# BOARD MEETING

**Date:** Wednesday, 31 May 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

**Apology:** -

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

**Board Administrator:** Brenda Crene

**Public Agenda**

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

| | | | |
|---|---|---|---|
| 8. | Chief Executive Officer's Report | 46 | |
| 9. | Financial Performance Report | 47 | |
| 10. | Board Health & Safety Champion's Update (verbal) – Dr Helen Francis | | |
| 11. | Consumer Story (verbal) - Kate Coley | | |
| | **Section 2: Reports from Committee Chairs** | | |
| 12. | HB Clinical Council – Co-Chairs Chris McKenna & Dr Mark Peterson | 48 | 1.50 |
| 13. | HB Health Consumer Council – Chair, Graeme Norton | 49 | 2.00 |
| 14. | Maori Relationship Board – Chair, Ngahiwi Tomoana | 50 | 2.10 |
| | **Section 3: Decision** | | 2.20 |
| 15. | NZ Health Partnerships Ltd SOI and Annual Plan – Ken Foote | 51 | 2.30 |
| | **Section 4: Discussion / Information** | | |
| 16. | Health Literacy Principles and Implementation Approach – Kate Coley | 52 | 2.35 |
| 17. | Best Start Healthy Eating and Activity Plan update – Tracee TeHuia / Shari Tidswell | 53 | 2.50 |
| | **Section 5: Monitoring** | | |
| 18. | HBDHB Non-Financial Exceptions Report Q3 Jan-Mar 2017 – Tim Evans | 54 | 3.00 |
| 19. | Annual Maori Health Plan Dashboard Report for Q3 (Jan-Mar 2017) – Tracee TeHuia | 55 | 3.10 |
| 20. | HR KPIs Q3 Jan-March 2017 – Kate Coley | 56 | 3.20 |
| 21. | Te Ara Whakawaiora / Access 45-64 years *(Revised)* – Dr Mark Peterson | 57 | 3.30 |
| | **Section 6: General Business** | | |
| 22. | **Section 7: Recommendation to Exclude the Public** | | |
| | Under Clause 32, New Zealand Public Health & Disability Act 2000 | | |

**Public Excluded Agenda**

| Item | Section 8: Agenda Items | Ref # | Time (pm) |
|---|---|---|---|
| 23. | Minutes of Previous Meeting | | |
| 24. | Matters Arising – Review of Actions | | |
| 25. | Board Approval of Actions exceeding limits delegated by CEO | 58 | - |
| 26. | Chair's Update | | |
| 27. | Cranford Hospice (verbal update) – Ken Foote | | 3.40 |
| | **Section 9: Reports from Committee Chairs** | | |
| 28. | Finance Risk & Audit Committee – Chair Dan Druzianic | 59 | 3.55 |

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATETIRA PARTNERSHIP
TAUWHIRO CARE

**The next HBDHB Board Meeting will be held at 1.00pm on Wednesday 28 June 2017**

## Board "Interest Register" - 9 May 2017

| Board Member Name | Current Status | Conflict of Interest | Nature of Conflict | Mitigation / Resolution Actions | Mitigation / Resolution Actions Approved by | Date Conflict Declared |
|---|---|---|---|---|---|---|
| Kevin Atkinson (Chair) | Active | Chair of Unison Networks Limited | Potential Conflict of Interest. Non-Pecuniary interest.<br>Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB. Unison leases 3 generators which are located at Hawke's Bay Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines. | Will not take part in any decisions or discussions in relation to HBDHB electricity contracts.<br>Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation. | Chair of FRAC | 18.02.09 |
| | Active | Director of Unison Fibre Limited | Non pecuniary interest. Unison is now a provider of high speed broadband to the District Health Board. | Will not take part in any decision or discussions in relation to the provision of high speed broadband to the District Health Board | The Chair of FRAC | 17.11.10 |
| | Active | 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 | The Chair of FRAC | 22.02.17 |
| Ngahiwi Tomoana (Deputy Chair) | Active | Chair, Ngati Kahungunu Iwi Incorporated (NKII) | Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB:<br>(i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department.<br>(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.<br>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.<br>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 |
| Dr Helen Francis | Active | Alzheimer's Napier previously a Committee member<br><br>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<br><br>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.<br>Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation. | The Chair | 03.10.11 |
| | Active | HB Medical Research Foundation | Trustee | Declare this interest prior to any discussion in relation to the Foundation, and an appropirate mitigation action is decided on. | The Chair | 20.08.14 |
| Diana Kirton | Active | Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB. | Perceived Conflict of Interest. Non-Pecuniary interest. | Will not take part in any decisions in relation to surgical services provided by or contracted by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO | The Chair | 18.02.09 |

| Board Member Name | Current Status | Conflict of Interest | Nature of Conflict | Mitigation / Resolution Actions | Mitigation / Resolution Actions Approved by | Date Conflict Declared |
|---|---|---|---|---|---|---|
| | Active | Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014 | Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers. | Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on. | The Chair | 16.01.14 |
| | Active | 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.<br>Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation. | The Chair | 03.10.14 |
| Dan Druzianic | Active | Director of Markhams Hawke's Bay Limited | Potential Conflict of Interest. Some clients may from time to time be employed by or have contracts with HBDHB | Declare an interest at any time an issue arises concerning a client, and take no further part in any decision or discussion on this matter. | The Chair | 7.12.10 |
| 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<br>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<br><br>25.03.15<br>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) | 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 26 APRIL 2017, IN THE TE WAIORA ROOM,**
**DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS**
**AT 1.02PM**

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

**Apology** Dan Druzianic

**In Attendance**: Kevin Snee (Chief Executive Officer)
Members of the Executive Management Team
Chris McKenna (Co-Chair, HB Clinical Council)
Graeme Norton (Chair, HB Health Consumer Council)
Dr Russell Wills, Acting CMO
Brenda Crene, Board Administrator
Members of the public and media

**KARAKIA**

Ngahiwi Tomoana opened the meeting with a Karakia.

**APOLOGY**

Apology received from Dan Druzianic was noted.

**INTEREST REGISTER**

No changes to the interests register were advised.

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

**CONFIRMATION OF PREVIOUS MINUTES**

The minutes of the Board meeting held on 29 March 2017, were confirmed noting a minor spelling correction to the last page of the minutes.

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

**MATTERS ARISING FROM PREVIOUS MINUTES**

Item 1: Interest Register changes made. Remove action.

Item 2: Board Health and Safety Review provided to this meeting as an agenda item. Remove action.

Item 3: The Consumer feedback system actions conveyed by board members in March, had been noted by ED Quality & People, for future consideration.

It was requested that the Te Reo badges be considered as soon as possible.

Item 4: Chaplaincy Services

Facilitate opportunity for Rev Barbara Walker to speak to the Council(s). This item will remain as an action.

**BOARD WORK PLAN**

The Board Work Plan was noted with the following changes conveyed.

Tim Evans advised he was now the lead for **Briefing GP services in Wairoa** and this process may be delayed. He advised also that **Renal Services** Report required a lot more work – and will likely be delayed (from June).

Tim also conveyed that the **Clinical Services Plan** would be delayed due to financial constraints, and not be presented to the Board in May as scheduled. Wrapped up in this Plan is Renal/dialysis services (including Wairoa). It was advised there was a real commitment to Wairoa however as advised, the report was far from adequate and silent on Wairoa. Separate discussions would be held with Leigh White (for Long Term Conditions which Renal falls under); and Sharon Mason will have further discussions around "Renal House" in Wairoa to see if some traction can be made.

Concern was expressed by the Board that there appeared to be a common theme around emerging health service delays for the Wairoa community. Hine Flood had been challenged by Wairoa residents and was concerned about the lack of communication on health matters. The Board concurred as Renal/dialysis matters for Wairoa in particular, had been on the radar for some time.

The board were advised more detailed work was required and management wished to ensure solid recommendation(s) were put forward.

Tim Evans then confirmed that the **GP Services Briefing** would remain on the Board agenda for May.

Hine Flood suggested we need more focus on maximising opportunities, as well as the need to provide communication to the residents of Wairoa on health matters for their community.

Concern was raised regarding a February board action which sought a presentation on "**Vulnerable Children**" in April (this month), which had been delayed until August!

**Action: The detailed workplan will amended accordingly to reflect the noted changes.**

**CHAIR'S REPORT**

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

| Name | Role | Service | Years of Service | Retired |
|---|---|---|---|---|
| Margaret Sutherland | Duty Manager | Operations Directorate | 40 | 5 April 2017 |

- The $2 billion pay equity settlement covering five years had been announced. This will have a significant impact within the health sector and will form part of the budget to be announced in May.
- A thank you letter had been received by the Board (from Rev Barbara Walker and Colleen Kaye) to thank them for the opportunity provided to the Chaplaincy Services to address them at the Board Meeting in March.

- A letter had been received from Peter Anderson, Chair of NZ Health Partnerships Ltd) advising he was wishing to meeting the HBDHB Board (and the other 19 boards) over the next 18 months.

  **Action: Ken Foote to respond to Peter Anderson, Chair NZHPL**

- A request had been received from Craig Little for an HBDHB nomination for the Wairoa District Council's Community Partnership Committee. Te Pare Meihana had been nominated to attend the nine meetings held in Wairoa each year. It is likely that Kevin Snee and/or Kevin Atkinson will attend two of these meeting per year, during their planned six monthly visits to lift our visibility/presence in Wairoa.

**CHIEF EXECUTIVE OFFICER'S REPORT**

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

- The major focus of his report related to finance for the balance of the financial year to June 2017, stressing this was not about stopping work in particular areas, but delaying to enable us to get back on track to achieve a reasonable surplus.
- On a positive note, HBDHB were the best DHB in country for Hand Hygiene, thanks to nursing and clinical staff for this excellent result.
- Performance Measure Indicators were conveyed to the meeting including: shorter stays in ED; Improved access to Elective Surgery (struggling to get over 100%); and Faster Cancer Treatment. The latter was discussed in detail at the FRAC meeting.

**FINANCIAL PERFORMANCE REPORT**

The Financial report for March 2017, showed an adverse variance of $.6m (for the month) with a cumulative adverse variance of $1.8 million (year to date) which is significant. However the forecast surplus of $4.5m remains as the DHB are hopeful of support from the Ministry of Health for one off costs associated with the Gastroenteritis outbreak in August 2016.

Despite the analysis in February, that much of that month's pressure was one-off, it became clear that underlying pressures would drive further adverse results unless firm actions are taken. Staff have been briefed and are supportive of the 10 week window to minimise this adverse trend which has resulted in budgetary rules being put in place to curb the overspend.

Comments noted in addition to the report included:

The Board advised they were appreciative of management's response and were pleased that staff had been engaged.

Any flow on effect of current pressures is difficult to assess given that funding envelope has yet tobe received from the MoH for the 2017/18 financial year.

**Action for Communications to consider:** It was noted that some in the HB community do not understand why we focus on making surpluses. We we must reinforce to the public the reasons as this is used to fund capital projects (eg, the mental health unit; Wairoa health centre and upgrade to the Napier health centre; new maternity wing; new renal unit to name a few), to replace aging equipment and to enhance services.

**BOARD HEALTH & SAFETY RESPONSIBILITIES**

Following on from an active discussion around the boards overall responsibilities towards health and safety, it was decided to put in place a rotational schedule, with two members working together for overlapping periods of six months.

**RECOMMENDATION**

**That the Board:**

- **Endorse** the recommendation to rotate the Health and Safety Board Champion role across Board members
- **Note** the key pieces of work to be undertaken in the next 6 – 12 months

**Approved**

There was brief discussion but no decision around "Board Health and Safety Champion Updates" in future being on the FRAC agenda.

**Action:** **Ken Foote to prepare a rotational schedule for Board Health and Safety reporting going forward, commencing with Helen Francis (potentially for a nine month period to effect the first rotational overlap).**

**CONSUMER STORY**

Kate Coley relayed a positive story about a patient who was airlifted from Wairoa Hospital to Hastings Hospital. The consumers experience was shared which was one of gratitude to all concerned for the impressive delivery of care and treatment.

## REPORT FROM COMMITTEE CHAIRS

### Hawke's Bay Clinical Council

Dr Russell Wills, as member of Clinical Council spoke to the report which included the endorsement of the implementation phase of the **Clinical Council Governance Structure**. This would result in development (through those committees and their relevant advisory groups), of a new Clinical Council Dashboard.

Although yet to meet the respective advisory group chairs, Russell advised there was an opportunity here to recruit leadership talent across all groups! There will be 24 committees/advisory groups, and a need to ensure secretarial services will be available in July 2017.

Each committee will have performance measures. These measures will be designed with the respective chairs (taking some time). Attached to this would be the quality dashboard which will be advantageous for Council and ultimately the Board.

The Hawke's Bay Nursing & Midwifery Leadership Council Report contains a Dashboard which was referred to as an excellent example and one the clinical governance groups should take note of when developing their respective measures.

Other reports reviewed by Clinical Council included: Health & Social Care Localities update; Te Ara Whakawaiora – acute cardiovascular national indicator report; HB Radiology Service Committee Report; Laboratory Services Committee Report as well as a Rheumatic Fever update.

**Rheumatic Fever target**: Russell advised there have been no program failures related to Rheumatic fever, that the unusual cases which surfaced related to older teenagers in high decile Havelock North schools. We are successfully preventing Rheumatic Fever in low decile schools with the current programme.

The MoH will not continue to fund this program past 1 July 2017, with HBDHB funding continuing in low decile schools. **Healthy Homes:** Insulation and heating matters are being worked through (in winter months), especially in homes of children who had already been admitted and identified the illness was a housing related issue.

We now have a much more holistic system, and sophisticated exemplar programme we are proud of. If a landlord won't engage, the DHB work with the tenant to find another home.

**MRB representative attending Clinical Council:** Ngahiwi Tomoana advised that Kerri Nuku had reported on Clinical Council recently, and given the speciality nature of Council wondered if her presence was needed. She felt Council was very well run with high level discussions on a range of issues.

It was advised that Clinical Council value Kerri's presence.

## Maori Relationship Board

Ngahiwi Tomoana spoke to the report provided relating to MRB's meeting held on 12 April:

- Maori employed currently at 13.75% of the total workforce, and MRB feel this target should be lifted to 25% over next 5 years.

In response, the CEO advised that we recruit to turnover only. We would need to apply some reasonable scientific view as to what is achievable and commit to come back and have a conversation with MRB with a range of possibilities.

HBDHB compare very well compared to other DHBs in the country. However it is important we do not increase at one end and not across overall disciplines.

Tracee TeHuia advised the board that Kerri Nuku was on the Steering Group (for MRB) and there are currently 47 actions sitting underneath this. We are really eager to retain and recruit Maori staff. We currently have a very positive environment regarding hiring with KPIs for staff that hire (as part of their performance objectives). We work hard to achieve a culture shift, as we bring people into the organisation.

In the past 4-5 years we have seen a 55% increase in those identifying as Maori, in the workforce. We did plateau for a time but are now climbing again!

As evidence of a cultural shift occurring, there have been some within the organisation who did not initially identify as Māori – bit now advise they are in fact Māori.

This is about setting a target that can be achieved and the CEO advised that MRB are right to challenge management.

**Action: Maori Workforce – HBDHB management agreed to consider:**

**a) MRB's recommendation regarding Maori employed (currently at 13.75% of the total workforce) be lifted to 25% over next 5 years**

***ie., the 25% being based on the percentage of Maori within the HB population.***

**b) This discussion to include a review of comments from EXIT interviews of Maori Staff.**

**c) Confirm timing for inclusion on the MRB agenda to discuss what is achievable.**

Further discussions at the MRB Meeting included:

- Health and Social Care localities update received. Ngahiwi advised that 50% funding had been secured to send a Wairoa representative to Training on the NUKA system.
- TAW – Cardiovascular report was received.
- There was growing acknowledgement there is a strong focus and some very good things happening in Maori Health.

### Hawke's Bay Health Consumer Council

No meeting was held in April due to bad weather.

## FOR DISCUSSION AND INFORMATION

### Establishing Health and Social Care Localities in HB

Tracee TeHuia introduced Paul Malan and Jill Garrett who provided an overview of progress with locality development, in Central Hawke's Bay and Wairoa.

During this process the team have been keeping in mind the Regional Economic Development Strategy (REDS) presented to the board in 2016; and the Social Inclusion Strategy (to be provided to the Board in the near future). In addition they are working very closely with agencies to ensure real work was progressing and not overlapping.

In discussion the following was summarised:

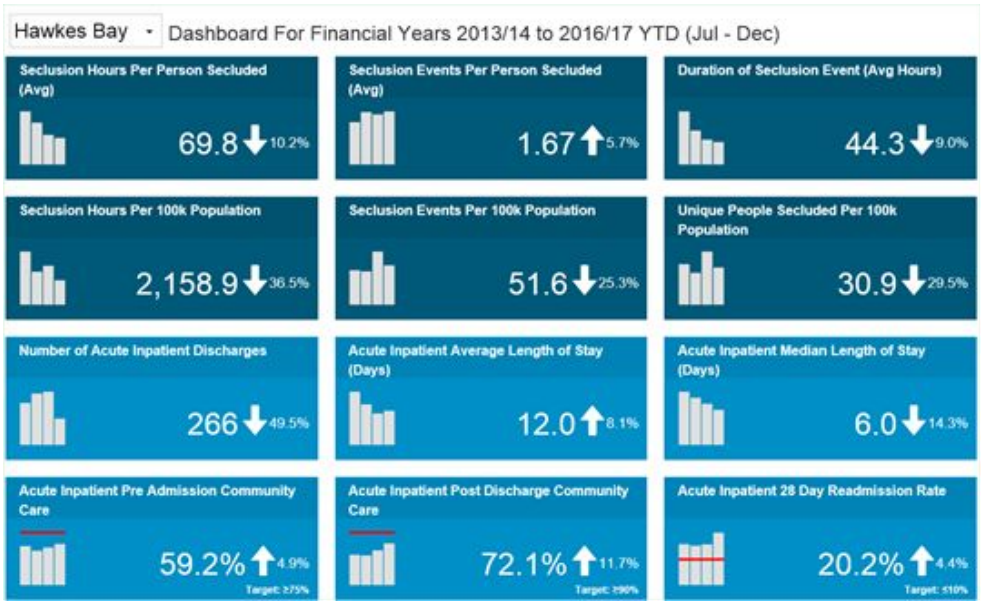
- At an operational level within the Ministry of Social Development (MSD) there had been a number of structural changes. The same had been experienced in Wairoa. The big challenge was to shift and change back office systems. There had been valuable conversations at network level however those worked with at the MSD did not have the mandate.
- MSD, Police and HBDHB are key to supporting the most vulnerable.
- Good learnings are being gleaned from Counties Manukau who have been working in this area and advise us that it takes time. We are making "considered" progress.

The next update on Health and Social Care Localities in HB, is due to the board in October and the Tracee advised she expecst to see some **significant achievements** made with the next 6 months especially in Wairoa and CHB.

### Benefits from Investment in Mental Health Services Redesign - Presentation

Allison Stevenson (Service Director), Simon Shaw (Medical Director) and Peta Rowden (Nurse Director) provided a presentation on the benefits from the capital investment.

In 2010 a case was made for investment with the approach taken to define the direction for work and ensure empowered patient outcomes. With the build completed in 2015 the conducive building design coupled with the much improved Model of Care has led to significant improvements in services and outcomes.



**Conclusions**

- This was a highly ambitious programme that achieved many of its goals
- The motivation of staff to offer improved service was key to success
- A new Model of Care has taken time to embed
- Culture change takes place over long time scales
- This has been a significant investment in financial and staff resources
- The successes and learnings of this project have strongly influenced other projects
- Successes achieved by this project required commitment to; investment, people, organisational development and values based leadership

Now Mental Health now receive nothing but praise for the wonderful service. The journey is still continuing and is working well with community support. A programme is about to start to credential practise nurses in mental health to support consumers in Primary Care.

Intersectoral work has led to conversations with the police and with Health HB, to break down some barriers. It is all about education and working collaboratively.

The Board applauded the efforts of the team and noted that what had been done with the model of care was incredible.

## FOR MONITORING

### Te Ara Whakawaiora / Cardiology

Russell Wills (as Acting CMO) provided an overview to the Board. There was some discussion around the ability (in time) for HB to provide additional cardiology services. Mid Central was also considering their service provision in this area. Is private hospital services an option?

**Action Russell Wills/John Gommans: The figures shown on page 4/5 of the report around Hawke's Bay Data by ethnicity for Quarter 3, will be reviewed as it appears to show a disproportionate number of Maori (as a percentage). The numbers will be clarified and provided in the "status" update to the May Board Meeting.**

It was noted that this is likely due to the small sample numbers of Maori presenting, as was advised to MRB at their recent meeting.

