BOARD MEETING

Date: Wednesday, 29 November 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
Dr Helen Francis
Diana Kirton
Jacoby Poulain
Heather Skipworth
Ana Apatu
Hine Flood

Apologies: Ngahiwi Tomoana and Hine Flood

In Attendance:
Dr Kevin Snee, Chief Executive Officer
Sharon Mason, Executive Director of Provider Services
Tim Evans, Executive Director of Corporate Services
Chris Ash, Executive Director of Primary Care
Kate Coley, Executive Director of People & Quality
Tracee Te Huia, Executive Director of Strategy & Health Improvement
Ken Foote, Company Secretary
Dr John Gommans, Chief Medical Officer, Hospital & Co-Chair Clinical Council
Dr Andy Phillips, Chief Allied Health Professions Officer & Co-Chair Clinical Council
Rachel Ritchie, Chair HB Health Consumer Council
Members of the public and media

Mintute Taker: Brenda Crene

Public Agenda

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

8.	Chief Executive Officer's Report	131	
9.	Financial Performance Report	132	
10.	Board Health & Safety Champion's Update	-	
	Section 2: Reports from Committee Chairs		
11.	HB Clinical Council – Co-Chairs, John Gommans and/or Andy Phillips	133	1.40
12.	HB Health Consumer Council – Chair, Rachel Ritchie	134	1.50
13.	Māori Relationship Board – Deputy Chair, Heather Skipworth	135	2.00
14.	Pacific Health Update – Caren Rangi, Talalelei Taufale and Paul Faleono	-	2.10
	Section 3: Decision		
15.	Surgical Services Expansion Project – Increasing Surgical Capacity (Business Case and Presentation) – Rika Hentschel / Anna Harland / John Rose	136	2.30
16.	Hawke's Bay Drinking Water Governance Joint Committee – Ken Foote	137	2.50
17.	Governance Reports and Presentations – Principles, Standards & Guidelines – Ken Foote	138	2.55
18.	Ka Aronui Ki Te Kounga / Focussed on Quality "Quality Accounts" – Jeanette Rendle	139	3.00
	Section 4: Discussion		
19.	Matariki Regional Economic Development Strategy and Social Inclusion Strategy – Tracee TeHuia/Shari Tidswell	140	3.05
	Section 5: Monitoring Reports – for information		
20.	Best Start Healthy Eating & Activity Plan – Healthy Weight Strategy – Tracee Te Huia/ Shari Tidswell	141	3.20
21.	Regional Tobacco Strategy for HB: 2015–2020 Update – Tracee TeHuia/Johanna Wilson	142	3.25
22.	Te Ara Whakawaiora - Smokefree (national indicator) – Tracee Te Huia/Johanna Wilson	143	3.30
23.	HBDHB Performance Framework Exceptions Q1 (Jul-Sept17) & Framework Results HBDHB Quarterly Performance Monitoring Dashboard for Q4 (2016/17) – Tim Evans	144	3.35
24.	Wairoa Health Centre Leases – Ken Foote	145	
	Section 6: General Business		
25.	**Section 7: Recommendation to Exclude the Public**		
	Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	Section 8: Routine	Ref #	Time (pm)
26.	Minutes of Previous Meeting		3.45
27.	Matters Arising – Review of Actions		
28.	Board Approval of Actions exceeding limits delegated by CEO	146	
29.	Chair's Update	-	
	Section 9: Reports from Committee Chairs		
30.	Finance Risk & Audit Committee – Chair Dan Druzianic	147	3.50
31.	Big Listen Feedback – verbal update Kate Coley	-	4.00

The next HBDHB Board Meeting will be held at 1.00pm on Wednesday 13 December 2017

Board "Interest Register" - 26 October 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	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 NZ Health Partnership Limited, *effective from 20 March 2017*	Lead, 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 NZ Health Partnerships Limited where specific legal or fiduciary conflict identified.	The Chair of FRAC	22.02.17
	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 of FRAC	26.10.17
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
	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	26.10.17
Dr 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

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
	Active	HB Medical Research Foundation	Trustee	Declare this interest prior to any discussion in relation to the Foundation, and an appropirate mitigation action is decided on.	The Chair	20.08.14
Diana Kirton	Active	Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB.	Perceived Conflict of Interest. Non-Pecuniary interest.	Will not take part in any decisions in relation to surgical services provided by or contracted by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO	The Chair	18.02.09
	Active	Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014	Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers.	Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on.	The Chair	16.01.14
	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
	Active	Member, Hawke's Bay Law Society Standards Committee	Law Society	No conflict perceived	The Chair	20.06.17
	Active	RENEW counselling services	Counsellor	No conflict perceived	The Chair	17.07.17
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
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; and the Mobility Action Plan (Muscular Skeletal)	Will not take part in any discussions or decisions relating to any actions or contracts with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15 29.03.17
	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) The U-Turn Trust renamed /rebranded "Whararíki Trust" advised 30-8-17	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 25 OCTOBER 2017, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.00PM

PUBLIC

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

In Attendance: Kevin Snee (Chief Executive Officer)
Drs Gommans and Phillips(co-Chairs, HB Clinical Council)
Rachel Ritchie (Chair, HB Health Consumer Council)
Members of the Executive Management Team
Members of the public and media
Annie Quinlivan (minutes)

KARAKIA

Ngahiwi Tomoana opened the meeting with a Karakia.

APOLOGY

No apologies recorded.

3. INTEREST REGISTER

No changes to the interests register were advised

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

4. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on 27 September 2017, were confirmed as a correct record of the meeting.

Moved: Dan Druzianic
Seconded: Hine Flood
Carried

5. MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: **Chaplaincy Service –** The Chair advised that a cheque had been received in support of the Chaplaincy service from the Hastings District Council. Board member Hine Flood advised that the Wairoa District Council Mayor and CEO were keen to support this however had suggested that this be on a pro rata basis. It was noted that the original request was that the Napier City and Hastings District Council's pay $16k and the Wairoa District and CHB Councils pay an $4k contribution to the chaplaincy service.

Item 2: **Drinking Water Governance Joint Committee Terms of Reference –** the Terms of Reference would be finalised and signed off at the next Board Meeting. Following that members would be appointed.

Item 3: **Consumer Story – Sasha Watt** – a positive response had been received back from Sasha Watt.

6. BOARD WORK PLAN

The Board Work Plan was noted

- In regard to the December 2017 Board meeting, the PHO Board had suggested that they meet with the HBDHB Board at the conclusion of the Board meeting ie., approximately 3.30pm. To accommodate this, it was suggested therefore that the FRAC meeting start at 9.30am.
- An update on The Big Listen – the Executive Director Strategy Health and Improvement advised that she had met with Ngati Kahungunu Iwi Incorporated to capture any expectations and it was agreed that the HBDHB would contract NKII to provide advice on this.

7. CHAIR'S REPORT

- The Drinking Water Governance Joint Committee had been discussed earlier under Matters Arising.
- Good progress had been made with regard to the Board performance review undertaken with the Instituate of Directors (IOD). The Chair advised that the IOD would be running the relevant reports this week. The strengths and weaknesses and results for this region would be reviewed at the Chairs Central Region meeting on the 6th November. The option would then be offered to HBDHB to look at its own performance and that a session facilitated by the IOD be run. There would be a charge for this session. The Board considered that the Company Secretary could facilitate this type of session and therefore the offer from the IOD would be declined. It was noted that the weakness in this particular process was the risk that those Board members who had been on the Board for more than one term were likely to have a greater level of confidence on a number of the questions posed compared to the first term board members.

Action: Company Secretary to facilitate a one hour session in November. FRAC to commence one hour earlier in November to allow for this session.

- The Chair commented on the Performance Monitoring Report from the Ministry of Health for quarter 4. It was accepted that the Faster Cancer Treatment target was not green, however improvements in other areas particular radiology was good and therefore overall a positive report for the quarter.

8. CHIEF EXECUTIVE OFFICER'S REPORT

The CEO provided an overview of his report with comments noted in addition to the report including:

- It was noted that there had been pressure on ED due to patient flow and demand on the hospital and a large amount of work was being undertaken in trying to address that.
- The indicator "better help for smokers to quit in maternity" – significant issues had been identified particularly within the Maori community and therefore some more detailed work would be done to understand this and address it with better tracking.
- The Financials for the quarter were tracking well. September had been a difficult month with the pressures of the flu in the community and then in October the Norovirus outbreak. The hospital had experienced a large number of staff being sick particularly in ED and AAU (front of house) which would have an impact on ED performance and electives. There had also been two rest homes who were currently in lockdown due to the Norovirus outbreak.
- Due to the Norovirus B2 had been closed to new admissions for over a week but it was anticipated that this would reopen later this day (25 October).
- A Faster Cancer Treatment presentation had been given to FRAC earlier today and performance indicated that it was improving. There had been issue around not identifying the right people being put on the appropriate pathway. It was requested that FCT be put on the Consumer Council agenda for the next meeting. **Action**

9. FINANCIAL PERFORMANCE REPORT

Tim Evans (ED of Corporate Services) spoke to the Financial Report for October 2017, which showed the first quarter result of $75,000 favourable to plan, with September $60,000 unfavourable reflecting higher surgical costs including electives.

Comments noted in addition to the report included:

- Favourable - Allied Health Professionals
- The reasons for under-spending on nursing was the increased budget constraints for nurses at the end of last year and this had some unintended consequence
- The $8.5m for Home Support Services this related to the wash up around pay equity.

10. HEALTH & SAFETY BOARD CHAMPION'S UPDATE

Peter Dunkerley provided a verbal update to the Board and advised that a new Health & Safety Advisor had been appointed – Christine Mildon. Christine had background in training, H&S system development and implementation, and ISO compliance.

Peter advised that the Health & Safety Board Champion role was still evolving and that over the next couple of months a clearer picture will emerge as to what this role could include; for example regular site visits, attendances at H&S Committee meetings etc.

REPORT FROM COMMITTEE CHAIRS

11. HB CLINICAL COUNCIL

Council met on 11 October 2017, an overview of issues discussed and/or agreed at the meeting were summarised by Co-Chair Andy Phillips.

The Co-Chairs were working closely with the Company Secretary to establish a balanced agenda between the types of issues Clinical Council should be involved with and provide advice back to the Board around clinical governance. There was also mention around the review of the number of advisory groups within the DHB that didn't have clear reporting lines and so it was felt that there was the potential to reduce a number of these advisory groups. The Chair noted these changes in Clinical Governance structures and requested a report on the value of these to the Board early in the new year.

12. HAWKE'S BAY CONSUMER COUNCIL

Chair Rachel Ritchie spoke to the report from the Council's meeting held on 12 October 2017 and took the report as read.

13. MĀORI RELATIONSHIP BOARD

Ngahiwi Tomoana spoke to the MRB meeting which had been held on 11 October 2017. Congratulations was given on the increased number of Maori nurses being employed at the HBDHB.

Ngahiwi also spoke around the planned visit by a delegation from Hawke's Bay to Alaska on 25 November 2017. The group included: Dr Ron Jane, Chrissy Hape, Hine Flood and George Reedy.

14. PASIFIKA HEALTH LEADERSHIP GROUP

Barbara Arnott (Chair of CPHAC) who oversees the PHLG advised that the Pasifika Health Leadership Group met on 9 October. Items noted in the report were as follows:

- Workforce
- Mental Health for Pasifika
- Pasifika Health Service
- The Chair of PHLG will personally present a report to the Board at the November meeting. A presentation on Pacific Health services (including navigators) will also be provided.

FOR DECISION

15. SHAREHOLDER AGM REPRESENTATION – Technical Advisory Services (TAS)

In addition the following points were discussed at the meeting:

- It was considered that the TAS Annual Report was disconnected with RHIP the programme.
- The strategic direction of TAS was questioned and the CEO advised that TAS did a large amount of work work outside of the health sector. One third of the work is done for the

Central Region; one third for the Ministry of Health and the other third for national DHB's with a small amount undertaken for other organisations.

RESOLUTION

That the Board

- Note the annual report for TAS for the year ended 30 June 2017
- Appoint Kevin Atkinson as the HBDHB representative to attend the TAS Annual General Meeting to be held on Wednesday 6 December 2017 with Kevin Snee appointed as his Alternate.

Moved **Barbara Arnott**
Seconded **Dan Druzianic**
Carried

16. SHAREHOLDER AGM REPRESENTATION – Allied Laundry Services Ltd

The draft reports and financial statements for Allied Laundry Services indicated a very successful year of consolidation following the significant expansion of the business in March 2016 and with Capital and Coast and Hutt Valley DHBs joining Allied. The company was currently reporting an operating surplus of $559k prior to the proposed Interest on Capital Dividends of $407k.

The Shareholders Agreement required each shareholder to appoint a representative for the AGM.

RESOLUTION

That the Board

- Note the Financial Statements for Allied Laundry Services Ltd would be made available once signed off by the Auditors.
- Appoint Ken Foote as the HBDHB Shareholder representative to attend the Allied Laundry Services Ltd Annual General Meeting to be held on Tuesday 28 November 2016, with Tim Evans appointed as his Alternate

Moved **Kevin Atkinson**
Seconded **Barbara Arnott**
Carried

17. COMMITTEE STRUCTURE AND MEETING SCHEDULE FOR 2018

The Board were presented with a report to consider the governance committee structures operating within the DHB. It was noted that there appeared to be general satisfaction with the existing structures, however it was acknowledged that there were some discussions going on with Ngati Kahungunu Iwi Inc about potentially enhancing the level and scope of HBDHB engagement with Māori. This could have a flow on impact on the role and function of MRB.

It was too early to anticipate this, so for planning purposes it had been assumed that MRB would continue to meet through 2018 under the current arrangements. A similar assumption

had been applied to all other committees on the basis that no changes would be made following the suggested review. The Board agreed to review the current structures so the assumptions were validated.

This schedule presented to the Board reflected the same meeting structure / processes as in 2017.

The Chair suggested whether the Board would feel that to enable them to be more productive and shorten the Board meeting day that the composition of FRAC include all Board members. It was proposed that the public excluded session of the Board meeting be held at the end of the FRAC meeting as this was also a publicly excluded meeting.

Those Board members currently not members of FRAC included:

- Ana Apatu
- Heather Skipworth
- Hine Flood, and
- Ngahiwi Tomoana

RESOLUTION

That the Board

Appoint Ana Apatu, Heather Skipworth, Hine Flood, and Ngahiwi Tomoana as additional members of the Finance Risk and Audit Committee (FRAC) as at 25 October 2017.

Moved **Kevin Atkinson**
Seconded **Barbara Arnott**
Carried

With regard to starting the FRAC meeting earlier and enabling the HBDHB Board to meet with the HB PHO in December, the following dates and times were agreed upon for the months of November and December:

November
9.00am – 11.30am .....FRAC
11.30am – 12.30pm.....Institute of Directors Board review
12.30pm – 1pm.....Lunch
1pm - 3pm.....Board

December
9.30am – 12noon .....FRAC
12noon – 12.30pm.....Public Excluded session (Board meeting)
12.30pm – 1pm .....Lunch
1pm - 3pm.....Board
3pm - 4pm.....HBDHB to meet with Board of the HB PHO

It was also agreed that in future the Chairs of Clinical and Consumer Council be provided with a copy of the FRAC agenda. **Action**

The following was also noted with regard to the 2018 meeting schedule:

- Board meetings to be held on the last Wednesday of the month except for ANZAC Day which would move to Tuesday 24th April 2018.
- The December Board meeting would be held on 19th December 2018.
- The May and November Clinical and Consumer Council dates needed to be confirmed as there had been consideration that this may be joint meetings.

Barbara Arnott departed the meeting at 3.10pm.

FOR INFORMATION / DISCUSSION

ESTABLISHING HEALTH AND SOCIAL CARE LOCALITIES IN HAWKE'S BAY

Executive Director Primary Care, Chris Ash provided an update to the Board on the establishment of Health and Social Care Localities in Hawke's Bay. His report provided in the agenda was taken as read however the following comments were made:

- Resources were being considered in what could be allocated to Wairoa to enable the capability to be assessed appropriate, thereby allowing the community to be responsible for the health care provided.
- It was suggested that a timeframe around targets be integrated into the project and that some KPI's around the future reporting and actions arising also be built in.
- There had been an obvious transformation in Wairoa in the leadership role in the last 12 months.

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:

20. Confirmation of Minutes of Board Meeting
21. Matters Arising from the Minutes of Board Meeting
22. Board Approval of Actions exceeding limits delegated by CEO
23. Chair's Update
24. Hawke's Bay Clinical Council
25. HB Health Consumer Council
25. Finance Risk and Audit Committee Report

Moved: **Kevin Atkinson**
Seconded: **Dan Druzianic**
Carried

The public section of the Board Meeting closed 3.30pm

Signed: _____
Chair

Date: _____

BOARD MEETING - MATTERS ARISING
(Public)

Action #	Date Issue first Entered	Action to be Taken	By Whom	Month	Status
1	29 Mar 17 28 June 17 Aug 17 Sept 17 Oct 17	**Chaplaincy Service Costs:** Letters were sent (at end of June) to the four local Council Mayors seeking support with Chaplaincy costs. Four LTAs declined. Letter sent to HBRC who subsequently declined support. Hastings and Wairoa reconsidered and will contribute.	Tim Evans		Ken to take the lead on this.
2	25 Oct 17	**Institute of Directors** – Ken Foote to facilitate a one hour session for the Board in November	Ken Foote	Nov	Held morning 29 Nov 2017
3	25 Oct 17	**HB Clinical Council – Governance structure**(s) A report to be brought back to the Board on the changes in the clinical governance structures and the value of these.	Co Chairs	Feb 18	Included on the detailed workplan. Remove action.
4	25 Oct 17	**FCT presentation** to be considered at the November Consumer Council agenda	Andy Philips	Nov	On Consumer Council Agenda 9 November.
5	25 Oct 17	**FRAC and Board meeting – change of times** Consumer and Clinical Councils be provided with a copy of the FRAC agenda.	Ken Foote Ken Foote	Nov & Dec	Actioned. Brenda to provide monthly. Remove action.

HAWKE'S BAY DISTRICT HEALTH BOARD – WORKPLAN

Mtg Date	Papers and Topics	Lead(s)
13 Dec 17	Audit NZ Final Management Report for the audit of HBDHB for y/ June 2017	Tim Evans
	The Big Listen – Update	Kate Coley
	Clinical Services Plan - Update	Tracee TeHuia
	HR KPIs	Kate Coley
Jan 2018	**No Meeting**	
28 Feb	Feedback Consumer Story Workshop December (by Councils) Board action	Kevin Snee
	Transform and Sustain Strategic Dashboard (6 monthly)	Tracee TeHuia
	Quality Annual Plan – 2017-18 6 month progress report	Kate Coley
	People Strategy	Kate Coley
	Te Ara Whakawaiora / Culturally Competent Workforce incorporating Building a Diverse Workforce	Kate Coley
	Implementing the Consumer Engagement Strategy	Kate Coley
	Clinical Services Plan	Tracee TeHuia
	Addressing high rate of Suicide in HB	Tracee TeHuia
	Ngatahi Vulnerable Children's Workforce Development - progress since August Report	Tracee TeHuia / Russell Wills
	Clinical Governance Committee Structure Report (Board Action)	Gommans/Phillips
	Monitoring	
	HR KPIs Q2 Oct-Dec 17	Kate Coley
	HBDHB Non-Financial Exceptions Report Q2 Oct-Dec 17 + MoH dashboard Q1	Tim Evans
	Collaborative Pathways Update	Mark Peterson
7 Mar	**HB Health Sector Leadership Forum**	
28 Mar	Annual Plan 2018/19 First Draft (2nd draft May)	Tracee TeHuia
	Establishing Health and Social Care Localities in HB	Chris Ash
	Recognising Consumer Participation Policy Amendment	Kate Coley
	Oncology Model of Care	Sharon Mason
	Monitoring	
	Te Ara Whakawaiora – Breastfeeding (national indicator)	Chris McKenna
25 Apr	Transform and Sustain Monthly Report and A3 Overview	Tracee TeHuia
30 May	Annual Plan Second Draft	Tracee TeHuia
	Best Start Healthy Eating & Activity Plan update (for information - 6 mthly Nov-May-Nov18)	
	Monitoring	Kate Coley
	HR KPIs Q3 Oct-Dec 17	Tim Evans
	HBDHB Non-Financial Exceptions Report Q3 Oct-Dec 17 + MoH dashboard Q2	
30 Jun	Consumer Experience Feedback (revised method) Q3	Kate Coley
	Youth Health Strategy (Board action June 2017)	Tracee TeHuia

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** 131
	For the attention of: **HBDHB Board**
Document Owner:	Kevin Snee, Chief Executive Officer
Reviewed by:	Not applicable
Month as at	22 November 2017
Consideration:	For Information

RECOMMENDATION

That the Board

1. **Note** the contents of this report.

INTRODUCTION

In October the Hawke's Bay health system remained under pressure but the pressure is lessening, however the flow through the hospital remains sub-optimal. Partly the problem relates to a continuing issue with norovirus, however their remain are other intrinsic problems, that continue to cause difficulties. I will ask for a report to come to the Board in the New Year to explain how we intend to address this.

This month, as well as the routine performance reports, the agenda has a real public health feel about it with papers on drinking water, economic development, social inclusion, smoking and obesity. We will also present a proposal, which describes how we are intending to significantly increase our on-site surgical capacity. Finally there will be an opportunity, in part two of the meeting, for the Board to discuss the findings of the "Big Listen" and to have an input into the immediate actions we intend to take. We will bring this back to the December meeting with the short term actions and advise the Board how we intend to proceed going forward.

PERFORMANCE

PERFORMANCEMeasure / Indicator	Target	Month of October	Qtr to end October	Trend For Qtr
Shorter stays in ED (ED6)	≥95%	90.7%	91.4%	▲
Improved access to Elective Surgery (2017/18YTD)	100%	-	101.5%	▬

Waiting list	*Less than 3 months*	*3-4 months*	*4+ months*
First Specialist Assessments (ESPI-2)	2,749	459	68
Patients given commitment to treat, but not yet treated (ESPI-5)	1,011	169	38

Faster cancer treatment* *(The FCT Health Target definition has changed for 2017/18 financial year. Patients who breach the 62 day target due to Capacity Constraint are still counted against target however patients who breach the target due to Clinical Decision or Patient Choice are now excluded).*	≥90%	100% (September 2017)	88.1% (6m to September 2017)	▬
Increased immunisation at 8 months (3 months to end of September)	≥95%	---	94%	▼
Better help for smokers to quit – Primary Care	≥90%	90.2% (15m to October)	---	▼
Better help for smokers to quit – Maternity	≥90%	---	85.7% (Quarter 4, 2016/17)	▼
Raising healthy kids (New)	≥95% (by Dec 2017)	---	94% (6m to October)	▼
Financial – month (in thousands of dollars)	(625)	(828)	---	---
Financial – year to date (in thousands of dollars)	(2,749)	(2,877)	---	---

***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%	*10/19 = 53.0%*	*84/114 = 74%*

This month's ED6 performance has improved but remains significantly below our target. This has shown signs of further improvement in October, but only through the intervention of very senior managers and clinical leaders. This is not a self-correcting system and we need to find a better way of breaking out of this cycle of deterioration, which requires intervention to reset it and return to more clinically appropriate levels. We continue to deliver our elective plan and our numbers of patients waiting longer than four months are too high. This is primarily due to problems in ophthalmology where we have had a significant reduction in FTE over a prolonged period; we are not alone in New Zealand in this regard. A full-time locum ophthalmologist will be in place by the end of November and a permanent appointment will be in place. The ophthalmology department has also put in place an innovative approach to managing follow-ups using optometrists and specialist nurses. My view is that this is a short-term problem where the department is working hard to mitigate any problems and any risk is being managed well; we are in regular contact with the Ministry of Health (MoH) to ensure they are happy with our approach. There is, as yet, no new data on helping smokers to quit in pregnancy, however smoking advice in primary care continues above target. I have asked for work to be done to

examine the data collection issues in the smoking in pregnancy target to assure us of its validity – currently it is considered to be only a developmental target.

Faster cancer treatment remains close to target, although the problem of identifying the right number of people remains. So while we have hit 100 percent in September, the numbers identified were far too small, measures have been taken to ensure that those numbers increase – as they do we may see our apparent performance decline. Raising healthy kids is at 94 percent for the six months to October, a small decline in performance, but still good overall.

Financial performance
The year-to-date result to the end of October is $128 thousand unfavourable to plan, with October $203 thousand unfavourable. Whilst this is a relatively small adverse variance it underlines the importance of vigilance and early intervention. Last year we intervened too late - we will not make the same mistake again.

PASIFIKA HEALTH UPDATE
The Pasifika community is a small and vibrant community in Hawke's Bay. Whilst they are clearly a high health needs community they also have a series of community and cultural assets that we are working with to improve the wellbeing of the community. The Pasifika Health Leadership Group (PHLG) will present to the Board their reflections on:

- progress to date
- highlights across 2017
- work undertaken with families by the Pacific Navigators

SURGICAL SERVICES EXPANSION PROJECT – INCREASING SURGICAL CAPACITY
The Surgical Expansion Project is bringing forward its Detailed Business Case, which focuses on the surgical capacity required by 2020, taking a view that the Clinical Services Plan will then provide a road map of how surgical demand will be provided for beyond this. This business case follows from the Indicative Business Case which was presented to FRAC and Board in March 2017.
The solution put forward proposes increased surgical capacity by:

- changing models of care
- working practices
- building an eighth operating theatre
- continuing our outsourcing partnership with private suppliers

This will require additional operational costs and a capital investment of $12 million for building an eighth operating theatre for the hospital, reconfiguring the pre and post-operative areas as well as some work in Sterile Services. It also includes some capital investment in the wrap-around services that support the surgical service.

HAWKE'S BAY DRINKING WATER GOVERNANCE JOINT COMMITTEE
Final terms of reference for this new Joint Committee have been agreed between representatives of the proposed members and have now been sent to all member Boards/Councils for formal approval. If/once the terms of reference are approved by the Board, we formally become a member and are therefore required to appoint two representatives (and alternates) to participate and vote on the Joint Committee. The attached paper sets out the background, detail and process to assist the Board with making the above decisions.

GOVERNANCE REPORTS AND PRESENTATIONS – PRINCIPLES, STANDARDS AND GUIDELNES
MRB, Consumer Council and some Board members have recently raised a number of concerns about the content and quality of some reports and presentations being made to governance groups, as well as limited references to the level and nature of engagement undertaken in developing the reports. As a result, some 'Principles, Standards and Guidelines' for Governance Reports and Presentations (originally issued in 2013) have been refreshed, and an updated 'Governance Report Overview' developed. A recommendation is being put to the Board for these 'Principles, Standards and Guidelines' to be adopted, including the proposed 'Governance Report Overview'.

KA ARONUI KI TE KOUNGA / FOCUSSED ON QUALITY
The Quality Accounts, initiated in 2013 by the Ministry of Health and the Health Quality and Safety Commission are annual reports to the public from DHBs about the quality of services they deliver. Ka Aronui Ki Te Kounga - Focussed on Quality is Hawke's Bay's fifth edition and includes articles on how the health sector in Hawke's Bay is improving the quality of services it delivers, responding to community feedback and details performance against national quality and safety indicators.

MATARIKI REGIONAL ECONOMIC DEVELOPMENT AND SOCIAL INCLUSION STRATEGIES
Matariki is made up of two strategic documents - Regional Economic Development and Social Inclusion. The Matariki Governance Group agreed that there would be no economic development without social inclusion, and a project was established in August 2016. The resulting Social Inclusion Strategy pulls together input from community consultations. The Strategy's three themes: Growing Socially Responsible Employment; Preparing People for Work; Whanau and Community Driving Social Inclusion, reflect this community input. Moving forward, the Matariki Strategies will be integrated, then work will commence to engage community and stakeholders in leading and delivering actions. The Board's endorsement of Social Inclusion is an important step, allowing the DHB to include the Social Inclusion actions in our annual planning process.

HEALTHY WEIGHT STRATEGY - BEST START: HEALTHY EATING AND ACTIVITY PLAN
There has been significant progress in the last six months including; establishment of an Advisory Group, an evaluation of the Maternal and Child Nutrition and Physical Activity programme, and engagement with the early childhood sector. There has been a ground swell of workplaces and Councils moving toward "fizz free" or "water only" environments. Schools have reinforced their "water only" messages.

The HBDHB Healthy Eating Policy has been ranked as one of the top three DHBs in New Zealand in terms of effectiveness. HBDHB has once again been successful in achieving the national target for four year olds "Raising Healthy Kids". We are investigating ways to further monitor the effectiveness of this work – with a second childhood measurement point for more effective monitoring.

REGIONAL TOBACCO STRATEGY FOR HAWKE'S BAY, 2015-2020 UPDATE AND TE ARA WHAKAWAIORA REPORT
In the last 12 months the DHB has been involved in embedding a new cessation service – Te Haa Matea with our community partners (Te Taiwhenua o Heretaunga, Te Kupenga Hauora - Ahuriri and Choice Kahungunu Health). New ways of working continues to support secondary care in providing brief advice, maternity services to support pregnant women to quit and primary care to achieve target.

We are achieving and/or very close to achieving all our MoH targets. Discussions with pharmacies are underway to increase access to cessation support for people in our communities. Challenges include the continuing high rate of smoking for pregnant Māori women. This will be addressed by a comprehensive strategy, available late 2017.

HBDHB PERFORMANCE FRAMEWORK EXCEPTIONS QUARTER ONE AND MINISTRY OF HEALTH QUARTERLY PERFORMANCE MONITORING DASHBOARD QUARTER FOUR
We continue to achieve 95 percent of immunisations at eight months. Our "Raising Healthy Kids" performance is now hitting target at 95 percent and our PHO enrolment is at the required 90 percent. Heart and diabetes checks have increased to cover over 88 percent of the target population. However, we continue to fall short on two major targets, 8.6 percent of our attendees are spending more than six hours in the emergency department. Also, while we are now only 2 percent short of the 90 percent faster cancer treatment target, we are not fast tracking enough patients to make that performance meaningful.

WAIROA HEALTH CENTRE LEASES
New leases have been agreed with Wairoa Medical Centre and Queen Street Practice to occupy space in the Wairoa Health Centre. Given the total period of these leases is 6 years (including rights of renewal), under the provisions of the NZ Public Health and Disability Act, the prior written approval of the Minister of Health is required before the leases can be executed. Seeking the approval of the Minister, requires evidence of a Board resolution approving the leases.
A brief paper is therefore included with a recommendation to achieve this.

CONCLUSION

This month our health system continues under pressure with high levels of community and staff sickness. We have coped reasonably well and in October some of the pressures appear to be abating. There has, however, been a lot of work in October to fulfil our public health agenda, to review the feedback from the Big Listen and to develop our Clinical Services Plan which will help us moving forward.

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report, October 2017** 132
	For the attention of: **HBDHB Board and the Finance Risk and Audit Committee (FRAC)**
Document Owner: Document Author(s):	Tim Evans, Executive Director Corporate Services Phil Lomax, Financial Accountant
Reviewed by:	Executive Management Team
Month:	November 2017
Consideration:	For Information

RECOMMENDATION

That the Board and FRAC

- Note the contents of this report

1. Executive Director Corporate Services' comments

Financial performance

The year-to-date result to the end of October is $128 thousand unfavourable to plan, with October $203 thousand unfavourable. The in-month variance was improved by the release of $250 thousand of the contingency, leaving an underlying unfavourable variance of $453 thousand. The key drivers for this were medical staff $413 thousand (use of locums for cover and flow), undelivered savings not yet removed from budgets $345 thousand, outsourcing activity to external providers $324 thousand and clinical supplies $128 thousand. These were partially offset by a favourable prior year community pharmacy wash up $500 thousand and allied health professional staff $321 thousand (vacancies and delay in change of shift times).

Year-end forecast

The forecast year-end result remains as a $1.5 million surplus. Cost pressures identified in the forecast process include:

	$'m
Additional outsourced clinical services including elective surgery	(1.8)
Clinical supplies including implants/prostheses and pharmaceuticals	(1.0)
Revenue not received for In Between Travel	(1.0)
Net cost of medical vacancy and leave cover	(0.9)
Interest and depreciation	(0.8)
	(5.5)

Offsetting the cost pressures are:

	$'m
Contingency	3.0
Non-medical vacancies	2.5
Reduced corporate costs	0.2
Reduced provider costs	0.1
	5.8

However $2.3 million of savings will not be achieved from current planned actions, and those savings will need to be found from as yet unidentified efficiencies. The forecast reported below assumes the savings will be identified and achieved.

2. Resource Overview

	October				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)	(828)	(625)	(203)	-32.4%	(2,877)	(2,749)	(128)	-4.6%	1,500	3
Contingency utilised	250	250	-	0.0%	250	1,000	750	75.0%	3,000	8
Quality and financial improvement	597	757	(160)	-21.1%	2,127	2,848	(721)	-25.3%	10,812	11
Capital spend	1,266	1,993	(726)	-36.4%	4,843	7,970	(3,127)	-39.2%	23,920	16
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,252	2,324	72	3.1%	2,248	2,328	81	3.5%	2,319	5 & 7
	CWD	CWD	CWD	%	CWD	CWD	CWD	%	CWD	
Case weighted discharges	2,960	2,460	499	20.3%	9,105	10,088	(983)	-9.7%	28,386	5

$250 thousand of the contingency was released in October recognising part of the additional costs being incurred in meeting elective surgery targets.

Identified savings plans, 99.9% of the Quality and Financial Improvement (QFI) programme, were 75% achieved October year-to-date. The shortfall is mainly in Inter District Flows (IDFs).

The capital expenditure plan was phased evenly across the year, as detailed project planning was not complete at the time the budget was set. The under-spend to October reflects the relatively early stage of planning and ordering of capital items that should catch up later in the year.

The Full Time Equivilent (FTE) variance reflects vacancies across a number of areas.

Case weighted discharge data reflects a catch-up in coding that is now approximately 1,000 case-weights behind. The catch-up should be complete in the next month or two.

3. Financial Performance Summary

$'000	October				Year to Date				Year End Forecast	Refer Section
	Actual	Budget	Variance		Actual	Budget	Variance			
Income	45,206	45,215	(9)	0.0%	180,208	180,562	(354)	-0.2%	554,585	4
Less:										
Providing Health Services	22,306	21,624	(682)	-3.2%	86,990	86,201	(788)	-0.9%	264,101	5
Funding Other Providers	19,593	20,008	415	2.1%	78,798	79,709	912	1.1%	239,440	6
Corporate Services	3,983	3,852	(130)	-3.4%	16,270	15,974	(296)	-1.9%	48,272	7
Reserves	152	357	204	57.3%	1,028	1,426	399	28.0%	1,271	8
	(828)	**(625)**	**(203)**	**-32.4%**	**(2,877)**	**(2,749)**	**(128)**	**-4.6%**	**1,500**	

Income
Lower than budgeted In-Between-Travel (IBT) and elective services funding partly offset by higher income from other DHBs and ACC.

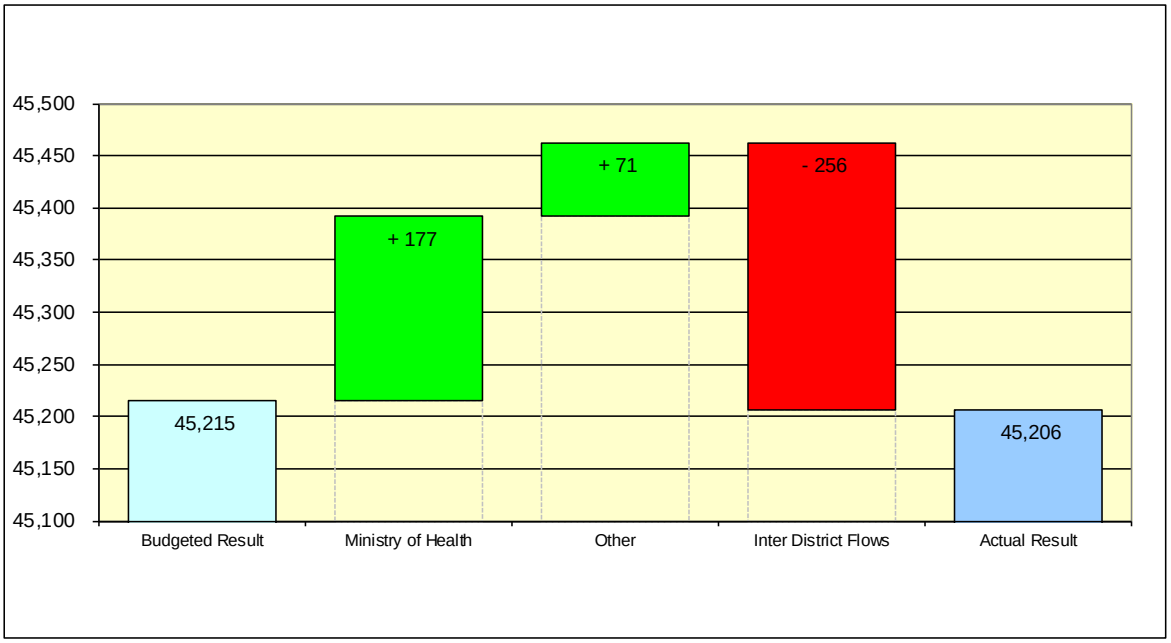
Providing Health Services
Unachieved efficiencies, elective surgery, clinical supplies and patient transport costs, partially offset by vacancies in allied health and nursing.

Funding Other Providers
Recoveries, release of provisions, wash-ups and rebates generally relating to 2016/17.

4. Income

$'000	October				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Ministry of Health	43,286	43,110	177	0.4%	171,700	172,333	(633)	-0.4%	529,332
Inter District Flows	437	693	(256)	-37.0%	2,627	2,771	(144)	-5.2%	8,170
Other District Health Boards	338	333	6	1.7%	1,437	1,331	106	7.9%	4,102
Financing	75	74	1	1.9%	268	295	(27)	-9.2%	857
ACC	451	415	36	8.6%	1,918	1,733	185	10.7%	5,648
Other Government	87	60	27	44.3%	195	163	32	19.4%	445
Patient and Consumer Sourced	76	104	(28)	-27.2%	384	417	(33)	-7.8%	1,374
Other Income	457	361	95	26.3%	1,676	1,451	224	15.5%	4,653
Abnormals	-	65	(65)	-100.0%	2	66	(64)	-97.1%	3
	45,206	**45,215**	(9)	0.0%	**180,208**	**180,562**	(354)	-0.2%	**554,585**

October

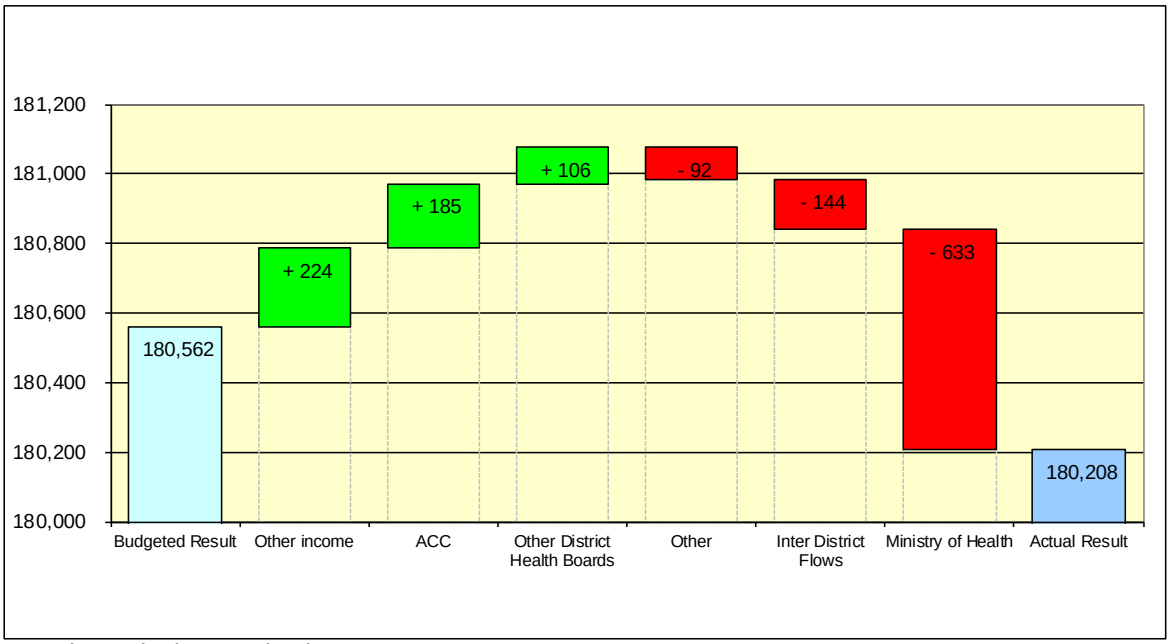


Note the scale does not begin at zero

Ministry of Health (favourable)
Additional income relating to PHO performance payments, cancer nurse coordination, the Say Ahh programme, and adult cancer services.

Inter District Flows (unfavourable)
Provision for reduced income based on latest data from MOH and other DHBs.

Year to Date



Note the scale does not begin at zero

Other Income (favourable)
Special funds and clinical trials income, rent from surplus properties, and various cost recoveries.

ACC (favourable)
Non acute rehabilitation, ACC surgery, and community nursing.

Other District Health Boards (favourable)
Patient transport reimbursements, including cover for Nelson-Marlborough DHB while their service was down. Reimbursements from Tairawhiti DHB continue to decline.

Inter District Flows (favourable)
Reflects latest available information from MOH and other DHBs.

Ministry of Health (unfavourable)
Lower than budgeted In-Between-Travel (IBT), and elective services funding.

5. Providing Health Services

	October				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure by type $'000									
Medical personnel and locums	5,470	5,022	(448)	-8.9%	19,896	19,573	(324)	-1.7%	63,051
Nursing personnel	6,399	6,414	16	0.2%	24,574	25,293	718	2.8%	75,258
Allied health personnel	2,658	3,017	359	11.9%	11,148	12,070	922	7.6%	35,181
Other personnel	1,980	2,023	43	2.1%	7,853	8,036	183	2.3%	23,955
Outsourced services	968	641	(327)	-51.1%	3,264	2,563	(701)	-27.4%	9,517
Clinical supplies	3,233	2,774	(459)	-16.5%	13,418	11,703	(1,715)	-14.7%	36,427
Infrastructure and non clinical	1,599	1,732	134	7.7%	6,836	6,965	129	1.9%	20,711
	22,306	**21,624**	(682)	-3.2%	**86,990**	**86,201**	(788)	-0.9%	**264,101**
Expenditure by directorate $'000									
Medical	5,721	5,670	(51)	-0.9%	22,915	22,413	(502)	-2.2%	69,769
Surgical	4,803	4,452	(350)	-7.9%	18,815	18,200	(614)	-3.4%	56,957
Community, Women and Children	3,622	3,538	(84)	-2.4%	14,099	14,209	111	0.8%	42,535
Older Persons, Options HB, Menta	2,894	2,825	(69)	-2.4%	11,132	11,395	263	2.3%	33,956
Operations	3,393	3,231	(162)	-5.0%	12,817	12,782	(34)	-0.3%	38,673
Other	1,875	1,908	33	1.7%	7,212	7,201	(11)	-0.1%	22,211
	22,306	**21,624**	(682)	-3.2%	**86,990**	**86,201**	(788)	-0.9%	**264,101**
Full Time Equivalents									
Medical personnel	321.0	331.1	10	3.1%	314	329	15	4.5%	345.2
Nursing personnel	929.6	933.9	4	0.5%	915	938	23	2.5%	916.7
Allied health personnel	427.1	480.6	53	11.1%	454	481	27	5.6%	478.4
Support personnel	139.1	136.1	(3)	-2.2%	134	136	2	1.8%	136.0
Management and administration	271.6	272.8	1	0.4%	269	275	5	1.9%	271.7
	2,088.4	**2,154.5**	66	3.1%	**2,085**	**2,158**	72	3.4%	**2,148.0**
Case Weighted Discharges									
Acute	2,125	1,718	407	23.7%	6,361	7,023	(662)	-9.4%	19,385
Elective	637	545	92	16.9%	1,918	2,205	(286)	-13.0%	6,451
Maternity	124	147	(22)	-15.1%	617	671	(54)	-8.1%	2,000
IDF Inflows	73	51	23	44.7%	209	189	19	10.2%	550
	2,960	**2,460**	499	20.3%	**9,105**	**10,088**	(983)	-9.7%	**28,386**

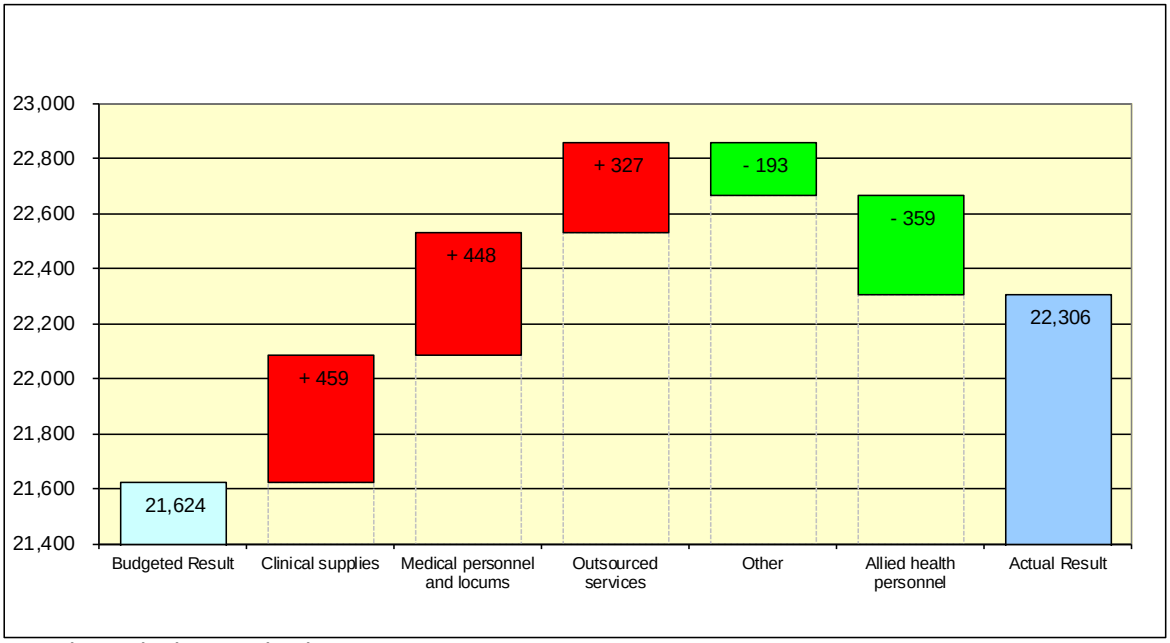
Directorates

- Surgical services – outsourced elective surgery, unachieved efficiencies and implants and prostheses.
- Medical services – locums for medical vacancies and leave cover, and unachieved efficiencies.
- Operations – patient transport costs.

Case Weighted Discharges

Case weighted discharges have been included to indicate the catch up in coding. Coding is approximately one to two weeks behind that equates to about 1 thousand caseweights, and is expected to catch-up completely over the next month or two.

October



Note the scale does not begin at zero

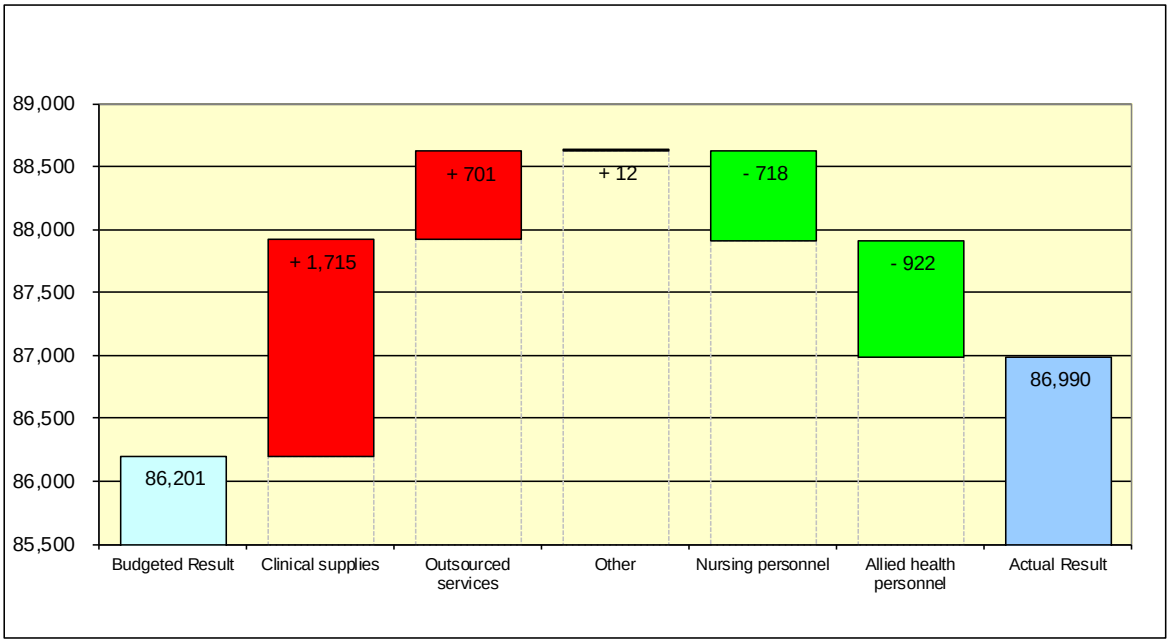
Clinical supplies (unfavourable)
Efficiencies not achieved for savings targets not yet allocated to budgets and patient transport costs.

Medical personnel and locums (unfavourable)
Elective surgery and vacancies in psychiatric medicine, radiology and physicians. The cost of locum cover is significantly higher than cost savings from vacancies.

Outsourced services (unfavourable)
Outsourced elective surgery to Royston, PET scans, and higher costs for after-hours radiologist services, as the old supplier exited the market.

Allied health personnel (favourable)
Removal of a provision for increasing MRT hours of work now unlikely to proceed, and vacancies in psychologists, social workers and occupational therapists.

Year to date



Note the scale does not begin at zero

Clinical supplies (unfavourable)
Efficiencies not achieved and patient transport.

Outsourced services (unfavourable)
Royston and other elective surgery, PET scans and other radiology.

Nursing personnel (favourable)
Difficulty recruiting to new senior nursing positions earlier in the year.

Allied health personnel (favourable)
Vacancies mainly in psychologists, social workers, technicians, and therapists. Removal of the provision for increasing MRT hours of work impacting on October.

Full Time Equivalents (FTE)

FTEs are 72 (3.4%) favourable year-to-date including:

Medical personnel (15 FTE / 4.5% favourable)

- Vacancies mainly in CWC (Community, Women and Child), Older Persons/Mental Health, Surgical, and Medical services. Includes a number of unfilled new positions.

Nursing personnel (23 FTE / 2.5% favourable)

- Mostly vacant senior nursing positions across a wide range of departments. Includes a number of unfilled new positions.

Allied Health Personnel (27 FTE / 5.6% favourable)

- Mostly mental health staff and technicians. The increase in October relates to the removal of the provision for increasing MRT hours of work.

MONTHLY ELECTIVE HEALTH TARGET REPORT
YTD To September 2017

Plan for 2017/18	On-Site	Outsourced	IDF Outflow	TOTAL
Non Surgical - Arranged	13		57	**70**
Non Surgical - Elective	67		120	**187**
Surgical - Arranged	545		152	**697**
Surgical - Elective	5,186	754	680	**6,620**
TOTAL	**5,811**	**754**	**1,009**	**7,574**

		YTD October 2017			
		Actual	Plan	Var.	%Var.
On-Site	Avastins	68	68	0	0.00%
	ENT	131	170	-39	-22.94%
	General Surgery	295	291	4	1.37%
	Gynaecology	184	184	0	0.00%
	Maxillo-Facial	80	75	5	6.67%
	Ophthalmology	304	317	-13	-4.10%
	Orthopaedics	177	205	-28	-13.66%
	Orthopaedics - Major Joints	79	88	-9	-10.23%
	Skin Lesions	59	59	0	0.00%
	Urology	184	173	11	6.36%
	Vascular	46	61	-15	-24.59%
	Surgical - Arranged	197	182	15	8.24%
	Non Surgical - Arranged	20	4	16	400.00%
	Non Surgical - Elective	25	22	3	13.64%
On-Site	**Total**	**1849**	**1899**	**-50**	**-2.63%**
Outsourced	ENT	36	43	-7	-16.28%
	General Surgery	103	90	13	14.44%
	Gynaecology	3	0	3	0.00%
	Maxillo-Facial	13	15	-2	-13.33%
	Ophthalmology	77	48	29	60.42%
	Orthopaedics	1	0	1	0.00%
	Orthopaedics - Major Joints	32	34	-2	-5.88%
	Skin Lesions	1	0	1	0.00%
	Urology	12	16	-4	-25.00%
	Vascular	7	2	5	250.00%
Outsourced	**Total**	**285**	**248**	**37**	**14.92%**
IDF Outflow	Cardiothoracic	30	26	4	15.38%
	ENT	21	13	8	61.54%
	General Surgery	21	18	3	16.67%
	Gynaecology	6	8	-2	-25.00%
	Maxillo-Facial	44	61	-17	-27.87%
	Neurosurgery	14	26	-12	-46.15%
	Ophthalmology	12	13	-1	-7.69%
	Orthopaedics	12	7	5	71.43%
	Paediatric Surgery	30	26	4	15.38%
	Skin Lesions	17	15	2	13.33%
	Urology	4	3	1	33.33%
	Vascular	4	6	-2	-33.33%
	Surgical - Arranged	55	48	7	14.58%
	Non Surgical - Arranged	18	18	0	0.00%
	Non Surgical - Elective	38	36	2	5.56%
IDF Outflow	**Total**	**326**	**324**	**2**	**0.62%**
TOTAL		**2,460**	**2,471**	**-11**	**-0.45%**

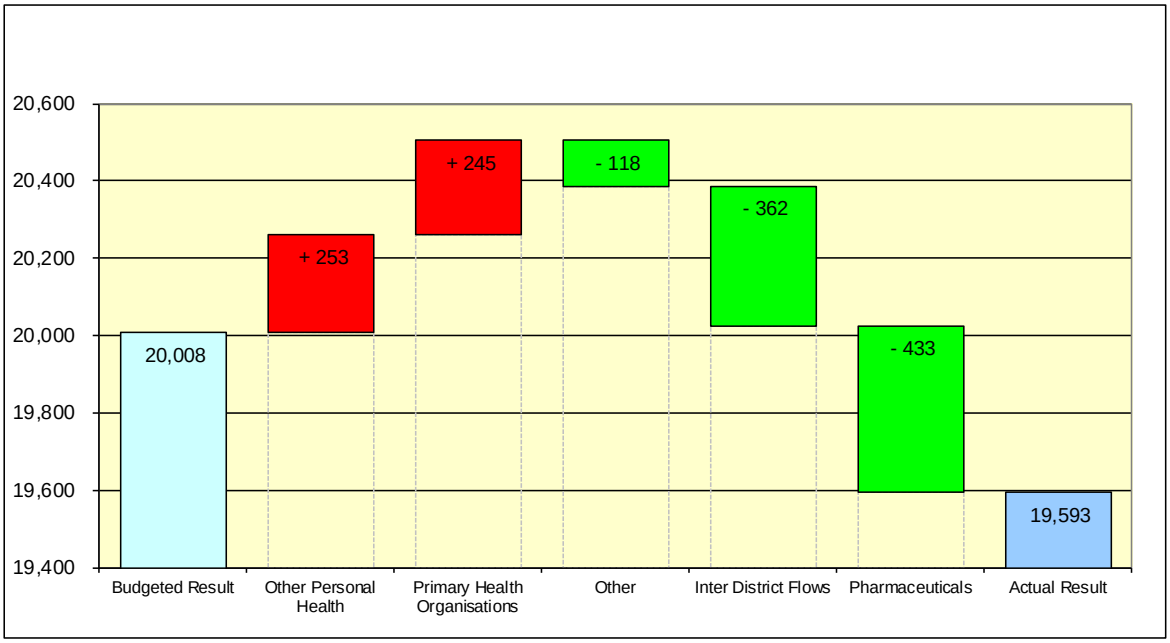
		Oct-17			
		Actual	Plan	Var.	%Var.
On-Site	Avastins	17	17	0	0.00%
	ENT	30	47	-17	-36.17%
	General Surgery	73	71	2	2.82%
	Gynaecology	57	49	8	16.33%
	Maxillo-Facial	33	21	12	57.14%
	Ophthalmology	83	95	-12	-12.63%
	Orthopaedics	44	42	2	4.76%
	Orthopaedics - Major Joints	10	18	-8	-44.44%
	Skin Lesions	18	18	0	0.00%
	Urology	50	41	9	21.95%
	Vascular	2	13	-11	-84.62%
	Surgical - Arranged	35	51	-16	-31.37%
	Non Surgical - Arranged	4	1	3	300.00%
	Non Surgical - Elective	2	5	-3	-60.00%
On-Site	**Total**	**458**	**489**	**-31**	**-6.34%**
Outsourced	ENT	9	13	-4	-30.77%
	General Surgery	37	25	12	48.00%
	Gynaecology	2	0	2	0.00%
	Maxillo-Facial	5	11	-6	-54.55%
	Ophthalmology	19	10	9	90.00%
	Orthopaedics	0	0	0	0.00%
	Orthopaedics - Major Joints	5	10	-5	-50.00%
	Skin Lesions	0	0	0	0.00%
	Urology	1	5	-4	-80.00%
	Vascular	3	1	2	200.00%
Outsourced	**Total**	**81**	**75**	**6**	**8.00%**
IDF Outflow	Cardiothoracic	6	6	0	0.00%
	ENT	3	4	-1	-25.00%
	General Surgery	3	4	-1	-25.00%
	Gynaecology	4	2	2	100.00%
	Maxillo-Facial	4	17	-13	-76.47%
	Neurosurgery	3	7	-4	-57.14%
	Ophthalmology	4	2	2	100.00%
	Orthopaedics	1	2	-1	-50.00%
	Paediatric Surgery	4	8	-4	-50.00%
	Skin Lesions	3	4	-1	-25.00%
	Urology	0	1	-1	-100.00%
	Vascular	1	2	-1	-50.00%
	Surgical - Arranged	9	13	-4	-30.77%
	Non Surgical - Arranged	6	6	0	0.00%
	Non Surgical - Elective	13	10	3	30.00%
IDF Outflow	**Total**	**64**	**88**	**-24**	**-27.27%**
TOTAL		**603**	**652**	**-49**	**-7.52%**

Note: This report was run on 8th November 2017. Skin Lesions and Avastins are reported to plan. Data is subject to change.

6. Funding Other Providers

$'000	October Actual	October Budget	October Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Payments to Other Providers									
Pharmaceuticals	3,309	3,742	433	11.6%	14,419	14,929	510	3.4%	44,282
Primary Health Organisations	3,211	2,966	(245)	-8.3%	12,187	12,079	(108)	-0.9%	36,996
Inter District Flows	4,106	4,468	362	8.1%	17,194	17,470	276	1.6%	51,812
Other Personal Health	2,156	1,903	(253)	-13.3%	7,397	7,666	269	3.5%	23,556
Mental Health	1,029	941	(88)	-9.4%	3,851	3,781	(70)	-1.9%	11,339
Health of Older People	5,440	5,636	196	3.5%	22,449	22,417	(32)	-0.1%	67,204
Other Funding Payments	341	351	10	2.9%	1,302	1,368	67	4.9%	4,250
	19,593	20,008	415	2.1%	**78,798**	**79,709**	912	1.1%	239,440
Payments by Portfolio									
Strategic Services									
Secondary Care	3,559	3,952	393	9.9%	15,065	15,433	368	2.4%	45,870
Primary Care	8,389	8,194	(195)	-2.4%	32,464	33,017	553	1.7%	99,783
Mental Health	1,209	1,260	52	4.1%	4,949	5,057	108	2.1%	14,856
Health of Older People	5,739	5,948	209	3.5%	23,752	23,639	(113)	-0.5%	71,012
Other Health Funding	33	33	(0)	0.0%	147	133	(14)	-10.5%	400
Maori Health	558	498	(60)	-12.1%	1,981	1,932	(49)	-2.5%	6,102
Population Health	106	122	16	13.0%	439	497	58	11.7%	1,419
	19,593	20,008	415	2.1%	**78,798**	**79,709**	912	1.1%	239,440

October



Note the scale does not begin at zero

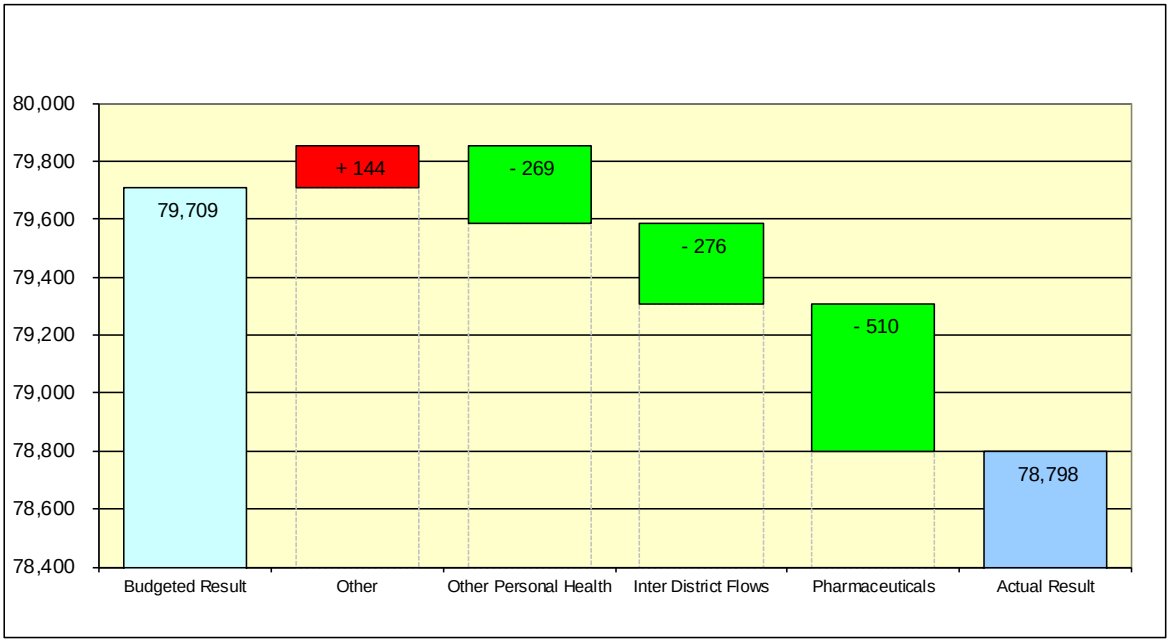
Other personal health (unfavourable)
Laboratory services, GMS and rural support payments.

Primary Health Organisations (unfavourable)
Higher payments relating to performance, offset by additional MOH income.

Inter District Flows (favourable)
Provision for lower outflows based on MOH and other DHBs information.

Pharmaceuticals (favourable)
Higher 2016/17 wash-up and rebate than expected.

Year to Date



Other personal health (favourable)
Recovery of funding for school-based services. Includes release of provisions from 2016/17.

Inter District Flows (favourable)
Release of the provision for undischarged long stay patients in August.

Pharmaceuticals (favourable)
Higher 2016/17 wash-up and rebate than expected.

7. Corporate Services

$'000	October Actual	October Budget	October Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Operating Expenditure									
Personnel	1,299	1,323	23	1.8%	5,252	5,274	22	0.4%	15,747
Outsourced services	22	68	45	67.2%	286	271	(16)	-5.8%	827
Clinical supplies	(80)	(90)	(11)	-11.8%	(238)	(293)	**(56)**	**-19.1%**	(436)
Infrastructure and non clinical	880	767	**(113)**	**-14.7%**	3,548	3,590	42	1.2%	9,654
	2,121	2,067	(55)	-2.6%	8,849	8,841	(8)	-0.1%	25,792
Capital servicing									
Depreciation and amortisation	1,156	1,080	**(76)**	**-7.0%**	4,602	4,313	**(289)**	**-6.7%**	14,020
Capital charge	705	705	-	0.0%	2,820	2,820	-	0.0%	8,459
	1,861	1,785	(76)	-4.2%	7,422	7,133	(289)	-4.1%	22,480
	3,983	**3,852**	(130)	-3.4%	**16,270**	**15,974**	(296)	-1.9%	**48,272**
Full Time Equivalents									
Medical personnel	0.3	0.3	(0)	-16.6%	0	0	0	3.3%	0.3
Nursing personnel	15.3	15.1	(0)	-1.3%	13	15	2	11.4%	14.9
Allied health personnel	0.6	0.4	(0)	-58.9%	1	0	(1)	-126.5%	0.4
Support personnel	9.7	9.1	(1)	-6.7%	9	9	0	0.8%	9.1
Management and administration	137.7	145.0	**7**	**5.1%**	139	146	7	4.8%	146.5
	163.6	**169.9**	6	3.7%	**163**	**171**	8	4.9%	**171.2**

Infrastructure for October relates mainly to the Big Listen, Oracle licensing costs, and postgraduate nursing training.

Depreciation is partly accelerated depreciation of some lower value IT assets, and higher capitalisation of assets in 2016/17 than was allowed for in depreciation budgets for 2017/18.

8. Reserves

$'000	October Actual	October Budget	October Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Expenditure									
Contingency	-	250	**250**	**100.0%**	750	1,000	**250**	**25.0%**	2,750
Transform and Sustain resource	140	102	(37)	-36.6%	246	410	**163**	**39.9%**	1,206
Other	13	4	(8)	-197.1%	31	17	(14)	-84.5%	(2,685)
	152	**357**	**204**	**57.3%**	**1,028**	**1,426**	**399**	**28.0%**	**1,271**

$250 thousand of the contingency was released in October recognising part of the additional costs being incurred in meeting elective surgery targets.

9. Financial Performance by MOH Classification

$'000	October Actual	October Annual Plan	October 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	42,538	42,606	(68) U	169,637	170,265	(629) U	523,526	524,510	(983) U
Less:									
Payments to Internal Providers	23,237	23,237	-	97,329	97,679	350 F	284,668	285,018	350 F
Payments to Other Providers	19,593	20,008	415 F	78,798	79,709	912 F	239,440	239,055	(385) U
Contribution	**(292)**	**(639)**	**346 F**	**(6,490)**	**(7,123)**	**633 F**	**(582)**	**437**	**(1,019) U**
Governance and Funding Admin.									
Funding	274	274	-	1,098	1,098	-	3,294	3,294	-
Other Income	3	3	-	10	10	-	30	30	-
Less:									
Expenditure	196	259	63 F	900	1,003	103 F	3,119	3,215	96 F
Contribution	**81**	**18**	**63 F**	**208**	**105**	**103 F**	**205**	**108**	**96 F**
Health Provision									
Funding	22,963	22,963	-	96,231	96,581	(350) U	281,374	281,724	(350) U
Other Income	2,666	2,607	59 F	10,561	10,286	275 F	31,029	30,654	375 F
Less:									
Expenditure	26,245	25,574	(672) U	103,388	102,599	(788) U	310,526	311,423	898 F
Contribution	**(616)**	**(4)**	**(612) U**	**3,405**	**4,268**	**(863) U**	**1,877**	**955**	**923 F**
Net Result	**(828)**	**(625)**	**(203)** U	**(2,877)**	**(2,749)**	**(128)** U	**1,500**	**1,500**	**(0)** 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, or unbudgeted new funding received during the year and the associated expenditure.

$'000	October Mgmt Budget	October Annual Plan	October 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	42,606	42,527	79 F	170,265	169,875	390 F	524,510	524,124	386 F
Less:									
Payments to Internal Providers	23,237	23,143	(94) U	97,679	97,303	(376) U	285,018	283,900	(1,118) U
Payments to Other Providers	20,008	19,747	(261) U	79,709	79,274	(435) U	239,055	238,724	(331) U
Contribution	**(639)**	**(363)**	**(276) U**	**(7,123)**	**(6,702)**	**(421) U**	**437**	**1,500**	**(1,063) U**
Governance and Funding Admin.									
Funding	274	274	-	1,098	1,098	-	3,294	3,294	-
Other Income	3	3	-	10	10	-	30	30	-
Less:									
Expenditure	259	278	19 F	1,003	1,111	108 F	3,215	3,324	108 F
Contribution	**18**	**(1)**	**19 F**	**105**	**(3)**	**108 F**	**108**	**(0)**	**108 F**
Health Provision									
Funding	22,963	22,869	94 F	96,581	96,205	376 F	281,724	280,606	1,118 F
Other Income	2,607	2,569	38 F	10,286	10,134	152 F	30,654	30,089	565 F
Less:									
Expenditure	25,574	25,698	125 F	102,599	102,384	(216) U	311,423	310,695	(728) U
Contribution	**(4)**	**(261)**	**257 F**	**4,268**	**3,956**	**312 F**	**955**	**-**	**955 F**
Net Result	**(625)**	**(625)**	**(0)** U	**(2,749)**	**(2,749)**	**(0)** U	**1,500**	**1,500**	**(0)** U

11. Quality and Financial Improvement Programme

The table below shows 99.9% of the $10.8 million of general efficiency plans have been identified to date, and that $2.1 million of savings have been achieved against a year-to-date target of $2.8 million.

Provider services general efficiencies are 76% of the year-to-date identified plans, down from 83% in September. The large items in the $340 thousand shortfall are in Surgical Services (non-recurrent schemes), Medical Services (staff management), and Community, Women and Child (vacancy management).

