BOARD MEETING

Date: Wednesday, 29 March 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

Apology: 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 held 22 February 2017 - Minutes of a Special Board Meeting held 15 March 2017		
5.	Matters Arising - Review of Actions		
6.	Board Workplan		
7.	Chair's Report – verbal		

8.	Chief Executive Officer's Report - Minister's Letter of Expectations - Quarter Two 2016/17 Health Target Results	20	
9.	Financial Performance Report – February 2017	21	
10.	Health & Safety Board Champion's Update (verbal) - Helen Francis	-	
11.	Consumer Story (verbal) - Kate Coley	-	
	Section 2: Reports from Committee Chairs		
12.	HB Clinical Council - Co-Chairs Chris McKenna & Dr Mark Peterson	22	1.50
13.	HB Health Consumer Council - Chair, Graeme Norton	23	2.00
	Section 3: Decision		
14.	Palliative Care in Hawke's Bay - Our vision and priorities for the future 2016–2026 Chris McKenna, Chief Nursing Officer	24	2.10
15.	Draft Annual Plan for 2017 – Tim Evans, Tracee TeHuia	25	2.25
	Section 4: Discussion / Information		
16.	Chaplaincy Presentation – Barbara Walker (Chaplain)	-	2.35
17.	Travel Plan Report - Sharon Mason and Andrea Beattie	26	2.45
	Section 5: Monitoring		
18.	Te Ara Whakawaiora / Access 0-4 (local indicator) - Mark Peterson / Nicky Skerman	27	2.55
19.	Te Ara Whakawaiora / Breast Feeding (national indicator) - Chris McKenna	28	3.05
	Section 6: General Business		
20.	**Section 7: Recommendation to Exclude the Public**		
	Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	Section 8: Agenda Items	Ref #	Time (pm)
21.	Minutes of Previous Meeting		3.10
22.	Matters Arising – Review of Actions		
23.	Board Approval of Actions exceeding limits delegated by CEO	29	
24.	Chair's Update		
	Section 9: Decision / Discussion / Information		
25.	Havelock North Gastroenteritis Outbreak August 2016 – Kate Coley	30	3.15
26.	Cranford Hospice – Ken Foote	31	3.35
	Section 10: Reports from Committee Chairs		
27.	Finance Risk & Audit Committee – Chair Dan Druzianic 27.1 Final Management Report on the Audit of HBDHB for y/e June 2016 27.2 Audit NZ Engagement / Arrangement Letter	32 33 -	3.50
28.	HB Clinical Council - Co-Chairs Chris McKenna & Dr Mark Peterson	34	4.05

Next Meeting: 1.00 pm, Wednesday 26 April 2017

Board "Interest Register" - 9 March 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
	Active	Board Member of Health Partnership Limited (HPL), *effective from 9 March 2017*	Led, supported and owned by the 20 DHBs, NZ Health Partnerships creates efficiencies in the health sector that allow more to be spent on frontline services.	Will not take part in any decisions in relation to HPL	The Chair of FRAC	22.02.17
Ngahiwi Tomoana (Deputy Chair)	Active	Chair, Ngati Kahungunu Iwi Incorporated (NKII)	Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB: (i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department. (ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department.	Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB.	The Chair	01.05.08
	Active	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

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
	Active	Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014	Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers.	Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on.	The Chair	16.01.14
	Active	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 22 FEBRUARY 2017, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.00PM

Present: Kevin Atkinson (Chair)
Dan Druzianic
Peter Dunkerley
Diana Kirton
Barbara Arnott
Jacoby Poulain
Ana Apatu
Hine Flood

Apology Ngahiwi Tomoana, Heather Skipworth and Helen Francis

In Attendance: Kevin Snee (Chief Executive Officer)
Members of the Executive Management Team
Chris McKenna (Chair, HB Clinical Council) and Dr John Gommans (CMO)
Graeme Norton (Chair, HB Health Consumer Council)
Members of the public and media

Minutes Brenda Crene

KARAKIA

Hine Flood opened the meeting with a Karakia.

APOLOGIES

Nil

INTEREST REGISTER

No changes to the interests register were advised

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

Action: Note Kevin Atkinson on the Interest register as Board member of Health Partnerships Limited from 9th March 2017.

CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on 14 December 2016, were confirmed as a correct record of the meeting.

Moved: Dan Druzianic
Seconded: Peter Dunkerley
Carried

MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: **Fracture Clinic / Orthopaedic Department near ED –** this was raised for consideration in August 2016 and has been considered by the parties who are working towards a solution. The COO asked for the item to be removed in the meantime as they are working on systems and processes, and future thinking and opportunities would see this revisited in the future. In the meantime there is a close relationship between ED and the fracture clinic / orthopaedics. Remove item.

Item 2: **Adult Inpatient Experience Results** – Update provided by Dr Gommans around query with services as to whether families can be in attendance when specialists visit their loved ones. Item closed.

Item 3: **Dental introduction to Pasifika Health** – Dr Whyman has been put in touch with the PHLG Chair. Remove action.

Item 4: **Raising Healthy Kids** – Comments were provided and noted. Remove action.

BOARD WORK PLAN

The Board Work Plan was noted.

Confirming the HB Health Sector Leadership Forum will be held on Wednesday 15 March with the focus on social investment and health outcomes leaders want to see delivered. Part of the programme will look at the support of technology.

Action: Issue the draft programme to board members for the HB Health Sector Leadership day on 15 March.

The topic of Home Dialysis will be rescheduled as a district review around Renal Services is being undertaken.

Action: Home Dialysis will be rescheduled on the workplan as "Renal Services Review" for the May 2017 board meeting.

The Board requested an update on the Vulnerable Children project from Russell Wills.

Action: An update on the Vulnerable Children Project would be scheduled for the April 2017 board meeting.

The Chair requested an update on Car Parking at the meeting which was provided by the CEO.

CHAIR'S REPORT

- The Chair advised the following retirement, 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
Josephine Ross	Registered Nurse	Communities Women & Children	23	17 January 17

- The Letter of Expectations had been received from Minister for the 2017/18 year, noting strong emphasis on care in the community and services provided closer to home, especially for long term conditions. Focus also to consider local initiatives to fit in context with the health strategy. Living within our means remains a challenge. Focus remains on health targets and streamlining annual plans.
- Health targets were released 21 February 2017, with improvements noted.
  - Congratulations on Targets.
  - Immunisation top performance continued.
  - Congratulations for the smokers to quit target at 87%. The Chair and board conveyed their congratulations to the PHO management and staff on the achievement of that result.
  - Raising healthy kids was of concern and however was receiving focus.
  - Faster Cancer Treatment (FCT) was low. An extensive discussion had been held at the FRAC meeting on this and the Chair advised there was a feeling of confidence the result would be achieved by June.
- Financially, Hawke's Bay continues to remain in a positive financial position. Currently 11 DHBs were negative to budget (at 6 months); with 12 DHBs anticipate producing a positive result at financial year end in June 2017.
- It was noted the Patient Portal had grown and 445 general practices nationally are offering this.

- Concerns around car parking were raised by the Chair. On investigations around a suggestion to have angle parking placed in McLeod street, the Hastings District Council advised that for the work involved it would only result in three additional car parks overall.
- Board members were advised that the Chair and CEO had been invited to meet the Ahuriri District Health (ADH) Board on 20 December 2016. They found this a positive meeting and conveyed that ADH were currently focusing on the Maraenui Care Centre.
- **DHBs joint induction day held in Wellington on 9 February:**
  Disappointment was expressed by those who had attended, especially by new board members. Members were urged to fill in the feedback forms provided, however it was felt the forms were inadequate to fully express members concerns. It was felt a letter conveying the members concerns would be more appropriate.

  Action: A joint submission from the board members who attended the 9 February 2017 Induction day in Wellington would be assembled by Ken Foote. The notes taken at the board meeting would be retained and additional feedback sought via email.

BOARD COMMITTEE MEMBERSHIP

Following a brief discussion as placements had been discussed by Board members prior, the following resolution was approved

RECOMMENDATION

That the Board appoint the board members to the respective committees as outlined below.

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		●	●	●	●		

Moved Barbara Arnott
Seconded Diana Kirton

Carried

CHIEF EXECUTIVE OFFICER'S REPORT

The CEO provided an overview of his report summarised, with additional comments around parking, as noted below:

Travel Plan Update:
Strategy developed a year ago. Parking costs will be introduced from 1 March 2017, with all money raised put back into parking improvements.

- It was noted that 345 patients utilised the free bus service in January, with more and more patients choosing to ride the bus instead of drive.
- Staff were being encouraged to cycle, providing secured bike sheds and showers as required
- To support biking and walking with maps provided.
- 75 staff members have advised they will be utilising free car pooling
- The Travel plan was specifically designed to alleviate parking problems in and around the Hastings hospital site. Wider initiatives were being developed for the wider area.
- A board member advised that "Neighbourly" (Facebook) was being monitored and she noted the majority of discussion for those residing in the Taradale area was supportive. Some on the site advised they could not use the service(s) as they lived in the country! However they could easily park their vehicles near respective bus stops and ride the bus to appointments at no cost.
- Regular updates on travel and parking will be provided to the Board including patient and staff feedback.

A dip in ED Performance was noted with 162 ED presentations recently, being the highest ever! We are working with our GP partners to ascertain where improvements can be made.

FINANCIAL PERFORMANCE REPORT

The financial result report for January 2017 showed 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.

Going forward challenges remain around activity levels to recover and achieve our savings programs. EMT have put in place a supplementary programme to achieve the rest of the financial year. A lot of work has been done with decision makers reviewing options to address current shortfalls.

HEALTH & SAFETY BOARD CHAMPION'S UPDATE - nil to report.

CONSUMER STORY

Kate Coley provided a short story on a UK visitor to NZ who was highly complimentary of the seamless treatment he received in HB for a fractured leg (from GP/ED/Surgery/Nuirsing/Physio). The cost on this occasion was covered by ACC.

Around 2,500 visitors from other countries are treated in HB annually. We have an obligation to treat acute illness and chasing debt is always a problem. It was noted that seasonal workers now have health insurance as part of their working conditions.

REPORT FROM COMMITTEE CHAIRS

Hawke's Bay Clinical Council

Chris McKenna spoke to the report from the Council meeting held 8 February, 2017. She conveyed Dr Mark Peterson's apology.

In Summary:

- ICU report: Actions are receiving focus through to resolution.

- Council oversees the development of Pathways with good progress being made.
- Received an update on the Orthopaedic review
- Imaging Guidelines were supported and endorsed by Council
- Choosing wisely – actively working through clinical leaders to roll out across the community. Also about choosing what we do well for patients.
- Radiology paper was received.

Appointment to HB Clinical Council

Following the receipt of resignation from a Senior Nurse representative on Council, the following recommendation to appoint Robyn O'Dwyer's replacement was approved.

RESOLUTION

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

Moved Barbara Arnott
Seconded Hine Flood

Carried

Hawke's Bay Health Consumer Council

Graeme Norton Chair of Council advised the outcomes of their meeting held on 9 February, 2017:

- Youth Council members were welcomed to the meeting and two representative would attend the monthly meetings. Ethnicity and age of the Youth group was raised and seen as a good representation. This group had been engaged in the development of the Youth Strategy.
- The TAW report around access had been received and Consumer Council endorsed MRBs comments. It was full of graphs and results but there appeared to be a lack in understanding of what was working, and what was not.

  The report that came through EMT was without recommendation, which had been included prior to being issued to the committees however had not gone back through EMT. There was an expectation the recommendations related to the analysis and this had not occurred. No one had highlighted that 0-4 year olds were dropping despite doing a lot of things to improve. It was difficult to understand why there were differences between Pasifika and Maori.

  Action: The Te Ara Whakawaiora / Access report recommendations need to be re-written to focus on the analysis provided. The revised report would be considered by EMT prior to being resubmitted to the Board in March.

Māori Relationship Board (MRB)

The report provided to the board outlining the MRB meeting held on 8 February, 2017 was taken as read.

Pasifika Health Leadership Group

The meeting was not held due to lack of quorum and was being rescheduled.

FOR DECISION / DISCUSSION / INFORMATION

Orthopaedic Review phase 2

Andy Phillips provided a presentation to members on the second phase of the Orthopaedic Review including:

Community Care MAP - Opportunities to Inform System Change:
- Intentional service design to abolish inequity
- Self-management support programmes
- Use of patient outcome and experience knowledge
- Shared record - Whānau Tahi
- "Virtual" GP consult
- Relationship Centred Practice

Dynamic pathways 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 .

In summary, questions raised included:

- Queried access to surgery by middle aged who have huge impacts on their working life and huge impacts on their families. Can we have these people seen faster and not just rely on the points system to ensure they get treated and back to work. The Chair asked that more consideration be given to this area.

  In response, this was recognised and was already covered within the" social impact assessment" within the national scoring tool utilised by Hawke's Bay. HB are also working on joint injections and having GPs trained in this area.

- It was noted the paper was supported by Clinical and Consumer Councils.

- MRB asked to have an "Ethnicity Māori Waiting List" added to the assessment tool for surgical procedures.

  This was a specific request that may need a change in policy.
  In response, this may not be able to be considered. A discussion with surgical services would be had on how this may be done with no commitment made. Must understand what this would mean, first and foremost. Need to be very careful as we do not need/want people flowing into our communities to have treatment.

  Action: Consider an Ethnicity Māori Waiting List being added to the assessment tool for surgical procedures.

RECOMMENDATION

That the 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.

Adopted

Community Representatives on Te Matau a Maui Health Trust

An overview of the recommended appointment was conveyed to members in line with the report provided. The board accepted the recommended appointments which conclude in March 2020:

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).

Adopted

MONITORING

HR KPIs Q2 Oct-Dec 2016

Kate Coley commented on the report summarised below:

- Steady progress has been made with improving Maori employment (in HB health). The emphasis has been shifted now on to how best to retain the Maori workforce, before we get to an exit interview.
- Annual Leave at 2 years plus has been tracking at below the prior year with work continuing in the area to improve.
- It was noted that staff turn-over has been slightly above the benchmark – need to do more work around themes in exit interviews.

It was noted that management and administrator numbers had increased 4.6% of late. HBDHB do remain below the cap and vacancies were being filled, however we need to ensure there are not any other reasons/issues?

HBDHB Non-Financial Exceptions Report Q2 Oct-Dec 2016 including the MoH Dashboard

Anne Speden the new Chief Information Officer (CIO) was introduced to the Board.

The areas of progress, achievement and focus were summarised.
Customer focused booking, dental and orthopaedic remain areas of focus. Also work around Pacific Island rates with a team refocusing in this area.

An error had been picked up with data in the area of "Children with obesity" with incorrect historical data up to mid November being incorrect (and flowing through). This is a DHB monitored target.

Annual Māori Health Plan Non-Financial Exceptions Report Q2 Oct-Dec 2016

Patrick LeGeyt and Justin Nguma provided an overview of the report.

In summary:

- Good progress has been made in mental health (under 19 year old access and Compulsory Treatment Orders).
- ASH rates continue to improve for 0-4 year olds towards the expected target of 83%.
- The COO has a KPI relating to improving Maori Employment and progress is being made with staff's cultural shift in thinking in the interview process. There is a good working group focusing on how to improve workforce recruitment opportunities for Māori, apprenticeships, EIT and work experience.
- Rheumatic fever rates in HB had risen. Dr John Gommans commented increases were largely in areas where the rheumatic fever campaign had not traditionally been focused
- The Te Ara Whakawaiora (TAW) programme has historically monitored/tracked progress and making effective Māori health gains. Although there is no Annual Maori Health Plan in 2017/18, there is a real desire to retain the TAW monitoring programme through 2017/18.

  Action Patrick LeGeyt: The presentation rosettes indicates where HB are doing particularly well, however the board were wanting to compare HB with other comparable populations such as BOP, Northland and Lakes.

Te Ara Whakawaiora / Access (local indicator)

The comment raised earlier that the recommendations were not strong enough. The problem was clear but needed to pull together at an operational level as to what the recommendations will be need to be brought back by Dr Mark Peterson.

GENERAL BUSINESS

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

RESOLUTION TO EXCLUDE THE PUBLIC

RESOLUTION

That the Board

Exclude the public from the following items:

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

For Information /Discussion

28. High Level Budget Presentation 2017/18

29. Integrating GP Services to Primary & Secondary Care

30. Maintaining the Radiology Service to Primary & Secondary Care

31. Cranford Hospice

Reports and Recommendations from Committee Chairs

32. Finance Risk and Audit Committee Report

33. HB Clinical Council

Moved: **Peter Dunkerley**
Seconded: **Hine Flood**
Carried

The public section of the Board Meeting closed 3.10pm

Signed: _____
Chair

Date: _____

MINUTES OF A SPECIAL BOARD MEETING
HELD ON WEDNESDAY 15 MARCH 2017, IN THE CHEVAL LOUNGE,
HASTINGS RACECOURSE AT 1.00PM

Present:	Kevin Atkinson (Chair) Ngahiwi Tomoana Dan Druzianic Peter Dunkerley Diana Kirton Barbara Arnott Ana Apatu Jacoby Poulain
Apology	Helen Francis
In Attendance:	Ken Foote

A letter had been received from Jenny Black, Chair National DHB Chairs, seeking Shareholder Approval for a written resolution.

Given the need to have all shareholding DHB's in a position to sign the written resolution on 20 March 2017, it was necessary for HBDHB to gain approval through a special meeting, given most Board members were together on the day for the Hawke's Bay Heatlh Sector Leadership Forum Workshop.

Kevin Atkinson advised that all his colleague DHB Chairs were supportive of this resolution being adopted by NZ Health Partnerships Ltd. He personally believed that 'Chief Executives" could remain as potential Directors, but given the circumstances and timing of this urgent request, recommended that the Board approve the Resolution.

RESOLUTION

That the Board (as a shareholder of NZ Health Partnerships Ltd) approves a Special Resolution of the Company that:

1. The existing constitution of the Company is altered in the following manner:

   The paragraph found at the end of **clause 9.3(b)(i)** of the constitution, which reads:

   > "The notice of appointment of each director must be signed by each DHB Shareholder jointly appointing that Director. Each Director must be a Chair or Chief Executive of one of the DHB Shareholders appointing the Director. The DHBs will endeavour to ensure that the composition of DHB Directors includes a mix of DHB Chairs and DHB Chief Executives."

   is altered by deleting the term "Chief Executive" and replacing it with the term "Deputy Chair", and deleting the last sentence of that paragraph so that the altered paragraph now reads:

   > "The notice of appointment of each director must be signed by each DHB Shareholder jointly appointing that Director. Each Director must be a Chair or Deputy Chair of one of the DHB Shareholders appointing the Director."

2. The Company adopts the alteration to the constitution in the form circulated in this resolution.

Moved: **Ana Apatu**
Seconded: **Peter Dunkerley**
Carried

The meeting closed at 1.20pm

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	22 Feb 17	**Interest Register update for Kevin Atkinson** from 9 March 2017	Admin		Actioned
2	22 Feb 17	**Issue *draft* programme to board** members for the HB Health Sector Leadership Forum on 15 March.	Admin		Actioned
3	22 Feb 17	Board Workplan: a) **HB Health Sector Leadership Forum:** issue draft programme to the Board. b) Home Dialysis will be rescheduled from the March board meeting to June and be referred to as "**Renal Services Review"**. (Advised May at the board meeting – since revised to June). c) **Vulnerable Children Project**: an update will be provided by Russell Wills at the April 2017 board meeting.	Ken Foote Sharon Mason Sharon Mason	 June Apr	Actioned Included on the Workplan. Actioned Included on the Workplan. Actioned
4	22 Feb 17	**DHB Joint Induction Day – Wellington 9 February** • A submission letter from the board members who attended the Induction day will be assembled by Ken Foote.	Ken Foote		Actioned

Action No	Date Issue first Entered	Action to be Taken	By Whom	By When	Status
5	22 Feb 17	**Te Ara Whakawaiora / Access** paper: • The report recommendations need to be re-written to focus on the analysis provided. The revised report would be considered by EMT prior to being resubmitted to the Board.	Mark Peterson	March	The report has been split with 0-4 yrs in March 45-64 yrs to April meeting as more work is required.
6	22 Feb 17	**Orthopaedic Review – Phase 2:** • Consideration of request from MRB to have an "Ethnicity Māori Waiting List" added to the assessment tool for surgical procedures.	Sharon Mason		Refer below for feedback.
7	22 Feb 17	**Annual Maori Health Plan non-financial exceptions report Q2 Oct-Dec 2016:** The presentation rosettes indicated where HB were doing particularly well, however the board wish to compare HB with other compariable populations (eg, BoP, Northland and Lakes).	Tracee TeHuia / Patrick LeGeyt		

ITEM 6 : Orthopaedic Review – Phase 2

Sharon Mason checked with the MOH regarding the orthopaedic national prioritisation tool and whether there is a weighting applied for ethnicity. The response received is that orthopaedic prioritisation tool has no weighting for any ethnicity. This is because it is applied to an individual rather than a population, so measures individual need and ability to benefit.

ITEM 7 : AMHP Non-Financial Exceptions Report action

In response, the Māori Health Improvement Team will be inputting the comparison of HBDHB Māori health indicators with the following DHBs into Q3 AMHP Report. These DHBs have been selected due to their total population and Māori population sizes and percentages and regional characteristics having the closest similarities to HBDHB.

DHB	Total Population (NZ Census 2013)	Total Māori Population	Māori Population Percentage
Hawkes Bay	151,695	34,977	23%
Northland	151,692	44,928	29.6%
Lakes	98,187	31,440	32%
Bay of Plenty	205,995	42,277	23%
Mid Central	162,564	28,347	17.4%

HAWKE'S BAY DISTRICT HEALTH BOARD
WORKPLAN

Mtg Date	Papers and Topics	Lead(s)
26 Apr	People and Culture Strategy (2016-2021)	Kate Coley
	Patient Experience Results	Kate Coley
	Mental Health Consolidation / Benefits Realisation (final) from Oct16	Sharon Mason
	Vulnerable Children Project from Feb Board	Sharon Mason
	Board H&S responsibilities – agenda item (review 6 monthly)	Ken Foote
	HBDHB Telephony Business Case	Tim Evans
	Transform & Sustain Strategic Dashboard	Tracee TeHuia
	Health and Social Care Localities	Tracee TeHuia
	Social Inclusion Stategy	Kevin Snee
	Pasifika Health Leadership Group invite to attend Board Meeting	
	Monitoring	
	Te Ara Whakawaiora / Access *revised from Feb Report* 45-65 years	Mark Peterson
31 May	Best Start Healthy Eating Plan (yearly review)	ED S&HIP
	People Strategy (2016-2021 first draft (p/excl)	Kate Coley
	Health Literacy update	Kate Coley
	Legislative Compliance	Kate Coley
	Community Pharmacy Service Agreement	Tim Evans
	Social Inclusion	Tracee TeHuia
	Final Draft Annual Plan 2017	Tracee TeHuia
	Monitoring	
	HBDHB Non-Financial Exceptions Report Q3 Jan-Mar 17 + MoH dashboard Q2	Tim Evans
	HR KPIs Q3	Kate Coley
29 June	Patient Experience Results Qtly	Kate Coley
	Youth Health Strategy update for Information	ED S&HIP / Nicky S
	Renal Services Review	Sharon Mason
	Pasifika Health Leadership Group incl Dashboard (6mthly)	
	Monitoring	
	Te Ara Whakawaiora / Oral Health (national indicator)	Sharon Mason / Robin W
26 July	Quality Accounts draft	Kate Coley
	Transform & Sustain Strategic Dashboard	Tracee TeHuia
	Histology Laboratory and completion of the Education Centre (final approval of tender)	Sharon Mason / Trent
30 Aug	People Strategy (2016-17) final	Kate Coley
	Monitoring	
	HR KPIs quarterly	Kate Coley
	HBDHB Non-Financial Exceptions Report Q4 Apr-Jun 17 + MoH dashboard Q3	Tim Evans

Mtg Date	Papers and Topics	Lead(s)
6 Sept	**HB Health Sector Leadership Forum – East Pier, Napier**	
27 Sept	Orthopaedic Review – phase 3 draft	Andy Phillips
	Quality Accounts final	Kate Coley
	Patient Experience Results Qtly	Kate Coley
	Final Annual Plan 2017	Carina Burgess
	Interim Annual Report	Tim Evans
	Monitoring	
	Te Ara Whakawaiora – Healthy Weight Strategy (national Indicator)	ED S&HIP
25 Oct	People Strategy Quarterly Report	Kate Coley
	Health and Social Care Localities Update	ED S&HIP
	Annual Report 2017 (Board and FRAC)	Tim Evans
	Transform & Sustain Strategic Dashboard	Tracee TeHuia
	Travel Plan Update Report	Sharon Mason
29 Nov	***Monitoring***	
	HR KPIs quarterly	Kate Coley
	HBDHB Non-Financial Exceptions Report Q1 Jul-Oct 17 + MoH dashboard Q4	Tim Evans
13 Dec	Audit NZ Final Management Report on the audit of HBDHB for y/e June 2017	Tim Evans
	Transform & Sustain Strategic Dashboard	Tracee TeHuia
	Patient Experience Review since inception	Kate Coley

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** 20
	For the attention of: **HBDHB Board**
Document Owner:	Dr Kevin Snee, Chief Executive Officer
Reviewed by:	Not applicable
Month as at	21 March 2017
Consideration:	For Information

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Recommendations

That the Board

1. Note the contents of this report.

INTRODUCTION

This month we highlight our focus on delivering the Minister's expectations. We have identified a key opportunity to improve palliative care through the new strategy which will form the basis of our service and infrastructure redesign as we move forward. We also report back on the progress made in our work on our travel plan 'Go Well' and on our Annual Plan for next year.

I also attach the letter from the Minister of Health providing commentary on our quarter two performance.

PERFORMANCE

Measure / Indicator	Target	Month of February	Qtr to end February	Trend For Qtr
Shorter stays in ED	≥95%	91.7%	92.8%	▼
Improved access to Elective Surgery (2016/17YTD)	100%	-	98.9%	▼
Waiting list		***Less than 3 months***	***3-4 months***	***4+ months***
First Specialist Assessments (ESPI-2)		2,732	652	148
Patients given commitment to treat, but not yet treated (ESPI-5)		971	107	8
Faster cancer treatment*	≥85%	80% (January 2016)	66.4% (6m to January 2016)	▲
Increased immunisation at 8 months (3 months to end of January)	≥95%	---	94.4%	▬
Better help for smokers to quit – Primary Care	≥90%	86.5% (As at January, 2016)	---	▼
Better help for smokers to quit – Maternity	≥90%	---	88.5% (Quarter 2, 2016/17)	▼

Measure / Indicator	Target	Month of February	Qtr to end February	Trend For Qtr
Raising healthy kids (New)	≥95% (by June 2017)		72% (6m to January 2016/17)	▲
Financial – month (in thousands of dollars)	$6,215	$5,192	---	---
Financial – year to date (in thousands of dollars)	$3,547	$2,372	---	---

***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%	*20/19 = 109%*	*125/114 = 109.6%*

Performance this month shows a deterioration in our Shorter Stays in Emergency Departments (ED 6) performance. There has, however, been an improvement in March. Elective activity remains below plan although there is a plan in place to deliver all elective targets by the end of June. Faster Cancer Treatment has improved in January to 80 percent for the month; it will take a number of months before the six month average significantly improves. The 'Raising Healthy Kids' target has improved again and our revised target for January for the previous six months is 72 percent - we can expect a significant improvement in quarter three. Smoking in primary care has seen a small decrease in January.

The financial result for the month of February is a significantly unfavourable variance of $1.0 million making a year-to-date adverse variance of $1.2 million. Our capacity to manage in-year variances this year has been significantly adversely affected by the RMO strikes and the campylobacter outbreak.

MINISTER'S LETTER OF EXPECTATIONS

I thought it would be worth highlighting the key areas that the Minister highlighted in the attached Letter of Expectations and how we are performing so the Board can have some assurance that we are addressing his key priorities.

Living Within our Means

The DHB has an unequalled track record of financial control, delivering planned surplus for investment for the past six years. We have developed a medium term (three year) financial strategy for this year and the next two, committing to an average $3 million per year surplus. This smooths out the one-off gain on disposal of Napier Hospital which had been banked with the Ministry. A disciplined and planned approach to efficiency savings, and the promise of concomitant investment in local infrastructure, have underpinned and motivated the commitment of the local health sector to delivering the bottom line. Making a planned surplus is part of our positive narrative for local investment and local service change.

This year the two RMO strikes and the campylobacter outbreak in Hawke's Bay are challenging our ability to fully deliver planned surplus. Even so, our proportionate surplus is likely to be, once again, the largest of any District Health Board in New Zealand.

Long Term Conditions/Care Closer to Home

Hawke's Bay has a high proportion of people living in deprivation comparatively in New Zealand. Long term conditions have become the most significant cause of death and disease. Hawke's Bay is above the national prevalence (1 in 6 out of 11 chronic disease risk factors for adults aged 15 years and over). The financial burden of this equates to 15 percent of the total health spend. Currently 81 percent of funds associated with long term conditions is spent on acute management and rehabilitation services, and only 19 percent on early intervention and prevention.

The DHB's Transform and Sustain Strategy is aligned with the New Zealand Health Strategy aimed toward reducing the burden on hospital services by providing care "closer to home" with a focus on patient-centred care ("people-powered"), promoting wellness and reducing the effects of illness ("smart system – one team"). To this end, a Long Term Conditions Framework has been developed to integrate physical and mental health care.

In delivering its Transform and Sustain Strategy, the DHB has invested in and is delivering innovative models of care with excellent patient outcomes. This includes the spine clinic run by Advanced Practice Physiotherapists to resolve chronic back pain and disability that is providing excellent patient outcomes and resulting in 85 percent of patients not needing to see an Orthopaedic Surgeon. The nurse-led respiratory clinic has demonstrated a reduction in the emergency department admissions, decreased in-patient admissions and a greater compliance to treatment. This service delivers increased ownership of their condition by clients, and an active participation to improve health and well-being within a health professional-patient-whanau-community partnership. Additionally, the Pulmonary Rehabilitation service provides programmes in Napier, Hastings and the rurals collaboratively working with primary and community care organisations.

A nurse-led clinic for people with macular degeneration performs avastin intravitreal injections and saved 408 appointments with an Ophthalmologist during 2016. Other nurse-led ophthalmology initiatives introduced include virtual retinal screening, nurse-led glaucoma clinics and post-operative cataract clinics.

The Skin Pilot Programme provides nurse assessments and prescribing under standing orders to free-up access for treatment for this disadvantaged group. Using innovation funding, this programme is being rolled out to promote healthy skin messages to Early Childhood Centres/Te Kohanga Reo/School aged children, whānau and key stakeholders. The aim is to see less children admitted to hospital for skin infections.

Our Diabetes Nurse Specialists are now working in partnership with General Practice to reduce referral to specialist services. This has delivered a reduction in First Specialist Assessments (FSAs) of 26 percent since 2010 and follow-up appointments have decreased by 10 percent. The majority of insulin initiations are now completed in primary care by practice nurses with support from Clinical Nurse Specialists, who are also prescribers.

Working Across Government

The District Health Board has been a member of the inter-agency group LIFT since its inception in 2014. The group has engaged all four local authorities, Hawke's Bay Regional Council, Iwi and Government agencies in Hawke's Bay. Its focus has been on developing Hawke's Bay's Regional Economic Development Strategy, signed off in 2016. By April the group will have received, and is expected to approve, the Social Inclusion Strategy with agreed accountabilities. Simultaneously, the DHB has proceeded to establish a joint work programme with the Ministry of Social Development focusing on areas of priority, particularly for vulnerable families. More recently we have replicated this initiative with Police. The inaugural meeting between the DHB and Post Treaty Settlement Groups (Te Kei o Takitimu) was held in January with positive progress made on relationship building and better understanding the needs of Hapū. The DHB's expectation is to meet more consistently upfront to establish a work programme between us. All of these efforts are being captured in the Annual Plan for monitoring purposes into 2017-18.

Child and Adolescent Mental Health and Addictions

Child and Adolescent Mental Health and Addictions has been meeting the Transition Plan key performance indicator (KPI) over the past nine months. The team has given this a lot of focus and has also increased exception monitoring which is picking up errors. The team will continue to focus on transition planning in 2017, and will be trialling new documentation to enhance this process. The new Whānau Tahi system is a one assessment/one plan electronic programme whereby a consumer only needs to tell their story once. This is recorded and can be updated through the consumer's journey which provides a fully updated, live history comprehensive assessment of each client. Consumer plans can also be printed and given to the consumer to take home. We are in the process of entering all clients into the system.

National Health Targets
HBDHB has a strong focus on achieving and improving performance against faster cancer treatment, elective surgical delivery and ED 6 hours.

Faster Cancer Treatment Target (FCT)
There is strong commitment to improve the outcomes of people with cancer. Initiatives to ensure that the new target of 90 percent (effective July 2017) of patients receive their first cancer treatment within 62 days include continuous case management of individual patients, executive-led weekly meetings to resolve issues, utilising electronic information system tools recently developed to give visibility across the DHB, showing all patients on the 62 day pathway, and a staff member dedicated to support prospective tracking working across tumour stream teams. Internal professional standards have been put in place to improve timely diagnostics and management and are being closely managed at executive level. This includes CT reporting within 10 days, multi-disciplinary management team decision within 28 days and triaging turnaround times within 72 hours. There is strong commitment from clinical leads and tumour stream teams in secondary care, with engagement from Primary Care, to ensure best practice is delivered. The FCT Governance Group includes a clinical lead supported by an Executive Management lead and includes representatives from all of the health services including Primary Care. There is continuous improvement of clinical and management processes supported by improvement advisors and the Chief Information Officer. The FCT monthly target was 80 percent in January 2017 and 64.1 percent (rolling six month target to December 2016). We expect to hit the 90 percent target by June 2017.

Shorter Stays in ED
There is ongoing focus to improve the outcomes and experience of people with acute illness presenting to ED. Enhanced SMO and Registered Nurse staffing in the department has enabled more effective decision making for ED presentations, and fast track processes have been reviewed.

The DHB has recently initiated a programme called “FLOW” to improve patient journeys and ensure our patients receive more timely care. The ambition is to give patients back precious time by reducing the time they spend unnecessarily in hospital. The programme has four key focus areas under development for improving overall hospital coordination and flow, with key activities including improvements to the Acute Assessment Unit model of care, criteria-based ward discharge plans and effective processes for managing acute presentations of patients with frailty. The establishment of a Surgical Assessment Unit is being planned. The recent appointment of an Integrated Operations Centre Manager will strengthen the focus on managing flow across the hospital and have a strong connection with the Primary and Community Sector.

There is commitment to improved integration with Primary Care. Planned actions include rotation of General Practitioners (GPs) through ED following the success of this during the recent RMO strike. This will improve relationships between GPs, SMOs, practice nurses, and ED Nurse Practitioners. The Allied Health response team (Orbit) provides a seven day service to ED across extended hours; this innovative team facilitates discharges from ED, prevents admissions into hospital and works in close partnership with St John’s to enable patients to be managed effectively in their own home. The work completed in quarter two has seen the shorter stays target reach 94.7 percent. We expect to hit 95 percent for the remaining two quarters through to June 2017.

The DHB was visited by the Ministry of Health’s ED Target Champion, Angela Pitchford, who recognised many excellent initiatives in place and the critical need to address the medical department’s model of care to improve flow.

Improved Access to Elective Surgery
Detailed service and production planning is under way to put in place the surgical capacity required to deliver contracted elective surgery to the Hawke’s Bay population within the coming year. There is a commitment to ensure that the service delivers high quality care, is efficient and cost effective. Elective services will be delivered through local, regional and national purchasing strategies including strengthening relationships with local private providers. There will be a continual emphasis on ensuring that all surgical specialties meet the national standard intervention rate.

Raising Healthy Kids Target
There is strong commitment to improve HBDHB's target results. These results have been low due to how the data was recorded in the B4 Schools database, where processes were not completely in place until September 2016. We are confident that we will see an increase in these results in quarter three. The DHB is also confident there are robust pathways for the referral of children identified as obese back to their GP as well as referral onto the active families programme when there is parental consent, The latest Ministry of Health data to 7 February 2017 shows HBDHB at 75 percent and tracking towards 80 percent for quarter three. HBDHB was visited by target champion Professor Hayden McRobbie in February who said he was happy with the progress.

Streamlining of DHB Annual Planning
The Minister's expectations to streamline annual plans for DHBs is well underway with the Minister's priorities clearly set out. HBDHB has had three years experience aligning the Annual Māori Health Plan with the Annual Plan, therefore we are using our learnings to achieve this expectation. Bottom-up service planning is almost complete and will feed into strategic planning, with the first draft of the Annual Plan due to the Ministry in March. A Clinical Services Plan is due for completion in 2017/18 which will also feed into our strategic planning. The Minister's expectation for DHBs considering longer term Strategic Plans, i.e. 10 year horizon, will be built into our Transform and Sustain programme over time. All priorities set by the Minister for next year are expected to have an equity focus.

