BOARD MEETING

Date: Wednesday, 22 February 2017

Time: 1.00pm

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

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

Apologies: Helen Francis and Ngahiwi Tomoana

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

Board Administrator: Brenda Crene

Public Agenda

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

9.	Financial Performance Report – January 2017	3	
10.	Health & Safety Board Champion's Update	-	
11.	Consumer Story - Kate Coley	-	
	Section 2: Reports from Committee Chairs		
12.	HB Clinical Council - Co-Chairs Chris McKenna & Dr Mark Peterson	4	1.50
13.	HB Clinical Council Appointment - Ken Foote	5	
14.	HB Health Consumer Council - Chair, Graeme Norton	6	2.00
15.	Māori Relationship Board - Deputy Chair, Heather Skipworth	7	
16.	Pasifika Health Leadership Group	-	
	Section 3: Decision / For Discussion or Information		
17.	Orthopaedic Review phase 2 Draft - Dr Andy Phillips	8	2.20
18.	Community Representatives on Te Matau a Maui Health Trust - Ken Foote	9	
	Section 4: Monitoring		
19.	HR - KPIs Q2 Oct-Dec 16 - Kate Coley	10	2.30
20.	HBDHB Non-Financial Exceptions Report Q2 Oct-Dec 16 plus MoH dashboard	11	2.40
21.	Annual Māori Plan Non-Financial Exceptions Report Q2 Oct-Dec 16 Tracee TeHuia	12	2.50
22.	Te Ara Whakawaiora / Access (local indicator) - Mark Peterson	13	3.10
	Section 5: General Business		
23.	**Section 6: Recommendation to Exclude the Public**		
	Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	Section 7: Agenda Items	Ref #	Time (pm)
24.	Minutes of Previous Meeting		
25.	Matters Arising – Review of Actions		
26.	Board Approval of Actions exceeding limits delegated by CEO	14	3.15
27.	Chair's Update - Central Region DHB Symposium		
	Section 8: For Information / Discussion		
28.	High Level Budget Presentation 2017/18 - Peter Kennedy	-	3.25
29.	Integrating GP Services in Wairoa - verbal - Sharon Mason	-	3.35
30.	Maintaining the Radiology Service to Primary & Secondary Care - Sharon Mason, Paula Jones and Andrew West	15	3.45
31.	Cranford Hospice - Hayley Anderson and Ken Foote	16	4.05
	Section 9: Reports from Committee Chair		
32.	Finance Risk & Audit Committee – Chair Dan Druzianic	17	4.10
33.	HB Clinical Council - Co-Chairs Chris McKenna & Dr Mark Peterson	18	

Next Meeting: 1.00 pm, Wednesday 29 March 2016

Board "Interest Register" - 14 February 2017

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Kevin Atkinson (Chair)	Active	Chair of Unison Networks Limited	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB. Unison leases 3 generators which are located at Hawke's Bay Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	Chair of FRAC	18.02.09
	Active	Director of Unison Fibre Limited	Non pecuniary interest. Unison is now a provider of high speed broadband to the District Health Board.	Will not take part in any decision or discussions in relation to the provision of high speed broadband to the District Health Board	The Chair of FRAC	17.11.10
	Active	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 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
Jacoby Poulain	Active	Board Member of Eastern Institute of Technology (EIT)	Perceived conflict - HBDHB has a Memorandum of Understanding (MOU) with EIT relating to training and development in health related occupations	Will not take part in any decisions or discussions in relation to the MOU between HBDHB and EIT	The Chair	14.1.14
	Active	Councillor Hastings District Council	Potential conflict as potential advocate for Hastings District population whereas HBDHB coveres whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.1.14
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumatua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust (aligned to Iron Maori Limited)	The Trust has contracts with HBDHB including the Green Prescription Contract	Will not take part in any discussions or decisions relating to the Contract with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15
	Active	Director of Kahungunu Asset Holding Company Ltd	The asset portfolio of the company in no way relates to health, therefore there is no perceived conflict of interest.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	26.10.16
Peter Dunkerley	Active	Trustee of Hawke's Bay Helicopter Rescue Trust	Actual conflict of interest. The Trust provides helicopter patient transfer services to HBDHB	Will not take part in any decision or discussion in relation to any contract or financial arrangement between HBHRT and HBDHB	The Chair	15.05.14
Ana Apatu	Active	CEO of U-Turn Trust (U Turn is a member of Takitimu Ora Whanau Collective)	Relationship and and may be contractural from time to time	No conflict	The Chair	5.12.16
	Active	Chair of Directions	Relationship and contractual	Potential Conflict as this group has a DHB Contract	The Chair	5.12.16
	Active	Chair, Health Promotion Forum	Relationship	No conflict	The Chair	5.12.16
Hine Flood	Active	Member, Health Hawkes Bay Priority Population Committee	Pecuniary interest - Oversight and advise on service delivery to HBH priority populations.	Will not take part in any conflict of interest that may arise or in relation to any contract or financial arrangement with the PPC and HBDHB	The Chair	14.02.17
	Active	Councillor for the Wairoa District Council	Perceived Conflict - advocate for the Wairoa District population and HBDHB covers the whole of the Hawkes Bay region.	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.02.17

MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 14 DECEMBER 2016, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.40PM

Present:	Kevin Atkinson (Chair) Ngahiwi Tomoana Dan Druzianic Peter Dunkerley Diana Kirton Barbara Arnott Heather Skipworth Ana Apatu (newly elected) Hine Flood (newly appointed)
Apology	Helen Francis
In Attendance:	Kevin Snee (Chief Executive Officer) Members of the Executive Management Team Chris McKenna and Dr Mark Peterson -part (co-Chair HB Clinical Council) Graeme Norton (Chair, HB Health Consumer Council) Caren Rangi (Chair, Pasfika Health Leadership Group)
Minutes	Brenda Crene

KARAKIA

Ngahiwi Tomoana opened the meeting with a Karakia following the photographs being taken.

New Board members Ana Apatu and Hine Flood were welcomed to the meeting following a Powhiri; and the Chair provided a brief overview of the term ahead.

A values video entitled **"Health with Heart"** was viewed and members advised of the re-launch of our vision, values and behaviours across the organisation and sector, to further assist culture change and embed values in all that we do.

INTEREST REGISTER

No changes to the interests register were advised, however newly appointed member Hine Flood will advise her interests prior to the 22nd February Meeting. Ana Apatu's Interests had already been received.

Peter Dunkerley advised of a potential conflict in one item on the days Agenda, however the Chair did not expect any conflict relating to the Air Ambulance Services briefing provided.

CONFIRMATION OF PREVIOUS MINUTES

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

Moved: **Dan Druzianic**
Seconded: **Peter Dunkerley**
Carried

Smoke Free Target: Ana Apatu commented on the importance of GPs relaying the smoking message to patients, as important and powerful.

MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: **Fracture Clinic / Orthopaedic Dept. near ED** –This review will come back to the Board at a later date and be included on the workplan once timing had been ascertained.

Item 2: **Home Dialysis -** cost of power to consumers: A review had been undertaken to gauge what other DHBs around the country do. The board were advised that HBDHB in future would provide $105 per quarter to those dialysing at home. Currently there were 16 who would receive this payment. Remove action.

Item 3: **Position Statement on Reducing Alcohol-Related Harm** - Council advocacy noted. Remove action.

Item 4: **"Laboratory Specimen Labelling"** – The 30 November action was to identify the total number of transactions that puts the labelling errors into context (DFI). This had been provided by way of a late paper and it was advised by Tim Evans, the errors were a approximately 0.5% of the total and were being closely monitored. Remove action.

Civil Defence Message – Preparedness planning for the sector was underway. Everyone must take responsibility for their own personal preparedness if a strong earthquake should hit, given the heightened potential of a tsunami.

BOARD WORK PLAN

The Board Work Plan was noted.

CHAIR'S REPORT

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

Name	Role	Service	Years of Service	Retired
Gill Knight	Staff Midwife	Women Children & Youth	32	17-Dec-16
Janet Wynyard	Registered Nurse	Women Children & Youth	40	11-Dec-16
Elizabeth (Lucy) Petty	RN & Clinical Nurse Coordinator	Surgical Directorate	30	16-Dec-16
Dawn Ladd	Call Centre Operator	Planning Information & Finance	36	30-Dec-16
Berry Rangi	Pacific Island Cancer Prevention & Screening	Population Health	10	20-Dec-16
Jocelyn Tonge	Receptionist - Inpatient	Operations Directorate	38+	2-Dec-16
Jocelyn Crawley	Registered Nurse	Medical Directorate	24	2-Dec-16

- It was with sadness that the Board were advised of the death of Phil Sunderland, Chair of Mid Central DHB. Phil had chaired a number of symposiums and was very well respected gentlemen in the health area.
- The positive financial position of the Oliver Smales Trust was relayed to members. The Trust accepts applications to fund education and training from nursing staff and therapists working with children and youth in Hawke's Bay.

CHIEF EXECUTIVE OFFICER'S REPORT

The CEO provided an overview of 2016 including the Mental Health facility build and reconfigured service model; the Maternity Unit opened in July, the only one in NZ with low risk baby deliveries in a "low risk facility" (located on the hospital site); the DHB was proud to have delivered its 6th year of financial surpluses. Have also had some problems including: power outages; Havelock North gastro outbreak; RMO strike also troublesome with delivery of elective work with news there may be another strike in January 2017.

Next year we look forward to the development of the Clinical Services Plan (different from other DHBs) by starting in Primary Care and building up. This is important for the new Board to look carefully at it will be a key legacy for the population in this 3 year term on how we develop services and the infrastructure. Most of the planning around this will occur over the next 3 years.

The CEO was a little concerned over the year to date financial performance however acknowledged the focus remains to deliver the surplus as budgeted.

A General Manager has been appointed to Health Hawke's Bay to ensure continuity with the loss of Nicola Ehau (Acting CEO). Wayne Woolrich who currently works at HHB in a senior management role has been appointed to the role for 12 months. To ensure progress around integration and trust within primary care, the DHB will be talking and working more closely with General Practices as the pending new appointment of

Executive Director Primary Care, once made would be working very closely with primary care, and be charged with putting in place health and social care networks and managing/holding the budget for primary care funding.

The application to revoke Minister's consent to dispose of property at 307 Omahu Road was appended to the CEO's report and noted.

FINANCIAL PERFORMANCE REPORT

The Financial report for November 2016, showed favourable variance of $16 thousand for the month, with year to date an adverse variance of $235 thousand. A Letter of Expectations had been received from the Minister of Health advising a change in the capital finance policy. This was a technical issue and Finance provided detail pertaining to this change. There would not be any immediate impact and long term it is expected to be cost neutral.

Debt to Equity Swap

RECOMMENDATION

The Board:

1. Noted that from 15 February 2017, DHBs will no longer access Crown debt financing for funding of Capital investment.
2. **Agreed** as outlined in the Minister's letter of 10 November 2016.

Carried

The document was available for signing at the conclusion of the Board Meeting.

In summary:

- Noted IDFs had been fully recognised and contingency to date utilised to achieve this position. FRAC had discussed how to renew and refresh the IDF profile. IDFs do not cover private to public, however a test could be undertaken to receive approval from Southern Cross (or other agency).
- Not doing so well on our savings target, currently meeting 67% of our target to date.
- The DHB was still forecasting a $5m surplus with a lot of hard work

HEALTH & SAFETY BOARD CHAMPION'S UPDATE

No report was provided this month.

CONSUMERS : ADULT INPATIENT EXPERIENCE SURVEY RESULTS

Kate Coley provided a presentation of the national Consumer Survey results for quarter 1 (July-Sept 2016). This survey had been running for two years. As with other DHB's, HB forward a survey every three months to a selection of adults (400) who spend at least one night in our hospital asking them to participate in the survey.

We scored between 8.4 and 8.7 out of 10 across the four domains of communication, coordination, partnership and physical and emotional needs. About the same as the NZ average.

In summary:

- Hawke's Bay sit close to or on the national average; survey respondents by ethnicity: NZ European/Pakeha 78%; not specified 5%; Samoan 1% and Maori 16%, (noting the national average was 11% being Maori); with the majority of respondents were in the age group 45-64 with the next highest group responding being 65-74.
- The "Physical and emotional needs" area rated highest in all survey nationally. This was reflected in the HBDHB score and our two highest rated questions.
- Share quarterly next year in March, June, September, December (national level reports and DHB specific). The detail can be extrapolated out in whatever way desired . It was suggested a full review could be provided once per year in whatever form required. **Action include on workplan.**
- Early on in the survey process Consumer Council had provided input and were pleased with the outcome.

- **Next steps** will include: response rates; Working with directorates; Sharing detail quarterly, Quality initiatives – Discharge planning HQSC; and a New Event reporting system.

Queries and responses summarised:

- Asked for more consideration of how to ensure families can be in attendance when specialists visit their patients so that ultimately they could be better engaged around treatment. Felt this could be managed better as it was noted family members or entire whānau can wait all day.
  Action: Dr Gommans to consider if this can be better managed.
- Instead of a surveys, maybe engage with focus groups (patients and families), or with different surveys for the various age groups? At the end the results need to be consistent and comparable which may dictate a more simplistic approach for the data, however focus groups were seen as important also.
- A survey incorporating feedback on physicians? This would need to be included in employment agreements as a KPI's for personal development purposes but was not imminent.

REPORT FROM COMMITTEE CHAIRS

Hawke's Bay Clinical Council

Chris McKenna provided an overview of the report from the Council's meeting held on 7 December 2016, advising there was currently great engagement within Council

- Endorsed the work being done around the Long Term Conditions Framework
- Endorsed the progression of work on Relationship Centred Practice and Nuka model of care.
- Supported the very good work being undertaken on the collaborative clinical pathways.
  Mark advised the focus now was not on developing more pathways but implementing what we have. Looking to an Auckland provider to assist with this.
- Approved the final version of the Complementary Therapies Policy, originally raised originally by one of our GP members

Hawke's Bay Health Consumer Council

Graeme Norton Chair of Council advised the outcomes of Council's meeting held on 8 December 2016:

- The Consumer Group had commenced work with the Project Management Office to create high level guidance around how we build effective consumer engagement into start-up/ initiation of new projects, focussing first on the projects under Transform & Sustain. A Workshop would be held on this.
- Close to having a Consumer Engagement Strategy and Toolbox around the kind of engagement and process going forward, so staff can see more easily how to put the pieces together.
- Endorsed the draft Long Term Conditions(LTC) Framework along with feedback that should widen and deepen this to become "*Our Hawke's Bay Wellness Framework*". The LTC document contained a lot of very good stuff.

Pasifika Health Leadership Group (PHLG)

Chair, Caren Rangi was in attendance and provided an presentation and overview of their meeting and a holistic view December and the Workshop held on 8th December and in summary this included:

- The new investment provided to Pacific health was very much appreciated.
- PHLG had identified the following principles they would like to see applied in the configuration of health services for Pacific people:
  - *Partnership* between Pacific-qualified people and general health services
  - *Reciprocity* - where all skills (Pacific community, clinical) are strongly connected, equally valued and shared
  - *Access* – single point of entry for all referrals
  - *Holistic* – where the whole situation of the Pacific person, their family and community is considered.
  - *Strengths-based Pacific values framework* - where services delivered are underpinned by Pacific values, models and approaches.

In summary:

- Navigators will be the key to progress through 2017.
- Dr Caroline McElnay was acknowledged for her passion and dedication to Pasifika health, and PHLG wished her well in her new role with the MoH.

- **Action: Sharon Mason to introduce Dr Robin Whyman** to Caren Rangi, to discuss dental health within the pacific population.
- Linking to the pacific peoples in Wairoa (although a very small population base, and often transient) was very worthwhile and work was already occurring with Pacific whanau in Wairoa. This was of interest to new board member, Hine Flood.
- There were seasonal upsurges or pacific people coming into and leaving HB and it was noted that those employing transient workers were expected to arrange health insurance for those individuals.
- Capturing and enrolling new-born pacific infants (via women in hospital linking to quadruple enrolments) was raised. The volume related to approximately 30 pacific babies born each quarter and with such small numbers, if with only 2 or 3 who may slip through the net. These would be picked up by agencies or medical professionals looking after the child's early health. The areas of progress noted on the Dashboard related all related to children's health, smokers to quit, smears and GP utilisation rates for pacific people
- Indicator 4 " *Percentage of new-born infants enrolled with a general practice by three months (2013-2106)"* noted that HB were the only region to ever hit this indicator across the country.
- It was noted that Caren Rangi was very passionate about her role as Chair which was applauded.

Pasifika Health Dashboard

This document was not discussed in detail with the writers unavailable, however the achievements, areas of progress and challenges were noted.

FOR DECISION

Improving Endoscopy Services - Construction Contract Approval

Trent Fairey, Project Manager – Facilities spoke to the business case provided

This work had been progressing since 2012. The purpose of this paper is to gain approval from the HBDHB Board of Directors to appoint a contractor for the construction of the Endoscopy Services Facility. Tenders had been received and evaluated and management seeks approval from the Board for the letting of the construction contract to the nominated contractor with completion scheduled for August 2018.

In summary:

- The process had been very robust having worked closely with architects and engineers. Had undertaken a value engineering workshop and also provided Health and Safety workshops during the evolving process.
- On 9 November the Endoscopy Services project was put to tender. A subsequent change had occurred to the document since issue in early November.
- Geotechnical issues had been reviewed with several scenarios put forward for consideration. These were explained to the board in detail and advised that geotech had escalated the price by 10%
- With the project now over $10m, MoH approval will now be sought to continue.
- No work would commence on this project until there was an agreed solution to the geotech structural system.
- It was noted the scope of this project has never changed since inception in 2012

RESOLUTION

That HBDHB Board:

1. **Approve.** A total capital project budget of **$11,792,685** subject to approval of the contract in the public excluded section.
2. **Note.** The implementation timeline as indicated in this paper with the 'Go-Live' date scheduled for August 2018.
3. **Note.** Due to the total project costs exceeding $10 million, this project is now subject to Ministry of Health & Finance approval.
4. **Note.** Potential risk with the final geotechnical design still exists, and the facilities project manager will report back to the EMT in March 2017 once the extent of these remedial works has been established.

Moved **Barbara Anott**
Seconded **Diana Kirton**

Carried

FOR DISCUSSION AND INFORMATION

Draft Palliative Care in Hawke's Bay 2016-2026

Mary Wills introduced the team involved with the development of this strategy and acknowledged Chris McKenna as project sponsor.

A presentation entitled Palliative Care in HB our vision and priorities for the future 2016-2026, was provided showing:

- There are changing patterns of illness and complexity
- Predictions of a 50% increase in the need for palliative care by 2038
- People aged 84 – 94 will increase from 420 (2016) to 870 by 2038
- People aged 95+ will increase 100 (2016) to 200 by 2038
- People will be living longer with co-morbidities, dementia, increased frailty and disability
- Functional decline towards end of life will be harder to predict
- We need a sustainable specialist palliative care workforce
- We need to begin now to build sustainability, to educate, to train, to support primary palliative care providers, carers and our communities.
- Palliative care is everybody's business.

Page 25 included the priorities; actions required; and outcomes measured. A Specialist Palliative Care Service is in place and if done right can deliver to the rest of the region. There is a single point of entry to this Service with all care services and GPs feeding in (one source of the truth which is coordinated daily via an Patient Care Management System). The majority of care (including Specialist Care) was being provided in the community (approx. 80%).

The strategy document was out for consultation with feedback expected by the end of December, and Wairoa was being approached. Hine offered to help with this which was acknowledged and would likely be taken up **- Action.** Currently a service goes weekly to Wairoa and liaises with parties and meets with GPs including the Wairoa Health facility employees.

The final "Palliative Care in Hawke's Bay 2016-2026 strategy" will be received by the Board in March.

Transform & Sustain Programme Refresh

Tracee TeHuia, General Manager, Maori Health and Kate Rawstron Project Management Office Manager were available for this discussion and advised the new board members they were happy to provide more detailed information separately, if required.

This strategy commenced in 2013 in response to work done by Dr Caroline McElnay on inequity in Hawke's Bay and identified the need to focus on developing 11 key intentions. The strategy itself was not being reviewed here, just the projects within the strategy following a review of where there was a need to implement a new work programme, with 32 projects identified. No detailed planning has occurred at this stage, just working on the high level assumptions at this time.

The Deputy Chair Ngahiwi Tomoana advised that progress and support was attributable to the current personnel driving this and was concerned if there was a change in personnel we may lose momentum.

It was advised that two new roles project manager roles were being developed to manage work streams.

The board supported the papers and endorsed the recommendations

Transform & Sustain Strategic Dashboard Q1 Jul-Sept 2016

The report was taken as read with Tracee Te Huia advising efforts were focused on aligning indicators to the plan and ensuring we had the right indicators in place going forward. Descriptors had been used to assist understanding on what is being reported and to enable progress to be tracked. Each indicator has champions monitoring the improvement of those indicators, which are aligned with Transform and Sustain and take into account "Triple Aim" and the HB Strategy above that.

The detail provided was in simplified form to show whether an indicator is travelling in the right direction.

Te Ara Whakawaiora – Healthy Weight

In recognition of the importance of healthy childhood weight and healthy eating, the MoH (in July 2016) established a new Raising Healthy Kids target (which is incorporated into the Maori Health Plan and TAW reporting.

There was some general discussion around very young children's attendance to Tamariki Ora / Plunket and age ranges for attendance at/to each. This will be further investigated and Board members advised the report was noted. **Action**

Orthopaedic Review – Closure of Phase 1

Andy Phillips and Carina Burgess provided an overview of the project and the mobility action plan progress (with the assistance of Government funding $6m NZ wide).

In discussion outside of the detail contained in the report:

- Those awaiting assistance who are very incapacitated and unable to work was queried. This is a social return on investment and the national scoring tool does consider the employment aspect.

  This is not just about those with clinical needs, it is about keep people into work (ie Social inclusion programme).

The Board advised well done for the work undertaken thus far.

Travel Plan Update

Andrea Beattie project manager, provided a further update to the Travel Plan to that included with the papers.

- New bus services in place from 26 September (not getting high numbers on the services but a good start)
- Patient utilisation of bus travel has increased by 20% from October to November (when appointment card issued make patients aware of the free bus service) Comms needed.
- Extension of patient bus travel across all routes on the network starts 1 January 2017
- Circulation of flyers to patients underway using Booking personnel & PHO networks
- Discussions continuing with HBRC around possible incentives for staff commuting by bus
- New car park area opened off McLeod Street
- Reconfiguration & re-marking of parking areas to commence late December/early January
- Installation of pay & display machines planned for mid-late January
- New bike racks installed
- New secure bike lock-up on order – due on site late January
- Process/criteria for parking fee exemptions under development with input from services (working with staff and how that may be managed)
- Parking complaints reduced by 20 (24%) on same period in 2015.

Summary of queries raised:

- How is data collected for those travelling on the buses (patients and staff)?
- More promotion needed for staff (has been on staff notices, Facebook and radio advertising).
- Do not expect to change behaviour immediately it will be gradual

Likely to fully change over to paid parking following Waitangi Weekend in February 2017

GENERAL BUSINESS

Te Matatini 2017 Presentation

An overview of the National Kapa Haka programme Te Matatini 2017, being held at the Hawkes Bay Regional Sports Park, 22-26 February was relayed to board members. A short video presentation was provided and board members were invited to attend.

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

RESOLUTION TO EXCLUDE THE PUBLIC

RESOLUTION

That the Board

Exclude the public from the following items:

23. Confirmation of Minutes of Board Meeting
    - Public Excluded

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

25. Board Approval of Actions exceeding limits delegated by CEO
26. Improving Endoscopy Services Construction Contract Approval
27. Annual Stocktake of HBDHB Owned and Leased Properties
28. Air Ambulance Services
29. Cranford Hospice
30. Finance Risk and Audit Committee Report

Moved: **Heather Skipworth**
Seconded: **Diana Kirton**
Carried

The public section of the Board Meeting closed 4.30pm

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	31/8/16	**Fracture Clinic / Orthopaedic Dept near ED:** Investigating options and opportunities. Progressing with verbal updates to the Board in the interim.	Sharon Mason		
2	14/12/16	a) Include the national "**Adult Inpatient Experience Results"** onto board workplan quarterly (March, June, September, December). b) **A full review can be made available annually** (probably for the December 17 meeting) in whatever form required. c) Asked for more consideration of how to ensure families can be in attendance when specialists visit their patients so that ultimately they could be better engaged around treatment. Felt this could be managed better as it was noted family members or entire whānau can wait all day. Dr Gommans to consider if this can be better managed.	Admin Kate Coley Dr John Gommans		Noted for the workplan Refer comments on following page.
3	14/12/16	Introduce Dr Robin Whyman (Clinical Director for Oral Health) to the Chair of the Paskifka Health Leadership Group, Caren Rangi.	Sharon Mason		Actioned
4	14/12/16	**Raising Healthy Kids** discussion around very young children's attendance to Tamariki Ora / Plunket. There was confusion around the age bands for each group and whether there was a "gap".	Shari Tidswell for DPH		Refer comments on the following page.

Item 2a: Adult Inpatient Experience Results: provided by Dr John Gommans

The wards have confirmed that:

1. Specialists are happy to meet with patient's families on the wards, either during scheduled ward rounds or at specific requests.
2. Best timing varies between wards given specialists other commitments eg not all specialists round every day plus they need to promptly attend sessions in operating theatre or clinics
3. Surgical ward rounds usually occur between 730 and 830am
4. Medical ward rounds usually occur between 830 and 1230am
5. Families are advised to let the ward nurses know they are present so that medical teams can be informed.
6. If there are requests for specific meetings or difficulties for families with these times then the Charge Nurse Manager or their deputy can usually organise alternative arrangements.
7. Often a medical or surgical registrar will be available to meet with families at short notice if a specialist is not available.

Item 4: Matters Arising Raising Healthy Kids: provided by Shari Tidswell

Board member's question referring to earlier intervention (i.e. before 4 years) and the Board member's perception there is a "gap".

The report provided to the Board refers to a national target "Raising Healthy Kids". The target is linked to the Before School Check where four year olds have their BMI calculated and received support to improve nutrition and physical activity. The reports detail focuses on this target.

The wider HBDHB "Best Start: Healthy Eating and Activity Plan" has a lifespan approach – aligning programmes/activity to support healthy weight from conception to 10 years. For under 5 years the following work is planned or implemented:

- Conception to birth – gestational diabetes screening and support, Maternal GRx Programme
- Birth – 6 months – promoting and supporting breastfeeding – lactation support, free breast pumps, promoting Breastfeeding Friendly places and World Breastfeeding Week. Mama Aroha programme training delivered to providers working with mothers and babies.
- 4 months – 2 years – Healthy First Food (Well Child/Plunket staff are trained to deliver the programme. Wider community training has also been provided). Resources developed to support delivery of the programme (co-design with whanau). Delivered both as part of home visits and at group sessions.
- 18 months to 4 years – Healthy Foods resources (developed with whanau and Before School Check providers) includes a conversation tool and healthy weight plan (plan is developed with whanau). Active Families Under 5 programme, provides further support for 3 and 4 year olds. Work has begun with early childhood education to support healthy food and activity choices.

We continue to develop the alignment and actives to support health weight under 5 years.

According to the Ministry of Health- Well Child schedule, nutrition can be discussed at all scheduled visits as part of health education. The link below will take you to the "Well Child/Tamariki Ora National Schedule", which details the provider, assessments, support and education provided and the age of visits.

http://www.health.govt.nz/publication/well-child-tamariki-ora-national-schedule-2013

HAWKE'S BAY DISTRICT HEALTH BOARD
WORKPLAN

Mtg Date	Papers and Topics	Lead(s)
15 March	**HB Health Sector Leadership Forum (Cheval Lounge, Hastings Racecourse)**	
29 March	Consumer Story	Kate Coley
	Adult Inpatient Experience Results qtly (advised Dec 16)	Kate Coley
	Health and Social Care Networks (6 monthly update)	Tracee TeHuia
	Draft Annual Plan 2017	Tracee TeHuia
	Pasifika Leadership Group (in attendance)	Tracee TeHuia
	NKII MoU Relationship Review	Tracee TeHuia/Ken Foote
	Travel Plan Update	Sharon Mason
	Home Dialysis Presentation to the Board – action Nov 2016	Sharon Mason
	External Audit Engagement Arrangements	Tim Evans
	HB Palliative Care Strategy (final)	Tim Evans
	Chaplaincy Presentation	
	Monitoring	
	Te Ara Whakawaiora / Breastfeeding (national indicator)	Dir Pop Health
30 March	**"Regional DHBs Symposium" (Solway Park. Masterton)**	
26 Apr	People and Culture Strategy (2016-2021)	Kate Coley
	Mental Health Consolidation / Benefits Realisation (final) from Oct16	Sharon Mason
	Board H&S responsibilities – agenda item (review 6 monthly)	Ken Foote
	New Investment Bids	Tim Evans
	Monitoring	
	Te Ara Whakawaiora / Cardiology (national indicator)	John Gommans
31 May	Best Start Healthy Eating Plan (yearly review)	Dir Pop Health / Shari
	Final Draft Annual Plan 2017	Tracee TeHuia
	Monitoring	
	HR KPIs Q3	Kate Coley
29 June	Adult Inpatient Experience Results Qtly	Kate Coley
	Final Youth Health Strategy	Dir Pop Health / Nicky S
	Final Suicide Prevention Postevention update against 2016 Plan.	Dir Pop Health / Penny T
	Pasifika Health Leadership Group incl Dashboard (6mthly)	Dir Pop Health / T.
	Monitoring	
	Te Ara Whakawaiora / Oral Health (national indicator)	Sharon Mason / Robin W
26 July	Alcohol Position Statement Update for information	Dir Pop Health / Rachel E
	Histology Laboratory and completion of the Education Centre (final approval of tender)	Sharon Mason / Trent
30 Aug	***Monitoring***	
	HR KPIs Q3	Kate Coley

Mtg Date	Papers and Topics	Lead(s)
6 Sept	**HB Health Sector Leadership Forum (East Pier, Napier)**	
27 Sept	Staff Engagement Survey	Kate Coley
	Adult Inpatient Experience Results Qtly	Dir Pop Health / Shari
	Health and Social Care Networks Update	Tracee TeHuia
	Final Annual Plan 2017	Tracee TeHuia
	Annual Report (Interim)	Tim Evans
	Orthopaedic Reivew – phase 3 Draft	Andy Phillips
	Suicide Prevention Report (6 monthly update for information)	Dir Pop Health / Penny T
	Monitoring	
	TAW Healthy Weight Strategy, national Indicator	DIr Pop Health
25 Oct	People and Culture Strategy (2016-2021 HR progress 6 monthly	Kate Coley
	Annual Report 2017	Tim Evans

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Board Members on Committees** 1
	For the attention of: **HBDHB Board**
Document Owner:	Kevin Atkinson (Chair)
Reviewed by:	Board members
Month:	February 2017
Consideration:	For Decision

RECOMMENDATION

That the Board

- Appoint the board members to the respective committees as outlined below.

BACKGROUND

Following consulation with members, the Chair provides the following detail regarding board members to the respective committees. Once approved, this membership will apply from March 2017, for the term of the current Board (December 2019).

It is to be noted that the Community and Public Health Advisory Committee (CPHAC), the Disability Advisory Committee (DSAC) and the Hospital Advisory Committee (HAC) have not met for some time, however are able to be convened at any time, if required.

Papers for MRB and FRAC will be issued to all board members and all members are welcome to attend MRB and/or FRAC meetings if they so wish. However, members only will be noted on the attendance forms circulating at the meeting for signature.

Board Member	***ARAC***	***HAC***	***DSAC***	***CPHAC***	***MRB***	***FRAC***	***Alliance***
Kevin Atkinson (Board Chair)	*Chair*	●	●	●		●	
Peter Dunkerley	●	*Chair*	●	●		●	
Diana Kirton	●	●	*Chair*	●		●	
Barbara Arnott		●	●	*Chair*		●	●
Ngahiwi Tomoana		●	●	●	*Chair*		
Dan Druzianic	●	●	●	●		*Chair*	
Helen Francis		●	●	●		●	
Jacoby Poulain		●	●	●		●	
Heather Skipworth		●	●	●	●		
Ana Apatu		●	●	●	●		
Hine Flood		●	●	●	●		

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** 2
	For the attention of: **HBDHB Board**
Document Owner:	Dr Kevin Snee, Chief Executive Officer
Reviewed by:	Not applicable
Month as at	17 February 2017
Consideration:	For Information

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Recommendations

That the Board

1. Note the contents of this report.

INTRODUCTION

This month we have a number of papers highlighting our performance across a range of areas. In general it is improving, particularly compared to our unusual dip in performance in quarter one in a number of important areas. In addition, we will be discussing integrated services in Wairoa, the development of our radiology services, orthopaedic services, and our budget for next year. Within this report I have highlighted the actions we are taking to improve our performance toward delivering the 62 day target in cancer treatment. This is a key piece of work in order to lift our deliverables as the quarter 2 figures show we continue to compare poorly with the rest of the country.

PERFORMANCE

Measure / Indicator	Target	Month of January	Qtr to end January	Trend For Qtr
Shorter stays in ED	≥95%	93.9%	93.9%	▼
Improved access to Elective Surgery (2016/17YTD)	100%	-	99.5%	▲

Waiting list	*Less than 3 months*	*3-4 months*	*4+ months*
First Specialist Assessments (ESPI-2)	3,596	728	164
Patients given commitment to treat, but not yet treated (ESPI-5)	1,167	148	53

Faster cancer treatment*	≥85%	66.7% (December 2016)	65.4% (6m to December 2016)	▲
Increased immunisation at 8 months (3 months to end of January)	≥95%	---	94.4%	▼
Better help for smokers to quit – Primary Care	≥90%		87.4% (As at December, 2016)	▲
Better help for smokers to quit – Maternity	≥90%	88.5% (Quarter 2, 2016/17)	---	▼

Measure / Indicator	Target	Month of January	Qtr to end January	Trend For Qtr
Raising healthy kids (New)	≥95% (by June 2017)	92%	63% (6m to January 2016/17)	▲
Financial – month (in thousands of dollars)	($2,718)	($2,546)	---	---
Financial – year to date (in thousands of dollars)	($2,668)	($2,820)	---	---

***Based on the expected annual cancer registrations for the DHB supplied by the Ministry, the DHB is expected to identify at least 228 people a year (19 a month) as patients with a high suspicion of cancer.*

Faster Cancer Treatment Expected Volumes v Actual	*Target*	*Month Actual / Expected*	*Rolling 6m Actual / Expected*
	100%	*15/19 = 79%*	*127/114 = 111.4%*

Performance this month shows a continued improvement towards plan of our elective activity in spite of the RMO strikes and the campylobacter outbreak. Our ED6 target has reduced slightly as our hospital has come under pressure in January and February. There has been a step change in our primary care smoking target performance with current performance at 87.4 percent. The 'Raising Healthy Kids' Target has improved and is expected to continue to improve towards target for the rest of the year. The Quarter 2 data reported by the Ministry at 40% only represents data to November. December and January have seen a significant improvement - our figure for the 6 months from August to January is at 63%.

Financial performance improved in January with a favourable variance of $172 thousand, though it was anticipated that the improvement would be greater, making a year-to-date adverse variance of $152 thousand.

Faster Cancer Treatment (FCT)
HBDHB quarterly results (for six months to November 2016) were 63.4 percent for the 62 day target (currently 85 percent target, increasing to 90 percent in June 2017). Since September 2016 (52.9 percent,) there was an improvement in October (57 percent) and November (70 percent) 2016. However, a slight reduction in December (66.7 percent) consistent with previous trends and external provider access for that time of the year. Due to the rolling six month data that the Ministry receives, it is not envisaged that sustained improvement or compliance with the Health Target will occur prior to the end of quarter three.

Current initiatives in progress that will help the DHB to achieve the target within this timeframe include:
- Strengthened governance i.e. Andrew Phillips - EMT support, primary care represented on Governance Group
- Raised the profile of FCT Strategy - presented to Directorate Leadership Teams (2/2/17) and Grand Round (15/2/17)
- Rebranding - 'Is it OK to wait?'. Communications team working with team to develop collateral to be socialised on Nettie, HBDHB webpage etc
- Breach date (specific to each patient) being added to all documentation/requests and electronic fields
- ECA cancer module now live and being used by FCT team daily
- Weekly case-management meeting, supported by Directorate Leadership Team and Dr Elaine White evolving well. Significant progress being regarding which patients should be included and/or come off the 62 day pathway due to a treatment plan having been agreed - e.g. lung tumour stream – patients being taken off 62 day pathway after FSA has identified infection that requires six weeks of antibiotic treatment.

- Seeking Ministry clarification for 'watch and wait' decisions being a 'treatment option'. Does the clock stop on 62 day pathways with this decision?
- Dedicated resource to support prospective tracking appointed in December 2016, embedded well and working across tumour stream teams.
- Internal standards being implemented to improve timely diagnostics and management i.e.
  - CT referral pathway - 10 days
  - Referral to MDM - 28 days
  - Triaging turnaround times - 72 hours
- Engagement occurring with clinical leads and tumour stream teams to ensure patients are being identified with an HSCan at triaging, critical clinical information is provided on request forms, assisting with identifying and escalating constraints and barriers to ensure timeliness.
- Engaging with tumour stream clinicians to improve and standardise referral triaging form templates e.g. Breast tumour stream - will enable the capture of more patients on the 62 day pathway at point of referral triage (note there was a previous reluctance to tick both HSCan and to be seen within two weeks boxes).
- Working alongside Leigh White (Portfolio Manager) to streamline Map of Medicine clinical pathways that meet FCT requirements and ease of use in primary care.

CONSUMER STORY

A positive story this month will be shared about a non-resident and their journey through the health system in New Zealand while recently here on holiday, from GP to ED, to theatre, pharmacy, physiotherapy and beyond.

