore for quarter two (to the end of December 2015). The report is sound overall. Our only red traffic light is in under 19 year olds mental health waits in spite of the good work that has been in this area. A cross-reference to the exceptions report shows that the performance has improved since Quarter two, but has some way to go to target. Team leaders are actively monitoring and chasing longer waits, and we are moving from sending letters to making phone calls to patients to arrange appointment dates.

ANNUAL MĀORI HEALTH PLAN QUARTER THREE
HBDHB's Annual Māori Health Plan 2015-2016 quarter three report demonstrates continued improved health trends particularly with immunisation rates for eight month old and four year olds, pre-school oral health enrolments, quicker access to angiograms, PHO enrolments and cervical screening. We have seen a welcome improvement with cultural training attendances by medical staff increasing from 19 percent in quarter two to 32 percent in quarter three. However, there is still significant work to do to improve Māori under compulsory mental health treatment orders and Māori workforce recruitment.

HUMAN RESOURCES KPIs QUARTER THREE
Māori staff representation in the workforce has moved little in the last quarter and the gap to our 2015/16 target sits at 57 at 31 March 2016. To address this gap we continue to deepen our focus in Nursing staff and extending our focus to include Allied Health staff. We will be developing a recruitment campaign for launch in July to attract more Māori to come and work for the DHB.

There are no concerns with sick leave or staff turnover and the Occupational Health & Safety KPI has improved markedly from the previous quarter and is below the target and below the level for the same quarter last year. Contracted FTE figures are higher than last year which is also reflected in the Accrued FTE figures discussed briefly in the HR KPI report and more fully in the Financial report.

For annual leave the total liability at 31 March 2016 is $1.2m favourable to the position at 30 June 2015. Most of this favourable movement can be attributed to reduced hours in leave balances other than annual leave (Statutory Lieu leave etc) and reflects our broader focus on all leave balances not just annual leave. We are the third best performing mid-sized DHB and the eighth best of the 20 DHBs for this measure.

TE ARA WHAKAWAIORA / CARDIOVASCULAR
The report focuses on the two acute coronary syndrome (ACS) indicators (high risk ACS accepted for angiogram within three days of admission and ACS patients who have completed data collection), which were introduced as indicators of District Health Board (DHB) performance by the Ministry of Health in 2013/14. The DHBs actively monitor these two indicators of concern.

There has been a positive result, with HBDHB and all DHBs within the central region meeting both indicators for the first time in quarter three (December 2015 to February 2016). The challenge for the service now is to sustain this improved compliance.

SUMMARY
In summary, our performance has been sound across a range of indicators and we have been putting in place clear plans for next year. In addition, we have been making progress in developing a range of services to address healthy eating and activity, how consumers are enabled to book appointments, how we all travel to and from our hospital and how we manage our information service.

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report, April 2016** 45
	For the attention of: **HBDHB Board and the Finance Risk and Audit Committee (FRAC)**
Document Owner: Document Author(s):	Tim Evans, GM Planning, Informatics & Finance Finance Team
Reviewed by:	Executive Management Team
Month:	May, 2016
Consideration:	For Information

RECOMMENDATION

That the Board and FRAC
Note the contents of this report

1. GM Planning Informatics & Finance comments

Financial performance

The result for April is an unfavourable variance of $173 thousand, making the year to date result $15 thousand favourable. Slower than planned implementation of new investments partly offset the cost of elective surgery outsourced to Royston.

Contingency of $250 thousand has been released to cover the rest of the elective surgery costs. This is in addition to the year to date part of the $1.0 million transferred to Surgical Services and the $90 thousand contributed to the corporate 3percent savings plan. This leaves $1.66 million of the contingency uncommitted with two months of the year remaining.

Forecast result

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

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

Efficiencies not achieved in the sustain programme, are expected to be offset by savings achieved elsewhere and delays in implementing new investments.

Note that the IDF and elective services wash-ups contribute uncertainty to the forecast.

2. Resource Overview

	April				Year to Date				Year End Forecast	Refer Section
	Actual	Budget	Variance		Actual	Budget	Variance			
	$'000	$'000	$'000	%	$'000	$'000	$'000	%	$'000	
Net Result - surplus/(deficit)	(223)	(50)	(173)	-344.5%	(4,334)	(4,349)	15	0.3%	3,990	3
Contingency utilised	91	250	159	63.7%	908	2,500	1,592	63.7%	3,000	8
Quality and financial improvement	311	767	(456)	-59.5%	6,530	7,501	(971)	-12.9%	8,721	11
Capital spend	696	1,892	(1,196)	-63.2%	14,559	17,574	(3,015)	-17.2%	21,358	16
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,223	2,175	(48)	-2.2%	2,135	2,172	37	1.7%	2,188	5 & 7
	CWD	CWD	CWD	%	CWD	CWD	CWD	%	CWD	
Case weighted discharges	1,850	2,075	(225)	-10.9%	23,521	22,726	795	3.5%	27,407	5

The result for April is an unfavourable variance of $173 thousand, with $1.158 million of the contingency utilised ($833 thousand transferred to surgical, $75 thousand contributed to the corporate 3 percent savings plan, and $250 thousand for elective surgery).

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

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

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

Case weighted discharges are 10.9% below plan in April, but remain ahead of plan year to date. High acute general surgery, gastroenterology, orthopaedic and paediatric volumes are partly offset by low maternity and internal medicine case-weights.

3. Financial Performance Summary

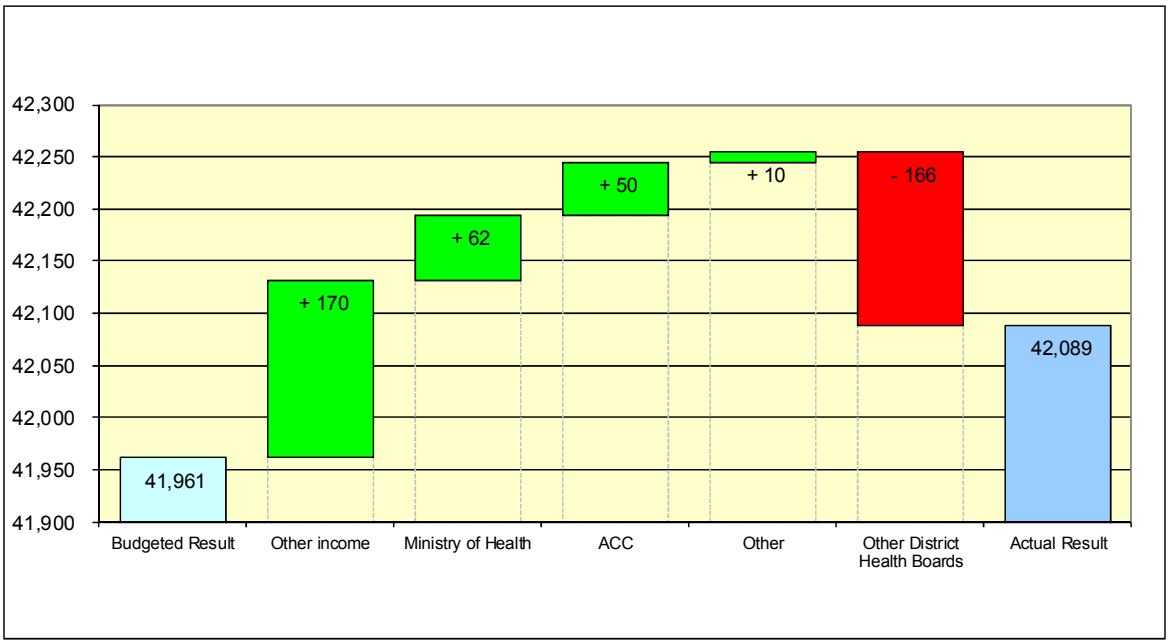
	April				Year to Date				Year End Forecast	Refer Section
$'000	Actual	Budget	Variance		Actual	Budget	Variance			
Income	42,089	41,961	127	0.3%	419,147	419,703	(556)	0.1%	512,614	4
Less:										
Providing Health Services	20,164	19,518	(645)	-3.3%	199,716	197,700	(2,016)	-1.0%	241,372	5
Funding Other Providers	18,555	18,798	244	1.3%	185,764	187,852	2,088	1.1%	221,164	6
Corporate Services	3,445	3,407	(38)	-1.1%	34,912	35,436	524	1.5%	43,388	7
Reserves	148	288	140	48.5%	3,090	3,064	(25)	-0.8%	2,701	8
	(223)	**(50)**	(173)	344.5%	**(4,334)**	**(4,349)**	**15**	-0.3%	**3,990**	

Donations and bequests together with additional funding from MOH and ACC more than offset the reduction of income from Tairawhiti DHB. Outsourcing to Royston, non-achievement of efficiencies, and locum cover, are partly offset by allied health vacancies in providing health services. Later than planned funding of new investments, lower cost access and medicine use reviews, more than offsets increasing costs in home care. Reserves are driven by lower depreciation and amortisation costs.

4. Income

$'000	April				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Ministry of Health	39,954	39,892	62	0.2%	398,901	398,758	143	0.0%	488,485
Inter District Flows	624	624	0	0.0%	6,240	6,236	5	0.1%	7,487
Other District Health Boards	192	358	(166)	-46.3%	2,856	3,644	(788)	-21.6%	3,476
Financing	76	83	(7)	-8.9%	1,154	838	316	37.7%	1,322
ACC	557	506	50	10.0%	4,421	5,149	(728)	-14.1%	5,291
Other Government	53	35	18	52.9%	317	345	(28)	-8.1%	386
Patient and Consumer Sourced	125	122	3	2.8%	1,018	1,271	(253)	-19.9%	1,246
Other Income	513	342	170	49.8%	4,172	3,462	710	20.5%	4,863
Abnormals	(4)	-	(4)	0.0%	67	-	67	0.0%	58
	42,089	**41,961**	127	0.3%	**419,147**	**419,703**	(556)	-0.1%	**512,614**

April Income



Note the scale does not begin at zero

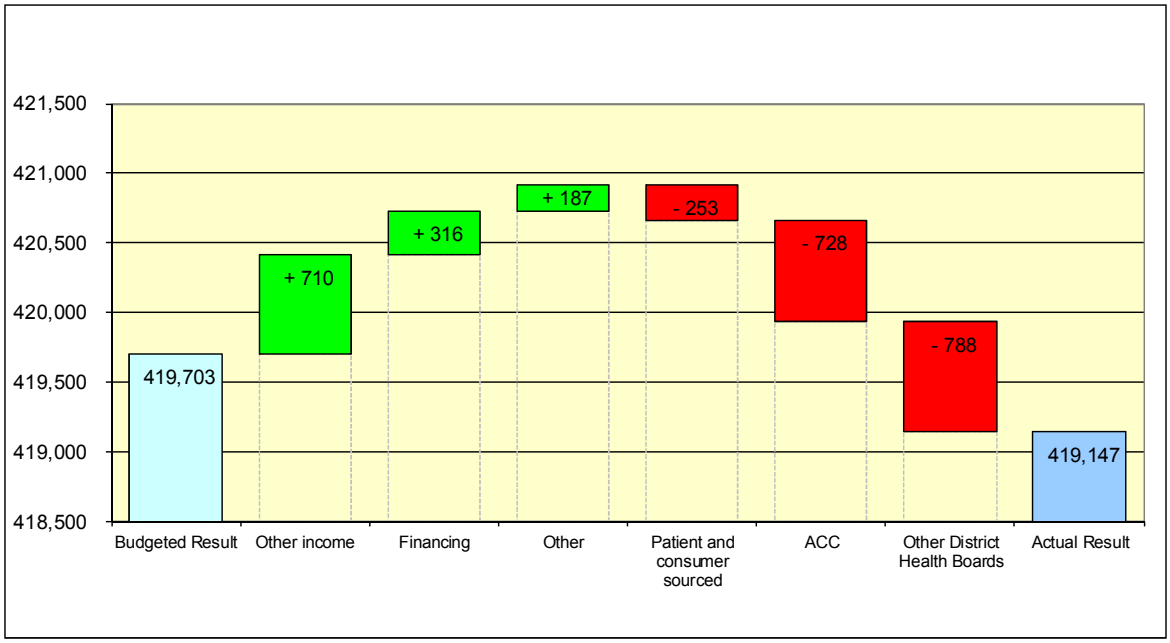
Other income (favourable)
Includes clinical trial income and donations (unbudgeted), including a bequest from Kenneth Morrison and donations from Countdown Kids.

Ministry of Health (favourable)
InterRAi, clinical training (offset by expenditure), and perinatal mental health.

ACC (favourable)
Non acute rehabilitation.

Other District Health Boards (unfavourable)
Lower sales of cancer drugs to Tairawhiti DHB, mostly offset by lower expenditure. Lower oncology income from Mid Central DHB.

Year to date Income



Note the scale does not begin at zero

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

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

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

ACC (unfavourable)
Mainly prioritisation of elective surgery over ACC volumes.

Other District Health Boards (unfavourable**)**
Lower sales of cancer drugs to Tairawhiti DHB, marginally offset by higher oncology clinic charges to Mid Central DHB. Both offset in expenditure.

5. Providing Health Services

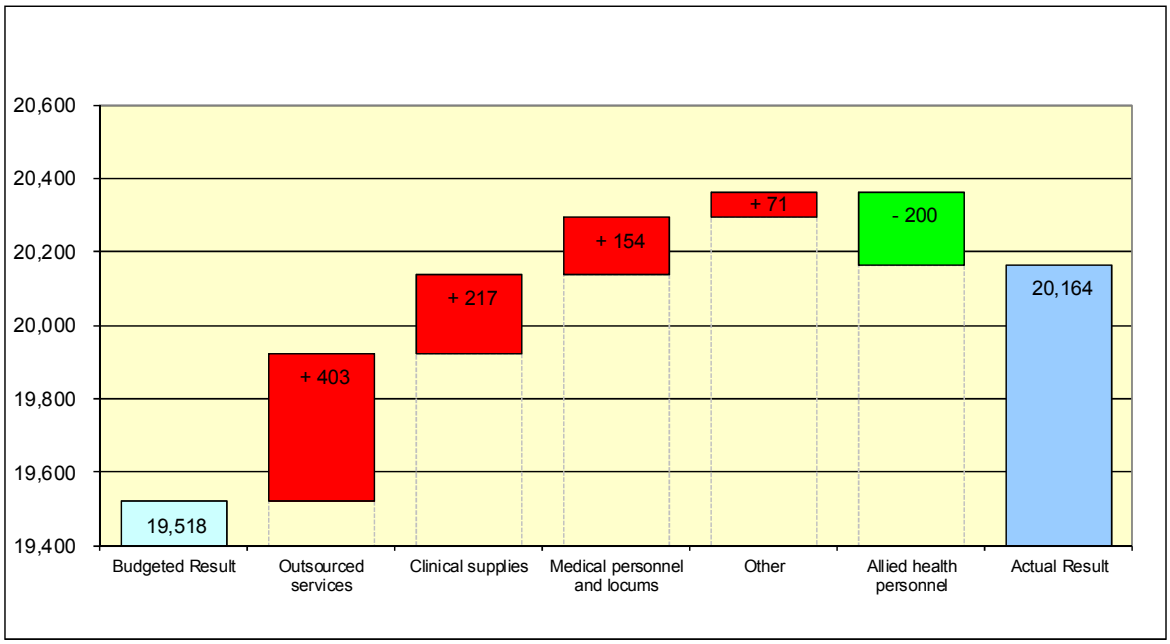
	April				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure by type $'000									
Medical personnel and locums	4,326	4,172	(154)	-3.7%	48,020	46,051	(1,969)	-4.3%	57,830
Nursing personnel	6,127	6,163	36	0.6%	58,404	58,729	325	0.6%	70,108
Allied health personnel	2,427	2,627	200	7.6%	25,292	26,837	1,545	5.8%	30,534
Other personnel	1,673	1,664	(9)	-0.6%	16,849	16,838	(11)	-0.1%	20,237
Outsourced services	865	462	(403)	-87.3%	5,249	4,353	(896)	-20.6%	6,604
Clinical supplies	3,066	2,850	(217)	-7.6%	30,413	29,417	(996)	-3.4%	37,368
Infrastructure and non clinical	1,679	1,582	(98)	-6.2%	15,490	15,475	(15)	-0.1%	18,691
	20,164	**19,518**	(645)	-3.3%	**199,716**	**197,700**	(2,016)	-1.0%	**241,372**
Expenditure by directorate $'000									
Acute and Medical	5,409	5,316	(93)	-1.8%	54,592	53,300	(1,292)	-2.4%	65,697
Surgical Services	4,603	4,164	(439)	-10.5%	45,021	42,657	(2,364)	-5.5%	54,492
Women Children and Youth	1,673	1,652	(21)	-1.3%	16,367	16,336	(31)	-0.2%	19,631
Older Persons & Mental Health	2,639	2,678	38	1.4%	27,230	27,855	624	2.2%	32,822
Rural, Oral and Communlty	1,797	1,818	21	1.2%	17,991	18,364	373	2.0%	21,650
Other	4,042	3,891	(151)	-3.9%	38,514	39,188	674	1.7%	47,080
	20,164	**19,518**	(645)	-3.3%	**199,716**	**197,700**	(2,016)	-1.0%	**241,372**
Full Time Equivalents									
Medical personnel	298.9	296.4	(3)	-0.9%	304	302	(2)	-0.6%	303.8
Nursing personnel	935.8	891.8	(44)	-4.9%	882	886	4	0.5%	893.7
Allied health personnel	434.8	444.4	10	2.2%	416	442	26	5.9%	445.6
Support personnel	139.2	128.8	(10)	-8.1%	131	128	(3)	-2.0%	129.4
Management and administration	249.5	245.8	(4)	-1.5%	246	245	(1)	-0.4%	247.2
	2,058.3	**2,007.2**	(51)	-2.5%	**1,979**	**2,004**	25	1.2%	**2,019.6**
Case Weighted Discharges									
Acute	1,184	1,361	(177)	-13.0%	16,706	15,561	1,146	7.4%	18,824
Elective	561	524	36	6.9%	5,332	5,168	165	3.2%	6,195
Maternity	76	163	(87)	-53.1%	1,137	1,705	(567)	-33.3%	2,035
IDF Inflows	29	27	2	7.9%	345	293	52	17.9%	353
	1,850	**2,075**	(225)	-10.9%	**23,521**	**22,726**	795	3.5%	**27,407**

Directorates

The unfavourable result for April relates to:

- Surgical Services – major joint elective surgery outsourced to Royston, and vacancy and leave cover (medical personnel).
- Acute and Medical – Vacancy and leave cover (medical personnel).

April Expenditure



Note the scale does not begin at zero

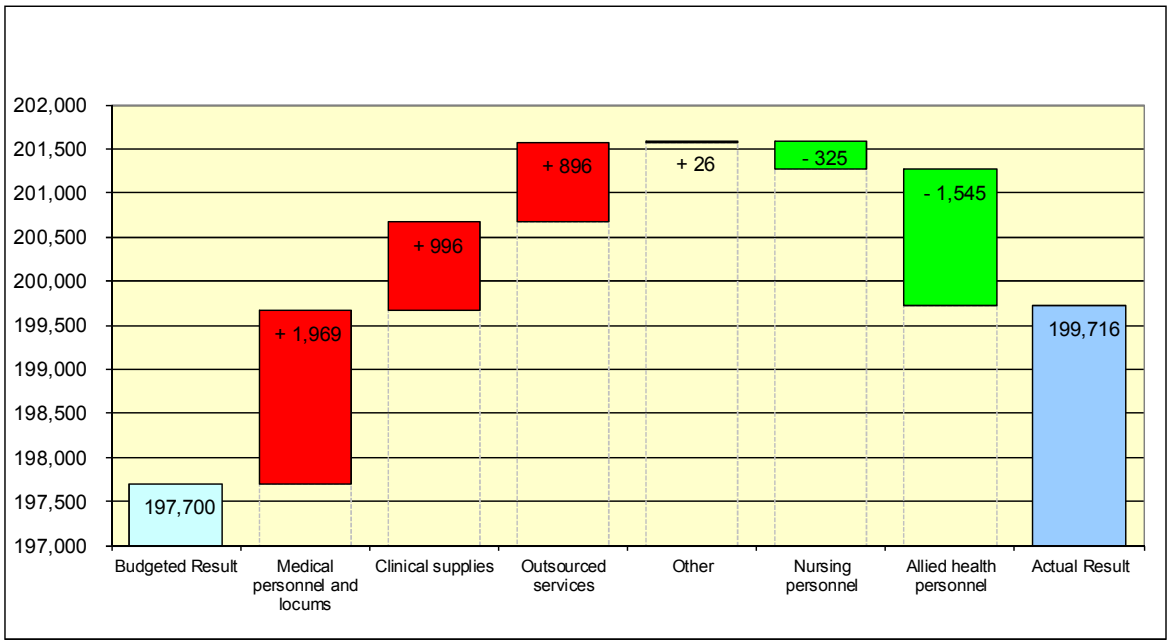
Outsourced services (unfavourable)
Outsourcing to Royston to meet the major joint target and ESPI compliance.

Clinical supplies (unfavourable)
Efficiencies not achieved.

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

Allied health personnel (favourable)
Vacancies in therapies, MRTs, community support and laboratory technicians.

Year to date Expenditure



Note the scale does not begin at zero

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

Clinical supplies (unfavourable)
Savings targets not achieved.

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

Nursing personnel (favourable)
Slower than planned incurrence of GP/DN alignment costs, and vacancies in rural services.

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

Full time equivalents (FTE)

FTEs are 25 favourable year to date, including:

Allied health personnel (26 FTE / 5.9% favourable)

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

Nursing personnel

- Low numbers in Ata Rangi and vacancies in rurals during the year, have been offset by higher nursing FTEs in Acute & Medical and Surgical services over the last two months. The higher numbers relates to above budgeted leave and training cover, higher staffing levels in ED/AAU and B2, higher staffing in surgical wards to meet targets and to staff up for the opening of the A2 surgical overflow ward.

The effect of the Easter holiday on annual leave payment rates was lower than budgeted, and together with the lower staffing in Ata Rangi and vacancies, more than offset the cost of the additional staffing.

MONTHLY ELECTIVE HEALTH TARGET REPORT
YTD To April 2016

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

		YTD April 2016			
		Actual	Plan	Var.	%Var.
On-Site	Avastins	164	164	0	0.0%
	ENT	380	352	28	8.0%
	General Surgery	813	879	-66	-7.5%
	Gynaecology	491	461	30	6.5%
	Maxillo-Facial	118	103	15	14.6%
	Ophthalmology	937	565	372	65.8%
	Orthopaedics	739	781	-42	-5.4%
	Skin Lesions	149	148	1	0.7%
	Urology	367	377	-10	-2.7%
	Vascular	125	94	31	33.0%
	Surgical - Arranged	458	320	138	43.1%
	Non Surgical - Elective	52	157	-105	-66.9%
	Non Surgical - Arranged	26	59	-33	-55.9%
On-Site	Total	4819	4460	359	8.0%
Outsourced	Cardiothoracic	0	0	0	0.0%
	ENT	152	298	-146	-49.0%
	General Surgery	174	147	27	18.4%
	Gynaecology	6	48	-42	-87.5%
	Maxillo-Facial	41	92	-51	-55.4%
	Neurosurgery	0	0	0	0.0%
	Ophthalmology	47	0	47	0.0%
	Orthopaedics	6	21	-15	-71.4%
	Paediatric Surgery	0	0	0	0.0%
	Skin Lesions	2	0	2	0.0%
	Urology	33	22	11	50.0%
	Vascular	7	0	7	0.0%
	Surgical - Arranged	0	0	0	0.0%
	Non Surgical - Elective	0	0	0	0.0%
	Non Surgical - Arranged	0	0	0	0.0%
Outsourced	Total	468	628	-160	-25.5%
IDF Outflow	Cardiothoracic	58	70	-12	-17.1%
	ENT	36	35	1	2.9%
	General Surgery	39	45	-6	-13.3%
	Gynaecology	24	29	-5	-17.2%
	Maxillo-Facial	153	126	27	21.4%
	Neurosurgery	49	35	14	40.0%
	Ophthalmology	26	21	5	23.8%
	Orthopaedics	16	27	-11	-40.7%
	Paediatric Surgery	37	39	-2	-5.1%
	Skin Lesions	59	53	6	11.3%
	Urology	4	3	1	33.3%
	Vascular	13	51	-38	-74.5%
	Surgical - Arranged	127	305	-178	-58.4%
	Non Surgical - Elective	109	0	109	0.0%
	Non Surgical - Arranged	29	0	29	0.0%
IDF Outflow	Total	779	839	-60	-7.2%
		6066	5927	139	2.3%

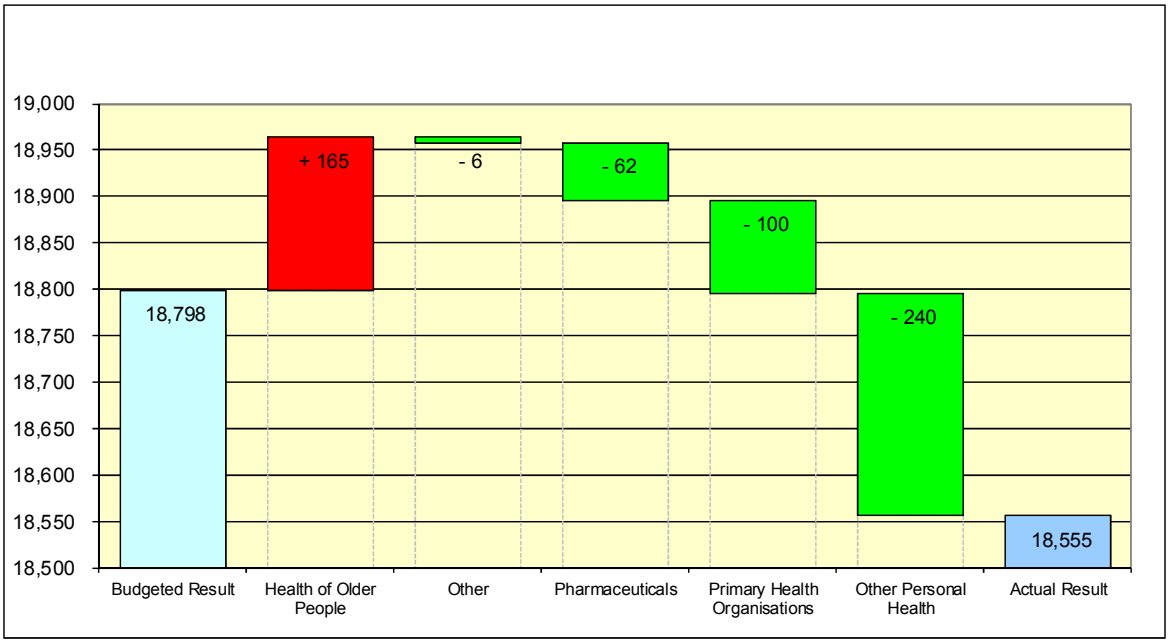
		April 2016			
		Actual	Plan	Var.	%Var.
On-Site	Avastins	16	17	-1	-5.9%
	ENT	25	36	-11	-30.6%
	General Surgery	78	89	-11	-12.4%
	Gynaecology	55	47	8	17.0%
	Maxillo-Facial	10	11	-1	-9.1%
	Ophthalmology	121	57	64	112.3%
	Orthopaedics	68	79	-11	-13.9%
	Skin Lesions	10	15	-5	-33.3%
	Urology	40	38	2	5.3%
	Vascular	10	9	1	11.1%
	Surgical - Arranged	66	32	34	106.3%
	Non Surgical - Elective	1	16	-15	-93.8%
	Non Surgical - Arranged	0	6	-6	-100.0%
On-Site	Total	500	452	48	10.6%
Outsourced	Cardiothoracic	0	0	0	0.0%
	ENT	37	35	2	5.7%
	General Surgery	30	17	13	76.5%
	Gynaecology	0	6	-6	-100.0%
	Maxillo-Facial	0	11	-11	-100.0%
	Neurosurgery	0	0	0	0.0%
	Ophthalmology	0	0	0	0.0%
	Orthopaedics	5	3	2	66.7%
	Paediatric Surgery	0	0	0	0.0%
	Skin Lesions	1	0	1	0.0%
	Urology	3	3	0	0.0%
	Vascular	1	0	1	0.0%
	Surgical - Arranged	0	0	0	0.0%
	Non Surgical - Elective	0	0	0	0.0%
	Non Surgical - Arranged	0	0	0	0.0%
Outsourced	Total	77	75	2	2.7%
IDF Outflow	Cardiothoracic	5	6	-1	-16.7%
	ENT	3	3	0	0.0%
	General Surgery	4	4	0	0.0%
	Gynaecology	0	2	-2	-100.0%
	Maxillo-Facial	1	12	-11	-91.7%
	Neurosurgery	4	3	1	33.3%
	Ophthalmology	1	2	-1	-50.0%
	Orthopaedics	3	3	0	0.0%
	Paediatric Surgery	3	4	-1	-25.0%
	Skin Lesions	0	5	-5	-100.0%
	Urology	2	0	2	0.0%
	Vascular	1	5	-4	-80.0%
	Surgical - Arranged	11	29	-18	-62.1%
	Non Surgical - Elective	6	0	6	0.0%
	Non Surgical - Arranged	0	0	0	0.0%
IDF Outflow	Total	44	78	-34	-43.6%
		621	605	16	2.6%

Please Note: The data dislpayed is as at 6th May 2016. IDF Events not yet captured in NMDS will not be reported above

6. Funding Other Providers

$'000	April Actual	April Budget	April Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Payments to Other Providers									
Pharmaceuticals	3,305	3,367	62	1.8%	35,019	35,251	233	0.7%	41,955
Primary Health Organisations	2,758	2,858	100	3.5%	28,088	28,687	599	2.1%	33,839
Inter District Flows	3,903	3,899	(4)	-0.1%	39,075	38,987	(88)	-0.2%	46,872
Other Personal Health	1,917	2,156	240	11.1%	19,091	19,888	797	4.0%	20,855
Mental Health	1,131	1,116	(16)	-1.4%	11,209	11,156	(53)	-0.5%	13,366
Health of Older People	5,114	4,949	(165)	-3.3%	49,422	49,489	67	0.1%	59,442
Other Funding Payments	428	454	26	5.7%	3,860	4,394	534	12.1%	4,835
	18,555	18,798	244	1.3%	**185,764**	**187,852**	2,088	1.1%	221,164
Payments by Portfolio									
Strategic Services									
Secondary Care	4,165	4,148	(17)	-0.4%	41,267	41,537	270	0.7%	47,603
Primary Care	7,249	7,417	168	2.3%	73,034	74,047	1,012	1.4%	87,646
Chronic Disease Management	325	345	19	5.6%	3,255	3,468	213	6.2%	3,935
Mental Health	1,131	1,112	(19)	-1.7%	11,205	11,118	(87)	-0.8%	13,354
Health of Older People	4,892	5,035	142	2.8%	49,849	50,346	497	1.0%	59,816
Other Health Funding	-	(17)	(17)	-100.0%	(48)	(167)	(119)	-71.3%	(73)
Maori Health	532	526	(6)	-1.1%	5,140	5,263	123	2.3%	6,245
Population Health									
Women, Child and Youth	152	114	(38)	-32.9%	1,131	1,079	(52)	-4.9%	1,377
Population Health	108	118	10	8.3%	930	1,161	231	19.9%	1,260
	18,555	18,798	244	1.3%	**185,764**	**187,852**	2,088	1.1%	221,164

April Expenditure



Note the scale does not begin at zero

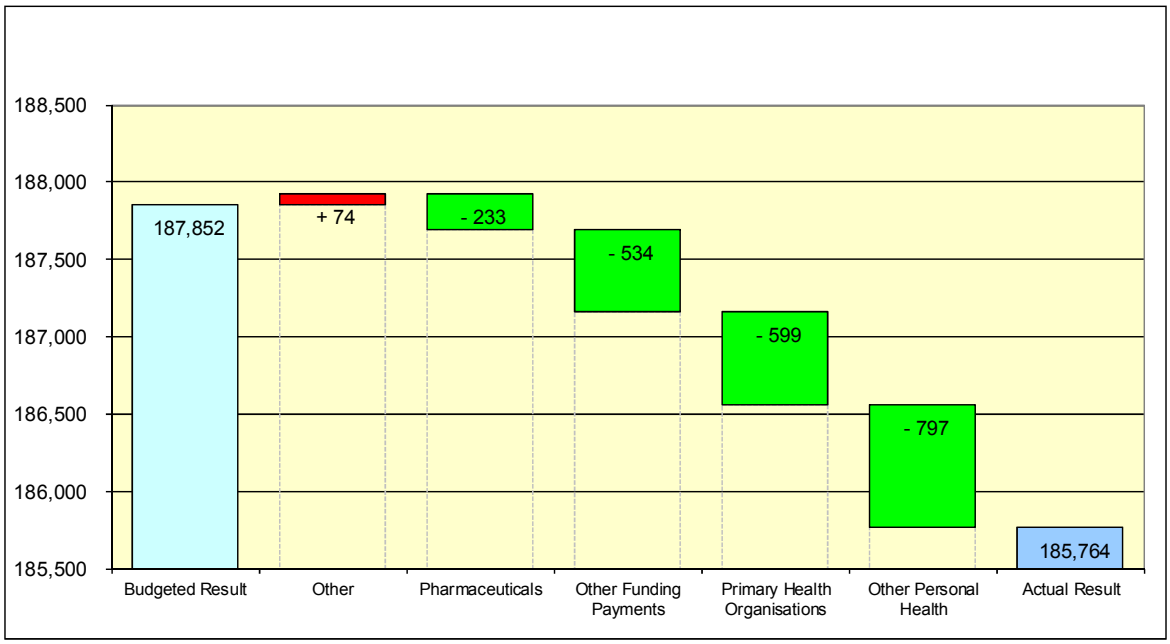
Health of Older People (unfavourable)
Higher than budgeted home support mostly offset by lower residential hospital care.