Clinical Leadership
Both our Clinical Council and Consumer Council continue to provide the necessary governance for our Board, ensuring that the voice of clinicians and consumers is heard in regards to key strategic direction and decisions. The DHB is also implementing a new clinical governance structure to ensure there is significant clinical oversight provided with regards to patient safety and quality of care. Our clinical leadership partnerships are increasingly effective within the Executive Management Team and across the sector. Our clinical leaders continue to develop and frame the strategy and the culture of the organisation as part of their professional accountabilities. Our clinical leaders will continue to work in close partnership with operational directors to provide effective delivery of operational performance, deliver high quality safe care to ensure excellent patient outcomes, cost effective services and ultimately the improved health of our communities. Our focus for the next 12 months will be on ensuring that across all our professional groups we continue to foster an inter-disciplinary approach to supporting better patient outcomes. Annually the DHB undertakes talent mapping to identify the potential of our current clinical leaders and to support succession planning and the identification of emerging talent. Over the next 12 months the DHB will be looking to align this mapping strategy to the State Services Commission programme. We continue to invest in our clinical leaders through our transformational leadership programme and executive coaching programme and, with the development of an overarching People Strategy, this will ensure the continuing investment in building their skills and capability.

CONSUMER STORY
This month we will share the quarterly consumer experience feedback report. It will include feedback mechanisms, results, themes and improvement activities.

HAWKE'S BAY PALLIATIVE CARE STRATEGY
The Palliative Care Strategic Plan has been developed with input from Whānau and the community and overseen by an integrated clinical governance steering group. *Live well, stay well, die well* details this vision and identifies six priorities which are all linked to measureable outcomes. The strategy will be discussed further in the agenda.

DRAFT ANNUAL PLAN FOR 2017
The first draft Annual Plan is due to be submitted to the Ministry on 31 March 2017. The Minister has requested that Māori health plans and annual plans are fully integrated this year so a Māori health plan has not been produced. Plans need to be more streamlined and follow a template. Therefore, the focus of the plan is on meeting the Minister's expectations. The draft has been jointly developed with clinicians, managers and the PHO, and has received positive feedback from the committees so far.

TRAVEL PLAN

There has been plenty of activity in the last quarter, most notably the launch of the paid parking scheme from 1 March 2017. Pre-requisite works such as car park remarking, installation of pay and display machines and signage were completed over January-February together with a host of back-end processes such as reviewing the car parking policy, meetings and implementing the communications strategy. The Go Well team has been processing large volumes of applications for permits and exemptions, plus the sale of staff parking coupons. On launch day it was most satisfying to see availability of parks for patients and visitors. On average there has been in excess of 30 parks available within the main car park since launch date, with some great consumer feedback to parking personnel on the ground and via social media. Other activities have also taken place such as HBDHB hosting a Hawke's Bay Commuter Challenge breakfast, installation of a new secure cycle lock-up for staff, identification of shower facilities for active commuters, and development and publishing of parking and amenities maps. It has also been pleasing to note the increase in patients using the free bus service since the scheme was expanded on 1 January 2017.

TE ARA WHAKAWAIORA / ACCESS (0-4 YEARS)

After the discussion at the Board last month, requesting some strengthened recommendations on the Ambulatory Sensitive Hospitalisation (ASH) rates, because the rates for the 0-4 age group were good compared to national rates, and the 45-64 were comparatively poor, it was decided to separate the two reports. The revision of the paper for 0-4 years is on the agenda for today's meeting and the report for 45-64 years will now come back to the April meeting.

TE ARA WHAKAWAIORA / BREASTFEEDING (NATIONAL INDICATOR)

Breastfeeding is a HBDHB key priority for improved infant and national outcomes and initiatives. Breastfeeding rates for Māori mothers have not increased showing us that we need to work on new initiatives to meet the needs of Māori mothers and their whānau. The Te Ara Whakawaiora breastfeeding paper in the agenda shows the recommended actions to support and improve on this target.

CONCLUSION

We have seen good progress in reaching agreement on our palliative care strategy, producing a good, streamlined annual plan and have implemented our travel plan effectively. The key issue this month is the significant adverse financial variance; whilst we do not believe this will put us into deficit, it puts the level of planned surplus to invest in future years at significant risk.

Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

16 DEC 2016

8.1

Mr Kevin Atkinson
Chairperson
Hawke's Bay District Health Board
Private Bag 9014
Hastings 4156

kevin.atkinson@penkev.co.nz

Dear Mr Atkinson

Letter of Expectations for DHBs and Subsidiary Entities 2017/18
The Government is committed to improving the health of New Zealanders and continues to invest in key health services. In Budget 2016 Vote Health received an additional $568 million, the largest increase in seven years, demonstrating the Government's on-going commitment to protecting and growing our public health services.

Refreshed New Zealand Health Strategy
The refreshed New Zealand Health Strategy provides DHBs and the wider sector with a clear strategic direction for delivery of health services to ensure that all New Zealanders live well, stay well and get well.

The DHB annual plans are the primary document for demonstrating DHB delivery of the Strategy, and your 2017/18 annual plan is expected to clearly demonstrate the linkages between the five themes of the Strategy and your DHB's performance story, activities and outcomes, while also maintaining a focus on Māori health outcomes and health equity.

In particular I want to see a strong focus on providing care in the community and for services to be provided closer to home, especially for the management of long-term conditions.

Finally, I want your Board to very carefully consider how any new local initiatives fit within the context of the Strategy.

Living Within our Means
While the global economic environment continues to be challenging, DHB funding has continued to be increased year on year. DHBs need to budget and operate within allocated funding and must have clear plans to improve year-on-year financial performance. Your DHB's financial performance is currently tracking to plan for 2016/17, and I trust that you will continue to consider where your DHB can make efficiency gains. You and your Board must monitor and hold your Chief Executive accountable against these expectations as keeping to budget allows investment into new and more health initiatives.

Improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs. In particular your Board must work closely with NZ Health Partnerships Ltd on ensuring the delivery of their current work programmes and services.

Working Across Government
I expect DHBs to continue supporting cross-agency work to support vulnerable families and progress outcomes for children and young people, including working with the new Ministry for Vulnerable Children, Oranga Tamariki once this has been established.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

All DHBs must continue to work closely with other social sector organisations to achieve cross-sector goals in relation to the Government's Better Public Services initiatives, and other initiatives, such as the Prime Minister's Youth Mental Health Project, the Childhood Obesity Plan and the *Living Well with Diabetes* Plan.

Locally, I expect Hawke's Bay DHB will continue working with other agencies to sustain its reduction in rheumatic fever through the delivery of its rheumatic fever prevention plan, continue current activity to maintain high coverage rates for all immunisation milestones, and improve the rate of child and youth with transition plans from child and adolescent mental health and youth-focussed alcohol and other drug services.

National Health Targets

All of the national health targets are very important for driving overall performance, and have resulted in major improvements in the health outcomes of New Zealanders. I expect DHBs to remain focussed on achieving and improving performance against all six health targets. The *faster cancer treatment* target remains a top priority for service delivery for DHBs and further progress is expected during 2017/18.

The first national result for the *raising healthy kids* health target is 49 percent. I expect results for all DHBs to improve considerably each quarter as referral processes and clinical pathways are fully implemented.

Locally, Hawke's Bay DHB has shown good performance in relation to the *increased immunisation* health target. However, performance in relation to the other health targets needs to be improved, particularly for the *faster cancer treatment* and *better help for smokers to quit* health targets. Please ensure delivery of these health targets is a priority for your DHB.

Streamlining of DHB Annual Planning

In order to ensure that the Health Strategy is informing DHB planning, DHB annual plans will be streamlined in 2017/18 so that they are focussed on my key expectations for your DHB. Your DHB should also be considering longer-term strategic planning (ten-year horizon) as a way to deliver on the vision of the Health Strategy, and I expect that in the future you will be able to demonstrate this planning.

Working regionally also continues to be important, and I expect that when you are considering your long-term strategic planning you are also considering this in a regional context.

There are a number of key planning priorities for 2017/18 that DHBs will need to clearly respond to in their annual plans. These planning priorities have been selected in order to progress the key Government expectations outlined above, and also to progress other key health initiatives, such as Bowel Screening, implementation of the Healthy Ageing Strategy and continued integration of health care in order to better prevent and manage long term conditions, and provide services and care in the best ways to meet local needs. This will require ongoing engagement with your primary and community partners, including implementation of the System Level Measures.

The full list of my planning priorities for 2017/18 is attached for your information. I have asked the Ministry to provide separate advice about how each of these should be reflected in your plan.

Concluding comments

In implementing your annual plan it is important that clinicians are engaged and involved throughout; clinical leadership is fundamental in delivering high-quality health services.

Please note that I am not requiring DHBs to refresh their statements of intent (SOIs) for tabling in 2017/18. However, please ensure you review your SOI produced in 2016/17 to confirm that there are no significant changes. The statements of performance expectations will still need to be produced and tabled.

Keep in mind that the Budget 2017 process will clarify the priorities outlined in this letter and other Government priorities, and more information will be provided when available, including information on planning priorities.

Finally, please note that the provisions of the Enduring Letter of Expectations continue to apply. The Letter can be accessed on the State Services Commission's website.

I would like to thank you, your staff, and your Board for your continued commitment to delivering quality health care to your population. I look forward to seeing your achievements throughout 2017/18.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

2017/18 DHB Annual Planning Priorities

Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy Better Public Service (contributory) Target
Supporting Vulnerable Children Better Public Service Target
Reducing Rheumatic Fever Better Public Service Target
Increased Immunisation Better Public Service and Health Target
Shorter Stays in Emergency Departments Health Target
Improved Access to Elective Surgery Health Target
Faster Cancer Treatment Health Target
Better Help for Smokers to Quit Health Target
Raising Healthy Kids Health Target
Bowel Screening
Mental Health
Healthy Ageing
Living Well with Diabetes
Childhood Obesity Plan
Child Health
Disability Support Services
Primary Care Integration
Pharmacy Action Plan
Improving Quality
Living Within our Means
Information Technology
Workforce.

Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

8.2

15 MAR 2017

Mr Kevin Atkinson
Chair
Hawke's Bay District Health Board
Corporate Office
Private Bag 9014
HASTINGS 4156

Dear Kevin

Quarter two 2016/17 health target results have now been finalised, with some positive national progress.

- The *improved access to elective surgery* target has been met again this quarter with a result of 103 percent.
- Six DHBs have now achieved the *faster cancer treatment* health target, the national result of 82 percent is 3.9 percent higher than last quarter.
- There has been good progress towards the *raising healthy kids* target, the national result of 72 percent is a notable increase on the quarter one result of 49 percent.
- The *shorter stays in emergency departments* result has increased by 0.8 percent to 94 percent this quarter.

In addition to the progress highlighted, the *increased immunisation target* results remains steady at 93 percent.

The *better help for smokers to quit* primary care result has had a further decrease for the second consecutive quarter. More focus is needed as the current national result of 86 percent is seeing us slip further away from the target goal after getting to 88 percent in quarter four 2015/16.

Looking at your local results, although the DHB achieved the *shorter stays in emergency departments* and *increased immunisation* health targets this quarter, I expect stronger results in relation to the *improved access to elective surgery* and *faster cancer treatment* targets.

As quarter three is well under way, opportunities for you to influence year end health target results for your DHB must be taken now if they are to have a significant impact in 2016/17.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

Feedback on your DHB's results across all health target areas is provided by the Ministry's Target Champions in appendix one. More detailed results are provided in appendix two.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

cc: Dr Kevin Snee, Chief Executive, Hawke's Bay District Health Board
PHO Chairs
PHO CEOs

Appendix one - Feedback from Target Champions on your results for the quarter

Angela Pitchford, Target Champion, Shorter stays in emergency departments

Congratulations on achieving the *shorter stays in emergency departments* health target for the first time since quarter four 2014/15.

I am looking forward to visiting Hawke's Bay Hospital on 10 March 2017 to hear more about the initiatives that the DHB has implemented that have helped achieve the health target.

I hope to see Hawke's Bay DHB continue to achieve this health target in quarter three 2016/17.

Jess Smaling, Target Champion, Improved access to elective surgery

Hawke's Bay DHB has not achieved its quarter two health target. In the year to date, 3,751 people were provided with elective surgery in the year to date, which is 29 discharges (1 percent) behind plan. However, well done on lifting your delivery from last quarter and we look forward to seeing you achieve your year-end target.

It is also important to keep a close eye on your additional commitments for the Additional Orthopaedic and General Surgery Initiative to ensure delivery against phased plans.

As the new Target Champion for the *improved access to elective surgery* target, I am looking forward to working closely with you and your team on improving access to elective care for patients.

Andrew Simpson, Target Champion, Faster cancer treatment

I am concerned that Hawke's Bay DHB's achievement has not improved this quarter. The result of 65 percent places the DHB at the bottom of the DHB rankings for the *faster cancer treatment* health target.

I expect the DHB to make better progress in 2017. It is crucial that there is strong support from senior management in implementing system-wide improvements to the quality and timeliness of cancer care. I look forward to visiting the DHB in April 2017 to discuss performance and how it can be improved sustainably.

Pat Tuohy, Target Champion, Increased immunisation

Congratulations to Hawke's Bay DHB for reaching the *increased immunisation* target. The DHB continues to produce strong results for both the overall population and the Māori population. I am particularly pleased to see the low rate of children being immunised late.

It is now two years since the target for immunisation at age eight months was increased to 95 percent and Hawke's Bay DHB has achieved the target in all

but one quarter in this time. This is outstanding, please pass on my thanks to all your team.

John McMenamin, Target Champion, Better help for smokers to quit
Hawke's Bay DHB had a solid performance this quarter, increasing 6.5 percent to a result of 87.4 percent.

I acknowledge that the DHB has issues with gathering accurate patient contact information. I suggest that the DHB focus resourcing on training reception staff to collect accurate patient information upon their arrival to the practice. I will be in contact with the DHB soon to review progress and offer any advice and support that is required.

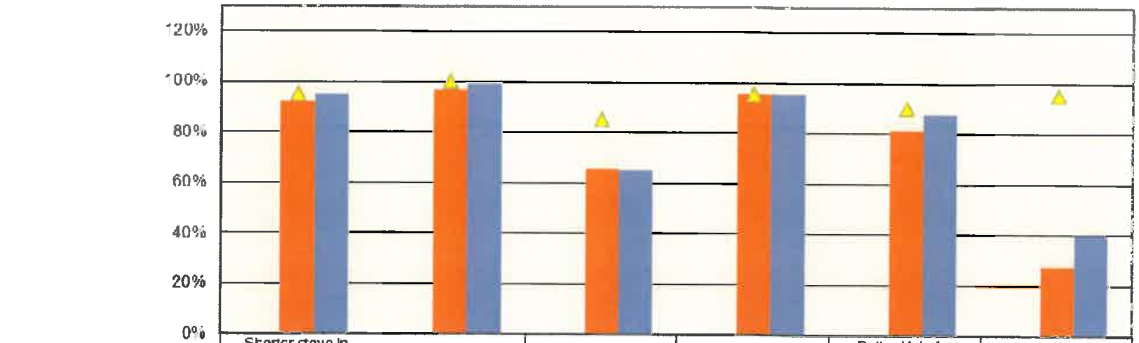
Hawke's Bay DHB did not achieve the maternity target. I look forward to seeing the DHB achieve both targets next quarter.

Hayden McRobbie, Target Champion, Raising healthy kids
It is pleasing to see that Hawke's Bay DHB has demonstrated improvement in this health target, although progress has been somewhat slow. I understand that there are a range of reasons for this and I have been reassured that the results will show substantial improvement by quarter three. I look forward to visiting the DHB in late February 2017 and will be interested to see the progress being made.

Appendix two

Quarter two 2016/17 results for your DHB

Hawke's Bay DHB health targets quarter two 2016/17 results

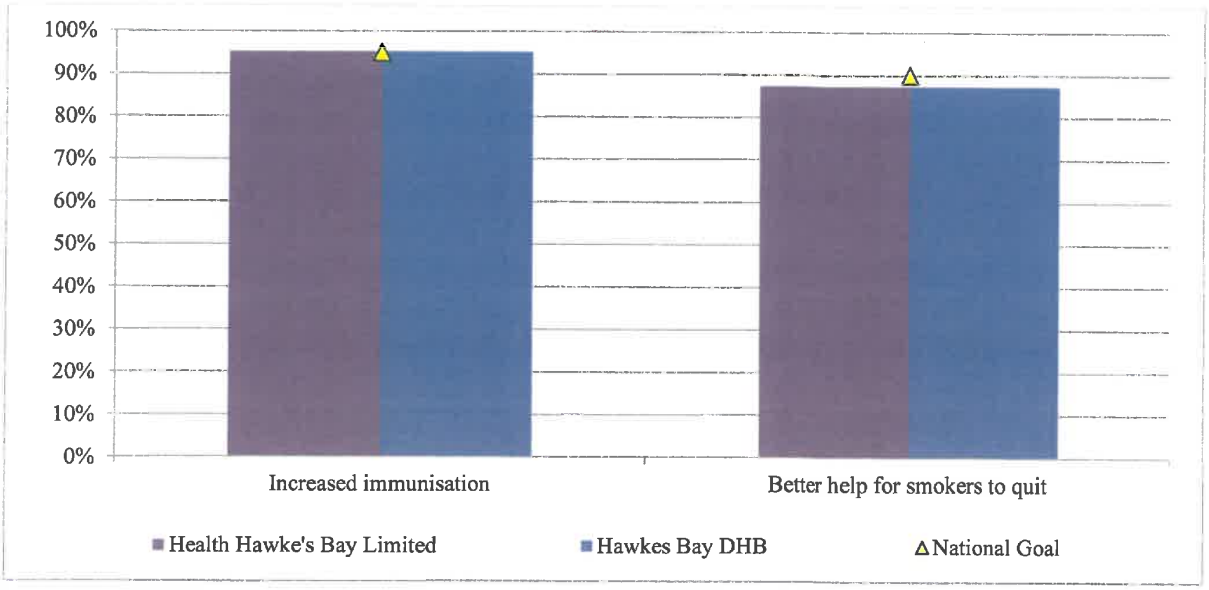


	Shorter stays in Emergency Departments	Improved Access to Elective Surgery	Faster Cancer Treatment	Increased Immunisation	Better Help for Smokers to Quit - Primary Care	Raising Healthy Kids
Ranking Quarter two 2016/17	11	14	20	3	10	16
Quarter one 2016/17	92.4%	96.0%	65.6%	95.4%	80.9%	27.3%
Quarter two 2016/17	94.7%	99.2%	64.8%	95.3%	87.1%	39.8%
National goal	95.0%	100.0%	85.0%	95.0%	90.0%	95.0%

Quarter two 2016/17 PHO results for the PHOs operating within your DHB's region

Hawke's Bay DHB primary care health targets: Quarter 2 2016/17 results

	Increased immunisation	Better help for smokers to quit
Health Hawke's Bay Limited	95%	87%
Hawke's Bay DHB	**95%**	**87%**
National Goal	95%	90%



HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report, February 2017** 21
	For the attention of: **HBDHB Board and the Finance Risk and Audit Committee**
Document Owner: Document Author(s):	Tim Evans, Executive Director of Corporate Services Finance Team
Reviewed by:	Executive Management Team
Month:	March, 2017
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board and Finance, Risk and Audit Committee:

1. Note the contents of this report.

1. Executive Director of Corporate Services Comments

Financial Performance

The result for the month of February is an unfavourable variance of $1.0 million making a year to date adverse variance of $1.2 million.

This significantly adverse result is driven by a number of issues which have aggregated to a large number. Our resilience to unexpected cost has also been eroded by the events of previous months, in particular the first strike by Resident Medical Officers (RMOs), and the Gastroenteritis outbreak which used up much of our contingency and budgetary slack.

The main factors driving to total variance are: nursing costs at $0.6 million (including less Annual Leave than budgeted, Ward A2 open more than planned, Midwifery costs); RMO strike costs at $0.4 million (payment to our senior doctors and GPs to cover striker's duties); Efficiency savings shortfall at $0.3 million; Accident Compensation Corporation income $0.2 million; and Clinical Supplies $0.1 million (these last three existing trends exacerbated by our need to recover surgical activity in the wake of the strikes).

The only positive to be taken from these adverse numbers is that many of the factors appear to be one-off events or corrections. There will clearly be pressure for the remaining four months of the year, we will clearly have to work hard to reduce, offset and mitigate it, but it looks like this is an exceptional month.

Forecast year end result

This month's performance leads us to forecast a $4.5 million surplus for the 2016-17 year. This is below our $5.0 million. The result is, furthermore, contingent on the Ministry of Health responding positively to our request to cover the costs of the Havelock North gastroenteritis outbreak. It will also be necessary to achieve most of the efficiency targets, expected to be difficult, and fulfil the surgical health target activity within existing resources.

2. Resource Overview

	February				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)	5,192	6,215	(1,023)	-16.5%	2,372	3,547	(1,175)	-33.1%	4,500	3
Contingency utilised	100	250	150	60.0%	2,600	2,000	(600)	-30.0%	3,000	8
Quality and financial improvement	1,144	1,083	61	5.6%	6,376	8,667	(2,291)	-26.4%	13,000	11
Capital spend	678	1,753	(1,075)	-61.3%	6,248	15,023	(8,775)	-58.4%	22,042	16
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,209	2,193	(17)	-0.8%	2,207	2,186	(21)	-1.0%	2,203	5 & 7
	CWD	CWD	CWD	%	CWD	CWD	CWD	%	CWD	
Case weighted discharges	2,779	2,127	652	30.7%	19,902	18,508	1,394	7.5%	27,609	5

The remaining contingency is $400 thousand, well below the $1 million that would be expected if the contingency was released evenly over the year. The contingency released prior to this month includes cover for the cost of the gastroenterology outbreak in Havelock North. In the month we released a proportionate share of the opening balance for the remainder of the year.

The Quality and Financial Improvement (QFI) programme has achieved 74% 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 for February and year-to-date, including gastroenterology, general and vascular surgery, paediatrics and general internal medicine marginally offset by lower orthopaedic surgery.

3. Financial Performance Summary

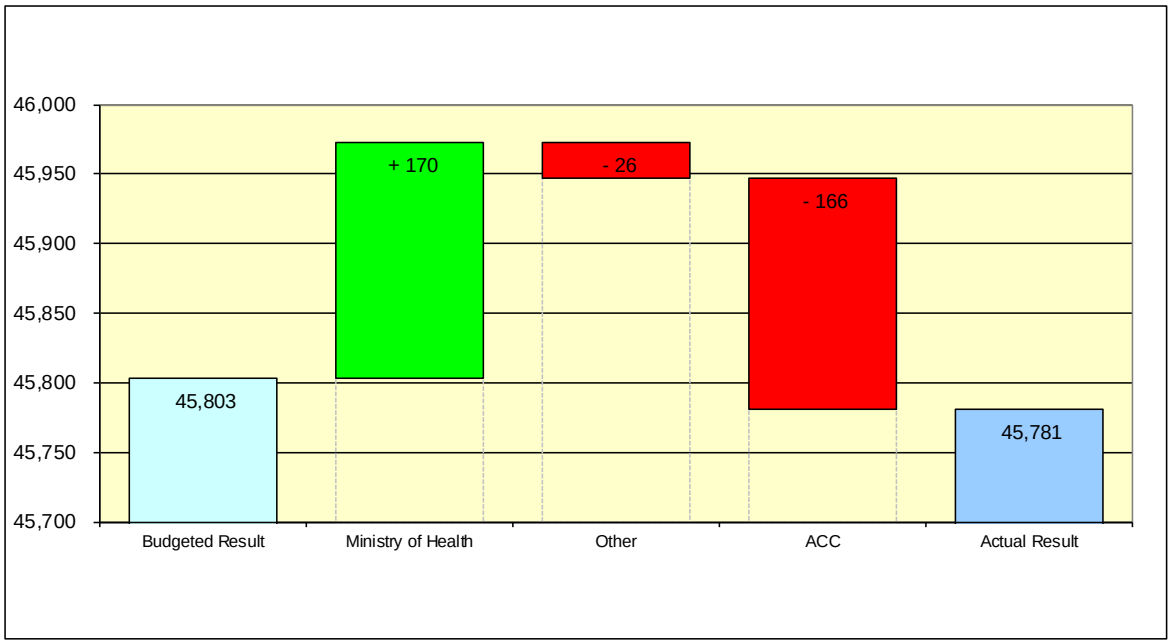
	February				Year to Date				Year End Forecast	Refer Section
$'000	Actual	Budget	Variance		Actual	Budget	Variance			
Income	45,781	45,803	(21)	0.0%	351,361	349,822	1,538	-0.4%	534,440	4
Less:										
Providing Health Services	19,100	17,758	(1,342)	-7.6%	167,711	162,624	(5,087)	-3.1%	252,069	5
Funding Other Providers	18,506	18,377	(130)	-0.7%	152,455	151,206	(1,249)	-0.8%	228,886	6
Corporate Services	2,967	3,395	428	12.6%	31,113	31,459	346	1.1%	48,470	7
Reserves	16	58	42	71.8%	(2,290)	987	3,276	332.1%	514	8
	5,192	**6,215**	**(1,023)**	**-16.5%**	**2,372**	**3,547**	**(1,175)**	**-33.1%**	**4,500**	

Additional MOH income is offset by lower ACC income due to capacity constraints. Nursing annual leave taken at different times than budgeted, efficiencies yet to be achieved and cover for hospital administration services drive the providing health services result. The reversal of a provision is reflected in the corporate services result.

4. Income

$'000	February				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Ministry of Health	43,951	43,781	170	0.4%	335,709	333,514	2,195	0.7%	510,714
Inter District Flows	630	629	1	0.1%	5,209	5,030	179	3.6%	7,724
Other District Health Boards	319	334	(15)	-4.5%	2,481	2,668	**(187)**	**-7.0%**	3,797
Financing	66	68	(2)	-3.2%	563	589	(26)	-4.4%	859
ACC	327	493	**(166)**	**-33.7%**	3,354	3,974	**(620)**	**-15.6%**	5,177
Other Government	17	25	(8)	-31.5%	246	308	**(62)**	**-20.2%**	424
Patient and Consumer Sourced	113	119	(6)	-5.2%	766	962	**(196)**	**-20.4%**	1,251
Other Income	353	355	(1)	-0.3%	3,036	2,711	**325**	**12.0%**	4,497
Abnormals	6	0	6	3316.8%	(4)	66	**(70)**	**-106.0%**	(3)
	45,781	**45,803**	(21)	0.0%	**351,361**	**349,822**	1,538	0.4%	**534,440**

February Income

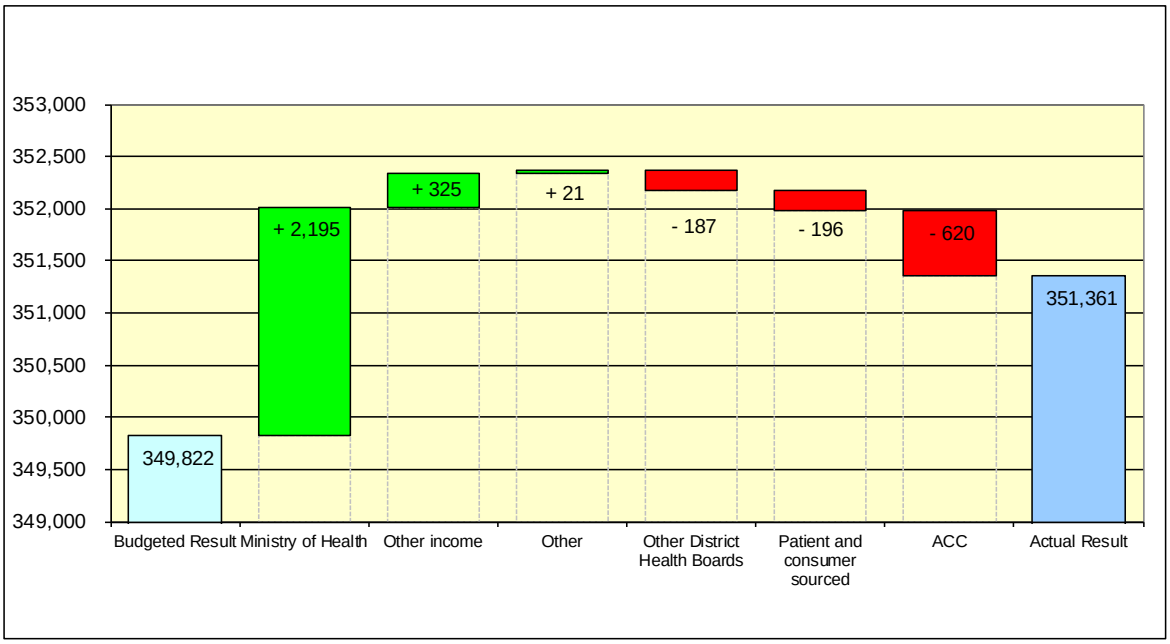


Note the scale does not begin at zero

Ministry of Health (favourable)
Additional income for Very Low Cost Access (VLCA), In Between Travel (IBT) and health promotion.

ACC (unfavourable)
Lower ACC income as capacity is used to meet elective surgery targets, and reduced 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.

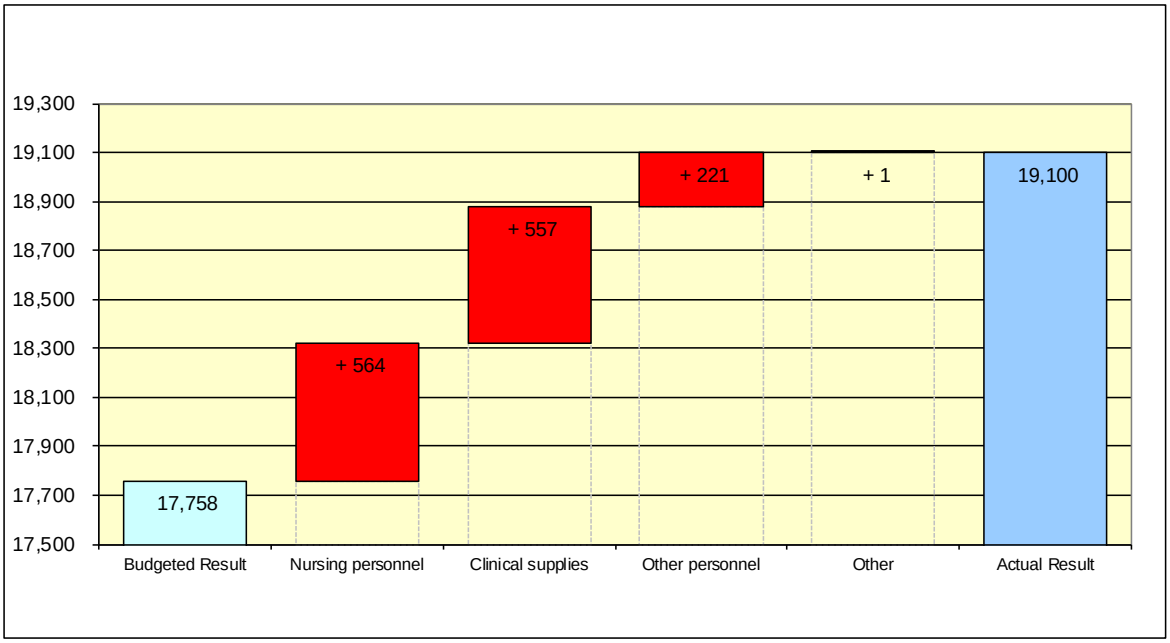
5. Providing Health Services

	February				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure by type $'000									
Medical personnel and locums	4,367	4,210	(157)	-3.7%	40,058	39,563	(495)	-1.3%	59,778
Nursing personnel	5,514	4,950	**(564)**	**-11.4%**	48,703	47,752	(951)	-2.0%	73,675
Allied health personnel	2,473	2,483	10	0.4%	20,973	21,855	881	4.0%	32,170
Other personnel	1,701	1,481	**(221)**	**-14.9%**	14,259	13,608	(652)	-4.8%	21,621
Outsourced services	597	605	8	1.4%	6,148	5,500	**(647)**	**-11.8%**	10,183
Clinical supplies	3,022	2,466	**(557)**	**-22.6%**	24,547	21,493	**(3,054)**	**-14.2%**	34,679
Infrastructure and non clinical	1,426	1,565	**138**	**8.8%**	13,022	12,852	(170)	-1.3%	19,963
	19,100	**17,758**	**(1,342)**	**-7.6%**	**167,711**	**162,624**	**(5,087)**	**-3.1%**	**252,069**
Expenditure by directorate $'000									
Medical	5,004	4,664	**(340)**	**-7.3%**	45,313	43,299	(2,014)	-4.7%	67,794
Surgical	4,582	3,888	**(694)**	**-17.9%**	37,909	35,899	**(2,010)**	**-5.6%**	56,184
Community, Women and Children	3,119	2,996	(123)	-4.1%	28,615	27,878	(736)	-2.6%	42,779
Older Persons, Options HB, Menta	2,496	2,450	(45)	-1.8%	22,144	22,067	(76)	-0.3%	33,290
Operations	2,872	2,771	(101)	-3.7%	24,146	23,837	(309)	-1.3%	36,707
Other	1,027	989	(39)	-3.9%	9,585	9,644	59	0.6%	15,315
	19,100	**17,758**	**(1,342)**	**-7.6%**	**167,711**	**162,624**	**(5,087)**	**-3.1%**	**252,069**
Full Time Equivalents									
Medical personnel	283.5	309.1	**26**	**8.3%**	315	315	(0)	0.0%	315.5
Nursing personnel	933.8	887.9	**(46)**	**-5.2%**	908	882	(26)	-3.0%	891.8
Allied health personnel	441.8	451.8	10	2.2%	432	450	17	3.9%	452.7
Support personnel	138.7	127.0	**(12)**	**-9.2%**	133	126	**(7)**	**-5.4%**	127.5
Management and administration	248.6	240.4	(8)	-3.4%	253	243	(10)	-4.0%	244.7
	2,046.4	**2,016.1**	(30)	-1.5%	**2,041**	**2,016**	(25)	-1.3%	**2,032.2**
Case Weighted Discharges									
Acute	1,983	1,424	**560**	**39.3%**	13,729	12,581	**1,148**	**9.1%**	18,713
Elective	511	521	(10)	-1.9%	4,201	4,293	(92)	-2.1%	6,451
Maternity	200	147	**53**	**36.3%**	1,425	1,344	**80**	**6.0%**	2,000
IDF Inflows	85	36	49	136.7%	547	290	**257**	**88.5%**	445
	2,779	**2,127**	**652**	**30.7%**	**19,902**	**18,508**	**1,394**	**7.5%**	**27,609**

Directorates

- Medical includes vacancy and leave cover for medical staff, efficiencies not achieved yet, gastrointestinal pharmaceuticals and biologics, and ED nursing personnel.
- Surgical includes high acute demand in February, efficiencies not achieved, fee for service payments for additional surgery sessions, and other payments relating to doctors including transfer of leave to other DHBs (timing), course fees, professional fees and relocation costs.
- Community, Women and Children is mostly efficiencies not achieved, increased paediatric and maternity volumes, additional junior medical staff, and locums for sabbatical leave cover.

February Expenditure



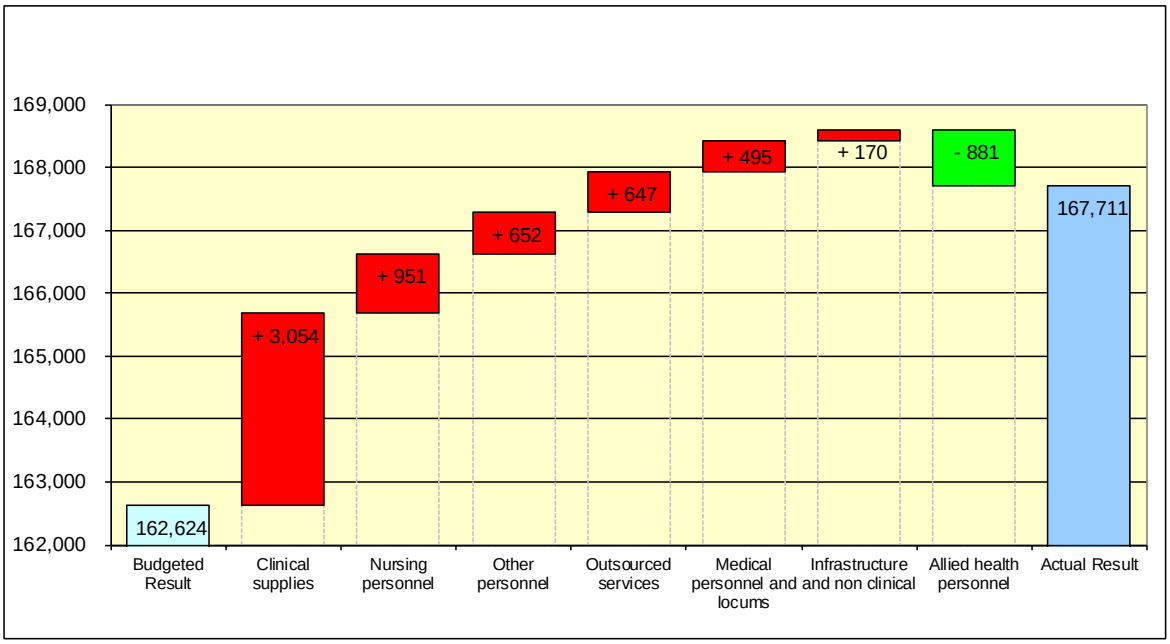
Note the scale does not begin at zero

Nursing personnel (unfavourable)
Annual leave costs following the holiday period. Higher staffing levels in Surgical, Community, Women and Children, and Medical services. Some planned efficiencies achieved elsewhere.