## 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
    - Public Excluded

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

22. Board Approval of Actions exceeding limits delegated by CEO

23. Chair's Update

24. Cranford Hospice

25. Finance Risk and Audit Committee Report
    - Banking Supplier Recommendation

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

The public section of the Board Meeting closed 3.30pm

**Signed:** _____
**Chair**

**Date:** _____

5

# BOARD MEETING - MATTERS ARISING
# (Public)

| Action No | Date Issue first Entered | Action to be Taken | By Whom | Month | Status |
|---|---|---|---|---|---|
| 1 | 29 Mar 17<br><br><br><br><br><br><br>26 Apr 17 | **Chaplaincy Services:**<br>1. Facilitate an opportunity for Rev Barbara Walker to speak to the HB Mayoral Forum.<br>2. Develop funding options for contributions to the $60k shortfall within the Chaplaincy service.<br>Items remain as an action. | Board Chair<br><br>Tim Evans | | Mayor of Hastings to advise Board Chair of potential date(s) |
| 2 | 26 Apr 17 | **Respond to Letter** received by Chair Kevin Atkinson from the Chair of of NZHPL regarding a visit. | Ken Foote | Apr | Actioned |
| 3 | 26 Apr 17 | **Communications** to public as to why HBDHB focus on making surpluses. | Ken Foote | Apr | Actioned.<br>Referred to in ongoing Comms re financial positon. |
| 4 | 26 Apr 17 | **Board Health and Safety Responsibilities:**<br>Prepare a rotational schedule for Board H&S reporting going forward. | Ken Foote | May | Schedule available for board members to complete at the May meeting. |
| 5 | 26 Apr 17 | **Maori Workforce:**<br>Management agreed to consider:<br>a) MRB's recommendation regarding Maori employed (currently at 13.75% of the total workforce) be lifted to 25% over next 5 years<br>*ie., the 25% being based on the percentage of Maori within the HB population.*<br>b) This discussion to include a review of comments from EXIT interviews of Maori Staff.<br>**c)** Confirm timing for inclusion on the MRB agenda to discuss what is achievable. | Kate Coley | ~~June~~<br>July | Paper and presentation to be developed for discussion at EMT and then to MRB in July. This item has been included on the workplan. |

| Action No | Date Issue first Entered | Action to be Taken | By Whom | Month | Status |
|---|---|---|---|---|---|
| 6 | 26 Apr 17 | **TAW / Cardiology**<br>The figures shown on page 4/5 of the TAW report around Hawke's Bay Data by ethnicity for Quarter 3, will be reviewed as it appears to show a disproportionate number of Maori (as a percentage). The numbers will be clarified and provided in the "status" update to the May Board Meeting. | | May | Refer below |

**Item 6 The following detail was provided by Dr John Gommans:**

*"The Clinical Leader for Cardiology has reviewed the records of the small number of Maori patients (4) with high risk acute coronary syndromes who did not receive coronary angiography within 72 hours during the four months of December 2016 to March 2017. The delays in all 4 cases were due to a combination of limited access to local angiography facilities in Hawkes Bay (e.g. 3 admitted on a Friday with next angiography session on a Tuesday) and their comorbid conditions requiring further investigations and treatment prior to angiography in Hawke's Bay (all 4 cases)."*

# HAWKE'S BAY DISTRICT HEALTH BOARD – WORKPLAN

| Mtg Date | Papers and Topics | Lead(s) |
|---|---|---|
| **31 May** | Health Literacy update<br>Best Start Healthy Eating Plan (*yearly review*)<br>***Monitoring***<br>HBDHB Non-Financial Exceptions Report Q3 Jan-Mar 17 + MoH dashboard Q2<br>Annual Maori Health Plan Q4 - Dashboard<br>HR KPIs Q3<br>Te Ara Whakawaiora / Access *revised from Feb Report 45-65 years* | Kate Coley<br>Tracee TeHuia<br><br>Tim Evans<br>Tracee TeHuia<br>Kate Coley<br>Mark Peterson |
| **29 June** | Consumer Experience Results Qtly<br>People Strategy (2016-2021) first draft<br>Youth Health Strategy update for Information<br>Clinical Services Plan<br>Renal Services Review<br>***Monitoring***<br>Te Ara Whakawaiora / Oral Health (national indicator) | Kate Coley<br>Kate Coley<br>Tracee TeHuia<br>Tracee TeHuia<br>Tim Evans<br><br>Sharon Mason |
| **26 July** | Quality Accounts draft<br>Consumer Engagement Strategy<br>Recognising Consumer Participation<br>Maori Workforce (from 26 April action)<br>Histology Laboratory and completion of the Education Centre (final approval of tender)<br>Social Inclusion | Kate Coley<br>Kate Coley<br>Kate Coley<br>Kate Coley<br>Sharon Mason<br>Tracee TeHuia |
| **30 Aug** | People Strategy (2016-17) final<br>Ngātahi Vulnerable Children Project (Board action Feb 17)<br>Transform & Sustain Strategic Dashboard<br>***Monitoring***<br>Annual Maori Health Plan Q4 – Dashboard<br>HBDHB Non-Financial Exceptions Report Q4 Apr-Jun 17 + MoH<br>HR KPIs quarterly<br>Te Ara Whakawaiora / Culturally Competent Workforce (local ind)<br>Te Ara Whakawaiora / Mental Health and AOD (national / local) | Kate Coley<br>Tracee TeHuia<br>Tracee TeHuia<br><br>Tracee TeHuia<br>Tim Evans<br>Kate Coley<br>Kate Coley<br>Sharon Mason |
| **6 Sept** | **HB Health Sector Leadership Forum – East Pier, Napier** | |

| Mtg Date | Papers and Topics | Lead(s) |
|---|---|---|
| **27 Sept** | Orthopaedic Review – phase 3 draft<br>Quality Accounts final<br>Consumer Experience Results Qtly<br>Final Annual Plan 2017<br>Annual Report (Interim)<br>***Monitoring***<br>Te Ara Whakawaiora – Healthy Weight Strategy (national Indicator) | Andy Phillips<br>Kate Coley<br>Kate Coley<br>Carina Burgess<br>Tim Evans<br><br>Tracee TeHuia |
| **25 Oct** | Board H&S Champion - progress<br>People Strategy Quarterly Report<br>Establishing Health and Social Care Localities Update<br>Annual Report 2017 (Board and FRAC) | Kate Coley<br>Kate Coley<br>Tracee TeHuia<br>Tim Evans |
| **29 Nov** | ***Monitoring***<br>Travel Plan Update Report<br>HR KPIs quarterly<br>Te Ara Whakawaiora – smoking (national Indicator)<br>Maori Annual Plan Q1 Dashboard<br>HBDHB Non-Financial Exceptions Report Q1 Jul-Oct 17 + MoH dashboard Q4 | <br>Sharon Mason<br>Kate Coley<br>Tracee TeHuia<br>Tracee TeHuia<br>Tracee TeHuia |
| **13 Dec** | Audit NZ Final Management Report on the audit of HBDHB for y/e June 2017<br>Consumer Experience Qtly feedback and Annual Review since inception<br>Transform and Sustian Report (TBC as timelines very tight) | Tim Evans<br>Kate Coley<br>Tracee TeHuia |
| **Jan 2018** | **No meeting** | |

Timing to be determined for the following :

Primary Health Care Strategy for Wairoa (previously GP Services)
NKII Relationship Update
Urgent Care in HB

# CHAIR'S REPORT

Verbal

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Chief Executive Officer's Report** 46 |
| | For the attention of: **HBDHB Board** |
| Document Owner: | Dr Kevin Snee, Chief Executive Officer |
| Reviewed by: | Not applicable |
| Month as at | 24 May 2017 |
| Consideration: | For Information |

8

**Recommendations**

**That the Board**

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

**INTRODUCTION**

This month we have seen general improvements in our performance and a welcome return to a healthier financial performance, due to the hard work of our staff and the series of measures introduced to control costs. We are now more optimistic about ending the year in surplus, albeit one that will be less than intended. The quarter three Ministerial Target performance summary is attached (Appendix1).

This month has also seen the release of the Stage 1 Report of the Inquiry into the Campylobacter Outbreak in Hawke's Bay. There are clearly many lessons to be learned for all parties but it is clear, as the report states, that:

> *"…responses to the August 16 outbreak were generally well handled, particularly by the Hawke's Bay District Health Board."*

So whilst there is no room for complacency and improvements will be made, our response was generally well handled and staff involved should be congratulated for the hard work they put in to reduce the impact on our community. Another key issue from the report is the importance of building good relationships between organisations both formally and informally. This has been a key focus of mine over recent years not simply in relation to public health matters. I have attached a summary report from Dr Nick Jones on the findings of the Inquiry and the implications for the DHB (Appendix 2).

**PERFORMANCE**

| Measure / Indicator | Target | Month of April | Qtr to end April | Trend For Qtr |
|---|---|---|---|---|
| Shorter stays in ED | ≥95% | 95.2% | 95.2% | ▲ |
| Improved access to Elective Surgery (2016/17YTD) | 100% | - | 99.3% | ▲ |

| *Waiting list* | *Less than 3 months* | *3-4 months* | *4+ months* |
|---|---|---|---|
| ***First Specialist Assessments (ESPI-2)*** | 2,850 | 475 | 46 |
| ***Patients given commitment to treat, but not yet treated (ESPI-5)*** | 1,003 | 100 | 38 |

| | | | | |
|---|---|---|---|---|
| Faster cancer treatment* | ≥85% | 78.6% (March 2016) | 69.4% (6m to March 2016) | ▲ |
| Increased immunisation at 8 months (3 months to end of April) | ≥95% | --- | 95.0% | ▲ |
| Better help for smokers to quit – Primary Care | ≥90% | 86.4% (As at March, 2016) | --- | ▲ |
| Better help for smokers to quit – Maternity | ≥90% | --- | 92.8% (Quarter 3, 2016/17) | ▲ |
| Raising healthy kids (New) | ≥95% (by June 2017) | --- | 81% (6m to February 2016/17) | ▲ |
| Financial – month (in thousands of dollars) | 1,846 | 1,760 | --- | --- |
| Financial – year to date (in thousands of dollars) | 3,910 | 2,047 | --- | --- |

***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%* | *14/19 = 74%* | *111/114 = 94.7%* |

Ministerial Targets

Performance in this month shows an improvement in our Shorter Stays in Emergency Departments (ED 6) so that we continue above the 95% target; we have seen some pressure more recently with high numbers of ED presentations and admissions. Elective activity remains below plan, however we are getting closer to our planned delivery. Faster Cancer Treatment continues to improve so that whilst we are the worst performing DHB over a six month period, we are mid-range for the previous three months. Raising healthy kids, smoking targets and immunisation have all seen improvements

Financial Performance

The result for the month of April was an unfavourable variation of $0.1 million, slightly increasing our cumulative adverse variance for the year-to-date to $1.9 million. We have been under financial watch for two weeks of the month reported. The pattern of steep rise in adverse variance has stopped, with a small adverse for the month ($85 thousand) delivered despite a high inter-district flow pressure including one very high cost case.

This is an encouraging turn in our financial direction of travel, but we still need to persist with the hard work of detailed financial control to year end. We need to recognise the terrific contribution of budget managers and staff throughout the organisation to regaining and retaining financial grip.

**CONSUMER STORY**
This month's consumer story is presented in the form of a Health and Disability Commissioner complaint and will be shared with you to highlight the family perspective, organisational review, learnings identified and implemented, together with the family response to the DHB's processes and findings.

**NZ HEALTH PARTNERSHIPS LTD**
In accordance with the Crown Entities Act 2004 and Shareholders Agreement, NZ Health Partnerships has prepared a Combined Statement of Intent 2017-2021 and Statement of Performance Expectations 2017/18, and a final Annual Plan 2017/18. The NZ Health Partnerships Board has approved these documents and has now sent them to shareholding DHBs for review and approval. 31 May 2017 has been set as the deadline date for DHB shareholder written approval.

**HEALTH LITERACY UPDATE**
The HBDHB Health literacy principles have been developed based on the *six dimensions of a health literate environment* with the aim of making healthcare easier for people to access, understand and use. The next stage of the project is to implement these principles to reduce the health literacy complexities of the health system as well as improving the health knowledge of our consumers. Whilst these principles have been developed, work has been underway to focus on improving how clinicians and health professionals engage with patients and their families and this aligns to the training that has already been implemented across GP Practices.

**BEST START: HEALTHY EATING AND ACTIVITY PLAN**
There has been significant activity over the past year contributing to the Best Start: Healthy Eating and Activity Plan. The plan has proved to be robust and has been able to adapt to external changes including responding to the joint Water Only Schools request from Ministry of Education and Ministry of Health and also developing the process and supporting material for the national Raising Healthy Kids target linked to Reducing Childhood Obesity Plan. We are moving to the next level by sharing the strategy with our key partners and will be extending our planned activity to include an intersectorial approach.

**DRAFT ANNUAL PLAN 2017**
Due to the delay in receiving feedback from the Ministry of Health on the Draft Annual Plan, the final draft was unable to be completed in time for the Board meeting. Once all of the feedback has been received, changes will be made to the plan and the Final Draft will be circulated. This is expected to be completed by the first week of June.

Given the feedback to date, the main changes to be made are around increasing the equity focus for Electives Health Target, Raising Healthy Kids Health Target, Mental Health and Primary Care Integration.

Since submitting the draft, the Ministry has also announced the addition of two new Better Public Service Targets which need to be incorporated into the plan but we are yet to receive guidance on that. The new targets are:

- Healthy Mums and Babies: 'By 2021, 90 percent of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80 percent by 2019, with equitable rates for all population groups'
- Keeping Kids Healthy: 'By 2021, a 25 percent reduction in the rate of hospitalisations for avoidable conditions in children aged 0 - 12 years, with an interim target of 15 percent by 2019'

**HBDHB NON-FINANCIAL EXCEPTIONS REPORT QUARTER THREE**
We are performing well on quickly administering thrombolysis drugs to over 83 percent of stroke patients; immunising over 92 percent of our five year olds, and keeping elective lengths of stay in hospital down to 1.57 days. We are improving on Elective Surgery at 99 percent and tracking to hit target by year end; treating 69 percent of high risk cancer patients within 62 days; raising healthy kids; reducing DNAs, and increasing the percentage of our kids with caries free teeth. We must get better at promptly registering patients with acute coronary syndrome.[1]

[1] Signs and symptoms due to decreased blood flow in coronary arteries such that part of the heart muscle is unable to function properly or dies.

We also failed to hit the rheumatic fever target, but with low numbers and a very good starting point we will miss the target because of a few atypical cases which don't conform to the type of case we are targeting with a program of prevention.

**ANNUAL MĀORI HEALTH PLAN QUARTER THREE**

HBDHB's Annual Māori Health Plan 2016-2017 Quarter 3 Report demonstrates continued improved health trends particularly with Child Immunisations (8 Month), 4 Year Old Healthy Weight Referrals, PHO Enrolments, 5 Year Old Caries Rates (oral health), Cancer Screening for Māori women (Cervical/Breast), Access to Mental Health and Alcohol and Other Drugs (AOD) Services (0-19 Year Old) and HBDHB Māori Workforce. However, there is still significant work to do to improve rates of Māori under Compulsory Treatment Orders (mental health), medical staff undergoing Cultural Training, Māori breastfeeding rates, and Māori Smoking Rates (two weeks postnatal).

**HUMAN RESOURCES KEY PERFORMANCE INDICATORS QUARTER THREE**

There has been good progress in the Māori representation figures with staffing at 31 March 2017 up to 13.46 percent against the 2016/17 target of 13.75 percent, which means a gap of nine. As at 30 April 2017 the gap has reduced to four. Staff turnover is currently 10.31 percent for the year, which is above the 10 percent annual benchmark. The two main reasons for staff leaving are; retirements and employees moving to positions outside HBDHB. While these reasons give no particular cause for concern, we will be completing a full review of how we undertake exit interviews across the whole of the organisation to understand the issues and reasons for people leaving while identifying areas for improvement. Annual leave 2+ years is slightly below last year's level. We will be reviewing and updating the contents of this KPI report to incorporate a broader People & Quality view with the intention to roll these updated KPIs out to the organisation.

**TE ARA WHAKAWAIORA / ACCESS 45-65 YEARS**

In response to the Te Ara Whakawaiora / Access report provided in February, it was agreed the Board would be provided with further detail around the recommendations. The report was subsequently split in two with the 0-4 year old group provided in to the Board in March. The report today provides a summary of actions focusing on the 45-64 years old group relating to cardiac conditions, respiratory illness and cellulitis.

**COMMUNITY PHARMACY SERVICES AGREEMENT**

The current Community Pharmacy Services Agreement (CPSA or 'the Contract') expires on 30 June 2017 and will be replaced by a 12 month contract extension with additional services and funding. Our draft 2017/18 budget for Community Pharmacy reflects the CPSA 2017/18 negotiation. The CPSA 2017/2018 extension includes funding for the following new services: smoking cessation, expanded inclusion criteria for mental health into the pharmacy long term conditions service, as well as workforce development funding.

**CONCLUSION**

This month's report represents a more positive performance both clinically and financially. Underpinning this good performance is the efficient and effective business as usual of which there are a number of examples on the agenda today. We have also seen the report published from the Inquiry into the Outbreak in Havelock North which gives all local organisations food for thought and opportunities to improve.

# How is My DHB performing?

MINISTRY OF HEALTH
MANATŪ HAUORA

**2016/17 QUARTER THREE (JANUARY–MARCH 2017) RESULTS**

www.health.govt.nz/healthtargets

## Shorter stays in Emergency Departments

| | | Quarter three performance (%) | 95% | Change from previous quarter |
|---|---|---|---|---|
| 1 | West Coast | 100 | | – |
| 2 | Wairarapa | 98 | | ▲ |
| 3 | Waitemata | 97 | | – |
| 4 | Bay of Plenty | 96 | | – |
| 5 | South Canterbury | 96 | | – |
| 6 | Tairawhiti | 95 | | – |
| 7 | Nelson Marlborough | 95 | | – |
| 8 | Counties Manukau | 95 | | – |
| 9 | Auckland | 95 | | – |
| 10 | Whanganui | 94 | | – |
| 11 | Canterbury | 94 | | – |
| 12 | Hawke's Bay | 94 | | – |
| 13 | Lakes | 94 | | – |
| 14 | Hutt Valley | 93 | | ▼ |
| 15 | Northland | 92 | | – |
| 16 | Southern | 92 | | ▼ |
| 17 | Capital & Coast | 92 | | ▲ |
| 18 | Taranaki | 92 | | ▼ |
| 19 | MidCentral | 91 | | ▼ |
| 20 | Waikato | 88 | | – |
| | All DHBs | 94 | | – |

**Shorter stays in Emergency Departments**

The target is 95 percent of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours. The target is a measure of the efficiency of flow of acute (urgent) patients through public hospitals, and home again.

## Improved access to Elective Surgery

| | | Quarter three performance (%) | 100% | Progress against past (discharges) |
|---|---|---|---|---|
| 1 | Taranaki | 113 | | ▲ |
| 2 | Northland | 113 | | ▲ |
| 3 | Waikato | 110 | | ▲ |
| 4 | Whanganui | 109 | | ▲ |
| 5 | Waitemata | 108 | | ▲ |
| 6 | Counties Manukau | 107 | | ▲ |
| 7 | Hutt Valley | 106 | | ▲ |
| 8 | Tairawhiti | 106 | | ▲ |
| 9 | West Coast | 105 | | ▲ |
| 10 | MidCentral | 105 | | ▲ |
| 11 | Nelson Marlborough | 104 | | ▲ |
| 12 | Bay of Plenty | 104 | | ▲ |
| 13 | Lakes | 104 | | ▲ |
| 14 | Wairarapa | 102 | | ▲ |
| 15 | Hawke's Bay | 99 | | ▼ |
| 16 | Southern | 98 | | ▼ |
| 17 | Canterbury | 98 | | ▼ |
| 18 | Capital & Coast | 98 | | ▼ |
| 19 | South Canterbury | 96 | | ▼ |
| 20 | Auckland | 96 | | ▼ |
| | All DHBs | 104 | | ▲ |

**Improved access to elective surgery**

The target is an increase in the volume of elective surgery by an average of 4,000 discharges per year. DHBs planned to deliver 142,690 discharges for the year to date, and have delivered 5,394 more.

## Faster Cancer Treatment

| | | Quarter three performance (%) | 85% | Change from previous quarter |
|---|---|---|---|---|
| 1 | Waitemata | 92 | | ▲ |
| 2 | Canterbury | 87 | | ▲ |
| 3 | Auckland | 87 | | ▼ |
| 4 | Waikato | 86 | | – |
| 5 | Nelson Marlborough | 85 | | – |
| 6 | West Coast | 83 | | ▲ |
| 7 | Southern | 83 | | – |
| 8 | Northland | 83 | | – |
| 9 | Bay of Plenty | 82 | | ▼ |
| 10 | South Canterbury | 81 | | ▼ |
| 11 | Lakes | 80 | | ▼ |
| 12 | Wairarapa | 79 | | ▼ |
| 13 | Tairawhiti | 79 | | ▼ |
| 14 | Capital & Coast | 78 | | ▼ |
| 15 | Counties Manukau | 76 | | ▲ |
| 16 | MidCentral | 75 | | ▼ |
| 17 | Taranaki | 72 | | ▼ |
| 18 | Hutt Valley | 70 | | ▲ |
| 19 | Whanganui | 69 | | ▼ |
| 20 | Hawke's Bay | 69 | | ▲ |
| | All DHBs | 82 | | – |

**Faster cancer treatment**

The target is 85 percent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks. Results cover those patients who received their first cancer treatment between 1 October 2016 and 31 March 2017.