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

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

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

Year to date Expenditure



Note the scale does not begin at zero

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

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

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

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

7. Corporate Services

$'000	April Actual	April Budget	April Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Operating Expenditure									
Personnel	1,210	1,194	(17)	-1.4%	12,203	12,333	130	1.1%	14,707
Outsourced services	68	86	18	21.1%	944	865	**(79)**	**-9.2%**	1,133
Clinical supplies	11	0	(10)	-2138.7%	130	5	**(125)**	**-2612.2%**	151
Infrastructure and non clinical	892	762	**(130)**	**-17.0%**	7,046	7,081	35	0.5%	8,231
	2,181	2,043	**(138)**	**-6.8%**	20,322	20,283	(39)	-0.2%	24,221
Capital servicing									
Depreciation and amortisation	1,104	1,204	**100**	**8.3%**	10,977	11,451	474	4.1%	13,398
Financing	160	160	1	0.3%	1,626	1,631	5	0.3%	1,952
Capital charge	-	-	-	0.0%	1,987	2,071	84	4.1%	3,816
	1,264	1,364	**100**	**7.4%**	14,590	15,153	563	3.7%	19,166
	3,445	**3,407**	(38)	-1.1%	**34,912**	**35,436**	524	1.5%	**43,388**
Full Time Equivalents									
Medical personnel	-	-	-	0.0%	0	-	(0)	0.0%	-
Nursing personnel	11.2	16.4	**5**	**31.5%**	12	16	5	29.6%	16.5
Allied health personnel	-	-	-	0.0%	0	-	(0)	0.0%	-
Support personnel	9.0	9.4	0	4.4%	9	9	0	0.0%	9.4
Management and administration	144.6	141.9	(3)	-1.9%	134	142	**8**	**5.4%**	142.8
	164.7	**167.6**	3	1.7%	**155**	**168**	**12**	**7.2%**	**168.7**

Outsourced services includes administrative support for the Doctor's unit and diagnostic coding, and the DHB's contribution to the HB Intersectoral Advisor position. Clinical supplies including planned savings and health promotion costs, are offset by savings achieved elsewhere. Depreciation and amortisation costs reflects the later than budgeted opening of the new mental health inpatient unit.

8. Reserves

$'000	April Actual	April Budget	April Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Expenditure									
Contingency	(8)	159	**167**	**104.9%**	1,425	1,592	**167**	**10.5%**	1,180
Transform and Sustain resource	57	40	(17)	-43.0%	427	393	(33)	-8.4%	759
Other	100	89	(10)	-11.4%	1,239	1,079	**(159)**	**-14.8%**	762
	148	**288**	**140**	**48.5%**	**3,090**	**3,064**	(25)	-0.8%	**2,701**

The Other category includes loss on disposal of assets and TAS audits relating to 2014/15.

9. Financial Performance by MOH Classification

$'000	April Actual	April Annual Plan	April Variance	Year to Date Actual	Year to Date Annual Plan	Year to Date Variance	End of Year Forecast	End of Year Annual Plan	End of Year Variance
Funding									
Income	40,015	39,962	53 F	401,445	401,527	(82) U	491,587	491,789	(202) U
Less:									
Payments to Internal Providers	20,588	20,588	0 F	218,065	218,065	0 F	262,986	263,091	104 F
Payments to Other Providers	18,555	18,798	244 F	185,764	187,852	2,088 F	221,164	224,184	3,020 F
Contribution	**872**	**576**	**296 F**	**(2,384)**	**(4,390)**	**2,006 F**	**7,437**	**4,514**	**2,922 F**
Governance and Funding Admin.									
Funding	262	262	-	2,616	2,616	-	3,140	3,140	-
Other Income	3	3	-	35	25	10 F	40	30	10 F
Less:									
Expenditure	247	251	4 F	2,246	2,538	292 F	2,754	3,049	295 F
Contribution	**17**	**13**	**4 F**	**405**	**103**	**302 F**	**426**	**121**	**305 F**
Health Provision									
Funding	20,326	20,326	(0) U	215,450	215,450	(0) U	259,847	259,951	(104) U
Other Income	2,071	1,997	75 F	17,667	18,152	(484) U	20,987	21,479	(491) U
Less:									
Expenditure	23,510	22,962	(547) U	235,472	233,662	(1,810) U	284,707	282,076	(2,631) U
Contribution	**(1,112)**	**(639)**	**(473) U**	**(2,355)**	**(61)**	**(2,294) U**	**(3,873)**	**(646)**	**(3,227) U**
Net Result	**(223)**	**(50)**	**(173) U**	**(4,334)**	**(4,349)**	**15 F**	**3,990**	**3,990**	**0 F**

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

10. Management Budget Movements

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

The major changes between revenue and expense lines are usually due to health provision savings programmes. As these numbers have firmed up some savings programmes are around growing revenue rather than reducing costs. In 2015/16 changes to the operation of the price volume schedule (payments by the funder to the provider arm) will also create movements between the annual plan and the management budget.

$'000	April Mgmt Budget	April Annual Plan	April Movement	Year to Date Mgmt Budget	Year to Date Annual Plan	Year to Date Movement	End of Year Mgmt Budget	End of Year Annual Plan	End of Year Movement
Funding									
Income	39,962	39,788	174 F	401,527	399,649	1,877 F	491,789	489,518	2,271 F
Less:									
Payments to Internal Providers	20,588	20,148	(439) U	218,065	217,948	(117) U	263,091	263,334	243 F
Payments to Other Providers	18,798	18,654	(144) U	187,852	186,196	(1,656) U	224,184	222,194	(1,990) U
Contribution	**576**	**986**	**(409) U**	**(4,390)**	**(4,494)**	**104 F**	**4,514**	**3,990**	**524 F**
Governance and Funding Admin.									
Funding	262	262	-	2,616	2,616	-	3,140	3,140	-
Other Income	3	3	-	25	25	-	30	30	-
Less:									
Expenditure	251	261	10 F	2,538	2,639	101 F	3,049	3,170	121 F
Contribution	**13**	**3**	**10 F**	**103**	**2**	**101 F**	**121**	**(0)**	**121 F**
Health Provision									
Funding	20,326	19,887	439 F	215,450	215,332	117 F	259,951	260,194	(243) U
Other Income	1,997	1,961	36 F	18,152	17,571	580 F	21,479	20,865	613 F
Less:									
Expenditure	22,962	22,887	(75) U	233,662	232,760	(903) U	282,076	281,060	(1,016) U
Contribution	**(639)**	**(1,039)**	**400 F**	**(61)**	**144**	**(205) U**	**(646)**	**0**	**(646) U**
Net Result	**(50)**	**(50)**	**(0) U**	**(4,349)**	**(4,349)**	**(0) U**	**3,990**	**3,990**	**(0) U**

11. Quality and Financial Improvement Programme

Row Labels	Sum of Planned Savings	Count of Planned Savings	Sum of ytd savings target	Sum of YTD actual Savings	Sum of monthly savings
CORPORATE	**1,360**	**14**	**1133**	**1133**	**113**
Green	1,360	14	1133	1133	113
Health Services	**7,000**	**69**	**5631**	**4721**	**580**
Amber	1,022	4	851	572	54
Green	5,638	60	4496	4148	526
Red	341	5	284	0	0
Maori Health	**82**	**1**	**69**	**69**	**7**
Green	82	1	69	69	7
POPULATION HEALTH	**70**	**2**	**58**	**58**	**3**
Green	70	2	58	58	3
STRATEGIC SERV	**1,688**	**2**	**610**	**549**	**61**
Green	1,688	2	610	549	61
Grand Total	**10,200**	**88**	**7501**	**6530**	**764**

The $764 thousand savings shortfall year to date is all in Health Services where we have achieved 90% of our year to date savings plan target. The gap in the savings plan for Health Services has largely been covered by additional savings made in other programs not on the original savings plan. These include delayed staff appointments and intense management of all discretionary spend e.g travel.

Health Services

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

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

The four amber programmes are:

- Acute and Medical (2 projects):
  - Year to date savings of $468 thousand against a $631 thousand target, 74% attained.
- Chief Operating Officer:
  - Year to date savings of $40 thousand against a $132 thousand target, 30% achieved.
- Surgical:
  - Year to date savings of $64 thousand against a target of $88 thousand 73% achieved

Corporate, Maori Health, Population Health and Strategic Services

All green

12. Financial Position

30 June		*April*				*Annual*
2015	$'000	*Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2015*	*Budget*
	Equity					
120,014	Crown equity and reserves	102,965	108,540	5,574	(17,048)	108,183
(32,388)	Accumulated deficit	(19,673)	(24,759)	(5,085)	12,714	(16,420)
87,626		83,292	83,781	489	(4,334)	91,763
	Represented by:					
	Current Assets					
14,970	Bank	19,109	(3,334)	(22,443)	4,140	8,756
1,703	Bank deposits > 90 days	1,741	1,564	(178)	39	1,564
17,862	Prepayments and receivables	10,968	18,086	7,118	(6,893)	18,146
3,881	Inventory	4,052	3,799	(253)	171	3,845
1,220	Non current assets held for sale	1,220	-	(1,220)	-	-
39,635		37,091	20,115	(16,976)	(2,544)	32,310
	Non Current Assets					
148,434	Property, plant and equipment	152,203	164,865	12,663	3,769	166,016
2,298	Intangible assets	1,969	1,998	29	(328)	2,217
7,301	Investments	9,201	9,119	(82)	1,900	9,351
158,033		163,373	175,982	12,610	5,340	177,583
197,668	**Total Assets**	**200,464**	**196,097**	**(4,366)**	**2,796**	**209,894**
	Liabilities					
	Current Liabilities					
-	Bank overdraft	-	-	-	-	-
29,960	Payables	37,498	35,549	(1,949)	7,538	35,540
35,239	Employee entitlements	34,832	31,849	(2,983)	(408)	32,660
65,199		72,329	67,397	(4,932)	7,130	68,200
	Non Current Liabilities					
2,342	Employee entitlements	2,342	2,419	77	-	2,431
42,500	Term borrowing	42,500	42,500	-	-	47,500
44,842		44,842	44,919	77	-	49,931
110,042	**Total Liabilities**	**117,172**	**112,316**	**(4,855)**	**7,130**	**118,131**
87,626	**Net Assets**	**83,292**	**83,781**	**489**	**(4,334)**	**91,763**

The variance from budget for:

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

13. Employee Entitlements

30 June		*April*				*Annual*
2015	$'000	*Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2015*	*Budget*
7,916	Salaries & wages accrued	6,875	5,102	(1,772)	(1,041)	5,482
1,370	ACC levy provisions	1,853	1,056	(797)	483	1,176
4,951	Continuing medical education	5,734	5,295	(439)	783	4,860
19,383	Accrued leave	18,636	18,908	273	(747)	19,649
3,962	Long service leave & retirement grat.	4,076	3,906	(170)	114	3,925
37,582	**Total Employee Entitlements**	37,174	34,268	(2,906)	(408)	35,091

14. Treasury

Liquidity management

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

Debt management

The term debt facility with MOH is for $42.5 million, and is fully drawn. A further $5 million relating to the disposal of the Napier site, is available for the mental health build, and is likely to be drawn down in the last quarter of calendar 2016. The DHBs interest exposure is managed through a spread of maturity dates, rather than the use of derivative financial instruments, and the average cost of borrowing is currently 4.58%. No debt will become current until the 2017/18 financial year, and $25 million is for terms longer than five years.

The drawdown of $6.5 million in June 2012 increased the amount maturing in March 2019 to $11.5 million. This was done to take advantage of the low interest rate applying to that maturity, but it also puts the balance for that year above the $10 million limit set in the Treasury Management Policy.

Foreign exchange risk management

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

15. Capital Expenditure

2016 Annual Plan		Actual $'000	Year to Date Budget $'000	Variance $'000
	Source of Funds			
	Operating Sources			
13,872	Depreciation	10,977	11,451	474
3,990	Surplus/(Deficit)	(4,334)	(4,349)	(15)
(113)	Working Capital	9,621	11,631	2,010
17,749		16,263	18,733	2,469
	Other Sources			
-	Special funds and clinical trials	195	-	(195)
5,000		195	-	(195)
22,749	**Total funds sourced**	**16,459**	**18,733**	**2,274**
	Application of Funds:			
	Block Allocations			
3,856	Facilities	2,333	3,149	816
3,000	Information Services	753	2,327	1,574
5,200	Clinical Plant & Equipment	2,231	4,361	2,130
-	Minor Capital	26	27	1
12,056		5,343	9,864	4,521
	Local Strategic			
665	Renal Centralised Development	100	554	454
848	New Stand-alone Endoscopy Unit	192	581	388
5,654	New Mental Health Inpatient Unit Development	6,648	4,712	(1,937)
2,035	Maternity Services	1,971	1,767	(204)
100	Upgrade old MHIU	-	83	83
9,302		8,912	7,697	(1,215)
	Other			
-	Special funds and clinical trials	195	-	(195)
-	Transform and Sustain	3	-	(3)
-	Other	106	12	(94)
-		304	12	(292)
21,358	***Capital Spend***	***14,559***	***17,574***	***3,015***
	Regional Strategic			
1,391	RHIP (formerly CRISP)	1,900	1,159	(740)
1,391		1,900	1,159	(740)
22,749	**Total funds applied**	**16,459**	**18,733**	**2,274**

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

Monthly Project Board Report
Apr 2016

HAWKE'S BAY District Health Board

New Mental Health Unit Development

Project Director: G Carey-Smith

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

Phase 3: Service & Facility Establishment

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

1). Service redesign of acute mental health services to align with the HBDHB 2012 Mental Health Model of Care. Includes for investment in alternatives to inpatient care, with an increased focus on care provided in the community.

2). A replacement mental health inpatient unit on the Hawke's Bay Regional Hospital site.

3). A replacement mental health sub-acute facility, co-located with the inpatient unit.

4). A replacement of the Recovery Centres to move to some services within the community and a Day programme (co-located with the inpatient unit).

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

Project Budget Status

Total Approved Project Budget	Total 15/16 Total Forecast Spend	$	7,272,000
Total Project Spend to Date	Total 15/16 Spend to Date	$	6,648,000
Percentage of Total Spend vs Budget	Percentage 15/16 Spend vs Forecast		91%

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

Deliverable Dates

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

Key Achievements this period

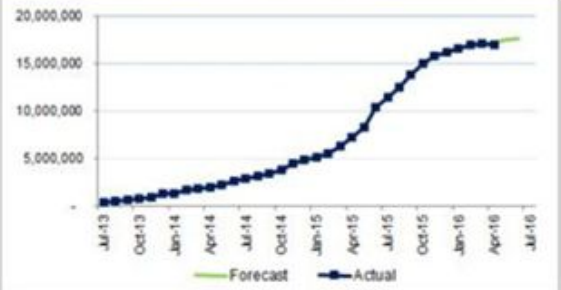
Planning for Phase 3 completed.
Ongoing development and implementation work for IDP and SPoE. Continue to work with vendor and internally to confirm the feasibility for IS developments needed to support the new model of care and implement SPoE and ensure IS systems necessary to support operations.
Focus continues on integration across services, embedding Vision & Behaviour statement and strengthening community mental health.
Review of Transition to Nga Rau Rakau commenced.

Planned Activities next period

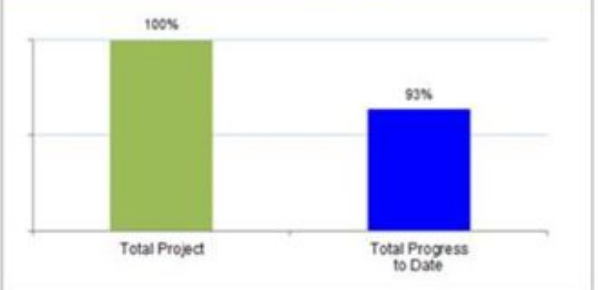
Embedding, integration & review of changes implemented; includes reporting, procedures, Vision & Behaviour statement, patient journey.
SPoE - progressing towards implementation
IDP - Working group meeting weekly. Recruitment of lead priority.
Implementation of 1 Assessment. 1 Plan
Strengthen Community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

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

Forecast vs Actual Spend



Total Project Progress



16. Rolling Cash Flow

	Actual	April Forecast	Variance	May Forecast	Jun Forecast	Jul Budget	Aug Budget	Sep Budget	Oct Budget	Nov Budget	Dec Budget	Jan Budget	Feb Budget	Mar Budget	Apr Budget
Cash flows from operating activities															
Cash receipts from Crown agencies	41,766	41,105	661	40,751	42,668	43,876	42,407	51,446	43,734	42,407	42,407	43,864	42,517	42,439	43,635
Cash receipts from revenue banking	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from donations, bequests and clinical trials	117	-	117	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	725	440	285	423	456	394	412	404	472	409	417	406	428	430	428
Cash paid to suppliers	(25,136)	(25,129)	(7)	(23,636)	(24,660)	(27,648)	(24,416)	(26,169)	(24,631)	(24,572)	(25,144)	(24,301)	(21,384)	(24,973)	(24,977)
Cash paid to employees	(14,566)	(15,272)	706	(14,641)	(16,139)	(14,101)	(19,755)	(15,244)	(15,188)	(17,855)	(14,471)	(16,743)	(14,482)	(19,568)	(15,345)
Cash generated from operations	**2,905**	**1,144**	**1,762**	**2,897**	**2,325**	**2,521**	**(1,352)**	**10,437**	**4,386**	**390**	**3,210**	**3,227**	**7,079**	**(1,671)**	**3,741**
Interest received	76	84	(8)	86	82	81	80	67	66	80	72	75	68	75	73
Interest paid	(304)	(419)	115	(261)	(190)	(330)	(330)	(95)	(41)	(69)	(160)	(359)	(325)	(139)	(60)
Capital charge paid	-	-	-	-	(3,910)	-	-	-	-	-	(4,142)	-	-	-	-
Net cash inflow/(outflow) from operating activities	**2,678**	**809**	**1,869**	**2,721**	**(1,693)**	**2,271**	**(1,603)**	**10,408**	**4,411**	**400**	**(1,020)**	**2,942**	**6,822**	**(1,735)**	**3,753**
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	-	-	-	-	0	0	0	0	0	0	1,220	0	0	0	0
Acquisition of property, plant and equipment	(696)	(2,015)	1,319	(1,730)	(1,976)	(2,599)	(2,599)	(2,599)	(2,599)	(2,599)	(3,599)	(2,599)	(2,599)	(2,599)	(2,599)
Acquisition of intangible assets	-	(50)	50	-	-	-	-	-	-	-	-	-	-	-	-
Acquisition of investments	(269)	0	(269)	0	(348)	-	-	(285)	-	-	(285)	-	-	(285)	-
Net cash inflow/(outflow) from investing activities	**(966)**	**(2,065)**	**1,099**	**(1,730)**	**(2,324)**	**(2,599)**	**(2,599)**	**(2,884)**	**(2,599)**	**(2,599)**	**(2,664)**	**(2,599)**	**(2,599)**	**(2,884)**	**(2,599)**
Cash flows from financing activities															
Proceeds from equity injection	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Proceeds from borrowings	-	-	-	-	-	-	-	-	-	5,000	-	-	-	-	-
Repayment of finance leases	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Equity repayment to the Crown	-	-	-	-	(357)	-	-	-	-	-	-	-	-	-	-
Net cash inflow/(outflow) from financing activities	**-**	**-**	**-**	**-**	**(357)**	**-**	**-**	**-**	**-**	**5,000**	**-**	**-**	**-**	**-**	**-**
Net increase/(decrease) in cash or cash equivalents	1,712	(1,256)	2,968	991	(4,375)	(328)	(4,202)	7,524	1,812	2,801	(3,684)	343	4,223	(4,619)	1,154
Add:Opening cash	19,139	19,139	-	20,851	21,841	17,467	17,139	12,937	20,461	22,273	25,074	21,390	21,733	25,956	21,337
Cash and cash equivalents at end of year	**20,851**	**17,882**	**2,968**	**21,841**	**17,467**	**17,139**	**12,937**	**20,461**	**22,273**	**25,074**	**21,390**	**21,733**	**25,956**	**21,337**	**22,491**
Cash and cash equivalents															
Cash	7	7	-	7	7	7	7	7	7	7	7	7	7	7	7
Short term investments (excl. special funds/clinical trials)	17,757	14,780	2,977	18,748	14,373	14,047	9,845	17,369	19,181	21,982	18,298	18,641	22,864	18,245	19,399
Short term investments (special funds/clinical trials)	3,085	3,093	(9)	3,085	3,085	3,085	3,085	3,085	3,085	3,085	3,085	3,085	3,085	3,085	3,085
Bank overdraft	2	2	(0)	2	2	-	-	-	-	-	-	-	-	-	-
	20,851	**17,883**	**2,968**	**21,842**	**17,467**	**17,139**	**12,937**	**20,461**	**22,273**	**25,074**	**21,390**	**21,733**	**25,956**	**21,337**	**22,491**

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

CONSUMER STORY

Verbal Presentation

OURHEALTH HAWKE'S BAY Whakawateatia	**HB Health Consumer Council & HB Clinical Council** 42
	For the attention of: **HBDHB Board**
Document Owner:	Graeme Norton, Chair of Combined Meeting
Reviewed by:	Chris McKenna, Co-Chair Clinical Council
Month:	May 2016
Consideration:	For Information

11

RECOMMENDATION

That the Board

Note the contents of this report

HB Health Consumer Council joined with Clinical Council on 11 May 2016, an overview of issues discussed/agreed at this joint meeting.

BEST START HEALTHY EATING STRATEGIC PLAN (FINAL)

The Plan was endorsed by the Clinical Council and Consumer Council. Members of Consumer Council have had considerable input into plan development and there was strong support for the positive approach to this challenge.

CUSTOMER FOCUSED BOOKING PROGRAMME (UPDATE)

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

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

Questions / feedback from Clinical and Consumer Council Members:

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

- The customer doesn't just need a booking system, they need flexibility.
- There needs to be a way to ensure that the demand is understood and translated across to the services which are being provided. Otherwise the individual is trying on their own to get the service at a time which is helpful for them.
- Hoping to see a reduction in the amount of DNA rates; and increased customer satisfaction in the ability to arrange their own appointment times.
- Is there going to be a linked system for other appointments e.g. appointments to see paediatrician/audiology etc on the same day? Yes, that is in the process of being developed.

TRAVEL PLAN – (VERBAL UPDATE)

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

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

Questions / feedback from Clinical and Consumer Council Members:

- We get a lot of feedback from our consumers regarding the lack of parking, there is a lot of communications for and to staff, what is the plan to inform our community on what we are doing? We have a web page and did a survey last year, but that is only a small proportion of the community. The travel plan is about influencing staff behaviour so our consumers have more options
- It is crucial that patient focused booking and the travel plan are co-ordinated, transport has been identified as a barrier to care. It is important that people are advised of the public transport options and those who are utilising public transport have priority for appointment times to fit in with this
- There seems to be a focus on getting staff to work and car usage. A bigger part of the plan is also the health benefits of not running cars, not much talk about bike sharing and other options like that which can be used in urban areas. It would be good to see this as well as the public transport options. Andrea advised that Population Health are part of this team and they are looking at the active health side
- Acknowledge that the electronic system is the way to go, but aware that particularly the elderly and some of the lower socio-economic families don't have access to technology so there still needs to be some thought given to them.

YOUTH HEALTH STRATEGY (DRAFT)

The Chair advised that some members of the Consumer Council have had a fair amount of input into this strategy, co-operating with Population Health. Dr Caroline McElnay advised that this is the first time that anyone has seen it written down as a strategy document.

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

Questions / feedback from Clinical Council and Consumer Council members:

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

Positive feedback on the work to date.

OURHEALTH HAWKE'S BAY Whakawateatia	**Reappointments to HB Health Consumer Council** 43
	For the attention of: **HBDHB Board and Health Hawke's Bay Ltd Board**
Document Owner:	Ken Foote, Company Secretary
Reviewed by:	Not applicable
Month:	May 2016
Consideration:	For Endorsement

12

RECOMMENDATION

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

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

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

It is now recommended that both Board endorse these reappointments.

HAWKE'S BAY District Health Board

MEMO

To:	Kevin Snee, Chief Executive HBDHB Liz Stockley, Chief Executive, Health Hawke's Bay Ltd
From:	Ken Foote, Company Secretary HBDHB
Subject:	**REAPPOINTMENTS TO HAWKE'S BAY HEALTH CONSUMER COUNCIL**
Date:	16 May, 2016

BACKGROUND

The Hawke's Bay Health Consumer Council was established in June 2013 with an independent Chair and fifteen members. Half of the members were appointed for one year, and the other half for two.

The current Terms of Reference provisions relating to membership include:

- 15 members plus a Chair
- Members appointed for up to two years
- Members may be reappointed for no more than three terms

In the last three years, six members have resigned (for various reasons), four of which have been replaced and a process is now underway to appointments to the two remaining vacancies.

RETIREMENT BY ROTATION – DUE JUNE 2016

Members due to retire by rotation and number of terms they will have completed in June follows:

Tenure	Term	Expiry
James Henry	1st	June 16
Malcolm Dixon	1st	June 16
Leona Karauria	2nd	June 16
Rosemary Marriott	2nd	June 16
Terry Kingston	2nd	June 16
Tessa Robin	2nd	June 16
Heather Robertson	2nd	June 16

As Chair, Graeme has canvassed those whose membership expires in June 2016 regarding their intentions and willingness to continue to serve. All wish to be reappointed and believe they have business to finish and further contributions to make.

There are 7, 5 of whom will be on their 3rd and final term, the other two on a second term. Graeme is comfortable they be reappointed as each is making a constructive contribution and their experience is valuable.

Graeme also notes that his intention as Chair in the next year is to ensure we have a pool of talent developing to replace these folk when their time is up. A potential source is the various groups that are forming as directorates to engage in co-design work.

RECOMMENDATION

It is therefore recommended that the following Members of Consumer Council be reappointed for a further two year term expiring in June 2018:

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

Ken Foote
Company Secretary

APPROVAL

Kevin Snee, CEO HBDHB — 17/5/16 Date

Liz Stockley, CEO Health Hawke's Bay — 18 May 2016 Date

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

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board (MRB)** 44
	For the attention of: **HBDHB Board**
Document Owner:	Heather Skipworth (Deputy Chair)
Reviewed by:	Not applicable
Month:	May, 2016
Consideration:	For Information

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RECOMMENDATION

That the Board

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

PURPOSE

The purpose of this report is to provide the Board with an overview of the issues discussed/agreed at the MRB meeting held on 12 May 2016. This report also asks the Board to consider MRBs advice and recommendations regarding the Best Start: Healthy Eating and Activity Plan Final.

Best Start Healthy Eating and Activity Plan Final

Shari Tidswell (Team Leader, Healthy Population Advisor) provided MRB with a brief update of the plan highlighting the plan writer's responses to the committee's feedback and the implementation of the pragmatic changes. Including the application of the Health Equity Assessment Tool (HEAT) and future plan to apply the tool at the roll-out of the programme to ensure focus on the target group continues. MRB endorsed the Best Start: Healthy Eating and Activity Plan Final to go to the Board, in consideration of MRBs advice and recommendations as listed above in the Recommendations to the Board.

Customer Focussed Booking

Carleine Receveur (Senior Change Manager) provided MRB with a brief update on the programme reassuring MRB that there has been a lot of foundation work happening but has not been clearly visible. MRB noted the report and provided the following feedback:

- 'Kanohi ki te kanohi' (face to face) was identified as a key element to the success of the DNA Project because Māori respond better to kanohi ki te kanohi. The practice is a key mechanism to obtain real authentic consumer feedback about the services. This practice was not evident in the programme and MRB emphasised that it should be.
- Review of the DNA Policy was a recommendation of the DNA Project but has not been completed. The policy is not a preventative one and only comes into action when the consumer DNAs.
- Examine the Booking Protocols to engage the Māori Health Service (MHS) at an earlier stage of the DNA pathway as a preventative approach. Such as, when booking appointments include the MHS to identify any barriers from inception
- The terminology 'whānau' includes the entire whānau. Therefore, the whānau approach needs to be translated into the programme. The Steering Group could challenge themselves to look at how to transform the current programme into a whānau approach.

Travel Plan Update

MRB were updated on developments and requested that communication is extended to community. The following feedback was provided:

- Avoid the $1.00 a day charge if possible. If charging a fee per day cannot be avoided, the charge to remain at $1.00 per day and no higher. It was viewed that putting a charge on parking has the potential to increase DNAs. The 'philosophical principle' may be the main issue with visitors taking offence to paying for parking to visit a sick family member
- Finding car parks during visiting hours or clinic times is very difficult. It is hoped that the proposed changes will assist this issue
- Good to see that the plan did not turn into a money making venture.

Annual Māori Health Plan Quarter 3 Report (Jan-Mar 2016)

Provision of Cardiovascular Disease services had been a problem locally and across the region. The improvement this quarter was noted and described as impressive. We are not only meeting the target but Māori have faster access for angiography geographically in comparison to non-Māori. MRB acknowledged Dr John Gommans and his team for their efforts for this performance.

Staff completing Cultural Training progress has been slow and challenging. The increase in the number of medical staff from 19 percent in Quarter 2 to 32 percent this quarter was outstanding and Dr John Gommans and other senior doctors were acknowledged for being champions of the cause. In addition it was acknowledged that the Executive team are taking this seriously and are demanding staff to attend.

Progress in the Pre-school Oral Health Enrolments for Māori under 5 years target was also noted.

There was concern regarding Māori under the Mental Health Act (MHA) Compulsory Treatment Order (CTO) and the widening inequity between Māori and non-Māori. Justifiably why this indicator is inclusive of the Te Ara Whakawaiora Programme. Additional focus areas are Transition Planning for youth leaving the Child, Adolescent and Family Services (CAFS) that needs improving, and Access to Care for both Mental Health and Alcohol and Other Drugs (AOD) services.