Clinical supplies (unfavourable)
Mainly efficiencies not yet achieved or achieved elsewhere. Also implants and blood.

Other personnel (unfavourable)
The minimal leave cover budgeted for hospital administration services is not coping with high workloads and long term sick leave, and higher than budgeted leave cover for support personnel, both contribute to the variance.

Year to Date Expenditure



Clinical supplies (unfavourable)
Mainly efficiencies not yet achieved or achieved elsewhere. Also includes clinical leases, reusable instruments, low value equipment and laparoscopic equipment.

Nursing personnel (unfavourable)
Nursing staff taking leave at different times to that budged. Also includes some additional staffing, overtime, and termination payments.

Other personnel (unfavourable)
Additional administration staffing to provide cover, leave taken differing from budgeted timing.

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

Medical personnel and locums (unfavourable)
Vacancy and leave cover, and additional surgery sessions.

Infrastructure and non-clinical (unfavourable)
Efficiencies not yet achieved.

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

Full time equivalents (FTE)

FTEs are 25 unfavourable year to date including:

Nursing personnel (26 FTE / 3.0% unfavourable)

- Higher than budgeted staffing in certain areas including ED and the medical wards. Some planned efficiencies have been achieved elsewhere.

Management and administration personnel (10 FTE 4.0% unfavourable)

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

Support personnel (7 FTE / 5.4% unfavourable)

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

partly offset by:

Allied Health Personnel (17 FTE / 3.9% favourable)

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

Medical FTEs are on budget year to date.

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**

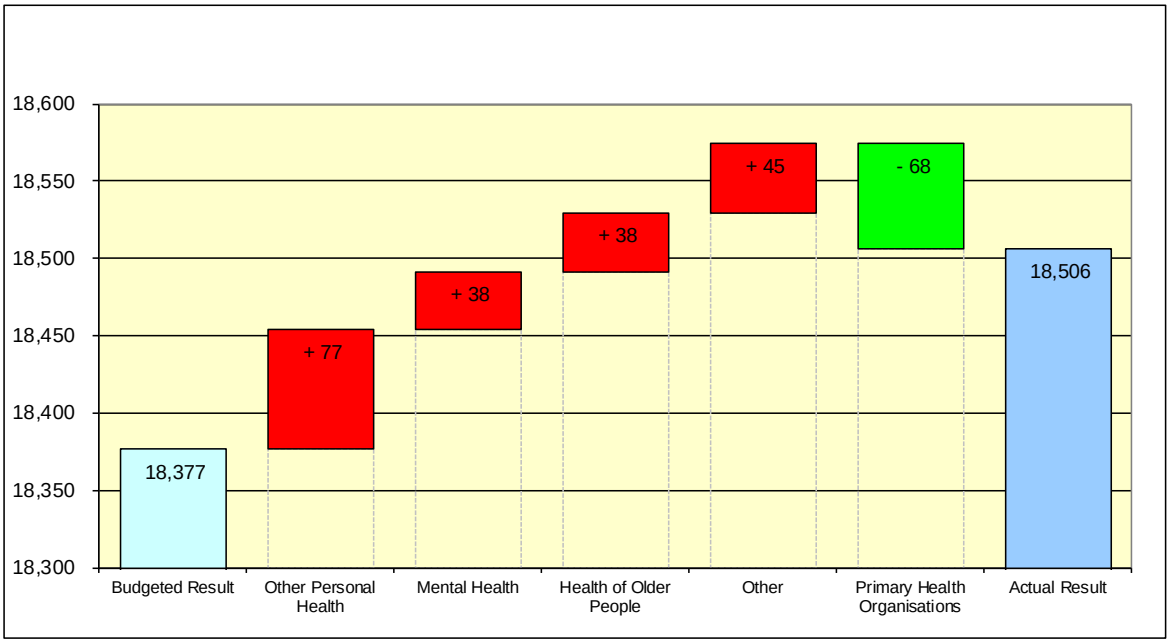
		YTD Feb-17						Feb-17			
		Actual	Plan	Var.	%Var.			Actual	Plan	Var.	%Var.
On-Site	Avastins	131	131	0	0.0%	On-Site	Avastins	16	16	0	0.0%
	ENT	351	371	-20	-5.4%		ENT	45	45	0	0.0%
	General Surgery	541	582	-41	-7.0%		General Surgery	57	70	-13	-18.6%
	Gynaecology	370	327	43	13.1%		Gynaecology	47	39	8	20.5%
	Maxillo-Facial	112	119	-7	-5.9%		Maxillo-Facial	13	14	-1	-7.1%
	Ophthalmology	660	703	-43	-6.1%		Ophthalmology	81	90	-9	-10.0%
	Orthopaedics	517	591	-74	-12.5%		Orthopaedics	68	80	-12	-15.0%
	Skin Lesions	113	113	0	0.0%		Skin Lesions	14	14	0	0.0%
	Urology	310	281	29	10.3%		Urology	48	34	14	41.2%
	Vascular	111	90	21	23.3%		Vascular	8	11	-3	-27.3%
	Surgical - Arranged	345	278	67	24.1%		Surgical - Arranged	34	30	4	13.3%
	Non Surgical - Elective	48	123	-75	-61.0%		Non Surgical - Elective	1	15	-14	-93.3%
	Non Surgical - Arranged	21	45	-24	-53.3%		Non Surgical - Arranged	2	5	-3	-60.0%
On-Site	**Total**	**3630**	**3754**	**-124**	**-3.3%**	**On-Site**	**Total**	**434**	**463**	**-29**	**-6.3%**
Outsourced	Cardiothoracic	0	28	-28	-100.0%	Outsourced	Cardiothoracic	0	4	-4	-100.0%
	ENT	105	94	11	11.7%		ENT	10	14	-4	-28.6%
	General Surgery	197	173	24	13.9%		General Surgery	26	23	3	13.0%
	Gynaecology	11	24	-13	-54.2%		Gynaecology	0	4	-4	-100.0%
	Maxillo-Facial	24	45	-21	-46.7%		Maxillo-Facial	0	7	-7	-100.0%
	Neurosurgery	0	12	-12	-100.0%		Neurosurgery	0	1	-1	-100.0%
	Ophthalmology	94	18	76	422.2%		Ophthalmology	0	0	0	0.0%
	Orthopaedics	51	50	1	2.0%		Orthopaedics	2	0	2	0.0%
	Paediatric Surgery	0	2	-2	-100.0%		Paediatric Surgery	0	0	0	0.0%
	Skin Lesions	2	0	0	0.0%		Skin Lesions	0	0	0	100.0%
	Urology	48	52	-4	-7.7%		Urology	2	8	-6	-75.0%
	Vascular	16	28	-12	-42.9%		Vascular	3	4	-1	-25.0%
	Surgical - Arranged	0	0	0	0.0%		Surgical - Arranged	0	0	0	0.0%
	Non Surgical - Elective	0	0	0	0.0%		Non Surgical - Elective	0	0	0	0.0%
	Non Surgical - Arranged	0	0	0	0.0%		Non Surgical - Arranged	0	0	0	0.0%
Outsourced	**Total**	**548**	**526**	**22**	**4.2%**	**Outsourced**	**Total**	**43**	**65**	**-22**	**-33.8%**
IDF Outflow	Avastins	1	0	1	0.0%	IDF Outflow	Avastins	0	0	0	0.0%
	Cardiothoracic	49	51	-2	-3.9%		Cardiothoracic	5	6	-1	-16.7%
	ENT	22	31	-9	-29.0%		ENT	3	3	0	0.0%
	General Surgery	30	32	-2	-6.3%		General Surgery	3	4	-1	-25.0%
	Gynaecology	27	16	11	68.8%		Gynaecology	4	2	2	100.0%
	Maxillo-Facial	101	126	-25	-19.8%		Maxillo-Facial	7	15	-8	-53.3%
	Neurosurgery	53	29	24	82.8%		Neurosurgery	4	4	0	0.0%
	Ophthalmology	20	21	-1	-4.8%		Ophthalmology	2	2	0	0.0%
	Orthopaedics	21	13	8	61.5%		Orthopaedics	3	2	1	50.0%
	Paediatric Surgery	50	34	16	47.1%		Paediatric Surgery	8	4	4	100.0%
	Skin Lesions	41	50	-9	-18.0%		Skin Lesions	11	6	5	83.3%
	Urology	15	4	11	275.0%		Urology	4	0	4	0.0%
	Vascular	11	10	1	10.0%		Vascular	1	1	0	0.0%
	Surgical - Arranged	110	200	-90	-45.0%		Surgical - Arranged	11	23	-12	-52.2%
	Non Surgical - Elective	78	0	78	0.0%		Non Surgical - Elective	8	0	8	0.0%
	Non Surgical - Arranged	38	0	38	0.0%		Non Surgical - Arranged	1	0	1	0.0%
IDF Outflow	**Total**	**667**	**617**	**50**	**8.1%**	**IDF Outflow**	**Total**	**75**	**72**	**3**	**4.2%**
TOTAL		**4845**	**4897**	**-52**	**-1.1%**	**TOTAL**		**552**	**600**	**-48**	**-8.0%**

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

6. Funding Other Providers

$'000	February Actual	February Budget	February Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Payments to Other Providers									
Pharmaceuticals	3,241	3,236	(5)	-0.2%	29,225	29,177	(48)	-0.2%	43,209
Primary Health Organisations	2,801	2,869	68	2.4%	23,261	23,371	110	0.5%	35,290
Inter District Flows	3,810	3,776	(34)	-0.9%	30,573	30,211	(361)	-1.2%	45,678
Other Personal Health	1,821	1,744	(77)	-4.4%	16,354	14,259	**(2,094)**	**-14.7%**	24,873
Mental Health	1,186	1,148	(38)	-3.3%	8,960	9,165	206	2.2%	13,559
Health of Older People	5,197	5,159	(38)	-0.7%	40,708	41,270	562	1.4%	60,974
Other Funding Payments	451	445	(6)	-1.4%	3,376	3,752	**377**	**10.0%**	5,302
	18,506	18,377	(130)	-0.7%	**152,455**	**151,206**	(1,249)	-0.8%	228,886
Payments by Portfolio									
Strategic Services									
Secondary Care	3,661	3,898	**237**	**6.1%**	33,368	31,184	**(2,183)**	**-7.0%**	49,149
Primary Care	7,505	7,368	(137)	-1.9%	62,822	62,713	(109)	-0.2%	94,962
Chronic Disease Management	-	-	-	0.0%	-	-	-	0.0%	-
Mental Health	1,186	1,131	(55)	-4.9%	9,095	9,046	(48)	-0.5%	13,694
Health of Older People	5,225	5,215	(10)	-0.2%	41,109	41,700	591	1.4%	61,519
Other Health Funding	98	(59)	**(157)**	**-267.6%**	626	561	**(65)**	**-11.6%**	767
Maori Health	492	515	23	4.4%	3,806	4,146	**340**	**8.2%**	6,138
Population Health									
Women, Child and Youth	216	208	(8)	-3.6%	907	1,043	**136**	**13.0%**	1,533
Population Health	123	100	(23)	-22.8%	723	814	91	11.2%	1,125
	18,506	18,377	(130)	-0.7%	**152,455**	**151,206**	(1,249)	-0.8%	228,886

February Expenditure



Note the scale does not begin at zero

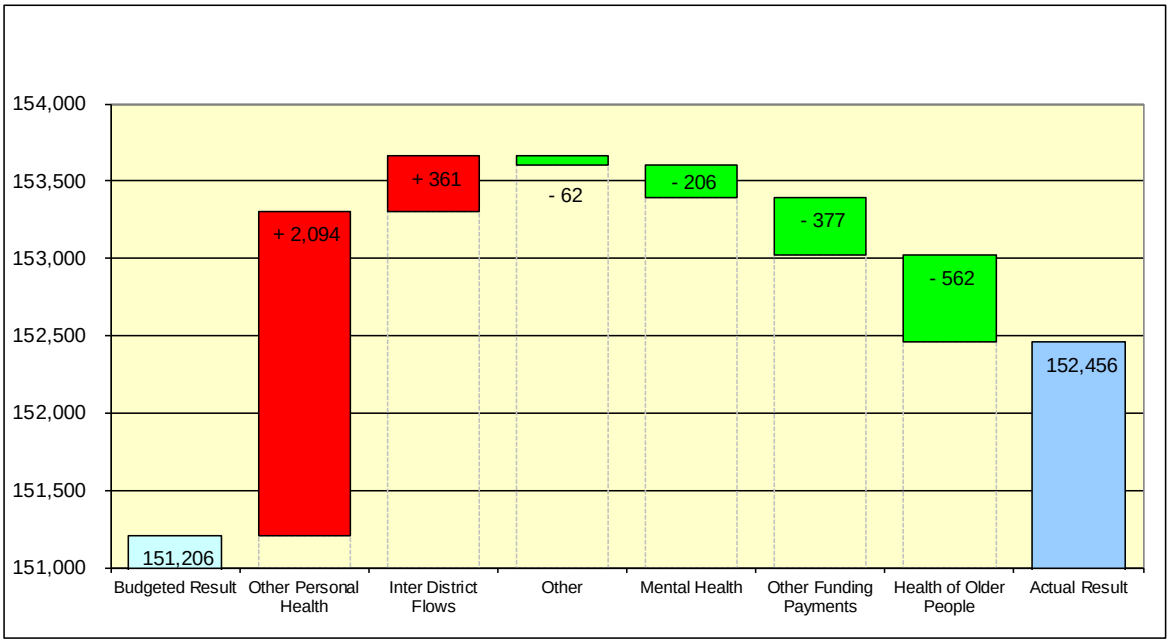
Other personal health (favourable)
Further release of the provision for PHO rural services funding, and underspend relating to 2015/16.

Mental health (unfavourable)
Catch-up of regional audit services provided by TAS.

Health of older people (unfavourable)
Higher home support costs are not fully covered by reduced residential care costs.

Primary Health Organisations (favourable)
Unspent non-very low cost access funding for under 6 year olds, and reduced fee for service charges from Health Hawke's Bay.

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	February Actual	February Budget	February Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Operating Expenditure									
Personnel	1,541	1,256	(285)	-22.7%	10,964	10,198	(766)	-7.5%	16,205
Outsourced services	160	119	(42)	-35.0%	855	771	(84)	-10.9%	1,216
Clinical supplies	7	9	3	27.4%	80	76	(5)	-6.2%	107
Infrastructure and non clinical	583	686	103	15.0%	6,213	6,775	562	8.3%	8,854
	2,291	2,070	(221)	-10.7%	18,113	17,820	(293)	-1.6%	26,381
Capital servicing									
Depreciation and amortisation	1,046	1,163	117	10.0%	9,039	9,157	118	1.3%	13,789
Financing	(370)	162	533	328.1%	777	1,344	567	42.2%	1,978
Capital charge	-	-	-	0.0%	3,184	3,138	(46)	-1.5%	6,322
	676	1,325	649	49.0%	13,000	13,639	639	4.7%	22,089
	2,967	**3,395**	428	12.6%	**31,113**	**31,459**	346	1.1%	**48,470**
Full Time Equivalents									
Medical personnel	0.7	0.3	(0)	-159.5%	0	0	(0)	-39.0%	0.3
Nursing personnel	19.3	14.4	(5)	-33.8%	13	14	2	12.5%	14.5
Allied health personnel	0.4	0.4	(0)	-10.2%	0	0	(0)	-11.0%	0.4
Support personnel	9.4	9.3	(0)	-0.8%	9	9	(0)	-0.2%	9.4
Management and administration	133.1	152.1	19	12.5%	143	146	3	1.8%	146.6
	163.0	**176.6**	14	7.7%	**166**	**170**	4	2.5%	**171.2**

A provision for additional costs has been reversed as the expense is now unlikely.

8. Reserves

$'000	February Actual	February Budget	February Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Expenditure									
Contingency	(94)	6	100	1718.0%	(2,519)	81	2,600	3222.3%	3,863
Transform and Sustain resource	56	37	(19)	-50.3%	130	438	308	70.4%	261
Other	54	15	(40)	-266.6%	100	468	368	78.7%	(3,610)
	16	**58**	42	71.8%	**(2,290)**	**987**	3,276	332.1%	**514**

Contingency usage year to date includes:

- $1.3 million to offset IDF provisioning
- $1.0 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	February Actual	February Annual Plan	February 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	44,427	44,226	201 F	338,216	335,952	2,265 F	514,626	511,184	3,442 F
Less:									
Payments to Internal Providers	21,995	21,974	(21) U	184,119	183,648	(471) U	279,800	279,328	(471) U
Payments to Other Providers	18,506	18,377	(130) U	152,455	151,206	(1,249) U	228,886	227,630	(1,257) U
Contribution	**3,925**	**3,875**	**50 F**	**1,642**	**1,098**	**544 F**	**5,940**	**4,226**	**1,714 F**
Governance and Funding Admin.									
Funding	266	266	-	2,130	2,130	-	3,197	3,197	-
Other Income	3	3	-	19	20	(1) U	29	30	(1) U
Less:									
Expenditure	292	481	188 F	1,980	2,372	392 F	3,345	3,573	228 F
Contribution	**(24)**	**(212)**	**188 F**	**170**	**(221)**	**391 F**	**(119)**	**(346)**	**227 F**
Health Provision									
Funding	21,729	21,708	21 F	181,989	181,517	471 F	276,603	276,131	471 F
Other Income	1,352	1,575	(222) U	13,125	13,851	(725) U	19,785	20,638	(853) U
Less:									
Expenditure	21,791	20,731	(1,060) U	194,554	192,698	(1,856) U	297,709	295,650	(2,059) U
Contribution	**1,291**	**2,552**	**(1,261) U**	**559**	**2,670**	**(2,111) U**	**(1,321)**	**1,120**	**(2,441) U**
Net Result	**5,192**	**6,215**	**(1,023)** U	**2,372**	**3,547**	**(1,175)** U	**4,500**	**5,000**	**(500)** U

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) also create movements between the annual plan and the management budget.

$'000	February Mgmt Budget	February Annual Plan	February 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	44,226	44,328	(102) U	335,952	336,568	(617) U	511,184	511,803	(619) U
Less:									
Payments to Internal Providers	21,974	21,823	(151) U	183,648	180,876	(2,772) U	279,328	275,461	(3,867) U
Payments to Other Providers	18,377	18,762	386 F	151,206	153,673	2,466 F	227,630	231,341	3,711 F
Contribution	**3,875**	**3,742**	**132 F**	**1,098**	**2,020**	**(922) U**	**4,226**	**5,000**	**(774) U**
Governance and Funding Admin.									
Funding	266	268	(2) U	2,130	2,146	(15) U	3,197	3,220	(23) U
Other Income	3	3	-	20	20	-	30	30	-
Less:									
Expenditure	481	271	(210) U	2,372	2,166	(206) U	3,573	3,250	(323) U
Contribution	**(212)**	**-**	**(212) U**	**(221)**	**-**	**(221) U**	**(346)**	**-**	**(346) U**
Health Provision									
Funding	21,708	21,555	153 F	181,517	178,730	2,787 F	276,131	272,241	3,890 F
Other Income	1,575	1,547	28 F	13,851	13,674	176 F	20,638	20,366	272 F
Less:									
Expenditure	20,731	20,629	(102) U	192,698	190,878	(1,820) U	295,650	292,608	(3,042) U
Contribution	**2,552**	**2,472**	**79 F**	**2,670**	**1,526**	**1,144 F**	**1,120**	**(0)**	**1,120 F**
Net Result	**6,215**	**6,215**	**0** F	**3,547**	**3,547**	**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 74% of our year-to-date savings target (up from 69% 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	1,017,861	1,005,375	99%
Health Services	8,292,287	5,528,192	3,869,218	70%
Population Health	26,166	17,444	17,444	100%
Maori	148,195	98,797	98,797	100%
Health Funding	3,006,808	2,004,539	1,385,333	69%
Grand Total	**13,000,248**	**8,666,832**	**6,376,167**	**74%**

Row Labels	Sum of Planned Savings	Sum of ytd savings target	Sum of YTD actual Savings
AMBER	**4,768,619**	**3,179,079**	**2,311,632**
Acute Medical	2,407,523	1,605,015	1,023,262
Business Intelligence	9,012	6,008	-
CEO	145,930	97,287	97,287
Depreciation	517,008	344,672	344,672
FAC	22,652	15,101	10,565
Information Services	326,304	217,536	217,536
OPE	283,469	188,980	37,165
Surgical	676,082	450,722	425,394
WCY	380,638	253,759	155,751
RED	**2,393,502**	**1,595,668**	**255,264**
Human Resources	123,967	82,645	82,645
OPE	78,975	52,650	-
OPRS	205,850	137,233	20,619
Strategic Services	1,153,808	769,205	150,000
Surgical	764,875	509,917	2,000
WCY	66,028	44,019	-
Grand Total	**7,162,121**	**4,774,747**	**2,566,896**

12. Financial Position

30 June		*February*				*Annual*
2016	$'000	*Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2016*	*Budget*
	Equity					
102,608	Crown equity and reserves	145,108	105,733	(39,375)	42,500	105,376
(10,973)	Accumulated deficit	(8,601)	(12,722)	(4,120)	2,372	(11,268)
91,635		136,507	93,011	(43,495)	44,872	94,108
	Represented by:					
	Current Assets					
15,552	Bank	20,391	11,428	(8,963)	4,839	8,523
1,724	Bank deposits > 90 days	1,755	1,741	(14)	31	1,741
22,433	Prepayments and receivables	21,762	18,490	(3,272)	(671)	18,618
4,293	Inventory	4,257	4,016	(241)	(36)	4,044
1,220	Non current assets held for sale	625	-	(625)	(595)	-
45,222		48,791	35,676	(13,115)	3,569	32,927
	Non Current Assets					
151,944	Property, plant and equipment	149,993	163,860	13,868	(1,951)	166,159
2,037	Intangible assets	1,707	861	(846)	(330)	665
9,777	Investments	10,430	8,907	(1,523)	653	9,476
163,758		162,130	173,628	11,499	(1,628)	176,299
208,980	**Total Assets**	**210,920**	**209,304**	**(1,616)**	**1,940**	**209,226**
	Liabilities					
	Current Liabilities					
-	Bank overdraft	-	-	-	-	-
38,137	Payables	34,942	30,635	(4,307)	(3,195)	30,697
34,070	Employee entitlements	36,834	35,742	(1,092)	2,764	34,484
-	Current portion of borrowings	-	6,000	6,000	-	6,000
72,208		71,776	72,377	601	(431)	71,180
	Non Current Liabilities					
2,638	Employee entitlements	2,638	2,416	(222)	-	2,438
42,500	Term borrowing	-	41,500	41,500	(42,500)	41,500
45,138		2,638	43,916	41,278	(42,500)	43,938
117,345	**Total Liabilities**	**74,414**	**116,293**	**41,879**	**(42,931)**	**115,118**
91,635	**Net Assets**	**136,507**	**93,011**	**(43,495)**	**44,872**	**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, and the swap of the DHB's debt into equity on 15 February;
- 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;
- Borrowing, both term and current, reflect the debt to equity swap.
- Employee entitlements – see below

13. Employee Entitlements

30 June		*February*				*Annual*
2016	$'000	*Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2016*	*Budget*
7,466	Salaries & wages accrued	9,468	7,901	(1,567)	2,002	6,559
482	ACC levy provisions	1,301	689	(612)	819	851
5,348	Continuing medical education	6,056	6,097	40	708	5,131
19,149	Accrued leave	18,680	19,378	698	(468)	20,249
4,263	Long service leave & retirement grat.	3,966	4,094	128	(297)	4,131
36,708	**Total Employee Entitlements**	39,472	38,158	(1,314)	2,764	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 $42.5 million term debt facility with MOH was swapped into equity on 15 February. The $5 million equity injection for the mental health build, has been requested from MOH. The DHB now has no interest rate exposure relating to debt.

Foreign exchange risk management

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

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	9,039	9,157	118
5,000	Surplus/(Deficit)	2,372	3,547	1,175
(2,479)	Working Capital	37,662	(3,330)	56,447
16,961		49,073	9,373	57,741
	Other Sources			
-	Special funds and clinical trials	35	-	(35)
1,220	Sale of assets	-	1,220	(1,220)
5,000	Borrowings	(42,500)	5,000	(47,500)
6,220		(42,465)	6,220	(48,755)
23,181	**Total funds sourced**	**6,607**	**15,593**	**8,986**
	Application of Funds:			
	Block Allocations			
3,183	Facilities	1,510	2,172	662
3,125	Information Services	440	2,083	1,643
5,464	Clinical Plant & Equipment	1,702	3,590	1,889
11,772		3,652	7,846	4,193
	Local Strategic			
2,460	MRI	-	1,639	1,639
500	Renal Centralised Development	240	333	93
3,000	New Stand-alone Endoscopy Unit	683	1,999	1,316
710	New Mental Health Inpatient Unit Development	397	473	76
100	Maternity Services	132	67	(65)
400	Upgrade old MHIU	1,007	586	(421)
400	Travel Plan	40	267	226
400	Histology and Education Centre Upgrade	21	148	127
1,100	Fluoroscopy Unit	-	733	733
200	Education Centre Upgrade	-	(67)	(67)
9,270		2,520	6,178	3,657
	Other			
-	Special funds and clinical trials	35	-	(35)
1,000	New Technologies/Investments	-	1,000	1,000
-	Other	40	-	(40)
1,000		75	1,000	925
22,042	***Capital Spend***	***6,248***	***15,023***	***8,775***
	Regional Strategic			
1,139	RHIP (formerly CRISP)	360	570	210
1,139		360	570	210
23,181	**Total funds applied**	**6,607**	**15,593**	**8,986**

16. Rolling Cash Flow

	Actual	February Forecast	Variance	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast	Jul Budget	Aug Budget	Sep Budget	Oct Budget	Nov Budget	Dec Budget	Jan Budget	Feb Budget
Cash flows from operating activities															
Cash receipts from Crown agencies	41,049	45,523	(4,474)	42,272	43,493	41,974	48,895	43,210	41,712	45,478	52,018	41,846	41,601	43,315	45,259
Cash receipts from revenue banking	-	-	-	4,200	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from donations, bequests and clinical trials	33	-	33	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	452	470	(18)	489	447	455	451	426	425	427	492	432	439	428	448
Cash paid to suppliers	(22,812)	(24,123)	1,311	(27,439)	(25,553)	(24,411)	(29,963)	(27,144)	(25,790)	(26,397)	(24,932)	(25,223)	(25,825)	(24,761)	(21,644)
Cash paid to employees	(15,719)	(14,671)	(1,048)	(19,540)	(15,421)	(17,916)	(15,662)	(13,909)	(19,483)	(15,098)	(15,100)	(17,792)	(14,458)	(16,750)	(14,515)
Cash generated from operations	**3,003**	**7,199**	**(4,196)**	**(18)**	**2,966**	**102**	**3,721**	**2,582**	**(3,135)**	**4,410**	**12,478**	**(737)**	**1,758**	**2,233**	**9,549**
Interest received	66	68	(2)	75	73	75	73	81	80	67	66	80	72	75	68
Interest paid	(578)	(325)	(253)	0	(0)	(0)	0	(0)	(0)	(0)	(0)	(0)	(0)	(0)	0
Capital charge paid	-	-	-	-	-	-	(5,476)	-	-	-	-	-	(5,493)	-	-
Net cash inflow/(outflow) from operating activities	**2,491**	**6,942**	**(4,451)**	**58**	**3,039**	**177**	**(1,682)**	**2,662**	**(3,055)**	**4,476**	**12,544**	**(657)**	**(3,663)**	**2,307**	**9,617**
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	10	0	10	0	0	0	0	0	0	0	0	0	1,220	0	0
Acquisition of property, plant and equipment	(634)	(1,972)	1,338	(1,897)	(1,966)	(2,296)	(2,518)	(2,988)	(2,988)	(2,988)	(2,988)	(2,988)	(3,988)	(2,988)	(2,988)
Acquisition of intangible assets	(44)	(345)	301	(20)	(20)	(20)	-	(85)	(85)	(85)	(85)	(85)	(85)	(85)	(85)
Acquisition of investments	-	-	-	(1,075)	-	-	(284)	-	-	(285)	-	-	(285)	-	-
Net cash inflow/(outflow) from investing activities	**(668)**	**(2,317)**	**1,649**	**(2,992)**	**(1,986)**	**(2,316)**	**(2,802)**	**(3,073)**	**(3,073)**	**(3,358)**	**(3,073)**	**(3,073)**	**(3,138)**	**(3,073)**	**(3,073)**
Cash flows from financing activities															
Proceeds from equity injection	42,500	-	42,500	-	-	-	-	-	-	-	-	-	-	-	-
Proceeds from borrowings	(42,500)	-	(42,500)	-	-	-	-	-	-	-	-	-	-	-	-
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	1,823	4,625	(2,802)	(2,935)	1,053	(2,139)	(4,842)	(411)	(6,128)	1,118	9,471	(3,730)	(6,801)	(766)	6,544
Add:Opening cash	20,326	20,326	-	22,149	19,214	20,267	18,128	13,286	12,876	6,747	7,865	17,337	13,606	6,805	6,039
Cash and cash equivalents at end of year	**22,149**	**24,951**	**(2,802)**	**19,214**	**20,267**	**18,128**	**13,286**	**12,876**	**6,747**	**7,865**	**17,337**	**13,606**	**6,805**	**6,039**	**12,583**
Cash and cash equivalents															
Cash	4	4	-	4	4	4	4	7	7	7	7	7	7	7	7
Short term investments (excl. special funds/clinical trials)	19,104	21,912	(2,808)	16,169	17,221	15,083	10,241	9,773	3,645	4,763	14,234	10,504	3,703	2,937	9,481
Short term investments (special funds/clinical trials)	3,042	3,035	7	3,042	3,042	3,042	3,042	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095
Bank overdraft	(1)	(0)	(1)	(1)	(1)	(1)	(1)	-	-	-	-	-	-	-	-
	22,149	**24,951**	**(2,802)**	**19,215**	**20,267**	**18,129**	**13,287**	**12,875**	**6,747**	**7,865**	**17,336**	**13,606**	**6,805**	**6,039**	**12,583**

BOARD HEALTH & SAFETY CHAMPION'S UPDATE

Verbal

HAWKE'S BAY
District Health Board
Whakawāteatia

CONSUMER STORY

11

Verbal

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Clinical Council** 22
	For the attention of: **HBDHB Board**
Document Owner:	Chris McKenna and Dr Mark Peterson as Co-Chairs
Reviewed by:	Not applicable
Month:	March, 2017
Consideration:	For Information

12

RECOMMENDATION

That the Board

Review the contents of this report; and

Note that Clinical Council:

- **Supported** the HB Palliative Care Strategy
- **Supported** the Clinical Committees Review
- **Supported** the draft Annual Plan 2017/18

- **Note** the following papers were received:
  - Travel Plan update
  - Te Ara Whakawaiora / breastfeeding (local indicator)
  - Maternity Clinical Governance Group update
  - Falls Minimisation Committee update

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

The following papers were considered:

- ***HB Palliative Care Strategy***

The Clinical Council noted the amendments to the strategy following workshops with primary care and meetings with key stakeholders and consumers. It was noted that further discussion needs to occur around outcome measures.

- ***Clinical Committees Review***

The Clinical Council noted the contents of the report which included draft terms of references (TOR) for the top five clinical committees, proposed chairs and key responsibilities of both the clinical committees and advisory groups. The TOR, proposed chairs and key responsibilities were endorsed. Following discussion at the meeting, decision also made to include a Deputy Chair for each committee.

- ***Draft Annual Plan 2017/18***

The first draft of the annual plan was tabled and discussed. The content of the draft report was noted.

Others reports provided for information and discussion included:

- ***Travel Plan Update***

The quarterly update was provided for information. Commendation given to Andrea Beattie, Property and Contracts Officer and project team for the implementation of this initiative. It is pleasing to note the positive feedback received from consumers on site and via social media on ability to find a car park.

- **Te Ara Whakawaiora / breastfeeding (local indicator)**

Noted the contents of the report.

- **Maternity Clinical Governance Group Update**

Noted the contents of the report.

- **Falls Minimisation Committee Update**

Noted the contents of the report.

OURHEALTH HAWKE'S BAY Whakawateatia	**HB Health Consumer Council**	23
	For the attention of: **HBDHB Board**	
Document Owner:	Graeme Norton, Chair	
Reviewed by:	Not applicable	
Month:	March 2017	
Consideration:	For Information	

13

RECOMMENDATION

That the Board

Review the contents of this report; and

Note that Consumer Council:

- **Supported** the HB Palliative Care Strategy - Final
- **Supported** the Draft Annual Plan 2017

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

The following papers were considered:

- ***HB Palliative Care Strategy - Final***

Council members noted the incorporation of their earlier feedback into the final document, suggested some minor amendments and endorsed the strategy for consideration by the board.

- ***Annual Plan 2017 (Draft)***

Council noted the content of the draft report and endorsed the draft annual plan. It was noted that the format of the report is constrained by Ministry template and the council supports a two page summary document and action plan being developed to aid clarity and understanding.

Others reports provided for information and discussion included:

- ***Consumer Engagement Strategy Draft***

Council gave feedback on the first draft of this strategy and provided some guidance on how the document could be tightened, become more pithy and accessible for staff.

- ***Consumer Council Chair/Membership Appointment/Renewal Process***

The current term of the Chair expires and six positions on Council are up for appointment/renewal in June 2017. When the Consumer Council was first set up four years ago, it was the intention to get achieve stability and lay foundations. Council members are on two year appointments with a maximum of three terms (six years in total). It would appear to be appropriate to broaden the profile of this group through a more public process. There will likely be a public recruitment process for a Chair and Council members. The form of that public process is with the Chief Executive for consideration. Current members who wish to be considered for renewal will be encouraged to apply through the process.

HAWKE'S BAY District Health Board Whakawāteatia	**Palliative Care in Hawke's Bay** 24
	For the attention of: **HBDHB Board**
Document Owner: Document Author:	Chris McKenna, Chief Nursing Officer Mary Wills, Head of Strategic Services (has now let the DHB)
Reviewed by:	Executive Management Team, HB Clinical Council and HB Health Consumer Council, Māori Relationship Board (by email March)
Month:	March, 2017
Consideration:	For approval

14

RECOMMENDATION

That the HBDHB Board:

1. Note amendments to the plan following workshops with primary care, palliative care stakeholders, consumers and in rural areas
2. Approve the plan.

OVERVIEW

A draft plan was circulated in December 2016. Overall feedback has been positive and stakeholders believed that the plan covers high priorities for the next 10 years.

The document has been amended to reflect the following comments:

- Changing the name to emphasise early intervention and "Living Well"
- A clearer focus on equity
- Describing the role of primary care and the relationship with specialist services
- The implementation plan will use the feedback from consumers and rural areas to inform the detailed action plan

Stakeholders would like timelines for implementation and more detail about how actions will be implemented and funded. The timeframes will be determined by the national palliative care strategy, the Healthy Ageing Strategy and budget announcements in May.

Live Well
Stay Well
Die Well

Palliative Care in Hawke's Bay

Our vision and priorities for the future 2016 – 2026

Live Well Stay Well Die Well

Executive Summary

"You matter because you are you, and you matter to the last moment of your life.
We will do all we can, not only to help you die peacefully, but also to live until you die"
Dame Cicely Saunders

Dying is a normal part of the human experience and affects people regardless of age. Whenever a person dies in Hawke's Bay, there are impacts for their family/whānau, friends, work colleagues and the community in which they live. Many people would prefer to die in their own home, cared for and surrounded by their loved ones.[1] Others will die in hospice, hospital or aged residential care, by choice or by necessity.

The experience of dying, and of caring for loved ones at the end of life, can have a deep and lasting impact on those involved. Poorly supported dying, with inadequate symptom control and failure to meet the needs of those who are dying as well as those who care for them, may lead to a complicated bereavement process for those left behind. In contrast, high quality and well-co-ordinated care at the end of life provides a setting for a healthy experience of death for both family/whānau and surrounding community.