ORTHOPAEDIC REVIEW PHASE TWO

It is evident that there are a large number of people in the community living with pain and disability caused by musculoskeletal conditions. This number is expected to rise as the population of Hawke's Bay ages and the incidence of osteoarthritis increases. The redesign of Musculoskeletal and Orthopaedic services was set out in three phases. The first phase, now complete, involved increasing surgical capacity and making conservative treatment options available. The second phase involves the co-design of a new pathway. There will be three clear goals of this work namely:

- Community Care: Whānau ora approach delivered through Mobility Action Programme. The first patients are expected to be enrolled by 1 March 2017 with the programme completing by 30 June 2018.
- Primary Care: Dynamic hip and knee pathways to ensure GPs and patients have appropriate expectations. The learnings from this work will be disseminated by 30 June 2017.
- Secondary Care: Ensure that best practice is delivered through fully implementing Principles of Enhanced Recovery After Surgery. It is anticipated that this work will be completed by 30 June 2018.

HUMAN RESOURCES KEY PERFORMANCE INDICATORS

There is steady progress in the Māori representation figures with current staffing up to 13.02 percent against the 2016/17 target of 13.75 percent - which means a gap of 22. At present we are developing a mechanism whereby all Māori staff who resign from the organisation will be offered the opportunity to meet with an appropriate individual e.g. COO, GM Māori Health, to discuss any issues or concerns that they might have. From this it is hoped that we are able to identify ways to provide support so we are better able to retain these individuals. Staff turnover, in general, is currently 10.51 percent for the year, which is above the 10 percent annual benchmark. Two main reasons for leaving are staff retirements and employees moving to positions outside HBDHB. While these reasons give no particular cause for concern, we will be completing a full review of how we undertake exit interviews across the whole organisation to ensure we more effectively identify the issues and reasons for people leaving and identifying areas for improvement. Annual leave 2+ years is still tracking below last year's level.

HBDHB NON-FINANCIAL EXCEPTIONS REPORT QUARTER TWO

We are achieving emergency department waiting times target for the quarter with our 94.7 percent achievement rounded up to 95 percent. We continue to perform well on immunisation and falls assessment targets; this is heartening as both are early interventions to keep our population healthy.

We need to improve performance in: Faster Cancer Treatment, where we are now fast-tracking more patients, but not yet getting them definitive treatment quickly enough; Diabetes where we are falling short on the percentages of identified diabetics (particularly Māori diabetics) who have their blood sugar levels under control; and Cervical Screening where we are still not reducing a relatively small gap from target.

TE ARA WHAKAWAIORA / ACCESS (Ambulatory Sensitive Hospitalisation (ASH) Rates 0-4 and 45-64 years)

The Te Ara Whakawaiora report on ASH rates for the 0-4 age group shows we are doing very well as a DHB, both in terms of national comparisons of overall ASH rates, where we are well below the national average, and that of the equity gap between Māori and non-Māori rates, which is quite small and narrowing over time.

The good performance in the 0-4 age group is not replicated in the 45-64 age group where our rates are above average. It is notable, however, that the DHBs with similar rates to HBDHB are Lakes, Northland and Waikato that have somewhat similar demographics. The equity gap for chronic obstructive pulmonary disease and congestive heart failure, in particular, are very concerning and we will need to consider how these can be addressed.

TRANSFORM AND SUSTAIN STRATEGIC DASHBOARD QUARTER TWO

The Transform and Sustain Dashboard continues to identify areas where progress is being made as well as highlighting areas where focus is still required. Faster Cancer Treatment remains one of these areas of focus with results unchanged and consistently below target. However, the DHB is now consistently seeing the recommended number of patients in each six month period. There have been multiple discussions with the FCT (faster cancer treatments) Governance group and clinical teams for internal standards.

ANNUAL MĀORI PLAN QUARTER TWO

HBDHB's Annual Māori Health Plan 2016-2017 quarter two report demonstrates the continuation of good performance of Cancer Screening (Cervical Screening), Immunisations (8 weeks), ASH Rates (0-4 year olds), PHO enrolment and Access to Alcohol and Other Drugs (AOD) services (0-19 year olds). For these priority indicators, HBDHB are all ranked in the top five of all DHBs in New Zealand. There have been improvements in Mental Health Compulsory Treatment Orders down from 183.9 per 100,000 population to 179.9, Child Obesity where 44 percent of Māori Children with BMI in 98th percentile at B4SC were referred to a health professional for nutritional advice (up 18 percent) and Māori Workforce grew 0.5 percent from 12.5 percent in quarter one to 13.0 percent in quarter two. Areas of concern include Acute Hospitalisations for Rheumatic Fever increasing from 4.82 in quarter one to 7.3 in quarter two, ASH Rates for 45-64 year age groups went up slightly from 196 percent to 211.3 percent and Cultural Competency Training of Medical staff, despite a 25.6 percent increase in 2015/16, decreased from 39.9 percent in quarter one to 37.7 percent in quarter two.

BUDGET REVIEW – PRESENTATION

The Budget setting process is particularly fluid this year. We have had no definitive 2017-18 budget envelope issued by the Ministry of Health. The general guidance we have received from Ministry officials is open to a wide range of interpretations. However, we still have to file a financial plan on 1 March. Peter Kennedy, Head of Finance, will be updating on the current state of play and setting out our working assumptions.

INTEGRATING GP SERVICES IN WAIROA (VERBAL) – (PUBLIC EXCLUDED)

The board will receive a presentation from the Community, Women & Children Directorate providing an update on the current opportunities and challenges related to the delivery of health services in Wairoa. Recruitment of Rural GPs is and remains a challenge. However, there are opportunities to reshape our rural workforce and the recent appointment of a rural nurse specialist role in Wairoa is a positive step. The presentation will focus on the Wairoa health services journey to date, collaboration between GP practices, future opportunities to support practices working together, sector-wide engagement and the local communities working together for local solutions.

MAINTAINING THE RADIOLOGY SERVICE TO PRIMARY AND SECONDARY CARE

Radiology was placed on the corporate risk register on 5 May 2016. Concerns were raised around the robustness of the existing review processes, delays in reporting certain non-urgent images and waiting times for MRI, CT and Ultrasound scans. An external review has been undertaken and a draft plan developed with options for the delivery of radiology services across the primary and community sector.

SUICIDE PREVENTION PROJECT UPDATE

This six month project investigating Coroner Carla na Nagara's recommendations of four youth suicides in Flaxmere ended on 31 December 2016 and a full report, complete with recommendations, was submitted to the Governance Group, Transform and Sustain Committee and Executive Management Team. The recommendations were to increase the suicide prevention coordinator role to full-time and to start implementation of the report's findings. These include strengthening community participation and relationship building across sectors with the community, and completing robust community consultation on a whānau wellbeing facility. The project reaffirmed the linkages between suicides and social determinants such as low income, education and mental health issues and the impact of childhood adversity or trauma, otherwise termed Adverse Childhood Experiences, increasing the risks by four to twelve-fold for suicide, addictions and depression. This suicide prevention role will therefore link closely with evolving work on the social inclusion strategy currently being developed by the Hawke's Bay intersectoral group.

CONCLUSION

In general our performance is improving, but our underlying financial performance poses a risk to the delivery of our financial target for this year. We have, however, highlighted areas where service improvement continues.

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report, January 2017** 3
	For the attention of: **HBDHB Board and the Finance Risk and Audit Committee (FRAC)**
Document Owner: Document Author(s):	Tim Evans, Executive Director of Corporate Services Finance Team
Reviewed by:	Executive Management Team
Month:	February 2017
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 the month of January is a favourable variance of $172 thousand making a year to date adverse variance of $152 thousand. The anticipated self-correction in January was not as sizeable as expected, and the contingency now covers the cost of outsourced elective surgery to maintain discharge volumes affected by the RMO strike, the gastroenteritis outbreak in Havelock North, and the provision for IDF volumes.

Forecast year end result

The forecast for the 2016-17 year is a $5 million surplus. This result is contingent on the Ministry of Health agreeing to assist in the costs of the Havelock North gastroenteritis outbreak, achievement of most of the efficiency targets, and on our ability to fulfil the surgical health target activity within existing resources. The surgical health target activity is impacted by the gastro outbreak and strike action from the Resident Medical Officers (RMO) on two occasions. We are currently reviewing our activity plan to establish if it is possible to achieve the target within existing resources or if we will need to outsource some of this impact at additional cost to the DHB.

2. Resource Overview

	January				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)	(2,546)	(2,718)	172	6.3%	(2,820)	(2,668)	(152)	-5.7%	5,000	3
Contingency utilised	(75)	250	325	130.0%	2,425	1,750	(675)	-38.6%	3,000	8
Quality and financial improvement	1,002	1,083	(81)	-7.5%	5,232	7,583	(2,351)	-31.0%	10,200	11
Capital spend	644	1,753	(1,109)	-63.2%	5,570	13,270	(7,701)	-58.0%	22,042	16
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,208	2,178	(30)	-1.4%	2,206	2,188	(17)	-0.8%	2,206	5 & 7
	CWD	CWD	CWD	%	CWD	CWD	CWD	%	CWD	
Case weighted discharges	2,410	1,945	465	23.9%	17,122	16,381	742	4.5%	27,609	5

The remaining contingency is $675 thousand after we have released $750 thousand more than would normally be expected on a year to-date basis. It covers the cost of outsourced elective surgery to maintain discharge volumes affected by the RMO strike and gastroenteritis outbreak in Havelock North, the non-achievement of planned efficiencies, and higher volume driven patient transport costs.

The Quality and Financial Improvement (QFI) programme has achieved 69% of planned savings year-to-date.

Capital continues behind plan. A number of projects have not started at the estimated times projected in the capital plan, and the major radiology equipment purchases have been delayed into future years.

The FTE variance year-to-date reflects offsetting factors including high patient volume in some areas, efficiencies not yet achieved, unbudgeted leave cover including long term sick leave, cover for employees undergoing training, and vacancies.

Case weighted discharges (CWD) reflect high acute volumes year-to-date, including gastroenterology, general and vascular surgery, and paediatrics partly offset by lower acute general internal medicine, and orthopaedic surgery, both acute and elective.

3. Financial Performance Summary

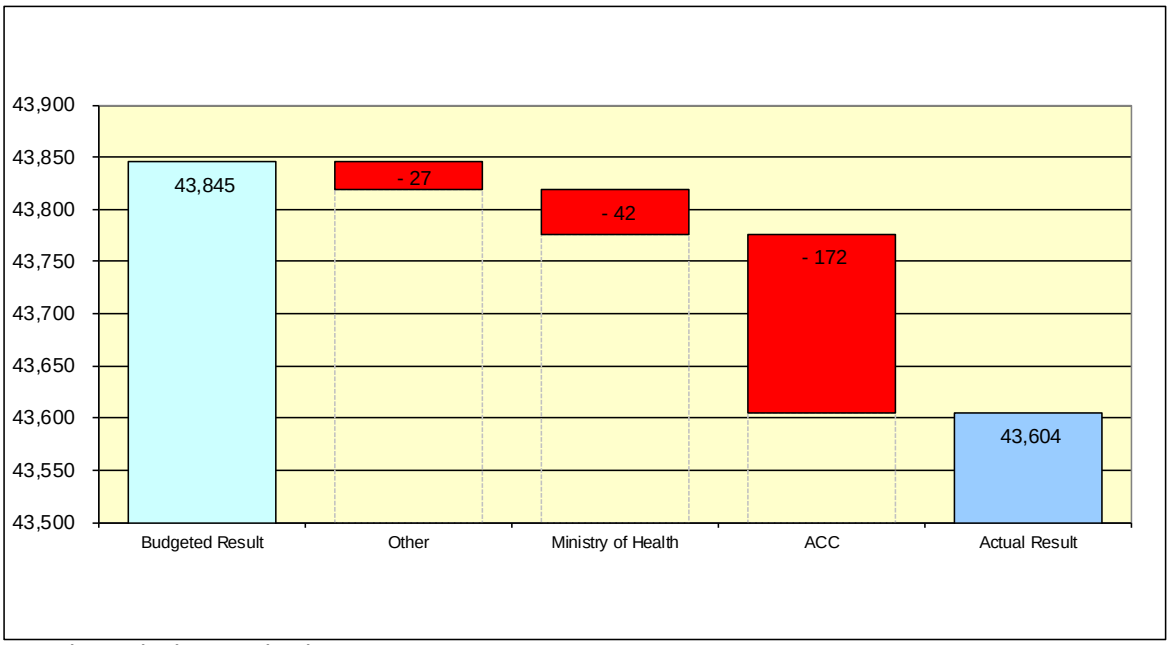
	January				Year to Date				Year End Forecast	Refer Section
$'000	Actual	Budget	Variance		Actual	Budget	Variance			
Income	43,605	43,845	(241)	-0.5%	305,580	304,020	1,560	-0.5%	534,556	4
Less:										
Providing Health Services	24,355	24,648	293	1.2%	148,612	144,866	(3,745)	-2.6%	252,071	5
Funding Other Providers	18,646	18,575	(71)	-0.4%	133,949	132,830	(1,119)	-0.8%	228,873	6
Corporate Services	3,096	3,284	188	5.7%	28,146	28,064	(82)	-0.3%	48,139	7
Reserves	54	56	2	3.6%	(2,306)	929	3,235	348.3%	473	8
	(2,546)	**(2,718)**	172	-6.3%	**(2,820)**	**(2,668)**	(152)	5.7%	**5,000**	

Lower ACC income due to capacity constraints, is offset by reduced costs in providing health services due to allied health vacancies, and delay incurring support costs for the Regional Health Information Project (RHIP).

4. Income

$'000	January Actual	January Budget	January Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Ministry of Health	41,801	41,843	(42)	-0.1%	291,759	289,733	2,025	0.7%	510,745
Inter District Flows	630	629	2	0.3%	4,580	4,401	178	4.1%	7,723
Other District Health Boards	329	334	(5)	-1.4%	2,163	2,335	**(172)**	**-7.4%**	3,807
Financing	68	75	(7)	-9.2%	498	521	(23)	-4.5%	861
ACC	321	493	**(172)**	**-34.8%**	3,028	3,481	**(454)**	**-13.0%**	5,276
Other Government	36	18	18	102.2%	228	283	**(54)**	**-19.2%**	442
Patient and Consumer Sourced	88	120	(32)	-26.4%	653	842	**(190)**	**-22.5%**	1,220
Other Income	331	334	(3)	-0.9%	2,682	2,357	**326**	**13.8%**	4,491
Abnormals	-	0	(0)	-100.0%	(10)	66	**(77)**	**-115.7%**	(9)
	43,605	**43,845**	(241)	-0.5%	**305,580**	**304,020**	1,560	0.5%	**534,556**

January Income

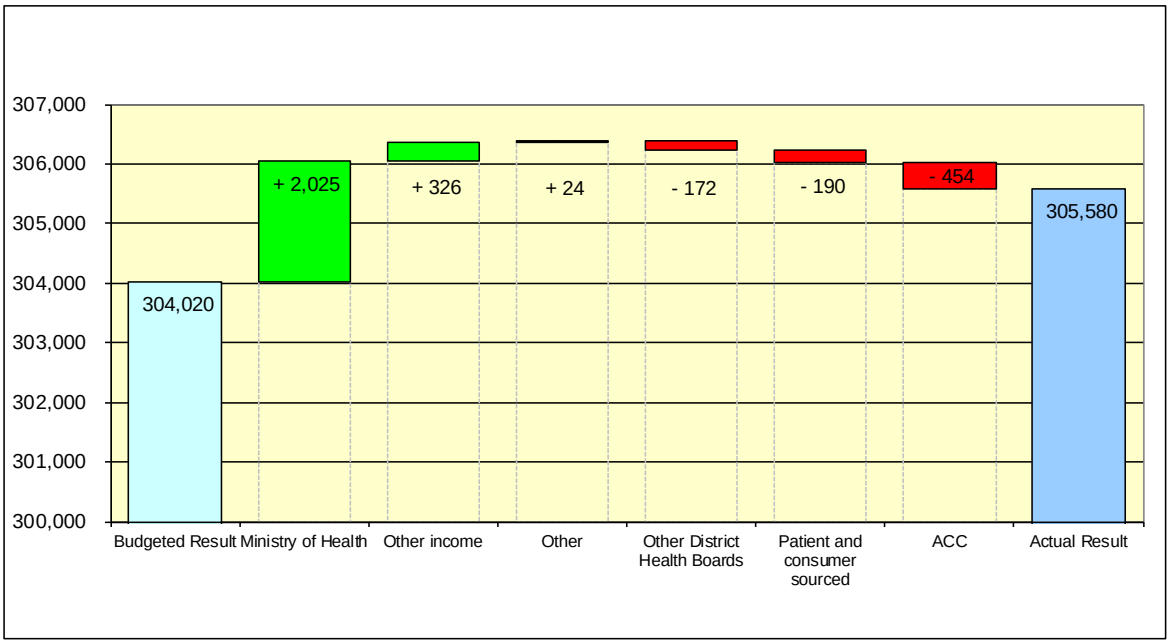


Note the scale does not begin at zero

Ministry of Health (unfavourable)
Minor adjustments to PVS funding.

ACC (unfavourable)
Lower ACC orthopaedic surgery and rehabilitation volumes due to lower demand.

Year to Date Income



Ministry Of Health (favourable)
Mainly high cost patient treatment income, child development and in-between-travel funding.

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

Other District Health Boards (unfavourable)
Lower than budgeted cancer drug sales to Tairawhiti DHB, marginally offset by patient transport recoveries from a number of DHBs.

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

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

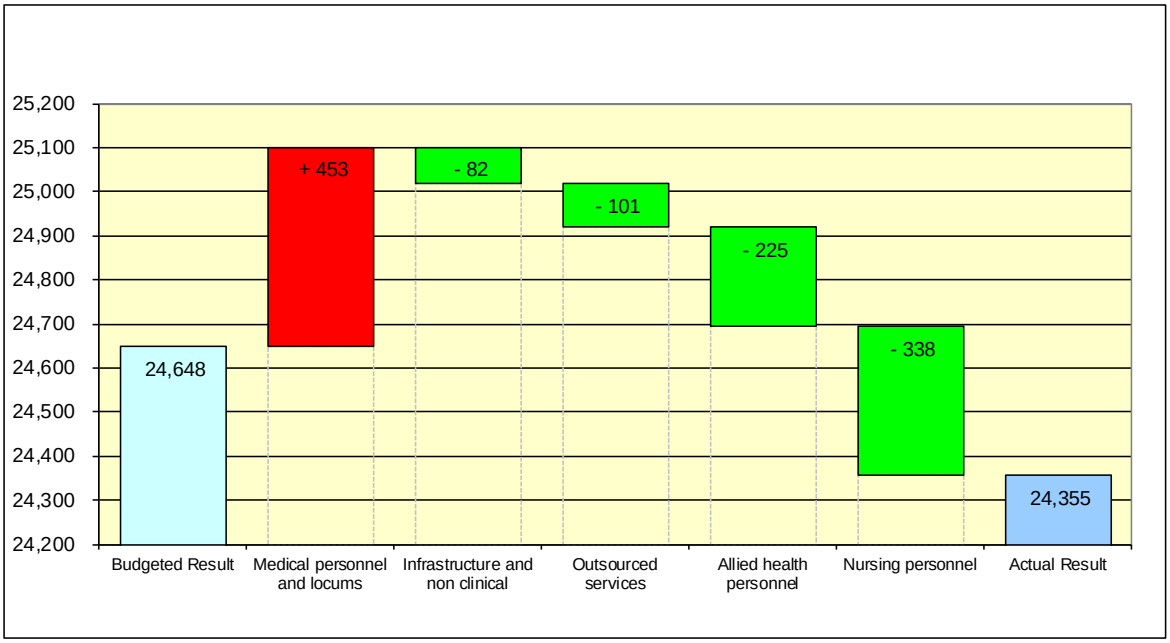
5. Providing Health Services

	January				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure by type $'000									
Medical personnel and locums	8,141	7,688	(453)	-5.9%	35,691	35,354	(338)	-1.0%	59,279
Nursing personnel	7,200	7,538	338	4.5%	43,190	42,802	(387)	-0.9%	73,492
Allied health personnel	2,527	2,753	225	8.2%	18,501	19,372	871	4.5%	32,397
Other personnel	1,774	1,791	18	1.0%	12,558	12,127	(431)	-3.6%	21,494
Outsourced services	515	616	101	16.3%	5,551	4,896	(656)	-13.4%	10,569
Clinical supplies	2,712	2,677	(35)	-1.3%	21,525	19,028	(2,497)	-13.1%	34,654
Infrastructure and non clinical	1,486	1,584	99	6.2%	11,596	11,288	(308)	-2.7%	20,186
	24,355	**24,648**	293	1.2%	**148,612**	**144,866**	(3,745)	-2.6%	**252,071**
Expenditure by directorate $'000									
Medical	7,171	7,195	24	0.3%	40,308	38,635	(1,674)	-4.3%	67,991
Surgical	5,307	5,617	311	5.5%	33,327	32,011	(1,316)	-4.1%	55,891
Community, Women and Children	4,017	4,170	153	3.7%	25,496	24,882	(614)	-2.5%	42,702
Older Persons, Options HB, Menta	3,108	3,330	222	6.7%	19,648	19,617	(31)	-0.2%	33,513
Operations	3,020	3,090	71	2.3%	20,860	20,591	(269)	-1.3%	35,907
Other	1,733	1,246	(487)	-39.1%	8,972	9,131	159	1.7%	16,067
	24,355	**24,648**	293	1.2%	**148,612**	**144,866**	(3,745)	-2.6%	**252,071**
Full Time Equivalents									
Medical personnel	384.5	344.5	(40)	-11.6%	319	316	(3)	-1.1%	315.5
Nursing personnel	931.5	905.3	(26)	-2.9%	904	880	(24)	-2.7%	891.8
Allied health personnel	389.9	420.7	31	7.3%	431	449	18	4.1%	452.7
Support personnel	133.0	122.5	(11)	-8.6%	133	126	(6)	-4.9%	127.5
Management and administration	227.1	225.5	(2)	-0.7%	253	243	(10)	-4.1%	245.1
	2,066.1	**2,018.6**	(48)	-2.4%	**2,039**	**2,015**	(25)	-1.2%	**2,032.6**
Case Weighted Discharges									
Acute	1,691	1,289	402	31.2%	11,746	11,157	589	5.3%	18,713
Elective	447	452	(5)	-1.1%	3,690	3,772	(82)	-2.2%	6,451
Maternity	171	171	(0)	0.0%	1,225	1,198	27	2.3%	2,000
IDF Inflows	100	33	68	208.3%	462	254	208	81.7%	445
	2,410	**1,945**	465	23.9%	**17,122**	**16,381**	742	4.5%	**27,609**

Directorates

- Medical includes vacancy and leave cover for medical staff, efficiencies not achieved, gastrointestinal pharmaceuticals and biologics, and ED nursing personnel.
- Surgical includes efficiencies not achieved, and outsourced elective surgery.
- Community, Women and Children is mostly efficiencies not achieved, increased paediatric and maternity volumes, additional junior medical staff, and locums for sabbatical leave cover.

January Expenditure



Note the scale does not begin at zero

Medical personnel and locums (unfavourable)
RMO strike cover.

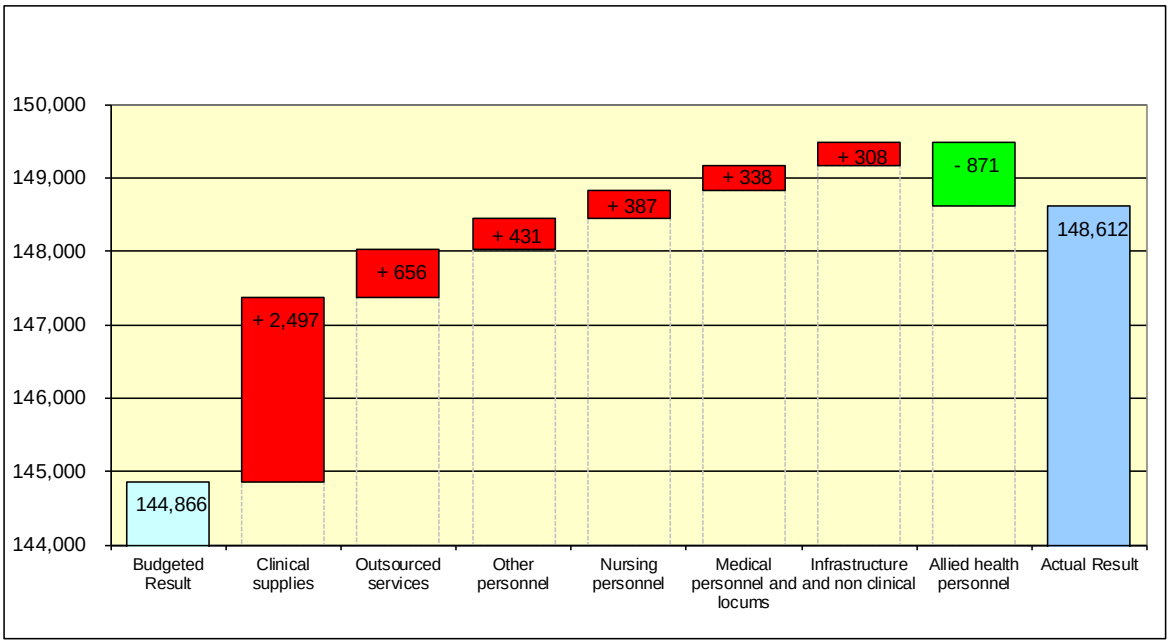
Infrastructure and non-clinical (favourable)
Laundry costs, improved provisioning for doubtful debts, outsourced maintenance and compliance costs, partly offset by higher legal fees.

Outsourced services (favourable)
Reduced elective surgery at Royston over the holiday period.

Allied health personnel (favourable)
Vacancies.

Nursing personnel (favourable)
Impact of the holiday period.

Year to Date Expenditure



Clinical supplies (unfavourable)
Efficiencies not yet achieved.

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

Nursing personnel (unfavourable)
Additional staffing, overtime, and termination payments.

Medical personnel and locums (unfavourable)
Vacancy and leave cover and impact of the RMO strike.

Infrastructure and non-clinical (unfavourable)
Gastroenteritis outbreak costs and efficiencies not yet achieved, partly offset by lower hotel, laundry and cleaning costs and reduced Maori CTA expenditure.

Allied Health personnel (favourable)
Mainly mental health vacancies including community staff, psychologists and community support. Also includes vacancies in health promotion and health protection.

Full time equivalents (FTE)

FTEs are 25 unfavourable year to date including:

Nursing personnel (24 FTE / 2.7% unfavourable)

- Higher than budgeted staffing in certain areas including: ED, medical wards, rural and community services, and Ata Rangi.

Management and administration personnel (10 FTE 4.1% unfavourable)

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

Support personnel (6 FTE / 4.9% unfavourable)

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

partly offset by:

Allied Health Personnel (18 FTE / 4.1% favourable)

- Vacancies mainly in social workers and psychologists, therapies, health promotion and technicians.

Medical FTEs are 1.1% unfavourable year to date (3 FTEs).

MONTHLY ELECTIVE HEALTH TARGET REPORT
YTD To January 2017

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

		YTD January 2017			
		Actual	Plan	Var.	%Var.
On-Site	Avastins	115	115	0	0.0%
	ENT	306	326	-20	-6.1%
	General Surgery	485	512	-27	-5.3%
	Gynaecology	323	288	35	12.2%
	Maxillo-Facial	99	105	-6	-5.7%
	Ophthalmology	579	613	-34	-5.5%
	Orthopaedics	450	511	-61	-11.9%
	Skin Lesions	99	99	0	0.0%
	Urology	263	247	16	6.5%
	Vascular	103	79	24	30.4%
	Surgical - Arranged	313	248	65	26.2%
	Non Surgical - Elective	45	108	-63	-58.3%
	Non Surgical - Arranged	16	40	-24	-60.0%
On-Site	**Total**	**3196**	**3291**	**-95**	**-2.9%**
Outsourced	Cardiothoracic	0	24	-24	-100.0%
	ENT	95	80	15	18.8%
	General Surgery	171	150	21	14.0%
	Gynaecology	11	20	-9	-45.0%
	Maxillo-Facial	24	38	-14	-36.8%
	Neurosurgery	0	11	-11	-100.0%
	Ophthalmology	94	18	76	422.2%
	Orthopaedics	48	50	-2	-4.0%
	Paediatric Surgery	0	2	-2	-100.0%
	Skin Lesions	2	0	2	0.0%
	Urology	46	44	2	4.5%
	Vascular	13	24	-11	-45.8%
	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**	**504**	**461**	**43**	**9.3%**
IDF Outflow	Avastins	1	0	1	0.0%
	Cardiothoracic	41	45	-4	-8.9%
	ENT	17	28	-11	-39.3%
	General Surgery	26	28	-2	-7.1%
	Gynaecology	23	14	9	64.3%
	Maxillo-Facial	93	111	-18	-16.2%
	Neurosurgery	48	25	23	92.0%
	Ophthalmology	18	19	-1	-5.3%
	Orthopaedics	18	11	7	63.6%
	Paediatric Surgery	42	30	12	40.0%
	Skin Lesions	29	44	-15	-34.1%
	Urology	11	4	7	175.0%
	Vascular	9	9	0	0.0%
	Surgical - Arranged	99	177	-78	-44.1%
	Non Surgical - Elective	67	0	67	0.0%
	Non Surgical - Arranged	35	0	35	0.0%
IDF Outflow	**Total**	**577**	**545**	**32**	**5.9%**
TOTAL		**4277**	**4297**	**-20**	**-0.5%**

		January 2017			
		Actual	Plan	Var.	%Var.
On-Site	Avastins	14	14	0	0.0%
	ENT	58	41	17	41.5%
	General Surgery	70	65	5	7.7%
	Gynaecology	35	37	-2	-5.4%
	Maxillo-Facial	19	13	6	46.2%
	Ophthalmology	96	76	20	26.3%
	Orthopaedics	43	68	-25	-36.8%
	Skin Lesions	11	11	0	0.0%
	Urology	27	32	-5	-15.6%
	Vascular	9	10	-1	-10.0%
	Surgical - Arranged	44	18	26	144.4%
	Non Surgical - Elective	3	13	-10	-76.9%
	Non Surgical - Arranged	5	6	-1	-16.7%
On-Site	**Total**	**434**	**404**	**30**	**7.4%**
Outsourced	Cardiothoracic	0	2	-2	-100.0%
	ENT	6	8	-2	-25.0%
	General Surgery	26	15	11	73.3%
	Gynaecology	0	0	0	0.0%
	Maxillo-Facial	6	4	2	50.0%
	Neurosurgery	0	1	-1	-100.0%
	Ophthalmology	1	0	1	0.0%
	Orthopaedics	0	0	0	0.0%
	Paediatric Surgery	0	0	0	0.0%
	Skin Lesions	0	0	0	0.0%
	Urology	2	3	-1	-33.3%
	Vascular	2	3	-1	-33.3%
	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**	**43**	**36**	**7**	**19.4%**
IDF Outflow	Avastins	0	0	0	0.0%
	Cardiothoracic	2	6	-4	-66.7%
	ENT	0	4	-4	-100.0%
	General Surgery	1	4	-3	-75.0%
	Gynaecology	1	2	-1	-50.0%
	Maxillo-Facial	7	14	-7	-50.0%
	Neurosurgery	2	4	-2	-50.0%
	Ophthalmology	0	3	-3	-100.0%
	Orthopaedics	1	1	0	0.0%
	Paediatric Surgery	6	4	2	50.0%
	Skin Lesions	3	6	-3	-50.0%
	Urology	0	1	-1	-100.0%
	Vascular	1	1	0	0.0%
	Surgical - Arranged	9	25	-16	-64.0%
	Non Surgical - Elective	6	0	6	0.0%
	Non Surgical - Arranged	6	0	6	0.0%
IDF Outflow	**Total**	**45**	**75**	**-30**	**-40.0%**
TOTAL		**522**	**515**	**7**	**1.4%**

Please Note:This report was run on 8th February 2017. Skin Lesions and Avastins have been adjusted to plan. Data is subject to change.

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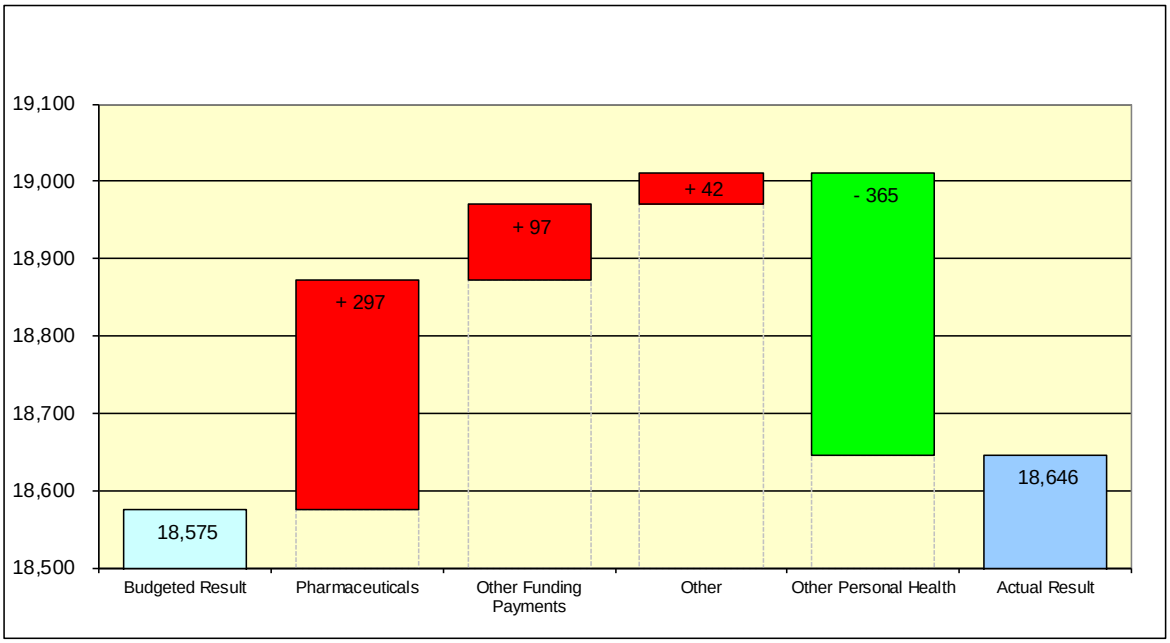
6. Funding Other Providers

$'000	January Actual	January Budget	January Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Payments to Other Providers									
Pharmaceuticals	3,748	3,451	(297)	-8.6%	25,984	25,941	(43)	-0.2%	43,157
Primary Health Organisations	2,876	2,869	(8)	-0.3%	20,460	20,502	42	0.2%	35,358
Inter District Flows	3,796	3,776	(20)	-0.5%	26,763	26,435	(328)	-1.2%	46,032
Other Personal Health	1,363	1,728	365	21.1%	14,533	12,516	(2,017)	-16.1%	24,649
Mental Health	1,145	1,148	3	0.2%	7,774	8,018	244	3.0%	13,522
Health of Older People	5,176	5,159	(17)	-0.3%	35,512	36,111	599	1.7%	60,829
Other Funding Payments	541	444	(97)	-21.9%	2,924	3,307	383	11.6%	5,326
	18,646	18,575	(71)	-0.4%	**133,949**	**132,830**	(1,119)	-0.8%	228,873
Payments by Portfolio									
Strategic Services									
Secondary Care	3,968	3,898	(70)	-1.8%	29,706	27,286	(2,420)	-8.9%	49,615
Primary Care	7,630	7,524	(106)	-1.4%	55,317	55,344	27	0.0%	94,807
Mental Health	1,145	1,131	(14)	-1.3%	7,909	7,916	7	0.1%	13,657
Health of Older People	5,213	5,215	2	0.0%	35,884	36,485	601	1.6%	61,396
Other Health Funding	98	89	(10)	-10.8%	528	620	92	14.8%	705
Maori Health	495	515	20	3.9%	3,313	3,630	317	8.7%	6,066
Population Health									
Women, Child and Youth	52	104	51	49.5%	691	834	143	17.2%	1,526
Population Health	44	100	57	56.5%	600	714	114	15.9%	1,102
	18,646	18,575	(71)	-0.4%	**133,949**	**132,830**	(1,119)	-0.8%	228,873

January Expenditure



Note the scale does not begin at zero

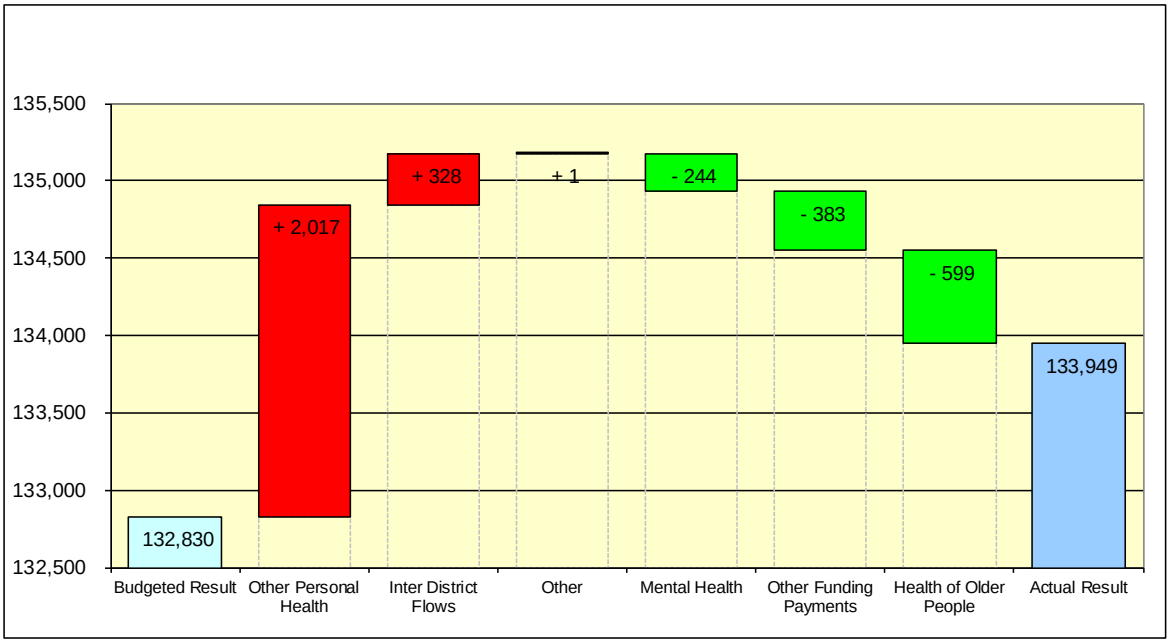
Pharmaceuticals (unfavourable)
Accrued based on expenditure trends.