Obesity, being a primary cause of heart disease and diabetes, led to a discussion about Bariatric Surgery as a treatment for people with obesity. While our HBDHB Annual Plans focus for obesity is on prevention targeting children and youth, there is less focus on the older people with obesity. The current amount of surgeries we provide per year is six or seven and this could be increased if that was seen as the priority. An investigation of the evidence is required to rationalise the increase of surgeries per annum. Kevin Snee (CEO HBDHB) has agreed to respond to MRBs enquiry and request the Equity Champion undertakes the investigation.

Te Ara Whakawaiora Priorities & Reporting Schedule 2016-17

The objective of Te Ara Whakawaiora Programme is to monitor and address inequity. MRB requested that the HEAT tool be embedded into the system to ensure this work is then reported to MRB. By having this process in place would mean MRB didn't need to keep checking that a HEAT assessment has been applied. It was advised that the Equity Champion is working with Māori health and Strategic Services to develop this process. It is due back to MRB in August.

Youth Health Strategy Draft

MRB provided the following feedback:

- Strategies that connect or at least should, aren't i.e. the Suicide Prevention Strategy.
- Minimize the negative connotations, as raised earlier in the discussion about obesity to avoid negative labelling of children and youth
- Ensure the strategy does not separate Māori youth from their marae or whānau base but includes this aspect. Whānau connectivity is critical and it is hoped the strategy focuses on strengthening whānau bonds
- Consider MRBs advice from the previous meeting in March to be incorporated in to the strategy as this had not been done
- Establish or better utilise an existing Youth Intersectoral Group to maintain connectivity between all services as there are a lot of agencies working in silo both within the DHB and community
- MRB to consider having a youth representative on its Board. Consumer Council are currently recruiting two youth representatives which is great!

MRB Representation on Clinical Council – Appointment Delayed

MRB agreed further discussion needs to occur to include the development of a profile to inform interested parties of the roles responsibilities and MRBs expectations. This is a pertinent position alongside all other Clinical Council members responsible for ensuring best value from Clinical Council to benefit the Māori population of Hawke's Bay. The capacity to fully commit to the position due to the high level of commitment required for this role was noted. A back-up person to the position may be required. Once a profile has been developed, members will be emailed the profile with a request for any 'Expressions of Interest'.

HAWKE'S BAY District Health Board Whakawāteatia	Final Drafts of the: **HBDHB Annual Plan 2016/17** **HBDHB Māori Health Plan 2016/17** **Central Regional Services Plan 2016/17** 45 For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Tim Evans, GM Planning Informatics and Finance Carina Burgess, Acting Head of Planning
Reviewed by:	Executive Management Team (EMT)
Month:	May, 2016
Consideration:	For Information

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RECOMMENDATION

That the Board:

- Approve the Final HBDHB Annual Plan 2016/17 and Central Regional Services Plan 2016/17 subject to any minor changes that may occur from the final feedback received by MoH on 13th June.
- Note the HBDHB Māori Health Plan is incorporated into the HBDHB Annual Plan 2016/17.
- Delegate two members to review/approve minor changes and sign the Final documents prior to 17th June.

OVERVIEW

Feedback from the Ministry of Health (MoH) on the First Drafts of the HBDHB Annual Plan 2016/17, HBDHB Māori Health Plan 2016/17 and the Central Regional Services Plan 2016/17 has been received. The majority of the feedback was regarding technical issues such as timeframes and measurable activities requiring minimal changes for the Final Draft, which is due back to the MOH by 30th May 2016.

Up to date versions of the Final Drafts and Final Documents will be made available as they are completed. Please send any comments to carina.burgess@hbdhb.govt.nz

Timeline

Feedback from MOH on First Drafts received	2nd May
Final feedback from staff	20th May
Final Drafts to EMT	24th May
Final Drafts to Board	25th May
Any changes from EMT/Board incorporated into Final Draft Annual Plan, Māori Health Plan and Regional Services Plan, Submitted to MOH and loaded onto Diligent	30th May
Final Draft HBDHB Annual Plan to the Board	2nd June
Final Drafts to Māori Relationship Board (MRB)	8th June
Feedback on Final Draft of Annual Plan, Māori Health Plan and Regional Service Plan from MOH	13th June
Delegated Board Members to review, approve and sign Final Plans	16th June
Final Annual Plan and Regional Service Plan due to MOH	17th June
Final HBDHB Māori Health Plan 2016/17 due to MOH	30th June

Changes to the Annual Plan (Including HBDHB Māori Health Plan)

Delivering on Priorities and Targets

The MOH provided feedback on the Annual Plan which was split into 29 sections. Of these, 24 were approved subject to some minor changes regarding timeframes or measurable activities. The sections that weren't supported and the reasons for this were:

Section	Feedback
Breast Screening*	The DHB needs to outline how they will identify women who are unscreened or under-screened and how they will promote breast screening to Māori women, and ensure activities are measurable and have a time frame.
Cervical Screening*	The DHB needs to provide an activity related to identifying women who are unscreened or under-screened, and also ensure that several of the activities are specific and measurable.
Mental Health (Compulsory Treatment Orders)*	The DHB needs to provide a completed section that relates to reducing the rate of Māori treated under community treatment orders.
Health of Older People	The DHB needs to include more detail on actions and measurement for system integration for older people and dementia pathways and include a commitment to implementing the in-between travel settlement agreement.
Shorter Stays in the Emergency Department	The DHB needs to include more specific actions that identify how it will achieve the Shorter Stays in Emergency Departments Health Target throughout 2016/17 and a commitment to complete its implementation of the ED Quality Framework by 30 June 2017.

*Māori Health Priorities

The leads are rectifying these issues and issues will be resolved in time to submit the Final Draft to the MOH by 30th May

System Level Measure (SLMs)

SLMs are replacing the Integrated Performance and Incentive Framework (IPIF). However, information on what is required in the annual plans has not yet been provided to DHBs. We are prepared to take this forward with Health Hawke's Bay once more information is received from the MOH.

The New Zealand Health Strategy

The MOH were satisfied with how the plan was aligned to the Draft NZ Health Strategy but this needs to be updated to align with the Final NZ Health Strategy.

Financial

The $3m surplus will not change however there may be changes to the detail relating to new investment and efficiencies.

Changes to the Regional Service Plan

The Regional Services Plan was made up of 10 sections and of these, two were not supported in the first draft. These were:

Section	Feedback
Health of Older People	The Region needs to provide more actions and measures to show progress on the work programmes for dementia and interRAI.
Cardiac Services	The Region needs to clarify specific actions and measures, including clinical prioritisation, and achievement of standardised intervention rates, and actions to support this.

Central TAS is working with the Regional Networks and DHB planners on these sections.

ACCOMPANYING DOCUMENT(S)

HBDHB Annual Plan 2016/17 Final Draft v2.0

To be provided on 30th May:

- HBDHB Māori Health Plan Final Draft v2.0
- Central Region Regional Service Plan 2016/17 Final Draft

Final Draft
HBDHB ANNUAL PLAN 2016/17

To be provided 24 May 2016
(on the Website and Diligent)

HAWKE'S BAY District Health Board Whakawāteatia	**Best Start: Healthy Eating and Activity** 46
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Dr Caroline McElnay, Director Population Health Shari Tidswell, Team Leader/Health Promotion Advisor Kim Williams and Tracy Ashworth, Population Health Advisors
Reviewed by:	Executive Management Team, Māori Relationship Board (MRB), Clinical and Consumer Council
Month:	May 2016
Consideration:	For Approval

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RECOMMENDATION

That the Board:

1. Note responses to committee feedback.
2. Approve the Best Start: Healthy Eating and Activity Plan.

OVERVIEW

This Plan responds to the HBDHB's request for further detail on how we address childhood obesity and reduce inequities. A draft plan was presented to HB Clinical Council, HB Health Consumer Council and the Māori Relationship Board. Feedback has been incorporated into this Final Plan which is presented to the Board for approval.

BACKGROUND

The benefits of healthy eating and activity are far reaching including positively impacting on oral health, mental health and injury prevention and reducing the risk of cancers, heart disease and diabetes later in life.

What does the evidence show as effective?

A focus on the early years of life gives the greatest opportunity to achieve healthy weights across the lifespan.

- Healthy weight gain for pregnant women – this supports healthy birth weights for babies
- Healthy first foods - early behaviours are influential on our long-term health, children who are breastfed maintain healthy weight over their lifetime. Toddlers who eat healthy develop healthy eating habits over their lifetime
- School based programmes which support healthy eating and activity - children who are physically active and eat a healthy diet continue to be active and less likely to be obese
- Children influence the whānau and community – e.g. the results of Waikato's Project Energise
- Environments which support healthy eating choices and activity – settings (schools, churches) where the healthy choice is easy are effective in changing behaviours

Early intervention needs to include, changing the 'obesogenic environment' to a healthy eating one through; leadership, role modelling, consistent messaging, supporting healthy eating settings i.e. schools, workplaces and events, and retailers, and making healthy choices easy. An equity approach targeting Pasifika, Māori and high deprivation communities will provide the greatest gains.

What did the stakeholder and community input say?

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

- The focus needs to be wider than the individual and include whānau and the environmental influences.
- Equity issues need to be addressed.
- Community and whānau engagement in programme design and delivery is critical in achieving sustainable outcomes.
- Build on existing effective initiatives to gain the benefit of existing skill and community linkages.
- Prevention and intervention activities need to be part of healthy lifestyle changes which support whānau to achieve their health goals and uses a whole of community approach.

HOW HAVE WE RESPONDED TO COMMITTEE FEEDBACK?

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

Committee/s	Feedback	Response	Page reference
EMT	More detailed for activities	Added 'how' and 'when'	13-16
EMT	Include a sugar focus	Specified sugar reduction in Objective 1 & 2, stated the sugar focus in activities. Agree that a settings and whānau approach includes responding to the "sugar" evidence, so while not specifically stated sugar is part of food literacy, healthy eating policy, leading key messages and programme content.	Whole document
Clinical, EMT	Focus on physical activity	Clarified the need to address an identified gap for healthy eating.	3
Clinical, Consumer, EMT, MRB	Issues: engaging retailers, levels of food literacy, national programmes, impact of poverty	Leadership and flexibility are needed to respond to these. The Plan does allow for both	Whole document
Clinical	WHO, Ending Childhood Obesity report, integration	Included the six recommendations and clarified the links to our local implementation. All six are covered in the Plan's activities	5 & 6
EMT, Clinical Consumer	Change the Plan title to reflect physical activity, acknowledge obesity	Community and MRB feedback was to not focus on obesity, in order to reflect a lifestyle approach. We have included "activity"	Cover
Consumer	Change image on cover page	Changed to children climbing	Cover
Consumer	Coverage, limitations of the decile system, rural communities	The overarching value of addressing inequity will be applied to all activities	3 & 12
Consumer	Clarifying the purpose of the Plan is delivering activities	Opening paragraph rewritten to state this	3
Māori Relationship Board	Reduce the use of "obesity" in the document. The term has a negative impact for children.	"Reducing obesity" has been replaced with "increasing healthy weights" and the strategy title has been updated to "A Hawke's Bay Healthy Weight Strategy". Obesity remains in the document when others are quoted, when referring to the clinical measure and in titles of documents.	Whole document

We also note the endorsement of the focus on childhood, environmental approach, training for providers working with whānau (including health professionals), engagement with community in designing programmes, delivering via existing programmes/services, healthy lifestyle approach and HBDHB leadership. It was also noted that we need to be flexible enough to respond to a changing context (Health and Safety Act, new research and national programmes) and needs (rural communities and school decile system).

OBJECTIVES OF THE PLAN

Objective	Description
1. Increase healthy eating environments, by increasing healthy eating choices and physical activity, and reducing access to sugar	Addressing the environment by increasing healthy food choices in settings that children engage with including; education, marae, events and communities. Advocating for changes in marketing, retail and councils. Also reducing access to sugar i.e. Water Only Schools, SSB Free Events and support whānau to make informed consumer choices.
2. Develop and deliver prevention programmes – via food literacy, maternal nutrition, sugar reduction, physical activity and implementing policy	Implementing programmes which support healthy eating and physical activity for pregnant women, support breastfeeding, encourage healthy first foods, support whānau with healthy lifestyle changes, reduce sugar intake and school programmes which reinforces healthy eating messages and engage whānau in existing programmes shown to prevent the health risks associated with weight gain by maintaining healthy weight.
3. Intervention – support people to have healthy weight	Screening programmes identifying weight issues early and address weight gain via education, increased food literacy and whānau programmes. Screening during pregnancy and under five confer the greatest benefits over a lifetime.
4. Provide leadership in healthy eating	A population-wide improvement in healthy eating requires a cross-sector approach - the HBDHB is ideally placed to provide leadership and support key stakeholders in promoting healthy food environments, prevention programmes and early intervention.

This Plan provides an evidenced-based approach to increasing healthy weights for children in Hawke's Bay and will be delivered with community partners in order to support whānau engagement. Finally, the HBDHB has a role in leadership and will need to advocate for changes nationally and locally to develop an environment which supports healthy lifestyle changes.

Best Start: Healthy Eating and Activity

A plan for improving healthy eating and active lives for children in Hawke's Bay

2016-2020

May 2016

Table of Contents

Executive Summary

Best Start: Healthy Eating Plan

The purpose of this Plan is to outline the Hawke's Bay District Health Board's activities which will achieve the goal - "improving healthy eating and active lives for Hawke's Bay children". It also summarises the sources which informed the Plan's development:

- reports, plans and strategies which inform the context for healthy weight in childhood
- key evidence and input from key stakeholders, including communities

The activities fall into four objectives developed from the informing sources:

- Increasing healthy eating environments, by increasing healthy eating choices and physical activity opportunities and reduces sugar intake.
- Developing and delivering prevention programmes which include; food literacy, maternal nutrition, sugar reduction, implementing healthy policy and physical activity in early childhood and schools.
- Interventions which support children to have healthy weight.
- Providing leadership in Hawke's Bay for healthy eating.

These objectives have indicators which will help us measure progress toward our goal and this progress will be reported annually. The Plan is based on the principles of reducing inequity, engaging with whānau and Pasifika communities, health leadership and sustainable change.

How can we achieve healthy weight children in Hawke's Bay?

- Evidence supports a focus on early years to achieve the greatest opportunity for healthy weights across the lifespan
- Promoting healthy food environments, through leadership, role modelling, consistent messaging, supporting healthy eating settings i.e. workplaces and events, and working with retailers to make healthy choices the easy choice.
- We will make the greatest gains by having an equity approach targeting Pasifika, Māori and high deprivation communities.
- Stakeholder and community input noted that prevention and intervention activities need to be part of healthy lifestyle changes which support whānau to achieve their health goals and use a whole of community approach.
- We need a greater focus on healthy eating behaviour change while supporting existing physical activity initiatives. We noted a wide range of activity based programmes in Hawke's Bay and only a few healthy eating programmes, so the Plan's emphasis is on nutrition to address this gap.

This Plan outlines activities that will support whānau and communities to engage with programmes and interventions which support health weight.

What is the situation we aim to change?

Increase the number of health weight children

Over a third of our Hawke's Bay population is obese with higher rates for Māori (48%) and Pasifika (64%) populations. Obesity is the second leading risk to health in the Hawke's Bay. Rates have been increasing over the past decade.

Obesity leads to a range of diseases including heart disease, diabetes and cancer and these incur high medium- and long- term costs to individuals, whānau, communities, the health sector and wider social services. (Detailed data has been presented in the Equity Report[1]). We can change this trend by focusing on increasing the number of healthy weight children.

Create a healthy eating environment
Children are consuming more calorie rich, nutrient poor food which is easily available and cheap. While the cause may seem simple the systems we need to change to increase the number of healthy weights are complex: culture, economics, access, knowledge, family structure, working patterns, government policy and genetics all have a part to play in the choices we make in what and how much we eat and what we feed our children.

Make the healthy choice the easy choice
Unlike tobacco, where the message is simple, "don't start smoking or quit", food, exercise and healthy weight messages are dependent on a range of factors i.e. age, gender, type of activity. Therefore the key is to make changes to our wider community which means influencing our employers, retailers, food manufacturers, education sector, government departments, whānau and iwi, to provide environments which support healthy eating and activity in a daily lives.

What has been shown to work?

- Healthy weight gain in pregnancy supports healthy birth weights for babies.
- Introduction of appropriate 'first foods' develops healthy eating behaviours and supports life time healthy eating Healthy First Foods – breastfeeding supports healthy weights for both mother and baby. Toddlers who eat healthy food and appropriate portions develop healthy eating habits over their lifetime.
- School based programmes which support healthy eating and activity - school aged children who are physically active and eat a healthy diet continue to be active and maintain healthy weights.
- Children influencing the health behaviours of whānau and community - the best example in New Zealand are the outcomes of Waikato's Project Energise and safety belts usage.
- Making the healthy choice the easy choice is effective in changing behaviours. When children only have water to drink they drink water e.g. water only events and schools.
- Leveraging of the benefits of healthy eating and physical activity including positively impacting on oral health, mental health and injury prevention and reducing chronic diseases.

[1] HB DHB Equity Report. http://www.ourhealthhb.nz/assets/Strategy-Documents/13676-HealthEquity-Report-PRINTlr.pdf

Context

The greatest health benefit comes from prevention and early intervention so focussing on the childhood leads to increases in healthy weight for children and adults

International

The World Health Organisation's (WHO) "Ending Childhood Obesity Report (ECHO)[2]" calls for governments to take leadership and for all stakeholders to recognise their moral responsibility in acting on behalf of the child to reduce the risk of obesity by addressing the following comprehensive recommendations:

1. Promote the intake of healthy foods and reduce the intake of unhealthy foods and sugar-sweetened beverages by children and adolescents.
2. Promote physical activity and reduce sedentary behaviours in children and adolescents.
3. Preconception and pregnancy care to reduce the risk of childhood obesity.
4. Early childhood diet and physical activity guidance and support to develop healthy habits.
5. Promote health, nutrition and physical activity for school-age children by promoting healthy school environments.
6. Provide family-based lifestyle weight management services for children and adolescents.

National

Since the retraction of the Healthy Eating Healthy Action Strategy in 2009, there has been no overarching strategy for healthy weight available to support DHB planning. In 2015 the Ministry of Health released the "Childhood Obesity Plan[3]" which will be implemented at a local level via DHBs, schools, sports trusts and community organisations. The following six action areas align with the WHO ECHO report:

1. Increasing awareness and making healthy choices easier i.e. health star rating.
2. Supporting healthy weight gain in pregnancy and childhood.
3. Reducing the risk of progression to obesity in adulthood.
4. Slowing the progression of obesity related complications, such as diabetes and heart disease.
5. Maximizing the effectiveness and efficiency of obesity treatment.
6. Monitoring trends in obesity/complications and evaluating prevention intervention programmes.

Local

To support strategic coordination and alignment across these contexts, A Hawke's Bay Healthy Weight Strategy (Appendix A) using a lifespan approach was adopted in 2015 and this Plan has been developed to respond to the childhood part of the lifespan approach. The Plan outlines the evidence, stakeholder and community views, alignment and framework used to achieve the goal of "improving healthy eating and activity for children in Hawke's Bay". It is supported by the following objectives which align closely with both the Ministry's Childhood Obesity Plan and the ECHO report's recommendations:

1. Increase healthy eating and physical activity environments.
2. Develop and deliver prevention programmes.
3. Intervention to support children to have healthy weight.
4. Provide leadership to enable healthy eating behavior.

Locally, we have organisations supporting healthy eating and active lifestyles. They include active transport plans which promote walking and cycling, and community-led healthy lifestyle programmes, such as, Iron Māori and Patu Aotearoa, and community gardens i.e. based in schools and marae.

[2] World Health Organization 2016 "Ending Childhood Obesity" http://www.who.int/end-childhood-obesity/en/

[3] Ministry of Health, New Zealand, "Childhood Obesity Plan" http://www.health.govt.nz/our-work/diseases-and-conditions/obesity/childhood-obesity-plan

The HBDHB supports a range of these initiatives via funding, resources and expertise. Healthy eating practices have also been implemented in workplaces such as; the HBDHB, schools with sugar free drinks policies and events promoting healthy food. These plans and activities help make the healthy choice easier, however Hawke's Bay rates of obesity are increasing. Further action is needed including; building on the effective programmes/activities currently delivered, extending the environmental influences, having a greater focus on nutrition, increasing the leadership supporting healthy eating and coordinating activity strategically.

Evidence

Obesity is an equity issue, with 25% of Pasifika and 19% of Māori children being obese at 4 years compared to 12% for other ethnicities, inequity starts early. (HB Data)

Current data

Obesity is the second leading risk factor affecting health in New Zealand (after tobacco-use). It is linked to a range of diseases with high health and non-health costs. One-third of New Zealand's population is obese compared to an average OECD obesity rate of 17%; in fact only three OECD countries rate higher (United States, Mexico and Hungary) and our closest neighbour Australia, has a 25% rate[4].

Obesity is unfairly distributed in New Zealand with rates for Māori children twice and Pasifika three times the total population rate, and children living in our most deprived areas are more likely to be obese than those living in our least deprived areas (one and a half times and three times respectively)[5]. This inequity profile is reflected in Hawke's Bay with 19% of Māori and 25% of Pasifika children aged 2–14 years obese compared to 12% for non-Māori[6]. B4 School Check data also shows total four year old obesity prevalence is 4.2%, while Māori rates are 6% and Pasifika nearly 14%, with 6% of four year olds living in quintile 5 areas obese compared to 1.8% for four year olds living in quintile 1 areas.

Obesity impacts

At a societal level there is also an impact for our health system, it has been estimated that medical costs attributed to excess weight and obesity in 2006, were NZ$686 million[7]. There are other costs including infrastructure costs required by organisations to adjust for obese clients and staff. The impact of obesity goes beyond poor health outcomes, reduced quality of life and reduced life expectancy. The New Zealand Institute of Economic Research report identified that obesity impacted on a wide range of areas including; lower wages, increased sick leave, lower school education achievement, poorer mental health and barriers to public infrastructure i.e. plane seat being too small[8]. These impacts affect whānau and the community economically and socially.

Increasing childhood healthy weights

Increasing childhood healthy weights is particularly important as overweight children are more likely to develop adult obesity that continues throughout their lifetime[9] because pre-conditions for obesity are set very early in life[10].

[4] OECD. (2013). "Overweight and obesity", in OECD Factbook 2013: Economic, Environmental and Social Statistics, OECD Publishing.

[5] Ministry of Health. (2015). *Tatau Kahukura: Māori Health Chart Book 2015*. (3rd edition). Wellington: Ministry of Health

[6] Ministry of Health. (2015). *Annual update of Key Results 2014/15: New Zealand Health Survey*. Wellington: Ministry of Health.

[7] La A, et al. (2012). Health care and lost productivity costs of overweight and obesity in New Zealand. Aut NZ J Public Health 2012;36(6):550-6.

[8] New Zealand of Economic Research, The Wider Economic and Social Cost of Obesity, January 2015

[9] Sundborn, G., Mwerriman, T.R., Thornley, S., Metcalf, P., Jackson, R. (2014). An 'End-Game' for sugar sweetened beverages? Pacific Health Dialog. Vol 20 (1).

[10] Morton, S.M.B., Maternal nutrition and fetal growth and development, in Developmental Origins of Health and Disease, P.D. Gluckman, Hanson, M.A., Editor. 2006, Cambridge University Press: Cambridge. P. 98-130.

The familial influence is the biggest influence on dietary intake and level of physical activity for children, therefore any approach needs to be cognisant with whānau acceptance and involvement. Furthermore, education provides a logical setting for approaches to enable healthy eating and activity environments for children.

Children spend approximately a third of their waking hours during the school term in a structured school environment that has close links with whānau. Evidence shows that early intervention programmes delivered in this setting are particularly effective because behaviour change is reinforced across the wider school and home environment. The food environment has changed over time; access to fast foods and sugary drinks has increased, while the availability of fresh foods has decreased. Exposing children to food marketing on the journey to and from school, at school and during screen time impacts on whānau ability to make healthy food choices.

The food environment forms part of the largest and most significant impact on increases in obesity - the "obesogenic environment". This is the complex influences in the environment which influence our lifestyle and eating behavior. There is strong evidence to show that advertising high calorie low nutrition food to children increased consumption by children. Auckland University conducted a review of supermarkets in 2015 to assess their food content. 60% of food did not meet Ministry of Health Healthy Eating Guidelines[11] (low in sugar, salt and fat). If our main food source i.e. the supermarket, has mostly unhealthy food it is likely you will be eating unhealthy food.

Healthy public policy is one of society's most powerful mechanisms for environmental change. Parallels for increasing healthy weights can be drawn to tobacco control. For example, limiting marketing on television, creating smokefree spaces and increasing taxes on tobacco products changed the environment, influenced people's decisions, and consequently smoking rates dropped. Sustained advocacy for similar interventions could provide the catalyst for change in the obesity epidemic[12].

There is evidence that brief interventions can support at least short-term improvements in behavioral change and body weight if they combine both physical activity and nutrition components, are delivered by appropriately trained practitioners, encourage self-monitoring, foster support networks, and are flexible enough to respond to individual circumstances[13].

The health sector needs to develop and deliver evidence based information and education campaigns to raise awareness of the health problems related to poor nutrition, overweight and obesity in a format that is appropriate for the groups and settings most vulnerable. This can only be achieved through appropriate and meaningful engagement with priority groups and settings to determine the current levels of health literacy and appropriate way to communicate key messages. Only a well–informed consumer is able to make rational decisions.

[11] Ministry of Health, "Healthy Eating Guidelines"
[12] http://www.hsph.harvard.edu/obesity-prevention-source/policy-and-environmental-change/
[13] Cavill N et al. Brief interventions for weight management. Oxford: National Obesity Observatory, 2011.

Stakeholder and Community Input

Engagement with community, whānau and settings children engage with is vital

To gain further local knowledge and engagement we sought input from stakeholders and community to help us understand the issues from their perspective and how they feel these issues can best be addressed. Overall this input aligned with the evidence and reinforced the need to continue to engage whānau in development and delivery, use consistent messages, build on existing effective programmes and support settings children engage in to provide healthy eating environments. We have noted that physical activity is supported in a wide range of ways including; schools, sports clubs, dance groups, community facilities and out of school programmes, but there needs to be more support for healthy eating. (Appendix B notes the source documents for the summaries below)

The **Maternal Nutrition programme** has ensured feedback and consultation occurs throughout development and delivery, providing an opportunity for participants to inform the programme's development. Key themes identified were:

- A supportive and trusting relationship between advisors (programme supports) and participants is a key facilitator of programme success. This relationship is about the needs and priorities of participants being listened to and embedded within a plan that will work for their lifestyle.
- Programme design needs to reflect a wellbeing approach by promoting a holistic view that is about participants investing in their own health and the things (food, exercise, etc.) that will benefit their wellbeing. This decentralises nutrition and exercise, and prioritises the women and their babies in a way that is well placed to ensure the sustainability of any changes women make.
- The majority of responses indicated significant flow-on effects to the whānau with respect to increased physical activity and healthy dietary changes.

Stocktake of healthy eating and activity initiatives offered to Hawke's Bay primary schools used consultation to provide an overview of healthy eating and activity initiatives offered and explored the views of stakeholders. Key themes identified were:

- Healthy eating and beverage policies must be better understood by their users and consistently implemented across settings.
- All food and beverages provided in schools must meet New Zealand Food Nutrition Guidelines.
- Access to sugary food and beverages and high fat, processed foods on the journey to/from school and within the environment undermines school healthy eating ethos.
- Food security is a contributing factor.
- Sustainable healthy eating behaviour change is transferrable across the wider school community and the home environment.
- Whānau should feel empowered to participate in programme development, activities and desired outcomes.
- A school-based physical activity programme that encourages whānau participation is needed for ***all*** children
- Programme components must have the capacity to be tailored to local needs.

Consumer Council input came from a workshop session with Council representatives in January 2016. This identified key enablers for change:

- Using belief structures, key groups/stakeholders including Government
- Strengthening connections
- Culturally appropriate modes

Initiatives, approaches and key messages identified:

- Wellbeing literacy, coordinated pathways
- Using points of influence i.e. pregnancy, parenting, education curriculum
- Promoting incidental exercise, hooks to engage
- Doing our best for our children, translate healthy into everyday life
- Work with whānau and make the healthy choice the easy choice

The overall view was to work at a range of levels from individuals to whānau, settings, communities and politically to create the greatest gains.

Māori Relationship Board Feedback

During 2015 support was given for the Strategy i.e." the strategy is a very comprehensive plan that exhibits a number of activities" and "supportive of the current strategy in term of its focus". There were further recommendations including; engaging whānau, HBDHB showing leadership, engaging with the community, speaking to the right people and work more closely with Māori. These have been picked up in the development of this Plan. Further feedback was sought to develop this Plan in March 2016 as noted below (meeting minutes March 2016).

- We need an equity lens on this strategy, how are we watching for any unintended consequences.
- The strategy is a starting point but there is a need to have teenage youth involved who are our future parents and leaders, nutrition advice to Māori homes and communities needs to be included.
- Investigate the cultural aspect of food because part of 'Manaaki' (a Māori custom) is to feed the people.
- It would have been useful to see the local information, the geographical spread and if we are improving or not. It would also be valuable to see where we align with other DHB initiatives, what they are doing and how do we measure against them.
- This is not just a DHB issue it is a community issue so we need to involve hapū and iwi.
- The issue is that sugary and takeaway foods are more affordable so obesity ties into the living wage discussion. Addiction ties into obesity.
- We need to stop siloing the issues that are bad; addiction, sexual health, oral health, obesity, smokefree, and suicide etc. It's about employing the whānau into good lifestyles. When we change the whānau environment we change the way they look at themselves and opt for good decisions as a by-product.

Overall the stakeholder and community input reinforced the evidence, with the following overarching themes:

- Focus needs to be wider than the individual and include whānau and the environmental influences.
- Equity issues need to be addressed.
- Community and whānau engagement in programme design and delivery is critical in achieving sustainable outcomes.
- Build on existing effective initiatives to gain the benefit of existing networks, skill and community linkages.

Alignment

Leadership is critical and all stakeholders needs to use their influence

Hawke's Bay DHB is well placed to lead healthy eating. To lead, we need to engage across a wide range of stakeholders including private sector, government bodies and community organisations to deliver the complex and multi-factorial solutions required to increase healthy weight. Recognizing and acting on obesity is crucial – particularly in childhood so we can slow progression of a greater burden of disease.

To be responsive to whānau and our communities, healthy eating will be incorporated with wider healthy lifestyle programmes and be supported in an environment which makes the healthy choice the easy choice. The Plan works with providers who have existing whānau relationships, uses settings which influence wider community and whānau, and aligns with national resources, programmes and messages.

"A Hawke's Bay Healthy Weight Strategy" (Appendix A) provides a lifespan approach to support coordination and alignment, for services, messages, initiatives and monitoring. The table below uses the Strategy's age groups and this Plan's key outcome areas to show where this coordination and alignment occurs for health services supporting child healthy weights.

Strategy Groups	Environment	Prevention	Intervention	Leadership
0-4 years	Advocacy to change marketing practices Policy support for ECEs-MoH Licensing Criteria	Resources to support breastfeeding, first foods – maternity services, Well Child/Tamariki Ora Early engagement with LMC and oral health services Messages- media community	Workforce development/screening tools/resources- midwives, Well Child/Tamariki Ora, and B4 School Check Clinical pathway- pediatric dietetic services	Breastfeeding Strategy National Obesity Plan Primary care- general practice and LMCs Well Child/Tamariki Ora health network Māori Health Plan TAW targets
5-12	Policy support for schools Advocacy-Health Promoting Schools programme	Consistent messaging –Health Promoting Schools, nutrition programmes, Fruit in School, PHNs, Water Only Schools	Supporting whānau based programmes- Sport HB, Iron Māori, community providers General practice Secondary services	MoE, principals, school boards National Obesity Plan
13-18	Policy support for schools- MoE	Food literacy workforce development- PHNs, teachers, community workers	School clinics General practice	HB Youth Health Strategy National Obesity Plan

Plan Framework

As outlined earlier, this Plan was informed by:

- Evidence, which clearly shows nutrition is the key in healthy weight, change needs to be lifestyle and must have a whānau and community approach and best outcomes are achieved when focusing on early intervention and early years.
- Stakeholder and consumer input supports the evidence with issues such as; food literacy, environmental and economic influences, whānau engagement and a cross-sector approach all being required to support lifestyle changes.
- Our local Strategy provides a structure to align the wide range of national and local activity needed for sustainable change.