## Increased Immunisation

| | | Quarter three performance (%) | 95% | Change from previous quarter |
|---|---|---|---|---|
| 1 | South Canterbury | 96 | | ▲ |
| 2 | Canterbury | 94 | | – |
| 3 | Hawke's Bay | 94 | | – |
| 4 | Auckland | 94 | | – |
| 5 | Southern | 94 | | – |
| 6 | Counties Manukau | 94 | | – |
| 7 | MidCentral | 93 | | ▼ |
| 8 | Wairarapa | 93 | | ▼ |
| 9 | Whanganui | 93 | | – |
| 10 | Capital & Coast | 93 | | ▼ |
| 11 | Hutt Valley | 93 | | ▼ |
| 12 | Taranaki | 92 | | – |
| 13 | Waitemata | 92 | | – |
| 14 | West Coast | 91 | | ▲ |
| 15 | Lakes | 91 | | ▼ |
| 16 | Waikato | 90 | | ▼ |
| 17 | Nelson Marlborough | 89 | | ▼ |
| 18 | Northland | 88 | | ▼ |
| 19 | Bay of Plenty | 86 | | – |
| 20 | Tairawhiti | 85 | | ▼ |
| | All DHBs | 92 | | – |

**Increased immunisation**

The national immunisation target is 95 percent of eight-month-olds have their primary course of immunisation at six weeks, three months and five months on time. This quarterly progress result includes children who turned eight-months between 1 January and 31 March 2017 and who were fully immunised at that stage.

## Better help for Smokers to Quit

| | | Quarter three performance (%) | 90% | Change from previous quarter |
|---|---|---|---|---|
| 1 | West Coast | 92 | | – |
| 2 | Tairawhiti | 92 | | ▲ |
| 3 | Bay of Plenty | 90 | | – |
| 4 | Lakes | 90 | | – |
| 5 | Counties Manukau | 89 | | – |
| 6 | Wairarapa | 89 | | ▲ |
| 7 | Hutt Valley | 89 | | – |
| 8 | Auckland | 88 | | – |
| 9 | Waitemata | 88 | | – |
| 10 | MidCentral | 87 | | ▲ |
| 11 | Canterbury | 87 | | ▲ |
| 12 | Hawke's Bay | 86 | | – |
| 13 | Waikato | 86 | | – |
| 14 | Capital & Coast | 86 | | – |
| 15 | Taranaki | 86 | | – |
| 16 | South Canterbury | 85 | | ▼ |
| 17 | Nelson Marlborough | 84 | | ▼ |
| 18 | Whanganui | 84 | | – |
| 19 | Northland | 82 | | – |
| 20 | Southern | 73 | | ▼ |
| | All DHBs | 86 | | – |

**Better help for smokers to quit**

The target is 90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.

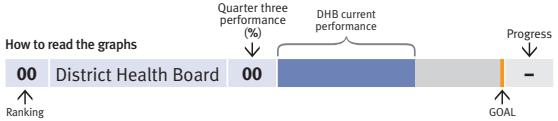
## Raising Healthy Kids

| | | Quarter three performance (%) | 95% | Change from previous quarter |
|---|---|---|---|---|
| 1 | Waitemata | 100 | | – |
| 2 | Whanganui | 100 | | ▲ |
| 3 | Auckland | 99 | | ▲ |
| 4 | Canterbury | 93 | | ▲ |
| 5 | Hutt Valley | 91 | | – |
| 6 | Counties Manukau | 91 | | ▲ |
| 7 | MidCentral | 89 | | – |
| 8 | Wairarapa | 88 | | ▲ |
| 9 | Waikato | 84 | | ▲ |
| 10 | Northland | 83 | | ▲ |
| 11 | Hawke's Bay | 81 | | ▲ |
| 12 | Lakes | 79 | | ▲ |
| 13 | South Canterbury | 79 | | ▼ |
| 14 | Southern | 78 | | ▲ |
| 15 | Capital & Coast | 73 | | ▲ |
| 16 | Tairawhiti | 70 | | ▲ |
| 17 | Nelson Marlborough | 67 | | ▲ |
| 18 | Taranaki | 61 | | ▲ |
| 19 | Bay of Plenty | 55 | | ▲ |
| 20 | West Coast | 17 | | ▲ |
| | All DHBs | 86 | | – |

**Raising healthy kids**

The target is that by December 2017, 95 percent of obese children identified in the Before School Check programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions. Data is based on all acknowledged referrals for obese children up to the end of the quarter from Before School Checks occurring in the six months between 1 September 2016 to 28 February 2017.

**How to read the graphs**




*Health target results are sourced from individual DHB reports, national collections systems and information provided by primary care organisations.*

***This information should be read in conjunction with the details on the website www.health.govt.nz/healthtargets***

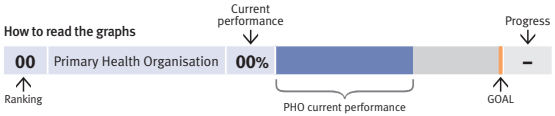
New Zealand Government

# How is My PHO performing?

MINISTRY OF HEALTH
MANATŪ HAUORA

**2016/17 QUARTER THREE (JANUARY TO MARCH) RESULTS**

**How to read the graphs**




## Increased Immunisation

**Using Ministry of Health Data**

| | | Quarter three performance | 95% | Change from previous quarter |
|---|---|---|---|---|
| 1 | Well Health Trust | 98% | | – |
| 2 | Cosine Primary Care Network Trust | 97% | | – |
| 3 | South Canterbury Primary & Community | 97% | | ▲ |
| 4 | Rural Canterbury PHO | 97% | | – |
| 5 | Christchurch PHO Limited | 97% | | – |
| 6 | East Health Trust | 96% | | – |
| 7 | Alliance Health Plus Trust | 96% | | ▲ |
| 8 | Ora Toa PHO Limited | 96% | | ▲ |
| 9 | Compass Health – Wairarapa | 96% | | – |
| 10 | Pegasus Health (Charitable) Limited | 95% | | ▼ |
| 11 | Health Hawke's Bay Limited | 95% | | – |
| 12 | Total Healthcare Charitable Trust | 95% | | – |
| 13 | WellSouth Primary Health Network | 95% | | – |
| 14 | Central Primary Health Organisation | 94% | | ▼ |
| 15 | National Hauora Coalition | 94% | | ▼ |
| 16 | Procare Networks Limited | 94% | | – |
| 17 | Compass Health – Capital and Coast | 94% | | ▼ |
| 18 | Kimi Hauora Wairau (Marlborough PHO Trust) | 94% | | ▼ |
| 19 | Whanganui Regional PHO | 94% | | – |
| 20 | Midlands Health Network – Taranaki | 94% | | ▼ |
| 21 | Te Awakairangi Health Network | 93% | | ▼ |
| 22 | Hauraki PHO | 93% | | – |
| 23 | Midlands Health Network - Waikato | 92% | | – |
| 24 | Waitemata PHO Limited | 92% | | – |
| 25 | Midlands Health Network – Tairawhiti | 92% | | ▼ |
| 26 | Manaia Health PHO Limited | 91% | | ▼ |
| 27 | Rotorua Area Primary Health Services Limited | 91% | | ▼ |
| 28 | Western Bay of Plenty PHO Limited | 91% | | – |
| 29 | West Coast PHO | 90% | | ▲ |
| 30 | Auckland PHO Limited | 90% | | ▼ |
| 31 | Nga Mataapuna Oranga Limited | 89% | | ▲ |
| 32 | Midlands Health Network – Lakes | 87% | | ▼ |
| 33 | Te Tai Tokerau PHO Ltd | 87% | | ▼ |
| 34 | Nelson Bays Primary Health | 86% | | ▼ |
| 35 | Eastern Bay Primary Health Alliance | 86% | | – |
| 36 | Ngati Porou Hauora Charitable Trust | 74% | | ▼ |
| | All PHOs | 93% | | – |

**Increased immunisation**

The national immunisation target is 95 percent of eight-month-olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time. This quarterly progress includes children who turned eight months between January and March 2017, are enrolled in a PHO and who were fully immunised at that stage. Consequently, the All PHOs percentage above will be different to the All DHBs percentage.

## Better Help for Smokers to Quit

**Using Primary Health Organisation Data**

| | | Quarter three performance | 90% | Change from previous quarter |
|---|---|---|---|---|
| 1 | Nga Mataapuna Oranga Limited | 96% | | ▲ |
| 2 | Ngati Porou Hauora Charitable Trust | 95% | | ▲ |
| 3 | East Health Trust | 95% | | ▲ |
| 4 | Midlands Health Network – Tairawhiti | 92% | | ▲ |
| 5 | West Coast PHO | 92% | | – |
| 6 | Total Healthcare Charitable Trust | 91% | | – |
| 7 | Midlands Health Network – Lakes | 90% | | – |
| 8 | Procare Networks Limited | 90% | | – |
| 9 | Western Bay of Plenty PHO Limited | 90% | | – |
| 10 | Auckland PHO Limited | 90% | | – |
| 11 | Rotorua Area Primary Health Services Limited | 89% | | – |
| 12 | Eastern Bay Primary Health Alliance | 89% | | – |
| 13 | Te Awakairangi Health Network | 89% | | – |
| 14 | Nelson Bays Primary Health | 89% | | ▼ |
| 15 | Compass Health – Wairarapa | 89% | | ▲ |
| 16 | Rural Canterbury PHO | 88% | | ▲ |
| 17 | Manaia Health PHO Limited | 88% | | ▲ |
| 18 | Pegasus Health (Charitable) Limited | 87% | | – |
| 19 | Central Primary Health Organisation | 87% | | ▲ |
| 20 | Midlands Health Network - Waikato | 87% | | – |
| 21 | Health Hawke's Bay Limited | 86% | | – |
| 22 | Compass Health – Capital and Coast | 86% | | ▲ |
| 23 | Well Health Trust | 86% | | – |
| 24 | Hauraki PHO | 86% | | – |
| 25 | Cosine Primary Care Network Trust | 86% | | ▼ |
| 26 | Midlands Health Network – Taranaki | 86% | | – |
| 27 | Alliance Health Plus Trust | 85% | | – |
| 28 | South Canterbury Primary & Community | 85% | | ▼ |
| 29 | Whanganui Regional PHO | 85% | | – |
| 30 | Waitemata PHO Limited | 85% | | – |
| 31 | Ora Toa PHO Limited | 83% | | ▼ |
| 32 | Christchurch PHO Limited | 82% | | ▲ |
| 33 | National Hauora Coalition | 80% | | ▼ |
| 34 | Kimi Hauora Wairau (Marlborough PHO Trust) | 75% | | ▼ |
| 35 | Te Tai Tokerau PHO Ltd | 74% | | ▼ |
| 36 | WellSouth Primary Health Network | 73% | | ▼ |
| | All PHOs | 86% | | – |

**Better help for smokers to quit**

The target is 90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.

*Health target results use information sourced from national collections and primary care organisations.*

***More information on the health targets can be found on www.health.govt.nz/healthtargets***

New Zealand Government

# SUMMARY REPORT ON STAGE ONE OF THE HAVELOCK NORTH DRINKING WATER INQUIRY:

## Key findings and implications for the Hawke's Bay District Health Board

Nicholas Jones
Acting Clinical Director Population Health

May 2017

## Inquiry Key Findings and Highlights

An overview of the inquiry with key findings and highlights is included in part one of the report[1]. The inquiry made 15 key findings and identified 5 key issues or highlights. The findings address the causes of the outbreak as well as faults or failings.

The inquiry found that the outbreak was caused by contamination of the drinking water with campylobacter most likely from sheep faeces. The most likely pathway for contamination was found to be the flow of faeces contaminated water from fields where lambs were grazing into a pond and from there into the aquifer and flowing under the ground 90 metres where it entered a bore supplying water to Havelock North.

In terms of faults or failings the inquiry made no findings in respect of the Hawke's Bay District Health Board (HBDHB or the DHB). The majority of findings were directed to the Hawke's Bay Regional Council (HBRC) and the Hastings District Council (HDC). Two key findings were however directed towards staff employed by the DHB in the role of Drinking Water Assessor (DWA).

The inquiry recognized that DWAs have responsibilities independently of the DHB. The DHB whilst being contracted to deliver DWA services has no mandate to provide oversight of DWAs in their statutory role. In the DWA role officers are accountable to the Director General of Health with quality assurance being provided through a third party agency (IANZ). The CEO has written to the Director General so that a discussion can take place to resolve this anomalous situation.

Key Finding (l) was that "DWAs were too hands-off in applying the Drinking-water Standards. They should have been stricter in ensuring the District Council complied with its responsibilities, such as having an Emergency Response Plan and meeting the responsibilities of its Water Safety Plans."

Key Finding (m) states "The DWAs failed to press the District Council sufficiently about the lack of risk assessment, analysis of key aquifer catchment risks, including the link between the Brookvale Road bores and the nearby pond, and a meaningful working relationship between it and the Regional Council. They also failed to require a deeper and more holistic investigation into the unusually high rate of transgressions in the Havelock North and Hastings reticulation systems."

## Implications for the DHB

With respect to short term implications the findings have already been addressed with considerable increases in rigor being applied to DWA work. There has also been a considerable increase in the level of collaboration among DHB staff and relevant staff from Napier City, Hastings District Council and the Regional Council. This has been facilitated by the establishment of an interagency "Joint Working Group" (discussed further below)

There are no DWAs currently on staff and this lack of DWA capacity locally remains a risk. The risk is currently being managed through a combination of DWA expertise contracting and arrangements with MidCentral DHB. Medium and longer term implications, such as the need to clarify oversight and management arrangements for DWAs, have been raised with the Ministry of Health and will be addressed in stage two of the inquiry.

Two staff are currently in training as DWAs to increase local capacity and will be in place in early 2018

[1] https://www.dia.govt.nz/Government-Inquiry-into-Havelock-North-Drinking-Water-Report---Part-1---Overview

The inquiry identified **five** key issues or "highlights". Implications for the DHB are discussed as follows:

**1. There was a similar outbreak in 1998**

There is a need to establish better longitudinal records for drinking water information so as to strengthen institutional memory. There was concern raised that HDC failed to learn from the 1998 outbreak. It is important that all local organisations ensure that key learnings from events are implemented and not forgotten as members of staff move on.

It would also appear that DWAs often worked in isolation to resolve issues. When other agencies failed to respond to requests for action there did not appear to be any process for follow up at more senior levels. Since the outbreak the drinking water assessment unit has established a policy outlining the process for escalating issues to senior staff.

The Ministry of Health is responsible for the operation and development of a national drinking water information system and is about to introduce a new version of the system. It is unclear whether historical information will be available through the new system. The need for longitudinal records within drinking water information systems has however been raised as an issue for stage two of the inquiry.

**2. The Te Mata aquifer (which was the source of the contaminated water) can no longer be regarded as secure (unaffected by activities on the surface)**

With the source water from Brookvale bores no longer classified as secure, treatment of at least the Brookvale road water is likely to be necessary for the foreseeable future. On the recommendations of the inquiry HDC has established a high level of treatment and monitoring for the water supplied from the Brookvale bore. The increased demands relating to the new regime have in turn created additional demand on the Population Health service.

With equipment previously used for fluoride dosing now being repurposed for chlorine dosing, HDC will need to invest in additional equipment before it can reinstate fluoridation.

The increased risk to the Te Mata aquifer may also increase risks to other users of water from the aquifer. We have highlighted this issue with both Hastings District Council and Hawke's Bay Regional Council

Havelock North is also supplied water from Hastings city bores drawing water from the Heretaunga aquifer. Since the outbreak concerns have also been raised about the security of source water in parts of the Heretaunga aquifer.

As with the risks in the Te Mata aquifer concerns about a potential for contamination of the Heretaunga aquifer raises concerns about risks to other users of water from affected parts of the aquifer. Both HDC and the regional council are aware of these concerns and are investigating the extent of risk. The DHB has advised both councils of the need to provide interim advice to other water users concerning possible risks and mitigation measures.

**3. There was a relatively high number of transgressions (detections of e.coli) in the Havelock North water supply prior to the outbreak**

Drinking Water Assessors (DWAs) employed by the DHB were responsible for determining whether council responses to transgressions were adequate. Other staff (Team Leader Health Protection and Medical Officers of Health) were generally notified of transgressions for information only.

On each occasion a transgression was reported to a DWA they found council responses to transgressions to be satisfactory and consistent with the requirements of the drinking water standard. The inquiry has found however that they failed to recognize the need for more thorough investigation or for enforcement action to be carried out by either a Health Protection Officer or a Medical Officer of Health.

The inquiry has essentially established a more stringent standard in relation to the investigation and management of water transgressions. It is likely that relevant aspects of the drinking water standard itself will be reviewed in stage two of the inquiry. In the interim is is clear that simply following the letter of the drinking water standard is no longer acceptable. Both water supplier and DWA need to consider whether changes to the aquifer are taking place and whether transgressions detected in the drinking water reticulation may in fact be due to contamination of the source water even when source water samples show no sign of contamination.

In responding to transgressions water suppliers are now routinely requesting real time information about illness occurrence in potentially affected areas. There is an expectation that the DHB can provide information on the number of children away from school, the number of patients seen by GPs and the number of presentations to ED. This expectation has arisen from the fact that real time illness information proved to be crucial to the decision to commence chlorination before confirmatory tests were available in August 2016. Transgressions have become considerably less frequent in the Hastings supply since chlorination was commenced. With Napier City increasing the extent of its testing regime transgressions are being reported more frequently.

There is no existing system for reporting real time school absenteeism or gastro information and collection of required data remains ad hoc and manual. The demands on Population Health, school and practice staff have increased and this ad hoc process is unlikely to be sustainable. The need for an information system solution has been highlighted as a matter for consideration in stage two of the inquiry.

The Population Health team has now put in place a fortnightly review of both illness and water testing data to ensure that all relevant staff are informed and able to determine whether there are any links between drinking water transgressions and illness trends.

**4. A poor working relationship between HDC and HBRC resulted in lost opportunities to recognize and mitigate risks**

The poor relationship documented by the inquiry may have contributed to a lack of awareness of risks concerning the Te Mata aquifer by our DWAs and other staff. For example DHB staff were unaware of concerns HBRC staff had that the pumping of water from Brookvale 1 bore may draw water from the stream nearby.

However the main implication for the DHB has been the need for the DHB to assist in building more effective working relationships between all parties involved in drinking water safety. During the outbreak investigation we established a working group of scientists and council staff to support a co-ordinated approach to microbiological investigations.

In November the DHB CEO proposed the establishment of a Joint Working Group[2] to promote collaboration among the three parties responsible for drinking water safety. This group was subsequently established and is chaired by Mr Chris Tremain as an independent party. The group has been established for at least 12 months and will be reviewed in December 2017.

[2] https://www.dia.govt.nz/diawebsite.nsf/Files/Havelock-North-Drinking-Water/$file/CB090.pdf

**5. Risk of protozoa contamination needs more attention**

While not deemed a failure the inquiry noted that the response did not sufficiently consider the risk of protozoa contamination.

There appears to be an ongoing debate as to what the risks of protozoa contamination are in New Zealand ground water supplies. The inquiry noted that protozoa have been responsible for several water supply related outbreaks around the world and in New Zealand. Many outbreaks due to protozoa will have been in supplies with a surface water source. Furthermore we understand that protozoa have not been detected in studies on ground water in NZ to date. This issue will no doubt be the subject of further investigation in stage 2 of the inquiry

Nevertheless until such time as risks are more fully understood it is likely that water suppliers will need to take a more precautionary approach and consider the use of boil water notices more frequently than would have previously occurred. There will also be an increased expectation that ground water supplies, not deemed to be secure, will receive treatment to fully mitigate against protozoa risk.

HDC is likely to introduce UV treatment for at least one additional Hastings city supply bore in the near future to address the risks from potential protozoal contamination. The assessment of risk that suggests there is a need for additional treatment will be relevant to risks for other ground water users as noted under issue 3 above.

## Historical Events and Issues

In addition to discussion concerning that 1998 outbreak the inquiry report draws attention to a number of other missed opportunities to identify risk in part 6 of the report. These included: the complaint by a former DHB Health Protection Officer concerning a non secure bore in a sheep paddock close to bore 2; a lack of communication among parties about a significant transgression in July 2013 following heavy rainfall and earthworks at Te Mata Mushrooms, the granting of consent to Te Mata mushrooms for the discharge of dairy farm effluent and waste water from composting to land near the bore, and the detection of contamination in the Brookvale 3 bore in October 2015.

**Implications for the DHB**

The implications of these findings are discussed under highlight 3 above. The issues of consents for earthworks and discharges to ground at Te Mata Mushrooms remain relevant to the safety of the water now supplied from bore 3. Both HBDHB and HDC have expressed an interest in these matters.

Te Mata Mushrooms has recently applied for retrospective consent for earthworks that may have resulted in the 2015 contamination of bore 3. Dairy farming and the related discharge of effluent has not commenced but could still occur given the current status of the consents already granted. The DHB has also raised concerns with the HBRC that the council is currently not able to decline such a consent because of provisions within it's current resource management plan and possible changes are being considered within the TANK process.

## Additional Failings in respect of Drinking Water Assessors

In addition to the two key findings related to DWAs the inquiry makes a number of other observations in Part 11 of the report.

- The level of liaison by the DWAs with the District Council was insufficient. The DWAs needed to be more proactive and engaged.
- The DWAs were aware that bore heads 1 and 2 were situated below ground level, that the area was prone to flooding, and that the water supply was not chlorinated. They were aware of a previous

campylobacter outbreak involving bores 1 and 2 in 1998, but did not bring the lessons learned from it effectively to the District Council's attention.