Other funding payments (unfavourable)

Maori primary health

Other personal health (favourable)
Release of the provision for PHO rural services funding, and underspend relating to 2015/16.

Year to Date Expenditure



Other Personal Health (unfavourable)
IDF wash-up provisions (included under other personnel health to allow MOH to consolidate inter DHB transactions), and high cost patient expenditure, partly offset by lower GMS payments.

Inter district flows (unfavourable)
2015/16 wash-ups and MOH adjustments to IDF payments to reflect service changes.

Mental health (favourable)
TeTaiwhenua crisis respite repayment and lower payments for community residential beds.

Other Funding Payments (favourable)
Release of Maori primary health accruals from 2015/16

Health of Older People (favourable)
Lower residential care costs partly offset by higher home support.

7. Corporate Services

$'000	January Actual	January Budget	January Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Operating Expenditure									
Personnel	1,156	1,188	32	2.7%	9,423	8,942	(481)	-5.4%	15,835
Outsourced services	90	88	(2)	-2.6%	695	652	(43)	-6.6%	1,145
Clinical supplies	3	9	7	69.0%	74	66	(7)	-11.0%	121
Infrastructure and non clinical	530	668	138	20.7%	5,630	6,089	459	7.5%	8,742
	1,779	1,953	174	8.9%	15,821	15,749	(72)	-0.5%	25,843
Capital servicing									
Depreciation and amortisation	1,152	1,151	(0)	0.0%	7,993	7,994	2	0.0%	13,911
Financing	165	180	15	8.1%	1,148	1,182	34	2.9%	2,063
Capital charge	-	-	-	0.0%	3,184	3,138	(46)	-1.5%	6,322
	1,317	1,331	14	1.1%	12,324	12,314	(10)	-0.1%	22,296
	3,096	**3,284**	188	5.7%	**28,146**	**28,064**	(82)	-0.3%	**48,139**
Full Time Equivalents									
Medical personnel	0.0	0.4	0	88.4%	0	0	(0)	-24.3%	0.3
Nursing personnel	9.3	14.0	5	33.7%	12	15	3	22.4%	14.9
Allied health personnel	0.5	2.2	2	79.5%	0	4	3	88.0%	3.2
Support personnel	8.7	8.6	(0)	-1.2%	9	9	(0)	-0.2%	9.4
Management and administration	123.5	133.8	10	7.7%	144	145	1	0.6%	146.0
	142.0	**159.1**	17	10.8%	**166**	**174**	7	4.3%	**173.8**

Year to date, costs of the RMO strike and management restructuring are partly offset by less than planned expenditure on the Regional Health Information Project.

8. Reserves

$'000	January Actual	January Budget	January Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Expenditure									
Contingency	75	5	(70)	-1555.9%	(2,425)	75	2,500	3339.3%	-
Transform and Sustain resource	8	38	30	78.9%	73	400	327	81.7%	234
Other	(29)	13	42	324.5%	46	454	408	90.0%	239
	54	**56**	2	3.6%	**(2,306)**	**929**	3,235	348.3%	**473**

Lower than expected recovery of only $75 thousand into the contingency. Contingency usage year to date includes:

- $1.3 million to offset IDF provisioning
- $0.8 million for costs relating to the gastroenteritis outbreak
- $0.3 million for costs relating to the RMO strike.

Contingency budgets transferred to operational costs reconcile as follows:

	$'000
Original contingency budget	3,000
Plus:	
Revenue banking	4,200
Less:	
Additional surplus agreed with MOH	-500
Feasibility studies	-600
Elective surgery delivery costs	-1,942

Melanoma and oncology treatments	-295
Remaining contingency budget	3,863

All of the contingency has been released for the forecast.

9. Financial Performance by MOH Classification

$'000	January Actual	January Annual Plan	January 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	41,943	41,914	28 F	293,790	291,726	2,064 F	514,626	511,184	3,442 F
Less:									
Payments to Internal Providers	21,328	21,299	(29) U	162,124	161,673	(450) U	279,779	279,328	(450) U
Payments to Other Providers	18,646	18,575	(71) U	133,949	132,830	(1,119) U	228,873	227,783	(1,090) U
Contribution	**1,969**	**2,040**	**(71) U**	**(2,283)**	**(2,777)**	**494 F**	**5,975**	**4,073**	**1,901 F**
Governance and Funding Admin.									
Funding	266	266	-	1,864	1,864	-	3,197	3,197	-
Other Income	2	3	(1) U	17	18	(1) U	29	30	(1) U
Less:									
Expenditure	237	270	33 F	1,687	1,891	204 F	3,184	3,243	59 F
Contribution	**31**	**(1)**	**32 F**	**194**	**(10)**	**203 F**	**42**	**(16)**	**58 F**
Health Provision									
Funding	21,062	21,033	29 F	160,260	159,809	450 F	276,582	276,131	450 F
Other Income	1,660	1,928	(268) U	11,773	12,276	(503) U	19,901	20,638	(737) U
Less:									
Expenditure	27,268	27,718	450 F	172,764	171,967	(797) U	297,499	295,827	(1,673) U
Contribution	**(4,546)**	**(4,756)**	**210 F**	**(731)**	**118**	**(850) U**	**(1,017)**	**943**	**(1,960) U**
Net Result	**(2,546)**	**(2,718)**	**172 F**	**(2,820)**	**(2,668)**	**(152) U**	**5,000**	**5,000**	**-**

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

10. Management Budget Movements

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

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

$'000	January Mgmt Budget	January Annual Plan	January 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	41,914	41,890	25 F	291,726	292,241	(515) U	511,184	511,803	(619) U
Less:									
Payments to Internal Providers	21,299	20,968	(331) U	161,673	159,053	(2,621) U	279,328	275,461	(3,867) U
Payments to Other Providers	18,575	18,865	290 F	132,830	134,910	2,081 F	227,783	231,341	3,559 F
Contribution	**2,040**	**2,056**	**(16) U**	**(2,777)**	**(1,722)**	**(1,055) U**	**4,073**	**5,000**	**(927) U**
Governance and Funding Admin.									
Funding	266	268	(2) U	1,864	1,878	(13) U	3,197	3,220	(23) U
Other Income	3	3	-	18	18	-	30	30	-
Less:									
Expenditure	270	271	1 F	1,891	1,895	4 F	3,243	3,250	7 F
Contribution	**(1)**	**-**	**(1) U**	**(10)**	**-**	**(10) U**	**(16)**	**-**	**(16) U**
Health Provision									
Funding	21,033	20,700	333 F	159,809	157,175	2,634 F	276,131	272,241	3,890 F
Other Income	1,928	1,908	20 F	12,276	12,127	149 F	20,638	20,366	272 F
Less:									
Expenditure	27,718	27,382	(336) U	171,967	170,248	(1,719) U	295,827	292,608	(3,219) U
Contribution	**(4,756)**	**(4,774)**	**17 F**	**118**	**(946)**	**1,064 F**	**943**	**(0)**	**943 F**
Net Result	**(2,718)**	**(2,718)**	**0 F**	**(2,668)**	**(2,668)**	**0 F**	**5,000**	**5,000**	**0 F**

11. Quality and Financial Improvement Programme

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

At the end of January we have achieved 69% of our year-to-date savings target (up from 65% at end of December).

Row Labels	Sum of Planned Savings	Sum of ytd savings target	Sum of YTD actual Savings	%age Savings Achieved
Corporate	1,526,792	890,628	880,022	99%
Health Services	8,292,086	4,837,050	3,037,704	63%
Population Hea	26,166	15,264	15,264	100%
Maori	148,195	86,447	86,447	100%
Health Funding	3,006,808	1,753,971	1,212,167	69%
Grand Total	**13,000,047**	**7,583,361**	**5,231,603**	**69%**

Row Labels	Sum of Planned Savings	Sum of ytd savings target	Sum of YTD actual Savings
AMBER	**4,416,281**	**2,576,164**	**1,795,142**
Acute Medical	2,407,323	1,404,272	872,504
Business Intelligence	9,012	5,257	-
CEO	145,930	85,126	85,126
Depreciation	517,008	301,588	301,588
FAC	22,652	13,214	4,300
Information Services	326,304	190,344	190,344
OPE	283,469	165,357	62,108
Surgical	338,945	197,718	153,430
WCY	365,638	213,289	125,743
RED	**3,147,636**	**1,836,121**	**275,272**
Human Resources	123,967	72,314	69,289
OPE	289,465	168,855	44,905
OPRS	205,850	120,079	24,675
Strategic Services	1,153,808	673,055	131,250
Surgical	1,241,136	723,996	833
WCY	133,410	77,823	4,320
Grand Total	**7,563,917**	**4,412,285**	**2,070,414**

12. Financial Position

30 June 2016	$'000	January Actual	January Budget	January Variance from budget	January Movement from 30 June 2016	Annual Budget
	Equity					
102,608	Crown equity and reserves	102,608	105,733	3,125	-	105,376
(10,973)	Accumulated deficit	(13,793)	(18,936)	(5,143)	(2,820)	(11,268)
91,635		88,815	86,797	(2,018)	(2,820)	94,108
	Represented by:					
	Current Assets					
15,552	Bank	18,572	6,292	(12,280)	3,020	8,523
1,724	Bank deposits > 90 days	1,755	1,741	(14)	31	1,741
22,433	Prepayments and receivables	13,833	18,457	4,624	(8,600)	18,618
4,293	Inventory	4,268	4,010	(258)	(25)	4,044
1,220	Non current assets held for sale	625	-	(625)	(595)	-
45,222		39,053	30,500	(8,553)	(6,169)	32,927
	Non Current Assets					
151,944	Property, plant and equipment	150,375	163,269	12,894	(1,569)	166,159
2,037	Intangible assets	1,744	908	(836)	(293)	665
9,777	Investments	10,430	8,920	(1,510)	653	9,476
163,758		162,549	173,097	10,548	(1,209)	176,299
208,980	**Total Assets**	**201,602**	**203,597**	**1,995**	**(7,378)**	**209,226**
	Liabilities					
	Current Liabilities					
-	Bank overdraft	-	-	-	-	-
38,137	Payables	30,212	30,747	535	(7,925)	30,697
34,070	Employee entitlements	37,438	36,143	(1,294)	3,367	34,484
-	Current portion of borrowings	-	6,000	6,000	-	6,000
72,208		67,650	72,890	5,240	(4,558)	71,180
	Non Current Liabilities					
2,638	Employee entitlements	2,638	2,410	(227)	-	2,438
42,500	Term borrowing	42,500	41,500	(1,000)	-	41,500
45,138		45,138	43,910	(1,227)	-	43,938
117,345	**Total Liabilities**	**112,787**	**116,800**	**4,013**	**(4,558)**	**115,118**
91,635	**Net Assets**	**88,815**	**86,797**	**(2,018)**	**(2,820)**	**94,108**

The variance from budget for:

- Equity reflects the amount the budgeted opening balance differs from the 2015/16 result and the variance in the 2016/17 result year-to-date;
- Bank and property, plant and equipment mainly reflect the lower capital spend;
- Non-current assets held for sale was adjusted for the reclassification of 307 Omahu Road to property, plant and equipment in November;
- Term borrowing has been delayed to February to coincide with the debt to equity swap.
- Employee entitlements – see below

13. Employee Entitlements

30 June 2016	$'000	January Actual	January Budget	January Variance from budget	January Movement from 30 June 2016	Annual Budget
7,466	Salaries & wages accrued	9,452	7,901	(1,551)	1,986	6,559
482	ACC levy provisions	1,176	658	(518)	694	851
5,348	Continuing medical education	6,289	6,338	49	941	5,131
19,149	Accrued leave	19,207	19,573	365	59	20,249
4,263	Long service leave & retirement grat.	3,951	4,084	133	(312)	4,131
36,708	**Total Employee Entitlements**	40,075	38,554	(1,521)	3,367	36,922

14. Treasury

Liquidity management

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

Debt management

The 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 as equity in February when the proposed swap of debt to equity is expected to occur. 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 before the debt to equity swap is expected to occur.

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

See next page.

2017 Annual Plan		*Actual $'000*	*Year to Date Budget $'000*	*Variance $'000*
	Source of Funds			
	Operating Sources			
14,440	Depreciation	7,993	7,994	2
5,000	Surplus/(Deficit)	(2,820)	(2,668)	152
(2,479)	Working Capital	720	2,294	14,014
16,961		5,893	7,620	14,168
	Other Sources			
-	Special funds and clinical trials	36	-	(36)
1,220	Sale of assets	-	1,220	(1,220)
5,000	Borrowings	-	5,000	(5,000)
6,220		36	6,220	(6,256)
23,181	**Total funds sourced**	**5,929**	**13,840**	**7,911**
	Application of Funds:			
	Block Allocations			
3,183	Facilities	1,262	1,907	645
3,125	Information Services	339	1,823	1,484
5,464	Clinical Plant & Equipment	1,553	3,135	1,582
11,772		3,153	6,865	3,712
	Local Strategic			
2,460	MRI	-	1,434	1,434
500	Renal Centralised Development	232	292	59
3,000	New Stand-alone Endoscopy Unit	614	1,749	1,135
710	New Mental Health Inpatient Unit Development	341	414	73
100	Maternity Services	132	58	(73)
400	Upgrade old MHIU	981	552	(429)
400	Travel Plan	6	233	227
400	Histology and Education Centre Upgrade	19	114	95
1,100	Fluoroscopy Unit	-	641	641
200	Education Centre Upgrade	-	(83)	(83)
9,270		2,325	5,405	3,080
	Other			
-	Special funds and clinical trials	36	-	(36)
1,000	New Technologies/Investments	-	1,000	1,000
-	Other	55	-	(55)
1,000		92	1,000	908
22,042	***Capital Spend***	***5,570***	***13,270***	***7,701***
	Regional Strategic			
1,139	RHIP (formerly CRISP)	360	570	210
1,139		360	570	210
23,181	**Total funds applied**	**5,929**	**13,840**	**7,911**

16. Rolling Cash Flow

	Actual	January Forecast	Variance	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast	Jul Budget	Aug Budget	Sep Budget	Oct Budget	Nov Budget	Dec Budget	Jan Budget
Cash flows from operating activities															
Cash receipts from Crown agencies	41,941	43,315	(1,374)	45,523	42,121	43,420	38,542	52,857	44,780	41,382	45,384	51,977	41,777	41,601	43,315
Cash receipts from revenue banking	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from donations, bequests and clinical trials	(25)	-	(25)	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	851	428	423	470	445	443	445	443	426	425	427	492	432	439	428
Cash paid to suppliers	(24,190)	(25,677)	1,487	(24,123)	(26,029)	(25,581)	(24,435)	(29,883)	(27,144)	(25,118)	(27,069)	(24,932)	(25,223)	(25,825)	(24,761)
Cash paid to employees	(15,920)	(16,713)	793	(14,671)	(19,539)	(15,375)	(17,869)	(15,647)	(13,909)	(19,483)	(15,098)	(15,100)	(17,792)	(14,458)	(16,750)
Cash generated from operations	**2,657**	**1,354**	**1,304**	**7,199**	**(3,002)**	**2,906**	**(3,318)**	**7,771**	**4,152**	**(2,793)**	**3,644**	**12,437**	**(806)**	**1,758**	**2,233**
Interest received	68	75	(7)	68	75	73	75	73	81	80	67	66	80	72	75
Interest paid	-	(359)	359	(325)	-	-	-	-	-	-	-	-	-	-	-
Capital charge paid	-	-	-	-	-	-	-	(5,476)	-	-	-	-	-	(5,493)	-
Net cash inflow/(outflow) from operating activities	**2,726**	**1,069**	**1,656**	**6,942**	**(2,927)**	**2,979**	**(3,242)**	**2,367**	**4,233**	**(2,713)**	**3,711**	**12,504**	**(726)**	**(3,663)**	**2,308**
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	0	0	-	0	0	0	0	0	0	0	0	0	0	1,220	0
Acquisition of property, plant and equipment	(643)	(1,617)	974	(1,972)	(2,180)	(2,025)	(1,905)	(2,143)	(2,511)	(2,511)	(2,511)	(2,511)	(2,511)	(3,511)	(2,511)
Acquisition of intangible assets	(1)	(315)	314	(345)	(340)	(265)	(115)	(70)	(85)	(85)	(85)	(85)	(85)	(85)	(85)
Acquisition of investments	-	(8)	8	-	(1,075)	-	-	(284)	-	-	(285)	-	-	(285)	-
Net cash inflow/(outflow) from investing activities	**(644)**	**(1,940)**	**1,296**	**(2,317)**	**(3,595)**	**(2,290)**	**(2,020)**	**(2,497)**	**(2,596)**	**(2,596)**	**(2,881)**	**(2,596)**	**(2,596)**	**(2,661)**	**(2,596)**
Cash flows from financing activities															
Proceeds from equity injection	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Proceeds from borrowings	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Repayment of finance leases	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Equity repayment to the Crown	-	-	-	-	-	-	-	(357)	-	-	-	-	-	-	-
Net cash inflow/(outflow) from financing activities	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**(357)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Net increase/(decrease) in cash or cash equivalents	2,081	(871)	2,952	4,625	(6,522)	689	(5,263)	(487)	1,637	(5,309)	829	9,907	(3,322)	(6,324)	(288)
Add:Opening cash	18,245	18,245	-	20,326	24,951	18,429	19,118	13,855	13,368	15,005	9,696	10,525	20,433	17,110	10,786
Cash and cash equivalents at end of year	**20,326**	**17,374**	**2,952**	**24,951**	**18,429**	**19,118**	**13,855**	**13,368**	**15,005**	**9,696**	**10,525**	**20,433**	**17,110**	**10,786**	**10,498**
Cash and cash equivalents															
Cash	4	7	(3)	4	4	4	4	4	7	7	7	7	7	7	7
Short term investments (excl. special funds/clinical trials)	17,288	14,272	3,016	21,912	15,390	16,079	10,816	10,329	11,903	6,594	7,423	17,331	14,008	7,684	7,395
Short term investments (special funds/clinical trials)	3,035	3,095	(61)	3,035	3,035	3,035	3,035	3,035	3,095	3,095	3,095	3,095	3,095	3,095	3,095
Bank overdraft	(0)	-	(0)	(0)	(0)	(0)	(0)	(0)	-	-	-	-	-	-	-
	20,327	**12,004**	**2,953**	**24,951**	**18,429**	**19,118**	**13,855**	**13,368**	**15,005**	**9,696**	**10,525**	**20,433**	**17,110**	**10,786**	**10,497**

BOARD HEALTH & SAFETY CHAMPION'S UPDATE

Verbal

HAWKE'S BAY
District Health Board
Whakawāteatia

CONSUMER STORY

11

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**HB Clinical Council Council** 4
	For the attention of: **HBDHB Board**
Document Owner:	Chris McKenna and Dr Mark Peterson (co-Chairs)
Reviewed by:	Not applicable
Month:	February 2017
Consideration:	For Information

RECOMMENDATION

That the Board note Clinical Council:

- **Noted** the update on progress around the ICU Learnings Report
- **Endorsed** the Collaborative pathways Proof of Concept Proposal
- **Noted** the proposed evaluation framework for the 13-17 Primary Care subsidy
- **Endorsed** the Radiology Imaging Guidelines for Secondary Care

Council met on Wednesday 8 February 2017, an overview of issues discussed and/or agreed at the meeting are provided below.

The following papers were considered:

- ***ICU Learning Report – Update on Progress***

Kate Coley, DQIPS provided an update on the progress to date on the recommendations as outlined in the action plan. The ICU SMO job sizing and rostering practices are outstanding but progress is being made. There are a number of actions regarding external reviews and making sure we have a robust process around undertaking reviews, which is completed. Currently reviewing the nursing fte and a further paper would be presented in the future. This report will come back to the Clinical Council each quarter until all recommendations have been completed. The intention is that all of the actions are implemented and that the Clinical Council is aware what is being done around the ICU learnings. It is important that all the loops are closed.

- ***Collaborative Pathways Proof of Concept Proposal***

Clinical pathways on paper or via Map of Medicine (MoM) have been underutilised by clinician's and we are looking at ways to make the pathways more approachable, easier to use and to provide other benefits for clinicians. It is about streamlining the process and making it user friendly. NexxT does not create the pathway, they provide the electronic tool. In the proposal NexxT will take two of the pathways (hips and knees and cellulitis) to use in the proof of concept to show what they can do to take them from static pathways to a more user friendly and dynamic one.

Following discussion the Clinical Council endorsed the proof of concept implementation at a cost of $35,000 with the same conditions as recommended by EMT:

(a) The success factors of this tool were identified

(b) Clarification be obtained from the provider NexxT for any ongoing costs if they were the successful vendor after the proof of concept trial period concluded
(c) Note that the Map of Medicine contract be reviewed in June 2017
(d) A comprehensive paper come back to EMT and Clinical Council outlining the value of collaborative pathways and what the appropriate tool would be for this.

- **13-17 Year Old Primary Care Zero Rated Subsidy Framework**

Clinical Council considered a paper around the evaluation framework for the 13-17 year old Primary Care subsidy programme. The paper included what those evaluation measures should look like. There was some discussion around the proposed measures and a number of further suggestions were made which would be fed back to the relevant individuals.

- **Orthopaedic Review Phase 2 (Draft)**

Paper was reviewed and discussed by Clinical Council. Very supportive of the phased approach to these challenges and Clinical Council noted this second phase and the goals outlined in the report.

- **Imaging Guidelines**

Clinical Council reviewed the proposed imaging guidelines in the secondary care environment and the national criteria for access to community radiology.

Dr West advised that the current guidelines for primary care had been developed using the best evidenced based information from the New Zealand health care model, what are appropriate examinations to be asking for in a primary health care environment, an indication for assessment and the appropriate imaging test to do. For secondary care there are no national guidelines or pathways and the DHB has had to develop its own imaging guidelines. The guidelines developed are based around the guidelines produced by Waikato DHB, which reflect international guidelines coming out of Australia and the Choosing Wisely Initiative. It is an easy clinical guideline to look through, based on a clinical problem, you use the appropriate imaging test. Radiology will prioritise referrals according to these guidelines. Variation from the guidelines may require a case by case discussion.

Clinical Council supported and endorsed the guidelines.

Other Papers provided:

- **Annual Maori Health Plan - Quarter 2**

Clinical Council noted the report.

- **Te Ara Whakawaiora / Access (Local Indicator)**

  Feedback provided to Chair of Clinical Council and paper amended accordingly for Board.

OURHEALTH HAWKE'S BAY Whakawateatia	**Appointment to HB Clinical Council** 5
	For the attention of: **HBDHB Board and Health Hawke's Bay Ltd Board**
Document Owner:	Ken Foote, Company Secretary
Reviewed by:	Not applicable
Month:	February 2017
Consideration:	For Endorsement

13

RECOMMENDATION

That the Board endorse the CEO's approval to appoint Lee-Ora Lusis to Clinical Council with her first term expiring in September 2019.

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 Clinical Council. The memo provides some background to the recommendation, and the CEO's approval.

It is now recommended that both Boards endorse this reappointment.

HAWKE'S BAY
District Health Board
Whakawāteatia

Memo

To:	**Kevin Snee, CEO HBDHB** **Wayne Woolrich, General Manager, Health Hawke's Bay**
From:	Ken Foote, HBDHB Company Secretary
Date:	19 January 2017
Subject:	**Appointment to Clinical Council – Lee-Ora Lusis**

Due to the resignation of Robyn O'Dwyer from Council in late 2016, the co-Chairs issued an "Expression of Interest" request for a replacement. A selection process was then followed for those who responded to this EOI.

From this process, Lee-Ora Lusis has now been recommended for appointment to the "Senior Nurse Primary Care" vacancy.

Lee-Ora is the Clinical Nurse Manager at Totara Health Clinic and additionally is preparing for endorsement by NCNZ as a Nurse Practitioner- Primary Care. Lee-Ora has extensive experience in primary care nursing, public health nursing and was formally practiced as a Lead Maternity Carer in the rural sector of Wanganui some years ago.

Lee-Ora's iwi is Ngati Kahungunu.

Lee-Ora's application is supported by Emma Foster CEO of Totara Health and Chris McKenna (as co-Chair of Council) who both note confidence in Lee-Ora's experience showing her to be well placed to ensure her Maori Health and Primary Care experience will be a positive contribution to Clinical Council.

RECOMMENDATION

That Lee-Ora Lusis be appointed to Clinical Council for her first term expiring September 2019

APPROVAL

We approve the above recommendation

Kevin Snee
CEO HBDHB

25/1/17
Date

Wayne Woolrich
General Manager, Health Hawke's Bay Ltd

25/1/17
Date

HAWKE'S BAY District Health Board Whakawāteatia	**HB Health Consumer Council** 6
	For the attention of: **HBDHB Board**
Document Owner:	Graeme Norton (Chair)
Reviewed by:	Not applicable
Month:	February 2017
Consideration:	For Information

RECOMMENDATION

That the Board note Consumer Council:

- **Endorsed** the Terms of Reference for the Youth Consumer Council
- **Noted** the approach of redesigning our musculoskeletal pathways and the design goals for the three aspects of the community, primary and secondary care
- **Discussed** and provided comments/suggestions on the Te Ara Whakawaiora/Access (local indicator) for feedback to the champion and relevant clinical director

Council met on Thursday 9 February 2017, an overview of issues discussed and/or agreed at the meeting are provided below.

The following matters/papers were considered:

- ***Youth Consumer Council***

On the back of the Youth Strategy DHB and Directions have facilitated the coming together of a group of diverse young people to form a youth consumer group. This is a stunning group of young people with diverse backgrounds and interest and with strong linkages to other youth groups within the HB community. EMT endorsed this group to become a subgroup of consumer council. Two representatives will come to each Consumer Council meeting and the participants will rotate on a regular basis. The Terms of Reference for the Youth Consumer Group has been endorsed. This group will report 6 monthly to the full council.

- ***Orthopaedic Review Phase 2 Draft***

Consumer Council have been actively involved in the design process for musculoskeletal pathways and this session was an opportunity to review progress and give further input to refine the approach. A number of specific suggestions were made. The Consumer Council notes the approach of the second phase and the design goals for the three aspects of the community, primary care and secondary care.

- ***Te Ara Whakawaiora Access (ASH Rates 0-4 & 45-64 years)***

Whilst this report had been slotted for information it provoked some lively discussion amongst members. The chair was charged with taking feedback to the clinical champion and relevant clinical director.

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board (MRB)** 7
	For the attention of: **HBDHB Board**
Document Owner:	Heather Skipworth (Deputy Chair)
Reviewed by:	Not applicable
Month:	February 2017
Consideration:	For Information

RECOMMENDATION

That the Board

Review the contents of this report; and

Note that MRB:

- **Agreed:** for an independent workshop/wānanga with members, to discuss the impacts of Fluoridation on populations. The Wānanga is to be coordinated by Lynlee Aitcheson-Johnson and any recommendations be bought back to a formal MRB meeting.
- **Recommend:** an ethnicity and equity rating for assessment for surgery be included into the assessment tool.
- **Recommend:** that the ASH report formulate better recommendations that improves the performance of the indicator
- **Supported:** Annual Māori Health Plan (AMHP) and the changes for an integrated plan on the proviso that Māori health monitoring is not lost in wider reporting. It is expected that all annual plan indicators be reported by ethnicity to allow monitoring for inequity.
- **Supported:** MRB being reviewed and the progress to date by Ngati Kahungunu Iwi Inc, the Taumata and Post Treaty Settlement Groups.

MRB met on 8 February 2017, an overview of issues discussed and/or agreed at the meeting are provided below.

The following papers were considered:

ORTHOPAEDIC REVIEW - PHASE 2 Musculoskeletal and Orthopaedic Service Redesign

MRB was supportive of the work being undertaken by the group but reiterated that its important that pain management be given priority, that Māori men need support to give an accurate report on their health status (often minimised due to their pride) and that rurual communities coverage needs to be considered in programmes such as the Mobility Action Programme. In addition the point raised about wage earners no longer being able to work impacts on the social aspects and living conditions of whanau. Following these issues being raised it was recommended by MRB that an ethnicity and equity rating for assessment for surgery be included into the assessment tool.

TE ARA WHAKAWAIORA: ACCESS (LOCAL INDICATOR)

- The ASH rates for 45-64 year age group for heart disease, skin infections, respiratory infections and diabetes,
- The ASH rates for 0-4 year age group for dental, cellulitis and asthma.
  MRB was concerned at the lack of recommendations for 45-64 year olds given the poor performance against this indicator. While the report was a good one describing the problem it didn't highlight how the problem would be tackled. MRB requested that the team formulate better reommendations and send these to MRB

ANNUAL MĀORI HEALTH PLAN Q2 FULL REPORT AND NON-FINANCIAL EXCEPTIONS REPORT

- MRB thought that the rating of non performing indicators against other DHBs using the Trendly tool was innovative and engaging. The discussion about Te Ara Whakawaiora was highlighted stating that with the integrating of plans it was important that the non-performance report through TAW must continue. Having leadership and champions on these indicators aids governance groups to better understand the issues and in turn supports better outcomes. Discussion about top priorities for MRB for the next annual plan 2017/18 were:

  - Obestity for all ages including children
  - Mental Health and Addiction services
  - ASH 45-64 year olds
  - Oral health for children
  - Increasing Māori staff numbers in DHB

ANNUAL MĀORI HEALTH PLAN (AMHP)

- The Ministry of Health provided advice to DHBs for planning this year. Annual Māori Health Plans will now be embedded into Annual Plans. The plan is to be a more robust and high level plan that demonstrates how DHBs will prioritise inequity. MRB stated that this is not a new process for HBDHB as we have had integrated plans for the previous three years. This has worked well in terms of leadership by whole of sector on Māori health improvement. Our expectation is that DHB will report all indicators within the AP by ethnicity so that inequity is not hidden. In addition we recommend Te Ara Whakawaiora continues as a programme across the whole of the AP.

MRB REVIEW – UPDATE FROM NKII CHAIR

- The MRB is under review and currently considering a Governance Board structure that sits under NKII and works in partnership with Local Authority and Government Agencies. The composition of the Board could be a collaboration of 50/50 Iwi representatives and Industry CEOs. The objective of the Board is to set the directive for strong and vibrant whanau in Kahungunu and to monitor outcomes. With input and support by the Taumata of Kahungunu, this development with take between 6 to 12 months. It is expected that once the Terms of Reference is set for this Board (Toiora) that DHB will then decide on whether there is a role for MRB in the future.

HAWKE'S BAY District Health Board Whakawāteatia	**Orthopaedic Review – Phase 2 (Draft)** 8
	For the attention of: **HBDHB Board**
Document Owner(s):	Andy Phillips and Mark Petersen
Document Author(s):	Carina Burgess, Patrick Le Geyt, Tae Richardson and Andy Phillips
Reviewed by:	Executive Management Team, Māori Relationship Board, HB Clinical Council and HB Health Consumer Council
Month:	February 2017
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board

- Note the approach to the Second Phase of redesigning our musculoskeletal and orthopaedic pathways
- Note the three redesign goals for :
  Community Care: Addressing health inequities using Whanau ora approach delivered through Mobility Action Programme
  Primary Care: Ensuring that GPs and patients have appropriate expectations delivered by introducing dynamic hip and knee pathways
  Secondary Care: Improving patient outcomes and experience of elective surgery by fully implementing Principles of Enhanced Recovery After Surgery.

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SITUATION

This paper gives a brief overview of the proposed approach to redesigning services for people within our community who have pain and disability resulting from Musculoskeletal and Orthopaedic conditions

BACKGROUND

It is evident that there are a large number of people in the community living with pain and disability caused by musculoskeletal conditions. This number is expected to rise as the population of Hawke's Bay ages and the incidence of osteoarthritis increases.

The redesign of Musculoskeletal and Orthopaedic services was set out in three phases. The first phase, now complete involved increasing surgical capacity and making conservative treatment options available. The second phase involves the co-design of a new pathway. The third phase will now be carried out within the Clinical Service Plan to effectively manage demand and align capacity over two to five years and address 'third horizon' issues over ten years that will require innovative approaches. The initiatives completed in the first phase included:

- Implementing non-surgical treatment options by increasing physiotherapy and other allied health resource.
- Implementing a new pathway for back pain patients offering an alternative non-surgical treatment option.
- Improved patient communication and collaborative services within the DHB.
- Reducing wait times throughout the pathway.
- Setting thresholds for surgery based on data for orthopaedic scoring and Oxford score.
- Increasing surgical capacity to deliver on the major joint replacement target.
- Building a partnership between HBDHB, Health Hawkes Bay PHO and Iron Maori to gain MoH funding and deliver a Mobility Action Programme

The Principles

The redesign of the pathway will deliver on the New Zealand triple aim

- Improved health and equity for all populations.
- Improved quality, safety and experience of care.
- Best value for public health system resources.

Within this broad purpose, the pathway redesign will be consistent with Hawkes Bay DHB vision and values

Our vision is *"healthy hawke's bay*", *"te hauora o te matau-*a-*maui" which means* excellent health services working in partnership to improve the health and well-being of our people and to reduce health inequities within our community.

Our values and behaviours are articulated as

he kauanuanu – showing respect for each other, our staff, patients and consumers
akina – continuously improving everything we do.
raranga te tira – working together in partnership across the community
tauwhiro - delivering high quality care to patients and consumers

These values and behaviours will be delivered for hip and knee pain by redesign using the following principles :

1. Equity based care, treating greatest need first
2. Do no harm
3. Doing only what is necessary to achieve the desired outcomes
4. Choosing wisely, openly together with the patient
5. Consistently apply evidence based and knowledge based clinical practice
6. Staff co creating health with the public, patients & partners.

Within these principles, the redesign will consider reliable delivery of high quality services by improving value to patients and the DHB. Value is defined as outcomes relative to costs, it encompasses efficiency. The design will consider issues such as decision making criteria and thresholds for different interventions in the context of minimising harm, waste and unwarranted variation.

There will be three clear goals of this work namely:

Community Care:	Whanau ora approach delivered through Mobility Action Programme. The first patients are expected to be enrolled by 1st March 2017 with the programme completing by 30th June 2018
Primary Care:	Dynamic hip and knee pathways to ensure GPs and patients have appropriate expectations. The learnings from this work will be disseminated by 30th June 2017.
Secondary Care:	Ensure that best practice is delivered through fully implementing Principles of Enhanced Recovery After Surgery. It is anticipated that this work will be completed by 30th June 2018

ASSESSMENT

During a workshop on the 8th of November, a group of primary and secondary care clinicians identified current problems and challenges arising during a patient's journey related to the management of Osteoarthritis.

1. **Appropriate referral**
   a. High demand vs availability - The threshold is a reflection of capacity.
      Varies by month and depends on budget cycle. Formula constantly changes, lack of consistency.
   b. Location of scoring in secondary care results in unnecessary referrals to orthopaedics and a longer queue.
   c. GPs not well informed so unable to manage patient expectations
   d. Ensuring appropriate patient selection, i.e. people who will have quality of life after surgery and not life-limited after surgery.
   e. Limited capacity in allied health and surgical services to meet demand
   f. Patient's condition deteriorating while on a waiting list
   g. GPs need confidence systems work and that there is an integrated system and communications.
   h. What happens with inappropriate referral – providing management advice for primary care
2. **Communication between services**
   a. No communications from specialty services to primary care
   b. Breaking down silos
   c. Transparency of information about services offered. E.g. Joint school
   d. Disconnect with involvement of aged residential care
3. **Patient expectations (also patient literacy)**
   a. Perception that they won't get care or referred (may have heard stories from friend's experience's)
   b. Expecting surgery as the only treatment option. Patient not aware that they could be on a physio instead of a surgical pathway
   c. Patient disappointment
   d. Patient's not seeking help until they are in severe discomfort or disability.

4. **Cost to patient**
    a. Costs for appointments and alternative therapy
    b. Support and management for patients that don't meet criteria
5. **Management of patients who aren't appropriate for surgery**
    a. Decreased or poor access to treatment options
6. **Pain management**
    a. Delays in pain management
    b. No pain services – ensure this is managed
7. **Future planning** of patients on a hip or knee pathway – know who is in early stage so they will have an idea of what future funding and services are required.
8. **Coding** - Clarity and consistency around coding (eg. SNOMED)
9. **Management of comorbidities**
10. **Monitoring outcomes** e.g. post op infection, readmission rates, quality of life, supporting data, cross reference social metrics

ELEMENTS OF THE NEW PATHWAY

The pathway will be built on a Whānau Ora model of care. It will be specifically designed to address health inequities experienced by Māori, Pacific and quintile 5 consumers, and will be designed to meet the needs of both the working age and elderly population. The model will serve people with previous or current employment in heavy labouring jobs and those with barriers to paid work, training or caring for whānau due to musculoskeletal conditions.

The model will include self-referral (including walk in), referral by any health practitioner and invitation using MSD database matching of consumers fulfilling entry criteria. The model will include raising awareness through both informal (community) and formal (publically funded health and social services, NGOs, Pacific Churches and community centres, workplaces) networks.

Outcome/exit measures will support Whānau Ora outcomes including reduced pain, improved function, increased social and cultural participation and increased local capacity. The model will be constructed specifically to address NZ Triple Aim outcomes with particular emphasis placed on a reduction in unmet need, reducing the need for GP consultations and unnecessary referral to secondary care.