Goal: Improving healthy eating and active lives for children in Hawke's Bay

Guiding Values

- Reducing health inequity in our Hawke's Bay communities, use an equity lens to review and deliver this Plan
- Improving Māori health outcomes
- Engaging the Pasifika communities
- Enable cross-sector leadership
- Approaches and activities support and engage whānau and communities
- A sustainable population health approach

As illustrated by the values, this Plan has a strong commitment to reducing the social and health inequities associated with poor nutrition and weight gain.

Objectives

Objective	Description
1. Increase healthy eating environments, by increasing healthy eating choices and physical activity, and reducing sugar	Addressing the environment by increasing healthy food choices in settings that children engage with including; education, marae, events and communities. Advocating for changes in marketing, retail and councils. Also reducing access to sugar i.e. Water Only Schools, SSB Free Events and support whānua to make informed consumer choices
2. Develop and deliver prevention programmes – via food literacy, maternal nutrition, sugar reduction, physical activity and policy	Implementing programmes which support healthy eating and physical activity for pregnant women, support breastfeeding, encourage healthy first foods, support whānau with healthy lifestyle changes, reduce sugar intake and school programmes which reinforces healthy eating messages and engage whānau in existing programmes shown to prevent the health risks associated with weight gain by maintaining healthy weight.
3. Intervention – support people to have healthy weight	Screening programmes identify weight issues early and address weight gain via education, increases food literacy and whānau programmes. Screening during pregnancy, and under five confer the greatest benefits over a lifetime.
4. Provide leadership in healthy eating	A population wide improvement in healthy eating requires a cross-sector approach, the HBDHB is ideally placed to provide leadership and support key stakeholders in promoting healthy food environments, prevention programmes and early intervention.

Objectives, Indicators and Actions

Objective 1: Increase healthy eating and activity environments

Indicator 1a: Increase the number of schools with healthy eating policies

Indicator 1b: Increase the number of settings including workplaces, churches and marae with healthy eating policy

What the data shows

There is limited data for the region, monitoring this objective will require the collection of baseline data for each indicator using the schools data in HealthScape and surveying other settings.

Activity to deliver objective one			
	What	**How**	**When**
Current activity	• Work with settings to increase healthy eating including education, schools, workplaces, events, Pasifika churches, marae • Support national messaging including sugar reduction i.e. Water Only • Advocate for changes in marketing and council planning	• Healthy eating policies which reduce sugar intake in 5 ECE centres, key community events increase healthy food choices, 4 Pasifika churches have a healthy eating approaches and guidelines for marae reviewed with Ngāti Kahungunu Iwi Incorporated • Communication plan implemented for national messages Submissions made • Supporting the implementation of programmes and plans i.e. i Way, Active Transport, Sport HB and Ngāti Kahungunu Iwi Incorporated plans	July 2017
New actions	• Support education settings to implement healthy eating and food literacy- early childhood, primary schools secondary schools, • Establishing a base measure for monitoring • Engage cross-sector groups to gain support and influence to increase healthy eating environments • Investigate food security for children and their whānau identifying issues	• 50% increase in schools with “water only” policy annually • Decile 9/10 communities have a whānau co-designed programme delivered in primary schools, - trialled 2016, 5 new schools annually • All schools surveyed for status in healthy eating/water only policies • Establish a group to influence changes in the environment across Hawke’s Bay • Partner with Auckland University to establish a baseline for the Hawke’s Bay food environment and monitor annually	Reported annually to 2020
Key partners	Ministry of Education, school boards, principals, school communities (including whānau), Ngāti Kahungunu Iwi Incorporated, employers, Councils, event organisers		

Objective 2: Develop and deliver prevention programmes

Indicator 2a: Rates of breastfeeding at 6 weeks increase

Indicator 2b: Number of healthy weight children at 4 years remain stable or improves

What the data shows

- Child fully or exclusively breastfeeding at 6 weeks rates as 68% for total population, 58% Māori and 74% Pasifka (December 2015 Ministry of Health)
- 76.5% of Hawke's Bay four year olds are healthy weight, 65.2% Māori and 66.9% Pasifika (2014 Before School Check data, Health Hawke's Bay)

Actions and Stakeholders			
	What	**How**	**When**
Current activity	• Implementing Maternal Nutrition Programme activities- breastfeeding support, healthy first foods • Supporting settings to implement healthy eating/sugar reduction programmes/policies • Supporting health promoting schools	• Breastfeeding support resources provided via Hauora • All Well Child/Tamariki Ora providers trained in Healthy First Foods • All schools, ECE, Well Child/Tamariki Ora Providers with health eating policies are provided with information resources and advice • Health Promoting Schools health promoters are up-skilled to implement healthy eating approaches	July 2017
Next actions	• Extend the Maternal Nutrition programme developing programmes in ECE and resources to support B4 School Check providers • Supporting healthy pregnancies, via education and activity opportunities • Support the development of whānau programme (building on existing successful programme) • Develop food literacy resources including sugar reduction messages -deliver via programme and settings • Support healthy eating programmes and approaches in schools	• Deliver training to LMCs, Well Child providers and B4 School Check nurses to increase skills to promote healthy eating- Healthy Conversation, Healthy First Foods, B4 School Check resources • Contract and support local provider/s to deliver the maternal healthy eating activity programme • Contract and support local provider/s to deliver whānau based programmes i.e. Active Families • Deliver key messages for whānau with 2–3 year olds • Develop food literacy resources for B4 School Check provider, promote Healthy First Food and heart foundation school resources • Support the co-designed programme for deprivation 9/10 communities	Reported annually until 2020
Key partners	Hauora providers, early childhood education providers, schools, principals, boards, Ministry of Education, workplaces, Ngāti Kahungunu Iwi Incorporated, Councils, LMCs, Maternity Services, Heart Foundation, Sport HB, Iron Māori, Patu Aotearoa		

15.1

Objective 3: Intervention to support children to have healthy weight

Indicator 3a: Increase referral to programmes which support healthy lifestyles and whānau engagement for 4 year olds with a BMI over 21

Indicator 3b: Increase food literacy training to targeted workforce including midwives, Well Child/Tamariki Ora, education workforces, social services and Before School Check practitioners.

What the data shows

- 55 Hawke's Bay children were identified with BMI over 21, of these, 47 were referred to interventions including Pre-school Active Families and the remaining 8 were given advice. Of the referrals 55% were Māori, 29% other and 19% Pasifika. (2015 B4 School Check Clinical Data- Health Hawke's Bay)
- 57 participants attended breastfeeding support training, 23 Well Child staff attended First Foods Trainer Workshops and 83 health professionals attended Gestational Diabetes updates (2015 HBDHB Maternal Nutrition Report to MoH)

Activities and Stakeholders			
	What	**How**	**When**
Current activity	• Screening including gestational diabetes, Well Child/Tamariki Ora and B4 School Checks • Whānau activity based programmes for under 5s • Paediatric dietetic referrals	• Monitor the screening and responding referrals • Fund Active Families under Five and monitor implementation. Investigate extending to further providers • Monitor referrals and outcomes	July 2017 Māori Health Targets - 6 monthly to the Board
New actions	• Support screening in maternal programme, Well Child/Tamariki Ora and B4 School Checks • Provide whānau based programmes to support lifestyle changes which support healthy weight i.e. Active Families • Support referrals to programmes via a range of pathways • Develop a clinical pathway from well child/primary care to secondary services • Support child health workforce, to deliver healthy conversations	• Support training for health professionals completing screening - maternal, Well Child/Tamariki Ora and B4 School Checks. • Contract community providers to take referrals for whānau with an overweight child (3-12 years) • Clinical pathway developed with key stakeholders- whānau, parents, children and health professionals • Healthy Conversation training delivered	Annually until 2020
Key partners	Well Child/Tamariki Ora, primary care, general practises, LMCs, Strategic Services, Oral Health Services, Paediatric Services, Maternity Services		

Objective 4: Provide leadership in healthy eating

Indicator 4a: Monitor the implementation of the HB DHB Healthy Eating policy

Indicator 4b: Engage support from key partners

What the data shows

Hawke's Bay District Health Board policy is compliant with MoH requirements December 2015. Obesity responses have been workshopped with cross-sector leaders and presented at the Intersectorial Forum in 2015.

Activities and Stakeholders			
	What	**How**	**When**
Current activity	• Share information, evidence and best practice and healthy weight data with key community partners • Show leadership by establish the HBDHB Healthy Eating Policy and implementing the Healthy @ Work workplan	• Regular updates provided via Maternal, Well Child/Tamariki Ora and B4 School Check forums. Regular meetings with community providers • Review and monitor the HBDHB Healthy Eating Policy and support the implementation of the Health @ Work workplan	July 2017
New actions	• Lead an equity focus by applying an equity lens to review this plan and delivered activity • Lead messaging and delivery to reduce sugar intake • Align HBDHB Healthy Eating Policy with national food and beverage guidelines • Develop a process for a cross-sector approach to support healthy eating environments • Influence key service delivery stakeholders to maintain best practise and consistent messaging • Continue engagement with community particularly key influencers for Māori and Pasifika i.e. marae and church leaders	• Equity assessment written and finding used to refine this plan to improve response to equity • Cross-sector activity includes a sugar reduction focus • Reviewed policy reflects the healthy eating guidelines • Framework/process implemented for cross-sector approach and inter-agency activity reported • Hauora, general practice, LMCs, contracted community providers provide national messages consistently to whānau, community and their workplace • Key activities Waitangi Day celebrations - policy/guidance document development Ngāti Kahungunu Iwi Incorporated and engagement with Pasifika church leaders	Ongoing until 2020
Key partners	Iwi leaders, Ngāti Kahungunu Iwi Incorporated staff, community leaders, governments department leaders, local authorities leaders, non-government organisations leader, private sector leaders, Pasifika community leaders, Ministry of Health, Ministry of Education		

Monitoring process

It is proposed that implementation of this Plan will be informally monitored via the Population Health Advisors Team and formally monitored via reporting on the HBDHB Annual Plan and to governance committees via key target measures and an annual report on activities.

There are also a number of aligned monitoring and reporting pathways for healthy weight:

- National targets including B4 School Check, breastfeeding rates (quarterly reporting)
- Population Health Core Plan six monthly and annual reporting
- Reporting on alignment with national guidelines for DHB Healthy Eating policy
- HBDHB Māori Health Target- healthy weights at 4 years
- Maternal Nutrition Programme outcomes framework (evaluations) reporting to MoH six monthly
- Schools Programme outcomes (evaluation), Population Health Plan
- Health Promoting Schools reporting framework

Data limitations:

- Data for over 5s is limited and not consistent
- Engaging with schools data is yet to be explored
- There is no baseline data for the healthy eating environment including food security
- There are time lags in data from the Ministry of Health i.e. breastfeeding data

Delivery mechanism

Annual plans detail the activities, outcome measures and who is responsible for activities being achieved. We deliver these activities with community partners i.e. Well Child/Tamariki Ora providers. Each of the activities is included in annual planning for HBDHB, particularly in the Population Health Service Annual Plan (Appendix C) where the:

- advocating for healthy eating environment and policy is part of the health promotion section
- develop and delivery of whānau based programmes is included in the maternal nutrition and health promotion sections
- support tools and workforce development for screening and referrals for interventions appear in the maternal nutrition section and health promotion sections
- information sharing and policy leadership is in the health promotion section
- consistent messaging and alignment national messages is in the health promotion sections
- developing a cross-sector model is in the health promotion section

While HBDHB have a leadership role, we need to partner with local government, schools, workplaces, community providers and Ngāti Kahungunu Iwi Incorporated to support healthy eating environments. As such, delivery detail will be outlined in these organisations plans and contracts.

Finally, timing of delivery is dependent on funding sources, as they become available new actions can be initiated. For example the HBDHB will negotiate with MoH in 2017 for funding associated with the National Childhood Obesity Plan, Population Health has secured another year of Maternal Nutrition funding from MoH and are completing a business case for EMT to funding a school aged programme.

Appendices

Appendix A: "A Hawke's Bay Healthy Weight Strategy"

Summary document previously presented to the May 2015 HBDHB Board.
http://www.hawkesbay.health.nz/file/fileid/50532

Appendix B: Stakeholder Feedback

Reports are available on request for:

- Schools Stocktake Feedback
- Maternal Nutrition and Active Families Evaluation (client and stakeholder feedback)
- Minutes from Consumer Council workshop
- Māori Relationship Board meeting minutes (June 2015, September 2015 and March 2016)

Appendix C: Population Health Annual Plan

Available on request and has been presented to the HBDHB Board as part of the Annual Plan approval process.

BUDGET UPDATE AND INVESTMENT PRIORITISATION

Verbal Presentation

TRAVEL PLAN QUARTERLY UPDATE

Verbal Update

HAWKE'S BAY District Health Board Whakawāteatia	**Customer Focused Booking Programme Update** 48
	For the attention of: **HBDHB Board**
Document Owners:	Sharon Mason, COO
Document Author:	Carleine Receveur
Reviewed by:	Health Services Leadership Team, Executive Management Team, Maori Relationship Board (MRB), Clinical and Consumer Council
Month:	May, 2016
Consideration:	For Information

RECOMMENDATION

That the Board:

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

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SUMMARY

The Customer Focused Booking project is making steady and sound progress towards a booking environment that is customer focused. High level achievements include the project identifying and supporting a Customer Focused Booking training programme for booking staff and the progression of UBook as an IS enabler for on line customer clinic booking.
Ensuring that the DHB has a stable platform for clinic scheduling and booking is a prerequisite for introducing the UBook system. However the project has found that there is a lack of operational processes and supporting business rules that enable certainty for booking in the clinic environment. The DHBs high level of rescheduling of patient appointments due to hospital driven reasons is an indicator of this issue. For the organisation to utilise the functionality of the UBook there needs to be clinic scheduling operational processes designed and implemented. Due to the complexity and depth of work involved in clinic scheduling, the Customer Focused Booking is shifting from a project to a programme. Under this umbrella programme a discreet project for Clinic Scheduling and Booking is being developed.

BACKGROUND

Since July 2012 there have been numerous attempts to introduce Customer (Patient) Focused Booking principles and system changes. The scope of work has included the clinic and booking environments of the elective specialties that sit within the Elective Services Patient Indicators (ESPI).

A customer focused approach is one in which places the customer at the heart of the booking process. The key elements of a customer focused booking system include:

1. DHB values and behaviours e.g. customers feel respected
2. Effective customer engagement for good health outcomes
3. Customer participation and input e.g. when arranging appointment times, so responsive to their needs
4. Ease of understanding and navigation e.g. customers know how and who to contact about their appointment
5. Support mechanisms for staff to enable them to deliver an exceptional customer experience are in place
6. IS systems that support the outcomes identified to occur
7. A mechanism to monitor the system and ensure continuous quality improvement.

A patient survey conducted in 2012 provided evidence that improvements in the booking system was required. Some of the high level findings included that 45% of the respondents had their appointment rescheduled, 20% indicated that they were not given enough notice of their appointment and 18% indicated that staff did not make an effort to make an appointment that suited.

Despite design workshops and processing mapping a consensus of the way forward was not agreed or implemented. In July 2015 the Chief Operating Officer (COO) requested that the project be re-activated and incorporate the findings and work from the DNA project.

In response to the COO's request a new project was formed and renamed as "Customer Focused Booking" to signal a focus on customer service based principles and that this was a new project with a different approach.

LAST UPDATE

The last project update was provided to the Consumer / Clinical Council and Board in September 2015. At this time a new project team was established with a new project sponsor, steering group, project manager, and project framework. As a result of recent horizon scanning the opportunity was taken to present Hutt Valley's District Health Board (HVDHB) UBook – a customer focused booking system developed by HVDHB. There was overwhelming support from both councils and board for HBDHB to adopt this system.

It was also signalled that the project included the outcomes / actions from the DNA project (which are inherently linked to achievement of this project's goal). There are natural links/synergies/ interdependencies that were evident from the outset, however the two projects had run in isolation of each other.

PROGRESS TO DATE

Since the last update in September 2015 the project has made good steady progress. The project work streams have evolved and matured as the intelligence gathering has occurred. The project has invested time in investigating current processes and understanding what the current status and issues are. This has been an important investment as there are significant areas requiring system improvement to support and sustain Customer Focused Booking principles. Due to the complexity and level of change required the Customer Focused Booking project has now moved into a programme of work with both a fully developed project and work streams under this umbrella.

The current work streams are described below with commentary on progress to date.

1. IS Solution

Since September 2015 IS staff continued to work closely with HVDHB. Dependency was on HVDHB to write up the necessary installation files so HBDHB could progress UBook as the IS option. There have been significant delays in receiving UBook installation files, however they were issued to HBDHB on the 16/3/2016. In the interim another potential IS solution was identified through the WEBPAS vendor, referred to as Ultragenda. This product has not yet been released in New Zealand. The IS staff conducted a review of Ultragenda including requirements and costs comparing the product with UBook. Cost alone (at half million yearly licencing fee) made this an unrealistic option for HBDHB.

2. Clinic Scheduling

A prerequisite for enabling customer focused booking is to have a stable clinic scheduling environment whereby clinic booking can be made in advance with high assurance that these clinics would not be changed. A recent investigation into clinic scheduling conducted as part of the project found that there was significant amount of rescheduling of clinics. The main reasons for this was dominated by the hospital environment (refer to appendix one)

The project released an internal report describing the findings of an investigation into current clinic scheduling processes from a booking administration perspective.

The high level findings included:

- Lack of business rules
- No methodology to calculate FSA to follow up clinics
- High level of rescheduling
- Clinic Templates not reflective of the work that is being done e.g. overbooking

From these finding it has become clear that there is a need to establish a platform of business rules and processes in the clinic environment to enable Customer Focused Booking. Due to the complexity of the issue Clinic Scheduling has now moved to a separate project under the Customer Focused Booking programme of work.

The purpose of this specific project is to design a platform of clinic scheduling business processes across the foundation components for the ESPI speciality clinics so that the DHB can optimise wait list management, deliver on agreed performance measures and support customer focused booking principles.

3. Customer Focused Booking Training

Customer service excellence in a health setting comes with a unique set of challenges and opportunities. Patients frequently suffer high level of stress, not only from illness or injury but also from the levels of customer service given.

The project recognised that to support our customers we need to support booking and administration staff – as a key group of people that interact with our customers, navigating the complexity of our health system. To do this the Customer Focused Booking project engaged the services of Business Training NZ who have developed a one day workshop referred to as “Putting the Patient First – Customer Service Strategies for Healthcare Professionals”.

Five workshops were conducted in early February with a total number of 49 staff participating. The workshop goals were to provide skills and techniques that are required to communicate in ways that will enhance patient satisfaction, the overall patient experience and the experience of staff. The workshop facilitators have experience working with health professionals and administration staff in a number of different health settings across New Zealand.

A participant evaluation was conducted which indicated an overwhelming positive response to the course with all participants recommending this workshop to colleagues (see appendix two). The Administration management team have been keen to ensure the learnings from the course were built on and embedded in the way "we do our business". Initiatives such as visual resources and prompts to support customer focused booking and monthly "Director of First Impressions" are examples of how the team have used the training to support a customer focused booking approach as business as usual.

4. Text to Remind and Demographics

These two work streams are currently being supported by an Improvement Advisor from Quality Improvement and Patient Safety, who works in partnership with the business owner and project manager. The text to remind and demographics workstream were formed as a direct result of the observations that were being relayed back to the business from the DNA project. The initial focus of both work streams was to form a clear understanding of the issues with the current system and to recommend improvements. A fundamental issue for both work streams has been the lack of documented processes to ensure a standardised approach and shared understanding of the process, roles and responsibilities.

Next Steps

A key focus of activity will be on the installation of UBook into the HBDHB environment.

The provisional IS timeframe is provided below:

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

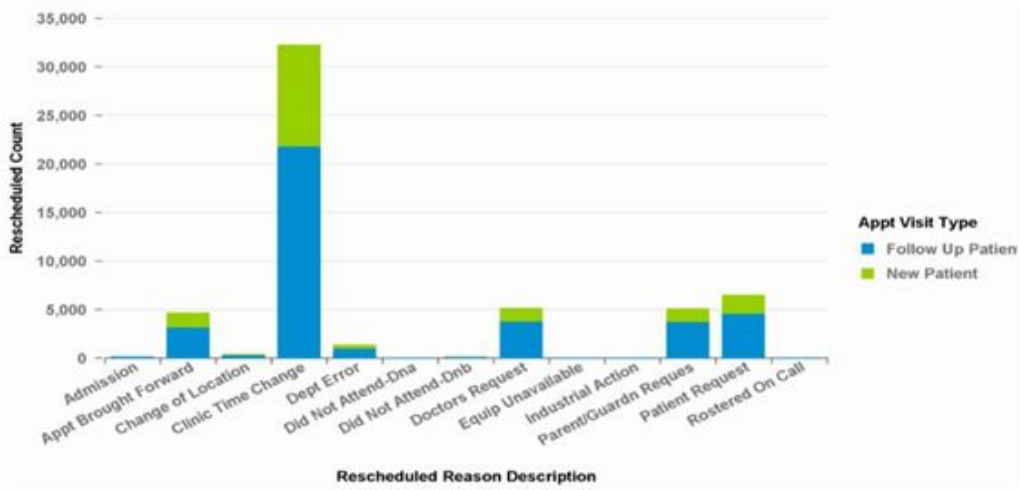
At time of the submission of this report it was anticipated that UBook would go live before the end of December 2016. One of the risks to achieving the go live date is gaining the necessary security clearance. The installation of UBook will be the first HBDHB experience of opening the DHBs IS patient information to the external environment. It is essential that robust testing, documentation and analysis are followed through to ensure the highest level of security is maintained, as this will set a precedence for future IS developments for HBDHB.

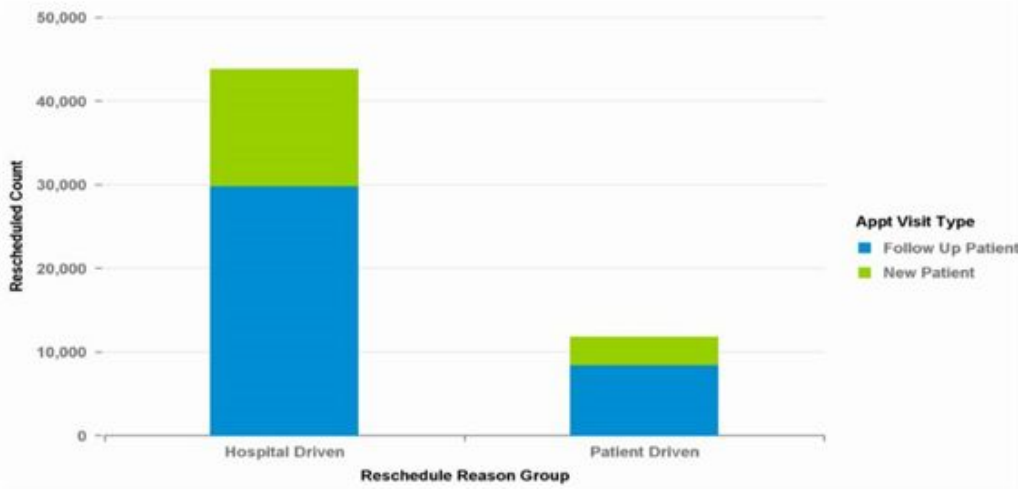
In parallel to the IS UBook work, the Clinic Scheduling project will commence with the aim of having a pilot speciality engaged and ready to be the first pilot for UBook outpatient booking in December.

Appendix One: Reschedule volumes by reason January 2013 – December 2015

Reason Group	Reason Description	Follow Up Patient	New Patient	TOTAL
Hospital Driven	Appt Brought Forward	3,113	1,535	4,648
	Change of Location	246	116	362
	Clinic Time Change	21,714	10,550	32,264
	Dept Error	901	444	1,345
	Doctors Request	3,711	1,374	5,085
	Equip Unavailable	7	9	16
	Industrial Action	23	12	35
	Rostered On Call	10	6	16
Hospital Driven	Total	29,725	14,046	43,771
Patient Driven	Admission	96	18	114
	Did Not Attend-Dna	17	17	34
	Did Not Attend-Dnb	64	27	91
	Parent/Guardn Reques	3,644	1,427	5,071
	Patient Request	4,511	1,949	6,460
Patient Driven	Total	8,332	3,438	11,770
TOTAL		38,057	17,484	55,541

Reason Grou
Hospital Drive
Patient Driver
TOTAL





Appendix Two: Customer Focused Booking Training – Participant Evaluation

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MAXIMISING STAFF PERFORMANCE

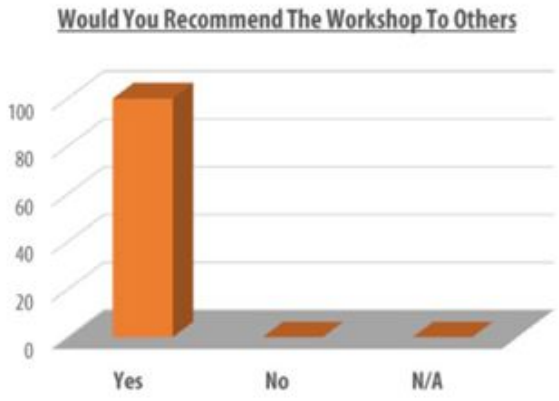
Analysis of Participant Evaluations

Programme	Customer Service Strategies for Health Professionals
Client	Hawkes Bay District Health Board
Date	2nd, 3rd, 4th, 5th & 9th February 2016
Facilitator	Gerry Hassan
No. of Evaluations	49

What did you think about the content of the workshop?	Nothing New	Useful	Very Useful	Excellent	Total Responses
No. of replies	0	2	22	25	49
Percentage	0	4	45	51	100

What was your impression of the facilitator?	Ineffective	Acceptable	Good	Excellent	Total Responses
No. of replies	0	0	2	46	48
Percentage	0	0	4	96	100

I would recommend that my colleagues go to this workshop	Yes	No	N/A	Total Responses
No. of replies	48	0	0	48
Percentage	100	0	0	100



18

HAWKE'S BAY District Health Board Whakawāteatia	**Information Service Function Review** 49
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Tim Evans Tim Evans
Reviewed by:	
Month:	May, 2016
Consideration:	For Information

RECOMMENDATION

That the Board:

Note the progress update and next targets below.

19

OVERVIEW

This is an update on progress since Board agreed the recommendations of the Davanti review of our Information Services Function.

BACKGROUND

We appointed Davanti Consulting to review the District Health Board's Information Systems function (that is our I.S. department, not our hardware and software).

We asked Davanti to assess and document:

- The challenges and tasks facing the department now, and those likely to arise
- The capability of the department in terms of skills, experience, and expertise
- The capacity of the department in terms of manpower, functions, and scale
- The resilience of the department in terms of business process and practice
- Any gaps (and consequent business risks) between challenge and capability/ capacity/ resilience

We asked them to express a clear opinion as to the fit between challenge and resources and make recommendations on short, medium, and long term actions required to mitigate immediate risks and to maintain or build "fit for purpose" Information Systems function going forward.

THE DAVANTI REPORT

The report identifies **3 challenges** facing the I.S. Department:

- Lack of documentation, appropriate team structure, and formal process;
- Focus on managing current state not building the future;
- Lack of formal governance and engagement with stakeholders

The report proposes **5 changes** to the I.S operating model:

- Set up formal governance structures to include IS and business stakeholders to keep IS accountable to their users;
- Create an "Enterprise Architect" function to plan the future and make sure we are moving toward it;
- Separate innovative "build" and routine "operate" functions to improve focus and delivery of both;
- Formalise project delivery capability to standardise and ensure appropriate use of project management methods;
- Reorganise IS resources along the technology layer domains of application and infrastructure, to reduce risk of undocumented knowledge and increase flexibility.

The report sets out in detail 11 project plans to achieve the required change over a 26 month timeline, and recommends the creation of at least three new roles.

PROGRESS TO DATE

The following areas have been progressed to date:

- **Steering group** – Draft Terms of Reference to EMT on 24 May 2016

  Draft terms of reference have been agreed with project Management Office, circulated for comment and (by the time of Board meeting) taken to Executive Management Team for approval.

- **Technical Mentorship** for GMPI&F – established

  Technical mentorship has been secured with an experienced external expert - the Chief Operating Officer of Spark Connect. First meeting held on 13 May.

- **Departmental reorganisation** - Initial staff meetings and HR support

  Initial meeting and discussion have been held between GMPI&F and Information Service Team leaders (4 May), and the full Business Intelligence Team (9 May). A meeting and discussion with the full IS team will have been held by the time of Board meeting (19 May). Human Resource advice will be provided by Lisa Ternent, and an initial meeting has been held.

NEXT TARGETS

The following "first six months" targets will be pursued, subject to Steering Group confirmation:

⇒ Reorganisation described and consultation completed.

⇒ Enterprise Architect role described, and advertised.

⇒ Implementation milestones localised and published.

⇒ KPIs developed and published.

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Transform & Sustain Strategic Dashboard Q3 Jan-Mar 2016** 50
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Tim Evans, GM Planning Informatics and Finance Peter Mackenzie, Operational Performance Analyst
Reviewed by:	Executive Management Team
Month:	May 2016
Consideration:	For Monitoring

Background

The Transform and Sustain Strategic dashboard has been developed to measure our Vision and Values and progress towards long term Transform and Sustain strategic objectives. In December FRAC and the Board endorsed the reorganisation of strategic non-financial reporting to better reflect the strategic roles between the two committees. It was agreed that the Transform and Sustain Dashboard would be presented to the Board quarterly.

Current results are colour coded to Red if significantly below target, Amber if below target but close to achieving target and Green if achieving target. There is also a trend line against each vital sign and dimension, this shows the trend over time and how each indicator is tracking to target. As this is the first issue of the dashboard not all indicators have a clear trend line but in future issues the trend line will start to become clearer and help to predict future trajectories.

Provided on the back of the dashboard are definitions of each measure.