- The DWAs did not notice or press the District Council on inadequacies in their Water Safety Plan risk assessments.
- A bore head security report was required for the drinking water to be classified as secure, and this was regularly requested, but not supplied for more than 5 years. The DWAs should have required annual reporting from the District Council on bore head security and maintenance.
- DWAs did not do enough to require the District Council to produce evidence of its system for the inspection and maintenance of the Brookvale Road bores.
- There was a need for a contingency plan in the District Council's Water Safety Plan. The DWAs communicated with the District Council about this over a number of years but no contingency plan was provided. Although not explicitly required by law, the DWAs could have required the District Council to have a contingency plan in place.
- There was a contamination event involving Brookvale Road Bore 3 in October 2015, and the DWAs could have responded better to this event.

**Implications for the DHB**

These issues have all been addressed through the increased levels of engagement between DWA and HDC staff since the outbreak. Bores 1 and 2 have been decommisioned and Brookvale bore 3 is above ground. HDC is undertaking a programme of work to raise all other below ground bores, implement a system for recording and monitoring inspection and maintenance and has revised its water safety plan including a contingency plan. Contracted DWA staff and other DHB staff are holding regular operational water safey meetings and issues are being monitored through the Joint Working Group.

In the medium term stage two of the inquiry will need to consider whether there is a need for legislative and resourcing changes to the DWA model (as previously mentioned the CEO has already written to the Director General on this matter). Stage two will also consider whether there is a need for the Drinking-water Standards to be more focussed on proactive planning.

## Assessment of Responses to the Outbreak

In the overview section of part 1 the report notes that "Responses to the August 2016 outbreak were generally well handled, particularly by the Hawke's Bay District Health Board. The report goes on to note that "There were, however, significant gaps in readiness, such as the District Council's lack of an Emergency Response Plan, draft boil water notices, and up-to-date contact lists for vulnerable individuals, schools and childcare centres."

Part 13 discusses outbreak events and part 14 provides more detail concerning the inquiry's assessment of both preparedness and response by both the district council and the DHB.

Key learnings from the assessment of the response were that:

- There was a lack of clarity around the division of roles and responsibilities between the DHB and HDC at the 4.45 meeting on Friday 12 August
- There was a lack of preparedness for a drinking water emergency on the part of both HDC and HBDHB. This included a lack of process for notifying key stakeholders such as vulnerable households, boarding schools, and aged care facilities of a boil water notice.
- The DHB Population Health Service's work in detecting and responding to the outbreak was judged to be excellent by the inquiry. However the inquiry noted that the DHB failed to effectively convey its view as the likely magnitude of the outbreak in the first few days. This in turn was found to have delayed HDC's response to welfare issues in the community.

**Implications for the HBDHB**

As has been noted above both HDC and HBDHB have devoted considerable attention to the development of contingency plans for drinking water contamination since the outbreak. Awareness of the risks associated with drinking water contamination has clearly been raised in Hawke's Bay and across New Zealand.



The requirements of the planning and intelligence role within HBDHB's emergency management system, including the production of forecasts on the likely magnitude of outbreaks, are under review.

It should also be noted that many of the issues relating to outbreak response have already been identified through the DHB's own internal review. The action plan arising from the internal review will now be reviewed with a view to incorporating any additional actions arising from the inquiry

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Financial Performance Report, April 2017** 47 |
| | For the attention of: **HBDHB Board and the Finance Risk and Audit Committee** |
| Document Owner:<br>Document Author(s): | Tim Evans, Executive Director Corporate Services<br>Phil Lomax, Financial Accountant |
| Reviewed by: | Executive Management Team |
| Month: | May 2017 |
| Consideration: | For Information |

**RECOMMENDATION**

**That the HBDHB Board and Finance Risk and Audit Committee**

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

# 1. Executive Director Corporate Services' comments

## Financial performance

The result for the month of April is an unfavourable variance of $0.1 million, slightly increasing our cumulative adverse variance for the year to date to $1.9 million.

This is a significant improvement on the pattern of the last few months, slowing the rate of increase for the adverse variance. The relatively flat overall figure for the month includes an adverse result for our Funder function, (largely driven by one very high Case-Weight Inter District Flow patient), and better than budgeted spending overall by our Provider, and Corporate functions, and by reserves.

This first period of the "financial watch" measures which we instituted following last month's report is beginning to deliver the required shift in our financial performance. We still have a testing challenge to maintain this improvement to the end of June. Great credit for the initial shift has to go to the efforts and actions of individual managers and budget holders throughout the organisation.

## Elective Health Target

Elective discharges improved from 1.1% under target (adjusted) in March to 0.7% under target year to date in April. Electives are therefore on track, with a phased plan for the remainder of the year, to recover to achieve plan.

## Forecast year end result

The forecast surplus has been adjusted from $4.5 million to $3.5 million as we now have written confirmation of the Ministry's decision not to contribute to the exceptional cost of the Havelock North gastroenteritis outbreak. The forecast will be difficult to achieve as it is effectively a $1.5 million adverse, i.e. improving by $0.4 million on our current $1.9 million in the next two months. However detailed forecasting work with individual directorates and funder portfolios supports our estimate that the forecast is achievable.

# 2. Resource Overview

| | April | | | | Year to Date | | | | Year End Forecast | Refer Section |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | | |
| | $'000 | $'000 | $'000 | % | $'000 | $'000 | $'000 | % | $'000 | |
| Net Result - surplus/(deficit) | 1,760 | 1,846 | (85) | -4.6% | 2,047 | 3,910 | **(1,863)** | **-47.7%** | 3,500 | 3 |
| Contingency utilised | 100 | 250 | **150** | **60.0%** | 2,800 | 2,500 | **(300)** | **-12.0%** | 3,000 | 8 |
| Quality and financial improvement | 1,193 | 1,083 | **110** | **10.2%** | 8,147 | 10,833 | **(2,686)** | **-24.8%** | 9,800 | 11 |
| Capital spend | 494 | 1,753 | **(1,259)** | **-71.8%** | 8,468 | 18,529 | **(10,061)** | **-54.3%** | 15,651 | 16 |
| | FTE | FTE | FTE | % | FTE | FTE | FTE | % | FTE | |
| Employees | 2,275 | 2,230 | (45) | -2.0% | 2,218 | 2,196 | (22) | -1.0% | 2,209 | 5 & 7 |
| | CWD | CWD | CWD | % | CWD | CWD | CWD | % | CWD | |
| Case weighted discharges | 2,446 | 1,998 | **447** | **22.4%** | 25,316 | 22,914 | **2,402** | **10.5%** | 27,609 | 5 |

A further one month share of the remaining contingency was released in April leaving $200 thousand in the reserve. The contingency released year to date includes cover for the cost of the gastroenterology outbreak in Havelock North.

The Quality and Financial Improvement (QFI) programme has achieved 75% of planned savings year-to-date.

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

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

Case weighted discharges (CWD) reflect continuing high acute volumes into April. Year-to-date, the main specialties driving the result are gastroenterology, general internal medicine, general surgery, paediatrics, vascular surgery, and partly offset by lower orthopaedic surgery.

# 3. Financial Performance Summary

| | April | | | | Year to Date | | | | Year End Forecast | Refer Section |
|---|---|---|---|---|---|---|---|---|---|---|
| $'000 | Actual | Budget | Variance | | Actual | Budget | Variance | | | |
| Income | 43,892 | 44,388 | (496) | -1.1% | 438,286 | 436,805 | 1,481 | -0.3% | 533,838 | 4 |
| *Less:* | | | | | | | | | | |
| Providing Health Services | 20,118 | 20,278 | 160 | 0.8% | 211,818 | 204,452 | (7,366) | -3.6% | 255,428 | 5 |
| Funding Other Providers | 19,327 | 18,958 | (369) | -1.9% | 189,997 | 189,469 | (527) | -0.3% | 227,969 | 6 |
| Corporate Services | 2,997 | 3,214 | **217** | **6.7%** | 37,594 | 37,848 | 254 | 0.7% | 46,408 | 7 |
| Reserves | (311) | 92 | **403** | **437.3%** | (3,169) | 1,126 | **4,294** | **381.6%** | 533 | 8 |
| | **1,760** | **1,846** | (85) | -4.6% | **2,047** | **3,910** | **(1,863)** | **-47.7%** | **3,500** | |

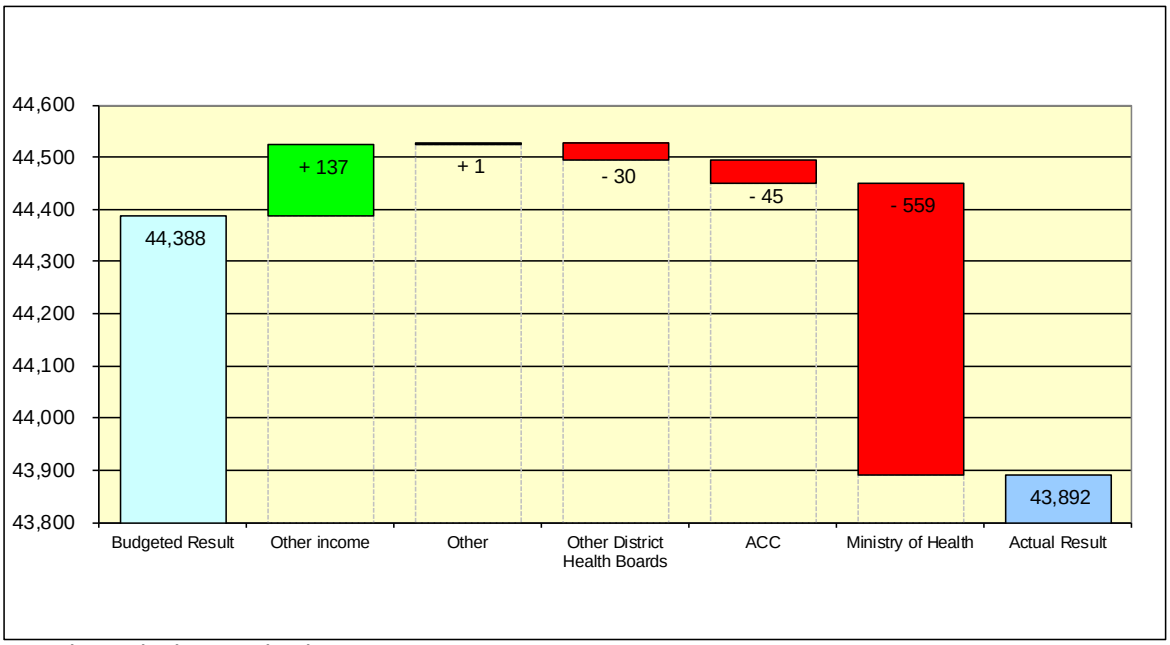
The variances for both income and reserves reflect the debt/equity swap and are cost neutral. A large increase in IDF costs relating to a long stay patient, have been offset by reduced provisions for PHO performance, Health of Older People and Maori health payments to other providers, along with lower corporate costs.

# 4. Income

| $'000 | April Actual | April Budget | April Variance | | Year to Date Actual | Year to Date Budget | Year to Date Variance | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| Ministry of Health | 41,704 | 42,263 | (559) | -1.3% | 418,040 | 416,310 | 1,730 | 0.4% | 509,312 |
| Inter District Flows | 630 | 629 | 2 | 0.3% | 6,470 | 6,287 | 183 | 2.9% | 7,727 |
| Other District Health Boards | 303 | 334 | (30) | -9.0% | 3,152 | 3,335 | **(183)** | **-5.5%** | 3,812 |
| Financing | 81 | 73 | 8 | 11.4% | 733 | 737 | (4) | -0.5% | 881 |
| ACC | 496 | 541 | (45) | -8.3% | 4,633 | 5,040 | **(407)** | **-8.1%** | 5,698 |
| Other Government | 94 | 76 | 18 | 23.8% | 357 | 401 | (44) | -11.0% | 567 |
| Patient and Consumer Sourced | 91 | 118 | (27) | -23.0% | 1,032 | 1,202 | **(170)** | **-14.2%** | 1,258 |
| Other Income | 493 | 356 | **137** | **38.6%** | 3,873 | 3,425 | **448** | **13.1%** | 4,587 |
| Abnormals | - | 0 | (0) | -100.0% | (4) | 67 | **(71)** | **-106.0%** | (4) |
| | **43,892** | **44,388** | **(496)** | **-1.1%** | **438,286** | **436,805** | **1,481** | **0.3%** | **533,838** |



## April Income




*Note the scale does not begin at zero*

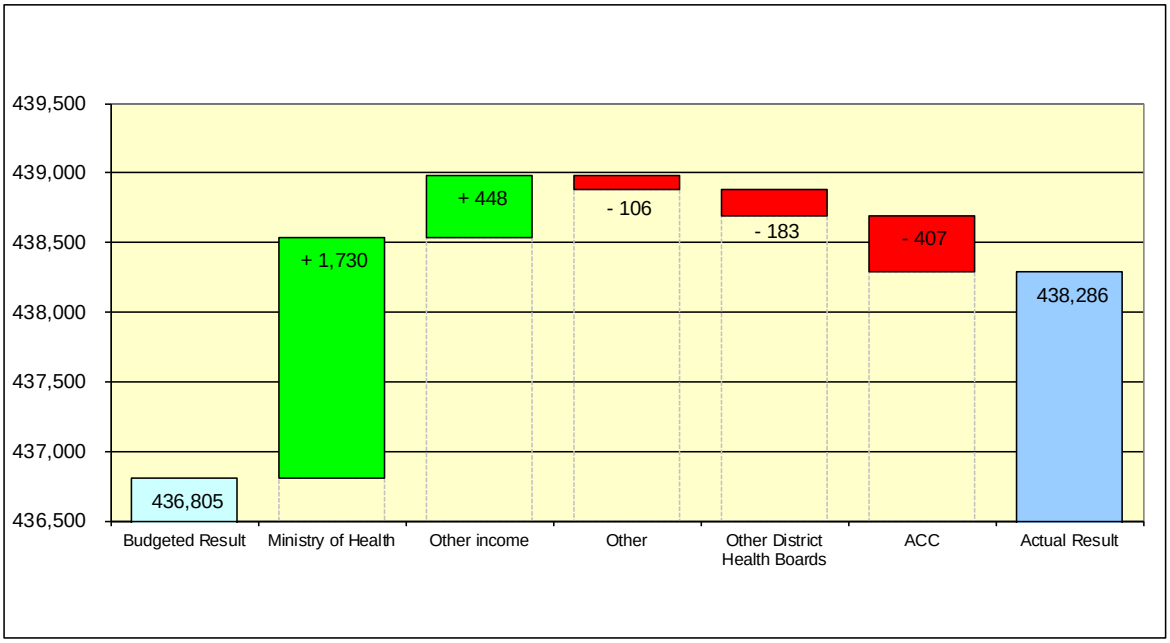
**Other Income** (favourable)
Mainly income in advance from 2015/16 released to cover the cost of a medical training position.

**Other District Health Boards** (unfavourable)
Lower oncology income.

**ACC** (unfavourable)
Lower ACC elective surgery.

**Ministry of Health** (unfavourable) Funding adjustments relating to capital charges, elective surgery, PHO performance and low cost access were partially offset by high cost treatment funding. The adjustment for capital charges is cost neutral and is offset in reserves (see section 8).

## Year to Date Income




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

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

**Other District Health Boards** (unfavourable)
Oncology clinics for Mid-Central DHB.

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

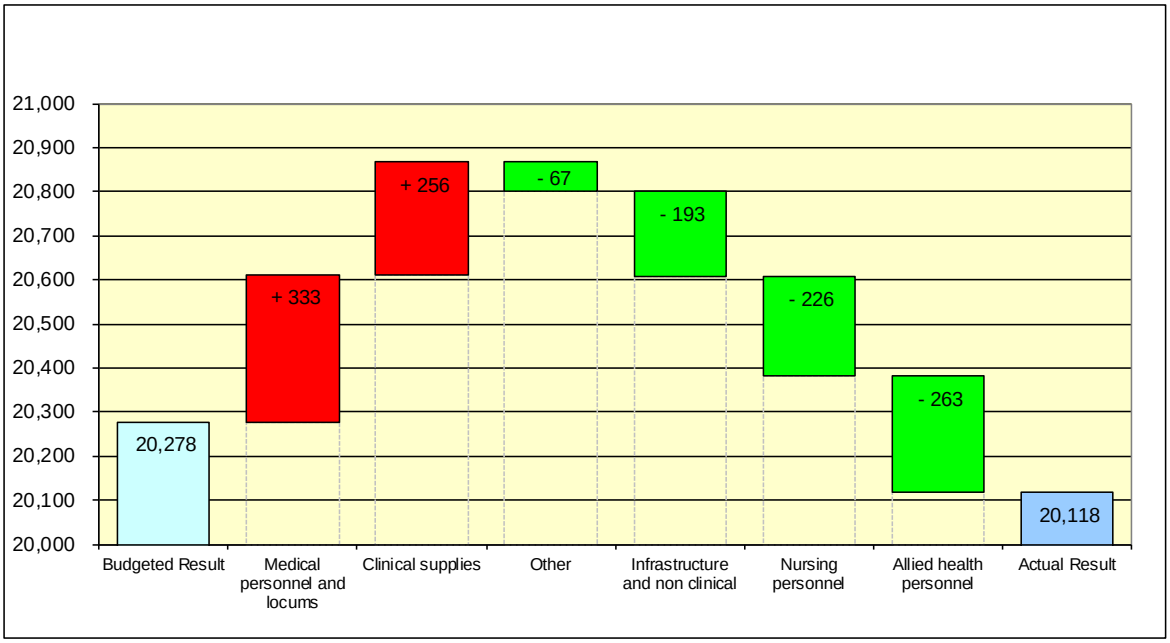
# 5. Providing Health Services

| | April | | | | Year to Date | | | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | |
| **Expenditure by type** $'000 | | | | | | | | | |
| Medical personnel and locums | 4,600 | 4,267 | (333) | -7.8% | 50,286 | 48,960 | (1,325) | -2.7% | 60,574 |
| Nursing personnel | 5,789 | 6,015 | 226 | 3.8% | 60,889 | 59,803 | (1,086) | -1.8% | 74,120 |
| Allied health personnel | 2,523 | 2,786 | 263 | 9.4% | 26,444 | 27,730 | 1,285 | 4.6% | 32,129 |
| Other personnel | 1,964 | 1,958 | (6) | -0.3% | 18,241 | 17,603 | (639) | -3.6% | 22,001 |
| Outsourced services | 695 | 767 | 72 | 9.4% | 8,069 | 6,952 | (1,117) | -16.1% | 9,807 |
| Clinical supplies | 3,077 | 2,821 | (256) | -9.1% | 31,356 | 27,293 | (4,063) | -14.9% | 37,008 |
| Infrastructure and non clinical | 1,471 | 1,664 | 193 | 11.6% | 16,531 | 16,111 | (421) | -2.6% | 19,787 |
| | **20,118** | **20,278** | 160 | 0.8% | **211,818** | **204,452** | (7,366) | -3.6% | **255,428** |
| **Expenditure by directorate** $'000 | | | | | | | | | |
| Medical | 5,293 | 5,191 | (102) | -2.0% | 56,702 | 53,993 | (2,709) | -5.0% | 68,177 |
| Surgical | 4,315 | 4,028 | (287) | -7.1% | 48,015 | 44,641 | (3,374) | -7.6% | 57,999 |
| Community, Women and Children | 3,409 | 3,386 | (23) | -0.7% | 35,818 | 34,845 | (972) | -2.8% | 42,885 |
| Older Persons, Options HB, Menta | 2,895 | 3,098 | 204 | 6.6% | 28,088 | 28,084 | (3) | 0.0% | 34,026 |
| Operations | 2,793 | 3,015 | 222 | 7.4% | 30,395 | 30,243 | (152) | -0.5% | 36,893 |
| Other | 1,414 | 1,560 | 147 | 9.4% | 12,799 | 12,645 | (154) | -1.2% | 15,447 |
| | **20,118** | **20,278** | 160 | 0.8% | **211,818** | **204,452** | (7,366) | -3.6% | **255,428** |
| **Full Time Equivalents** | | | | | | | | | |
| Medical personnel | 337.4 | 305.5 | (32) | -10.4% | 318 | 315 | (4) | -1.2% | 315.5 |
| Nursing personnel | 920.2 | 919.0 | (1) | -0.1% | 911 | 885 | (26) | -2.9% | 892.9 |
| Allied health personnel | 452.1 | 461.2 | 9 | 2.0% | 435 | 453 | 19 | 4.1% | 455.3 |
| Support personnel | 136.2 | 127.8 | (8) | -6.6% | 133 | 127 | (6) | -5.1% | 127.5 |
| Management and administration | 266.7 | 251.9 | (15) | -5.9% | 257 | 248 | (9) | -3.6% | 249.8 |
| | **2,112.6** | **2,065.4** | (47) | -2.3% | **2,055** | **2,028** | (26) | -1.3% | **2,041.1** |
| **Case Weighted Discharges** | | | | | | | | | |
| Acute | 1,633 | 1,349 | 283 | 21.0% | 17,329 | 15,482 | 1,847 | 11.9% | 18,713 |
| Elective | 561 | 452 | 109 | 24.2% | 5,419 | 5,389 | 30 | 0.6% | 6,451 |
| Maternity | 159 | 160 | (1) | -0.7% | 1,777 | 1,675 | 102 | 6.1% | 2,000 |
| IDF Inflows | 93 | 37 | 56 | 151.7% | 791 | 367 | 424 | 115.5% | 445 |
| | **2,446** | **1,998** | 447 | 22.4% | **25,316** | **22,914** | 2,402 | 10.5% | **27,609** |

## Directorates

- Surgical includes efficiencies not achieved, locum vacancy and leave cover, and fee for service payments for additional surgery sessions.
- Medical includes vacancy and leave cover for medical staff, efficiencies not achieved yet, gastrointestinal pharmaceuticals and biologics.
- Community, Women and Children is mostly efficiencies not achieved, increased paediatric and maternity volumes, additional junior medical staff, and locums for sabbatical leave cover.