A co-design approach will build on the strengths of existing services and address access and other barriers. The model will include delivery in local communities therefore reducing the need for transport. Services will be culturally responsive and flexible around people's lifestyle e.g. work and training commitments, child care etc. The pathway will include workplace clinics for Hawke's Bay's key unskilled labour employers such as horticulture, food processing, meatworks, forestry and shearing.

A specific focus of the model will be to increase local community capacity to ensure sustainability with appropriate ongoing PHO and DHB support. The pathways will be fully aligned with Hawke's Bay Health Sector's Transform and Sustain strategic framework.

A key deliverable will be improving patient experience, clinical outcomes and value for money. Growing evidence tells us that consumer experience is a good indicator of the quality of health services. Better experience, stronger partnerships with consumers, and consumer and family-centred care have been linked to improved health, clinical, financial, service and satisfaction outcomes.

The pathway will ensure a consistent approach to collection, measurement and use of consumer experience information on a regular basis including measures of communication, partnership, co-ordination and physical and emotional needs.

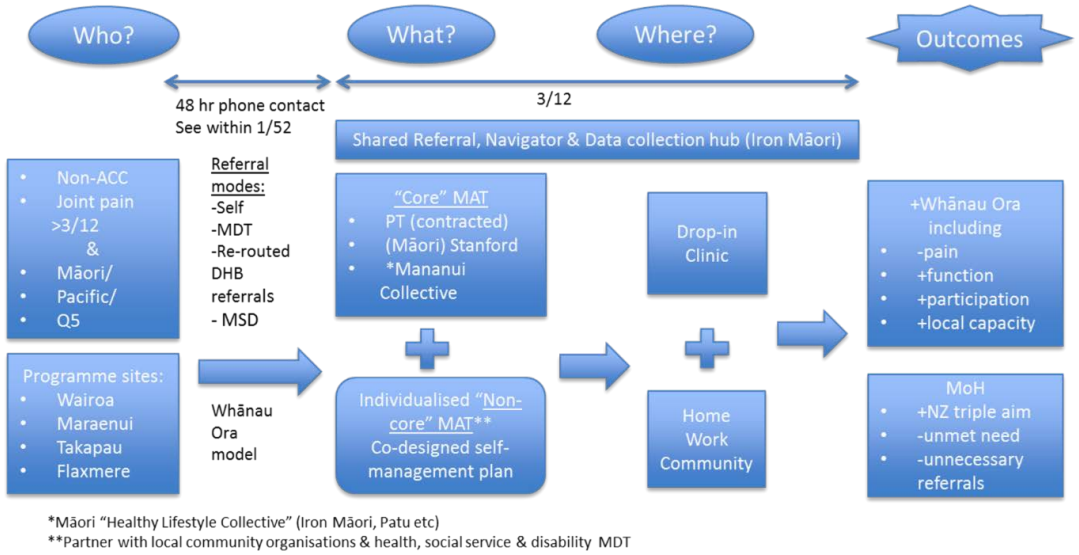
The pathway will address education and training needs of staff including relationship centred practice and cultural competency. Verbal and written communication will be in a consumer's preferred language (using translators if necessary). A health literacy "universal precautions" approach to communications will be implemented, given our understanding of health literacy levels in NZ, particularly for Māori. The system will support health literacy with services being easily accessible and navigable. The Whānau Ora model of care requires a partnership approach between consumer and service. In a Whānau Ora model of care, experience of care extends beyond supporting physical and emotional needs to cultural ones. The Stanford and Whariki Long Term Condition programme will further enhance consumer experience by developing, amongst other things, the person's own communication and decision making skills as well as dealing with the physical and emotional needs of their condition. The programme covers long term conditions in general therefore the pathway has the potential to improve the management of coexisting morbidities as well as musculoskeletal pain and disability.

Clinical outcomes will be enhanced not only by improved consumer experience of care, but also by a reduction in unmet need and inequity and through an emphasis on early intervention. It is recognised that early intervention for prevention and treatment is very important, especially around maintaining physical activity, as activity itself is evidenced to be beneficial for osteoarthritis.

As experience of care, quality (clinical effectiveness) and equity are cross cutting dimensions of the NZ Triple Aim, it can be argued that value for money cannot be achieved without them. The pathway will deliver value for money by equitable and improved health outcomes due to early intervention, and by a reduction in unnecessary referral to orthopaedic clinic. This will obviously free up orthopaedic outpatient capacity to focus on those most likely to benefit from this resource. Improved economic contributions would also be expected as people become able / better able to participate in work/ training and social obligations. These contributions are likely to be considerable given that musculoskeletal conditions are the leading cause of disability in NZ. With a wider lens, inequity itself has an uncontested effect on economic growth with evidence suggesting that in the decade 1990-2010, NZ experienced the largest impact of inequality on GDP growth of any OECD country.

The pathway will comprise physiotherapy, Stanford and Whariki Long Term Condition programme and a Māori Lifestyle Collective (a suite of kaupapa Māori healthy lifestyle services including Iron Māori and Patu programmes). In addition, the pathway will include an individualised, co- designed self-management programme and all existing publically funded health, social service and disability services and those provided by local community organisations.

The pathway will build on the Mobility Action Programme pathway shown above as well as existing hip/knee pathways.



ESTABLISHING A 'DYNAMIC' PATHWAY

At its meeting of 10th January, EMT agreed to work in partnership with NEXXT to develop dynamic pathways. Subsequently a sub-group agreed that dynamic hip/knee pathways would be the exemplars for this development. The purpose will be to develop a Patient Centric journey that encourages;

- the sharing of information
- the delivery of consistent best practice care and
- the measurement of outcomes.

The Key Benefit Areas will be:

- The generation and communication of appropriate referrals
- Improved communication and transparency of information between providers across both primary and secondary care
- The systematic collection of information to assist in planning and funding and to understand gaps in patient care.
- To identify in advance from the condition of the existing patients on chronic care pathways, if there is a likely to be an increase or decrease in demand
- Supporting patient literacy
- Reducing ASH rates

The hip and knee osteoarthritis pathways provided in both primary and secondary care settings will:

- Allow scoring or aspects of scoring in primary care to prevent inappropriate referrals
- Provide guidance when a patient's condition does not meet the threshold for a referral - management, in particular physiotherapy

- Provide the ability to build a moving threshold aspect into the pathway
- Facilitate and manage the criteria for appropriate patient selection
- Deliver transparency between health providers as to who is doing what and how long the patient has been managed for
- Enable the coordination of services and health care providers involved in patient care, e.g. GP, hospital orthopaedic team, physiotherapy, allied health

This will increase provider efficiency by reducing inappropriate referrals, improving communication and speeding up the delivery of care for patients.

Non-surgical management/checklists will be monitored and reviewed, pre and post op, according to the point the patient is at within a pathway, for example: pain management,

This will help to set the right patient expectations and help them to feel their on-going care is being managed. This will lead to better patient outcomes.

Possible inclusion of patient questionnaires to monitor their wellness, mental health, outcomes and social factors.

This will provide an insight into the wider well-being of the patient, allowing for appropriate care to be referred, leading to an overall better patient outcome.

Monitoring outcomes for hip or knee replacement surgery.

This will provide background data that can be used to optimise the care delivery and assistance provided to patients. Over time this will lead to better patient outcomes and a more effect use of resources.

Data on hip and knee osteoarthritis pathways will guide future planning and funding of services or points of low or high demand.

Data will be provided that can be used to forecast forward demand by patients. Over time this will lead to a more effect use of resources and a more consistent service for patients.

CO-DESIGN OF THE COMMUNITY/PRIMARY CARE PATHWAY

It has been agreed that this work will be undertaken by the Collaborative Pathways group. A partnership will be agreed with NEXXT to design the dynamic pathway. A steering group of primary and secondary care clinicians will be established. Initial work will be undertaken to describe the approach which will be discussed with a variety of stakeholders including patients with musculoskeletal conditions, patient groups such as greypower, primary and secondary care clinicians. Learnings from these discussions together with an initial design will be presented by the end of June 2017.

SECONDARY CARE PATHWAY

There has already been much work done in secondary care in HBDHB to implement the best practice principles of surgery to acute and elective orthopaedic pathways. Enhanced recovery after surgery ensures that patients : -

- Are in the optimal condition for treatment
- Are better informed about their care
- Are exposed to extensive pre-habilitation

- Experience a more streamlined, standardised care pathway
- Are exposed to evidence-based methods of enhancing care
- Experience optimal post-operative rehabilitation

The work will ensure that for each patient:

- Patients receive extensive Pre-Op Information
- Joint School is delivering appropriate patient expectation and preparation
- Anaesthetic Regime is optimised
- Pain Relief is provided without using opiates wherever possible
- Appropriate early mobilisation is provided
- Staff have appropriate expectations of patient early recovery

The aim of the next phase of this work will be to:

- Improve Patient Experiences
- Deliver standardised treatment pathways for all patients, all of the time
- Deliver Process Improvement resulting in Outcome Improvement

HAWKE'S BAY District Health Board Whakawāteatia	**Community Representatives on Te Matau a Maui Health Trust** 9
	For the attention of: **HBDHB Board**
Document Owner:	Ken Foote (Company Secretary)
Document Author:	Ken Foote (Company Secretary)
Month:	February 2017
Consideration:	For Approval

RECOMMENDATION

That the Board

Appoint the following to be Trustees of Te Matau a Maui Health Trust for a three year term commencing March 2017

Kevin Atkinson (Hastings)

Leigh White (Napier); and

Charles Lambert (Wairoa)

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BACKGROUND

Te Matau a Maui Health Trust was established in 2011 to hold the shares in Health Hawke's Bay Ltd being the "new" company operating as a single Primary Care Organisation (PHO) in Hawke's Bay.

Of particular relevance to this report is clause 9.5 of the Trust Deed:

> *"9.5 – Four (4) Trustees shall be appointed to represent the general community and shall be appointed by the Hawke's Bay District Health Board in consultation with all of the territorial local authorities within the Hawke's Bay Region. One (1) of these Trustees must be ordinarily resident in the Wairoa District and one (1) of these Trustees must be ordinarily resident in the Central Hawke's Bay District."*

The current "community trustees" are:

Kevin Atkinson	(Hastings)
Leigh White	(Napier)
Denise Eaglesome	(Wairoa)
Leanne Hutt	(Central Hawke's Bay)

Leanne was reappointed for a second term last year, so she is not due to retire by rotation until March 2019.

Kevin, Leigh and Denise however are all retiring by rotation in March 2017 (next month). Kevin and Leigh have made themselves available for reappointment. Denise has not.

APPOINTMENT / REAPPOINTMENT PROCESS

In accordance with clause 9.5 above, the Mayors of Hastings, Napier and Wairoa have been consulted on potential reappointments (new appointments as appropriate. The Mayors of Hastings and Napier have indicated their Council's support for the reappointment of Kevin Atkinson and Leigh White respectively. The Major of Wairoa has advised his Council wish to nominate Charles Lambert as the Wairoa resident trustee.

Based on this consultation, it is therefore recommended that the following be appointed / reappointed as Trustees for a period of three years from March 2017.

Kevin Atkinson	(Hastings)
Leigh White	(Napier)
Charles Lambert	(Wairoa)

HAWKE'S BAY District Health Board Whakawāteatia	**Human Resource KPIs (Q2 October-December 2016)** 10
	For the attention of: **HBDHB Board**
Document Owner: Document Author:	Kate Coley, Executive Director of People and Quality Jim Scott, Workforce Analyst
Reviewed by:	Executive Management Team
Month:	February 2017
Consideration:	Monitoring

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report.

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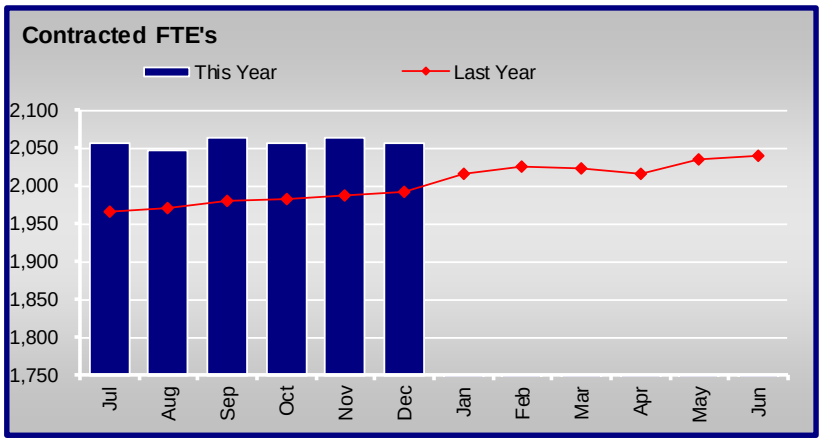
Headcount and positions

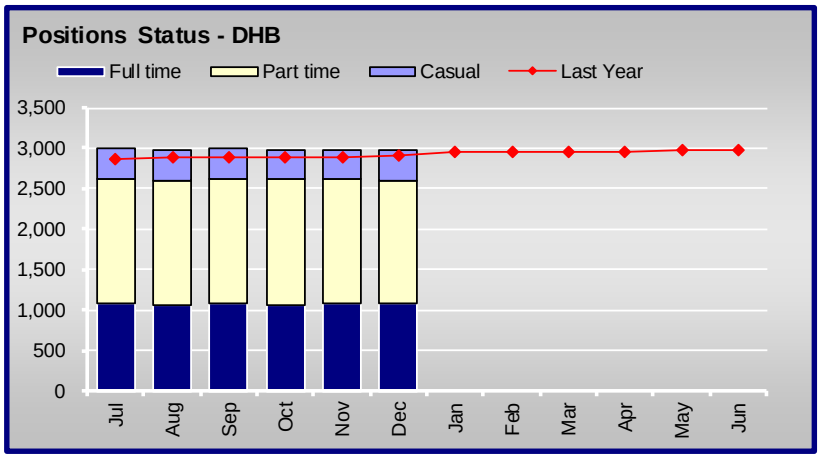
Reporting on headcount/ positions is a snapshot in time rather than an average for the month or year.



Contracted FTEs
2055.9 at 31 Dec. 2016
1991.2 at 31 Dec. 2015
= 3.3% increase

Overall increases/ (decreases)

	FTE	
Medical	9.8	4.3%
Nursing	20.5	2.5%
Allied Health	15.1	3.7%
Support	2.1	1.7%
Mge. & Admin	17.2	4.6%
Total	**64.7**	**3.3%**



Positions filled:
2972 at 31 Dec. 2016
2911 at 31 Dec. 2015
= 2.1% increase (61 positions)

Of the 2972 positions (last year in brackets):
36% are full-time (36%)
51% are part-time (51%)
13% are casual (13%)

Overall increases/ (decreases) – breakdown of 2.1% increase

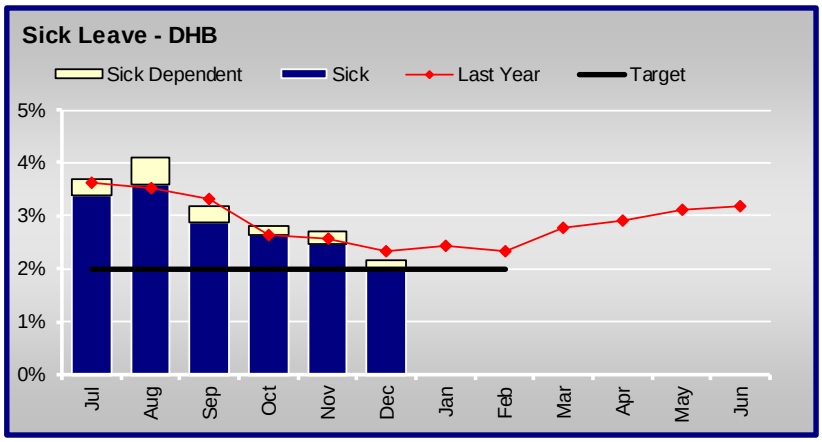
	Full time	Part time	Casual	Total	% change
Medical	13	(6)	1	8	3.1%
Nursing	4	11	(6)	9	0.6%
Allied Health	18	(4)	7	21	4.0%
Support	2	0	(2)	0	0.0%
Management & Admin	3	21	(1)	23	5.2%
Totals	**40**	**22**	**(1)**	**61**	**2.1%**

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%



Dec 2016 = 2.18%
Dec 2015 = 2.32%

YTD Dec '16 = 3.10%
YTD Dec '15 = 2.99%

HBDHB is currently ranked the lowest of 4 mid-sized DHBs.

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

31 Dec. 2016 – 3rd lowest out of 18 DHBs (12 months ended Dec. 2016 ranked 7th lowest)

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

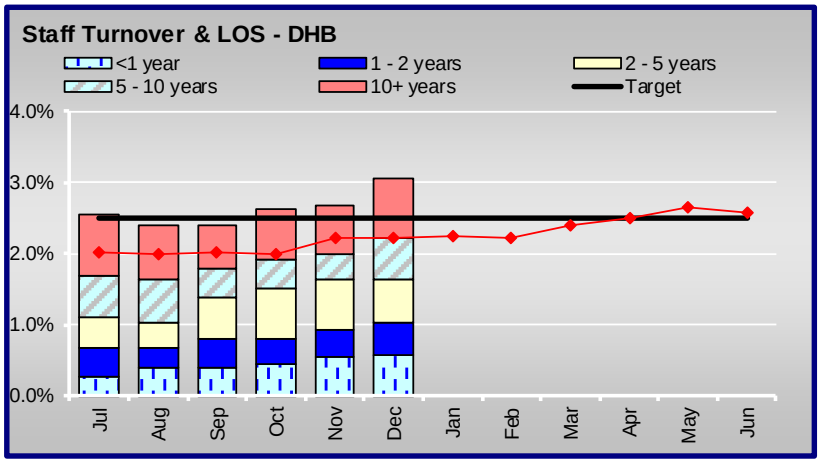
Staff Turnover

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 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 Dec '16 = 3.05% which is above the target of 2.50%. See reasons below.

12 months to Dec '16 = 10.51% which is above the 10% annual target. See reasons below.

2263	Staff at 1 Oct '16
53	New Staff
(73)	Staff resignations
35	Change of status – mostly fixed term to permanent
2278	Staff at 31 Dec '16

Reasons for leaving included in Staff Turnover	**Quarter**	**Last 12 months**
Moving to a position outside HBDHB	20	56
Relocating outside HB	8	37
Retirement	20	50
Not returning from parental leave	5	13
Personal	6	12
Family reasons	0	9
Further education	1	4
Other reasons	5	22
Unknown reason	4	31
Total	**69**	**234**

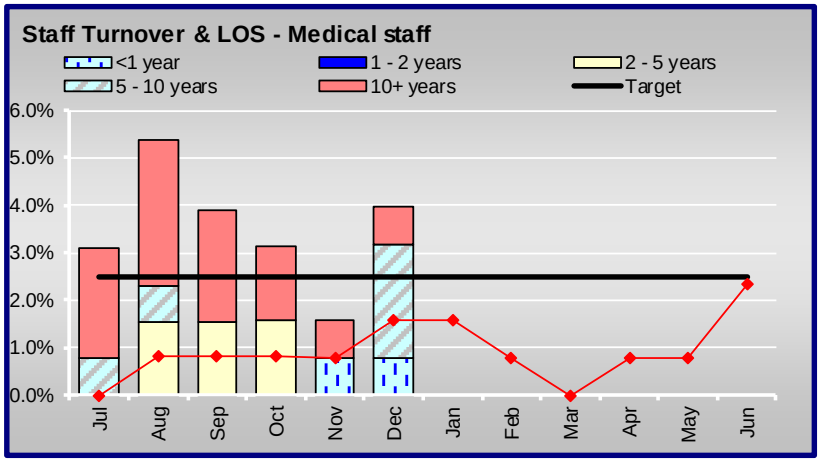
Note difference to staff resignations figure above is due to non-voluntary resignations (medical grounds, redundancy etc.)

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

31 Dec. 2016 – 17th lowest out of 18 DHBs (12 months ended Dec. 2016 ranked 7th lowest)

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

Staff Turnover – Medical Staff



3 months ended Dec '16 = 3.97% which is above the 2.50% target. See reasons below.

12 months to Dec '16 = 10.16% which is above the 10% annual target. See reasons below.

126	Staff at 1 Oct '16
1	New Staff
(5)	Staff resignations
1	Change of status – casual to permanent
0	Trf other staff group
123	Staff at 31 Dec '16

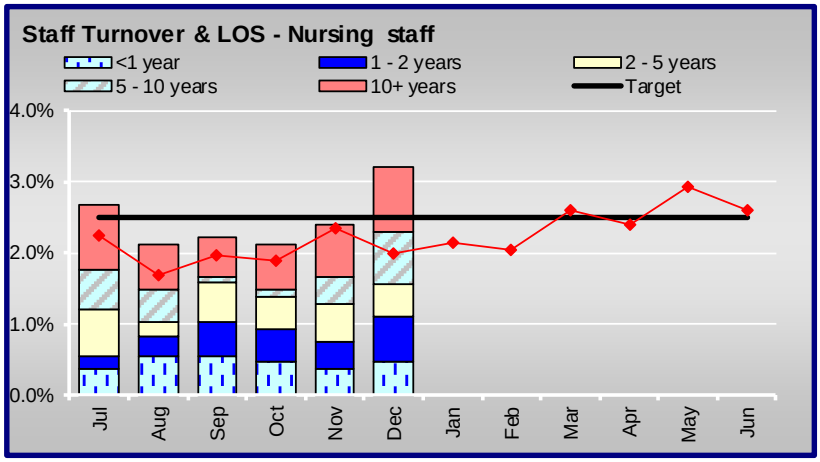
Reasons for leaving included in Staff Turnover	Quarter	Last 12 months
Moving to a position outside HBDHB	4	5
Retirement	1	5
Personal		1
Other reasons		1
Unknown reason		1
Total	**5**	**13**

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

31 Dec. 2016 – 18th lowest out of 18 DHBs (12 months ended Dec. 2016 ranked 11th lowest)

31 Dec. 2016 – 2nd lowest out of 4 mid-sized DHBs (12 months ended Dec. 2016 3rd lowest)

Staff Turnover – Nursing Staff



3 months ended Dec '16 = 3.19% which is above the target of 2.50%. See reasons below.

12 months to Dec '16 = 10.68% which is above the 10% annual target. See reasons below.

1096	Staff at 1 Oct '16
24	New Staff
(37)	Staff resignations
35	Change of status – mostly fixed term to permanent
(2)	Trf other staff group
1116	Staff at 31 Dec '16

Reasons for leaving included in Staff Turnover	Quarter	Last 12 months
Moving to a position outside HBDHB	6	22
Relocating outside HB	4	18
Retirement	12	26
Not returning from parental leave	4	10
Personal	3	5
Family reasons	0	6
Other reasons	5	15
Unknown reason	1	13
Total	**35**	**115**

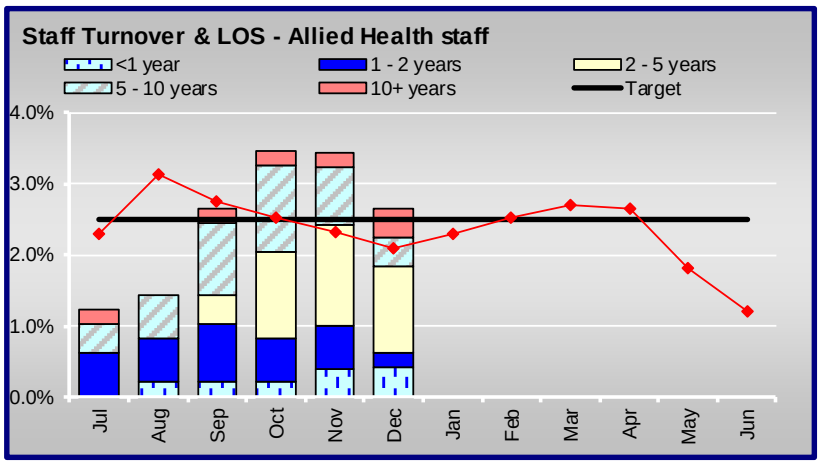
Note difference to staff resignations figure above is due to non-voluntary resignations (medical grounds, redundancy etc.)

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

31 Dec. 2016 – 17th lowest out of 18 DHBs (12 months ended Dec. 2016 ranked 9th lowest)

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

Staff Turnover – Allied Health Staff



3 months ended Dec '16 = 2.64% which is slightly above the 2.50% target. See reasons below.

12 months to Dec '16 = 9.32% which is below the 10% annual target.

492	Staff at 1 Oct '16
14	New Staff
(14)	Staff resignations
(4)	Change of status – fixed term or casual to permanent
3	Trf other staff group
491	Staff at 31 Dec '16

Reasons for leaving included in Staff Turnover	Quarter
Moving to a position outside HBDHB	5
Relocating outside HB	3
Retirement	2
Not returning from parental leave	1
Personal	2
Total	**13**

Note difference to staff resignations figure above is due to non-voluntary resignations (medical grounds, redundancy etc.)

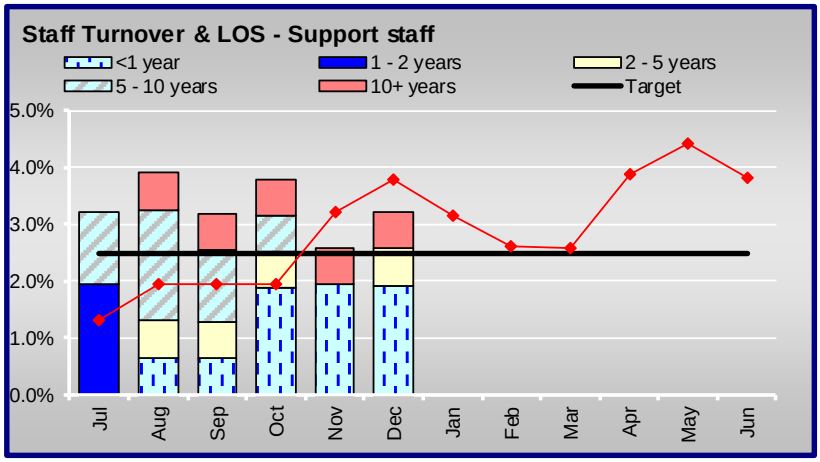
Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

31 Dec. 2016 – 13th lowest out of 18 DHBs (12 months ended Dec. 2016 ranked 3rd lowest)

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

19

Staff Turnover – Support Staff



3 months ended Dec '16 = 3.21% which is above the 2.50% target. See reasons below.

12 months to Dec '16 = 12.90% which is above the 10% annual target. See reasons below.

156	Staff at 1 Oct '16
5	New Staff
(5)	Staff resignations
1	Change of status – casual to permanent
0	Trf. other staff group
157	Staff at 31 Dec '16

Reasons for leaving included in Staff Turnover	**Quarter**	**Last 12 months**
Moving to a position outside HBDHB	2	6
Relocating outside HB		2
Retirement		1
Not returning from parental leave		1
Personal	1	2
Family reasons		1
Further education		2
Other reasons		1
Unknown reason	2	4
Total	**5**	**20**

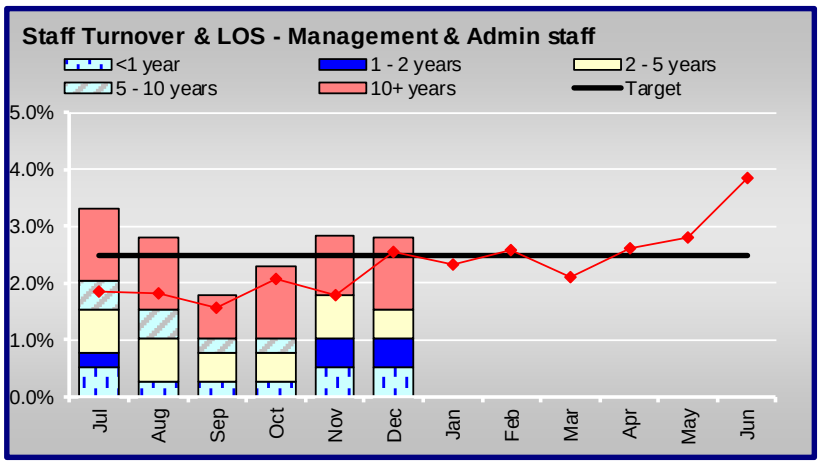
Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

31 Dec. 2016 – 16th lowest out of 18 DHBs (12 months ended Dec. 2016 ranked 13th lowest)

31 Dec. 2016 – 4th lowest out of 4 mid-sized DHBs (12 months ended Dec. 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 Dec '16 = 2.80% which is above the 2.50% target. See reasons below.

12 months to Dec '16 = 10.70% which is above the 10% annual target. See reasons below.

393	Staff at 1 Oct '16
9	New Staff
(12)	Staff resignations
2	Change of status – mostly fixed term to permanent
(1)	Trf from staff groups
391	Staff at 31 Dec '16

Reasons for leaving included in Staff Turnover	**Quarter**	**Last 12 months**
Moving to a position outside HBDHB	3	10
Relocating outside HB	1	7
Retirement	5	14
Personal	0	1
Further education	1	1
Other reasons	0	1
Unknown reason	1	7
Total	**11**	**41**

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

31 Dec. 2016 – 11th lowest out of 18 DHBs (12 months ended Dec. 2016 ranked 9th lowest)

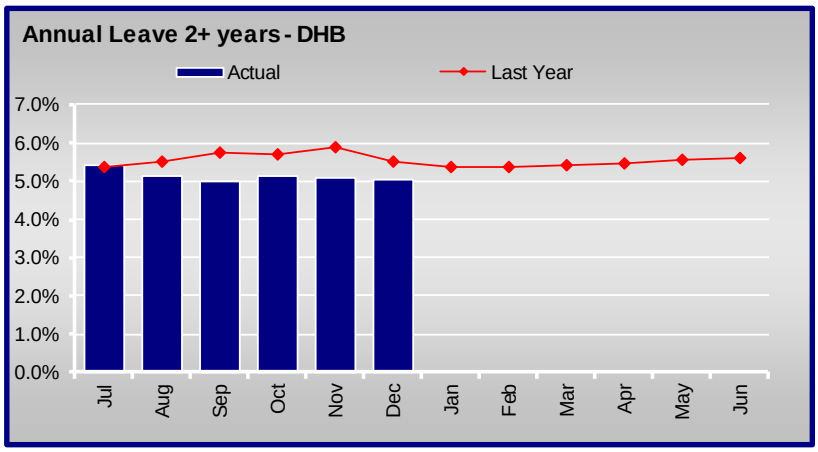
31 Dec. 2016 – 4th lowest out of 4 mid-sized DHBs (12 months ended Dec. 2016 ranked 4th lowest)

19

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%.



Dec '15 = 5.51% (140 staff)
Dec '16 = 5.04% (131 staff)
Decreased by 9.

We are the sixth best performed DHB for this KPI.

The total liability at 31 December 2016 was $18.644m compared to $18.776m at 30 June 2016. This $131k improvement is made up of:

1. $76k favourable driven by a decrease in the hours owing.
2. $55k favourable driven by a decrease in the average rates.

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 52.0% in September 2011 to 64.3% in September 2016.

	Average AL balance (hours)	% staff with an annual entitlement of 5 or more weeks Annual Leave
Dec. 2016	124.04	64.6%
Dec. 2011	117.80	52.0%

Note also that the total leave hours owed (includes statutory lieu leave etc.) and average leave balance is less than this time last year:

	Total Hours Owed	Employees with leave balance	Average Leave balance (hours)
Dec. 2016	444,839	2602	170.96
Dec. 2015	446,198	2542	175.53

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

31 Dec. 2016 – 6th lowest out of 18 DHBs (Dec. 2015 – 7th lowest of 20 DHBs)

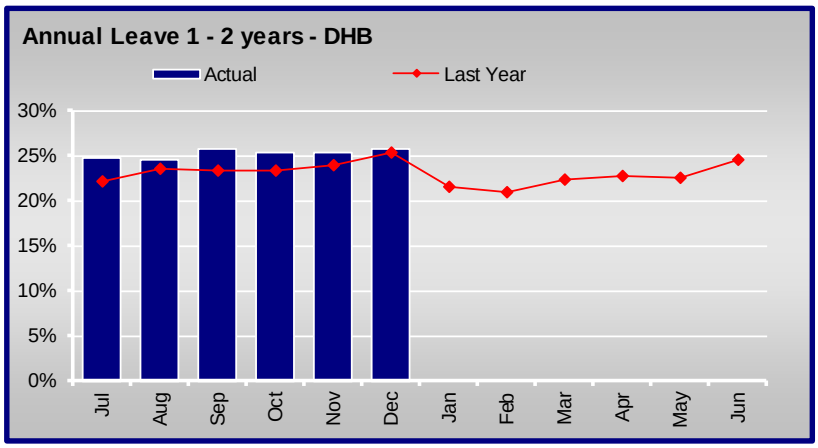
31 Dec. 2016 – 3rd lowest out of 4 mid-sized DHBs (Dec. 2015 – 4th lowest of 6 DHBs)

31 Dec. 2016 – 2nd lowest of 5 Central Region DHBs (Dec. 2015 – 3rd lowest of 6 DHBs)

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%.



Dec '15 = 25.25% (641 staff)
Dec '16 = 25.63% (666 staff)
Increased by 25

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

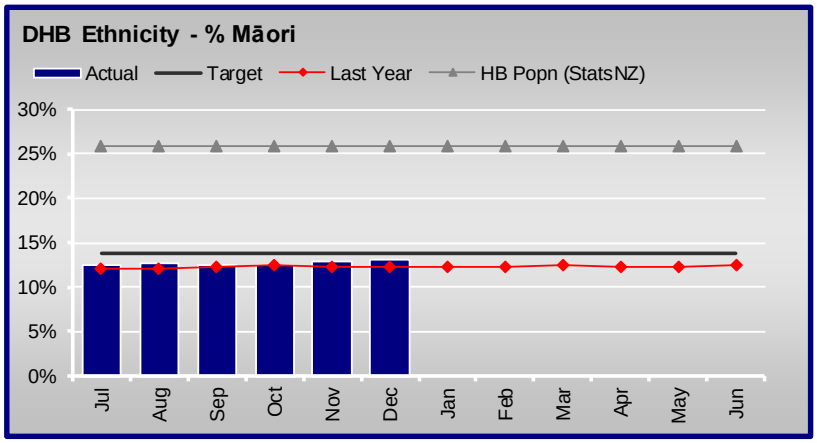
19

Staff Ethnicity

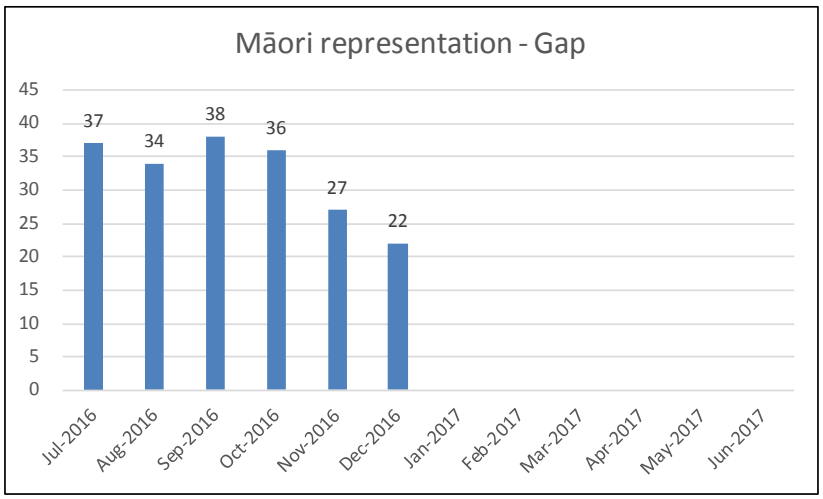
Measure the number of positions at HBDHB where the incumbents identify themselves as Māori

Target is set at 10% improvement on previous year. 2016/17 target = 13.75%. The Māori population for HB is 25.9%

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 December 2011 the percentage of Māori staff was 8.8% compared to 13.0% at 31 December 2016.



Māori staff representation in the Workforce:

	People	Positions
Dec. '16	13.43%	13.02%
Dec. '15	12.61%	12.26%

December 2016 breakdown:

	Positions filled	% of Total
NZ & European	2228	74.97%
Maori	387	13.02%
Pacific Islands	30	1.01%
Other	256	8.61%
Not known	71	2.39%
Total	**2972**	

Support staff (28.19%) and Management & Admin staff (17.20%) exceed the DHB target.

Allied Health (13.51%) Medical (4.15%) and Nursing staff (11.32%) are below the target.

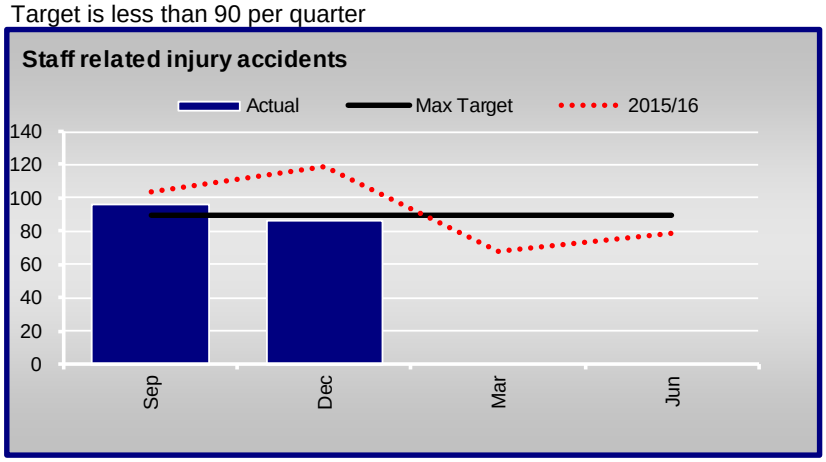
The gap to our target sits at 22 at 31 December 2016.