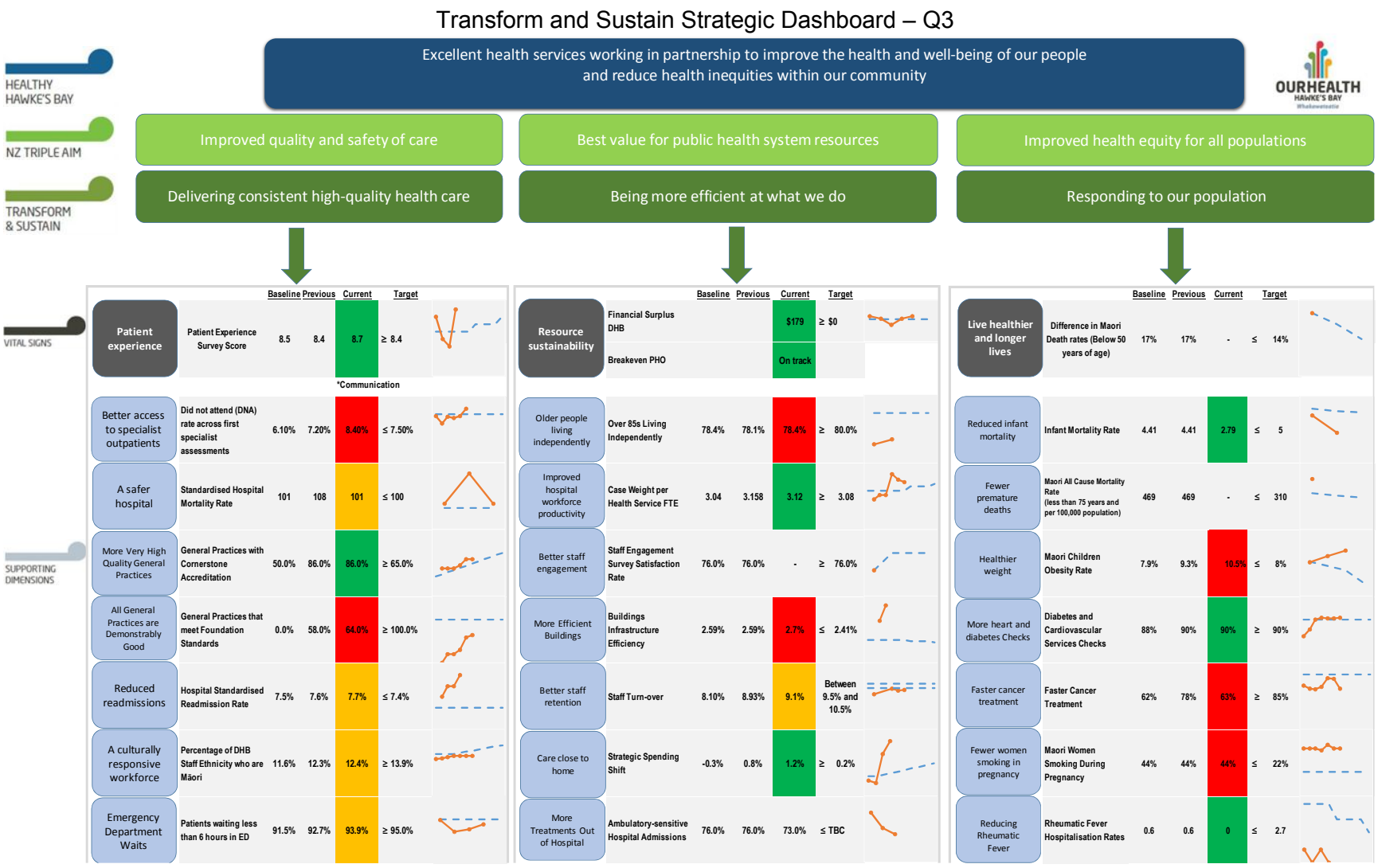
Focus Areas

We propose to use the framework as a tool for board (through FRAC discussion items) to focus on specific areas where the dashboard indicates poor performance or progress.

We will need to involve clinicians as well as appropriate managers wherever possible to get an understanding of the underlying causes and some analysis. The board will want to see action planning responses to drive consequent corrective action.

The first area for discussion will be Faster Cancer Treatment. This is already programmed as a FRAC discussion item on today's meeting.

A systematic consideration of under-performing dashboard measures will be developed to follow this initial discussion if board are happy with this approach.



Ambulatory-senative hospital admissions: The measure has been re-developed by the Ministry during 2015/16 and as a result there is no current target, a target will be set for the 2016/17 during the planning round.
Difference in Māori death rates: There is no update for this quarter, a request has gone to NZ stats for data and we would expect an update in Q4
Māori all cause mortality rate: There is no update for this quarter, a request has gone to NZ stats for data and we would expect an update in Q4

	Measure	Definition
Patient Experience	Communication	Patient Experience Survey - Dashboard only displays Domain with the lowest score each quarter. Target ≥ 8.4
	Partnership	Patient Experience Survey - Dashboard only displays Domain with the lowest score each quarter. Target ≥ 8.4
	Co-Ordination	Patient Experience Survey - Dashboard only displays Domain with the lowest score each quarter. Target ≥ 8.4
	Physical and Emotional Needs	Patient Experience Survey - Dashboard only displays Domain with the lowest score each quarter. Target ≥ 8.4
Better Access to Specialist Outpatients	Did not attend (DNA) rate across first specialist assessments	Patients who do not show up to an outpatient appointment without any prior notice
A Safer Hospital	Standardised Hospital Mortality Rate	Ratio of actual to expected hospital deaths
More Very Higher Quality General Practices	General Practises with Cornerstone Accreditation (Practices with Population >3,142)	GP's with Cornerstone accreditation (CORNERSTONE is an accreditation programme specifically designed by the Royal New Zealand College of General Practitioners for general practices in New Zealand) it allows GP's to measure themselves against a defined set of standards.
All General Practices are Demonstrably Good	General Practices that meet Foundation Standards	The Foundation Standard represents what is considered to be the minimum legal, professional, and regulatory requirements for general practice
Reduced Readmissions	Hospital Standardised Readmission Rate	Patients re-admitting to the hospital within 28 days of being discharged. MOH target.
A Culturally Responsive Workforce.	Percentage of DHB Staff Ethnicity who are Maori	The % of staff employed at the DHB that identify their ethnicity as Maori
Emergency Department Waits	Patients waiting less than 6h in ED	Health Target. Patients waiting less than 6 hours in the ED department

Resource Sustainability	Financial Surplus DHB	$0 or + variance to budget
	Breakeven PHO	Financial result = $breakeven
Older People Living Independently	Over 85s Living Independently	The proportion of 85years who are not living in ARC
Improved Hospital Workforce Productivity	Case Weight per Health Service FTE	Numerator: Total caseweights. Denominator: Total Doctor and Nursing FTE. Improve productivity by either increasing case weights or decreasing
Better Staff Engagement	Staff Engagement Survey Satisfaction Rate	% engaged employees at HBDHB based on the Engagement questions in the staff engagement survey
More Efficient Buildings	Buildings Infrastructure Efficiency	Numerator : Total Infrastructure costs (everything to do with buildings & facility costs e.g. buildings, lease, maintenance, depreciation, rates . Denominator: Infrastructure costs weighted output e.g. service weights which is everything we do e.g. caseweights, contacts, face to face, tests, appointments
Better Staff Retention	Staff Turn-over	Turn-Over of HBDHB employees
Care Closer to Home	Strategic Spending Shift	To shift resources from hospital and IDFs to Primary and Community by 0.5% p.a.
More Treatment Out of Hospital	Ambulatory-sensitive hospitalisations	HBDHB ASH rate relative to the national Rate as a percentage. (the Ministry of health have recently updated the indicator and are currently collecting baseline data. A target will be set as part of the 2016/17 planning process).

Live Healthier and Longer Lives	Premature deaths under 50 years	The number of deaths under the age of 50 as a percentage of all deaths. Gap between Maori and Non-Maori.
Reduced Infant Mortality	Infant Mortality Rate	HB Children who die from any cause under the age of 1 / total number of live births in the year
Fewer Premature Deaths	Maori All Cause Mortality < 75	The age standardised rate of death for Maori people under the age of 75. per 100,000
Healthier Weight	Obesity Rate	Prevalence of Maori children having a B4shcool check who are obese according to the international obesity task force.
More Heart and Diabetes Checks	Better diabetes and cardiovascular services	Health Target. Enrolled people in the PHO who are eligible for a CVD risk assessment who have had a CVD risk recorded within the last 5 years.
Faster Cancer Treatment	Faster Cancer Treatment	62 Day FCT Health Target
Fewer women smoking in pregnancy	Maori Woman Smoking During Pregnancy	% All Maori Women who are recorded as smoking at the birth of their baby.
Reducing Rheumatic Fever	Rheumatic Fever Hospitalisation Rates	Rate per 100,000 TBC

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Performance Framework Exceptions Quarter 3 2015/16** **HBDHB Quarterly Performance Monitoring Dashboard Quarter 2 2015/16** 51
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Tim Evans, GM Planning Informatics and Finance Peter Mackenzie, Operational Performance Analyst
Reviewed by:	Executive Management Team
Month:	May 2016
Consideration:	For Monitoring

RECOMMENDATION

That the Board:

Note the contents of this report.

OVERVIEW

The purpose of this paper is to provide the Board with exception reporting on the Hawke's Bay District Health Board's performance on the Statement of Intent (SOI) and the District Annual Plan (DAP). A quick reference summary dashboard will be supplied prior to the meeting and shows our position as at the end of this quarter for all indicators. The dashboard uses traffic light methodology (as described on page 4) to represent this. Detailed information is included for all indictors where the variance to target was greater than 0.5% (indicated on the dashboard as a red cell with a 'U' symbol).

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As this report ends 31 May 2016, the results in some instances may vary to those presented in other reports.

BACKGROUND

The National Health Board (NHB) facilitates DHB performance planning and monitoring within the Ministry of Health. DHB non-financial monitoring arrangements operate within wider DHB accountability arrangements including legislative requirements, obligations formalised via Crown Funding Agreements and other contractual requirements, along with formal planning documents agreed with the Minister of Health/Minister of Finance.

ANNUAL PLAN (AP) 2015/2016

The AP is a statutory requirement that includes the key actions and outputs the DHB will deliver in order to meet Government priorities and Health targets. Through the AP, the DHB has formally agreed to deliver on the performance expectations associated with the measures in the NHB-mandated monitoring framework.

STATEMENT OF PERFORMANCE EXPECTATIONS (SPE) 2015/16

The SPE is produced annually within the context of the four-year Statement of Intent (SOI) 2014-18. The SPE informs the House of Representatives of the performance expectations agreed between a Minister and a Crown Entity. Formal agreement is gained annually through

the AP process and actual performance is assessed and reported through the audited HBDHB Annual Report.

HAWKE'S BAY DISTRICT HEALTH BOARD (HBDHB) PERFORMANCE FRAMEWORK

The four dimensions of the non-financial monitoring framework, which was developed by the Ministry as a mandatory framework, will reflect DHB's functions as owners, funders and providers of health and disability services.

The 4 dimensions of DHB performance are:

- Achieving Government's priorities and targets (Policy priorities)
- Meeting service coverage requirements and supporting sector inter-connectedness (System Integration)
- Providing quality services efficiently (Ownership/Provider Arm)
- Purchasing the right mix and level of services within acceptable financial performance (Outputs/service performance)

KEY FOR DETAILED REPORT AND DASHBOARD

Baseline	Latest available data for planning purpose
Target 2015/16	Target 2015/16
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target
U (Unfavourable)	Actual to date is unfavourable to target
Trend direction ▲	Performance is improving against the previous reporting period or baseline
Trend direction ▼	Performance is declining
Trend direction -	Performance is unchanged

CONTENTS

PERFORMANCE HIGHLIGHTS

Achievements

- More Heart and Diabetes checks. The provisional result provided by the Ministry is 90% which is level with the target of 90% for the fourth successive quarter.

- (Provisional) Improved Access to Elective Surgery. At the end of the quarter the result is 102.2%.

- Immunisation at 8 months. We have achieved target for Maori and Pacific as well as the total population at 95.8% which is an improvement of 2.5% from the previous quarter.

- Number of enrolled pre-school and primary school children overdue for their school examination. The target of <5% is achieved for all ethnicities.

Areas of Progress

- Shorter Stays in ED. Patients waiting less than 6 hours in ED has increased slightly from 92.7% to 93.9%, however this is still below the target of 95% (page 5)

- Oral MDFT (missing, decayed, filled teeth) score at year 8 saw improved results from the previous year 0.96 but are still unfavourable to target <0.88 (page 12)

- Cervical Screening. There has been a small increase for the total and other populations. Maori and Pacific decreased slightly (page 16).

Areas of Focus

We continue to focus our efforts in order to make gains with particular emphasis in the following areas:

- Better Help for Smokers to Quit for Pregnant woman. This is a new indicator for the financial year and the result for this quarter was 88.6% which is below the target of 90% and a drop from the previous quarter (page 8).

- Faster Cancer Treatment. Results have decreased from the previous quarter to 64.3% and remain below the target of 85%. A program of work is underway to increase the number of patients identified with a high suspicion of cancer at referral. This will enable us to identify more patients with cancer and manage timeframes more effectively (page 6).

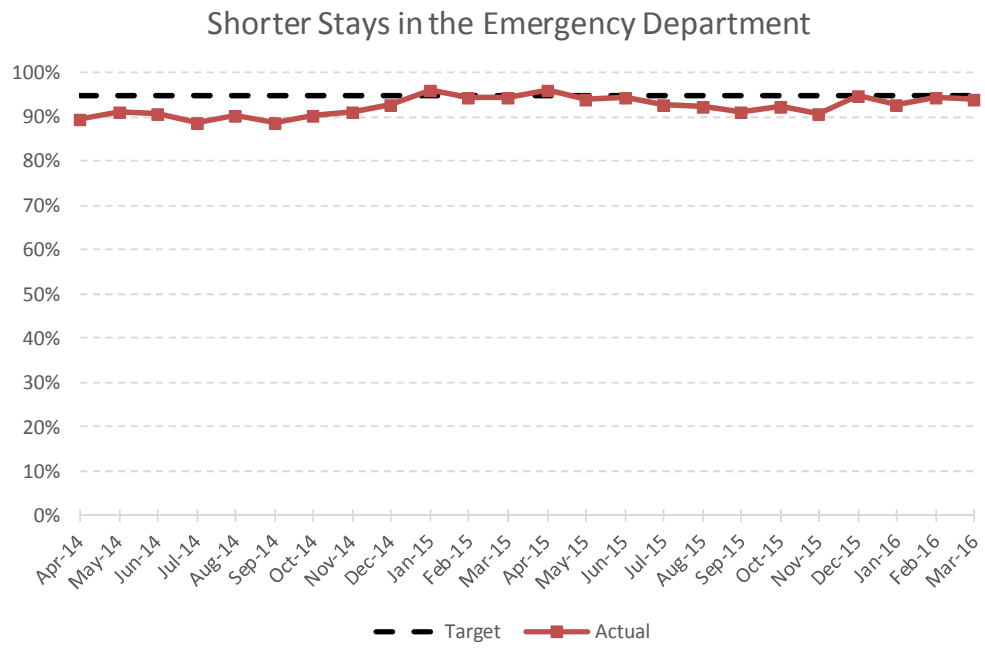
- Children Caries Free at 5 Years of Age. Results have dropped slightly for all ethnicities from the previous year with the total declining by 2.1% to 54.4% against a target of 65%. The DHB has a number of population health programmes in place that will support oral health including healthy housing and healthy eating programmes (page 13)

DIMENSION 1 – ACHIEVING GOVERNMENT PRIORITIES AND TARGETS

Health Target: Shorter stays in emergency departments
95% of all people attending the Emergency Department will be admitted, transferred or discharged within six hours

Baseline [1]	Previous result [2]	Actual to Date [3]	Target 2015/16	Trend direction
91.5%	92.7% (U)	93.9% (U)	≥95%	▲

Please note: Data presented in the graph are monthly results, whilst the data in the result section above ('Previous result' and 'Actual to date') are for a 3 month period.



Comments:
There has been increased presentations to ED in Q3 2015/16 (11,509) compared to Q3 2014/15 (10,697). Despite this compliance against the target has increased from 92.7% in Q2 2015/16 to 93.9% in Q3 2015/16. Ongoing daily reviews and analysis of breaches are managed by the service and wider teams via the daily operations meeting. Ongoing initiatives to enhance and standardise front of house functions, develop an operations service and 'hospital at a glance' and review Acute Assessment Unit (AAU) model of care will ensure resources are maximised in the appropriate areas at the most appropriate times. Nursing resources and rosters have been reconfigured to assist with surge management and ensure safe rostering particularly out of hours.

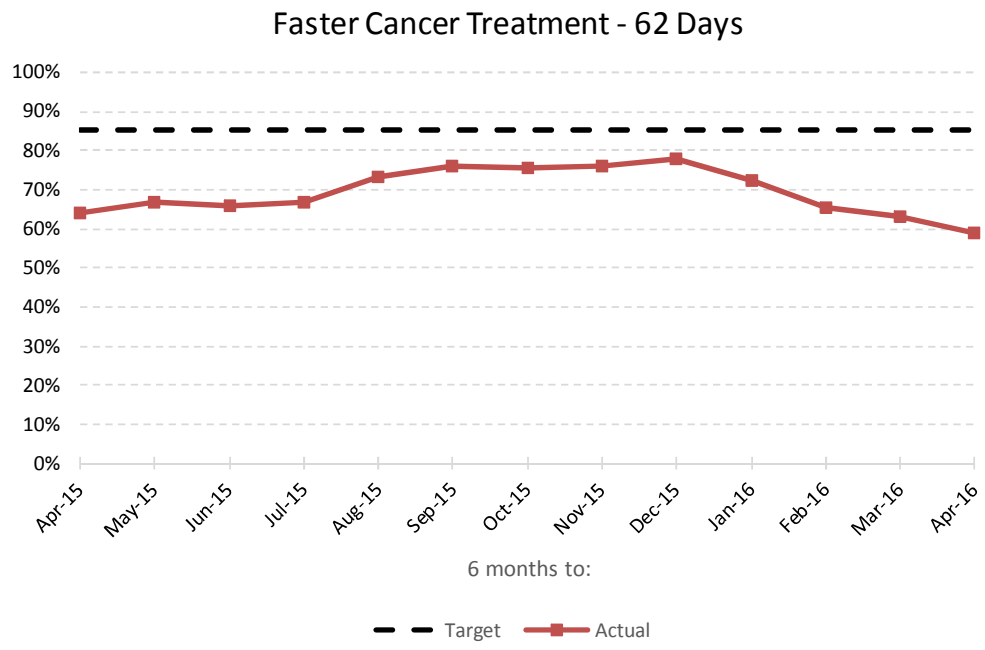
21

1 October to December 2014

2 October to December 2015

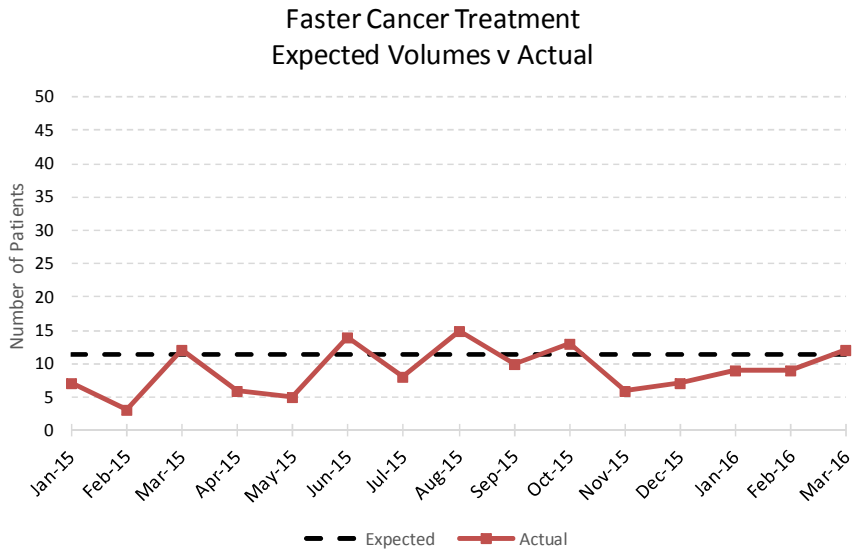
3 January to March 2016

Health Target: Faster Cancer Treatment - patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer					
Key Performance Measures	**Baseline**	**Previous result** [4]	**Actual to Date** [5]	**Target 2015/16**	**Trend direction**
	61.5%	78% (U)	64.3% (U)	≥85%	▼



Comments:
March results are a slight improvement on February results. However the 6 month results reflect the drop in volumes from November 2015. The volume of patients identified with a high suspicion of cancer and a need to be seen in 2 weeks is below the MoH model of cancer demand for HBDHB. Health services is working to identify these volumes.

**Based on the expected annual cancer registrations for the DHB supplied by the Ministry, the DHB is expected to identify at least 76 people a year (11.4 a month) as patients with a high suspicion of cancer.*



4 January to June 2015

5 October 2015 to March 2016

Health Target: Better help for smokers to quit – Primary Care
90% of patients who smoke are seen by a health practitioner in primary care are offered brief advice and support to quit smoking

Key Performance Measures	Baseline [6]	Previous result [7]	Actual to Date [8]	Target 2015/16	Trend direction
Total	96.1%	75.0% (U)	77.6% (U)	≥90%	▲
Māori	98.3%	74.5% (U)	-	≥90%	*
Pacific	96.3%	70.7% (U)	-	≥90%	*
Other	96.3%	75.8% (U)	-	≥90%	*

**the definition to this indicator changed at the start of 2015-16. A time series chart will be provided once there is enough data points.*

Source: Ministry of Health

Comments:
Health Hawke's Bay continues to work with practices to ensure all Smoking Brief Advice (SBA) conversations are captured in the patient management system. It has been noted that not all practices were aware of the criteria for recording information. Health Hawke's Bay funds DrInfo for 24 practices and the DrInfo team have just updated the smoking brief advice audit to reflect the Ministry of Health smoking brief advice criteria.

We have ongoing actions to drive improvement in this area including ensureing benchmarking reports are being shared with the appropriate staff and plans are made to meet forecasted overdue SBA patients, conducting routine audits/query builds at practice level as well as developing and distributing resources defining the criteria for the Smoking Brief Advice indicators.

6 October to December 2013. Source: DHB Shared Services

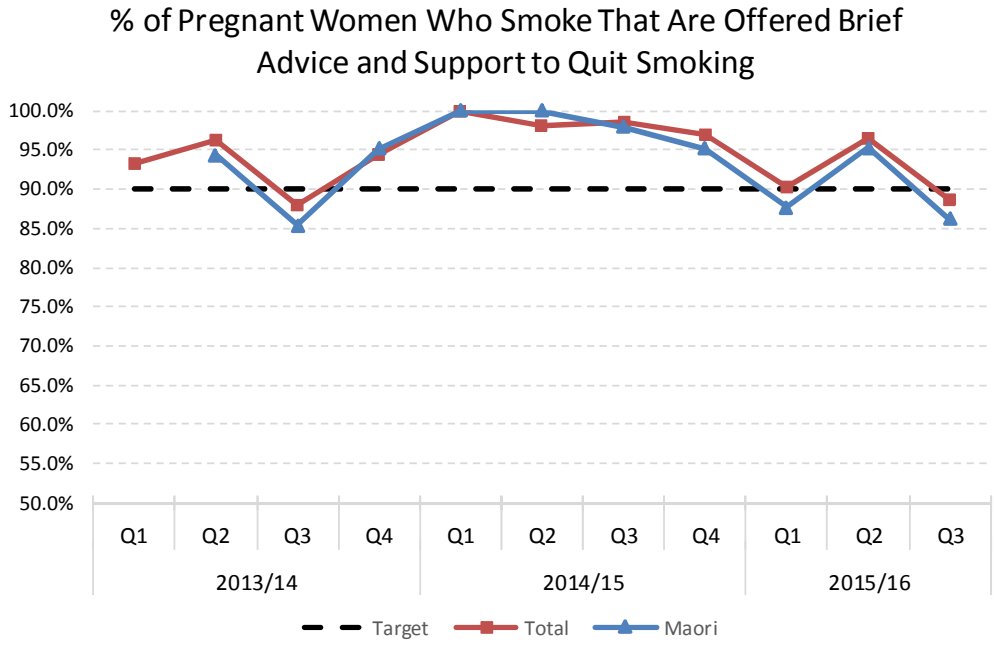
7 October to December 2015. Source: DHB Shared Services

8 January to March 2016. Source: DHB Shared Services

Health Target: Better help for smokers to quit – Maternity

90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking

Key Performance Measures	Baseline [9]	Previous result [10]	Actual to Date [11]	Target 2015/16	Trend direction
Total	98.1%	96.5% (F)	88.6% (U)	≥90%	▼
Māori	100.0%	95.2% (F)	86.2% (U)	≥90%	▼



Source: Ministry of Health

Comments:

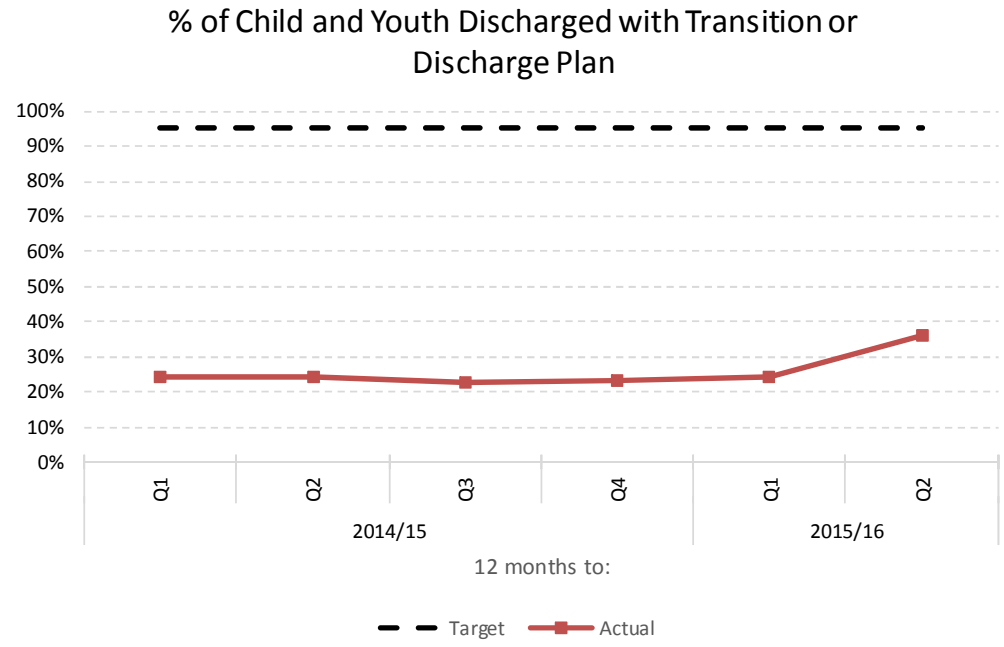
The HBDHB has audited quarter two results to identify any systems or processes that could be impacting the target results. We will continue to work closely with our Business Intelligence and administration teams internally to drive improvement. Some of the barriers to reducing smoking in pregnancy are the attrition from referral to quitting and also we need to further expand referral reach to the Primary Care Sector. To help improve results going forward the DHB Smokerfree and Child Health Coordinator is providing ongoing support and connection to their Midwife colleagues.

9 October to December 2013. Source: DHB Shared Services

10 October to December 2015. Source: DHB Shared Services

11 January to March 2016. Source: DHB Shared Services

Improving mental health services using transition (discharge) planning (PP7)					
Key Performance Measures	**Baseline** [12]	**Previous result** [13]	**Actual to Date** [14]	**Target 2015/16**	**Trend direction**
Total	25.0%	24.16% (U)	36.17% (U)	≥95%	▲



Comments:
It is pleasing to see an improvement in the result for Q2. The Child & Youth Teams will have a focus on this issue during their team meetings. We are currently undertaking an audit to assess the possibility plans are being completed but not being correctly recorded in the patient management system (where the compliance reports are generated).

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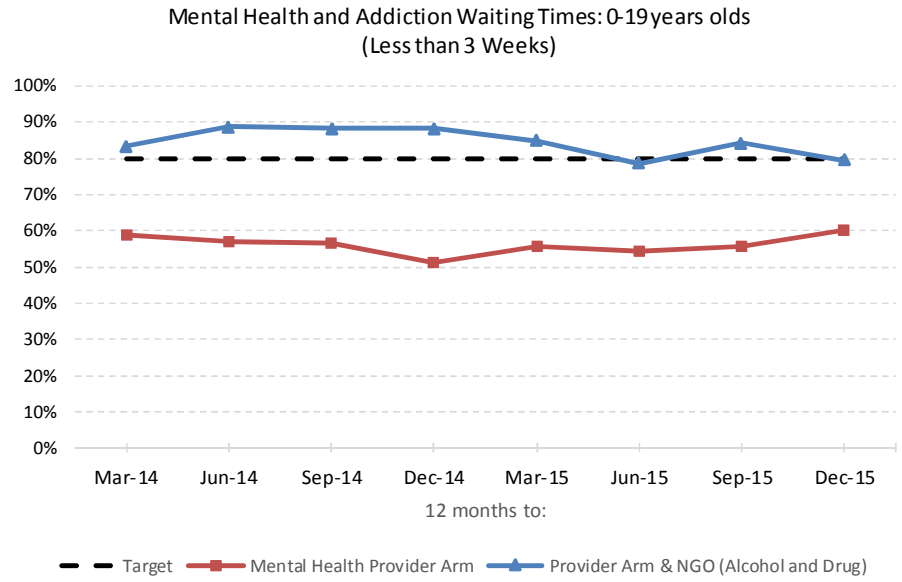
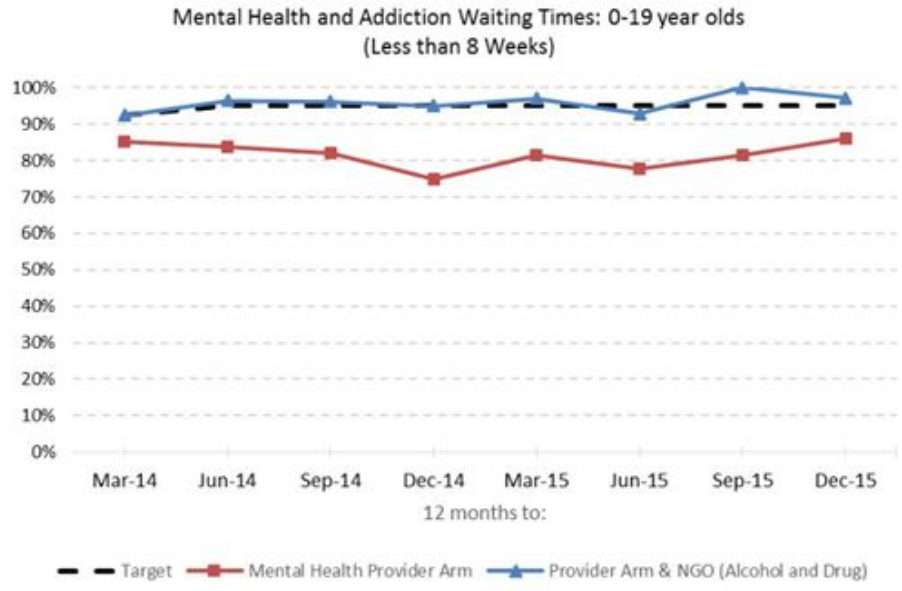
12 October 2014 to September 2015.