## April Expenditure




*Note the scale does not begin at zero*

**Medical personnel and locums** (unfavourable)
Locums for vacancy cover, and additional radiology SMO costs.

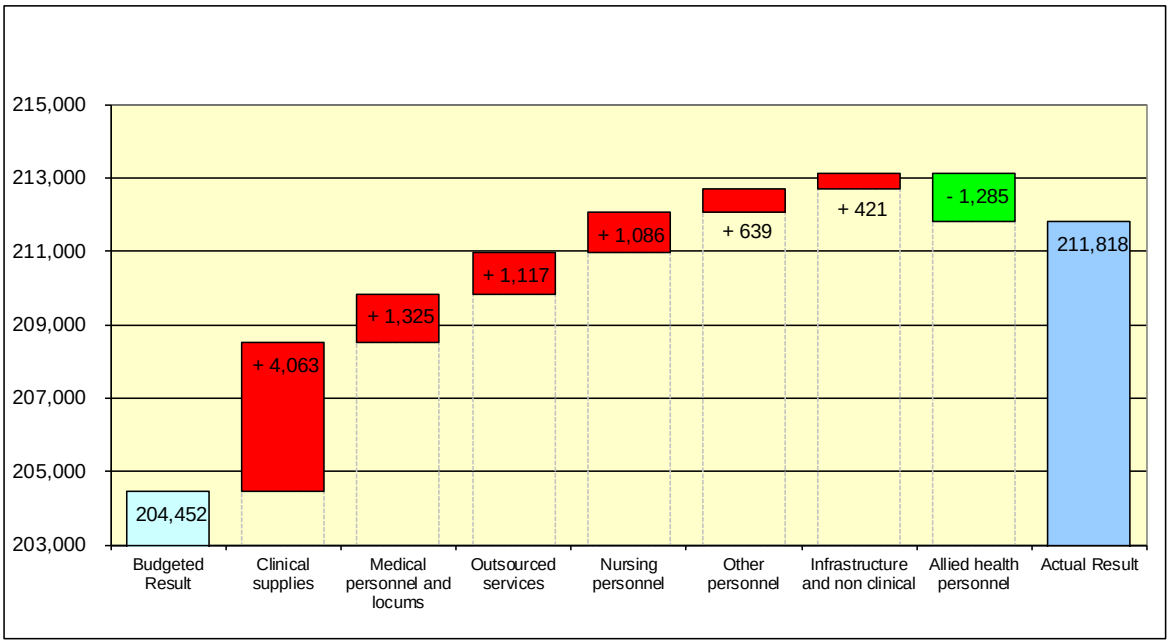
**Clinical supplies** (unfavourable)
Efficiencies not yet achieved or achieved elsewhere, and oncology drugs, partly offset by lower health promotion costs.

**Infrastructure and non-clinical** (favourable)
Food and laundry services, and feasibility costs.

**Nursing personnel** (favourable)
Vacancies and annual leave.

**Allied health personnel** (favourable)
Vacancies

## Year to Date Expenditure




**Clinical supplies** (unfavourable)
Mainly efficiencies not yet achieved or achieved elsewhere. Also includes patient transport costs and biologics.

**Medical personnel and locums** (unfavourable)
Locums for vacancy and leave cover, leave not taken, additional sessions to meet targets, additional radiology SMO costs and some additional RMO positions.

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

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

**Other personnel** (unfavourable)
Maori Health vacancies, management restructuring costs, and additional administration staffing to provide cover.

**Infrastructure and non-clinical** (unfavourable)
Efficiencies not yet achieved, and legal costs relating to the gastroenterology outbreak.

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

## Full time equivalents (FTE)

FTEs are 26 unfavourable year to date including:

**Nursing personnel** (26 FTE / 2.9% unfavourable)

- Higher than budgeted staffing in certain areas including ED and the medical wards. Some planned efficiencies have not been achieved or have been achieved elsewhere.

**Management and administration personnel** (9 FTE 3.6% unfavourable)

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

**Support personnel** (6 FTE / 5.1% unfavourable)

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

partly offset by:

**Allied Health Personnel** (19 FTE / 4.1% favourable)

- Vacancies mainly in technicians, health promotion, social workers, community support workers and occupational therapy.

Medical FTEs are close to budget. Usually medical FTEs will be favourable because vacancy and leave cover is often provided by locums who do not generate an FTE. However year to date reductions caused by vacancies and staff on leave have been offset by leave not taken and new positions.

# MONTHLY ELECTIVE HEALTH TARGET REPORT
# YTD To April 2017

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

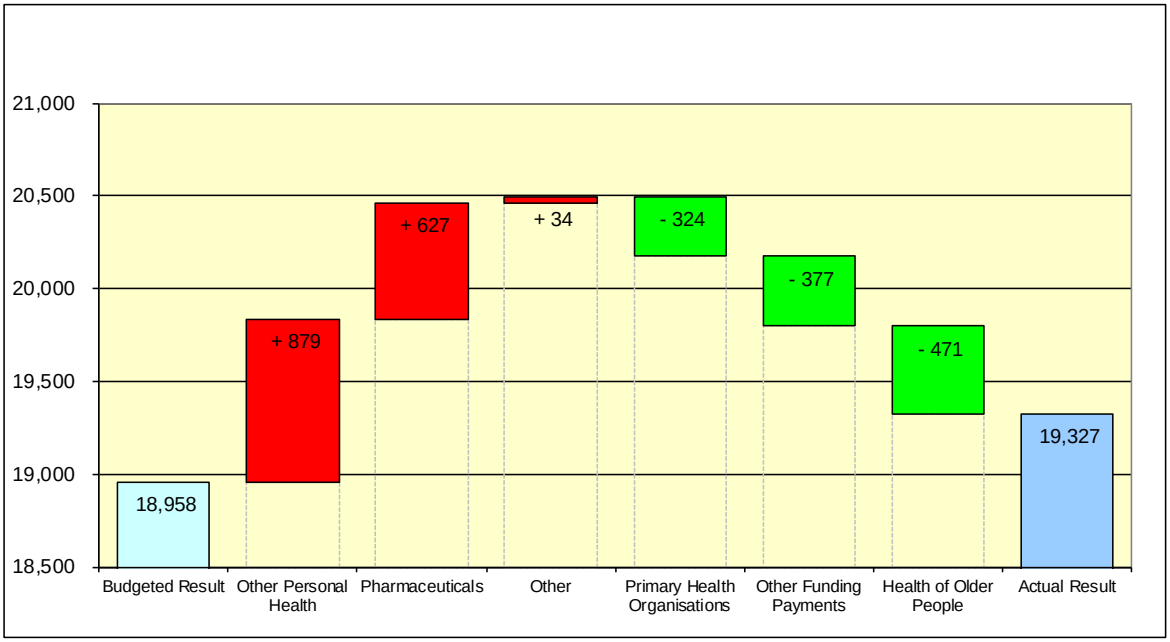
| | | YTD April-17 | | | | | | Apr-17 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Actual | Plan | Var. | %Var. | | | Actual | Plan | Var. | %Var. |
| On-Site | Avastins | 164 | 164 | 0 | 0.0% | On-Site | Avastins | 14 | 14 | 0 | 0.0% |
| | ENT | 443 | 464 | -21 | -4.5% | | ENT | 47 | 38 | 9 | 23.7% |
| | General Surgery | 690 | 728 | -38 | -5.2% | | General Surgery | 71 | 61 | 10 | 16.4% |
| | Gynaecology | 466 | 409 | 57 | 13.9% | | Gynaecology | 43 | 34 | 9 | 26.5% |
| | Maxillo-Facial | 127 | 149 | -22 | -14.8% | | Maxillo-Facial | 5 | 12 | -7 | -58.3% |
| | Ophthalmology | 792 | 887 | -95 | -10.7% | | Ophthalmology | 56 | 75 | -19 | -25.3% |
| | Orthopaedics | 666 | 755 | -89 | -11.8% | | Orthopaedics | 63 | 68 | -5 | -7.4% |
| | Skin Lesions | 143 | 143 | 0 | 0.0% | | Skin Lesions | 12 | 12 | 0 | 0.0% |
| | Urology | 401 | 351 | 50 | 14.2% | | Urology | 37 | 29 | 8 | 27.6% |
| | Vascular | 145 | 112 | 33 | 29.5% | | Vascular | 14 | 9 | 5 | 55.6% |
| | Surgical - Arranged | 451 | 341 | 110 | 32.3% | | Surgical - Arranged | 54 | 17 | 37 | 217.6% |
| | Non Surgical - Elective | 65 | 155 | -90 | -58.1% | | Non Surgical - Elective | 4 | 13 | -9 | -69.2% |
| | Non Surgical - Arranged | 22 | 58 | -36 | -62.1% | | Non Surgical - Arranged | 0 | 6 | -6 | -100.0% |
| **On-Site** | **Total** | **4575** | **4716** | **-141** | **-3.0%** | **On-Site** | **Total** | **420** | **388** | **32** | **8.2%** |
| Outsourced | Cardiothoracic | 0 | 35 | -35 | -100.0% | Outsourced | Cardiothoracic | 0 | 2 | -2 | -100.0% |
| | ENT | 122 | 120 | 2 | 1.7% | | ENT | 8 | 11 | -3 | -27.3% |
| | General Surgery | 258 | 220 | 38 | 17.3% | | General Surgery | 22 | 18 | 4 | 22.2% |
| | Gynaecology | 11 | 32 | -21 | -65.6% | | Gynaecology | 0 | 3 | -3 | -100.0% |
| | Maxillo-Facial | 35 | 59 | -24 | -40.7% | | Maxillo-Facial | 2 | 6 | -4 | -66.7% |
| | Neurosurgery | 0 | 16 | -16 | -100.0% | | Neurosurgery | 0 | 2 | -2 | -100.0% |
| | Ophthalmology | 123 | 18 | 105 | 583.3% | | Ophthalmology | 21 | 0 | 21 | 0.0% |
| | Orthopaedics | 78 | 51 | 27 | 52.9% | | Orthopaedics | 13 | 0 | 13 | 0.0% |
| | Paediatric Surgery | 0 | 2 | -2 | -100.0% | | Paediatric Surgery | 0 | 0 | 0 | 0.0% |
| | Skin Lesions | 3 | 0 | 0 | 0.0% | | Skin Lesions | 0 | 0 | 0 | 100.0% |
| | Urology | 53 | 67 | -14 | -20.9% | | Urology | 3 | 6 | -3 | -50.0% |
| | Vascular | 19 | 36 | -17 | -47.2% | | Vascular | 1 | 4 | -3 | -75.0% |
| | Surgical - Arranged | 0 | 0 | 0 | 0.0% | | Surgical - Arranged | 0 | 0 | 0 | 0.0% |
| | Non Surgical - Elective | 0 | 0 | 0 | 0.0% | | Non Surgical - Elective | 0 | 0 | 0 | 0.0% |
| | Non Surgical - Arranged | 0 | 0 | 0 | 0.0% | | Non Surgical - Arranged | 0 | 0 | 0 | 0.0% |
| **Outsourced** | **Total** | **702** | **656** | **46** | **7.0%** | **Outsourced** | **Total** | **70** | **52** | **18** | **34.6%** |
| IDF Outflow | Avastins | 2 | 0 | 2 | 0.0% | IDF Outflow | Avastins | 0 | 0 | 0 | 0.0% |
| | Cardiothoracic | 53 | 64 | -11 | -17.2% | | Cardiothoracic | 2 | 6 | -4 | -66.7% |
| | ENT | 32 | 39 | -7 | -17.9% | | ENT | 4 | 3 | 1 | 33.3% |
| | General Surgery | 47 | 40 | 7 | 17.5% | | General Surgery | 5 | 4 | 1 | 25.0% |
| | Gynaecology | 29 | 20 | 9 | 45.0% | | Gynaecology | 1 | 2 | -1 | -50.0% |
| | Maxillo-Facial | 124 | 157 | -33 | -21.0% | | Maxillo-Facial | 8 | 13 | -5 | -38.5% |
| | Neurosurgery | 61 | 35 | 26 | 74.3% | | Neurosurgery | 0 | 3 | -3 | -100.0% |
| | Ophthalmology | 29 | 27 | 2 | 7.4% | | Ophthalmology | 1 | 3 | -2 | -66.7% |
| | Orthopaedics | 28 | 16 | 12 | 75.0% | | Orthopaedics | 1 | 1 | 0 | 0.0% |
| | Paediatric Surgery | 62 | 43 | 19 | 44.2% | | Paediatric Surgery | 1 | 4 | -3 | -75.0% |
| | Skin Lesions | 60 | 62 | -2 | -3.2% | | Skin Lesions | 10 | 5 | 5 | 100.0% |
| | Urology | 16 | 5 | 11 | 220.0% | | Urology | 0 | 0 | 0 | 0.0% |
| | Vascular | 13 | 13 | 0 | 0.0% | | Vascular | 1 | 1 | 0 | 0.0% |
| | Surgical - Arranged | 128 | 251 | -123 | -49.0% | | Surgical - Arranged | 4 | 23 | -19 | -82.6% |
| | Non Surgical - Elective | 98 | 0 | 98 | 0.0% | | Non Surgical - Elective | 1 | 0 | 1 | 0.0% |
| | Non Surgical - Arranged | 44 | 0 | 44 | 0.0% | | Non Surgical - Arranged | 0 | 0 | 0 | 0.0% |
| **IDF Outflow** | **Total** | **826** | **772** | **54** | **7.0%** | **IDF Outflow** | **Total** | **39** | **68** | **-29** | **-42.6%** |
| **TOTAL** | | **6103** | **6144** | **-41** | **-0.7%** | **TOTAL** | | **529** | **508** | **21** | **4.1%** |

Please Note:This report was run on 5th May 2017. Skin Lesions and Avastins have been adjusted to plan.
Data is subject to change.

# 6. Funding Other Providers

| $'000 | April Actual | April Budget | April Variance | | Year to Date Actual | Year to Date Budget | Year to Date Variance | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| **Payments to Other Providers** | | | | | | | | | |
| Pharmaceuticals | 4,057 | 3,430 | (627) | -18.3% | 36,307 | 36,104 | (203) | -0.6% | 43,564 |
| Primary Health Organisations | 2,819 | 3,142 | 324 | 10.3% | 29,134 | 29,643 | 508 | 1.7% | 34,892 |
| Inter District Flows | 3,796 | 3,776 | (20) | -0.5% | 38,165 | 37,764 | (400) | -1.1% | 45,717 |
| Other Personal Health | 2,974 | 2,096 | (879) | -41.9% | 21,063 | 18,495 | (2,568) | -13.9% | 25,062 |
| Mental Health | 1,163 | 1,148 | (15) | -1.3% | 11,277 | 11,461 | 184 | 1.6% | 13,572 |
| Health of Older People | 4,688 | 5,159 | 471 | 9.1% | 50,693 | 51,587 | 894 | 1.7% | 60,838 |
| Other Funding Payments | (170) | 206 | 377 | 182.5% | 3,358 | 4,416 | 1,058 | 24.0% | 4,322 |
| | 19,327 | 18,958 | (369) | -1.9% | **189,997** | **189,469** | (527) | -0.3% | 227,969 |
| **Payments by Portfolio** | | | | | | | | | |
| Strategic Services | | | | | | | | | |
| Secondary Care | 5,045 | 3,898 | (1,147) | -29.4% | 42,681 | 38,980 | (3,701) | -9.5% | 50,695 |
| Primary Care | 8,355 | 8,075 | (280) | -3.5% | 78,720 | 79,049 | 328 | 0.4% | 94,521 |
| Chronic Disease Management | - | - | - | 0.0% | - | - | - | 0.0% | - |
| Mental Health | 1,163 | 1,148 | (15) | -1.3% | 11,412 | 11,461 | 49 | 0.4% | 13,707 |
| Health of Older People | 4,699 | 5,198 | 498 | 9.6% | 51,125 | 51,976 | 851 | 1.6% | 61,342 |
| Other Health Funding | (2) | 68 | 70 | 102.5% | 108 | 697 | 589 | 84.5% | 72 |
| Maori Health | 220 | 340 | 119 | 35.1% | 4,286 | 5,013 | 727 | 14.5% | 5,453 |
| Population Health | | | | | | | | | |
| Women, Child and Youth | 148 | 145 | (3) | -1.9% | 1,156 | 1,292 | 136 | 10.5% | 1,470 |
| Population Health | (301) | 87 | 389 | 445.3% | 509 | 1,001 | 493 | 49.2% | 710 |
| | 19,327 | 18,958 | (369) | -1.9% | **189,997** | **189,469** | (527) | -0.3% | 227,969 |

## April Expenditure




*Note the scale does not begin at zero*

**Other personal health** (unfavourable)
Unexpected IDF charge relating to a Hawke's Bay patient transferred to Auckland by Capital Coast DHB.

**Pharmaceuticals** (unfavourable)
Adjustment of expenditure to align with Pharmac forecasts.

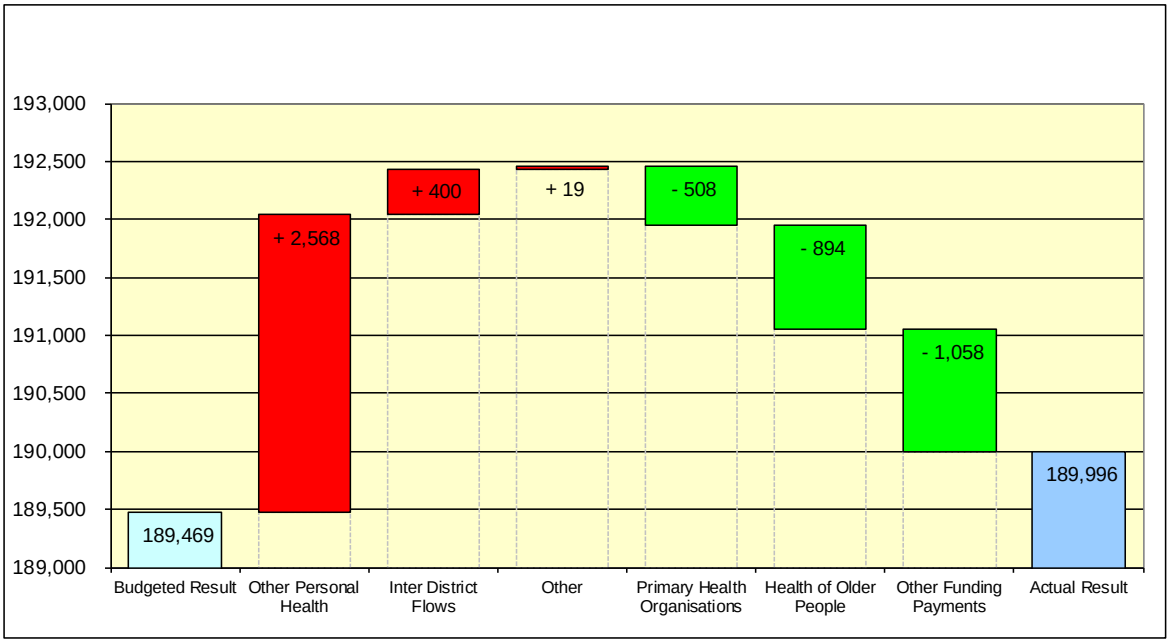
**Primary Health Organisations** (favourable)
Lower costs for first contact services and services to improve access.

**Other funding payments** (favourable)
Release of Maori primary health and population health accruals for work unlikely to be completed this year.

**Health of Older persons** (favourable)
Lower residential care costs.



## Year to Date Expenditure




**Other Personal Health** (unfavourable)
IDF wash-up provisions (included under other personnel health to allow MOH to consolidate inter DHB transactions), and high cost patient expenditure, partly offset by lower GMS payments, and the release of new investment budgets that are unlikely to be spent this year.

**Inter district flows** (unfavourable)
Overspend largely in acute activity related to cardiothoracic, cardiology, general medicine, haematology, oncology and plastics.