Strategic Planning general efficiencies are at 71% of the year-to-date identified plans, up from 55% last month. IDF outflows makes up $249 thousand of the shortfall and reflects the lead time for referral practice changes. Management of Enliven volumes and GMS payments comprise most of the remaining variance.

Service	2017/18 Annual Savings Plans	YTD Savings Planned	YTD Savings Achieved	YTD Var	% YTD Planned Savings Achieved	% of Annual Plan YTD
Corporate	996,999	176,104	116,927	(59,177)	66%	12%
Provider Services	4,911,865	1,407,857	1,067,500	(340,357)	76%	22%
Strategic Planning	4,598,000	1,096,964	779,434	(317,530)	71%	17%
Strategy and Health Improvement	285,440	167,297	162,972	(4,325)	97%	57%
Grand Total	**10,792,304**	**2,848,222**	**2,126,832**	**(721,390)**	**75%**	**20%**

12. Financial Position

30 June 2017	$'000	October Actual	October Budget	Variance from budget	Movement from 30 June 2017	Annual Budget
	Equity					
149,751	Crown equity and reserves	149,751	149,751	-	-	149,394
(7,406)	Accumulated deficit	(10,283)	(7,222)	3,061	(2,877)	(2,973)
142,345		139,468	142,528	3,061	(2,877)	146,421
	Represented by:					
	Current Assets					
16,541	Bank	17,945	17,845	(100)	1,404	15,536
1,690	Bank deposits > 90 days	1,654	1,755	101	(36)	1,755
26,735	Prepayments and receivables	20,687	22,543	1,856	(6,049)	22,951
4,435	Inventory	4,515	4,361	(154)	80	4,419
625	Non current assets held for sale	625	625	-	-	-
50,025		45,426	47,128	1,702	(4,600)	44,661
	Non Current Assets					
152,411	Property, plant and equipment	152,738	154,752	2,014	327	160,576
1,820	Intangible assets	1,694	2,036	342	(126)	2,962
10,701	Investments	10,701	11,372	671	-	12,105
164,932		165,133	168,160	3,027	201	175,642
214,957	**Total Assets**	**210,559**	**215,288**	**4,729**	**(4,398)**	**220,302**
	Liabilities					
	Current Liabilities					
-	Bank overdraft	-	-	-	-	-
35,447	Payables	33,910	35,256	1,346	(1,537)	35,762
34,528	Employee entitlements	34,544	34,804	260	16	35,381
69,975		68,454	70,060	1,606	(1,521)	71,143
	Non Current Liabilities					
2,638	Employee entitlements	2,638	2,699	62	-	2,739
2,638		2,638	2,699	62	-	2,739
72,612	**Total Liabilities**	**71,091**	**72,759**	**1,668**	**(1,521)**	**73,882**
142,345	**Net Assets**	**139,468**	**142,528**	**3,061**	**(2,877)**	**146,421**

The variance from budget for:

- Equity reflects the amount the budgeted opening balance differs from the 2016/17 result, and the 2017/18 variance from budget;
- Property, plant and equipment mainly reflect the lower than budgeted capital spend;
- Payables reflects lower funding wash-up accruals from MOH.
- Employee entitlements – see below

13. Employee Entitlements

30 June 2017	$'000	October Actual	October Budget	Variance from budget	Movement from 30 June 2017	Annual Budget
7,853	Salaries & wages accrued	8,930	7,953	(977)	1,077	7,756
522	ACC levy provisions	476	167	(310)	(45)	501
4,869	Continuing medical education	4,190	4,803	614	(679)	5,553
19,819	Accrued leave	19,410	20,218	807	(409)	19,883
4,103	Long service leave & retirement grat.	4,175	4,363	188	72	4,426
37,165	**Total Employee Entitlements**	37,181	37,504	322	16	38,119

14. Treasury

Change of banking arrangements

The DHB changed banks from Westpac to BNZ on 24 October in accordance with a sector-wide agreement arranged by NZ Health Partnerships Limited (NZHPL). The change-over was reasonably smooth.

Liquidity management

The surplus cash of all DHBs is managed by NZHPL under a sweep arrangement facilitated by Westpac and BNZ. The DHB provides forecast cash flow information to NZHPL, to allow it 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 DHB 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

Capital spend is $3.4 million behind plan year-to-date, including the surgical expansion that is in the planning stage, and information technology that is expected to be spent later in the year.

See table on the next page.

2018 Annual Plan		*Actual $'000*	*Year to Date Budget $'000*	*Variance $'000*
	Source of Funds			
	Operating Sources			
13,625	Depreciation	4,602	4,313	(289)
1,500	Surplus/(Deficit)	(2,877)	(2,749)	128
9,166	Working Capital	2,844	6,655	3,811
24,290		4,569	8,219	3,650
	Other Sources			
-	Special funds and clinical trials	274	-	(274)
625	Sale of assets	-	-	-
625		274	-	(274)
24,915	**Total funds sourced**	**4,843**	**8,219**	**3,376**
	Application of Funds:			
	Block Allocations			
3,400	Facilities	654	1,308	654
3,200	Information Services	46	1,066	1,020
3,400	Clinical Plant & Equipment	1,416	958	(458)
10,000		2,116	3,332	1,216
	Local Strategic			
1,082	Renal Centralised Development	415	361	(54)
6,306	New Stand-alone Endoscopy Unit	1,746	2,101	355
134	New Mental Health Inpatient Unit Development	67	45	(22)
500	Upgrade old MHIU	10	167	156
243	Travel Plan	61	81	19
1,555	Histology and Education Centre Upgrade	49	518	469
3,000	Surgical Expansion	-	1,000	1,000
500	Radiology Extension	-	167	167
600	Fit out Corporate Building	-	200	200
13,920		2,349	4,638	2,289
	Other			
-	Special funds and clinical trials	274	-	(274)
-	Other	104	-	(104)
-		377	-	(377)
23,920	***Capital Spend***	***4,843***	***7,970***	***3,127***
	Regional Strategic			
995	RHIP (formerly CRISP)	-	249	249
995		-	249	249
24,915	**Total funds applied**	**4,843**	**8,219**	**3,376**

Monthly Project Board Report
Oct 2017

HAWKE'S BAY District Health Board

Improving Endoscopy Services. Phase 3
Service transition and Facilities Development.

Project Manager Facilities Development: **Trent Fairey**

Overall Project Progress	Quality & Safety Risk Status	Time Status	Financial Status
34%	G	G	G

Phase 3: Service transition & Facility Development

Formal approval of the Business Case was received in December 2016 from the Hawke's Bay District Health Board for the construction of a stand-alone Gastroenterology Service building (improving Endoscopy services).
Phase 1 Service & Facility Planning, and Phase 2 Design & Tendering of service facility have been completed on time and within budget.
Phase 3 Service Transition and Facility construction is now underway. This phase concentrates on the construction of the facility to enable the service transition in late 2018. Trialling a new shift in endoscopy unit to cover the additional RN responsibilities associated with managing the end to end process for endoscopy services. Reviewing the equipment to support care delivery pre and post endoscopy.
A fourth and final phase of the project will complete the Improving Endoscopy Services programme, focusing on the development of the service and delivery of the bowel screening programme.

Project Budget Status

Total Approved for Capital Budget	**$ 11,670,000**	Total 17/18 Forecast Spend	**$ 6,300,000**
Total Project Spend to Date	$ 3,988,050	Total 17/18 Spend to Date	$ 1,746,578
Percentage of Total Spend vs Budget	34%	Percentage 17/18 Spend vs Forecast	28%

Project initiation was completed on the 27th February 2017 on approval of the site specific safety plan. Project total spend is now tracking inline with initial predictions. The addition of the level 1 variation to contract for an approved $1,300,000 will be integrated into the total project costs in the month of November. Total cost and timeframe reporting will change to take into account this variation. Project spend will track in a similar range to the current predictions with he variation costs coming into the project in the first quarter of 2018/19 financial year.

Deliverable Dates

Geotechnical design and Testing	Complete	Internal construction - Building Services	May-18
Site specific safety plan review and approval	Complete	Furniture , Fittings and Equipment installation	Jun-18
Earthworks and Excavation	Complete	Building services commissioning	Jul-18
Foundation construction	Complete	Facility Sign off & Certificate of Public Use	Aug-18
Structural Steelwork installation	Nov-17	Service Training and Transition to Staged start up	Sep-18
Concrete floor structures	Dec-17	Full operational capacity available and Service Go Live	Oct-18
Exterior and Roof Cladding	Mar-18	Post Implementation Review & Post Occupancy Evaluations	Feb-19

Key Achievements this period

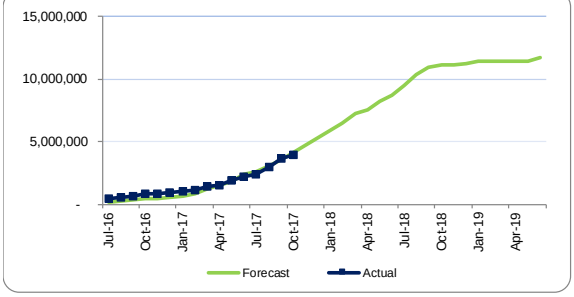
Grids D through to G structural steel has now been completed, Grids G through to K are now under manufacture with installation programmed for late November. Concrete floor to ground level has now been poured with the level one pour expected before the 24th of November. Level 1 Variation has been agreed with GEMCO construction, revised programme has been agreed providing the completed building in September 2018 with operational activity planned from October 2018.
No accidents reported in this period, 2nd Quarter H&S Audit pass mark of 96.4%. Independent H&S auditing continues with Safe on Site for the HBDHB recording a similar 94% pass rate..

Planned Activities next period

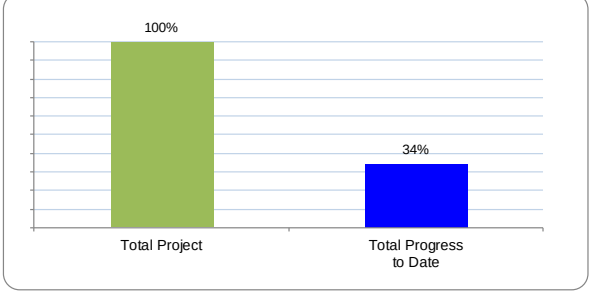
Completion of Structural steel in Grids G through to K, Completion of concrete floor to level 1
Installation of stage 3 Buckling Resistant Braces
Completion of foundation walls in Grids G to K.

Risks & Issues of Note	Mitigation & Resolutions
Specialised Furniture, Fittings and Equipment. Procurement process delays the installation dates.	Ensure timely decision making from the clinical teams, allowing procurement from off-shore manufacturers in a controlled manner.

Actual Spend



Total Project Progress



16. Rolling Cash Flow

	Actual	October Forecast	Variance	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast	Jul Budget	Aug Budget	Sep Budget	Oct Budget
Cash flows from operating activities															
Cash receipts from Crown agencies	46,476	50,882	(4,406)	48,046	44,663	45,702	47,685	44,761	44,686	47,620	48,213	44,365	43,638	52,459	44,805
Cash receipts from revenue banking	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from donations, bequests and clinical trials	61	-	61	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	2,304	505	1,798	461	445	471	477	471	471	477	493	440	446	440	505
Cash paid to suppliers	(27,902)	(27,599)	(304)	(27,822)	(27,430)	(27,692)	(24,800)	(27,872)	(27,778)	(26,654)	(27,743)	(28,113)	(26,670)	(29,968)	(27,677)
Cash paid to employees	(15,507)	(15,900)	393	(18,820)	(15,238)	(23,227)	(16,141)	(15,951)	(16,251)	(18,918)	(15,950)	(15,532)	(20,705)	(15,683)	(15,901)
Cash generated from operations	**5,432**	**7,889**	**(2,457)**	**1,864**	**2,440**	**(4,745)**	**7,220**	**1,409**	**1,128**	**2,525**	**5,013**	**1,160**	**(3,291)**	**7,249**	**1,733**
Interest received	75	74	1	74	74	74	74	74	74	74	74	74	74	74	74
Interest paid	-	-	-	(69)	(90)	(16)	4	178	(4)	(84)	(84)	(14)	(15)	201	(7)
Capital charge paid	(705)	0	(705)	0	(4,230)	0	0	0	0	0	(4,230)	0	0	0	0
Net cash inflow/(outflow) from operating activities	**4,802**	**7,962**	**(3,160)**	**1,869**	**(1,806)**	**(4,688)**	**7,297**	**1,661**	**1,198**	**2,515**	**773**	**1,220**	**(3,232)**	**7,523**	**1,799**
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	-	-	-	-	625	-	-	-	-	-	(0)	-	-	-	-
Acquisition of property, plant and equipment	(1,246)	(1,601)	355	(1,243)	(1,478)	(1,548)	(1,549)	(1,845)	(1,537)	(1,995)	(2,292)	(2,203)	(2,203)	(2,203)	(2,203)
Acquisition of intangible assets	(20)	(83)	63	(237)	(227)	(200)	(175)	(150)	(163)	(163)	(290)	(154)	(154)	(154)	(154)
Acquisition of investments	-	-	-	-	0	-	-	0	-	-	0	-	-	0	-
Net cash inflow/(outflow) from investing activities	**(1,266)**	**(1,684)**	**417**	**(1,480)**	**(1,079)**	**(1,748)**	**(1,724)**	**(1,994)**	**(1,700)**	**(2,158)**	**(2,582)**	**(2,357)**	**(2,357)**	**(2,356)**	**(2,357)**
Cash flows from financing activities															
Proceeds from equity injection	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Proceeds from borrowings	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Repayment of finance leases	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Equity repayment to the Crown	-	-	-	-	-	-	-	-	-	-	(357)	-	-	-	-
Net cash inflow/(outflow) from financing activities	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**(357)**	**-**	**-**	**-**	**-**
Net increase/(decrease) in cash or cash equivalents	3,536	6,279	(2,743)	389	(2,885)	(6,435)	5,574	(334)	(501)	357	(2,167)	(1,137)	(5,589)	5,167	(557)
Add:Opening cash	16,063	16,063	-	19,599	19,988	17,103	10,668	16,242	15,908	15,407	15,764	13,597	12,461	6,872	12,039
Cash and cash equivalents at end of year	**19,599**	**22,342**	**(2,743)**	**19,988**	**17,103**	**10,668**	**16,242**	**15,908**	**15,407**	**15,764**	**13,597**	**12,461**	**6,872**	**12,039**	**11,482**
Cash and cash equivalents															
Cash	4	4	0	4	4	4	4	4	4	4	4	4	4	4	4
Short term investments (excl. special funds/clinical trials)	16,853	19,311	(2,458)	17,242	14,357	7,922	13,496	13,162	12,661	13,018	10,851	9,715	4,126	9,293	8,736
Short term investments (special funds/clinical trials)	2,742	3,026	(284)	2,742	2,742	2,742	2,742	2,742	2,742	2,742	2,742	2,742	2,742	2,742	2,742
Bank overdraft	0	-	(0)	-	-	-	-	-	-	-	-	-	-	-	-
	19,599	**22,342**	**(2,743)**	**19,988**	**17,103**	**10,668**	**16,242**	**15,908**	**15,407**	**15,764**	**13,597**	**12,461**	**6,872**	**12,039**	**11,482**

The operating forecasts for 2017/18 year are based on the draft budget completed in June 2017, and the forecast completed at the end of October 2017. Changes have been made to the phasing of some major cash-flows based on best estimates of when they will occur e.g. elective services revenue, IDF wash-up and the rest home worker's pay equity settlement.

10

BOARD HEALTH & SAFETY CHAMPION'S UPDATE

Verbal

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Clinical Council**	133
	For the attention of: **HBDHB Board**	
Document Owner:	Dr John Gommans (Chair)	
Reviewed by:	Not applicable	
Month:	November 2017	
Consideration:	For Information	

RECOMMENDATION

That the Board

Review the contents of this report; and

Note that Clinical Council:

- **Endorsed** the Surgical Services Expansion Project – Increasing Surgical Capacity Business Case, recommendations 2 and 3.
- **Endorsed** the new members of the HB Clinical Research Committee
- **Supported** the Matariki Regional Economic Development Strategy and Social Inclusion Strategy.

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

Surgical Services Expansion Project – Increasing Surgical Capacity (Business Case and Presentation)

A presentation was provided by Rika Hentschel, Service Director – Surgical Services, Dr John Rose - Surgical Director, Anna Harland - Perioperative Unit Manager and Ben Duffus - Improvement Advisor. Following the presentation a general discussion took place including outcome measures for patients; location of the Day Surgery Unit within theatre; information systems, future proofing for possible 9th and 10th theatres; extending the theatre routine week to 6 or 7 days, the patient journey and having an appropriate environment which has privacy if difficult conversations need to be had.

It was also acknowledged that hospital services needs to work more closely with GPs regarding who is being referred for surgery and those patients that can be managed more conservatively in the community. A whole of system approach is needed from time of initial referral through to discharge back into the community.

Clinical Governance – Committees and Advisory Groups

Council noted that at the October Board meeting, it was requested that Council reflect on the number and value of committees and advisory groups in Council's clinical governance restructure. Following

discussion it was agreed that a sub-group will review the structure prior to further discussion at our next meeting on 6 December. A report will be provided to the Board in February.

Clinical Services Planning Update

The Company Secretary advised Council that he is now the Project Lead for the Clinical Services Plan (CSP) and provided an overview document which outlines the CSP and what it will do i.e. describe the current capability and capacity of services (baseline); describe the challenges facing service provision now and in the future; and develop high-level options that will help us meet those challenges. He advised that the updated timeline included two themed workshops on the aging population and high needs and deprived populations plus two themed workshops on hospital services and primary and community services will be held during January and February. Workshops will also be held on 6 and 7 March to review the findings. At the end of March the draft plan will be available and feedback can be provided. The final draft CSP will go to the Board in April.

Matariki Regional Economic Development Strategy and Social Inclusion Strategy

An update was provided by Bill Murdoch, Senior Advisor - Economic Policy and Evaluation, Hastings District Council and Shari Tidswell, Intersectoral Development Manager on the two strategies developed and the actions to be delivered. A general discussion took place regarding role of small businesses, land availability and affordable housing, increasing capacity of public transport, linking training with likely future jobs, environmental health and working closely with social agencies.

HB Clinical Research Committee Report

The Committee had no issues of concern to report. The new representatives on the Committee are Justin Nguma representing Maori Health Service, Dr Ross Freebairn representing the University of Otago, and Sara Salman, Pharmacist representing the PHO.

Clinical Advisory & Governance Committee

Concern was raised regarding misdirected results i.e. results not going to the ordering clinician or going to the incorrect General Practice. Discussion indicated that while the problems are well understood there are multiple contributing factors and there is not a simple fix as it is a whole of system problem. The groups currently involved in this work will report back to Clinical Council to provide an update re: work progress and timelines.

Reports for information were noted from the following:

- Best Start Healthy Eating & Activity Plan – Healthy Weight Strategy
- Regional Tobacco Strategy for Hawke's Bay 2015-2010
- Te Ara Whakawaiora – Smokefree (national indicator)

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Health Consumer Council** 134
	For the attention of: **HBDHB Board**
Document Owner:	Rachel Ritchie, Chair
Reviewed by:	Not applicable
Month:	November, 2017
Consideration:	For Information

12

RECOMMENDATION

That the Board

Review the contents of this report and;

Note that Consumer Council:

- **Endorsed** the Surgical Services Expansion Project – Increasing Surgical Capacity recommendations 2 and 3 of
- **Supported** the Faster Cancer Treatment work undertaken
- **Discussed** the Matariki Regional Economic Development Strategy and Social Inclusion Strategy and resolved to a lot time at a later meeting to discuss further)
- **Resolution** that the CEO and Management develop a Disability Strategy for HBDHB.
- **Note** the following papers were received:
  - Best Start Healthy Easting & Activity Plan – Healthy Weight Strategy
  - Te Ara Whakawaiora – Smokefree (national indicator)
  - Regional Tobacco Strategy for Hawke's Bay (2015-2020)

Council met on 9 November 2017. It was a very full meeting with a number of presentations and the balance to allow presenters sufficient time and allow good discussion, is an area requiring further work. An overview of issues discussed and/or agreed at the meeting are provided below:

Surgical Services Expansion Project – Increasing Surgical Capacity

A presentation was provided by Anna Harland, Perioperative Unit Manager, Rika Hentschel, Service Director – Surgical and the project team. Following the presentation general discussion took place including: reason for increased demand and type of surgeries; consumer involvement (workshop with patients who had surgery recently, feedback online via Facebook and paper surveys); unmet need, the clinical services plan will help inform for theatres 9 and 10; endoscopy build and the changes that will be made in the theatre block; access and clear signage while changes are underway.

Faster Cancer Treatment

A presentation was provided by Rika Hentschel, Service Director – Surgical Service and Paula Jones, Service Director - Medical Service. Following the presentation general discussion took place including: future electronic development for referrals; patients having surgery at tertiary centres i.e. Auckland and Wellington (will continue for certain types of cancers); and travel assistance for

patients. It was noted the target in question relates to particular category making up a small number of cancer patients overall (last 2 months were approx 9 and 10 respectively.)

The team was congratulated for the good work being done.

Matariki Reginal Economic Development Strategy and Social Inclusion Strategy

Shari Tidswell, Intersectoral Development Manager and Bill Murdock, Senior Advisor, Economic Policy & Evaluation, Hastings District Council provided a presentation on the two strategies developed and the actions to be delivered.

General discussion took place regarding tendering for projects and the living wage; resourcing to support community groups to implement initiatives and the importance of Consumer Council reinforcing the health and wellbeing of our population in order to make the strategy work.

It is fair to say this paper generated quite a lot of discussion and it was agreed more time was to be made available to discuss the paper at a later meeting.

Consumer Council Disability Strategy

A "think tank" meeting of Consumer Council members was held on 19 October to discuss the development of a Disability Strategy for HBDHB.

Key points noted:
- It needs to be a 'usable' Strategy – not one that gets put in the bottom drawer
- it needs a champion high up in the organisation
- the strategy needs to be linked to the United Nations Convention on the Rights of Persons with Disabilities;
- it needs to link to existing plans e.g. Matariki etc
- the spirit is to encourage and empower people with disabilities

A resolution for the CEO and Executive Management Team was passed:

"That the HBDHB CEO be requested to establish a process and assign resources to the development of an empowering Hawke's Bay Health Sector Disability Strategy, and the implementation of an effective action plan, in accordance with the brief provided to this meeting."

Other points noted at the Council meeting included:
- Acknowledging the review of the Clinical Council sub-committees and in particular the potential requirement for Consumer input across the number of committees
- A Consumer Council member has been appointed to the Clinical Services Plan and the Urgent Care work

The following papers were received for information only:
- Best Start Healthy Easting & Activity Plan – Healthy Weight Strategy
- Te Ara Whakawaiora – Smokefree (national indicator)
- Regional Tobacco Strategy for Hawke's Bay (2015-2020)

Our December meeting is a joint meeting with Clinical Council. An update on CSP and Big Listen will generate good discussion. An update and ' where to from here' for Consumer Centric Care is also scheduled.

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board (MRB)**	135
	For the attention of: **HBDHB Board**	
Document Owner:	Heather Skipworth (Deputy Chair)	
Reviewed by:	Not applicable	
Month:	November 2017	
Consideration:	For Information	

13

RECOMMENDATION

That the HBDHB Board

Review the contents of this report; and

Note that MRB:

1. **Noted** the recommendation of the Surgical Expansion Project, including the additional surgical capacity required by 2020 and **endorsed** the:
   - Expansion of in-house capacity by building and staffing an 8th operating theatre and wrap around services, and continued outsourcing (Option 5).
   - Investment of $12 million for capital costs associated with expanding in-house capacity and to proceed to tender for these capital works.
2. **Supported** the reintroduction of the proposed 'Principles, Standards and Guidelines' for the development of Governance Reports and **endorsed** the recommendation to the Board to adopt the proposed 'Principles, Standards and Guidelines' including the proposed 'Governance Report Overview'.

MRB met on 8 November 2017. An overview of issues discussed and recommendations at the meeting are provided below.

The following reports and papers were discussed and considered:

Surgical Expansion Project

MRB noted and endorsed the recommendation of the Surgical Expansion Project. They also provided the following feedback for Sharon Mason (Executive Director, Provider Services) and the project team to consider:

- Public and Private Partnership is a concern as research has proven these partnerships have not always yielded the expected outcomes.
- The plan is related to capital costs to develop necessary capacity to meet expanding demand, however, the additional cost associated with human resources is not evident.
- Internal sourcing for leave cover should also be made more explicit within the plan.
- There are concerns about doctors referring their public waiting list patients to their private clinics. Therefore greater monitoring of this trend needs to be considered.

Matariki Regional Economic Development and Social Inclusion Strategies
MRB noted the contents of the strategies and provided the following feedback for consideration:

- Ensure that the voluntary sector are involved and the homeless are included in Social Inclusion
- This is an opportunity for HBDHB to role model as a socially responsible employer by:
    - bringing up all employees' salaries to the living wage
    - employing more Māori
    - employing more young people
    - ensuring all contracted parties/businesses meet similar criteria as socially responsible employers.

Kōrero Mai Project

'Kōrero Mai' was initiated to ensure the Māori voice is included into The Big Listen following concern that MRB's feedback about concerns that the questionnaire was not inclusive of all cultures, particularly Māori and Pacific. Furthermore, that ethnicity data was not being captured appropriately. MRB want to ensure Kōrero Mai adds value by making certain that what we are delivering works for both Māori, Pacifica and non-Māori. Hayley Turner (Project Manager) will work closely with MRB to ensure MRBs outcomes are included and align with The Big Listen and CSP. Dr Fiona Cram was asked by MRB to develop an approach and is working with Patrick LeGeyt (Acting General Manager Māori Health) and Ngāti Kahungunu Iwi Inc. who will lead this engagement activity to feedback into the People Strategy (The Big Listen) project and also Clinical Services Plan (CSP).

Dr Kevin Snee (CEO) stated that Kōrero Mai needed to made visible at an Executive Management Team level and suggested that Patrick LeGeyt, (Acting General Manager Māori Health, provide a report detailing the Korero Mai project.

Governance Reports and Presentations – Principles, Standards and Guidelines

MRB noted and supported the reintroduction of the proposed 'Principles, Standards and Guidelines' for the development of Governance Reports tabled by Ken Foote, Company Secretary. The principles, standards and guideline is very clear, easy to follow and prompts the report writer to highlight key outcomes/ impacts on vulnerable populations and implications/ outcomes arising from the application of a HEAT tool that impact on reducing inequities/ disparities. MRB endorse the recommendation to the Board to adopt the proposed 'Principles, Standards and Guidelines' including the proposed 'Governance Report Overview'.

Best Start Health Eating & Activity Plan Update

MRB noted the progress of the plan and thanked Shari Tidswell (Intersectoral Development Manager) for her efforts evident in the results. I acknowledged Shari for her honesty and transparency reporting the truths including what was not working. The results of this initiative is an example of effective communication and engagement, and a collaborative partnership. I thanked Shari and encouraged her to keep up the great work that is having a positive impact on better equity outcomes.

Te Ara Whakawaiora: Smoking (National Indicator) and the Regional Tobacco Strategy for HB - Annual Update

Shari Tidswell and Johanna Wilson (Acting Smokefree Programme Manager) spoke to both papers because the linkages between the papers. The contents of both reports was noted in particular the increase in Smoking Mothers. EMT have asked Shari and her team to pull together a working group to reverse the trend and review what we are currently doing.

MRB provided the following feedback for consideration:

- Encourage 'Tane' to get on board to promote and support wahine to quit smoking
- Work with whānau to participate more in physical activities

- Enrol the entire whānau to get on board to quit smoking
- Need to get more disruptive – is this more a social issue? Investigate how we can address the issue such as integrated health care, therapeutic programmes and cultural wellbeing programmes i.e. spiritual healing etc. It is time to consider what are the cultural wellness responses to smoking

HBDHB Non-Financial Exceptions Quarter 1 (July-Sept 2017) Full Report – Late Paper

Peter McKenzie (Operational Performance Analyst) presented the new consolidated report highlighting the following:

- Layout has changed to a dashboard
- Annual Māori Health Plan is integrated into Annual Plan (AP).
- The AHP has 72 indicators. Currently looking at the Population Health Plan to identify inequity and identifying activities on how to address these at a service level
- Indicators with trending inequities will be considered for the Te Ara Whakawaiora programme
- Individual numbers and timeline graphs are not included currently in the new format. But investigating how to include these but space is scarce. Timelines are included in full report.

MRB would also consider hosting a workshop on the new dashboard and exceptions report. They will also consider engaging Dr Russell Wills from a quantitative and qualitative perspective as the Medical Director of the Quality Manager, and the Flow Project and Faster Cancer Treatment teams to possibly present at the workshop.

HAWKE'S BAY
District Health Board
Whakawāteatia

PACIFIC HEALTH UPDATE

Presentation

14

HAWKE'S BAY District Health Board Whakawāteatia	**Surgical Services Expansion Project Increasing Surgical Capacity** 136 Detailed Business Case Briefing Paper
	For the attention of: **HBDHB Board**
Document Owner: Document Author:	Sharon Mason, Executive Director Provider Services Project Working Group
Reviewed by:	The project's Clinical Advisory Group and Steering Group, Executive Management Team, MRB (shortform), Clinial and Consumer Council
Month:	November, 2017
Consideration:	For Approval

15

RECOMMENDATION

That the Board:

1. **Note** that additional surgical capacity is required by 2020.
2. **Endorse** the expansion of in-house capacity by building and staffing an 8th operating theatre and wrap around services, and continued outsourcing (Option 5).
3. **Endorse** the investment of $12 million for capital costs associated with expanding in-house capacity and to proceed to tender for these capital works.

OVERVIEW

The Surgical Expansion Project is seeking approval from the Board to invest in the Perioperative Unit and supporting wrap around services to enable more surgery to be performed by 2020. This includes:

- re-furbishing the Perioperative Unit
- building an 8th operating theatre
- investing in wrap around services
- recruiting staff to deliver an increased workload

The Detailed Business Case (DBC) expands on the preferred way forward outlined in the Indicative Business Case (IBC) which was approved by the Board in March 2017. It does not seek to completely resolve surgical capacity issues in the longer term or suggest ways in which un-met need within the community might be met. Instead it offers a solution for keeping abreast with growth in surgical demand whilst Hawke's Bay District Health Board (HBDHB) awaits the outcome of The Clinical Service Plan on which long term planning will be based.

BACKGROUND

A concerted effort over the last four years has improved the output from the existing operating theatres where an additional 989 accumulative hours of elective surgery was achieved using existing resources, equating to an 11% improvement. These gains were achieved through a combination of quality improvements geared at reducing late starts, improving turnaround times between patients,

and ensuring vacant theatre sessions are back filled. Ongoing improvement opportunities have achieved modest gains evidenced by a levelling off of in-house production and an increased reliance on outsourcing to achieve the annual production plan. Sapere Research Group who are leading The Clinical Services Plan have noted that the theatre utilisation we achieve here at HBDHB is one of the best they have seen across New Zealand.

In March 2017 an Indicative Business Case (IBC) to expand surgical capacity was submitted and approved by the Board which led to this DBC. Modelling for the DBC suggests there will be continued growth in surgical demand across acute and elective work underpinned by demographic changes. Acute activity stems from increasing requirements for surgery and the growing clinical complexity of these cases. For example, there have been an extra 337 hours of acute surgery provided over the last 3 years. This restricts the ability of the service to meet elective production in house. Elective demand is driven by funding from the Ministry of Health based on their own requirements and demographic changes. Combined, elective and acute growth will create a scenario where HBDHB will have a shortfall of 2,721 funded theatre hours by 2019-20 (the Gap) which roughly equates to an additional 1,500 procedures over and above what is currently done in the existing 7 theatres.

Preferred Option

The IBC outlined a long list of 6 options for how HBDHB could respond to the Gap in a way that can be further built upon once the outcomes of The clinical Services Plan are known. These options were analysed, shortlisted, costed, and a preferred option identified (Option 5). The DBC revisited the same 6 options and re-evaluated them using revised population and scenario modelling and once again Option 5 came out as the preferred option.

The preferred option is made up of a combination of model of care changes, building internal capability and continued outsourcing with the majority of the Gap provided for through increasing internal capability. The foundation of the preferred option is investment in:

- The Perioperative unit to enable it to cope with increasing volumes from an 8th theatre and giving consideration as to how these areas might work for up to 10 theatres. This includes pre and post-surgery areas, Sterile Services and theatre storage.
- Wrap-around services that support theatres also require investment to support increasing theatre production to enable them to cope with increasing volumes.

These investments are a combination of additional staff and capital building works backed by model of care and business process changes. The 8th operating theatre is the final deliverable in this sequence of work to ensure the Perioperative Unit and wrap-around services are ready for the additional workload when the 8th theatre opens. These works will pave the way for future theatre expansion in the future at a later decision point.

Consumer Engagement

The driving intention of this project is to work with and for our Hawke's Bay community to increase the number of surgeries provided whilst we await the findings and subsequent long term planning from The Clinical Services Plan. Ensuring we do this in a way that is supportive of how consumer's experience their surgical journey is crucial, for example changing models of care to enhance the revised layout of the Perioperative Unit in a way that is supportive of the consumers experience.

In order to inform the planning for this project consumers have been involved through an online survey posted on the HBDHB Facebook page, paper versions of the survey given to surgical patients and a consumer workshop where the proposed floor plans for the Perioperative Unit and Pre Admissions Clinics were discussed.

A lot of the feedback we have had from consumers on this project to date has been around how well we do or don't communicate with them and their whānau support throughout their surgical journey

and therefore changes made to models of care and business processes will focus on improving this. Other feedback has centred around the way in which whānau support are included on the day of surgery such as providing a waiting area for them whilst their loved one is in theatre and private spaces in which whānau can have discussions with surgeons and other staff involved in their loved ones care.

Once the DBC has been approved and the Project moves in to phase 3 implementation, these changes to models of care, business processes and the intended building works will be worked through jointly with consumers and staff to enable the final design to best meet the needs of our Hawke's Bay community in the year 2020 whilst we await the outcomes of The Clinical Services Plan.

Surgical Services Expansion Project

Increasing Surgical Capacity

Detailed Business Case

DOCUMENT CONTROL

Document Information

Document Author	Project Working Group
Document Owners	Sharon Mason & Rika Hentschel
Document Location	\\FS3\share\Projects\Surgical Services Expansion
Status	FINAL
For the attention of	**The Board, Hawke's Bay District Health Board**
Consideration	For Approval

Document History

Version	Date	Summary of Changes
1	05 October 2017	Draft
2	09 October 2017	Working draft
3	16 October 2017	Final draft
4	25 October 2017	Edits from Clinical Advisory Group and Steering Group
5 - FINAL		Post EMT

Document Review

Version	Issue Date	Reviewers	Comments
3	12 October 2017	Clinical Advisory Group	
3	13 October 2017	Project Steering Group	
4	7 November 2017	Executive Management Team	
5 - FINAL	17 November 2017	Submitted to FRAC and HBDHB Board for approval	

HAWKE'S BAY District Health Board Whakawāteatia

Document Sign Off

This document requires the following approvals

Name	Role	Approval
Sharon Mason Executive Director Provider Services	Senior Responsible Owner	Signature: Date:
Rika Hentschel Service Director, Surgical Services	Project Sponsor	Signature: Date:
John Rose Anaesthetist Surgical Expansion Project	Clinical Lead Surgical Expansion Project	Signature: Date:
Kerri Cooley Nursing Director, Surgical Services	Nursing Lead Surgical Expansion Project	Signature: Date:

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EXECUTIVE SUMMARY

Introduction

This Detailed Business Case (DBC) seeks approval to invest $12 million to re-fit the perioperative unit, build an 8th operating theatre, invest in wrap around services and recruit additional staff to deliver increased surgical capacity from financial year 2019-20 in-house, in conjunction with continued outsourcing. The strategic intent of this investment is to increase surgical capacity in the short term in a way that makes future expansion possible. This DBC does not seek to completely resolve surgical capacity issues in the longer term or suggest ways in which un-met need within the community might be met. Instead it offers a solution for keeping abreast with growth in surgical demand whilst HBDHB awaits the outcome of The Clinical Service Plan on which long term planning will be based. This DBC expands on the preferred way forward outlined in the indicative business case (IBC) which was approved by the Board in March 2017.

This business case follows the Better Business Cases process and is organised around the five case model:

1. Strategic Case – provides a robust case for change
2. Economic Case - optimises value for money
3. Commercial Case - is commercially viable
4. Financial Case -is financially affordable
5. Management Case - is achievable

Strategic Case

This DBC seeks to answer the following question using the 2019-20 financial year as the base:

How can HBDHB assess and acquire the additional theatre capacity and capability required to meet the surgical requirements of its population in the most efficient and cost effective manner?

The Strategic Case aims to quantify the “additional theatre capacity required”. This requires understanding future demand and the limits of current capacity. Modelling of future demand was built around three concepts: what was “most likely” to happen, a “worst case” scenario where growth is greater than anticipated and a "lean/efficient” scenario where growth is less. The building blocks for each scenario were assumptions about demand for acute, arranged, and elective surgery, and changes to day case rates. The table below summarises the findings in 2019-20 and compares this with 2016-17.

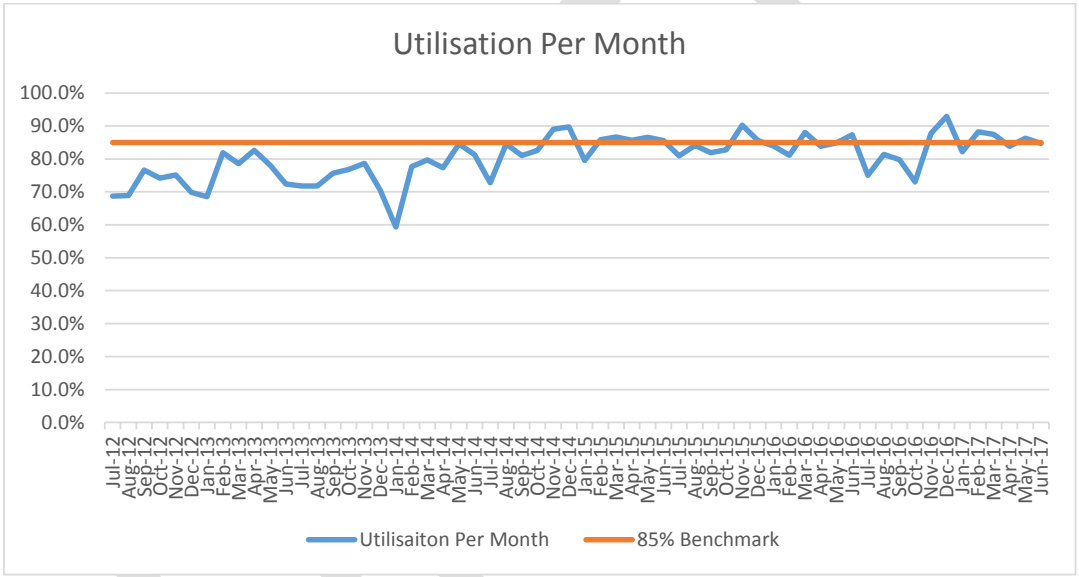
	2016/17 (base)				2019/20 (projected)			
Scenario	Surgical Volume	Theatre Hours	Bed Days	Total Case Weights	Surgical Volume	Theatre Hours	Bed Days	Total Case Weights
Lean/ Efficient	10,377	15,280	25,659	13,678	10,432	15,842	23,271	13,320
Worst Case	10,377	15,280	25,659	13,678	11,520	18,192	29,046	15,145
Most Likely	10,377	15,280	25,659	13,678	11,105	16,855	27,080	14,636

Table 1: Shows the 3 scenarios developed for the DBC.

The Most Likely scenario was chosen for further analysis. The growth in theatre hours for both elective and acute surgery has been analysed so that the Gap can be produced, showing the difference between current in-house capability and future demand.

Current Gap 2016-17:	Total surgical hours required minus theatre hours used in-house 15,280- 14,134 = 1,146
Projected Gap 2019-20:	Total surgical hours required minus theatre hours used in-house 16,855– 14,134 = 2,721

The next section examines HBDHB's capacity to respond to the Gap. The table below highlights the improvements made to theatre utilisation over the past five years. The 2016-17 Central Region Annual Plan has suggested 85% theatre utilisation target which takes into account vacant sessions, turnaround times, late starts and early finishes.



Graph 1: Shows the growth in theatre utilisation in-house from July 2012 – June 2017compared against the 2016-17 Central Regions Annual Plan benchmark.

Although the surgical directorate continues to drive productivity improvements to both elective and acute theatre delivery, further gains using existing resources are limited. More importantly, the anticipated growth in demand for surgical procedures in coming years will far outstrip any efficiency gains that may be able to be achieved.

The Most Likely Scenario predicts the Gap between what needs to be provided and what can be provided in-house to be 2,721 theatre hours by 2019-20. The growth in the Gap is based on the assumption that in-house operations are nearing capacity in terms of what they can produce given current resourcing. This is evidenced by the levelling off of in-house production shown in the graph above and a reduction in opportunities for large scale improvement initiatives.

Economic Case

The Economic Case discusses the options available to HBDHB for acquiring the additional 2,721 theatre hours by 2019-20 and identifies a preferred solution. Six options were created for the long list process, using combinations of buying capacity, building capacity or "sweating" existing capacity. Of these, three were selected for the shortlist process and more detailed economic analysis:

Option	Way in which the Gap is managed
Option 2	The gap managed by continuing to outsource
Option 5	The gap managed by building internal capability and outsourcing what remains **(preferred)**
Option 6	The gap managed by increasing theatre hours and outsourcing what remains

Table 2: Shows the 3 shortlisted options.

Option 5 was preferred as it is a sustainable option where the Gap is fully met through increased internal production and continued outsourcing. This provided the best clinical, and cost effective results and alignment with the New Zealand Triple Aim.

The preferred option includes investment in both the Perioperative Unit and wrap around services that support surgery and includes additional staff, capital building works and changes to models of care and business practices. The Project working group engaged with the wrap around services (e.g. Surgical Wards, HDU/ICU Nutrition and Food, Community Nursing, Pharmacy, Radiology, Laboratory, Administration Staff, Allied Health, Outpatient Clinics etc.) The outcome of these discussions was that some improvements are required now to allow for the additional work. These are likely to be a combination of Model of Care changes additional FTE and supplies Capital investment for wrap-around services will predominantly be in inpatient beds and outpatient (Villas) clinic rooms.

The investment in surgical expansion and the supporting wrap around services contained within the preferred option affords HBDHB an opportunity to maximise the efficiency of the Perioperative Unit and wrap around services, to enhance the patient experience, and to introduce new ways of working coupled with enabling works that support the future development of Theatres 9 and 10.

Commercial Case

Proceeding with Option 5 will require the hiring of additional staff and procurement strategies for capital building works, equipment and outsourcing contracts. The procurement of the capital building works and equipment will follow a conventional design and construct approach. The design specification and requirements will be agreed with key stakeholders. Contractors and vendors will then be selected on the basis of a competitive tender process to complete the detailed design and construction of the required works for the separate packages. The final awarding of tenders to the successful tenderers will be the subject of a separate request for approval to the Board.

The existing contract with Royston is due to expire in 2018 and is currently the subject of renewal negotiations. This process is led by HBDHB contracts team outside of this Project. A working group have been tasked with developing how inpatient and outpatient areas will need

to expand, and what incremental FTE is needed across the services to ensure that the whole of hospital is able to manage the additional surgical volumes.

Financial Case
The proposed capital cost for the preferred option is $12 million. No external funding is being sought to support the Project. HBDHB is expected to resource the build and ongoing operational and capital costs through existing budgets and some additional population based funding in respect of the additional elective and acute activity.

Management Case
Once the DBC is approved, the project will continue and enter its third phase, *Implementation.* The planning of which will commence immediately following approval. When theatre 8 opens in February 2020 it is expected to be fully staffed and operating at full capacity. The phasing of the building works has purposefully left the build of theatre 8 until last to ensure that when it opens the Perioperative Unit and the wrap around services are able to manage this additional capacity.

Likewise changes to Models of Care and business processes need to be documented early enough to inform hiring decisions for the roles required across the whole of hospital to support the additional theatre capacity as of February 2020.

Key Project Milestones	Indicative Date
New Pre-ads clinic rooms opens	August 2018
Relocated Staff change + lunch room open	December 2018
Model of Care changes documentation completed	February 2019
2019-20 Production Plan completed (with OT8)	February 2019
Recruitment: Periop Unit and Wrap around services commenced	May 2019
Re-furbished Perioperative area opens	September 2019
Sterile Services refurbishment completed	December 2019
Recruitment: Periop Unit and Wrap around services completed	January 2020
8th Theatre Opening at 100% full capacity	February 2020

Table 3: Shows the key project milestones for the implementation of .phase of the Project.

RECOMMENDATIONS

That the Board:

1. **Note** that additional surgical capacity is required by 2020.
2. **Approves** the expansion of in-house capacity by building and staffing an 8th operating theatre and wrap around services, and continued outsourcing (Option 5).
3. **Approves** the investment of $12 million for capital costs associated with expanding in-house capacity and to proceed to tender for these capital works.

INTRODUCTION

Purpose of this Business Case

Hawke's Bay District Health Board (HBDHB) is a crown entity that fills both provider and funder roles for the provision of health services for the population of Hawke's Bay. In 2017-18 The Ministry of Health (MOH) funded HBDHB $520 million dollars to improve, protect and promote the health of the estimated 161,300 people that live in the region. The purpose of this Business Case sets is to assess the surgical capacity and capability required to meet the needs of the Hawke's Bay population in the 2019-20 financial year.

Approximately 80% of the region's population live in Napier and Hastings, with 10% living close to the two smaller urban areas of Waipukurau and Wairoa. The remaining 10% live in remote or rural areas.

There are 3 key differences in the demographics of the Hawke's Bay population compared with national rates:

1. Hawke's Bay has a higher proportion of people in the over 65 year old cohort (19% vs. 15%)
2. Hawke's Bay has a higher percentage of people in the lowest quintile of deprivation (28% vs. 20%)
3. Hawke's Bay has a higher percentage of Māori living in the area (26% vs. 16%)

These factors have critical ramifications for the demand on health care in the region and sets the context for how HBDHB needs to respond.

The DBC provides analysis of future surgical demand based on current levels of intervention where the amount of elective surgery provided reflects the amount of funding available i.e. it does not address the issue of unmet need. In the absence of increased funding, increasing the relative amount of elective surgery requires shifting funds towards this aim. This is a strategic decision that sits beyond the scope of this project and lies within the remit of the Clinical Services Plan (see below).

Strategic Alignment

This Detailed Business Case (DBC) is consistent with and aligned to the New Zealand Health Strategy, The Central Region Strategy and HBDHB's Transform and Sustain strategic programme. It sets out how HBDHB intends to plan for and respond to the projected changes to surgical delivery largely bought about by changes to its population, and ensure that consistent high quality care is delivered.

The Clinical Services Plan is currently being developed and will be finalised in early 2018. It is a ten year plan that takes a whole of sector approach building on the platform of the Transform and Sustain strategic programme. The aim is to bring through opportunities for changing the health sector to cope with a rising burden over a ten year horizon. The Clinical Services Plan shares a common approach as this Project has done for predicting surgical growth however this DBC will focus on a shorter horizon and will provide more detailed analysis focused solely on surgical capacity and the wrap around services that support this.

Overview of Business Case

The Indicative Business Case (IBC) determined what surgical capacity would be required in the coming years to service the population and the means by which this could be acquired in the most efficient and cost effective manner. The IBC was approved by the board in March 2017 and recommended the build of an eighth operating theatre and continued outsourcing to third party providers (Option 5). The DBC re-examines the analysis and recommendations from the IBC and provides more detail on the cost and impact of the recommended way forward.

Business Case Methodology

Preparation of this DBC is consistent with and has been guided by the Better Business Case methodology promoted by Treasury. The aim of the five case model of the Better Business Case approach is to instil confidence in decision-makers by ensuring a standard is followed that promotes analysis of strategic alignment, value for money and best outcomes.

As the programme of work will exceed $10 million, the National Capital Committee will be kept fully informed of progress as it determines its requirements and process for approval.

1. STRATEGIC CASE

1.1. The Business Problem

This Detailed Business Case seeks to answer to following question:

> *How can HBDHB assess and acquire the additional theatre capacity and capability required to meet the surgical requirements of its population in the most efficient and cost effective manner?*

The first step to answering this question involves quantifying the "*additional theatre capacity required".* There are two core issues that must be understood in this regard:

Issue 1: What will future surgical demand look like?

Issue 2: What are the limitations of current arrangements?

The first question involves understanding what population factors are likely to contribute to future growth in surgical demand. The second question explores the current arrangements and discusses whether these will be suitable for managing anticipated growth.

1.2. Issue 1 - Future Surgical Demand

Changes to increased surgical demand are underpinned for the most part by population growth, and in particular, the concentration of that growth in the over 65 years, Māori and Pacific populations and those living in areas of relatively high material deprivation.

1.2.1. Changes in Age Related Demographics

Nationally, the proportion of the population who are over 65 is projected to increase from 14% in 2013 to 17% in 2023. In Hawke's Bay, the proportion over 65 will rise from 17% in 2013 to 21% in 2023[1]. In 2013, there were 26,200 people over 65 living in Hawke's Bay. From 2013 to 2023, when the region as a whole will only see modest growth, there will be an estimated 10,000 additional people in the over 65 cohort (Appendix 1).

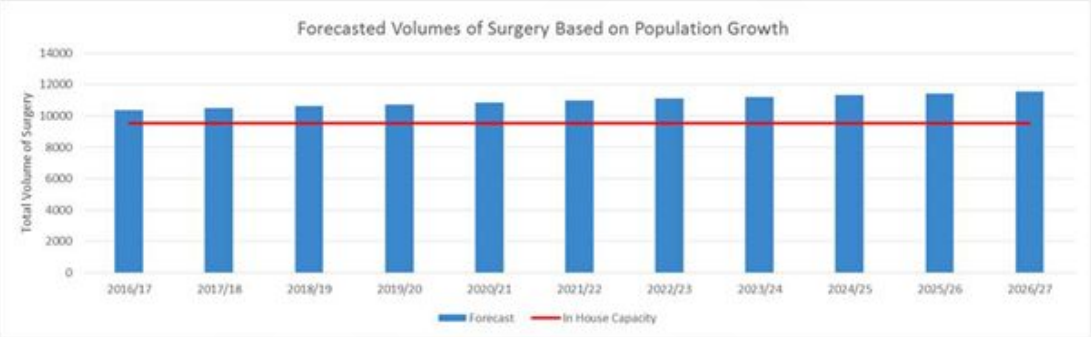
This has critical ramifications for health planning as a growing number of New Zealanders enter the stages of their lives where they have the most interactions with the healthcare system including increased rates of both acute and elective surgery. For example the over 65 age group in Hawke's Bay represented 18% of the population in 2015-16, however they accounted for 37% of the acute and elective operations performed in-house.

[1] Statistics New Zealand, Summary of Resident Total Population Projections, 2018-2043; 2013 base

1.2.2. Inequity in Demographics

Whilst the biggest demographic driver for surgical demand will be an ageing population, the Māori and Pacific Island populations have higher rates of acute surgery (statistically significant) and elective surgery (not statistically significant). This is consistent with higher rates of injury, some cancers, obesity and poorer health outcomes[2] observed in this group. As mentioned above, the Hawke's Bay region has a higher percentage of Māori compared to the National average and this is expected to increase significantly from 26% in 2018 to 34% in 2038[3], adding a further increase in demand for surgery.

The basis of this DBC is to determine the total future surgical demand and how best to create the capacity for this demand in the financial year 2019-20. The types of surgery and needs of individual groups can be considered once the total surgical volume is known and the direction of travel established. The graph below shows the growing gap between the total volume of publicly-funded surgery and current in house capacity:



Graph 1: shows expected future increases in publicly funded surgery against in-house capacity

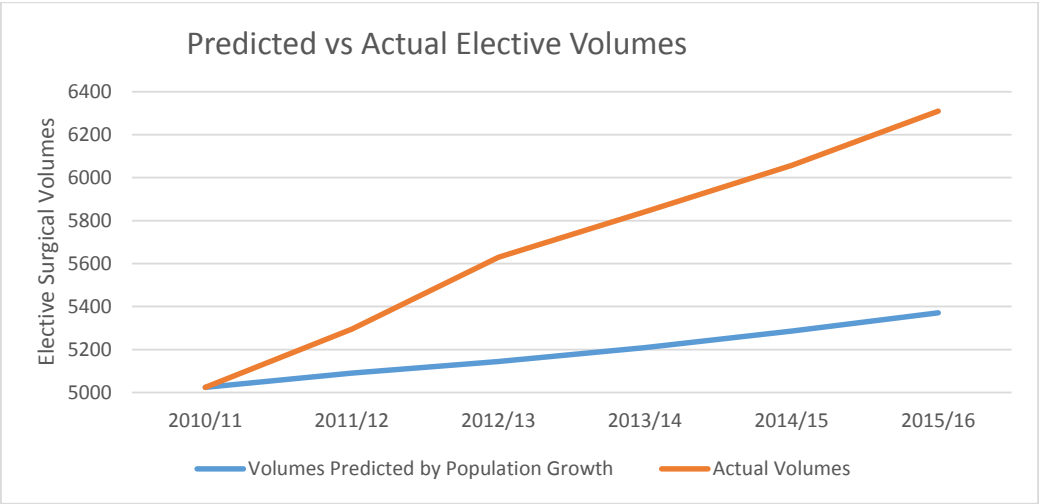
In effect these changes in the demographics of the region coupled with modest population growth mean that HBDHB can expect to be providing 11,541 operations in 10 years' time, if it continues to provide surgery at the same rate per age group as it does today. This would indicate an increase of 1,163 from 2016-17 volumes.

1.2.3. Other Factors Impacting Growth

The above forecasts assume that demographic changes alone will contribute to growth in surgical demand. However there are other factors that may contribute to rates of growth that exceed these projections. For example if we examine the growth in elective surgery from a base year of 2010-11 through to 2015-16, there was a widening Gap between what population growth forecasts predicted and what actually occurred. By 2015-16 actual elective discharges were 17% higher than population based predictions.

[2] (Health Equity In Hawkes Bay 2014 and 2016)

[3] Statistics New Zealand, Summary of Resident Total Population Projections, 2018-2043; 2013 base



Graph 3: shows historical volumes in Elective surgery at HBDHB compared to predicted volumes based on population growth and demographic changes.

Elective surgical volumes growing faster than predicted by population growth and demographic changes are an indicator of the extra emphasis put on Elective surgery by the Minister of Health.

1.2.4. Promotion of Elective Surgery by Minister of Health

Current Government policy has placed increased emphasis on delivering elective surgery. Their analysis in 2007 indicated that they intended to raise intervention rates for elective surgery from 278 per 10,000 population in 2007-08 to 385 in 2026. On a practical level this requires 4,000 extra elective surgeries nationally above population growth each year[4]. HBDHB's share of this would be 3.9% or 156 discharges per annum as per the Electives Heath Target.

1.2.5. Standardised Intervention Rates (SIR)

The Ministry of Health compiles a list of elective intervention rates by speciality for all DHBs'. These are standardised by age, gender, ethnicity and deprivation to allow DHBs to compare their intervention rates against the national standard. Intervention rates do not necessarily indicate what the right rate of surgery should be instead they compare individual DHBs with the national mean, taking DHB population demographics into account. Investing in specialties where local SIRs are significantly lower than the national average or where there was unmet need identified by other methods, would mean increasing theatre production beyond the rate of population growth. It is envisaged that the Clinical Services Plan will give direction as to how SIRs and unmet need might be adjusted for and therefore how this impacts on theatre sessions has not been accounted for in the scenario forecasts used here.

[4] Ministry of Health: Targeting More Elective Operations, Improved Access to Elective Surgery, March 2011

1.2.6. Changes to IDF Purchasing Patterns

Changes to the pattern of how Inter District Flow (IDF) volumes are managed can have an impact on the amount of surgery provided locally. The majority of current IDF cases are elective. These IDF's are either because HBDHB does not resource that particular surgical specialty (e.g. Plastic Surgery, Paediatric Surgery, and Cardiothoracic Surgery) or because the complexity of the case warrants a specific surgical intervention that cannot be performed in region. Acute cases are also sent out of region due to complexity or they may be cases where a Hawke's Bay resident sustains an injury while out of the region that requires immediate surgery. For the purposes of the DBC it has been assumed that traditional IDF referral patterns will remain the same.

1.3. Scenario Forecasting

1.3.1. Indicative Business Case Forecasts

In order to evaluate the potential impact of these factors, a series of scenarios were created. For the IBC these scenarios were labelled A, B, C, D, & E. Each scenario used the 2015-16 Financial Year as a base and projected increases using the factors that contribute to growth discussed above. For the purpose of the IBC, Scenario C was used to give an understanding of the scale of *the Business Problem*. See Appendix 2 for details of how these scenarios were constructed.

1.3.2. Detailed Business Case Forecasts

After approval of the IBC, the project team employed a revised approach for predicting future demand. This revised approach used a more complex analysis to produce a more complete picture of future demand and to understand the impact of this growth on the wider hospital services. New scenarios were built around three core concepts: what the modelling suggested was "most likely" to happen, a "worst case" scenario where growth is greater than historical patterns and a "lean/efficient" scenario where growth is less than anticipated, see Appendix 3. The building blocks for each scenario were assumptions about demand for acute, arranged, and elective surgery, and changes to day case rates.

For acute, arranged and other elective growth, assumptions were made based on the evidence of last three years for theatre hours, volumes and bed days. For the elective health target, assumptions were made about the three components of the MoH's elective programme, the equitable share, the additionals (General Surgery and Orthopaedic) and the regional component. For each component historical data was analysed to predict a pattern of what might emerge in future.

Day case assumptions were built after analysing 3 years of data for all public hospitals in New Zealand. Analysis was conducted on HBDHB's ability to improve its day case rate for the 15 procedures with the largest opportunity for improvement. If HBDHB matched the top 5 performers in the country for these procedures, 99 patients would be converted from inpatients

to day. This analysis was used as the basis for assumptions for the three scenarios. See Appendix 3 for details of how the above factors were modified each of the three scenarios and contrasted with population modelling.

1.3.3. Scenario Outputs

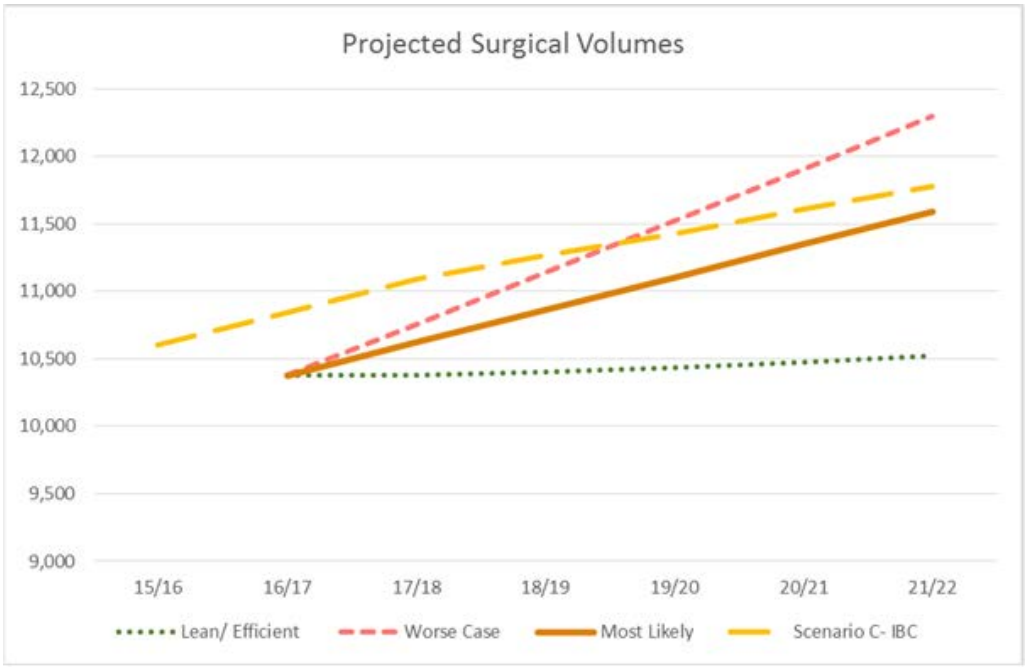
For each scenario, four key outputs were produced: surgical volumes, theatre hours, bed days, and case-weights.

1. **Surgical volumes** refers to the number of operations performed. These are a mixture of elective, arranged and acute procedures.
2. **Theatre hours** refers to the number of hours used to deliver the surgical volumes.
3. **Bed days** refers to the total number of inpatient days used for the patients undergoing operations.
4. **Case-weights** refers to the relative complexity of the treatment given to each patient. Complexity is calculated based on time in theatre, number of days in hospital, patient demographics and associated costs of treatment.

The table below summarises the three scenarios against the four outputs described. Scenario C from the IBC is also included for comparison:

	2019/20				2020/21				2021/22			
Scenario	Surgical Volume	Theatre Hours	Bed Days	Total Case Weights	Surgical Volume	Theatre Hours	Bed Days	Total Case Weights	Surgical Volume	Theatre Hours	Bed Days	Total Case Weights
Lean/ Efficient	10,432	15,842	23,271	13,320	10,473	16,097	22,680	13,372	10,524	16,378	22,157	13,437
Worst Case	11,520	18,192	29,046	15,145	11,906	19,291	30,308	15,652	12,295	20,460	31,644	16,164
Most Likely	11,105	16,855	27,080	14,636	11,348	17,420	27,579	14,956	11,593	18,006	28,091	15,287
Scenario C- IBC	11,430	16,144	28,308	15,427	11,608	16,399	28,922	15,719	11,775	16,638	29,495	15,989

Table 3: Shows Surgical Volumes, Theatre Hours, Bed Days and Case Weights for the 4 Scenarios over a 3 year period.



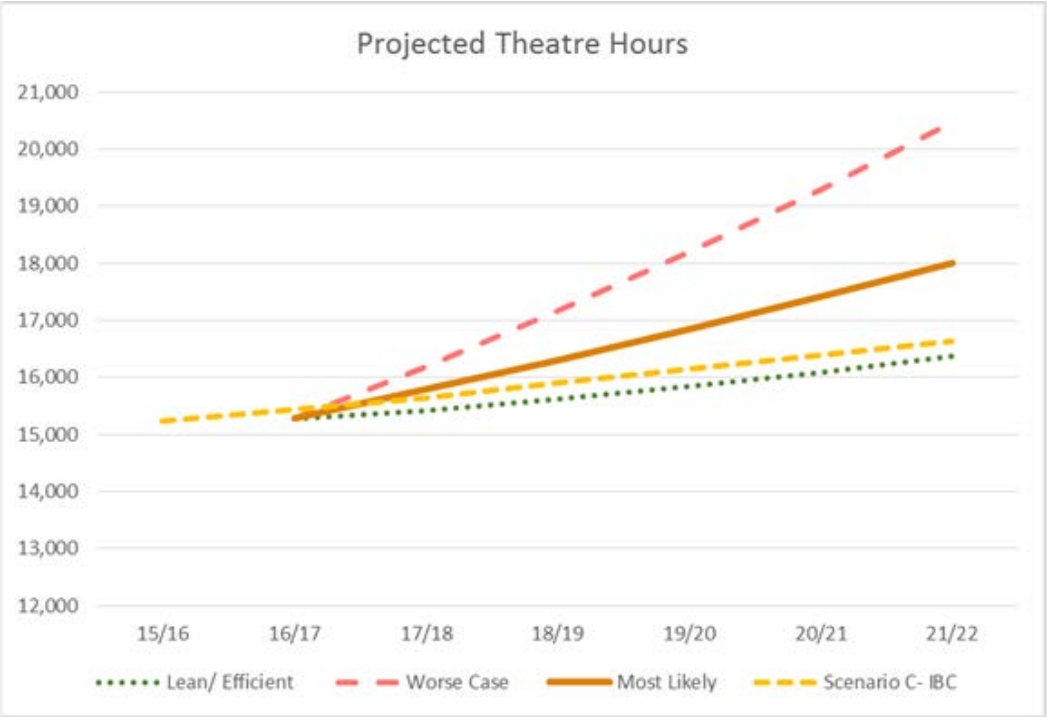
Graph 4: Shows the growth in Surgical Volumes for the 4 Scenarios.

As shown in the graph above there are two critical distinctions between the forecasting done for the IBC and the DBC, firstly, the IBC forecasted from a 2015-16 base whereas the DBC forecasting used 2016-17 as a base. 2016-17 volumes were less than the previous year (10,377 vs 10,604). Reasons for the decline are an unplanned resource shortfall in specialties such as Ophthalmology and ENT that produce a high number of operations per session combined with a substitution with specialities with higher clinical complexity. For example, Ophthalmology used 131 less theatre hours in 2016-17 vs 2015-16. These 131 hours were used by specialties that produce a lower number of operations per session.

Secondly, the IBC forecasting focused primarily on surgical volumes as the measure for capacity whereas the DBC uses theatre hours aligning to the MoH's Production Planning Guidance[5] that recommends using Theatre Hours as the primary measure of both demand and capacity. The chief aim of the IBC was to demonstrate the scale of the problem and to suggest the most appropriate method of solving the issue. In this case, using surgical volumes was adequate to demonstrate growing demand and the lack of theatre resource to meet that demand. The DBC undertook the analysis further by investigating the total cost to the organisation to understand the impact on the warp around services that support surgery.

Given these two points, it is important to understand the distinction between forecasts based on surgical volumes and theatre hours. The IBC forecast assumes a higher starting point and shows demand higher in 2019-20 than the Most Likely Forecast of the DBC although the paths begin to converge at a future point. The table below shows the scenario forecasts for the theatre hours which tells quite a different story:

[5] Ministry Of Health, Production Planning Guidance, 2017.



Graph 5: Shows the growth in Theatre Hours for the 4 Scenarios.

The table below shows the total surgical volumes and theatre hours for operations done in-house for last three Financial Years:

	2014/15	2015/16	2016/17	Variance % (min-max)
Surgical Volumes	9,892	9,963	9,545	4.4%
Theatre Hours	14,052	14,032	14,134	0.7%

Table 4: Shows surgical volumes and the corresponding theatre hours

The number of theatre hours used internally over the last three years has shifted only slightly, however theatre volumes are more variable. Constant theatre hours with declining surgical volumes should not be mistaken for a decline in productivity as described above, surgical volumes are a product of clinical complexity and the relative mix of specialties used on that particular year.

Although the DBC analysis has produced four outputs, the primary measure for demonstrating demand and capacity has been theatre hours and for the purpose of the DBC the 2019-20 data from the Mostly Likely Scenario will be used to give an understanding of the scale of the Business Problem.

1.3.4. Forecasted Gap in Theatre Hours (the Gap)

For the Most Likely scenario, the growth in theatre hours for both elective and acute surgery has been analysed so that the Gap can be produced, shows the difference between in-house capability and future demand. The following equations show the logic employed:

Gap	Calculation
Base Gap **FY 2016-17**	Total surgical hours required – theatre hours used in-house 15,280- 14,134= 1,146
Forecasted Gap **FY 2019/20**	Total surgical hours required – theatre hours used in-house 16,855– 14,134= 2,721

Table 5: Shows the calculation used to define the Gap

By 2019-20, HBDHB will have a shortfall of 2,721 theatre hours (the Gap) made up of a mixture of both acute and elective work. Gaps have also been calculated for surgical volumes, bed days, and case-weights. The latter two calculations are particularly useful for the Economic Case.

Most Likely Scenario	Theatre Hours	Surgical Volumes	Bed Days	Total Case Weights
Gap 2019/20	2,721	1,563	1,528	1,837

Table 6: Shows the most likely scenario developed for the DBC

Currently the 2016-17 Gap is all outsourced, however in the future the Gap could be serviced by a combination of additional outsourcing and changes that enable in-house production to increase. This reasoning is based on the assumption that the current level of in-house activity is at, or near, capacity which will be explored in the second part of the Strategic Case.

A Gap is a permanent feature of how HBDHB provides surgery, and in itself does not represent a problem, rather it is the scale of the Gap that is the issue. The projected 2019-20 Gap is nearly 2 times greater than the Gap in the last financial year and over 6.5 times greater than the historical average in the 2005 - 2010 period

1.3.5. Slowing Growth

The scenarios do not take into consideration how improved population health, early intervention, better social services, and education could potentially slow demand for elective or acute surgery. While these are desirable objectives, in practice they are unlikely to provide substantial reductions in the short to medium term. It is envisaged that the Clinical Services Plan will give direction as to how demand for surgery might be reduced and therefore how this impacts on theatre sessions has not been accounted for in the scenario forecasts used here.

1.3.6. Impact of Advancements in Surgical Techniques

Clinical patterns and advancements in surgical techniques have improved outcomes for patients' e.g. laparoscopic techniques (keyhole surgery) are less invasive for patients and therefore their recovery is quicker. However, these refinements often place additional strain on the length of time in theatre a procedure takes. For example removing an Appendix until recently involved open surgery which although less demanding on theatre time, took a long period of recovery on the ward compared to modern techniques now used. Today removing an Appendix is done laparoscopically which takes longer in theatre however recovery is quicker, requiring less time on the ward and the patient is able to resume their normal level of function sooner.

What surgical advancements and technology will be available in the future is uncertain and therefore how this impacts on theatre sessions has not been accounted for in the scenario forecasts.

1.4. Issue 2 – Limitations of Existing Arrangements

Given the forecasted Gap of 2,721 theatre hours in 2019-20, it is important to understand the limitations of the current arrangements. This sets the framework for determining whether these arrangements will be suitable for meeting the Gap.