The quality of care provided in the Hawke's Bay region to those at the end of life is everyone's responsibility. Death is not a subject that should be avoided or concealed. It is one of the great certainties of life, and involvement in caring for those people who are dying can, not only strengthen family relationships, encourage compassion and resilience, and promote positive connections in the community, enhance respect for health and life, and reduce community fears about death and dying.

We will extend the ways we receive patient feedback and hear what is important to patients and family/whānau. Patients and whānau have told us they are not always told when a person is dying. Having "conversations that count" earlier can support everyone to understand what is happening.

As the numbers of people needing palliative care grows rapidly over the next 10 years, we will need to be culturally responsive in our practice. Services will need to respond to Māori and Pacifika needs. This will be supported by shared leadership, working as one team and with agreed priorities for the next 10 years.

We will recruit and train staff in palliative care. This includes sustainable medical staff and replacement of our retiring nursing workforce. Allied health and family support team members will work with primary care to provide a multidisciplinary response for patients with dementia and who are frail. Our focus on education and training will develop the next generation of palliative care practitioners in primary and specialist palliative care.

We will agree how services provide access 24 hours a day 7 days a week. As the national strategies for Healthy Ageing and Palliative Care are implemented in Hawke's Bay, we will invest in sustainable specialist palliative care services and education and training. This will be supported by technology, shared information across services and using information to inform service improvement.

Our six priorities for the future will improve care for people and their family/whānau. To achieve this requires us to work together as one team to strengthen the foundations on which our vision is built.

[1] Gomes, Calanzan, Gysels, Hall, Higginson *Heterogeneity and changes in preferences for dying at home: a systemic review* 12:7 BMC Palliative Care 2013 12:7

Live Well Stay Well Die Well

Our six priorities:

1. **Each person and their family/whānau will have their individual needs as the centre of care**
2. **Each person gets access to high quality individualised care and we improve equity**
3. **Comfort and wellbeing maximised**
4. **Care is coordinated**
5. **The community is involved**
6. **People are prepared to care**

Live Well Stay Well Die Well

Introduction

In today's society, people are increasingly expressing the importance of choice and independence as major components of dignity in advancing illness and old age. Most of us expect to make decisions, not only on how we live our last years, months, weeks and days of life but also on how and where we die. With advances in chronic disease management, single disease approaches for planning end of life will make less sense as functional decline towards end of life could be very hard to predict. This will have wide reaching implications for the co-ordination of care, health and social needs, predictions of future outcomes, referrals and patient, family/whānau experience and choice.

Increasing numbers of people with neurodegenerative conditions like dementia suggests an increasing need for early participation in planning for, and conversations about dying if we are going to be able to provide quality care to those at end of life.

Palliative care is recognised as a speciality that focuses on patient centred care, but as future demands for services increase, more than ever we will need to ensure we continue to place the patient and their family/whānau needs and goals at the centre. Our response to needs will have to be tailored so that we are providing just the right amount of support to empower and enable individuals to achieve their goals and to live their lives until they die. Services will need to ensure that they are providing a culture of enablement alongside our care. This will enable people greater choice, independence and dignity in advancing illness and/or old age.

For Hawke's Bay the level of need for palliative care is hard to predict. There is literature stating that for most people their palliative care needs can be met through good primary palliative care provided by general practitioners, hospitals, aged residential care, district nurses and Māori health providers without the need for direct care provision of specialist palliative care. [2] [3] Providing palliative care needs to be a core part of everyone's practice.

[2] Temel, J.S, Greer, J.A, Muzikansky, M.A, Gallagher, E.R, Admane, M.B, et al (2010). *Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer*. N Engl J Med 2010; 363:733-42

[3] Quill, T.E., & Abernethy, A.P. (2013). *Generalist plus Specialist Palliative Care — Creating a More Sustainable Model.* N Engl J Med; 368:1173-1175March 28, 2013DOI: 10.1056/NEJMp1215620

What is palliative care?

Palliative care is the care of people who are dying from active, progressive diseases or other conditions that are not responsive to curative treatment. Palliative care embraces the physical, social, emotional and spiritual elements of wellbeing–tinana, whānau, hinengaro and wairua – and enhances a person's quality of life while they are dying. Palliative care also supports the bereaved family/whānau.[4]

The principles of palliative care are that it:

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intends neither to hasten or postpone death
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the patient's illness and in their own bereavement
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- will enhance quality of life, and may also positively influence the course of illness
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Palliative care is provided according to an individual's need, and may be suitable whether death is days, weeks, months or occasionally even years away. It may also be suitable sometimes when treatments are being given aimed at extending quality of life.

It should be available wherever the person may be located. It should be provided by all health care professionals, supported where necessary, by specialist palliative care services.

Palliative care should be provided in such a way as to meet the unique needs of people from particular communities or groups. This includes but is not limited to: Māori, children and young people, immigrants, those with intellectual disability, refugees, prisoners, the homeless, those in isolated communities and lesbian, gay, transgender and intersex people.[5]

[4] Ministry of Health. (2001). *New Zealand Palliative Care Strategy*. Wellington. MoH

[5] Palliative Care Subcommittee, NZ Cancer Treatment Working Party (2007) *New Zealand Palliative Care: A Working Definition.* [Online]. Available from: http://www.moh.govt.nz/moh.nsf/pagesmh/2951/$File/nz-palliative-care-definitionoct07.pdf.

Palliative care will be delivered by both primary palliative care and specialist palliative care providers working together as one team. [6]

Primary palliative care (PPC) refers to care provided by general practices, Māori health providers, allied health teams, district nurses, aged residential care staff, general hospital ward staff as well as disease specific teams e.g. oncology, respiratory, renal and cardiac teams. The care provided is an integral part of usual clinical practice. Primary palliative care providers assess and refer people to specialist palliative care services when the needs of the person exceed the capability of the primary palliative care provider.[7]

Specialist palliative care (SPC) is palliative care provided by those who have undergone specific training or accreditation in palliative care/medicine, working in the context of a multidisciplinary team of palliative care health professionals.

Specialist palliative care may be provided by hospice or hospital based palliative care services where people have access to at least medical and nursing palliative care specialists.

Specialist palliative care is delivered in two key ways:

- Directly – direct management and support of the person and family/ whānau where more complex palliative care needs exceed the physical, spiritual or social resources of the primary provider. SPC involvement with any person and the family/ whānau can be continuous or episodic depending on the changing need.
- Indirectly – to provide advice, support, education and training for other health professionals and volunteers to support the primary provision of palliative care.

Future need

Like all of New Zealand, and the World, the increasing numbers of people dying and the changing patterns of illness means the number of people who could benefit from a palliative approach to care is increasing. We will need to manage resources and ensure that we have the right people equipped to care and support the needs of those with a life limiting condition.

Evidence is showing us that in the next 20 years we will have more people dying. They will be living with and dying from not only malignant conditions such as cancer, but chronic conditions and multiple comorbidities, including dementia. Their longevity will be frequently compromised by fragility and disability.[8]

[6] Palliative Care Council of New Zealand. (2012). New Zealand Palliative Care Glossary. Wellington: Ministry of Health

[7] Hospice New Zealand. (2011). *Hospice New Zealand standards for the care of people approaching the end of life.* Wellington: MoH

[8] Ministry of Health (2016). *Review of Adult Palliative Care Services*, DRAFT June 2016

Live Well Stay Well Die Well

For New Zealand the estimates are:

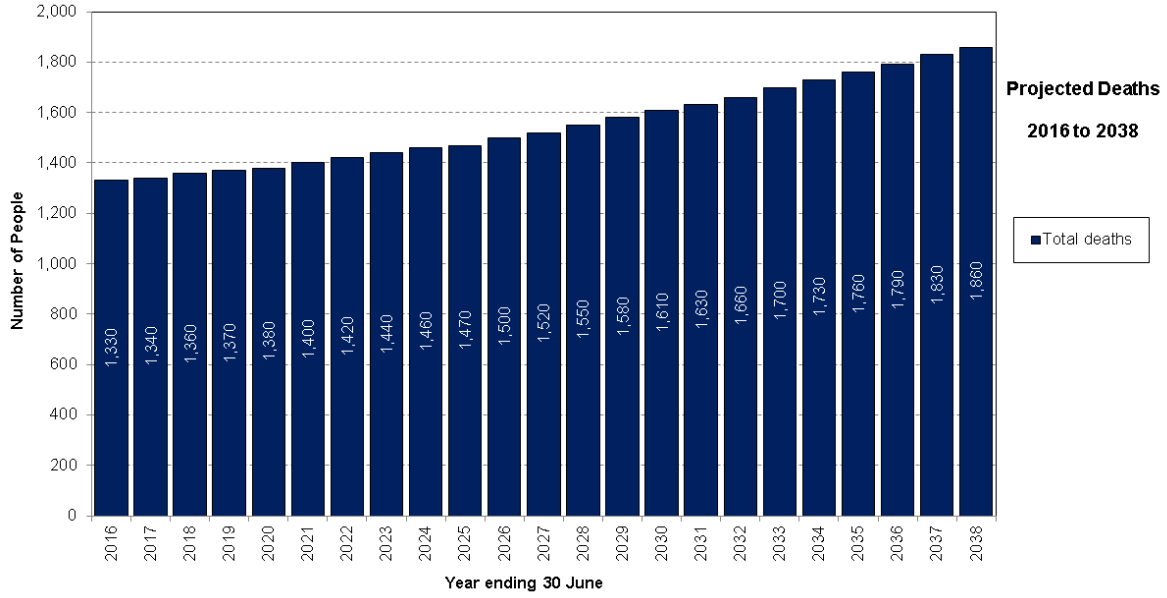
- Projected deaths will increase by almost 50 percent (from 30,000 to 45,000 per annum in 2038).
- Deaths will reach 55,500 per annum by 2068. This is the result of people living longer than before, coupled with an absolute increase in numbers due to the “baby boom” generation (born between 1946 – 1965) entering their older years.
- There will be rapid ageing of those deaths. In 20 years over half of the deaths will be in the age group 85 years and older. Deaths at the oldest ages will be predominantly women.
- Over the last decade deaths from circulatory system conditions have been declining and deaths from other conditions, including respiratory conditions, dementia and frailty, have been proportionally increasing.

For Hawke’s Bay our data is showing us:

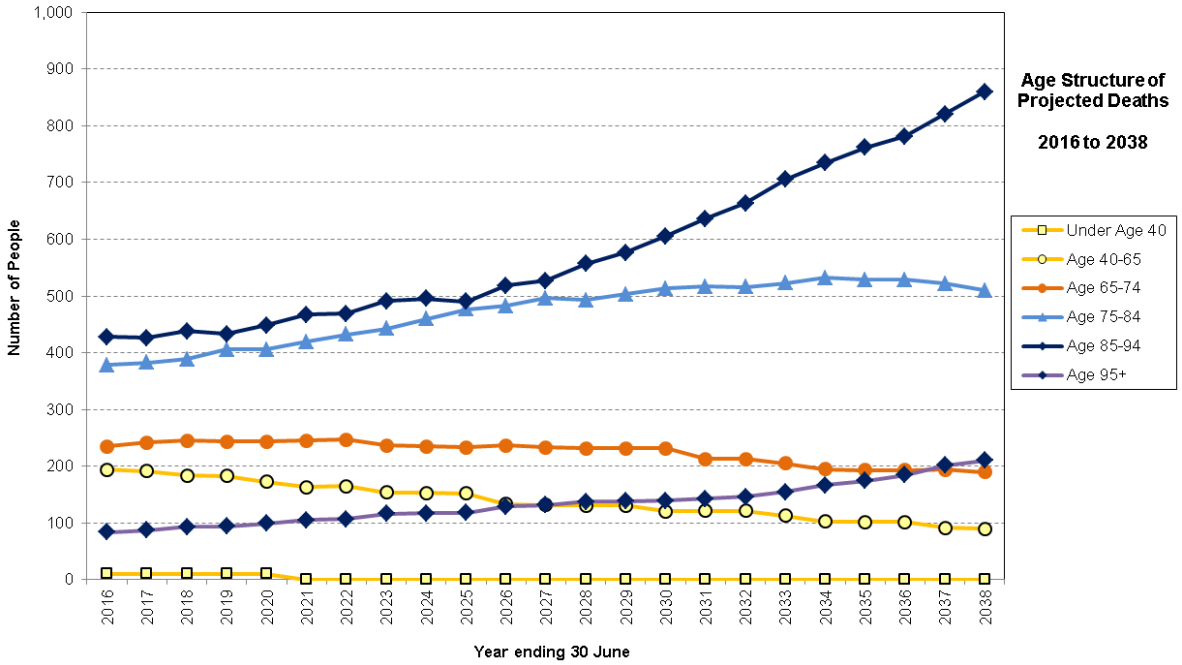
- The number of deaths per year will increase by over 500 people. From 1,330 predicted for 2016 to 1,860 by 2038. See graph 1.
- People in the 84-94 age group will more than double from 420 in 2016 to 870 by 2038. See graph 2.
- We will also see an increase in the 95 years and over age group with increases from 100 in 2016 to 200 by 2038.
- The number of Māori and Pasifika people dying will increase and whilst the numbers are relatively small per annum, the increased incidence of poverty plus barriers to access caused by cultural differences and lack of resources means that they are likely to require more support to achieve equitable outcomes.
- The estimated number of people dying who are likely to benefit from palliative care services is 822 in 2015 rising to 927 in 2025.
- The Hospice NZ Palliative Care Demand Model suggests that Cranford Hospice could possibly have been involved with 822 deaths in 2015 based on population data. They were actually involved in 663 deaths. There may be an unmet need of approximately 160 patients currently per annum.

Uptake of specialist and primary palliative care services by Māori (15.8%) and Pasifika (1.1%) was in line with their younger population profiles in 2014. However, it is not known whether the experiences of those groups is equitable, or whether they receive similar number of contacts per person as other non-Maori, non-Pasifika people.

Graph 1 : Number of projected deaths in Hawke's Bay 2016 to 2038



Graph 2 : Estimated change in age of death in Hawke's Bay from 2016 to 2038

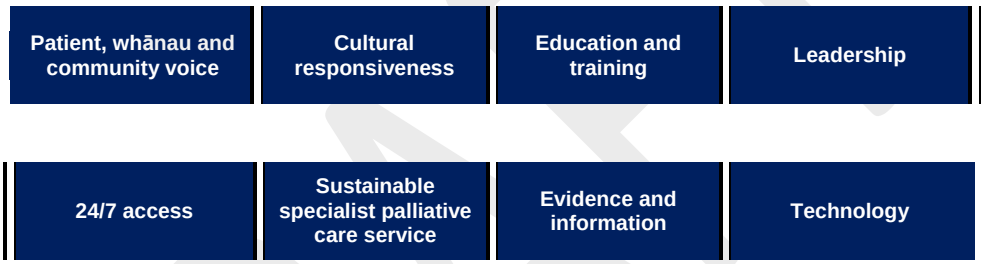


Acknowledgement: This document was developed using the National Palliative and End of Life Care Partnership. Ambitions for Palliative and End of Life Care; A national framework for local action 2015-2020. www.endoflifeambitions.org.uk.

Foundations on which our vision is built

"All people who are dying and their family/whanau who could benefit from palliative care have timely access to quality palliative care services that are culturally appropriate and are provided in a coordinated way"[4]

To realise our vision we have identified eight foundations that need to be in place to meet our commitments to palliative care in Hawke's Bay. They are necessary for each and underpin the whole. These foundations are prerequisites for success in providing quality palliative care to our community now and into the future.



1. Patient, Whānau and Community Voice

Systems for palliative care are best designed in collaboration with people who have had personal experience of death, dying and bereavement. We need to ensure that we are listening to the voices of patients, family/whānau, carers and communities in all that we do.[9] We need to engage communities in their own care design and how health services are delivered. Patients and whānau have told us they need better information so they are aware of support and can access it when they need it.[9] [10]

2. Equity and Cultural Responsiveness

We will provide culturally responsive care that is mindful of the beliefs and values of patients, family/whanau. This will include considering how to provide palliative care for the growing numbers of Māori and Pasifika who will need these services. When providing palliative care for Māori it is essential to see things through the patient's eyes. This includes understanding cultural influences on the pathway of death, acknowledging the strengths and resources of whānau and taking the time to understand what is important to the person. Whānaungatanga, kanohi ki te kanohi, wairuatanga, and the availability of Māori kaitakawaenga are all important for effective communication with Māori patients and their family/whānau.[11] [12]

[9] Boon, A. (2012). *Excellence through Patient and Family Centred Care; Literature Review.* Wellington: Health Quality and Safety Commission

[10] Layden, Connelly, Sandeman, Hekerem, Alexander, McLoughlin & Tyrrell. (2014). *Understanding palliative and end of life care through stakeholder and community engagement.* BMJ Support Palliat Care 2014;4:117-118 doi:10.1136/bmjspcare-2014-000653.39

[11] Ministry of Health. (2014). *Palliative Care and Māori from a Health Literacy Perspective.* Wellington: Ministry of Health.

[12] BPAC. (2016). *Providing palliative care to Maori.* http://www.bpac.org.nz/resources/campaign/palliative/palliative_maori.asp

3. Education and Training

To have palliative care as everybody's business there is a large education programme that needs to be implemented. We will need to educate patients, family/whānau, carers and primary palliative care providers in palliative care. With increasing demands on time we will need to look at a range of methods to teach appropriate knowledge and skills in end of life care. They include face-to-face, e-learning, simulation, reflective learning, health promotion, telemedicine, case studies, death reviews, mentoring and supervised clinical practice. We also need to look at ways to educate and train our informal workforce, unpaid volunteers and carers so they too are well equipped to provide hands on care and support. We will need to understand death and dying and advance care planning.

For PPC providers core elements will include:

- Identifying patients who need palliative care
- Breaking bad news
- Conversations with patients and their family/ whānau around advance care planning
- Providing care according to patient and family/whanau needs
- Basic symptom management
- Psychosocial support
- Knowledge of when to refer to specialist palliative care

These should be routine aspects of care delivered by any PPC health practitioner.

With a greater focus on primary palliative care, we will need a sustainable and sufficient specialist workforce to provide advice, support and education to PPC providers. They will also be educated, trained and equipped to manage and care for those who will need complex palliative care management including those with dementia and frailty.

There needs to be a focus on increasing opportunities for introducing and training students in all disciplines in palliative care.

In 2016 Cranford Hospice was successful in its submission for Ministry of Health innovation funding. The following roles have been established, based on feedback from General Practice and Aged Residential Care.

The existing Aged Residential Care Palliative Care Resource Nurse position increased from 0.6 to 1.2 full time equivalent. The Aged Residential Care liaison nurse will support and teach skills in palliative care.

A new 0.9FTE Palliative Care Nurse Practitioner supports primary care and rural services. This role works within General Practice with an emphasis in the first instance on rural populations in Central Hawke's Bay and Wairoa. The focus of this role will be to develop the skills, capacity and systems/processes required in primary care to deliver high quality primary palliative care. The Nurse Practitioner will support a primary care training programme and establish a process for regular case review with practices.

A new Caregiver Support Coordinator provides support to family/whanau caring for palliative patients by mobilising existing support services and volunteer networks.

4. Leadership Specialist and Primary

Shared leadership with clear responsibilities will deliver our vision and priorities. A business case will describe the priorities for investment so that services are planned to meet Hawke's Bay population needs.

Clinical leadership must be at the heart of this strategic vision to ensure that each person and their family/whānau receives the care they need, at the right time, by the right people. They must be committed to the priorities and are key in ensuring outcomes are met. As the Ministry of Health finalises the Palliative Care Strategy and Healthy Ageing Strategy, we will link new national priorities to our agreed local priorities.

5. Access 24 hours, 7 days a week

Every person at the end of life should have access to services 24 hours, 7 days per week (24/7). In times of distress, uncontrolled pain and other symptoms cannot wait for office hours. People need to know who to contact, no matter what the time. PPC providers, especially GPs, are providing the majority of care. They need to be resourced to meet the demands, with access to 24/7 advice and support from SPC. Pre-emptive charting and protocols for district nurses, ambulance, aged residential care and other community services need to be in place. For those who experience complex symptoms, the SPC nursing and medical team needs to be able to provide advice, care and support to those in need.

In Hawke's Bay we have a PPC programme that is intended to support patients who have a life limiting condition. The funding allocated to this programme is focussed on providing patients with dedicated care led by their primary health care team that works to moderate symptoms, pain, physical stress and the mental stressors associated with serious illness. The goal of this programme is to support planned care to improve the quality of life for both patients and their families.

A patient is offered access to this programme when they meet criteria and when there is a sense of need to provide palliative care therapies when no cure can be expected and when there is an expected length of life of six months or less. We will plan for sustainable funding past 30 June 2017.

6. Sustainable Specialist Palliative Care Service

Specialist palliative care is a vital foundation if we are to realise our vision and our priorities. Our specialist service needs to be equipped and resourced to meet the needs of complex patients, family/whānau, increased education needs, support of primary palliative care providers, advice and support 24/7.

There is a national shortage of palliative medicine specialists, an ageing nursing workforce and the low use of allied health teams.[1 13] Allied health professionals are commonly part of the palliative care multidisciplinary team in other countries (e.g. United Kingdom) but are not always in New Zealand.

SPC has been working hard since 2011 to build its workforce for the future needs with the introduction of advanced trainee positions, the introduction and expansion of clinical nurse specialists in hospice and hospital and the development of a nurse practitioner role. There is still work to do to ensure that we have a sustainable workforce that is well educated and equipped to meet needs.

Alongside new innovation and new roles the core clinical team positions need development to meet current and future demands. Our specialist medical workforce is an urgent priority. We do not have a sustainable medical workforce to meet required needs. With increasing complexity of patient and family/whānau needs and population growth we need to plan to increase resources.

This is not unique to Hawke's Bay. In 2014 the national Palliative Medicine and Training Coordination Committee surveyed District Health Boards and reviewed work force projections for Senior Medical Officer positions. They found 12 Senior Medical Officer positions were vacant and over the next five years to 2019, vacancies due to retirement would increase this to 30.[8]

The current medical, nursing, allied health, family support workforce is summarised in Appendix 1. Proposed roles and FTEs are described for 2026, to be able to cope with an increased demand for clinical care provision, advice, mentorship, supervision, rural support and education.

Over 50% of our SPC nursing workforce are eligible for retirement in the next 2 to 5 years. In the last few years we have been successful in recruiting for positions, as more nurses are considering palliative care as a speciality. These nurses will need time (2 to 3 years) to specialise and train. As half of our experienced workforce retires in the next 5 years providing support, mentorship and training will be challenging.

We have proposed increases in the nursing workforce to meet the increased need for complex care provision, an increase in inpatient beds at Hospice from 8 up to10, increased education and mentorship of primary care providers and training new specialist nursing staff. Staff, services and facilities will respond to the growing numbers of people with dementia and frailty.

To provide a holistic approach to care, SPC has also been growing its family support team and allied health team. This team will almost double to be able to meet demands in the community, especially with increased frailty, the need for a rehabilitative approach and patients living for longer with multiple comorbidities. As interdisciplinary teams develop further with primary care we will improve our communication and systems so we coordinate with new services such as engAGE services for frail older people.

[13] Palliative Care Council. (2013). *Needs Assessment for Palliative Care: Summary Phase 2 Report: Palliative Care Capacity and Capability in New Zealand* June 2013

To respond to the needs of the Hawke's Bay population, we will integrate Cranford Hospice and the Hospital Specialist Palliative Care team (HPCT) to form one specialist palliative care service for Hawke's Bay. This integrated service will provide quality clinical care at Cranford Hospice, within the community, and an in-reach consultation liaison service to the Hawke's Bay Fallen Soldiers Memorial Hospital. The service will use the same management support, human resources and clinical guidelines across all care settings. There will be one single point of entry to SPC, and care will be more seamless no matter what bed you are in or which setting that bed is placed in. SPC will be delivered equitably, with greater care coordination and with opportunities for workforce development. There will be rotation of staff across hospice, community and hospital areas.[14]

7. Technology

Care planning conversations need to be effectively recorded and appropriately shared through electronic systems. Electronic systems will need to support wider access to information, extended information context and new functions, such as write access by multiple sources. Access to Advanced Care Plans, pre-emptive charting and crisis plans must be maximised.[13] [15]

8. Evidence and Information

We need to ensure that data and evidence, including people's accounts of their experience of care are used effectively to inform learning, improvement. We will improve the collection, analysis, interpretation and dissemination of data related to palliative and end of life care. This will include evidence relating to needs, provision, activity, indicators and outcomes.[15]

[14] Canadian Hospice Palliative care Association. (2013). *Innovative Models of Integrated Hospice Palliative Care, the Way Forward Initiative: An Integrated Palliative Approach to Care.*

[15] The Scottish Government. (2015). *Strategic Framework for Action on Palliative and End of Life Care 2016-2021.* Edinburgh: The Scottish Government.

1 Each person and their family/whānau will have their individual needs as the centre of care

"On one occasion the hospice nurse arrived after he was discharged from hospital and worked through the discharge summary to make sure we understood the plan"
Wife of patient

What we already know

- People are unique, they want to be listened to, respected and involved in their care.
- People and their family/whānau require care. The needs of all individual members need to be identified and addressed.
- Leaders and care professionals need to be innovative in how they ask, record and work to support choices, particularly with limited resources.
- People, family/ whānau want to be involved in their care. They should be given all the information, advice and support they need to make decisions about it.
- Advance care planning gives everyone a chance to say what is important to them, ahead of time. It helps people understand what the future might hold and to say what treatment they would and would not want. It helps people, their families and healthcare teams plan for the future and end of life care.[16]
- Having conversations about death, dying and end of life requires compassion, knowledge, experience, sensitivity and skill on the part of the health professional involved. A series of conversations may be needed to determine the goals, values and wishes of the person and their family/ whānau in order to reach decisions about the appropriate plan of care.

[16] Northern Regional Alliance. (2016). *Advance Care Planning asks "What matters to you?"* http://www.advancecareplanning.org.nz/

Live Well Stay Well Die Well

The building blocks we need in place

Enablers for person centred care

Care must be delivered by systems that are carefully and consciously designed to ensure people retain control and are active participants in their care. Whenever possible care must be respectful of the person's values and preferences[5]

Access to social support

There is a mix of health, personal and social need at the end of life and afterwards which requires skilled assessment and available resources, delivered in an appropriate environment.

Meaningful conversations

People should have the opportunity to say what's important to them and be well informed about dying, death and bereavement by the right people in the right way at the right time[16]

Clear expectations

People and their family/whānau should know what they are entitled to expect as they reach the end of their lives[17]

Integrating the philosophy

The philosophy of person centred care is promoted and integrated into models of care across the health and social sectors

Good end of life care includes bereavement

Caring for the individual includes understanding the need to support the unique set of relationships between family, friends, carers, other loved ones and their community, and includes preparations for loss, grief and bereavement[18]

[17] National Palliative and End of Life Care Partnership. *Ambitions for Palliative and End of Life Care; A national framework for local action 2015-2020.* www.endoflifeambitions.org.uk.

[18] Heatley, R. (2006). *Carers' services guide*. London: Help the Hospices

Live Well Stay Well Die Well

2 Each person gets access to high quality individualised care and we improve equity

"The hospital palliative care team explained what 'hospice' meant, communication was great. Once this had been explained they were happy to accept a referral"
Consumer feedback

What we already know

- The number of Māori and Pasifika people dying will increase and whilst the numbers are relatively small per annum, the increased incidence of poverty in this population and the barriers to access caused by cultural difference and lack of resources means that they are likely to require more support to achieve equitable outcomes.[11]

- We cannot identify and predict when every person will die. The population is ageing and chronic conditions and co-morbidities will increase, making this even more difficult.

- Adults living in Wairoa and Central Hawke's Bay had fewer face to face contacts with SPC than in urban areas. They did not receive a corresponding increase in GP contacts, suggesting an inequity between urban and rural service delivery.[19]

- There is substantial data available regarding the palliative population. This needs to be standardised and used appropriately to identify the needs of the Hawke's Bay population and inform decision making.[20]

- Access to good and early palliative care can improve outcomes, not only with regards to quality of life, but also life expectancy.[2] [17]

- The way messages relating to the likely outcomes of medical conditions are communicated to people, affect their transition from curative to palliative care and willingness to accept referral to specialist palliative care.

- A public health approach recognises and plans to accommodate those disadvantaged by the economy, including rural and remote populations, tangata whenua, the homeless, lesbian, gay, bisexual, transgender and intersex communities.

- "Until recently, almost all assessments of the quality of palliative care focused on care structures and processes rather than on outcomes. Outcome measures are widely used in palliative care research to describe patient populations or to assess the effectiveness of interventions, but they are not, as yet, always incorporated into routine clinical practice".[21]

[19] *HBDHB palliative care data 2016*

[20] McLeod, H. (2016*). Hospice New Zealand Data Project Plan*

[21] Bausewein et al. (2016). EAPC *White Paper on outcome measurement in palliative care: Improving practice, attaining outcomes and delivering quality services.* Palliat Med. 2016 Jan;30(1):6-22. doi: 10.1177/0269216315589898. Epub 2015 Jun 11.

The building blocks we need in place

Person centred outcome measurement

With a consistent data set, improvement can be tracked and action taken to ensure all providers are accountable for enabling fair access to quality care.

Using data

"Well-organised data collection can help us to target different population groups and track their progress towards better outcomes, access and wider goals shared with other agencies. Information we collect can improve our understanding of the cause and effect relationships between health and other social services, the effectiveness of different ways of working, and the value for money offered by different interventions".[4]

Unwavering commitment

To achieve equity and access, provision and responsiveness requires unwavering commitment to local contracts and sustainable funding.

Referral criteria

A clear referral process is designed to ensure limited resources are appropriately allocated to serve those most in need. Other barriers to access are proactively evaluated and reduced to ensure an equitable service.

Community partnerships

Local plans should include partnerships between different faith groups and cultural communities, as well as the diverse organisations that support children and young adults, people living with different life shortening illness, and those managing the difficulties of older age.

Population based needs

Palliative care needs for the Hawke's Bay population should inform service design and resource allocation.

3 Comfort and wellbeing maximised

"The hospice doctor was the first to look at my whole picture, she asked "what sort of person are you? Do you want to know anything? She was the first to work with my interest in other therapies"
Patient feedback

What we already know

- What matters most to people at the end of life is good control of pain and other symptoms and being accompanied by but not a burden to their family/whānau.[8]
- People want to be considered as a whole. We need to care for physical, spiritual, family and mental health needs.
- Many people approaching death are fearful of being in pain or distress. Dying and death can be a powerful source of emotional turmoil, social isolation and spiritual or existential distress.[17]
- The experience of dying, and of caring for loved ones at the end of life, can have a deep and lasting impact on those involved. Poor support and inadequate symptom control may mean we fail to meet the needs of those who are dying, as well as those who care for them. This may lead to a complicated bereavement process for those left behind.
- A rehabilitation approach to palliative care is central to the person-centred ethos of hospice care, and promotes a culture that helps patients to thrive, not just survive, when faced with uncertainty and serious illness.[22]
- "The benefits of this rehabilitative approach are huge, not only for patients and their families but for hospices too, as they seek to respond to the challenges of supporting more people living longer with chronic conditions".[22]
- Members of the interdisciplinary team offer a diverse range of skills in the provision of emotional, social, psychosocial, cultural, religious and spiritual support, and it is recognised that all team members play a vital role.

[22] Hospice UK. (2015). *Rehabilitative palliative care: enabling people to live fully until they die – A challenge for the 21st century*.

The building blocks we need in place

Recognising distress whatever the cause

"Promptly recognising, acknowledging and working with the person to assess the extent and cause of the distress, and considering together what might be done to address this is important. This must be available in every setting."[17]

Skilled assessment and symptom management

Attending to physical comfort and pain and symptom management is the primary obligation of health professionals at this time of a person's life. Their skills to do so must be assured and kept up to date.[17]

Addressing all forms of distress

The experience of suffering associated with physical symptoms may be caused or made worse by emotional or psychological anguish or social or spiritual distress. Addressing this requires professionals to recognise, understand and work to alleviate the causes.

Priorities for care of the dying person

The delivery of care is respectful, individualised and tailored to the person who is in their last days of life. This includes acknowledgement of physical, spiritual, social, mental and cultural factors important to each individual and their family/whanau. Mechanisms to incorporate these factors into the delivery of care are prioritised as decided by the person, wherever they may be dying.

Specialist palliative care

Specialist palliative care is available to those people whose assessed needs exceed the capability of the primary palliative care provider. Specialist palliative care is responsible for supporting primary palliative care to achieve improved outcomes for patients and their family/whānau.

Rehabilitative palliative care

Rehabilitation aims to improve quality of life by enabling people to be as active and productive as possible, with minimum dependence on others, regardless of life expectancy.[22]

Fit for purpose facility

A suitable, well located facility will ensure that everyone has access to expertise and care. It also provides a hub for community engagement.

4 Care is coordinated

"It feels like the nurses are all up with the play, we don't have to repeat the story each time, it quickly felt like they really know us"

Patient feedback

What we already know

- People report not having a clear understanding of the role of the multiple health services involved in their care.
- Feedback indicates that lack of coordinated care and services increases the stress experienced by the patient, their carer/s, family and whānau. The alleviation of this would add significantly to their quality of life.
- People feel supported and safe with 24 hour advice available. The quality of the advice directly influences the level of trust people have with a service as a whole.
- Poor communication and failure to share information about the person who is dying is a recurrent theme when care is not good enough.[17]
- Primary palliative care professionals, including aged residential care staff report the increased confidence and increased ability to provide quality of care when access to specialist advice is available.
- High quality and well-co-ordinated care at the end of life provides a setting for a healthy experience of death for both family/whānau and the surrounding community.[15]
- People at the end of life with high levels of health, support and palliative needs require flexible packages of quality home nursing and support services to enable them to die at home, and to support their family and whanau at this time.

Live Well Stay Well Die Well

The building blocks we need in place

Systems for shared records

Health records for all people living with a life-limiting condition must include documentation of their assessed needs, as well as their preferences for end of life care. The person must have given their informed consent and the records should be shared electronically with all those involved in their care.

Clear roles and responsibilities

People living with life limiting conditions may have different services involved in their care. It is essential that people and their families know who and where to turn to for advice in times of change or crisis.

A system-wide response

Coordinated services need to be responsive to need in the community. These systems must include enabling dying people and their family/whānau access to 24/7 advice and support.

Continuity in partnership

Communication between service providers and consistent knowledge across settings, facilitates the smooth and timely delivery of quality care.

5 The community is involved

What we already know

- Talking about death, dying and bereavement is avoided in most community groups.
- Many members of the community do not understand what palliative care is.
- People who are dying and bereaved people often feel disconnected or isolated from their communities and networks of support.[17]
- Globally there is much known about helping to nourish compassionate and resilient communities, and how to build capacity to provide practical support.[17]
- Death, dying and loss affect everybody.
- The majority of people living and eventually dying from life-limiting conditions spend the greater part of their time at home being cared for and supported by family members, friends and neighbours.
- Many people feel unprepared when faced with the experiences of life-limiting conditions, death and bereavement and are uncertain about how to offer support and assistance.
- The experience of death, dying and bereavement can bring additional personal, health and social costs to those left behind. Much of this is preventable and/or relievable if the right supports are available in the right place at the right time.[23]
- The use of volunteers maximises community engagement and promotes partnerships between agencies and the community. Volunteers add value to the patient and family experience and complement the work of paid staff.

[23] Kellehear, A. (1999). *Health Promoting Palliative Care.* Melbourne: OUP

Live Well Stay Well Die Well

The building blocks we need in place

Compassionate and resilient communities

In a compassionate community, people are motivated by compassion to take responsibility for and care for each other with collective benefit.
http://www.charterforcompassion.org/index.php/shareable-community-ideas/what-is-a-compassionate-community

Public awareness

A community will be in the best position to care when they are comfortable with death and dying, can understand the difficulties people face, and know what help is available.

Practical support

Practical support, information and training are needed to enable families, neighbours and community organisations to help.