**Primary Health Organisations** (favourable)
Reducing volume.

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

**Other Funding Payments** (favourable)
Mostly the release of Maori primary health accruals from 2015/16.

# 7. Corporate Services

| $'000 | April Actual | April Budget | April Variance | | Year to Date Actual | Year to Date Budget | Year to Date Variance | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| **Operating Expenditure** | | | | | | | | | |
| Personnel | 1,053 | 1,162 | 109 | 9.4% | 13,267 | 12,455 | (812) | -6.5% | 15,877 |
| Outsourced services | 85 | 92 | 7 | 7.8% | 1,082 | 955 | (127) | -13.3% | 1,296 |
| Clinical supplies | 16 | 9 | (7) | -72.3% | 121 | 95 | (26) | -27.6% | 94 |
| Infrastructure and non clinical | 546 | 599 | 53 | 8.9% | 7,386 | 8,003 | 617 | 7.7% | 8,792 |
| | 1,699 | 1,862 | 163 | 8.7% | 21,856 | 21,507 | (349) | -1.6% | 26,058 |
| **Capital servicing** | | | | | | | | | |
| Depreciation and amortisation | 1,118 | 1,178 | 60 | 5.1% | 11,315 | 11,505 | 191 | 1.7% | 13,665 |
| Financing | - | 174 | 174 | 100.0% | 777 | 1,698 | 921 | 54.2% | (101) |
| Capital charge | 180 | - | (180) | 0.0% | 3,646 | 3,138 | (509) | -16.2% | 6,784 |
| | 1,298 | 1,351 | 54 | 4.0% | 15,738 | 16,341 | 603 | 3.7% | 20,348 |
| | **2,997** | **3,214** | 217 | 6.7% | **37,594** | **37,848** | 254 | 0.7% | **46,407** |
| **Full Time Equivalents** | | | | | | | | | |
| Medical personnel | 0.4 | 0.3 | (0) | -24.8% | 0 | 0 | (0) | -35.0% | 0.3 |
| Nursing personnel | 12.6 | 14.5 | 2 | 13.3% | 13 | 14 | 2 | 13.1% | 14.5 |
| Allied health personnel | 1.0 | 0.4 | (1) | -157.9% | 1 | 0 | (0) | -35.5% | 0.4 |
| Support personnel | 9.8 | 9.3 | (1) | -5.9% | 9 | 9 | (0) | -0.5% | 9.4 |
| Management and administration | 138.9 | 140.4 | 1 | 1.0% | 140 | 143 | 3 | 1.9% | 142.9 |
| | **162.7** | **164.8** | 2 | 1.3% | **163** | **167** | 4 | 2.6% | **167.5** |

Personnel includes restructuring costs including recruitment. Financing and capital charges reflect the debt to equity swap. The swap is cost neutral with the variance from budget offset in income (see section 4).

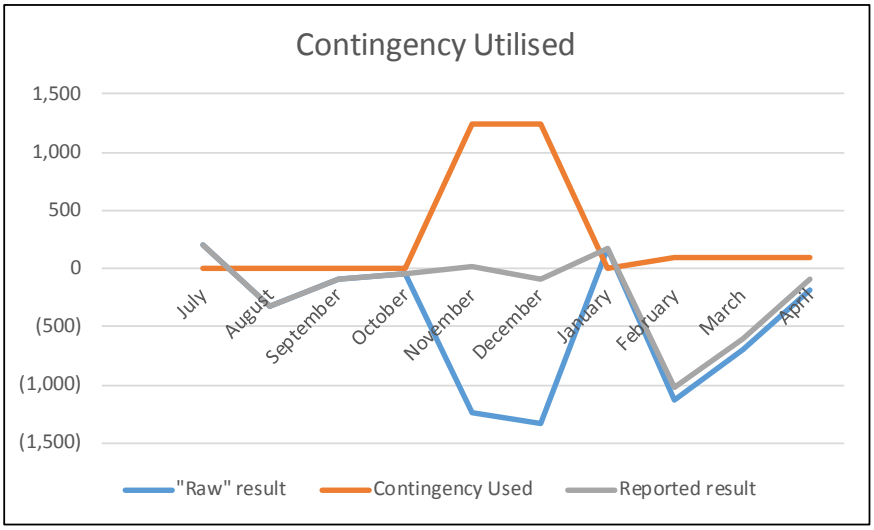
# 8. Reserves

| $'000 | April Actual | April Budget | April Variance | | Year to Date Actual | Year to Date Budget | Year to Date Variance | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| **Expenditure** | | | | | | | | | |
| Contingency | (165) | 15 | 180 | 1218.9% | (3,302) | 60 | 3,362 | 5617.6% | 552 |
| Transform and Sustain resource | 9 | 37 | 28 | 75.5% | 139 | 518 | 378 | 73.1% | 207 |
| Other | (155) | 40 | 195 | 484.8% | (7) | 548 | 554 | 101.2% | (225) |
| | **(311)** | **92** | 403 | 437.3% | **(3,169)** | **1,126** | 4,294 | 381.6% | **533** |

Contingency usage year to date includes:

- $1.4 million to offset IDF provisioning
- $1.0 million for costs relating to the gastroenteritis outbreak
- $0.3 million for costs relating to the RMO strike.
- $0.1 million to release a pro rata portion of the remaining contingency

The impact of contingency utilisation on the reported result over the financial year is graphed below.




Contingency budgets transferred to operational costs reconcile as follows:

| | *$'000* |
|---|---|
| Original contingency budget | 3,000 |
| *Plus:* | |
| Revenue banking | 4,200 |
| *Less:* | |
| Additional surplus agreed with MOH | -500 |
| Feasibility studies | -600 |
| Elective surgery delivery costs | -1,942 |
| Melanoma and oncology treatments | -295 |
| Additional resource for payroll and health records | -61 |
| Remaining contingency budget ($3.0 million of general contingency, and $0.8 million T&S) | 3,802 |

All of the contingency has been released for the forecast.

# 9. Financial Performance by MOH Classification

| $'000 | April Actual | April Annual Plan | April Variance | Year to Date Actual | Year to Date Annual Plan | Year to Date Variance | End of Year Forecast | End of Year Annual Plan | End of Year Variance |
|---|---|---|---|---|---|---|---|---|---|
| **Funding** | | | | | | | | | |
| Income | 41,276 | 41,884 | (608) U | 420,436 | 418,814 | 1,622 F | 512,598 | 511,288 | 1,310 F |
| *Less:* | | | | | | | | | |
| Payments to Internal Providers | 21,941 | 21,413 | (528) U | 229,748 | 228,702 | (1,046) U | 280,654 | 279,687 | (967) U |
| Payments to Other Providers | 19,327 | 18,958 | (369) U | 189,997 | 189,469 | (527) U | 227,969 | 227,305 | (664) U |
| Contribution | **7** | **1,513** | **(1,505) U** | **692** | **643** | **49 F** | **3,975** | **4,296** | **(321) U** |
| **Governance and Funding Admin.** | | | | | | | | | |
| Funding | 266 | 266 | - | 2,663 | 2,663 | - | 3,197 | 3,197 | - |
| Other Income | 3 | 3 | - | 24 | 25 | (1) U | 29 | 30 | (1) U |
| *Less:* | | | | | | | | | |
| Expenditure | 180 | 299 | 119 F | 2,544 | 2,971 | 428 F | 3,296 | 3,573 | 277 F |
| Contribution | **88** | **(30)** | **119 F** | **144** | **(283)** | **427 F** | **(70)** | **(346)** | **276 F** |
| **Health Provision** | | | | | | | | | |
| Funding | 21,675 | 21,147 | 528 F | 227,085 | 226,039 | 1,046 F | 277,457 | 276,490 | 967 F |
| Other Income | 2,613 | 2,501 | 112 F | 17,825 | 17,966 | (141) U | 21,211 | 21,398 | (187) U |
| *Less:* | | | | | | | | | |
| Expenditure | 22,623 | 23,285 | 661 F | 243,698 | 240,454 | (3,244) U | 299,073 | 296,838 | (2,235) U |
| Contribution | **1,665** | **364** | **1,301 F** | **1,211** | **3,551** | **(2,339) U** | **(406)** | **1,050** | **(1,455) U** |
| **Net Result** | **1,760** | **1,846** | **(85)** U | **2,047** | **3,910** | **(1,863)** U | **3,500** | **5,000** | **(1,500)** U |

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

# 10. Management Budget Movements

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

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

| $'000 | April Mgmt Budget | April Annual Plan | April Movement | Year to Date Mgmt Budget | Year to Date Annual Plan | Year to Date Movement | End of Year Mgmt Budget | End of Year Annual Plan | End of Year Movement |
|---|---|---|---|---|---|---|---|---|---|
| **Funding** | | | | | | | | | |
| Income | 41,884 | 41,661 | 223 F | 418,814 | 419,035 | (221) U | 511,288 | 511,803 | (515) U |
| *Less:* | | | | | | | | | |
| Payments to Internal Providers | 21,413 | 21,287 | (126) U | 228,702 | 225,184 | (3,518) U | 279,687 | 275,461 | (4,226) U |
| Payments to Other Providers | 18,958 | 19,515 | 557 F | 189,469 | 192,808 | 3,338 F | 227,305 | 231,341 | 4,036 F |
| Contribution | **1,513** | **858** | **654 F** | **643** | **1,044** | **(401) U** | **4,296** | **5,000** | **(704) U** |
| **Governance and Funding Admin.** | | | | | | | | | |
| Funding | 266 | 268 | (2) U | 2,663 | 2,682 | (19) U | 3,197 | 3,220 | (23) U |
| Other Income | 3 | 3 | - | 25 | 25 | - | 30 | 30 | - |
| *Less:* | | | | | | | | | |
| Expenditure | 299 | 271 | (29) U | 2,971 | 2,707 | (264) U | 3,573 | 3,250 | (323) U |
| Contribution | **(30)** | **-** | **(30) U** | **(283)** | **-** | **(283) U** | **(346)** | **-** | **(346) U** |
| **Health Provision** | | | | | | | | | |
| Funding | 21,147 | 21,019 | 128 F | 226,039 | 222,502 | 3,537 F | 276,490 | 272,241 | 4,249 F |
| Other Income | 2,501 | 1,976 | 525 F | 17,966 | 17,244 | 722 F | 21,398 | 20,366 | 1,032 F |
| *Less:* | | | | | | | | | |
| Expenditure | 23,285 | 22,007 | (1,277) U | 240,454 | 236,879 | (3,575) U | 296,838 | 292,608 | (4,231) U |
| Contribution | **364** | **987** | **(624) U** | **3,551** | **2,866** | **684 F** | **1,050** | **(0)** | **1,050 F** |
| **Net Result** | **1,846** | **1,846** | **0** F | **3,910** | **3,910** | **0** F | **5,000** | **5,000** | **0** F |

# 11. Quality and Financial Improvement Programme

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

At the end of April we have achieved 75% of our year-to-date savings target (unchanged from March).

| Row Labels | Sum of Planned Savings | Sum of ytd savings target | Sum of YTD actual Savings | %age Savings Achieved |
|---|---|---|---|---|
| Corporate | 1,526,792 | 1,272,326 | 1,170,037 | 92% |
| Health Services | 8,292,287 | 6,910,239 | 5,099,873 | 74% |
| Population Health | 26,166 | 21,805 | 21,805 | 100% |
| Maori | 148,195 | 123,496 | 123,496 | 100% |
| Health Funding | 3,006,808 | 2,505,673 | 1,731,667 | 69% |
| **Grand Total** | **13,000,248** | **10,833,540** | **8,146,878** | **75%** |

| Row Labels | Sum of Planned Savings | Sum of ytd savings target | Sum of YTD actual Savings |
|---|---|---|---|
| **AMBER** | **6,055,703** | **5,046,419** | **3,625,440** |
| Acute Medical | 2,407,523 | 2,006,269 | 1,532,610 |
| DON | 10,587 | 8,823 | - |
| FAC | 34,114 | 28,428 | 21,003 |
| Information Services | 326,304 | 271,920 | 185,963 |
| OPE | 553,717 | 461,431 | 311,602 |
| Strategic Services | 853,000 | 710,833 | 710,833 |
| Surgical | 1,474,734 | 1,228,945 | 603,576 |
| WCY | 395,723 | 329,769 | 259,853 |
| **RED** | **1,727,667** | **1,439,723** | **187,500** |
| Business Intelligence | 9,012 | 7,510 | - |
| FAC | 17,563 | 14,636 | - |
| OPE | 47,619 | 39,682 | - |
| Strategic Services | 1,153,808 | 961,507 | 187,500 |
| Surgical | 484,665 | 403,888 | - |
| WCY | 15,000 | 12,500 | - |
| **Grand Total** | **7,783,370** | **6,486,142** | **3,812,940** |

# 12. Financial Position

| 30 June 2016 | $'000 | April Actual | April Budget | April Variance from budget | April Movement from 30 June 2016 | Annual Budget |
|---|---|---|---|---|---|---|
| | **Equity** | | | | | |
| 102,608 | Crown equity and reserves | 150,108 | 105,733 | (44,375) | 47,500 | 105,376 |
| (10,973) | Accumulated deficit | (8,927) | (12,359) | (3,432) | 2,047 | (11,268) |
| 91,635 | | 141,182 | 93,374 | (47,807) | 49,547 | 94,108 |
| | **Represented by:** | | | | | |
| | Current Assets | | | | | |
| 15,552 | Bank | 27,256 | 8,358 | (18,898) | 11,704 | 8,523 |
| 1,724 | Bank deposits > 90 days | 1,755 | 1,741 | (14) | 31 | 1,741 |
| 22,433 | Prepayments and receivables | 17,969 | 18,554 | 585 | (4,464) | 18,618 |
| 4,293 | Inventory | 4,335 | 4,030 | (305) | 42 | 4,044 |
| 1,220 | Non current assets held for sale | 625 | - | (625) | (595) | - |
| 45,222 | | 51,940 | 32,684 | (19,256) | 6,717 | 32,927 |
| | Non Current Assets | | | | | |
| 151,944 | Property, plant and equipment | 149,904 | 165,024 | 15,120 | (2,040) | 166,159 |
| 2,037 | Intangible assets | 1,690 | 764 | (926) | (347) | 665 |
| 9,777 | Investments | 10,675 | 9,192 | (1,483) | 898 | 9,476 |
| 163,758 | | 162,269 | 174,979 | 12,710 | (1,489) | 176,299 |
| **208,980** | **Total Assets** | **214,208** | **207,663** | **(6,545)** | **5,228** | **209,226** |
| | **Liabilities** | | | | | |
| | Current Liabilities | | | | | |
| 38,137 | Payables | 35,577 | 30,897 | (4,680) | (2,561) | 30,697 |
| 34,070 | Employee entitlements | 34,813 | 33,465 | (1,348) | 742 | 34,484 |
| - | Current portion of borrowings | - | 6,000 | 6,000 | - | 6,000 |
| 72,208 | | 70,389 | 70,362 | (28) | (1,818) | 71,180 |
| | Non Current Liabilities | | | | | |
| 2,638 | Employee entitlements | 2,638 | 2,427 | (211) | - | 2,438 |
| 42,500 | Term borrowing | - | 41,500 | 41,500 | (42,500) | 41,500 |
| 45,138 | | 2,638 | 43,927 | 41,289 | (42,500) | 43,938 |
| **117,345** | **Total Liabilities** | **73,027** | **114,289** | **41,262** | **(44,318)** | **115,118** |
| | | | | | | |
| **91,635** | **Net Assets** | **141,182** | **93,374** | **(47,807)** | **49,547** | **94,108** |

The variance from budget for:

- Equity reflects the amount the budgeted opening balance differs from the 2015/16 result and the variance in the 2016/17 result year-to-date, the swap of the DHB's debt into equity on 15 February, and the $5 million equity injection for the mental health build;
- Bank and property, plant and equipment mainly reflect the lower capital spend;
- Non-current assets held for sale was adjusted for the reclassification of 307 Omahu Road to property, plant and equipment in November;
- Borrowing, both term and current, reflect the debt to equity swap.
- Employee entitlements – see below

# 13. Employee Entitlements

| *30 June* | | *April* | | | | *Annual* |
|---|---|---|---|---|---|---|
| *2016* | $'000 | *Actual* | *Budget* | *Variance from budget* | *Movement from 30 June 2016* | *Budget* |
| 7,466 | Salaries & wages accrued | 7,503 | 5,513 | (1,990) | 37 | 6,559 |
| 482 | ACC levy provisions | 1,384 | 775 | (609) | 902 | 851 |
| 5,348 | Continuing medical education | 5,630 | 5,614 | (16) | 282 | 5,131 |
| 19,149 | Accrued leave | 18,949 | 19,878 | 929 | (200) | 20,249 |
| 4,263 | Long service leave & retirement grat. | 3,984 | 4,112 | 129 | (279) | 4,131 |
| 36,708 | **Total Employee Entitlements** | 37,450 | 35,892 | (1,558) | 742 | 36,922 |

# 14. Treasury

**Liquidity management**

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

**Debt management**

The $42.5 million term debt facility with MOH was swapped into equity on 15 February 2017. The $5 million equity injection for the mental health build, was received in March. The DHB now has no interest rate exposure relating to debt.

**Foreign exchange risk management**

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

# 15. Capital Expenditure

See next page.

| 2017 Annual Plan | | Actual $'000 | Year to Date Budget $'000 | Variance $'000 |
|---|---|---|---|---|
| | Source of Funds | | | |
| | **Operating Sources** | | | |
| 14,440 | Depreciation | 11,315 | 11,505 | 191 |
| 5,000 | Surplus/(Deficit) | 2,047 | 3,910 | 1,863 |
| (2,479) | Working Capital | 38,147 | (2,251) | 57,042 |
| 16,961 | | 51,508 | 13,164 | 59,096 |
| | **Other Sources** | | | |
| - | Special funds and clinical trials | 64 | - | (64) |
| 1,220 | Sale of assets | - | 1,220 | (1,220) |
| 5,000 | Borrowings | (42,500) | 5,000 | (47,500) |
| 6,220 | | (42,436) | 6,220 | (48,784) |
| **23,181** | **Total funds sourced** | **9,072** | **19,384** | **10,312** |
| | Application of Funds: | | | |
| | **Block Allocations** | | | |
| 3,183 | Facilities | 2,124 | 2,828 | 705 |
| 3,125 | Information Services | 615 | 2,528 | 1,913 |
| 5,464 | Clinical Plant & Equipment | 2,039 | 4,501 | 2,461 |
| 11,772 | | 4,778 | 9,857 | 5,079 |
| | **Local Strategic** | | | |
| 2,460 | MRI | - | 2,049 | 2,049 |
| 500 | Renal Centralised Development | 387 | 417 | 30 |
| 3,000 | New Stand-alone Endoscopy Unit | 1,144 | 2,499 | 1,355 |
| 710 | New Mental Health Inpatient Unit Development | 356 | 591 | 235 |
| 100 | Maternity Services | 132 | 33 | (98) |
| 400 | Upgrade old MHIU | 1,311 | 652 | (659) |
| 400 | Travel Plan | 192 | 333 | 141 |
| 400 | Histology and Education Centre Upgrade | 62 | 214 | 152 |
| 1,100 | Fluoroscopy Unit | - | 916 | 916 |
| 200 | Education Centre Upgrade | - | (33) | (33) |
| 9,270 | | 3,584 | 7,672 | 4,088 |
| | **Other** | | | |
| - | Special funds and clinical trials | 64 | - | (64) |
| 1,000 | New Technologies/Investments | - | 1,000 | 1,000 |
| - | Other | 42 | - | (42) |
| 1,000 | | 106 | 1,000 | 894 |
| ***22,042*** | ***Capital Spend*** | ***8,468*** | ***18,529*** | ***10,061*** |
| | **Regional Strategic** | | | |
| 1,139 | RHIP (formerly CRISP) | 605 | 855 | 250 |
| 1,139 | | 605 | 855 | 250 |
| **23,181** | **Total funds applied** | **9,072** | **19,384** | **10,312** |