375	Māori Staff - 1 Oct. '16
30	New Staff
(18)	Staff resignations
0	Changes to ethnicity
387	Māori Staff – 31 Dec. '16

Occupational Health & Safety KPIs

Staff related injury accidents reported

Workplace injuries reported.
Target is less than 90 per quarter



Total for the quarter = 86
October = 32
November = 30
December = 24

Percentage of total staff by quarter:

Dec. '16	2.9%
Compared to: Dec. '15	4.1%

Of the 86 for the June quarter:

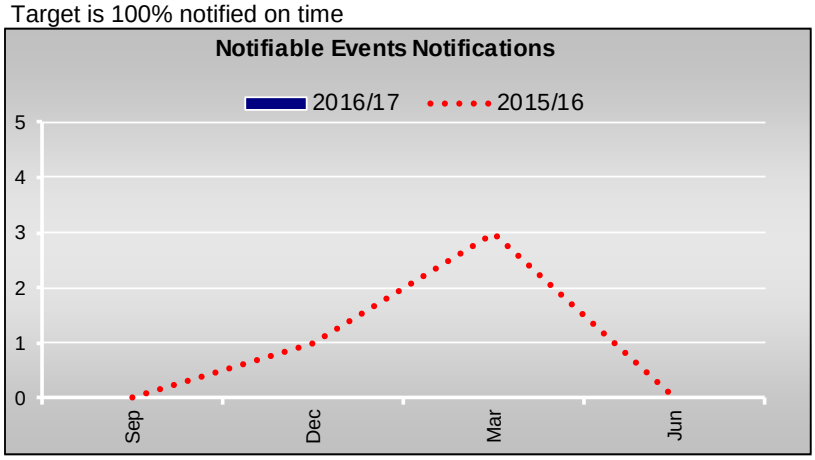
- 22 back injuries/ sprain/ strain
- 16 cuts/ bruises/ lacerations/ burns
- 14 needlestick injuries and exposure to blood and body fluids
- 34 remaining included concussion, dislocation, graze/ abrasion, gradual onset and fracture.

None of the above were notified to Work Safe NZ as a notifiable event.

Notifiable Events

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



There were no notifiable events reported for the quarter.

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Performance Framework Exceptions Quarter 2 (Oct-Dec 2016)** 11 **HBDHB Quarterly Performance Monitoring Dashboard Quarter 1 (Jul-Sept 2016)**
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Tim Evans, Director of Finance and Information Peter Mackenzie, Operational Performance Analyst
Reviewed by:	Executive Management Team
Month:	February 2017
Consideration:	Monitoring

RECOMMENDATION

That the HBDHB 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 December 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) 2016/2017

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) 2016/17
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 2016/17	Target 2016/17
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

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PERFORMANCE HIGHLIGHTS

Achievements

- Shorter Stays in ED. Patients waiting less than 6 hours in ED is favourable to target this quarter at 94.7% (rounded up to 95%). This is an increase of 2.3% over the previous quarter.

- Immunisation at 8 months. We have achieved target for the total population at 95.3%. Maori is currently at 94.4% against a target of 95%

- Fall Assessments. We have achieved the target for the number of fall assessments carried out 96.7% and the number of patients at risk who have been given a fall prevention plan 98% for the second successive quarter.

Areas of Progress

- Raising Health Kids. This is a new Health Target set by the Ministry of Health for 2016/17. We are currently at 40% against a target of 95%. This is up from 21% in the previous quarter. We have seen similar increase in both Maori and Pacific Rates (page 6).

- Secondary mental health service utilisation target was achieved for Total and Maori across the age groups (0-19, 20-64) but was slightly under the target for the age group 65+. This quarter the result was 1.12% against the target of 1.15% (page 7).

- Mental Health – Transition Plans. The result has increased to 92.5% and is expected to achieve the target of 95% by next quarter (page 8).

- DNA Rates – Overall the DHB has a favourable result for DNA at 6.7% against a target of <7.5%. Maori rates are unfavourable to target but have improved over last quarter by 1.2% to 14.2% (page 16).

Areas of Focus

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

- Faster Cancer Treatment. The result for patients treated within 62 day has decreased 0.2% to 65.4% this quarter. The number of patients identified as at high risk has also decreased slightly over the quarter but is still favourable to its target of 100%. (page 5).

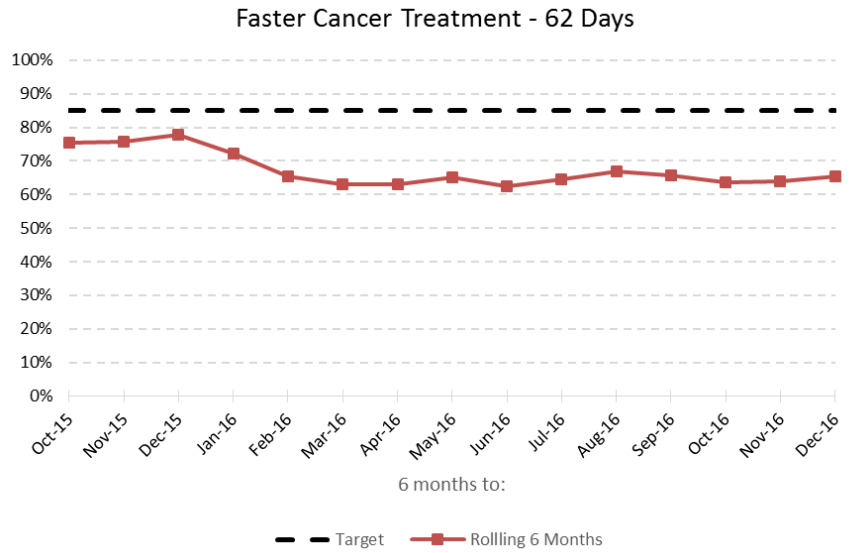
- Diabetes. The total population 46.2% and Maori rate 39.3% are unfavourable to target 55% (page 10).

- Cervical Screening. There has been little or no change in the cervical screening rates and the total rate is 76.7% against a target of 80% (page 13).

DIMENSION 1 – ACHIEVING GOVERNMENT PRIORITIES AND TARGETS

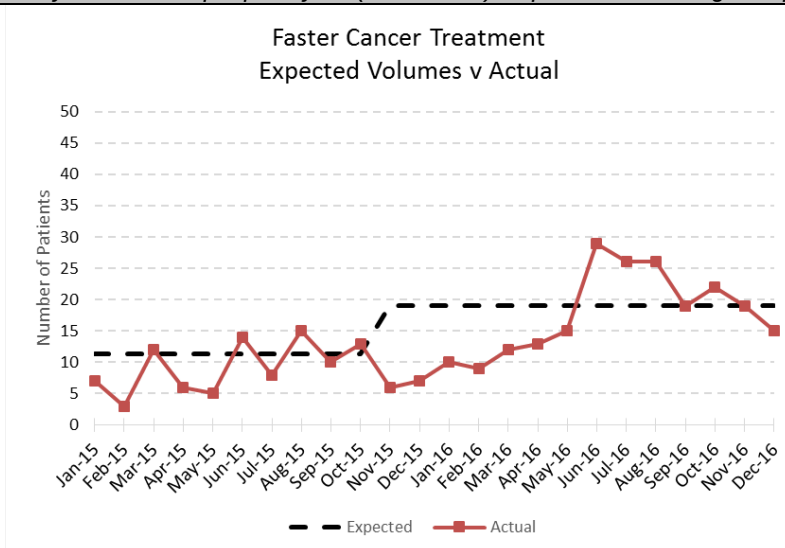
Health Target: Faster Cancer Treatment
Patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer

Key Performance Measures	Baseline [1]	Previous result [2]	Actual to Date [3]	Target 2016/17	Trend direction
Total	77.6%	65.6% (U)	65.4% (U)	≥85%	▼



Comments:
Internal standard reporting commenced for MDM access for the NHIs submitted for the health target. The December result indicates that 50% of those patients identified with a HSC (high suspicion of cancer) attended MDM within 28 days of their hospital referral. A new ECA module is enabling improved tracking of referrals prioritised with HSC. The challenge continues with identification of the HSCan at the referral prioritisation stage.

Based on the expected annual cancer registrations for the DHB supplied by the Ministry, the DHB is expected to identify at least 228 people a year (19 a month) as patients with a high suspicion of cancer.



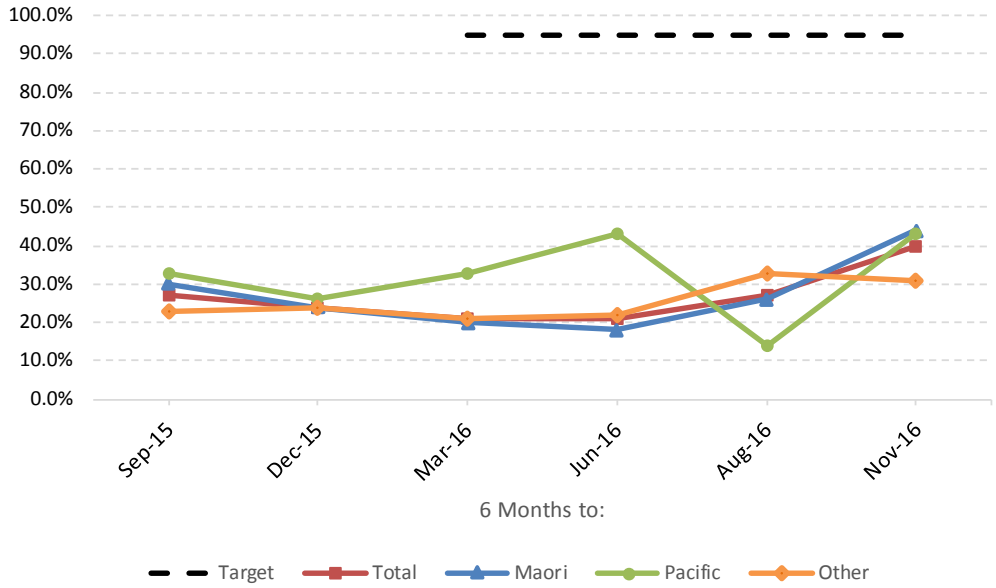
1 6 *months to December 2015*

2 *6 months to September 2016*

3 *6 months to December 2016*

Health Target: Raising Healthy Kids
95 percent of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

Key Performance Measures	Baseline [4]	Previous result [5]	Actual to Date [6]	Target 2016/17	Trend direction
Total	27.0%	27% (U)	40% (U)	≥95%	▲
Māori	30.0%	26% (U)	44% (U)	≥95%	▲
Pacific	33.0%	14% (U)	43% (U)	≥95%	▲
Other	23.0%	33% (U)	31% (U)	≥95%	▼



Source: Ministry of Health

This is a new Health Target introduced by the Ministry of Health for the 2016/17 year. The target is 95% by June 2017 and has been included in the exceptions report as a way of monitoring progress over the financial year.

Comments:
We continue to have data issues with children from the pre target period still included in the second quarter data. However there has still been a significant increase from quarter 1-2 for Maori (18%). All children are given advice and support on nutrition, activity and lifestyle interventions and referral to GP by the practise nurse. We will continue to embed process and monitor progress of this indicator.

4 *6 months to December 2013. Source: DHB Shared Services*

5 *6 months to June 2016. Source: DHB Shared Services*

6 *6 months to November 2016. Source: DHB Shared Services*

Improving the health status of people with severe mental illness through improved access (PP6)					
Key Performance Measures	**Baseline** [7]	**Previous result** [8]	**Actual to Date** [9]	**Target 2016/17**	**Trend direction**
0-19 years – Child and Youth					
Total	4.1%	4.28% (F)	4.26% (F)	≥4%	▼
Māori	4.6%	4.93% (F)	4.92% (F)	≥4%	▼
Pacific	3.0%	2.4% (U)	2.14% (U)	≥4%	▼
Other	3.7%	3.83% (F)	3.79% (U)	≥4%	▼
20-64 years – Adults					
Total	4.9%	4.98% (F)	5.11% (F)	≥5%	▲
Māori	8.8%	8.87% (F)	9.26% (F)	≥5%	▲
Pacific	3.0%	2.4% (U)	2.14% (U)	≥5%	▼
Other	3.8%	3.8% (U)	3.83% (U)	≥5%	▲
65+					
Total	1.0%	1.09% (F)	1.12% (U)	≥1.15%	▲
Māori	1.0%	1.17% (F)	1.19% (F)	≥1.15%	▲
Pacific	1.0%	0.65% (F)	1.0% (U)	≥1.15%	▲
Other	1.1%	1.08% (F)	1.1% (U)	≥1.15%	▲
Comments: It is pleasing to see we are achieving target in the 0-19 and 20-64 age groups for both Total and Maori populations. 65+ has seen an improvement over the previous quarter and has increase by 0.3%, this specific age group is not reaching target due to a number of issues including mortality, social issues. Work continues to improve rates and we expect to be closer to the target next quarter.					

7 12 months to September 2011

8 12 months to March 2016

9 12 months to September 2016

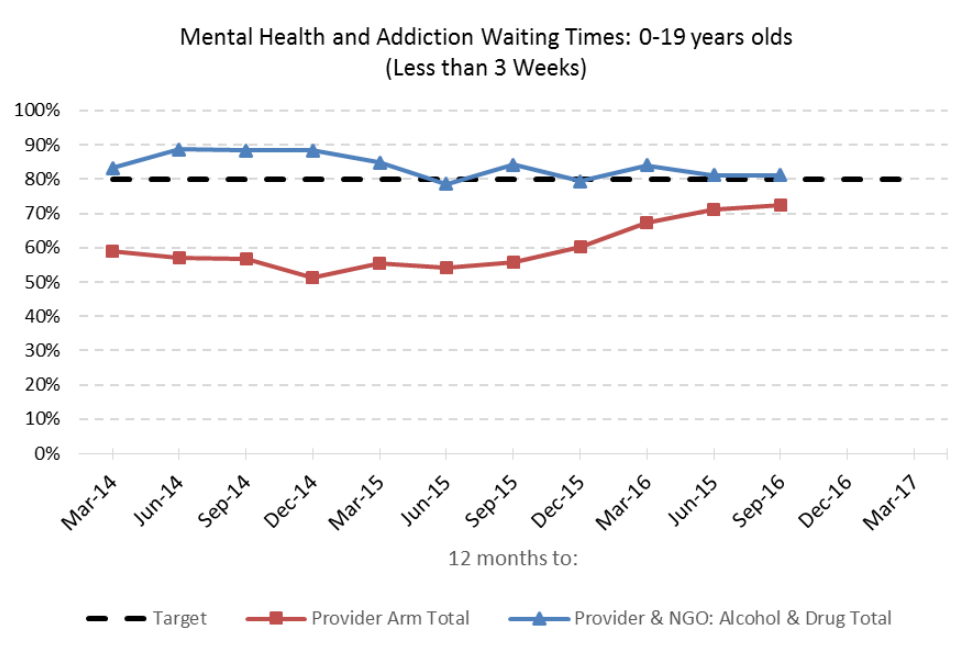
Improving mental health services using transition (discharge) planning (PP7)					
Key Performance Measures	**Baseline** [10]	**Previous result** [11]	**Actual to Date** [12]	**Target 2016/17**	**Trend direction**
Total	-	-	92.5%	≥95%	▬
A new definition was provided for 2016/17, a time series will provdied when more data becomes available.					
Comments: With the new definition our results are much improved over previous quarters however the data covers a 12 months period and it is results from Feb, Mar, and April 2016 which are bringing down the total. Changes to the process early in 2016 have meant for the last 8 months we have been achieving target consistently and we expect by next quarter that we will be reaching target overall.					

10 January 2015 to December 2015.

11 April 2015 to March 2016.

12 July 2015 to June 2016..

Shorter waits for non-urgent mental health and addiction services (PP8): Mental Health Provider Arm					
Key Performance Measures	**Baseline [13]**	**Previous result [14]**	**Actual to Date [15]**	**Target 2016/17**	**Trend direction**
Mental Health Provider Arm: Age 0-19 < 3 Weeks					
Total	60.1%	71.2% (U)	72.3% (U)	≥80%	▲
Maori	63.2%	70.6% (U)	74.1% (U)	≥80%	▲
Pacific	75.0%	72.7% (U)	68.4% (U)	≥80%	▼
Other	56.9%	71.3% (U)	71.1% (U)	≥80%	▼
Addictions (Provider Arm & NGO): Age 0-19 < 3 Weeks					
Total	84.2%	81.2% (F)	81.1% (F)	≥80%	▼
Maori	90.5%	81.6% (F)	80.5% (F)	≥80%	▼
Pacific	-	-	-	≥80%	*
Other	61.5%	80% (F)	83.9% (F)	≥80%	▲
Mental Health Provider Arm: Age 0-19 < 8 Weeks					
Total	81.5%	91.2% (U)	91.7% (U)	≥95%	▲
Maori	86.5%	91.7% (U)	93.6% (U)	≥95%	▲
Pacific	91.7%	90.9% (U)	94.7% (F)	≥95%	▲
Other	85.3%	90.6% (U)	90% (U)	≥95%	▼
Addictions (Provider Arm & NGO): Age 0-19 < 3 Weeks					
Total	99.5%	92.8% (U)	94.6% (F)	≥95%	▲
Maori	100.0%	91.7% (U)	93.6% (U)	≥95%	▲
Pacific	-	-	-	≥95%	*
Other	92.3%	93.3% (U)	96.8% (F)	≥95%	▲



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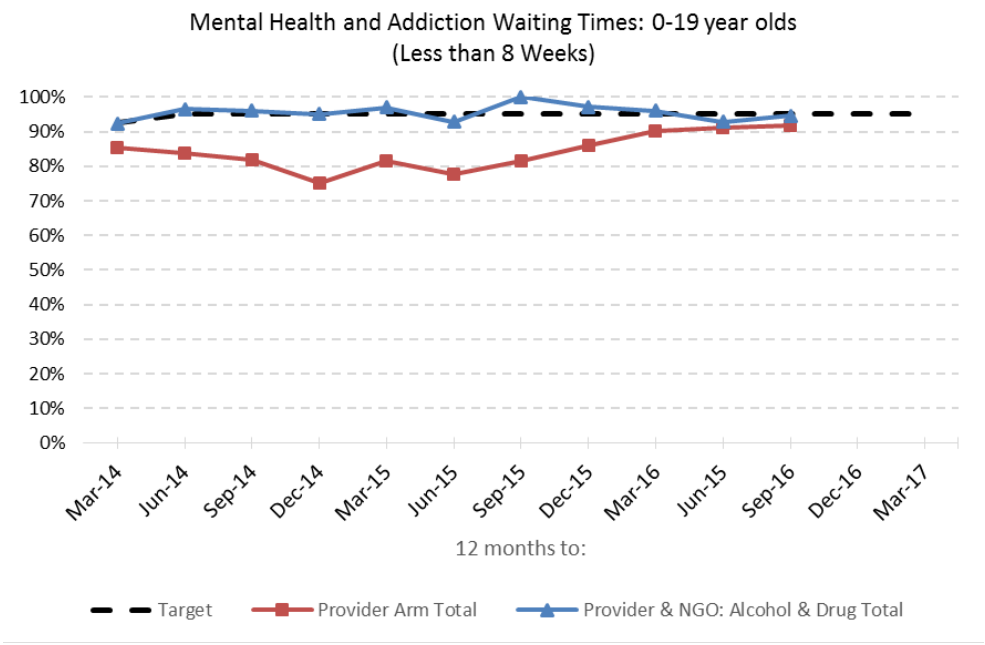
[13] 12 months to December 2015

[14] 12 months to March 2016

[15] 12 months to June 2016



Source: Ministry of Health

Comments:
There are currently several steps undertaken to reduce wait times including having referral meeting's 3 times a week, designated clinician phone referreral with parents the morning of receiving the referral and having the appointment calendar in front of you so clients can arrange a time then and there. In Addition we also Email CAPA and Clinicians so they are aware of referral and a letter can be sent out of confirmation immediately although if the appointment is for the next few days we don't send a letter. Other initiatives included appointments made to suit the family /child for example schools, homes, medical centres and NGO's and the Introduction of Back up Duty/Choice slots daily so clients can be seen that day if needed. Ongoing review of wait times is also occurring via regular reporting, which is informing further strategies.

Improved management for long-term conditions (CVD, Diabetes and Stroke) (PP20) – Diabetes Management
People aged 15-74 with a HbA1c equal to or less than 64mmols

Key Performance Measures	Baseline [16]	Previous result [17]	Actual to Date [18]	Target 2016/17	Trend direction
Total	41..4%	47.3% (U)	46.2% (U)	≥55%	▼
Māori	37.8%	38.8% (U)	39.3% (U)	≥55%	▲
Pacific	45.5%	79.2% (F)	79.2% (F)	≥55%	—
Other	60.7%	65.7% (F)	65.4% (F)	≥55%	▼

Comments:
HHB (Health Hawkes Bay) have formalised DCIP with all general practices (with the exception of one due to not delivering to this programme). The DCIP have required a greater focus on clinical leadership within each practice, and provision of systematic follow up of patients respective of need. This has included a requirement to have a process in place for prioritising education and at least annual follow for patients with pre-diabetes. This will be further supported as PIPI (Pre-diabetes Intervention programme) that is scheduled to roll out in March 2017. New reporting has been developed by HIT team that shows HbA1c: %HbA1c< 64mmols: HbA1c >65mmols-<80mmols: HbA1c >81mmols-<100mmols: %HbA1c >101. This has been drilled to individual practice level and provides an opportunity to target those with increased risk factors. HHB have shared commitment with HBDHB to implement Service Review Matrix with a diabetes focus to utilise structure and methodologies to effect change. This is likely to be implemented in Quarter 3 if overall intent of the framework is supported.

16 *12 months to December* 2015

17 *12 months to September 2016*

18 *12 months to December 2016*

Key Performance Measures	Baseline [19]	Previous result [20]	Actual to Date [21]	Target 2016/17	Trend direction
Reducing Rheumatic fever (PP28)					
Total	0.6	1.86 (U)	2.48 (U)	≤1.5	▼
Maori	2.48	7.3 (U)	7.3 (U)	≤1.5	▬
Pacific	-	16.47 (U)	16.47 (U)	≤1.5	▬
Comments: There have been 2 meetings this quarter, the Housing Coalition members have updated the HB Housing Profile, developed a tenancy training package, distributed warm dry home resources and support retrofit insulation programmes. Pacific and Māori portfolio managers are in the process of contracting to community providers to enhance community engagement. The key parties meeting monthly to focus on campaign to get Rheumatic Fever messages out before winter 2017.					

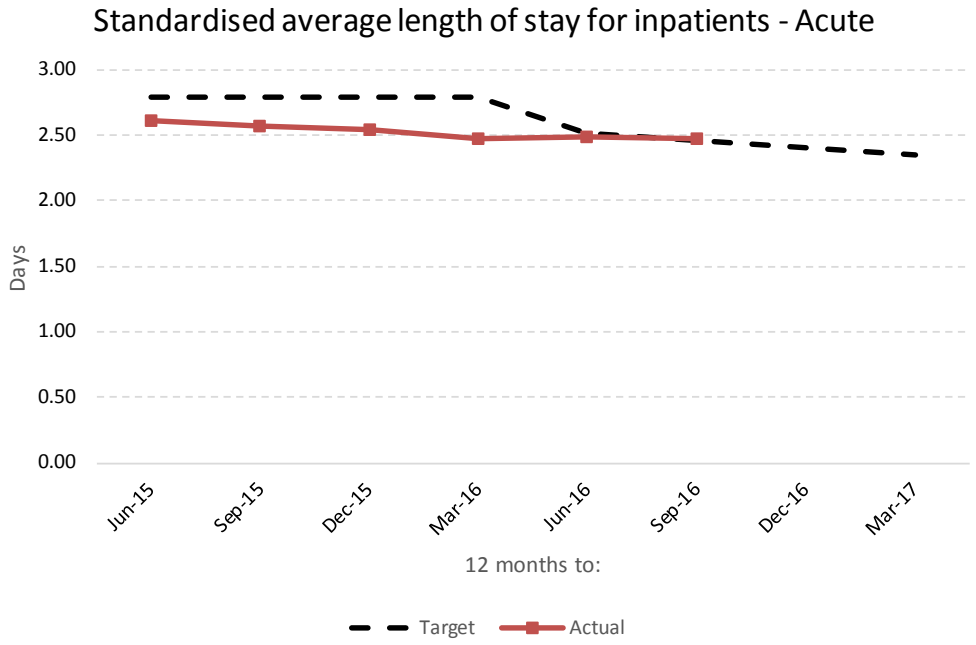
19 October to December 2012.

20 July 2015 to June 2016 (12 month data)

21 July to September 2016 (3 month data)

DIMENSION 3 – OWNERSHIP

Inpatient Average Length of Stay (ALOS) - Acute (OS3)					
Key Performance Measures	**Baseline** [22]	**Previous result** [23]	**Actual to Date** [24]	**Target 2015/16**	**Trend direction**
Days	2.55	2.49 (U)	2.48 (U)	≤2.46	▲



Source: Ministry of Health

NOTE: The definition of this indicator has been updated and now includes day cases

Comments:

Ongoing work continues to reduce acute average length of stay as part of the 4000 Bed Day Project, being facilitated by QIPS and the AAU FLOW project being led by FGI and the Medical Directorate. Key areas include ensuring early senior decision making, criteria based discharging (CBD) and patients having an estimated date of discharge (EDD). There is also work underway to expand the hours the SMO is present in AAU. This will support early senior decision making and ensure every patient has a plan of care in place early in their admission ultimately resulting in increased 0 day discharges. As part of the 4000 day project, work is currently underway in AAU and Ward A1 in relation to CBD and EDDs, with the intention to roll-out across other areas in coming months.

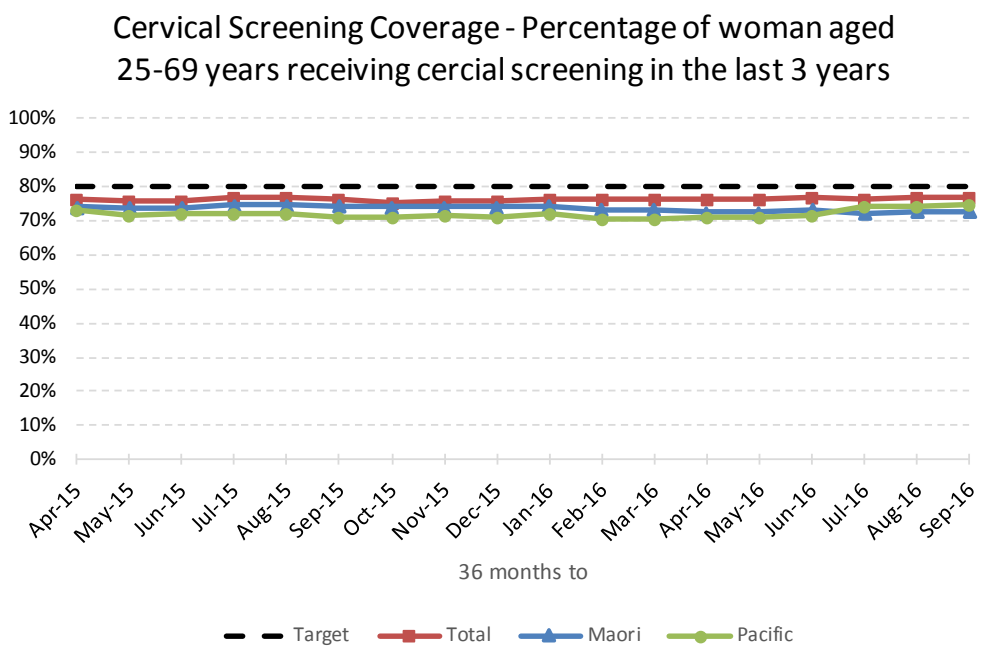
22 12 months to December 2014

23 12 months to December 2015. Source: Ministry of Health

24 12 months to March 2016. Source: Ministry of Health

DIMENSION 4 – SERVICE PERFORMANCE

Percentage of women aged 25-69 years receiving cervical screening in the last 3 years					
Key Performance Measures	**Baseline** [25]	**Previous result** [26]	**Actual to Date** [27]	**Target 2016/17**	**Trend direction**
Total	75.8%	76.9% (U)	76.7% (U)	≥80%	▼
Māori	74.1%	72.7% (U)	72.8% (U)	≥80%	▲
Pacific	71.2%	74.2% (U)	74.8% (U)	≥80%	▲
Other	76.5%	78.2% (U)	78.9% (U)	≥80%	▲



Source: National Screening Unit

Comments:

Although we continue to rank high in coverage out of the 20 DHBs in the country for our Maori women, the increase in coverage is slow, due to the decrease in smears of 28% on Maori women in the last 6 months compared to the same time in 2015.

We are now working in collaboration with Totara Health, our Kaiawhina is supporting nurse smear takers from the practice taking smears in the community, this initiative began late November 2016. We may increase to two days a week when the vacant position for the Pacific Community Support worker is filled. Providing smears in the community is intensive and requires significant time to engage and encourage the women to been screened, but we are encouraged with the feedback received from the women who tell us 'they have only had the smear because it was offered to them in the home'.

25 36 months to 31 December 2015. Source: National Screening Unit

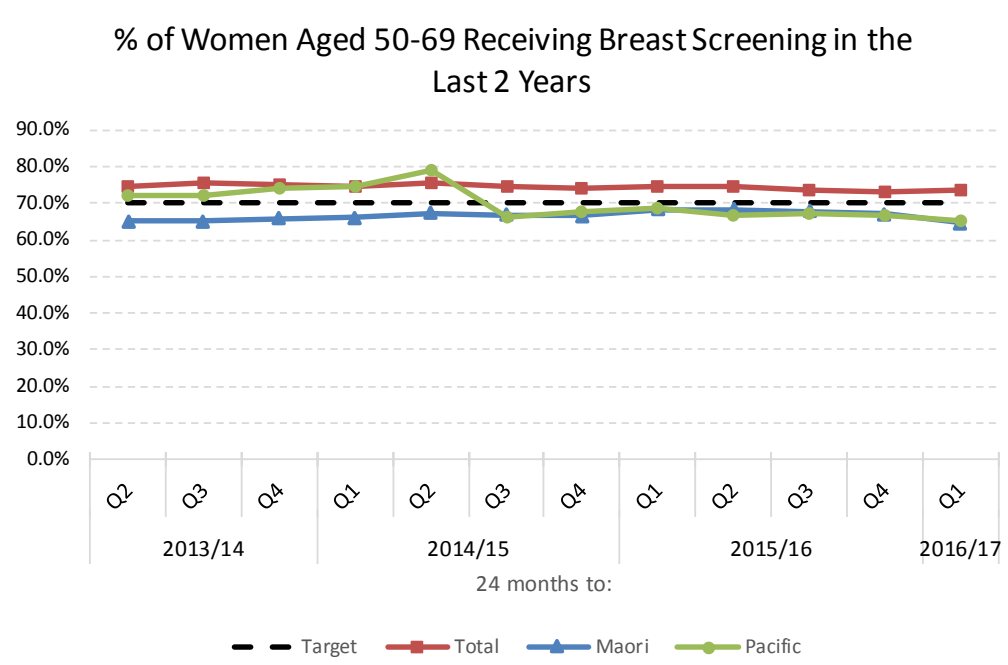
26 36 months to 31 August 2016. Source: National Screening Unit

27 36 months to 30 September 2016. Source: National Screening Unit

PREVENTION SERVICES – POPULATION BASED SCREENING SERVICES

Percentage of women aged 50-69 years receiving breast screening in the last 2 years

Key Performance Measures	Baseline [28]	Previous result [29]	Actual to Date [30]	Target 2015/16	Trend direction
Total	74.7%	73.2% (F)	73.6% (F)	≥70%	▲
Māori	68.4%	67.1% (U)	64.7% (U)	≥70%	▼
Pacific	66.5%	66.6% (U)	65.4% (U)	≥70%	▼
Other	76.0%	74.5% (F)	75% (F)	≥70%	▲



Source: Breast Screen Coast to Coast

Comments:

We are continuing to work with GP practices to improve participation of NCSP priority group women in screening e.g. Best Practice in Primary Care project and contacting Māori and Pacific women who have never had a cervical smear or have not. We've developed a referral process for General Practice to refer our Priority women who are 5years and overdue to our ISP's via Population Screening Team, this will roll out in early 2017. We are ensuring accuracy of participant ethnicity data held on National Cervical Screening Programme Register and ethnicity data on NHI.

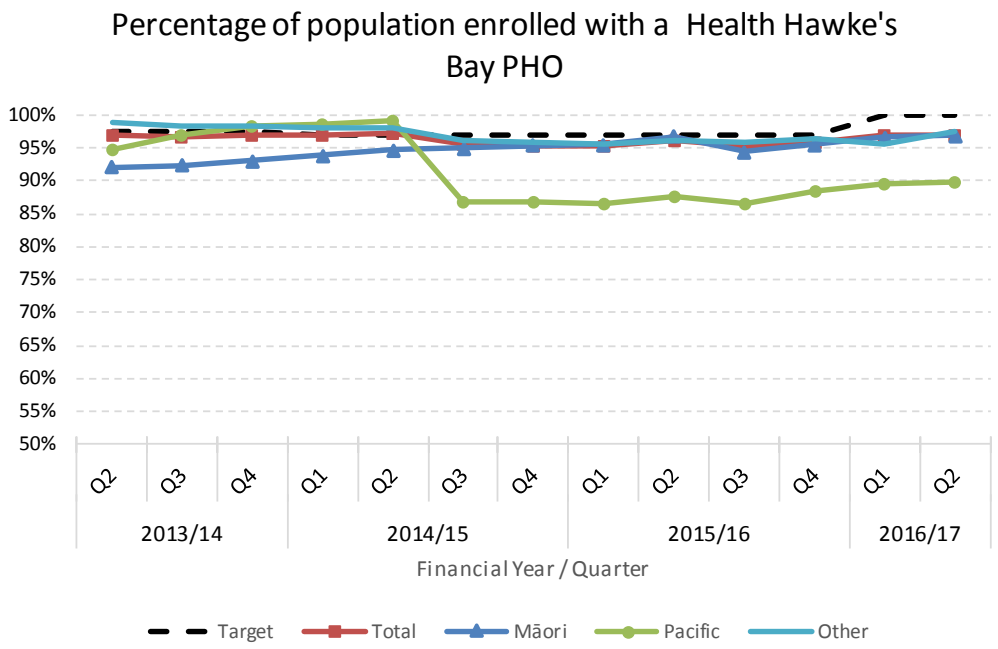
Recent population projections released by the National Screening Unit show that in the next five years (2016-2021) Hawke's Bay's NCSP eligible Māori and Pacific populations will increase by 7% and the Asian population will increase by 16%. A challenge for the sector.

28 24 months to December 2014. Source: Breast Screen Coast to Coast

29 24 months to June 2016. Source: Breast Screen Coast to Coast

30 24 months to September 2016 . Source: Breast Screen Coast to Coast

Proportion of the population enrolled in the PHO					
Key Performance Measures	**Baseline** [31]	**Previous result** [32]	**Actual to Date** [33]	**Target 2016/17**	**Trend direction**
Total	96.4%	97% (U)	97.1% (U)	≥100%	▲
Māori	97.2%	96.6% (U)	96.8% (U)	≥100%	▲
Pacific	88.7%	89.6% (U)	89.8% (U)	≥100%	▲
Other	96.5%	97.4% (U)	97.5% (U)	≥100%	▲



Source: Ministry of Health

Comments:
Although the enrolment percentage this quarter appears to be low there has been a slight increase for the 3rd successive quarter. The HN Enrolment programme is still available for those consumers who are not enrolled to become enrolled and receive a 45 minute health assessment with a nurse and 15minute doctor consultation. HHB (Health Hawkes Bay) will continue to promote the programme to encourage enrolment with HHB General Practices.

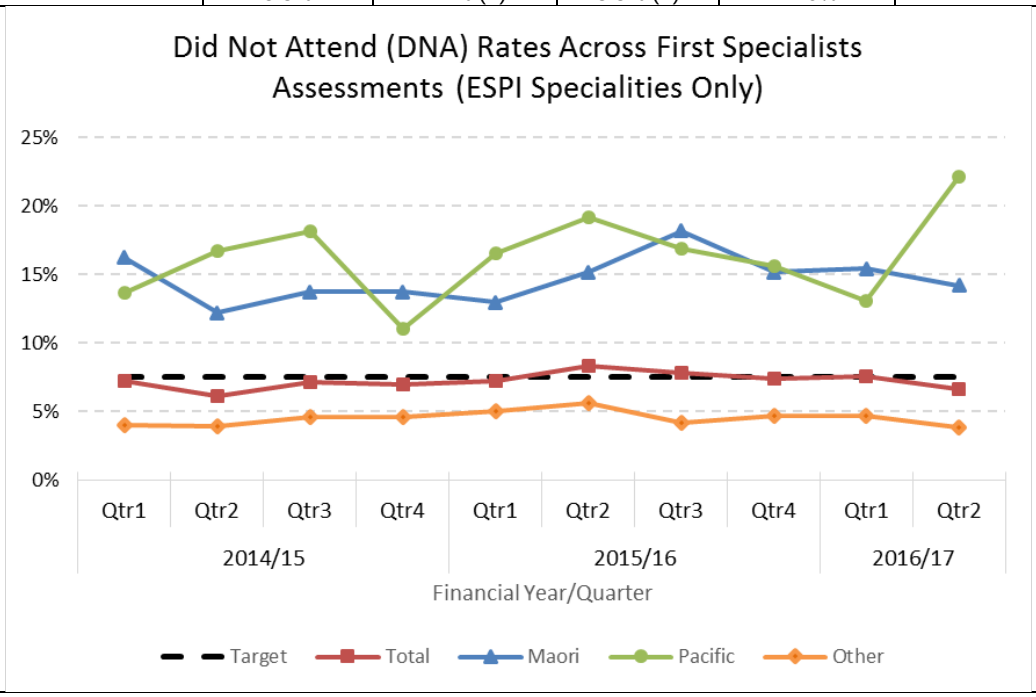
20

31 October to December 2015.

32 July to September 2016.

33 October to December 2016.

Did not attend (DNA) rate across first specialist assessments[34]					
Key Performance Measures	**Baseline** [35]	**Previous result** [36]	**Actual to Date** [37]	**Target 2016/17**	**Trend direction**
Total	8.1%	7.5% (F)	6.7% (F)	≤7.5%	▲
Māori	14.9%	15.4% (U)	14.2% (U)	≤7.5%	▲
Pacific	18.3%	13% (U)	22.1% (U)	≤7.5%	▼
Other	5.3%	4.7% (F)	3.8% (F)	≤7.5%	▲



Comments:
Work continues to pilot preventative DNA processes across the three specialties. Despite the busy holiday period and RMO strikes, the process seems to be working, with good communication between the Kaitakawaenga's and the Outpatient Booking team and monitoring of progress and results continue.