Volunteers

To meet our commitment, more should be done locally to recruit, train, value and connect volunteers into a more integrated effort to help support people, their family/whanau and communities.[17]

6 People prepared to care

"People didn't focus on physical symptoms – hospice staff were able to see the whole picture" Consumer feedback

What we already know

- The recruitment and retention of palliative care medicine specialists in urban and provincial areas is a major issue.[24] This is also an issue for Hawke's Bay.
- We have an ageing specialist palliative care nursing workforce.
- The demand for palliative care services, and thus workforce, will increase slowly over the next ten years but thereafter will increase more rapidly in line with the ageing population.[24]
- There is a growing need for a workforce that is culturally competent to accommodate diverse personal, cultural and spiritual customs and values.[8]
- Feedback suggests that the relationship people have with their GP and practice nurse is extremely important.
- The ageing population and emphasis on integrated care means that home and personal caregiver roles are becoming an increasingly critical part of the palliative care multidisciplinary team.
- Much of palliative care is provided by family members as informal carers. Reliance on informal carers and the volunteer workforce will only increase and we will need to support them to undertake potentially more complex roles.[8]
- A primary palliative care workforce works best when it is well-informed, educated and supported by specialist palliative care in caring for those with life-limiting conditions.
- Specialist palliative care services will need the capability and capacity to be able to provide care, support and educate others to meet projected demands and complexities of care.
- In order to meet identified needs of patients and their family/whanau we need a diverse range of skill and expertise within the interdisciplinary team.
- Staff can only compassionately care when they are cared for themselves. They must be supported to sustain their compassion so that they can remain resilient. This allows them to use their empathy and apply their professional values every time.[19]

[24] Ministry of Health. (2011). *Palliative Care Workforce Service Review; Health Workforce New Zealand.* Wellington: Ministry of Health

The building blocks we need in place

Knowledge base

Only well-trained competent and confident staff can bring professionalism, compassion and skill to the most difficult, and intensely delicate, physical and psychological caring.[17]

Support and resilience

Dealing with death and dying can be challenging. The potential impact of providing end of life care should not be minimised by clinicians, the team or the health service.[25]

Sustainable workforce

A sufficient formal and informal workforce is needed to provide the necessary hands-on support, advice and education, now and into the future.

Using technology

Professionals have to adapt to new ways of learning and interacting with the people that they are supporting and they need help and guidance to do so. Technology can also play a significant role in enhancing professional's self-directed learning and development.[17]

Clinical governance

Specialist and primary palliative care services will lead and co-ordinate a single system of care.

[25] Australian Commission on Safety and Quality in Health Care. (2015). *National Consensus Statement: essential elements for safe and high-quality end-of-life care.* Sydney: ACSQHC

HOW WE PLAN TO STRENGTHEN OUR FOUNDATIONS AND MEET OUR PRIORITIES

OUR PRIORITIES

Each person and their family/whānau will have their individual needs as the centre of care

- Enablers for person centred care
- Access to social support
- Meaningful conversations
- Clear expectations
- Integrating the philosophy
- Bereavement Support

Each person gets access to high quality individualised care and we improve equity

- Using data
- Unwavering commitment
- Person centred outcome measurement
- Population based needs
- Referral criteria
- Community partnerships

Comfort and wellbeing is maximised

- Recognising distress
- Skilled assessment & symptom management
- Priorities for care of the dying person
- Addressing all forms of distress
- Specialist palliative care
- Rehabilitative palliative care
- Fit for Purpose Facility

Care is coordinated

- Systems for shared records
- Clear roles and responsibilities
- System-wide response
- Continuity in partnership

The community is involved

- Compassionate communities
- Public awareness
- Practical support
- Volunteers

All staff are prepared to care

- Knowledge base
- Support and resilience
- Using technology
- Sustainable workforce
- Clinical governance

ACTIONS REQUIRED

- Services are co-designed with patients and whānau.
- Implementation of a rehabilitative approach to palliative care.
- Patients and family members know where to go for palliative care and are connected to services
- Information, education and visibility in the community on innovative ways to increase awareness and community culture around death and dying.
- Health and support workforce is skilled and informed to be able to support conversations around death and dying.
- Training and supervision systems in place to support the development of SPC workforce.
- Specialist palliative care provide education and support the efforts of primary palliative care providers in delivering patient care.
- Last Days of Life (Te Ara Whakapiri) Pathway is developed and implemented across the region.
- Integration of Cranford Hospice and Hospital Palliative Care Team to form one specialist palliative care service.
- Confirm sustainable and responsive after hours primary palliative care arrangements
- Specialist medical workforce developed to meet minimum recommended requirements.
- Develop and expand nurse-led initiatives and expert roles such as the Nurse Practitioner.
- Increase the role and size of the allied health and family support services.
- New purpose built facility for specialist palliative care. Increase from 8 up to 10 inpatient beds as per recommendations.[13]
- Look for opportunities to expand volunteer and informal support services in the community.
- Information technology systems accessible across primary and specialist settings. Palcare or other system.
- Continued involvement in national data work – to develop measurable patient outcomes.
- Research and evaluation outcomes are used to inform best practice.

OUTCOME MEASUREMENTS

- Maintain feedback from family members surveyed after death using a standard questionnaire relating to comfort and wellbeing. Satisfaction for SPC in 2016 is 99%.
- People with palliative care needs living in aged residential care facilities have care plans reflecting individual needs and best practice via documentation peer review.
- 95% of referrals to specialist palliative are accepted, reflecting appropriateness.
- Monitor access to SPC compared to our population profile & then adapt services to respond:
  - - Death by ethnicity in HB.
  - - Access by area reflects deaths in each area.
  - - Access by condition reflects deaths by condition.
- The proportion of people dying where they live will increase.
  - The proportion of people dying in hospital with SPC needs will decrease by one third from 34% to 21% by 31 December 2018
- 100% of aged residential care facilities and hospital wards have implemented the Last Days of Life Care (Te Ara Whakapiri) Plan supported by Specialist Palliative Care services.
- New SPC facility built using co-design principles by 31 December 2019.
- 20% nursing staff under the age of 50 by 2021.
- Increase the proportion of Maori workforce in SPC from 5.7% to 11.4% by 2026.
- SPC FTE medical staff increased from 3.2 to 6.8 by 31 December 2018
- 70% of GP practice have access to the electronic patient management system Palcare (or another) by 1 July 2018 and 70% of hospital by 1 July 2021.
- National palliative care outcome measures are implemented and used for data collection and evaluation by 31 December 2017.

FOUNDATIONS

- Patient, whānau and community voice
- Equity and cultural responsiveness
- Education and training
- Leadership
- 24/7 access
- Sustainable specialist palliative care service
- Evidence and information
- Technology

14.1

Appendix 1

Table 1: Current & Proposed Specialist Workforce

Role 2016	Full Time Equivalent (FTE)	Proposed Roles 2026	Full Time Equivalent (FTE)
Palliative medicine specialist (Hospital 0.5; Hospice 0.5)	1.0	Palliative medicine specialist	2.4
Medical officer special scale Advanced trainee (currently in Hospital)	1.8 0.4	Medical officer special scale or GP with special interest, or advanced trainee or registrar physician training. (Covering community, hospice inpatient unit and hospital services)	3.0
		House officer trainee Hospital & Hospice	1.0
Medical Director	0.4	Medical Director	0.4
TOTAL	**3.6**		**6.8**

Table 2: Current & Proposed Nursing Workforce

Roles 2016	Full Time Equivalent (FTE)	Proposed Roles 2026	Full Time Equivalent (FTE)
Nurse Practitioner Candidate	0.9	Nurse Practitioner	0.9
Clinical Nurse Specialists Hospital 2.0; Hospice 2.8	4.8	Clinical Nurse Specialists Hospital 2.0; Hospice 3.0	5.0
Aged Care Liaison Nurses	1.2	Aged Care Clinical Nurse Specialist	2.0
Registered Nurses inpatient unit and community nurses	18.2	Registered Nurses inpatient unit and community nurses, new graduate position	21.8
Education	0.5	Education	2.0
	0.8	Enrolled Nurse	0.8
		Health care assistants	3.0
TOTAL	**26.4**		**35.5**

Table 3: Current & Proposed Allied Health & Family Support Workforce

Roles 2016	Full Time Equivalent (FTE)	Proposed Roles 2026	Full Time Equivalent (FTE)
Counsellor	1.0	Counsellor	2.0
Social Worker	1.0	Social Worker	2.0
Pastoral Care	0.8	Pastoral Care	1.0
Carer Support Coordinator	1.0	Carer Support Coordinator	1.6
Music Therapist	0.4	Music Therapist	0.6
Kaitakawaenga	0.8	Kaitakawaenga	1.0
Cultural Advisor	0.2	Cultural Advisor	0.2
Pharmacist	0.5	Pharmacist	0.8
Occupational Therapist	0.6	Occupational Therapist	1.0
		Physiotherapist	1.0
TOTAL	**6.3**		**11.2**

Consumer feedback 2015 – 2016

This information is from written and verbal feedback. Quotes are adapted to maintain confidentiality

PRIMARY PALLIATIVE CARE

Almost all mentioned their GP – always expressed strongly, whether good or bad This is a very important relationship. Majority spoke positively about their GP, the sense of support, advocacy and availability. Practice nurses mentioned occasionally, positive addition to sense of support.
Criticisms related to communication:
- of prognosis and introduction of the idea of referral to Hospice
- availability, the need to be able to access as needed and not to have to see other GPs who don't know them
- concentration on physical / medical needs of the patient

SECONDARY PALLIATIVE CARE

Some people reported satisfaction with the service they were provided if/when admitted. Of those that met with the HPCT, all but one was positive and the communication provided relief and more confidence and understanding of hospice.
Several negative experiences expressed of communication from specialists / doctors regarding diagnosis and prognosis. These were all expressed with quite a bit of emotion. Mostly related to 'abruptness' or suddenness of the message. Some felt that this was even "rude" and left them with negative feelings including an inability to ask questions. Many left not knowing what 'palliative care' was and afraid to accept the referral.
Many felt the doctors at the hospital were only interested in one aspect of them and this was a barrier to quality care.

I can tell my GP anything, she is a great advocate

The Hospital Palliative Care Team explained what 'hospice' meant, communication was great. Once this had been explained they were happy to accept referral

It is hard to get the same GP so we have to "start again" each time - this stopped us talking about Long Term Care like we wanted to. GP is there for/focuses on "medical matters"

When they decide they can't do anything medically for you, you are off on your own, they don't want to know you….

My out-patient appointment made all the difference, they linked everything together

Cranford people are non-intrusive; responsive and great for advice

When we ask for a visit – the response is always "yip, no problem"

The doctor was the first to look at the "whole picture"

SPECIALIST PALLIATIVE CARE

The majority of those visited described having strong beliefs about Hospice as a 'place to die' and were unhappy about the referral, some saying that this meant they refused referral initially and later regretted this once they learned what it is really about.
All felt that Cranford Hospice staff were great and there were no complaints or criticism about this. Often people felt supported and safe with the 24 hour advice available.
People didn't focus on physical symptoms – most were more interested in talking about the general feeling of psychosocial support and several mentioned that the Hospice staff were able to see the 'whole picture'.
Actually coming into the Hospice building for an appointment was universally a positive experience and reduced fears / barriers to accepting admission if needed.
People talked about the need to keep 'living' and things like vague appointment times were interruptions to that.

Rural feedback 2016 – 2017

Having the conversations about what to expect, who is in charge, what the person and whānau want is really important

Carers with recent experience of deaths in the family were prepared to discuss death & dying. They would be comfortable doing an advance care plan with their family

Explain what to expect next in the journey so that whanau can anticipate what they need and why

A rural approach is needed as accessing services in remote areas can be difficult

Making sure the medical people involved are all aware of all of that so plans can be put in place so it happens as the family expect and want it to

Provide really solid carer support that continues after the person has passed

Link people to networks within the community

Having access to local staff who know you and your family is really important. Health navigator/supporter who can direct you to what you need just ahead of when you need it and explain how to use the service

Health professionals need to have more of a palliative care approach.

Good at interventions & surgeries - quality of life

Don't leave it too late. Timing is crucial. Still not easy but a relief to have support

Who should I be listening to? Chemist, GP, nurse

Need more of a group approach – GP, specialists, district nurse

Hospital visits are rushed

No social work input

How it could have been different plays on my mind

Reassurance helps

Needed a syringe driver much earlier for pain relief

When is it palliative care?

One nurse made all the difference in our lives. She asked you know you are going to die -have you planned anything? I couldn't say it & neither could he. The last three months with him were wonderful. The doctor who knows us well said he didn't like to tell me. I felt in limbo.

HAWKE'S BAY District Health Board Whakawāteatia	**DRAFT Hawke's Bay District Health Board Annual Plan 2017/18** 25
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Tim Evans and Tracee Te Huia Carina Burgess, Head of Planning and Robyn Richardson, Health Services Planner
Reviewed by:	Executive Management Team, HB Clinical Council, HB Health Consumer Council and Māori Relationship Board (via email, no meeting held in March)
Month:	March, 2017
Consideration:	For Information

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RECOMMENDATION

That HBDHB Board

- Note the draft contents, timeline and process for the Hawke's Bay DHB Annual Plan 2017/18 and provide feedback to Carina Burgess
- Approve the Draft Annual Plan subject to any changes discussed

OVERVIEW

The first draft of the Hawke's Bay DHB Annual Plan is currently under development and is due to the Ministry of Health (MoH) by 31st March. It is being shared with you to approve the draft before it is submitted to the MoH

It is important to note that we only receive final guidance from the MoH for a number of priority areas on 17th March so some sections are still in development.

For 2017/18, Annual Plans and Māori Health Annual Plans have been fully integrated nationally so we will no longer have a Māori Health Annual Plan. The Minister has also requested that Annual plans follow a template so they are more streamlined and focussed on the Minister's priorities.

We are not required to prepare a Statement of Intent (SOI) in 2017, this will be retained for every third year (last SOI prepared in 2016).

Timeline

Presented to EMT	21st February
MoH Planning Guidance & NZ Health Strategy finalised	Early March
MRB (by email)	8th March
Clinical Council	8th March
Consumer Council	9th March
MoH final guidance received	17th March
Board	29th March
Ministry of Health (MoH)	31st March

Process

Despite changes to the Annual Plan, the process to develop it has been very similar to 2016/17. Planning, Strategic Services, the PHO, Population Health, Maori Health and Health Services are working closely to develop this plan. Each priority in ***Section 2: Delivering on Priorities***, has a small working group who are responsible for agreeing actions, leads and timeframes which will lead to better ownership of reporting going forward. Due to late information received from the MoH and conflicting priorities, not all of these groups have been able to meet before these papers were sent out but we are expecting that majority of these will be complete before the draft is submitted. There are also a number of activities which are to be confirmed (TBC) as more time and clarity is required to understand what activities will be carried out in the coming year.

Changes since 2016/17
Priorities

Through the new streamlined annual planning process, there is more emphasis on meeting our obligations to the Minister across the twenty-two priority areas identified and less on our local strategy and priorities.

HBDHB has had an integrated Annual Plan and Māori Health Annual Plan for three years now so the national move to integrating the plans is not new to us. However, we are now restricted to only the Minister's priorities so we will need to ensure that our local equity priorities are included in Regional, portfolio and service level planning.

In the Minister's letter of expectations sent in December 2016, he identified fiscal discipline, working across government and achieving the National Health Targets as areas of priority. All of these areas have been addressed in the Annual Plan.

Reporting

A number of new Performance Measures have been added to the Non-Financial Performance Framework from the MoH. All of 2016/17 Maori Health Annual Plan priority measures (e.g Breastfeeding, SUDI, Breast Screening, PHO enrolment etc) are now included. This means that for the first time we will need to report against performance on these measures to the MoH quarterly. A new measure ***PP38: Delivery of response actions agreed in annual plan*** has been added which means from Q1, we will be required to report on all activity in the annual plan to the MoH quarterly.

Due to the increased number of MoH performance measures, I have indicated in ***Appendix 1: Statement of Performance Expectations***, where we are currently in discussion about removing some measures

System Level Measures

The System Level Measures Improvement Plan is to be included as an appendix to the Annual Plan 2017/18. The first workshop for developing the plan was held in February. From this, smaller working groups have been formed to develop the plan. This will be submitted to the MoH in April.

ATTACHMENTS

Hawke's Bay District Health Board Annual Plan 2017/18 Draft v0.5

Hawke's Bay District Health Board

Annual Plan and Statement of Performance Expectations 2017/18

Draft v0.5

OUR VISION

"HEALTHY HAWKE'S BAY"

"TE HAUORA O TE MATAU-A-MAUI"

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

TAUWHIRO

Delivering high quality care to patients and consumers

RĀRANGA TE TIRA

Working together in partnership across the community

HE KAUANUANU

Showing respect for each other, our staff, patients and consumers

ĀKINA

Continuously improving everything we do

Hawke's Bay District Health Board Annual Plan 2017/18

DHB Contact Information:
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Hawke's Bay District Health Board
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HASTINGS
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CONTENTS

1 OVERVIEW OF STRATEGIC PRIORITIES

1.1 Strategic Intentions

Hawke's Bay District Health Board (HBDHB) is a Crown Entity and is the Government's funder and provider of public health and disability services for the population in our defined district. Our Statement of Intent 2016-19 outlines our strategic intentions for the next four years and shows how local outputs impact on our population and contribute to local, regional and system-level outcomes.

As a sector we have a common vision: "Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community." We face challenges such as the growth in chronic illness, our aging population and vulnerability in a large sector of our community. Our strategy, Transform and Sustain, seeks to overcome these challenges. Our three long term goals are: everyone experiences consistent, high quality care; the health system is efficient and sustainable; and people live longer, healthier lives.

In 2016 Transform and Sustain was refreshed to ensure that we are closely aligned to the New Zealand Health Strategy and it's themes as shown in figure 1 below.

Figure 1: Transform and Sustain linked to the New Zealand Health Strategy themes.

We work collaboratively with our Central Region partners, our local primary health organisation (PHO), Health Hawke's Bay and other sectors for optimal arrangements. Using these relationships we have planned our contribution to the Government's priorities for the health system, which include fiscal discipline, working across government, and achieving the National Health Target.

1.2 Our Population

The population of Hawke's Bay district has some unique characteristics compared to the rest of New Zealand in terms of health status and socio-demographics, and this provides us with some specific challenges. We have a higher proportion of Māori (26% vs 16%), more people aged over 65 years (19% vs 15%) (Statistics New Zealand, Summary of Resident Total Population Projections, 2018-2043; 2013 base) and more people living in areas with relatively high material deprivation (28% vs 20%)

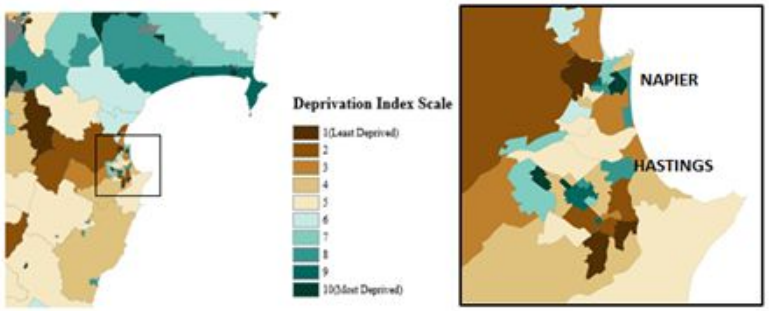

Figure 2: Hawke's Bay District relative deprivation NZDep13

Growth in the population is being driven by a younger age profile in the Māori and Pasifika population, which results in a higher birth rate, plus increased life expectancy across our whole population.

These projected population changes emphasise the need for HBDHB to maintain our focus on improving Māori and Pasifika health and to reorient our services to address and manage age-related health issues as guided by the New Zealand Healthy Ageing Strategy

Te Tiriti o Waitangi guarantees equitable health and social outcomes for everyone, and all Government agencies have a role in making sure that happens. The role and expectations of District Health Boards (DHBs) is emphasised in the New Zealand Public Health and Disability Act, 2000 (NZPHD Act) and our DHB partners with Health Hawke's Bay to co-ordinate the delivery of publicly funded health care and wellness support services. DHB responsibilities are based on:

- **Partnership** – working together with Iwi, hapū, whānau and Māori communities to develop strategies for improving the health status of Māori.
- **Participation** – involving Māori at all levels of the sector in planning, developing and delivering of health and disability services that are put in place to improve the health status of Māori.
- **Protection** – ensuring Māori well-being is protected and improved, and safeguarding Māori cultural concepts, values and practices. This includes the elimination of Māori health disparities by improving access to services and health outcomes for Māori.

Mai, our Māori Health Strategy 2014-19 and our Pacific Health Action Plan 2014-2018 have been developed to align with; the above principles and Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018.

In 2016 we updated the Health Equity in Hawke's Bay report, an analysis and report on health status in Hawke's Bay. The main focus of the report is equity because health inequities are differences in health status that are avoidable or preventable and therefore unfair.

The report finds many inequities in health in Hawke's Bay, particularly for Māori, Pasifika and people living in more-deprived areas. There are also areas where, with determined and focused effort, we have improved outcomes and reduced inequities. This demonstrates that inequities are not inevitable. We can change them if we have the courage and determination to do so.

The Health Equity Report concludes that inequity affects everyone and, for a difference to be made, we must tackle this collectively and take responsibility as a community. Since release, the findings of the report have been widely shared. The level of interest has been very positive and has led to the Hawke's Bay Intersectoral Forum, LIFT Hawke's Bay,[1] taking a role in developing a Social Inclusion Strategy to address priority areas. This multi-agency approach aims to bring a full range of relevant providers together with public, philanthropic and private funders to implement novel opportunities to integrate efforts that will address inequity as a community.

1.3 Long Term Investment

As a District Health Board, we have worked hard to create financial stability and use our internally generated funds to systematically invest in improved health services for our population. Looking forward, we aim to maintain this stability and continue to make smart investment decisions to meet the changing needs of the population.

Our Long Term Investment Plan (LTIP) outlines Hawke's Bay District Health Board's ten year investment plan based on a simplified outlook to the future from a local, regional and National perspective. In 2017/18 a Clinical Services Plan.is being developed to best inform where we will need to prioritise future investment and the LTIP will be updated accordingly.

[1] Includes Mayors, Members of Parliament, Iwi, Local and Regional Councils, Business HB, EIT, Government agencies – Housing NZ; Police, Corrections, Ministry of Social Development, Ministry of Education, Te Puni Kokiri, DHB

1.4 Statement from the Chair and Chief Executive

X_____ X_____

Dr Kevin Snee, Chief Executive
Hawke's Bay District Health Board

Kevin Atkinson, Board Chair
Hawke's Bay District Health Board

MINISTER OF HEALTH

X_____
Hon. Dr Jonathan Coleman, Minister of Health

THE PRIMARY HEALTHCARE ORGANISATION

X_____
Wayne Woolrich, General Manager Health Hawke's Bay – Te Oranga Hawke's Bay

MĀORI RELATIONSHIP BOARD

X_____
Ngahiwi Tomoana, Chair - HBDHB Māori Relationship Board

ALLIANCE LEADERSHIP TEAM

X_____
Bayden Barber, Member – Hawke's Bay Alliance Leadership Team

2 DELIVERING ON PRIORITIES

This section outlines activity to improve performance against Government priorities, and our contribution to the Central Region's priorities. It provides a sense of our commitment of resources to implementing those priorities, how we coordinate our efforts, and how we will measure success.

Acknowledgement

The 2017/18 planning process for this Annual Plan included setting up groups of stakeholders around each priority area. Accountability for collating each section was shared between co-leads from Health Hawke's Bay and HBDHB to ensure that there was PHO participation in the preparation of this plan. The public health unit and frontline clinicians played a vital role in developing the sections over the planning period in 2017.

Leaders from Māori and Pacific Health were consulted with at various stages in the planning process. Māori health priorities are indicated throughout the document and where possible, all measures will be reported on by ethnicity.

2.1 Government Planning Priorities

Government Planning Priority	Focus Expected for Hawke's Bay DHB	Link to NZ Health Strategy	Hawke's Bay DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance	1. 2. 3. 4.		PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered	1. Train all School Based Health Service (SBHS) nurses to use advanced standing orders for contraception 2. All nurses, both SBHS and primary and community, working under standing orders, have an annual update and assessment 3. Develop initiatives within the Sexual Health Governance Group action plan to better engage males in their reproductive health.	Q4 100% trained Q4 100% completion Q4 5% increase in males accessing	PP38: Delivery of response actions agreed in annual plan
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team	1. Violence Intervention Programme (VIP) Improvement Group to; establish aggregated quarterly reporting for all health service units so high performing units can support units that wish to improve screening rates, disclosure rates and training (no, % by ethnicity);	TBC	PP27: Supporting Vulnerable Children

			2. review quarterly report and provide operational support and leadership to services who wish to improve; establish VIP improvement plan in each area. 3. Develop a family violence screening KPI for Health Services to be implemented in 18/19 4. Extend scope of multi-agency maternal wellbeing and child protection group to provide support for pregnant women and children up to 2 years(as opposed to 6 weeks as in the past) 5. Establish a Pregnancy and Parenting Service: Assertive Outreach to vulnerable whānau experiencing drug and alcohol issues	Q4 Q1-4 Q2	
Reducing Rheumatic Fever BPS Target	Sustain reduction in rheumatic fever through the delivery of the rheumatic fever prevention plan.	Value and high performance	5. Using an equity focus, extend the Healthy Homes programme to 500 annual referrals *(subject to allocation of funding)* 6. Continue with Say Ahh programme in targeted schools, and primary care *(subject to allocation of funding)* 7. Continue to monitor time between admission and notification of a new cases of rheumatic fever to the Medical Officer of Health. 8. Undertake case reviews of all Rheumatic Fever cases and address identified system failures	Q4 500 referrals Q1-4 Q1-4	PP28: Reducing Rheumatic Fever
Increased Immunisation BPS and Health Target 	Continue current activity, in accordance with national immunisation strategies and service specifications, to maintain high (target) coverage rates for all immunisation milestones.	Value and high performance	1. Survey all child birth educators on their knowledge, confidence and activity around educating people of all cultures on immunisation 2. Meet all major milestones on the HPV immunisation communication plan are achieved to ensure a systematic process and avoid gaps in service delivery. 3. Work with Māori providers and other organisations to improve their capability by: Providing educations sessions; Ensuring there are authorised vaccinators; and Providing support with the cold chain 4. Develop a how to guide for general practice to enable correct recording of influenza vaccines to ensure these link to the National Immunisation Register (NIR) 5. Work with Kahungunu Executive to explore opportunities to increase capacity and capability for immunisation in Wairoa	Q2 Q1-4 Q3, Q4 Q3 Q4	Immunisation Health Target PP21: Immunisation Services
	Provide a prioritised list of the service improvement activities you will implement in 2017/18 to improve acute patient flow within your hospital(s).	Value and high performance	1. Work with Francis Health to roll out the FLOW programme to work with staff across the hospital to improve patient journeys. Four key focus areas: Emergency Department - high performing and supported department; refining our Acute Assessment Unit(s) by extending senior doctor cover, introducing ambulatory models of care, enhancing direct GP referrals and exploring the merits of a	Q2	ED Health Target

			surgical assessment unit; improving our systems and process to discharge patients from our inpatient wards by focussing on increased earlier in the day discharges and how we manage patients who have longer stays; ensuring our processes are effective in managing patients with frailty from presentation in ED, through their patient journey on to discharge		
			2. Implement Internal Professional Standards (Medical Staff)		
			3. Implement a Nurse Practitioner led model of care	Q2	
			4. Complete implementation of ED Quality Framework and ensure processes and systems are in place to enable monitoring of mandatory and non – mandatory measures	Q4	
			5. Primary Care ED Co-Operative Programme (PCED) to assist key general practices to develop and implement a new multidisciplinary model of care for high users of ED	Q4	
			6. Development of the functions within the Integrated Operations Centre with a focus on Patient Flow including; resource allocation: bed capacity; Primary Care communication	Q4	
Improved Access to Elective Surgery Health Target 	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	**Value and high performance**	1. Deliver TBC elective discharges in 2017/18	Q4	Electives Health Target
			2. TBC activity for Increasing surgical capacity once indicative business case approved	TBC	
			3. Continue to monitor theatre productivity via Theatre Management committee	Q1-4	
			4. Deliver TBC Major Joint, TBC Orthopaedic other and TBC General Surgery discharges in 2017/18	Q4	Additional Orthopaedic and General Surgery Initiative
			5. Deliver 21 Major Joint Replacement per 10,000 and 27 Cataract Procedures: per 10,000	Q4	SI4: Standardised Intervention Rates
			6. TBC 4000 bed days and FLOW project alignment	TBC	OS3: Inpatient Length of Stay (Electives)
			7. TBC ambulatory volumes	Q4	Electives and Ambulatory Initiative
			8. TBC bariatric discharges	Q4	Bariatric Initiative
			9. Review patient flow pathways specialty by specialty to identify blockages and areas where efficiencies can be made	Q3	Elective Services Patient Flow Indicators
			10. Carry out Service Review for vascular service	Q2	

Faster Cancer Treatment Health Target 	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	One team	1. Review the use of electronic referral system, by GPs, for suspicion of cancer TBC 2. Establish internal standards for: • Time frames from date of referral to multi-disciplinary meeting (MDM) and from MDM to decision to treat • Timeframes from referral to CT and from CT to CT report 3. Develop a protocol for consistent involvement of Clinical Nurse Co-ordinators in referral prioritisation to support identification of high suspicion cancer. 4. Develop and implement an alternative pathway for benign breast in collaboration with primary care 5. Broaden attendance (medical, surgical, radiology) at MDMs 6. Support or comply with Central Cancer Network (CCN) activities 7. Review options to establish a FCT navigator role in primary care to identify the at risk populations and to develop diagnostic pathways that enable equitable access.	Q3 Q2 Q1 Q2 Q2 Q1-4 Q3	Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target 	Strengthening the DHB smoking cessation plan with input from primary care and smoking cessation providers.	Value and high performance	1. Implement the co-created Regional Tobacco Strategy 2. Review forms used in Primary Care Patient Management System to embed mandatory Smokefree fields 3. Provide benchmarking data and audit support for governance reporting to manage performance of the Health Target 4. Support high prevalence populations by providing sufficient training in Wairoa, expanding incentivised programme for young Maori women, monitoring referrals from GPs following the Early Engagement roll out and investigating cessation support tools e.g. 'vaping' 5. Support the establishment of the aligned cessation service, using input from providers by providing project support and developing training and communication plans 6. Continue to screen inpatients in maternity services, offering support to quit for mothers and whanau and monitor Smokefree rates at discharge from Maternity Unit	Q1-4 Q2 Progress Report Q1-4 Draft Report Q2 Q1 Q1-4	Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals

Raising Healthy Kids Health Target 	Identify activities to sustain efforts and progress towards achieving the Raising Healthy Kids target by December 2017.	Closer to home	1. Close monitoring of progress against the Health Target 2. Monitor implementation of Healthy Conversation tools 3. Support collective action to reduce childhood obesity by implementing the Best Start: healthy eating and activity Plan 4. Monitor family-based nutrition and lifestyle interventions	Q1 Meet target Q2 Q3 Q2, Q4	Healthy Kids Health Target
Bowel Screening	Contribute to development activities for the national bowel screening programme, including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.	Value and high performance			PP29: Improving waiting times for diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including reducing the rate of Māori under community treatment orders.	One team			PP36: Reduce the rate of Māori on the mental health Act: section 29 community treatment orders relative to other ethnicities.
	Improve population mental health, especially for priority populations including vulnerable children, youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.	Value and high performance			PP38: Delivery of response actions agreed in annual plan PP26 PP8

Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	Closer to home			PP23: Improving Wrap Around Services – Health of Older People
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards r Diabetes Care.	Closer to home	1. The Stanford Programme for self-management of chronic disease will be offered by general practice to people who are diagnosed with pre-diabetes 2. Pre-diabetes patients (meeting inclusion criteria) will be offered participation in the PIPI programme (primary care nurses offering nutrition and lifestyle support) 3. Establish audit and reporting processes for both retinal screening and podiatry services for medium to high risk patients 4. All general practices will develop an annual Diabetes Care Improvement Plan (DCIP) with a focus on the delivery of quality care to their respective diabetes population. 5. Build capability of our primary care nursing work force by developing outcomes based goals and a role structure for CNS shared care with primary care 6. Analyse diabetes population by monitoring of HbA1c across general practice through provision of trend reports. This will inform the focus to increase services for Māori 7. Review model of care for secondary services	Q2 4 sessions Q1-4 Q2 Q2 Q2 Q4 TBC	PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services
Childhood Obesity Plan	Commit to progress DHB-led initiatives from the *childhood obesity plan*.	Closer to home	Implement the activities identified for 2017/18 from the Best Start Plan (Childhood Obesity Plan for HBDHB)		PP38: Delivery of response actions agreed in annual plan

Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	Value and high performance			PP38: Delivery of response actions agreed in annual plan
Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances).	One team	1. Representatives for physical and sensory disability and also for intellectual and neurological disability are required on Consumer Council 2. Co-location of Mental Health Emergency services with Emergency Department 3. All new reception builds have a lower section 4. Allied health departments have tools to support communication, movement, and activities of daily living but use is dependent on request from staff for support tools or assessment	N/A	PP38: Delivery of response actions agreed in annual plan
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector	Closer to home	1. Develop a guideline for transferal of resource to support capability and capacity in primary care 2. Chief Information Officer(CIO) HBDHB, with input from Health Hawkes Bay, to inform future integration platforms for Information Technology 3. Initiate project to Investigate ways of incentivising improved Primary Care outcomes 4. Promote joint sector wide clinical leadership and clinically led decision-making through the HB Clinical Council monthly meetings, on behalf of the Alliance Leadership Team 5. Under the Transform and Sustain programme; further develop a structure for implementing localised prioritised projects: Health and Social Care Localities. 6. TBC activity on Collaborative Pathways subject to funding	Q4 Q1 Q3 Q1-4 Q4	PP22: Delivery of actions to improve system integration including SLMs

	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix	Value and high performance	7. Work with our stakeholders toward our jointly developed and agreed System Level Measure Improvement Plan. See Appendix	Q2	PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the Community Pharmacy Services Agreement.	One team	1. Support local implementation of national pharmacy contract Integrated Pharmacist Services in the Community (85% signed up) 2. Align Community Based Pharmacy Services in Hawke's Bay Strategic Direction 2016 – 2020 with the Ministry of Health's Pharmacy Action Plan (PAP) 3. Work with the HHB to strengthen pharmacy representation at governance and service development level 4. Work with the HHB to strengthen pharmacy representation at governance and service development level	Q1 Q2 Q2 Q4	PP38: Delivery of response actions agreed in annual plan
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	Value and high performance	1. Maintain front-line ownership of improvement targets driven by directorate leadership and oversight provided by Clinical Council representing sector wide clinical leadership 2. Support the ongoing inpatient National Patient Experience Survey and the roll out in Primary Care. 3. Develop and implement a local patient experience survey, and set of processes to utilise results alongside the National Patient Survey 4. Develop and implement a Consumer Engagement Framework to ensure the voice of the consumer is utilised in the right way on a consistent basis across the health sector 5. Implementation and initiation of Health Literacy programme of work 6. Maintain and support Consumer Council to advise HBDHB board	Q1-4 Q3 Q3 Q1 Q1 Q1-4	PP38: Delivery of response actions agreed in annual plan
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	Value and high performance	TBC		Agreed financial templates.

Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services - Stroke - Major Trauma - Hepatitis C.	**NA.**	1. Work with the Cardiac Network to design and implement consistent initiatives that address barriers for Māori accessing primary care, commencing with atrial fibrillation and heart failure. TBC 2. Achieve 8% of more of eligible patients thrombolysed 3. Develop agreed regional clinical guidelines and inter-hospital transfer processes to manage major trauma patients within the region. 4. Work with Central Region community Hepatitis C service to ensure all people living with or at risk of Hepatitis C have access to information, testing, assessment and treatment if appropriate 5. Support the implementation and use of a clinical healthcare pathway, for identification, assessment and treatment of patients with Hepatitis C	Q4 Q1-4 Q2, Q4 Q1-4	NA.