## 16. Rolling Cash Flow

| | Actual | April Forecast | Variance | May Forecast | Jun Forecast | Jul Budget | Aug Budget | Sep Budget | Oct Budget | Nov Budget | Dec Budget | Jan Budget | Feb Budget | Mar Budget | Apr Budget |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cash flows from operating activities** | | | | | | | | | | | | | | | |
| Cash receipts from Crown agencies | 40,934 | 43,294 | (2,360) | 41,705 | 52,759 | 43,965 | 43,244 | 43,417 | 52,577 | 46,986 | 43,533 | 43,643 | 46,625 | 43,630 | 43,627 |
| Cash receipts from donations, bequests and clinical trials | 12 | - | 12 | - | - | - | - | - | - | - | - | - | - | - | - |
| Cash receipts from other sources | (1,278) | 443 | (1,721) | 446 | 441 | 439 | 439 | 439 | 504 | 439 | 452 | 451 | 451 | 451 | 451 |
| Cash paid to suppliers | (20,899) | (26,783) | 5,884 | (24,663) | (30,193) | (27,221) | (25,865) | (26,731) | (26,094) | (26,456) | (26,892) | (25,612) | (23,361) | (26,456) | (26,410) |
| Cash paid to employees | (17,224) | (15,342) | (1,882) | (18,048) | (15,743) | (15,294) | (20,463) | (15,361) | (15,533) | (18,480) | (14,964) | (22,873) | (15,786) | (15,610) | (15,927) |
| **Cash generated from operations** | **1,544** | **1,611** | **(67)** | **(561)** | **7,264** | **1,888** | **(2,645)** | **1,764** | **11,453** | **2,489** | **2,129** | **(4,392)** | **7,930** | **2,015** | **1,741** |
| Interest received | 81 | 73 | 8 | 75 | 73 | 74 | 74 | 74 | 74 | 74 | 74 | 74 | 74 | 74 | 74 |
| Interest paid | - | (0) | 0 | 544 | 356 | (14) | (15) | 201 | (7) | (69) | (90) | (16) | 4 | 178 | (4) |
| Capital charge paid | (180) | - | (180) | - | (5,906) | (0) | (0) | (0) | (0) | (0) | (8,537) | (0) | (0) | (0) | (0) |
| **Net cash inflow/(outflow) from operating activities** | **1,445** | **1,684** | **(239)** | **58** | **1,787** | **1,948** | **(2,587)** | **2,039** | **11,520** | **2,494** | **(6,425)** | **(4,334)** | **8,007** | **2,266** | **1,810** |
| **Cash flows from investing activities** | | | | | | | | | | | | | | | |
| Proceeds from sale of property, plant and equipment | - | 0 | (0) | 0 | 0 | - | - | - | - | - | - | - | - | - | - |
| Acquisition of property, plant and equipment | (451) | (2,266) | 1,815 | (2,284) | (3,190) | (2,568) | (2,568) | (2,568) | (2,568) | (2,568) | (2,568) | (2,568) | (2,568) | (2,568) | (2,568) |
| Acquisition of intangible assets | (43) | (20) | (23) | (20) | - | (338) | (338) | (338) | (338) | (338) | (338) | (338) | (338) | (338) | (338) |
| Acquisition of investments | (245) | (245) | 0 | - | (245) | - | - | (249) | - | - | (249) | - | - | (249) | - |
| **Net cash inflow/(outflow) from investing activities** | **(739)** | **(2,531)** | **1,792** | **(2,304)** | **(3,435)** | **(2,906)** | **(2,906)** | **(3,155)** | **(2,906)** | **(2,906)** | **(3,155)** | **(2,906)** | **(2,906)** | **(3,155)** | **(2,906)** |
| **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 | 706 | (847) | 1,553 | (2,246) | (2,006) | (959) | (5,493) | (1,116) | 8,613 | (413) | (9,580) | (7,241) | 5,100 | (889) | (1,096) |
| Add:Opening cash | 23,308 | 28,305 | (4,997) | 24,014 | 21,768 | 19,762 | 18,803 | 13,310 | 12,194 | 20,807 | 20,394 | 10,814 | 3,573 | 8,674 | 7,785 |
| **Cash and cash equivalents at end of year** | **24,014** | **27,457** | **(3,444)** | **21,768** | **19,762** | **18,803** | **13,310** | **12,194** | **20,807** | **20,394** | **10,814** | **3,573** | **8,674** | **7,785** | **6,689** |
| **Cash and cash equivalents** | | | | | | | | | | | | | | | |
| Cash | 4 | 4 | - | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Short term investments (excl. special funds/clinical trials) | 25,984 | 24,419 | 1,565 | 18,741 | 16,735 | 15,773 | 10,280 | 9,163 | 17,776 | 17,364 | 7,783 | 543 | 5,643 | 4,754 | 3,658 |
| Short term investments (special funds/clinical trials) | 3,015 | 3,033 | (18) | 3,015 | 3,015 | 3,026 | 3,026 | 3,026 | 3,026 | 3,026 | 3,026 | 3,026 | 3,026 | 3,026 | 3,026 |
| Bank overdraft | 8 | 1 | 6 | 8 | 8 | - | - | - | - | - | - | - | - | - | - |
| | **29,011** | **27,458** | **1,553** | **21,768** | **19,762** | **18,804** | **13,311** | **12,194** | **20,807** | **20,395** | **10,814** | **3,574** | **8,674** | **7,785** | **6,689** |

The forecast for the 2017/18 year is based on the draft budget, and may change substantially dependant on the budget.

# BOARD HEALTH & SAFETY CHAMPION'S UPDATE

Verbal

HAWKE'S BAY
District Health Board
Whakawāteatia

# CONSUMER STORY

11

Verbal

| | | |
|---|---|---|
| OURHEALTH HAWKE'S BAY Whakawateatia | **Hawke's Bay Clinical Council** | 48 |
| | For the attention of:<br>**HBDHB Board** | |
| Document Owner: | Chris McKenna and Dr Mark Peterson as Co-Chairs | |
| Reviewed by: | Not applicable | |
| Month: | May, 2017 | |
| Consideration: | For Information | |

12

**RECOMMENDATION**

**That the Board note that Clinical Council reviewed and commented on the following:**

- Clincial Services TOR and programme
- Health Literacy Principles & Proposed Action Plan
- ICU Progress Report
- Best Start Healthy Eating and Activity Plan Update
- Legislative compliance programme report
- Annual Maori Plan Dashboard (Q3)
- HB Clinical Research Committee update
- Infection Prevention & Control committee

Council met on 10 May 2017, an overview of issues discussed and/or agreed at the meeting are provided below.

## The following papers were noted:

***Clinical Services Plan***

Sapere presented to Clinical Council the methodology and TOR for undertaking this piece of work. Clinical Council rasied a number of observations:

- Intention is to develop a plan on how we serve our community better in a whole of system approach to reduce inequities in outcomes
- We need to find different ways to deliver services
- Flexibility in our staff and systems and physical environment so that we can adapt with changes over the next 15-20 years
- The need to engage all the workforce, not just clinical and consultation with consumers and Maori communities will be integral

Clinical Council noted that there would be opportunity in a variety of forums to provide input. Clinical Council noted the TOR for this project.

***ICU Review 2013 Progress Report***

Clinical Council received an update on progress with the Learnings review and the ICU Review 2013. Good progress was being made and it was hoped that as part of the Clinical Services Plan there would be an opportunity to better define the ICU model of care.

***Health Literacy Progress Update***

The Clincial Council discussed the principles and the action plan for the next phase which is focussed on reducing the burden on consumers by addressing system issues alongside improving the way in which clinicians engages with consumers. Feedback from MRB was also tabled with the need to build the skills and capability of our consumers health knowledge in their community and work alongside the PHO. The next phase of the project is how we become a health literate system. The HEAT tool has been used to ensure that the work undertaken will have a positive impact in reducing inequities and a sustainable model and tools are in place. Feedback and observations from Clincial Council included:

- There is a lack of health literacy with practitioners who do not know the system well either, there are a lot of gaps
- It is important to empower staff with knowledge on health literacy so they can drive it, rather than it coming from the top
- Education is a key determinate. Building health knowledge should be an additional principle and intersectorial work will be crucial
- International literature is clear, it is the literacy of the system and not individual's health literacy that make the difference.

The Clinical Council **noted** the health literacy principles and the proposed action plan

***Best Start Healthy Eating and Activity Plan Update***

CLincial Council received a paper providing an update around progress and were shown a number of resources that were being utilised to supported growing the health literacy of consumers. As part of the development of the Social Inclusion strategy a number of strategies were being worked up to be included in this overarching plan.

**Legislative compliance programme report**

The report was included in the meeting papers for information. No issues noted and endorsed the proposed review of the mechanism for undertaking the legislative compliance programme in the future.

## Monitoring Reports

A number of monitoring reports were provided:

***Annual Maori Plan Dashboard (Q3) -***

Clinical Council noted the report. It was noted that the % of staff completing Engaging Effectively with Maori was not progressing as well as hoped. It was noted that a stocktake of all the work around this and the recruitment and retention of Maori staff was going to be undertaken and a refreshed programme of work to create a diverse workforce with the necessary skills would be presented to MRB in July.

**HB Clinical Research Committee update**

Dr John Gommans, Chief Medical and Dental Officer and Chair of the Hawke's Bay Clinical Research Committee advised that the Annual Report was included in the meeting papers for information. The committee meets quarterly and looks at research being undertaken across the sector. There are no governance concerns about how procedures are being done.

The Clinical Council **noted** the contents of the report.

**Infection Prevention & Control committee**

The trends in the report are within the thresholds agreed by the Infection Control Committee. The hand hygiene compliance rate as at 31 March was 88.7%, the highest compliance rate in New Zealand. For the last three quarters HBDHB has been first or second, which is good sustained performance around hand hygiene. The Gold Auditors were commended for their work to capture the hand hygiene “moments”.

| | |
|---|---|
| OURHEALTH HAWKE'S BAY Whakawateatia | **HB Health Consumer Council** 49 |
| | For the attention of: **HBDHB Board** |
| Document Owner: | Graeme Norton, Chair |
| Reviewed by: | Not applicable |
| Month: | May 2017 |
| Consideration: | For Information |

13

**RECOMMENDATION**

**That the Board**

Review the contents of this report; and

**Note that Consumer Council:**

- **Supported** the principles in the Health Literacy Principles & Implementation Paperl
- **Endorsed** the Consumer Engagement Strategy

Council met on 11th May 2017, an overview of issues discussed and/or agreed at the meeting are provided below.

**The following papers/matters were considered:**

- ***Health Literacy Principles & Implementation***

Whilst the council supports the principles in the document members were critical of aspects including:

- the report itself was "dense" and could have been more readable and accessible
- it would have benefited from inclusion of real life examples that are pithy and model what we mean
- evidence from work already done on this via the PHO and elsewhere seemed to be missing; we don't want wheel reinvention here
- some more emphasis on access and navigation is needed.

- ***Recognising Consumer Participation***

Council members gave a range of suggestions and comments on how consumer participation might be recognised as part of a process to review and, if necessary, change the current board policy on this subject. Council supported using the Auckland DHBs' policy as a base point to be modified for local flavour and then for consideration. Once finalised it will be submitted for consideration.

- ***Consumer Engagement Strategy (Final)***

Council endorsed the consumer engagement strategy having worked on it in draft previously. This document will now go to EMT for their approval to go through Board via Clinical Council and MRB.

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

The recruitment process for chair (August) and member positions (June) is underway with letters out to all known health groups plus local newspaper and social media carrying the information.

- ***Disability Liaison***

There is a recurring theme at our council meetings that experience of those with disailities who enter services is not as good as it should be, that other regions are more up with the play and that we could be doing better. We intend to do some work on this issue at our next council meeting and report back on our findings. This will also assist with a M0H request for information recently received on the issue.

- ***Farewell Jim Morunga***

James “Jimmy” Morunga OBE was an inaugural member of our council. His passing earlier this month was marked by special karakia and a sharing of memories of his sharp wit and valued contribution to our work. We will miss him.

| | | |
|---|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Māori Relationship Board (MRB)** | 50 |
| | For the attention of:<br>**HBDHB Board** | |
| Document Owner: | Ngahiwi Tomoana (Chair) | |
| Reviewed by: | Not applicable | |
| Month: | May 2017 | |
| Consideration: | For Information | |

**RECOMMENDATION**

**That the HBDHB Board**

Note the contents of this report.

14

MRB met on 10 May 2017, an overview of issues discussed and recommendations at the meeting are provided below.

**The following reports and papers were discussed and considered:**

**MRB REPRESENTATION AT HB CLINICAL COUNCIL**

MRB discussed the value of Māori representation on DHB committees and emphasized ensuring the right person and expertise represent accordingly. It was agreed when there is a strategic issue impacting on Māori to be presented to HB Clinical Council, an MRB representative will be present. MRB will develop a process to ensure MRB are in attendance at Clinical Council meetings to address strategic issues.

**DNA STATISTICS**

MRB were concerned with the increase in DNA rates. They were pleased that the DNA will be reintroduced into the Te Ara Whakawaiora programme with a renewed focus. There is a project in place to improve patient processes.

**CULTURAL COMPETENCY**

The MRB were concerned with the lack of traction with RMO's participating in Cultural Competency Training. The Cultural Competency framework is currently being refreshed by Dr James Graeme (Senior Advisor Cultural Competency, Māori Health Service). MRB are interested in reasons why RMOs and SMOs are not attending cultural competency training and have asked GM Māori Health to investigate and report back to MRB the current Cultrual Competency training restrictions of RMO and SMOs.

**HEALTH LITERACY PRINCIPLES & IMPLEMENTATION APPROACH**

Adam McDonald (Health Literacy Advisor) presented the Health Literacy Principals paper. MRB acknowledge that Health Literacy is a priority for the health system and particularly the impact on Māori community. MRB want to see health knowledge built into the community and recommend this be a priority for the Health Literacy project implementation.

The MRB **supported** the **Executive Director of People and Quality** to develop and evolve a system to assist the consumer becoming health literate and build the health knowledge within the community.

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **NZ Health Partnerships - Statement of Intent and Annual Plan** 51 |
| | For the attention of: **HBDHB Board** |
| Document Owner: | Ken Foote, Company Secretary |
| Month: | May 2017 |
| Consideration: | For Approval |

**RECOMMENDATION**

**That the HBDHB Board**, as a shareholder in NZ Health Partnerships Ltd

1. **Approve** the NZHP Combined Statement of Intent 2017-2021 and Statement of Performance Expectations 2017/18
2. **Approve** the Annual Plan 2017/18

15

The attached letter from the Chief Executive, NZ Health Partnership sets out the background and status of this request for DHB shareholder approval. The two key documents are also attached.

The Board will need to discuss / approve these documents at the meeting to be held on 31 May 2017 to meet the timelines set out in the attached letter.

**COMMERCIAL IN CONFIDENCE**

# FOR SHAREHOLDER APPROVAL

## Annual Plan 2017/18, Combined Statement of Intent 2017 - 2021 and Statement of Expectations 2017/18

**To:** DHB Chairs and Chief Executives

**From:** Megan Main, Chief Executive, NZ Health Partnerships

**Date:** 11 May 2016

---

Dear Colleagues

I am pleased to forward for your approval our final Combined Statement of Intent 2017 - 2021 (SOI) and Statement of Performance Expectations 2017/18 (SPE), and final Annual Plan 2017/18 (Annual Plan) documents.

### Background

In accordance with the Crown Entities Act 2004 (s157A) and with our Shareholders Agreement, NZ Health Partnerships is required to prepare a SOI and an SPE. The combined SOI-SPE documents provide readers with a complete understanding of our strategic intentions for the next four years. It includes targets and measures to gauge how we progress and perform each year.

The Annual Plan also sets out our key programme, services and management priorities during the 2017/18 financial year. It provides information on the recent implementation of the Procurement Operating Model, establishment of the National Procurement Service, and a focus on the National Oracle Solution programme.

### Status

The NZ Health Partnerships Board has approved the draft SOI-SPE and Annual Plan documents, as enclosed, for DHB review and approval.

The table on the next page shows the steps required to achieve shareholder approval and meet Treasury requirements by 30 June. It details 31 May as the deadline date for your written approval.

### Action requested

Please forward your formal written approval on the SOI-SPE and Annual Plan documents to Geoff Goodwin, GM Corporate Services (geoff.goodwin@nzhealthpartnerships.co.nz) as soon as possible.

Please contact me with any questions or concerns: megan.main@nzhealthpartnerships.co.nz, or 021 720 213.

### Thank you

I thank you in advance for your consideration of these NZHP accountability documents. I look forward to hearing your feedback and finalising these accountability documents for the 2017/18 year.

**COMMERCIAL IN CONFIDENCE**

NZ HEALTH PARTNERSHIPS

## Timeline

In accordance with our legislative requirements, the table below shows the steps necessary to have the NZ Health Partnerships Statement of Intent 2017 - 2021 and Statement of Performance Expectations 2017/18 approved and signed by 30 June 2017.

| | Actions | By who | By when |
|---|---|---|---|
| 1. | Communicate in advance with CFOs regarding target timeline | NZHP | 5 May |
| 2. | Circulate draft SOI-SPE and Annual Plan documents to DHBs | NZHP | 11 May |
| 3. | Forward your DHB written approval of the SOI-SPE and Annual Plan, via Board resolutions and/or Chief Executive letter to: geoff.goodwin@nzhealthpartnerships.co.nz | Chairs Chief Executives | 31 May* |
| 4. | Board approval of the SOI-SPE and Annual Plan | NZHP | 16 June |
| 5. | SOI-SPE and Annual Plan feedback received from Audit New Zealand and Grant Thornton | Auditors | 23 June |
| 6. | Submit SOI-SPE to Minister of Health, House of Representatives and Ministry of Health receive | NZHP | 26 June |
| 7. | Commence SOI-SPE and Annual Plan implementation | NZHP | 1 July |

15

## Note

* As communicated with CFOs recently, in the event that your DHB Board meeting schedule is outside this timeline, we shall keep the log for written approvals/resolution open.

## Attachments

- Final NZ Health Partnerships' Statement of Intent 1 July 2017 to 30 June 2021 and Statement of Expectations 1 July 2017 to 30 June 2018.
- Final NZ Health Partnerships' Annual Plan 1 July 2017 to 30 June 2018.

E.98

NZ HEALTH PARTNERSHIPS

# Statement of Intent

**1 July 2017 to 30 June 2021**

**and**

# Statement of Performance Expectations

**1 July 2017 to 30 June 2018**

# Contents

# Chair's foreword

NZ Health Partnerships (NZHP) is entering its third year of operation, and we continue to see strong sector engagement and commitment for collaboration. We are entering an exciting time as an organisation, with opportunity to leverage our role as a single voice for District Health Boards (DHBs) and provide real value for our shareholders.

Recent implementation of the Procurement Operating Model represents a significant opportunity to unlock value across the health sector. By reducing complexity, and leveraging the capability of DHBs, PHARMAC and the Ministry of Business Innovation and Employment, we can reduce procurement costs and ultimately drive better health outcomes.

In 2017/18 we will focus on providing the National Procurement Service for DHBs. Establishing the national service at NZHP will align our related responsibilities for sector-wide procurement planning and business planning intelligence services. Much of our focus will be on increasing returns on DHB investment in procurement.

Also in 2017/18 and beyond, we will focus on the National Oracle Solution. We will continue employing sector expertise as well as building a robust programme structure and plan that the sector can have confidence in.

A common theme across the commercial services portfolio is the need to effectively manage change in order to optimise value for our shareholders.

We will embed a new Shared Banking provider and contract, and negotiate a new Collective Insurance Agreement including selecting a broker to provide services from 2018/2019. For Food Services we will operationalised a revised governance model and actively manage Compass Group to ensure DHBs, their patients and community-based customers receive the best service possible.

Internally, we will continue implementing our Strategic Business Plan which was approved by the Board in October 2016. The Plan will build our organisational health and performance by focusing on our people and processes, optimising return from DHBs' current investments, identifying opportunities to deliver greater returns in the future and continuing to build alignment with our shareholders.

The last of these, which is alignment, is the key to success for any cooperative. As we enter a period a significant but positive change in the procurement landscape we commit to working with our shareholders and other partners transparently to help build collaboration and trust. Trust between the different organisations in the cooperative will build alignment. Alignment, and a shared understanding of where we can best leverage our combined scale and strength, will unlock real value for the sector.

Peter Anderson
Chair

# Statement of responsibility

The Statement of Intent (SOI) and Statement of Performance of Expectations (SPE) have been prepared by the Board of NZHP in accordance with Part 4 of the Crown Entities Act 2004.

The SOI sets out strategic intentions of NZHP for the four year period from 1 July 2017 to 30 June 2021. The SPE sets out our performance measures and targets for the period from 1 July 2017 to 30 June 2018.

In signing this document, we acknowledge that we are responsible for the information it contains.

## Signed on behalf of the Board

### Peter Anderson
Chair

### Terry McLaughlin
Chair of Finance, Risk, Audit and Compliance Committee

## Countersigned

### Megan Main
Chief Executive

### Geoff Goodwin
General Manager Corporate Services

E.98

# Part One

# Statement of Intent

15

SECTION ONE

# OUR OPERATING ENVIRONMENT

# Who we are

**NZHP is part of the New Zealand Health and Disability Sector.**

## Our Purpose

NZHP is a multi-parent Crown-entity subsidiary that is supported and owned by New Zealand's 20 DHBs.

As a cooperative, NZHP's purpose is to enable DHBs to collectively maximise shared services opportunities for the national good. Put another way, NZHP exists to support DHBs to serve their communities and achieve their strategic objectives.

## What we do

We collaborate with DHBs as our shareholders, co-creators and customers. In partnership we identify, develop and implement initiatives for the sector's mutual benefit.

With an aging population, increasing cost of new clinical equipment, and rising public demand, our initiatives are focused on creating financial efficiencies for DHBs.

By thinking, acting and investing collaboratively DHBs are able to achieve greater benefits than they would by operating independently.

However, what we do is about more than cost reduction. While the company's primary focus is on administrative, support and procurement activities, most of our work has direct or indirect clinical implications. Ultimately, patient outcomes are at the heart of the company and our operations.

## Governance and Accountability

NZHP works in a commercial manner within a public sector environment. The company operates under a Board, as well as programme and service governance structures with strong DHB representation. The Board comprises four regional DHB Chairs and three independent Directors. It is chaired by an independent Director.

**New Zealand Health Partnerships Board:**

- Peter Anderson (Chair)
- Deryck Shaw
- Kevin Atkinson
- Rabin Rabindran
- Jo Hogan
- Terry McLaughlin

Alongside NZHP Chief Executive, Megan Main, each programme and service has a DHB Chief Executive Sponsor. These Sponsors help drive strategic delivery and support performance through the promotion of strong stakeholder engagement.

## Strategic Partnerships

NZHP actively works to foster strategic relationships across the sector. Organisations with which we work closely include the Ministry of Health, PHARMAC, Ministry of Business, Innovation and Employment, Treasury, Department of Internal Affairs, commercial organisations and other health-sector shared services organisations.

## Statutory and Compliance Requirements

As a Crown Entity subsidiary, NZHP is required to comply with a variety of legislation including the:

- Companies Act 1993
- New Zealand Public Health and Disability
- Act 2000
- Crown Entities Act 2004
- Public Finance Act 1989
- Official Information Act 1982.