1.4.1. Existing Arrangements

The manner in which HBDHB provides surgery for its population is classified in two broad ways: Surgery that HBDHB provides using its own resources (in-house) and surgery that it sources through external suppliers (outsourced). Each of these categories has further sub-categories depending on the type of surgery and the location it is provided.

Looking at the last complete financial year, 2016-17, the following table shows theatre hours used in each of these categories.

In-house			Outsourced
Elective	**Acute**	**Acute Arranged**	**Royston**
7,618 (53.9% of in-house total)	5,174 (36.6% of in-house total)	1,342 (9.5% of in-house total)	1,146
Total in-house= 14,134			
Surgical procedures provided for patients that have been booked on to a waiting list for 7 days or more after the decision to treat.	Surgical procedures provided during an acute admission to hospital.	Surgical procedures provided after an Acute admission, where the patient has a planned re-addition within 7 days.	Elective procedures funded by HBDHB but provided by Royston hospital.

Table 7: Total Theatre Hours used by HBDHB 2016/17 financial year by category

1.4.2. Royston Arrangements

15.1

Royston hospital performs elective surgery across the same specialties as HBDHB however they are limited to patients that fit a certain criteria for example Royston does not have an Intensive Care Unit (ICU). As such HBDHB does not send patients requiring, or who might require ICU post-operative care to Royston. Those patients that are suitable are lower complexity patients who are generally fit and well, not old or frail, with a BMI<35 and who do not require complex surgery. This restricts the volume of patients that are suitable and in turn means the cases are generally of a lower case weight. For example the average case weight for a procedure performed in-house in 2016-17 was 1.34 compared to 1.05 for procedures sent to Royston Hospital.

1.4.3. IDF Arrangements

The majority of IDF cases are elective, either because HBDHB does not resource that particular surgical specialty (e.g. Plastic Surgery, Paediatric Surgery, and Cardiothoracic Surgery) or because the complexity of the case warrants a specific surgical intervention that cannot be performed in region. Acute cases are also sent out of region due to complexity or they may be cases where a Hawke's Bay resident sustains an injury while out of region that requires immediate surgery. For the purposes of this DBC it has been assumed that traditional IDF referral patterns will remain the same.

1.4.4. In-house Arrangements

Hawke's Bay Fallen Soldier's Memorial Hospital has seven operating theatres offering a mixture of elective and acute procedures including one theatre that operates as an acute theatre 365 days per annum.

In simplistic terms, there are five elective theatres, one acute, and one that does a mix of both acute and elective work. However the reality is not as clear cut as all available sessions across all seven theatres are used for both elective and acute work in order to maintain optimum theatre utilisation including back filling in order to fill all available sessions.

Operating Theatre (OT)	Timetabled Theatres Session *(All theatres are regularly backfilled by all specialties except for OT5*	Normal Hours	Resourced Theatre Hours per year	Actual Theatre Hours per year	Theatre Utilisation
OT 1	Elective -predominantly, General Surgery	Mon-Fri 8:30 – 16:30	1,944	1,726	89%
OT 2	Elective -predominantly, Ophthalmology	Mon-Fri 8:30 – 17:30	1,944	1,513	78%
OT 3	Elective -predominantly, ENT & Gynaecology	Mon-Fri 8:30 – 16:30	1,944	1,577	81%
OT4	Elective -predominantly, Urology and Gynaecology	Mon-Fri 8:30 – 15:30	1,944	1,622	83%
OT5	Acute surgery only, all specialties-predominantly, General Surgery (open for life or limb after 11pm at night)	Mon-Sun 08:00 – 23:00	5,475	4,141	76%
OT6	Mix of elective and acute Orthopaedic	Mon-Fri 8:30 – 16:30	1,944	1,765	91%
OT7	Elective -predominantly, Orthopaedic	Mon-Fri 8:30 – 16:30	1,944	1,778	91%
GRAND TOTAL			**17,139**	**14,134***	**82%**

Table 8: HBDHB theatre description and theatre hours from 2016/17 financial year
* Total includes 11 hours of theatre time conducted in Villa 6 (epidural steroid injections)

1.4.5. Constraints with Current Arrangements

Constraints in current arrangements can be thought of in two ways:

- Capacity of in-house operations
- Growth in Royston volumes

Each of these factors are explored in detail below.

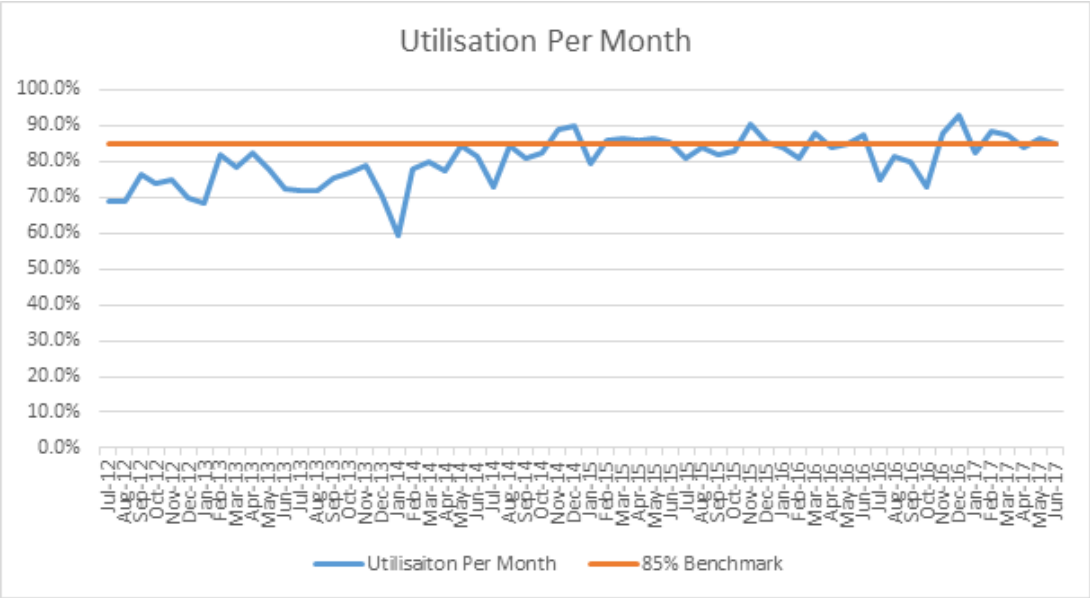
1.4.5.1. Capacity of in-house Operations

Through concerted effort the total number of theatre hours delivered in-house by the 7 operating theatres has increased over the last three years by 8.6%. This is equivalent to 1,114 hours of operating time. The graph below shows the percentage of theatre hours used out of all possible resourced hours for all theatres apart from theatre 5 (acute theatre) based on two key indicators:

1. How many theatre sessions were used
2. How many minutes of those sessions were used (wheels in – wheels out)

The first is governed by how successful theatre scheduling is at back filling vacant theatre sessions due to Surgeon absences. Planned absences are able to be back filled well in advance however last minute absences due to a Surgeon calling in sick can be impossible to

back fill at short notice and Surgeon absences with limited notice are also difficult to back fill due to staffing availability. For example in the first 7 weeks of the current Financial Year 2017-18, 99% of all possible elective sessions were booked (310 out of 313), and 93.9% of these sessions (291 out of 310) proceeded as planned. The second indicator, minutes, is influenced by whether a session starts on time, ends on time and the time taken between each patient (turn-around time). Due to these factors it is not possible to reach 100%. The 2016-17 Central Region Annual Plan has suggested 85% theatre utilisation which takes into account vacant sessions, turnaround times, late starts and early finishes.



Graph 6: Shows the growth in theatre utilisation in-house from July 2012 – June 2017 compared against the 2016-17 Central Regions Annual Plan benchmark.

The Operation Productivity project which ran from September 2014 – December 2015 was successful in changing business practices to reduce unfilled sessions, improve start times, and minimise turnaround times between patients. This is reflected in the graph above which shows utilisation approaching the optimum threshold. During the last 24 months, apart from the impact of the gastro outbreak and junior doctor strikes, this growth has levelled off suggesting that further improvements to utilisation may be limited.

Additionally, there are significant pressures in the current Perioperative environment as a result of previous efforts to optimise utilisation without expanding the existing footprint. Areas of significant pressure include the Pre Admissions Clinics, Day of Surgery Unit, Equipment Storage, Sterile Services, and Post Anaesthetic Care Unit. The infrastructure and processes in these areas were originally designed to cope with a much lower volume of patients than what goes through the unit today and although some minor modifications have been made over time, limitations in the existing design makes it increasingly difficult for the Perioperative Unit to cope with today's volumes.

The running of the Perioperative Unit in this manner limits HBDHB's ability to respond to events such as described above that have the potential to interrupt theatre production. At the time of these events the theatres were running at full capacity to keep up with the Production Plan in order to achieve elective targets and there was limited recourse to respond to these downturns in throughput.

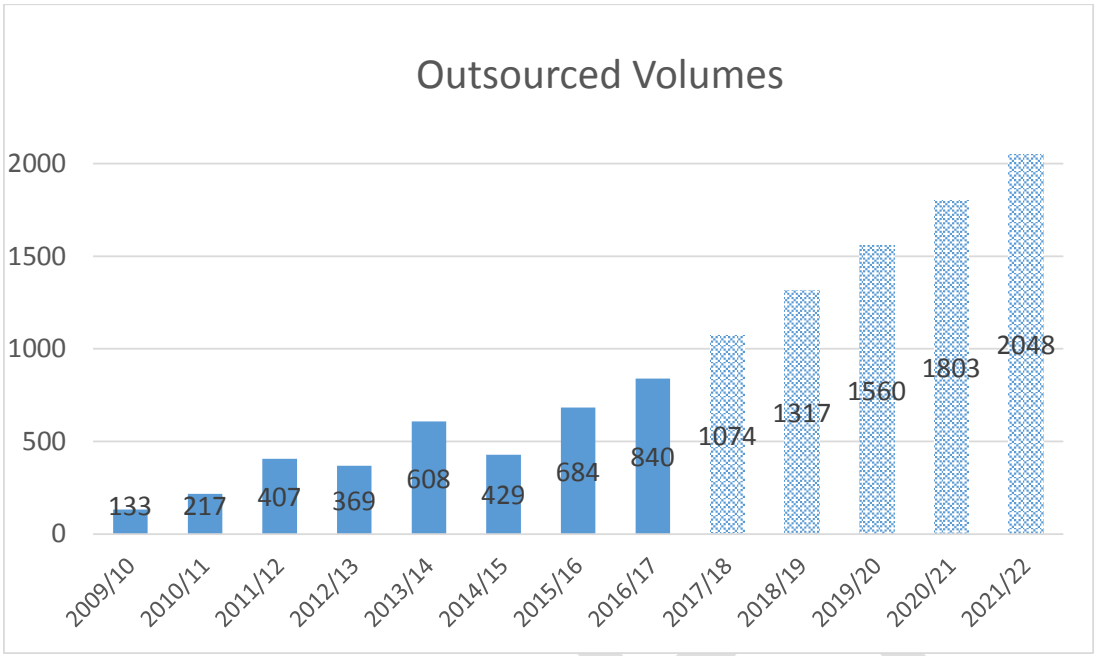
In addition, HBDHB lacks the resources to respond to other clinical priorities as they emerge. For example, the Faster Cancer Treatment (FCT) Target from the MoH requires HBDHB to commence cancer treatment for 90% of patients within 62 days of referral as a high suspicion case. This would mean increasing the availability of theatre sessions to cater to these patients however, given the constraints in capacity, this is not always possible.

Operating at the capacity levels described above may also increase clinical risk. For example, during normal weekday hours when all 6 elective theatres and 1 acute theatre are operational any additional emergency surgery e.g. acute trauma, or emergency caesarean births must be managed by interrupting a theatre's operating list. Normally, this is done by assessing which theatre is in-between cases or is nearing completion and using that theatre to accommodate the emergency procedure. To date, all weekday in-hours emergency cases have been accommodated in this manner, however it is possible that if multiple acute emergencies were to arrive at the same time there could be extended delays which could lead to death or serious harm whilst they wait for an occupied theatre to become free.

Although business as usual (BAU) will continue to drive improvements to both elective and acute theatre delivery, further gains in productivity using the existing resources and floor plan layout will be limited. More importantly, the anticipated growth in demand for surgical procedures in coming years will far outstrip any efficiency gains that may be able to be achieved.

1.4.5.2. Growth in Royston Volumes

The limitations of in-house operations are highlighted by the increased reliance on Royston Hospital to achieve surgical volumes. In the 2005-2010 period HBDHB outsourced an average of 229 patients per annum. This volume grew to 840 for the 2016-17 Financial Year.



Graph 7: Shows the forecasted growth in outsourcing if in-house capacity is not expanded.

As will be further discussed in the Economic Case achieving recent theatre targets have been underpinned primarily by increased outsourcing due to the in-house resources being at capacity. Continuing to outsource to Royston is something that HBDHB intends to continue as a means of filling the Gap in future years. However due to the size of the Gap in coming years Royston may be unable to fill this in its entirety given its current capacity, resourcing and the increasing complexity of HBDHB patients. Additionally the costs associated with outsourcing may well be financially unsustainable due to economies of scale.

1.4.5.3. Hours of Business

Elective surgery is scheduled during normal business hours Monday to Friday, depending on session lists can vary from 0830-1630 or 0830 -1730.
For acutes, there is one dedicated theatre open and resourced 24/7 for all emergency surgery and another acute theatre is open and resourced 0830-1630 Monday to Friday. Recently due to an increase in acute surgery we have opened and resourced a second acute theatre every Sunday.

1.5. Investment Benefits - Delivering the Additional Volumes -

The benefits from delivering additional surgical volumes have been identified at a high level, these are discussed below.

Key Benefits

Delivering the additional surgical volumes will provide benefits for consumers, staff and the organisation. These benefits are summarised as follows:

For consumers

- Enable more people to access appropriate surgery.
- Timely surgical intervention means an improved quality of life, an earlier return to independence and active participation in his/her or their communities.
- Process improvements to Models of Care and Patient Flow are better suited, more convenient and safer for the patient. Assuming that regardless of which method/option is selected to deliver the surgical volumes, suitable Model of Care improvements will be made to the process.

For Health Professionals

- Increased availability of theatre sessions will enable more interventions and better health outcomes for specialties with a growing demand.
- Enhanced working environment will be achieved through a whole of system approach by integrating the surgical wrap around services and Models of Care.
- Potential for enhanced career development, training and workforce opportunities.

For HBDHB

- Align the planning for the District's populations changing demographics, changing health needs and Ministry of Health annual Targets.
- Clear visibility of how HBDHB will contract for the delivery of both elective and acute surgical services both internally and through the use of IDF's and private providers.
- Maximising whole the of Hawke's Bay surgical capacity in the most cost efficient way.

1.6. Summary of the Business Problem

Understanding how HBDHB can meet the surgical needs of its population in the future, requires an appreciation of what surgical growth might look like. This is underpinned to a large extent by predicted population growth. However, other factors are likely to contribute to growth beyond population forecasts including government policies (e.g. Ministry of Health Targets) and repatriation of some IDF's. Modelling of various scenarios of growth was undertaken based on these factors.

The Most Likely Scenario has been used for modelling in this DBC. This scenario predicts the Gap between what needs to be provided and what *can* be provided in-house to be 2,721 theatre hours by 2019-20. The growth in the Gap is based on the assumption that in-house

operations are nearing capacity in terms of what they can produce given current resourcing. This is evidenced by a levelling off of in-house production and a reduction in opportunities for large scale improvement initiatives.

Thus, the original objective of this Detailed Business Case can be re-phrased as:

> *How can HBDHB assess and acquire the additional theatre capacity and capability required to close the Gap (2,721 theatre hours by 2019-20) to enable us to meet the surgical requirements of its population in the most efficient and cost effective manner?*

The scale of the problem has been defined, and the Economic Case will seek to answer this question as it is now phrased.

2. ECONOMIC CASE

The Strategic Case identified the need for an additional 2,721 theatre hours by 2019-20. The Economic Case discusses the options available to HBDHB and identifies a preferred solution to service the Gap.

2.1. Options Analysis

The options available for meeting the Gap can be classified in four broad categories:

1. **Buy** the additional capacity required
2. **Build** the additional capacity required
3. **Buy and Build** the additional capacity required.
4. **Sweat** existing resources to a greater extent to cover the additional capacity required.

These form the building blocks used to create options for solving *the Business Problem* in the IBC and again here in the DBC.

2.2. Key Assumptions:

All options that were considered as possible solutions for *providing surgery in the most cost effective and sustainable manner* were based on the following key assumptions:

- Existing internal capability (OT1-7) will improve from 14,134 hours to 14,194 reflecting a 0.5% improvement in theatre utilisation.
- An Orthopaedic acute session will run every Sunday. With theatre utilisation matching 2016-17 actuals, this provides an additional 114 hours per year.
- An 8th operating theatre will provide 1,743 hours of theatre time per year operate with the same theatre utilisation as the other elective theatres taking into account improvements described in assumption 1. This results in 86% theatre utilisation.
- An 8th operating theatre would open at full capacity on 1 February 2020
- For the purpose of calculating the long list of options it has been assumed that: The output from running 5 theatres every Saturday would produce the equivalent theatre hours as would an 8th operating theatre i.e. one theatre operating 5 days a week equals the same as 5 theatres operating one day a week.
- In order to measure the impact of additional in-house activity, assumptions have been made as to which specialties might utilise the theatre time made available by

theatre 8. General Surgery, Orthopaedics, Ophthalmology, Urology and ENT were chosen based on predicted growth, current volumes of outsourcing and plans for recruitment over the next 12 months.

- The following priority was employed for determining the type of surgery done in any additional capacity:
    1. Growth in acute theatre hours
    2. Growth in arranged acute theatre hours
    3. Growth in elective theatre hours
    4. Remaining capacity used to move out-sourced hours in-house.

- Sterile Services is able to remain where it is for theatre 8 but would need to relocate for a 9th theatre due to floor space constraints.

- The Anaesthetists office is at capacity and although the building works for SSD and Theatre 8 do not require its relocation, the expanded Anaesthetist headcount required to service the 8 theatres does mean that some expansion of their office space is required. Additionally due to its current location this office will need to be relocated if theatres 9 & 10 go where SSD is currently located. The capital budget for this Project does not include a budget to either refurbish or fit out of a new office.

- Although this project has focused on the surgical capacity required in the financial year 2019-20, the demand forecast modelling that was done for the Project suggests that approximately 3 years after theatre 8 opens a 9th theatre would be required. The twenty year capital plan for HBDHB is due for refresh following the completion of The Clinical Services Plan due for release in early 2018. When the twenty year capital plan is refreshed it will consider the appropriate locations for future theatres, outpatient clinic rooms and wards. It will also recommend the appropriate location of Sterile Services to support any future theatre developments.

- That the private sector will have the capacity to manage the outsource volumes we intend to send to them over coming years. Royston is set to open a fifth operating theatre which will assist with their ability to contribute to this.

- HBDHB has enough volumes that are suitable to be outsourced given the private sectors lack of ICU capability. The current contract negotiations with Royston achieve a pricing matrix that continues to support outsourcing large volumes to them at an affordable rate.

- The building works required to deliver increased in-house capacity must enable the existing seven theatres to continue operating at full capacity during the build. Additionally it assumes that Royston's own building project for their 5th operating theatre is managed in such a way that enables their existing theatres to accommodate the outsourcing we send to them.

- Any proposed development will not compromise options for future expansion.

2.3. Organisational Implications and Dependencies

The Project interrelates with numerous Initiatives already underway at HBDHB. A number of these Initiatives have interdependencies with the Project which should be factored in to ensure the planning and delivery of the Project enables the achievement of its required deliverables. A full set of dependencies is listed in Appendix 4.

- The Clinical Services Plan
- Central Regional Service Plan
- HBDHB's Annual Plan
- Surgical Directorate Service Plan
- Gastroenterology Facility development and Service Transition

2.4. Key Risks if the Project not Undertaken

If the Project is not undertaken there is potential for the following impacts:

- The whole of Hawke's Bay surgical capacity would remain close to current levels constraining HBDHB's ability to serve its population. This will result in potential harm to patients due to delays in patient care, putting HBDHB at risk of failing to meet waiting times and activity targets e.g. compromising the Faster Cancer Treatment Pathway.
- HBDHB would need to introduce measures to further constrain access to surgery e.g. the threshold for surgery will increase to the effect that the number of cases eligible for surgery would be restricted, eliminating access to affordable healthcare for the majority of users.
- HBDHB would need to explore using out of region providers for surgery which increases the burden on families who must travel to and stay in these locations
- HBDHB loses the ability to access new sources of revenue from available MoH funding.
- The volume of outsourced procedures could continue to increase possibly above financially affordable and sustainable levels.

2.5. Key Risks If the Project is Undertaken

By proceeding with the Project there is potential for the following impacts:

- Full theatre production during the building works could be compromised.
- Recruitment for required new staff is not completed in time for the opening of the 8th theatre.

- Procurement of Capital Works exceeds the predicted timeline and or exceeds the budget.
- Government changes in policy for elective surgery result in less funding for elective surgery.
- Surgical demand is higher than the assumptions used in the scenario modelling predicted, leading to increased activity sooner than anticipated.
- Investment in wrap-around services is insufficient to cope with new levels of demand
- Skill mix of new staff is insufficient for new levels of clinical complexity.

2.6. Long List of Options

2.6.1. Purchasing Criteria

A long list of six options, described in the table below, was developed for the IBC based on the building blocks described above:

Option	Description
Option 1	**Existing internal + Continued Gap** Manage the gap by controlling the flow of demand. This is achieved by raising thresholds for access to surgery. In this option the Gap disappears and production is maintained at historic levels.
Option 2	**Existing internal + buy the Gap** Assume the gap will continue to be managed by outsourcing. This is in effect the status quo option, except the gap is significantly higher than historic trends.
Option 3	**Existing internal + build extra internal+ reduction in continued Gap** Gap managed by building internal capability. Reduction of remaining gap by restricting access to surgery.
Option 4	**Existing internal + sweat internal+ reduction in continued Gap** Gap managed by increasing operating hours of the theatres**.** Reduction of remaining gap by restricting access to surgery.
Option 5	**Existing internal+ build extra internal+ buy outsource the Gap** Gap managed by building internal capability. Remaining Gap outsourced.
Option 6	**Existing internal + sweat internal+ buy outsource the Gap** Gap managed by increasing operating hours of the theatres**.** Remaining Gap outsourced.

Table 9: Shows the long list of 6 Options that have been considered to solve the Business Problem

2.6.2. Evaluation Criteria for Long List of Options

In the IBC the long list was evaluated in terms of its ability to meet the Funders' investment objective as defined above, namely meeting the surgical requirements of the population. Since the volume of additional surgical requirements are beyond current production levels in-house defined as 2,721 theatre hours by 2019-20, each option was assessed in terms of its ability to reach this target. For this DBC the same evaluation criteria was used again this time using the most likely scenario.

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6

Total Theatre Hours - to be purchased	16,855	16,855	16,855	16,855	16,855	16,855
Theatres 1-7 current production	14,134	14,134	14,134	14,134	14,134	14,134
Gap	2,721	2,721	2,721	2,721	2,721	2,721
Theatres 1-7 improved production	174	174	174	174	174	174
Net Gap	2,547	2,547	2,547	2,547	2,547	2,547
8th Theatre			1,743		1,743	
6 Day Service				1,743		1,743
Outsourcing		2,547			804	804
Unmet need	2,547	0	804	804	0	0
Total available Capacity	14,308	16,855	16,051	16,051	16,855	16,855
Does this give us the Capacity we require?	NO	YES	NO	NO	YES	YES

Table 10: Shows the long list of 6 Options and whether they are able to produce the required capacity.

As in the IBC Options 2, 5 and 6 once again were considered credible options to bring forward to the shortlist as they met the Gap in its entirety. The remaining options were discounted on the basis the Gap that remained would increase unmet need which would have to be managed in the community by increasing thresholds for access to surgery.

2.7. Short List of Options

2.7.1. Evaluation Criteria for Short List

The table below shows the criteria used in evaluating each of the short listed options in both the IBC and DBC.

		Measurement		
Criteria	**Description**	**Does not meet criteria (red)**	**Partially meets criteria (amber)**	**Meets criteria (green)**
Clinical risk	Does the proposed option bring any additional clinical risk?	High Risk	Medium Risk	Low Risk
Strategic fit	Is the proposed option a good strategic fit?	Poor Fit	Moderate Fit	Good Fit
Workforce development	What opportunities does the option provide for developing HBDHB workforce?	Little or no opportunity	Some Opportunity	Good Opportunity
Consumer experience	What impact will the option have on the consumer experience?	Poor experience	No likely change in consumer experience	Opportunity for Improved experience
Feasibility	Is the option a practical solution that can be delivered by 2019/20?	Not practical	Somewhat practical	Practical
Long term sustainability	Does the option represent a good long term solution? Can it be counted on to continue	Unlikely to be a sustainable solution	Uncertain long term sustainability	Good long-term solution

	to meet increasing demand?			
Total contribution over 10 years	How much will the option cost?	High Cost	Medium Cost	Low Cost

Table 11: Shows the criteria used to assess the 3 short listed options

2.7.2. Short List Evaluation

	Option 2	Option 5	Option 6
Clinical Risk	Large volumes of outsourcing would mean average in-house case load would be increasingly complex. This puts pressure on wards and support services	Improvements to Model of Care will decrease risk	Increased clinical risk in out of hours Elective work A recent study demonstrated that mortality for operations done on the weekend was higher than those done during the week[6]
Strategic Fit	Consistent with the strategic intent to develop a One Hawke's Bay Health System but inconsistent with the intent to enhance its own capability and capacity and Central Region Vision of consistency of clinical pathways	Links with Transforming Patient Experience Transform and Sustain as it seeks to redevelop the Model of Care alongside capital developments	Consistent with Transforming out of hours inpatient care
Workforce Development	Limits workforce development and career opportunities.	Positive for workforce development and career opportunities.	Current employee conditions/ contracts are not conducive to increased Elective weekend work. Extensive change management required.
Consumer experience	Potential for improved experience by optimising patient flow	Potential for improved experience by optimising patient flow	Some benefit, as improving access at weekends may be viewed positively.
Feasibility	It is unclear if Private provider capacity exists to fully outsource the Gap. RFP process would need to be undertaken to confirm level of capability and interest.	Assumes capital and additional staff can be sourced.	Requires a major change management programme over an extended time period to succeed. Considered not possible by 2019/20.
Long term sustainability	Assumes a robust tender process will identify private providers with long term sustainable capacity	Maintains strategic relationship with private partners, builds internal capability and allows for further expansion of capacity.	Maintains strategic relationship with private partners. However, sweating assets will be overtaken by the growth in volumes in the medium term.

[6] Perioperative Mortality in New Zealand, Health Quality and Safety Commission, 2016

Net Present Cost (NPC)	-$49,416,742	-$55,198,855	-$53,623,769
Summary	Unlikely to be a practical solution. To keep costs comparable would involve a significant discount being negotiated compared to the current contract. Stranded costs retained by HBDHB.	A long term sustainable option where the Gap is fully met through increased internal production and outsourcing, providing the best clinical and cost effective results. The enabling works contained within this option allows for the future development of Theatres 9 and 10 when required.	This option has a large impact on the whole of hospital system and costs. Additionally clinical risk factors are known to increase for procedures performed outside of normal work hours. Requires a major change management programme over an extended time period to succeed. Considered not possible by 2019/20.

Table 12: Shows the evaluation of the 3 short listed options

2.7.3. Net Present Cost

In evaluating the options, and to allow for a like for like comparison, a net present cost (NPC) was calculated using the *Most Likely* scenario modelling from the Strategic Case (1,837).

2.7.4. Short List Evaluation Summary

As in the IBC the preferred option is once again **Option 5** buy existing internal + build extra internal + buy outsource. This option is preferred because it is the most affordable, holds the least clinical risk, maximises the total available theatre space in the district across both public and private and is the most practical solution.

Option 5 was tested further by checking for alignment with the New Zealand Triple Aim:

Aim	Option 5 (preferred)
Improved quality, safety and experience of care	Re-build of perioperative area and accompanying model of care changes will improve patient experience and align processes with clinical best practice.
Improved health and equity for all populations	Improves the amount of surgery provided in region, thereby reducing the impact on families who may have to travel out of region for their surgery.
Best value for public health system resources.	Option 5 is the most affordable solution.

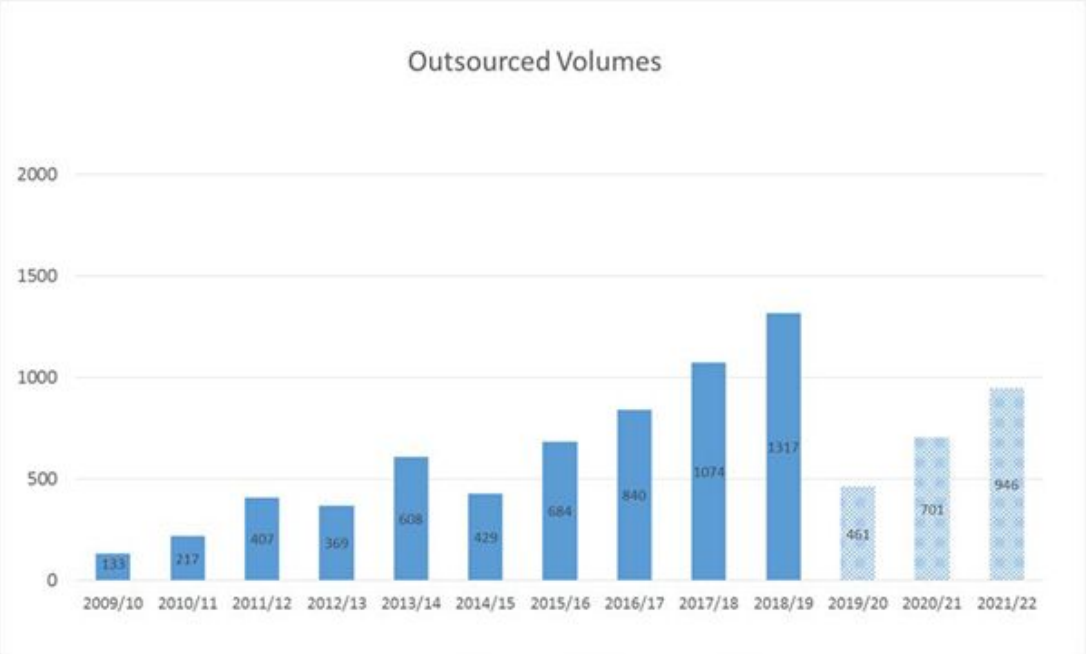
Table 13: Shows how Option 5 aligns to the New Zealand Triple Aim

2.8. Details of the Preferred Option

As described in the Financial Case the preferred option (Option 5) requires creating additional in-house capacity for approximately 1,743 theatre hours per annum through:

- Continued maximising the utilisation of the existing 7 theatres with the same case mix
- $12 million capital investment to build of an 8th operating theatre, reconfiguration of the Perioperative unit and some wrap around services.

The remaining Gap will continue to be outsourced to a private provider, approximately 804 theatre hours in 2019-20.The below graph shows outsourcing volumes in the years following theatre 8 opening.



Graph 8: Shows the forecasted outsourcing after in-house capacity is expanded to include an 8th theatre.

To achieve this Option 5 requires the Perioperative unit at HBDHB to be reconfigured to accommodate the additional theatre including:

- Increased Perioperative staffing e.g. nursing.
- Reconfigure Sterile Services to support 8 theatres.
- Establish a dedicated loan equipment area.
- Relocate Pre Admissions unit out of the Periop footprint.
- Relocate the Periop staff change rooms, lunch room and meeting rooms to make way for these changes.
- Fit out theatre 8, and purchase clinical equipment.
- Expand theatre storage for sterile, non-sterile stores and storage of equipment e.g. image intensifying machines.
- Change the layout of the day surgery unit
- Establish an OR Hub in the centre of the department
- Enable suitable patients to either walk, be wheeled in a chair or go by bed to the operating theatre.
- Establish a Whānau support person waiting area near or within the Perioperative unit.
- Review the Processes for the stocking of theatre stores and waste removal.
- Expand the PACU beds spaces and equipment storage areas.
- Reconfigure Perioperative management staff offices to a central partly shared space.

Wrap around services changes required to support Option 5 include:

- Increase the available inpatient bed capacity by 5 beds and corresponding FTE required to deliver care for these additional beds.
- Invest in out-patient clinic areas to better accommodate the corresponding changes in clinics required to support the additional surgical volumes.
- Some incremental increases in FTE across several of the wrap around services to manage the corresponding increase in volumes e.g. Radiology.
- Some model of care changes across some services e.g. supporting discharge planning in the pre admission process.

A high level timeline for the above programme of works can be found in Appendix 5. The next section will focus primarily on the requirements for building the capacity for the 1,743 theatre hours. Consideration for Royston contractual arrangements is covered in the Commercial Case.

2.8.1. Surgical Mix

In the preferred option (Option 5) the surgery hours modelled in the most likely scenario excluding IDF's can be described as follows:

Type	2016-17	2019-20
In-house	93.5%	95.2%
Outsourced	7.5%	4.8%
Total	100%	100%

Table 14: Shows the likely mix of total surgery hours for in-house and outsourced

Looking at the makeup of in-house procedures across all eight operating theatres can be described as:

Type	2016-17	2019-20
In-house Elective	53.9%	54.9%
In-house Acute	36.6%	36.4%
In-house Arranged	9.5%	8.7%
Total	100%	100%

Table 15: Shows the likely total mix of surgery hours in-house

2.8.2. Capital Works

The preferred option requires investment in a range of enabling works within the Perioperative Unit and a new operating theatre (theatre 8). Preliminary estimates of costs for these works have been prepared by external consultants for the purposes of this business case only and elaborated on in Appendix 6, 7 and 8 (capital works).

The project is comprised of three interdependent stages of building works to accommodate expansion to the Perioperative Unit and build an additional operating theatre. It also includes capital costs for wrap-around areas that are significantly impacted by the theatre expansion.

Stages 1a and 1b involve the relocation of facilities that do not need to sit in close proximity the theatres. Stages 2a, 2b and 2c involve building new pre and post-operative areas to accommodate projected demand from an 8th Theatre. Stages 3a and 3b include building the 8th Theatre and investing in the CSSD department. A full description of each construction stage can be found in Appendix 8 and the corresponding timeline for this in Appendix 7.

As noted in the Strategic Case there are significant pressures in the current Perioperative environment today that make expansion problematic. The Perioperative Unit is working beyond capacity as a result of existing "sweat the asset" efforts. Investment is required to improve the capability and productivity of the Perioperative Unit to manage both existing and future volumes. Stages 1, 2 and 3b of the capital works address this.

All of these enabling works are associated with delivering the total acute and elective surgical theatre hours in-house by 2019-20. The capital budget is the minimum investment required to successfully deliver this work. In some cases, there was opportunity to re-develop an area to accommodate further theatre expansion. This is detailed in the table above.

Investing in all the areas within the Perioperative Unit to support the theatres is fundamental to improve Patient Flow, and to enable expansion beyond the current 7 theatres. Failing to develop these areas in advance of opening an 8th operating theatre, would mean severely limiting any additional production.

2.8.3. Impact on Wrap Around Services

The project working group engaged with the wrap around services throughout the hospital that support surgery and are therefore likely to be affected by the Perioperative development and an 8th operating theatre. These discussions were held with services such as Inpatient Wards, ICU/HDU, Nutrition and Food, Orderlies, Community Nursing, Pharmacy, Radiology, Laboratory, Administration Staff, Allied Health, Outpatient Clinics and Procurement.

All impacted areas indicated that they are currently operating at or above capacity (Appendix 16). Improvements are required to these areas to allow for the additional volume of surgical work. These are likely to be a combination of business process and Model of Care changes, additional FTE, and some capital investment. Potential changes to Models of Care are described below and in Appendix 9. The financial case provides some indication of what capital

and operating expenses might be needed to accommodate the predicted volume increase. However more detailed assessment is required in all areas as discussions mature and costs become firmer. Some assumptions have been made regarding a likely capital investment in wrap-around services. These focus on the impact on inpatient and outpatient areas.

Surgical Inpatient Beds:
The Mostly Likely Scenario forecasted a gap of 1,419 bed days in 2019-20. Assuming a buffer of 20% creates a demand for 1,774 bed days or 4.9 beds per day. There is the potential to expand A2 by an additional 8 bed spaces that could be used for the additional surgical inpatients beds. Capital investment estimates have been provided based on these assumptions. In practical terms, how A2 is managed is a strategic decision that must be considered alongside other organisation inpatient bed requirements. Theatres 1-7 are responsible for only 28% of all bed demand in the hospital and there are a number of initiatives underway that may reduce bed demand or suggest a direction for what type of bed capacity should be built. Examples include Patient Flow, AT&R project and Cost Savings initiatives by the Medical and Surgical directorates. Additionally the ICU unit has indicated that the current ICU/HDU capacity has been reached. Decisions about how to create additional HDU capacity would need to be part of this decision-making process.

Outpatient Clinics:
Some outpatient clinic areas are at capacity and increasing SMOs could require additional physical clinic space. Areas of concern are Villa 3 and 4 (Urology, Ophthalmology, and ENT) and A2 (General and Vascular Surgery). Separate to this project The Surgical Service has a piece of work currently underway that is looking at the ESPI2 referral and follow up process. This work will be used to inform the final solution for the Outpatient areas for this Project which might include some capital upgrades or renting additional off site clinic space.

2.8.4. Changes to Models of Care

Investment in the enabling works and new operating theatre affords HBDHB an opportunity to maximise the efficiency of the Perioperative Unit, to enhance the patient experience and introduce new ways of working. There are a number of initiatives that have already examined current working practices and possible improvements. Some of these were identified as part of Operation Productivity and other projects, but not developed further pending the outcome of the IBC. These and others have been launched for this project. Additionally each wrap around service contacted as part of the impact assessment for the DBC recognised opportunities for improvements for their Model of Care. Examples of identified Model of Care changes for the Perioperative Unit and wrap around services can be found in Appendix 9.
The opportunity will continue to be explored to extend business hours to include evening and weekend elective theatre sessions including the impact on wrap around services. As we identify and implement these opportunities this will lead to a reduction in outsourcing.

2.9. Summary of Economic Case

The Economic Case rechecked the analysis considered how best to accommodate the anticipated gap of 2,721 theatre hours by 2019-20. The long list of options explored how best to meet this demand by either buying, building or sweating the current assets. From here a short list of options emerged. Option 5, which suggests a combination of building an 8th theatre and continuing the outsourcing relationship with Royston, was chosen as the preferred option both in the IDC and again here in the DBC.
Option 5 provides the best value for money, the lowest clinical risk, and the most timely and practical solution. The question posed at the beginning of the DBC has now been answered:

> *The most efficient and cost effective manner for HBDHB to acquire the additional theatre capacity and capability required to close the Gap (2,721 theatre hours by 2019-20) is through increasing internal capacity by building an 8th operating theatre and continue outsourcing.*

The capital works for the Project has considered expanding key areas predominantly within the Perioperative Unit in the first instance as additional volumes will not be achieved without this expansion and accompanying Model of Care initiatives which look critically at current systems and processes. Information has been gathered to allow assumptions to be made about the scale and type of capital investments, and Model of Care changes required. However these are assumptions and not certainties. Many of these are in the early stages of development and require more work to confirm, the detail of which will be worked through once this Detailed Business Case is approved.

3. Commercial case

3.1. Procurement Strategy

Proceeding with Option 5 will require the recruitment of additional staff and procurement strategies for the following:

- Capital building works
- Equipment
- Outsource contracts

The procurement strategy for each of these will follow the procedures detailed in HBDHB's Procurement Policy and Procedures (HBDHB/OPM/081). The policy references the February 2015 directive from Ministers of State Services that stipulates the DHBs must follow the Principles of Government Procurement Rules of Sourcing. There are five key principles to follow:

1. Plan and manage for great results
2. Be fair to all suppliers
3. Get the right supplier
4. Get the best deal for everyone
5. Play by the rules

According to the HBDHB procurement policy, the strategy for purchasing goods and services is determined by the monetary threshold. As this project has a whole of life cost of greater than $100,000 it will therefore use the guidelines for this spend bracket details of which can be found in Appendix 15.

The Government Electronic Tender Service (GETS) will be used to provide Requests for Tender (RFT) and Requests for Proposals (RFP) as required for individual purchases or bulk contract situations.

3.2. Commitment to Environmental Sustainability

HBDHB values the important role environmental sustainability plays in enabling us to operate in a way that meets our present needs without compromising the fabric of the social community, economy or the natural environment, so that future generations continue to benefit.

In all activities, HBDHB will seek to support environmental sustainability and improve our environmental performance in all capital projects. Key principles to be a considered for this project include minimising harm, maximising efficiency, applying a whole-of-life view, implementing sustainable design, trialling new technologies and leading by example.

The target areas where we can see the most significant financial, social and environmental impacts are:

- Energy and Carbon Management.
- Sustainable Waste Management.
- Sustainable Water Management.
- Sustainable and Efficient Buildings and Site Design.
- Sustainable Transportation and Travel Management.

3.3. Service Requirements

The procurement of the capital building works and equipment will follow a conventional design and construct approach. The design specification and requirements will be agreed with key stakeholders. Contractors and vendors will then be selected on the basis of a competitive tender process to complete the detailed design and construction of the required works for the separate packages that cover:

- The build of Theatre 8 on the site of the current staff room and meeting room.
- The refurbishment of the Perioperative Unit to support 8 Operating Theatres.
- The relocation of the Pre-Admission Clinics
- Reconfigure Sterile Services.
- Changes to Outpatient Villas.

The final awarding of tenders to the successful tenderers will be the subject of a separate request for approval to the Board.

3.4. Contractual Relationship with our Outsource Partners

Scenario modelling indicates that delivery of the forecasted additional volumes is dependent upon accessing the capacity available in the private sector for those surgical procedures within its scope to deliver. At present there is one private provider (Royston) in the district however other providers have shown an interest in entering the region and additionally there are private providers outside the district that HBDHB has partnered with in the past.

The existing Royston relationship is important to HBDHB in that it provides the flex in capacity needed to assist in meeting contracted volumes and Ministry of Health Targets. The proposed outsourcing volumes in Option 5 are less than the volumes outsourced in 2016-17 so it is assumed these can be accepted at a reasonable price. Furthermore using a local provider supports HBDHB's strategic goal to build one "Hawkes Bay health system" where use of both public and private assets in the district are maximised for the benefit of all. For example hiring in the public system also benefits the private system as many surgeons work across both sectors.

The existing contract with Royston is due to expire in 2018 and is currently the subject of renewal negotiations. The outsourced volumes indicated in this DBC have been factored in as part of those renewal negotiations which are being led by HBDHB contracts team outside of this Project.

3.5. Payment and Risk Allocation

Payment for the capital works will be made as per the negotiated agreement with the successful tenderers, which is anticipated to be a weighted fixed price contract reflecting current market conditions thereby minimising risk to HBDHB.

The risk allocation has not been agreed at this stage, and would be negotiated with the successful tenderer as part of the appointment process at the conclusion of the tender.

3.6. Design and Documentation of Capital Works

In April following the approval of the IBC the design and documentation process was commenced and a concept design has been completed for the Perioperative Unit to give a provisional indication of how each area would need to be expanded and adapted to enable cost estimates to be calculated by a quantity surveyor. On approval of the DBC this process will move to the detailed design and documentation stage where a more accurate costing is able to be completed to ensure that the design both meets requirements and is within budget.

3.7. Model of Care and Process Changes

As described in the Economic Case several model of care changes within the Perioperative Unit are required to support Option 5.

- Operating Room Hub
- Enable suitable patients to walk, be wheeled in a chair or go by bed to the operating theatre
- Pre and Post-operative patient flow
- Whānau support person waiting area

Several department processes have also been identified as needing to be changed including:

- stocking of theatre stores
- removal of waste
- storage of beds
- Storage of patients personal belongings

3.8. Wrap Around Services Changes

In the Economic Case several changes within the wrap around services that support surgical delivery were identified to support Option 5.

- Increase the available inpatient surgical bed capacity by 5 beds.
- Reconfigure Outpatient clinics to better accommodate the corresponding increase in surgical volumes.
- Some incremental increases in FTE across several of the services to manage the corresponding increase in surgical volumes.
- The inclusion of Allied Health in the pre Admission process to improve discharge planning, using a similar model as joint school which has been very effective at reducing lengths of stay.

A working group made up of managers and staff have been tasked with developing these over the next 18 months to ensure that the whole of hospital capacity is able to manage the additional surgical volumes that comes from theatre eight.

4. Financial Case

4.1. Preferred Option Financial Analysis

This chapter summarises the overall affordability of the preferred option over the life of the investment.

4.2. Capital Works

As stated in the Economic Case the capital works required to deliver the preferred option is comprised of three interdependent stages of building works to accommodate expansion to the Perioperative Unit and build an additional operating theatre. It also includes capital costs for wrap-around areas that are significantly impacted by the theatre expansion.

4.3. Capital and Operating Funding Requirements

Analysis of the preferred option shows that it is affordable and will be cash flow positive after 10 years. This assessment takes into account operational cash flows and accounting charges, including depreciation and interest. The total cost over 10 years for all three of the short listed options is very similar with the preferred option (Option 5) being the most expensive of the three, as shown in the table below.

Shortlisted Options	Net OPEX (OPEX)	Net Present Cost (NPC)	Capital Investment (CAPEX)
Option 2	-71,012,985	-49,416,742	2.9 million
Option 5 (Preferred)	-70,743,047	-55,198,855	12 million
Option 6	-76,115,350	-53,623,769	3.2 million

Table 16: Shows the total contribution over 10 years for the 3 shortlisted options

The financial model described in Appendix 10 gives a detailed breakdown of the financial logic used to assess the affordability of the preferred option.

4.4. Funding and Affordability

The capital works will be self-financed from existing reserves set aside by HBDHB from the 20 year capital works master planning programme. Some of the growth in electives will be funded through existing Ministry of Health elective targets arrangements with the remainder funded from Population Based Funding.

There is the potential for new revenues to be earned from the repatriation of Plastics volumes currently performed at Hutt Valley DHB and additional elective surgeries contracted for by the Ministry of Health in satisfaction of government health policy objectives. However the purchasing scenario presented as a baseline and the financial modelling used here take no account of these opportunities which in themselves add further weight to the need for additional capacity.

4.5. Financial Assumptions

The financial assumptions used in the financial modelling incorporate the scenario modelling outlined in 1.3 of the Strategic Case and the key assumptions in 2.2 of the Economic Case.

4.6. Financial Risks

The modelling has assumed cost increases for the following risks:

- MECA rates in future years for Nurses and Allied Health professionals which are due to expire this financial year (2017-18)
- Exchange rates for clinical supply purchase than assumed
- Impact on wrap around services is greater than what modelling suggest
- Acute growth above what modelling suggest

A risk register of the financial risks is located in Appendix 11.

5. Management Case

5.1. Project Management Planning

Once the DBC receives formal approval, the project will continue and enter its third phase, Implementation. The three phases of the project are described in Appendix 13. Due to the short timeline for the Project, the planning for all of the implementation activities will need to immediately commence as soon as the DBC is approved.

Theatre 8 is expected to operate at full capacity as of when it opens on 1 February 2020. The phasing of the building works has purposefully left the build of theatre 8 until last to ensure that when it opens the Perioperative Unit and the wrap around services are able to manage this additional capacity. To do this the building works in the Perioperative Unit, Sterile Services and wrap around services all need to be completed ahead of time with the very first building activities involving clearing floor space for the changes in the Perioperative unit. Likewise changes to Models of Care and business processes need to be documented early enough to inform hiring decisions for the roles across the whole of hospital required to support the additional theatre capacity. Recruitment and training of the additional staff is planned to be completed one month prior theatre 8 opening. Selection, purchasing, commissioning and training of new equipment will also be completed prior to theatre 8 opening

5.2. Project Structure and Governance

The governance structure and organisational chart used to support the delivery of the project was agreed at the beginning of Phase two and will continue as is. This consists of a project working group, steering group and a clinical advisory group supported by a wider pool of stakeholders from across the whole of hospital, Appendix 14.

The project will continue to be managed in line with standard HBDHB project management methodologies for registered projects which align with PRINCE2 and Project Management Institute standards for effective project management. This ensures effective management of scope, budget, time, human resources, procurement, quality, communications, risk and integration.

5.3. Key Project Milestones

The key project milestones and indicative dates are summarised in the following table.

Key Project Milestones	Indicative Date
New Pre-ads clinic rooms opens	August 2018
Relocated Staff change + lunch room open	December 2018
Model of Care changes documentation completed	February 2019
2019-20 Production Plan completed (with OT8)	February 2019
Recruitment: Periop Unit and Wrap around services commenced	May 2019
Re-furbished Perioperative area opens	September 2019
Sterile Services refurbishment completed	December 2019
Recruitment: Periop Unit and Wrap around services completed	January 2020
8th Theatre Opening at 100% full capacity	February 2020

Table 17: Shows the key milestones required to deliver Option 5

5.4. Change Management Planning

Model of care changes will be made in parallel and be ready for the opening of the 8th theatre. These changes will follow a robust change management process and include detailed stakeholder and consumer engagement to ensure the success of these initiatives. As projects can result in impacts on staff, service users and their whanau, the organisation and the wider public, these changes may cause distress if it is not effectively managed. HBDHB seeks to minimise any potential distress by using effective change management tools and processes. Successful implementation of the Project will depend on a seamless transition to the new Perioperative environment and the production planning and capacity planning functions of the hospital effectively managing the increased volumes.

Planning of the change management and communications/engagement strategies were started during phases one and two of the project and will continue during the third phase to ensure potential impacts to culture, processes, systems and people are identified. The Change Management Plan will confirm responsibilities for assisting people through the changes and the key activities, timeframes and responsibilities for assisting the transition. The Change Management Plan will include:

- Stakeholder analysis.
- Communications Plan (including agreed timing for communication and engagement activities and arrangements for feedback).
- Provision of appropriate support at key points to assist people through the transition (including formal HR change management as per employment agreements).
- Training and education Plan.
- Process and workflow change.

5.5. Consumer Engagement

A presentation was given to the combined Consumer and Clinical Council on July 12th, 2017 to give an overview of the indicative business case and development of the DBC. Consumers were engaged during the development of the Detailed Business Case via an online survey and invited to participate in a workshop with some key project members held on 4th October 2017 where consumers viewed at the concept floor plans for both the Day Surgery Unit and Pre Admissions unit as well as a discussion around some of the proposed changes to models of care. The outcome of this workshop was that the consumers stated they liked the proposed changes and that they would also like to be involved in the detailed planning of these changes. After the Detailed Business Case is approved and the project moves to phase three implementation, further consumer workshops will be held to work through the detailed planning for the proposed changes to floor plans and models of care as they go from concept to final.

5.6. Benefits Management Planning

The key benefits expected to be realised as a result of this investment have been identified in the Strategic Case. Key Performance Indicators (KPIs) and measures of benefit realisation will be identified and agreed with the funder and key stakeholders at the commencement of the next phase as part of Benefits Realisation Plan. As projects progress and more becomes known about the challenges of achieving the outcomes, benefits can become diluted or fade away over time. Therefore a structured approach will be taken to ensure the anticipated benefits are realised. To guide this the Project will have a Benefits Realisation Plan, which will outline how the benefits will be managed and the accountabilities that will be applied. This Benefits Realisation Plan will be created during the detailed planning for phase 3 implementation once the DBC has been approved. The key principles of these planning activities are:

- Ensuring benefits are clearly defined and understood at the outset, are robust and based on accurate modelling.
- Planning the points or milestones in the implementation phase where benefits should be realised, so that activities can be driven towards the right outcome.
- Tracking progress during the Project and beyond, as benefits realisation may occur during or after the closure of the Project.
- Assigning ownership of each benefit area to ensure focus is maintained.
- Key Performance Indicators (KPIs) and measures for assessing benefit realisation.

Comprehensive planning will be undertaken as part of the detailed planning for phase 3 implementation. This will include the mechanisms to assign accountability, track progress, achievement of milestones and ongoing monitoring post Go Live against the KPIs developed for this purpose during the DBC phase of the Project .These will be used to measure the outcomes of the Project in the benefits realisation review which will be carried out as part of the post project evaluation.

5.7. Risk Management Planning

The project will utilise the standard Hawke's Bay District Health Board project approach to risk management, to provide assurance to stakeholders and the Projects governance that the risks are being proactively identified and mitigated as the Project progresses.

Identifying, evaluating, planning and resourcing responses/mitigations and monitoring risks will all be undertaken on a regular basis throughout the Project. Risks and issues are being logged in the Project Risk/Issues Register. This is a live document that is updated continually throughout the project, to reflect the current status of risks and issues arising so that all key risks and issues are be reported and escalated as required. Risks are rated using the table found in Appendix 16.

5.8. Post Project Evaluation Planning

Monitoring Arrangements

The Project is be subject to standard Hawke's Bay District Health Board internal monitoring and review.

Post Project Evaluation

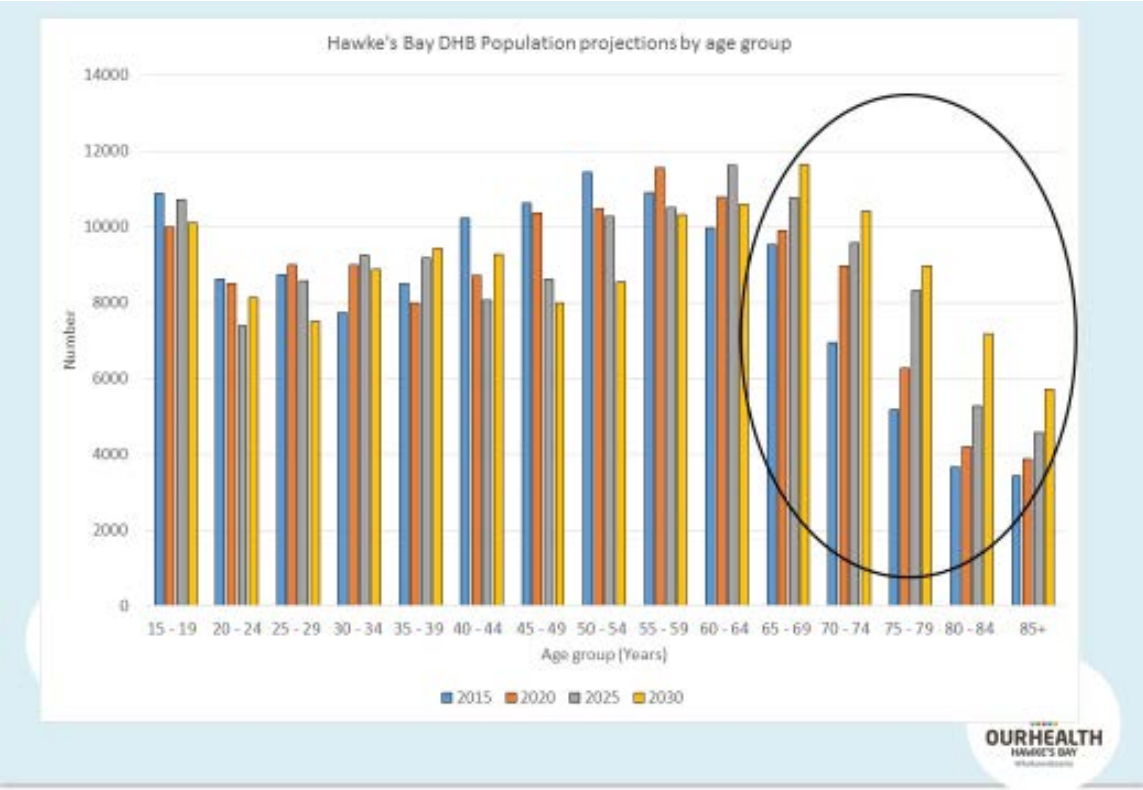
Post project evaluation will be undertaken during project close to assess how well the project was implemented to determine the extent of benefits realised against plan.

Project Completion Evaluation will take place within a month of project closure. It would confirm the extent to which deliverables have been completed and reconcile the project budget and timelines to plan. This review also considers lessons learned and would identify the extent to which the expected benefits have been realised at that point.

Post Implementation Review would take place at an agreed date post implementation, to allow time for the benefits to be realised and data to be available to management to support the review and assessment. The review would assess the benefits realised compared to what was claimed in the business case, would identify new benefits realised but not claimed in the business case, and would include planning for ongoing improvements in performance.

APPENDICIES

Appendix 1 Population & Demographics



Graph 9: Shows the projected changes in age groups for the Hawke's Bay region from 2015 - 2030

HAWKE'S BAY District Health Board Whakawāteatia

Appendix 2 IBC Scenarios

	Base= 2015/16 Financial Year	Population growth - age profile	SIR all Specialties	SIR Orthopaedics only	Ministry of Health additional elective work	IDF Plastics performed locally
Scenario A	☑	☑				
Scenario B	☑	☑	☑			
Scenario C	☑	☑		☑		
Scenario D	☑	☑			☑	

Table 18: factors considered in the scenarios used in the IBC

Appendix 3 DBC Scenarios

	Base Financial Year 2016/17	•	• Acute Growth	Arranged Growth	Elective (Health Target) Growth	Elective (Non-Health Target) Growth	Day Case Rate
Scenario –Most Likely	☑		Average growth in Theatre hours and events from last 3 years	Average growth in Theatre hours and events from last 3 years	” HBDHBs share of 4,000 elective discharges per annum plus half “additionals” and full regional. This is same as 17/18 ask	Average growth in Theatre hours and events from last 3 years	Day case rate will improve by 2.6% (90 extra day cases)
Scenario– Lean/Efficient	☑		Lowest growth in Theatre hours and events from last 3 years	Lowest growth in Theatre hours and events from last 3 years	**Slightly reduced share of 4,000 with no “additional” or “regional”**	Lowest growth in Theatre hours and events from last 3 years	Day case rate will improve by 3.2% (110 extra day cases)
Scenario– Worst Case	☑		Highest growth in Theatre hours and events from last 3 years	Highest growth in Theatre hours and events from last 3 years	HBDHBs share of 4,000 elective discharges per annum plus full “additionals” and full regional This is the same as the 16-17 ask	Highest growth in Theatre hours and events from last 3 years	No change
Scenario D – Population	☑		Profiled based on population changes	Profiled based on population changes	Profiled based on population changes	Profiled based on population changes	

Table 19: Shows factors considered in the scenarios used in the DBC

Appendix 4 Organisational Implications and Dependencies

Service	Initiative	Project dependent	Project Risk	Implication for the Project
HBDHB Funder	Royston Contract renewal (in region)	Yes	No	Yes
HBDHB Funder	Outsourcing: Private Providers (out of region)	No	No	Yes
HBDHB	Plastics & Burns repatriation	No	No	Yes
Surgical Directorate	"Operation Productivity"	No	No	Yes
Surgical Directorate	Surgical Services Directorate Specialty Reviews and Clinical Service Plan	No	No	Yes
Surgical Directorate	Surgical recruitment Maxillofacial , ENT, Orthopaedic, General Surgery, Urology	No	No	Yes
Medical Directorate	Gastro Project (Endoscopy Build)	Endoscopy need to have moved out of the Theatre complex (Perioperative Unit) before Theatre 8 can be commissioned	Could delay commissioning of Theatre 8	Yes
Medical Directorate	Radiology Service Review	Yes	Yes, ability to handle increased volumes	Yes
Medical Directorate	ED Project Flow: getting patients through ED within 6 hours	No	No	Yes
Operations Directorate	Labs expansion Histology Service	Yes	Ability to handle increased volumes	Yes
Surgical Directorate	SP2 Patient Flow Project	Yes	No	Yes

Table 20: shows initiatives already underway at HBDHB that could interrelate to the Project

Appendix 5 High level Project Timeline Across all Work Streams
(DRAFT)

Task Name	Duration	Start	Finish
Phase 1: Indicative Business Case	18 wks	Mon 28/11/16	Fri 31/03/17
Phase 2: Detailed Business Case	**42.4 wks**	**Wed 19/04/17**	**Thu 8/02/18**
investigations & writing	25.6 wks	Wed 19/04/17	Fri 13/10/17
internal Approvals	6.8 wks	Fri 13/10/17	Wed 29/11/17
National Capital Committee approval	17.4 wks	Wed 11/10/17	Thu 8/02/18
Phase 3: Implementation	**145 wks**	**Mon 19/06/17**	**Sun 29/03/20**
Staff hiring & Training	**80 wks**	**Thu 14/06/18**	**Wed 25/12/19**
Periop staff hiring & training	26 wks	Thu 27/06/19	Wed 25/12/19
Wrap around Services staff hiring & training	26 wks	Thu 27/06/19	Wed 25/12/19
Anaesthetist SMO hiring	78 wks	Thu 14/06/18	Wed 11/12/19
Capital Works	131.6 wks	**Mon 19/06/17**	**Wed 25/12/19**
Capital Works documentation	38 wks	Mon 19/06/17	Fri 9/03/18
Capital Build works	**95.6 wks**	**Mon 26/02/18**	**Wed 25/12/19**
Stage 1 construction works	31 wks	Mon 26/02/18	Fri 28/09/18
Stage 2 Construction	40 wks	Mon 3/12/18	Fri 6/09/19
Stage 3 Construction	15.6 wks	Mon 9/09/19	Wed 25/12/19
Model of Care & Process Changes	**131.6 wks**	**Mon 19/06/17**	**Wed 25/12/19**
Periop Model of care & processes	131.6 wks	Mon 19/06/17	Wed 25/12/19
Wrap around Services Model of care & processes	107.8 wks	Fri 1/12/17	Wed 25/12/19
Go live theatre 8	13.8 wks	Wed 25/12/19	Sun 29/03/20

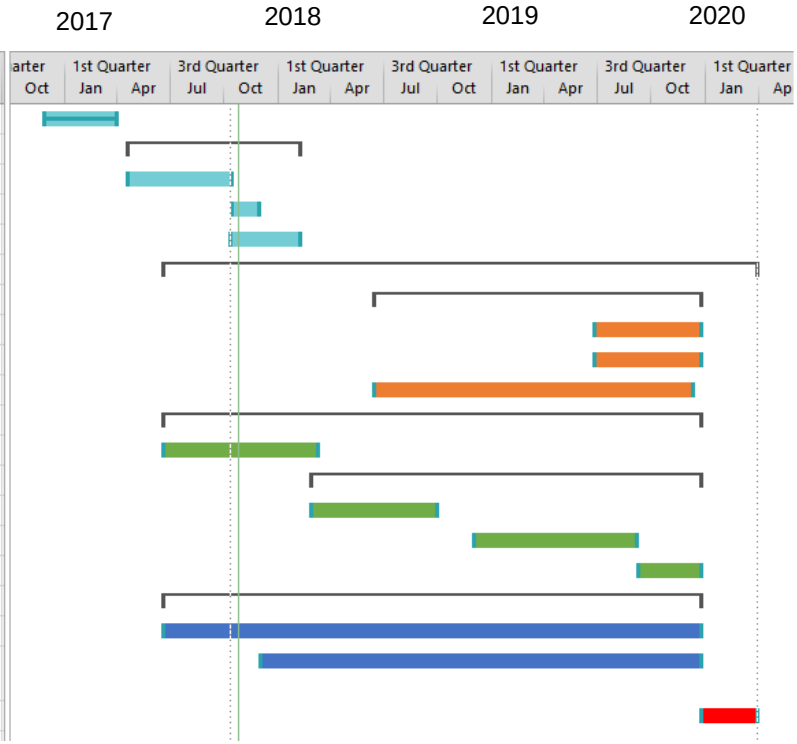


Table 21: shows the overall programme for the Implementation phase of the Project

HAWKE'S BAY District Health Board Whakawāteatia

Appendix 6 Capital Works - drawings (DRAFT)

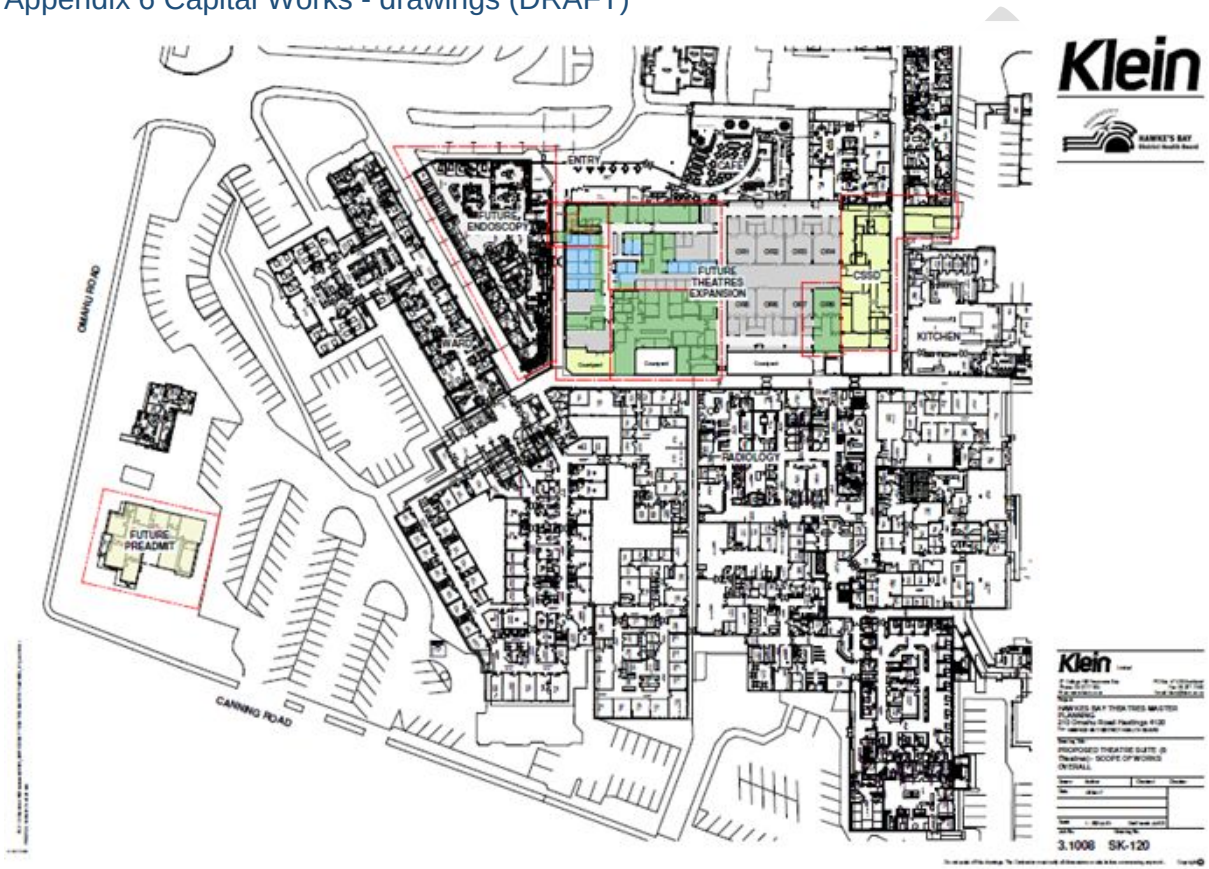


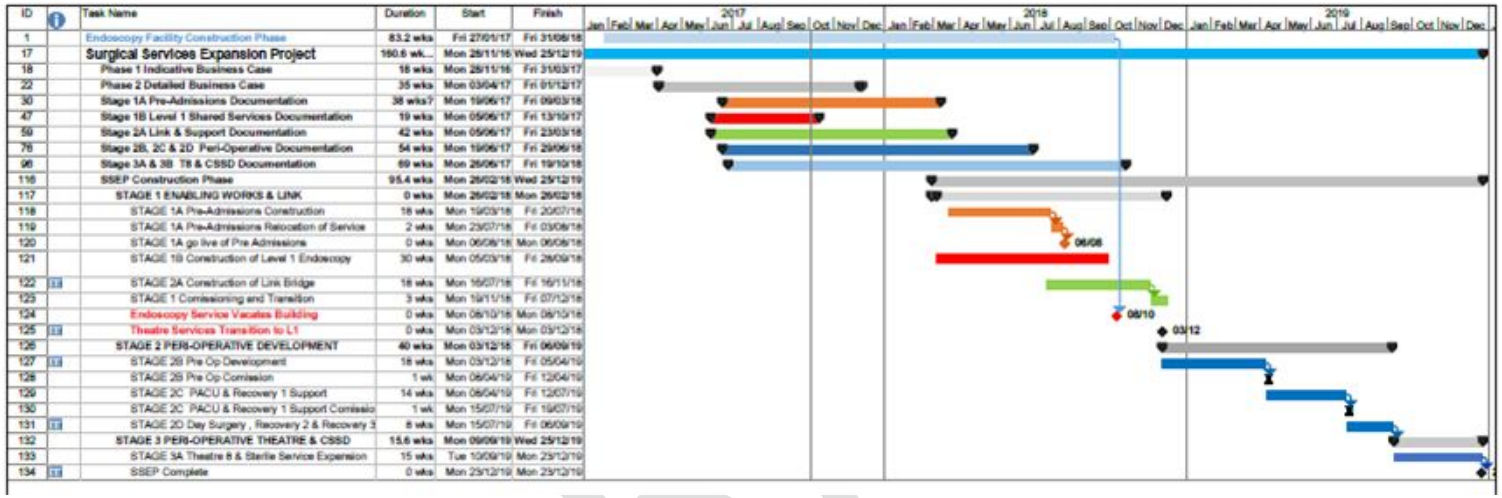
Image 1: Shows the Perioperative unit outlined in red including top floor of the new Endoscopy building and a new extension between Villa 2 and the kitchen.