2.2 Financial Performance Summary

(Refer to Appendix One for further detail)

Projected Statement of Revenue and Expense *For the year ended 30 June* *In thousands of New Zealand Dollars*	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Ministry of Health - devolved funding	487,400	506,882	506,777	522,944	539,027	555,147
Ministry of Health - non devolved contracts	4,395	3,842	13,803	14,092	14,372	14,674
Other District Health Boards	11,455	11,530	10,055	10,266	10,471	10,691
Other government and Crown agency sourced	5,933	5,718	5,359	5,472	5,581	5,698
Patient and consumer sourced	1,313	1,220	1,321	1,349	1,376	1,405
Other	6,616	5,363	5,285	4,768	5,081	5,572
Operating revenue	517,113	534,556	542,600	558,891	575,908	593,187
Employee benefit costs	187,322	196,281	205,381	211,131	217,676	224,207
Outsourced services	15,116	18,157	14,590	14,896	15,194	15,512
Clinical supplies	44,463	38,304	40,294	38,383	36,320	35,386
Infrastructure and non clinical supplies	45,990	47,941	49,608	51,341	53,093	54,330
Payments to non-health board providers	219,856	228,873	230,726	241,139	250,626	260,753
Operating expenditure	512,747	529,556	540,600	556,890	572,909	590,187
Total comprehensive revenue and expense	4,366	5,000	2,000	2,000	3,000	3,000

Projected Summary of Revenues and Expenses by Output Class *For the year ended 30 June* *in millions of New Zealand Dollars*	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Prevention services						
Revenue	10.5	10.7	9.4	9.9	10.3	10.7
Expenditure	10.1	9.8	9.4	9.8	10.2	10.7
	0.4	0.9	-	-	-	-
Early detection and management						
Revenue	112.7	119.3	120.4	125.7	130.9	136.4
Expenditure	110.5	117.7	120.4	125.7	130.9	136.4
	2.2	1.6	-	-	-	-
Intensive assessment and treatment						
Revenue	321.4	330.8	338.9	346.0	354.3	362.1
Expenditure	320.4	328.9	336.9	344.0	351.3	359.1
	1.0	1.9	2.0	2.0	3.0	3.0
Rehabilitation and support						
Revenue	72.5	73.8	74.0	77.3	80.5	84.0
Expenditure	71.7	73.2	74.0	77.3	80.6	84.0
	0.8	0.6	-	-	-	-
Net Result	**4.4**	**5.0**	**2.0**	**2.0**	**3.0**	**3.0**

2.3 Local and Regional Enablers

Local and Regional Enabler	Focus Expected for Hawke's Bay DHB	Link to NZ Health Strategy	Hawke's Bay DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments.	Smart system	1. Engage with Central TAS to agree on an implementation plan and timeline for Orion Clinical Portal	Q2	Quarterly reports from regional leads.
			2. Develop a timeline for commencing implementation of ePA (Medchart)	Q2	
			3. Primary care Clinical Portal:Roll out implementation of the provider portal for district nurses, to additional providers and their services	Q4	
			4. Event Reporting System; Select preferred provider and initiate project	Q2	
			5. Telephone Successor System: Initiate planning work for co-design and contract activities	Q4	
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team	1. Establish a new 'People Strategy' to enable achievement of Transform & Sustain strategy in driving culture change across the organisation. Develop a reporting framework and key performance indicators.	Q1	
			2. Prioritise the development of a local Training Hub to ensure effective delivery of training across the sector to increase capability.	Q2	
			3. Initiate a focus on all Māori Staff to ensure effective retention strategies are fully in place	Q1	
			4. Reduce inequity for staff paid below living wage through a variety of initiatives including training, health & wellbeing etc.	Q3	
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home	One Team			PP23: Improving Wrap Around Services – Health of Older People

	and community support services as per Action 9a of the Healthy Ageing Strategy.				

3 SERVICE CONFIGURATION

3.1 Service Change

The table below is a high-level indication of some potential changes.

Change	Description	Expected Benefits	Local, Regional or National
Urgent Care	In partnership with general practices and emergency department implement Urgent Care Service improvements.	More consistent and effective access to appropriate urgent care across the district. Reduce hospital admissions and improve equity.	Local
Primary Mental Health	A redesign of primary mental health services is underway and this will change current delivery.	Earlier access for mild and moderate mental health concerns targeting under-served populations. Better links between primary, community and secondary mental health services.	Local
Adults Alcohol and Other Drugs (AOD) model of care implementation	Implementation of change management plan for an Adult AOD Model of Care pathway across six Central Region DHB's. As well as residential options, the model includes: Withdrawal management; Respite/stabilisation; Adult AOD peer support; Whānau Ora approaches to care.	Improved care continuity for AOD service consumers Improved access for Māori and Pacific populations Enable provision of services under the proposed Substance Addiction (Compulsory Assessment and Treatment) Bill to be implemented in 2017/18.	Regional
Community Pharmacy and Pharmacist services	Implement the national Community Pharmacy Services Agreement and develop local services.	More integration across the primary care team. Improved access to pharmacist services by consumers. Consumer empowerment. Safe supply of medicines to the consumer. Improved support for vulnerable populations. More use of pharmacists as a first point of contact within primary care.	National
Laboratory Services	Maintaining safe, accessible laboratory services may lead to a change in the range of laboratory services available 24/7 at all current delivery sites.	Service coverage expectations for clinically-appropriate laboratory tests will be emphasised. Better use of health system resources.	Local
Surgical Expansion Project	Project to expand HBDHB surgical in-house capacity to better meet elective health targets and HB population surgical needs.	HBDHB able to better meet elective health targets and population surgical needs in-house and within in budget.	Local
Ophthalmology – Glaucoma	Utilising community optometrists via a shared care model to conduct glaucoma follow ups.	Increased clinic capacity and reduced clinical risk for glaucoma patients	Local
Youth Services	Youth service redesign process continues from 2016 and is a focus for 2017/19. This is based on the HBDHB youth health strategy 2016-19	Better access for youth. Services designed with input from youth and stakeholders.	Local
	U18 free access to General Practice Services for high needs youth population i.e. Maori, Pasifika.	67% of the 13-17 year population will have access to free primary care (in and out of hours).	Local
	Completion by General Practice of Youth Friendly Primary Care assessment tool.	General practice can be more responsive and receptive to the needs of Youth population.	Local

Model of Care (primary)	Funding allocated by PHO/DHB to support the development of models of care that support patient / relationship centred practice.	Patient care models that demonstrate – consumer input into model of care and priority areas that will lead to heightened self-management and improved health outcomes particularly for Long Term Conditions Models will demonstrate utilisation of multidisciplinary and interdisciplinary team approaches and increased utilisation of the nursing workforce as clinical leads in primary care provision	Local
Long Term Conditions (LTC) Management	LTC Framework developed for implementation to begin May 2017	More consistent and effective approach to manage LTC and support self-management	Regional
Health and Social Care Localities	Providing integrated service models specific to geographical localities based on local identified health needs	Consumers accessing appropriate services closer to their home	Local
Faster Cancer Treatment	From 1/07/2017 HBDHB will be repatriating from MidCentral DHB all Hawke's Bay delivered volumes. This will involve the; Redesigining of our oncology service model and Redesigning and refurbishing our buildings.	More streamlined services working toward meeting the FCT target	Regional

Service Integration

In line with Transform and Sustain and the National drive to shift services out of the specialised hospital setting and into the community, HBDHB are continually reviewing services and considering where these could be provided in the community and/or with better integration with primary care.

Procurement of Health & Disability Services

HBDHB periodically undertakes competitive processes (Registration of Interest, Request for Proposals etc.), in accordance with the Ministry of Business Innovation and Employments Government Rules of Sourcing. Competitive processes may be undertaken for several reasons including, the time since the last competitive process and changes in service design. Competitive processes ensure cost effective services, increase innovation and can enhance efficient service provision. Competitive processes may result in a change of provider

Note A: HBDHB is permitted and empowered under Section 25 of the New Zealand Public Health and Disability Act 2000 (the Act) to negotiate and enter into any service agreements (and amendments to service agreements) which it considers necessary in fulfilling its objectives and/or performing its functions pursuant to the Act.

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4 STEWARDSHIP

Our transform and sustain programme is showing good results. We are making significant improvements in delivering services for patients, achieving more equitable health outcomes and improving staff engagement. Initiatives such as Acute Inpatient Management 24/7 (AIM 24/7) and others focusing on our after-hours services, theatre productivity, mental health model of care and health of older persons services, are all delivering significant improvement across the sector. These improvements are being achieved within our current funding. In addition, our engagement with and commitment to the Health Quality and Safety Commission's programmes – specifically, Quality and Safety Markers (QSMs), Quality Accounts, and Patient Experience Indicators – provide the public with evidence and transparent links comparing our performance to national benchmarks and declarations about the quality of the services we fund and provide.

4.1 Managing our Business

Processes for Achieving Regular Financial Surpluses

Closing the gap between planned expenditure and expected income is normal business in the health system. As the world economic environment puts even more pressure on all Government spending, Hawke's Bay DHB, as the lead Government agent for the Hawke's Bay public health budget, must continually look for ways to live within an expectation of lower funding growth.

Hawke's Bay DHB continues with its strategic direction to provide a $3m year-on-year surplus. This surplus is required to enable us to continue to invest in various infrastructure initiatives required to meet the needs of our community.

We continue with our strategy of responsible reduction in our cost base by

- Stopping doing things that are clinically ineffective of for which there is insufficient supporting evidence
- Doing things more efficiently by redesigning processes to drive out waste or errors
- Embracing opportunity to enhance quality by providing better care with the available resources

Our focus on reducing our cost base together with opportunities to increase our revenues will produce additional resources for our transformation program.

Shifting Resources

To ensure that our change in focus is also matched by a shift of resources, we have agreed measures to monitor changes in deploying resources over time. Figure 3 illustrates a model for measuring and managing a shift of resources. The aim is to measure, monitor and realign expenditure in these categories and to shift resources purposely.

The shape of the curve will change, with the care models fundamentally transformed to enable more effective deployment of resources. This is not about shifting resources from one provider to another, but rather it is about changing the service model.

Investment and Asset Management

Regional capital investment approaches are outlined in RSP and individual sections contain capital investment plans. HBDHB is committed to working with the regional capital planning committee on the development of our local plans and assisting our regional colleagues in development of the regional capital plan and its implementation.

Formal asset management planning is undertaken at HBDHB. We have developed a 10 year long term investment plan which outlines our planed asset expenditure in the absence of a clinical services plan.

Approvals at regional and national level are sought depending on the threshold of any proposed investment to help ensure that there is some national consistency in development of the health assets. We will continue to work nationally with the development of the various national initiatives and regionally on the development of a regional solution for our information technology applications.

4.2 Building Capability

Workforce

The health system needs skilled clinical leaders, team leaders and managers in place to support team performance so that we can achieve transformation. Our teams must continually focus on providing excellent services, improving health and well-being, working in partnership and improving equity, and they must be empowered to try new ways of doing things. This applies to service delivery and support functions. We are working together to support and develop the workforce and the organisations.

Development of a new workforce development framework and strategy focussing on our medical, nursing, allied, support and management and administration workforces.Our Child Protection Policies comply with the requirements of the Vulnerable Children Act, 2014. A copy is available from our website: www.Hawke'sbay.health.nz

Communications

The communications team is committed to looking at new and fresh ways to engage successfully with our community and our staff. We challenge our staff to think about effective strategies and how best to communicate them so people can better manage their way through the complexities of the health system. We are always looking to help staff promote new ideas and new initiatives through more effective and compelling communication.

Health Information

In transforming the health system, one of the biggest challenges we face is developing an information system that matches our ambitions for service integration. We are working with our regional partners to deliver a regional health informatics strategy to support improvements in Information Communication Technology (ICT) over the outlook period. The Central Region ICT vision is about the efficient delivery of the right information to the right people at the right time, on an anywhere, anyhow basis to achieve the desired health outcomes and improved organisational performance

Achieving the region's vision for health informatics will contribute to improved consumer experience, better support for clinicians and other health professionals and more integrated care.

There are many areas that require better ICT support and we recognise the importance of rigorous investment to achieve this. We have developed and information systems strategy and a business intelligence work plan to underpin and complement Transform and Sustain.

Inter-Agency Collaboration

Hawke's Bay District Health Board is working closely with other agencies to improve outcomes for the population through 'LIFT Hawke's Bay – Kia Tapatahi'. The group is working towards a common vision: Hawke's Bay is a vibrant, cohesive and diverse community, where every household and every whānau is actively engaged in, contributing to, and benefiting from, a thriving Hawke's Bay". Two strategies being developed and implemented through this forum are the Regional Economic Development Strategy and a Social Inclusion Strategy.

Note A: Subsidiary Companies and Investments

Currently, there are no subsidiary companies in which HBDHB has a controlling interest[2] and HBDHB has no plans to acquire shares or interests in terms of section 100 of the Crown Entities Act 2004. HBDHB has an interest in one multi-parent subsidiary: Allied Laundry Services Limited. Other shareholders are MidCentral DHB, Taranaki DHB, Whanganui DHB, Capital and Coast DHB and Hutt Valley DHB. Allied Laundry Services Limited has an exemption from producing a Statement of Intent (SOI). MidCentral DHB will report on Allied Laundry Services Limited in its SOI, on behalf of Hawke's Bay, Taranaki and Whanganui DHB

Note B: HBDHB has a Health and Safety Policy detailing our commitment to providing a safe and healthy environment for all persons on our sites and business. The policy incorporates the Board-approved Health and Safety Statement which is reviewed every 2 years. The last review was in April 2014.

[2] As defined in section 58 of the Companies Act 1993

5 PERFORMANCE MEASURES

5.1 2017/18 Performance Measures

The DHB monitoring framework aims to provide a view of performance using a range of performance markers. Four dimensions are identified reflecting DHB functions as owners, funders and providers of health and disability services. The four identified dimensions of DHB performance cover:

- Achieving Government's priority goals/objectives and targets or 'Policy Priorities'
- Meeting service coverage requirements and supporting sector inter-connectedness or 'System Integration'
- Providing quality services efficiently or 'Ownership'
- Purchasing the right mix and level of services within acceptable financial performance or 'Outputs'.

It is intended that the structure of the framework and associated reports assists stakeholders to 'see at a glance' how well DHBs are performing across the breadth of their activity, including in relation to legislative requirements, but with the balance of measures focused on Government priorities. Each performance measure has a nomenclature to assist with classification as follows:

Code	Dimension
PP	Policy Priorities
SI	System Integration
OP	Outputs
OS	Ownership
DV	Developmental – establishment of baseline (no target/performance expectation is set)
SLM	Inclusion of 'SLM' in the measure title indicates a measure that is part of the 'System Level Measures' identified for 2017/18.

Performance measure	Performance expectation
HS: Supporting delivery of the New Zealand Health Strategy	Quarterly highlight report against the Strategy themes.
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19 Age 20-64 Age 65+
PP7: Improving mental health services using wellness and transition (discharge) planning	95% of clients
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	80% of people seen within 3 weeks. 95% of people seen within 8 weeks.
PP10: Oral Health- Mean DMFT score at Year 8	Year 1: Year 2:
PP11: Children caries-free at five years of age	Year 1: Year 2:
PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)	Year 1: Year 2:
PP13: Improving the number of children enrolled in DHB funded dental services	Year 1: Year 2:
PP20: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	**Focus Area 1: Long term conditions** - Report on activities in the Annual Plan. **Focus Area 2: Diabetes services** - Implement actions from Living Well with Diabetes - Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1C indicator).

Performance measure	Performance expectation
	Focus Area 3: Cardiovascular health - 90% of the eligible population will have had their cardiovascular risk assessed in the last 5 years. - Percentage of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the past 5 years. **Focus Area 4: Acute heart service** - 70% of high-risk patients receive an angiogram within 3 days of admission. - Over 90% of patients presenting with ACS who undergo coronary angiography who have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days. - Over 95% of patients undergoing cardiac surgery at the regional cardiac centres will have completion of Cardiac Surgery registry data collection within 30 days of discharge. **Focus Area 5: Stroke services** - 8% or more of potentially eligible stroke patients thrombolysed 24/7. - 80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway. - 80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission.
PP21: Immunisation coverage	95% of two year olds fully immunised 95% of four year olds fully immunised 75% of girls fully immunised – HPV vaccine 75% of 65+ year olds immunised – flu vaccine
PP22: Delivery of actions to improve system integration including SLMs	Report on activities in the Annual Plan.
PP23: Improving Wrap Around Services for Older People	Report on activities in the Annual Plan.
PP25: Prime Minister's youth mental health initiative	Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three

Performance measure	Performance expectation
	secondary schools, teen parent units and alternative education facilities and actions undertaken to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS. Initiative 3: Youth Primary Mental Health. As reported through PP26 (see below). Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.
PP26: The Mental Health & Addiction Service Development Plan	Provide reports as specified for the focus areas of Primary Mental Health, District Suicide Prevention and Postvention, Improving Crisis Response services, improving outcomes for children, and improving employment and physical health needs of people with low prevalence conditions.
PP27: Supporting vulnerable children	Report on activities in the Annual Plan.
PP28: Reducing Rheumatic fever	Focus Area 1: Reducing the Incidence of First Episode Rheumatic Fever Report progress against BPS target. Provide progress report against rheumatic fever prevention plan. Provide report on lessons learned and actions taken following reviews. Focus Area 2: report progress in following-up known risk factors and system failure points in cases of first episode and recurrent acute rheumatic fever.

Performance measure	Performance expectation
PP29: Improving waiting times for diagnostic services	95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days). 95% of accepted referrals for CT scans, and 90% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days). 90% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days. 70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days. 70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days.
PP30: Faster cancer treatment	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.
PP31: Better help for smokers to quit in public hospitals	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.
PP32: Improving the accuracy of ethnicity reporting in PHO registers	Report on progress with implementation and maintenance of Ethnicity Data Audit Toolkit (EDAT).
PP33: Improving Māori enrolment in PHOs	Meet and/or maintain the national average enrolment rate of 90%.
PP34: Improving the percentage of women who are smoke free at two weeks postnatal	TBC
PP35: Reducing SUDI infant deaths	TBC

Performance measure	Performance expectation
PP36: Reduce the rate of Māori on the mental health Act: section 29 community treatment orders relative to other ethnicities.	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.
PP37: Improving breastfeeding rates	60% of infants are exclusively or fully breastfed at three months.
PP38: Delivery of response actions agreed in annual plan	Report on activities in the Annual Plan.
SI1: Ambulatory sensitive hospitalisations	TBC
SI2: Delivery of Regional Service Plans	Provision of a progress report on behalf of the region agreed by all DHBs within that region.
SI3: Ensuring delivery of Service Coverage	Report progress towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage (as identified by the DHB or by the Ministry).
SI4: Standardised Intervention Rates (SIRs)	Major joint replacement procedures - a target intervention rate of 21 per 10,000 of population. Cataract procedures - a target intervention rate of 27 per 10,000 of population. Cardiac surgery - a target intervention rate of 6.5 per 10,000 of population. Percutaneous revascularization - a target rate of at least 12.5 per 10,000 of population. Coronary angiography services - a target rate of at least 34.7 per 10,000 of population.
SI5: Delivery of Whānau Ora	Provide reports as specified about engagement with Commissioning Agencies and for the focus areas of

Performance measure	Performance expectation
	mental health, asthma, oral health, obesity, and tobacco.
SI7: SLM total acute hospital bed days per capita	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.
SI8: SLM patient experience of care	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.
SI9: SLM amenable mortality	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.
SI10: Improving cervical Screening coverage	80% coverage for all ethnic groups and overall.
SI11: Improving breast screening rates	70% coverage for all ethnic groups and overall.
OS3: Inpatient Length of Stay	Elective LOS suggested target is 1.47 days, which represents the 75th centile of national performance. Acute LOS suggested target is 2.3 days, which represents the 75th centile of national performance.
OS8: Reducing Acute Readmissions to Hospital	TBA – indicator definition currently under review.
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	**Focus Area 1: Improving the quality of data within the NHI** New NHI registration in error (causing duplication) Group A >2% and <= 4%, Group B >1% and <=3%, Group C >1.5% and <= 6% Recording of non-specific ethnicity in new NHI registrations - >0.5% and <= 2% Update of specific ethnicity value in existing NHI record with non-specific value - >0.5% and <= 2%

Performance measure	Performance expectation
	Validated addresses excluding overseas, unknown and dot (.) in line 1 - >76% and <= 85% Invalid NHI data updates – TBA **Focus Area 2: Improving the quality of data submitted to National Collections** NBRS collection has accurate dates and links to National Non-admitted Patient Collection (NNPAC) and the National Minimum Data Set (NMDS) - >= 97% and <99.5% National Collections File load Success - >= 98% and <99.5% Assessment of data reported to NMDS - >= 75% Timeliness of NNPAC data - >= 95% and <98% **Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data** (PRIMHD)Provide reports as specified about data quality audits.
Output 1: Mental health output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.
DV4: Improving patient experience	No performance expectation/target set.
DV6: SLM youth access to and utilisation of youth appropriate health services	No performance expectation/target set.
DV7: SLM number of babies who live in a smoke-free household at six weeks post natal	No performance expectation/target set.

APPENDIX A: STATEMENT OF PERFORMANCE EXPECTATIONS & FINANCIAL PERFORMANCE

1 Statement of Performance Expectations

This section includes information about the measures and standards against which Hawke's Bay District Health Board's (HBDHB) service performance will be assessed. For the purpose of our Statement Performance Expectations (SPE), our services are grouped into four reportable Output Classes:

- **Prevention Services;**
- **Early Detection and Management Services;**
- **Intensive Assessment and Treatment Services;**
- **Rehabilitation and Support Services.**

The SPE describes information in respect of the first financial year of our Statement of Intent and the performance measures are forecast to provide accountability. The outputs and measures presented are a reasonable representation of the full range of services provided by the organisation. Where possible, we have included past performance (baseline data) and the performance target to give the context of what we are trying to achieve and to enable better evaluation of our performance.

Service Performance

Explaining the contribution that our services make towards achieving the population and system level outcomes and impacts outlined in our Statement of Intent above, requires consideration of service performance. For each output class, we will assess performance in terms of the New Zealand Triple Aim (Figure 2). Maintaining a balance of focus across the Triple Aim is at the core of the Health Quality and Safety Commission's drive for quality improvement across the health sector.

The system dimension: Best value for public health system resources

For each output class we show expected funding and expenditure to demonstrate how output class performance will contribute to the outcome of a financially sustainable system.

The population dimension: Improved health and equity for all populations

Services may target the whole population or specified sub-populations. In either case we select measures that apply to the relevant group. These measures usually refer to rates of coverage or proportions of targeted populations who are served and are indicative or responsiveness to need.

The individual dimension: Improved quality, safety and experience of care

Ensuring quality and safety, within hospitals and wider health services, is a fundamental responsibility of DHBs. Measurements in this dimension indicate how well the system responds to expected standards and contributes to patient and consumer satisfaction.

Note: all targets are an annual target or, where monitored quarterly, show the expected performance by the end of quarter four. Targets are set at the total population level and monitored, where appropriate, across different population groups to gauge the equity of results. A detailed technical description of each indicator is available in a data dictionary maintained by our information services.

The HBDHB Statement of Performance Expectations for the 2016/17 year follows:

X_____ X_____

Board Member Board Member

Code		Description
MH		Māori Health Plan Targets
HT		Health Targets
MoH Performance Measures - see Appendix 4	**PP**	Policy Priorities
	SI	System Integration
	OP	Outputs
	OS	Ownership
	DV	Developmental
N/A		Data not available

1.2 OUTPUT CLASS 1: Prevention Services

Prevention Services are publicly funded services that protect and promote good health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population, as distinct from treatment services which repair or support health and disability dysfunction. Prevention Services address individual behaviours by targeting population-wide physical and social environments to influence health and well-being. Prevention Services include: health promotion and education services; statutory and regulatory services; population based screening programmes; immunisation services; and, well child and school services.

Prevention Services *For the year ended 30 June* *in millions of New Zealand Dollars*	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Ministry of Health	10.3	10.5	9.2	9.7	10.1	10.5
Other sources	0.2	0.2	0.2	0.2	0.2	0.2
Income by Source	**10.5**	**10.7**	**9.4**	**9.9**	**10.3**	**10.7**
Less:						
Personnel	1.3	1.3	1.4	1.4	1.5	1.5
Clinical supplies	0.1	-	-	-	-	-
Infrastructure and non clinical supplies	0.3	0.3	0.3	0.3	0.3	0.3
Payments to other providers	8.4	8.2	7.7	8.1	8.4	8.8
Expenditure by type	**10.1**	**9.8**	**9.4**	**9.8**	**10.2**	**10.7**
Net Result	**0.4**	**0.9**	-	-	-	-

On the continuum of care, Prevention Services are population-wide and are designed to focus attention on wellness of the general population and on keeping the "at risk" population healthy. It is important to emphasise that the concept of wellness extends to the entire population, including those who already have a health condition or disability.

Objective: People are better protected from harm and more informed to support healthier lifestyles and maintenance of wellness

Through collective action with communities and other sectors, we aim to protect the general population from harm and keep them informed about good health so that they are supported to be healthy and empowered to take control of their well-being. We aim to reduce inequities in health outcomes as quickly as practicable and we recognise that they often arise out of issues that originate outside the health system. Prevention programmes include the use of legislation, policy, education and community action to increase the adoption of healthy practices amongst the population and to overcome environmental barriers to good health.

How will we assess performance?

Short Term Outcome	Indicator	MoH Measure	Baseline					2017/18 Target
			Period	Māori	Pacific	Other	Total	
Better help for smokers to quit	% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	PP31	Oct-Dec 2016	99.2%	100%	98.7%	99.0%	≥95%
	% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	HT	Oct-Dec 2016	85.1%	82.2%	89.8%	87.4%	≥90%
	% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking	HT	Oct-Dec 2016	78.8%	N/A	N/A	88.5%	≥90%

Short Term Outcome	Indicator	MoH Measure	Baseline					2017/18 Target
			Period	Māori	Pacific	Other	Total	
	Proportion of babies who live in a smoke-free household at six weeks post natal	SLM						
	% of pregnant Māori women that are smokefree at 2 weeks postnatal	SI5	Jul-Dec 2015	65.6%	93.5%	92.1%	80.0%	≥95%
Increase Immunisation coverage in Children	% of 8 month olds who complete their primary course of Immunisations	HT	Oct-Dec 2016	94.4%	100%	95.9%	95.3%	≥95%
	% of 2 year olds fully immunised	PP21	Oct-Dec 2016	95.4%	100%	93.6%	94.7%	≥95%
	% of 4 year olds fully immunised by age 5	PP21	Oct-Dec 2016	95.8%	91.2%	91.8%	93.5%	≥95%
Increase HPV immunisation rates	% of girls that have received HPV dose three	PP21	Jun 2016	87.8%	73.3%	54.9%	68.4%	≥75%
Increase the rate of seasonal influenza immunisations in over 65 year olds	% of high needs 65 years olds and over influenza immunisation rate	PP21						≥75%
Reduced incidence of first episode Rheumatic Fever	Acute rheumatic fever initial hospitalisation rate per 100,000	PP28H						≤1.5
More women are screened for cancer	% of women aged 50-69 years receiving breast screening in the last 2 years	SI11	2 Years to Sep 2016	64.7%	65.4%	75.0%	73.6%	≥70%
	% of women aged 25–69 years who have had a cervical screening event in the past 36 months	SI10	3 Years to Sep 2016	72.8%	74.8%	78.9%	76.7%	≥80%
Reduce the rate of Sudden Unexplained Death of Infants (SUDI)	Rate of SUDI deaths per 1,000 live births	PP35						0.4
Better rates of breastfeeding	% of infants that are exclusively or fully breastfed at 6 weeks of age		6 months to Dec 2015	66%	82%	N/A	72%	75%
	% of infants that are exclusively or fully breastfed at 3 months of age	PP37	6 months to Jun 2016	39%	46%	N/A	51%	60%

1.3 OUTPUT CLASS 2: Early Detection and Management Services

Early Detection and Management services are delivered by a range of health and allied health professionals in various private, not-for-profit and Government service settings to individuals and small groups of individuals. The Output Class includes primary health care, primary and community care programmes, child and adolescent oral health and dental services, pharmacist services, and community referred tests and diagnostic services. The services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the district.

On the continuum of care these services are mostly concerned with the "at risk" population and those with health and disability conditions at all stages.

Early Detection and Management						
For the year ended 30 June	2016	2017	2018	2019	2020	2021
in millions of New Zealand Dollars	Audited	Forecast	Projected	Projected	Projected	Projected
Ministry of Health	106.5	114.2	115.5	120.8	125.8	131.1
Other District Health Boards (IDF)	2.8	1.9	2.0	2.5	2.5	2.5
Other sources	3.4	3.2	2.9	2.5	2.6	2.7
Income by Source	**112.7**	**119.3**	**120.4**	**125.7**	**130.9**	**136.4**
Less:						
Personnel	16.7	17.5	18.4	18.9	19.5	20.1
Outsourced services	0.3	1.4	1.2	1.2	1.2	1.3
Clinical supplies	0.5	0.5	0.5	0.5	0.5	0.4
Infrastructure and non clinical supplies	3.0	3.1	3.2	3.3	3.4	3.5
Payments to other District Health Boards	2.5	2.4	2.4	2.5	2.5	2.6
Payments to other providers	87.5	92.8	94.7	99.3	103.8	108.6
Expenditure by type	**110.5**	**117.7**	**120.4**	**125.7**	**130.9**	**136.4**
Net Result	**2.2**	**1.6**	-	-	-	-

Objective: People's health issues and risks are detected early and treated to maximise well-being

For people who are at risk of illness and or injury, we will undertake activities that raise awareness and recognition of risky behaviours and practices and improve the opportunity of early detection of health conditions. If people are assisted to identify risk early, and those at risk are screened to detect health conditions early, then behavioural changes and treatment interventions are often easier with less complications and greater chances of returning to a state of good health or of slowing the progression of the disease, injury or illness. Targeting environmental barriers to good health and connecting people with health services earlier is the intention because early detection of health issues or risks leads to better opportunities to influence long-term outcomes.

How will we assess performance?

Short Term Outcome	Indicator	MoH Measure	Baseline					2017/18 Target
			Period	Māori	Pacific	Other	Total	
Improved access primary care	% of the population enrolled in the PHO	PP33	Oct-16	96.8%	89.9%	97.5%	97.1%	90%
Avoidable hospitalisation is reduced	Ambulatory sensitive hospitalisation rate per 100,000 0-4 years	SI1 / SI5 / PP22(SLM)	12m to Sep-16	5,755		4,469	5,272	TBC[3]
	Ambulatory sensitive hospitalisation rate per 100,000 45-64 years	SI1		7,801		3,167	4,063	TBC
More pregnant women under the care of a Lead Maternity Carer (LMC)	% of women booked with an LMC by week 12 of their pregnancy		Jul to Sep 2016	49.2%	54.5%	75.9%	65.7%	≥80%
Better oral health	% of eligible pre-school enrolments in DHB-funded oral health services	PP13						≥95%

[3] *This target will be set as part of the System Level Measures process*

Short Term Outcome	Indicator	MoH Measure	Baseline					2017/18 Target
			Period	Māori	Pacific	Other	Total	
	% of children who are carries free at 5 years of age	PP11 / SI5						≥69%
	% of enrolled preschool and primary school children not examined according to planned recall	PP13						≤4.7%
	% of adolescents using DHB-funded dental services	PP12						≥87%
	Mean 'decayed, missing or filled teeth (DMFT)' score at Year 8	PP10						≤0.88
Improved management of long-term conditions	Proportion of people with diabetes who have good or acceptable glycaemic control	PP20	12m to Dec-16	46.2%	39.3%	79.2%	65.4%	TBC
	% of the eligible population having had a CVD risk assessment in the last 5 years	PP20	5y to Dec-16	84.5%	84.0%	88.9%	87.8%	≥90%
Less waiting for diagnostic services	% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days	PP29	Dec-16				95.1%	≥95%
	% of accepted referrals for MRI scans who receive their scans within 6 weeks	PP29	Dec-16				48.0%	≥90%
Increase referrals of obese children to clinical assessment and family based nutrition, activity and lifestyle interventions	% 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.	HT / SI5	6m to Nov-16	44%	43%	31%	40%	≥95%

1.4 OUTPUT CLASS 3: Intensive Assessment and Treatment Services

Intensive Assessment and Treatment Services are delivered by a range of secondary, tertiary and quaternary providers to individuals. This Output Class includes: Mental Health services; Elective and Acute services (including outpatients, inpatients, surgical and medical services); Maternity services; and, Assessment, Treatment and Rehabilitation (AT&R) services. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment, such as a 'hospital', and they are generally complex in nature and provided by specialists and other health care professionals who work closely together. There are also important links with community-based services before people come into hospital services and after they are discharged – these links must be well coordinated and work as seamlessly as possible.

Intensive Assessment and Treatment						
For the year ended 30 June	2016	2017	2018	2019	2020	2021
in millions of New Zealand Dollars	Audited	Forecast	Projected	Projected	Projected	Projected
Ministry of Health	305.7	314.5	324.4	332.1	339.9	347.2
Other District Health Boards (IDF)	5.7	3.8	4.2	5.2	5.3	5.4
Other sources	10.0	12.5	10.3	8.8	9.2	9.6
Income by Source	**321.4**	**330.8**	**338.9**	**346.0**	**354.3**	**362.1**
Less:						
Personnel	163.8	171.7	179.6	184.6	190.4	196.0
Outsourced services	14.7	16.8	13.4	13.7	14.0	14.2
Clinical supplies	43.2	37.2	39.2	37.4	35.3	34.4
Infrastructure and non clinical supplies	41.0	42.8	44.4	46.0	47.6	48.6
Payments to other District Health Boards	45.7	44.6	44.3	45.6	46.5	47.5
Payments to other providers	12.0	15.8	16.0	16.8	17.5	18.3
Expenditure by type	**320.4**	**328.9**	**336.9**	**344.0**	**351.3**	**359.1**
Net Result	**1.0**	**1.9**	**2.0**	**2.0**	**3.0**	**3.0**

HBDHB provides most of this Output Class through the Provider Arm, Health Services. However, some more specialised hospital services are funded by HBDHB to be provided by other DHBs, private hospitals, or other providers. Where this happens, other providers are monitored in terms of the Operational Policy Framework or specific contracts and in accordance with industry standards. On the continuum of care these services are at the complex end of "conditions" and are focussed on individuals with health conditions and prioritised to those identified as most in need.

Objective: Complications of health conditions are minimised and illness progression is slowed down

People who are suffering from injury or illness will be diagnosed accurately and offered the most effective treatment available as early as possible. We will coordinate activities that support people to reduce the complications of disease, injury and illness progression so that they have better health, in terms of survival, and are also able to participate effectively in society and be more independent. It is important that identified disparities are also reduced as quickly as practicable

How will we assess performance?

Short Term Outcome	Indicator	MoH Measure	Baseline					2017/18 Target
			Period	Māori	Pacific	Other	Total	
Less waiting for ED treatment	% of patients admitted, discharged or transferred from an ED within 6 hours	HT	Oct-Dec 2016	94.7%	95.7%	96.5%	94.7%	≥95%
Faster cancer treatment	% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks from Q1 2016/17	HT	6m to Dec-16				65.4%	≥90%
More elective surgery	Number of elective surgery discharges[4]	HT	12m to Jun-16	N/A	N/A	N/A	7,469	TBC

[4] Health Target Elective Discharges is a number of publicly funded, casemix included, elective and arranged discharges for people living within the DHB district.

Short Term Outcome	Indicator	MoH Measure	Baseline					2017/18 Target
			Period	Māori	Pacific	Other	Total	
Patients with ACS receive seamless, coordinated care across the clinical pathway	% of high-risk patients will receiving an angiogram within 3 days of admission.	PP20	Oct to Dec-16	61.1%	100%	75.3%	73.1%	≥70%
	% of angiography patients whose data is recorded on national databases	PP20	Oct to Dec-16	95.0%	66.7%	96.8%	95.5%	≥95%
Equitable access to care for stroke patients	% of potentially eligible stroke patients who are thrombolysed	PP20	Oct to Dec 16				10.2%	≥8%
	% of patients admitted to the demonstrated stroke pathway	PP20	Oct to Dec 16				88.1%	≥80%
	% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	PP20	Oct to Dec 16					≥80%
Equitable access to surgery - Standardised intervention rates for surgery per 10,000 population for:	Major joint replacement	SI4	12m to Sep-16	N/A	N/A	N/A	21.5	21
	Cataract procedures			N/A	N/A	N/A	58.7	27
	Cardiac surgery			N/A	N/A	N/A	6.6	6.5
	Percutaneous revascularisation			N/A	N/A	N/A	13.1	12.5
	Coronary angiography			N/A	N/A	N/A	39.0	34.7
Shorter stays in hospital	Average length of stay Elective (days)	OS3	12m to Sep-16	N/A	N/A	N/A	1.56	1.47
	Average length of stay Acute (days)	OS3	12m to Sep-16	N/A	N/A	N/A	2.48	2.3
Fewer readmissions	Acute readmissions to hospital	OS8						TBC
Quicker access to diagnostics	% accepted referrals for elective coronary angiography completed within 90 days	PP29						95%
	% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks	PP29	Dec-16	100%	N/A	90.9%	91.7%	90%
	% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)	PP29	Dec-16	100%	100%	92.7%	93.9%	70%
	% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date	PP29	Dec-16	100%	-	97.6%	98.1%	70%

Short Term Outcome	Indicator		MoH Measure	Baseline					2017/18 Target
				Period	Māori	Pacific	Other	Total	
Fewer missed outpatient appointments	Did not attend (DNA) rate across first specialist assessments			Oct-Dec 2016	14.2%	22.1%	3.8%	6.7%	≤7.5%
Better mental health services Improving access Better access to mental health and addiction services	Proportion of the) population seen by mental health and addiction services	Child & youth (0-19	PP6	Oct 2015 – Sep 2016	4.92%	2.14%	3.79%	4.26%	TBC
		Adult (20-64)	PP6		9.26%	2.14%	3.83%	5.11%	TBC
		Older adult (65+)	PP6		1.19%	1.00%	1.11%	1.12%	TBC
Reducing waiting times Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	% of 0-19 year olds seen within 3 weeks of referral	Mental Health Provider Arm	PP8	Oct 2015 – Sep 2016	74.1%	68.4%	71.1%	72.3%	≥80%
		Addictions (Provider Arm and NGO)	PP8		80.5%	-	83.9%	81.1%	≥80%
	% of 0-19 year olds seen within 8 weeks of referral	Mental Health Provider Arm	PP8		93.6%	94.7%	90.0%	91.7%	≥95%
		Addictions (Provider Arm and NGO)	PP8		93.6%	-	96.8%	94.6%	≥95%
Improving mental health services using discharge planning	% children and youth with a transition (discharge) or wellness plan		PP7	Jan-Dec 2016				92.5%	≥95%
Increasing consumer focus More equitable use of Mental Health Act: Section 29 community treatment orders	Rate of s29 orders per 100,000 population		PP36 / SI5	Oct-Dec 2016	179.9	-	62.1	90.1	≤81.5

1.5 OUTPUT CLASS 4: Rehabilitation and Support Services

This output class includes: Needs Assessment and Service Coordination (NASC); palliative care; rehabilitation; home-based support; aged residential care; respite care and day care for adults. Many of these services are delivered following a 'needs assessment' process and involve coordination of input from a range of providers. Rehabilitation and Support services assist people with enduring conditions and disabilities to live independently or to receive the support that they need either temporarily or over the rest of their lives. HBDHB provides NASC services through Options Hawke's Bay - a unit that reports to our General Manager, Integrated Care Services. Other services are provided by our Provider Arm, General Practice and a number of community-based NGOs and private organisations. On the continuum of care these services provide support for individuals who have complex, complicated or end-stage conditions.