What is evident following the above close monitoring of DNA patients over the last Quarter, is that there are inconsistencies across the DHB with following DNA policy, and adhering to the agreed DNA tracing process, particularly with Maori patients. CFB (customer focused booking) is currently looking into an initiative of how to remind and re-educate all staff of HBDHB's expectations of managing patients who DNA, with particular emphasis on managing Maori DNA patients. This will help to ensure the Kaitakawaenga's are notified / introduced to the process at appropriate times so they can make a difference, particularly with reducing re-occurring DNA's amongst our Maori population.

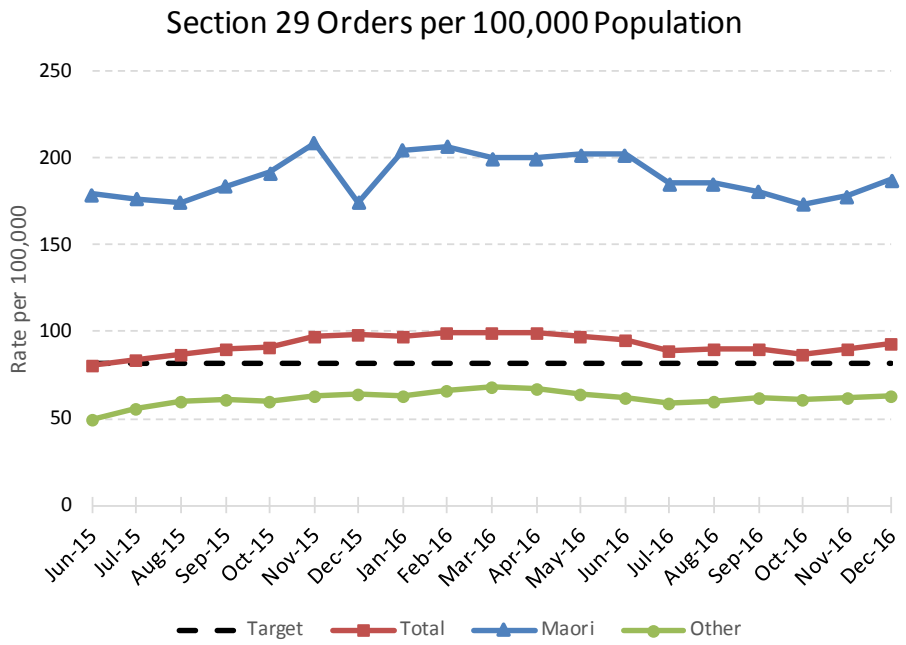
34 *ESPI specialities only*

35 *October to December 2015*

36 *July to September 2016*

37 *October to December 2016*

Rate of Section 29 orders per 100,000					
Ethnicity	**Baseline [38]**	**Previous result [39]**	**Actual to Date [40]**	**Target 2016/17**	**Trend direction**
Total	97	90.1 (U)	89.1 (U)	≤81.5	▲
Māori	196	183.9 (U)	179.9 (U)	≤81.5	▲
Other	93.4	60.1 (F)	62.1 (F)	≤81.5	▼



Comments:
The inequity in this measure remains evident. The wananga that was signalled in the last quarterly report was held in December and attracted a wide range of stakeholders who reflected on their experiences in respect of contributory factors to the high rate of CTOs (compulsory treatment orders) amongst Maori.
The key outcome from the wananga was a renewed commitment to work together across the sector to understand and address the underlying contributory factors. This includes: engaging whānau through the home-based treatment team; communication through the central coordination service for all providers; implementation of the intensive day treatment programme; reduction of restrictive care practices; increasing group interaction options in the community; and more referral and liaison with community providers.

20

38 *October to December 2015*

39 *July to September 2016*

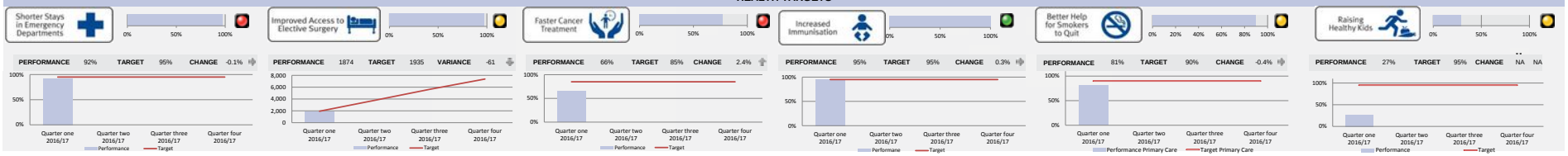
40 *October to December 2016*

MINISTRY OF HEALTH
MANATŪ HAUORA

Hawke's Bay DHB performance monitoring report quarter one 2016/17

Monitoring Status Standard Monitoring

HEALTH TARGETS



IMPROVING SYSTEM INTEGRATION

Service Reconfiguration

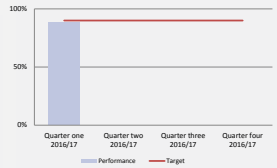
The DHB continues to invest in transforming primary and community services. We look forward to specific timeframes for their Transform & Sustain Programme in quarter two.

System Level Measures

Improvement Plans

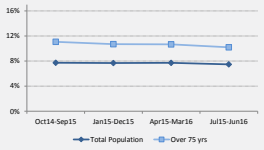
Ambulatory sensitive hospitalisations per 100,000 for 0-4 years old	NA
Acute hospital bed days per capita	NA
Patient experience of care	NA
Amenable mortality rates	NA

More Heart and Diabetes Checks

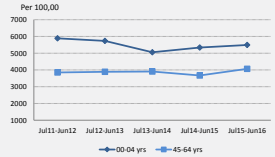


OWNERSHIP VIEW

Acute Readmission Rates (standardised)



Ambulatory Sensitive Hospitalisation Rates



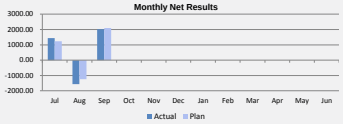
FINANCIAL MANAGEMENT

Financial Performance Rating: Needs Watching

NET RESULT: YTD-Sep 2016

Actual	1,895	Plan	2,098	Variance	(203)

Monthly Net Results



PROGRESS AGAINST LOCAL ACTIONS AS DEFINED IN THE DHB ANNUAL PLAN

IMPROVED MANAGEMENT FOR LONG TERM CONDITIONS

- Improved management for long term conditions
- Improved management for diabetes services
- Improved management for acute heart services
- Improved management for stroke services

IMPROVING WRAP AROUND SERVICES – HEALTH OF OLDER PEOPLE

Immunisation Coverage

	Goal	Performance	
Immunisation coverage at 2 and 5 years of age			
Immunisation coverage at 2 years of age	95%	96%	
Immunisation coverage at 5 years of age	95%	92%	
Human papillomavirus immunisation	65%	NA	NA

WAITING TIMES

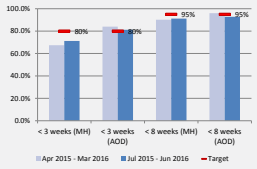
Diagnostic waiting times

	Goal	Performance
Coronary angiography (<90 days)	95%	100.0%
Radiology		
CT Scan (<42 days)	95%	87.4%
MRI Scan (<42 days)	85%	52.8%

	Goal	Performance
Colonoscopy		
Urgent colonoscopy (<14 days)	85%	93.0%
Non-urgent colonoscopy (<42 days)	70%	97.6%
Surveillance colonoscopy (<84 days)	70%	94.6%

Mental Health

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



Patients Waiting For FSA and Treatment

PATIENTS WAITING FOR FSA

	Jul	Aug	Sep	last mnth	3 mnths
ESPI 2	4	26	36	10	32
ESPI 2 %	0.1%	0.8%	1.1%	0.3%	1.0%

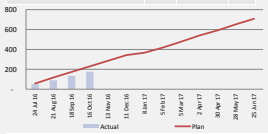
PATIENTS WAITING FOR TREATMENT

	Jul	Aug	Sep	last mnth	3 mnths
ESPI 5	34	33	22	-11	-12
ESPI 5 %	3.1%	3.0%	2.0%	-1.0%	-1.2%

Regional Provision Cardiac Surgery Delivery

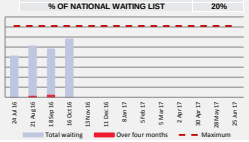
REGIONAL DELIVERY - CAPITAL & COAST DHB OF SERVICE

PERFORMANCE AGAINST PLAN	77%	VARIANCE	-54



WAITING LIST - CAPITAL & COAST DHB OF SERVICE

TOTAL REGIONAL WAITING LIST	58
% OF NATIONAL WAITING LIST	20%



SERVICE COVERAGE DELIVERY NA

Not reported in quarter one

REGIONAL SERVICE DELIVERY

Quarter one 2016/17

Overall Performance

National Priorities

- Cancer Services
  - Regional workplan delivery
  - Support for faster cancer treatment health target
- Cardiac Services
- Health of Older People
- Elective Services
- Stroke Services
- Mental Health and Addictions
- Major Trauma N/A
- Hepatitis C

Information Technology Critical Priorities

- Medicines Management -ePA N/A
- Clinical Workstation (CWS) and Clinical Data Repository (CDR)
- Replacement of legacy Patient Administration Systems (PAS)
- National Patient Flow

Health Workforce Regional Actions against Workforce Plan

Regional Quality and Safety

Regional Performance Highlights

There have been slight changes to the rating of national priorities, with the addition of two sub-ratings for the programmes in Cancer Services as well as the addition of a rating for Regional Health Quality and Safety. IT has also been adjusted to reflect current priorities in the regions and Major Trauma is to be rated on a six-monthly basis, starting in Q2.

The Central region received achieved ratings for seven out of ten of its national priorities in Q1, an improvement in overall performance since the last quarter.

For Stroke Services, the region is leading some strong initiatives with Telestroke, supporting improved thrombolysis services, thrombectomy evaluation, and rehabilitation services for all ages.

In IT services, the Regional Health Informatics Programme (RHIP) is progressing well and moving into an implementation phase. The WebPAS functional build is on track and the Ministry looks forward to reviewing the planned milestones for MidCentral and Whanganui DHBs' implementation.

Regional Performance Issues

For Cancer Services, the achievement of the FCT health target by Central DHBs is down from Q3 2015/16. However, the efforts being made in addressing issues in the diagnostics parts of the pathway, breach monitoring, and individual DHB FCT projects is noted.

For Cardiac Secondary Services, the number of patients waiting for cardiac surgery in the region remained below the maximum number expected for all except one week. Actual delivery of cardiac surgery procedures remain below plan, and intervention rates for angiography and cardiac surgery remain low. An improvement in this result is expected in future quarters and the Ministry acknowledges the work the region has undertaken with the Cardiac Network to identify and address barriers to access and develop options for future provision of cardiac services.

Capital & Coast, Hawkes Bay and Wairarapa DHBs are behind their Electives Health Target for Q1 and the partially achieved rating is also due to the waiting times performance. The Ministry looks forward to an improvement in the Central region's waiting time performance in future quarters and responses regarding the regional services programme.

CROSS-AGENCY PRIORITIES

Rising to the challenge

- Primary mental health
- District Suicide Prevention and Postvention

Reducing Rheumatic fever

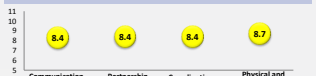
Supporting vulnerable children

Quality and Safety Markers

	Goal	Performance	
Falls risk assessment (Apr-Jun16)	90%	95%	
Hand hygiene (Apr-Jun16)	80%	87%	

	Goal	Performance	
Surgical site infections (Jan-Mar 2016):			
Antibiotic administered in the right time	100%	100%	
Patients receive cefazolin or cefuroxime	95%	97%	

Patient Experience



PERFORMANCE HIGHLIGHTS

The DHB has achieved the increased immunisation health target this quarter.

Good financial performance.

PERFORMANCE ISSUES

The DHB's progress in the Faster cancer treatment health target is concerning with achievement remaining in the mid 60s this quarter with a result of 66 percent. This result also places the DHB in the bottom quarter of the DHB rankings. Visits to well performing DHBs are planned, and it is crucial that there is strong support from senior management to implement ideas and learnings gained from these visits.

The DHB is also ranked in the bottom quartile for all other health targets except increased immunisation target.

Delivery of the New Zeeland Health Strategy - DHB Highlights for the Quarter

People-Powered
A youth strategy has been completed and published in Q1

Closer to Home
The Hawke's Bay Intersectoral group is in the progress of developing a social inclusion strategy. A consultant has been appointed and initial ideas have been shared with the agencies.

Value and High Performance
HBDHB and the Health Hawke's Bay have worked together to develop a jointly agreed improvement plan for the system level measures framework. This will allow us to monitor outcomes from a whole system perspective.

One Team
HBDHB and Health Hawke's Bay have put a 5th cohort of leaders through the transformational leadership programme over Q1 and Q2.

Smart System
3x General Practices have been signed up and are ready to start using NZePS froom October 2016.

Delivery of the New Zeeland Health Strategy - Regional Highlights for the Quarter

People-Powered
Equity data is being included in all data measures to ensure that any discrepancies can be examined.

Closer to Home
Continuation of maternal mental health hub and spoke model focusing on home based treatment and enhancing capacity and capability across the whole region.

Value and High Performance
NGOs, Primary Care and DHBs are involved in the pre-planning of the first physical wellbeing forum for people with high and complex needs.

One Team
Scoping to identify regional priorities. An increasing trend in wait times for adult forensic patients has been identified and enabled services respond. The needs for professional development in the workplace have now been assessed.

Smart System
Data for eating disorder services is being drawn from three areas; PRIMHD, NMDS and local community team data. Regional workforce development information is being distributed and highlights training events.

20.1

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 2016/17 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.
Improving System Integration	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 District Suicide Prevention and Postvention.
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.
Regional Service Delivery	A qualitative and quantitative 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.

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.
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.
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. Rates for 45-64 age group are age standardised using national population as a standard.
Supporting vulnerable children	Actions or initiatives to reduce deaths and hospitalisations due to assault, neglect or maltreatment of children and young people.
Delivery of the New Zeeland Health Strategy	All DHBs made strong commitments to the New Zealand Health Strategy in their annual plans. Each DHB and region has highlighted an action or initiative that provides an example of activity in the quarter in relation each strategy theme.
Diagnostic waiting times	Performance against the waiting time indicators for Coronary Angiography, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), and Colonoscopy.
District suicide prevention and postvention	Progress against the agreed 2015-2017 Suicide Prevention Plan is reported by describing highlights, exceptions and milestones for three of the actions, and noting any completed actions.
Human papillomavirus immunisation	Percentage of eligible girls fully immunised with human papillomavirous (HPV) vaccine. For 2016/17 the measure is the 2003 birth cohort measured at 30 June 2017. This measure is reported yearly in quarter four.
Immunisation coverage at 2 and 5 years of age	The percentage of children who have completed their age-appropriate immunisations by the age of 2 years and by the age of 5 years. The rating - indicated by the traffic light colour - is based on performance for both the 2- and 5-year-old milestones.
Improved management for long term conditions	DHBs are expected to report on delivery of the actions and milestones as identified in the 2016/17 annual plans for long term conditions (LTC), diabetes services, cardiovascular (CVD) health, acute heart service and stroke services.
Improving wrap around services -Health of Older People	DHBs are expected to report on delivery of the actions and milestones as identified in the 2016/17 annual plans for health of older people services including home and community support services, InterRAI, dementia care pathways, HOP specialists and fracture liaison services.
More heart and diabetes checks	Proportion of the eligible adult population that have had their cardiovascular disease risk assessment in the last five years. The population are PHO enrolled adults.
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.
Patients waiting for FSA (ESPI 2)	The total number on the waiting list waiting longer than four months for a first specialist assessment (FSA) for the last three months, and the number waiting as a % of the total list. ESPIs are the set of elective services patient flow indicators.
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. ESPIs are the set of elective services patient flow indicators.
Primary mental health	This measure is to monitor access to evidence-informed physiological therapies for mental health and additions issues in primary care.
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.
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).
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.

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.**

**** This is the first time Raising Healthy Kids has been reported as a health target. Thus comparison with the previous quarter is not applied.**

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)	

HAWKE'S BAY District Health Board Whakawāteatia	**Annual Māori Health Plan Q2 (Oct - Dec 2016) Non-Financial Exceptions Report** 12
	For the attention of: **HBDHB Board**
Document Owner:	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 and Māori Relationship Board
Month:	February 2017
Consideration:	Monitoring

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report.

OVERVIEW

The purpose of this paper is to provide MRB, HB Clinical Council, HB Consumer Council and the HBDHB Board with exception report for Quarter 2 on the implementation of the 2016 – 2017 Annual Māori Health Plan. A quick reference summary dashboard will be supplied prior to the meeting and shows our position as at the end of Quarter 1 for all indicators. The dashboard uses traffic light methodology with detailed information and symbols for all indictors. For example, in a situation where the performance of the indicator for the current quarter is higher than the previous quarter this symbol '▲' will be used to show an upward trend while an opposite symbol '▼' will be used to show a downward trend. In cases where the variance to the annual target for the indicator is greater than 0.5% this symbol **'U'***(indicated on the dashboard in red)* will be used to indicate unfavourable trend and 'F' for favourable trend*(indicated on the dashboard in green colour)*toward the annual target *(see the table below).*

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KEY FOR DETAILED REPORT AND DASHBOARD

Baseline	Latest available data for planning purpose
Target 2015/16	Target 2016/17
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

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2016-2017 ANNUAL MĀORI HEALTH PLAN QUARTER 2 PERFORMANCE HIGHLIGHTS

Achievements

1. Access to referral services for alcohol and other drugs for 0-19 year old Māori within 3 weeks has slightly decreased from 81.6% in Q1 to 80.5% in Q2, but still tracking positively above the expected target of ≥ 80%.

Areas of progress

1. Immunization rates for 8 months old Māori for Q2 has remained unchanged from 94.6% in Q1, tracking positively towards the expected target of ≥ 95%. This rate lowers the disparity gap between Māori and non- Māori from 2.1% in Q1 to 1.8 in Q2.

2. The number of Māori enrolled with HHB PHO increased slightly from 96.6% in Q1 to 96.8% in Q2 and trending positively towards the target of ≥ 100%. This brings the disparity gap between Māori and non- Māori for Q2 to less than 1%. Currently HBDHB ranks 4th among all DHBs in the country for Māori PHO enrolments

3. The ASH rates for Māori 0-4 year old group has dropped from 91.7% in Q1 to 84.9% in Q2 and trending positively towards the expected rate of ≤ 83%. This lowers the disparity gap between Māori and non- Māori from 11.4% in Q1 to 7.1% in Q2. HBDHB ranks 3rd among the best DHBs in the country for ASH rates among the 0-4 year olds.

4. Cervical screening for 25-69 year old Māori women for Q2 is 72.8% up slightly from 72.7% in Q1 with a disparity gap of 6% between Māori and non- Māori compared to 5% recorded in Q1. Nonetheless, this indicator continues to trend positively towards the target of ≥80% putting HBDHB ahead of all other DHBs in the country.

5. Māori Workforce grew by less than 1% from 12.5% in Q1 to 13% in Q2 trending towards the expected target of 13.8% or 22 employees to the target of 409 Māori staff.

6. Access to referral services for alcohol and other drugs for 0-19 year old Māori within 8 weeks has increased slightly from 91.7% in Q1 to 93.6% in Q2, tracking positively towards the expected target of ≥ 95%. This lowers the disparity gap between Māori and non- Māori from 1.1% in Q1 to 1% in Q2.

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Challenges

1. Acute hospitalization for Rheumatic Fever has steadily remained at 7.3% from Q1 and tracking more than 20% away from the expected target of ≤1.5.

2. Māori under Mental Health Act compulsory treatment orders (CTO) has decreased from 183.9 per 100,000 population in Quarter 1 to 179.9 per 100,000 population in Q2. However, the indicator is tracking behind the target of ≤ 81.5 with a disparity gap of 117.8.between Māori and non- Māori in Q2 compared to 94.2 in Q1.

3. ASH rates for Māori 45-64 years went up slightly to 211.3% in Q2 from 196% in Q1 trailing behind the target of ≤ 123% with a significant disparity gap of 101.3% between Māori and non- Māori.

4. Breast screening for 50-69 Māori women dropped from 67.1% in Q1 to 64.7% in Q2 tracking positively towards the target of ≥ 70%. This rate presents a disparity gap of about 11% between Māori and non- Māori compared to 7.4% in Q1.

5. The Māori staff cultural competency training shows some slight increase from 78.8% in Q2 to 80.7% in Q2. While the numbers of staff training across professions went up slightly across the service, the number of staff training among the medical staff dropped by 2.2% from 39.9% to 37.7% in Q2.

National ranking by Trendly.

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 2 SEPTEMBER – DECEMBER 2016 DASHBOARD REPORT

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 at 8 Months (3m)	92.6%	94.4%	94.4%	96.2%	≥ 95%	-2		↑
65+ Influenza (3m)	68.0%	56.5%	Update available in Q4		≥ 75%	-		↑

Rheumatic Fever

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Total	Period target	Individual Numbers to Target (approx)	Time Series Trend (12 months)	Desired Trend
Hospitalisation rate (6m)	2.48	7.3	7.3	2.48	≤ 1.5	-1		↓

Breastfeeding

Indicator	Baseline	Prior period result	Actual to date Maori	Actual to date Total	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
QIF Data (6m)								
At 6 Weeks	58.0%	67.0%	Update available in Q3		≥ 75%	-		↑
At 3 months	46.0%	39.0%			≥ 60%	-		↑
At 6 months	46.0%	48.0%			≥ 65%	-		↑

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 (12m)	2.09	2.1	Update expected Q4		≤ 0.4			↓
Caregivers given SUDI Prevention Info (12m)	72.8%	72.8%			≥ 100%			↑

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 (3m)	65.3%	74.1%	Update available in Q3		≥ 95%	-		↑
% Caries Free at 5yrs (3m)	36.0%	36.0%			≥ 67%	-		↑

Tobacco

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 (6m)	53.0%	65.6%	Update expected Q3		≥ 95.0%	-		↑

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) (3m)	196.0	183.9	179.9	62.1	≤ 81.5	-		↓

Access to Care

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 (3m)	97.2%	96.6%	96.8%	97.5%	≥ 100%	-1310		↑

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
0-4 years (6m)	82.1%	91.7%	84.9%	77.8%	≤ 83%	-145		↓
45-64 years (6m)	172.0%	196.0%	211.3%	110.0%	≤ 138%	-2706		↓

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) (3m)	74.1%	72.7%	72.8%	78.9%	≥ 80%	-656		↑
Breast screening (50-69 yrs) (3m)	68.4%	67.1%	64.7%	75.0%	≥ 70%	-93		↑

Maori Workforce

Indicator	Baseline	Prior period result	Actual to date Maori	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	2.9%	3.4%	4.2%	≥ 13.8%			
Management & Administration	16.5%	16.5%	17.2%	≥ 13.8%			
Nursing	10.6%	10.8%	11.3%	≥ 13.8%			
Allied Health	12.6%	13.2%	13.5%	≥ 13.8%			
Support Staff	28.2%	27.4%	28.2%	≥ 13.8%			
Māori staff - HBDHB (3m)	12.3%	12.5%	13.0%	≥ 13.8%	-		↑

Cultural Responsiveness

Indicator	Baseline	Prior period result	Actual to date	Period target	Individual Numbers to Target (approx)	Time Series Trend	Desired Trend
Medical	19.2%	39.9%	37.7%	≥ 100.0%			
Management & Administration	79%	87.0%	88.4%	≥ 100%			
Nursing	70%	82.9%	85.4%	≥ 100%			
Allied Health	77%	86.2%	89.2%	≥ 100%			
Support Staff	36%	63.3%	64.9%	≥ 100%			
HBDHB (3m)	66%	78.8%	80.7%	≥ 100%	-		↑

Obesity

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
Referred for Nutrition (3m)	30%	26%	44%	40%	≥ 95%	-		↑
Bariatric Surgery (3m)	7	0	0	0	-	0.00		-

Alcohol and Other Drugs

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
% of 0-19 year olds seen within 3 weeks of referral (3m)	91%	81.6%	80.5%	81.1%	≥ 80%	Numbers available in Q3		↑
% of 0-19 year olds seen within 8 weeks of referral (3m)	100%	91.7%	93.6%	94.6%	≥ 95%			↑

The number in brackets identifies the frequency at which data is updated:
(3m) 3 months
(6m) 6 months
(12m) 12 months

QUARTERLY PERFORMANCE AND PROGRESS UPDATE

Appendix 1

Alcohol and Other Drugs

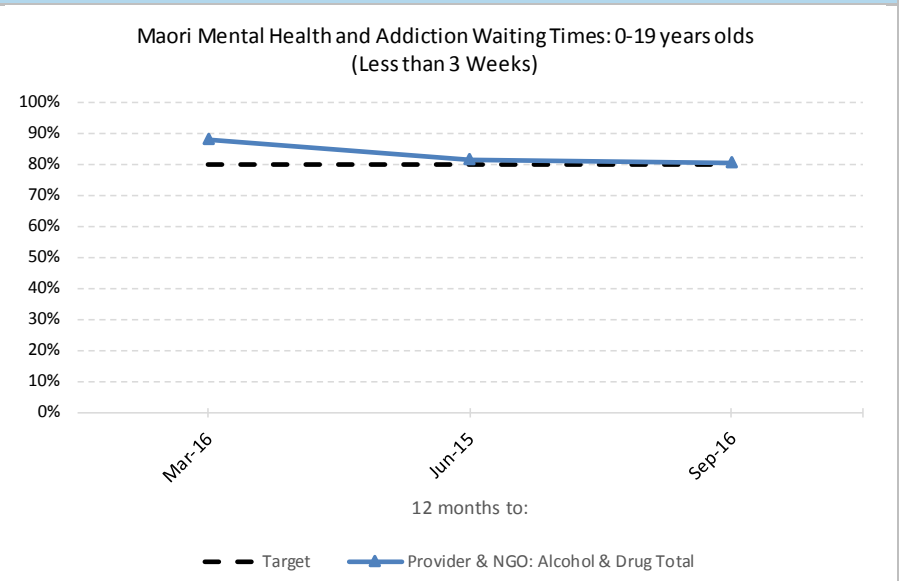
Outcome: % of 0-19 year olds seen within 3 weeks of referral

Key Performance Measures	Baseline[1]	Previous result[2]	Actual to Date[3]	Target 16-17	Trend direction
Provider Arm and NGO: Seen within 3 weeks Ages 0-19					
Māori	90.5%	81.6% (F)	80.5% (F)	≥80%	▼
Pacific	-	-	-	≥80%	*
Other	61.5%	80% (F)	83.9% (F)	≥80%	▲
Total	84.2%	81.2% (F)	81.1% (F)	≥80%	▼

Access to referral services for alcohol and other drugs for 0-19 year old Māori within 3 weeks has slightly decreased from 81.6% in Q1 to 80.5% in Q2, but still tracking positively above the expected target of ≥ 80%.

The trend observed here is a product of collaborative work with referrers (e.g., schools, CYF) in ensuring that we provide most seamless service possible for Māori. There is good and strong commitment among providers to ensure that the response to referrals is timely.

Time series



1 January 2015 to December 2015

2 April 2015 to March 2016

3 July 2015 to June 2016

Appendix 2

Increasing Immunisation

Outcome: 95% 8 month olds completing primary course of immunisation

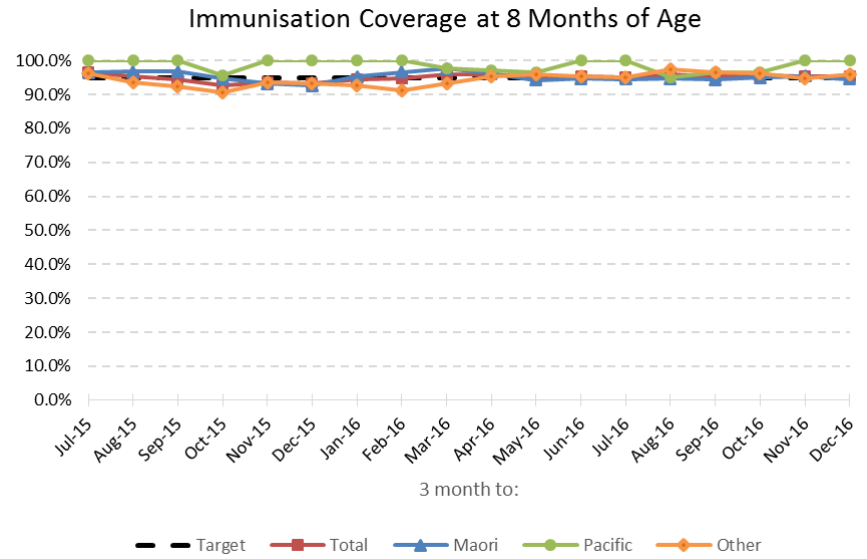
Key Performance Measures	Baseline[4]	Previous result[5]	Actual to Date[6]	Target 16-17	Trend direction
Māori	92.6%	94.4% (U)	94.4% (U)	≥95%	—
Pacific	100.0%	96.4% (F)	100% (F)	≥95%	▲
Other	93.3%	96.5% (F)	96.2% (F)	≥95%	▼
Total	93.3%	95.4% (F)	95.3% (F)	≥95%	▼

Comments:

Immunization rates for 8 months old Māori for Q2 has remained unchanged from 94.6% in Q1, tracking positively towards the expected target of ≥ 95%. This rate lowers the disparity gap between Māori and non- Māori from 2.1% in Q1 to 1.8 in Q2.

This trend is attributed to the effective use of the NIR database and the immunization outreach service team to identify, track down, and immunize children who have missed out on their immunization.

Time series



Source: National Immunisation Register, Ministry of Health

4 October to December 2015

5 April to June2016

6 July to September 2016

Appendix 3

Access to Care

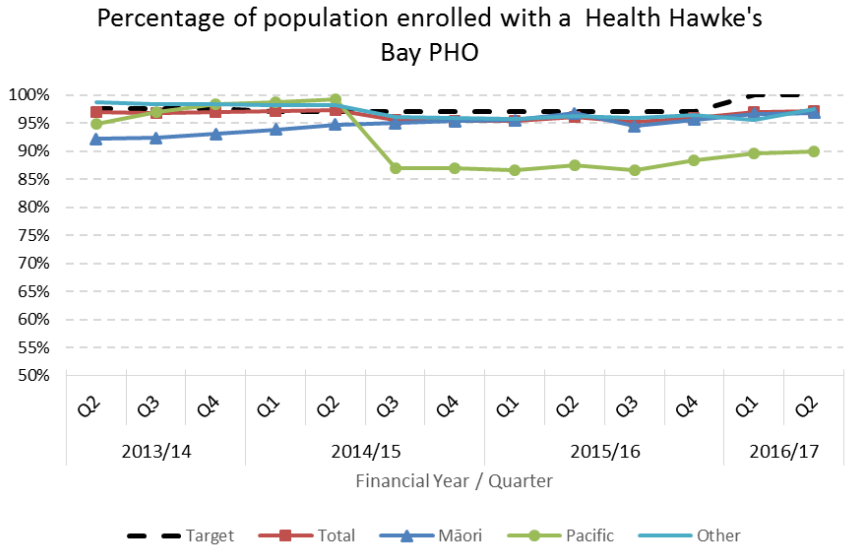
Outcome: Increase enrolment in the PHO – Target: % of the population enrolled in the PHO

Key Performance Measures	Baseline[7]	Previous result[8]	Actual to Date[9]	Target 16-17	Trend direction
Māori	97.2%	96.6% (U)	96.8% (U)	≥100%	▲
Pacific	88.7%	89.6% (U)	89.8% (U)	≥100%	▲
Other	96.5%	97.4% (U)	97.5% (U)	≥100%	▲
Total	-	95% (F)	96% (F)	≥80%	▲

Comments:

The number of Māori enrolled with HHB PHO increased slightly from 96.6% in Q1 to 96.8% in Q2 and trending positively towards the target of ≥ 100%. This brings the disparity gap between Māori and non- Māori for Q2 to less than 1%.

The HN Enrolment programme is still available for health consumers who are not yet enrolled to become enrolled. New enrolees receive a 45 minute free health assessment with a nurse and 15 minute doctor consultation. HHB will continue to promote this programme to encourage more enrolment with HHB General Practices.



Appendix 4

7 October 2015
8 April 2015
9 July 2016

Ambulatory Sensitive Hospitalization (ASH)

Outcome: Reduction in Ambulatory Sensitive Hospitalisation (ASH) rates in 0-4 year olds.

Key Performance Measures	Baseline [10]	Previous result[11]	Actual to Date[12]	Target 16-17	Trend direction
Māori	82.1%	91.7% (U)	84.9% (U)	≤82.8%	▲
Other	66.1%	63.8% (F)	66% (F)	-	▼
Total	73.0%	80.3% (F)	77.8% (F)	-	▲

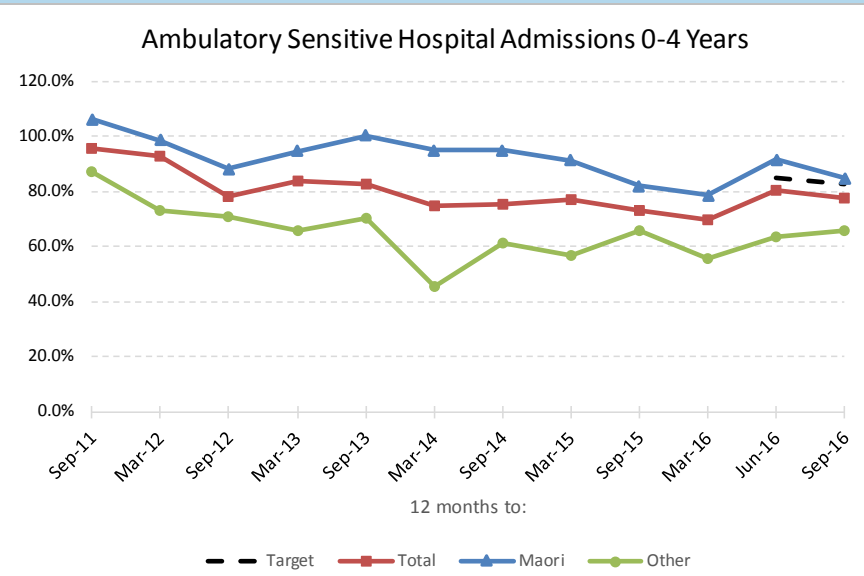
** To focus on equity the Māori target has been set at 'within 5% of the Total'*

The ASH rates for Māori 0-4 year old group has dropped from 91.7% in Q1 to 84.9% in Q2 and trending positively towards the expected rate of ≤ 83%. This lowers the disparity gap between Māori and non-Māori from 11.4% in Q1 to 7.1% in Q2.

In 2016 the largest differences between Hawkes Bay Māori rates and national rates in the 0-4 year age group are in the conditions Cellulitus and Asthma. Improvements have been made in the rates for Asthma over the last 12 months but there has been a decrease in the performance for Cellulitus.

Up to September 2016, the top 3 ASH conditions for Māori in the 0-4 year age group are: Dental Conditions, Asthma and Respiratory Infections- Upper and ENT.

Time series



Source: Ministry of Health

Appendix 5

21

1012 months to September 2015
1112 months to September 2015
1212 months to March2016

Cancer Screening

Outcome: Achieve the National Cervical Screening Programme (NCSP) national – Target: 80% of 25-69 years

Key Performance Measures	Baseline [13]	Previous result[14]	Actual to Date[15]	Target 16-17	Trend direction
Māori	74.1%	72.7% (U)	72.8% (U)	≥80%	▲
Pacific	71.2%	74.2% (U)	74.8% (U)	≥80%	▲
Other	76.5%	78.2% (U)	78.9% (U)	≥80%	▲
Total	75.8%	76.9% (U)	76.7% (U)	≥80%	▼

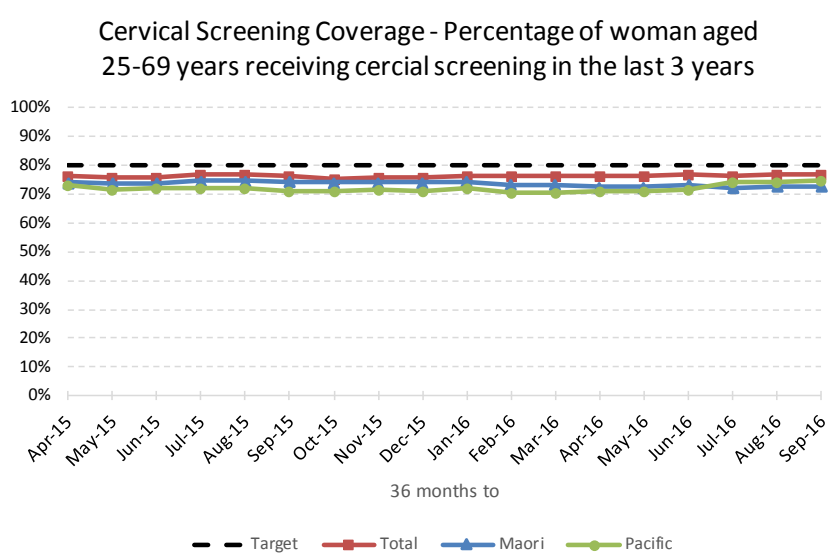
Comments:

Cervical screening for 25-69 year old Māori women for Q2 is 72.8% up slightly from 72.7% in Q1 with a disparity gap of 6% between Māori and non- Māori compared to 5% recorded in Q1. Nonetheless, this indicator continues to trend positively towards the target of ≥80%.