15.1

Image 2: Shows the first stage of the building works for the Perioperative Unit – the new Pre Admissions Clinic rooms on the corner of Omahu and Canning Roads in the cottage recently vacated by Renal

Image 3: Shows the subsequent stages of the building works for the Perioperative Unit, following the relocation of Pre Admissions

Appendix 7 Capital Works Timeline (DRAFT)



ID	Task Name	Duration	Start	Finish
1	Endoscopy Facility Construction Phase	83.2 wks	Fri 27/01/17	Fri 31/08/18
17	Surgical Services Expansion Project	160.6 wk...	Mon 28/11/16	Wed 25/12/19
18	Phase 1 Indicative Business Case	18 wks	Mon 28/11/16	Fri 31/03/17
22	Phase 2 Detailed Business Case	35 wks	Mon 03/04/17	Fri 01/12/17
30	Stage 1A Pre-Admissions Documentation	38 wks?	Mon 19/06/17	Fri 09/03/18
47	Stage 1B Level 1 Shared Services Documentation	19 wks	Mon 05/06/17	Fri 13/10/17
59	Stage 2A Link & Support Documentation	42 wks	Mon 05/06/17	Fri 23/03/18
76	Stage 2B, 2C & 2D Peri-Operative Documentation	54 wks	Mon 19/06/17	Fri 29/06/18
96	Stage 3A & 3B T8 & CSSD Documentation	69 wks	Mon 26/06/17	Fri 19/10/18
116	SSEP Construction Phase	95.4 wks	Mon 26/02/18	Wed 25/12/19
117	STAGE 1 ENABLING WORKS & LINK	0 wks	Mon 26/02/18	Mon 26/02/18
118	STAGE 1A Pre-Admissions Construction	18 wks	Mon 19/03/18	Fri 20/07/18
119	STAGE 1A Pre-Admissions Relocation of Service	2 wks	Mon 23/07/18	Fri 03/08/18
120	STAGE 1A go live of Pre Admissions	0 wks	Mon 06/08/18	Mon 06/08/18
121	STAGE 1B Construction of Level 1 Endoscopy	30 wks	Mon 05/03/18	Fri 28/09/18
122	STAGE 2A Construction of Link Bridge	18 wks	Mon 16/07/18	Fri 16/11/18
123	STAGE 1 Comissioning and Transition	3 wks	Mon 19/11/18	Fri 07/12/18
124	Endoscopy Service Vacates Building	0 wks	Mon 08/10/18	Mon 08/10/18
125	Theatre Services Transition to L1	0 wks	Mon 03/12/18	Mon 03/12/18
126	STAGE 2 PERI-OPERATIVE DEVELOPMENT	40 wks	Mon 03/12/18	Fri 06/09/19
127	STAGE 2B Pre Op Development	18 wks	Mon 03/12/18	Fri 05/04/19
128	STAGE 2B Pre Op Comission	1 wk	Mon 08/04/19	Fri 12/04/19
129	STAGE 2C PACU & Recovery 1 Support	14 wks	Mon 08/04/19	Fri 12/07/19
130	STAGE 2C PACU & Recovery 1 Support Comissio	1 wk	Mon 15/07/19	Fri 19/07/19
131	STAGE 2D Day Surgery , Recovery 2 & Recovery 3	8 wks	Mon 15/07/19	Fri 06/09/19
132	STAGE 3 PERI-OPERATIVE THEATRE & CSSD	15.6 wks	Mon 09/09/19	Wed 25/12/19
133	STAGE 3A Theatre 8 & Sterile Service Expension	15 wks	Tue 10/09/19	Mon 23/12/19
134	SSEP Complete	0 wks	Mon 23/12/19	Mon 23/12/19

Table 22: shows the capital works programme for the Implementation phase of the Project

Appendix 8 Capital Works - Stages (DRAFT)

Stage 1A: New Pre-Admission Clinic

At Present the Pre-Admission Clinics are located within the theatre block. There is no clinical need for them to be in this location and their presence blocks the changes required within the theatre complex for the Project. The original design of the Perioperative Unit did not include Pre-Admission Clinic space in its footprint, therefore clinics are being run in areas that are not purpose built or designed to have patients and support persons. Furthermore, as it stands, Pre Admissions are fundamentally short of space. This compromises the patient experience, and raises staff frustration levels. Enabling works are needed to clear Pre-Admission Clinics from the theatre footprint and re-locate them to new facilities.

A site for the new Pre-Admission Clinic has been found on the corner of Omahu and Canning roads using facilities vacated by Renal. Capital investment is required to re-purpose the vacant unit to accommodate the Pre-Admissions team. The new design will include 10 clinic rooms and sufficient office space for nurses and doctors. This will allow 3 clinics to be run simultaneously rather than the current 2.

Stage 1B: Shared Services Level 1

The first floor of the Endoscopy build will be modified to include a staff team room and changing rooms shared with Endoscopy, and the creation of office space and meeting rooms for Perioperative staff. A link bridge and stairs will be build connecting the first floor of Endoscopy with the ground floor of the theatre block.

Stages 1a and 1b collectively create the additional space required for the Perioperative Unit to expand. (Stages 2 and 3)

Stage 2A: ***Revised 2nd-Stage recovery area, improved waiting area***

Works in stage 2 are focused on improving the capacity of the Perioperative Unit. The Day Surgery Unit (DSU) is operating at capacity which means it cannot safely accommodate any more elective patients during the week. At times it is running beyond capacity and patients are admitted into corridor areas or wards have been asked to assist with admitting patients' pre-operatively.

The new design for DSU separates the pre and post-operative areas. Currently many of the pre and post processes take place in the same area. For example, Day Surgery patients are admitted and discharged from the same bed space. This prevents good patient flow and compromises patient privacy. Stage 2a will involve converting what is now a mixed pre and post-operative area to an exclusively post-operative area. These changes will accommodate up to 10 operating theatres.

Stage 2B: ***Expansion of PACU + revised storage and support***

PACU and the post-operative areas will be expanded to cope with volumes from the additional theatre with 17bed bays plus one that is fully enclosed for infections patients. These changes will accommodate up to 10 operating theatres.

Theatre storage is currently beyond capacity and could not cope with the additional equipment and supplies increased capacity will bring. Storage is being used in a manner that is inconsistent with the original design and although some minor remedial work has been done, a major over-haul is required to cope with current volumes and will most certainly be required for theatre 8. Reconfiguring storage will occur in all stages, however it is documented here as the majority of the work will take place during this stage.

Stage 2C: ***Creation of new pre-op area for acute and elective admissions***
The final component of Stage 2 involves creating a new pre-op area for acute and elective patients. Elective patients will be catered for in a mixture of bed bays, chairs and private consultation rooms. The exact mix and plans for this area will be determined by Model of Care changes that are underway. Acute patients will come in the same entrance as current practice, and will be separated from elective patients, however the creation of an OR Hub will allow staff to manage acute and elective patients from a central point.

Stage 3A: ***Build & commission theatre 8***
During the last major development in the theatre block when theatre 7 was built, the location of an 8th Operating theatre was identified. This space is currently used as the staff tea room and theatre meeting room for Perioperative staff. The construction of the 8th theatre involves converting this space into a fully functioning operating theatre fitted out to be a general theatre able to accommodate all specialties as are the other 7.

Stage 3B: ***Re-purposed CSSD (Sterile Services)***
The Sterile Services Unit (CSSD) is at capacity and its location next to the proposed theatre 8 site, makes some re-design inevitable. Theoretically, CSSD has sufficient space to deal with the volumes from 8 theatres. However the Sterile Store that sits between theatre and CSSD needs to expand which will encroach in to CSSD's area. Additionally the current configuration, particularly the location of the sterilizers, prevents optimal flow. Investment in this area will improve the process flow to some degree and improve compliance with standards. The planned works will support 8 operating theatres however there is not enough available square for CSSD to expand in to for theatres 9 and 10 therefore it will need to be relocated at some point in the future therefore the investment in to CSSD at this stage has been kept to a minimum.

Appendix 9 Model of Care Changes

	Potential Model of Care Change	Status
Perioperative Unit	Storage including flow of equipment and supplies, location, medication storage, sterile and non-sterile store location.	In progress
	PACU: Extra bed spaces will be available, with some that are purpose built for LSCS patients with support persons and baby, therefore increasing privacy for all patients. Dedicated bed space for infectious patients.	Awaiting DBC approval
	Inwards and Outward Goods: Dedicated area co-located with sterile services for loan equipment, inwards and outwards goods, biomedical area and material coordinators office. Therefore improving efficiencies and communication.	In progress
	Waste including how waste is moved and stored within the unit	In progress
	Patients walking to Theatre. Recommendations for how patients can be moved from the pre-op area to Theatres.	In progress
	Pre-op Patient Flow. How the unit will function with a newly designed pre-op area. Utilising the same staff to check in both acute and elective patient, therefore improving acute theatre turnaround. The Pre-op area has been brought closer to the theatres therefore connecting the two areas better, which should improve communication and ease of staff moving between both areas.	In progress
	Post- op Patient Flow. How the unit will function with a newly designed post-op rea. Includes consideration of the Stage 1 and Stage 2 interplay and use of Discharge Lounge.	In progress
	Bed Storage. New process needed for providing beds for Theatre, wards and recovery	In progress
	OR Hub. New process needed for deciding how this new facility will work for communication, handover meetings and displaying key information.	In progress
Wrap Around services	Pharmacy – potential for Pharmacy to be involved in pre-admission process to reduce re-work and complications on ward	In progress
	Procurement – discussions being held as part of Savings Plan initiatives. Smarter storage systems, introduction of latest technology to avoid unnecessary movement of goods. Moving more items to impress to save valuable clinical time	Awaiting DBC approval
	Dieticians – potential for Dieticians to be involved in pre-admission process to reduce re-work and complications on ward	In progress
	Outpatients – Tweak rosters to better utilise clinic sessions. Consider occasional late night or Saturday clinics. Keep more clinics open during holidays. Better use of Napier, Wairoa and CHB space. Flexible clinic spaces, so multiple specialties are able to use the same room.	Awaiting DBC approval

	Allied Health - IPP: inter-professional practice to reduce duplication of effort on wards. Involvement in pre-ads process would reduce workload post-op and improve LOS.	Awaiting DBC approval
	Maternity: New process agreed for changing into scrubs in the maternity ward for staff and patient support to allow them to move directly into theatre on arrival to the Perioperative unit.	In progress
	ICU/HDU – Consider better resourced ICU to maximise physical bed space. Plan for an approach that caters to high acuity complex patients on the wards that are not held in HDU due to capacity issues.	Awaiting DBC approval
	Orderlies - Break the delineation between outside & inside orderlies i.e. just have theatre orderlies, Flexible rostering with Orderlies trained to work anywhere in the hospital.	Awaiting DBC approval

Table 23: Shows the model of care changes required to deliver Option 5

Appendix 10 Financial Model

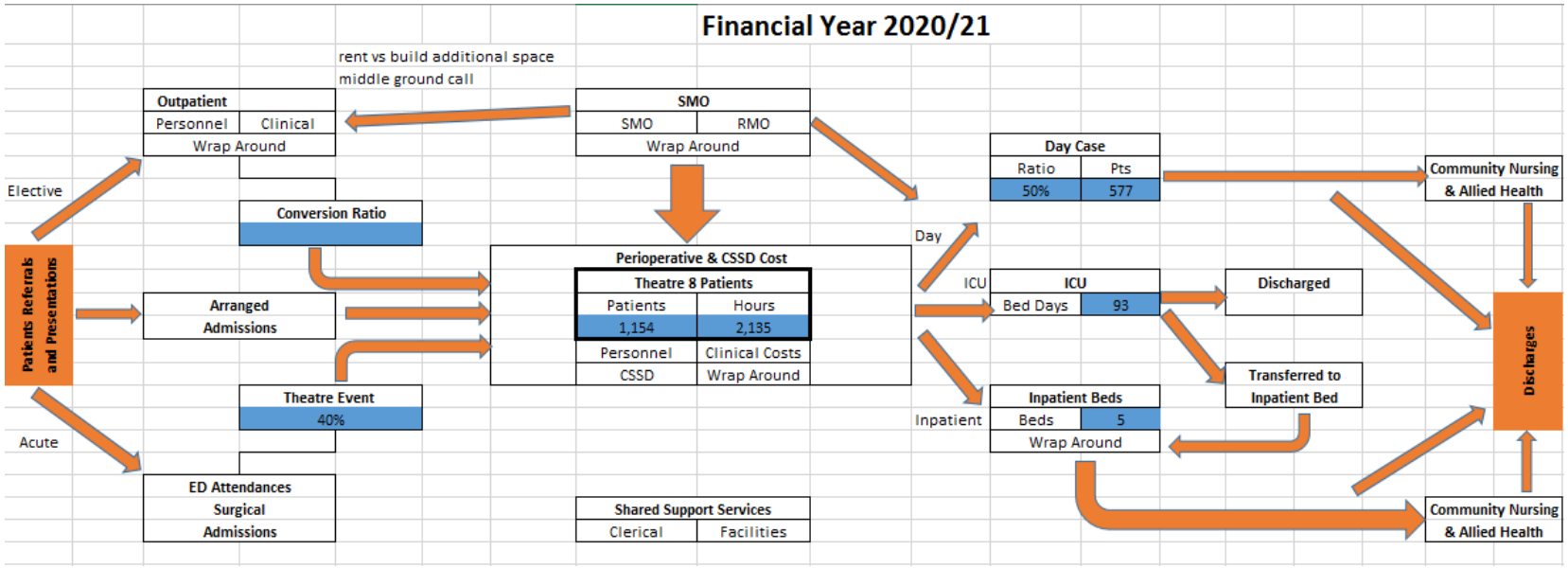


Table 24: Shows a depiction of the financial model

15.1

Appendix 11 Financial Risks and Contingencies

Risk	Contingencies
Preferred option operational and or capital costs are higher than anticipated.	Standard project management procedures would be in place to ensure that scope creep is minimised, and costs were contained within the budget allowed. The Facilities element of the project would be led and managed by an experienced HBDHB Facilities Manager and the overall project actual and anticipated spend would be actively monitored through governance structure as laid out in the Management Case
Income to organisation is higher or lower than anticipated. This includes changes to how the elective programme is financed by the Ministry of Health.	Assumption is that changes in government policy and funding will not occur. If there is less funding associated with the elective programme, then HBDHB retains the ability to reduce outsourcing rates to affordable levels. If it is higher we have the ability to expand capacity to perform additional volumes through outsourcing partnerships. If volumes decrease we have the ability to reduce levels of outsourcing.
Growth in demand is closer to the Worst Case model rather than the Most Likely model meaning Theatre 8 is predominantly an acute theatre.	Outsourcing numbers will be much higher than anticipated. This pushes up outsourcing costs considerably, but does not change need for internal capacity. It may signal the need to commence work on Theatre 9 quicker than planned or extend working hours.
Building works impact on Theatre's ability to maintain 100% capacity and current year elective targets are difficult to achieve forcing higher rates of outsourcing and therefore cost model is not able to be achieved	Appropriate staging of building works will minimise or eliminate all together then need to shut down any theatres.
Case mix is different to what was assumed and wrap around services including wards and out patients are not able to support theatre eight effectively and therefore cost model is not able to be achieved.	HBDHB retains the ability to change the mix of patients that are outsourced. It may decide to outsource more complicated cases and focus on maximising the number of Day Cases done internally.

Table 25: Shows the financial risks for the assumptions used to calculate the costs for Option 5

Appendix 12 Procurement guidelines for spend over $100,000

Whole of Life Cost	*Plan*	*Source*	*Manage*	*Reference*
$100,000 or more	• Specialist engagement; either Logistics and or Purchasing, Facilities and Operational Support or Contract Management Team depending on the nature of the good, service or work. • Procurement Plan • Specifications and evaluation criteria • Tender response schedule • Conflict of interest declaration • Approval by delegated financial authority holder	• Open tender on Government Electronic Tender Site • Use HBDHB standard contract or customised contract • Debrief unsuccessful suppliers • Publish contract and award notice • Obtain specialist procurement to lead the process	• Contract Management Plan • Post implementation review for complex / high value projects • Milestone reviews or like regular reporting • End of contract review • Documents filed • Original signed contract for operational expenditure to Contracts Management Team, for registration in the FMIS central contracts database.	• Procurement Toolkit 2.5 & 6: Purchases over $100,000

Table 26: Shows the HBDHB procurement guidelines for spend over $100,000

Appendix 13 Project Phases

Phase One of the Project (define problem, agree solution) developed an Indicative Business Case that went as far as to recommend the preferred option for purchasing the additional volumes HBDHB requires and sought approval for the estimated capital required to deliver the preferred option and the operational expenditure required for further developing the solution and writing the Detailed Business Case.

Phase Two (planning for the delivery of the solution) Post approval of the Indicative Business Case the Project planned and developed the DBC. Additionally in Phase Two, the Capital Building Work Stream was initiated so some capital works could commence.

Phase Three (delivery of the solution) is the Go-Live of all Work Streams implementation plans such as recruitment and training of staff, build of the 8th Operating Theatre, reconfiguration of the Day of Surgery Unit and sterile Services.

HAWKE'S BAY
District Health Board
Whakawāteatia

Appendix 14 Project Organisation Chart

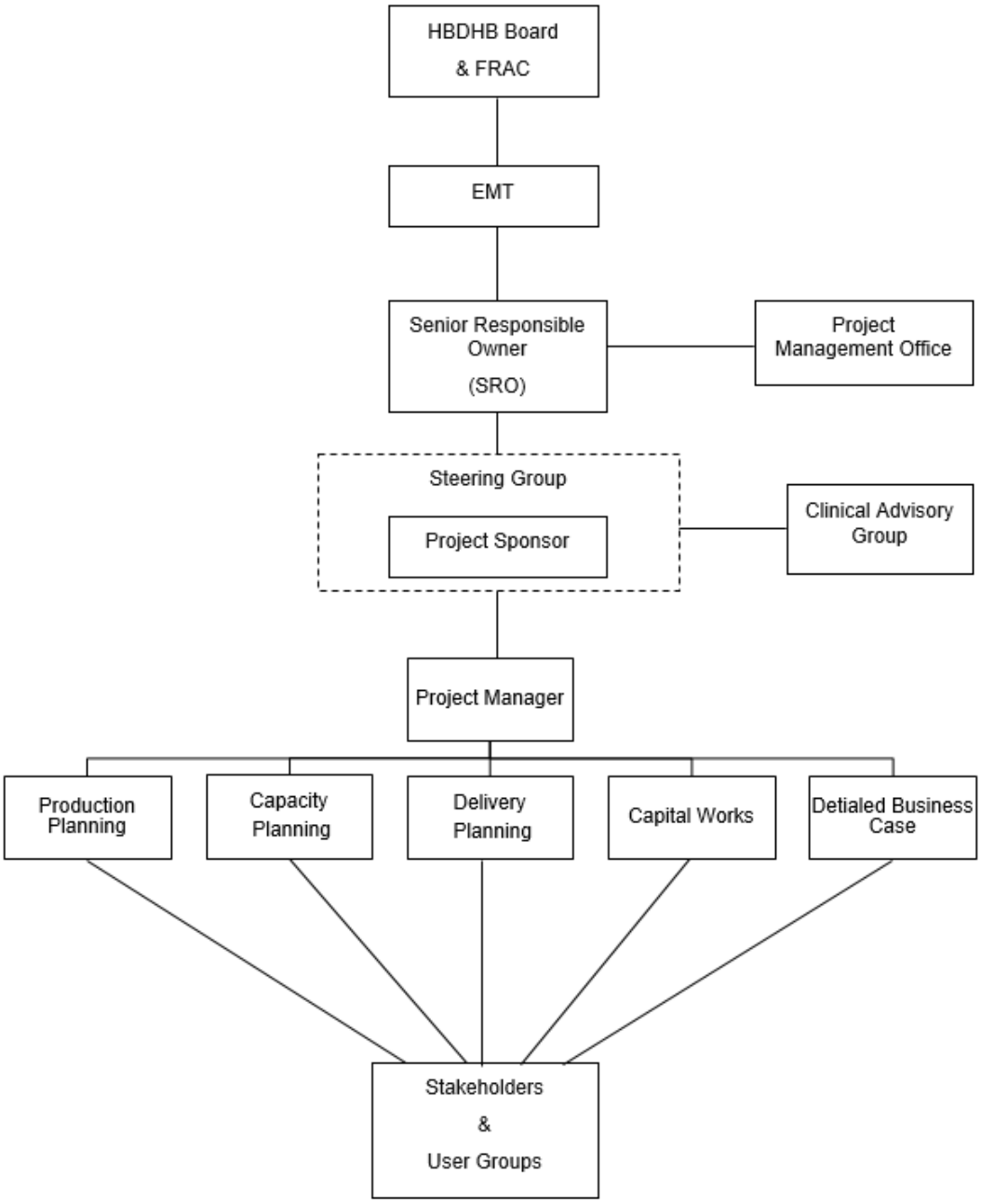


Image 4: Shows the organisation chart for the Project

Appendix 15 Risk Ratings

	IMPACT	High - Major or extensive POSITIVE impact	Medium – Moderate POSITIVE impact	Low – Insignificant POSITIVE impact	High - Major or extensive NEGATIVE impact	Medium – Moderate NEGATIVE impact	Low – Insignificant NEGATIVE impact
Likelihood of risk occurring	CODE	H+	M+	L+	H-	M-	L-
High – almost certain to occur	H	9	8	4	-9	-8	-4
Medium – may occur / moderate chance	M	7	5	2	-7	-5	-2
Low – unlikely / rare	L	6	3	1	-6	-3	-1

Table 27: Shows the risk ratings used to calculate the level of risk

HAWKE'S BAY District Health Board Whakawāteatia

Appendix 16 Wrap Around Services Status

Wrap Around Services	Current Status	Impact of OT8	Impact of OT9 & 10
Surgical Wards	Struggles to cope with demand particularly with Medical outliers during winter months.	Capital and FTE investment required.	Sizeable capital and FTE investment required.
Outpatient Clinics	Most clinic spaces are full. Off-campus locations are also being used.	Capital and FTE investment required.	Sizeable capital and FTE investment required.
Pre Admissions	Lack of clinic rooms causes clinics to be held in inappropriate spaces. Lack of office space inhibits staff preparing patients' notes.	Lack of clinic rooms causes clinics to be held in inappropriate spaces. Lack of office space inhibits staff preparing patients' notes.	Lack of clinic rooms causes clinics to be held in inappropriate spaces. Lack of office space inhibits staff preparing patients' notes.
Anaesthetist office	Existing lack of office space inhibits administration of the department, individual practice, and oversight of trainees. FTE required.	Increased FTE coupled with already short fall of office space inhibits administration of the department, individual practice, and oversight of trainees. FTE required.	Increased FTE coupled with already short fall of office space inhibits administration of the department, individual practice, and oversight of trainees. FTE required.
Administration	Operates a reduced service during sickness or leave.	FTE required	FTE required
Pharmacy	Operates a reduced service during sickness or leave.	FTE required	FTE required
ICU/HDU	Tends to always be at capacity and fails to meet current demand.	Nursing FTE required to convert HDU beds to ICU beds	Further nursing FTE plus potential for increasing beds from 11 to 15
Orderlies	Lack of orderlies trained to work in theatre, struggles to cope with demand during sickness or leave.	FTE required + increased training.	FTE required increased training.
Laboratory	Struggles to cope with demand during sickness or leave. Capital investment currently underway to build a histology laboratory space to provide appropriate accommodation for today's volumes and service future expansion.	FTE required (Pathologist)	FTE required (Pathologist)
Allied Health	Work from General Surgery and Orthopaedics places strain on service. Struggles to cope with demand during sickness or leave.	Additional Bowel, joint replacement, and vascular surgery will place intense demands on service. FTE and additional equipment for the Short Term loans store required.	Any additional increase in volumes will required proportional FTE and equipment for the Short Term loans store required.
Maternity	The number of caesarean section births has levelled out, existing arrangements mostly working well.	The number of caesarean section births are not expected to increase, existing arrangements mostly working well.	Model of care changes required. Sufficient elective caesarean operating lists needed.

Paediatrics	Current capacity is able to manage surgical volumes.	Increased surgical volumes may require additional resources.	Increased surgical volumes may require additional resources.
Radiology	Majority of work is supporting General Surgery, Orthopaedics and Urology. Operates a reduced service during sickness or leave.	Image intensifier (II) and MIT needed to operate + impact on all diagnostics. FTE required.	Further FTE and potentially additional equipment.
Procurement, Logistics & Supply Chain	Struggles to cope with demand during sickness or leave.	FTE required. Storage systems will require some investment.	FTE required Storage systems will require investment.
Facilities (maintenance)	Operates a reduced service during sickness or leave.	Additional maintenance required to service new equipment.	Additional maintenance required to service new equipment.
Biomedical Engineering	Coping with demand although currently servicing more pieces of equipment per FTE than national guidelines. Operates a reduced service during sickness or leave.	FTE required.	FTE required As surgical equipment becomes more complex the skill mix and tools required to service equipment is becoming more technical and specialised.
Nutrition & Food Services - Kitchen	Currently at capacity for meal volumes with current staffing levels and equipment.	Kitchen could manage increased volumes with additional FTE and supplies. Additional equipment would also be required if meal numbers >30 meals.	Additional FTE and supplies required with increased meal numbers. Additional equipment would be required with increased meal numbers >40 meals.
Nutrition & Food Services - Dieticians	At capacity and has difficulty meeting current demand. Struggles to cope with demand during sickness or leave.	FTE required to meet demand pre and post-surgery.	FTE required to meet demand pre and post-surgery.
Sterile Services	The layout of the unit is very cramped and inefficient. Current flow of equipment as it goes through the cleaning process does not comply with the Standard at certain one point in the process.	Capital investment required to improve compliance and work around the encroachment of storage for sterile stores needed for the theatres.	Unit would need to be relocated to enable it to be expanded to the required size and an additional steriliser.
Surgical Bookers	Sometimes struggles to cope with demand during sickness or leave.	FTE required	FTE required

Table 28: Shows the current status of the wrap around services and the impact of theatres 8, 9& 10 if no changes are made.

Appendix 17 Glossary of Terms

Arranged Acute is when a patient presents under an acute admission, but does not necessarily require surgery immediately on arrival at the hospital. The patient is sent home and returns within 7 days for surgery or waits on an inpatient ward for surgery.

Back Filling refers to the use of a vacant theatre session that would otherwise be unused due to a cancelled theatre session when a surgeon is absent either due to leave or illness.

Case Weight measures the relative complexity of a surgical procedure.

CAG is an acronym for Clinical Advisory Group which is one of the governance groups of the Project. It is made up of key clinical stakeholder including senior medical officers (SMO's) and nurses from the Surgical Directorate as well as clinical representatives from the wrap around services that support surgery.

Clinical Pathways is one of the main tools used to manage the quality of healthcare concerning the standardisation of processes.

Discharges varies from volumes as a unit of measure as one patient may have multiple surgical procedures per discharge.

DSU is an acronym for Day Surgery Unit. Where approximately 90% of all elective surgery patients are admitted for pre-theatre preparation. Patients that are day cases will return to the DSU post operatively and be discharged home. Patients that require an overnight stay in hospital post operatively will go to an inpatient ward area.

Dry Theatre is a term used in contract negotiations with Private Providers to describe that the price includes a partly staffed operating theatre i.e. does not include the Surgeon.

Flow is the progressive movement of people, equipment and information through a sequence of processes.

HDU is an acronym for High Dependency Unit: where patients receive intensive one to one nursing, patients are breathing independently.

ICU is an acronym for Intensive care unit, where patients receive intensive one to one nursing, all patients are incubated.

IDF is an acronym for District Flows which is a National framework set up to enable DHB's to make best use of the Specialist Surgical Teams around the country to ensure all New Zealand residents can access the specialist care required.

Model of Care broadly defines the way health services are delivered. It outlines best practice care and services for a person, population group or patient cohort as they progress through the stages of a condition, injury or event. It aims to ensure people get the right care, at the right time, by the right team and in the right place.

PACU is an acronym for Post Anaesthetic Care Unit, formally known as Recovery. PACU provides intensive one to one nursing care to patients' in the immediate post-operative, post-anaesthesia and post-procedure period.

Patient Flow is the flow of patients between staff, departments and organisations along a pathway of care. How services are accessed, when and where assessment and treatment is available, and who it is provided by.

Pre Admissions Clinics: Elective patients are assessed pre-operatively a few weeks prior to their surgery date by a Nurse, House Officer and Anaesthetists. Fit and well patients having minor surgery may only require a telephone call from the anaesthetist, however a patient having complex surgery with some other sign cant health issues would attend a clinic at the hospital and might see the nurse house surgeon and Anaesthetist.

Perioperative is a globally recognised term used to describe the activities immediately before, during and after surgery.

Perioperative Unit (Periop) is comprised of the Pre Admission Clinics, Day Surgery Unit (DSU), the full suite of Operating Theatre s, Sterile Services and the Post Anaesthetic Care Unit (PACU).

Production Planning describes the way in which the operating theatre rosters are scheduled and both the number and type of cases are put through theatre on a given day. As acute cases happen as and when required the focus of Production Planning is on elective and arranged acute cases.

A **Session** is the term used for a half day theatre session. Session times are set as:
Morning Session: 08:30 –-12:30
Afternoon Session: 13:30 – 17:30
Full Day theatre session: 08:30 – 16:30

Session Utilisation refers to how many sessions were used out of the total available sessions.

Sterile Services Unit is responsible for the cleaning and sterilising of instruments and equipment used in theatre, Endoscopy, the wards and outpatient clinics.

Theatre Minutes describes the utilisation of a theatre session which varies depending on the type and complexity of the procedures being performed.

Theatre Reception: approximately 90% of acute surgery patients come via theatre reception from an inpatient ward prior to surgery for a final check in via a hospital bed or trolley pushed by an orderly. The patient flow of this entrance to theatre is designed for patients who are already at the hospital on the day of surgery.

Theatre Utilisation refers to the total theatre minutes used per session "wheels in/ wheels out" of theatre.

23 Hour Care Unit is a short stay unit for patients who require a slightly extended recovery from Surgery before going home. Currently Hawke's Bay Fallen Soldiers Memorial Hospital does not have one of these.

Volume: number of surgical procedures performed.

Wrap Around Services refers to the whole of Hospital support and resources required to support the patients' journey through their surgical pathway.

Wet Theatre is a term used in contract negotiations with Private Providers to describe that the price includes a fully staffed operating theatre including a Surgeon.

HAWKE'S BAY District Health Board Whakawāteatia	**HB Drinking Water Governance Joint Committee**	137
	For the attention of: **HBDHB Board**	
Document Owner & Author:	Ken Foote, Company Secretary	
Month as at	November 2017	
Consideration:	For Decision	

RECOMMENDATION

That the Board

1. **Note** the discussion at the October Board meeting (as recorded in the Minutes)
2. **Note** the Draft minutes of the meeting of the Hawke's Bay Drinking Water Governance Joint Committee held on Tuesday 24 October
3. **Approve** the updated Terms of Reference and accept membership of the Hawke's Bay Drinking Water Governance Joint Committee
4. **Appoint** two representatives (plus alternates) to participate and vote on the Joint Committee.

16

BACKGROUND – TERMS OF REFERENCE

The development of a Hawke's Bay Drinking Water Governance Joint Committee Terms of Reference (TOR) has been under discussions for some months. HBDHB provided feedback on an earlier draft, after considering it at the August Board Meeting. Most of the DHB suggested changes were subsequently incorporated into a revised version of the ToR that was then considered by member representatives at a meeting held on 24 October 2017. Draft Minutes of that meeting are attached.

Member representatives at that meeting unanimously agreed on a number of further changes which have been included in the attached (final) version of the ToR, which is now being submitted to all member organisations for approval / adoption. Of particular note, is the addition of clause 6.2 for clarity.

HBDHB representatives at the meeting (Kevin Atkinson and Ana Apatu) provided the Board a verbal update on these issues at the October meeting (noted in the minutes).

MEMBER REPRESENTATIVES

Clauses 3.2 and 3.3 of the ToR provide for:

3.2 Each member organisation may appoint two (2) representatives.

3.3 To ensure the work of the Joint Committee is not unreasonably disrupted by absences, each party may appoint alternative representatives.

Should HBDHB Board approve the attached ToR and accept membership of the Hawke's Bay Drinking Water Governance Joint Committee, representatives and alternates (if required) will need to be formally appointed.

Hawke's Bay Drinking Water Governance Joint Committee

Terms of Reference

1. Background

1.1. In August 2016 a significant water contamination event occurred that affected the Hawke's Bay community of Havelock North. The Government established an Inquiry into the Havelock North water supply.

1.2. It became apparent during the Government Inquiry that in order to achieve a systematic approach to ensuring safe and reliable drinking water, there was a need to strengthen interagency working relationships, collaboration and information sharing pertaining to drinking water.

1.3. The Inquiry asked a Joint Working Group (JWG) initially comprising staff representatives of the Hawke's Bay District Health Board, Hawke's Bay Regional Council and the Hastings District Council to implement its 17 initial recommendations. As this group has evolved it has become apparent that many drinking water issues will require an ongoing forum for regional collaboration and decision making. Napier City Council has also joined the Joint Working Group, as well as a Drinking- Water Assessor from the Central North Island Drinking Water Assessment Unit.

1.4. Ngāti Kahungunu Iwi Incorporated has called for the agencies involved in water management to view water as a taonga, the lifeblood of the land and people. They consider that drinking water should be set as the number one priority for water use in decision-making processes related to water.

1.5. It is within this context that the Hawke's Bay Drinking Water Governance Joint Committee has been established. The principal focus of the Committee is on drinking water, however drinking water cannot be considered in isolation from other fresh water management issues. For that that reason the focus of the Committee will be twofold:

1.5.1. To provide governance oversight for planning and decision making on regional drinking water matters; and

1.5.2. To consider and make recommendations where appropriate to decision-making bodies with responsibility for broader freshwater management issues or planning, or infrastructure issues that have implications for drinking water and/or drinking water safety.

2. Purpose

2.1. The parties agree that water is a taonga, the lifeblood of the land and people. They further agree that the Joint Committee established under this Terms of Reference is intended to give practical meaning and effect to this agreement.

2.2. The Committee is established to provide governance oversight to the existing JWG regarding the implementation of recommendations from the Inquiry Panel and then the evolution of the JWG into a more permanent officials working group.

2.3. In the context of this agreement including 2.1 and 2.2 above, the purpose of the Hawke's Bay Regional Drinking Water Governance Joint Committee is to give governance oversight and direction in respect of:

2.3.1. Programmes and initiatives to protect and enhance drinking water quality, quantity, safety and reliability

2.3.2. Improving and maintaining effective inter-agency working relationships relating to drinking water, including monitoring the extent and effectiveness of cooperation, collaboration and information sharing between the agencies, monitoring mechanisms to achieve these desired outcomes, and encouraging member parties to give adequate

consideration to the safety and reliability of drinking water in the carrying out of their range of functions

2.3.3. strategies, priorities and implementation monitoring related to drinking water management, including drinking water sources, infrastructure matters and drinking water emergency response

2.3.4. recommending to relevant decision making fora (including bodies with responsibility for regional and district level planning), initiatives and priorities affecting drinking water and changes to strategies and work programmes to protect and enhance drinking water quality, quantity, safety and reliability, having regard to the needs of the region for adequate and secure water resources suitable for the supply of safe drinking water.

2.4. The geographic scope of the Joint Committee's jurisdiction shall be over drinking water related matters on the land and catchment areas within territorial authorities who elect to be members of the Joint Committee (the participating territorial authorities) plus such other land and catchment areas within the authority of the Hawke's Bay Regional Council that have an impact upon drinking water within the participating territorial authorities.

3. Members/Parties

3.1. If they elect to take up membership and establish the Joint Committee, each of the following shall be a Member Organisation of the Hawke's Bay Drinking Water Governance Joint Committee and a party to this document and the establishment of the Joint Committee:

3.1.1. Hawke's Bay District Health Board

3.1.2. Hawke's Bay Regional Council

3.1.3. Central Hawke's Bay District Council

3.1.4. Hastings District Council

3.1.5. Napier City Council

3.1.6. Wairoa District Council

3.2. Each member organisation may appoint two (2) representatives.

3.3. To ensure the work of the joint Committee is not unreasonably disrupted by absences each party may appoint alternative representatives.

3.4. The Joint Committee shall appoint an Independent Chairperson of the Joint Committee, at the beginning of each triennium. The Independent Chairperson shall be appointed for that term of the Joint Committee but is not precluded from a subsequent term as Independent Chairperson if so appointed.

3.5. Water is of particular importance to Māori, and Māori have certain statutory rights in respect of decision making relating to water under the Resource Management Act 1991 and the Local Government Act 2002. Some iwi representatives have been involved in discussions leading to the proposal for this Joint Committee but have not determined whether or not they wish to formally participate on the Joint Committee. Provision is made for Māori representation to be added to the Committee should Māori organisations with authority in respect of the geographic areas over which this Joint Committee has jurisdiction indicate that they wish to formally join the Committee.

3.5.1. Notwithstanding any decision by Māori organisations under 3.5 above, the member organisations will take steps to consult with, and take into account the interests of, Māori as appropriate in terms of local authority decision making requirements in respect of matters before the Joint Committee.

4. Name

4.1. The Hawke's Bay Drinking Water Governance Joint Committee shall be known as the **Hawke's Bay Drinking Water Governance Joint Committee (HBDWGJC).**

5. Status

5.1. By agreement of the local authority members, the Hawke's Bay Drinking Water Governance Joint Committee is established as a Joint Committee under clause 30 and clause 30A of Schedule 7 of the Local Government Act 2002. It is a Committee of each of the member local authorities.

5.2. By this agreement between the parties, the Committee shall also include members who are not local authorities.

6. Delegated Authority

6.1. The Hawke's Bay Drinking Water Governance Joint Committee shall have authority to undertake such steps as are necessary to give effect to the purpose of the Hawke's Bay Water Governance Joint Committee including:

6.1.1. Reviewing and amending as necessary the Terms of Reference for the Joint Working Group that comprises officers working for the member organisations

6.1.2. Receiving reports from and giving direction to the officials Joint Working Group that leads interagency cooperation and work programmes on drinking water quality, quantity, safety and reliability and/or the Chief Executives of the member agencies

6.1.3. Commissioning reports and studies

6.1.4. Making recommendations to member organisations about strategies, priorities and work programmes relating to the quality, quantity, safety and reliability of drinking water

6.1.5. Making recommendations to appropriate parties on matters within the purpose of the Joint Committee.

6.2. For avoidance of doubt, the Hawke's Bay Drinking Water Governance Joint Committee shall have authority to make recommendations to Member Organisations, but has NOT been delegated and does not bear any legal responsibility for:

6.2.1. Any power or function that cannot be delegated by a local authority in accordance with clause 32 Schedule 7 of the Local Government Act 2002; and

6.2.2. Directing, instructing or committing any Member Organisation to a particular course of action, operational activity, strategy or work programme relating to the quality, quantity, safety and reliability of drinking water.

7. Administering Authority and Servicing

7.1. The members of the Hawke's Bay Drinking Water Governance Joint Committee shall work with the JWG established to lead interagency cooperation and work programmes on drinking water quality, quantity, safety and reliability. The JWG, together with the Chief Executives of the member agencies, will provide reports and information to the Joint Committee.

7.2. The Administering Authority of the Joint Committee shall be the Hawke's Bay Regional Council.

8. The Remuneration

8.1. Each member organisation of the Hawke's Bay Drinking Water Governance Joint Committee shall be responsible for the cost of its participation on the Joint Committee.

8.2. The Joint Committee shall agree on the apportionment of the costs of the Independent Chairperson on the recommendation of the JWG.

8.3. The JWG shall agree, by consensus, the apportionment of any costs arising from the work approved by the Joint Committee.

9. Meetings

9.1. The Standing Orders of the Hawke's Bay Regional Council will be used to conduct Joint Committee meetings.

9.2. The Joint Committee shall meet not less than 6 monthly or at such other times and places as agreed for the achievement of the purpose of the Joint Committee.

10. Quorum

10.1. The quorum at any meeting shall be not less than half of the member representatives on the Joint Committee plus one representative, provided that each of the member organisations shall have at least one representative present, and the number present includes the Independent Chairperson.

11. **Voting**

11.1. The membership shall strive at all times to reach a consensus.

11.2. Each representative and the Independent Chairperson shall be entitled to one vote on any item of business.

11.3. There shall be no casting vote.

12. Chairperson and Deputy Chairperson

12.1. Member representatives shall appoint, by agreement, an Independent Chairperson who shall be entitled to one vote, and in the case of an equality of votes does ***not*** have a casting vote.

12.2. The Joint Committee shall also appoint, every three years, by simple majority vote from among the representatives, a Deputy Chairperson.

13. **Variations**

13.1. Any Member may propose an amendment (including additions or deletions) to the Terms of Reference which may be agreed to by the Joint Committee as a recommendation for consideration by the member organisations.

13.2. Once agreed to by the Joint Committee, amendments to the Terms of Reference shall have no effect until each member organisation has agreed to the amendment.

14. Review

14.1. The member organisations agree that these Terms of Reference shall be formally reviewed at least once every three years

15. **Good Faith**

15.1. The parties to this Terms of Reference agree to act in good faith towards each other and to give effect to the purpose of the Joint Committee.

Dated: ----------

Signed on behalf of the Hastings District Council _____

Signed on behalf of the Napier City Council _____

Signed on behalf of the Central Hawke's Bay District Council _____

Signed on behalf of the Wairoa District Council _____

Signed on behalf of the Hawke's Bay District Health Board _____

Signed on behalf of the Hawke's Bay Regional Council _____

Unconfirmed

MINUTES OF A MEETING
OF THE HAWKE'S BAY DRINKING WATER GOVERNANCE
JOINT COMMITTEE

Date: Tuesday 24 October 2017

Time: 1.00pm

Venue: Council Chamber
Hawke's Bay Regional Council
159 Dalton Street
NAPIER

Present:
T Aitken (CHB DC)
A Apatu **(HB DHB)**
K Atkinson (HB DHB)
P Bailey (HBRC)
T Belford (HBRC)
S Burne-Field (CHB DC)
S Hazlehurst (HDC)
K Price (NCC)
C Tremain (Acting Chair)
K Watkins (HDC)
K Wise (NCC)
S Nixon (HDC Alternate)

In Attendance:
L Hooper – HBRC Governance Manager
J Palmer – HBRC CE
I Maxwell – HBRC Group Manager Resource Management
R McLeod – HDC CE
W Jack – NCC CE
N Jones – HB DHB
C Thew – HDC

1. Welcome/Apologies/Notices

James Palmer, acting as Chair to open the meeting, welcomed everyone to the meeting.

There was discussion about the appointment or election of a Chairperson for the Joint Committee and agreement reached that Chris Tremain be invited to act as Chair for today's meeting, and that an Independent Chair be sought rather than electing one of the member agency representatives.

Mr Tremain introduced the purpose of the Joint Committee as established out of the Working Group tasked with implementing the recommendations of the Havelock North Government Inquiry.

2. Conflict of Interest Declarations

There were no conflict of interest declarations.

Ms Ana Apatu advised that she has agreed to participate on the HDC-HBRC "Gastro Outbreak Community Assistance Scheme" application assessment panel and so will consider whether that precludes her appointment to the Joint Committee when the District Health Board is making its appointments.

3. Member Agency Appointments

The intent of the item is to confirm those appointments made to date, by member agencies.

Discussion traversed:

- Maori representation and whether representatives from the Regional Planning Committee be sought – to enable wider PSG involvement, which was agreed to by those present
- Additional stakeholder groups that may be invited to join the membership of the Joint Committee, e.g. Drinking Water Assessors, and note that all 'other appointments' will need to be agreed by the participating councils.
- The District Health Board has yet to appoint representatives, and will do that once the Board has met and formally adopted the Terms of Reference and agreed participation on the Joint Committee.
- No representatives of Wairoa District Council present.

DWG1/17

Resolutions

That the Hawke's Bay Drinking Water Governance Joint Committee:

1. Receives and notes the "Member Agency Appointments" staff report.
2. Confirms the following appointments to the Joint Committee by Member Agencies, being:
   - 2.1. Councillors Tim Aitken and Shelley Burne-Field representing Central Hawke's Bay District Council, and Mayor Alex Walker as Alternate
   - 2.2. Councillors Sandra Hazlehurst and Kevin Watkins representing Hastings District Council, and Councillor Simon Nixon as Alternate
   - 2.3. Councillors Paul Bailey and Tom Belford representing Hawke's Bay Regional Council
   - 2.4. Councillors Keith Price and Kirsten Wise representing Napier City Council
3.. Notes that representative appointments for the Hawke's Bay District Health Board and Wairoa District Council are still to be confirmed.

Tremain moved from Chair
CARRIED

4. Independent Chairperson's Appointment and Election of Deputy Chairperson

Indications from the group support the appointment of an Independent Chair and so the process for such an appointment to be undertaken was discussed. A suggestion was made that Mr Tremain consider the JC Chair role, and seek appointment of a replacement Chair for the Joint Working Group.

There is an expectation that the inquiry will give a significant regional work programme to the Joint Working Group, which will in turn require Governance oversight and direction from the Joint Committee.

An invitation was extended, to representatives present, for membership on the Appointments Panel – with willingness expressed by Paul Bailey, Sandra Hazlehurst, Kirsten Wise and Tim Aitken, all of which were accepted.

DWG2/17 **Resolutions**

That the Hawke's Bay Drinking Water Governance Joint Committee:

1. Receives and notes the "Independent Chairperson's Appointment and Election of the Deputy Chairperson" staff report.
2. Agrees to the appointment process for an Independent Chairperson for the DWGC; being:
   - 2.1. Establishment of an Appointments Panel consisting of Paul Bailey, Sandra Hazlehurst, Kirsten Wise, and Tim Aitken, with Kirsten Wise to act as Chair of said Panel.
   - 2.2. Appointments Panel to establish criteria for the role and seek expressions of interest
   - 2.3. Appointments Panel to short-list candidates if required, and carry out interviews of those shortlisted
   - 2.4. Appointments Panel to make recommendation for appointment, including remuneration, to the DWGC.
3. Defers appointment of the Deputy Chairperson of the Hawke's Bay Drinking Water Governance Joint Committee until after appointment of the Independent Chairperson is confirmed.

Tremain moved from Chair
CARRIED

5. Hawke's Bay Drinking Water Governance Joint Committee Terms of Reference

Discussions covered:

- the purpose of the joint committee, including to continue the oversight provided by the Inquiry Panel once it's finished its process
- the legal responsibilities of agencies to deliver responsibilities and services as legislated, and collaboration between them
- the JC as part of the Governance structure of each of the member councils
- potential for cost sharing for the commissioning of work by the JC where required
- communication flows to the public – from the JWG, individual agencies, representatives on the JC, HBRC as administering authority for the JC
- agreement reached that case by case consideration will be given to communications and media releases, based on individual messages and who is

best, possibly geographically, to speak on behalf of the group

- Representatives on the JC are accountable for ensuring that the agency that appointed them collaborates and contributes to the efficient delivery of safe drinking water to the region.
- JC sets the Terms of Reference and work programme priorities for the JWG.
- Each agency is still legally responsible for the functions it is legislated to provide.
- Suggestion that once the JWG provides the JC with the work it's been doing, members will better understand what the Governance role and purpose entails
- Various amendments as proposed and highlighted in the attachment to the agenda, were agreed for recommending back to councils and the DHB for adoption.

DWG3/17

Resolutions

That the Hawke's Bay Drinking Water Governance Joint Committee:

1. Receives and notes the "Terms of Reference" staff report.
2. Agrees the finalised Terms of Reference as amended by today's meeting for referral back to each Member Organisation for agreement and adoption.

Tremain moved from Chair
CARRIED

6. Joint Working Group Work Plan

Next meeting will consist of a series of briefings on the Work Plan.

Queries and discussion traversed:

- Issues will be brought to the JWG for discussion and information sharing
- JWG Terms of reference need to be reviewed and re-set at the next meeting.
- Inquiry's report to government scheduled 8 December – with possible legislative change to follow.

Recommendation

That the Hawke's Bay Drinking Water Governance Joint Committee receives and notes the "Joint Working Group Work Plan" report.

Closure:

There being no further business the Chairman declared the meeting closed at 2.55pm on 24 October 2017.

Signed as a true and correct record.

DATE: ..... **CHAIRMAN:** .....

HAWKE'S BAY District Health Board Whakawāteatia	**Governance Reports and Presentations - Principles, Standards and Guidelines** 138
	For the attention of: **HBDHB Board**
Document Owner & Author:	Ken Foote, Company Secretary
Reviewed by:	Executive Management Team and Māori Relationship Board
Month:	November 2017
Consideration:	For Approval

RECOMMENDATION

That the HBDHB Board:

1. **Note** MRB's request that all governance reports meet the requirement to address the impact on reducing inequities/ disparities by including and recording specifically:
   - Key outcomes/impacts on vulnerable populations
   - Implications/outcomes arising from the application of a HEAT tool
2. **Note** Consumer Council's request to ensure that the level and nature of consumer engagement is noted on all governance reports.
3. **Adopts** the proposed 'Principles, Standards and Guidelines' for Governance Reports and Presentations, including the proposed 'Governance Report Overview'.

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BACKGROUND

In recent months, MRB have expressed concern about the quality of some of the reports coming to them for consideration, discussion and/ or approval.

On being advised of some 'Principles, Standards and Guidelines' issued in 2013 to address similar concerns at that time, MRB requested this to be updated. Such an update should address not only general quality concerns, but also specific requirements to ensure authors and reports:

- Have a checklist of issues to consider;
- highlight impact on inequity;
- use appropriate language;
- identify how Māori and others have been involved in co-design; and
- address issues involving social complexity and impacts on vulnerable populations.

At their meeting held on 8 November 2017, MRB noted and supported the attached Principles, Standards and Guidelines as an appropriate way of addressing their concerns, and recommended them to the HBDHB Board for adoption.

Similarly, Consumer Council have expressed concerns about the lack of reference to the level and nature of consumer engagement in the development of reports. Consumer Council's Chair had requested that this issue be addressed.

Several HBDHB Board members have also expressed concerns about the general quality of some reports.

UPDATED PRINCIPLES, STANDARDS AND GUIDELINES

The attached 'Principles, Standards and Guidelines' have been updated to address all the above concerns. While much of the document relate to qualitative issues, the Governance Report Overview focusses on content. The use of this Overview as both a checklist and a summary should provide a level of assurance that those issues of importance to governance, have been appropriately considered and included in the report.

HAWKE'S BAY
District Health Board
Whakawāteatia

GOVERNANCE REPORTS AND PRESENTATIONS

17.1

PRINCIPLES
STANDARDS AND GUIDELINES

Document Owner: Ken Foote, Company Secretary **November 2017**

Introduction

Board, MRB, PHLG, Clinical and Consumer Council members within the Hawke's Bay District Health Board (HBDHB) have responsibilities to give advice, make decisions, provide direction and generally provide assurance that HBDHB is performing well and meeting the goals objectives and obligations required of it. To do much of this they must rely on information and recommendations provided to them by management and senior clinical advisors through relevant reports and presentations. The quality and credibility of these, reports and presentations therefore, have the potential to significantly impact on the ability of these governance groups to effectively fulfill their responsibilities.

Recent experience has indicated that the quality of Reports and presentations needs to generally improve for the various governance groups to feel more confident about the advice they are receiving. Such improvement in the quality of reporting will be achieved through:

- Standards and Guidelines
  - The requirement to comply with the content standards, quality control measures and process guidelines set out in this report.
  - These standards and guidelines were first issued in March 2012, and have now been updated and refreshed to meet current requirements
- Governance Report Overview:
  - The requirement to complete a Governance Report Overview will provide a 'checklist' to ensure all relevant issues have been addressed in such reports.
- Training:
  - The identification and provision of relevant training

Given the potential implications of poor quality reporting, it needs to be noted that failure to comply with these standards, requirements and guidelines could result in a report or presentation being withdrawn from the agenda of a targeted meeting until the quality of the report or presentation is improved. It is the document owner and/or presenters personal responsibility to "get it right". Appropriate support assistance and advice is available if required.

K Snee
CEO

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17.1

1.0 REPORTS

1.1 Define a Report

A report is a document that communicates information gathered from research or analysis.

Characteristics of Reports

Reports that work	Reports that don't work
• Focus on the reader	• Are written from the writer's perspective
• Have a clear purpose	• Do not have a clear purpose
• Include only relevant content	• Are often simply a 'data dump'
• Have an easy-to-follow, cohesive structure	• Are muddled – findings, conclusions, and recommendations are mixed up
• Build a logical argument	• Have conclusions and recommendations that the evidence does not support
• Clearly acknowledge conflicting information	• Present only the information that supports preconceived ideas
• Add value by analyzing and interpreting	• Report only the data or events
• Present information in a variety of ways	• Contain too few tables, diagrams, graphs and lists
• Have frequent and informative subheadings	• Have infrequent and unhelpful headings and subheadings
• Use precise, familiar words.	• Use jargon and difficult words

1.2 Good Reports Should Meet a Standard

The standard adopted by HBDHB for all reports is Write Limited's Plain English Standard ie.

The Standard

1. The purpose of the document is clear at the start.
2. The content supports the purpose of the document.
3. The order of the content is clear and logical.
4. The headings are informative and clearly signpost the main messages.
5. The paragraphs are mostly short and focus on one topic.
6. The sentences are mostly straight forward.
7. The words are precise and familiar.

8. The tone supports the purpose of the document.
9. The layout helps the reader absorb the messages quickly and accurately.
10. The document is error free.

1.3 Good Reports Require a Good Process

The quality of any report will be significantly enhanced if a good, logical process is followed in structuring and writing it.

Guidelines for a Good Process include:

1.3.1 Identify the needs of your reader:

For Governance reports, you will have a general profile of your readers. For example you will have some idea of the level of knowledge your readers already have of your subject matter, which may influence your use of technical terms and assumptions you make.

Your tone should reflect the governance role provided by the group ie. reasonably formal and respectful.

1.3.2 Identify your purpose and desired outcome:

- You need to know exactly why you are writing your report, and what you want to achieve.

The purpose is why you are writing

The purpose may be to: Propose or recommend Seek direction Respond to a request Alert to a problem Present findings Update – annually, 6-monthly, when needed Request data or information

The outcome is what you want to achieve

The outcome may be: A decision A course of action approved A matter clarified or explained An accurate record An informed meeting A satisfied board or committee.

- Your purpose needs to be clearly stated up-front and where possible, reflected in the title of your report.

- Your outcomes should be reflected in your conclusions and/or recommendations.
- Your purpose and recommendations must match.

1.3.3 Use a writing process:

- Think – consider purpose, outcome, main messages, structure, and language.
- Outline – use diagrams, mind maps, headings and bullets, whiteboard,
- Write – write quickly, don't edit as you go.
- Edit – check purpose, outcome, main messages, structure, language
- Proof read – check grammar, punctuation, spelling, consistency, accuracy.

1.3.4 Collect and group your content:

Once you have identified your reader and your purpose, you need to:

- Collect your data
- Identify how much of the data you will need
- Group your data
- Place the groups into the best order for your reader and your desired outcome.

1.3.5 Use a Logical Structure:

The structure of reports needs to be sufficiently flexible, depending on what the report is, what its purpose is and what the reader requires of it.

Most reports however will have eight sections.

- Cover / Title Page (Governance Report Format)
- Table of Contents
- Executive Summary
- Introduction
- Problem or Opportunity Definition
- Body or discussion
- Findings and conclusions
- Recommendations

Additional levels of detail and/or information used and referred to in the body of the report may be attached as Appendices if you believe the reader may wish to refer to this. Avoid overusing appendices however, where they do not actually add value to the report.

Make appropriate use of headings and "sub headings". These should signal the content below so make sure they are informative and relevant.

1.3.6 Use Plain Language:

Plain language focuses on the reader. A plain English document is easy for the intended reader to read, understand and recall.

The Plain English Campaign defines plain English as:

- information that conveys its meaning clearly and concisely to its intended audience with the necessary impact and appropriate tone of voice; and
- language that the reader can understand and act upon from a single reading.

When documents are written plainly, readers are more likely to:

- understand and act on the information; and
- see you as credible and sincere.

Plain English is not 'dumbing down' the language, over-simplifying the message, or creating a 'one-size-fits-all' style of writing.

It is about applying the principle of "Health Literacy" or making health easy to understand. This includes minimizing the use of acronyms and 'jargon' or ensuring explanations are provided to assist the reader.

1.3.7 Write Easy to Read Sentences:

Keep your sentences relatively short and simple. Aim for an average of 15-20 words. Try to vary your sentence length within paragraphs to avoid a monotonous tone. Using transition words and phrases creates flow between you sentences.

Aim to:

- Keep to one main idea per sentence
- Put the main message first
- Keep subjects short
- Avoid interrupting the subject-verb connection.

1.3.8 Write Clear Recommendations

Recommendations are your opinion of the course of action that should be followed. Recommendations must be supported by the information, evidence, and analysis within the body of the report. The fundamental rule is 'no surprises'. You cannot recommend what you haven't discussed in your report.

A good recommendation will make sense independently from the body of the report – it can be lifted untouched from your report, voted on at a meeting, and recorded with confidence.

In addition, good recommendations:

- Identify all the decisions needed;
- make clear what is being decided;
- sometimes include a benefit statement
- set out clear options, if necessary;
- give clear instructions on the next steps; and
- identify who is to do what, by when.

Remember to keep recommendations:

- separate from your conclusions;
- accurate in every detail;
- free from discussion;
- free from acronyms and abbreviations.

Make sure your purpose and recommendations match

Always check that your purpose and recommendations match. If you include an action recommendation (agree, approve), then the purpose must make it clear to the reader that you are seeking a decision. (This paper seeks your approval for …)

1.3.9 Check your Report

Check your report against the Standard. Only when you are satisfied that your report meets the standard and has addressed and met the needs of the reader, should you pass it on for quality assurance.

1.4 Governance Report Overview

In addition to the above report development process, HBDHB Board have requested the reintroduction of a Governance Report Overview, to be included in Governance meeting agendas, immediately preceding any Governance Report. The purpose of this Overview Report is to immediately highlight to the Governance Groups:

- What the report is about;
- key background issues; including who has been involved / engaged;
- what the likely implications are;
- relevance of the report to priority areas of interest, particularly equity;
- the level and nature of engagement/consultation undertaken; and
- what the recommendations are.

A Template for this Governance Report Overview is attached as **Appendix A**.
Guidelines for completing this Overview are:

- include only high level key points;
- maximize use of bullet points
- should not cover more than two pages;
- must directly reflect the report to which it relates; and the
- template must be used in full, unaltered (enter “nil” on “N/A” if any section does not apply.

For ‘minor’ or very short reports, this Governance Report Overview may be used in lieu of an Executive Summary in the report itself. Care will need to be taken when doing this however, to ensure that the report itself would still be able to “stand alone” once it was disconnected from the Governance Agenda, and the associated Overview.

The Overview template headings should be used as a checklist at the beginning of the report writing process, particularly when “identifying the needs of your reader”. Having done this, all the issues/sections in the Overview Report should be addressed (or at least referred to) in the report itself. Extracting and/or summarizing these points from the Report for insertion into the Overview should then be a very simple process.

The final check is to ensure that the “Recommendation” reflects the “Purpose”!

2.0 QUALITY ASSURANCE - Reports

Despite our best endeavors, it is often difficult to be totally effective in constructively reviewing, editing and proofing our own work in preparing a report. The assistance of a PA or Team Secretary is often the first “independent” quality assurance step in the process as the document is constructed.

Beyond this, it is strongly recommended that Board reports are independently reviewed against the standards before submission to the Board Administrator for inclusion in any Agenda. This independent review needs to cover three key aspects of the report:

2.1 Content

Does the content meet the needs of the reader, is it logical, clear, easy to read and does it support the purpose of the document.

2.2 Specialist Subject Information

Is all specialist subject information accurate and any comment assumptions or deductions related to it supported by in house specialist subject "experts" eg., clinical/finance/Maori etc.

2.3 Layout, format and Language

Does the report meet the appropriate standards and guidelines for layout, font size, headings, paragraphs, sentences, words etc., and is it free or errors?

Whilst it is possible for one person to review all three components; generally three separate people will need to be involved ie.

- **Content**

Normally a peer or senior manager who has some familiarity with the subject, but who has not been directly involved in the development of the report. It needs to be someone who can take a Board member perspective. The Company Secretary could provide this function, if required.

- **Specialist Subject Information**

The clinical leader, manager or senior team member of the specialist team are the obvious choices to conduct this part of the review.

- **Layout, format and Language**

An experienced EA, PA or Team Secretary would be best placed to provide input or assurance on these issues.

Once all comment, input or assurance is received and the report modified or confirmed as appropriate, the report can then be placed on the appropriate EMT, FRAC, MRB, PHLG, Clinical/Consumer Councils or Board Agenda (as appropriate) with some confidence.

3.0 PRESENTATIONS

Presentations to the Board, FRAC, MRB, PHLG or Councils will normally be:

- Presentation of a report or paper previously distributed.
- Presentation on a new topic, for which no information has been previously distributed.

The key features and difference with each of these are:

- **Presentation on a report or paper previously distributed:**
  - Very clear purpose – to introduce the report, highlight the key points, initiate discussion and clarify the desired outcome.
  - May assume the paper has been read by all attendees.
  - Focus only on the key points.
  - No new information to be included.
  - Ensure all information aligns exactly with the report.
  - Keep it short and succinct.

- **Presentation on a new topic**
  - Requires purpose to be clearly stated up front.
  - The content supports the purpose
  - The content is clear and logical
  - Requires a similar process to that for writing a report.
  - The conclusions are supported.
  - The recommendations are clearly laid out and are directly aligned to the purpose.

In addition to the differences in purpose and structure identified above, there are many styles of presentation available, and also a variety of visual aids. Despite these differences however, there are some general principles that can be applied to all presentations, particularly those where Power Point slides are used.

3.1 Principles

3.1.1 Preparation

- Be clear about the purpose
- Structure to suit the audience and the time allocated.
- Tell a story in a logical sequence
- Stick to the key concepts
- Strive for clarity
- Finish strongly
- Rehearse – know what you are talking about and how long it takes.

3.1.2 Power Point

- Focus – using as few slides as possible
- Clarity and consistency – use clear simple visuals and contrast colours

- Use simple graphics where appropriate
- Keep text short – bullet points
- Use slides as prompts and highlights to talk to – not the whole story.
- Aim for impact and to maintain audience attention.
- Final slide = lasting thought
- Proof read to ensure accuracy

3.1.3 Delivery

- Arrive early/set up/ensure technology is working.
- Provide handouts before starting
- Jump right in and get to the point
- Give your rehearsed opening statement – don't improvise at the last minute.
- Talk at a natural moderate rate of speech.
- Project your voice, speaking clearly and distinctly
- Be flexible to keep within the time allocated.
- Relax
- Show some enthusiasm
- Concisely summarise
- End with the summary statement or questions you have prepared.

4.0 QUALITY ASSURANCE - Presentations

Presentations should follow a similar quality assurance process to reports, particularly checking on:

- Content
- Specialist Subject Information
- Layout, format and language

In addition, it is strongly recommended that all presentations be rehearsed/practiced in front of a peer/manager, for their comment or feedback, and also to assist with confidence.

Appendix A. Governance Report Overview Template

HAWKE'S BAY District Health Board Whakawāteatia	**Title of Paper**
	For the attention of: **HBDHB Board / Finance Risk and Audit Committee / Māori Relationship Board / Pasifika Health Leadership Group, Clinical or Consumer Council**
Document Owner:	Name, Designation
Document Author(s):	Names, Designations
Reviewed by:	Name / Group
Month:	Month, Year
Purpose	• Decision • Input/Discussion • Monitoring • Information
Previous Consideration Discussions	• HBDHB Board • Finance Risk and Audit Committee • Māori Relationship Board / Pasifika Health Leadership Group/ Clinical Council / Consumer Council
Summary	• Key Issues/Actions
Contribution to Goals and Strategic Implications	• Improving quality, safety and experience of care • Improving Health and Equity for all populations • Improving Value from public health system resources
Impact on Reducing Inequities/Disparities	• Key outcomes/impacts on vulnerable populations • Application of HEAT Tool – Implications / Outcomes
Consumer Engagement	• Level of engagement undertaken • Summary of input / feedback / comments received
Other Consultation /Involvement	• Who else was consulted / involved? • How was consultation undertaken and input incorporated?
Financial/Budget Impact	• Capital • Operating Costs/Revenue
Timing Issues	• Critical dates • Indicative timelines
Announcements/ Communications	If any: • Internal • Key Stakeholders • Community • Responsibility • Mode/method • Timing

RECOMMENDATION:

It is recommended that the xxxxx:

1. X
2. x

or

- x
- x

HAWKE'S BAY District Health Board Whakawāteatia	**Ka Aronui Ki Te Kounga – Focussed on Quality Our Quality Picture 2017 (Quality Accounts)** 139
	For the attention of: **HBDHB Board**
Document Owner: Document Author:	Kate Coley, Executive Director of People & Quality Jeanette Rendle, Consumer Engagement Manager
Month:	November 2017
Consideration:	For endorsement

RECOMMENDATION

That the Board:

1. **Endorse** "Ka aronui ki te kounga - Focussed on quality" for publication.

OVERVIEW

The publication of the annual Quality Accounts was initiated in 2013, following the Health Quality & Safety Commissions (HQSC) guidance publication in July 2012 and the MOH's request that Quality Accounts should be produced annually. Since that time HB health sector has published four sets of accounts detailing our performance against both national and local quality and safety indicators.

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The Quality Accounts are annual reports to the public from DHBs about the quality of services they deliver. As they are aimed at our community the intention is to keep them as short as possible, be visual, simple to read and understand, using photo's, images, stories, quotes, and examples to enhance the results and achievements.

The guiding principles are:-

- Accountability and transparency
- Meaningful and relevant whole of system outcomes
- Continuous quality improvement

FEEDBACK ON HB QUALITY ACCOUNTS 2016

Last year a working group was established to support the development and review of the Quality accounts publication for our community. It was a huge undertaking and presented multiple challenges. The link to last year's accounts as follows:
http://www.ourhealthhb.nz/assets/Publications/Our-Quality-Picture-2016-sml2.pdf

Previously the HQSC has reviewed all Quality Accounts providing annual feedback individually to DHB's and across New Zealand. From 2016, HQSC no longer provide feedback.

In 2016 around 400 publications and accompanying advertising posters were distributed across the community – to GP practises, health centres, public libraries, and community groups. The accounts were advertised in local newspapers and available on ourhealth website. It has been difficult to quanitify the level of readership. Feedback from the community was limited.

The feedback from stakeholders and community that we did receive resulted in the recommendation to have a smaller, more concise document this year with increased focus on the

quality improvements that have come about from community feedback and consumer engagement. A ‘you said, we did” type format. Also, less emphasis on improvements and quality initiatives within services (which perpetuates the idea of working in silos) with increased emphasis on improvements as a result of working together across the sector; in particular more content from Primary care.

QUALITY ACCOUNTS 2017
The communications team developed a template based on the recommendations from last year. The articles within were compiled through consultation with previous steering group and through consultation and guidance from EMT, MRB, Consumer and Clinical Councils.

Recommendation:
EMT, MRB, HB Consumer and Clincial Councils have endorsed the Quality Accounts for publication.

We recommend that the Board also endorses this years quality accounts “Ka aronui ki te kounga - Focussed on quality” for publication.

18.1

KA ARONUI KI TE KOUNGA

FOCUSSED ON QUALITY

OUR QUALITY PICTURE 2017

Kia ora and welcome to the fifth edition of 'Our Quality picture'. This is a snapshot of how our health system is working to meet the needs of the Hawke's Bay community. People should be at the centre of healthcare and in this edition we focus on what we have achieved in the last year, in response to feedback from our customers and community.

We recognise that providing healthcare is not without risk and our aim is to reduce unintentional harm or injury.

Inside we outline our progress and how we stack up nationally against patient safety priorities and national health targets.

Kate Coley, Executive Director of People and Quality

Te hauora o te Matau-a-Māui: Healthy Hawke's Bay

Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community.

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGA TE TIRA PARTNERSHIP
TAUWHIRO CARE

HE KAUANUANU RESPECT

Showing ***respect*** for each other, our staff, patients and consumers. This means I actively seek to understand what matters to you.

ĀKINA IMPROVEMENT

Continuous ***improvement*** in everything we do. This means that I actively seek to improve my service.

RARANGA TE TIRA PARTNERSHIP

Working together in ***partnership*** across the community. This means I will work with you and your whānau on what matters to you.

TAUWHIRO CARE

Delivering high quality ***care*** to patients and consumers. This means I show empathy and treat you with care, compassion and dignity.

NGĀ IHIRANGI / CONTENTS

You asked, we did

The following articles are examples of some of the things you told us

Youth Consumer Council

The Hawke's Bay Health system has its own Youth Consumer Council (YCC). The first of its kind in the country!

The formation of YCC was recommended as part of the youth health strategy that was finalised in July 2016. The development of this involved lots of consultation with health system staff, community groups and youth in Hawke's Bay.

We learned that youth partnerships, leadership and collaboration across the health system was really important. YCC was initiated in late 2016 to help make this happen!

Aged between 12 and 24 years, members of YCC ensure the youth voice is heard. They will also help the health system with ideas and concepts so it can be better connected with young people.

Charged with getting out and about, the council also meets with individuals in the community, other organisations and established youth groups so they can be well informed about what motivates young people to be proactive about their health. By engaging with youth face-to-face and interacting in different forums, YCC were able to confirm its three priorities:

- Teen Suicide Awareness
- Drug and Alcohol culture
- Mental Health

Dallas Adams, Chair off YCC and member Kylarni Tamaiva-Eria attend the monthly Hawke's Bay Health Consumer Council meetings. Whilst they found it intimidating at first they have now made positive connections and feel confident they have a platform to voice youth opinion and influence decision making in the health system. "They encourage us to have a say and that makes us feel valued," says Dallas.