13 October 2014 to September 2015.

14 January to December 2015.

Shorter waits for non-urgent mental health and addiction services (PP8): Mental Health Provider Arm					
Key Performance Measures	**Baseline [15]**	**Previous result [16]**	**Actual to Date [17]**	**Target 2015/16**	**Trend direction**
Mental Health Provider Arm: Age 0-19					
<3 weeks	56.7%	55.8% (U)	60.1% (U)	≥80%	▲
<8 weeks	88.3%	81.5% (U)	86% (U)	≥95%	▲
Addictions (Provider Arm & NGO): Age 0-19					
<3 weeks	82.0%	84.2% (F)	79.4% (U)	≥80%	▼
<8 weeks	96.1%	100% (F)	97.1% (F)	≥95%	▼





Source: Ministry of Health

Comments:

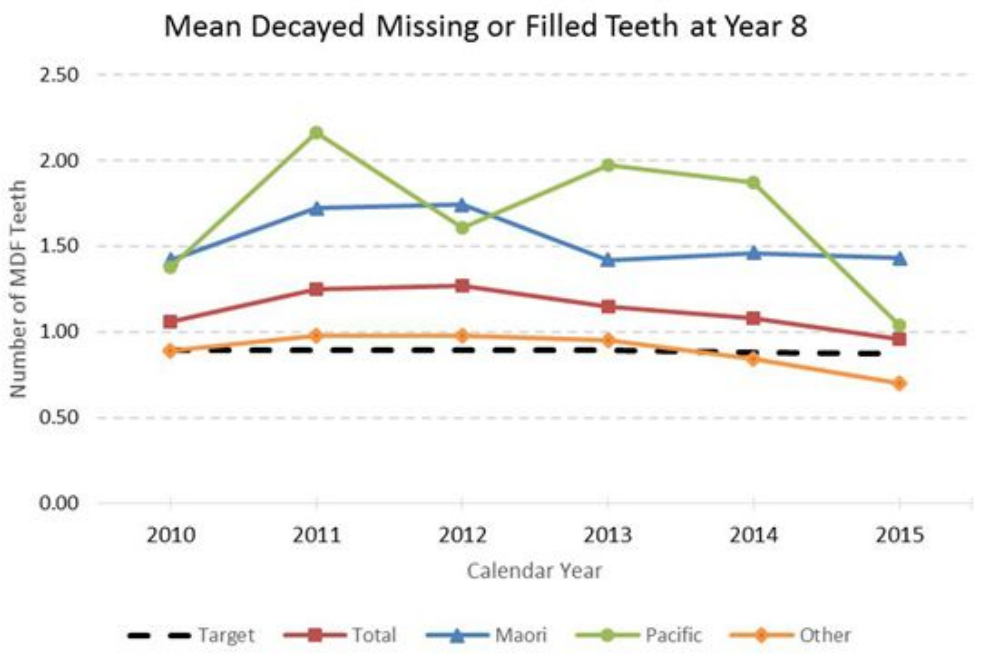
15 12 months to December 2014

16 12 months to September 2015

17 12 months to December 2015

In order to reduce waiting times Team Leaders are closely monitoring all referrals and following up with team members who have referrals approaching 21 days waiting time to ensure wait times are minimised. Paper letters were being sent to the people referred to offer an appointment time and date, This has, in many cases, caused delay in the person / family being seen. This practise has now ceased and has been replaced with phone calls to arrange first appointments

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



Comments:
Although HBDHB has not reached the target of <=0.87 we are very pleased to note that our DMF is 0.96 - this is the first time HBDHB has achieved a Year 8 DMF below 1. HBDHB is implementing a much stronger focus on preventive dental care in the community oral health service. This involves 3 quality indicators for clinical practice - fluoride varnish applied by 4 years, bitewing films taken by 6 years, and fissure sealants by 8 years. The DHB has a number of population health programmes in place that will support oral health including healthy housing and healthy eating programmes. It must be noted that <=0.87 is a signficant stretch target for a DHB where the 6 year mean for Year 8 DMF is 1.22.

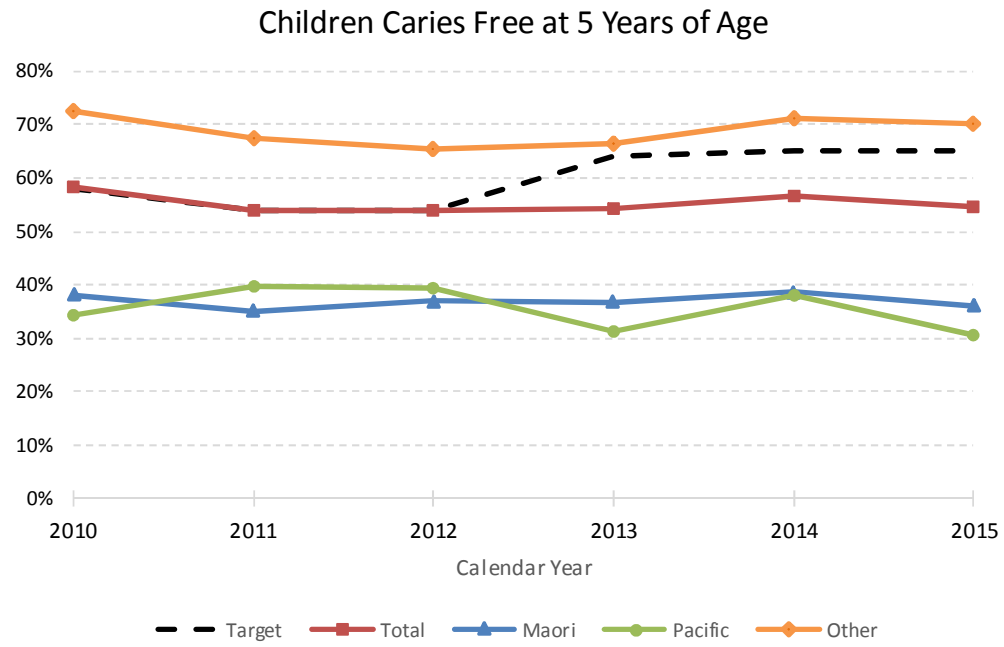
There will be more in depth reporting in the June Te Awa Whakawarora, with more detail on DHB programs.

18 Calendar Year 2014

19 Calendar Year 2014

20 Calendar Year 2015

Children caries free at 5 years of age (PP11)					
Key Performance Measures	**Baseline** [21]	**Previous result** [22]	**Actual to Date** [23]	**Target 2015/16**	**Trend direction**
Total	56.5%	56.5% (U)	54.4% (U)	≥65%	▼
Māori	38.7%	38.7% (U)	36% (U)	≥65%	▼
Pacific	38.0%	38% (U)	30.5% (U)	≥65%	▼
Other	71.2%	71.2% (F)	70.1% (F)	≥65%	▼



Comments:
HBDHB is implementing a much stronger focus on preventive dental care in the community oral health service. This involves 3 quality indicators for clinical practice - fluoride varnish applied by 4 years, bitewing films taken by 6 years, and fissure sealants by 8 years. The DHB has a number of population health programmes in place that will support oral health including healthy housing and healthy eating programmes.

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21 Calendar Year 2014
22 Calendar Year 2014
23 Calendar Year 2015

Key Performance Measures	Baseline [24]	Previous result [25]	Actual to Date[26]	Target 2015/16	Trend direction
Improving waiting time for diagnostic services (PP29)					
Coronary Angiography	89.8%	78.9% (U)	75.6% (U)	≥90%	▼
Computed Tomography (CT)	92.6%	88.6% (U)	96.4% (F)	≥90%	▲
Magnetic Resonance Imaging (MRI)	61.3%	59.5% (U)	57.5% (U)	≥80%	▼
Diagnostic Colonoscopy: Urgent	92.6%	81.3% (F)	90% (F)	≥75%	▲
Diagnostic Colonoscopy: Non-Urgent	39.7%	78.7% (F)	84.1% (F)	≥60%	▲
Surveillance Colonoscopy	50.7%	77.3% (F)	88.5% (F)	≥60%	▲

Comments:

Coronary Angiography: *(results only just confirmed, comments will be inserted once submitted to the MoH)*

MRI: We are currently working across the organisation to support radiology delivery to meet its targets. We are managing to reduce the number of patients waiting overt the 21 week period.

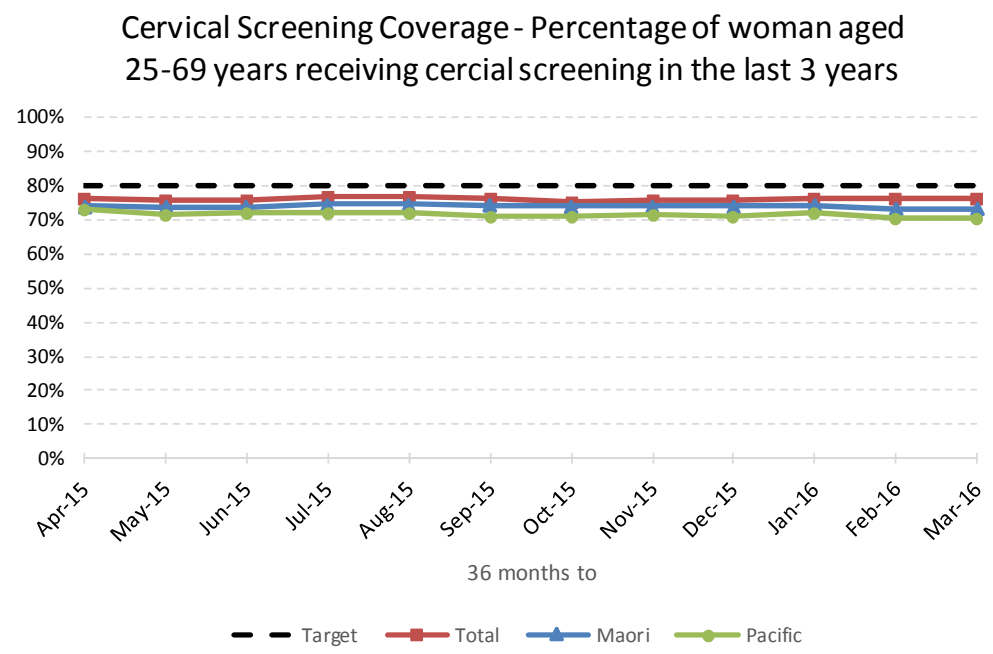
Colonoscopy: The increasing volumes of referrals is not being managed within the current capacity and the the short weeks in March compounded the problem. The intent is to utilise a Saturday session in April (confirmed for 20 patients) and to plan a similar mitigation in May.

24 October to December 2015.

25 December 2015.

26 March 2016

Percentage of women aged 25-69 years receiving cervical screening in the last 3 years					
Key Performance Measures	**Baseline** [27]	**Previous result** [28]	**Actual to Date** [29]	**Target 2015/16**	**Trend direction**
Total	76.9%	75.8% (U)	76.1% (U)	≥80%	▲
Māori	73.8%	74.1% (U)	73.2% (U)	≥80%	▼
Pacific	72.8%	71.2% (U)	70.4% (U)	≥80%	▼
Other	78.0%	76.5% (U)	77.2% (U)	≥80%	▲



Source: National Screening Unit

Please note: Rates of cervical screening coverage will now be reported for women aged 25-69 years, not 20-69 years as was previously reported. This change aligns with international best practice.[30]

Comments:

Whilst not achieving the 80% target, Hawke's Bay continues to be the top performing DHB for Maori coverage and exceeds the national average for Asian coverage. Work continues on the Best Practice in Primary Care project in addition to sending letters to unscreened and under-screened priority group women with the offer of a free cervical smear test and a $20 grocery voucher. Women who do not respond to the offer are contacted and followed up by Kaiawhina, with approximately a 30% uptake.

21

27 36 months to 31 December 2014. Source: National Screening Unit

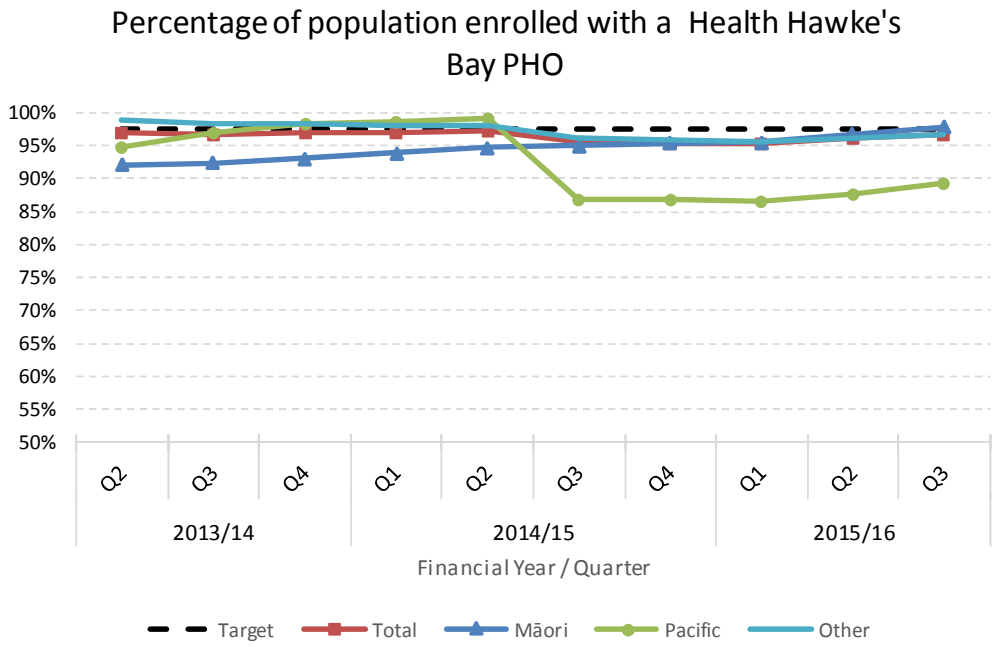
28 36 months to 31 December 2015. Source: National Screening Unit

29 36 months to 31 March 2016. Source: National Screening Unit

30 Cervical screening coverage: An update on calculation methods. National Screening Unit. http://www.nsu.govt.nz/health-professionals/4949.aspx

DIMENSION 4 – SERVICE PERFORMANCE

Proportion of the population enrolled in the PHO					
Key Performance Measures	**Baseline** [31]	**Previous result** [32]	**Actual to Date** [33]	**Target 2015/16**	**Trend direction**
Total	97.3%	96.4% (U)	96.4% (U)	≥97%	—
Māori	94.7%	97.2% (F)	95.9% (U)	≥97%	▼
Pacific	99.3%	88.7% (U)	88.5% (U)	≥97%	▼
Other	98.2%	96.5% (F)	97% (F)	≥97%	▲



Source: Ministry of Health

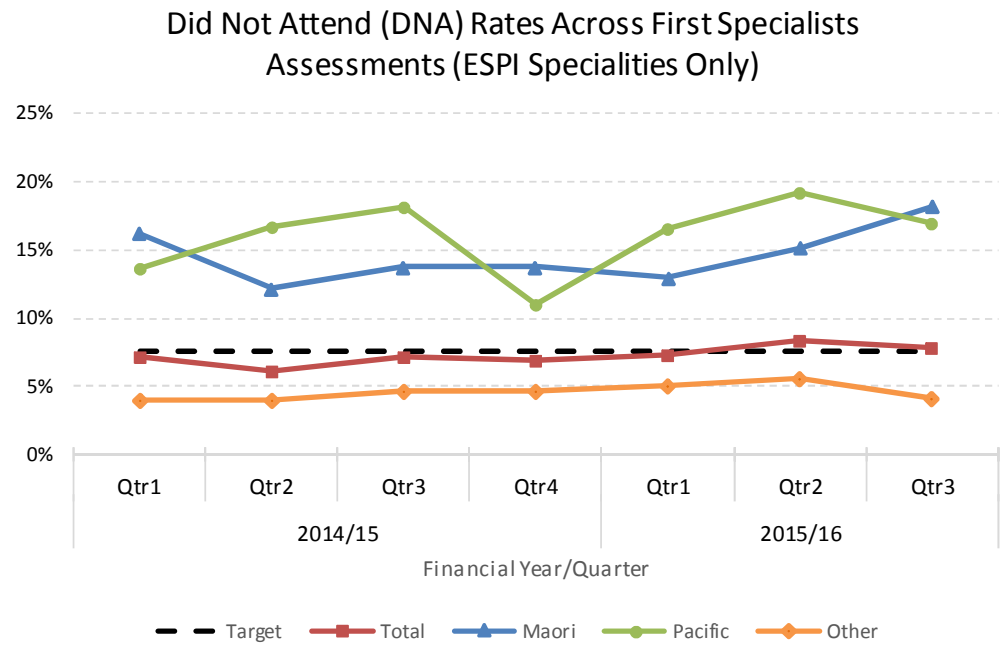
Comments:
As at 31 March 2016 – 624 consultations were provided to un-enrolled patients who are either Māori Pacific or living in a Quintile 5 residential area. 317 were GP consults, 307 were Nurse consults and 215 enrolments have been confirmed as identifying as Māori. It can take up to 20 weeks for a person to appear on the Health Hawke's Bay register and as at 31 March 2016 there is a total of 157 criteria to be confirmed.

31 October to December 2014.

32 October to December 2015.

33 January to March 2016.

Did not attend (DNA) rate across first specialist assessments[34]					
Key Performance Measures	**Baseline** [35]	**Previous result** [36]	**Actual to Date** [37]	**Target 2015/16**	**Trend direction**
Total	7.2%	8.4% (U)	7.8% (F)	≤7.5%	▲
Māori	16.2%	15.2% (U)	18.2% (U)	≤7.5%	▼
Pacific	13.6%	19.1% (U)	16.9% (U)	≤7.5%	▲
Other	4.0%	5.6% (F)	4.1% (F)	≤7.5%	▲



Comments:
Overall results have improved over this quarter, althrough there has been fluctuations in the ethnicity results. The Customer Focused Booking (CFB) project has identified a number of systemic issues that are currently being worked through . We are in the process of investigation the implementation of an innovative CFB portal.

21

34 ESPI specialities only

35 October to December 2014

36 October to December 2015

37 January to March 2016

Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital emergency department attendances (per 1,000)					
Age Band	**Baseline** [38]	**Previous result** [39]	**Actual to Date** [40]	**Target 2015/16**	**Trend direction**
Age 75-79	139.5	136.5 (F)	130.1 (F)	≤139.5	▲
Age 80-84	183.1	179.9 (F)	185.6 (U)	≤183.1	▼
Age 85+	254	229.2 (F)	230.4 (F)	≤231	▼

Comments:
Analysis of overall attendances at ED (i.e. all triage levels) for people over 75 years of age in 2014/15 showed a growth rate slightly lower than population growth. These age-specific rates at the 5 year age group level show some variation within that analysis. The 80-84 age group are unfavourable to trend and declining compared to the previous period. In absolute numbers, this represents 24 more people in quarter 3 compared to quarter 2 within a projected population of 3530 people. We are unable to discern a trend at this stage or to identify any particular driver, but we will continue to monitor closely.

Number of needs assessments completed (Disability Services)			
Key Performance Measures	**Baseline** [41]	**Actual to Date** [42]	**Target 2015/16**
	618	423 (U)	≥600 (Period target ≥450)

Comments:
The result reflects a 6% unfavourable result on the period target. The DSS team currently has 1223 clients, with reassessments due every three years. This means, on average, Options would complete 408 assessments per year, with a number of additional reassessments driven by changing need.

The DSS team is working within MoH timeframes for assessment and has a low number of overdue assessments (currently 1.1%). The unfavourable result is likely to be due to work conducted during 2013-2015 to ensure all assessments were up-to-date. This resulted in lower numbers of assessments being due in the 2015/16 financial year. The NASC information system is forecasting a further 120 assessments to be completed by the end of the financial year.

Work is being conducted in the residential team to smooth assessment dates evenly throughout the year, to reduce spikes in assessment numbers. Monitoring of time frames and overdue tasks is continually occurring – with results being reported to the Ministry of Health on a monthly basis as part of the Financial Reporting Suite.

38 October to December 2014

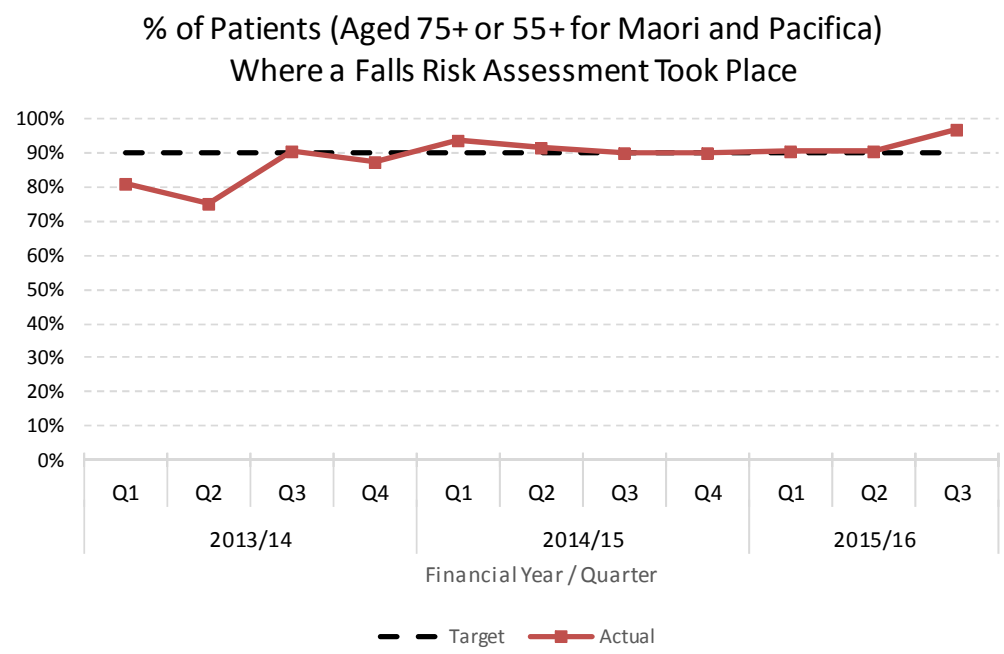
39 October to December 2015

40 January to March 2016.

41 2015/2015

42 July 2015 to March 2016. Please note this is a 9 month progress update on a 12 month indicator.

Percentage of older patients assessed for the risk of falling					
Key Performance Measures	**Baseline** [43]	**Previous result** [44]	**Actual to Date** [45]	**Target 2015/16**	**Trend direction**
	91.8%	90.5% (F)	97.1% (F)	≥90%	▲



Comments:
Non-completion of documentation for patients at risk has been a factor resulting in unfavourable target results for the last quarter. CNMs (Clinical Nurse Managers) are undertaking regular review to improve this.

As a result, renewed action plans are now in place in all clinical areas. We are particularly focusing on the following in order to further improve results:

1. Education
2. Auditing of patient records
3. CNM monitoring of falls documentation

21

43 October to December 2015. .

44 October to December 2015.

45 January to March 2016.

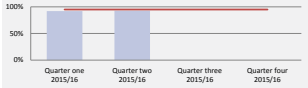
Hawke's Bay DHB performance monitoring report quarter two 2015/16

Monitoring Status Standard Monitoring

HEALTH TARGETS

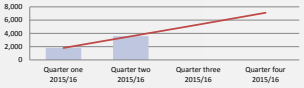
Shorter Stays in Emergency Departments

PERFORMANCE 93% TARGET 95% CHANGE 0.6%



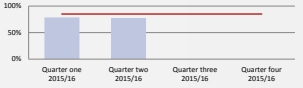
Improved Access to Elective Surgery

PERFORMANCE 3579 TARGET 3564 VARIANCE 15



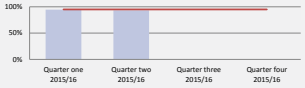
Faster Cancer Treatment

PERFORMANCE 78% TARGET 85% CHANGE -1.0%



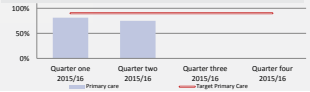
Increased Immunisation

PERFORMANCE 93% TARGET 95% CHANGE -1.2%



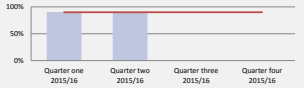
Better Help for Smokers to Quit

PERFORMANCE Primary Care 75% TARGET 90% CHANGE -6.2%



More Heart and Diabetes Checks

PERFORMANCE 90% TARGET 90% CHANGE 0.0%

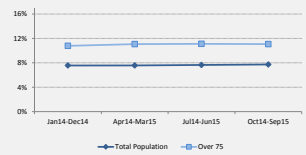


SERVICE RECONFIGURATION - SHIFTING SERVICES (IMPROVING SYSTEM INTEGRATION)

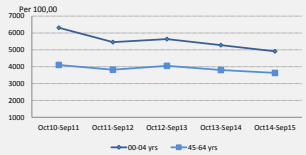
The DHB provided a comprehensive report which clearly outlined their commitment to reconfigure and shift services and their investment strategy.

OVERALL INDICATORS ACROSS DHBs

ACUTE READMISSIONS RATES (standardised)



AMBULATORY SENSITIVE HOSPITALISATION RATES



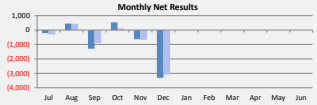
FINANCIAL MANAGEMENT

Financial Performance Rating: Needs Watching

NET RESULT

$'000	YTD-Dec 2015 Actual	Plan	Variance
YTD Net Result:	(4,460)	(4,412)	(48)

Monthly Net Results



MAIN FINANCIAL CATEGORIES

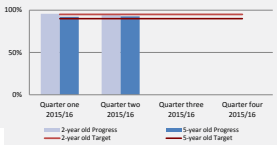
$'000	YTD-Dec 2015 Actual	Plan	Variance
Personnel Costs	(91,855)	(92,866)	1,011
Outsourced Services	(6,072)	(5,214)	(858)
Clinical Supplies	(21,915)	(21,749)	(166)
Infrastructure/Other Supplies	(21,993)	(21,011)	(982)

PROGRESS AGAINST LOCAL ACTIONS AS DEFINED IN THE DHB ANNUAL PLAN

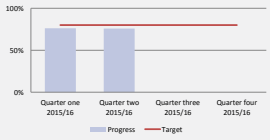
IMPROVED MANAGEMENT FOR LONG TERM CONDITIONS (CVD, DIABETES AND STROKE)

IMPROVING WRAP AROUND SERVICES – HEALTH OF OLDER PEOPLE

Immunisation Coverage



Cervical Screening Coverage



REGIONAL SERVICE DELIVERY

Quarter two 2015/16

Overall Performance

National Priorities		Information Technology Critical Priorities	
Cancer Services		eMedicines Reconciliation	
Cardiac Services		Clinical Workstation (CWS) and Clinical Data Repository (CDR)	
Health of Older People		Replacement of legacy Patient Administration Systems (PAS)	
Elective Services		National Infrastructure Platform (NIP)	
Stroke Services		Patient Portal	
Mental Health and Addictions		National Patient Flow	
Major Trauma			
Hepatitis C			

Health Workforce Regional Actions against Workforce Plan

Regional Performance Highlights

The Central region has received achieved ratings for half of its national priorities, a slight decrease in overall performance since the last quarter.

Mental Health and Addiction Services is one of the areas performing well and the development of the forensic inter-agency collaboration measurement tool and progress on perinatal and infant mental health are of particular note.

There are delays experienced by the region for Hepatitis C Services with receiving patient level transition data to help support more detailed project planning. The Ministry is continuing to work closely with the region to expedite this process. While considering the impact of these delays, the Ministry has agreed to change the deliverable date for the project plan from 31 December 2015 to 31 May 2016.

Regional Performance Issues

The region has achieved the ACS 'Door to Cath' indicator, however there are still some inconsistencies across the DHBs and plans are in place to address these. The data completion indicator was not achieved, but the result of 91.2% was close to the 95% target. For Secondary Services the region had above the maximum number of patients expected in the first week of the quarter and YTD delivery is behind plan.

There are good initiatives developing in the region to improve Stroke Services, including the requirement for improved rehabilitation data. The region has acknowledged that more work needs to be done to ensure that management decisions impacting on this outcome will be addressed.

As an outcome of an external report, a refreshed IT governance structure is in place and the RHIP team and Central region DHBs are working on an agreement on how to support ongoing regional activities. The NIP has been significantly delayed. Although work on a remediation process is underway until a robust remediation plan is in place the programme is at risk.

CROSS-AGENCY PRIORITIES

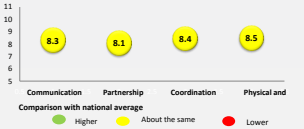
Prime Minister's youth mental health project	Reducing Rheumatic fever	Delivery of the children's action plan
Partially on track	On track	On track

Quality and Safety Markers

	Goal	Performance	
Falls risk assessment (Jul-Sep15)	90%	90%	
Hand hygiene (Jul-Oct15)	80%	86%	

Surgical site infections (Apr-Jun 2015):	Goal	Performance	
Antibiotic administered in the right time	100%	100%	
Patients receive cefazolin or cefuroxime	95%	97%	

Patient Experience**



WAITING TIMES

Diagnostic waiting times

	Goal	Performance
Coronary angiography (<90 days)	95%	78.9%
Radiology		
CT Scan (<42 days)	95%	88.7%
MRI Scan (<42 days)	85%	43.4%

	Goal	Performance
Colonoscopy		
Urgent colonoscopy (<14 days)	75%	82.4%
Non-urgent colonoscopy (<42 days)	65%	87.1%
Surveillance colonoscopy (<84 days)	65%	79.3%

Patients Waiting For FSA and Treatment

PATIENTS WAITING FOR FSA

	Oct	Nov	Dec	last mnth	3 mnths
ESPI 2	7	2	8	6	1
ESPI 2 %	0.2%	0.1%	0.3%	0.2%	0.0%

PATIENTS WAITING FOR TREATMENT

	Oct	Nov	Dec	last mnth	3 mnths
ESPI 5	21	7	56	49	35
ESPI 5 %	1.8%	0.6%	4.4%	3.8%	2.6%

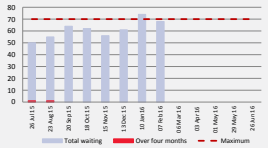
Regional Provision Cardiac Surgery Delivery

REGIONAL DELIVERY - CAPITAL & COAST DHB OF SERVICE

PERFORMANCE AGAINST PLAN 89% VARIANCE -45

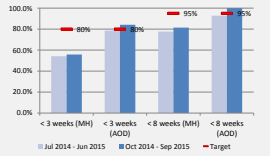
WAITING LIST - CAPITAL & COAST DHB OF SERVICE

TOTAL REGIONAL WAITING LIST	68
% OF NATIONAL WAITING LIST	28%



Mental Health

Mental health and addictions waiting times: Child and Youth aged 0-19 years



SERVICE COVERAGE DELIVERY

This quarter the DHB provided:

• Confirmation it is now funding a sharps disposal service for people using needles and syringes in the community, at no cost to the patient.

• Information on whether the DHB applies charges or co-payments related to dental reconstruction following oral cancer surgery.

• Identification of three actions from its suicide prevention plan that will be a key focus, however the DHB did not respond to a request for clarification regarding one of its actions.

PERFORMANCE HIGHLIGHTS

Good financial performance.

PERFORMANCE ISSUES

Youth mental health and addiction waiting times: The DHB waiting times were discussed at the internal mental health performance monitoring meeting given that the DHB's waiting times are poor and not improving. The Ministry will discuss with the DHB what has/will be put in place to improve the child and youth waiting times and when they expect improvements in performance.

How to read this dashboard

This dashboard shows a summary of most aspects of DHB performance. It combines indicators of DHB performance, as agreed in the 2015/16 Annual Plan, as well as complementary information such as financial net results, hospital indicators and other priorities. The structure has been designed to display DHB information using an 'at-a-glance' approach. It is not to be used for general publication. It groups information according to the following areas:

Health targets	Shows the progress made by the DHB against the health targets. The top bar chart show relative performance to target for each measure, while the time series charts absolute performance throughout the year.
Service Reconfiguration	This area displays information related to the progress DHBs are achieving in the implementation of the System Integration Programme.
Waiting Times	This area summarises an array of indicators that show DHB progress towards reducing waiting times.
Other Priorities	Emerging priorities such as the Prime Minister's youth mental health initiative.
Service coverage	Self-reported confirmation & exception report. DHBs must ensure service coverage expectations are met, or demonstrate resolution of service coverage gaps by providing an appropriate resolution plan, and adequate progress is being made against the resolution plan.
Financial Management	Overview of the financial performance of the DHB based on data provided by the DHBs in monthly financial templates.
Highlights and Lowlights	High level description of particular issues in which a DHB exceeded agreed performance expectations or has not met agreed performance expectation and does not have an appropriate resolution plan in place, or needs to progress further.

Each area includes one or more indicators. Definitions for those are as follow: (Definitions for health target indicators are shown in the health target summary table and therefore are not repeated here.)