This performance is attributed to the HBDHB integrated service approach across the screening pathways to track down and ensure that women who need these services are attended to. Providing smears in the community is intensive and requires significant time to engage and encourage the women to been screened, but we are encouraged with the feedback received from the women who tell us 'they have only had the smear because it was offered to them in the home'.

Although we continue to rank high in coverage out of the 20 DHBs in the country for our Māori women, the increase in coverage is slow, due to the decrease in smears of 28% on Māori women in the last 6 months compared to the same time in 2015. We too are no longer a target for the Ministry of Health so the PHO no longer receives funding for cervical screening.

Time series



Source: National Screening Unit

Appendix 6

133 years to December 2015

143 years to June 2015

153 years to August 2016

Māori Workforce Development

Outcome: Increased proportion of Māori employed by 10% yearly across HBDHB. Target 16/17 year 13.75%

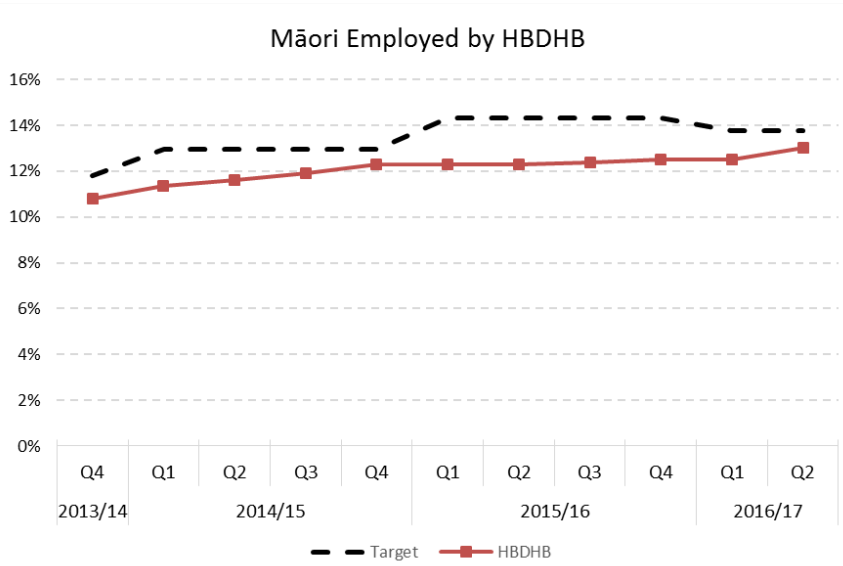
Key Performance Measures	Baseline [16]	Previous result[17]	Actual to Date[18]	Target 16-17	Trend Direction
Medical	2.90%	3.4% (U)	4.2% (U)	≥13.75%	▲
Management & Administration	16.50%	16.5% (F)	17.2% (F)	≥13.75%	▲
Nursing	10.60%	10.8% (U)	11.3% (U)	≥13.75%	▲
Allied Health	12.60%	13.2% (U)	13.5% (F)	≥13.75%	▲
Support Staff	28.20%	27.4% (F)	28.2% (F)	≥13.75%	▲
HBDHB	12.30%	12.5% (U)	13% (U)	≥13.75%	▲

Comments:

Māori Workforce grew by less than 1% from 12.5% in Q1 to 13% in Q2 trending towards the expected target of 13.8% or 22 employees to the target of 409 Māori staff.

Monthly progress reports are now being sent to EMT, HS Directorates, Nursing and Allied Health management.

Time series



Appendix 7

21

16 December 2014
17March2016
18June2016

Alcohol and Other Drugs

Outcome: % of 0-19 year olds seen within 8 weeks of referral

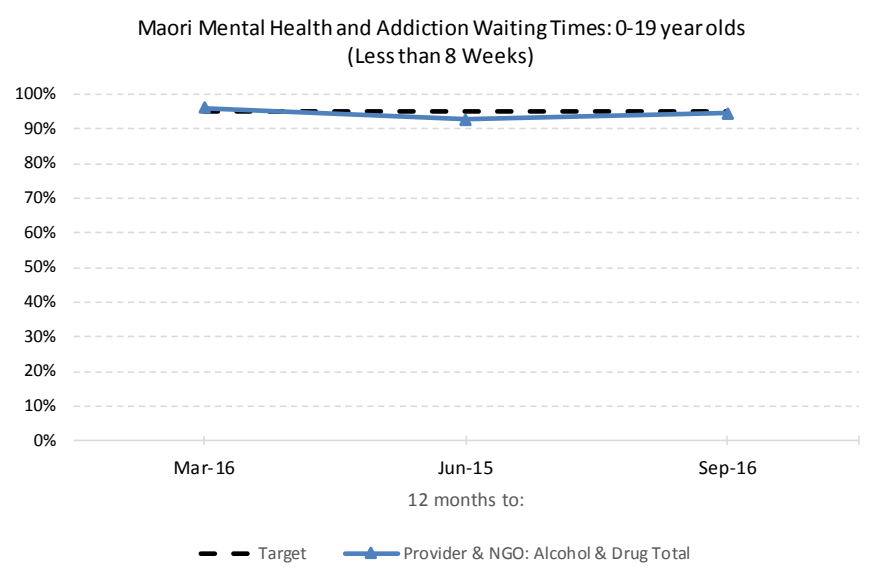
Key Performance Measures	Baseline [19]	Previous result[20]	Actual to Date[21]	Target 16-17	Trend direction
Provider Arm and NGO: Seen within 8 weeks Ages 0-19					
Māori	100.0%	100.0%	91.7% (U)	93.6% (U)	≥95%
Pacific	-	-	-	-	≥95%
Other	92.3%	92.3%	93.3% (U)	96.8% (F)	≥95%
Total	99.5%	99.5%	92.8% (U)	94.6% (F)	≥95%

Comments:

Access to referral services for alcohol and other drugs for 0-19 year old Māori within 8 weeks has increased slightly from 91.7% in Q1 to 93.6% in Q2, tracking positively towards the expected target of ≥ 95%.

Decreased wait times has been a focus over 2016 and is trending positively, although there has been an increase in referrals over time. We are also focusing on collaborative work with referrer (e.g., schools, CYF) so that we can provide the most seamless service possible.

Time series



Appendix 8

19 January 2015 to December 2015

20 April 2015 to March 2016

21 July 2015 to June 2016

Reducing Rheumatic Fever						
Outcome: Reduced incidence of first episode Rheumatic Fever						
Key Performance Measures	Baseline [22]	Previous result [23]	Actual to Date[24]	Target 16-17	Trend direction	
Māori	2.48	7.3 (U)	7.3 (U)	≤1.5	—	**Comments:** This will be reported annually (Q4)
Pacific	-	16.47 (U)	16.47 (U)	≤1.5	—	
Total	0.6	1.86 (U)	2.48 (U)	≤1.5	▼	

Appendix 9

21

22 July 2014 – June 2015

23 July 2015 – June 2016

24 July 2016 – September 2016

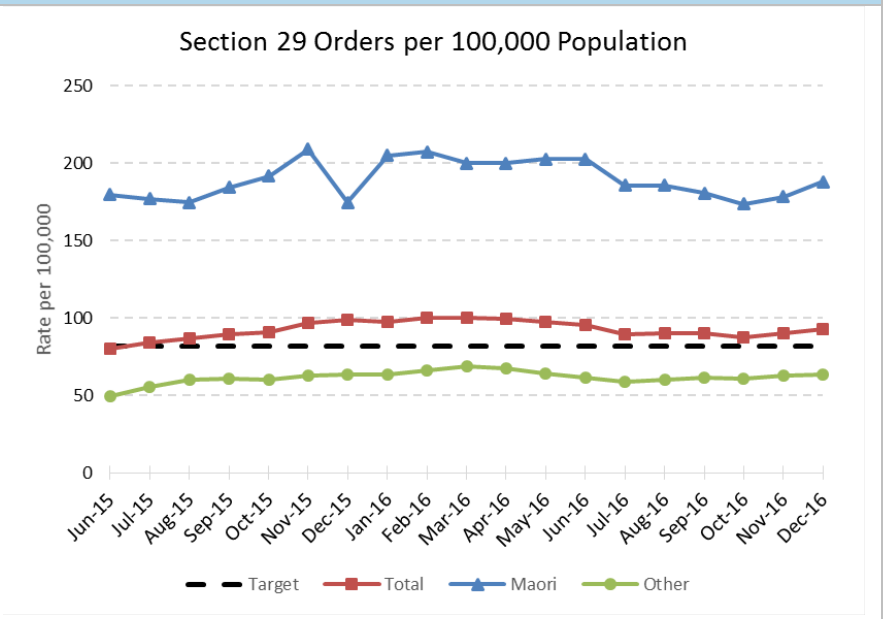
Mental Health
Outcome: Reduced rate of Māori under compulsory treatment orders to < 81.5 per 100,000 (total population)

Key Performance Measures	Baseline [25]	Previous result[26]	Actual to Date[27]	Target 15-16	Trend direction
Māori (per 100,000)	196	183.9 (U)	179.9 (U)	≤81.5	▲
Other (per 100,000)	93.4	60.1 (F)	62.1 (F)	≤81.5	▼
Total (per 100,000)	97	90.1 (U)	89.1 (U)	≤81.5	▲

Comments:

Māori under Mental Health Act compulsory treatment orders (CTO) has decreased from 183.9 per 100,000 population in Quarter 1 to 179.9 per 100,000 population in Q2. However, the indicator is tracking behind the target of ≤ 81.5 and the inequity between Māori (178.9) and non- Māori (62.1) is evident.

As a follow up on the concerns expressed by MRB on the high rates of Māori under CTO, Mental Health Services and Māori Health Service held a wānanga last quarter with wide range of stakeholders to examine the factors behind the high CTO trends among Māori. Among the resolutions from this wānanga was the stakeholders' renewed commitment to work together across the sector to address the underlying factors for high CTO rates among Māori. Among the strategies agreed on included: engaging whānau through the home-based treatment team; communication through the central coordination service for all providers; implementation of the intensive day treatment programme; reduction of restrictive care practices; increasing group interaction options in the community; and more referrals and liaison with community providers.



Appendix 10

Ambulatory Sensitive Hospitalization (ASH)						
Outcome: Reduction in Ambulatory Sensitive Hospitalisation (ASH) rates in 45-64 year olds.						
Key Performance Measures	Baseline [28]	Previous result[29]	Actual to Date[30]	Target	Trend direction	Time series

2812 months to September 2015

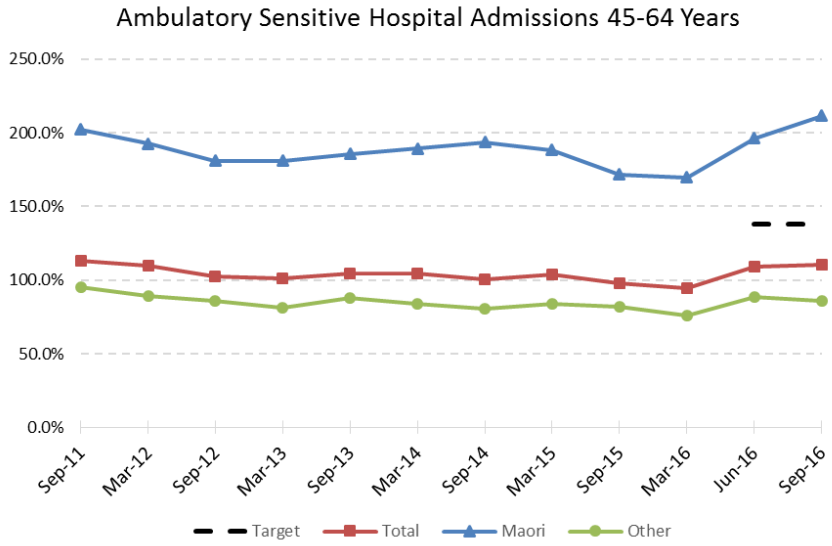
				16-17	
Māori	172.0%	196% (U)	211.3% (U)	≤138%	▼
Other	81.8%	88.2% (F)	85.8% (F)	-	▲
Total	98.0%	109% (F)	110% (F)	-	▼

Equity Gap – Sept 2015 – Sept 2016

	Local Equity Gap
Māori vs Other	245% (4625)
Pasifika vs Other	183% ((2647)

Comments:

ASH rates for Māori 45-64 years went up slightly to 211.3% in Q2 from 196% in Q1 trailing behind the target of ≤ 138% with a significant disparity gap of 101.3% between Māori and non-Māori.



Source: Ministry of Health

Appendix 11

Breast-screening

Outcome: Achieve the National Breast Screen Aotearoa (BSA) national – Target: 70% of 50-69 years

26*April to June 2016*

27*July to September 2016*

2812 months to September 2015

2912 months to September 2015

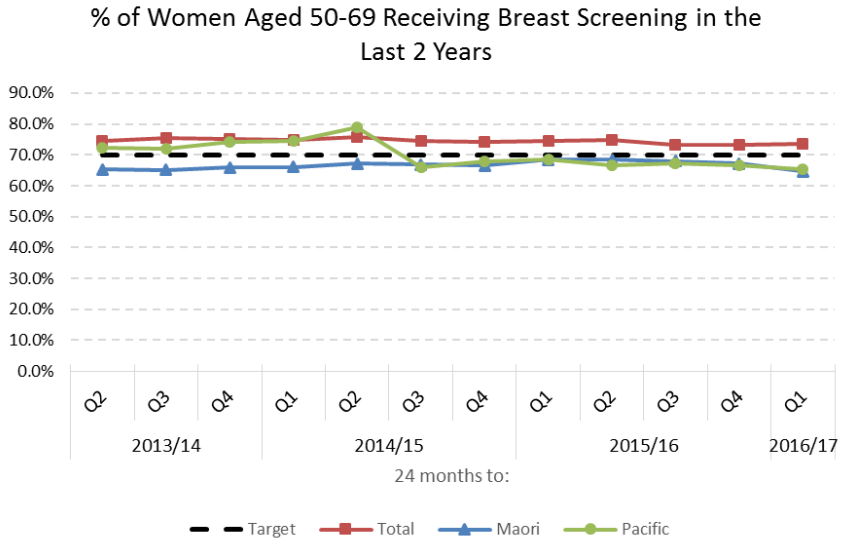
3012 months to March2016

Key Performance Measures	Baseline [31]	Previous result[32]	Actual to Date[33]	Target 16-17	Trend direction	Time series
Māori	68.4%	67.1% (U)	64.7% (U)	≥70%	▼	
Pacific	66.5%	66.6% (U)	65.4% (U)	≥70%	▼	
Other	76.0%	74.5% (F)	75% (F)	≥70%	▲	
Total	74.7%	73.2% (F)	73.6% (F)	≥70%	▲	

Comments:

Breast-screening for 50-69 Māori women dropped from 67.1% in Q1 to 64.7% in Q2 tracking positively towards the target of ≥ 70%. This rate presents a disparity gap of about 11% between Māori and non- Māori compared to 7.4% in Q1.

We will continue to work with GP practices and participating stakeholders in tracking and screening women at home where need be. Recent population projections released by the National Screening Unit show that in the next five years (2016-2021) Hawke's Bay's NCSP eligible Māori and Pacific populations will increase by 7% and the Asian population will increase by 16%. This is a challenge to our health sector.



Source: National Screening Unit

Appendix 12

Māori Staff Cultural Competency

Outcome: All staff working in the health sector have completed an approved course of cultural responsiveness training.

Key Performance Measures	Baseline [34]	Previous result[35]	Actual to Date[36]	Target 16-17	Trend direction	Time series

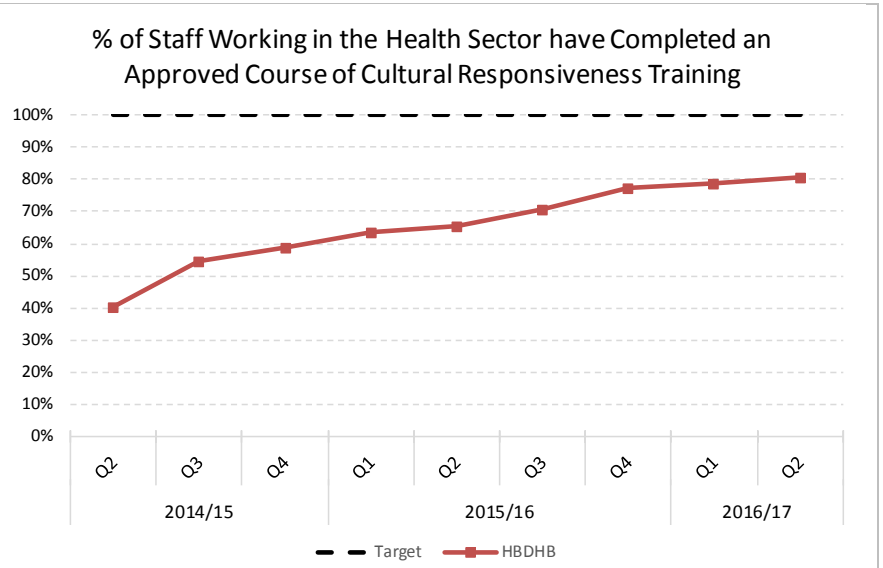
Appendix 13

Medical	19.20%	39.9% (U)	37.7% (U)	≥100%	▼
Management & Administration	79.10%	87% (U)	88.4% (U)	≥100%	▲
Nursing	70.00%	82.9% (U)	85.4% (U)	≥100%	▲
Allied Health	77.30%	86.2% (U)	89.2% (U)	≥100%	▲
Support Staff	35.60%	63.3% (U)	64.9% (U)	≥100%	▲
HBDHB	65.60%	78.8% (U)	80.7% (U)	≥100%	▲

Comments:

The Māori staff cultural competency training shows some slight increase from 78.8% in Q2 to 80.7% in Q2. While the numbers of staff training across professions went up slightly across the service, the number of staff training among the medical staff dropped by 2.2% from 39.9% to 39.7% in Q2 Current report shows DHB staff who have completed EEWM training or other cultural training.

Managers now have access to reports within PAL$ to monitor staff completion rates of EEWM and Treaty of Waitangi.



Obesity

Outcome: Reduce the incidence of Obesity in Hawke's Bay – Target: 95 percent of children with BMI ≥98th percentile identified in the Before School Check (B4SC) programme will be referred on for nutrition, activity and lifestyle interventions.

Key Performance Measures	Baseline [37]	Previous result [38]	Actual to Date [39]	Target 15-16	Trend direction	Comments
Māori	30.0%	26% (U)	44% (U)	≥95%	▲	
Other	23.0%	33% (U)	31% (U)	≥95%	▼	

37 6 months to September 2015

38 6 months to March 2016

39 6 months to June 2016

Total	27.0%	27% (U)	40% (U)	≥95%	▲	

Comments:

The B4SC programme data show an increase of 18% from 26% in the last quarter to 44% this quarter (pg14) for Māori children with BMI ≥98th percentile seen and provided with advice and support on nutrition, activity and lifestyle interventions and referral to GP by the Practise Nurse. We will continue to embed the process and monitor progress of this indicator.

We continue to have data issues, with children from the pre target period still included in the second quarter data. However, there has been a significant increase from quarter 1-2 (18%). All children have been given advice and support on nutrition, activity and lifestyle interventions and referral to GP by the practise nurse. We will continue to embed the process and monitor progress of this indicator.

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Access (ASH Rates 0-4 & 45-64 years)** 13
	For the attention of: **HBDHB Board**
Document Owner:	Dr Mark Peterson, Chief Medical Officer - Primary
Document Author(s):	Mary Wills, Head of Strategic Services; Jill Garrett, Strategic Services Manager – Primary Care; Nicky Skerman, Population Health Strategist, Women, Child & Youth
Reviewed by:	Executive Management Team; Māori Relationship Board, HB Clinical Council and HB Health Consumer Council
Month:	February 2017
Consideration:	For Monitoring

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report.

OVERVIEW

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

UPCOMING REPORTS

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

Priority	Indicator	Champion	Reporting Month
Access *Local Indicator*	Reducing acute admissions of Ambulatory Sensitive Hospitalisations (ASH): 1. 0-4 year olds - dental decay, skin conditions, respiratory and ear, nose and throat infections 2. 45-64 year olds - heart disease, skin infections respiratory infections and diabetes	Mark Peterson	February 2017

MĀORI HEALTH PLAN INDICATOR:

This report provides an update on programmes related to Ambulatory Sensitive Hospitalisations (ASH) for 0-4 and 45-64 years of age in Hawke's Bay.

Ambulatory Sensitive Hospitalisations (ASH) reflect hospital admissions for conditions which could potentially be prevented by early access to treatment in care. In many countries ASH is used as a means to assess the performance of primary care and to identify potential barriers to access.
However, while ensuring early access to effective primary care is still likely to be of considerable value in reducing ASH, in countries such as New Zealand, where large socioeconomic and ethnic disparities in child health exist, a greater emphasis may need to be placed on addressing those factors, often outside of the health sector, which drive the underlying burden of disease (e.g. household income, housing, nutrition, exposure to second hand cigarette smoke). This is because, even with optimal access, the ability of a general practitioner to prevent a paediatric pneumonia admission after the first crucial hours may be limited, but the opportunities available for a DHB to prevent paediatric respiratory infections via e.g. healthy housing projects and parental smoking cessation programmes may be considerable.

The Hawke's Bay DHB is committed to non-differential targets and significant inequality is seen in this indicator. Our work programmes focus on targeting vulnerable populations to reduce hospitalisation, improving the home environment and improving consistency of practice and early access to primary care programmes and reducing inequities.

WHY IS THIS INDICATOR IMPORTANT?

System Level Measures
The Introduction of the System Level Measures; targeted performance measures, came into effect beginning 2016-17. The measures include some previous health targets included in the Integrated Performance Incentive Framework and a set of newly introduced, nationally agreed performance measures. Ambulatory Sensitive Hospitalisation (ASH) rates are included in two System Level Measures.

- ASH 00-04yrs is reported against under the SLM-Ambulatory Sensitive Hospitalisation (ASH)
- ASH 45-64yrs is reported under the SLM-Acute Hospital Bed Days.

Each ASH band for total population is divided into; Māori, Pacific, Other[1]. Targets are derived from the DHB ASH rates for the Māori population. The base line rates for the DHB will be compared with national total population rates and targets set accordingly. These are expressed in rates per 100,000.

The Hawke's Bay District Health Board recognises that comparing Māori against national-total population data masks the equity gap. Therefore all Māori and Pasifika data reported against for ASH will include …… vs Other to adequately examine the equity gap.

Targets are to be set to work towards eliminating the gap within a 2-5 year period dependent on the base line. Using the base line as a measure, reducing the equity gap by half each year. If below 10% the aim is to eliminate the gap. Rates within 5% would be considered equitable (e.g. HBDHB Māori ASH rates to be at or below national total population rates) [2]

To September 2016, the Top Three ASH conditions for Māori in the 0-4 year age group were; Dental Conditions, Asthma and Respiratory Infections- Upper and ENT.

For the 2017 year the contributory measures regarding the System Level Measure of Reduced ASH rates for 0-4 years as agreed by Health Hawkes Bay and the Hawke's Bay DHB are:

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

- Paediatric respiratory training
- Increased Immunisation Health Target
- Oral Health Initiative

45-64 years

As of September 2016 the Top Three conditions contributing to the ASH rate for 45-64yrs were; cardiac conditions, respiratory (including COPD and Pneumonias) and Cellulitis.

For the 2017 year the target areas as identified in the SLM-Improvement Plan will be;

Acute Hospital Bed Days (SLM)

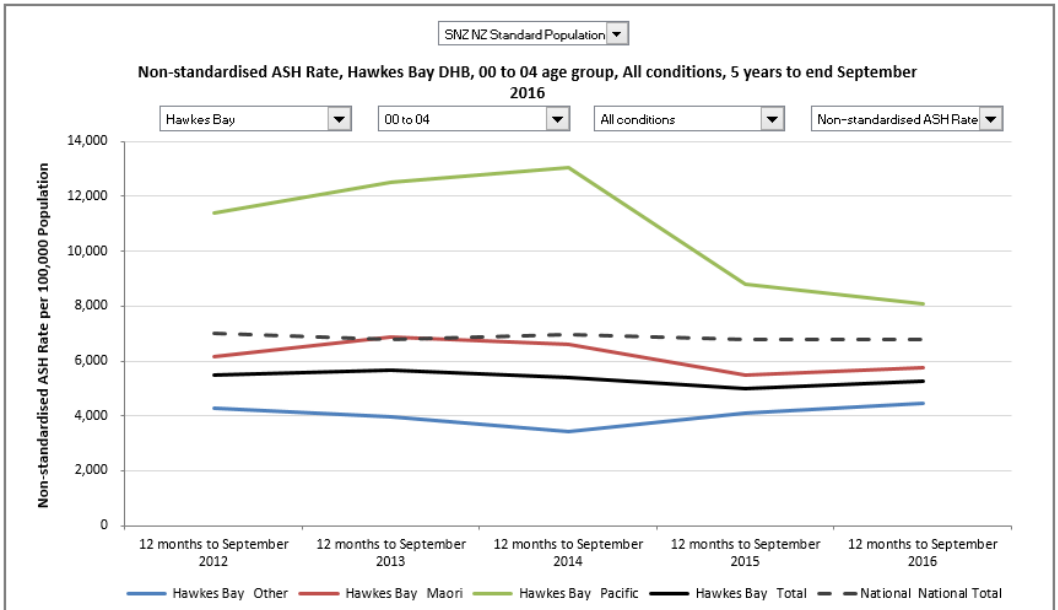
Contributory Measures

- ASH rates 45-64yrs
- Collaborative (Clinical) Pathways implementation for Cellulitis and Congestive Heart Failure
- Ed Admission rates; Cellulitis and Congestive Heart failure

HAWKE'S BAY DISTRIBUTION AND TRENDS

TARGET 0-4 YEAR AGE GROUP

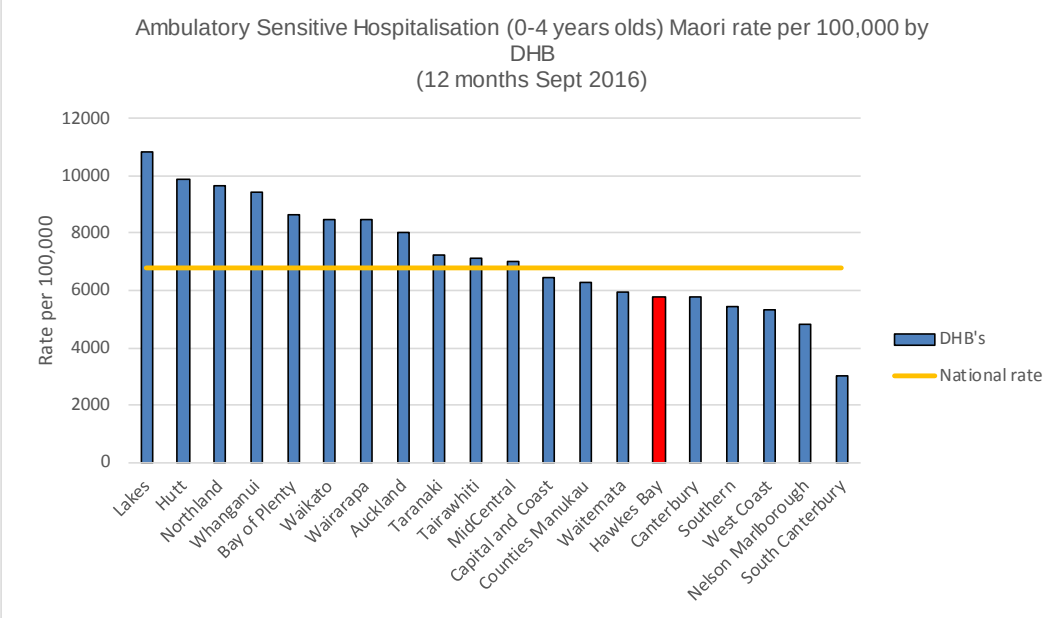
Hawke's Bay Māori ASH rates 0-4 year age group – 12 months to end Sept 2012-2016



		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	4,292	3,987	3,444	4,112	4,469
Hawkes Bay	Maori	6,178	6,865	6,619	5,479	5,755
Hawkes Bay	Pacific	11,405	12,500	13,030	8,788	8,088
Hawkes Bay	Total	5,489	5,683	5,382	4,995	5,272
National	Total	6,991	6,783	6,950	6,774	6,776

As at September 2016 Hawke's Bay tāmariki have lower rates of ASH compared to national rates for Māori and similar rates of ASH compared to national non-Māori. There has been a reduction in the gap between the Māori ASH rate and the national rates with a slight increase in the 12 month period to September 2016.

Māori ASH rates 0-4 year age group by DHBs – 12 months to end Sept 2016

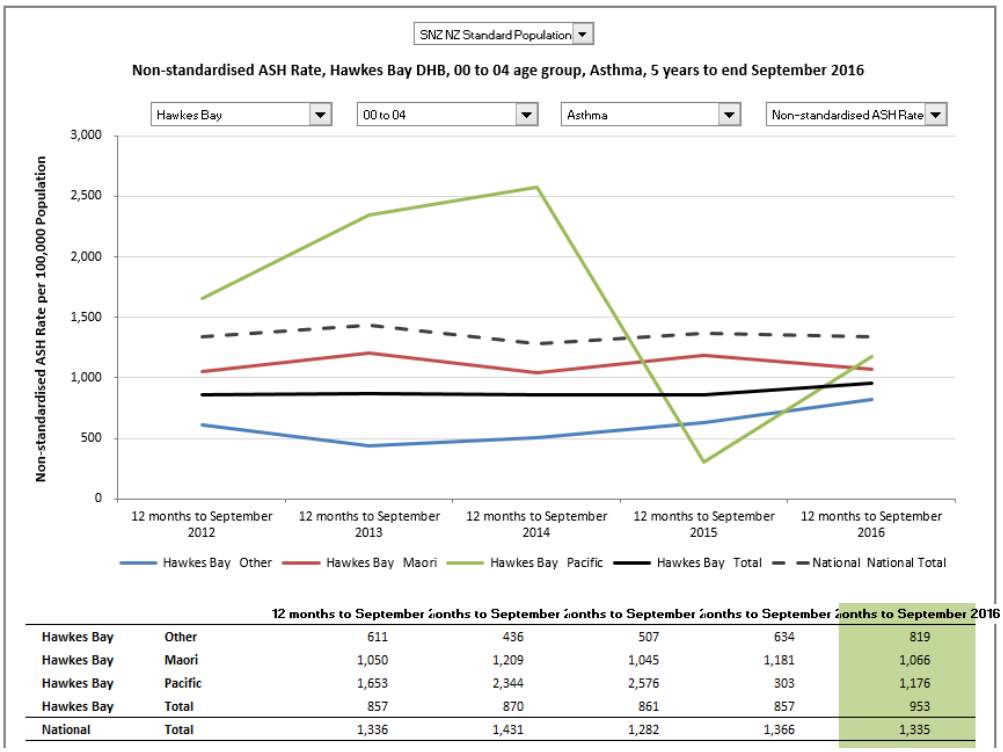


In the 12 months to September 2016 the Hawke's Bay Māori rate was 84.9% of the national rate and Hawke's Bay DHB was the 6th best performer of all DHBs with Māori rates substantially lower than national rates in this age group.

In 2016 the largest differences between Hawke's Bay Māori rates and national rates in the 0-4 year age group are in the conditions Cellulitus and Asthma - improvements have been made in the rates for Asthma over the last 12 months but there has been a decrease in the performance for Cellulitus.

Hawke's Bay Māori ASH rates 0-4yrs - improving

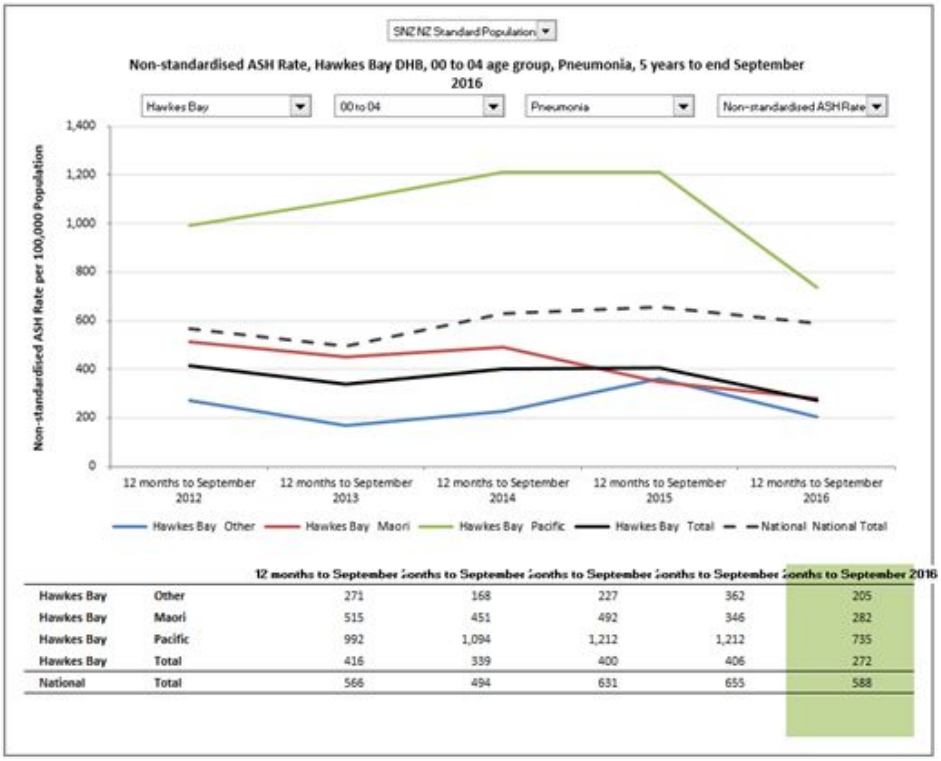
Asthma



		12 months to September 2012	12 months to September 2013	12 months to September 2014	12 months to September 2015	12 months to September 2016
Hawkes Bay	Other	611	436	507	634	819
Hawkes Bay	Maori	1,050	1,209	1,045	1,181	1,066
Hawkes Bay	Pacific	1,653	2,344	2,576	303	1,176
Hawkes Bay	Total	857	870	861	857	953
National	Total	1,336	1,431	1,282	1,366	1,335

Asthma is the 2nd ranked ASH condition for Māori 0-4 years yet rates have decreased slightly compared to the end of September 2015. There is also a reduction in the gap between Māori and non-Māori. By 12 months to end of September 2016 Māori rates were 23 % higher than rates for Other.

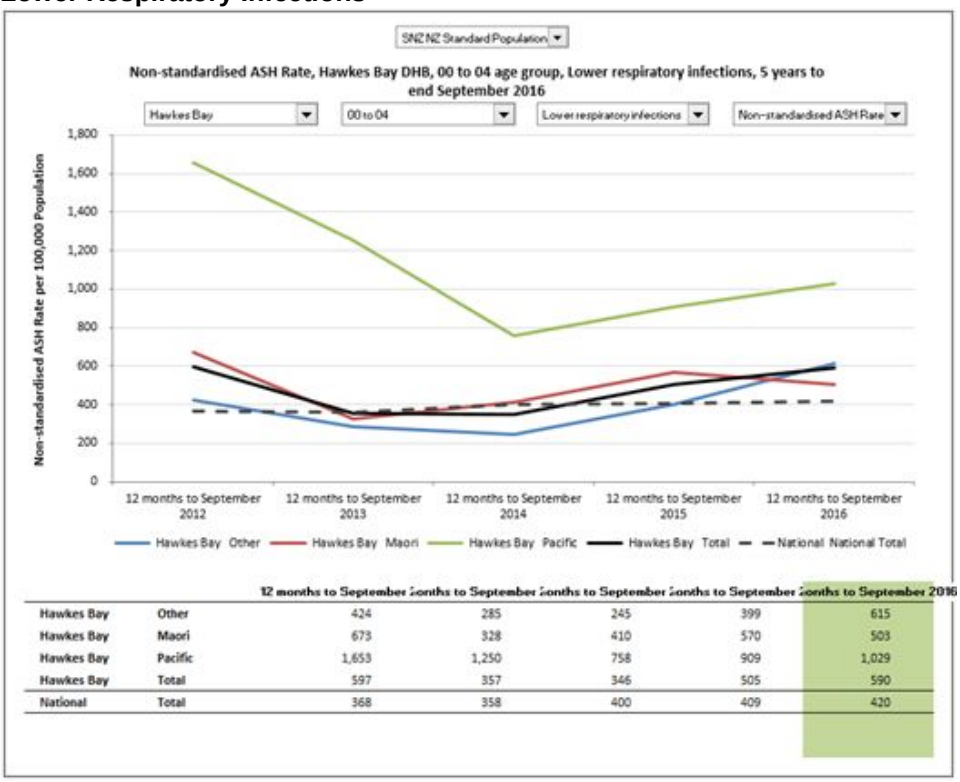
Pneumonia



		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	271	168	227	362	205
Hawkes Bay	Maori	515	451	492	346	282
Hawkes Bay	Pacific	992	1,094	1,212	1,212	735
Hawkes Bay	Total	416	339	400	406	272
National	Total	566	494	631	655	588

Pneumonia rates in the 0-4 years have decreased in the last two years. The Hawke's Bay Māori 0-4 year rate is half the national rate.