Did you know?

There are 19,300 15-24 year olds in Hawke's Bay. This is 12% of the total population.

Around 2,019 (11%) youth live in rural areas and 15,984 live in urban areas (based on 2013 census)

YCC member Deveraux Short-Henare has enjoyed learning about the health system and how he can influence changes to better meet the needs of youth through his role. "I accepted the nomination because I honestly believe that youth need to be represented and have a say on what a 'youth' health system looks like," "I think this group can enable that to happen." Deveraux and fellow member Tremayne Kotuhi recently represented YCC at Festival for the Future 2017. Hundreds of young innovators and influencers all gathered in Auckland to connect, explore issues, be inspired, and build ideas and skills to create the future. Tremayne came back motivated with new connections and ideas to test in Hawke's Bay.

The council has its own Facebook page, HB Youth Consumer Council ,where you can keep up-to-date with what they are up to.

Youth Consumer Council L to R: Dallas Adams (Chair), Kela Franklin, Tremayne Kotuhi, Turua Hudson, Kelly Thomson, Breeze Taurima, Kylarni Tamaiva-Eria, Jemma Russell

02

ĀKINA IMPROVEMENT

through your feedback and what we are doing about it.

Improving how we communicate with you

"He did not tell us what he was going to do. He went ahead without informing us or including us in the decision."

It is not uncommon for you to tell us, as health profesionals, that we could do better at listening to what you have to say, understanding what is most important to you and including you and your whānau in decisions about your care and treatment.

To support our staff in improving communication with consumers we started a training programme in March 2017 called 'relationship centred practice' which has so far been delivered to over one hundred Allied Health Professionals (Physiotherapists, Occupational Therapists, Dental Therapists, etc.). Online learning modules and face-to-face training workshops were developed with consumer involvement.

The training is a sustainable, skills-based training package aimed at providing health professionals with practical methods and strategies to improve their interactions with consumers and their whānau. This includes working in partnership, finding out what is important, what really matters to the consumer in terms of healthcare, and working together to come up with solutions.

This mana enhancing practice clearly puts the consumer and their whānau at the centre of their own healthcare - working in collaboration, building on strengths and being well supported to achieve the goals that are important in the context of their lives. It is focussed on improving the connection and quality of interactions with consumers who in turn get greater engagement and better health outcomes.

We have plans to roll this out to other health professionals in the hospital and community in 2017/18.

Staff have found this training valuable and it has allowed them to reflect on and improve their practise.

"I am much more aware of focusing on what the families want, how important it is to them and changing my approach to empower them more."

"The facilitator delivered the message effectively and simply and made me see how vital whakawhānaungatanga is, with every patient I see."

18.1

Making healthcare easy to understand

Making sure healthcare is easy for people to find, understand and use so that they can look after their health and wellness, is a key priority for the health system.

To do this we are committed to changing the way we deliver health care to the people of Hawke's Bay. We have taken the first step by setting principles around how we provide information such as pamphlets and letters, as well as how our health professionals talk with you about your health and wellness. This work began in 2015, through a range of online education programs for doctors and nurses working in the community.

The next step is to make sure everyone working in the sector is aware of the importance of making healthcare easy to understand. This involves working alongside our services and health professionals to help them make the changes that are needed to ensure this happens.

Ultimately, we want to make it as easy as possible for people to find the correct information or get to the right healthcare services, so they understand how they can best take care of themselves.

Achieving this will take time, but people will progressively notice a difference in the way they receive information and healthcare services in Hawke's Bay.

To make this easier, we need the help of our consumers to tell us how we are doing throughout this journey and where we need to make improvements and changes. Feel free to email us at: **feedback@hbdhb.govt.nz** with your thoughts.

This will go a long way in making sure healthcare is easy to understand to help you be well, get well and stay well.

03

Go Well Travel plan

We know that prior to March 2017 our community was having real trouble finding car parking at Hawke's Bay Hospital – whether coming to an outpatient appointment, or visiting loved ones. In 2016 a lack of car parks was one of our top complaint themes.

"trying to find parking can take up to 30 minutes. I ended up missing my appointment."

"I had an appointment for my moko at 9am. I couldn't find a park. When I did find one we were 50 minutes late for his appointment…"

Feedback like this was not unusual. Missing an appointment is inconvenient for our patients, impacts negatively on their overall experience of care and doesn't allow us to best manage our time and resources.

We listened to our community. The introduction of paid car parking in March 2017 and the promotion of alternative modes of transport has eased congestion. Patient and visitor parks are now freely available with about 30 spaces available at any given time. It is working well with plenty of positive feedback from people who are grateful to be able to easily find a park and this means a better overall experience, people attending appointments on time and less stress.

"I have used the car park twice this week for appointments, it was so nice to just be able to drive straight in and park without having to drive around endlessly. I was more than happy to pay the $1 each time for such an easy stress free arrival."

Tom Wihapi (pictured below), is our friendly parking officer overseeing the paid parking scheme. Tom averages 15km per day on the job and is only too happy to help visitors and patients with parking queries, lost car keys or machine issues.

"It has been going very smoothly. People are very understanding of the pay scheme and visitors especially are only too happy to be able to find a car parking space."

As well as paid car parking, HBDHB has also worked with the regional council and goBay buses to bring other transport options. Outpatients are making the most of the free bus transport option, with 519 trips to attend their appointments at the hospital or Napier Health in May alone. That's a staggering 122% increase on May last year!

Tom Moffatt (pictured right) says he enjoys catching the bus to his hospital appointments.

If you have an upcoming outpatient appointment at the hospital or Napier Health, you too can jump on the goBay network for free, together with a support person. Simply show your appointment letter or text reminder to the bus driver and you'll be on your way!

"It's completely hassle free, it's an easy way of getting across from Napier and I don't need to rely on anyone else."

Improving Outcomes for Māori

As Māori don't experience the same health outcomes as non-Māori we are strongly focused on improving this status using some key programmes to achieve this.

Te Ara Whakawaiora (the pathway to improved wellness), is a focussed Māori health improvement programme and one of the ways we are addressing Māori health concerns. It aims to gain traction, greater visibility and accelerate progress towards areas of health concern. There are a range of quality improvement initiatives including mental health, heart and diabetes care, oral health, healthy weight for children and workforce development.

Child Health improvement

In 2016/17 we have made some great gains towards improving the health of our Māori children. For children under five years of age preventable hospitalisations has dropped by over 12%, dental conditions decreased by 8% and 94% of all eight month old children were immunised. In 2017/18, our focus will be on reducing avoidable hospitalisations for respiratory and dental conditions, improving breastfeeding rates and access to dental treatment services as well as antenatal education programmes.

Cultural competency

We acknowledge the ethnic diversity of our community and value the cultural competency of our staff to effectively deliver health care services that meet our community's social, cultural, and linguistic needs. A culturally competent health care system can help improve health outcomes and quality of care, and can contribute to the elimination of health disparities.

In 2016/17 bilingual signage in Māori and English was introduced and over 80 percent of our staff received training on cultural competence and cross-cultural issues. We aim to have 100 percent trained by 2017/2018. The introduction of the Ngātahi Workforce Development Programme in 2017/2018 will also ensure those organisations and staff working with high need Māori whānau and children will undergo intensive cultural competency training.

Workforce diversity

We value an ethnically diverse workforce. We aim to ensure our staff and organisation reflect the community which we serve and the growing Māori population. In 2016/2017 the Māori workforce grew to 14.3% and we aim to increase this year-on-year. A focussed Māori workforce development strategy (Tūruki) has provided 38 tertiary scholarships to students studying towards health related careers and administered 162 Health Workforce NZ education grants for entry level health qualifications. In 2018 a focussed diversity workforce strategy is being developed for implementation.

Mobility Action Programme

A new exciting initiative we are introducing in 2017/18 is the Mobility Action Programme (MAP). MAP is a community-based programme of care for people with a range of musculoskeletal conditions involving physiotherapy, exercise and self management programmes to be delivered across Hawke's Bay. Consumers gain benefit from improved pain management, mobility and enjoyment of life.

Staff profile

Wairoa's Rural Nurse Specialist Nerys Williams is relishing the opportunity to make a difference in people's lives by helping them in whatever way she can. Her experiences, she says, have reinforced the importance of her role in keeping people out of hospital and delivering care in the home for rural patients.

Wairoa people are benefitting by having the opportunity to reduce travel to Hastings for procedures that can be provided by Nerys in their own home.

One experience, in particular, has had a positive impact on Nerys and listening to her recount the story of two sons who cared for their terminally ill father is touching.

"It was their Dad's dying wish to return to his papakāinga (original home)," says Nerys, who was determined to try and make that happen. With Nerys' training, the sons were able to inject medication into their Dads muscle over a period of four to five days, being fully responsible for the drug application, and providing constant attention to their Dad in the comfort of their home.

"The training was robust and this was supported by phone calls and daily visits by me to ensure the sons and wider whānau were supported well," said Nerys.

"Just as important was coordinating the wider support network including district nurses, occupational therapists and Cranford Hospice and I am proud of how well everyone pulled together to do their respective jobs with very short notice."

Improving Pasifika Health

Hawke's Bay District Health Board (HBDHB) is committed to improving Pasifika Health and has recently developed a Pasifika Health Team to work across the District Health Board and within the Pasifika community.

Talalelei Taufale is the Pasifika Health Development Manager. Talalelei coordinates, supports and influences work within the health system ensuring quality improvements are inclusive of Pasifika perspectives and approaches.

Amataga Iuli is the Pasifika Health Promoter. Amataga connects and builds rapport with the different Pasifika community groups to support and empower them to identify and prioritise their health and wellbeing.

Silia Momoisea and Paul Faleono are the Pasifika Health Navigators, they are connected with the Public Health Team, Child Team, Māori Health Services and other health professionals and clinicians to advocate for and support Pasifika families in the community.

Olive Tanielu, is well known in the health sector and has an extensive clinical background in health as the Pasifika Liaison nurse in the Community, Women & Children Directorate. Her new role in Pasifika Health Services has broadened to include general Pasifika health needs in secondary services.

Pasifika Health Team
Front row: (L to R) Silia Momoisea, Olive Tanielu, Amataga Iuli

Back row; (L to R) Paul Faleono, Talalelei Taufale

2009 2010 Pasifika Health Action Plan developed and finalised.

2011 November-Employed Pasifika Health Development Manager to implement Pasifika Health Action Plan.

2013 Pasifika Health Navigation Services contracted to work with Pasifika families.

Pasifika Health Leadership Group established.

2014 Nuanua Pasifika Health Workforce Group established to support the Pasifika Health Leadership Group.

Pasifika Health Service endeavour to have another opportunity in future to properly introduce all our commmunity connections.

2016 December Pasifika Health Navigation Service contract concludes.

2017 Pasifika Health Service established - Pasifika Health Development Manager, Pasifika Health Promoter, x2 Pasifika Health Navigators

Gastro Outbreak

In August 2016 Havelock North was affected by an unprecedented event in New Zealand as the town's water supply became contaminated with Campylobacter, affecting over 5000 people with illness.

During the crisis the health community responded really well. The incredible work happening in primary care played a huge role in keeping people out of hospital.

Dr Peter Culham is a General Practitioner at Te Mata Peak Practice in Havelock North and was rostered on to work the weekend of 13 and 14 August (when more people were presenting with the onset of illness).

"Whilst the team at Te Mata Peak Practice were aware of increasing gastroenteritis cases, thought to be Norovirus, the District Health Board and Hastings District Council through media and social media statements released on Friday night made us aware we were in for something more. On the Friday night we were also called by the district health board's Emergency Manager who told us they thought there was a high chance the outbreak was likely to be Campylobacter."

"It became apparent very early on Saturday morning the outbreak was worsening. I called in extra staff and we made the early decision to try and manage the epidemic via telephone consultation."

Saturday 13 August was described by Peter as a very long and busy day. Not only was he and his team managing Campylobacter cases, but also other illnesses, as well as attending and managing the death of a patient. The DHB instituted its critical incident management structure. District Nurses were moved into retirement villages which was very helpful, and the Te Mata Peak Practice team knew they needed to do things differently to cope with the numbers of sick people.

"We improved our processes further on Sunday. We arranged afterhours telehealth support via Auckland and had extra GPs working as well as increased administration and nursing support. Our doctors and nurses provided a telephone assessment service as well as traditional face-to-face consultations. IV fluid therapy was administered on site, in homes and residential care facilities which kept people out of hospital, by the district nurses."

On the Monday Peter said the entire team, minus those who were unwell themselves, were back on deck and focussed on assessing as many affected patients as possible. This was achieved by "deferring non-urgent work and making the most of telephone consultations." Te Mata Peak Practice was well supported by Health Hawke's Bay (The Primary Health Organisation). "They provided a clinical pharmacist and additional registered nurses to make proactive phone calls to check in on those vulnerable and at-risk people in the community; for example the elderly, diabetics (people with diabetes), and people with other medical conditions."

The incredible staff working in Te Mata Peak Practice and those that came to support them worked long into the week. Whilst numbers peaked on the Wednesday, staff were still seeing lots of patients through to the Friday night. Thankfully Peter was able to take a break over the weekend.

Innovations

Extensive use of telephone consultations helping us to assess large numbers of people, while enabling us to have face-to-face visits with the patients we were most concerned about.

Use of registered nurses to contact at risk patients via telephone. Those unaffected by the gastro outbreak were appreciative of the contact. Those affected were offered advice, telephone support or face-to-face consultations as required, to help them manage the illness with their co-existing conditions.

The DHB's decision to send District Nurses into the residential care villages was another great idea.

Throughout this incident there was constant communication with the district health board and Health Hawke's Bay (PHO).

"I was very proud of our team. Everyone pulled their weight and worked very hard. I believe we collaborated well with Health Hawke's Bay and the DHB. From this event we made a number of innovations which benefited our community."

Hawke's Bay DHB's response to the Gastro Outbreak

Hawke's Bay District Health Board's response to outbreak prevented more people from getting sick Population Health Service to gastro outbreak

Havelock North's 2016 gastroenteritis outbreak is the largest known waterborne disease outbreak, of its kind, in New Zealand, and while many people were affected with sickness those numbers could have been much higher had it not been for the swift response recognising the waterborne outbreak.

With over 5000 of the 14,000 Havelock North residents affected by campylobacteriosis, four deaths implicated, three people affected with Guillain-Barre syndrome and many affected by an arthritis type condition known as Reactive Arthritis, the outbreak undermined public confidence in a fundamental service of safe drinking water.

Despite the scale of the event and a small team to manage the population health events Hawke's Bay District Health Board has been widely well-recognised for its handling of the event.

The government inquiry, which is the final stage of its deliberations, and due to release its Stage Two findings at the end of 2017, noted that **"Responses to the August 2016 outbreak were generally well -handled, particularly by the Hawke's Bay District Health Board."**

The Hamilton report concurred with **"On receiving a test result on Friday 12 August that indicated the presence of E.coli in the Havelock North water supply .... The reaction by the HBDHB to the indication was also fast and showed commendable initiative and good judgement in collating the indications and concluding they were dealing with a waterborne organism in the Havelock North network causing an outbreak of gastroenteritis illness. Together the two authorities responded to the indications of the outbreak at a pace that would be difficult to better."**

Medical Officer of Health Dr Nick Jone's who led much of the district health board's population health response, said while there were learnings from the outbreak along with the recognised need for organisations to work better together, and more recognition of the role Drinking Water Assessors (DWAS) play, overall the swift response in recognising the waterborne outbreak prevented many more people from getting sick.

Chief executive of HBDHB Dr Kevin Snee said the health system in Hawke's Bay worked well by coordinating services and supporting community health services such as; pharmacies, general practice and district nursing, helping people recover in the community without the need for hospital care.

"Without this coordinated effort of health services working in an integrated way, hospital services would have been inundated and unable to cope and many more people would have suffered as a result."

Quick stats

64% experienced one episode of vomiting and/or diarrhoea

32% of people had a recurrence of the bug while **4%** of people experienced ongoing symptoms (as of 28 September)

an estimated **78%** of people who had symptoms took time off work or school

Boiling water before drinking:

82% of households boiled water during the outbreak

405 people who were sick took time off work

We have 10,000 vulnerable families living in our region. #whānau was developed out of a need and desire to provide whānau with a healthcare service that is 'real'. One that is focussed on whānau, increases their access to health services and ultimately reduces inequalities in our community.

#whānau is a collaboration between General Practice Totara Health and Choices, a Māori Health Provider of 22 years. Together they have built a foundation on relationships and trust. They have identified what their strengths and limitations are and are working together to 'fill the gaps' and make a difference in their community.

#whānau supports 50 vulnerable low income Māori whānau in Hastings and Flaxmere to reach their health ambitions. The #whānau team involves kaiawhina (support workers), midwives, nurses, GP's, pharmacists, nutritionists and physiotherapists.

The Kaiawhina work with whānau to develop whānau-led goals and aspirations and support them to better understand their health conditions. We know that some whānau who suffer from diabetes and cancer rate their personal health as excellent. This shows that some whānau do not understand their health conditions or accept their chronic health issues as normal because other whānau members suffer or suffered from the same thing. With greater understanding, whānau realise the urgency in their care and are more appreciative of the services the #whānau team can bring to them.

This has been a very successful programme. The 50 whānau selected have achieved 100% health targets every year for the past four years!

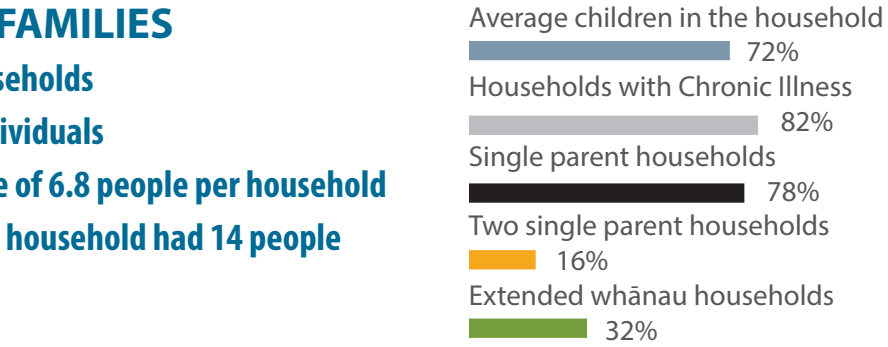
OUR FAMILIES

50 Households

340 Individuals

Average of 6.8 people per household

Largest household had 14 people



OUR ACHIEVEMENTS

Prior to 'Feel Good' Pilot		By the end of the 'Feel Good' Pilot
34%		**100%**
health checklist completed		health checklist completed
average per family	COMPARE	**for 100% of families**
380 checklist items completed		**1317 checklist items completed**
Childhood immunisations	53%	100%
Preschool dental enrolment	0%	100%
Cervical Screening	38%	100%
CVD Risk Assessment (men)	46%	100%

"It was much easier when she came along. Having health care made it easier to deal with other things."

"I didn't know what to say so she came with me. I feel comfortable now making appointments."

"It got me a job… I've never worked before. I'm like, far, I've missed out on all this."

"There were all these services out there but I didn't know how to access them and then [the Kaiawhina] showed up and I was like "thank you."

The #whānau team are proud of their results but equally excited about the future.

They are continually improving and their work to date has taught them that they need to develop more roles and innovative tools.

They are building a new education program and their new #whānau app is intended to bring health and 'other services' into the home with ease.

One Kaiawhina tells us…

"Because I have a team of experts around me, like doctors, nurses, navigators, I can help whānau better. I can get support from any of them at any time. They know what I do and I know what they do. We keep in touch through the whānau files."

"Some of my whānau need a lot of help and support and so I help them. I can be at WINZ office all day helping them fill out forms. I have helped over five whānau get into homes and get fireplaces. There is a lot of poverty out there and two or three families will live together to help buy food and pay rent."

"Some of my whānau haven't been to see a doctor in years, even though they have diabetes or other chronic illness. One of my whānau, a mum of five has cancer. She hasn't been back to her doctor for over a year. I helped her come back and engage with clinicians again."

"Most of my families just don't understand how their health matters. Some just accept that having diabetes or asthma is a part of their lives, as they have always lived with it."

"I have a lot of grandparents who are looking after their mokos. I help take them to the doctor and see our school nurse to follow up. Whatever it takes, no matter how long, it's what we do."

"It feels good to be able to walk in the door and take care of whatever it is they need. Before the program, I would only want to help with the cervical smears and then come back the next day to find children that needed immunisation. That isn't a good health care service."

"Now I provide what is needed to the entire whānau. That's #WHĀNAU!"

18.1

09

2016 Hawke's Bay Health Awards

Teams across the health system celebrated at the Hawke's Bay Health Awards in November 2016 at the The Opera House Plaza in Hastings. This was a night to recognise the collaboration and innovation taking place across our region as well as witness some new initiatives changing the landscape for future health developments.

The engAGE ORBIT team from Hawke's Bay DHB not only won the Excellence in Service Improvement Award but also took out the Supreme Award. This was in recognition of their move to a seven day allied health service which, since November 2015, has allowed the ORBIT team to see over 800 extra patients who would not otherwise have been seen. This change is likely a contributing factor to the decrease in the rate of conversion from ED presentation to hospital admission for over 65's compared to the same period for the previous year. While the number of ED presentations for over 65's has increased, the number being admitted to hospital has decreased.

ROYSTON HOSPITAL Acurity

Supreme Award
HAWKE'S BAY DHB
engAGE ORBIT Team

Southern Community Laboratories

Excellence in Service Improvement
HAWKE'S BAY DHB – engAGE ORBIT Team
The move to a seven day Allied Health service

band

Commitment to Quality Improvement and Patient Safety
ROYSTON HOSPITAL, ACURITY HEALTH GROUP LTD
Ensuring adherence to the Patient Code of Rights in an age of personal mobile devices

SKYLINE AVIATION

Excellence in Innovation
HEALTH HAWKE'S BAY, UNIVERSITY OF OTAGO, SPORT HAWKE'S BAY
The PIPI study - practice nurses preventing progression of prediabetes

HAWKE'S BAY District Health Board Whakawāteatia

Commitment to Reducing Inequities
TE TAIWHENUA O HERETAUNGA
Low fees for high needs: GP care in a kaupapa Māori context leading to improved equity

HEALTH HAWKE'S BAY Te Oranga Hawke's Bay

Excellence in Provider Collaboration and Integration
HAWKE'S BAY DHB, HEALTH HAWKE'S BAY, HAWKE'S BAY GENERAL PRACTICES, HOME-BASED SUPPORT SERVICES & AGED RESIDENTIAL CARE
engAGE MDTs: cross sector collaboration improves for frail older people

BUDDLEFINDLAY
NEW ZEALAND LAWYERS

Excellence in Clinical Practice
HAWKE'S BAY DHB
Perioperative Unit - Operation Productivity

OURHEALTH HAWKE'S BAY Whakawāteatia

Outstanding Contribution to Improving Health in Hawke's Bay
JEANETTE FRECHTLING
Hawke's Bay DHB

Ngā whāinga hauora ā-motu National health targets

KEY:
↑ Improved our performance against the health target.
↓ Our performance against the health target has declined
– Our performance against the health target has stayed the same.

HEALTH TARGET	TARGET	OUR RESULT (2016/17)	TREND (since last year)	COMMENT
Shorter stays in Emergency Department (ED)	95%	Not achieved 93.9%	↑	Despite continued growth in people presenting to ED we have improved on last year's performance, achieving the 95% target in two quarters. We have seen a marked improvement especially for those patients who don't need to be admitted to hospital. Around 98% are assessed and treated in ED and go home within five hours. Our next challenge is improving the flow of acute patients from ED into the hospital. The FLOW program of work is starting to address some of the core issues that will help improve patient flow across the hospital.
Improved access to elective surgery	100%	Exceeded 101.3%	–	This year we achieved our elective health target, as well as the orthopaedic joint and general surgery targets. This was despite the extraordinary pressures of the Havelock North Campylobacter outbreak and two Resident Medical Officer (RMO) strikes, which saw considerable reshuffling and rescheduling of elective surgery lists. We will continue to improve access to elective surgery for our community, by creating extra theatre space through projects; such as Endoscopy and Gastroenterology building and service move, which will free up space to allow more elective surgery capacity, as well as improving patient FLOW through the hospital.
Faster Cancer Treatment	85%	Not achieved 69.3%	↑	Since January 2017 there has been a strong focus on reducing the time taken from referral to treatment for cancer. The aim has been to improve outcomes and experience for people with cancer. By working in partnership with clinical teams in Hawke's Bay and those in major centres who treat people from our community the time taken to gain treatment has significantly reduced. An action plan has been developed by the clinical teams and we are confident that there will be further improvement over the coming months.
Increased immunisation	95%	Achieved	↑	Hawke's Bay continues to be a top performer in achieving the immunisation health targets.
Better help for smokers to quit (Primary Care)	90%	Exceeded 91%	↑	Health Hawke's Bay have been supporting its general practices with independent nurses contacting patients to update their smoking status and offer brief advice and cessation (stop smoking) support. Health Hawke's Bay has started to engage with workplaces to offer smoke-free support and are also in the process of organising some community events.
Raising healthy Kids* *Quarter 4 result only	95%	Exceeded 95%	N/A	The Ministry target expects that by December 2017, 95% of all obese children (98th percentile of weight) identified via a B4 School Check will be offered a referral to a health professional for clinical assessment and whānau -based nutrition, activity and lifestyle interventions. Hawke's Bay DHB currently sits at 96%. HBDHB has prioritised childhood healthy weight. This includes work supporting the national target - developing resources to support whānau with healthy eating and physical activity lifestyles, establishing an effective referral process and supporting primary care with tools.

National Patient Safety Priorities

The Health Quality and Safety Commission (HQSC) is driving improvement in the safety and quality of NZ healthcare through its quality improvement programme.

The key role of HQSC is to publish information and set targets (called quality and safety markers) to improve the quality of Healthcare in New Zealand.

The quality and safety markers help HQSC evaluate the success of its programmes and if the desired results are achieved. The targets help Hawke's Bay DHB monitor how it compares with other DHB's whilst challenging itself to do better.

Quality and safety markers monitor a set of clinical care indicators which cover falls, healthcare associated infections, safe surgery and medication safety.

For more information visit their website: www.hqsc.govt.nz

We know we are getting better in these care indicator areas because our results in the January to March 2017 quarter tells us that Hawke's Bay, compared to other DHB's, rate in the top three out of the five priorities. We are working hard to improve the fourth, which is our safer surgery marker and fifth area medication safety programme.

Staff and visitors participating in a Tai Chi taster class lead by Sport Hawke's Bay.

The safer surgery marker was introduced recently and it measures levels of teamwork and communication around the paperless surgical safety checklist. We know staff are doing it – we just need to get better at proving it.

Our 2017 April Falls Campaign across the whole region focussed on improving balance and strength, we had a great month working with other providers and we ended up being recognised nationally for our work. This is something everyone can do to help themselves. As we age it is harder to keep our balance and keep strong in our legs, but there are a lot of community programmes to help. Staff and visitors tried Tai Chi this year – thanks to Sport Hawke's Bay. Look at their website for a list of programmes: www.sporthb.net.nz.

Other national programmes which are coordinated by HQSC and which Hawke's Bay DHB are undertaking improvement work include:

- Recognising deteriorating patients - getting better at identifying when someone is getting sicker while in hospital and having a plan to help them faster;
- Medication Management - Managing the side effects of pain medication more proactively - i.e. when someone requires strong medication a side effect can be constipation (infrequent bowel movements). Proactively planning medicines for patients to counteract side effects is part of this improvement work.
- National Patient Experience Survey (in hospital) - this has been running for three years now and the feedback informs national improvement campaigns. The four domains all hospitals are measured on and HBDHB scores as follows: communication (85%), coordination (85%), partnership (85%) and physical and emotional needs (88%). HQSC is now working with the Primary Health Organisation in Hawke's Bay to roll out a patient experience survey in General Practice.

National Patient Safety Priorities **In hospital**

93% **Falls prevention 1**: Target 90%

94% **Falls prevention 2**: An increase from 86% last year. Target 90%

89% **Hand hygiene:** Target 70% - Top DHB well done.

100% **Surgical site infection 1:** Antibiotic administration 100%

98% **Surgical site infections 2:** right antibiotic and dose 98% (nationally approved sometimes people require something different).

Medication Safety: Hawke's Bay is not yet one of the DHBs doing this project - but there is work happening to help us to get ready for when it's our turn to get involved.

Let's Talk – Patient Safety Week

Patient Safety is top of mind every day in healthcare. 'Let's Talk' was the theme at Hawke's Bay Hospital during Patient Safety Week in November 2016 when we highlighted better communication between patients, whānau and health professionals. We had displays to highlight the Let's Talk campaign making sure we got the attention of staff, patients and visitors to the hospital and our 'what matters to you' whiteboards reinforced that whānau/family matters most.

Patient Safety Week is a Health Quality and Safety Commission initiative which we embrace every year. The theme for 2017 was medication safety. This topic was chosen because the patient experience survey question "Did a member of staff tell you about medication side effects to watch for when you went home?" consistently gets one of the lowest scores across all 20 DHB's in New Zealand.

CEO Dr Kevin Snee checks out a display alongside Jane Bailey, Patient Safety Advisor and Jeanette Rendle, Consumer Engagement Manager.

How to keep yourself safe when in hospital – here are our top tips:

- **Talk** with your doctor and nurse and tell them what you know about your illness or injury.
- **Ask** questions to help you understand your treatment – why you are having it, the choices, what will happen and the risks and benefits.
- **Clean** your hands often to help stop infection, and ask your visitors to clean their hands.
- **Keep** a list of and learn the names of the medicines you are taking, the reasons you are taking them and when and how to take them.
- **Ask** for the results of any tests you have and what happens next.
- **Get** to know your ward and make sure the call bell is always within easy reach.
- **Before** leaving hospital, ask what you and your family/whānau need to do at home.

18.1

Hand Hygiene

Hand hygiene is recognised worldwide as the single most effective way to prevent the spread of infection and improve the quality and safety of patients in our care. The 5 moments for Hand Hygiene is a programme developed by the World Health Organization (WHO), and implemented across all New Zealand District Health Boards (DHBs).

HBDHB continues to achieve a high level of compliance with the 5 moments for Hand Hygiene when compared to other DHBs. For the quarter ending March 2017, HBDHB achieved a compliance rate of 88.7% - the highest in NZ.

On 5 May, HBDHB celebrated World Hand Hygiene Day. Wall displays across the hospital were created by enthusiastic staff members, an information board was created in the main entrance, and a competition 'guess the hands' was run that created a sense of fun and engagement with staff, patients, and visitors.

It was also a time to celebrate and thank the Hand Hygiene champions within the hospital for their passion and dedication to the programme and ultimately the positive impact it has on patient safety.

Adverse events

Adverse Events are events which have resulted in serious harm to patients. This harm may have led to significant additional treatment, been life threatening or led to a major loss of function or unexpected death.

Adverse events are uncommon but taken seriously. For each event HBDHB conducts a formal review which follows the patient's journey through the hospitals' systems and processes.

What we learn from these reviews is important and we recognise that each event provides an opportunity to improve the care we provide.

Adverse events 2016/17

Clinical process – 12
Medication – 2
Fall – 8

Learning from Adverse Events

Several reviews at HBDHB have led to significant improvements on the front line, examples are:

- the appointment of more senior doctors
- reducing delays to reach definitive diagnosis
- education opportunities
- improvements to the transfer of care (handover from one health professional to another, or to a caregiver) – communication information gathering tools have been developed.

"[we] would like to thank you for investigating [his] death and providing a clear report. My primary intention was to ensure any lessons that could be learnt from this tragedy would possibly prevent others having to experience this and to that end we were heartened to see the changes in DHB operating procedures.

…the family was happy to see that our concerns were taken seriously by the depth and openness of the DHB report and the remedial actions that have since been implemented."

Future Focus

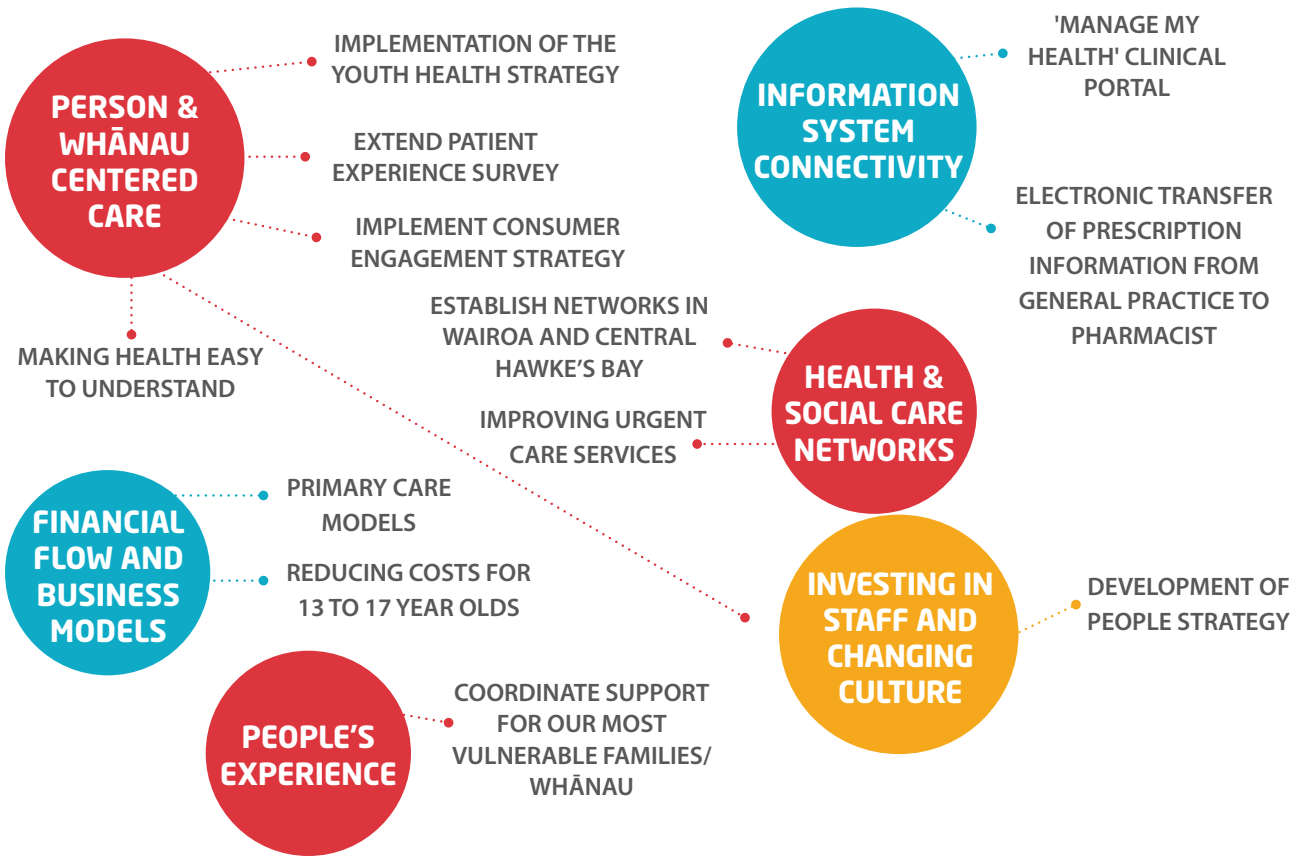
The organisation has invested in a new integrated risk management system which is intended to be rolled out in 2017/18. This brings new capabilities and allows the DHB to better monitor and manage its associated risks. The DHB hopes to bring the primary care sector on board with the system in 2018/19.

All adverse events are reported to the Health Quality and Safety Commission (HQSC). The commission is supporting DHBs to further improve their processes around event reviews. A strong focus for 2017/18 will be on more consistent consumer involvement in reporting, reviewing and learning from adverse events. The involved consumer and / or their whānau will be offered the opportunity to share their story as part of the review process.

TŌ TĀTOU ARONGA MŌ ĀPŌPŌ
OUR FUTURE FOCUS

With the refresh of the New Zealand Health Strategy, we will be working to ensure that: **All New Zealander's live well, stay well, get well in a system that is people powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system.**

We have reviewed our five year strategy Transform and Sustain which aligns to the New Zealand Health Strategy. We will support the elimination of inequity and prepare our health services for more numbers of younger Māori and growing numbers of older people and people with chronic conditions. Over the next two years we will identify further projects to respond to the changes in our population. We have included examples under each theme. To meet the needs of the Hawke's Bay population we need to continue to improve what we do.



Ko ā koutou whakahokinga kōrero
Your feedback

We welcome and appreciate receiving feedback. To improve our services we need to hear your story, good or bad. Your valuable comments help us see where we are performing well and where we could improve.

You can give feedback in a number of ways:

- email us: feedback@hbdhb.govt.nz
- complete an online feedback form: www.ourhealthhb.nz
- phone us: 0800 000 443
- complete a freepost feedback form which may be given to you when you visit, or which can be found in many areas across the DHB's sites.

You may receive a phone call or a request to complete a survey based on your experience. It is your choice to take part or not.

I MŌHIO RĀNEI KOE IA RĀ...
DID YOU KNOW THAT EVERY DAY...

1 fragile baby will be cared for in the special care baby unit

1 person will be admitted to CHB Hospital

2 people will be admitted to Wairoa Hospital

3 new referrals are managed by child development service

4 children will receive one of their vaccinations

6 babies will be born

21 people will get their free annual diabetes check

32 women will have a mammogram and a further 29 a cervical smear test

47 operations will be completed in one of Hawke's Bay Hospital's theatres

48 people will attend a clinic appointment at Napier Health

90 people will be admitted to Hawke's Bay Hospital

124 people will present to HB Emergency Department

152 visits will be made by district nurses and home service nurses

184 visits/appointments will be made to support people with mental health issues

194 children will be seen for their free dental health check

1,446 people will see their family doctor

4,743 prescriptions will be filled out

5,831 laboratory tests will be completed

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OURHEALTH
HAWKE'S BAY
Whakawāteatia

For more information visit www.ourhealthhb.nz

HAWKE'S BAY District Health Board Whakawāteatia	**Matariki Regional Economic Development Strategy and Social Inclusion Strategy** 140
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Tracee Te Huia, ED Strategy, Health & Improvement Shari Tidswell, Intersector Development Manager
Reviewed by:	Executive Management Team, MRB, Clinical & Consumer Council
Month:	November 2017
Consideration:	For information

RECOMMENDATION:

That the HBDHB Board

Notes development of the strategies and actions to be delivered.

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OVERVIEW

Matariki - Hawke's Bay Regional Economic Development Strategy and Action Plan 2016 and Social Inclusion Strategy 2017 set out detailed strategies and pathways to action the Matariki goal of "every household and every whānau is actively engaged in contributing to, and benefitting from, a thriving Hawke's Bay economy".

It was clearly identified in 2016 by both Iwi and hapū that to achieve this economic goal, all whānau and communities need to be socially included. Work on an aligned strategy to address the barriers to social inclusion for whānau and communities commenced in August 2016.

Matariki is a truly collaborative effort between iwi and hapū, the business sector, central government agencies, local authorities, community sector and social services. It has been designed in partnership as aspired for in Te Tiriti o Waitangi.

The development of each strategy draws on extensive consultation with a broad range of stakeholders. The Regional Economic Development Strategy (REDS) sought input from representatives in the business and the public sector, which included three wānanga held in Wairoa, Hastings and Masterton. The Social Inclusion Strategy sought input from; community, public, iwi and social services to draft the strategy gaining additional input from whānau and community in the development of the action plan. This included wānanga in Wairoa, Central Hawke's Bay, Hastings and Napier.

Working groups supporting the development of each document – Matariki REDS (Appendix One) and Matariki Social Inclusion Strategy (Appendix Two) – draw on a range of skills contributed by key stakeholders. Both strategies sought and received feedback and endorsement from the Matariki Board.

STRATEGY DEVELOPMENT PROCESS

This is a Te Tiriti O Waitangi based process with clear steps to ensure partnership, protection and participation are reflected in the Strategies and the delivery. Final decision-making and endorsement is provided by the Governance Group for Matariki, which includes joint chairs (Māori and non-Māori) and representation from iwi and hapū. Māori have been an integral part of the development of both Strategies and have provided leadership in the Matariki REDS. As part of this process Iwi and hapū identified that social inclusion is integral for economic development.

The Governance Group endorsed the necessity for a Social Inclusion Strategy. The Intersectorial Leadership Group initiated a structured approach for the region's social wellbeing. Kevin Snee sponsored the Strategy with key DHB staff providing input and support in the Strategy's development. Hastings District Council provided the coordination for this work. Key to the Social Inclusion Strategy was the whānau and community voice. To achieve this, stakeholder and sector engagement was undertaken, followed by further community wānanga to provide opportunity for whānau and community input into the Strategy and action planning.

TIMELINE FOR MATARIKI REGIONAL ECONOMIC DEVELOPMENT AND SOCIAL INCLUSION

Matariki REDS was originally initiated in April 2014 as a refresh of the REDS 2011. The refresh was led by a project team consisting of Business Hawke's Bay and representatives from the five local authorities. A board was formed with members drawn from the CEOs of the five local authorities, business (three), Ngati Kahungunu Iwi Incorporated (NKII), Te Taiwhenua O Heretaunga, HBDHB and EIT.

In August 2015 after extensive consultation (including 80 in-depth interviews and two innovation cafes) a draft strategy was completed. Further work was identified, including engagement with Māori. Central Government representatives from the Regional Economic Growth Programme (MBIE and MPI) then became involved as Hawke's Bay was identified as a key region for government economic development support.

In December 2015 consultation was held with Ngati Kahungunu Iwi Inc., Te Kei o Takitimu and Te Kahui Ohanga (TKO). The outcome was that Maori would participate as equal partners in the development of the strategy and actions plan via; Ngati Kahungunu Iwi Inc, Te Kei o Takitimu and Te Kahui Ohanga. This involved representatives from Te Kahui Ohanga, Te Puni Kokiri, NKII and MSD joining the project team. Te Kahui Ohanga also joined the Matariki Board and currently hold a co-chair position.

After further consultation through wānanga in February and March 2016, a final strategy and action plan acceptable to all partners was completed and Central Government officially launched Matariki REDS in July 2016.

In August 2016 the Intersectorial Leadership Group established a planning group to develop a Social Inclusion Strategy. The planning group members were drawn from the organisations participating in the Intersectorial Leadership Group plus Te Kahui Ohanga.

In September 2016 Haggerty and Associates were appointed to develop the Social Inclusion Strategy conducting a number of interviews with key stakeholder organisations throughout the region.

A draft strategy was presented to and confirmed by the Intersectorial Leadership Group Board in April 2017 and authorised ongoing development of the action plan.

Informed by the findings of the strategy report (from May to July 2017), further consultation took place to gain wider community input into the development of the action plan. This work was led by the planning group.

The Action Plan was completed in October 2017 and presented to the Matariki Board where it was duly endorsed.

The Matariki Board have requested a refresh of the Regional Economic Development Strategy and directed that work to integrate the two strategies and actions plans. Focus is on the integration of the two action plans and the development of a communications plan to inform key stakeholders and the community on the integrated strategy.

Concurrently, proposals are being considered on the appropriate representation for the Matariki Board to ensure that there is equal partnership and that both economic and social sectors are represented.

CHALLENGES

Identifying and agreeing on an effective governance structure
The structure needs to reflect the Te Tiriti o Waitangi partnership aspirations, provide a voice for each of the diverse sectors involved and be able to deliver the guidance and decision-making needed to support and lead the strategies.

Finding the resource and potentially increased capacity needed to deliver each strategy's actions
Many of the actions require specialised skills, additional investment and/or staff resourcing to support implementation. Agencies involved in the project groups implementing actions are often stretching capacity to complete this work on top of business as usual.

Monitoring and delivering 46 REDS and 10 Social Inclusion actions and the associated project groups effectively
Ensuring that the Governance Group have a complete overview of all work being delivered, languishing actions need to be identified and supported ensuring the actions are resulting in change for people in Hawke's Bay with the greatest need.

Māori partners have identified the need to combine the strategies to form one Matariki Strategy
This has been supported by the Matariki Governance Group. This will require additional input to provide a framework which combines economic development and social inclusion; followed by integration of the REDS and Social Inclusion actions to ensure alignment and effective delivery.

The Social Inclusion Strategy includes a focus on socially responsible employers, part of this is the "living wage" concept
Concern has been raised by employers and some business leaders on employer's ability to cover this additional cost.

STRATEGY FRAMEWORK AND ACTIONS

Matariki Regional Economic Development

The following 'Regional Economic Development Pillars' are used to achieve the goal of "every household and every whānau is actively engaged in contributing to, and benefiting from, a thriving Hawke's Bay economy":

- Improve pathways to and through employment
- Identify and support enterprises that want to grow
- Promote greater innovation, productivity and agility
- Become a beacon for inward investment, new business and skilled migrants
- Lead in the provision of resilient physical, community and business infrastructure
- Enhance visitor satisfaction and increase visitor spend

These pillars stand on a foundation of celebrating the world class lifestyle and environment available in Hawke's Bay and champion sustainability socially, economically and environmentally.

There are a total of 56 actions developed to support the pillars; each has a detailed project descriptor, project lead and project group working toward the Matariki goal. (Appendix One and Two). Current projects include Project 1,000 – which is working towards 1,000 young people gaining employment, Driver Licensing – increasing access to full licences and reducing 'not being licenced' as a barrier to employment. Projects updates are reported to the Governance Group via a project reporting tool. This tool provides transparency for all Matariki partners to review and monitor progress.

To measure economic progress from REDS the following indicators are used:

- Increase the median household income above the national average
- Accelerate jobs growth, in particular to create 5,000 new jobs in five years
- Raise to the top quartile of New Zealand regions in regional economic performance

MATARIKI SOCIAL INCLUSION

The Social Inclusion Strategy has three themes which capture the consultation feedback, these are:

- Growing socially responsible employment and enterprise
- Preparing people for work
- Whānau, households and communities driving social inclusion

The messages received from whānau and community consultation were that; they must have a voice and be listened to when it comes to the delivery of social support services, there must be a fundamentally different approach taken to how social services are delivered and, participation and collaboration are fundamental to effect delivery of social services. Furthermore, the approach used must include co-design, collaboration and be whānau driven.

The ten actions will be developed into projects and detailed project briefs will provide guidance to project leads. Actions include

- review the way we deliver social services to include a whānau-lead approach
- establish a mechanism that supports a whānau/community voice in decisions that affect them
- plan for affordable and social housing
- support employers to be socially responsible and link career development through compulsory schooling to tertiary education and employment. (Appendix Two)

To move these actions forward, the action plan identifies interim leads who will identify project leads and stakeholders to support the project development and delivery.

Work is required to refresh the Matariki Regional Economic Development Strategy merging this with the Social Inclusion Strategy. This will reinforce the statement from Māori partners in Matariki – "there is no economic development without social inclusion". The DHB will continue to provide leadership, contribute to the planning work and deliver actions.

CONCLUSION

These strategies are effective tools to support collaboration across government services, social services, hapū, iwi, local government, education, employers and business which is required to shift the Hawke's Bay to deliver a strong economic development and become a social inclusive region where all whānau can experience

NEXT STEPS

1. HBDHB Board to endorse with feedback provided by MRB, Clinical Council and Consumer Council
2. Integrate relevant components of both strategies into the HBDHB Annual Plan
3. Socialise the strategies with HBDHB and Health Hawke's Bay PHO
4. Use the strategies to inform the new five year strategy for HBDHB
5. Assist the process to merge both strategies to one Strategy as agreed by the Regional CEO Group
6. Agree an intersector outcomes framework regionally

Appendix One

MATARIKI

Hawke's Bay Regional Economic Development Strategy and Action Plan 2016

'Every household and every whānau is actively engaged in, contributing to and benefiting from a thriving Hawke's Bay economy.'


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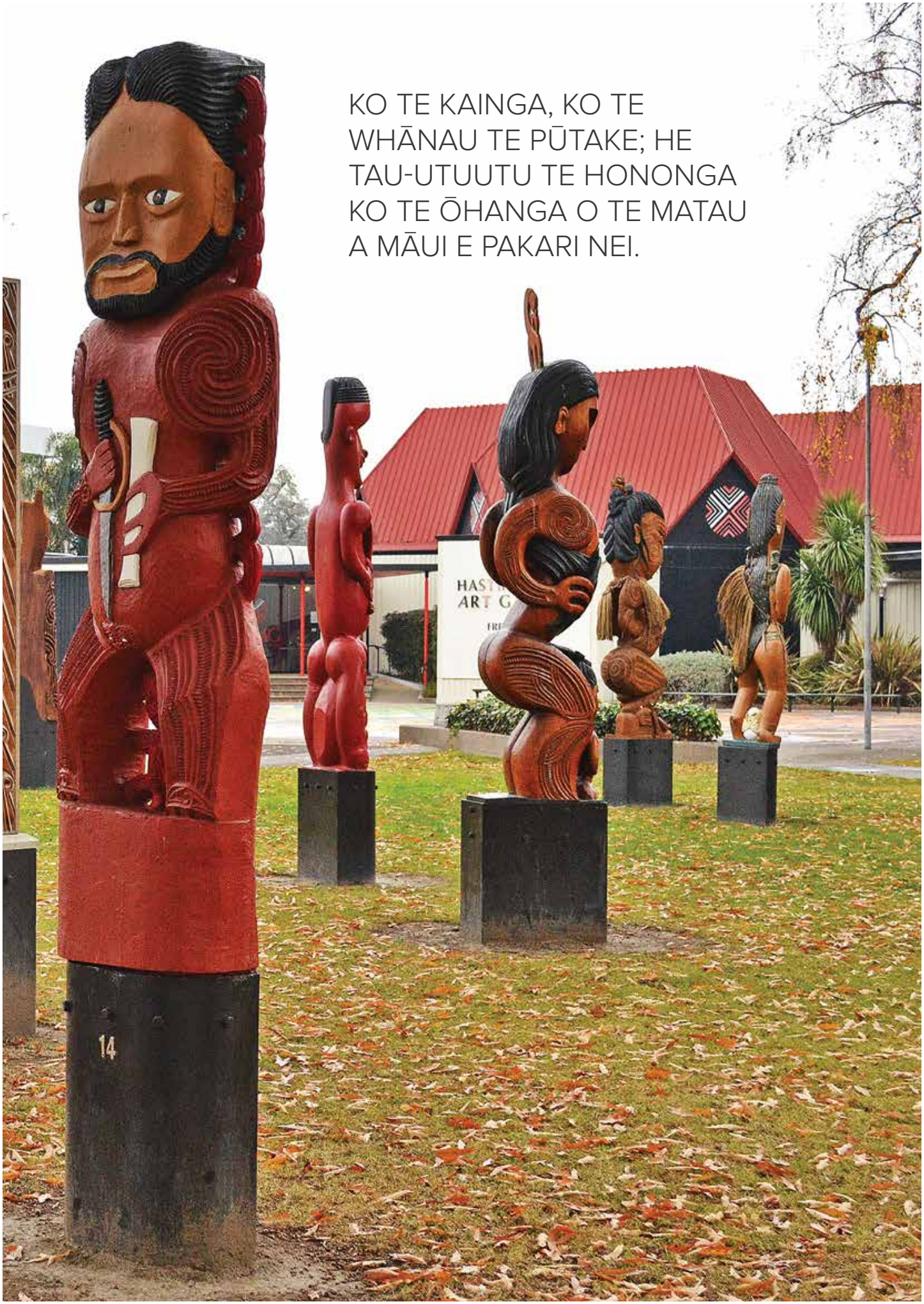

KO TE KAINGA, KO TE
WHĀNAU TE PŪTAKE; HE
TAU-UTUUTU TE HONONGA
KO TE ŌHANGA O TE MATAU
A MĀUI E PAKARI NEI.
14

MATARIKI – TE WHETU HERI KAI

The appearance of Matariki is the sign for future prosperity

The rise of Matariki in mid-June marks the Māori new year: a time for celebration, reflection and planning. If it rises clear and bold, then 'He kaihaukai te tau' we expect prosperity in that upcoming year. If it is dim and forgettable, 'He tau nihoroa', a lacklustre year with difficult conditions is in store.

Matariki means three things to this regional economic development strategy. It is its name, its conceptual framework, and the commitment by all partners for robust annual review and refinement. As Matariki has seven stars, the Matariki framework has seven points, each pivotal to maintaining the direction and integrity of the strategy for all the partners and stakeholders. Matariki is also key to ensuring that as a region we orientate ourselves towards the vision: 'Every household and every whānau is actively engaged in, contributing to and benefiting from, a thriving Hawke's Bay economy.'

Matariki Framework for Hawke's Bay Regional Economic Development	
Partnership by co-design	Values and worldview underpinning the strategy and its actions are an expression of co-design, and the implementation and monitoring are an inclusive collaboration. A treaty principle.
Outcomes for every household and every whānau	All actions, initiatives and projects in the Action Plan must provide outcomes in line with the vision.
Build our people's capability	There must be an emphasis on developing our people alongside infrastructure, assets and businesses.
Equality	A treaty principle, this requires reflection on who the intended audience and beneficiaries are, and a commitment to that being inclusive and equitable.
Business Growth Agenda 2015 He kai kei aku ringa	Our regional actions are designed to be as consistent as possible with both national economic strategies.
Whai rawa	Optimising assets in a full, holistic and sustainable way.
Pōtikitanga	Developing an enterprise mindset. Driving the thinking that goes behind business growth.

Ā-ROHE, Ā-KĀNOHI

A regional strategy making the most of Hawke's Bay and its people

This document sets out the Matariki – Hawke's Bay Regional Economic Development Strategy and Action Plan 2016 (REDS). We want this strategy to play a real part in economic growth in our region by offering practical guidance to councils, businesses, iwi, hapū, and other organisations and agencies.

Some of the strategy is about practical things that we can – or must – do to help growth. We have a lot of things going for us, and we have to make the most of them. Other parts of it are about the things we have to stop doing, whether it's conflicting interpretation of regulations or needless negativity, because they are getting in the way of growth. We have to be honest about the areas where we're holding people back, and deal to them. Both bits are important.

He toa takitini – A strategy developed in partnership

We're very proud that this strategy is, for the first time, a truly regional strategy, and that it has been designed in partnership, as aspired for in the principles of Te Tiriti o Waitangi. The strategy recognises the overarching frameworks of the Business Growth Agenda (2015) and its six growth areas and the Māori Economic Development Advisory Board's He Kai Kei Aku Ringa (2012) with its six goals.

This strategy involves the public sector at all levels and the private sector of all sizes. Māori partners were represented by Te Kāhui Ōhanga o Takitimu - a collective of Ngāti Kahungunu Iwi and Hapū post treaty settlement groups committed to driving economic development in Hawke's Bay. The strategy is focused on building from the whānau level to generate a healthier, wealthier, more inclusive and fulfilled population. It will only work if we all commit to supporting it and holding accountable the people who agree to deliver their parts of the process.

We need to acknowledge that numerous private, non-governmental and public organisations are already involved with economic development delivery in Hawke's Bay. If we are to achieve higher levels of economic performance and whānau success, their continued involvement in a way that recognises the role of each contributor is vital. So progressive networking between the different contributing organisations will be crucial.

He aronga whānui: he whakamana i te tangata – A strategy that diversifies and empowers

With this strategy, we want to make the most of Hawke's Bay's competitive advantages. We're looking to diversify the economic base of the region. We want to create lasting jobs for our people and to use our resources in a sustainable way.

To do these things, the strategy needs to be clear and succinct, and describe an approach that is workable and collaborative. That way we hope it will encourage buy-in from stakeholders and be something that our region's councils, businesses, iwi, hapū, and other organisations and agencies will use and embrace.

Nā wai, mā wai? – Who worked on the strategy?

A project management team worked on the strategy. They were guided by a governance group that included the Chief Executives of the local and regional councils and representatives from leading private sector, iwi, hapū, educational and health organisations in the region.

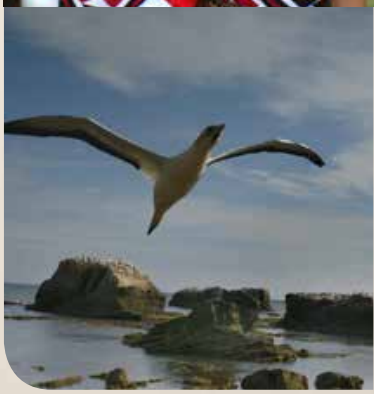
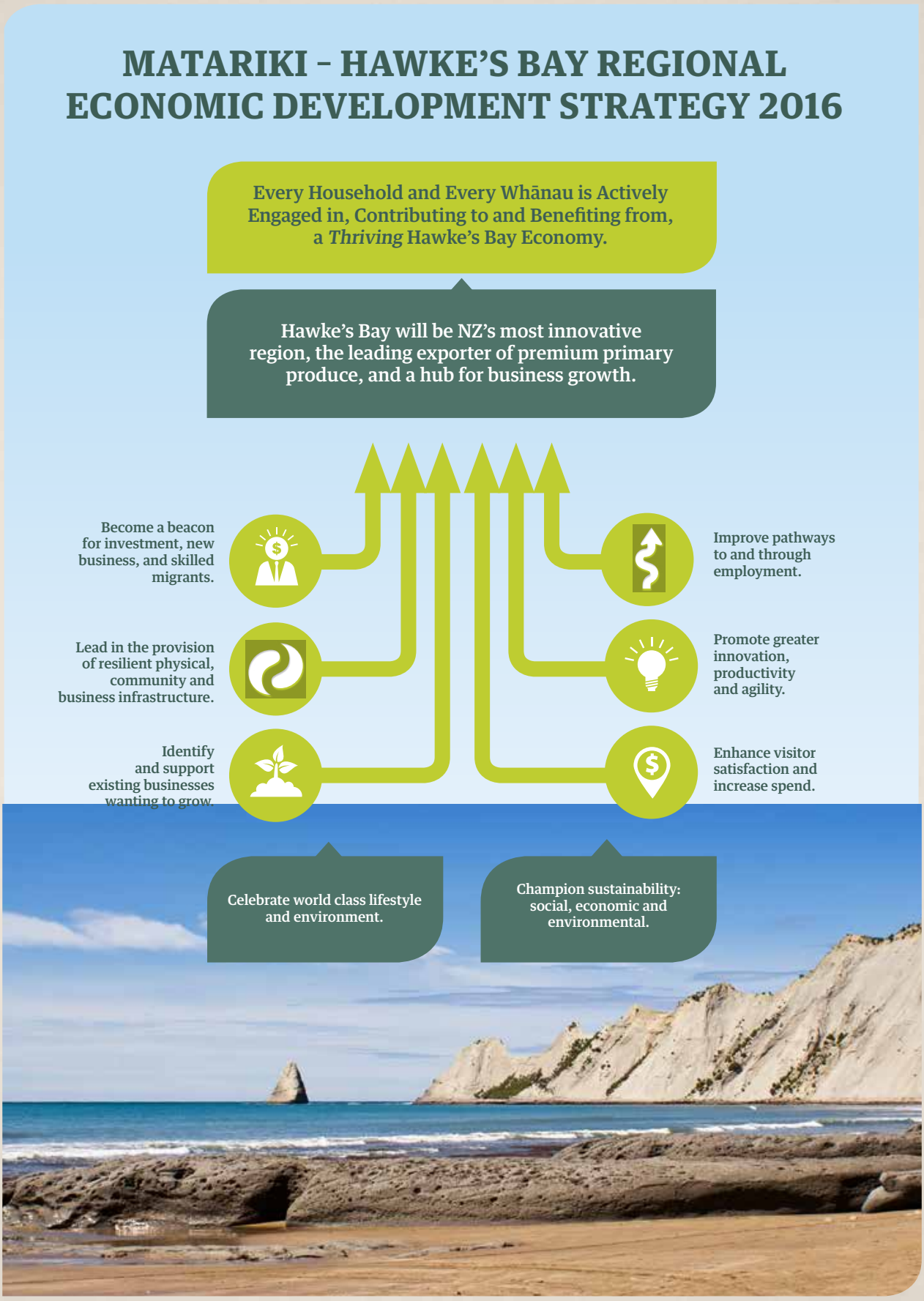


Figure 1: Hawke's Bay Economic Development Framework



OUR VISION:

Every household and every whānau is actively engaged in, contributing to and benefiting from, a thriving Hawke's Bay economy.

We will do this by making Hawke's Bay NZ's most innovative region, the leading exporter of premium primary produce, and a hub for business growth.

Strategic directions

- Improve pathways to and through employment
- Identify and support existing businesses wanting to grow
- Promote greater innovation, productivity and agility
- Become a beacon for investment, new business, and skilled migrants
- Lead in the provision of resilient physical, community, and business infrastructure
- Enhance visitor satisfaction and increase spend

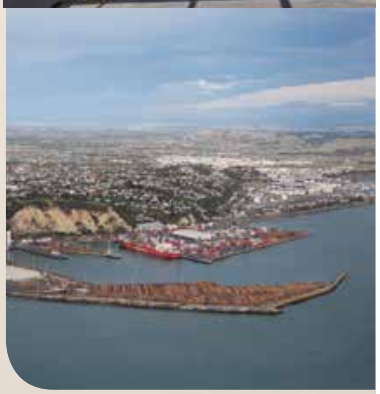
The above strategic directions will be viewed through the lens of 'enabling whānau success' and will collectively require coordinated execution at a regional level.

Goals

- To increase the median household income above the national median, for equitable growth
- To accelerate job growth, in particular to create 5000 net jobs in five years
- To raise to the top quartile of New Zealand regions in regional economic growth and sustain that position long-term

Objectives

- To have a Hawke's Bay-led, government-supported, investment in infrastructure
- To deliver consistent interpretation and communication of rules and regulations to improve the efficiency of regulatory processes across local government within the region
- To establish an enduring private/public economic development delivery model
- To leverage the region's natural advantages to optimise the export value of agribusiness and food and beverage manufacturing, further enhancing the premium positioning and value-add of Hawke's Bay produce
- To build upon and sustainably manage visitor growth
- To foster and support entrepreneurship
- To grow Māori participation in, and benefit from, economic development



THE CONTEXT: THE HAWKE'S BAY ECONOMIC DEVELOPMENT FRAMEWORK

Figure 1 (page 6) shows the strategic economic development framework. The goal of building a more valuable and sustainable export-led economy through diversification is underpinned by six cross-cutting themes that are designed to enhance the economic prosperity of the region. The framework also recognises the region's world-class lifestyle, its environment and the importance of sustainability.

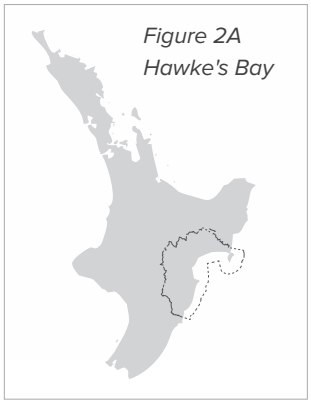
THE CONTEXT: OVERVIEW OF OUR REGION

Hawke's Bay is a relatively specialised regional economy with a small, but stable, population. Economic growth is gathering pace – we have a lot of things happening. We still have much to do particularly for our high-needs communities and our children: a third of our children are growing up in poverty and nearly half of Māori under five are living in households that depend on benefits. It is critical that opportunities and benefits of a thriving Hawke's Bay economy be accessed equitably.

Our consultation process for preparing this strategy revealed a regional economy that is expanding and poised to expand further. But we also observed growing constraints and pressures that need urgent attention. The region has a good foundation. As well, potential developments are on the way that, if carried out, are likely to lead to major new opportunities. We also found evidence of rapidly emerging new business activity in a range of service sectors.

The Matariki – Hawke's Bay Regional Economic Development Strategy and Action Plan 2016 applies to the geographical areas of Central Hawke's Bay District, Hastings District, Napier City, Wairoa District and small parts of Rangitikei District and Taupō District. The boundary coincides with the Hawke's Bay Regional Council (see Figure 2A). The area of focus for Te Kāhui Ōhanga o Takitimu includes Hawke's Bay, but goes beyond its boundaries, spanning the full length of the Ngāti Kahungunu rohe Mai Paritū ki Turakirae, from North of Te Mahia to Southern Wairarapa and linking to other Takitimu waka iwi and into the Pacific. The map provides locations of the different Kahungunu entities, including post treaty settlement groups and taiwhenua (Figure 2).

Figure 2 Geographical Context for the Matariki – Hawke's Bay Regional Economic Development Strategy and Action Plan 2016



DATA FROM: Information obtained from the Hawke's Bay Regional Council's Geographic Information Systems Database.

DISCLAIMER: The Hawke's Bay Regional Council cannot guarantee that the data shown on this map is 100% accurate.

OUR STRATEGIC DIRECTIONS

In the rest of this document we enlarge on each of the strategic directions for the Matariki – Hawke's Bay Regional Economic Development Strategy and Action Plan 2016:

- Improve pathways to and through employment
- Identify and support existing businesses wanting to grow
- Promote greater innovation, productivity and agility
- Become a beacon for investment, new business, and skilled migrants
- Lead in the provision of resilient physical, community, and business infrastructure
- Enhance visitor satisfaction and increase spend

ACTION PLAN DEFINITIONS:

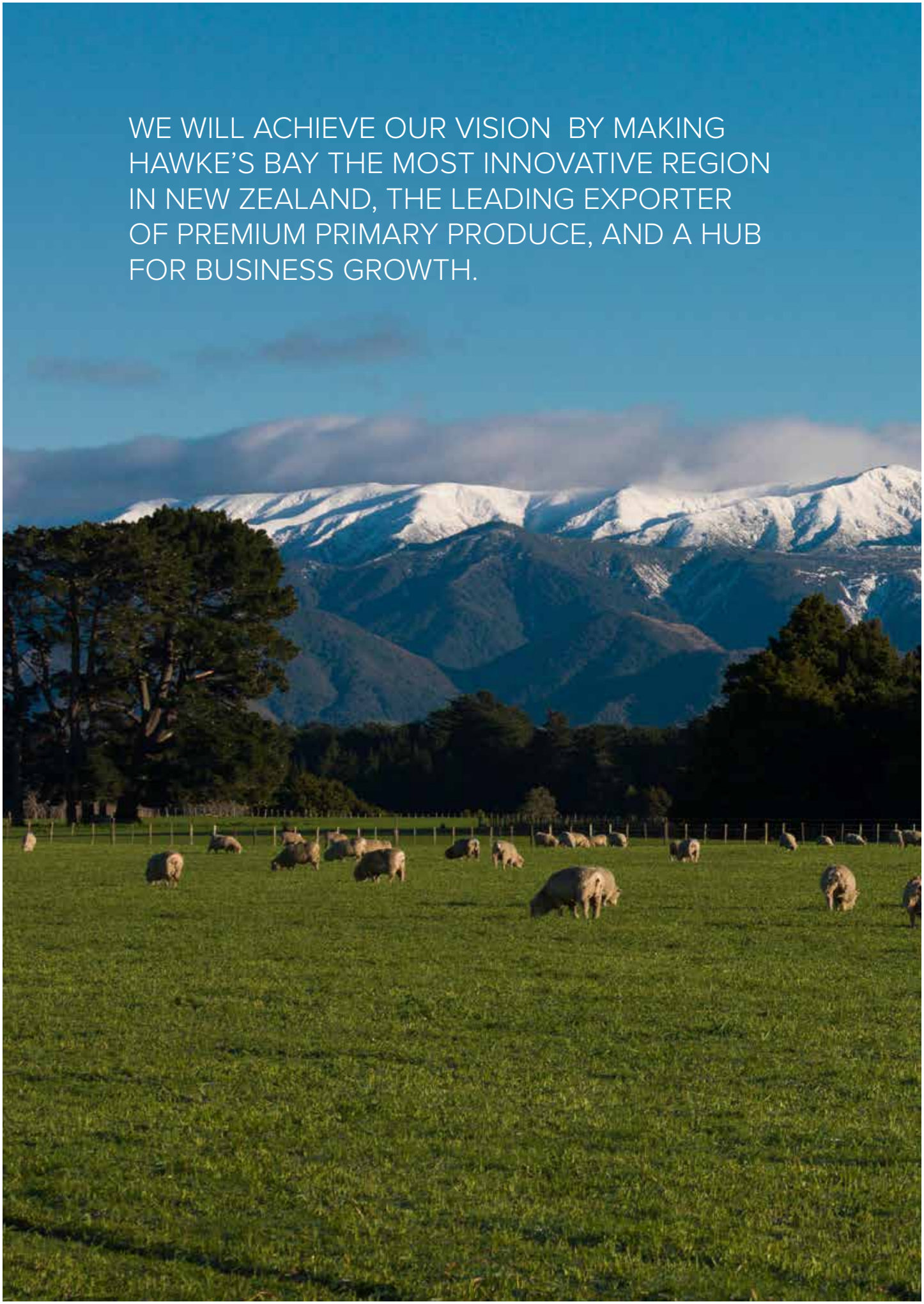
'Lead' The agency held accountable for, and the delivery of, the action.