Acute readmissions rates *	Acute readmission rates are defined as the number of unplanned acute readmissions to hospital within 28 days of a previous inpatient discharge that occurred within the 12 months to the end of the quarter, as a proportion of inpatient discharges in the 12 months to the end of the quarter. The rates are standardised by patient population characteristics, deprivation, rurality, patient health conditions, comorbidity and surgery, using national patient population as a 'standard'. Indirect standardisation using logistic regression method is applied to derive the rates.
Ambulatory sensitive hospitalisations (ASH) *	Ambulatory Sensitive Hospitalisations (ASH) result from diseases and conditions sensitive to prophylactic or therapeutic interventions deliverable through primary care and are, therefore, avoidable. The ASH rates are derived by the total number of 12-month ASH for DHB patients aged 0-4 and 45-64 as the numerators and the same age population of the DHB as the denominators respectively.
Improved management for long term conditions	DHBs are expected to report on delivery of the actions and milestones as identified in the 2015/16 annual plans for long term conditions (LTC), diabetes care improvement packages (DCIP), acute coronary syndrome (ACS) services, and stroke services.
Improving wrap around services -health for older people	DHBs are expected to report on delivery of the actions and milestones as identified in the 2015/16 annual plans for health for older people services including home and community support services, InterRAI, dementia care pathway, HOP specialists, fracture liaison services.
Immunisation coverage	The percentage of children who have completed their age-appropriate immunisations by the age of 2 years and by the age of 5 years (shown separately in the graph). The rating - indicated by the traffic light colour - is based on performance for both the 2- and 5-year-old milestones.
Cervical screening coverage	The number of eligible women (aged 25-69 years) screened in the three years to end of quarter being reported as a proportion of the hysterectomy adjusted female population.
Regional delivery - cardiac	Regional cardiac provider delivery against plan. DHBs submit four-weekly reports.
Waiting list - cardiac	Regional cardiac provider total waiting list against the waiting list target including those waiting over four months. Proportion of regional to national waiting list. DHBs submit four-weekly reports.
Patients waiting for FSA (ESPI 2)	The total number on the waiting list waiting longer than four months for an FSA for the last three months, and the number waiting as a % of the total list.
Patients waiting for treatment (ESPI 5)	The total number on the waiting list waiting longer than four months for treatment for the last three months, and the number waiting as a % of the total list.
Alcohol and drugs waiting times: * Child and Youth aged 0-19 years	Waiting times are measured from the time of referral for treatment to the first date the client is admitted to treatment, following assessment in any service whether it be NGO or provider arm.
Prime Minister youth mental health initiative	Reporting on service delivery and quality improvement in School Based Health Services, progress against local youth SLAT action plan to implement improvements in primary care responsiveness to youth, and youth primary mental health services (reported under PP26).
Reducing rheumatic fever *	A progress report against the DHB's rheumatic fever prevention plan (the regional plan for the South Island), plus hospitalisation rates per 100,000 DHB total population for acute rheumatic fever are 40% reduction from baseline (2009/10-2011/12).
Delivery of the children's action plan	Progress on delivery of the actions and milestones identified in DHB Annual Plans support the implementation of the Children's Action Plan and reduce child assaults.
Regional service delivery	A qualitative assessment of a progress report on behalf of the region agreed by all DHBs within that region. The report focuses on the actions agreed by each region as detailed in its RSP implementation plan.
Quality and Safety Markers	Progress toward the markers set by the Health Quality and Safety Commission. These include older patients receiving a falls assessment, compliance with good hand hygiene practice, and two surgical site infection measures: hip and knee replacement patients receiving 2g or more of cephazolin and antibiotic administered in the right time.
Patient Experience	Average rating out of 10 for inpatient experience across the four domains of communication, partnership, coordination of their care, and having physical and emotional needs met, based on results from the national patient experience survey.
Diagnostic waiting times	Performance against the waiting time indicators for Coronary Angiography, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), and Colonoscopy.
Performance highlights	Brief analysis of areas where a DHB is performing above expectations by achieving/exceeding a performance expectation, making significant progress from their base position, or implementing/leading an innovation process that will lead to performance improvement.
Performance issues	Brief analysis of areas where a DHB is performing below expectations, and actions being taken to resolve the issue(s)

***** Data for these measures covers a period prior to the current quarter to ensure complete coding of data.

The target definition of Better help for smokers to quit - primary care has change from quarter one 2015/16. There is no comparison to previous quarter.

****** Patient experience survey result is not shown for Tairawhiti, Nelson Marlborough and West Coast due to a small number of survey respondents.

Some indicators are for information only. Some, on the other hand, are accompanied by a traffic light colour.
This colour represents the perceived risk to a DHB achieving their target for the year.

The DHB is on track to achieve target	
Some aspects still need development / or the DHB is not tracking to target but has an appropriate resolution plan.	
The information available suggests the DHB is not on track to meet the target and does not have an appropriate resolution plan.	
To date, the DHB has provided no report.	NR
Not Applicable	NA

The Quality and Safety markers use a different traffic light scheme, to mimic that used by the Health Quality and Safety Commission.

Performance at or above the goal level	
Performance within 10/15% of the goal level (depending on the marker)	
Performance more than 10%/15% below the goal level (depending on the marker)	

21.1

HAWKE'S BAY District Health Board Whakawāteatia	**Annual Māori Health Plan Q3 (Jan-Mar 2016) Dashboard** 52
	For the attention of: **HBDHB Board**
Document Owner(s):	Tracee Te Huia, General Manager Māori Health
Document Author(s):	Patrick Le Geyt, Programme Manager Māori Health Justin Nguma, Senior Health & Social Policy Advisor Peter Mackenzie, Operational Performance Analyst
Reviewed by:	Executive Management Team, Clinical and Consumer Council
Month:	May, 2016
Consideration:	For Monitoring

RECOMMENDATION

That the Board

Note the contents of this report.

CONTENTS OF THE REPORT

This is a report on:

- The Māori health indicators agreed as part of the development of 2015 /16 Annual Māori Health Plan.

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A quick reference summary dashboard is included and shows our position as at the end of this quarter for all indicators. The dashboard uses traffic light methodology (as described in the key on page 4) to represent this.

As this report is for the period ending March 2016, some results may vary to those presented in other reports.

KEY FOR DETAILED REPORT AND DASHBOARD

Baseline	Latest available data for planning purpose
Target 15-16	Target 2015/16
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target
U (Unfavourable)	Actual to date is unfavourable to target
Trend direction ▲	Performance is improving against the previous reporting period or baseline
Trend direction ▼	Performance is declining
Trend direction -	Performance is unchanged

PERFORMANCE HIGHLIGHTS

Achievements

1. HBDHB continues to have the highest percentage in New Zealand for Cervical Screening for 25-69 year old Māori women (73.2%) and the lowest disparity gap between Māori and European (4% gap).
2. Immunisation rates for 8 month old Māori increased from 93.3% in Quarter 2 to 97.7% in Quarter 3 to be above the target of ≥ 95%.
3. Immunised rates for Māori 4 year olds remains above the expected target of ≥ 90% with 93.25 immunised in Quarter 3.
4. Quick Access to Angiograms for Māori exceeded the expected target of ≥70% with 80% in Quarter 3 up from 60% in Quarter 2.
5. The number of Māori enrolled in the Health Hawke's Bay PHO has reached the 97% target up from 96.75 in Quarter 2 to 97.8% in Quarter 3.

Areas of progress

1. Pre-school Oral Health Enrolments for Māori under 5 years of age increased from 65.3% in Quarter 2 to 74.1% in Quarter 3. There is still some work to do to reach the expected target of ≥90%.
2. Cultural Training for HBDHB staff has increased from 66% in Quarter 2 to 70.6% in Quarter 3. Medical staff increased 19% in Quarter 2 to 32.4% in Quarter 3.

Challenges

1. Māori under Mental Health Act Compulsory Treatment Orders has risen 16.7 from 196 per 100,000 population in Quarter 2 to 212.7 in Quarter 3. There remains a widening inequality between Māori and non-Māori of 113.1 per 100,000 population.
2. Immunisation rates for Māori under 2 year olds dropped slightly below the targets of ≥ 95% with 94.81% of all Māori 2 year olds immunized in Quarter 3.
3. Heart and Diabetes Checks remained relatively unchanged from 86.3% in Quarter 2 to 86% in Quarter 3 just under the expected target of ≥90%.
4. Breast Screening has remained unchanged from 68.4% in Quarter 2 to remain on 68.4% in Quarter 3.
5. Māori Workforce remained relatively static in Quarter 3 at 12.4%, an improvement of only 0.1% from Quarter 3, and is below the expected target of 14.3%.

Please note:

- Unless otherwise stated the results presented in this dashboard are for Māori.
- The approximated gap to achieving target numbers stated may only be one of a range of possible values that could deliver the targeted level/result.

ANNUAL MĀORI HEALTH PLAN, QUARTER 3 JANUARY - MARCH 2016 DASHBOARD REPORT

Access to Care
PHO Enrolment and ASH rates

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
PHO Enrolment	94.7%	96.7%	97.8%	96.7%	≥ 97%	346		↑
0-4 years (6m)	82.0%	82.0%	-	-	≤ -	-		↓
45-64 years (6m)	100.0%	98.0%	-	-	≤ -	-		↓

Child Health
Breastfeeding rates (3m)

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
QIF Data								
At 6 Weeks	68.0%	62.0%	-	-	≥ 75%	-		↑
At 3 months	54.0%	45.0%	-	-	≥ 60%	-		↑
At 6 months	59.0%	54.0%	-	-	≥ 65%	-		↑

Immunisation

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Immunisation (8 Months)	95.9%	92.6%	97.7%	93.2%	≥ 95%	7		↑
Immunisation (2 years)	95.0%	95.1%	94.8%	94.9%	≥ 95%	0		↑
Immunisation (4 years)	-	94.2%	93.2%	91.2%	≥ 90%	11		↑
65+ Influenza (3m)	68.0%	56.5%	-	-	≥ 75%	-		

Rheumatic Fever

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Hospitalisation rate (6m)	-	-	2.09	-	≤ 2.6	0		

Oral Health

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Pre-school enrolment rate	65.3%	65.3%	74.1%	99.8%	≥ 90%	-771		↑

SUDI

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Rate per 100,000	4.6	2.9	Update not available		≤ 0.5	-		

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

Time Series Key:
- Target
- Actual

Cardiovascular Disease

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Heart & diabetes checks	83.9%	86.3%	86.0%	90.8%	≥ 90%	-454		↑
Quick access to angiograms	66.7%	60.0%	80.0%	71.1%	≥ 70%	1		↑
Completion of registry data	12.5%	71.4%	100.0%	100.0%	≥ 95%	1		↑

Cancer

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Cervical screening (25-69 yrs)	73.8%	74.1%	73.2%	77.2%	≥ 80%	-604		↑
Breast screening (50-69 yrs)	67.2%	68.4%	68.4%	79.0%	≥ 70%	-54		↑

Smokefree

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Smokefree 2 weeks postnatal	58.0%	62.0%	53.0%	73.0%	≥ 86.0%	-		↑
Pregnant smokers Brief Advice to Quit	100.0%	95.2%	86.2%	88.6%	≥ 90.0%	-2		↑

Mental Health & Addictions

Indicator	Baseline	Prior period	Actual to date Maori	Actual to date Other	Period target	Individual Numbers	Time Series Trend	Desired Trend
Mental Health Act community treatment orders (per 100,000)	-	196	212.7	99.6	≤ 81.5	46		↓

Maori Workforce

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	2.7%	2.7%	2.9%	3.2%	≥ -			
Management & Administration	15.7%	16.5%	16.1%	-	≥ -			
Nursing	10.1%	10.6%	10.7%	-	≥ -			
Allied Health	11.9%	12.6%	12.4%	-	≥ -			
Support Staff	26.7%	28.2%	30.2%	-	≥ -			
Māori staff - HBDHB	11.6%	12.3%	12.4%	-	≥ 14.3%			↑

Cultural Responsiveness

Indicator	Baseline	Prior period result	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	9%	19%	32%	-	≥ -		
Management & Administration	43%	79%	82%	-	≥ -		
Nursing	41%	70%	75%	-	≥ -		
Allied Health	59%	77%	80%	-	≥ -		
Support Staff	12%	36%	39%	-	≥ -		
Māori staff - HBDHB	40%	65.5%	71%	-	≥ 100%			↑

Te Ara Whakawaiora Priorities

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Other	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Obesity (B4SC Healthy Weight for 4yrs)	-	26.0%	52%	56%	≥ 50%	-		↑
DNA's	16.2%	15.2%	18.20%	4.10%	≤ 7.50%	-135		↓
Oral Health (% Caries Free at 5yrs)	38.7%	38.7%	36.0%	70.1%	≥ 65%	-250		↑

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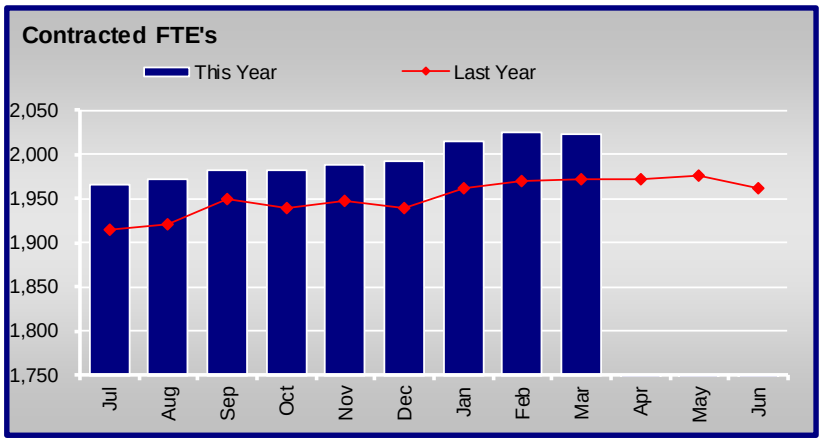
HAWKE'S BAY District Health Board Whakawāteatia	**Human Resource KPIs (Q3 Jan-Mar 2016)** 53
	For the attention of: **HBDHB Board**
Document Owner: Document Author:	John McKeefry, GM Human Resources Jim Scott, Workforce Analyst
Reviewed by:	Executive Management Team
Month:	May 2016
Consideration:	For Information

Headcount and positions

Reporting on headcount/ positions is a snapshot in time rather than an average for the month or year.



Contracted FTEs
2022.3 at 31 Mar 2016
1970.9 at 31 Mar 2015
= 2.6% increase

Overall increases/ (decreases)

	FTE	
Medical	5.6	2.4%
Nursing	8.0	1.0%
Allied Health	24.6	6.0%
Support	5.5	4.6%
Mge. & Admin	7.7	2.0%
Total	**51.4**	**2.6%**

Accrued FTE:

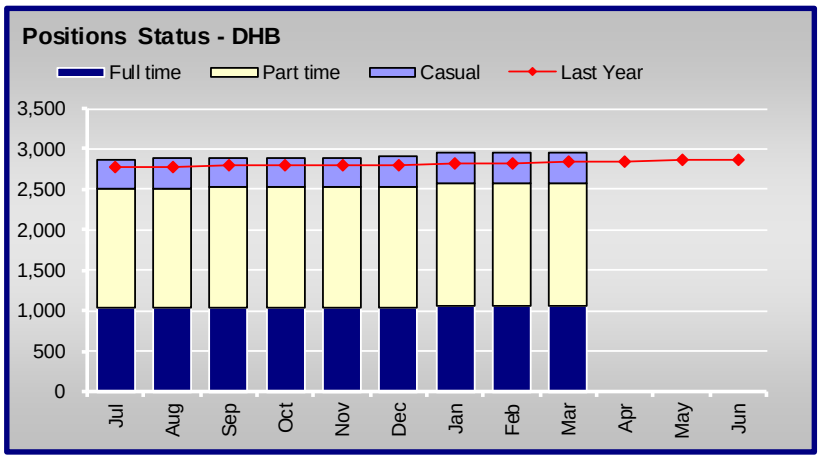
	Budget	Actual	Variance	% Variance
Month of March 2016	2229	2183	46	2.1%
Year to date to March 2016	2177	2136	41	1.9%

Accrued FTE has a year to date favourable variance to March of 41 or 1.9%. Details are in the Finance Report and include:

	FTE	Comments
Allied Health Personnel	28	Vacancies. Recruitment to positions for new models of care, low supply of applicants, delays in staged recruitment of pharmacy facilitators and difficulty recruiting laboratory vacancies.
Nursing Personnel	9	Management of low volumes in Ata Rangi and vacancies in rural services.

New Position Requests to Recruit approved by EMT in January to March 2016 quarter:

Position	FTE
Registered Nurse – Clinical Research	0.8
Intern Psychologist	1.0
Laboratory Scientist – Histology	1.0
Oral Clinical Director	0.2
Public Health Medicine Registrar	1.0
Clinical Psychologist for Cancer, Renal Health and Pain Management	1.0
Charge Preanalytical Services	1.0
Project Manager – Health & Social Care Network Development	1.0
Preanalytical Technician	0.4
Allied Health Professions Educator – Coaching & Relationship building	1.0
Clinical Pathways Facilitator	0.4
Administration Coordinator	0.6
Elective Booking Coordinator - Outpatients	0.4
Project Manager	0.8
Registered Nurses – ED	4.5
Gastroenterologist Physician	0.8
Social Worker – engAGE	1.0
Social Worker Assistant	1.0
Care Associates – Surgical Services	1.176
Registered Nurses – Surgical Services	6.76



Positions filled:
2948 at 31 Mar 2016
2834 at 31 Mar 2015
= 4.0% increase (114 positions)

Of the 2948 positions (last year in brackets):
36% are full-time (37%)
51% are part-time (51%)
13% are casual (12%)

Overall increases/ (decreases) – breakdown of 3.8% increase

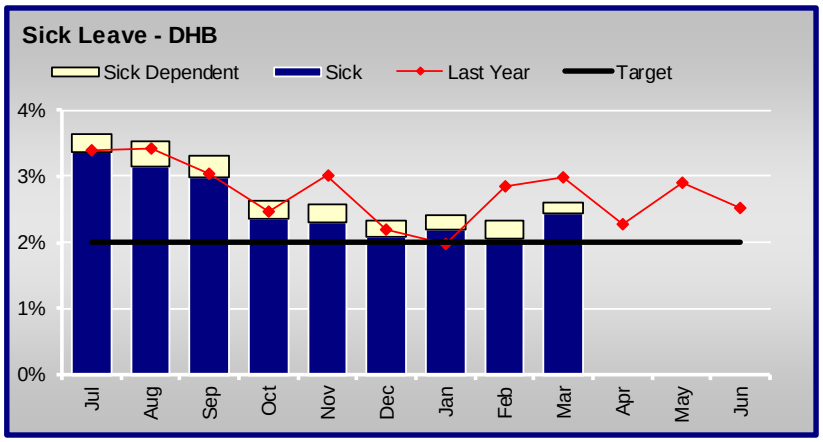
	Full time	Part time	Casual	Total	% change
Medical	(2)	11	5	14	5.3%
Nursing	(6)	23	44	61	4.3%
Allied Health	19	6	(5)	20	3.8%
Support	3	4	3	10	5.6%
Management & Admin	(2)	11	0	9	2.1%
Totals	**12**	**55**	**47**	**114**	**4.0%**

Sick Leave

The percentage of sick leave taken hours (paid and unpaid) to accrued FTE hours.

Note: as this KPI is reported early in the month, not all sick leave for the previous month has been recorded as yet. Figures and the graph will be adjusted in the following month.

Target is 2.00%



Mar 2016 = 2.61%
Mar 2015 = 2.98%

YTD Mar '16 = 2.81%
YTD Mar '15 = 2.80%

Sick leave pretty similar to last year with no concerns for March quarter or year to date to report.

HBDHB is the lowest of the mid-sized DHBs.

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

31 Mar. 2016 – 11th lowest out of 20 DHBs (12 months ended Mar. 2016 ranked 3rd lowest)

31 Mar. 2016 – 4th lowest out of 6 mid-sized DHBs (12 months ended Mar. 2016 ranked the lowest)

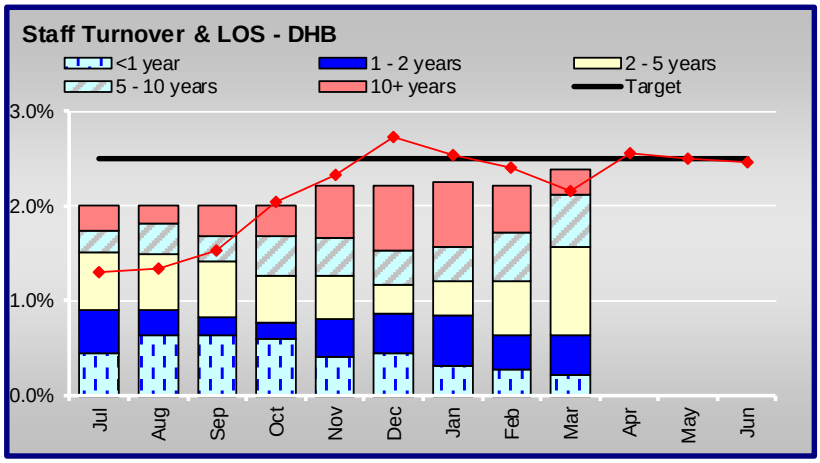
Staff Turnover

Incidence of staff resignations in an organisation. #Voluntary resignations ÷ Total headcount at the beginning of the period. Period is a rolling 3 Months

Note: Junior Doctors (RMOs), Temporary (fixed term) employees and casual employees are excluded from this measure. Employment terminations due to redundancy, death, dismissal and medical grounds are excluded.

A new table has been included in the notes for each section to show total headcount at the beginning of the period, new starts, resignations, transfer and changes of status to reconcile to total headcount at the end of the quarter.

Target is 2.50% per quarter.



3 months ended Mar '16 = 2.38% which is below the target of 2.50%

12 months to Mar '16 = 9.11% which is below the 10% annual target.

Allied Health turnover is slightly higher than the 10% annual target but present no concerns.

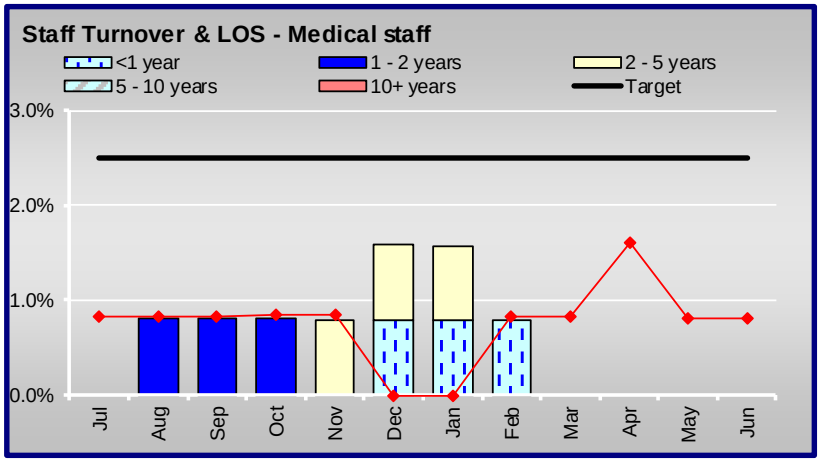
2226	Staff at 1 Jan '16
61	New Staff
(54)	Staff resignations
18	Change of status – mostly fixed term to permanent
2251	Staff at 31 Mar '16

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

31 Mar. 2016 – 4th lowest out of 20 DHBs (12 months ended Mar. 2016 ranked 8th lowest)

31 Mar. 2016 – 2nd lowest out of 6 mid-sized DHBs (12 months ended Mar. 2016 ranked 5th lowest)

Staff Turnover – Medical Staff



3 months ended Mar '16 = 0.0% which is below the 2.50% target.

12 months to Mar '16 = 3.23% which is below the 10% annual target.

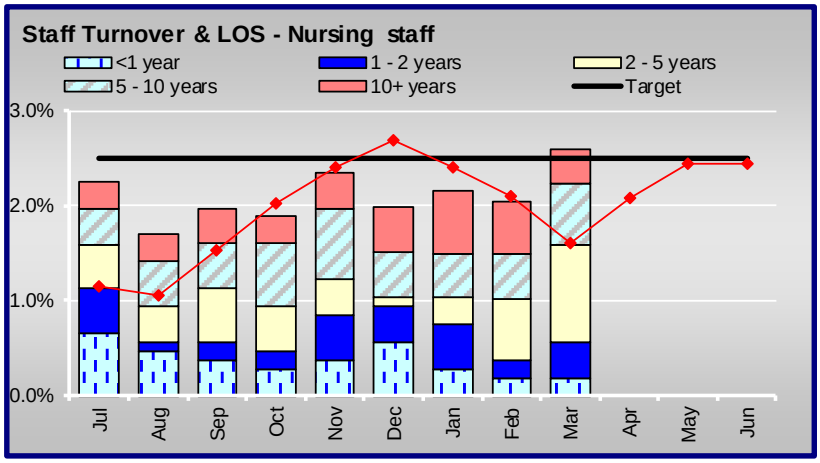
128	Staff at 1 Jan '16
1	New Staff
0	Staff resignations
0	Change of status –fixed term to permanent
129	Staff at 31 Mar '16

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

31 Mar. 2016 – the lowest out of 20 DHBs (12 months ended Mar. 2016 ranked 3rd lowest)

31 Mar. 2016 – the lowest out of 6 mid-sized DHBs (12 months ended Mar. 2016 ranked the lowest)

Staff Turnover – Nursing Staff



3 months ended Mar '16 = 2.60% which is slightly above the target of 2.50%

12 months to Mar '16 = 9.02% which is below the 10% annual target.

No significant trends.

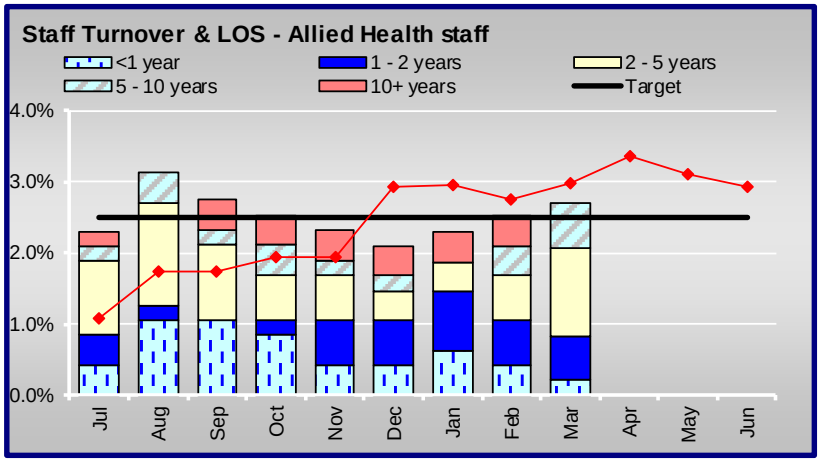
1077	Staff at 1 Jan '16
20	New Staff
(28)	Staff resignations
10	Change of status – mostly fixed term to permanent
1	Trf other staff group
1080	Staff at 31 Mar '16

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

31 Mar. 2016 – 12th lowest out of 20 DHBs (12 months ended Mar. 2016 ranked 9th lowest)

31 Mar. 2016 – 5th lowest out of 6 mid-sized DHBs (12 months ended Mar. 2016 ranked 5th lowest)

Staff Turnover – Allied Health Staff



3 months ended Mar '16 = 2.69% which is slightly above the 2.50% target.

12 months to Mar '16 = 10.48% which is above the 10% annual target.

This 10.48% represents 50 resignations in the year:

- 19 moved to position outside HBDHB.
- 10 relocating outside HB.
- 4 retired
- 3 family reasons
- 14 other reasons.

483	Staff at 1 Jan '16
19	New Staff
(14)	Staff resignations
7	Change of status – fixed term or casual to permanent
(1)	Trf other staff group
494	Staff at 31 Mar '16

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

31 Mar. 2016 – 8th lowest out of 20 DHBs (12 months ended Mar. 2016 ranked 7th lowest)

31 Mar. 2016 – 2nd lowest out of 6 mid-sized DHBs (12 months ended Mar. 2016 ranked 3rd lowest)

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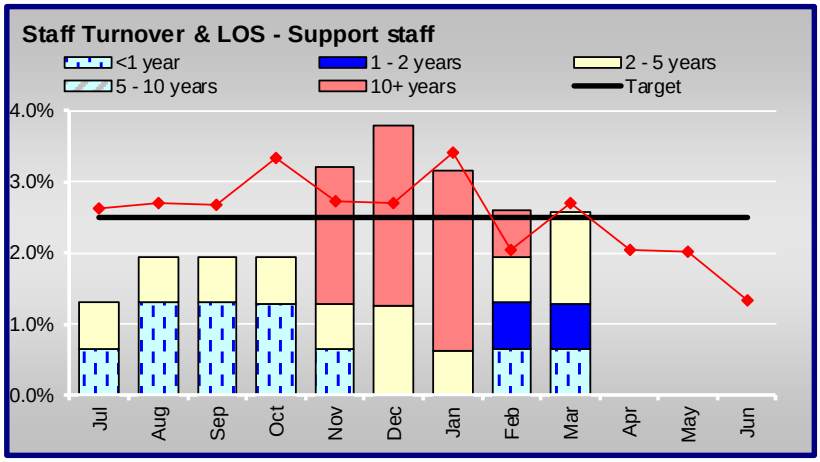
Staff Turnover – Support Staff



3 months ended Mar '16 = 2.58% which is slightly above the 2.50% target.

12 months to Mar '16 = 9.93% which is below the 10% annual target.

155	Staff at 1 Jan '16
5	New Staff
(4)	Staff resignations
1	Change of status – casual to permanent
0	Trf. other staff group
157	Staff at 31 Mar '16

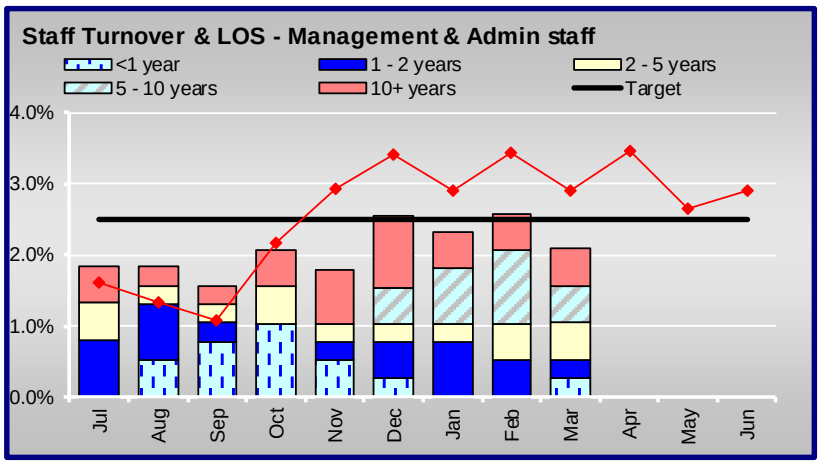
Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

31 Mar. 2016 – 10th lowest out of 20 DHBs (12 months ended Mar. 2016 ranked 12th lowest)

31 Mar. 2016 – 4th lowest out of 6 mid-sized DHBs (12 months ended Mar. 2016 ranked 3rd lowest)

Note a number of other DHBs outsource much of their Support staff which can impact on their Turnover rate.

Staff Turnover – Management & Administration Staff



3 months ended Mar '16 = 2.09% which is below the 2.50% target.

12 months to Mar '16 = 9.21% which is below the 10% annual target.