Lower Respiratory Infections

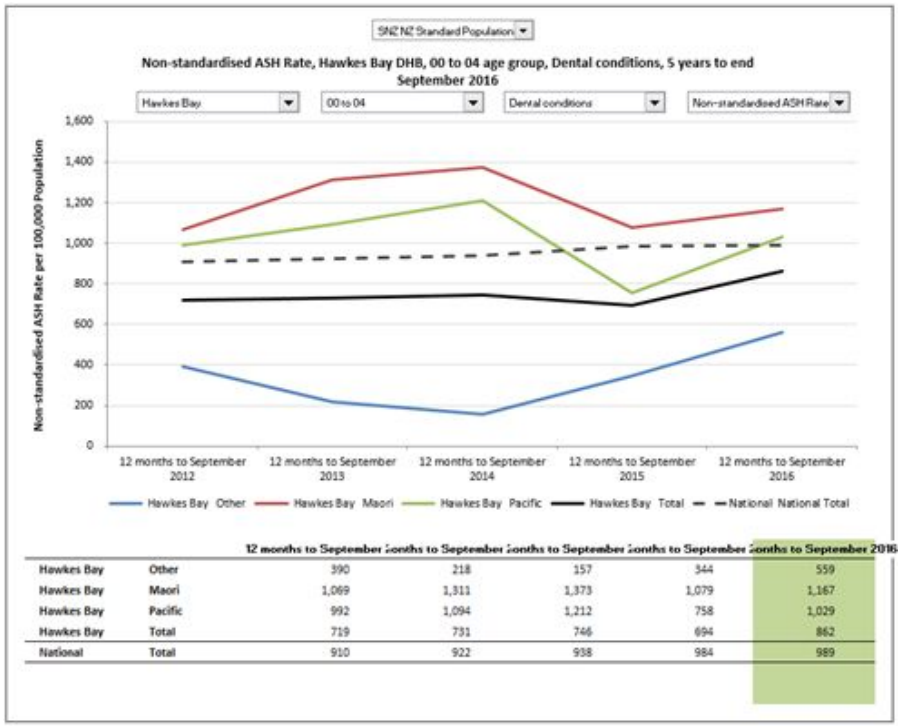


		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	424	285	245	399	615
Hawkes Bay	Maori	673	328	410	570	503
Hawkes Bay	Pacific	1,653	1,250	758	909	1,029
Hawkes Bay	Total	597	357	346	505	590
National	Total	368	358	400	409	420

Lower Respiratory Infections are 1.2 times the total national rate. In Hawke's Bay Māori 0-4 year olds are now the best performing ethnicity and is also below the rate for Hawke's Bay Other.

Hawke's Bay Māori Ash Rates 0-4yrs - Not Improving

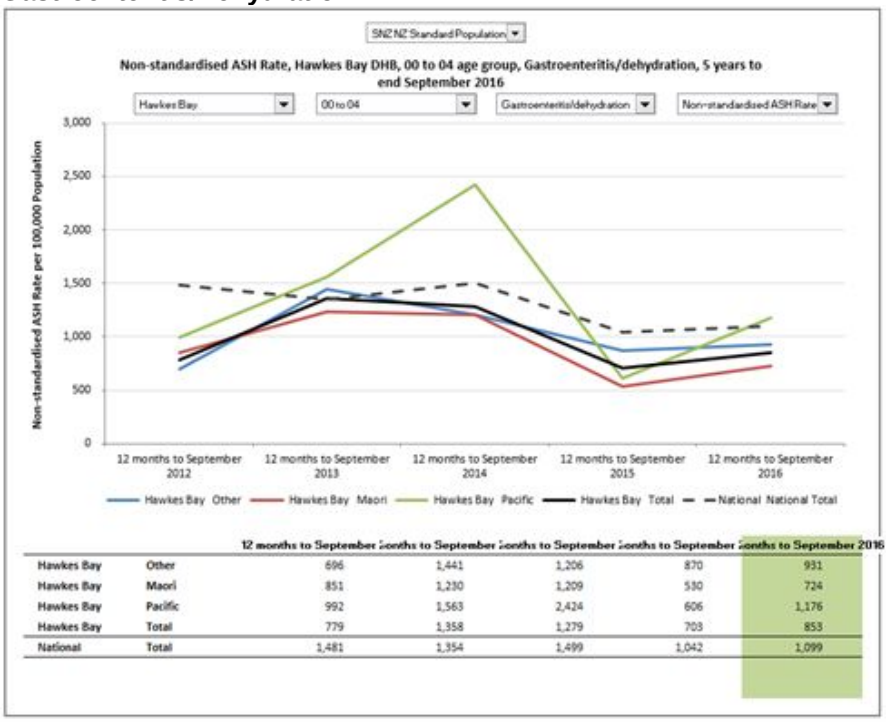
Dental



		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	390	218	157	344	559
Hawkes Bay	Maori	1,069	1,311	1,373	1,079	1,167
Hawkes Bay	Pacific	992	1,094	1,212	758	1,029
Hawkes Bay	Total	719	731	746	694	862
National	Total	910	922	938	984	989

Dental is the top ranked Māori ASH condition in the 0-4 year olds. Rates have increased in the last 12 months to September 2016 and Hawke's Bay Māori rates are 2 times the Hawke's Bay rate for Other and 1.2 times the total national rate.

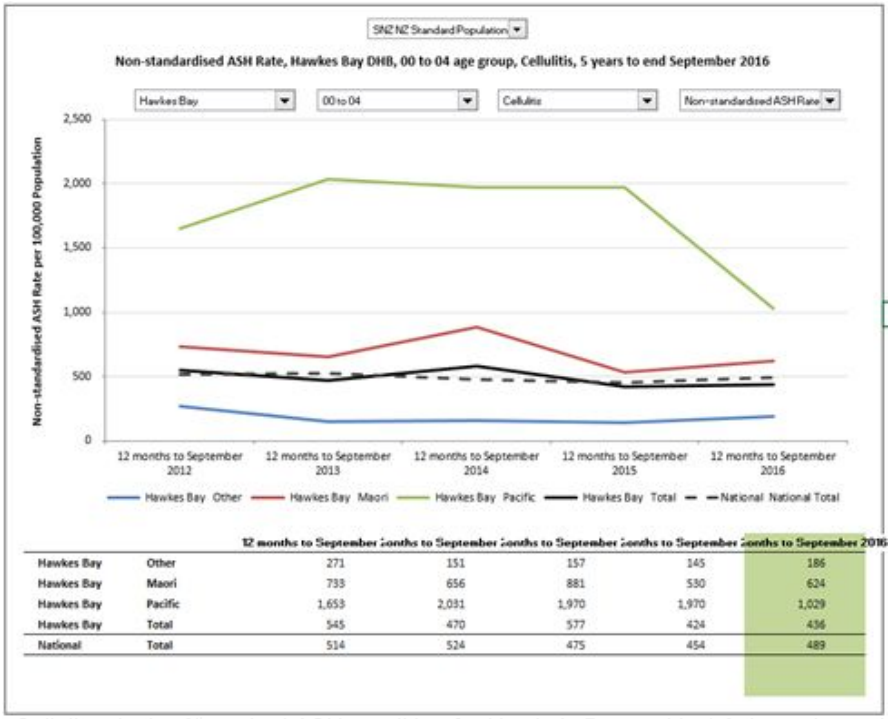
Gastroenteritis/Dehydration



		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	696	1,441	1,206	870	931
Hawkes Bay	Maori	851	1,230	1,209	530	724
Hawkes Bay	Pacific	992	1,563	2,424	606	1,176
Hawkes Bay	Total	779	1,358	1,279	703	853
National	Total	1,481	1,354	1,499	1,042	1,099

Ranked 4th for ASH conditions for Hawke's Bay Māori 0-4, Gastroenteritis/Dehydration increased over the current period 12 months to September 2016. Māori rates are lower than the Hawke's Bay non-Māori and below the national rates for total and Māori.

Cellulitis



		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	271	151	157	145	186
Hawkes Bay	Maori	733	656	881	530	624
Hawkes Bay	Pacific	1,653	2,031	1,970	1,970	1,029
Hawkes Bay	Total	545	470	577	424	436
National	Total	514	524	475	454	489

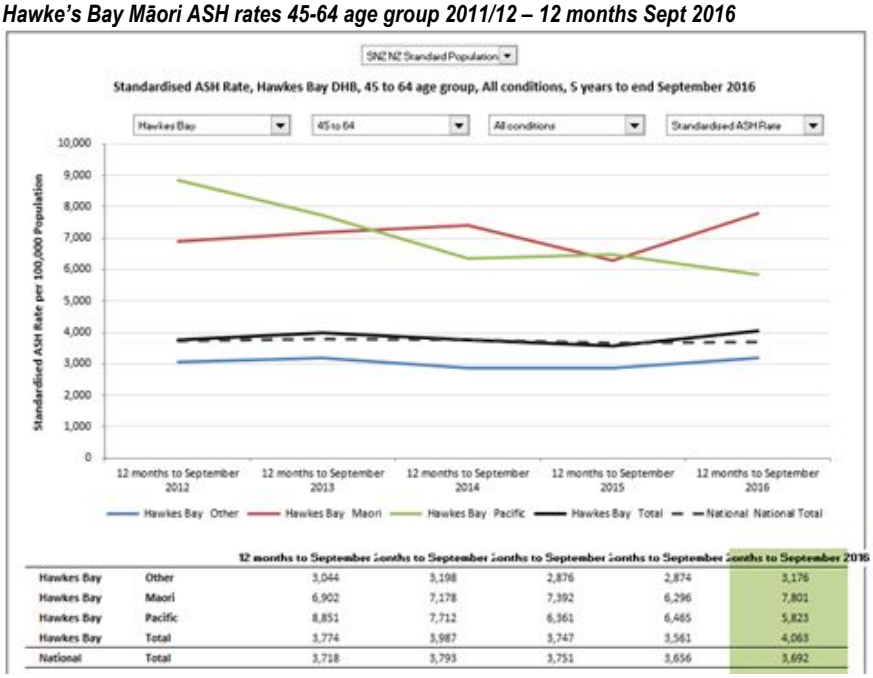
Cellulitus is the 6th ranked ASH condition for Hawke's Bay and is 1.3 times the national rate. There has been an increase from 530 per 100,000 for the period 12 months to September 2015 to 624 per 100,000 for the period 12 months to September 2016. It is also 3.4 times higher than the rate for Hawke's Bay Other.

ASH RATES 45-64 AGE GROUP

The expectation for ASH 45-64 is that there will be a minimum reduction by half of the equity gap between Māori and national total population base line data over a period of 2.5 years. Within 5% would be considered equity.[3]

Hawke's Bay Distribution and Trends

Hawke's Bay Māori ASH rates 45-64 age group 2011/12 – 12 months Sept 2016



		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	3,044	3,198	2,876	2,874	3,176
Hawkes Bay	Maori	6,902	7,178	7,392	6,296	7,801
Hawkes Bay	Pacific	8,851	7,712	6,361	6,465	5,823
Hawkes Bay	Total	3,774	3,987	3,747	3,561	4,063
National	Total	3,718	3,793	3,751	3,656	3,692

In period Sept 15-Sept 16	Increase in ASH rates Sept 15-Sept 16	Decrease in ASH rates Sept 15-Sept 16
Māori	1505	
Other	303	
Pasifika		642

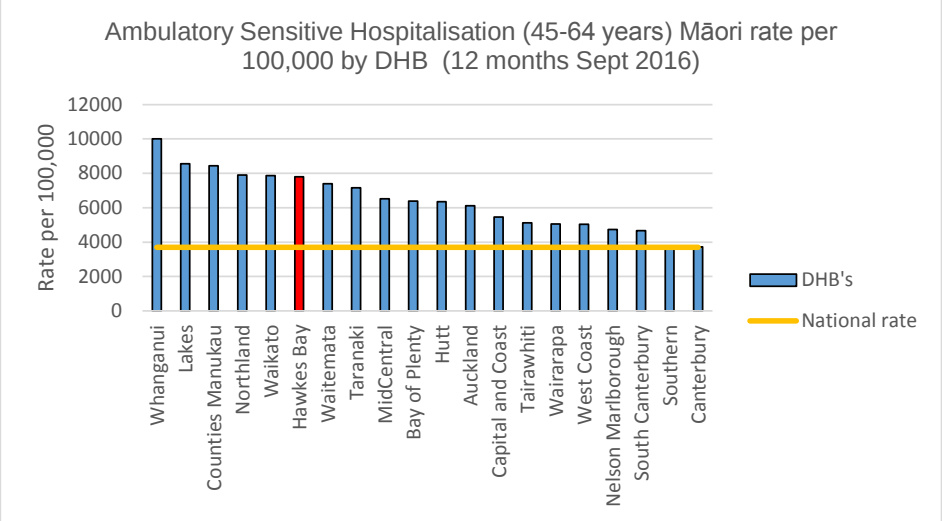
The top 3 ASH conditions for Māori in this age group are; Cardiac Conditions (Angina, Chest Pain, Myocardial Infarction), Respiratory (including COPD and Pneumonias) and Cellulitis.

There has been a decline in Hawke's Bay ASH rates in the 45-64 year age group in both Māori and non-Māori. In the 12 months to September 2016 the Hawke's Bay Māori rate was 1.9 times the Hawke's Bay non-Māori rate and 2.1 times the national rate.

The gap between the Hawke's Bay Māori rate and the Hawke's Bay non-Māori rate has widened between 2012 and 2016.

[3] As indicated by the MoH specifications for ASH rates.

Māori ASH rates 45-64 year age group by DHBs – 12 months to end Sept 2016

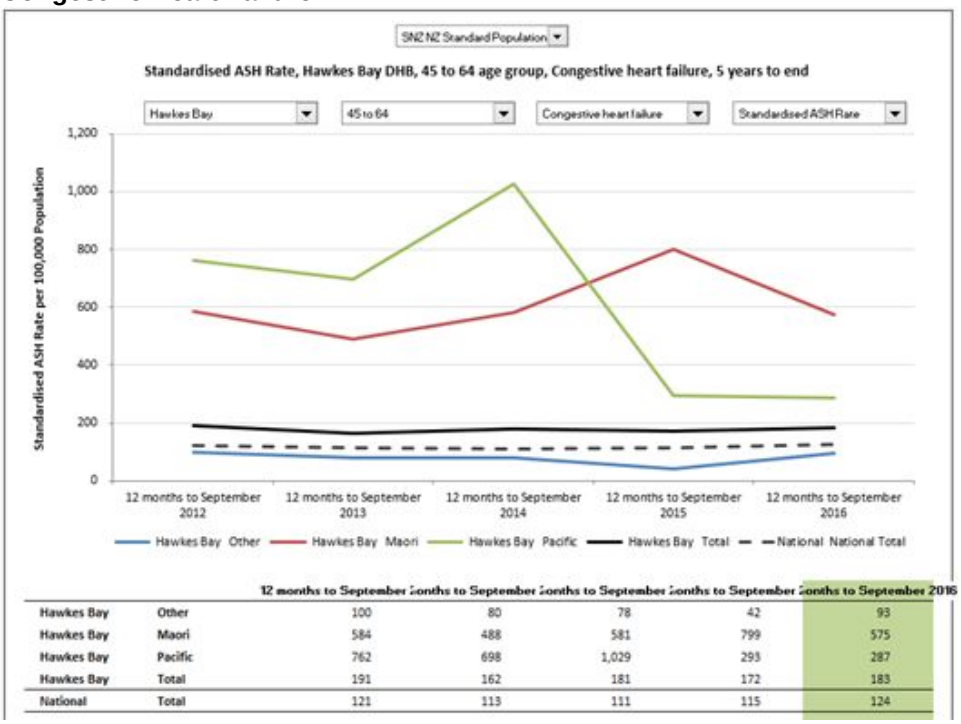


In the 12 months to September 2016 the Hawke's Bay Māori rate was 90% higher than the national rate and Hawke's Bay DHB is ranked 15th out of 20 DHBs. Māori rates are substantially higher than national rates in this age group across the majority of DHBs.

The largest differences in Māori rates and national rates by ASH condition in this age group are Congestive Heart Failure and Respiratory infections-COPD.

Hawke's Bay ASH rates 45-64yrs - conditions where Māori rates are - improving

Congestive Heart Failure

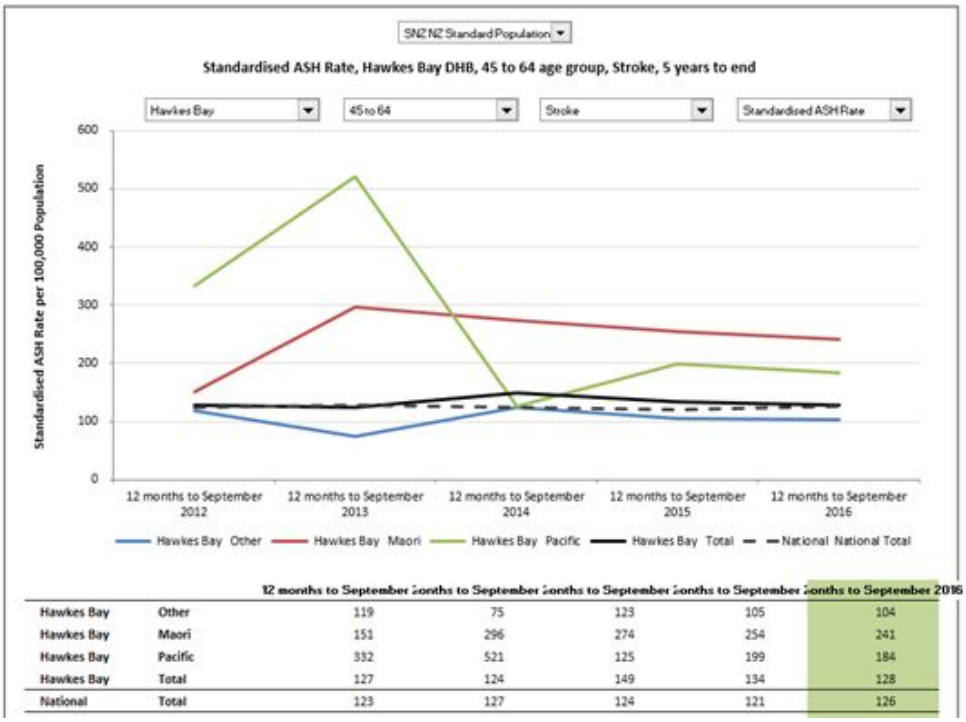


		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	100	80	78	42	93
Hawkes Bay	Maori	584	488	581	799	575
Hawkes Bay	Pacific	762	698	1,029	293	287
Hawkes Bay	Total	191	162	181	172	183
National	Total	121	113	111	115	124

Ranked 5th for ASH conditions Congestive heart failure has improved over the period 12 months and is now 0.3 times lower than 2015.

There is still a substantial gap between Hawke's Bay Māori and Hawke's Bay Other with the Māori rate being 6.1 times higher.

Stroke

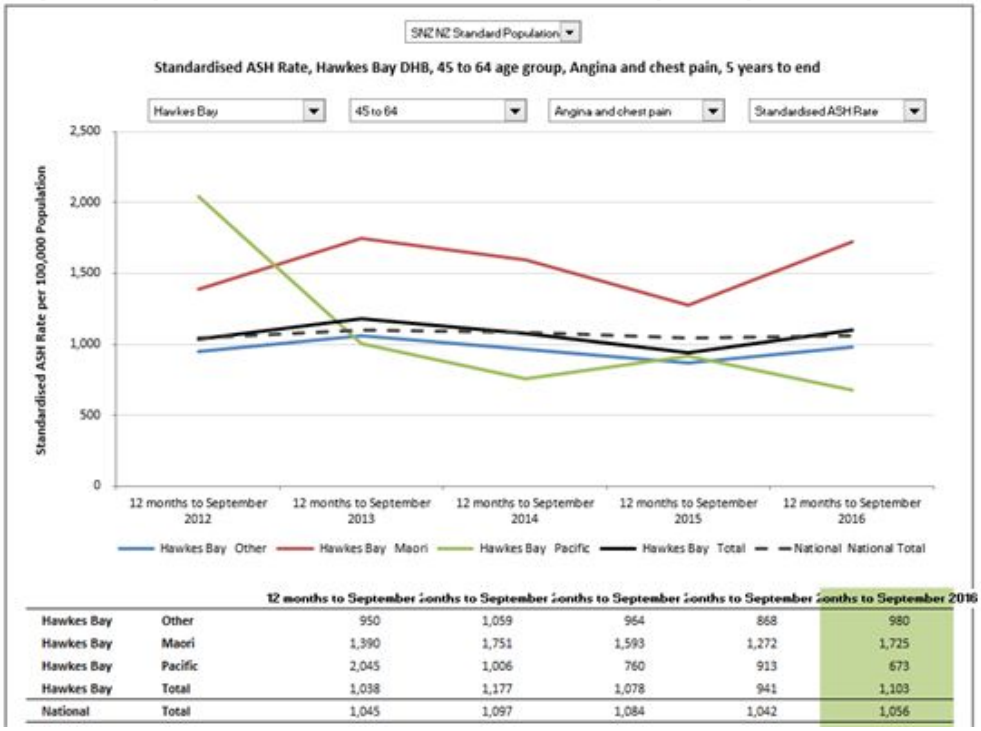


		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	119	75	123	105	104
Hawkes Bay	Maori	151	296	274	254	241
Hawkes Bay	Pacific	332	521	125	199	184
Hawkes Bay	Total	127	124	149	134	128
National	Total	123	127	124	121	126

Stroke has improved slightly over the period 12 months to September but is currently 1.9 the total national rate.

Hawke's Bay ASH rates 45-64yrs - conditions where Māori rates are - not improving

Angina – Top ranked ASH Condition for Hawke's Bay 45-64yrs

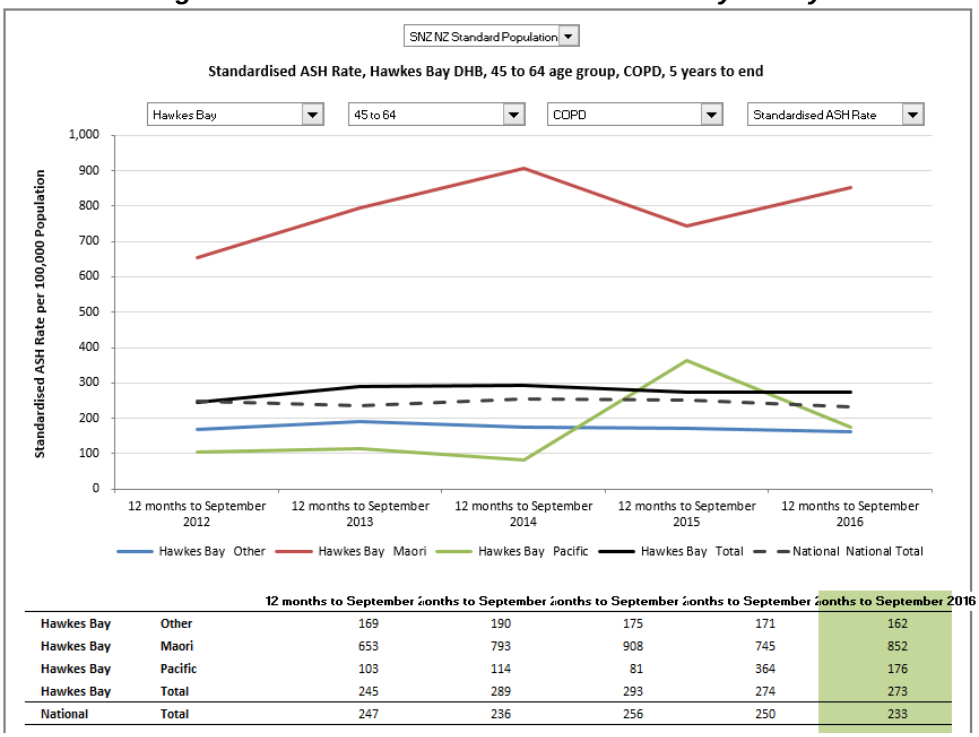


		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	950	1,059	964	868	980
Hawkes Bay	Maori	1,390	1,751	1,593	1,272	1,725
Hawkes Bay	Pacific	2,045	1,006	760	913	673
Hawkes Bay	Total	1,038	1,177	1,078	941	1,103
National	Total	1,045	1,097	1,084	1,042	1,056

Angina and chest pain is the top ranked ASH condition for Hawke's Bay Māori 46-64 and it has increased at a rate of 1.3 from the period 12 months to September 2015.

The rate is currently 1.6 times the national rate and 1.8 times the rate for Hawke's Bay Other.

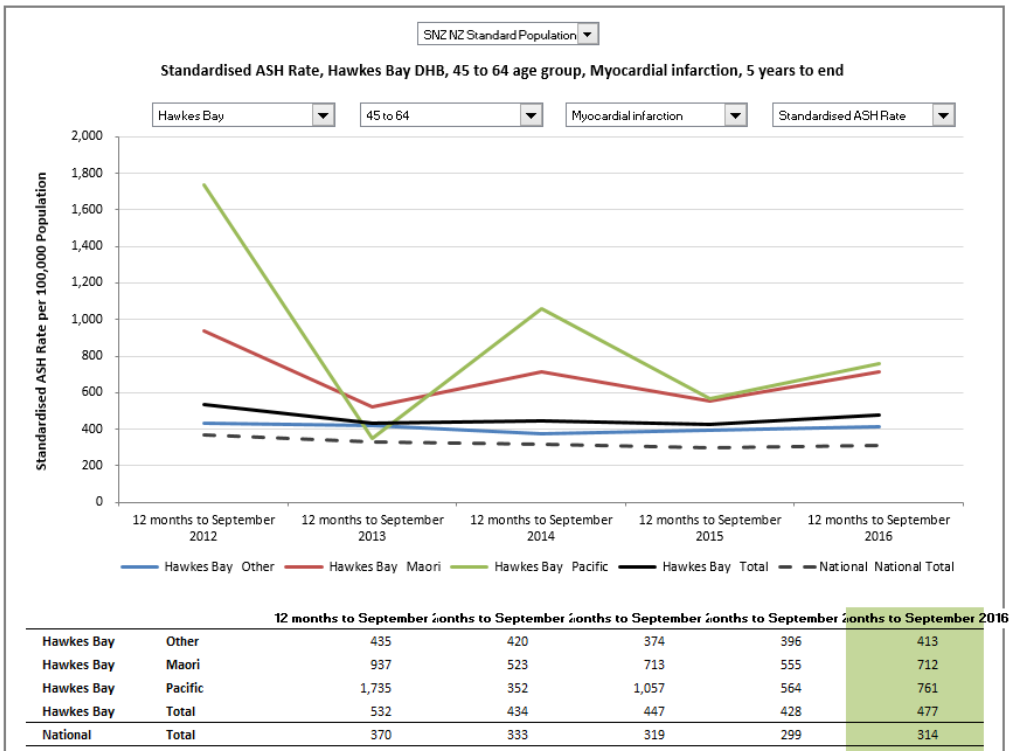
COPD – *2nd Highest ranked ASH condition of Hawke's Bay 45-64yrs*



		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	169	190	175	171	162
Hawkes Bay	Maori	653	793	908	745	852
Hawkes Bay	Pacific	103	114	81	364	176
Hawkes Bay	Total	245	289	293	274	273
National	Total	247	236	256	250	233

COPD is ranked 2nd for ASH conditions for Hawke's Bay Māori in the age group 45-64 years. There has been a 1.1 increase in the rate compared to the period 12 months to September 2015. Of greater signficance however is that the Māori rate currently sits 5.3 times higher than the rate for Hawke's Bay Other.

Myocardial Infarction - 3rd Highest ranked ASH condition of Hawke's Bay 45-64yrs



		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	435	420	374	396	413
Hawkes Bay	Maori	937	523	713	555	712
Hawkes Bay	Pacific	1,735	352	1,057	564	761
Hawkes Bay	Total	532	434	447	428	477
National	Total	370	333	319	299	314

Myocardial Infarction is ranked 3rd for ASH condition for Hawke's Bay Māori in the age group 45-64 years. The rate has increased at a rate of 1.2 in the period 12 months to September 2016 and has also widened against Hawke's Bay Other.

It is currently 1.7 times higher than the Hawke's Bay rate for Other.

REVIEW OF CURRENT AND PLANNED ACTIVITY RELEVANT TO SUPPORT THESE INDICATORS

0-4 YEAR OLDS

Paediatric respiratory training for Practice Champions

Paediatric respiratory training underway, 13 nurses from nine practices have currently completed. Health Hawkes Bay are working on a communication strategy out to general practice. Two further respiratory training sessions are scheduled.

The existing respiratory pathway has been modified to include children and a process is in place to support notification through to Practice Champions by CNS Paediatric Respiratory of all paediatric patients that have been admitted to hospital for asthma and wheeze.

Increased immunisation Health Target

Focus is on the measure: % of eight month olds who will have their primary course of immunisation (6 weeks, 3 months and 5 month immunisations events) on time. Hawke's Bay achieved target throughout the 2016 year. Concentrated efforts continue to ensure a targeted outreach service, provision of alternative venues and opportunistic immunisations in secondary services. Critical to the continued success of achieving the measure is a well-functioning NIR database which shares information between various child health databases.

Oral Health Initiative

The recommendations and findings report on 'Improving access to Community Dental Services for Tāmariki Māori' initiated by Population Health Service, Community Dental Service and Māori Health Service was released in July 2016. Key recommendations included; reinvesting resources with Well Child/Tāmariki Ora providers to manage children who are failing community dental appointments, introducing a patient focused booking system and revision of the 'hub and spoke' model of care.

Healthy Homes Programme

Hawke's Bay DHB and Health Hawkes Bay continue to fund a programme providing insulation and a range of interventions for households living in low socioeconomic areas who have significant health need. The greatest percentage of referrals into the Healthy Homes programme are for Māori and Pacific whānau. The MoH has expanded the criteria (and funding out to 2020) for the Healthy Homes Initiative which now includes pre-schoolers hospitalised for an indicator condition, at risk pregnant women/new mothers, and priority families with pre-schoolers for whom at least two of the following risk factors apply: CYF finding of abuse or neglect; caregiver with a Corrections history; mother has no formal qualification; and long-term benefit receipt

Work in Kohanga Reo

The re-establishment of DHB service provision within Hawke's Bay kohanga reo is now fully operational and enables the provision of education and advice to whānau, tamariki and kohanga around the management and treatment of skin conditions. As a result of a successful budget bid and investment, a new public health nurse was employed at the end of 2016, to continue to expand this programme.

The 'Clean it, Cover it, Treat it, Love it' skin resource has been translated for use in local Kohanga. This supports parents and Kaiako around best practice in recognition and management of skin issues. This aims to lead to earlier recognition and treatment of skin infections, avoiding the need for admission. Currently building feedback mechanisms for use of the resource into the action plan for 2017.

45-64 YEAR OLDS

Collaborative Pathways

Health Hawke's Bay and Hawke's Bay DHB are developing collaborative pathways across a range of conditions to improve practice by promoting the integration of services so that patients experience timely and consistent quality care that is coordinated in its approach within Hawke's Bay and reflects care that would be experienced elsewhere nationally.

Measuring the efficacy of the pathways is twofold. Firstly through analytics that would detail the current uptake and use of pathways within clinical practice and individual patient care and secondly through clinical patient / population health indicators.
Without both components, measuring the contribution that pathways make to patient outcomes is unreliable. The current platform on which the pathways are hosted does not currently provide this level of analytics.

An interactive application is going to be trialled with the anticipation that a fully interactive pathway can be developed. This would map how a pathway is being used by individual providers, link directly to patient information and ultimately be able to demonstrate the causal link between use of pathways to improve patient and population health outcomes.

Two pathways are being developed for a proof of concept. The cost of 35K has been approved by EMT (January 2017). The findings from the trial will be evident in June 2017 at which time the decision to extend to further pathways will be made by clinical council and EMT. It is anticipated that if the trial is successful all current pathways developed will be provided with the interactive function.

To date 30 pathways have been developed and GPs are increasing their use. From anecdotal evidence we can estimate that the most accepted pathways to date have been Respiratory (COPD), Dementia, Cellulitis and Last days of Life.

The new cellulitis pathway is reducing medication prescribing. This pathway was published and implemented into General Practice in November 2016 with the intent to change prescribing practice e.g. prescribe oral antibiotics and less use of intravenous antibiotics. However, if intravenous is required it is now a once daily administration rather than previous management which was twice daily – this saves the person time and cost to travel e.g. instead of two visits per day can be one. This pathway has been mirrored with slight changes and will be implemented into the Emergency Department, published date for February 2017. Consultants and nursing staff have received education and the change management is being led by the IV Clinical Nurse Specialist. Having this pathway in both primary and secondary care will endorse consistency of practice across both sectors.

The Congestive Heart Failure pathway aims to lead to improvements in consistency of practice not only in general practice but in aged residential care in the attempt to reduce and avoid hospital admissions. This is a very detailed prescribed pathway led by one of our dedicated Cardiologist and since publication has been reviewed with changes made due to national changes. This demonstrates the support from Clinical leads to ensue pathways are current within practice.

Promotion of all pathways is led by a small team that continues to socialise by visiting individual practices, promotion at CME/CNE training and quarterly newsletters.

Continuation of the Nurse-Led Respiratory Program

(Responding to Māori COPD rates-5.3 times the rate of Other)
Nurse led respiratory (including asthma and Chronic Obstructive Pulmonary Disease-COPD) clinics have been operating in General Practice since Sept 2014. Significant improvement and stabilisation of COPD rates for Pasifika and Other has been achieved.

This has not been the same for Māori, which currently sit at 5.3 time that of other with an annual increase of 1.2

Funding has been approved for the continuation of the pilot into a program of work that includes joint funding commitments from PHO and DHB. The focus of the program in its continued form will be addressing the high COPD rates of Māori

The service specifications are being developed currently and are being designed to intensify the focus on Māori outcomes and diversify the approaches whilst still repeating the proven work achieved with Other and Pasifika. The program methodology will follow and outcomes based framework.

Outcomes to date have seen decreases in ED presentations, hospitalisations and length of stay.

These outcomes can be attributed to the following key elements within the program:

- Emphasis on co-ordination and streamlining of client healthcare, with a strong Primary Health Care ethos focusing on early detection and timely management of chronic conditions at the primary care level.
- Nurse-led clinics are effective in co-ordination and self-management.
- Focus on Q4 and 5 patients representing 45% Māori accessing from quintile 5, and 65% Pacific) reflecting improved access to healthcare for high-needs clients
- Increased autonomy of nursing workforce with strengthened career pathway to CNS and Nurse Practitioner levels of competency
- Working in tandem with first line emergency services and pharmacy to provide patient management that reduces ED presentations for stabilisation.

Newly introduced elements to improve Māori Health outcomes are:

- Greater focus on whānau wellness vs the individual, supported by referral by Respiratory Clinical Nurse Specialist (R-CNS) to the whānau wellness program (PHO)
- Shift of emphasis on review rather than initial diagnosis allowing more people to be seen and more concentrated follow up
- The R-CNS to work with practice nurse champions alongside Māori health workers to improve capacity within the sector of specialist knowledge – management of respiratory conditions
- The R-CNS is working with exercise and health literacy teams to provide expert advice to improve program delivery and information
- Direct liaison by St John service with primary care for the management of patients instead of being transported to ED

Challenges:

- Disinvestment in secondary services with expectation of primary care to meet patient needs has not been accompanied by equivalent resources
- Non integration of primary and secondary service IT Patient Management Systems hinder real time transfer and visibility of clinical notes

The respiratory service will be used to trial the newly developed Draft Long Term Conditions Framework and the evaluation tool that has also been developed to support services in their planning reporting and implementation activities. The service has been selected to its focus on whānau based care, self-management focus and improved health outcomes for Māori.

Sharing Primary Care Practice Information

Business Intelligence has produced reports for a selection of general practices on their ED presentation and admission rates for consumers who had been identified as presenting 7+ times.
The pilot initiative was set up to help determine the causative factors. Initial findings have demonstrated a range of influences and the most informative was that the patients identified in the trail were both high users of ED and General Practice, with high to complex needs and or awaiting surgical intervention.

Sharing of practice level data – pertaining to consumer utilisation of hospital based services has proven to be effective in identifying opportunities for service integration and coordination of patient centred care.

The initiative is continuing and work is underway to extend to additional data sharing with an ever greater number of general practice involvement with the appropriate oversight for a confidentiality and IT governance perspective.

RECOMMENDATIONS FROM TARGET CHAMPION

As the Champion for the TAW ASH rate report there were two things that stood out for me.

1 For ASH rates 0-4 we are doing well, both with national comparisons and with the closing of the equity gap. We are now well in the lower half of the league table of DHB ASH rates in this age group and, pleasingly, the gap between the Maori rates and the total population is small and closing. Dental admissions is the one issue that does need to be highlighted were the rates are still high, however the work done with getting younger children engaged with the dental service should lead to improvements over the next 1-2 years.

2 For ASH rates in the 45-64 age group the HBDHB is at the wrong end of the league table with rates higher than the national average and some very large discrepancies between Maori and non-Maori. COPD and Heart Failure stand out as issues that need to be addressed.

CONCLUSION

There is significant work with COPD by the Respiratory Pilot which has now become BAU and for CHF the appointment of a CNS to work between primary and secondary care should help with this. It is interesting that CVD rates are much closer to the national average and have a much lesser equity gap. This could represent a time gap with improvements in primary prevention still to come through but could also indicate an treatment gap where Maori are not being treated as successfully for their CVD and therefore going on to develop CHF.

Dr Mark Peterson
Chief Medical Officer - Primary

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:

24. Confirmation of Minutes of Board Meeting
    - Public Excluded

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

26. Board Approval of Actions exceeding limits delegated by CEO
27. Chair's Update
28. Preliminary Budget - Presentation
29. Integrating GP Services in Wairoa - verbal
30. Maintaining the Radiology Service to Primary and Secondary Care
31. Cranford Hospice
32. Finance Risk and Audit Committee Report
33. Hawke's Bay Clinical Council

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).