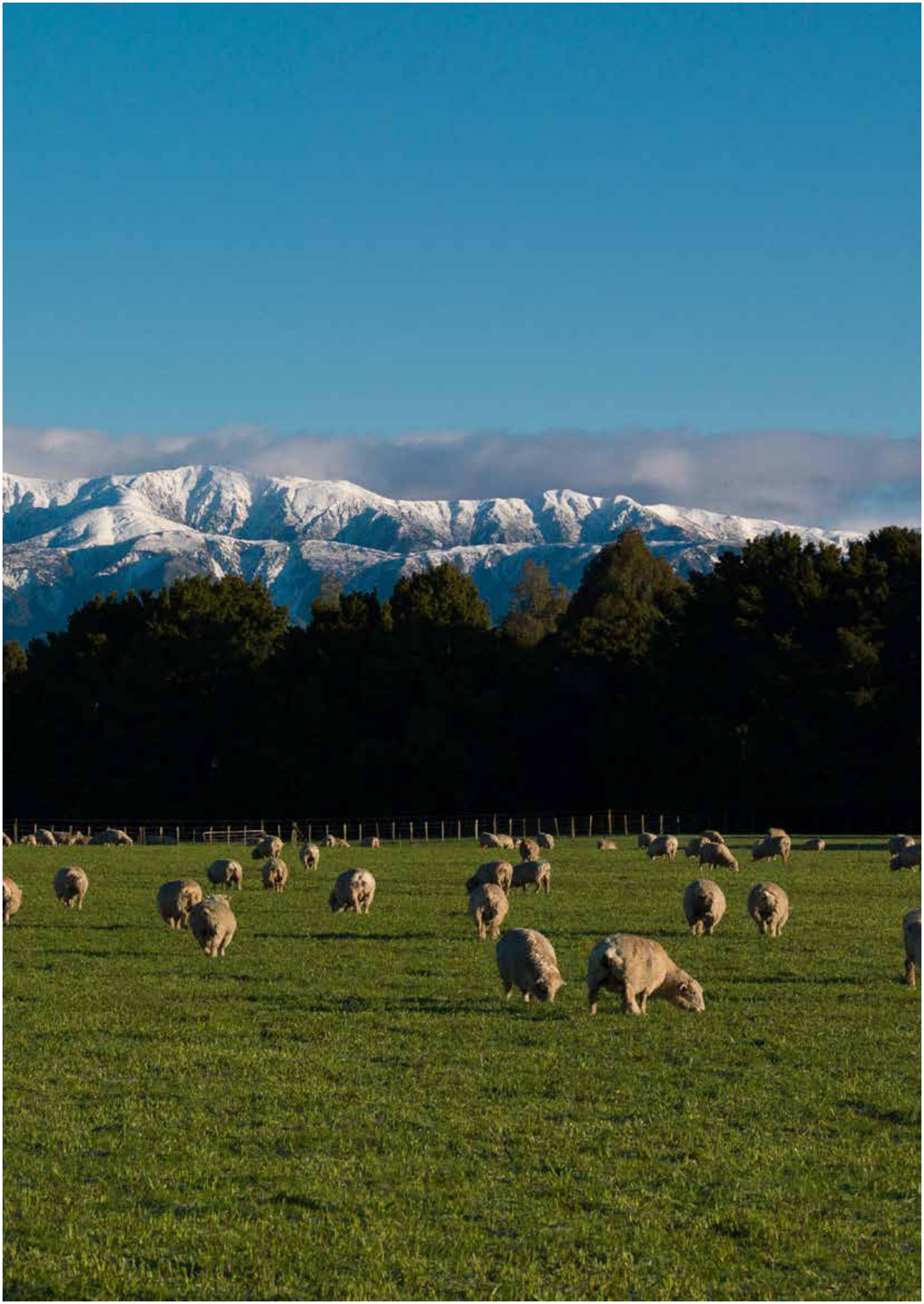
'Partner' Enabler through co-design, participation in, and support of, the implementation of the action.

Abreviation	Full Title
BHB	Business Hawke's Bay
Callaghan	Callaghan Innovation
CHBDC	Central Hawkes Bay District Council
Councils	Local Territorial Authorities for Central Hawke's Bay, Hastings, Napier and Wairoa together with Hawke's Bay Regional Council
EIT	Eastern Institute of Technology
HBDHB	Hawke's Bay District Health Board
HBRC	Hawke's Bay Regional Council
HBT	Hawke's Bay Tourism
HDC	Hastings District Council
MBIE	Ministry of Business, Innovation and Employment
MPI	Ministry for Primary Industries
MSD	Ministry of Social Development
NCC	Napier City Council
NGO	Non-governmental organisation
NZTA	New Zealand Transport Agency

NZTE	New Zealand Trade and Enterprise
TEOs	Tertiary Education Organisations
TKO	Te Kāhui Ōhanga
TPK	Te Puni Kōkiri
WDC	Wairoa District Council

1. Strategic Framework			
Work Area	**Actions**	**Lead Agency**	**Key Partners**
1. Areas of Strategic Focus	1.1 Undertake a stocktake of the organisations involved in economic development in the region and recommend the regional economic development delivery model to give effect to this strategy.	REDS Governance Group	Councils, HBT, BHB, Iwi, Hapū, Government Agencies
	1.2 Investigate a business case to Government for Hawke's Bay to leverage a sustainable competitive differentiation for long-term advantage	HDC	Councils, BHB, Iwi, Hapū, Government Agencies, Private sector
	1.3 Develop research capability to support the work and provide the evidence base for REDS implementation	NCC	Councils, Waikato University
	1.4 Develop measures for monitoring the potential impact and ultimate success of the strategy against the vision, and the principles of the Treaty of Waitangi	REDS Project Team	Councils, BHB, Iwi, Hapū, Government Agencies, Private sector


WE WILL ACHIEVE OUR VISION BY MAKING HAWKE'S BAY THE MOST INNOVATIVE REGION IN NEW ZEALAND, THE LEADING EXPORTER OF PREMIUM PRIMARY PRODUCE, AND A HUB FOR BUSINESS GROWTH.



ARA-RAU, HAUKŪ-NUI, HĀRO-O-TE-KĀHU

Improve pathways to and through employment

We know that access to ongoing, regular paid employment is a significant driver of improved health and wellbeing for households and whānau, and that it reduces crime and violence. Creating and enhancing pathways into employment is not a 'nice to have' for Hawke's Bay – it's a 'must have'. Regionally we must take action to minimise any potentially negative effects of external economic changes.

'Pathways to and through employment' is a strategy that can contribute to developing local resilience. By creating an empowered, more highly skilled and option-rich Hawke's Bay population, we will be better equipped to deal with both future employment needs and changing market dynamics. To do this, we need to build clear pathways into, and subsequently through, employment.

We know that employment opportunities exist across all sectors currently and we need to be more creative to ensure that they are captured by local people. Globally and nationally we've had a history of shifting markets and changing economic policies that are outside our direct control but have had a significant impact on households and on whānau. Forestry, freezing works, and farming in particular have gone through fluctuations that have affected local people's ability to be self-determining and financially stable.

The lower-skilled and unskilled workers are the most vulnerable through such market upheavals, which emphasises the importance of education and training as a critical part of the pathway to sustainable employment. We also have a local dependency on seasonal labour – 30% of which is currently filled by imported labour – because we struggle to match available labour supply with work opportunities.

On top of this, the world is continuing to change at an increasing pace, driven by advances in technology and global connectedness, and we need to give our people the skills and knowledge to help them navigate this uncertainty.

NGĀ HUARAHI WHAI RAWA – PATHWAYS TO EMPLOYMENT

When we refer to 'pathways to employment', we mean the need to train people to be work-ready, who can then be matched with 'employee-ready employers'. We're also talking about creating a skilled and resilient population that is equipped to thrive in an uncertain future.

Training, the first of these pathways, will require industry to lead and government agencies, schools, Eastern Institute of Technology (EIT) and other tertiary providers to respond in a coordinated way. A coordinated response to training will lead to an effective 'supply chain' that has benefits for all involved – but most importantly, for the person seeking employment.

How we incentivise and appropriately align these pathways will require changes in practice and government policy. We need to be prepared to build a defensible case for policy change and lobby to achieve it. We need to make sure that all pathways are supported by a youth-targeted programme to lift aspirations and help young people to see training as something normal. We also recognise the critical role of the household in making this programme successful.

By doing this, we will capture a greater proportion of the student cohort and reduce attrition. Furthermore, by fostering a 'business creation' mindset in the region's classrooms, homes and workplaces, we will encourage greater productivity and utilisation and further support business growth. Bridging the equality divide in the region must be central to all attempts to drive economic development.

Much is already happening in this space, particularly in tackling those youth 'Not in Education, Employment or Training' (NEET). Programmes supported by the Ministry of Social Development (MSD) are delivered by Wairoa College (The Wairoa Young Achievers Trust), Te Kupenga Hauora – Ahuriri, Te Taiwhenua o Heretaunga and Central Health Limited. Youth Futures, which is supported by the Local Authorities and MSD, is also active. Project 1000 is a new initiative that will link local people on benefits to 1000 new jobs over 3 years. Government agencies will work closely with employers and training providers to support those people into employment opportunities in key growth areas such as horticulture, viticulture, manufacturing and improved alignment of local infrastructure projects. This is a significant step towards achievement of the strategy's aspirational goal to create 5000 net jobs in five years.

We need to focus on greater regional coordination of activities by the different agencies involved. We need to focus on all people, including younger and older age groups. A region-wide assessment of all NEET providers is planned; this should be expanded to include all who should benefit from such support.

NGĀ HUARAHI WHAI RAWA – PATHWAYS THROUGH EMPLOYMENT

When we talk about 'pathways through employment' we are talking about the need to foster a spirit of lifelong learning across our collective workforce, and to lift the capability of local businesses to support such an approach. To do this, we need to work closely with local businesses to understand the current issues that block local people from progressing through their careers. We also need to work with EIT and others to clarify the options available for improvement.

The Hawke's Bay District Health Board (HBDHB) is the region's largest single employer and a leader in using employment to address inequity. Their Turuki programme is about improving the capacity and capability of Māori in the workforce and improving the cultural competence of the whole organisation. Their target is to increase Māori in the HBDHB workforce by 10 percent a year. The focus is not only on recruitment – it's also about developing and retaining staff.

Employees must also play their part, bringing a positive attitude to work and a great work ethic. Employers are looking for the basics: turning up for work each working day on time and having pride in your work.

2. Improve pathways to and through employment			
Work Area	**Actions**	**Lead Agency**	**Key Partners**
2. Improve pathways to and through employment	2.1 Project 1000: This project will link local people on benefits to 1000 new jobs over 3 years. The jobs would come from across all industries but would be mainly in the horticulture, viticulture, and manufacturing sectors, and through improved alignment of local infrastructure projects. The jobs will be a mix of casual, permanent full-time and part-time positions.	MSD	Councils, Iwi, Hapū, BHB, Government Agencies, Napier Port, HBDHB
	2.2 Ensure that all major infrastructure development projects (ref action 3.0) are required to consult with and optimise employment opportunities for local people - contributes to Project 1000	MSD	Councils, Iwi, Hapū, Government Agencies, Napier Port, HBDHB
	2.3 Build on existing and create new school - industry - tertiary partnerships to develop vocational pathways for all Hawke's Bay students - contributes to Project 1000	MoE	Councils, Iwi, Hapū, EIT, TEOs, Private sector
Enablers	2.4 Increase the number of youth with drivers licenses (especially in areas outside of the main urban centres where access is restricted) to ensure more youth are eligible for employment - contributes to Project 1000	MSD	Councils, Iwi, Hapū, NZTA
	2.5 Engage rangatahi in regional economic development (including Māori and regional economic development forums) so they increase their participation to the regional economy - contributes to Project 1000	REDS project team	Councils, Iwi, Hapū
	2.6 Conduct a regional mapping project to identify what is happening in the provision of education and employment opportunities for youth	Youth Futures Trust	Iwi, Hapū, Government Agencies, NGOs

Enablers	2.7 Extend the regional mapping project to other age groups	Councils	Iwi, Hapū, NGOs
	2.8 Investigate the feasibility of a joint venture agricultural training hub in Hawke's Bay to maximise opportunities for the local workforce to access employment in agriculture - contributes to Project 1000	MPI	Iwi, Hapū, EIT, TEOs, Private sector
	2.9 Explore, design and deliver a future-focussed programme, including digital enablement and internet-based technologies to develop a resilient population who can thrive in an uncertain future - contributes to Project 1000	MBIE	Iwi, Hapū
	2.10 Undertake Agriculture and Horticulture feasibility studies to invest in Māori business growth, job creation and workforce development - contributes to Project 1000	Iwi, Hapū	Councils, BHB, MPI, TPK, Private Partnerships

TO BUILD HOUSEHOLD AND WHĀNAU JOBS AND PROSPERITY, IT'S CRITICAL THAT WE FIND MORE GROWTH ENTERPRISES, SUPPORT THEM BETTER, ENCOURAGE THEM TO GROW FASTER AND HELP THEM TO SUSTAIN THEIR GROWTH.

WHAI RAWA

Identify and support existing businesses wanting to grow

'High growth' businesses represent by far the greatest source of opportunity for regional jobs growth and higher median incomes. High growth businesses sustain their investment through innovation and continuous improvement. These businesses maintain steady growth over some years, either continuously or in stages. They have both the capability and the commitment to grow.

Identifying and supporting growing businesses is the so-called 'sweet spot' of economic development and the approach that is most likely able to deliver the employment outcomes we all desire.

We got the very clear message from participants engaged in the REDS process that the region needs to give priority to 'growing our own'. It's already happening across the region. Here's what we found through the interview process:

- Hawke's Bay has many high-growth firms
- They are located in all sectors
- They are growing especially in the 'business to business' (B2B) or outsourcing economy, which typically uses digital platforms to achieve new growth and scale quickly
- The normal path to growth is by acquiring customers all over New Zealand.

To build household and whānau jobs and prosperity, it's critical that we find more growth enterprises, support them better, encourage them to grow faster and help them to sustain their growth. Encouraging growth among Hawke's Bay enterprises is so important because of the realities of the present economy:

- Many young people are leaving and not returning, contributing to Hawke's Bay's ageing demographic profile
- Large and old firms worldwide are shedding jobs and Hawke's Bay shows the same trends
- Larger cities will continue to dominate, and dominate in new ways while competition between regions will increase
- Disruption of existing businesses and business models is now a fact of life, and is accelerating. Competition is global.

No region is immune from these trends; and these trends are not reversible. The good news is that start-ups and high growth firms can be created anywhere, and in any sector.

Research on high-growth firms has established the following:

- While being a small proportion of all firms, high-growth firms create the greatest number of jobs

- High-growth enterprises are often under the radar, invisible to economic development agencies
- Key problems for high growth firms are: finding the right talent that can grow with the firm, securing non-debt capital to fund expansion, managing and growing capacity, implementing effective cost accounting practices, replicating successful geographic expansion
- Almost all high-growth firms face these same basic challenges, regardless of the firm's industry or location
- CEOs think they are alone in their struggles and have very few places to turn for peer advice or assistance
- Their biggest problem is the lack of supervisory and management talent.

This and other research will guide our new regional approaches. We are sure that encouraging more high growth businesses will give Hawke's Bay the greatest return on investments in regional development, and will lead to the greatest chance of creating more good jobs for household and whānau prosperity. We have got to do what we can to encourage growth.

WHANAKETANGA – BUILDING ON WHAT WE ALREADY DO

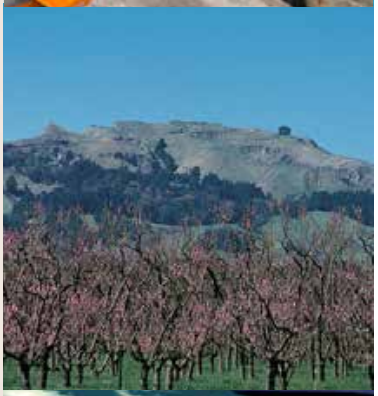
Hawke's Bay has numerous existing programmes and activities that encourage enterprise growth. However, we can do more to support local businesses that employ local staff.

One pioneering proposal is to get the key funders of significant capital projects (the councils, the District Health Board, Napier Port, and central government) to coordinate their projects over the next decade, and share the proposed programme with the local construction industry, EIT, ITOs and schools. This will mean that local companies can have the best chance to bid for the work, and employment opportunities are optimised for our people. Given that up to an estimated one billion dollars of capital spend is forecast for the next ten years, this exciting initiative will have a significant impact on employment prospects and career-development opportunities for the Hawke's Bay.

We will also work to foster a favourable local environment for business. We will especially find new ways of supporting those 'solopreneurs', who operate innovatively but at small scale, by encouraging networks and the outsourcing of core functions where these can be shown to make room for innovation.

The development of Business Hawke's Bay, and in particular the Hawke's Bay Business Hub, has created better access to services for businesses through a one-stop-shop model. The Hawke's Bay Business Hub has exceeded expectations with the co-location of multiple agencies involved in 'unleashing business potential' with client numbers increasing. It provides a shared space for collaboration. Just as with any venture, it is a process of continuous improvement and one of the opportunities lies in strengthening connections with Māori-led businesses that are also seeking to grow.

Other successful programmes and business advisory services have achieved considerable success, growing firm profits, increasing employment, and improvement in the capacity of management to drive growth. These include, for example:



- High Performance Work Initiative & Better by Lean (Callaghan Innovation)
- Regional Business Partners
- Private collaborative partners
- New Zealand Trade and Enterprise
- Te Puni Kōkiri
- The cluster of expertise located at Hawke's Bay Business Hub to support the growth of food and beverage businesses
- Business Mentors
- Institute of Directors
- Business Awards

MAHI TAHI – HARMONISING THE WAY LOCAL AUTHORITIES APPROACH REGULATION

We need to find ways to standardise the approach taken to regulation across all the Councils in Hawke's Bay where practical and allowed by legislation. The way applicants and councils approach regulation has a big effect on the quality of experience for users in areas such as consenting and compliance monitoring.

Businesses consulted have told us that the requirement to make multiple applications for regulatory approvals to different local authorities can be time consuming, lead to project delays and add to the cost of doing business. Concerns have also been raised about the differing interpretations of legislation or approaches to regulating the same activity in different planning documents between the various councils.

Any new business setting up or expanding is likely to come across the requirements to comply with one or more pieces of legislation. For example, this could be through altering an existing building or building something new, in which case they need to comply with the Building Act (BA). Other laws also need to be complied with, such as the Sale and Supply of Alcohol Act, the Food Act for food preparation, Regional and District Plans formed under the Resource Management Act or the Hazardous Substances and New Organisms Act. Not all these pieces of legislation are administered by local councils, but the majority of them are.

Councils need to ensure that adequate industrial, commercial and residential land, as well as resilient network infrastructure, is provided for future generations. Councils are engaged in regional initiatives such as the Heretaunga Plains Urban Development Strategy and other Regional and District planning processes.

We need to foster a regulatory culture in our local authorities that is pragmatic and proportionate, and focused on outcomes, not process. We aspire to have user-friendly planning and consenting processes by applying and interpreting legal requirements consistently.

3. Identify and support existing businesses wanting to grow			
Work Area	**Actions**	**Lead Agency**	**Key Partners**
3. Identify and support existing businesses wanting to grow	3.1 Establish a coordinated approach to major infrastructure development projects over the next decade, and partner with industry and education sector to optimise local business growth	NCC	Councils, HBDHB, Napier Port, Construction Industry, Education Sector, MSD, Te Kāhui Ōhanga
	3.2 Explore the establishment of an incubator for small businesses incorporating a business accelerator programme linked to existing and potential new co-working spaces	BHB, NCC	Councils, Iwi, Hapū, Private Sector, Callaghan
	3.3 Establish accessible business growth services to firms across the Region	TPK, BHB	Councils, Iwi, Hapū, TPK
Enablers	3.4 Identify start-ups and high growth firms and identify barriers to growth and local capability	BHB	Regional Business Partners
	3.5 Explore an annual Hawke's Bay Investor Summit to target investor markets to attract embeddable investment in Hawke's Bay	BHB, NZTE	Iwi, Hapū, Councils
	3.6 Support the coordinated development of existing and emerging Māori business leadership to maintain and grow participation in the regional economy	Iwi, Hapū	Councils, TPK, Private Sector

TĀNE-WHAKAPIRIPIRI

Lead in the provision of resilient physical, community, and business infrastructure

Significant investment lies ahead for the region. We need to deal with the consequences of historic patterns of development. Some of these have degraded environmental values and made us vulnerable to a changing climate and sea-level rise. We need some new infrastructure too, with opportunities to improve resilience and create new businesses and employment. At the same time it will make the region more attractive to visitors by both enhancing the visitor experience and supporting our region's export brand.

LAND TRANSPORT

The Governance Group has assisted, in collaboration with the Regional Transport Committee and the Gisborne Governance Group, in identifying key road transport infrastructure priorities for the region, and has been liaising with the Government on this critical matter. Given our significant reliance on primary production, efficient transport of goods from the field to production facilities, and then to Napier Port and the wider North Island is seen as key to growing and maintaining the prosperity of Hawke's Bay business, and therefore the region as a whole.

We are working with central Government to develop an action plan for the Gisborne and Hawke's Bay regions. Both the Hawke's Bay and Gisborne Governance Groups agree that the first priority for the region is State Highway 2 between Opotiki and Napier and related access routes to Napier Port. The road link, in its current form, is a major impediment to economic development in the region. The East Coast Regional Economic Potential Study (2014) identifies this road as a key priority.

There is also an opportunity to improve the connections between Wairoa and Napier/Hastings and Gisborne. Forestry forecasts show that tonnages from the Wairoa area alone would result in an almost fourfold increase to the current tonnage. Increased tonnage would further stretch and expose the existing route vulnerabilities, which are in the Napier Port catchment. The route is important because of the range of products that are being transported in and out of Wairoa and the northern part of Hastings District. It will improve access to vital services and any upgrades will improve the safety of the route as well as access to smaller rural communities.

Aside from the SH2 improvements, other improvement initiatives are the Napier Port Access project and improvements to State Highway 38. The Napier Port Access project is a key regional initiative and this work is recognised in part by the programme business case being funded directly from Crown Funds. The programme business case provides a number of projects designed to ensure safe and strong freight connections exist to service current and future needs of traffic moving to and from Napier Port. The delivery of the initiatives coming from this plan will be critical to the future movement of freight and the surrounding communities.

Sealing State Highway 38 through to Lake Waikaremoana will open up this key natural asset and improve the safety of tourists travelling to the lake. It is noted that the Bay of Plenty is proposing the sealing of their end of SH38. An increased project to seal the full route between Wairoa and Rotorua would further enhance the tourism potential along this full route and provide some increased resilience between the East Coast and the Central North Island.

As outlined in the Hawke's Bay Transport Investment Priorities document completed and forwarded to ministers earlier this year, weight restrictions on bridges and increasing truck sizes (particularly HPMV) will restrict access to some pivotal routes. Without focus, monitoring, and funding applied to improving the bridges those restrictions will impact on economic development.

TE HONONGA MATIHIKO – DIGITAL CONNECTIVITY

The digital economy is a critical component of the regional economic development strategy. We aim to create a safe, smart and connected region and to be a 'digital corridor' for our residents, businesses and visitors.

We'll be considering five initiatives:

- Broadband infrastructure enhancement across the region – in particular wi-fi nodes for all key community and tourism assets, including freedom camping areas, main road rest areas, community centres and halls, marae, council premises and tourism attractions such as cycle ways, using fixed radio broadband solutions
- Research into emerging digital technologies, new business models and opportunities for new collaborations in the region
- Community Connect – a programme to build digital skills and capacity across disparate regional communities, so as to open up digital possibilities to those currently denied reasonable access to fast and reliable broadband and 4G coverage
- Community resilience – a communications network designed to withstand adverse conditions and natural disasters that will serve the community and regional civil defence in times of emergency
- Employment Connect – a programme to connect our young people to jobs and to skills enhancement opportunities, using mobile applications and networks

Through these projects we want not just to enable access but to grow demand for broadband in the community. We also want to cultivate our growing digital skills base to create a platform for new start-ups and high-growth companies.

Broadband access issues are complex and vary considerably across the region. We need infrastructure and programs that will enable all our communities, localities and businesses to access the opportunities provided by connectivity.

Better broadband is already coming to Hawke's Bay through existing programmes and technologies. But not all areas are getting the benefits. And not all groups, businesses and communities realise just how transformative broadband is. We want to accelerate the process and in doing so to transform Hawke's Bay into a connected and networked twenty-first century economy and community.

OUR COMPETITIVE ADVANTAGE IS BUILT ON THE FOUNDATION OF FERTILE LAND, A QUALITY WATER SUPPLY, A FAVOURABLE CLIMATE AND THE ABILITY TO PRODUCE AND EXPORT WORLD LEADING QUALITY PRODUCTS.

WAI ORA – WATER STORAGE AND ENVIRONMENTAL ENHANCEMENT

The Ruataniwha Water Storage Scheme (RWSS) is proposed to be operational in 2019 and full irrigation uptake of 26,000-27,000ha is currently considered achievable. The initial impacts of the project occur during construction and will continue over the entire period of farm conversion. It is estimated this phase will generate 5,400 job-years of work and increase GDP by $490m. These impacts are anticipated to be spread over 12 years, but three quarters of the effects are estimated to occur in the first three years. Once the scheme is operating at full capacity, an annual GDP increase is estimated at $380 million with potentially an extra 3,580 ongoing jobs for the region.

In addition to the RWSS, further opportunities exist for water storage in other catchments including Wairoa and Ngaruroro. These possibilities can help build on the momentum, skills, jobs and associated industries of RWSS to maximise the value the region derives from its freshwater resources.

Wetland enhancement projects, such as at Waitangi and Peka Peka, and cycle ways on flood control infrastructure, are examples of new visitor experiences arising from environmental management. By carefully managing the environmental effects of increased use of our land and water resources, we can have win–wins for both the economy and the environment.

4. Lead in the provision of resilient physical, community and business infrastructure			
Work Area	**Actions**	**Lead Agency**	**Key Partners**
4. Lead in the provision of resilient physical, community and business infrastructure	4.1 Improve access to the Port of Napier to increase regional economic performance	Regional Transport Committee	HBRC, Napier Port, NZTA
	4.2 Support the timely implementation of the key strategic initiatives in the Regional Land Transport Plan.	Regional Transport Committee	Councils, Iwi, Hapū, NZTA
	4.2.1 Support the combined approach with Tairawhiti to achieve significant upgrades to SH2 between Napier and Opotiki	Regional Transport Committee	Councils, Iwi, Hapū, NZTA
	4.3 Accelerate the deployment of Ultra Fast Broadband throughout the Region, in particular to rural communities and marae	Councils	Iwi, Hapū, MBIE
	4.4 Ensure regional and district plans take a coherent and consistent approach to regulating common activities	Councils	Private Sector
	4.5 Investigate a common approach to consenting and regulatory approval	Councils	Private Sector
	4.6 Identify land available to support new business growth by liaising with councils	Councils	Iwi, Hapū, Private Sector
Enablers	4.7 Explore opportunities arising from water storage schemes should they proceed, in order to promote increased regional productivity	HBRC	Councils, Iwi, Hapū, Private Sector, EIT, MPI

PŌTIKITANGA

Promote greater innovation, productivity and agility

We want to create more higher-value jobs through innovation, as good jobs will provide prosperity to our households and whānau. Innovation, agility and productivity are three key drivers of business success that we can influence in a globally connected and technology-enabled world. These success factors along with a commitment and drive to improving social determinant factors in the region will allow for a sustainable and exciting economy.

Pōtikitanga is the inherent value that comes from Māui Tikitiki a Taranga and his risk-embracing and adventurous exploits. Māori business growth in the Hawke's Bay has a growing number of success stories and is an area of immense potential with the right support. Preliminary consultation with whānau across the region highlighted this opportunity and its commercial potential.

We'll see more jobs created if our existing enterprises grow and new enterprises start up. This strategy reviews how we currently help our enterprises to prosper, and in particular whether we can do things better, differently or with greater resources.

To prosper, businesses must continue to meet market demand. They must drive value into their products and services, optimise their pricing, establish good relationships with customers and their supply chain partners, and make sure they focus on continuous improvement. A common saying is that business leaders need to work 'on' their businesses as well as 'in' their businesses. Support services are available to help.

Innovation will also be critical for many of our businesses to meet community and market expectations for their environmental performance. We need to ensure we are using our precious natural resources most productively and in doing so getting 'more from less'. The agility of our businesses to adapt in the face of global change is critical to long-term economic and social resilience.

INNOVATION

Innovation is central to regional economic performance. It drives start-ups and high-growth firms and is critical for business to thrive. That is why nurturing innovation is so important to this strategy and why many of our planned actions will support innovation in Hawke's Bay.

Innovation is about 'marketable ideas' and about doing things better than anyone else. The sources of innovation are wide and varied. Innovation is not just the creation of patents, and is not just research and development, but includes the development of new products, processes, services, markets and business models. Our traditional strengths in premium primary production have been driven by innovation. Local firms right across the economy are now innovating in such diverse areas as robotics, new varieties of produce, business to business services, high tech and design.

Our task is to support the process of validating, developing and commercialising innovation.

PRODUCTIVITY

Productivity means improvement. It means working smarter, increasing output, and getting the best out of our people and natural resources. Productivity is not just profitability, but increasing productivity will help drive returns to the business.

We see significant potential to lift the productivity of Hawke's Bay businesses and other institutions. Encouraging businesses to do things smarter is central to this strategy and to the prosperity of the region. A good local example is pipfruit. New Zealand produces on average 64 tonnes per hectare with a goal to increase this production to 160 tonnes per hectare. Our nearest competitor is Chile on 42 tonnes. This productivity gain has been achieved while maintaining world-leading quality standards.

The New Zealand apple industry is the leading apple industry in the world, a position achieved through innovation in new varieties, in on-orchard growing practices, in post-harvest technologies, and in sophisticated international marketing practices.

However, as we grow the local economy, we need to make sure that we do nothing that increases the biosecurity risk to the local primary sector.

AGILITY

Agility is the capacity of firms to change course in response to changing market conditions. Agility requires a keen knowledge of markets, strategic sense, the capacity to work 'on' the business as well as 'in' the business and the courage to pivot towards new opportunities.

We aspire to support the development of 'agile' firms capable of operating in new or expanded markets, of adopting new technologies and changing their business as markets fail, prices collapse, customer preferences change, new competitors emerge, their businesses are disrupted, and so on.

IMPROVING WHAT WE DO ALREADY

The region is well served with programmes that aim to enhance productivity. Examples of current initiatives include:

- High Performance Work Initiative (HPWI)
- Callaghan Innovation – the Better by Lean/Innovation Readiness approach
- Regional Business Partners Programme
- Chamber of Commerce
- Private sector-driven business services.

Our challenge is to do more and better, to eliminate duplication, to close gaps, to meet market demand and to do so cost-effectively. Our strategic intent as a region must be to help firms drive business improvements through:

- The wider marketing of our existing resources and programs
- Increased resources in areas where this is needed, to match the greater demand that will grow as a result of our greater marketing efforts
- Greater linking and leveraging of existing tools
- Introducing new programmes where needed
- Embedding a technology focus in our programmes
- Using existing tools in new ways or in new areas
- Stretching eligibility and making programs generally more flexible
- Making sure the cost to businesses of productivity, innovation readiness and other enhancement programmes is something they can afford, especially for start-ups.

We could do more to further drive innovation, productivity and agility. For example, the start-up ecosystem needs much more effort and resourcing. We lack a business incubation system and business accelerator programmes for start-ups, and we plan to develop these for the region.

Government itself has an opportunity to be more innovative in how it supports industries and businesses. For example, in the trade policy area, such as opening market opportunities for NZ goods and services, much more could be gained by agencies such as MFAT, MPI and NZTE working more collaboratively and strategically with each other and with industries.

5. Promote greater innovation, productivity and agility			
Work Area	**Actions**	**Lead Agency**	**Key Partners**
5. Promote greater innovation, productivity and agility	5.1 Work in partnership with Iwi and Hapū to identify and support commercial opportunities and to support the innovative and entrepreneurial capacity of Māori	TKO	Councils, Iwi, Hapū, BHB, TPK, MBIE, MPI, Private Sector
	5.2 Establish a Regional Research Facility to provide an evidence-base and support decision-making to optimise regional assets through innovation-led productivity growth	BHB	Councils, Iwi, Hapū, Private Sector
	5.3 Support the expansion of the National Aquarium, including the development of marine research, to create high-skilled science-based employment	NCC	Councils, Universities, Private Sector

	5.4 Work with primary producers to ensure productivity gains deliver the improved environmental performance required for freshwater reform	HBRC	MPI, Private Sector
	5.5 Support natural resource users to identify and proactively manage business risks and opportunities arising from a changing climate	HBRC	MPI, Private Sector
Enablers	5.6 Ensure sustained funding for productivity and innovation development programmes to meet the needs of businesses in Hawke's Bay	Callaghan	Iwi, Hapū, BHB, MBIE, Private Sector
	5.7 Promote greater business agility and connectivity through better use of digital technology	BHB	Councils, Iwi, Hapū, NZTE, Private Sector
	5.8 Research the Hawke's Bay productivity gap so that causes can be identified and enable better targeting of support services	MBIE	Iwi, Hapū, BHB, EIT, Productivity Commission, Private Sector
	5.9 Conduct a regional natural-capital stocktake of primary sectoral productivity potential.	HBRC	Iwi, Hapū, MPI, Private Sector

MATANGI RAU

Become a beacon for investment, new business, and skilled migrants

Attracting new resources to Hawke's Bay will be an important stimulant of economic growth in the region.

The benefits of attracting firms, investment and migrants to Hawke's Bay are:

- new jobs
- new links and expanded networks
- ideas for new market/product development
- new skills
- new capital investment
- enhancement of supply chains
- diversification of the productive base adding to sustainability.

Resources invested will range from financial capital from external investors looking for opportunities, to businesses seeking to capitalise on the natural and competitive advantages the region has to offer, through to people attracted by the lifestyle and opportunities offered to their families.

The region excels in, and is world-renowned for, its quality food production. Our exports account for 52.5% of the region's GDP compared to 30.7% for total New Zealand – tangible evidence of the value of Hawke's Bay to the nation's export-driven economy. Our competitive advantage is built on the foundation of fertile land, a quality water supply, a favourable climate and the ability to produce and export world leading quality products. Maintaining the quality of the natural resource base on which the region depends will be essential to attracting investment and securing the social license for businesses to grow value from the resource base.

Opportunities already exist for external investors to forge partnerships with local businesses looking to grow or by creating standalone new business ventures. As a region, we are looking to attract entrepreneurs who will maximise production throughout the value chain from primary production to the final packaged product, and then to further capitalise through their global value chains.

In addition to primary production, Hawke's Bay also has a thriving knowledge economy. The primary sector is a natural conduit for furthering applied agri-science research from the laboratory to practical application throughout the primary industry value chain. Our region is also the home for niche technology businesses, with high tech an expanding sector attracting entrepreneurs with the quality lifestyle and the work life balance offered.

Our economic diversity is aided by a strong business services sector. Low operating costs relative to the large cities and a quality labour supply are proving attractive for businesses establishing or relocating to Hawke's Bay to conduct business services. Well-connected communications, transport links, and low property costs add to the reasons for establishing business in Hawke's Bay.

The Hawke's Bay economy is on the upturn and the region is currently one of New Zealand's strongest performing economies. New Zealand and overseas investors are recognising the business opportunities this momentum is creating.

Recent examples of investment from outside investors include: Rocket Lab; Rockit Apples, and Kiwibank.

6. Become a beacon for investment, new business and migrants			
Work Area	**Actions**	**Lead Agency**	**Key Partners**
6. Become a beacon for investment, new business and migrants	6.1 Work with Rocket Lab to develop opportunities to leverage business attraction off their Te Mahia initiative	WDC	Iwi, Hapū, HBT, MBIE
Enablers	6.2 Develop a targeted regional strategy for the attraction of businesses, investment and migrants	Councils, BHB	Iwi, Hapū, NZTE, Private sector
	6.3 Undertake specific Food & Beverage global opportunity assessments in order to identify new market-led opportunities for Hawke's Bay businesses	BHB	Councils, Iwi, Hapū, MBIE, NZTE, Private sector
	6.4 Support the establishment of the food and beverage supply chain network based on goat and sheep dairy	BHB	Councils, Iwi, Hapū, MBIE, MPI, Private sector
	6.5 Develop an agribusiness programme to identify specific sector issues and opportunities for business development and growth	BHB	Councils, Iwi, Hapū, Private Sector

KAHUNGUNU RINGA HORA

Enhance visitor satisfaction and increase spend

We live in a region with great food, world-class wine, an incredible climate, warm community and a lush landscape with history and beauty. Our region is accessed by road and plane, and increasingly by ship. The number of cruise ship visits to the Port has more than doubled since the mid-2000s and is projected to bring 91,500 passengers directly into Hawke's Bay next year. An increase in air traffic by Air New Zealand and the arrival of Jetstar will make it even easier to arrive and enjoy Hawke's Bay.

Add to this picture Hawke's Bay's impressive and growing list of events, which includes Te Matatini 2017, Iron Māori, Art Deco, Horse of the Year, F.A.W.C!, The Big Easy, Mission and Black Barn concerts, Air NZ Hawke's Bay Marathon and Tough Guy & Tough Girl.

During the research we came across the theme "One more night, one more coffee" to highlight the importance of every visitor's experience and contribution. When we do this well, Hawke's Bay will continue to grow as a premier visitor destination. The region has many of the things it needs to be a tourist mecca, but it still requires its people and its visitors to share this truth with the world. The work of Hawke's Bay Tourism as a key driver and delivery partner will help ensure our strong position in the visitor market, domestically and internationally.

Our visitors are organised into two groups, international and domestic (New Zealand-based) travellers, who bring different preferences and patterns. For the year ending March 2016 and based on conservative estimates, domestic travellers spent $405m and international travellers spent $135m. International visitors staying in commercial accommodation grew by 19.3% at year end March 2016.

The opportunity for international tourism to Hawke's Bay is in growing the important longer staying international markets of Australia, UK and USA but also providing tourism product that meets the need of the fast growing Chinese market. Domestic tourism provides the opportunity to build the visitor economy year-round therefore evening out the year so the industry can be sustainable. Attracting and hosting events and conferences play an important role in helping to balance visitor arrivals across the year. The biggest risk Hawke's Bay faces is that we do not have the infrastructure and tourism products to meet the needs of a growing visitor economy.

We can encourage sustainable visitor growth in number and spend by developing infrastructure with a focus on improving the visitor experience. Improved roading, greater digital connectivity, better facilities and other general development are all factors that will help.

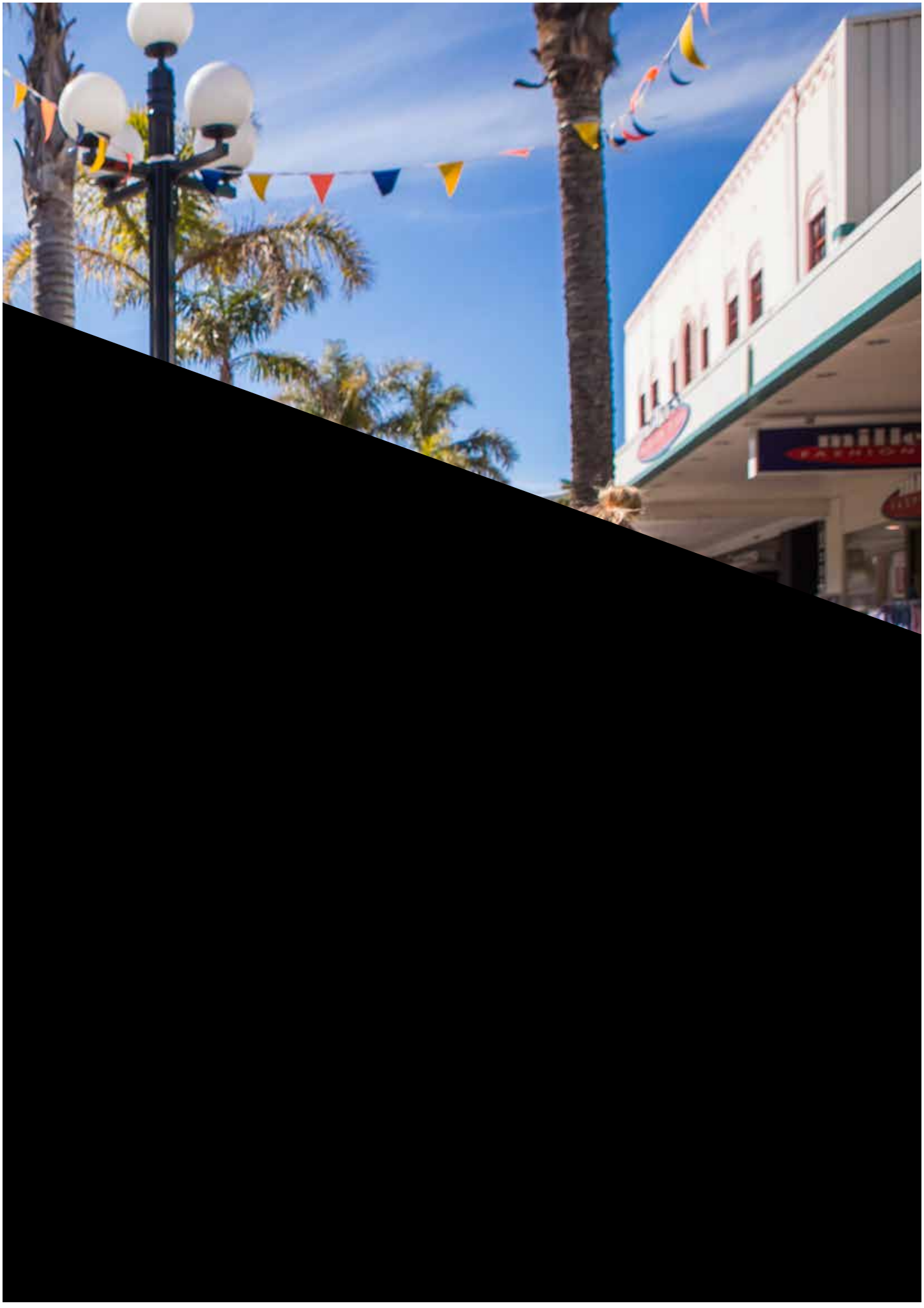
We can see room for visitor-focused product development especially in diversifying our offerings. We can develop products and services that use our people's skills and talents and display our character. A significant opportunity here is developing Māori-centred tourism, with ventures that engage whānau and tell our story. The arrival of Rocket Lab at Te Mahia Peninsula provides a unique opportunity to build tourism products centred on 'space-launch tourism' while also allowing the natural beauty and the extensive history of the area to be showcased.

To further combine visitor attraction and our drive for a sustainable future, we are seeking government support to create a world-class aquarium that is research-based

and conservation-focused. The project will be led by Napier City Council (NCC) who will work alongside Hawke's Bay Regional Council and Waikato University, with important roles played by the Department of Conservation, National Institute of Water and Atmospheric Research (NIWA), the Earthquake Commission (EQC), Massey University, GNS Science and the Zoo and Aquaria Association of Australasia. It is proposed that the new facility will be operational within two years of receiving funding support.

Enhance visitor satisfaction and increase spend			
Work Area	**Actions**	**Lead Agency**	**Key Partners**
7. Enhance visitor satisfaction and increase spend	7.1 Improve collaboration between organisations tasked with tourism product development and infrastructure spend and establish a coordinated approach to developing tourism products and a programme of initiatives in order to optimise visitor spend in Hawke's Bay	HBRC	Councils, Iwi, Hapū, BHB, HBT, MBIE
	7.2 Develop a Māori-centred tourism group to increase the experience, the spend and employment opportunities e.g. space launch tourism at Mahia Peninsula	Iwi, Hapū	Councils, HBT, MBIE, Private Sector
Enablers	7.3 Improve collaboration between the tourism industry and educational institutes to improve staff training	EIT	TEOs, Private Sector, HBT
	7.4 Support and resource continued collaboration between organisations responsible for events	HBT	Councils, Iwi, Hapū, MBIE
	7.5 Undertake a feasibility study for a Napier to Gisborne cycleway	HBT	Councils, MBIE

THE WORLD IS CONTINUING TO CHANGE AT AN INCREASING PACE, DRIVEN BY ADVANCES IN TECHNOLOGY AND GLOBAL CONNECTEDNESS. WE NEED TO GIVE OUR PEOPLE THE SKILLS AND KNOWLEDGE TO HELP THEM NAVIGATE THIS UNCERTAINTY.



New Zealand Government

APPENDIX TWO

Matariki

Hawke's Bay Regional Social Inclusion Strategy

'Hawke's Bay is a vibrant, cohesive, diverse and safe community, where every child is given the best start in life and everyone has opportunities that result in equity of outcomes'

This strategy was commissioned by 'LIFT Hawke's Bay: Making it Happen - Kia Tapa Tahi'[1] to support their 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'

[1] LIFT Hawke's Bay are a group of local leaders from Councils, Agencies and Community in the Hawke's Bay.

MATARIKI - HAWKE'S BAY REGIONAL SOCIAL INCLUSION STRATEGY

'Matariki - Hawke's Bay Regional Social Inclusion Strategy is the partner strategy to *Matariki – Hawke's Bay Regional Economic Development Strategy and Action Plan 2016.* It sets out a conscious and practical approach to social inclusion that benefits every household, whānau and community in Hawke's Bay.

Social inclusion is the ability of all individuals, households, whānau and communities to participate in the economic, social, cultural and political life of the community in which they live. This means people have access to some very basic but important things, including; enough income to sustain an ordinary life; a safe place to live; an education; the opportunity to develop skills that are valued; and services that support their health. Collectively these form the basis of the resources and opportunities to progress through life in a way that creates wellbeing for individuals, whānau, families, households and communities.

Matariki - Hawke's Bay Regional Social Inclusion Strategy supports the *Matariki - Hawke's Bay Regional Economic Development Strategy and Action Plan 2016* Framework by focusing on achieving improved outcomes for every whānau and household through economic inclusion. Economic growth is fundamental to social inclusion, and social inclusion is a key contributor to economic growth. Economic inclusion will benefit everyone in the Hawke's Bay, including local business by increasing the number of households participating in the economy.

OUR VISION

Hawke's Bay is a vibrant, cohesive, diverse and safe community, where every child is given the best start in life and everyone has opportunities that result in equitable outcomes.

Strategic Directions

1. Growing Socially Responsible Employment and Enterprise
2. Preparing People for Work
3. Whānau, Households and Communities Driving Social Inclusion

Goals

- All employers in Hawke's Bay implement policies for socially responsible employment.
- Hawke's Bay has more people in skilled employment, education or training.
- Hawke's Bay has proportionally fewer people in the more deprived sections of the population than the national average

Outcomes

- To have more households with at least one person on a living wage
- To raise the percentage of employees in high skilled jobs to above that of total New Zealand
- To increase the number of youth in employment, education or training
- To reduce the number of children living in households dependent on a main benefit
- To remove barriers to and through education for at risk young people
- To increase the connection of learning pathways from early learning to school to tertiary options to work
- To grow community participation in decisions that impact their communities
- To reduce the negative impact of drug use on individuals and their whānau
- To reduce the rate of violence experienced by individuals and whānau
- To improve access for individuals and whānau to healthy, affordable and sustainable housing
- To reduce the rate of obesity
- To increase life expectancy for all and eliminate the gap between Māori and non-Māori

Principles

Partnership by co-design - Values and worldview underpinning the strategy and its actions are an expression of co-design, and the implementation and monitoring are an inclusive collaboration. A treaty principle.

Outcomes for every household and every whānau - All actions, initiatives and projects in the Action Plan must provide outcomes in line with the vision.

Build our people's capability - There must be an emphasis on developing our people alongside infrastructure, assets and businesses.

Equity - A treaty principle, this requires reflection on who the intended audience and beneficiaries are and a commitment to that being inclusive and equitable.

Whai rawa - Optimising assets in a full, holistic and sustainable way.

Pōtikitanga - Developing an enterprise mind-set. Driving the thinking that goes behind business growth.

1. SOCIAL INCLUSION

Social inclusion is the ability of individuals, households and whānau to participate in their communities. Participation spans people's engagement in learning, working, social and cultural life, and having a voice in their community as described in Figure 1 below.

Figure 1: The four elements of Social inclusion

In order to participate, people need access to the resources, opportunities and capabilities that enable them to achieve the aspirations that matter to them, their households and whānau.

Resources: are the skills and assets necessary to participate including access to the 'essentials of life', including sufficient healthy food, safe and healthy housing, support for our children, physical health, social connection and safe communities to live in.[2]

Opportunities: mean that people are in an environment or have the social structures that enable them to make use of their capabilities and resources they have.

Capability: means people are able to utilise their resources and take up the available opportunities.[3]

The presence of resources, opportunities and capability can grow and support social inclusion. Conversely their absence will contribute to the accumulation of disadvantage and increasing exclusion.

[2] Wong, M., Saunders, P. 2012. Promoting Inclusion and Combating Deprivation: Recent Changes in Social Disadvantage in Australia. Social Policy Research Centre, University of New South Wales. Sydney.
[3] Based on the definition in a 2012 paper produced by the Australian Social Inclusion Board, "Social Inclusion in Australia: How is Australia Faring?"

2. WHY DO WE NEED A SOCIAL INCLUSION STRATEGY?

Societies and economies thrive when all individuals, whānau, households and communities have the resources to participate in their communities, buying goods and services and creating businesses. Increasing participation and improving income will have direct and indirect returns such as reduced crime, demand on the health service and reliance on benefits.

Participation is harder for some than others

Social exclusion is often caused by a number of persistent, inter-generational factors that accumulate to exacerbate disadvantage. It can be the result of the actions of other people, organisations, institutions or geographic communities. Social exclusion does not simply reflect a person's history and current circumstances, but also impacts on their future.

In Hawke's Bay, as in communities across New Zealand, disadvantage is unevenly distributed amongst our communities. There are some major groups of people in Hawke's Bay who are excluded, for example Māori, the disabled, mentally ill, and those whose patterns have been set for generations.

Māori experience adverse health, social and economic outcomes:

Māori experience inequity in health, justice, education, employment and housing outcomes. Māori social exclusion is based in colonization and has resulted in poverty and the loss of te ao Māori -culture, language and identity, the key building blocks for social inclusion. "Institutional racism can take place in policy making, funding decisions and service delivery. The results can be seen in the 7.3 year life expectancy gap between Māori and non-Māori."[4][5]

Households and whānau with low education outcomes and low income:

These whānau and households are likely to have lower quality homes, poor health, low educational attainment, have a benefit as their main source of income, participate in and experience greater levels of crime; have greater levels of family violence and greater levels of mental illness and addiction.

People experiencing inter-generational social exclusion:

People who experience inter-generational exclusion require the greatest levels of support and have the lowest levels of access to whānau and household resources to enter pathways into employment or enterprise.

Communities dominated by low incomes and fewer assets:

Where communities have high concentrations of low-income and fewer assets they are more likely to have poorer outcomes for their population than other communities.

People with poor health, disability or mental illness:

People who experience poor health, especially long term conditions or mental health, and those with a permanent disability are often excluded from society and experience significant levels of economic deprivation and poorer health.

Engaging people experiencing these challenges and barriers to participate socially and economically will lead them to have better quality lives and wellbeing

The economic and social exclusion experienced by these groups (mentioned above), can and will be addressed through the implementation of this Strategy and it's actions.

[4] Aotearoa Public Health Association, *Position Statement on Institutional Racism,* 2013

[5] Note Hawke's Bay life expectancy gap is 8.2 years for Māori males and 7.7 years for Māori females (Health Equity in HB Update 2016)

The opportunity in Hawke's Bay

In Hawke's Bay, economically, the picture is positive and for the first time, a truly regional strategy has been developed which involves the public sector at all levels and the private sector of all sizes to grow the Hawke's Bay Economy. *Matariki - Hawke's Bay Regional Economic Development Strategy and Action Plan 2016* has a vision of every whānau and household actively engaged in, contributing to and benefiting from a thriving Hawke's Bay. The organisations and entities involved in developing *Matariki - Hawke's Bay Regional Economic Development Strategy and Action Plan 2016* have recognised that economic growth alone is insufficient to fully realise the benefits. Hawke's Bay needs to engage those whānau and households who are socially excluded for a more sustainable economy. This is known as inclusive economic growth.

Populations in the Hawke's Bay experience inequity in outcomes from education, health, justice and social services. Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. Equity is a critically important aspect of creating social inclusion as it creates the sustainable environment in which people have the resources to participate in learning, working, local social and cultural life, and having a voice in their community.

A thriving society is where everyone is able to participate and make a significant contribution to achieving greater economic growth and productivity. Focusing on growing the skills of the local workforce will help ensure the future workforce and entrepreneurs have opportunities and the necessary skills to be successful. This will assist people to both contribute to, and experience the economic benefits for themselves, their whānau, their communities and the wider region.

Hawke's Bay Population Statistics

- At birth, non-Māori males are expected to live 8.2 years longer than Māori males
- One in seven people in quintile 5 die before the age of 50 compared to one in 25 people in quintile 1
- 42% of Māori children aged 0-4 years are living in household's dependent on benefit income (compared to 15% of Pakeha children)
- 250 Hawke's Bay children are in the care of Oranga Tamariki (Vulnerable Children's Agency)
- 25.9% of young Māori are not currently in employment, education or training (compared to 9.1% of young Pakeha New Zealanders)
- 67% of Māori students and 72% of other students are at their expected reading levels meaning that 33% of Māori children who are below their expected reading levels when they leave school
- Hawke's Bay rates of violent crime continues to be higher than the New Zealand average and is twice the rate for New Zealand as a whole

"BUSINESS CANNOT PROPOSER IN SOCIETIES THAT FAIL"
Kofi Annan (Previous UN Secretary General)

3. WORKING TOGETHER FOR SOCIAL INCLUSION

Social inclusion will be achieved through positive engagement with organisations and entities across Hawke's Bay.

"Social inclusion is everybody's responsibility. Only where governments, communities and businesses work together can social inclusion be achieved."

Key partners across the Hawke's Bay include:

- Iwi, Hapū, whānau and marae
- Clubs, and community organisations including churches
- Schools, ECE, tertiary institutions and workplaces
- NGOs and charities providing social services
- Local employers and business
- National or international employers and businesses
- District Health Board and primary care organisation
- Local councils, regional council
- Local offices of government agencies

Targeting excluded populations

Using the evidence of social and economic exclusion we have identified three approaches to considering populations:

ACTIVELY INCLUDE As groups they are less likely to experience social inclusion and economic participation due to discrimination, racism, prejudice and disability factors.	**TARGET** These are the whānau and households who are economically and/or socially excluded who need to be the focus of these strategies. These households and whānau will have the greatest levels of poor wellbeing and social exclusion.	**FOCUS EFFORT** Those communities where economic exclusion is clustered due to lower incomes, fewer assets and lower levels of support from agencies and councils.
Communities and whānau that may be excluded: • Māori • Pacific people • Those with mental illness and/or addiction • Those with disability • LGBTQ! – Rainbow communities • Pacific communities, refugees and immigrants	Whānau and households that are excluded : • Economically dependent on crime • Low income families • Those on main benefits • Low education levels • Parenting alone on low income • Youth who are NEET • Homeless and rough sleepers • Low income and engaged in justice or corrections • Older people without family and/or assets • Those experiencing violence at home	Places, for example: • Flaxmere • Wairoa • Raureka • Maraenui • Camberley • Isolated rural communities

Māori Partnership and Te Tiriti o Waitangi

The Crown and its agencies are obliged and committed to addressing issues of inequity for Māori as Treaty partners. This requires agencies to focus on delivering equity of outcomes for Māori individuals and whānau.

Māori social exclusion is routed in colonisation and subsequent policy and service delivery which did not address colonisation or social exclusion. Māori will have the greatest impact on uplifting Māori wellbeing through leadership, design and implementation of initiatives, with enabling support from government and non-government agencies. Government agencies will work in partnership with, and enable Post Settlement Governance Entities (PSGEs) to identify the most effective ways to restore culture and identity, grow the Māori economy and eliminate the long standing, historical exclusion of Māori in Hawke's Bay.

As a Treaty partner, government agencies have responsibility and accountability for effective service delivery, for Māori and need to be transparent in this accountability to their Treaty partner. As such, government agencies need to measure and report on services effectiveness for Maori and ensure their activities are improving equity.

Inclusive economic growth

As key partners, we will be targeting the excluded populations and striving for inclusive economic growth in Hawke's Bay. To achieve inclusive economic growth three things matter:

1. Level of Income

Evidence tells us that engagement in employment or enterprise that generates at least a 'Living Wage', even if it is by just one member of a household, can create wider improvements in wellbeing and opportunities for the whole whānau and household. A 'Living Wage' is the income necessary to provide workers and their families with the necessities of life. A 'Living Wage' will enable workers to live with dignity and to participate as active citizens in society. This is especially true for educational, health and future employment outcomes for children.

Households and whānau with a 'Living Wage' from quality employment or enterprise are more likely to experience:

- Better quality and more stable housing
- Safer children who experience less disadvantage
- Safe families and communities without violence
- Better physical health
- Better mental wellbeing
- Greater ability to leverage education, health and social service investment
- A life without the experience of the effects of crime or economically dependent on crime

Low income whānau and households are less likely to have the adequate resources, opportunities and capabilities for participation. The impact of low income is especially damaging as it flows on to future employment opportunities. This negatively effects health, social and employment outcomes perpetuating exclusion and inequality across generations. Low income can be addressed through education/training, greater access to employment and socially responsible employers.

2. The quality of participation

Whānau and households will not be assisted to thrive with tenuous employment, poor working conditions and lack of fulfilment. Education, social or healthcare services that consistently deliver poorer outcomes for some groups are not necessarily building the resources necessary to participate.

Ensuring the quality of employment and working to deliver equitable educational and health outcomes is central to the success of this Strategy. A focus on equity across the identified groups means attention can be focused on lifting the opportunities and outcomes for those groups of people who experience exclusion.

4. Education and skills

Success in education is a critical contributor to social outcomes and economic engagement across the life course. 'If we are serious about reducing inequalities, we must maintain our focus on improving educational outcomes across the socio-economic gradient.'[6]

[6] Marmot, M., 2010. Fair Society, Healthy Lives: The Marmot Review

4. DELIVERING THE VISION

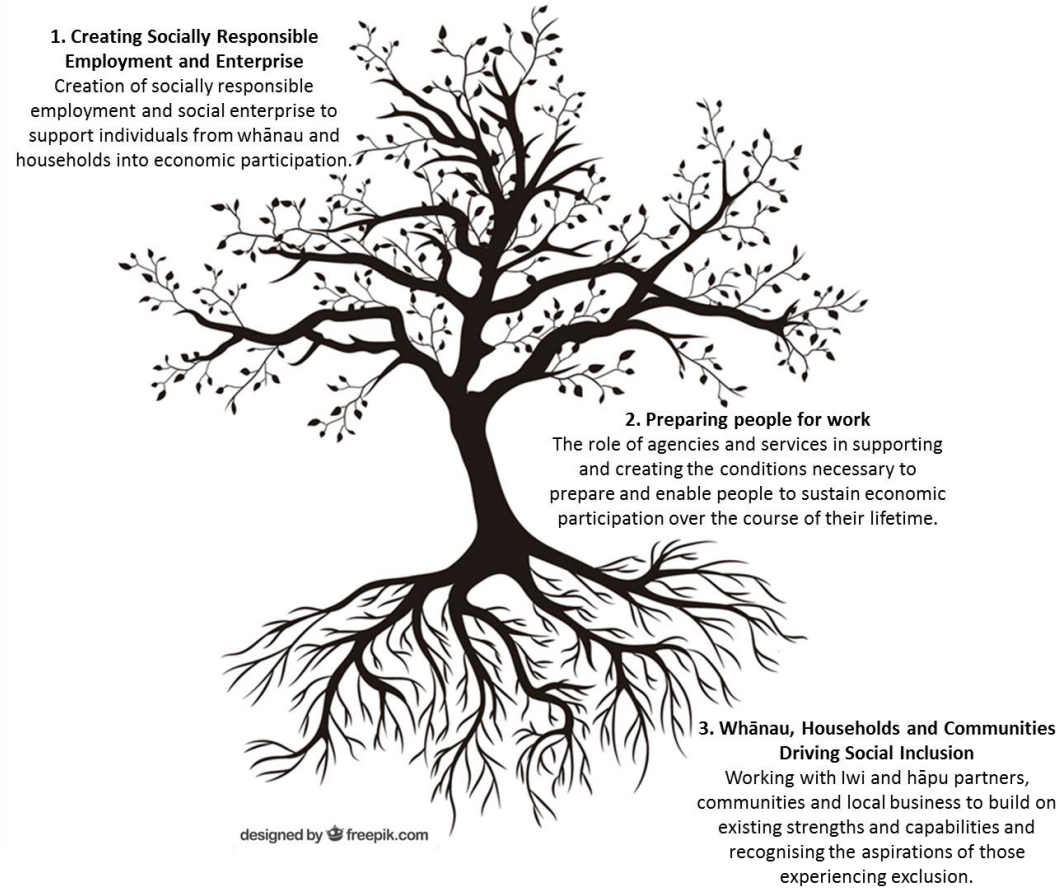
Matariki - Hawke's Bay Regional Social Inclusion Strategy proposes not just "more of the same", but a fundamentally different approach to addressing some of the most difficult issues that we face as a region. Tackling the hardest issues in our communities demands solutions not tried before; a far more collaborative approach; new partnerships across the community, and between the community and our Government and non-government agencies; structural change in our funding models; fresh prioritising; and the breaking down of silos and barriers to effect action.

Funders and service providers need to be accountable for effective and efficient services so this is not just about allocating new money or agencies running new programmes in traditional ways. Complex issues require co-created and co-funded solutions. Many agencies already do fine work in Hawke's Bay and we do not want to lose momentum on things that are already working. But we can do better and we must do better if we are to come anywhere near achieving this Strategy's ambitious goals and objectives.

We recognise that changing organisational behaviour and systems will be challenging, but doing more of the same will not help us achieve the social inclusion. We want Hawke's Bay to be known as the region for standout, innovative, joined-up thinking about how better to achieve engaged, inclusive, thriving communities.

The strategic directions outlined in this section are designed to outline areas where focussed new ways of working are most likely to improve everyone's ability to LEARN, WORK, ENGAGE and HAVE A VOICE.

Figure 2: Matariki - Hawke's Bay Regional Social Inclusion Strategy Strategic Directions



4.1. GROWING SOCIALLY RESPONSIBLE EMPLOYMENT AND ENTERPRISE

An economy that creates greater household and whānau wealth will enable a greater array of opportunities to lead a flourishing life and support a thriving local economy.

There are two mechanisms to create quality employment that focuses on the economic inclusion of those people who are more likely to be excluded; they are socially responsible employment and social enterprise.

Socially responsible employment

Socially conscious employment is where a commercial business makes a conscious choice to employ people with the greatest need and who will benefit socially and economically from the opportunity to work. They often consider this as their corporate social responsibility. For many it is linked to the sustainability of their business and the community and economy in which they operate. They offer quality employment and ensure employees move beyond minimum wage entitlements. This may be through active support for skill development or a ''Living Wage' choice.

Social enterprise

Social enterprises are businesses created to further a social purpose in a financially sustainable way. They are usually small businesses that:

- Provide income generation opportunities for people who need support
- Are sustainable - where income from sales is reinvested in their mission. They do not depend on philanthropy and can sustain themselves over the long-term
- Are scalable and their models can be expanded or replicated to other communities to generate greater impact

The impact of social enterprise are increases in household income and assets and providing greater stability for families, prioritising the use of locally provided goods and services, improving health and education outcomes and reducing welfare dependence.

There is potential for social enterprise to be developed to contribute to social inclusion and economic participation as part of overall economic development and socially responsible employment.

4.2. PREPARING PEOPLE FOR WORK

Government agencies and services have a role in supporting and creating the conditions necessary to prepare and enable people to sustain economic participation over the course of their lifetime.

Ara-rau, haukū-nui, hāro-o-te-kāhu in Matariki is focused on improving pathways to and through employment and getting people work ready and employers, employee ready. Preparing People for Work builds on this and places more emphasis on those that experience social exclusion. We need to equip people with the necessary skills for economic inclusion to avoid the poverty trap of welfare dependence, vulnerability to risk factors for social inclusions and improve their quality of life. Activity needs to target people who are out of work for reasons such as long term unemployment, poor skills, health problems or disabilities. Incorporating older people into economic activity will help address the challenges of our ageing population.

In this Strategy, work does not just encompass paid employment as many people who are socially excluded would benefit from being engaged in either employment, business, unpaid or voluntary work.

Education and skills

Education and skills are critical to people's ability to participate socially and economically. The Ministry of Education has a key role to play in this area and *Matariki - Hawke's Bay Regional Social Inclusion Strategy* is aligned with their long term plan to strengthen inclusion.

The graded relationship between socio-economic position and educational outcome has significant implications for subsequent employment, income, living standards, behaviours, and mental and physical health. If education (school and tertiary) significantly improves its performance for excluded populations, there will be an increased flow of skilled people entering our workplaces. Skills development should continue throughout the life course to ensure continued participation and development.

Better health and social services

The process of supporting employment is critical to success. Health and social services must support individuals, household and whānau to develop and maintain participation by rethinking how they deliver services. Turning up for work each day, on time, seems like a simple concept but for many it is not. Individuals, households and whānau need varying levels of support to ensure that:

- They are mentally and physically well
- They have adequate drug and alcohol addiction support
- Their specific disability needs are supported
- Their chronic conditions are being managed
- They are free from violence and dependence on crime
- They have access to adequate healthy food
- They have transport to and from their place of work
- Their dependents are cared for
- They have a healthy home to return to

Transitioning to work

For many people, entering or returning to the workforce can be difficult. Even with the relevant skills and health and social care services, some people do not have the knowledge of how to transition into the workforce. We need to ensure that young people, graduates, people returning from long term leave due to illness, trauma, parental leave, and imprisonment receive services to help in areas such as job applications, interviews, personal presentation, awareness of opportunities and self-confidence.

4.3. WHĀNAU, HOUSEHOLDS AND COMMUNITIES DRIVING SOCIAL INCLUSION

To achieve sustainable social inclusion, we need to focus on the development of the communities where people live, work and play. Identifying communities where social exclusion is clustered is key to this Strategy as it is within these communities the solutions and opportunities can be found and implemented.

Wairoa is a community with significant potential as it invests in its local resources. Understanding the opportunities must be specific to the places where people live.

Communities need to be enabled to recognise the aspirations of those experiencing exclusion and bring together peoples' goals, skills and resources with the relevant social services and other supports to achieve meaningful and enduring independence. There is a strong discourse that says that working with people, households and whānau strengths is not only useful, it is essential if we are going to support families to independence. This focus on resilience and capability over a lifetime is the focus of *Matariki - Hawke's Bay Regional Social Inclusion Strategy.*

For this to happen, a strong culture of autonomy and self-governance needs to be fostered within communities. All members of society must be given a voice and the ability to have input into decisions that affect them and their community. *Matariki - Hawke's Bay Regional Social Inclusion Strategy* seeks to actively engage education, health and social services to support individual communities to create healthy, safe, nurturing and sustainable environments for the greater well-being of their people.

'When families and communities are working well they are places and spaces that generate healthy lifestyles, safety, creativity, innovation, trust and belonging. Families and communities that are caring, confident and resilient are the best buffer against exclusion[7]'

What does whānau, households and communities driving social inclusion look like?

[7] Adams, D. (Social Inclusion Commissioner). September 2009. A Social Inclusion Strategy for Tasmania.

5. ACTIONS DELIVERING THE SOCIAL INCLUSION THEMES

The actions for Matariki Hawke's Bay Regional Social Inclusion Strategy (2017) have been developed in consultation with key stakeholder groups, entities, agencies and individuals. The ten actions identified complement the Matariki Hawke's Bay Regional Economic Development Strategy 2016 Action Plan.

Three key messages from the consultation underpinning the ten actions.

1) Whānau, families and communities must have a voice and be listened to when it comes to the delivery of social support services.
2) There must be a fundamentally different approach taken to the delivery of social support and service delivery must be co-created, collaborative and whānau driven.
3) Participation and collaboration are fundamental to delivery.

There will be further opportunity for whānau and communities to participate as each action is developed into a project and delivered. Participation needs to be wide reaching and not limited to service providers and government agencies; whānau, communities, employer groups and employers need to be involved. This participation will develop the actions and potentially build on these.

The key themes of:

- growing social responsible employment and enterprise

- preparing people for work

- whānau, households and communities driving social inclusion

Are delivered via the actions below using a collaborative approach. These address the barriers to social inclusion and support those social excluded.

Each theme has actions, a lead agency and key partners detailed in the table below.

Actions to enable whānau, households and communities to drive social inclusion

Theme	Action	Lead Agency	Key Partners
Growing social responsible employment and enterprise	Support the employment of people with challenges that may impact on their capacity to obtain or retain employment. Support will include, a tool-kit and guidance documents for socially responsible employment practises, and establishing community whānau-centric social support centres.	HBDHB	Iwi, Hapū, advocacy agencies, social service providers, employer groups, BHB, HBCoC, Corrections, MSD, HBDHB, MBIE human resources expertise, disability services.
	Engage with employers and employer groups to design, develop and advocate for socially responsible and innovative employment practises that support sustainable employment and retention of local labour.	Employer Group	MBEI, MSD, MPI, BHB, HBCoC, employer groups, employers, Iwi, Hapū, Corrections, Councils, youth services
Preparing people for work	Develop a framework for employers and training providers that identifies the future skills needs of employers and supports training providers to develop programmes to meet these needs. The framework will be informed by the MBEI/EIT research into future skills requirements for employment/industry.	EIT/MBEI	MSD, MPI, MoE, TEC, Schools, Principal Association, BHB, HBCoC, employers, employer groups, Iwi, Hapū, other tertiary education providers, youth services, Corrections, Councils.