383	Staff at 1 Jan '16
16	New Staff
(8)	Staff resignations
0	Change of status – mostly permanent. To fixed term
0	Trf from staff groups
391	Staff at 31 Mar '16

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

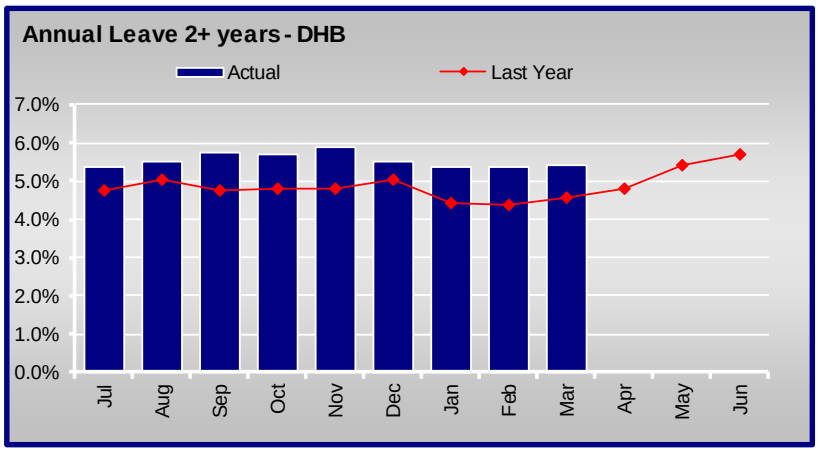
31 Mar. 2016 – 7th lowest out of 20 DHBs (12 months ended Mar. 2016 ranked 7th lowest)

31 Mar. 2016 – 3rd lowest out of 6 mid-sized DHBs (12 months ended Mar. 2016 ranked 4th lowest)

Accrued Annual Leave (2+ years)

The percentage of employees where accrued annual leave balance is greater than 2 years annual leave entitlement.

Target is 0%.



Jun '15 = 5.69% (143 staff)
Mar '16 = 5.43% (140 staff)
Reduced by 3

We are the third best performed mid-sized DHB for this KPI and the 8th best overall.

The percentage of staff with 2+ year's accumulated annual leave has decreased from 5.69% to 5.43% since 30 June 2015.

The total liability at 31 March 2016 was $17.9m compares to $19.1m at 30 June 2015. This $1.2m improvement is made up of:

1. $1.5m favourable driven by a decrease in the hours owing.
2. $0.3m unfavourable driven by an increase in the average rates.

Managers and Team Leaders, particularly in Health Services are working very hard to optimise leave being taken including the taking of short notice leave.

Note that the average AL balance has increased slightly over the last 5 years but that staff with 5 weeks (or more) annual entitlements increasing from 51.7% in March 2011 to 65.0% in March 2016.

	Average AL balance (hours)	% staff with an annual entitlement of 5 or more weeks Annual Leave
Mar. 2016	115.88	65.0%
Mar. 2011	114.53	51.7%

We have implemented all the actions identified in the 31 December 2015 HR KPI report and continue to optimise leave taken.

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

31 Mar. 2016 – 8th lowest out of 20 DHBs (Mar. 2015 – 5th lowest)

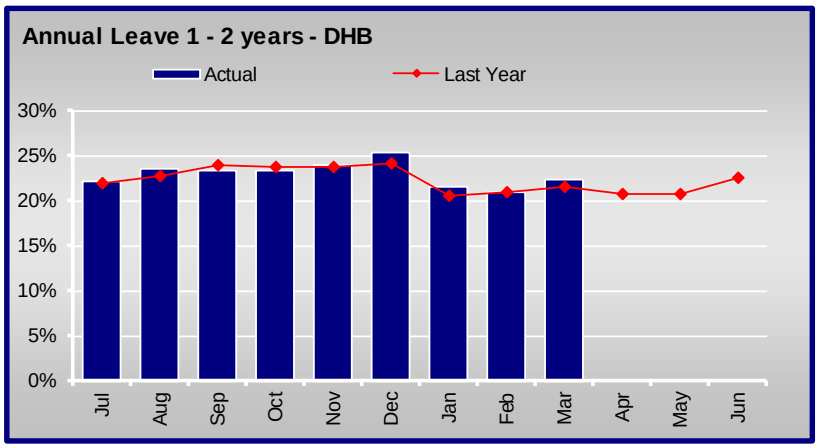
31 Mar. 2016 – 3rd lowest out of 6 mid-sized DHBs (Mar. 2015 – 2nd lowest)

31 Mar. 2016 – 3rd lowest of the central Region DHBs (Mar. 2015 – 3rd lowest)

Accrued Annual Leave (1 – 2 years)

The percentage of employees where accrued annual leave balance is between 1 and 2 years annual leave entitlement.

Target is 15%.



Jun ’15 = 22.43% (564 staff)
Mar ’16 = 22.24% (573 staff)

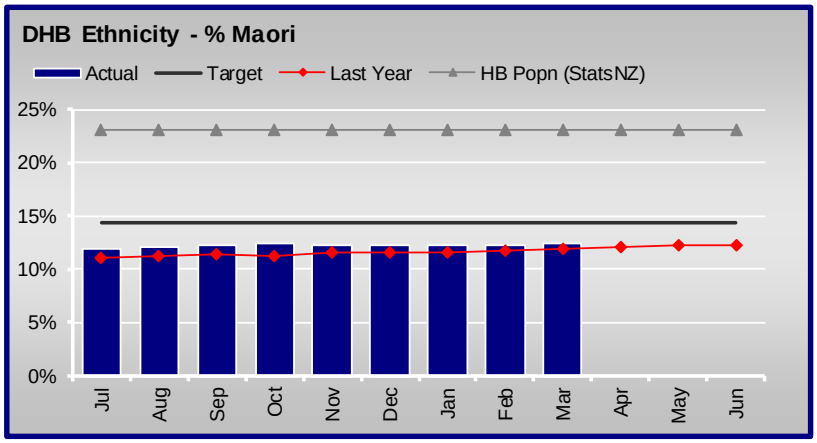
A slight decrease in the percentage of staff with 1 to 2 years of annual leave owing.

Staff Ethnicity

Measure the number of positions at HBDHB where the incumbents identify themselves as Māori

Target is set at 10% improvement on previous year. 2015/16 target = 14.3%. The Māori population for HB is 23.1%

Note - We generally report on positions so we can break our numbers down for reporting purposes by Occupational Group, Service, and Department etc. Some employees have more than one position in more than one Department, Service or occupational group



Note – at 31 March 2011 the percentage of Māori staff was 8.7% compared to 12.4% at 31 March 2016.

Māori staff representation in the Workforce:

	People	Positions
Mar '16	12.89%	12.38%
Mar '15	12.12%	11.93%

Mar 2016 breakdown:

	Positions filled	% of Total
NZ & European	2228	75.57%
Maori	365	12.38%
Pacific Islands	38	1.29%
Other	239	8.11%
Not known	78	2.65%
Total	**2948**	

Support staff (30.16%) and Management & Admin staff (16.14%) exceed the DHB target.

Allied Health (12.43%) Medical (3.24%) and Nursing staff (10.69%) are below the target. Nursing has been the primary focus for recruitment and has increased from 10.1% to 10.7% in the last year.

The gap to our target sits at 57 at 31 March 2016.

357	Maori Staff - 1 Jan 2016
25	New Staff
(17)	Staff resignations
	Changes to ethnicity
365	Maori Staff – 31 Mar 16

With the target increasing from 12.97% to 14.3% at 30 June 2016 it was recognised that we needed to deepen our focus in Nursing and broaden our focus to Allied Health as our second largest workforce.

To increase Maori staff representation in Nursing and Allied Health from current levels is a significant challenge and requires an approach where the competency Engaging Effectively with Maori is more highly valued by the organisation. To do this the competency of Engaging Effectively with Maori will be including in ALL position profiles and a question to establish competence for effectively engaging with Maori included in the interview question template and given double weighting. In addition the need to recruit more Maori is being re-promoted to all hiring managers and team leaders.

Māori Staffing Recruitment Plan 2015 / 2016 ***updated 4 May 2016***

Update of Recruitment plan including **focus on Allied Health and introduce additional initiatives for Nursing and other areas of the DHB** to increase Māori staff representation

Action	Who	Status
Keep Hiring Managers informed of need to increase Māori staff representation and advise KPI performance to date	Paul Davies Jim Scott	Reports sent monthly to CNO, Nurse Directors, CNMs and Director Allied Health and Allied Health Professional Leads
Recruitment Tool Kit updated to provide information and guidance on interviewing Māori candidates	Paul Davies	Tool Kit is currently up to date with a focus on Māori staff recruitment and is updated on a regular basis
NEtP Recruitment – targeted to increase Māori staff representation	Helen Ansell CNMs & NDs Recruitment	Ongoing since 2013 NEtP recruitment for Jan16 intake completed – 8 Māori Grads hired Recruitment underway for Sept16 intake – applications close 10 May.
Work with Kia Ora Hauora to identify Māori candidates who are keen to work in the Hawke's Bay and develop ongoing relationships	Paul Davies	Initial contact made with candidates and now following up with responses Working with Kia Ora Hauora and MHS to refresh list of students and put in place a talent pool
Include our values in Te Reo in all our advertising	Recruitment	In place
Develop Values Pre-Screening tool to ensure applicants aligned with DHB values and that they engage effectively with Māori Stage 1 will involve including a pre-screening question for all Team Leader / Manager roles – "research the HBDHB values and provide examples of how you have delivered on these in a previous role or situation"	Paul Davies	Completed Values Question "research the HBDHB values and provide examples of how you have delivered on these in a previous role or situation" now included in Interview Question template as Question 2, with a weighting of 2.
Ensure all HBDHB Hiring Managers complete Engaging Effectively with Māori course	EMT Managers Viv Kerr	In progress – by June 2016 As of 31 March 76.2% of Managers have completed EE|M
Ensure all members of an interview panel have completed Engaging Effectively with Māori, and for this eventually to be a mandatory requirement before they can be involved in selection and assessment	Paul Davies	In progress – by Oct 2016
Position profiles to be updated (key competencies and essential criteria) to include Engaging Effectively with Māori as currently this is included but defined as TOW responsibilities / cultural safety.	Emma Ellison	Completed – Position Profile template now includes EEM as a Key Competency; Demonstrates knowledge and understanding of local tikanga and Māori culture sufficiently to be able to respond appropriately to Māori

		Is visible, welcoming and accessible to Māori consumers and their whānau Actively engages in respectful relationships with Māori consumers and whānau and the Māori community Actively seeks ways to work with Māori consumers and whānau to maximise Māori experience
Update interview question template to ensure EEM is Q2 or Q3 and also it is weighted 2 or higher for assessment	Emma Ellison	Hiring Managers currently advised as and when required – Dec 2015 Templates updated – Feb 2016 EEM question **Can you tell us about a time when engagement with a Māori staff member/whanau/consumer didn't go well. What did you learn?** Now included in Interview Question template as Question 3, with a weighting of 2. Include in Recruitment training
Include a consumer representative on interview panel	Hiring Managers	In place for Senior Management and SMO Roles. Consumers invited to be on the interview panel and presentation panel Trialled for Nurse Director Māori Health – completed & worked well – to update Recruitment Tool Kit to advise of this option particularly for consumer facing roles Māori Consumer to be part of all Interview panels – this will be confirmed once the process for operating Maori Consumers is finalised by Director QIPS and GM Maori Health. In the interim Hiring Managers asked to request representative from Māori Health to go onto Interview panels
Develop "Day in the Life" success stories promoting current Māori staff	Patrick Le Geyt Paul Davies	15 people identified by Māori Health Services (MHS) Develop stories and use in promotional activity online from June 2016

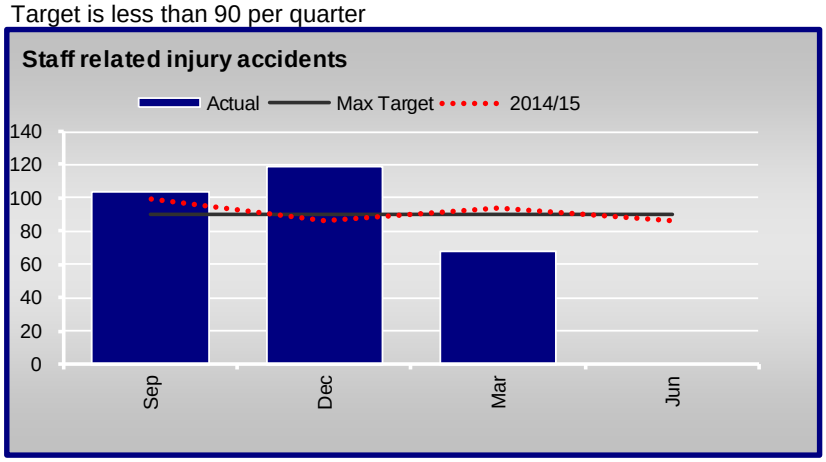
Enhance training to Hiring Managers on selection techniques, the support available from MHS and ensure their candidate selection focuses on the relationships the role needs and those who can best engage with Māori.	Paul Davies	Deliver as part of next HR Foundations Course, Recruitment module, - *next module due to be delivered August 2016*
Develop seminar to provide CV and interview training and support to candidates	Emma Ellison and Paul Davies	Presentation recently to Year 12/13 students completed Work with E & D and MHS to develop additional seminars – as of May 2016, and one on ones as required
Audit recent appointments where Māori have been unsuccessful to understand why	Paul Davies	Ad-Hoc manual reports provided on a case by case basis Waiting on report from Recruitment System-Taleo – under development by Taleo System Administrator - due 30 May 2016
Identify unsuccessful Māori applicants and refer to other Hiring Managers and MHS for other potential opportunities	Paul Davies	Ad-Hoc manual reports provided on a case by case basis Waiting on report from Taleo – under development by Taleo System Administrator - due 30 May 2016
Briefing of CNMs, Nurse Leaders, Allied Health Leaders, other Hiring Managers and Union bipartite forum to confirm focus on recruiting Māori staff and define specific initiatives to improve Māori staff representation in their areas	John McKeefry Paul Davies	Met with CNMs/Nurse Leaders and met with Union bipartite forum in April Briefing of other Hiring Managers to occur in May April 2016 - Met with Director of Allied Health and Allied Health Professional Leads to review current status and discuss areas of focus and additional initiatives
Investigate Māori Champions in area where an increase in Māori staff is a high priority e.g.; Surgical Nursing District Nursing Orderly Security	Paul Davies	To discuss with Service Directorates May 2016
Set up a work station in MHS to enable those Māori candidates without online access to apply for roles	Denal Meihana	To implement - June 2016. Met with Denal Meihana and confirmed that this will be in place with the reorganisation of staff in the Māori Health Unit Link to CV templates and Interview tips
Provide monthly reports to Hiring Managers (in addition to the Māori staff representation and advise KPI performance to date) - Total no. of Māori applicants / total applicants	Paul Davies	Waiting on report from Recruitment System -Taleo – under development by Taleo System Administrator - due June 2016

- Total no. of Māori shortlisted / total shortlisted - Total no. of Māori appointed / total shortlisted		
Review and analyse Exit Surveys to better understand why staff leave the DHB	HR Paul Davies	Exit Survey is Voluntary Add Question to the Survey form ; "What could we have done to keep you in the organisation?" Ask Hiring Managers to discuss exit with staff member and if not they are not comfortable ask the staff member to discuss their resignation with the HR Advisor or MHS representative
Implement a generic recruitment campaign to attract Maori staff to the Hawkes bay Health Sector	Paul Davies	Develop an integrated a campaign including Social media to attract Maori candidates and establish a talent pool – June 2016

Occupational Health & Safety KPIs

Staff related injury accidents reported

Workplace injuries reported.
Target is less than 90 per quarter



Total for the quarter = 68
January = 19
February = 21
March = 28

Percentage of total staff by quarter:

Mar '16	2.3%
Compared to: Mar '15	3.3%

The DHB is putting additional emphasis with the Worksafe Representatives in working with their teams in the identification of hazards and providing education to those teams. The DHB also initiated an online training tool to support greater awareness of health and safety in the organisation.

Of the 68 for the June quarter:

- 22 back injuries/ sprain/ strain
- 16 cuts/ bruises/ lacerations/ burns
- 10 needlestick injuries and exposure to blood and body fluids
- 20 remaining included fracture/ possible fracture, gradual onset discomfort, graze, abrasion.

3 of the above were notified to Work Safe NZ as serious harm injuries.

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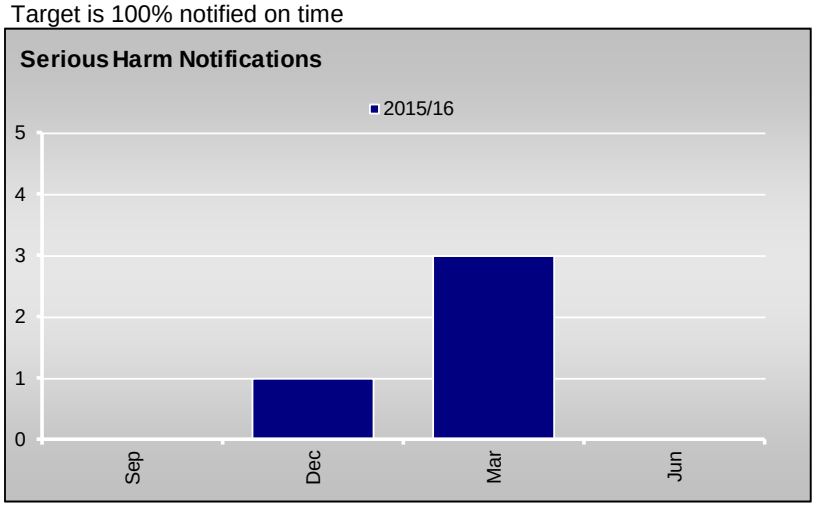
Serious Harm Injuries

Accidents notified to the Ministry of Business Innovation and Employment (MoBIE) as soon as possible'. Measured against next working day.

Target is 100% notified on time



Three serious harms were reported for the quarter.

These 3 harms were not notified to MoBIE by the next working day. Reasons included:

- First diagnosis was a query fracture until final diagnosis.
- Initial x-ray did not diagnose as a fracture.
- Inability to gain an official diagnosis over the weekend.

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Cardiovascular Disease** 54
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	John Gommans Gay Brown/Paula Jones
Reviewed by:	Health Service Leadership Team and Executive Management Team, Maori Relationship Board (MRB), Clinical and Consumer Council
Month:	May, 2016
Consideration:	For Information

RECOMMENDATION

That the Board:

Note the contents of this report.

OVERVIEW

This report is from Dr John Gommans, champion for the cardiovascular indicators. The report focuses on the two acute coronary syndrome (ACS) indicators (high risk ACS accepted for angiogram within three days of admission and ACS patients who have completed data collection), which were introduced as indicators of District Health Board (DHB) performance by the Ministry of Health in 2013/14.

There has been a positive result with the HBDHB and all DHBs within the central region meeting both indicators for the first time in quarter three (December 2015 to February 2016).

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Priority	Indicator	Measure	Champion	Reporting Month
Cardiovascular	• Total number (%) of all ACS patients where door to cath time is between -2 to 3 days of admission. • Total number (%) with complete data on ACS forms	70% of high risk >95% of ACS patients	John Gommans	April 2016

WHY IS THIS INDICATOR IMPORTANT?

To provide a national consistent reporting framework, all regions are required to report measure of ACS risk stratification and time to appropriate intervention using ANZACS-QI. HBDHB commenced using the ANZACS-QI system in September 2013. The DHBs actively monitor these two indicators of concern (figures 1 and 2)

FIGURE 1

% of Patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI and Cath/PCI registry data collection within 30 days.

ANZACS-QI

Registry Completion Quarterly Report - Apr 2016

Central Region DHBs

Period *	Central Region DHB Performance						
	CAPITAL AND COAST	HAWKES BAY	HUTT VALLEY	MID CENTRAL	NELSON MARLBOROUGH	WAIRARAPA	WHANGANUI
2014/2015 Q2 (Sep 2014 - Nov 2014)	6/75 (8.0%)	45/66 (68.2%)	19/38 (50.0%)	15/48 (31.3%)	78/89 (87.6%)	1/10 (10.0%)	2/14 (14.3%)
2014/2015 Q3 (Dec 2014 - Feb 2015)	47/64 (73.4%)	60/69 (87.0%)	34/36 (94.4%)	37/53 (69.8%)	68/80 (85.0%)	15/21 (71.4%)	14/17 (82.4%)
2014/2015 Q4 (Mar 2015 - May 2015)	68/69 (98.6%)	69/70 (98.6%)	46/46 (100.0%)	39/52 (75.0%)	76/88 (86.4%)	11/11 (100.0%)	27/28 (96.4%)
2015/2016 Q1 (Jun 2015 - Aug 2015)	68/68 (100.0%)	74/74 (100.0%)	47/47 (100.0%)	66/68 (97.1%)	64/66 (97.0%)	16/16 (100.0%)	21/21 (100.0%)
2015/2016 Q2 (Sep 2015 - Nov 2015)	82/83 (98.8%)	83/83 (100.0%)	52/52 (100.0%)	52/53 (98.1%)	58/70 (82.9%)	15/15 (100.0%)	24/24 (100.0%)
2015/2016 Q3 (Dec 2015 - Feb 2016)	73/73 (100.0%)	82/82 (100.0%)	42/42 (100.0%)	81/81 (100.0%)	64/64 (100.0%)	15/15 (100.0%)	33/34 (97.1%)

Quarter containing the date of admission signifying the start of each episode of care; Number (%) with both complete Cath Lab and ACS forms (Target is >95%); Denominator: Cath Lab pati

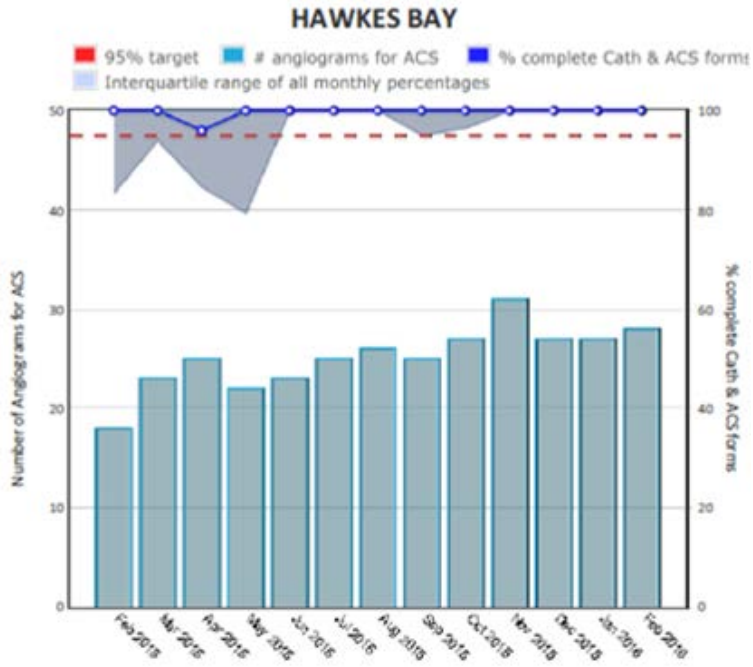


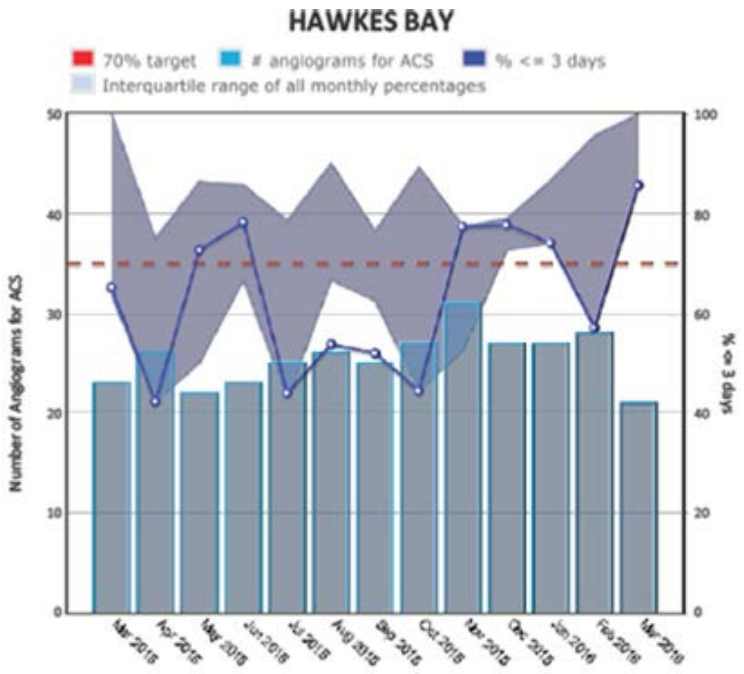
FIGURE 2
% of Patients Who Receive an Angiogram within 3 days of Admission

Door to Cath < 3-Days Quarterly KPI Report by DHB - Apr 2016

Central Region DHBs

Period	Central Region DHB Performance						
	CAPITAL AND COAST	HAWKES BAY	HUTT VALLEY	MID CENTRAL	NELSON MARLBOROUGH	WAIRARAPA	WHANGANUI
2014/2015 Q2 (Oct 2014 - Dec 2014)	64/76 (84.2%)	37/75 (49.3%)	26/35 (74.3%)	33/51 (64.7%)	74/86 (86.0%)	11/15 (73.3%)	10/13 (76.9%)
2014/2015 Q3 (Jan 2015 - Mar 2015)	53/57 (93.0%)	43/69 (62.3%)	28/41 (68.3%)	27/46 (58.7%)	87/90 (96.7%)	8/16 (50.0%)	12/21 (57.1%)
2014/2015 Q4 (Apr 2015 - Jun 2015)	65/69 (94.2%)	45/71 (63.4%)	30/42 (71.4%)	41/60 (68.3%)	68/78 (87.2%)	6/10 (60.0%)	17/28 (60.7%)
2015/2016 Q1 (Jul 2015 - Sep 2015)	65/73 (89.0%)	38/76 (50.0%)	41/51 (80.4%)	52/69 (75.4%)	60/67 (89.6%)	11/19 (57.9%)	13/21 (61.9%)
2015/2016 Q2 (Oct 2015 - Dec 2015)	76/83 (91.6%)	57/85 (67.1%)	32/50 (64.0%)	46/58 (79.3%)	62/68 (91.2%)	10/12 (83.3%)	14/27 (51.9%)
2015/2016 Q3 (Jan 2016 - Mar 2016)	68/76 (89.5%)	54/76 (71.1%)	40/42 (95.2%)	57/74 (77.0%)	55/57 (96.5%)	17/20 (85.0%)	22/31 (71.0%)

The dates are based on the dates of admission. Number (%) of all ACS patients where door to cath time is between -2 to 3 days. Target is 70%. Those with < -2 days are excluded from numerat



MĀORI PLAN INDICATOR:

HBDHB actively monitor the ethnicity breakdown for the ANZAC-QI and Cath/PCI registry data collection within 30 days. Refer to the tables (Figure 3 and 4) below for ethnicity breakdown for quarter three (December 2015 - February 2016).

FIGURE 3
% of Patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI and Cath/PCI registry data collection within 30 days.

HAWKES BAY

2015/2016 Q3 (Dec 2015 - Feb 2016)

	Maori	Pacific	Indian	Asian	Eur/Oth
Hawke's Bay	13/13 (100.0%)	3/3 (100.0%)	2/2 (100.0%)	1/1 (100.0%)	63/63 (100.0%)

FIGURE 4
% of Patients Who Receive an Angiogram within 3 days of Admission

HAWKES BAY

2015/2016 Q3 (Jan 2016 - Mar 2016)

	Maori	Pacific	Indian	Asian	Eur/Oth
Hawke's Bay	8/10 (80.0%)	1/2 (50.0%)	2/2 (100.0%)	1/1 (100.0%)	42/61 (68.9%)

Figures 5 and 6 below show overall HBDHB quarterly compliance from 2013/14.

FIGURE 5
% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI and Cath/PCI registry data collection within 30 days

		Target	Total	Maori	Pacific	Other
2013/14	Q2	95%	4.1%	6.7%	0.0%	0.0%
	Q3	95%	5.4%	0.0%	0.0%	0.0%
	Q4	95%	4.8%	0.0%	0.0%	0.0%
2014/15	Q1	95%	0.0%	0.0%	0.0%	0.0%
	Q2	95%	27.8%	12.5%		0.0%
	Q3	95%	61.1%	6.7%		0.0%
	Q4	95%	83.1%	90.9%	100.0%	81.0%
2015/16	Q1	95%	85.1%	91.7%	50.0%	85.0%
	Q2	95%	84.1%	71.4%		88.5%
	Q3	95%	100.0%	100.0%	100.0%	100.0%
	Q4	95%	0.0%	0.0%	0.0%	0.0%

FIGURE 6
% of patients who receive an angiogram within 3 days of admission

		Target	Total	Maori	Pacific	Other
2013/14	Q2	70.0%	68.9%	81.8%	100.0%	#DIV/0!
	Q3	70.0%	64.1%	45.5%	33.3%	70%
	Q4	70.0%	53.7%	72.7%	-	49%
2014/15	Q1	70.0%	75.7%	90.9%	50.0%	75%
	Q2	70.0%	49.3%	33.3%	-	52%
	Q3	70.0%	62.3%	66.7%	50.0%	62%
	Q4	70.0%	63.4%	58.3%	50.0%	65%
2015/16	Q1	70.0%	50.7%	38.5%	50.0%	53%
	Q2	70.0%	67.1%	60.0%	100.0%	71%
	Q3	70.0%	71.1%	80.0%	50.0%	70%
	Q4	70.0%	-	-	-	#DIV/0!

CHAMPION'S REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THIS INDICATOR?
Overall compliance against both indicators have increased over the last quarter and HBDHB met both indicators in quarter three of 2015/16.

This was achieved by close monitoring by the directorate leadership team and the development of an action plan in conjunction with the cardiology service.

Strategies to improve compliance to the data registry indicator included:

- Nursing staff, checking all incomplete forms and finalising or updating as required.
- All multiple Episodes of Care (EoC) checked and corrections made as required.
- Retraining on database process for staff using the system.
- Month and quarter reports discussed with cardiology staff using database.
- Patients transferred out from HBDHB before ACS EoC completed are followed up for database completion by CCDHB.

Strategies to improve compliance from the door to cath within three days indicator included:

- Increased access to angio suite confirmed each week.
- Potential angio patients admitted on Thursday are made priority to be seen first.
- Communication between CCDHB and HBDHB to support timely transfers of patients improved.

In addition to the above the TAS cardiology Network membership has recently been revised to include Central Region DHB Service Managers. This will ensure a continued focus on improving compliance.

Additional strategies that will continue to ensure sustained compliance for these indicators includes:

- Cardiologists revised roster, implemented 1 April 2016 which will support cardiologist availability for increased angio access.
- A specialty clinical nurse role currently going through the approval process will oversee and monitor the database in conjunction with the cardiology CNM to ensure adherence to the indicators.

RECOMMENDATIONS FROM TARGET CHAMPION

The Acute & Medical Directorate leadership team in conjunction with the cardiology service will continue to monitor and review it's strategies to ensure sustained compliance with both cardiovascular indicators. The service will continue to participate in TAS cardiac network activities to align with regional and national strategies.

CONCLUSION

There has been a positive result with the HBDHB and all DHBs within the central region meeting both indicators for the first time in quarter three (December 2015 to February 2016). The challenge for the service now is to sustain this improved compliance.

HAWKE'S BAY
District Health Board
Whakawāteatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

That the public now be excluded from the following parts of the meeting, namely:

26. Confirmation of Minutes of Board Meeting
- Public Excluded

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

28. Board Approval of Actions exceeding limits delegated by CEO

29. Chair's Report

Reports and Recommendations from Committee Chairs

30. Finance Risk and Audit Committee Report

30. HB Health Consumer and Clinical Council (joint meeting) Report

31. Maori Relationship Board Report

The general subject of the matter to be considered while the public is excluded, the reason for passing this resolution in relation to the matter and the specific grounds under Clause 32(a) of the New Zealand Public Health and Disability Act 2000 for the passing of this resolution are as follows:

- Official Information Act 1982 9(2)(ba) to protect information which is subject to an obligation of confidence.
- Official Information Act 1982 9(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions between the organisation, board and officers of the Minister of the Crown.
- NZPHD Act 2000, schedule 3, clause 32(a), that the public conduct of the whole or relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982).