Rehabilitation and Support *For the year ended 30 June* *in millions of New Zealand Dollars*	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Ministry of Health	69.3	71.6	71.6	74.4	77.6	81.0
Other District Health Boards (IDF)	3.0	2.0	2.2	2.7	2.8	2.8
Other sources	0.2	0.2	0.2	0.2	0.2	0.2
Income by Source	**72.5**	**73.8**	**74.0**	**77.3**	**80.5**	**84.0**
Less:						
Personnel	5.5	5.8	6.0	6.2	6.4	6.5
Outsourced services	0.1	-	-	-	-	-
Clinical supplies	0.7	0.6	0.6	0.6	0.5	0.5
Infrastructure and non clinical supplies	1.6	1.7	1.7	1.8	1.8	1.9
Payments to other District Health Boards	3.9	3.8	3.7	3.8	3.9	4.0
Payments to other providers	59.9	61.3	62.0	65.0	67.9	71.1
Expenditure by type	**71.7**	**73.2**	**74.0**	**77.3**	**80.6**	**84.0**
Net Result	**0.8**	**0.6**	-	-	-	-

Objective: People maintain maximum functional independence and have choices throughout life.

Where returning to full health is not possible we will work with our stakeholders to support and care for people so that they are able to maintain maximum function with the least restriction and the most independence. For people in our population who have end-stage conditions, it is important that they and their family or whānau are supported to cope with the situation, so that the person is able to live comfortably and to die without undue pain or suffering.

How will we assess performance?

OUTPUT CLASS 4 TO BE REVIEWED WITH HEALTHY AGING PLANNING

Short Term Outcome	Indicator		MoH Measure	Baseline					2017/18 Target
				Period	Māori	Pacific	Other	Total	
Better access to acute care for older people	Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population)	75-79 years		Jan 2016 – Dec 2016	164.3	175.0	111.2	124.0	≤139.5
		80-84 years			208.3	300.0	167.0	167.8	≤183.1
		85+ years			136.4	0	237.7	216.6	≤231.0
Better community support for older people	Acute readmission rate: 75 years +								<10%
	% of people receiving home support who have a comprehensive clinical assessment and a completed care plan		PP23						≥95%
	Percentage of people in aged residential care by facility and by DHB who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of the previous assessment.		PP23						77%

	The percentage of LTCF clients admitted to an Aged Residential Care (ARC) facility who had been assessed using an interRAI Home Care assessment tool in the six months prior to that first long term care facility (LTCF) assessment.	PP23						improve on current performance
Increased capacity and efficiency in needs assessment and service coordination services	Clients with a CHESS score (Change in Health, End-stage disease, signs and symptoms) of 4 or 5 at first assessment							<13.8%
Prompt response to palliative care referrals	Time from referral receipt to initial Cranford Hospice contact within 48 hours		Oct-Dec 2016	N/A	N/A	N/A	100%	>80%
More day services	Number of day services							≥21,791
More older patients receive falls risk assessment and care plan	% of older patients given a falls risk assessment % of older patients assessed as at risk of falling receive an individualised care plan		Oct-Dec 2016	N/A	N/A	N/A	96.7% 98.0%	90% 98%

2 Financial Performance

In accordance with the Crown Entities Act 2004, this module contains projected financial statements prepared in accordance with generally accepted accounting practice, and for each reportable class of outputs identifies the expected revenue and proposed expenses. The module also includes all significant assumptions underlying the projected financial statements, and additional information and explanations to fairly reflect the projected financial performance and financial position of the DHB. Summary financial performance statements for funding services, providing services, and governance and funding administration are also included in this module.

Performance against the 2017/18 financial year projections will be reported in the 2017/18 Annual Report.

2.1 Projected Financial Statements

Introduction

Hawke's Bay District Health Board is planning to deliver a surplus of $2 million this year. This is consistent with the $9 million over the three years ending 30 June 19 agreed with MOH in 2016/17. It enables the DHB to fund a proportionate capital programme, including in the plan period the completion of an endoscopy facility, radiology equipment upgrade and surgical expansion, all associated with service redesign.

The financial numbers are also consistent with the DHB's "Transform and Sustain" strategy. Resource deployment and assumed efficiencies are focussed on our three strategic challenges: responding to our population and patients; systematically ensuring quality in all of our services; and increasing our productivity.

Projected Financial Statements

Reporting entity

The financial statements of the District Health Board comprise the District Health Board, its 19% interest in Allied Laundry Services Limited, and its 16.7% interest in Central Region's Technical Advisory Services Limited. The District Health Board has no subsidiaries.

Cautionary Note

The prospective financial information presented in this section is based on one or more hypothetical but realistic assumptions that reflect possible courses of action for the reported periods concerned, as at the date the information was prepared. Actual results achieved for the period covered are likely to vary from the information presented, and the variations may be material.

The underlying assumptions were adopted on 25 May 2016.

Accounting Policies

The projected financial statements in this plan have been prepared in accordance with the Crown Entities Act 2004, which includes the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP). They projected financial statements have been prepared in accordance with tier 1 Public Benefit Entity Standards (PBE) accounting standards.

The accounting policies applied in the projected financial statements are consistent with those used in the 2015/16 Annual Report. The report is available on the DHB's website at www.hawkesbay.health.nz.

Projected Statement of Revenue and Expense						
For the year ended 30 June	2016	2017	2018	2019	2020	2021
in thousands of New Zealand Dollars	Audited	Forecast	Projected	Projected	Projected	Projected
Ministry of Health - devolved funding	487,400	506,882	506,777	522,944	539,027	555,147
Ministry of Health - non devolved contracts	4,395	3,842	13,803	14,092	14,372	14,674
Other District Health Boards	11,455	11,530	10,055	10,266	10,471	10,691
Other government and Crown agency sourced	5,933	5,718	5,359	5,472	5,581	5,698
Patient and consumer sourced	1,313	1,220	1,321	1,349	1,376	1,405
Other	6,616	5,363	5,285	4,768	5,081	5,572
Operating revenue	517,113	534,556	542,600	558,891	575,908	593,187
Employee benefit costs	187,322	196,281	205,381	211,131	217,676	224,207
Outsourced services	15,116	18,157	14,590	14,896	15,194	15,512
Clinical supplies	44,463	38,304	40,294	38,383	36,320	35,386
Infrastructure and non clinical supplies	45,990	47,941	49,608	51,341	53,093	54,330
Payments to non-health board providers	219,856	228,873	230,726	241,139	250,626	260,753
Operating expenditure	512,747	529,556	540,600	556,890	572,909	590,187
Total comprehensive revenue and expense	**4,366**	**5,000**	**2,000**	**2,000**	**3,000**	**3,000**

Table 1 – Projected Statement of Comprehensive Revenue and Expense

Projected Statement of Movements in Equity *For the year ended 30 June* *in thousands of New Zealand Dollars*	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Equity as at 1 July	**87,627**	**91,635**	**143,778**	**145,421**	**147,064**	**149,707**
Total comprehensive revenue and expense:						
Funding of health and disability services	9,117	5,975	2,000	2,000	3,000	3,000
Governance and funding administration	388	42	-	-	-	-
Provision of health services	(5,139)	(1,016)	-	-	-	-
	4,366	5,000	2,000	2,000	3,000	3,000
Contributions from the Crown (equity injections)	-	47,500	-	-	-	-
Repayments to the Crown (equity repayments)	(357)	(357)	(357)	(357)	(357)	(357)
Equity as at 30 June	**91,636**	**143,778**	**145,420**	**147,063**	**149,707**	**152,350**

Table 2 - Projected Statement of Movements in Equity

Projected Statement of Financial Position *For the year ended 30 June* *in thousands of New Zealand Dollars*	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Equity						
Paid in equity	35,216	82,359	82,002	81,645	81,288	80,931
Asset revaluation reserve	67,392	67,392	67,392	67,392	67,392	67,392
Accumulated deficit	(10,973)	(5,973)	(3,973)	(1,973)	1,027	4,027
	91,635	**143,778**	**145,421**	**147,064**	**149,707**	**152,350**
Represented by:						
Current assets						
Cash	14,263	22,031	2,947	4,785	9,225	16,121
Short term investments (special funds/clinical trials)	3,013	3,026	3,026	3,026	3,026	3,026
Receivables and prepayments	22,423	22,328	22,940	23,421	23,888	24,390
Loans (Hawke's Bay Helicopter Rescue Trust)	10	11	11	12	13	13
Inventories	4,293	4,332	4,419	4,511	4,601	4,698
Assets classified as held for sale	1,220	625	-	-	-	-
	45,222	52,353	33,343	35,756	40,754	48,249
Non current assets						
Property, plant and equipment	151,797	153,963	171,606	171,981	170,317	166,236
Intangible assets	8,239	1,561	5,169	5,923	7,238	8,527
Investment property	131	131	131	131	131	131
Investment in NZ Health Partnerships Limited	2,504	2,504	2,504	2,504	2,504	2,504
Investment in associates	1,045	8,539	9,534	9,534	9,534	9,534
Loans (Hawke's Bay Helicopter Rescue Trust)	42	29	15	-	-	-
	163,758	166,726	188,959	190,073	189,724	186,932
Total assets	**208,980**	**219,079**	**222,302**	**225,829**	**230,478**	**235,181**

Projected Statement of Financial Position - *Continued* ***For the year ended 30 June*** ***in thousands of New Zealand Dollars***	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Less:						
Current liabilities						
Payables and accruals	38,134	38,002	38,762	39,578	40,369	41,216
Employee entitlements	34,074	34,619	35,381	36,372	37,499	38,625
	72,207	72,621	74,143	75,950	77,868	79,841
Non current liabilities						
Employee entitlements	2,638	2,680	2,739	2,815	2,903	2,990
Loans and borrowings	42,500	-	-	-	-	-
	45,138	2,680	2,739	2,815	2,903	2,990
Total liabilities	**117,345**	**75,301**	**76,882**	**78,765**	**80,771**	**82,831**
Net assets	**91,635**	**143,778**	**145,421**	**147,064**	**149,707**	**152,350**

Table 3 - Projected Statements of Financial Position

Projected Statement of Cash Flows *For the year ended 30 June* *in thousands of New Zealand Dollars*	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Cash flow from operating activities						
Cash receipts from MOH, Crown agencies & patients	511,732	541,560	541,234	558,456	575,663	592,906
Cash paid to suppliers and service providers	(296,631)	(316,050)	(312,336)	(320,796)	(329,213)	(339,209)
Cash paid to employees	(187,513)	(194,698)	(204,561)	(210,289)	(216,808)	(223,312)
Cash generated from operations	27,588	30,812	24,336	27,371	29,642	30,385
Interest received	1,419	861	885	-	-	-
Interest paid	(1,855)	(1,866)	(164)	-	-	-
Capital charge paid	(6,783)	(6,322)	(8,549)	(8,700)	(8,808)	(8,982)
	20,369	23,486	16,508	18,671	20,834	21,403
Cash flow from investing activities						
Proceeds from sale of property, plant and equipment	123	605	625	-	-	-
Acquisition of property, plant and equipment	(16,733)	(14,693)	(30,821)	(16,476)	(16,037)	(14,150)
Acquisition of intangible assets	(395)	(35)	(4,055)	-	-	-
Acquisition of investments	(2,440)	(1,240)	(982)	-	-	-
	(19,446)	(15,364)	(35,233)	(16,476)	(16,037)	(14,150)
Cash flow from financing activities						
Proceeds from equity injections	(1,655)	-	-	-	-	-
Equity repayment to the Crown	1,298	(357)	(357)	(357)	(357)	(357)
	(357)	(357)	(357)	(357)	(357)	(357)
Net increase/(decrease) in cash and cash equivalents	567	7,765	(19,083)	1,838	4,440	6,896
Cash and cash equivalents at beginning of year	14,970	15,537	23,302	4,219	6,057	10,497
Cash and cash equivalents at end of year	15,537	23,302	4,219	6,057	10,497	17,393

Projected Statement of Cash Flows - *Continued* ***For the year ended 30 June*** ***in thousands of New Zealand Dollars***	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Represented by:						
Cash	14,263	22,031	2,947	4,785	9,225	16,121
Short term investments	1,274	1,271	1,271	1,271	1,271	1,271
	15,537	23,302	4,219	6,057	10,497	17,393

Table 4 - Projected Statement of Cash Flows

Projected Funder Arm Operating Results *For the year ended 30 June* *in thousands of New Zealand Dollars*	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Revenue						
Ministry of Health - devolved funding	487,400	506,882	506,777	522,944	539,027	555,147
Inter district patient inflows	8,107	7,723	8,371	8,547	8,718	8,901
Other revenue	258	20	-	-	-	-
	495,765	**514,626**	**515,148**	**531,491**	**547,745**	**564,048**
Expenditure						
Governance and funding administration	3,140	3,197	3,364	3,434	3,503	3,577
Own DHB provided services						
Personal health	218,802	232,626	244,775	249,917	254,915	260,269
Mental health	25,005	24,112	24,034	24,538	25,029	25,554
Disability support	14,719	13,810	8,990	9,179	9,362	9,558
Public health	4,463	5,205	641	653	666	679
Maori health	663	830	619	631	644	658
	263,652	276,582	279,058	284,918	290,616	296,718
Other DHB provided services (Inter district outflows)						
Personal health	46,657	46,032	44,894	45,837	46,754	47,736
Mental health	2,386	2,392	2,592	2,647	2,700	2,757
Disability support	3,053	3,138	3,339	3,409	3,477	3,550
	52,097	51,562	50,826	51,893	52,931	54,043

Projected Funder Arm Operating Results - *Continued*						
For the year ended 30 June ***in thousands of New Zealand Dollars***	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Other provider services						
Personal health	95,025	103,164	104,215	111,968	118,869	126,229
Mental health	10,848	11,130	11,365	11,605	11,837	12,086
Disability support	57,196	57,691	59,516	60,767	61,984	63,285
Public health	1,011	1,420	1,226	1,253	1,279	1,307
Maori health	3,679	3,905	3,577	3,653	3,726	3,803
	167,760	177,311	179,900	189,246	197,695	206,710
Total Expenditure	**486,648**	**508,651**	**513,148**	**529,491**	**544,745**	**561,048**
Net Result	**9,117**	**5,975**	**2,000**	**2,000**	**3,000**	**3,000**

Table 5 - Projected Funder Arm Operating Results

Projected Governance and Funding Administration Operating Results						
For the year ended 30 June *in thousands of New Zealand Dollars*	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Revenue						
Funding	3,140	3,197	3,364	3,434	3,503	3,577
Other revenue	111	29	30	31	31	32
	3,250	3,226	3,394	3,465	3,534	3,609
Expenditure						
Employee benefit costs	779	926	1,056	1,085	1,119	1,153
Outsourced services	506	468	514	525	536	547
Clinical supplies	23	2	3	-	-	-
Infrastructure and non clinical supplies	620	844	875	889	896	904
	1,929	2,239	2,448	2,499	2,551	2,604
Plus: allocated from Provider Arm	933	945	946	965	984	1,005
Net Result	**388**	**42**	-	-	-	-

Table 6 - Projected Governance and Funding Administration Operating Results

Projected Provider Arm Operating Results *For the year ended 30 June* *in thousands of New Zealand Dollars*	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Revenue						
Funding	263,652	276,582	279,058	284,918	290,616	296,719
Ministry of Health - non devolved contracts	4,395	3,842	13,803	14,092	14,372	14,674
Other District Health Boards	3,348	3,807	1,683	1,719	1,753	1,790
Accident Insurance	5,530	5,276	4,946	5,050	5,151	5,259
Other government and Crown agency sourced	403	442	413	422	430	439
Patient and consumer sourced	1,313	1,220	1,321	1,349	1,376	1,405
Other revenue	6,248	5,314	5,255	4,737	5,050	5,540
	284,889	296,483	306,480	312,287	318,748	325,826
Expenditure						
Employee benefit costs	186,543	195,355	204,326	210,046	216,557	223,054
Outsourced services	14,609	17,689	14,076	14,371	14,658	14,965
Clinical Supplies	44,440	38,303	40,291	38,383	36,320	35,386
Infrastructure and non clinical supplies	45,369	47,097	48,733	50,452	52,197	53,426
	290,961	298,444	307,425	313,252	319,732	326,831
Less: allocated to Governance & Funding Admin.	933	945	946	965	984	1,005
Net Result	(5,139)	(1,016)	-	-	-	-

Table 7 – Projected Provider Arm Operating Results

2.2 Significant Assumptions

General

- Revenue and expenditure has been budgeted on current Government policy settings and known health service initiatives.
- No allowance has been made for any new regulatory or legislative changes which increase compliance costs.
- No allowance has been made for the costs of unusual emergency events e.g. pandemic or earthquake.
- Allowance has been made for the implementation costs of and net savings from regional and national entity initiatives as advised by the Ministry of Health.
- No allowance has been made for any additional capital or operating costs that may be required by the National Oracle Solution (NOS) shared financial platform solution managed by New Zealand Health Partnerships Limited (NZHPL).
- Allowance has been made for net additional costs arising from the Regional Health Information Project (RHIP) of $1.0 million in 2017/18.
- The full year impact of ongoing transformation expenditure, and difficulties achieving the 2016/17 efficiency programme has required a $9.5 million efficiency programme for the 2017/18 year. Nominal increases in funding and inflationary increases in expenditure will require further savings of $3.5 million, $2.8 million and $1.8 million in 2018/19, 2019/20, and 2020/21 respectively. No allowance has been made for a new investment programme in the plan, however such programmes are likely and will require increases in the savings targets. Detailed plans for the new investment and efficiency programmes have yet to be defined, and the impact of the two programmes on financial performance have been recognised in clinical supplies.
- Unless otherwise stated, increases in revenue and expenditure due to changes in price levels have been allowed for at 2.1%, 2.0% and 2.1% for 2018/19, 2019/20 and 2020/21 respectively based on Treasury forecasts for CPI inflation in the Half Year Economic and Fiscal Update 2016 published 8 December 2016).

Revenue

- Crown funding under the national population based funding formula has not been finalised by MOH. In the interim, funding including adjustments has been allowed at $481.2 million for 2017/18. Funding for the 2018/19, 2019/20 and 2020/21 years will include nominal increases of $15.6 million per annum.
- Crown funding for non-devolved services of $39.4 million is based on agreements already in place with the appropriate Ministry of Health directorates, and assumes receipt of the DHB's full entitlement to elective services funding.
- Inter district flows revenue is in accordance with Ministry of Health advice.
- Other income has been budgeted at the District Health Board's best estimates of likely income.

Personnel Costs and Outsourced Services

- Workforce costs for 2017/18 have been budgeted at actual known costs, including step increases where appropriate. Increases to Multi Employer Collective Agreements have been budgeted in accordance with settlements, or where no settlement has occurred, at the District Health Board's best estimate of the likely increase. Personnel cost increases have been allowed for at 2.8%, 3.1% and 3.0% for 2018/19, 2019/20 and 2020/21 respectively based on Treasury forecasts for wage inflation in the Half Year Economic and Fiscal Update 2016 published 8 December 2016).
- Establishment numbers for management and administration staff have been capped by the Minister of Health at 417 FTEs, the same as 2016/17.

Supplies and Infrastructural Costs

- The cost of goods and services has been budgeted the District Health Board's best estimates of likely cost.
- No allowance has been made for cost increases/decreases relating to fluctuations in the value of the New Zealand Dollar.

Services Provided by Other DHB's

- Inter district flows expenditure is in accordance with MoH advice.

Other Provider Payments

- Other provider payments have been budgeted at the District Health Board's best estimate of likely costs

Capital Servicing

- Depreciation has been calculated to write off the cost or fair value of property, plant, and equipment assets, and amortisation has been calculated to write off the cost or fair value of intangible assets (software) less their estimated residual values, over their useful lives. The investment in NZHPL gives the DHB a right to use the systems they provide, so they are considered to have indefinite lives, and consequently no amortisation has been allowed for.
- Borrowings from MOH to all DHBs converted to equity on 15 February 2017. No costs related to borrowings have been recognised for Hawke's Bay DHB after 2016/17.
- The capital charge rate has been allowed for at 6% from 2017/18. The decrease in capital charge is offset by a compensating reduction in revenue from the Crown.

Investment

- The purchase of class B shares in New Zealand Health Partnerships Limited (NZHPL), relating to the Finance, Procurement and Supply Chain shared service, was completed in 2014/15 and took the total investment to $2,504,071. No allowance has been made for any further investment. No allowance has been made for any impairment of the asset over the time horizon of the plan.
- The District Health Board's share of the assets in RHIP will be amortised over their useful lives. The cost of amortisation is included in infrastructural costs. No allowance has been made for any impairment of the asset before 2021/22.
- No collaborative regional or sub-regional initiatives have been included other than RHIP.
- No increase in funding for existing associate organisations, Allied Laundry Services Limited and Central Technical Advisory Services have been allowed for.
- Property, plant, equipment, intangible asset expenditure, and investments in other entities are in accordance with the table below :

Investment	2017/18 $'m	2018/19 $'m	2019/20 $'m	2020/21 $'m
Buildings and Plant	14.5	8.9	8.1	6.0
Clinical Equipment	12.6	4.5	3.9	4.2
Information Technology	6.8	2.1	3.0	3.0
Capital Investment	**33.9**	**15.5**	**15.0**	**13.2**
New technologies/Investments	1.0	1.0	1.0	1.0
Investment in RHIP	1.0	-	-	-
Total Investment	**35.9**	**16.5**	**16.0**	**14.2**

Capital Investment Funding

- Capital investment will be funded from a number of sources including working capital in accordance with the following table:

Investment Funding	2017/18 $'m	2018/19 $'m	2019/20 $'m	2020/21 $'m
Total Investment	35.9	16.5	16.0	14.2
Funded by:				
Depreciation and amortisation	13.6	15.3	16.4	16.9
Operating surplus	2.0	2.0	3.0	3.0
Cash holdings	20.3	(0.8)	(3.4)	(5.7)
Capital Investment Funding	**35.9**	**16.5**	**16.0**	**14.2**

Property, Plant and Equipment

- Hawke's Bay District Health Board is required to revalue land and buildings when the fair value differs materially from the carrying amount, and at least every five years. The last revaluation was at 30 June 2015, and the next is likely at 30 June 2018. The effect of a revaluation is unknown, and no adjustment has been made to asset values as a consequence.

Debt and Equity

- Borrowings from MOH to all DHBs converted to equity on 15 February 2017. No borrowings have been recognised for Hawke's Bay DHB after 2016/17.
- Equity movements will be in accordance with the table below.

Equity	2017/18 $'m	2018/19 $'m	2019/20 $'m	2020/21 $'m
Opening equity	143.8	145.4	147.1	149.7
Surplus	2.0	2.0	3.0	3.0
Equity repayments (FRS3)	(0.4)	(0.3)	(0.4)	(0.3)
Closing equity	**145.4**	**147.1**	**149.7**	**152.4**

Additional Information and Explanations:

Disposal of Land

- Disposal of land is subject to current legislative requirement and protection mechanisms. Hawke's Bay District Health Board is required to notify land declared surplus to previous owners for offer back prior to offering it to the Office of Treaty Settlements, and before any sale on the open market.

APPENDIX B: SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

Currently in Development

CHAPLAINCY PRESENTATION

HAWKE'S BAY District Health Board Whakawāteatia	**Travel Plan Update** 26
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Sharon Mason, Chief Operating Officer Andrea Beattie, Property and Service Contracts Manager
Reviewed by:	Executive Management Team, HB Clinical and HB Health Consumer Councils and Māori Relationship Board (by email March)
Month:	March, 2017
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board:

Note the contents of the report

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Overview

The purpose of this report is to provide an update on progress since the previous update in November 2016.

Bus Services

Free patient bus transport across on all urban networks in Napier and Hastings commenced on 1 January 2017. Ridership for January 2017 was 345 pax. This is an increase of 61% on January 2016. For February there has been a 78% increase on 2016.

Complaints

The total number of complaints for 2016 was 63 compared with 88 in 2015. Complaint numbers for 2017 stands at 9.

Cycling

In March a new secure lock-up will be in place in place near the old Wards Block entrance and can accommodate up to 20 cycles.

HBDHB hosted a Commuter Challenge breakfast in February, with 73 participants.

Shower facilities identified and active transport amenities maps developed.

Guaranteed Ride Home Scheme

A guaranteed ride home scheme has been established which guarantees a staff member a ride home (by bus, fleet car or taxi) in the event of an emergency, if let down by carpool buddy, required to work unscheduled overtime, etc.

Parking Improvements

There has been a lot of activity around parking since November, including:

- Re-marking of Hospital parking.
- Car parks are now colour-coded to differing user groups.

- Parking signage has been installed.
- Additional car pool parks have been established due to demand.

Parking Controls / Management

- Installation of pay and display machines is complete.
- Payment for parking launched 1 March.
- Additional support personnel for first month of the parking launch are in place including parking attendant and administration staff.
- HBDHB Carpark Officer commenced 13 March.
- Good feedback from consumers on-site and via social media around availability of parking.

Parking – Back-end Processes

A number of back-end processes have been implemented and are on-going:

- Car parking policy has been circulated for feedback with approx. 55 individual and group responses.
- Communications is rolling out via staff notices, radio, newspaper, flyers, Facebook, webpage, etc.
- Go Well staff fielding large volumes of enquiries.
- Parking permit and payroll registrations are occurring.
    - 10,000+ staff parking coupons sold
    - 160+ staff registered to carpool for free
    - 125+ staff are using the ParkMate app

Parking – Fee Exemptions

A number of agreed parking fee exemptions include:

- Long-term user of health services
- Frequent user of health services
- Staff paid below “living” wage
- HBDHB volunteers (including Friends of the Emergency Department)
- On call parking at Gate 4
- Staff carpooling groups
- Renal patients driving themselves to an appointment
- Time limited parking areas

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Access (ASH Rates 0-4 years)** 27
	For the attention of: **HBDHB Board**
Document Owner:	Dr Mark Peterson, Chief Medical Officer - Primary
Document Author:	Nicky Skerman, Population Health Strategist, Women, Child & Youth
Reviewed by:	Executive Management Team, HB Clinical Council and HB Health Consumer Council, Māori Relationship Board (by email March)
Month:	March 2017
Consideration:	For Monitoring

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report.

18

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 year olds 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)

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:

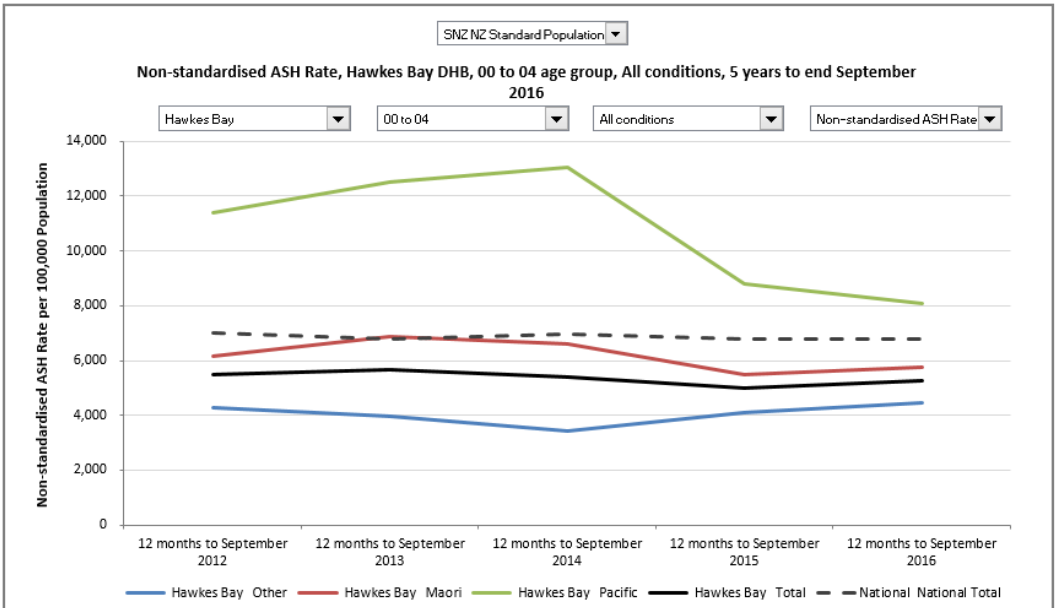
[1] MoH-System Integration SI1: Ambulatory sensitive hospitalisations.
[2] MoH-System Integration SI1: Ambulatory sensitive hospitalisations.

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

HAWKE'S BAY DISTRIBUTION AND TRENDS

TARGET 0-4 YEAR AGE GROUP

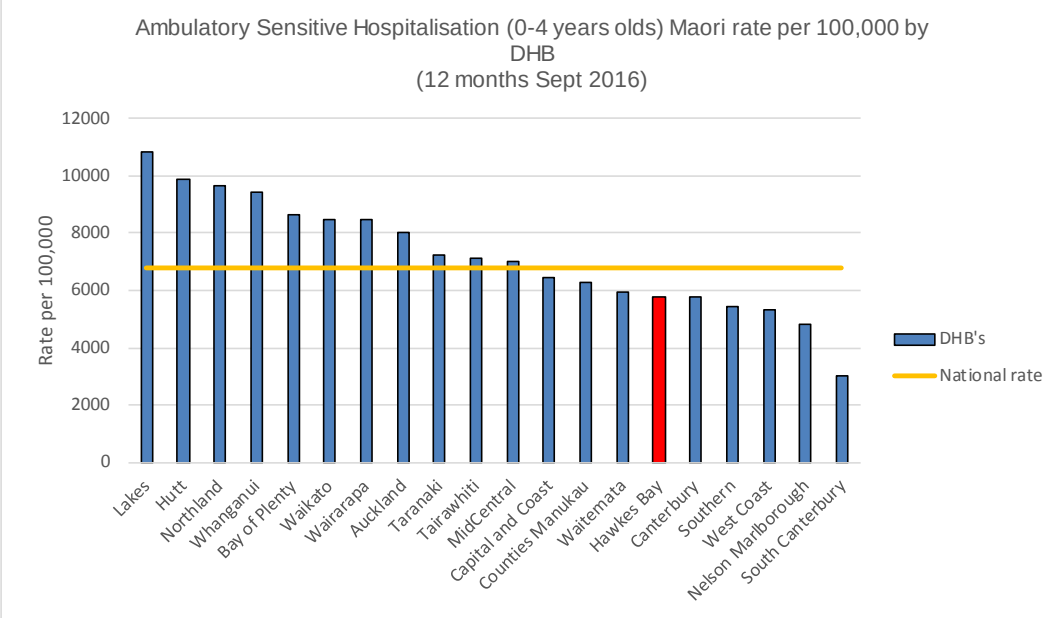
Hawke's Bay Māori ASH rates 0-4 year age group – 12 months to end Sept 2012-2016



		12 months to September 2012	12 months to September 2013	12 months to September 2014	12 months to September 2015	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

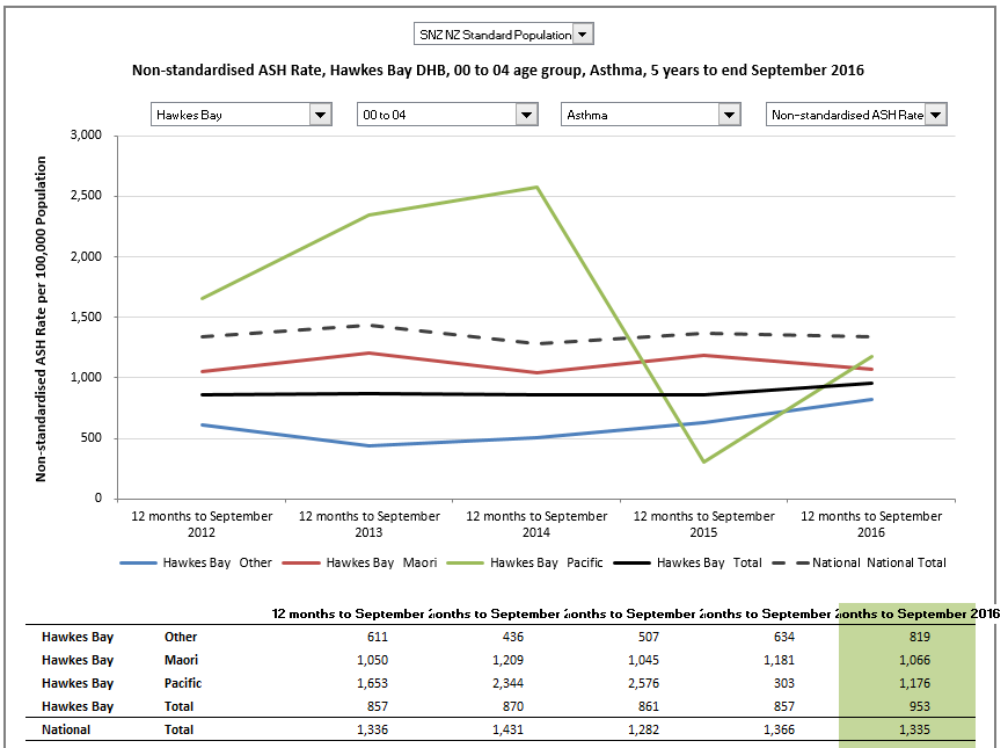


In the 12 months to September 2016 the Hawke's Bay Māori rate was 84.9% of the national rate and Hawke's Bay DHB was the 6th best performer of all DHBs with Māori rates substantially lower than national rates in this age group.

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

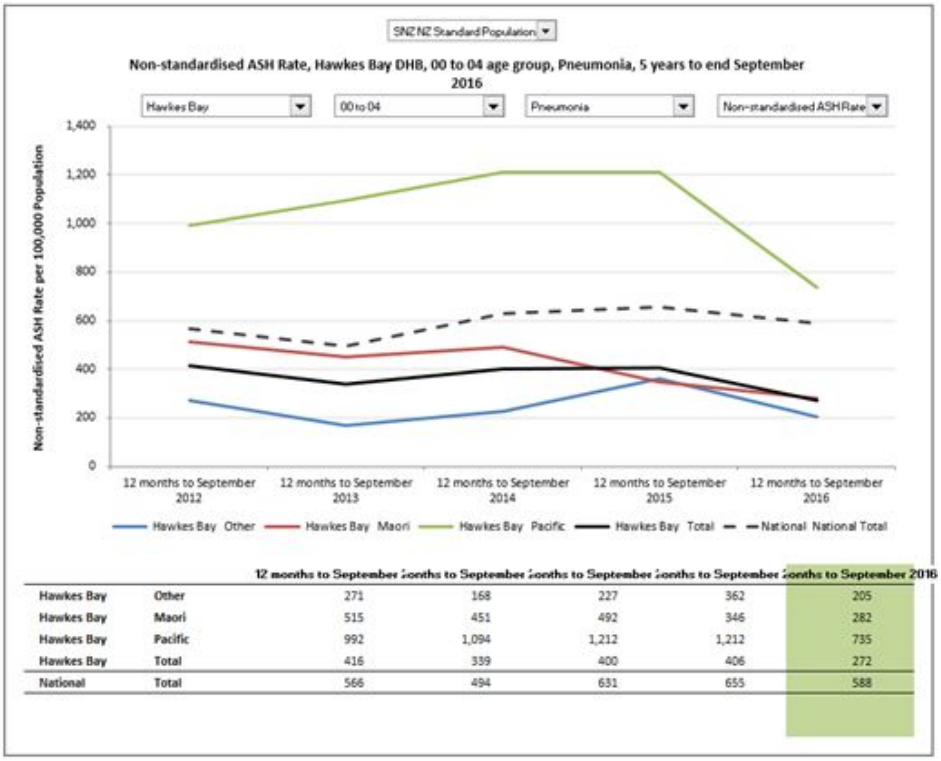
Asthma



		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.