Theme	Action	Lead Agency	Key Partners
Preparing people for work (cont'd)	Work with schools and Kahui Ako (Communities of Learning) to review and co-create career development and career pathways that are localised, responsive and future-facing for the needs of years 7 to 15 learners that need additional support.	Ministry of Education	Councils, government agencies, Iwi, Hapū, MSD, Kāhui Ako lead principals, Tertiary Education Commission, tertiary education providers, employer/industry groups.
Whānau, households and communities driving social inclusion	Develop a new sustainable operating system for government agencies and NGOs delivering of social support services. The operating system will be co-created, collaborative and whānau driven and; consider - funding, community need, delivery of services, and monitoring and evaluation measures.	Councils, Hāpu	Iwi, Hapū, HBDHB, Police, Te Puni Kōkiri, Corrections, Social Services Providers, Councils and Community Organisations
	Establish representative groups in locations across Hawke's Bay to enable the local community and whānau to have a voice and leadership in social and economic development. The groups will represent key local stakeholders, who may not be directly connected to Matariki REDS/ILG and; have the capacity and authority to represent their community in communication with Matariki REDS/ILG.	To be locally determined	Iwi, HBDHB, MSD, MoE, Oranga Tamariki, Police, Te Puni Kōkiri, Corrections, social services providers and community organisations
	Investigate and establish whānau-centric places connected to local communities, where people access a wide range of social support services for assisting preparation for and retention of employment. Places could include, digital, physical and mobile.	Oranga Tamariki, MSD, NGO	Iwi, Hapū, social service providers, community organisations, Councils, Corrections, Ministry of Education, Housing NZ, HBDHB, Health HB
	Review the Housing Coalition's membership and Terms of Reference to ensure that a strategic and comprehensive approach is taken to housing needs in the region. The approach will include: governance; quality and quantity; social, transitional and affordable housing.	Coalition Chairs	Housing Coalition members
	Undertake an analysis of social housing in the region, to inform a plan for the provision of sustainable, quality social housing, which meets demand. The analysis will include a quantitative study of current supply and projected demand, and an analysis of housing stock condition.	Coalition Chairs	Housing Coalition members
	Develop a plan that addresses issues affecting future supply and demand and considers innovative approaches to the provision of affordable housing. The plan will be informed by a review of the current supply and demand situation for affordable housing (owner occupied) in the region.	Coalition Chairs	Housing Coalition members

HAWKE'S BAY District Health Board Whakawāteatia	**Best Start: Healthy Eating and Activity Plan - Healthy Weight Strategy** 141
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Tracee Te Huia, ED Strategy, Health & Improvement Shari Tidswell, Intersector Development Manager
Reviewed by:	Executive Management Team, Maori Relationship Board, HB Clinical Council and HB Health Consumer Council
Month:	November 2017
Consideration:	For information

RECOMMENDATION:

That the HBDHB Board

- **Note** progress in the implementation of this Plan.

OVERVIEW

In 2015 the Healthy Weight Strategy and in 2016 the Best Start: Healthy Eating and Activity Plan were endorsed by the HBDHB Board. These documents guide the HBDHB's work in increasing the number of healthy weight people, with a focus on children. Work is delivered across HBDHB and other sectors including primary care, councils, education, workplaces and Ngati Kahungunu Iwi Inc.

Childhood healthy weight is also being reported to the HBDHB Board via Te Ara Whakawaiora performance programme and through the Raising Healthy Kids target. These reports share information and the Best Start Plan provides the direction and overview for all this work.

The Board requested six monthly progress reports. This report provides an overview of the progress and changes impacting the Plan's delivery.

REPORTING ON PROGRESS

Below is a summary of the highlights for each of the Plan's four objectives. Appendix One provides further detail of the progress on the Plan's activities to date.

1) Increasing healthy eating and activity environment

Information on the healthy weight environments survey has been shared with schools – children in urban areas are exposed to significant levels of advertising and access to unhealthy food in the vicinity of schools. Schools responding to our information requested all have "water only policies" and other healthy weight activities (including physical activity, lunch box policies, school vege gardens).

HBDHB have worked with Ngati Kahungunu Iwi Inc to deliver healthy weight environments at events, including Waitangi Day and Te Matatini, were venders provided healthy food options and removed fizzy. The DHB provided water trucks to promote drinking water. Staff provided input into the development of healthy event resources now available on the DHB website.

2) Develop and deliver prevention programmes

The Healthy Conversation Tool has completed its trial and been evaluated. Overall, B4 School Check nurses and whānau really liked the resource and are benefiting from its use. There is a working group completing a refresh (including Oral Health, Health HB and Child Health staff), ready for distribution early in 2018. The evaluation identified the need for further resource and work has commenced on a portion size plate for children. This resource will support whānau engaging with a range of service including Hauora, primary care, community services and oral health.

The Maternal Green prescription is now operational in Wairoa and has an excellent referral rate, attendance and engagement. Hapū wāhine are feeding back positive impacts and how much they enjoy attending.

Work continues with early childhood services to identify and develop resources to support healthy weight environments and inform whānau. The early childhood services' feedback includes; increasing the link between health and early childhood education, more effective access to a range of health resources and resources that are designed for the setting i.e. notice boards, newsletter content, website content and that we have consistent messages.

3) Intervention to support children to have healthy weight

HBDHB has reached the Raising Healthy Kids target six months earlier than the target date, with 95% of children identified at a B4 School Check in the 98th percentile weight being referred to primary care assessment.

As a DHB with a comprehensive approach to childhood healthy weight we are able to increase support for referrals for lifestyle programmes from the B4 School Check programme. This enables us to support more whānau with overweight 2 and 3 year olds, providing earlier intervention.

4) Provide leadership in healthy eating

An intersector group has been established to provide leadership across key organisations influencing healthy weight environment and activity including; Ngati Kahungunu Iwi Inc, councils, Ministry of Education and EIT.

The DHB Healthy Eating Policy has been assessed by Auckland University against other DHBs and HBDHB are ranked third behind Waitemata and Auckland.

CHANGING CONTEXT FOR CHILDHOOD HEALTHY WEIGHT

Since the HBDHB endorsed the Plan in November 2015, MoH have:

- Released a "Childhood Obesity Plan"
- Required HBDHB to review the recently approved Healthy Eating Policy to comply with the national guidelines
- Set a Raising Healthy Kids target (1 July 2016)

This MoH direction aligns with or was planned for in the Best Start Plan. HBDHB has adapted to respond to priorities and to take advantage of opportunities.

HBDHB entered into a Memorandum of Understanding with the Hawke's Bay Community Fitness Centre Trust that was established in November 2016. The Trust sets out to establish a two stage development for a facility at the Regional Sports Park to provide community and elite athlete programmes. Alongside this will be research projects that look at early childhood and school programmes, as well as a longitudinal study.

Once again, this aligns with the Best Start Plan and requires ongoing coordination of activities in the schools programme. To achieve this, the DHB coordinated the team that are working closely with Sir Graeme Avery and others engaged with the Hawke's Bay Community Fitness Trust to come

together to ensure good coordination of effort and resource. This is well received by all organisations and well attended. Additional work has dropped out of this engagement for DHB however this is seen as positive because it enhances coordination. DHB is also engaged in the pre-pilot for Kimi Ora School.

CONCLUSION

Overall, the team are on track with some adjustments made to respond to Ministry changes. There has been significant work completed and/or embedded as business as usual, i.e. Healthy First Food and breastfeeding support. New work has focused on MoH lead areas including; supporting the new Raising Healthy Kids target, water only policies in schools and the HBDHB Healthy Eating Policy.

New developments offer opportunities including new partnerships and potentially increased investment in healthy weight projects. MoH-led initiatives have increased the impact of this Plan's activities i.e. more schools with water only policies and a HBDHB policy with wider coverage.

NEXT STEPS

1. Investigate steps to have greater levels of nutrition/dietician support/knowledge in the community.

2. Address the identified need for a nutrition and physical activity advice/resource for early childhood education. This will reinforce key messages whānau receive via maternity services, primary care, hauora, WellChild/Plunket and B4 School Checks.

3. Continue the work to develop a primary schools programme – Public Health Nurses, Health Promoting Schools and Population Health Advisor working with community partners, MoE East Coast, Hawke's Bay Community Fitness Centre Trust and schools.

4. Continue work with councils to support healthy weight environments, investigate engagement with supermarkets to promote healthy eating choices, using the findings from the Auckland University healthy environment survey to support changes.

HAWKE'S BAY District Health Board Whakawāteatia	**Regional Tobacco Strategy for Hawke's Bay, 2015–2020 update** 142
	For the attention of: **HBDHB Board**
Document Owner:	Tracee Te Huia, ED Strategy and Health Improvement
Document Author(s):	Johanna Wilson, Acting Smokefree Programme Manager
Reviewed by:	Executive Management Team, Maori Relationship Board, HB Clinical Council and HB Health Consumer Council
Month:	November 2017
Consideration:	For information

RECOMMENDATION:

That the HBDHB Board:

Note the contents of this report.

OVERVIEW

In November 2015 the Regional Tobacco Strategy for Hawke's Bay, 2015–2020 was endorsed by the HBDHB Board with a yearly report to be provided to the Board and Committees. This is the second annual update of the Strategy, providing highlights from the three objective in the Strategy.

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BACKGROUND

The Health Equity Report 2014/16 identified tobacco use as the single biggest underlying cause of inequity of death rates and ill-health in Hawke's Bay[1]. Smoking is still more prevalent for Māori than any other ethnic group in New Zealand[2] and is more common in areas with a significant Māori population and in areas of deprivation. Pregnant women who are Māori or who live in a Quintile 5 area are five more times more likely to be smokers than non-Māori or women living in a Quintile 1 area[3].

The Regional Tobacco Strategy for Hawke's Bay 2015-2020 goal is for communities in Hawke's Bay to be smokefree/auahi kore – with Hawke's Bay whānau enjoying a tobacco free life. The Strategy has a strong commitment to reducing the social and health inequities associated with tobacco use and has three objectives:

- Cessation – help people stop smoking
- Prevention – preventing smoking uptake by creating an environment where young people choose not to smoke
- Protection - creating smokefree environments

[1] McElnay C 2014. Health inEquity in Hawke's Bay. Hawke's Bay District Health Board.
[2] Ministry of Health. 2011. Māori Smoking and Tobacco Use 2011. Wellington. Ministry of Health.
[3] McElnay C 2016. Health Equity in Hawke's Bay. Hawke's Bay District Health Board

The main source of information on smoking rates comes from the NZ Census but this will not be updated until 2018. The Ministry of Health funded ASH (Action on Smoking and Health) year 10 tobacco use survey and we have preliminary results for 2015.

This survey is an annual questionnaire of approximately 30,000 students from across New Zealand. HBDHB also collect smoking data on pregnant women engaging with our services, this included over 90% of women giving birth. These sources provides valuable and robust insight into rates of smoking.

WHAT'S HAPPENED IN ONE YEAR?

OBJECTIVE 1: HELPING PEOPLE TO STOP SMOKING

Te Haa Matea (Stop Smoking Services, Hawke's Bay)

At the same time HBDHB adopted the Tobacco Strategy, the Ministry of Health formed 16 regional Stop Smoking Services and one national smokefree advocacy group (1 July 2016). Hawke's Bay established Te Haa Matea - Te Taiwhenua o Heretaunga (Lead), Te Kupenga Hauora o Ahuriri, Choices Kahungunu Health Services and HBDHB. Te Haa Matea's mission is to help whānau stop smoking and 'breathe easy'.

HBDHB are contributing significantly to Te Haa Matea outcomes by providing project management, cessation services in Wairoa and Central Hawke's Bay, providing cessation programmes for pregnant women, developing cessation programmes and providing support for workplaces. HBDHB also provides leadership for the Smokefree Coalition which coordinates and delivers health promotion activity.

HBDHB developed a simple referral process to Te Haa Matea. Based on a business card theme, the card offers an 0800 number for anyone wanting help to stop smoking. The 0800 number is transferred to the HBDHB Smokefree Service, who phone, complete an initial assessment and offer a face-to-face service with a stop smoking practitioner in their region. The flip side of the card offers behavioural support. The Te Haa Matea cards were widely distributed to Stop Smoking Practitioners, general practices, workplaces and health services.

HBDHB are leading the way in cessation initiatives:

- Tag your Taniwha - a card designed to engage with health services at Te Matatini Kapa Haka Festival held in February.
- Tame your Taniwha - an eight week, teams of 3 stop smoking challenge. 22 teams have registered in the first competition which kicked off on 2 October and will finish on 30 November. A second competition will take place in April finishing on 31 May (World Smokefree Day). This will be followed by an evaluation in June 2018.
- Te Haa Matea Facebook page administered by the Smokefree Service. To date, the Facebook page has 441 likes, 445 regular followers, 60 video views with 928 post reaches. The Facebook page has opened the door to self-referrals to both the Wāhine Hapū – Increasing Smokefree Pregnancy Programme and Tame your Taniwha.

HBDHB provided funding to general practices to focus on contacting patients to update their smoking status, offer smoking brief advice and cessation support. Te Haa Matea are able to provide clients Smoking Brief Advice and Cessation Support status to Health Hawke's Bay to update their patient records and Health Hawke's Bay are able to refer patients to Te Haa Matea for behavioural and motivation support.

Rates of Smoking for Māori Women Remain High

Assisting women to stop smoking remains a priority. For Māori women giving birth this year, 44.2% were smokers (2017 data for women giving birth in HBDHB services). HBDHB have received the evaluation with a new range of resources to support Wāhine Hapū programme and we have added an incentive step to support greater engagement.

Smokefree are investigating programmes to support young Māori wāhine to remain smokefree – this will focus on 15 to 18 years. We will prioritise kura kaupapa Māori schools and schools with high numbers of Māori wāhine.

Smokefree Education, Training, Cessation Support

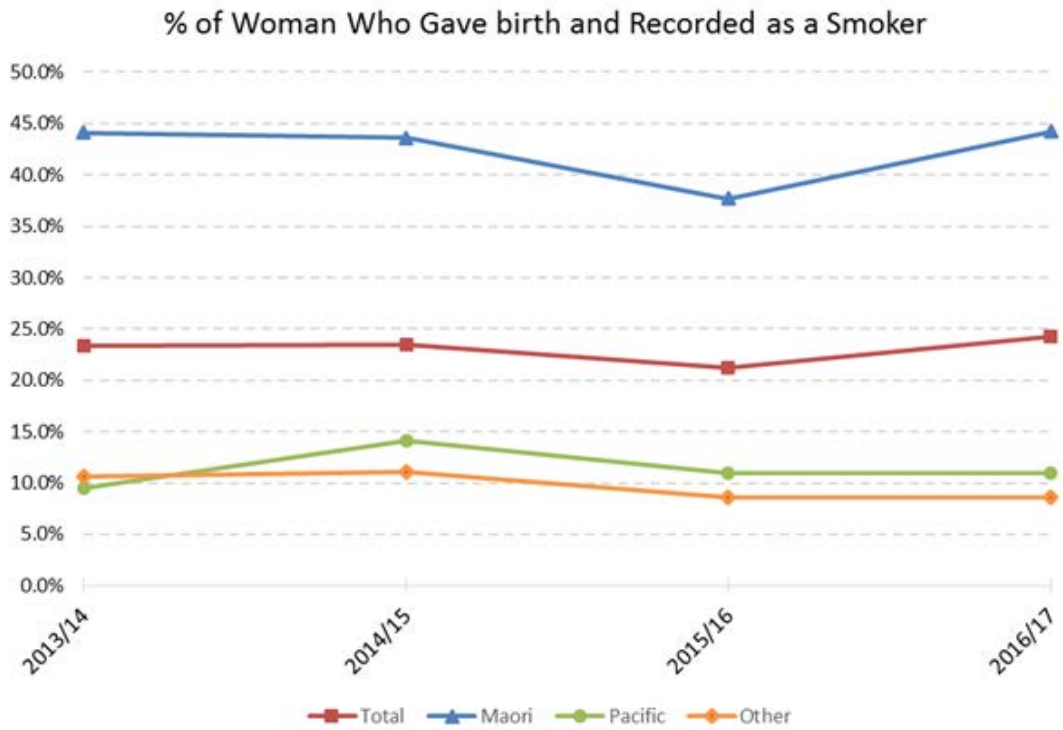
The Smokefree Team continues to support, primary and secondary care clinicians by:

- Understanding Nicotine Replacement Therapy (NRT) medicines
- How to chart NRT for patients
- Confidence in NRT conversations and
- Completing the "Helping People Stop Smoking" Ministry of Health training

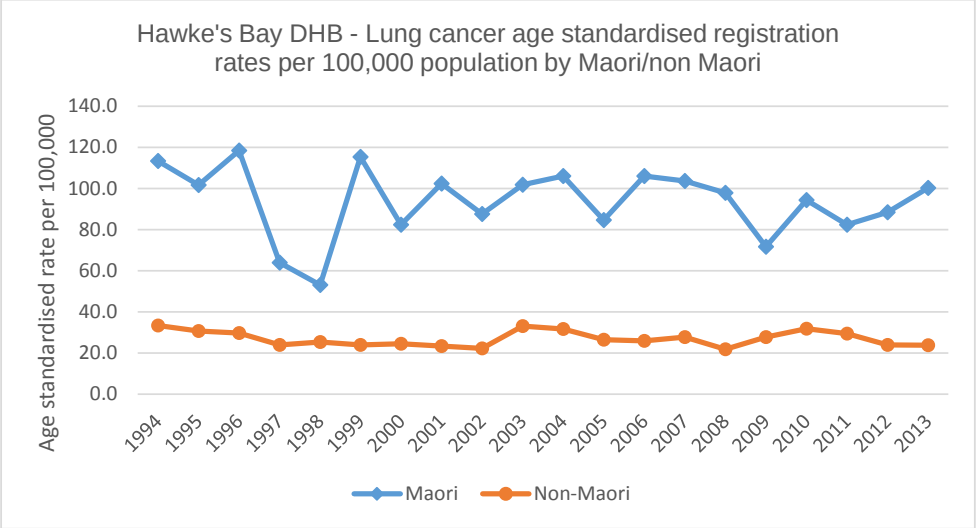
We have extended this to include presentations to Dental Association and pharmacists. We have had our first dentist complete cessation training.

Indicator 1a: Smoking prevalence (particularly Maori)
No update on prevalence until 2018 NZ Census. Current data has smoking rates at 18% for non-Māori and 47.4% for Māori in Hawke's Bay. Please refer to the HB Tobacco Strategy for details.

Indicator 1b: Smoking prevalence in pregnant women (particularly Maori women)
The data below provides a time series from 2007 to June 2017. Smoking rates for pregnant women have decreased from 2011 to 2016 with a significant reduction between 2015 to 2016 from 23.7% to 21%. There has been a rise in Māori women from 37.6% to 44.2% as births in Hawke's Bay have declined but the rates of births of Māori women have increased. Changes to ISPP, "Top 5 for my Baby to Thrive" promotion in general practice, greater engagement in healthy lifestyles programme (i.e. Maternal Nutrition), increases in the price of cigarettes again on 1 January 2018 and increased education/awareness will contribute to improving these rates.



Indicator 1c: Lung Cancer Incidence
This information is not available at this time and will report on it at a later date.



OBJECTIVE 2: PREVENTING SMOKING UPTAKE
Young people who smoke may acquire the habit and become addicted before reaching adulthood, making them less able to quit smoking and more likely to have a tobacco-related health problem.

Te Haa Matea provides smokefree clinics and education in workplace settings, trade training establishments and teen parent units to target young people. These include Tumu Timbers, Silver Fern Farms (CHB), Wit/Lighthouse, EIT Hawke's Bay, Trade and Commerce and both Teen Parent Schools. The Smokefree Team's Māori Support Worker is working with rangitahi as outlined above.

Indicator 2a: Prevalence of Year 10 students who have never smoked (particularly Maori students)
The annual ASH survey is not available until 2018. The percentage of all Māori year 10 students across New Zealand who never smoked was 16.2% in 2000 increasing to 59.2% in 2015. In 2015, Hawke's Bay noted 73% of year 10s, 54.33% of Māori year 10s and 50.95% of Māori wāhine year 10s have never smoked.

This is a significant improvement. Anecdotally we are told that price increases were a major contributor with "family and friends not supplying young people due to the cost". This social supply remains the leading source of tobacco for this age group.

Indicator 2b: Prevalence of Year 10 students living with one or more parent who smokes
This information is sourced from the NZ Census so will not be available until 2018.

OBJECTIVE 3: CREATING SMOKEFREE ENVIRONMENTS

Hawke's Bay DHB continues to visit all retailers at least once a year to deliver reminders on the legislative requirements, encourage a smokefree policy and check compliance. Successive outbreaks have meant limited resource to complete this work, we hope to re-establish visits and compliance work over the next 12 months.

We have prosecuted a retailer in Central Hawkes Bay as a result of controlled purchase operations - this is the third such prosecution and has been referred to the Ministry of Health.

Support Legislation and Policy Change for Smokefree Environment

As a member of the HB Smokefree Coalition, HBDHB supported a coordinated submission to support pharmacists to dispense NRT and e-cigarettes – the aim is to influence law change to further discourage smoking and support cessation.

Indicator 3a: Number of Tobacco Free Retailers

Number of smokefree retailers remains static.

CONCLUSION

- Cessation services (Te Haa Matea) is embedded.
- Programmes led by and contributed to by HBDHB, are seeing successes in supporting the reduction in smoking especially for Māori wāhine, workplace and high level of engagement in Wairoa.
- New rules for pharmacists have offered an opportunity to work with another primary care setting, which has the potential to access more smokers and increase cessation referral.

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora – Smokefree** 143
	For the attention of: **HBDHB Board**
Document Owner: Document Author:	Tracee Te Huia, ED Strategy and Health Improvement Johanna Wilson, Acting Smokefree Programme Manager
Reviewed by:	Shari Tidswell, Acting Service Manager Population Health, Executive Management Team, Maori Relationship Board, HB Clinical Council and HB Health Consumer Council
Month:	November 2017
Consideration:	Monitoring

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report.

OVERVIEW

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

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MĀORI HEALTH PLAN INDICATOR: Smokefree

- 95% of all patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking
- 90% of PHO enrolled patients who smoke have been offered help to quit by a health care practitioner in the last 15 months
- 90% of pregnant women who identify as smokers upon registration with a Lead Maternity Carer are offered brief advice and support to quit smoking
- 90% of young pregnant Māori women are referred to cessation support
- 95% of pregnant Māori women who are smokefree at 2 weeks postnatal

WHY ARE THESE INDICATORS IMPORTANT?

Most smokers want to quit, and there are immediate and long-term health benefits for those who do. The risk of premature death from smoking decreases soon after someone quits smoking and continues to do so for at least 10 to 15 years. There are valuable interventions that can be routinely provided in both primary and secondary care.

These targets are designed to prompt doctors, nurses and other health professionals to routinely ask the people they see, whether they smoke. The health professional is then able to provide brief advice and to offer quit support to smokers. There is strong evidence that brief advice from a health professional is highly effective at encouraging people to try to quit smoking, and to stay smokefree. Research shows that one in every forty smokers will make a quit attempt simply as a result of receiving brief advice. In the Health Equity Report 2014/16, tobacco use was highlighted as the single biggest underlying cause of inequity of death rates and ill health in Hawke's Bay.

CHAMPION'S REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THESE INDICATORS?

95% of all patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking

During the last year, health practitioners in the secondary care settings have continued to achieve the 95% target of all patients who smoke aged 15 years and over, are offered brief advice and help to stop smoking.

The Smokefree team provide ABC, Helping People Stop Smoking, Nicotine Replacement Therapy (NRT) educational support to clinical staff. It is important that patients who smoke within the hospital setting are:

- Charted NRT to manage their addiction; and
- Offered a referral for cessation and behavioural support on discharge

DHB coding staff monitor patient records for accuracy in smoking brief advice and cessation support documentation. The Smokefree team contact clinicians in breach of ABC & D (documentation). The number of breaches have decreased significantly during the last year as confidence in discussing ABC & D has increased.

The Smokefree Team are currently recruiting for a Smokefree Nurse Liaison, this position became vacant in August. This role is vital in supporting health professionals in hospital, general practices and community settings i.e. Royston Hospital. The role also provides behavioural and motivation support to patients in hospital and triage to Te Haa Matea (HB Stop Smoking Service including Te Taiwhenua o Heretaunga, Te Kupenga Hauora – Ahuriri and HBDHB).

90% of PHO enrolled patients who smoke have been offered help to quit by a health care practitioner in the last 15 months

		Target	Total	Māori	Pacific	Other	Non Maori
2016/17	**Q1**	90%	80.9%	79.8%	76.4%	82.6%	80.9%
	Q2	90%	87.4%	85.1%	82.2%	89.8%	87.4%
	Q3	90%	86.4%	83.9%	81.4%	89.1%	86.4%
	Q4	90%	91.0%	88.4%	87.1%	93.7%	91.0%

Health Hawke's Bay achieved 91% Smoking Brief Advice in the fourth quarter by:

- Working with the smokefree clinical champions in each practice.
- HBDHB provide funding to General Practices to focus on contacting patients to update their smoking status, offer smoking brief advice and cessation support
- Two Independent Registered Nurses (one funded by HBDHB and one contracted by the PHO) contact patients in the evenings and on the weekends on behalf of the practice
- Health Hawke's Bay have contracted Vensa Health (an independent health support company based in Auckland) to carry out text reminders for patients which will update patient smoking status.

Health Hawke's Bay had two practices that used "My Practice" as their patient management system. One practice was exceeding the 90% health target and the other one was struggling. Health Hawke's Bay worked with the latter to check how they were recording the information. It transpired that with "My Practice" you have to complete the cessation support section of the form for it to be counted. After sharing this with all practice staff, this practice also met and exceeded the 90% target.

Barriers to maintaining the 90% target over the next year are linked ability to contact patients:

- Disconnected numbers or wrong number or no phone
- Phone goes straight to voicemail
- Patient has moved overseas or transferred out to another practice

90% of pregnant women who identify as smokers upon registration with a Lead Maternity Carer are offered brief advice and support to quit smoking

	Month (3 months to)	Target	Total	Māori
2013/14	Q1	90.0%	93.2%	0.0%
	Q2	90.0%	96.3%	94.3%
	Q3	90.0%	87.9%	85.4%
	Q4	90.0%	94.5%	95.2%
2014/15	Q1	90.0%	100.0%	100.0%
	Q2	90.0%	98.1%	100.0%
	Q3	90.0%	98.6%	97.9%
	Q4	90.0%	96.9%	95.2%
2015/16	Q1	90.0%	90.3%	87.7%
	Q2	90.0%	96.5%	95.2%
	Q3	90.0%	88.6%	86.2%
	Q4	90.0%	89.0%	81.1%
2016/17	Q1	90.0%	91.2%	88.4%
	Q2	90.0%	88.5%	78.8%
	Q3	90.0%	92.8%	95.2%
	Q4	90.0%	85.7%	81.6%

Many of the antenatal women we encounter, started smoking at a young age and are surrounded in their homes by family members who are not smokefree (generational dependence). The antenatal women are often experiencing a lot of stress and are reluctant to receive support to quit because for them, it helps them to cope. Many have tried in the past and have found it too hard and others are reluctant to use Nicotine Replacement Therapy (NRT) as they have either tried it and not liked it or heard of others experiences and are unwilling to try.

The Maternal and Child Health Smokefree Coordinator has met with the antenatal clinic midwives to discuss the Wāhine Hapū – Increasing Smokefree Pregnancy Programme, outlining the reasons why they should refer their pregnant women who smoke. Posters for the programme are now in the waiting and clinic rooms at the antenatal clinic.

The Maternal and Child Health Smokefree Coordinator has met with the maternity coders to discuss difficulty in capturing up-to-date statistics when they are playing catch-up with file coding and Midwives not completing the smokefree pathway form in its entirety. These two issues reflect the outcomes as shown in the data. Projects for the next six months include:

- Reviewing the maternity smokefree pathway and smokefree referral forms
- Surveying midwives
- Surveying pregnant women who smoke and decline the Increasing Smokefree Pregnancy Programme

90% of young pregnant Māori women are referred to cessation support

Total referrals 339	Other	NZ Māori	NZ European	Pacific Island
AN 244	1	183	57	3
PN 36	1	24	9	2
Whānau 59	2	37	16	4

Referrals are sent in from many sources including LMC, Doctors, antenatal clinic midwives, postnatal ward midwives, nurses, Te Haa Matea stop smoking practitioners and self-referrals via Te Haa Matea Facebook page. Choices Heretaunga is the main provider for maternal cessation support, followed by Te Haa Matea stop smoking practitioners and in the case of Wairoa, the DHB Smokefree Service Coordinator.

Of the 339 referrals received, 160 consented to be on the Wāhine Hapū – Increasing Smokefree Pregnancy Programme (49%). 69% identified as Māori and 29% as European. Many decline from the referral to the programme as there are numerous struggles with other issues e.g. alcohol, drug use, financial and relationship issues.

The Smokefree team are currently trialling two initiatives to increase the number of referral consenting to be on the Programme.

- Referral process change - the Smokefree Māori Support Worker makes the initial face-to-face contact with the hapū wāhine in her home, providing initial support and a 'warm' hand over to Choices Heretaunga. Previously a flax was sent to Choices- Heretaunga.
- At this first meeting the pregnant woman is given two packets of new-born nappies for engaging in the Wāhine Hapū, providing instant reward for their positive choice.

Once the pregnant woman has consented to joining the Wāhine Hapū programme, a referral is sent to the stop smoking practitioner to continue the motivational and behavioural support for the next twelve weeks.

The Maternal and Child Health Smokefree Coordinator met with general practice staff with the "Top Five for my Baby to Thrive" resource, to encourage general practices to help pregnant women find a midwife, check their smoking status and refer to the Wāhine Hapū programme.

The successes of the Wāhine Hapū – Increasing Smokefree Pregnancy Programme include:

- Reaching the target population
- Engaging women with smoking cessation and behavioural support
- 96% smokefree at 4 weeks
- 73% smokefree at 12 weeks
- Approximately 30 women and 20 whānau members per year becoming smokefree

95% of Māori women who are smokefree at 2 weeks post-natal

	Target	Total	Maori	Pacific	High Deprivation
Jul - Dec 14	86%	79.0%	58.0%	94.0%	68.0%
Jan - Jun 15	86%	79.0%	62.0%	96.0%	70.0%
Jul - Dec 15	86%	73.0%	53.0%	81.0%	64.0%
Jan - Jun 16	86%	79.9%	65.6%	97.7%	72.6%
Jul - Dec 16	86%	80.0%	65.6%	93.5%	70.4%

Of those pregnant women referred to cessation support and who are successful at becoming smokefree during their pregnancy, many will return to smoking after the birth of their baby. Smoking is often a coping mechanism for stress and many women are reluctant to stop. Smoking is seen as "a breather" that assists coping with family social complexities and it gives them time-out from their baby/children and partners and it creates a break from boredom. It offers comfort, it facilitates socialising with their friends and for those who are isolated, it is their friend[1].

[1] Exploring why young Māori women smoke. Taking a new approach to understanding the experiences of people in our communities. 2017. Ministry of Health in collaboration with ThinkPlace.

CHAMPION'S REPORT OF ACTIVITY THAT WILL OCCUR TO INCREASE PERFORMANCE OF THESE INDICATORS?

Te Haa Mātea (HB Stop Smoking Services) is a partnership between Te Taiwhenua o Heretaunga, Te Kupenga Hauora o Ahuriri, Choices Kahungunu Health Services and HBDHB. Te Haa Mātea's mission is to help whānau stop smoking and 'breathe easy'. HBDHB are contributing significantly to Te Haa Matea outcomes by providing project management, cessation services in Wairoa and Central Hawke's Bay, providing cessation programmes for pregnant women, developing cessation programmes and providing support for workplaces.

HBDHB are leading the way in cessation initiatives:

- Te Haa Matea Facebook page administered by the Smokefree Service. To date, the Facebook page has 441 likes, 445 regular followers, 60 video views with 928 post reaches. The Facebook page has opened the door to self-referrals to both the Wāhine Hapū and connected people to Smokefree Pregnancy Programme and Tame your Taniwha challenge.
- Tag the Taniwha – a card designed to engage with health services at Te Matatini Kapa Haka Festival held in February.
- Tame your Taniwha – an eight week, team of three stop smoking challenge. 22 teams are registered in the first competition 2nd October to 30th November. A second competition is scheduled for April / May 2018.

These events and activities have supported partnerships between the HBDHB Smokefree Service and; other DHB services, Te Haa Matea, Kahungunu Executive, Hawke's Bay Smokefree Coalition, workplaces and our wider community to increase whānau quit attempts and smokefree status.

HBDHB provides leadership for the Hawke's Bay Smokefree Coalition which coordinates and delivers health promotion activity.

There has been an increase of interest in smokefree environments within workplaces. One initiative is - Quitline providing telephone support and the HBDHB providing face-to-face cessation support during work hours in workplaces. Workplace settings engaged include:

- Tumu Timbers
- Waipak Ltd
- Bostocks
- Heinz / Kraft
- Silver Fern Farms, CHB

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RECOMMENDATIONS FROM THE TARGET CHAMPION

We can achieve targets and the ultimate goal "Smokefree 2025" by working collaboratively and the programmes – Tame your Taniwha, Hapū Wāhine and joint events like Te Matatini, have provided an excellent pathway to strengthen the collaboration. We will continue to enhance existing collaboration and identify new opportunities.

Most of the indicators for this area are process indicators (measuring transactions or activity i.e. patients offered brief cessation advice) – the exception being the percentage of Māori women postnatal who are smokefree. The process indicators assume - inquiring about smokefree status and making referrals to cessation services will result in reductions in smoking rates. We must ensure that these process indicators are met and that a wide population health approach is being taken to reduce smoking rates in our priority groups.

There is good rationale for people to use e-cigarettes to help them stop smoking. E-cigarettes can provide nicotine, which is what people desire from smoking. Many of our whānau are making the switch from tobacco to 'vaping' and we need to support their nicotine replacement of choice. While the Ministry of Health are planning to change the law regulating e-cigarettes, this is not likely to happen until late 2018 for implementation in 2019. HBDHB need to be knowledgeable in the use of e-cigarettes to be effective stop smoking practitioners to our whānau who choose to 'vape'.

Smokefree service are investigating programmes to support young Māori wāhine to remain smokefree – this will focus on 15 to 18 years. We will prioritise Kura Kaupapa Māori schools and schools with high numbers of Māori wāhine.

Smokefree service are recruiting a Smokefree Stop Smoking Practitioner to deliver cessation support in workplaces, young Māori wāhine and cover Central Hawke's Bay. To increase coverage and support for whānau and communities.

CONCLUSION

Achieving these targets continue to be challenging. Working collaboratively in all settings will help us achieve the Aotearoa Smokefree 2025 goal.

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Performance Framework Exceptions Quarter 1 Jul-Sep 2017** 144 **HBDHB Quarterly Performance Monitoring Dashboard Quarter 4 Apr-Jun 2017**
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Tim Evans, Director of Finance and Information Peter Mackenzie, Operational Performance Analyst
Reviewed by:	Executive Management Team
Month:	November 2017
Consideration:	Monitoring for Information

RECOMMENDATION

That the HBDHB Board:

Note the contents of this report.

OVERVIEW

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

As this report ends September 2017, the results in some instances may vary to those presented in other reports.

BACKGROUND

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

ANNUAL PLAN (AP) 2017/2018

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

STATEMENT OF PERFORMANCE EXPECTATIONS (SPE) 2017/18
The SPE is produced annually within the context of the four-year Statement of Intent (SOI) 2014-18. The SPE informs the House of Representatives of the performance expectations agreed between a Minister and a Crown Entity. Formal agreement is gained annually through the AP process and actual performance is assessed and reported through the audited HBDHB Annual Report.

HAWKE'S BAY DISTRICT HEALTH BOARD (HBDHB) PERFORMANCE FRAMEWORK
The four dimensions of the non-financial monitoring framework, which was developed by the Ministry as a mandatory framework, will reflect DHB's functions as owners, funders and providers of health and disability services.

The 4 dimensions of DHB performance are:
- Achieving Government's priorities and targets (Policy priorities)
- Meeting service coverage requirements and supporting sector inter-connectedness (System Integration)
- Providing quality services efficiently (Ownership/Provider Arm)
- Purchasing the right mix and level of services within acceptable financial performance (Outputs/service performance)

KEY FOR DETAILED REPORT AND DASHBOARD

Baseline	Latest available data for planning purpose
Target 2017/18	Target 2017/18
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target
U (Unfavourable)	Actual to date is unfavourable to target
Trend direction ▲	Performance is improving against the previous reporting period or baseline
Trend direction ▼	Performance is declining
Trend direction -	Performance is unchanged

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PERFORMANCE HIGHLIGHTS

Achievements – For Total Population

- Immunisation at 8 months. We have achieved target for the total population at 95%. Maori is currently at 91.5% and Pacific are at 100% against a target of 95%. (page 8)

- Raising Health Kids. We are currently at 95% against a target of 95%. This is up from 10% in the previous quarter. Maori has increased 14% and currently sits at 92% and Pacific Rates are at 96% (page **Error! Bookmark not defined.**).

- Proportion of the population enrolled in the PHO. We have achieved the target of 90% for all ethnicities, for the Total and Maori we achieved 97% and for Pacific 90%.

Areas of Focus - For Equity

We continue to focus our efforts in order to make gains towards equity.

- Women booked with an LMC by week 12 of their pregnancy. The Quarter 1 result is 63% for the total population, 54% for Maori and 38% for Pacific, this is against a target of 80% (page 16).

- DNA Rate. Overall the DHB has a favourable results for DNA at 5.1% against a target of <7.5%. Maori rates are unfavourable to target but have improved over the last quarter by 1.8% to 10.5% (page 21)

- Mental Health. The DHB result for Q1 is a rate of 90.7 (per 100,000) and Maori is 175.1 (per 100,000) this is against a target of <81.5 (page **Error! Bookmark not defined.**).

Areas of Progress – For Total Population

- More Heart and Diabetes Checks. For the total population we achieved 88.4% against a target of 90%. Maori is currently 85.4% and Pacific at 84.3% (page 17)

Areas of Focus – For Total Population

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

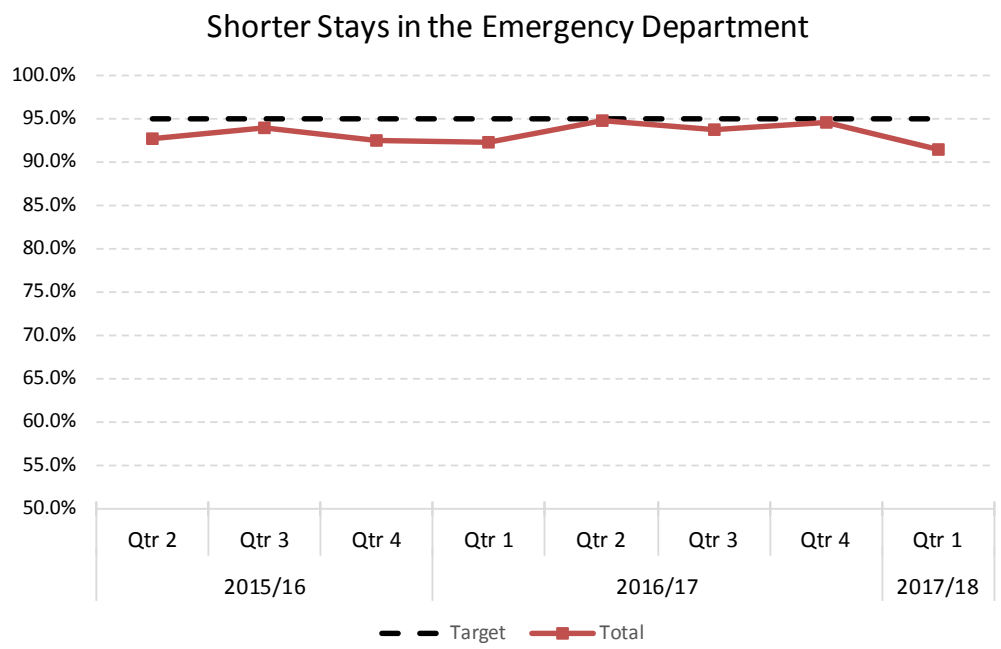
- Shorter Stays in Emergency Departments. The result for Quarter 1 is 91.4% overall with Maori sitting at 94% and Pacific at 95% against a target 95% (page 5).

- Faster Cancer Treatment. The result for Quarter 1 is 88% against a target of 90%, Maori are at 82% (page 6). We also have lower volumes that expected by the Ministry of Health.

Health Targets

Shorter Stays in Emergency Departments
95% of all people attending the Emergency Department will be admitted, transferred or discharged within six hours

Ethnicity	Baseline [1]	Previous result [2]	Actual to Date [3]	Target 2017/18	Progress against Previous Result
Total	94.7%	94.7% (F)	91.4% (U)	≥95%	▼
Maori	94.7%	95.4% (F)	93.8% (U)	≥95%	▼
Pacific	95.7%	97.9% (F)	95.0% (F)	≥95%	▼
Other	96.5%	94% (U)	89.8% (U)	≥95%	▼



Comments:
Work that is being done to support this measure includes now having an 8th permanent ED Physician which means we are now at full complement, we have also appointed a 3rd Nurse Practitioner. Additional nursing and medical resources have been provided to support patient flow across every weekend during busy winter months. We have flexible opening of additional ward bed capacity to support periods of high demand. A formal project around the General Medical model of care has commenced, this is to develop a medical staffing model that is resourced and organised to manage acute medicine (Acute Assessment Unit & Ambulatory Emergency Care) effectively alongside ward-based medicine and specialty medicine.

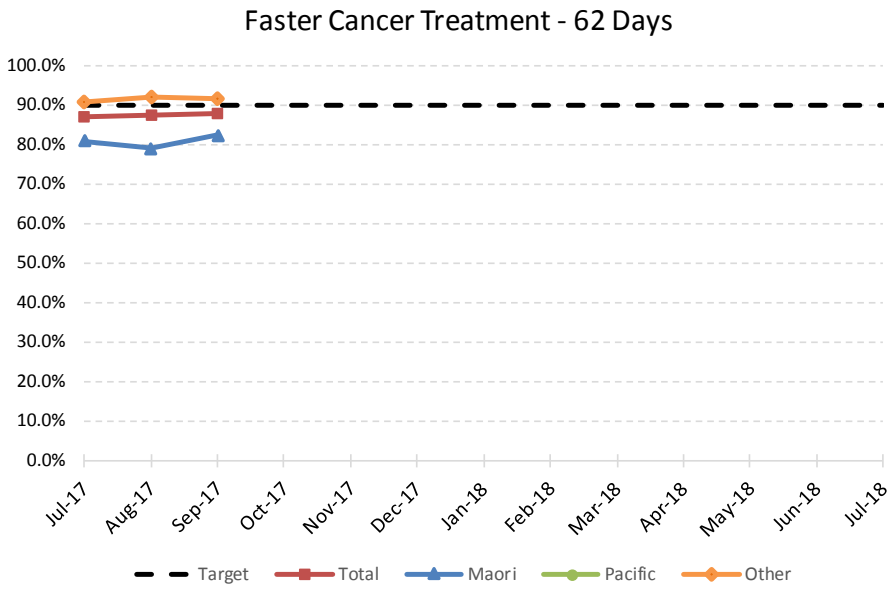
Several Barriers have been Identified to us achieving target including surges in demand across the winter months that have outstripped the physical capacity of ED and the resources applied to emergency medicine. These are being addressed through the patient flow initiatives and putting additional staffing resources into the Emergency Department. Once medical and NP resources in ED Fast Track are fully orientated, Fast Track will expand hours of operation at each end of the day. We have also had High levels of bed occupancy across acute areas during the winter months. This has attempted to be addressed through ongoing development of the Integrated Operations Centre functions and creation of additional capacity as demand has dictated. Pressure on inpatient specialties resulting in delayed reviews

1 *October to December 2016*
2 *April to June 2017*
3 *July to September 2017*

for referred patients is being addressed through the FLOW program of work and agreed increases to the medical workforce but in the short-term has been managed through committing additional staffing resources to support flow during periods of peak demand.

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

Key Performance Measures	Baseline [4]	Previous result [5]	Actual to Date [6]	Target 2017/18	Trend direction
Total	65.4%	87.7% (U)	88.1% (U)	≥90%	▲
Maori	-	78.9% (U)	82.4% (U)	≥90%	▲
Pacific	-	-	-	≥90%	*
Other	-	92.2% (F)	91.5% (F)	≥90%	▼



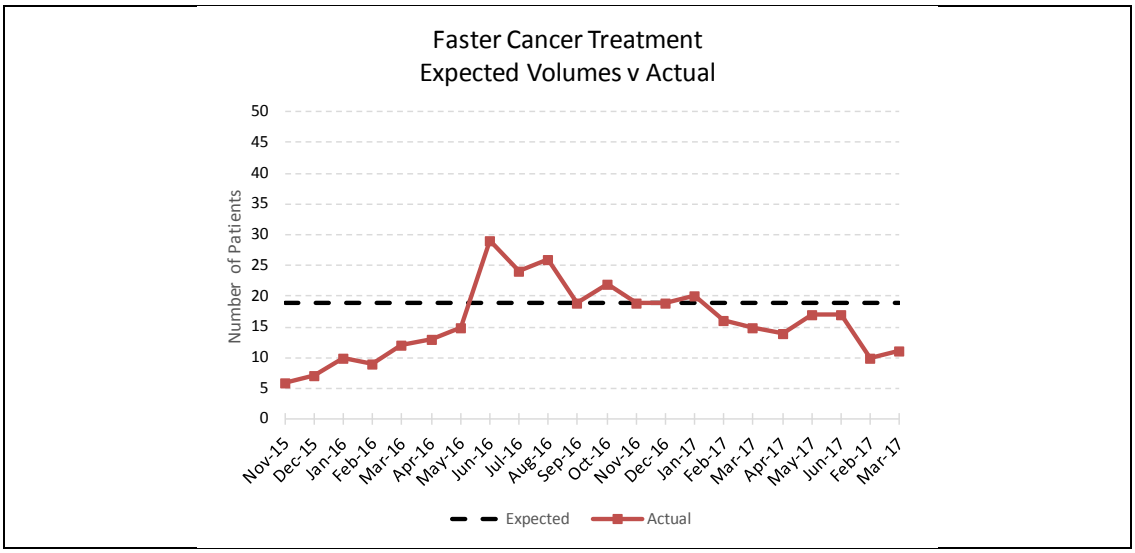
Comments:
HBDHB has achieved 100% compliance for the months of August and September. The expected volume of patients identified for the 62 day pathway remains low with the challenge being enable identify these patients at referral prioritisation. The FCT governance team is working with individual speciality teams to clarify the red flags for those patients with a high suspicion of cancer to facilitate improved data capture. The cancer nurse coordinators and the cancer support team are focused on supporting equitable access to local services e.g. blood tests and OPC appointments. The greatest barrier is access to external diagnostics in either Auckland, Midlands or Wellington, and treatments in Wellington and Auckland. The transport and accommodation allowance is based on a distance criteria for community card holders only. The logistics to get to the particular destination has been difficult enough for patients to decline at times. The importance of whanau support for any person on a cancer journey is acknowledged and understood. This concept needs to be recognised within the scope of the transport and accommodation allowances.

***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.*

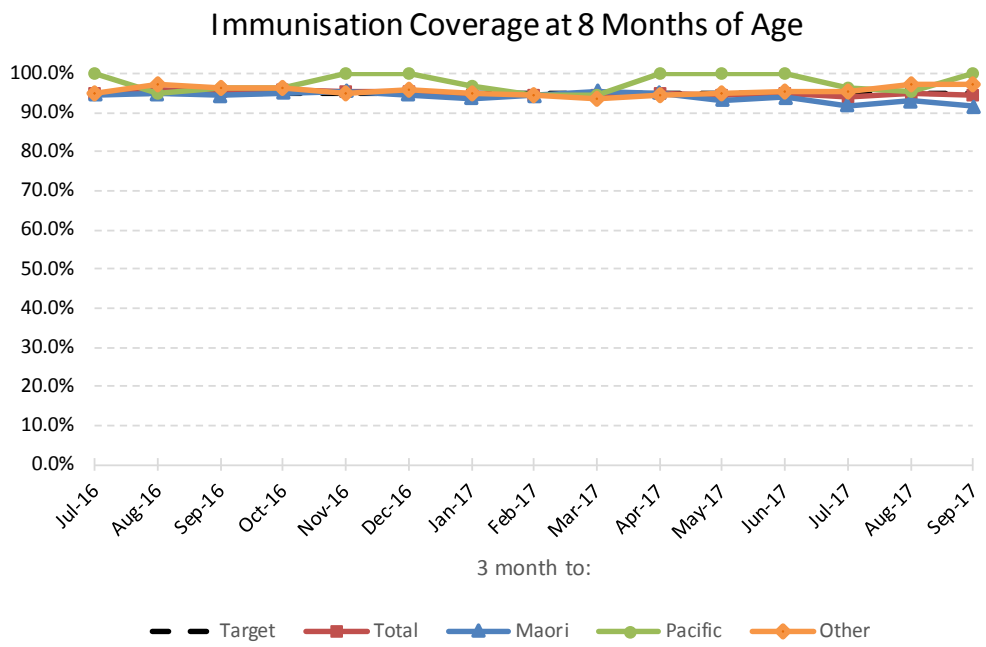
4 6 *months to December 2016*

5 *6 months to June 2017*

6 *6 months to September 2017*


Faster Cancer Treatment
Expected Volumes v Actual
Number of Patients
50
45
40
35
30
25
20
15
10
5
0
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Feb-17
Mar-17
Expected
Actual

Increased immunisation % of 2 year olds fully immunised					
Ethnicity	**Baseline** [7]	**Previous result** [8]	**Actual to Date** [9]	**Target 2017/18**	**Trend direction**
Total	95.3%	95% (F)	94.4% (U)	≥95%	▼
Māori	94.4%	94% (U)	91.5% (U)	≥95%	▼
Pacific	100.0%	100% (F)	100% (F)	≥95%	—
Other	95.9%	95.6% (F)	97% (F)	≥95%	▲



Data Source: National Immunisation Register

Comments:
We are really pleased with the quarter result as this has been another difficult quarter. We have inequity between Maori and non-Maori and we have been working hard with hesitant parents. The only consistent message that is coming through from the community is that negative messages are being posted online. I see that HPA (health promotion agency) is targeting some regions with online messaging and I wonder whether this could be extended out if this trend persists in HB. We identified 27 infants that had either declined or weren't complete for the quarter.

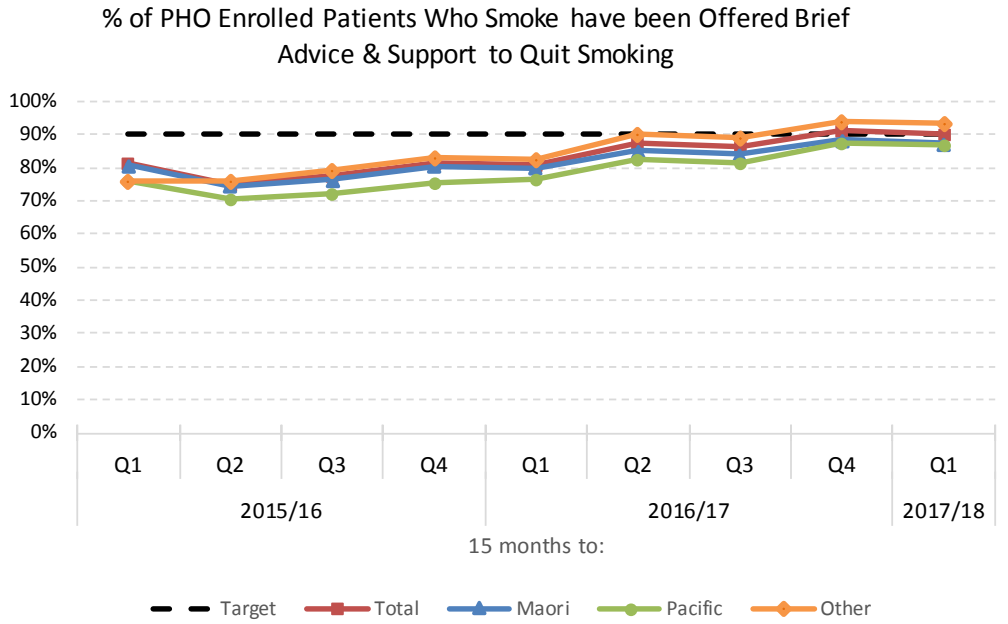
7 *October to December 2016. Source: National Immunisation Register, MOH*

8 *April to June 2017. Source: National Immunisation Register, MOH*

9 *July to September 2017. Source: National Immunisation Register, MOH*

Better help for smokers to quit – Primary Care
% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months

Key Performance Measures	Baseline [10]	Previous result [11]	Actual to Date [12]	Target 2017/18	Trend direction
Total	87.4%	91% (F)	90.2% (F)	≥90%	▼
Māori	85.1%	88.4% (U)	87.3% (U)	≥90%	▼
Pacific	82.2%	87.1% (U)	86.8% (U)	≥90%	▼
Other	89.9%	93.7% (F)	93.1% (F)	≥90%	▼



Source: Ministry of Health

Comments:
In order to support the achievement of the target and improve performance there are a range of activities that the DHB continuously undertake each quarter. For this quarter under Active Clinical Leadership/Clinical Champions, Health Hawke's Bay has sponsored a local Basketball Training Clinic to provide Smokefree Health Promotion to the 12 – 17 year olds that participated in the sports clinic. Each participant received a Smokefree information pack to share with their whānau, as well as a Smokefree toothbrush, lip balm and a bottle of water. Under the category Active, Dedicated Management To Support ABC Activities In General Practice, when the new Karo Reports are available each month, the PHO Performance Manager contacts each practice to tell them how many patients they have to follow-up, what coverage rate percentage they have currently achieved. Practices are also reminded there is funding available for dedicated time to follow-up on patients, or if they do not have the staff capacity they are offered the funded services of an independent nurse to follow-up on patients on behalf of the practice. We Continue to support clinical staff to complete their on-line e-learning Helping People Stop Smoking training with the support of the New Zealand Guidelines for Helping People to Stop Smoking. PHO Activities to Increase Delivery of ABC in General Practice include Providing independent nurses for ABC in General Practises for those practices who do not have the capacity to contact patients and also Providing stop smoking practitioner one day per week at the Te Taiwhenua o Heretaunga Hauora to follow-up on patients on behalf of the practice.

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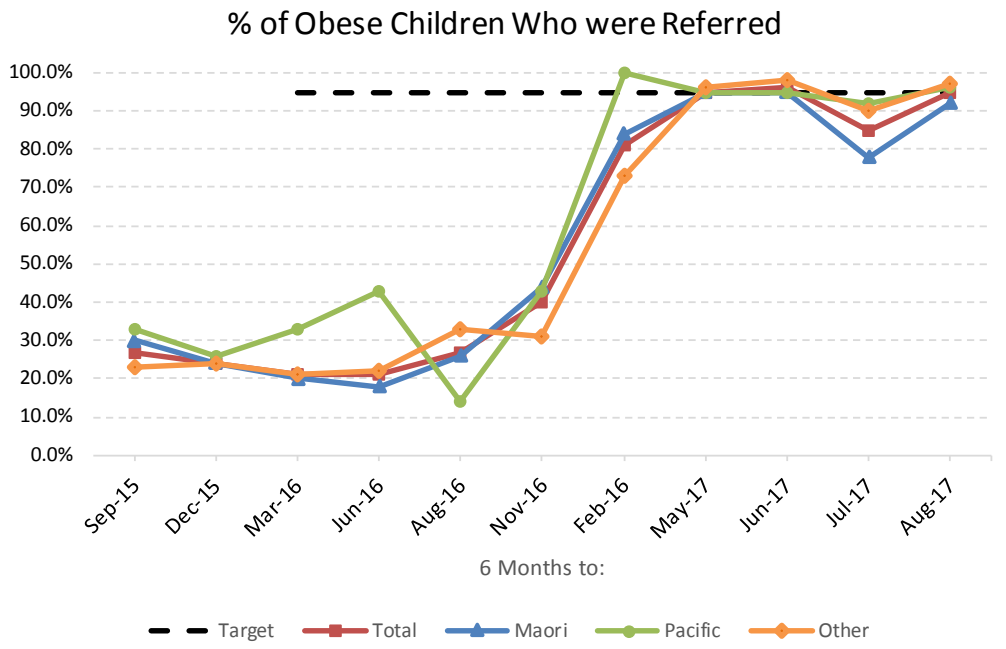
10 15 months to December 2016. Source: DHB Shared Services

11 15 months to June 2017. Source: *DHB Shared Services*

12 15 months to September 2017. Source: DHB Shared Services

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

Key Performance Measures	Baseline [13]	Previous result [14]	Actual to Date [15]	Target 2017/18	Trend direction
Total	40.0%	85% (U)	95% (F)	≥95%	▲
Māori	44.0%	78% (U)	92% (U)	≥95%	▲
Pacific	43.0%	92% (U)	96% (F)	≥95%	▲
Other	31.0%	90% (U)	97% (F)	≥95%	▲



Source: Ministry of Health

Comments:
We continue to achieve target overall, and we are closely monitoring progress monthly to ensure we retain this level. We have completed and evaluation of the Healthy Conversations Tool - which found the Tool is being well used and there are only minor changed needed to incorporate the feedback. There has been a request for a portion size plate/s to help with conversations- developing this resource is being investigated.

Part of the issue is that we are dealing with very small numbers (one child for Maori to meet target, .3 Pacifica and 2 for other to go under) so all are vulnerable to missing the target unless everything in the system is perfect.

What we found was the BMI is recalculating based on the child's age – so if the referral confirmation is coming back (within the timeframe) and the child age has gone up a month they can go from obese to over-weight, which sounds great but what it has meant is the data has picked them up as an un-referred child – Health HB have addressed this. We are monitoring so closely we are picking up the single cases like this.

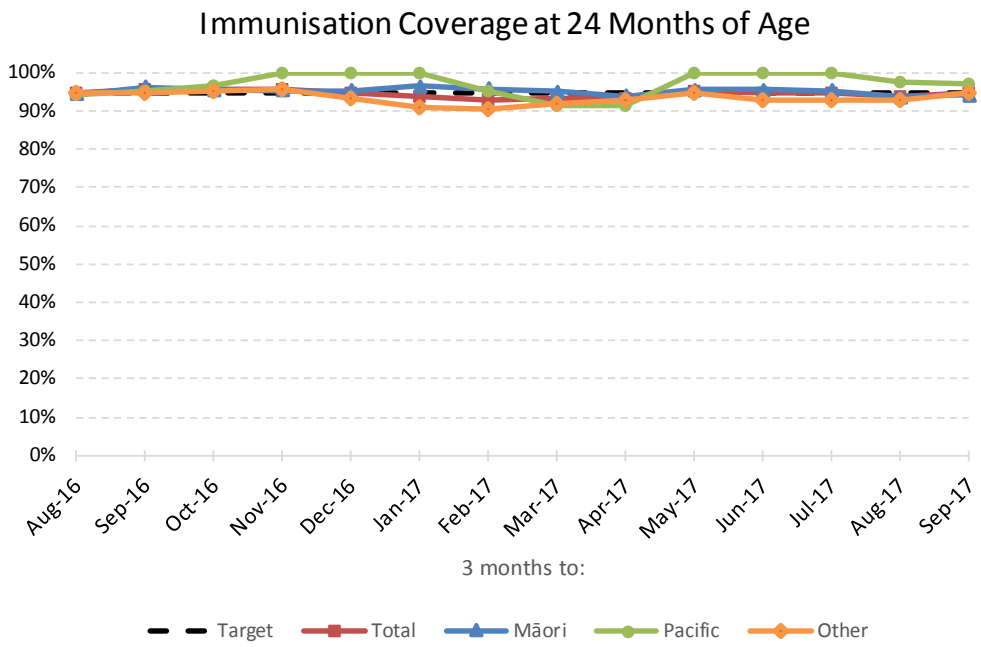
13 *6 months to September 2015. Source: DHB Shared Services*

14 *6 months to May 2017. Source: DHB Shared Services*

15 *6 months to August 2017. Source: DHB Shared Services*

Output Class 1: Prevention Services

Increase Immunisation: % of 2 year olds fully immunised					
Key Performance Measures	**Baseline** [16]	**Previous result** [17]	**Actual to Date**[18]	**Target 2017/18**	**Trend direction**
Total	94.7%	94.7% (F)	94.6% (F)	≥95%	▼
Māori	95.4%	95.7% (F)	94.1% (U)	≥95%	▼
Pacific	100.0%	100% (F)	97.1% (F)	≥95%	▼
Other	93.6%	92.8% (U)	94.7% (F)	≥95%	▲



Data Source:

Comments:

We are pleased with our results this quarter with considerable work continuing to track these children. We are also working closely with other child health services to locate and offer immunisation to these children. We have had six 15 month declines (3 Maori and 3 European) and 4 MMR only declines (2 Maori and 2 European) in the two year cohort. All families have had conversations with health professionals regarding immunisation.

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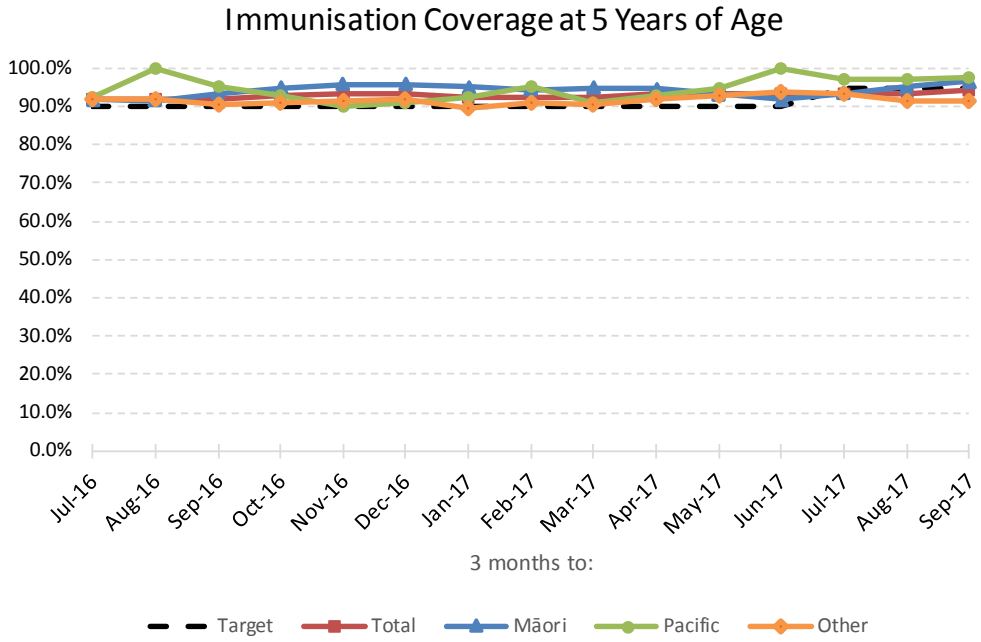
16 October to December 2016 . Source: National Immunisation Register, MOH

17 April to June 2017. Source: National Immunisation Register, MOH

18 July to September 2017. Source: National Immunisation Register, MOH

Increase Immunisation: % of 4 year olds fully immunised					
Key Performance Measures	**Baseline** [19]	**Previous result** [20]	**Actual to Date**[21]	**Target 2017/18**	**Trend direction**
Total	93.5%	93.2% (U)	94.2% (U)	≥95%	▲
Māori	95.8%	91.8% (U)	96.7% (F)	≥95%	▲
Pacific	91.2%	100% (F)	97.7% (F)	≥95%	▼
Other	91.8%	93.7% (U)	91.6% (U)	≥95%	▼



Data Source:

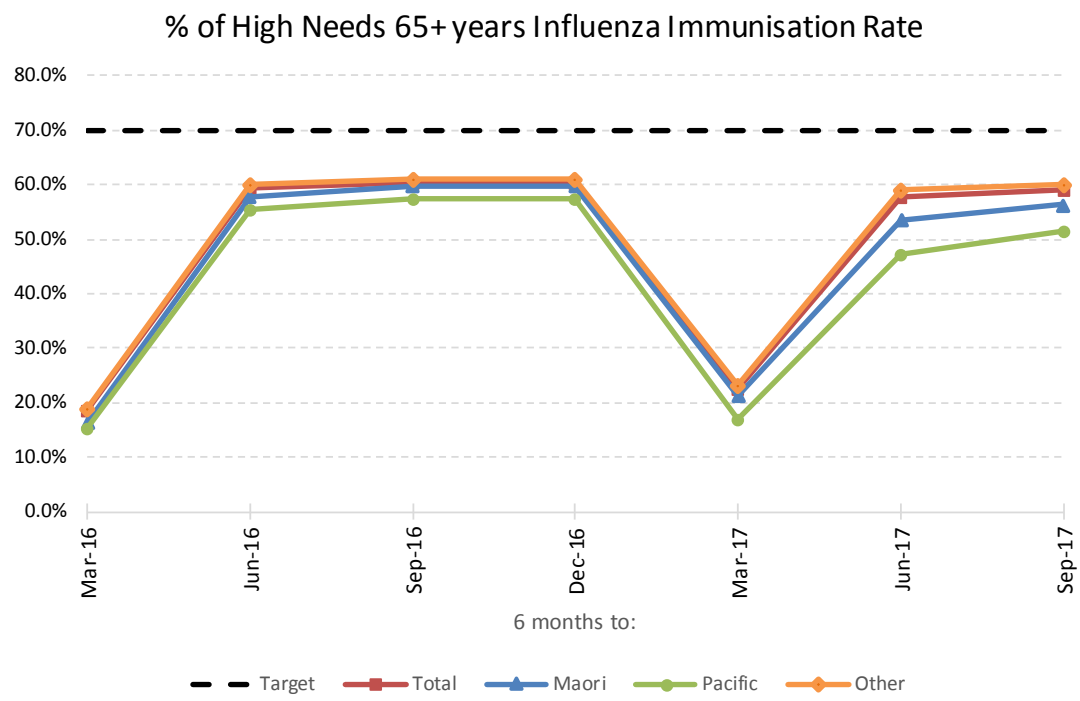
Comments:
We are pleased with our 4 year coverage and although not quite at 95% we were over this for Maori and Pacific which is pleasing. We apply the same processes for tracking and tracing 4 year olds as we do for the other target age groups. We also work closely with B4SC. However these children are harder to find due to several issues including address changes etc.

19 October to December 2016 . Source: National Immunisation Register, MOH

20 April to June 2017. Source: National Immunisation Register, MOH

21 July to September 2017. Source: National Immunisation Register, MOH

Increase Immunisation: % of 65+ year olds immunised – flu vaccine					
Key Performance Measures	**Baseline** [22]	**Previous result** [23]	**Actual to Date**[24]	**Target 2017/18**	**Trend direction**
Total	-	61.7% (U)	59.1% (U)	≥75%	▼
Māori	-	61.4% (U)	56.3% (U)	≥75%	▼
Pacific	-	57.7% (U)	51.5% (U)	≥75%	▼
Other	-	62.3% (U)	60% (U)	≥75%	▼



Data Source:

Comments:
Accurate reporting for influenza remains difficult due to not all immunisations being recorded on NIR. We know that our rates will be higher than 59.1% due to most occupational health providers not having the ability to message immunisations through to the register. It is great that immunisations given through pharmacies are now messaging. We have 2 contracts with Maori providers to deliver 100 influenza vaccines to eligible Maori and we also delivered approx. 40 influenza vaccines through the Whanau Wellness programme that HealthHB PHO run which we hope to be able to do again next year.

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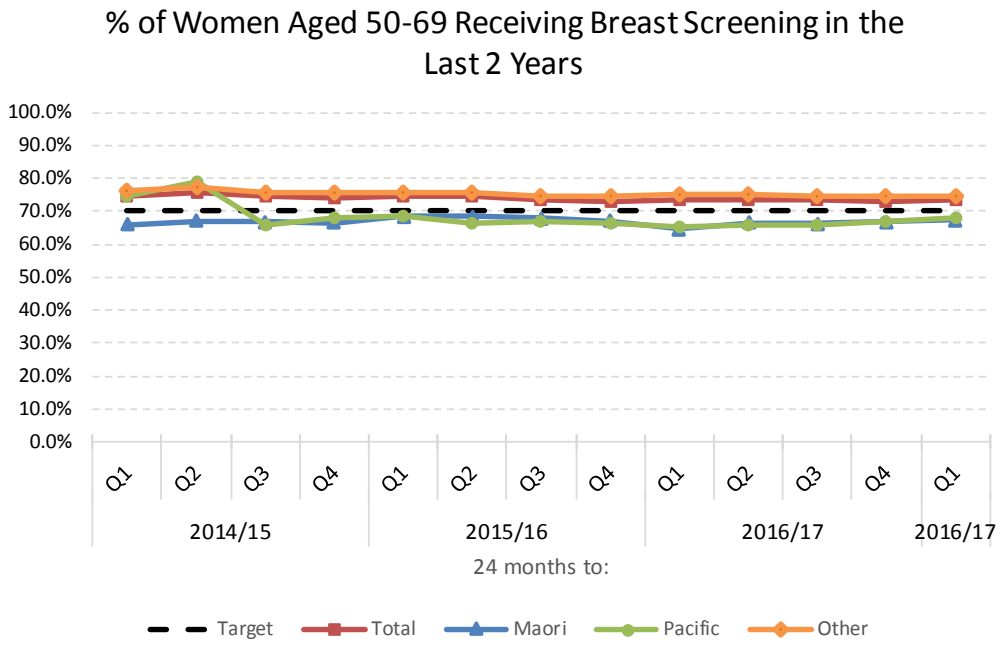
23 *6 months to June 2017. Source: National Immunisation Register, MOH*

24 *6 months to September 2017. Source: National Immunisation Register, MOH*

Improve Breast Screening Rates
% of women aged 50-69 years receiving breast screening in the last 2 years

Key Performance Measures	Baseline [25]	Previous result [26]	Actual to Date[27]	Target 2017/18	Trend direction
Total	73.6%	73.2% (F)	73.4% (F)	≥70%	▲
Māori	64.7%	66.8% (U)	67.4% (U)	≥70%	▲
Pacific	65.4%	66.9% (U)	67.9% (U)	≥70%	▲
Other	75.0%	74.5% (F)	74.6% (F)	≥70%	▲



Data Source:

Comments:
The process of contacting BSCC via phone seems to put many women off and they often will ask us to make an appointment. Women who have felt discomfort when having had their mammogram talk to others about how it felt, creating a stigma around the process of having a mammogram. Fear of the unknown the result could be cancer, so they will often say they would prefer not to know. All Hawke's Bay Maori and Pacific women who DNA or not respond to their appointments for their mammogram are referred to the Population Screening team, we then refer women to one of our 5 ISP's to contact the women and provide support to services, these referral outcomes are monitored every six months. We have just recently completed a successful campaign to encourage Maori and Pacific 45-69 who were unenrolled or underscreened on the BSA programme, gifting them a $20 Pak n Save gift card on completion of their mammogram. We are currently planning for the BSA Mobile visit to Wairoa late January and visit to Central Hawke's Bay in March / April 2018.