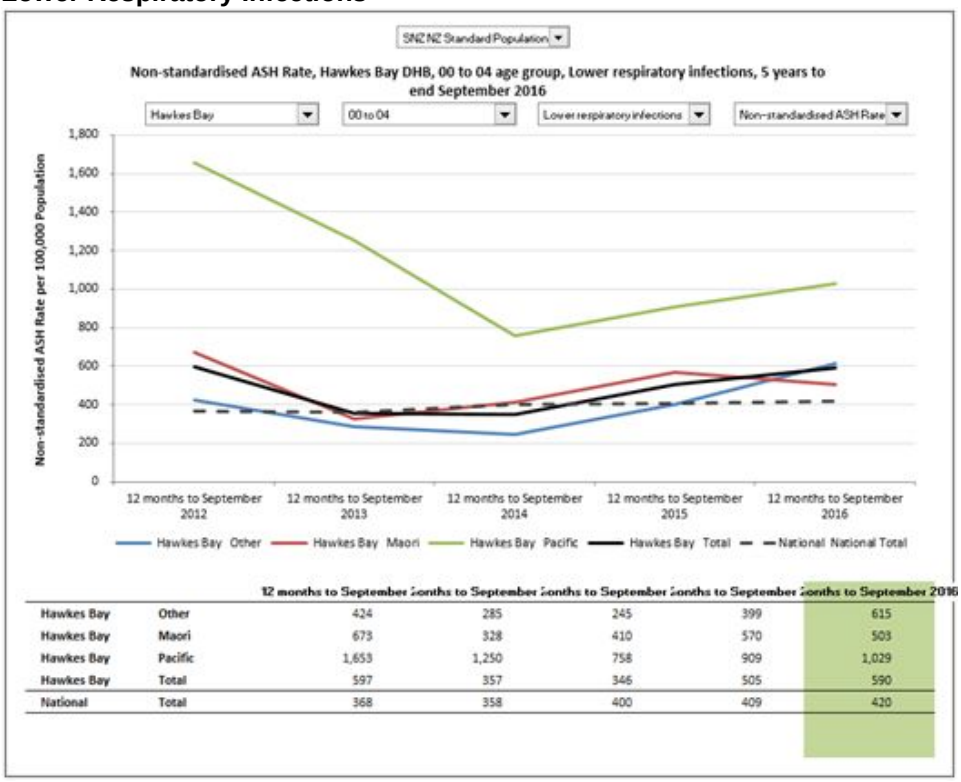
Pneumonia



		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

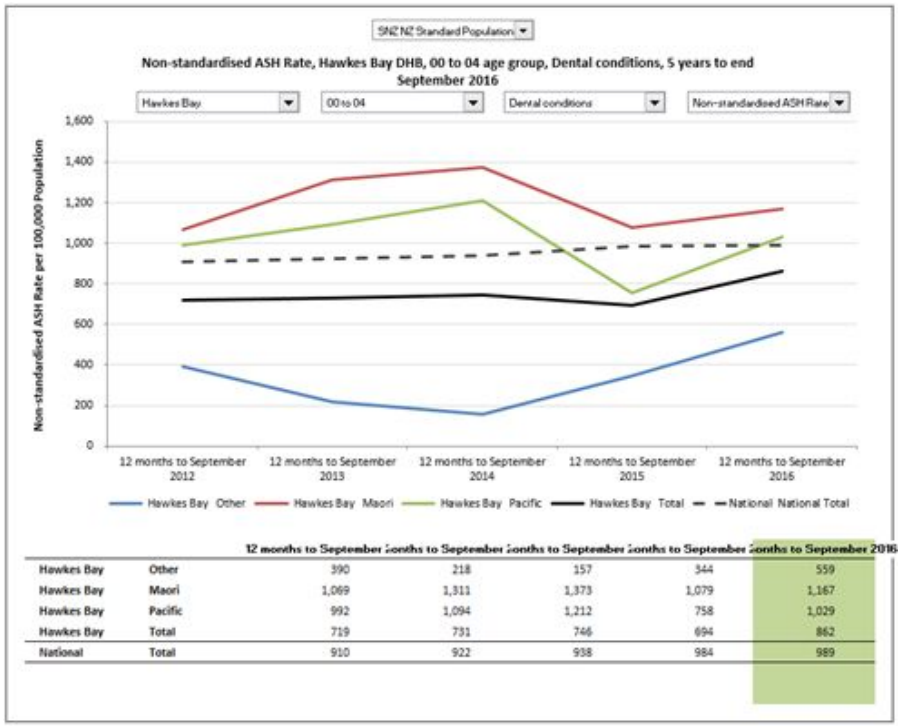


		12 months to September	12 months to September	12 months to September	12 months to September	12 months to September 2016
Hawkes Bay	Other	424	285	245	399	615
Hawkes Bay	Maori	673	328	410	570	503
Hawkes Bay	Pacific	1,653	1,250	758	909	1,029
Hawkes Bay	Total	597	357	346	505	590
National	Total	368	358	400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

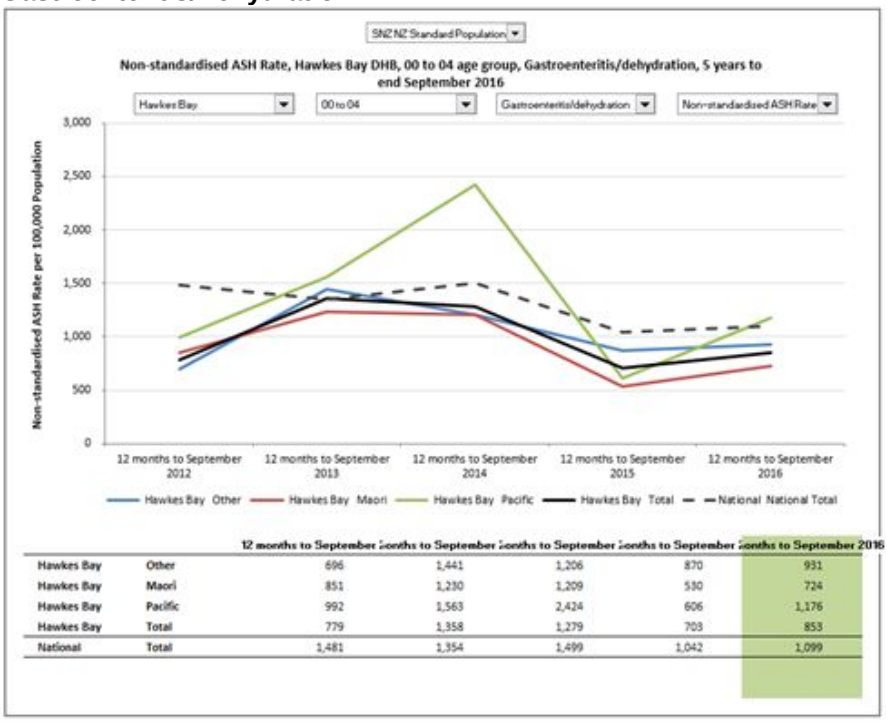
Dental



		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.

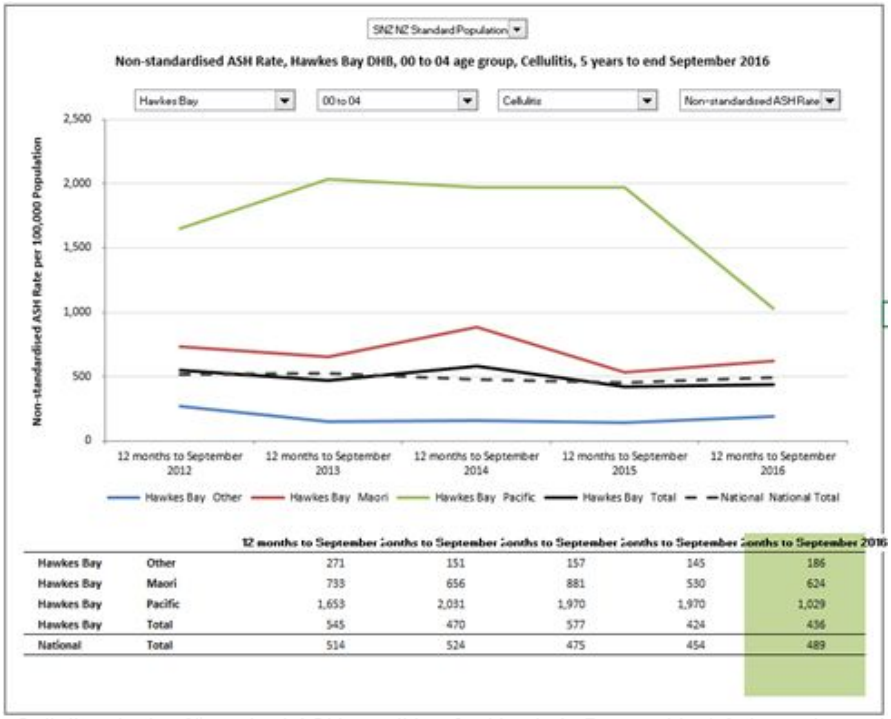
Gastroenteritis/Dehydration



		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.

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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. A file audit to access follow up practice in primary care is planned for April. .

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.

RECOMMENDATIONS FROM TARGET CHAMPION

As the Champion for the TAW ASH rate report the following recommendations respond to the findings of the report

ASH 0-4 years[3]:

Identified areas for improvement

Oral Health				
Three year/phase project to improve oral health status by addressing inequity in caries free under 5 years				
Phase of initiative	**Initiative**	**Description**	**Responsible**	**Phase**
Underway: scoped and in early implementation .	Under 5 years of age caries free equity project	Education package, fluoride varnish application, water only policies, consumer input, model of care changes, Well Child Tamariki Ora provider outreach services, Early intervention in general practice. HBDHB will encourage councils to ensure that water supplies are fluoridated.	Project sponsor: Clinical Director for Oral Health Project Manager: Children, Women and Community Deputy Service Director Project Steering Group	Phase 1 Feb – Nov 2017

[3] TAW report focuses on Maori Health but the intention is these initiatives are inclusive of Pasifika, knowing that pneumonia and lower respiratory are areas of where there is the greatest inequity for this population group.

Respiratory[4]				
Quality Improvement to implement best practice				
Phase of initiative	**Initiative**	**Description**	**Responsible**	**Phase**
Underway: Initiating in March	File audit of the respiratory pathway post ASH presentation to secondary services	Map current follow up practice in primary care Identify opportunities for intervention	Health Gains Advisor Health HB Programmes Manager, W, C & Y Portfolio	Phase 1 Mar – Apr 2017
Scoped: in initial planning phase	Best practice pathway for respiratory management post admission and return to primary care	Implement and monitor best practice post ASH presentation pathway in primary care. Focus on timeliness, quality, referral to services (healthy homes, smoking cessation) and consistent regional approach.	Health Gains Advisor Health HB Programmes Manager, W, C & Y Portfolio	Phase 2 May – Jul 2017
Ongoing:	Continue Paediatric respiratory training across whole of health sector	General Practice, pharmacists, Maori Health, social service providers	Health HB W, C & Y portfolio	Sustainability

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CONCLUSION

For ASH rates 0-4 we are doing well, both with national comparisons and with the closing of the equity gap. We are now 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.

The oral and respiratory areas both have collaborative programs of service improvement underway which should lead to improvements over the next 1-2 years.

Dr Mark Peterson
Chief Medical Officer - Primary

[4] Respiratory includes: Asthma, Pneumonia and Lower respiratory

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Breastfeeding (National Indicator)** 28
	For the attention of: **HBDHB Board**
Document Owner:	Chris McKenna, Chief Nursing Officer
Document Author(s):	Nicky Skerman, Population Health Strategist Charrissa Keenan, Health Gains Advisor, Māori Health Tracy Ashworth, Maternal, Child and Youth Portfolio Advisor Jules Arthur, Midwifery Director
Reviewed by:	Executive Management Team, HB Clinical and HB Health Consumer Councils and Māori Relationship Board (by email March)
Month:	March 2017
Consideration:	For approval

RECOMMENDATION

That the HBDHB Board

Endorse the content of this report.

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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 Chris McKenna, Champion for the Breastfeeding National Indicator.

UPCOMING REPORTS

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

Priority	Indicator	Measure	Champion	Responsible Manager	Reporting Month
Breastfeeding *National Indicator*	Improve breastfeeding rates for children at 6 weeks, 3 months and 6 months:		Chris McKenna	Nicky Skerman	**MAR 2017** **16 Feb 2017** to Kathy
	1. % of infants that are exclusively or fully breastfed at 6 weeks of age;	>75%			
	2. % of infants that are exclusively or fully breastfed at 3 months of age;	>60%			
	3. % of infants that are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)	>65%			

MĀORI PLAN INDICATOR:

Full and exclusive breastfeeding of infants at 6 weeks (≥ 75%), 3 months (≥ 60%) and full, exclusive and partial at 6 months (≥ 65%).

WHY IS THIS INDICATOR IMPORTANT?

The HBDHB is committed to non-differential targets to demonstrate and compare progress across populations groups. This indicator is important because it shows the health systems performance in the early years of a child's life. The breastfeeding indicator is reported to the Ministry of Health through the District Annual Plan and Annual Māori Health Plan and is a key component in the HBDHB Maternal Child Youth Strategic Framework 2015-18.

The HBDHB acknowledges breastfeeding as a key priority for improved infant and maternal health outcomes. Breastfeeding provides the optimum nutrition from birth, and is a foundation for later health and well-being. Breastfeeding has a range of advantages for both mother and pēpi/baby. These benefits include; health, nutrition, immunological, developmental, psychological, social and economic benefits. Research shows that children who are exclusively breastfed for around six months are less likely to suffer from childhood illnesses such as respiratory tract infections, gastroenteritis and otitis media as well as reducing the risk of SUDI and asthma. Breastfeeding is also linked to children maintaining healthy weight across their lifetime and reduced risk of obesity.

The HBDHB is an accredited Baby Friendly Hospital (BFHI) which means strategies to promote, protect and support breastfeeding are important to us. Improving breastfeeding rates in Hawke's Bay would significantly improve the health and well-being of our pēpi/babies now and into the future.

Despite the health benefits for both mother and child, breastfeeding rates in New Zealand remain low compared to those in the early 20th century. Breastfeeding research identifies that several common factors impact on a women's breastfeeding experience; the influence of a women's whānau; conflicting breastfeeding advice and insensitive cultural practices by health professionals; early breastfeeding issues, and negative community and societal responses to breastfeeding.

The Hawke's Bay Maternity Services Annual Report shows for the twelve-month period from 1 January to 31 December 2015, 1877 babies were born to 1858 mothers, of which 37.4% (695 women) were of Māori ethnicity. Of these mothers, 15% or 102 were young Māori mothers aged <20 years. The Hawke's Bay birthing population has a significantly higher proportion of Māori women compared to the national average.

BACKGROUND

There is no central place for monitoring progress in breastfeeding nationally. Currently, breastfeeding data is collected at discharge post-delivery at each DHB, and breastfeeding rates at two weeks are collected by Lead Maternity Carers and are reported directly to the Ministry of Health under Section 88. The Lead Maternity Carers data is only provided to DHBs bi-annually with at least a 12 month data delay. Well Child/Tamariki Ora (WC/TO) collection has improved to now include all providers for the 3 months and 6 months data sets but this also has a 6 month delay.

We acknowledge that we are struggling to meet the Ministry's targets for breastfeeding across both the age bands and ethnicities. We are especially disappointed that our efforts have not produced positive results to increase breastfeeding rates for Māori mothers. Clearly, our current systems and supports are not responding well enough to the needs of Māori mothers and their whānau.

The Māori Health Service and the Women, Child and Youth Portfolio are working closely to critically analyse our current efforts to address barriers that are impacting on breastfeeding uptake by Māori.

We also revisited literature about experiences and barriers to breastfeeding for Māori women and their whānau.[1]

These studies showed that mothers and whānau felt positively toward breastfeeding and generally expected to exclusively breastfeed, but main barriers that prevented whānau from achieving this goal included:

- lack of support when establishing breastfeeding, especially within the first 6 weeks
- lack of timely and culturally relevant advice
- comprehensible information

Based on these learnings, Māori Health have committed investment in a Community Breastfeeding Service. In response to this gain we need to investigate service redesign models within Hawkes Bay Maternity Services to work towards a more comprehensive and aligned Breastfeeding Support Service.

HAWKE'S BAY DISTRIBUTION AND TRENDS

Breastfeeding data as reported for the annual Māori Health Plan

The most recent data provided for the Māori Health Plan by the Ministry is shown below. As per the charts and tables, December 2015 breastfeeding rates for Māori at two weeks have remained the same compared to June 2015. The latest data set enables us to calculate the rate for 'Other' ethnicities (non-Māori and non-Pacific) for the first time and shows the breastfeeding rate for other ethnicities is 8.1% higher than Māori.

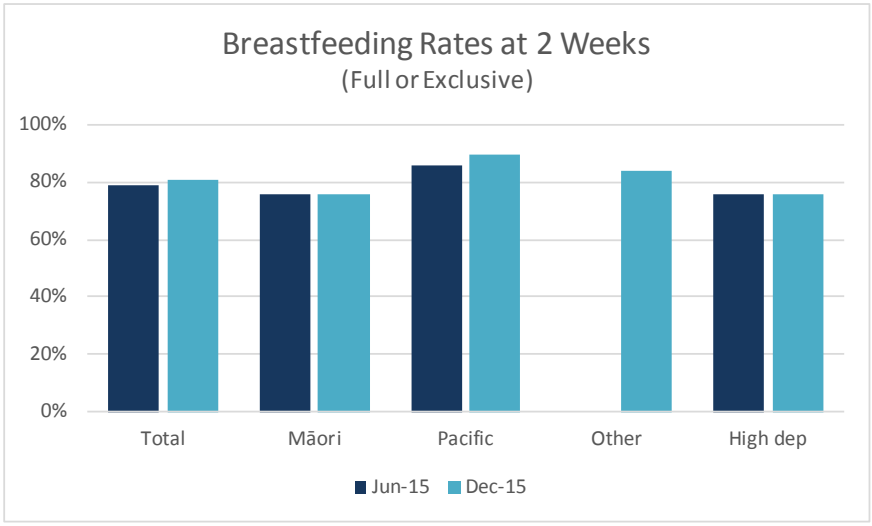
December 2015 breastfeeding rates for Māori at 6 weeks have remained at similar levels compared to June 2015. Māori are currently at 66% compared with an 'Other' ethnicities rate of 78% and a target of 75%.

There is currently no improvement in Māori breastfeeding at 3 months between December 2015 and June 2016. Data shows a clear drop off between 6 weeks and 3 months. Breastfeeding rates at 3 months currently sits at 39% for Māori, compared to a total rate of 51%, and significantly below the target of 60%. The data is not currently available to calculate the rate for 'Other' ethnicity for either 3 months or 6 months data.

These rates demonstrate a clear drop off between 6 weeks and 3 months.

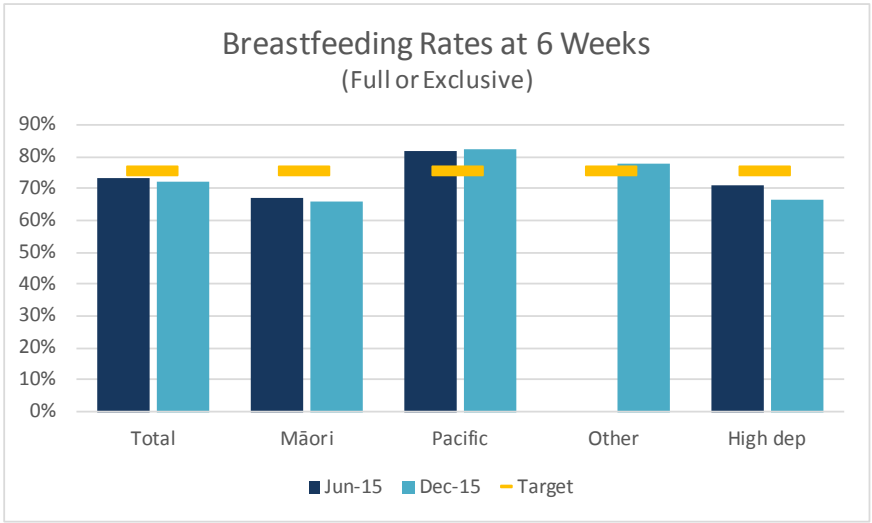
Breastfeeding at 6 months (which unlike 6 weeks and 3 months includes partial) has seen a slight increase from December 2015 to June 2016. Māori rates have increased by 2% and currently sit at a rate of 50% with the target being 65%. There has also been an increase for the total population of 3% and it now sits at 61%, 11% more than Māori.

[1] Manaena-Biddle, H; Waldon, J and Glover, M. Influences that affect Māori women breastfeeding [online]. Breastfeeding Review, Vol. 15, No. 2, 2007 Jul: 5-14. Availability: <http://search.informit.com.au/documentSummary;dn=439931119210257;res=IELHEA> ISSN: 0729-2759. [cited 14 Feb 17]



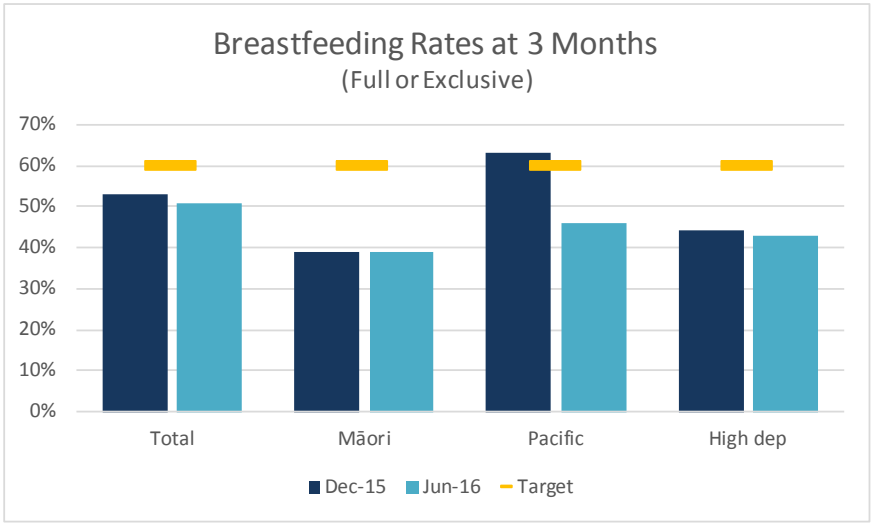
Breastfeeding at 2 Weeks

	Total	Māori	Pacific	Other	High dep
Jun-15	79%	76%	86%	-	76%
Dec-15	81%	76%	90%	84%	76%

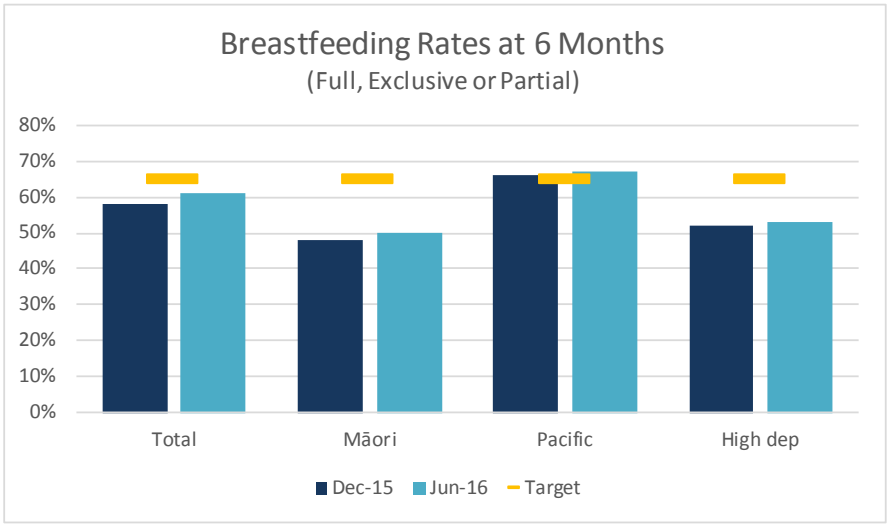


Breastfeeding at 6 weeks

	Total	Māori	Pacific	Other	High dep
Target	75%	75%	75%	75%	75%
Jun-15	73%	67%	82%	-	71%
Dec-15	72%	66%	82%	78%	67%



	Total	Māori	Pacific	High dep
Target	60%	60%	60%	60%
Dec-15	53%	39%	63%	44%
Jun-16	51%	39%	46%	43%



Breastfeeding at 6 months

	Total	Māori	Pacific	High dep
Target	65%	65%	65%	65%
Dec-15	58%	48%	66%	52%
Jun-16	61%	50%	67%	53%

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REVIEW OF CURRENT AND PLANNED ACTIVITY RELEVANT TO SUPPORT THE INDICATORS

Breastfeeding Support Service

The Breastfeeding Support Service is comprised of two components; the antenatal to six weeks and the Community model from 6 weeks to 6 months of age. These two components are vital to ensure a holistic, seamless pathway of breastfeeding support for mothers and their whānau, and to maximise opportunities to support mothers who need help to establish breastfeeding. The community breastfeeding service is already in the process of being established and we anticipate the new service to be fully operational by 1 July 2017. The early breastfeeding component of the service is limited in funding and some suggestions as to models for improvement are detailed in this paper.

However it must be acknowledged that real commitment to improving breastfeeding rates would mean some new investment in the model of care for the hospital service to provide an outreach focused service from the antenatal period through to handover to WC/TO providers.

Further detail is provided below:

Antenatal to six weeks: Early Breastfeeding Service Component

It is proposed that the HBDHB investigate options regarding the current Hospital Breastfeeding Service to maximise the opportunity to provide breastfeeding support for mothers and their whānau from the antenatal period through to the first six weeks of life. The intention is to identify early issues with breastfeeding, to provide mothers and whānau in their home or community clinic with the additional support and help they need to breastfeed.

As with any change in Model of Care resource is needed to make improvements. A more comprehensive approach (based on other DHB models) originally proposed is not feasible in this current funding environment so alternative options have been discussed with the Children Woman and Community directorate and need to be considered.

1) An investigation undertaken looking at what breastfeeding support mothers and whānau receive from their LMC under section 88. This will look at what could be done differently to support new mothers and whānau regarding advice, information, and where required support to pregnant women during the ante-natal period as their main care providers.

2) We also propose a movement of funding to look at a peer support/kaiawhina role, and the ability to provide home visiting options. This option would increase capacity in client contact in the hospital beyond the Hospital Breastfeeding Advisor (LC). Currently a large proportion (60%) of the breastfeeding advisor role is dedicated to maintaining BFHI requirements. The focus on BFHI is essential for our DHB and our commitment to breastfeeding, however it does mean that there is less time and resource to focus on other areas that could give us greater traction to progress our breastfeeding activities. The potential to consider a peer support/kaiawhina role will enable us to triage support to mothers and whānau to establish breastfeeding post-birth, and to put in place a plan that is responsive to her needs for when she is discharged whilst allowing the LC resource to deal with the more technical clinical cases.

   This focused support will especially benefit those mothers who leave the maternity unit in the first 48 hours post-delivery. Hawke's Bay Maternity Services Annual Report, indicates the average stay in Maternity was 1.9 days in 2015, this is before breastfeeding is established. The drop off rate for breastfeeding is particularly significant for Māori on post-natal discharge, so this new approach has the potential to benefit these mothers, and intervene at a time when the decision to continue to breastfeed may be vulnerable. These initiative will not only compliment and provide alignment via relationships and referrals with the community service component but will strengthen continuity between hospital and community for mothers, and attempt to remove barriers to access to breastfeeding support.

3) The third option would be to increase the length of stay in Maternity Services to allow mothers milk to come in and connection with support staff to establish breastfeeding.

We need to ensure we provide aligned hospital/community service that responds to consumers and works in partnership with Lead Maternity Carers and WC/TO providers in order to optimise the health and well-being of our pēpi/babies now and into the future.

Six weeks to six months: Community Breastfeeding Service Component
Funding has been secured from the Māori Health Portfolio for a Community Breastfeeding Support Service. The aim of this initiative is to provide specialised community breastfeeding support to Māori mothers and their whānau, post-discharge from Lead Maternity Care (LMC) services to 6 months of age. This service involves a specialised lactation consultant who will be responsible for working closely with mothers and whānau who are experiencing difficulties in establishing and maintaining breastfeeding in the home. This service is not intended to be a universal service, or an expansion of existing initiatives, but is a direct investment in specialised breastfeeding help for our Māori mothers and their whānau.

A key expectation of this service is that the lactation consultant must have the capability, experience, and relationships to prioritise the needs and expectations of Māori and therefore, the ability to relate and work in a Māori cultural context. Importantly, there is a clear expectation that this service will work closely with smoking cessation and safe sleeping programmes to maximum the health gain. We also understand that our experiences with pēpi and waiū cannot be seen in isolation of hapūtanga and whānau mai, and so, exploring opportunities to engage with mothers and their Lead Maternity Carers will be a focus.

Other breastfeeding supports:

Hawke's Bay Breastfeeding Governance Group
The Breastfeeding Governance Group meets quarterly. Their role is to provide a collaborative approach to improving breastfeeding rates in Hawke's Bay. This is supported by the long standing Hawkes Bay Breastfeeding Group which meets bi-monthly contributing to the promotion of breastfeeding in the community, providing resourcing and updates to health professionals and ensuring that the World Health Organisation Breastfeeding Code is upheld and responding to breaches. The Breastfeeding Governance Group has representation from across the hospital and community sectors, and also includes Wairoa participation.

Lead Maternity Carers Involvement
A concerted effort has been made during the past year to engage Lead Maternity Carers/midwives in both governance and operational forums to ensure the messages we convey amongst this critical workforce. We currently have several Lead Maternity Carer representatives on both the Hawke's Bay Breastfeeding Group and Governance Group including Nga Maia o Aotearoa representation, the professional organisation representing Māori in the area of maternity services.

Lead Maternity Carers / WC/TO collaboration – Working Better Together
A recent review of the transfer of care from Lead Maternity Carers to WC/TO highlighted some recommendations with the aim of informing any service linkage improvements between Lead Maternity Carers WC/TO service providers and improve early engagement and enrolment into WC/TO services including antenatal referrals and support shared models of care, this would also enhance breastfeeding support.

A collaborative symposium is planned for May 2017 which Hawke's Bay WC/TO providers and Lead Maternity Carer representatives are jointly planning, specifically to support and workshop 'Working Better Together' and awareness of the services and integration particularly for vulnerable women and whānau during the first 1000 days of life.

Mama Aroha
Work is well underway to embed consistent, culturally appropriate breastfeeding messaging and practices across the health, social support workforce and the wider whānau and community in response to the main theme identified in a breastfeeding stakeholder workshop held in 2014 to ensure "consistent messaging around breastfeeding resources and advice". A take home parent reference card covering breastfeeding, SUDI and smokefree has been locally developed with a Māori midwife, and lactation consultant and developer of the Mama Aroha Breastfeeding talk cards. This resource is now available to every women and her whānau birthing in Hawke's Bay. Consistent messaging has reached across the central region with MidCentral DHB ordering 5000 copies and Whanganui looking to purchase.

Alongside this, a number of the Lead Maternity Carers/DHB midwifery and WC/TO workforce have attended Mama Aroha training and carry comprehensive sets of highly visual Talk and Troubleshooting breastfeeding cards to support mothers and whānau throughout their breastfeeding experience. A 2016 feedback survey indicated these are well used with 81% of respondents using them in their practice.

Well Child/Tamariki Ora (WC/TO)
WC/TO providers have been developing Plan, Do, Study, and Act (PDSA) cycles on Breastfeeding. As an example, Te Tai Whenua O Heretaunga (TToH), for their PDSA decided to follow up the talk cards use in their consults with mothers. Of the 43 visits made to mothers in the following two week period, the study found 32 mothers were breastfeeding and the cards were used 22 times. Of the 10 visits where the cards were not used, the individual health worker had established the mother had her breastfeeding technique well in control. "The mama aroha cards are now the main resource used to highlight the benefits of breastfeeding and these are well received by the ladies and whānau".

There are also loan schemes in place at Kahungunu Executive and Te Taiwhenua o Heretaunga funded by the HBDHB for breastfeeding equipment. These loan schemes ensure all women can access breastfeeding pumps and equipment regardless of cost. Central Hawke's Bay Plunket also have six sets of breast pumps they hire out regularly.

Plunket's breastfeeding support in Central Hawke's Bay includes seven breastfeeding peer counsellors that are La Leche League trained. The service receives referrals from the Central Hawke's Bay lactation consultant, Lead Maternity Carers, as well as self-referrals.

Baby Friendly Hospital Initiative (BFHI)
The HBDHB underwent re-accreditation in February 2017 for Ata Rangi, Waioha and Wairoa maternity facilities. In New Zealand, all maternity services are required to achieve and maintain BFHI accreditation. The standards of care and services provided are audited by the New Zealand Breastfeeding Alliance (NZBA) every three years. The BFHI aims to improve exclusive breastfeeding rates and ensure evidenced-based best practice standards of care are offered by maternity services. Baby friendly facilities work to see that all women, regardless of their feeding method, receive unbiased information, support and professional advice in their decision to feed their babies.

Hapū Māmā Programme
The Māori Health Improvement Team is in the early stages of exploring a Kaupapa Māori ante-natal education programme. Ante-natal education enables and empowers pregnant women and their whānau to make informed decisions about their pregnancy care, the birth of their baby, and early parenting. We intend that waiū/breastfeeding will be a key focus of a Kaupapa Māori ante-natal education programme as evidence has shown that specific antenatal and early post natal education programs that focused on improving exclusive breastfeeding rates led to improved rates of such feeding[2] (Su LL, Chong YS, Chan YH, et al, 2007).

[2] Su LL, Chong YS, Chan YH, et al. Antenatal education and postnatal support strategies for improving rates of exclusive breast feeding: randomised controlled trial. *BMJ* 2007; **335:** 596–612.

FINANCIAL IMPLICATIONS OR OTHER KEY ISSUES AS REQUIRED

The current breastfeeding resource within Maternity services is comprised of a .9FTE Breastfeeding Advisor (LC) and a small additional contact volumes budget which supports Baby Café (drop in breastfeeding community clinic with LC in attendance 12 hours per week), ward contacts (providing and responding to requests for any women currently breastfeeding who may require hospital treatment – not necessary inpatients in maternity) and a once a month breastfeeding antenatal education class. Any changes proposed would require disinvestment in one or all of the above areas which will not necessarily correspond to improvements in breastfeeding rates. Our preference would be to seek new investment to increase service provision by including additional peer support resource and outreach resource for mothers to access. In terms of our current performance rates and the importance of breastfeeding as a key priority for improved infant and maternal health outcomes some further discussion is required.

RECOMMENDATIONS FROM TARGET CHAMPION

The first six weeks after a baby is born is critical to establishing successful breastfeeding. There are multiple factors that impact whether this occurs, for example; consistent messaging, health professional engagement and enrolment processes, and access to support from whānau and health professionals. It is essential that for any sustainable change to occur in the rates of breastfeeding, and to make gains in breastfeeding rates for Māori, efforts must be focussed in the antenatal and early postnatal periods (in addition to other activities already established).

We have reviewed our current approaches and have identified areas where we can do things differently to improve breastfeeding rates and particularly focus on achieving the 6 week target.

With a focus on developing strong relationships and providing consistent messages at the instigation of the breastfeeding journey, we aim to provide appropriate, effective, timely breastfeeding support in the crucial initiation stage of breastfeeding. We need to ensure greater alignment and ensure our services are tailored to support Māori mothers and whānau whilst continuing capacity building that has occurred through use of the Mama Aroha resources, collaborative engagement initiatives between Lead Maternity Carers, HBDHB and WC/TO providers and promotional supports for breastfeeding.

CONCLUSION

A comprehensive Breastfeeding Support Service comprising both a community and hospital component will significantly strengthen the DHB's efforts to improve breastfeeding rates, especially for Māori mothers and their whānau. The impact of not considering improvements and better alignment potential from the hospital service component service is that opportunities to provide appropriate support to mothers and their whānau in the ante-natal period will be lost, as well as the continuity from birth, post-natal discharge to community.

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:

21. Confirmation of Minutes of Board Meeting
    - Public Excluded

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

23. Board Approval of Actions exceeding limits delegated by CEO

24. Chair's Update

25. Havelock North Gastroenteritis Outbreak August 2016

26. Cranford Hospice

27. Finance Risk and Audit Committee Report
    - Audit NZ – Final Management Report on the Audit of HBDHB for y/e June 2016
    - Audit NZ Engagement / Arrangement Letter

28. 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).