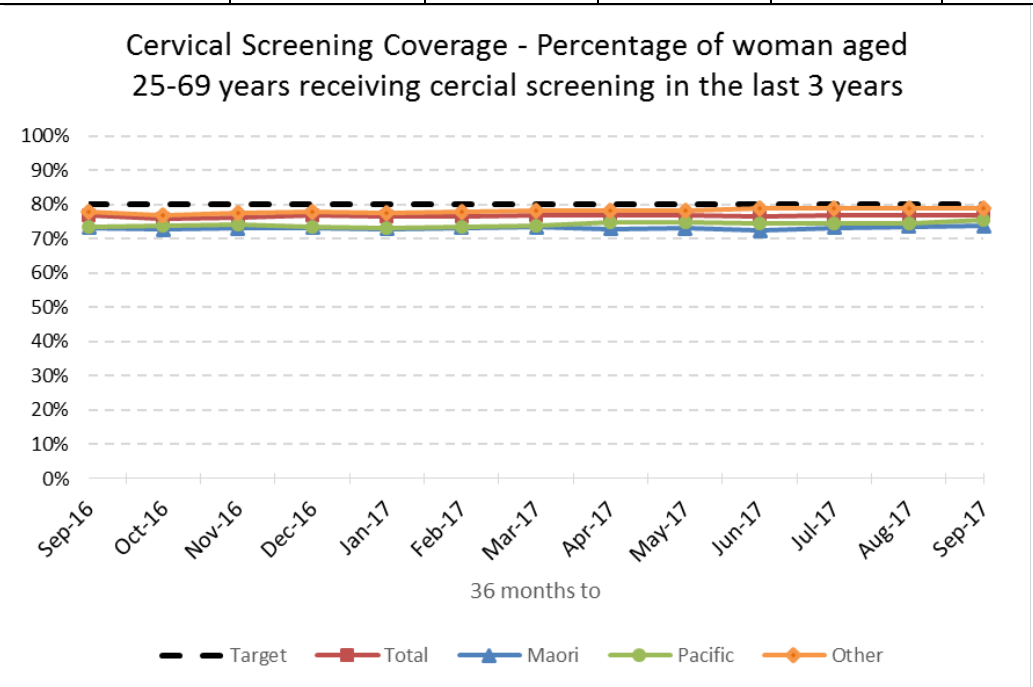
25 *24 months to December 2016 . Source: National Immunisation Register, MOH*

26 *24 months to June 2017. Source: National Immunisation Register, MOH*

27 *24 months to September 2017. Source: National Immunisation Register, MOH*

Improve Cervical Screening Rates
% of women aged 25–69 years who have had a cervical screening event in the past 36 months

Key Performance Measures	Baseline [28]	Previous result [29]	Actual to Date[30]	Target 2017/18	Trend direction
Total	76.7%	76.6% (U)	77.0% (U)	≥80%	▲
Māori	72.8%	72.4% (U)	73.8% (U)	≥80%	▲
Pacific	74.8%	74.4% (U)	75.5% (U)	≥80%	▲
Other	78.9%	78.9% (U)	78.9% (U)	≥80%	—



Data Source:

Comments:
We need more opportunistic smears to be taken at general practice and more options for women i.e. after hours clinics, smears offered in the homes and good support mechanisms. Increasing our staff capacity within the Population Screening team, enabling our Pacific Community Support worker to increase her hours to full time and having a smeartaker employed fulltime for a two year period. Some of the barriers we face are a lot of the first time woman have never engaged with their GPs and don't know anything about having their smears, they see their doctors as a place to go to only if they are sick. Another barrier is not having access to a nurse smeartaker, rather being told make an appointment and come back in two or three days. If a woman has decided she will have her smear its essential that the service is offered 'now', after hours clinics are also required. We are also aware that many women have had a bad experience when having their smear, which delays returning for subsequent smears, for example. In order to improve equity we have the Pak n Save programme funded by Health HB, all Maori, Pacific and women living in Dep 5 will receive a Pak n Save gift card of $20 if they have their smear. Our Kaiawhina, and Pacific Community Support worker work with either our Kaiwhakahaere or a nurse from Choices or Te Taiwhenua o Heretaunga offering smears to women in their home who are overdue or never been screened and registered with The Doctors- Napier, Totara Health, or Maraenui Medical Centre. Feedback from women who have been screened in their home indicates that it has made a big difference and wouldn't have had the smear otherwise. We have also had two staff clinics on the Hospital campus, and two clinics per month from September to December for Maori and Pacific women.

23

28 *26 months to December 2016 . Source: National Immunisation Register, MOH*

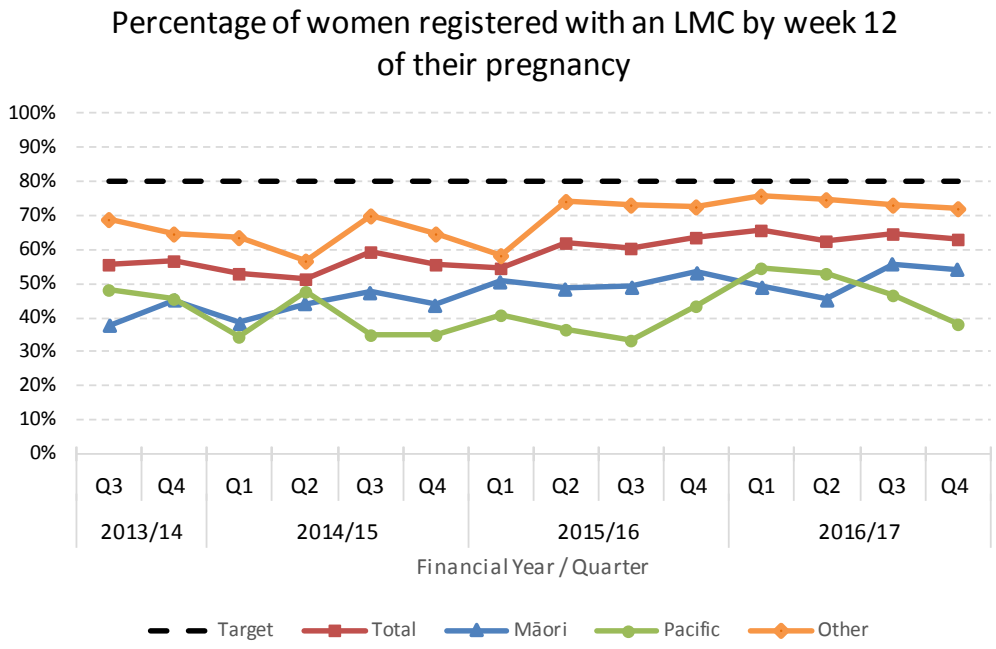
29 *36 months to June 2017. Source: National Immunisation Register, MOH*

30 *36 months to September 2017. Source: National Immunisation Register, MOH*

OUTPUT CLASS 2: Early Detection and Management Services

More Pregnant Women Under the Care of a Lead Maternity Carer (LMC)
% of women booked with an LMC by week 12 of their pregnancy

Key Performance Measures	Baseline [31]	Previous result [32]	Actual to Date [33]	Target 2017/18	Trend direction
Total	65.7%	64.8% (U)	63% (U)	≥80%	▼
Māori	49.2%	55.7% (U)	54.1% (U)	≥80%	▼
Pacific	54.5%	46.5% (U)	38.2% (U)	≥80%	▼
Other	75.9%	73.4% (U)	71.8% (U)	≥80%	▼



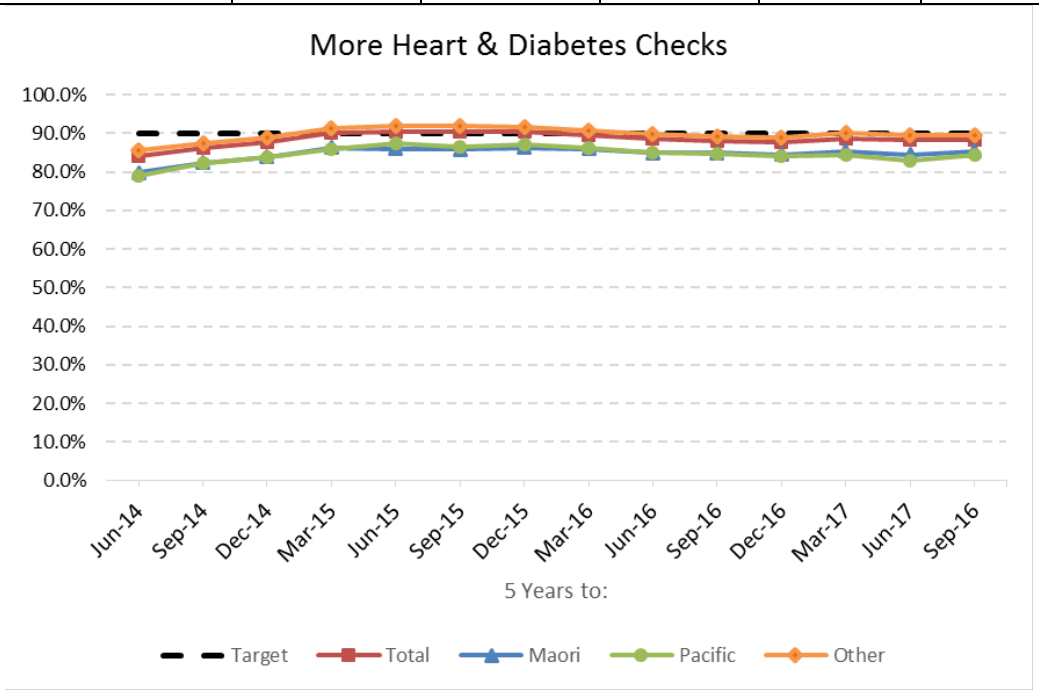
Comments:
We are demonstrating continued maintenance from the previous Q3 data following the campaign of engagement with our primary care partners in general practice. However of note is the ongoing missed target for all ethnicities but particularly our Pacific Island women and Maori women. There are a couple of issues that the DHB is currently working through: ensuring that all women who confirm pregnancy in GP are supported to book with a midwife prior to leaving the GP practice. Ensuring all women are aware of the need for a midwife early, how to find the LMC midwives in their community and the importance of this – the public campaign of the top 5 for my baby to thrive has been rolled out since May this year – the figures here are Q4 Apr-June 17. Traditionally PI women haven't engaged early in pregnancy as culturally get support from their family, the opportunity is for us to work with the PI engagement team to raise understanding and awareness and there is a plan to work with our pacific health team and a navigator to support engagement early. We are looking to improve Health Literacy, ensuring messaging is clear, simple and visual – see current early engagement campaign. Working with Nga Maia and Maori midwives to ensure all women who seek out care from them whom they are unable to book due to volume have support from DHB midwifery team to book and engage in the first 12 weeks of pregnancy. Continue to strengthen our primary care partnerships with the key focus for our general practice colleagues on booking women with an LMC at the appointment and discussing smoke free

31 October to December *2016.*

32 January to March 2017 .

33 April to June 2017

Improved Management of Long-Term Conditions (CVD, Acute heart health, Diabetes, and Stroke) % of the eligible population will have had a CVD risk assessment in the last 5 years					
Key Performance Measures	**Baseline** [34]	**Previous result** [35]	**Actual to Date** [36]	**Target 2017/18**	**Trend direction**
Total	87.8%	88.2% (F)	88.4% (U)	≥90%	▲
Māori	84.5%	84.4% (U)	85.4% (U)	≥90%	▲
Pacific	84.0%	82.7% (U)	84.3% (U)	≥90%	▲
Other	88.9%	89.6% (F)	89.4% (U)	≥90%	▼



Source: Ministry of Health

Comments:
Health HB have a program in place to work with VLCA (Very Low Cost Access General Practices) practices to increase uptake of CVDRA (Cardiovascular Risk Assessments) in Maori and Pasifika Male. The program is similar to a car warrant of fitness theme. The "WOF" provides rewards of attendance, that is a $20 Pak N Save Gift Card, and going in the draw for $800 tyres, this promotion ends 31/12/2017. Close monitoring is in place to map progress towards target with additional scope to further incentivise the program if results are not achieved. The Kaupapa of the program was inspired by a cohort of consumers, and VLCA practice staff

23

34 5 years to December 2016. Source: Ministry of Health

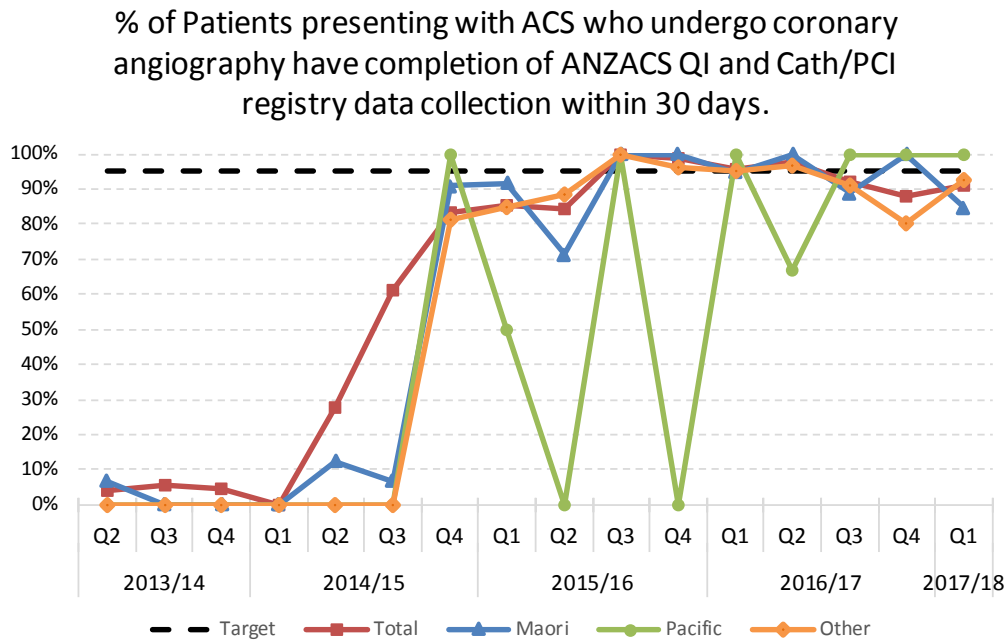
35 5 years to June 2017. Source: Ministry of Health

36 5 years to September 2017 . Source: Ministry of Health

OUTPUT CLASS 3: Intensive Assessment and Treatment Services

Patients with ACS Receive Seamless, Coordinated Care Across the Clinical Pathway
% of patients undergoing cardiac surgery at the regional cardiac centres who have completion of Cardiac Surgery registry data collection within 30 days of discharge

Key Performance Measures	Baseline [37]	Previous result [38]	Actual to Date [39]	Target 2017/18	Trend direction
Total	97.7%	88% (U)	90.8% (U)	≥95%	▲
Māori	66.7%	100% (F)	100% (F)	≥95%	—
Pacific	100.0%	100% (F)	84.6% (U)	≥95%	▼



Source: Ministry of Health

Comments:
ACS form completion has improved this quarter with 98%, 95% and 84% completion each month. This has been largely due to a dedicated senior nurse completing within her delegated work flow. The variation in Maori and Pacific results is due to a small cohort where an additional 1 or 2 patients makes the difference between being favourable or unfavourable.

37 October to December 2016. Source: Ministry of Health
38 April to June 2017. Source: Ministry of Health
39 July to September 2017 . Source: Ministry of Health

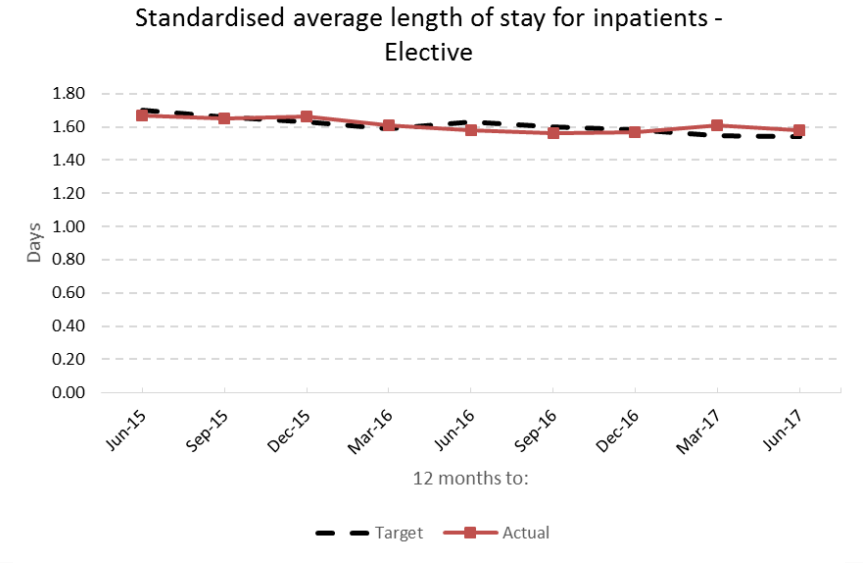
Equitable Access to Surgery – Standardised intervention rates for surgery per 10,000 population					
Key Performance Measures	**Baseline[40]**	**Previous result[41]**	**Actual to Date [42]**	**Target 2017/18**	**Trend direction**
Major joint replacement	21.5	20.6 (U)	21.8 (F)	≥21	▲
Cataract procedures	58.7	52.5 (F)	46.4 (F)	≥27	▼
Cardiac procedures	6.6	5.9 (U)	5.2 (U)	≥6.5	▼
Percutaneous revascularization	13.1	12.4 (U)	12.2 (U)	≥12.5	▼
Coronary angiography services	39	35.1 (F)	35.5 (F)	≥34.75	▲
Source: Ministry of Health					
Comments: Cardiac Surgery rate for June 2017 for HB was 5.21 with the target being 6.5. Intervention rates are reliant on access to CCDHB and the weekly elective service manager wait list report is received from CCDHB and is being monitored closely.					

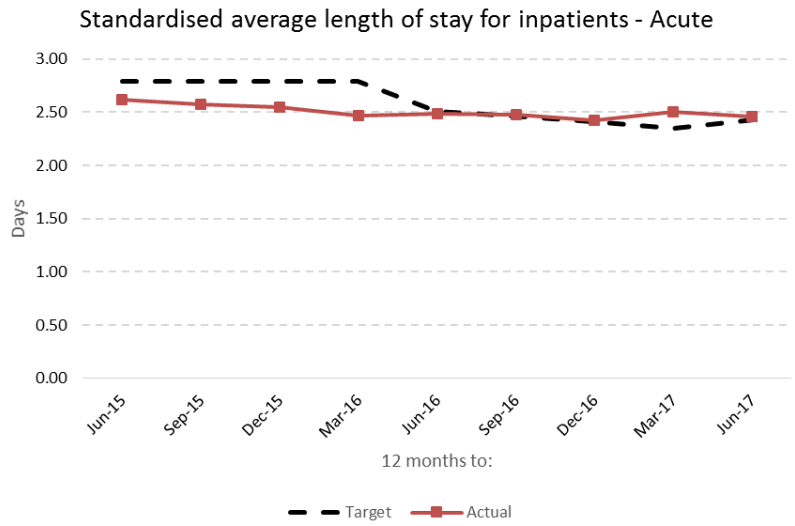
40 *12 months ending December 2016. Source MoH*

41 *12 months ending March 2017. Source MoH*

42 12 months ending June 2017. Source MoH

Shorter stays in hospital – Elective and Acute Length of stay Elective and Acute (days)					
Key Performance Measures	**Baseline** [43]	**Previous result** [44]	**Actual to Date** [45]	**Target 2017/18**	**Trend direction**
Elective	1.56	1.61 (U)	1.58 (U)	≤1.54	▲
Acute	2.48	2.5 (U)	2.46 (U)	≤2.43	▲





Source: Ministry of Health

Comments:
We have reduced the Elective ALOS from 1.61 in the previous quarter to 1.58 this quarter which is pleasing to see. However we have still not achieved the Ministry Target of 1.54. There are several initiatives within the hospital looking at reducing the length of stay, FLOW and 4000 bed Days include
Improving our systems and process to discharge patients from our inpatient wards by focusing on increased earlier in the day discharges and how we manage patients who have longer stays and Ensuring our processes are effective in managing patients with frailty from presentation in ED, through their patient journey on to discharge. These work streams are underpinned by Internal Professional Standards (IPS), which are measures we have developed to assess how our improvements are tracking. We will update you on these measures in future updates.

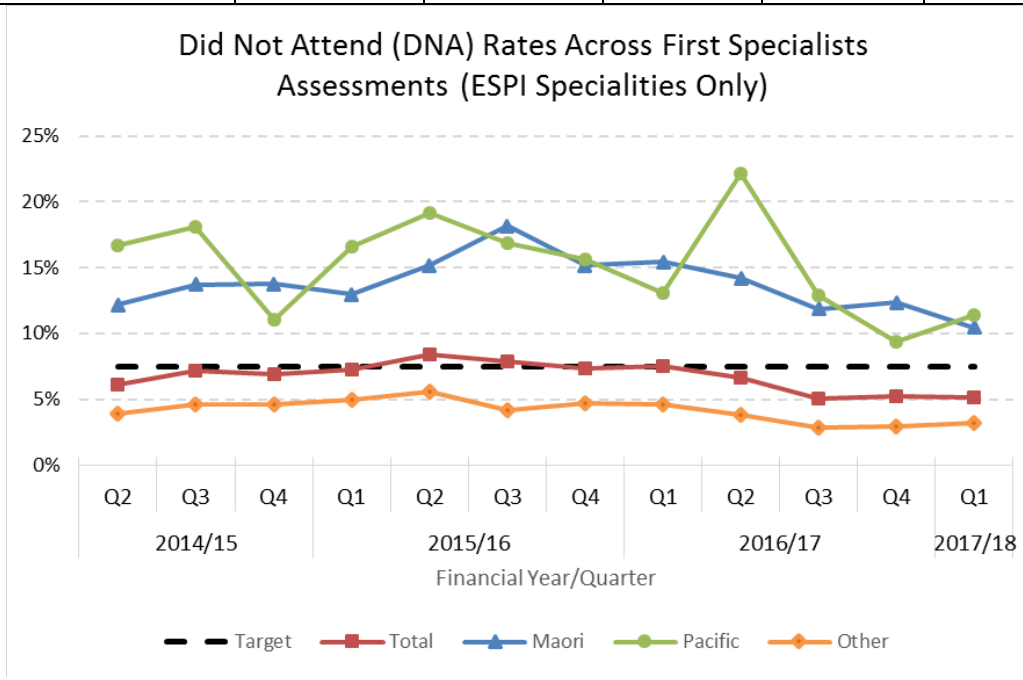
43 12 months to December 2016. Source: Ministry of Health

44 12 months to March 2017. Source: Ministry of Health

45 12 months to June 2017 . Source: Ministry of Health

Fewer missed outpatient appointments
Did not attend (DNA) rate across first specialist assessments

Key Performance Measures	Baseline [46]	Previous result [47]	Actual to Date [48]	Target 2017/18	Trend direction
Total	6.7%	5.2% (F)	5.1% (F)	≤7.5%	▲
Māori	14.2%	12.3% (U)	10.5% (U)	≤7.5%	▲
Pacific	22.1%	9.4% (U)	11.4% (U)	≤7.5%	▼
Other	3.8%	2.9% (F)	3.2% (F)	≤7.5%	▼



Source: Ministry of Health

Comments:
The overall DNA rate continues to remain under our target of 7.5%. This reflects the commitment from Booking staff to engage directly with our customers when booking their FSA, and the maturity of processes now in place using the preventative pathway with Kaitakawaenga. The Bookers are also pro-actively looking for initiatives to improve the communications with our customers – for example trialling evening calls to Patients last month with Maxillo – Facial led to '0 ' DNA rate for the month - which has proven to be effective and a trial we would like to pursue going forward across all specialties. Pacific Island rates continue to fluctuate more due to the distortion of the actual percentage of DNA against a low volume of attendances. Maori DNA rates continue to decline largely due to the effect of our new Kaitakawaenga establishing their own processes and working relationships across the DHB and in the community. Of note is a correlation with a spike in Maori DNA rates over the school holiday period, this requires further investigation into how we can overcome the accessibility to hospital appointments over school holidays for our Maori community.

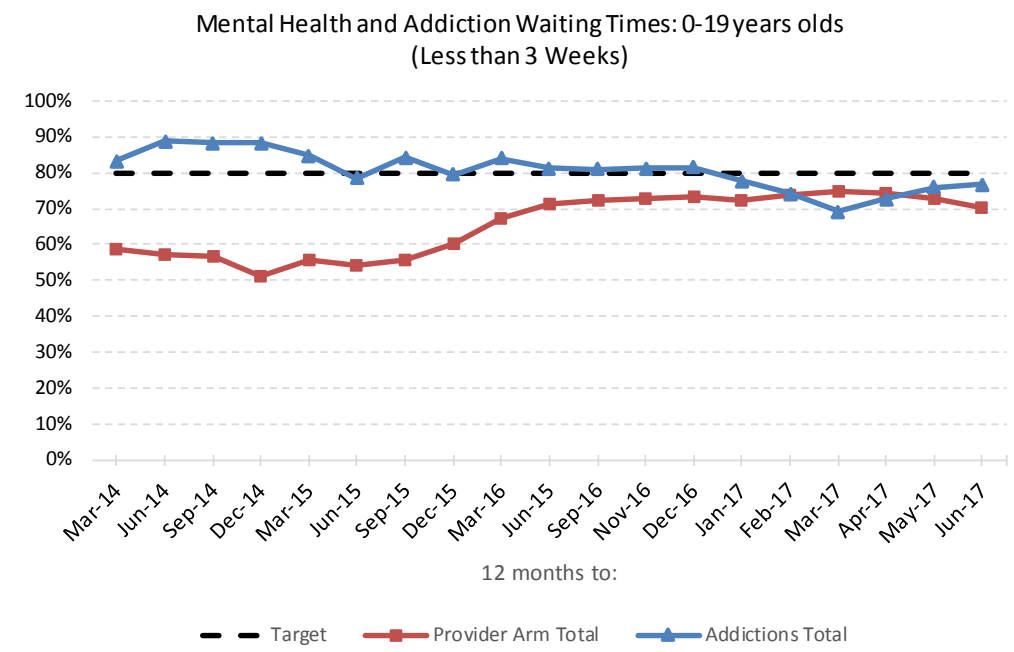
23

46 October to December 2016. Source: Ministry of Health

47 April to June 2017. Source: Ministry of Health

48 July to September 2017 . Source: Ministry of Health

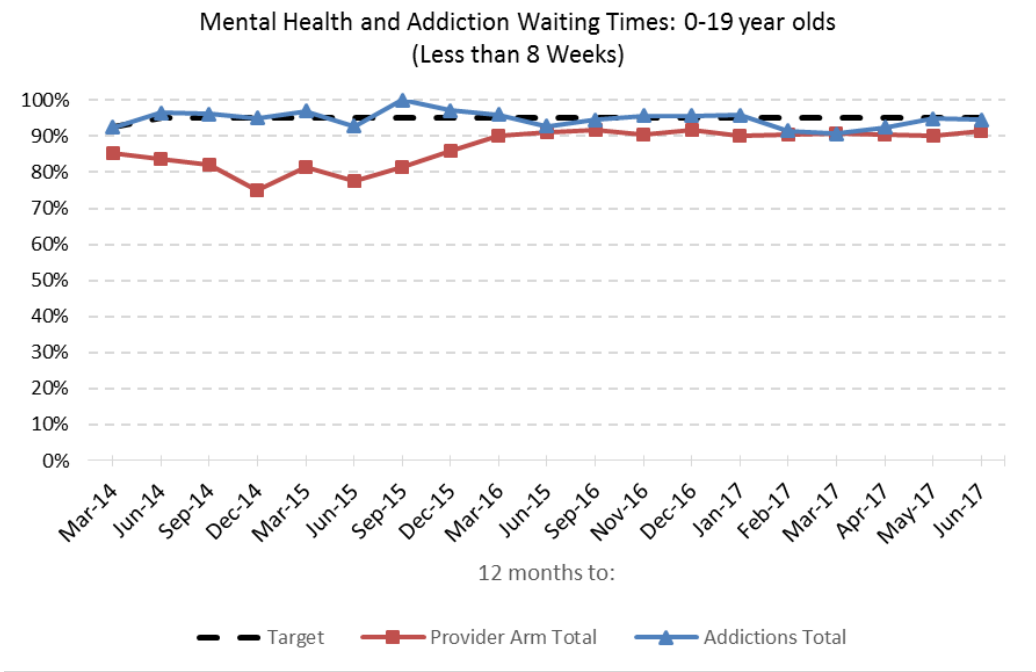
Reducing Mental Health Waiting Times: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds					
Key Performance Measures	**Baseline** [49]	**Previous result** [50]	**Actual to Date** [51]	**Target 2017/18**	**Trend direction**
Mental Health Provider Arm: Age 0-19					
<3 weeks - Total	72.3%	74.8% (U)	70.5% (U)	≥80%	▼
Maori	74.1%	78% (U)	71.8% (U)	≥80%	▼
Pacific	68.4%	72.2% (U)	61.1% (U)	≥80%	▼
Other	71.1%	72.6% (U)	70% (U)	≥80%	▼
<8 weeks – Total	81.1%	69.2% (U)	76.8% (U)	≥80%	▲
Maori	80.5%	61.5% (U)	68.8% (U)	≥80%	▲
Specific	-	0% (U)	50% (U)	≥80%	▲
Other	83.9%	83.3% (F)	90.9% (F)	≥80%	▲
Addictions (Provider Arm & NGO): Age 0-19					
<3 weeks – Total	91.7%	90.9% (U)	91.4% (U)	≥95%	▲
Maori	93.6%	92.8% (U)	92.1% (U)	≥95%	▼
Pacific	94.7%	88.9% (U)	0% (U)	≥95%	▼
Other	90.0%	89.7% (U)	90.6% (U)	≥95%	▲
<8 weeks - Total	94.6%	90.8% (U)	94.6% (F)	≥95%	▲
Maori	93.6%	92.8% (U)	92.1% (U)	≥95%	▼
Pacific	-	0% (U)	100% (F)	≥95%	▲
Other	96.8%	95.8% (F)	95.5% (F)	≥95%	▼



4912 months to December 2016

50 12 months to March 2017

51 12 months to June 2017



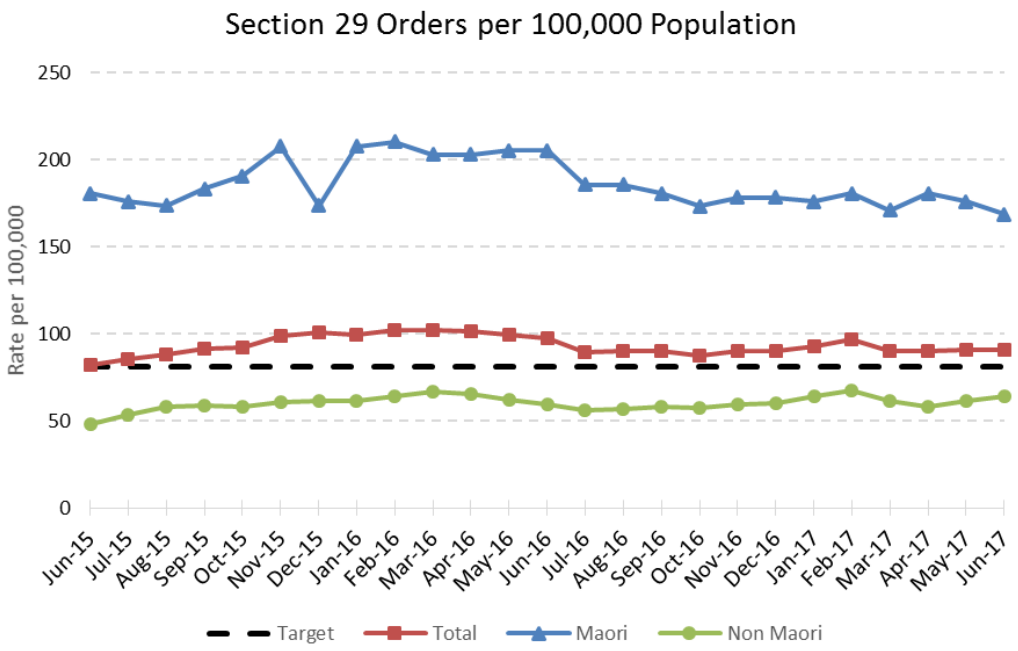
Source: Ministry of Health

Comments:

DNA's have had an impact on the wait times KPI and effort has gone into ensuring telephone contact with the family to make sure the proposed appointment time works best for the family. CAFS is conducting considerable initial appointments in settings familiar to the young person (i.e. at schools, at other agencies where the young person already has relationships). Timeliness and responsiveness are crucially affected by the match of capacity to demand. Of note, CAFS referral volumes have significantly increased since 2008, while FTE has remained stable over time (see graph below). Vacancies impact on wait times KPI, and we expect this to be seen in April – June 2017 (during which a number of vacancies were present). Recruiting in a timely manner is useful, but this needs to be balanced with getting the required skill mix. As per the data above, our youth addictions team (1.8 FTE) is showing an increase in wait times, now at 10.8% below the KPI. Analysis of specific cases indicates drivers for this include: (a) DNA's in nearly ½ cases (clinical review indicates strong follow-up) and (b) issues around data reporting (i.e., family contacts not appearing to trigger meeting the KPI), which CAFS Clinical Manager will discuss further with the health information reporting team. The data errors mean that performance is being underestimated.

More equitable use of Mental Health Act: Section 29 community treatment orders
Rate of s29 orders per 100,000 population

Ethnicity	Baseline [52]	Previous result [53]	Actual to Date [54]	Target 2017/18	Trend direction
Total	90.1	93.2 (U)	90.7 (U)	≤81.5	▲
Māori	179.9	175.9 (U)	175.1 (U)	≤81.5	▲
Other	62.1	64.6 (F)	61.5 (F)	≤81.5	▲



Comments:
We have early interventions such as Home Based Treatment, available to all ethnicities and the aim is to engage people and families early in the illness process avoiding the need for compulsory treatment wherever possible. We meet regularly with police to work together on engaging at risk people in treatment. Our Child and Adolescent team work with families, education (schools), and Oranga Tamariki to prioritise those at risk of developing serious mental illness and instituting treatment before the use of compulsory treatment becomes necessary. Te Ara ManaPou service is working with pregnant women and mothers of young children, where the woman has an addiction issues and is, for whatever reason, unwilling to engage with services. This will improve outcomes for a number of children though the reduction in needing to use compulsory treatment will not become evident for a couple of decades. The local response teams of the suicide postvention service actively reach out to those identified as being at increased risk after a suicide or serious suicide attempt with the intent of reducing serious mental health problems in those affected.

52 October to December 2016

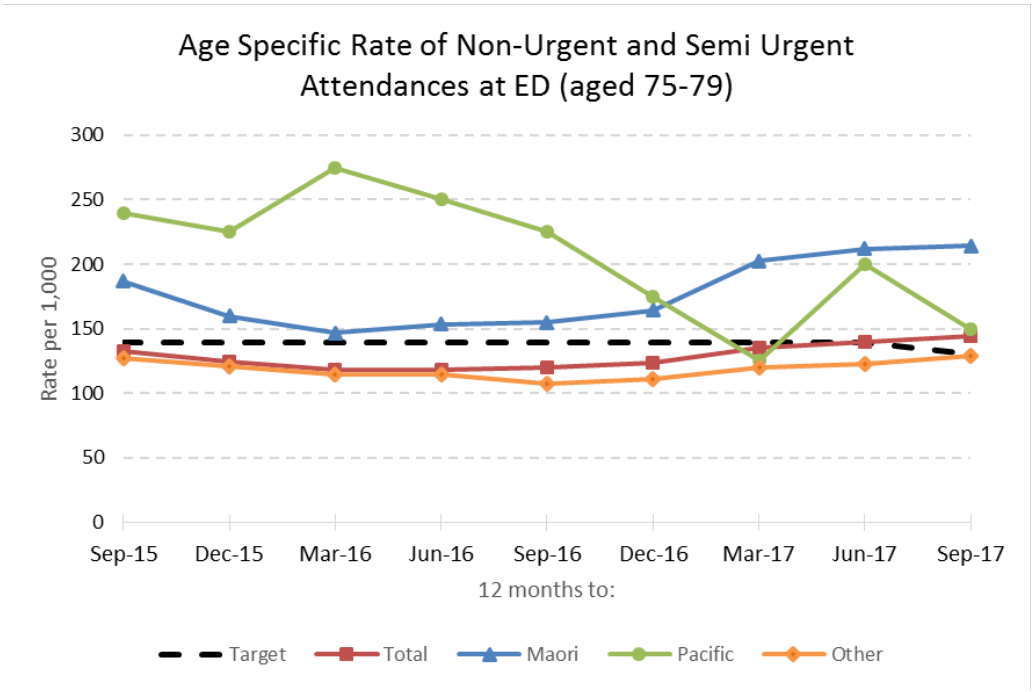
53 April to June 2017

54 July to September 2017

OUTPUT CLASS 4: Rehabilitation and Support Services

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)

Age Band	Baseline [55]	Previous result [56]	Actual to Date [57]	Target 2017/18	Trend direction
Age 75-79					
Total	124	139.4 (U)	144.5 (U)	≤130	▼
Maori	163	211.9 (U)	214.3 (U)	≤130	▼
Pacific	175	200 (U)	150 (U)	≤130	▲
Other	111	123 (F)	129.2 (F)	≤130	▼
Age 80-84					
Total	167	170.6 (U)	171.7 (U)	≤170	▼
Maori	208	179.2 (U)	162.5 (F)	≤170	▲
Pacific	300	175 (U)	175 (U)	≤170	—
Other	167	174.3 (U)	176.1 (U)	≤170	▼
Age 85+					
Total	216	216.9 (F)	222.3 (F)	≤225	▼
Maori	136	118.2 (F)	90.9 (F)	≤225	▲
Pacific	0	150 (F)	200 (F)	≤225	▼
Other	237.7	237.4 (U)	243.9 (U)	≤225	▼

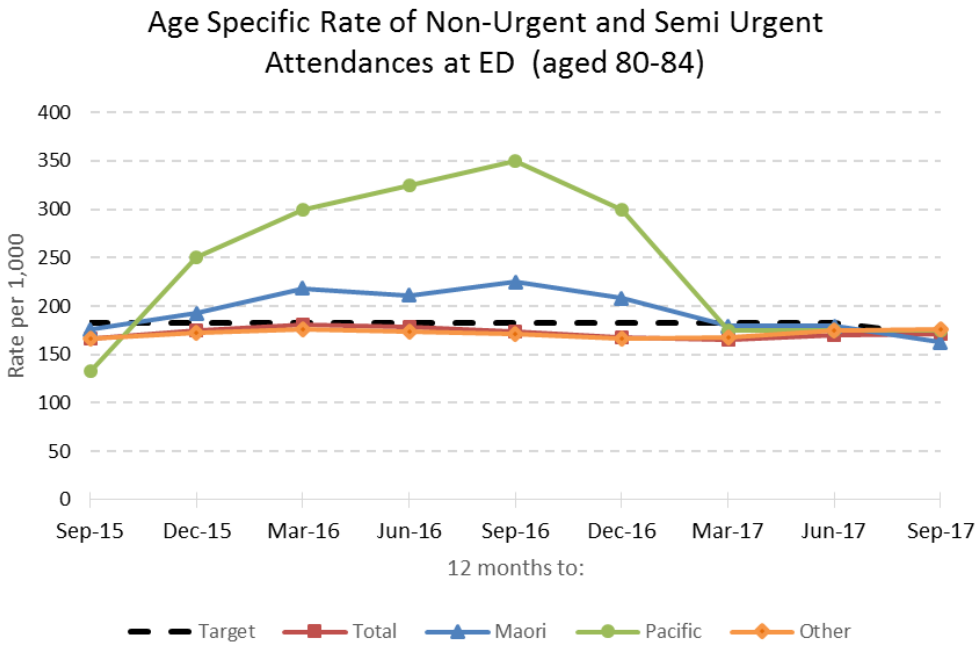


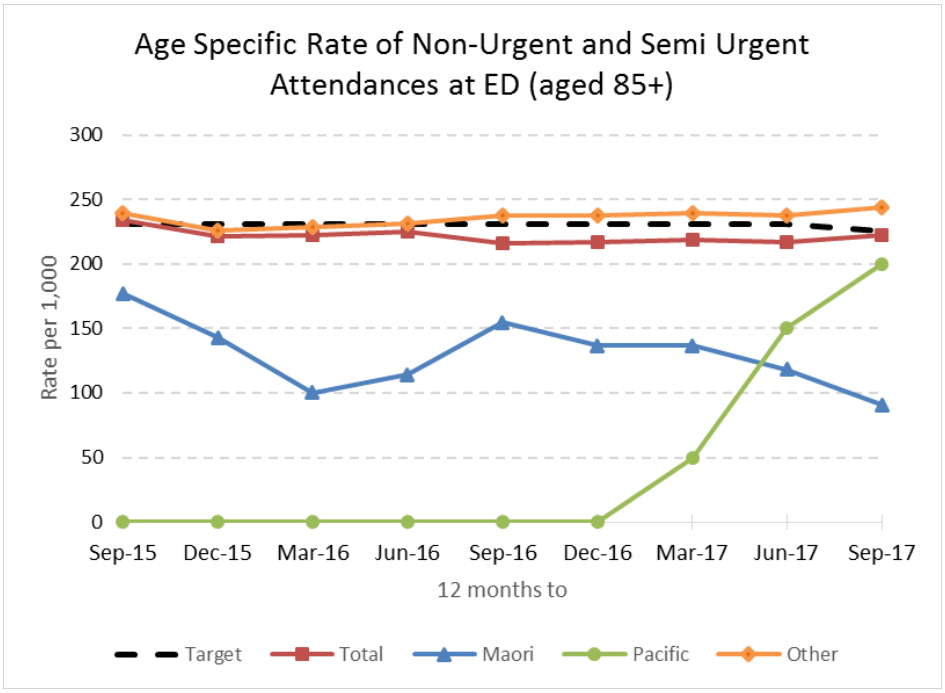
23

55 12 months to December 2016

56 12 months to June 2017

57 12 months to September 2017.





Comments:

For the Total population, age-specific rates are favourable for the oldest age group, slightly unfavourable in the 80-84 age group and significantly unfavourable in the younger age group (75-79 years). In terms of equity, Maori are most unfavourable in the 75-79 age group, while Other are most unfavourable in the 80-84 and 85+ age group. Across all age-groups Pacific are very close to the target rate. If the rates were on target, the Emergency Department would see (for the 12 months), 35 fewer Maori aged 75-79, 20 fewer Other aged 80-84 and 58 fewer Other aged 85+. During the first quarter of this year, the hospital reported periods of extreme business. Analysis during that time showed that the pressure was not disproportionate amongst older people, and the increase shown in this measure was, therefore, most likely to be due to seasonal pressures.

HBDHB PERFORMANCE FRAMEWORK RESULTS – QTR 1, 2017/18

Health Targets:	Target	Baseline	Total		Maori		Pacific		Other	
Shorter Stays in ED	≥ 95%	95%	91%		94%		95%		90%	*
Improved Access to Elective Services	≥ 100%	100%	101%	*	-	-	-	-	-	-
Faster Cancer Treatment	≥ 90%	65%	88%	*	82%	*	-	-	-	-
Increased Immunisation	≥ 95%	0%	95%		92%		100%		97%	*
Better Help for Smoker to Quit (Primary Care)	≥ 90%	99%	90%		87%		87%		93%	
Better Help for Smoker to Quit (Pregnant Women)	≥ 90%	89%	-	-	-	-	-	-	-	-
Raising Health Kids	≥ 95%	40%	95%	*	92%	*	96%	*	97%	*

Output Class 1: Prevention Services	Target	Baseline	Total		Maori		Pacific		Other	
Better Help for Smoker to Quit (Secondary Care)	≥ 95%	99%	97%	*	98%	*	100%	*	97%	*
% of 2 year olds fully immunised	≥ 95%	95%	95%		94%		97%		95%	*
% of 4 year olds fully immunised	≥ 95%	93%	94%	*	97%	*	98%		92%	
% of 65+ year olds immunised – flu vaccine	≥ 75%	62%	59%		56%		52%		60%	
Acute rheumatic fever initial hospitalisation rate per 100,000	≤ 1.5	0.0	0.6	*	-	-	-	-	-	-
% of women aged 50-69 years receiving breast screening in the last 2 years	≥ 70%	74%	73%	*	67%	*	68%	*	75%	*
% of women aged 25–69 years who have had a cervical screening event in the past 36 months	≥ 80%	77%	77%	*	74%	*	76%	*	79%	

Output Class 2: Early Detection and Management Services	Target	Baseline	Total		Maori		Pacific		Other	
% of the population enrolled in the PHO	≥ 90%	97%	97%		97%		90%		98%	
% of women booked with an LMC by week 12 of their pregnancy	≥ 80%	66%	63%		54%		38%		72%	
% of the eligible population will have had a CVD risk assessment in the last 5 years	≥ 90%	88%	88%	*	85%	*	84%	*	89%	
% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks)	≥ 95%	0%	95%		Under Development					
% of accepted referrals for MRI scans who receive their scans within 42 days (6 weeks)	≥ 90%	0%	70%	*						

Key:

Within 0.5% or Greater than Target
Within 5% of Target
Greater than 5% from Target

*	Favourable Trend from Previous Quarter

OUTPUT CLASS 3: Intensive Assessment and Treatment Services	Target	Baseline	Total		Maori		Pacific		Other	
% of high-risk patients will receiving an angiogram within 3 days of admission.	≥ 70%	72%	82%	*	80%	*	100%		-	-
% of patients undergoing cardiac surgery at the regional cardiac centres who have completion of Cardiac Surgery registry data collection within 30 days of discharge	≥ 95%	98%	91%	*	85%		100%		-	-
Major joint replacement	≥ 21	21.5	21.80	*	No Ethncity Data Available					
Cataract procedures	≥ 27	58.7	46.40							
Cardiac surgery	≥ 6.5	6.6	5.20							
Percutaneous revascularisation	≥ 12.5	13.1	12.20	*						
Coronary angiography services	≥ 34.7	39	35.11							
Length of stay Elective (days)	≥ 1.47	1.56	1.58		No Ethncity Data Available					
Length of stay Acute (days)	≥ 2.3	2.4	2.46							
% accepted referrals for elective coronary angiography completed within 90 days	≥ 95%	98%	93%		Under Development					
% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive),	≥ 90%	92%	96%							
% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)	≥ 70%	94%	81%							
% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date	≥ 70%	98%	97%							
Did not attend (DNA) rate across first specialist assessments	≤ 8%	7%	5%	*	11%	*	11%		3%	
% of 0-19 year olds seen within 3 weeks of referral: Mental Health Provider Arm	≥ 80%	72%	71%		72%		61%		70%	
% of 0-19 year olds seen within 3 weeks of referral: Addictions (Provider Arm and NGO)	≥ 80%	81%	70%		77%	*	69%	*	50%	
% of 0-19 year olds seen within 8 weeks of referral: Mental Health Provider Arm	≥ 95%	91%	91%	*	93%	*	0%		96%	*
% of 0-19 year olds seen within 8 weeks of referral: Addictions (Provider Arm and NGO)	≥ 95%	95%	95%	*	92%		100%		96%	
Rate of s29 orders per 100,000 population	≤ 81.5	90.1	90.70	*	175.1		-			

OUTPUT CLASS 4: Rehabilitation and Support Services	Target	Baseline	Total		Maori		Pacific		Other	
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 75-79 years	≤ 130	124	144.50		214.30		150.00	*	129.30	
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 80-84 years	≤ 170	208.3	171.70		162.50	*	175.00		176.10	
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 85+ years	≤ 225	216.6	222.30		90.90	*	200.00		243.90	
% of older people who have received long-term home and community support services in the last three months who have had an interRAI Home Care or a Contact assessment and completed care plan	≥ 95%	100%	100%		No Ethnicity Data Available					
Clients with a CHESS score (Change in Health, End-stage disease, signs and symptoms) of 4 or 5 at first assessment	≤ 14%	10%	8%	*						
Time from referral receipt to initial Cranford Hospice contact within 48 hours	≥ 80%	100%	98%	*						
% of older patients given a falls risk assessment	≥ 90%	97%	100%	*						
% of older patients assessed as at risk of falling receive an individualised care plan	≥ 98%	98%	99%	*						

Non Reported in Q1

Number of babies who live in a smoke-free household at six weeks post natal	≥ -	Waiting for Data from MoH
% of pregnant women who are smokefree at 2 weeks postnatal	≥ 95%	
% of girls fully immunised – HPV vaccine	≥ 75%	Reported in Q4
% of infants that are exclusively or fully breastfed at 6 weeks	≥ 75%	Waiting for Data from MoH
% of infants that are exclusively or fully breastfed at 3 months	≥ 60%	
Ambulatory sensitive hospitalisation rate per 100,000 0-4 years	-	Reported in Q2 and Q4
Ambulatory sensitive hospitalisation rate per 100,000 45-64 years	-	
% of eligible pre-school enrolments in DHB-funded oral health services	≥ -	Reported in Q3
% of children who are carries free at 5 years of age	≥ -	
% of enrolled preschool and primary school children not examined according to planned recall	≤ -	
% of adolescents(School Year 9 up to and including age 17 years) using DHB-funded dental services	≥ -	
Mean 'decayed, missing or filled teeth (DMFT)' score at Year 9	≤ -	
Proportion of people with diabetes who have good or acceptable glycaemic control (HbA1C indicator)	≤ 65%	Reported in Q2 and Q4
% of potentially eligible stroke patients who are thrombolysed 24/8	≥ 8%	
% 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	≥ 80%	
Acute readmissions to hospital	≤ TBC	Under Development
Proportion of the population seen by mental health and addiction services: Child & Youth (0-19)	0%	Reported in Q2 and Q4
Proportion of the population seen by mental health and addiction services: Adult (20-64)	0%	
Proportion of the population seen by mental health and addiction services: Older Adult (65+)	0%	
% of clients discharged will have a quality transition or wellness plan	≥ 95%	Under Development
Acute readmission rate: 75 years +	≤ -	Under Development
Number of day services	≥ -	Awaiting Data

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

Monitoring Status Standard Monitoring

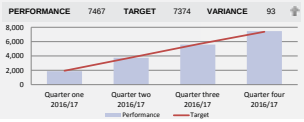
HEALTH TARGETS

Shorter Stays in Emergency Departments

PERFORMANCE 95% TARGET 95% CHANGE 1.1%

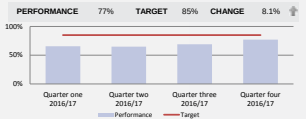
Improved Access to Elective Surgery

PERFORMANCE 7467 TARGET 7374 VARIANCE 93



Faster Cancer Treatment

PERFORMANCE 77% TARGET 85% CHANGE 8.1%

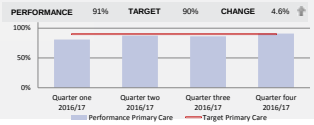


Increased Immunisation

PERFORMANCE 95% TARGET 95% CHANGE 0.6%

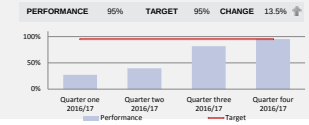
Better Help for Smokers to Quit

PERFORMANCE 91% TARGET 90% CHANGE 4.6%



Raising Healthy Kids

PERFORMANCE 95% TARGET 95% CHANGE 13.5%



IMPROVING SYSTEM INTEGRATION

Service Reconfiguration

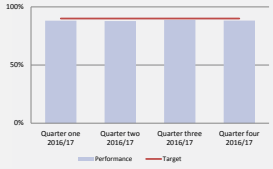
The DHB reports that it has key practices signed up to implement the integration suite of services including clinical pharmacy facilitators, district nursing and ENGAGE.

System Level Measures

Improvement Plans

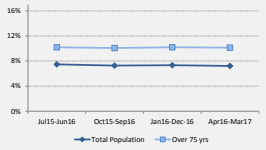
- Ambulatory sensitive hospitalisations per 100,000 for 0-4 years old
- Acute hospital bed days per capita
- Patient experience of care
- Amenable mortality rates

More Heart and Diabetes Checks

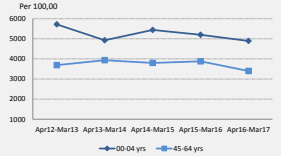


OWNERSHIP VIEW

Acute Readmission Rates (standardised)



Ambulatory Sensitive Hospitalisation Rates



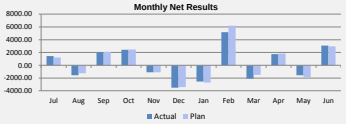
FINANCIAL MANAGEMENT

Financial Performance Rating: Close Watch

NET RESULT: YTD-Jun 2017

Actual	Plan	Variance
3,568	5,000	(1,432)

Monthly Net Results



PROGRESS AGAINST LOCAL ACTIONS AS DEFINED IN THE DHB ANNUAL PLAN

IMPROVED MANAGEMENT FOR LONG TERM CONDITIONS

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

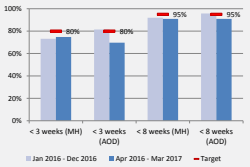
IMPROVING WRAP AROUND SERVICES – HEALTH OF OLDER PEOPLE

Immunisation Coverage

	Goal	Performance
Immunisation coverage at 2 and 5 years of age		
Immunisation coverage at 2 years of age	95%	95%
Immunisation coverage at 5 years of age	95%	93%
Human papillomavirus immunisation	70%	66%

Mental Health

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



WAITING TIMES

Diagnostic waiting times

	Goal	Performance
Coronary angiography (<90 days)	95%	97.2%
Radiology		
CT Scan (<42 days)	95%	95.1%
MRI Scan (<42 days)	85%	69.7%

	Goal	Performance
Colonoscopy		
Urgent colonoscopy (<14 days)	85%	100.0%
Non-urgent colonoscopy (<42 days)	70%	95.7%
Surveillance colonoscopy (<84 days)	70%	98.6%

Patients Waiting For FSA and Treatment

PATIENTS WAITING FOR FSA

	Apr	May	Jun	last mnth	3 mnths
ESPI 2	46	71	76	5	30
ESPI 2 %	1.4%	2.3%	2.6%	0.4%	1.2%

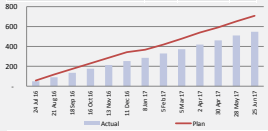
PATIENTS WAITING FOR TREATMENT

	Apr	May	Jun	last mnth	3 mnths
ESPI 5	35	33	6	-27	-29
ESPI 5 %	3.2%	3.1%	0.5%	-2.6%	-2.7%

Regional Provision Cardiac Surgery Delivery

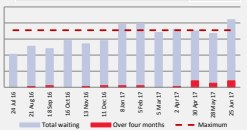
REGIONAL DELIVERY - CAPITAL & COAST DHB OF SERVICE

PERFORMANCE AGAINST PLAN 77% VARIANCE -161



WAITING LIST - CAPITAL & COAST DHB OF SERVICE

TOTAL REGIONAL WAITING LIST	84
% OF NATIONAL WAITING LIST	29%



SERVICE COVERAGE DELIVERY

This quarter the DHB provided an update on local data sharing to support clinical involvement in improving health target performance and also reported on progress re reducing unintended teenage pregnancy.

REGIONAL SERVICE DELIVERY

Quarter four 2016/17

Overall Performance

National Priorities

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

Information Technology Critical Priorities

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

Health Workforce Regional Actions against Workforce Plan

Regional Quality and Safety

CROSS-AGENCY PRIORITIES

Rising to the challenge

- Primary mental health
- District Suicide Prevention and Postvention

Reducing Rheumatic fever

Supporting vulnerable children

Quality and Safety Markers

	Goal	Performance
Falls risk assessment (Jan-Mar17)	90%	93%
Hand hygiene (Jan-Mar17)	80%	89%

	Goal	Performance
Surgical site infections (Oct-Dec 2016):		
Antibiotic administered in the right time	100%	100%
Patients receive cefazolin or cefuroxime	95%	98%

Regional Performance Highlights

The Central region received achieved ratings for eight out of eleven of its national priorities in Q4, no significant change since the last quarter.

For Mental Health and Addictions Services, the region has made good progress in completing 10 of the planned projects. There is good data supporting the Q4 report and the work being undertaken by the region.

There continues to be good progress in implementing integrated hepatitis C treatment and assessment services across the Region.

For Workforce, notable progress has occured over the year and there is good regional cooperation as well as inter-regional work. Activities that have not been started yet will be carried over into the 2017/18 plan.

For IT Services, the region continues to make good progress on the delivery of the components of the RHIP programme with planned activities continuing into 2017/18. The New Regional ICT Operating, Governance and Service Model has been approved and is being implemented and the funding pathway has been agreed for 2017/18.

Regional Performance Issues

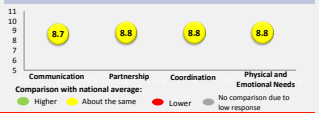
There are good efforts made by the region in assisting HVDHB and HBDHB to improve their Faster Cancer Treatment health target achievement, including increasing clinical engagement. Further work is required however to reach the 90% target.

For Cardiac ACS Services, the Central region performance for indicator 1 was 80.9% and for indicator 2 was 86.9% - a drop in the indicator 2. The regional Cardiac Network have liaised with NMDHB and this issue is expected to be resolved soon.

For Cardiac Secondary Services, the number of patients waiting for cardiac surgery in the region has been above the maximum number expected for 9 out of 13 weeks in Q4. Actual delivery of cardiac surgery procedures remains considerably below plan (-161), and intervention rates for angiography and cardiac surgery remain low. The Ministry acknowledges the work the region has undertaken and look forward to seeing an improvement in future quarters.

All DHBs in the region met their Elective health targets for 2016/17, most DHBs did not fully meet their targets for the extra discharges funded by the additional orthopaedic and general surgery funding. The partially achieved rating is also due to waiting times performance for April and May. The Ministry looks forward to an improvement in 2017/18.

Patient Experience



PERFORMANCE HIGHLIGHTS

Congratulation to the DHBs for having achieved five out of six health targets this quarter.

Good financial performance with unaudited surplus of $3.6 million despite additional costs incurred from the RMO strike and gastroenterology outbreak.

PERFORMANCE ISSUES

The number of patients waiting for Cardiac Secondary Services was above the target maximum number at the end of 2016/17. July and August 2017 results show significant improvement in the numbers waiting for surgery, and that the DHB is now meeting the maximum waiting list expectation.

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

People-Powered
The Oncology project, looking at improving local oncology services has begun with current work streams involving significant consumer and staff feedback

Closer to Home
The Hawke's Bay Intersectoral group Social Inclusion Draft Strategy has now gone through consultation, ready for an action plan to be developed

Value and High Performance
100% of community pharmacies have signed up to the new National Pharmacy contract.

One Team
Primary Care ED Co-Operative Programme (PCED) is progressing to assist key general practices to develop and implement a new multidisciplinary model of care for high users of ED.

Smart System
The pilot Medtech Manage My Health (this portal allows GPs to share relevant patient records with district nurses) has been evaluated and is now ready for roll out across further practices.

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

People-Powered
Health of Older People:
The region is taking a co-design approach in the development of dementia friendly Health of Older People webpages on their DHB sites.
Mental Health and Addiction:
Regional forums will include speakers from lived experience, primary care, NGO and DHBs.

Closer to Home
Health of Older People:
Advance care planning (ACP) training for health professionals delivered for Level 1A and Level 2 to support those with long term conditions to write their own ACPs.
Mental Health and Addiction:
Residential AOD model of care continues to be embedded providing a community based model.

Value and High Performance
Health of Older People:
Use of interRAI Home Care data within the region to benchmark DHBs performance over a rolling 18 month period to create conversations for improvement.
Mental Health and Addiction:
Scoping work resulting in identifying regional priority areas.

One Team
Health of Older People:
The Region's Benchmarking group and Regional Medical Leaders are collaborating re the National interRAI service to make information more clinically relevant and available to in-hospital health professionals
Mental Health and Addiction:
Alignment of regional and national workforce plans will indicate the best way the sector can work together to enhance workforce development.

Smart System
Mental Health and Addiction:
Working in collaboration with the Ministry of Health to enable using access data for eating disorder services from 3 different areas; PRIMHD, NMDS and local community team data has commenced. This will enable a whole system view of access to eating disorder services within the region.

How to read this dashboard

This dashboard shows a summary of most aspects of DHB performance. It combines indicators of DHB performance, as agreed in the 2016/17 Annual Plan, as well as complementary information such as financial net results, hospital indicators and other priorities. The structure has been designed to display DHB information using an 'at-a-glance' approach. It is not to be used for general publication. It groups information according to the following areas:

Health targets	Shows the progress made by the DHB against the health targets. The top bar chart show relative performance to target for each measure, while the time series charts absolute performance throughout the year.
Improving System Integration	This area displays information related to the progress DHBs are achieving in the implementation of the System Integration Programme.
Waiting Times	This area summarises an array of indicators that show DHB progress towards reducing waiting times.
Other Priorities	Emerging priorities such as the District Suicide Prevention and Postvention.
Service coverage	Self-reported confirmation & exception report. DHBs must ensure service coverage expectations are met, or demonstrate resolution of service coverage gaps by providing an appropriate resolution plan, and adequate progress is being made against the resolution plan.
Financial Management	Overview of the financial performance of the DHB based on data provided by the DHBs in monthly financial templates.
Regional Service Delivery	A qualitative and quantitative assessment of a progress report on behalf of the region agreed by all DHBs within that region. The report focuses on the actions agreed by each region as detailed in its RSP implementation plan.

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

Acute readmissions rates *	Acute readmission rates are defined as the number of unplanned acute readmissions to hospital within 28 days of a previous inpatient discharge that occurred within the 12 months to the end of the quarter, as a proportion of inpatient discharges in the 12 months to the end of the quarter. The rates are standardised by patient population characteristics, deprivation, rurality, patient health conditions, comorbidity and surgery, using national patient population as a 'standard'. Indirect standardisation using logistic regression method is applied to derive the rates.
Alcohol and drugs waiting times: * Child and Youth aged 0-19 years	Waiting times are measured from the time of referral for treatment to the first date the client is admitted to treatment, following assessment in any service whether it be NGO or provider arm.
Ambulatory sensitive hospitalisations (ASH) *	Ambulatory Sensitive Hospitalisations (ASH) result from diseases and conditions sensitive to prophylactic or therapeutic interventions deliverable through primary care and are, therefore, avoidable. The ASH rates are derived by the total number of 12-month ASH for DHB patients aged 0-4 and 45-64 as the numerators and the same age population of the DHB as the denominators respectively. Rates for 45-64 age group are age standardised using national population as a standard. Given that this meassure is in transition period from old to new definition, performance ratings on this measure are not shown in this quarter.
Delivery of the New Zeeland Health Strategy	All DHBs made strong commitments to the New Zealand Health Strategy in their annual plans. Each DHB and region has highlighted an action or initiative that provides an example of activity in the quarter in relation each strategy theme.
Diagnostic waiting times	Performance against the waiting time indicators for Coronary Angiography, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), and Colonoscopy.
District suicide prevention and postvention	Progress against the agreed 2015-2017 Suicide Prevention Plan is reported by describing highlights, exceptions and milestones for three of the actions, and noting any completed actions.
Human papillomavirus immunisation	Percentage of eligible girls fully immunised with human papillomavirous (HPV) vaccine. For 2016/17 the measure is the 2003 birth cohort measured at 30 June 2017. This measure is reported yearly in quarter four.
Immunisation coverage at 2 and 5 years of age	The percentage of children who have completed their age-appropriate immunisations by the age of 2 years and by the age of 5 years. The rating - indicated by the traffic light colour - is based on performance for both the 2- and 5-year-old milestones.
Improved management for long term conditions	DHBs are expected to report on delivery of the actions and milestones as identified in the 2016/17 annual plans for long term conditions (LTC), diabetes services, cardiovascular (CVD) health, acute heart service and stroke services.
Improving wrap around services -Health of Older People	DHBs are expected to report on delivery of the actions and milestones as identified in the 2016/17 annual plans for health of older people services including home and community support services, InterRAI, dementia care pathways, HOP specialists and fracture liaison services.
More heart and diabetes checks	Proportion of the eligible adult population that have had their cardiovascular disease risk assessment in the last five years. The population are PHO enrolled adults.
Patient Experience	Average rating out of 10 for inpatient experience across the four domains of communication, partnership, coordination of their care, and having physical and emotional needs met, based on results from the national patient experience survey. The survey covers patients in hospital during the second month of each quarter.
Patients waiting for FSA (ESPI 2)	The total number on the waiting list waiting longer than four months for a first specialist assessment (FSA) for the last three months, and the number waiting as a % of the total list. ESPIs are the set of elective services patient flow indicators.
Patients waiting for treatment (ESPI 5)	The total number on the waiting list waiting longer than four months for treatment for the last three months, and the number waiting as a % of the total list. ESPIs are the set of elective services patient flow indicators.
Primary mental health	This measure is to monitor access to evidence-informed psychological therapies for mental health and additions issues in primary care.
Quality and Safety Markers	Progress toward the markers set by the Health Quality and Safety Commission. These include older patients receiving a falls assessment, compliance with good hand hygiene practice, and two surgical site infection measures: hip and knee replacement patients receiving 2g or more of cephazolin and antibiotic administered in the right time.
Reducing rheumatic fever *	A progress report against the DHB's rheumatic fever prevention plan (the regional plan for the South Island), plus hospitalisation rates per 100,000 DHB total population for acute rheumatic fever are 40% reduction from baseline (2009/10-2011/12).
Regional delivery - cardiac	Regional cardiac provider delivery against plan. DHBs submit four-weekly reports.
Supporting vulnerable children	Actions or initiatives to reduce deaths and hospitalisations due to assault, neglect or maltreatment of children and young people.
Waiting list - cardiac	Regional cardiac provider total waiting list against the waiting list target including those waiting over four months. Proportion of regional to national waiting list. DHBs submit four-weekly reports.

Performance highlights	Brief analysis of areas where a DHB is performing above expectations by achieving/exceeding a performance expectation, making significant progress from their base position, or implementing/leading an innovation process that will lead to performance improvement.
Performance issues	Brief analysis of areas where a DHB is performing below expectations, and actions being taken to resolve the issue(s)

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

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

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

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

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

HAWKE'S BAY District Health Board Whakawāteatia	**Wairoa Health Centre: Leases to Wairoa Medical Centre & Queen Street Practice: Lease Term > 5 Years** 145
	For the attention of: **HBDHB Board**
Document Owner: Document Author:	Claire Caddie, Service Director, Community, Women & Children Andrea Beattie, Property & Service Contracts Manager
Reviewed by:	Kuini Puketapu, Wairoa Health Centre Manager and the Executive Management Team
Month:	November, 2017
Consideration:	For Decision

RECOMMENDATION

That the Board

1. **Approves** the proposed leases (with a total lease term of 6 years) for Wairoa Medical Centre and Queen Street Practice, to lease space in the Wairoa Health Centre.

2. **Notes** that these leases will require the written approval of the Minister of Health prior to execution.

OVERVIEW

Approval is sought from the Board to enter into two leases on the Wairoa Health Centre, both with terms in excess of 5 years. Under section 43 (2) of Schedule 3 of the Public Health and Disability Act 2000, any lease over 5 years duration (including renewals) requires the prior written approval of the Minister of Health.

BACKGROUND

In 2013 HBDHB constructed the Wairoa Integrated Family Health Facility at Wairoa Hospital. This comprised purpose built GP practice rooms and associated support spaces.

The Wairoa Medical Centre were already on the Health Centre campus, and moved into the new GP practice rooms in 2013.

It is proposed the Queen Street Practice will relocate to the Health Centre campus in February 2018.

The proposed leases are for terms of 2 years, with 2 rights of renewal of 2 years each, making a total of 6 years.

FINANCIAL IMPLICATIONS AND OTHER KEY ISSUES

The commencement rentals for the leases have been agreed for the Wairoa Medical Centre, and for Queen Street Practice. On top of this, both tenants will pay a contribution towards the overall operating expenses for the Health Centre.

The proposed leases have been prepared by Buddle Findlay.

HAWKE'S BAY
District Health Board
Whakawāteatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

26. Confirmation of Minutes of Board Meeting
    - Public Excluded

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

28. Board Approval of Actions exceeding limits delegated by CEO

29. Chair's Update

30. Finance Risk and Audit Committee Report

31. Big Listen Feedback

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).