## Risk Management

NZHP recognises that risk and issue management is essential for the delivery of its programmes and services. The aims of our risk and issues management processes are to improve the quality of decision making to minimise and manage adverse impacts.

SECTION TWO

# OUR STRATEGIC INTENTIONS

# Future direction

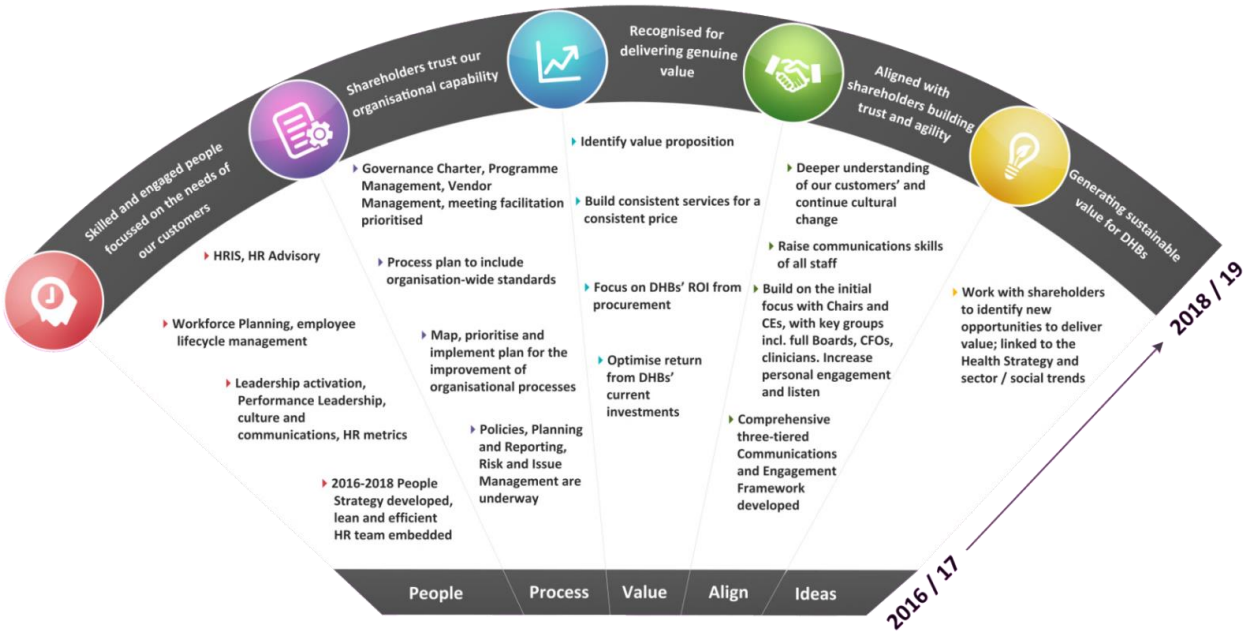
**NZHP will optimise its organisational performance and alignment with shareholders to deliver maximum value for the cooperative as a whole**

In 2015/16 NZHP conducted its first ever stakeholder survey. This was the key input into the development of NZHPs' Strategic Business Plan 2016/17 – 2018/19. The Plan aims to increase our organisational performance, continue to improve alignment with our shareholders and to deliver value now and in the future.

This will be achieved through five key work streams:

1. People
2. Process
3. Value
4. Alignment
5. Opportunities.

Diagram 1 – NZHP Strategic Business Framework




### Strategic work streams

All work streams, even those ostensibly with an internal focus, are focusing on delivering value for shareholders.

### 1. People

***Outcome: Skilled and engaged people focused on the needs of our customers (DHBs)***

We will employ people with not just technical skills but the ability to build relationships and communicate clearly. We will create a culture and performance systems that ensure our people are motivated, listen to their customers and remain focused on the commitments we make to make to our shareholders in planning documents and day-to-day interactions. We will embed and promote good workplace health and safety practices.

### 2. Process

***Outcome: Shareholders trust our organisational capability***

We will map, prioritise and implement a plan to improve all of our internal processes from risks and issues management through to working with our shareholders on the development and implementation of an agreed Decision Making Framework. The latter was discussed extensively at our March 2017 Shareholders' Meeting and the DHB directors and senior leaders present unanimously endorsed the need to prioritise this work. We are also focused on reducing our administration costs through better management practices and targeted improvement initiatives.

### 3. Value

***Outcome: Delivering genuine value now***

We will maximise the value generated from DHBs' current investment in our programmes and services by refreshing our programme and vendor management processes and through the central focus of improving DHBs' return on investment in procurement. Moving on from "benefits" to a more evolved Value Framework is another priority for this work stream. This too was prioritised at our March 2017 Shareholders' Meeting.

### 4. Alignment

***Outcome: Delivering genuine value now***

We will broaden our communications and engagement reach into full DHB Boards and senior leadership teams and will establish an effective clinical engagement model as part of work implementing the Procurement Operating Model. We will also focus on understanding the unique drivers and circumstances of each DHB to help inform the Decision Making Framework and shape value propositions particular to each of our shareholders.

### 5. Opportunities (Ideas)

***Outcome: Generating sustainable value for DHBs***

We will facilitate the development of a shared vision for how of how we want to leverage the cooperative's national scale and strength. This will include working with our shareholders to identify the challenges and opportunities that will benefit from a nationally coordinated DHB-driven response. And, without losing focus on our current work, we will engage with the sector to identify ways to innovate or leverage greater value from our current programmes and services. There may be fresh areas of opportunity to explore, although this will be a secondary focus.

## Strategic Alignment

Through our day-to-day work and by delivering on our strategic works streams we are key contributors to the government's goals of having an effective, integrated and innovative Health and Disability Sector that enables New Zealanders to live well, stay well and get well. All of programmes and services align to the five themes and goals of the refreshed New Zealand Health Strategy, as shown in Diagram 2.

Diagram 2 – NZ Health Strategy: 5 Strategic Themes

# Our programme, services and management

**Our programme teams work with the DHB-led governance and advisory groups to deliver fit for purpose solutions. Once implemented, programmes transition to a service which we manage on DHBs' behalf.**

## Programme

With the National Infrastructure Platform programme completed in June 2017, NZHP currently manages one programme, the National Oracle Solution (NOS). NZHP manages this programme alongside DHB experts and leaders in the NOS Business Owners Forum and Programme Steering Committee.

### NATIONAL ORACLE SOLUTION

Every year, DHBs spend about $1.3 billion buying goods and services, including everything from cotton wool buds through to hospital beds. Traditionally the purchasing of these goods and services has been done in a variety of ways across the 20 DHBs, with no single register or process for handling the transactions.

NOS is a common software solution which will replace the many systems DHBs currently use to source, order, store and pay for goods and services. Once in place, for the first time the sector will have visibility of the amount all 20 DHBs spend on individual goods and services. This will enable the bulk buying power of the sector to be leveraged for procurement initiatives – ensuring value for money and the right tools for the job.

*Focus for 2017/18*
In 2017/18 the build of the technology and supporting infrastructure for NOS will be completed and tested, ready for roll out. Implementation for NOS is structured in multiple waves, with Bay of Plenty, Canterbury, Waikato and West Coast DHBs first to go live on the new system. A change programme of this magnitude is challenging. We will capture lessons learned which will be used to inform both the planning and the implementation activities for future waves. Ultimately the DHBs will lead their own implementation and change management processes, with support from NZHP as requested.

# Services

NZHP currently manages four commercial services on behalf of DHBs: Shared Banking, Collective Insurance, DHB Procurement and Food Services. These services deliver both qualitative and financial value to DHBs.

## SHARED BANKING and COLLECTIVE INSURANCE

### Shared Banking

On any given day NZHP manages a cash balance of between $300m to $1.4b for the sector. Unlike the other services where we act as a vendor manager, NZHP delivers the banking service itself. We invest funds held in a range of low risk investments to optimise the return on funds and minimise fees, while ensuring sufficient cash is available to meet all DHBs' needs.

*Focus for 2017/18*
In 2017/18 we will transition to BNZ as the new Shared Banking provider. This new contract will substantially reduce the costs of transactional banking, minimise the cost of working capital and term borrowing facilities and maximise returns for credit balances. The DHBs will receive better individualised customer service with 33 BNZ Partner Centres throughout the country.

### Collective Insurance

Collectively DHBs have assets valued around $15b. On behalf of DHBs, NZHP seeks to negotiate the best insurance deal available on a collective basis.

Working together means the sector can offer insurers a portfolio that is geographically spread with a high level of risk identification and management processes in place. Substantial cover is gained as a result from a comparatively lower premium, compared to if each DHB were to insure on an individual basis.

*Focus for 2017/18*
In 2017/18 we will negotiate a new Collective Insurance Agreement to provide services from 2018/19 and onwards. In advance of putting the tender process in place, DHBs will join the All of Government Broker Panel which will tender and negotiate a longer term collective contract. It will involve the marketplace's best pricing for Liability Package, Motor Vehicle, Travel and Personal Accident insurance policies.

# DHB PROCUREMENT

DHB Procurement includes both implementation of the wider sector procurement operating model as well as delivery of National Procurement Service itself.

## Operating Model

In March 2017, DHB Chief Executives unanimously approved the health sector's new Procurement Operating Model. The Operating Model guides how the DHB Procurement Strategy will be operationalised. This covers approach, functions and roles within the sector.

Under the Joint Procurement Authority, NZHP will support implementation of the model over the next two to three years. Within the model, roles and responsibilities are defined for the Ministry of Business Innovation and Employment, PHARMAC, NZHP (national activity) and DHBs (working both collaboratively together or locally where DHBs purchase goods and services for their individual use).

## National Procurement Service

Under the new Operating Model, NZHP took over the healthAlliance national procurement service from 1 May 2017. This includes category and contract management, aligned planning, quality (process and standards oversight), strategic relationship management, and business information.

PHARMAC will incrementally take over medical device procurement over the next three years, while other procurement will eventually be handled collaboratively and locally. NZHP will work directly with PHARMAC and DHBs to manage this process.

*Focus in 2017/18*

In 2016, the DHB Procurement Strategy was endorsed by DHBs and approved by the NZHP Board. It represents a commitment to a collective way of working. This approach can extend the strategic reach of procurement to enable greater leverage of the national health spend and establish mutually beneficial relationships with suppliers. Savings attained through more effective sourcing and procurement practices create opportunities to reinvest in growth, personnel, facilities or other products and services.

In March 2017, DHBs approved a Procurement Operating Model including establishment of a new Procurement Service from 1 May 2017. In 2017/18 we will provide a Centre-led national procurement service for DHBs, delivering agreed procurement needs and managing contracts for the provision of clinical and non-clinical goods. It will involve contract management, clinical product coordination, and supplier relationship management and technology solutions to enable reductions in administrative and transactional costs.

## FOOD SERVICES

Under the Food Services Agreement (FSA), Compass Group NZ is contracted to provide patient meals, meals-on-wheels, and cafeteria services, ward supplies and optional services for six DHBs.

NZHP's focus is on ensuring appropriate governance, contract and vendor management are in place to ensure our participating shareholders receive the best service possible.

*Focus for 2017/18*
In 2017/2018 we will establish the revised FSA governance model and progress the expectations of the participating DHBs to renegotiate elements of the Terms and Conditions of the FSA to reflect the smaller participation level and maximise service delivery and commercial opportunities for all parties involved. We will commence delivery of the three year operating plan, and activate the tracking and reporting of benefits under the Compass Group NZ contract. The stated FSA benefits expectation is $1.8m per annum over the life of the contract.



# Management

## ORGANISATIONAL CAPABILITY

NZHP's work is supported by a lean team providing a range of core functions including Finance, Risk Management, Audit and Compliance; as well as Strategy, Business Performance, Human Resources, Change Management, Communications and Engagement. These are collectively known as Organisational Capability.

*Focus for 2017/18*
In 2017/18 we will implement the Communications and Engagement Strategy to ensure improved communication from all levels of the organisation, further enhance relationships with key DHB stakeholders. The execution of the People Strategy will continue to build a skilled and engaged workforce with the right capabilities, where people are focused on our strategic priorities and commitments made to our shareholders. In addition to the continuous improvement of finance, accounting, legal planning and performance processes, we will develop a range of corporate advancements including the creation of a Decision Making Framework, a new Value Framework, and a more effective Risk Management model.

E.98

Part Two

# Statement of Performance Expectations

# SECTION THREE

# OUR PERFORMANCE

# Measuring our performance

**The success of NZ Health Partnerships will be measured by its ability to deliver fit for purpose programmes and services that meet our shareholders' expectations and enable them to realise benefits.**

# Output Class 1 Programmes

DHBs invest in the programmes we develop. Our programme team works with DHBs as shareholders, co-creators and customers on the continued development and implementation of shared services initiatives for the national good. Once a shared service is built, it transitions to our service teams for delivery to our DHB customers.

## NATIONAL ORACLE SOLUTION

The National Oracle Solution (NOS) will design and build a single financial management information system ready for DHB implementation. The programme represents a significant investment for the sector and is a critical enabler for the National Procurement Service.

Table 1: NOS performance measures and targets 2017/18

| # | Performance Measure | Target | Type | When |
|---|---|---|---|---|
| 1 | Ensure readiness of Oracle Administration Model | Key positions filled and capability in place. | Quality | 30 June 2018 |
| 2 | Complete Technology Build | Solution acceptance testing successfully completed. | Quality Timeliness | 31 December 2017 |
| 3 | Complete Solution Readiness | User acceptance testing successfully completed. | Quality Timeliness | 30 June 2018 |
| 4 | Preparation for First Wave DHB Implementation | Preparation for First Wave DHB implementation completed with no open action items, due to start 1 July 2018 | Quality Financial Timeliness | 30 June 2018 |

Note: Planning for NOS design and build is underway, with detailed timelines scheduled for completion 30 June 2017. In the event that of the above target dates may change, they will be updated in the NZ Health Partnerships (NZHP) Quarter One Report 2017/18.

## Output Class 1: Financial Perspective

Table 2: Output Class 1 – financial budget for 2017/18

| | ***2017/18*** **Budget** ***$000's*** |
|---|---|
| **Revenue:** | |
| National Oracle Solution | 11,518 |
| National Infrastructure Platform (IBM settlement) | 1,735 |
| *Total revenue* | 13,253 |
| **Expenditure:** | |
| National Oracle Solution | 11,518 |
| National Infrastructure Platform (IBM settlement) | 1,735 |
| *Total Expenditure* | 13,253 |
| **Surplus/ (Deficit)** | 0 |

15

# Output Class 2 Services

NZHP works in a commercial manner within a public sector environment to provide high performing services that focus on creating efficiencies for DHBs with savings going back into frontline health services. Our services teams deliver qualitative and quantitative benefits to DHBs for Shared Banking, Collective Insurance, Food Services, Procurement and Organisational Capability.

## SHARED BANKING and COLLECTIVE INSURANCE

### Shared Banking

Banking and Treasury Services invests funds held in a restricted range of low risk investments to optimise returns on funds, while ensuring sufficient cash is available to meet all DHB needs. We manage a cash balance of between $300m to $1.4b through Shared Banking and Treasury functions.

Table 3: Shared Banking performance measures and targets 2017/18

| # | Performance Measure | Target | Type | When |
|---|---|---|---|---|
| 5 | New banking services provider implemented | Implementation of new banking services provider for 2017/18. | Timeliness | 31-Dec-17 |
| 6 | Delivery of efficient shared banking service | Delivery of a value added banking service including achievement of 0.10% minimum deposit margin above OCR and $2.5 million total benefits. | Financial | 30 June 2018 |
| 7 | Delivery of effective shared banking service | Delivery of shared banking service to DHBs satisfaction. | Quality | 30 June 2018 |

### Collective Insurance

The Collective Insurance Service is responsible for managing the insurance requirements for the DHBs, various joint ventures and subsidiaries. Each insurance tender and contract is made on a fit for purpose basis. Collectively DHBs have assets valued around $15b.

Table 4: Collective Insurance performance measures and targets 2017/18

| # | Performance Measure | Target | Type | When |
|---|---|---|---|---|
| 8 | New collective insurance agreement implemented | Negotiation of new collective insurance agreement completed and selected broker is in place for 2018/19. | Timeliness | 30 June 2018 |
| 9 | Delivery of efficient collective insurance service | Delivery of value add collective insurance service including achievement of $2.5m total benefits. | Financial | 30 June 2018 |
| 10 | Delivery of effective collective insurance service | Delivery of collective insurance service to DHBs satisfaction. | Quality Timeliness | 30 June 2018 |

## DHB PROCUREMENT SERVICE

The DHB Procurement Service ensures DHBs achieve increased value from collective procurement with a focus on clinical imperatives such as quality, safety, standardisation and sustainability; reducing overall procurement costs and increasing real return on investment; and by working with the DHBs as one team, for the national good.

Table 5: DHB Procurement Service performance measures and targets 2017/18

| # | Performance Measure | Target | Type | When |
|---|---|---|---|---|
| 11 | Implementation of structure to support operating model | Procurement capability and capacity is in place to support the procurement operating model. | Quality<br>Timeliness | 30 November 2017 |
| 12 | An operational clinical engagement framework | A clinical engagement framework is developed which supports the operating model, approved by JPA and implementation is underway. | Quality<br>Timeliness | 30 June 2018 |
| 13 | Aligned governance processes | Processes to support governance are in place and aligned to the procurement operating model. | Quality<br>Timeliness | 30 June 2018 |
| 14 | Enhance planning across multi-year processes | A rolling 3-year plan for procurement has been established, operationalised and approved by JPA. | Timeliness | 30 September 2017 |
| 15 | Transition of non-national contracts to DHBs | Procurement capability and capacity plans are in place to ensure DHBs are ready to receive non-national contracts, and all non-national contracts have been moved to suitable owners/managers. | Timeliness | 31 December 2017 |
| 16 | Delivery of efficient procurement service | Delivery of value-add procurement service including achievement of $6.1m total benefits. | Financial | 30 June 2018 |

## FOOD SERVICES

Food Services provides the contract and vendor management of the Food Services Agreement (FSA) with Compass Group NZ, on behalf of Auckland, Waitemata, Counties Manukau, Southern, Hauora Tairawhiti and Nelson Marlborough DHBs. Compass Group NZ provides approximately 60% of all patient meals served in New Zealand hospitals as well as other services such as Meals on Wheels.

Table 6: Food Services performance measures and targets 2017/18

| # | Performance Measure | Target | Type | When |
|---|---|---|---|---|
| 17 | Transition programme to active contract management | Vendor and customer relationship management framework is in place with active reporting and tracking of benefits realisation. | Quality<br>Timeliness | 31 December 2017 |
| 18 | Implement revised FSA governance model | Establishment of FSA Contract Management Group and associated strategy and operating model, with participation from all 6 DHBs. | Quality<br>Timeliness | 30 September 2017 |
| 19 | 3-year operating plan | Delivery and sign off of 1 to 3-year operating plan. | Quality<br>Timeliness | 30 June 2018 |
| 20 | Delivery of efficient food service | Delivery of value-add food service including achievement of $1.8m total benefits. | Financial | 30 June 2018 |

## ORGANISATIONAL CAPABILITY

NZHP's core functions including Finance, Risk Management, Audit and Compliance; as well as Strategy, Business Performance, Human Resources, Change Management, Communications and Engagement are collectively known as Organisational Capability.

Table 7: Organisational Capability performance measures and targets 2017/18

| # | Performance Measure | Target | Type | When |
|---|---|---|---|---|
| 21 | Embed Change Management Framework | Change Management Framework reviewed and applied to Programmes and Services as required. | Quality | 30 June 2018 |
| 22 | Implement Communications and Engagement Strategy | Detailed activity plan developed and implemented. | Quality | 30 June 2018 |
| 23 | Decision Making Framework | Development and implementation of agreed Decision Making Framework. | Quality Timeliness | To be confirmed |
| 24 | Implement Human Resources Strategy | Progress against the 10 strategic work streams in line with activity plan. | Quality | 30 June 2018 |
| 25 | Enhance internal processes | Deliver consistent, robust and sustainable processes across NZHP. | Quality | 30 June 2018 |
| 26 | Delivery of effective Corporate Services functions | On time delivery and continuous improvement of finance, accounting and legal services provided to NZHP and our stakeholders. | Quality Timeliness | 30 June 2018 |
| 27 | Enhance Planning and Performance function and processes | Planning and Performance framework and processes developed and implemented. | Quality | 31 August 2018 |
| 28 | Value Framework | Value framework and processes developed and embedded. | Quality | 28 February 2018 |
| 29 | Delivery of effective Risk Management | Enhance risk management culture across NZHP. | Quality | 30 September 2018 |

15

# Output Class 2: Financial Perspective

Table 8: Output Class 2 – financial budget for 2017/18

| | ***2017/18*** **Budget** ***$000's*** |
|---|---|
| **Revenue:** | |
| Shared Banking and Collective Insurance | |
| Interest Revenue from Shared Banking Facility | 12,000 |
| Shared Banking and Insurance Operations | 603 |
| Management Services | 5,105 |
| National Procurement Service | 4,850 |
| *Total Revenue* | 22,558 |
| **Expenditure:** | |
| Shared Banking and Collective Insurance | |
| Interest Expense from Shared Banking Facility | 12,000 |
| Shared Banking Operations | 603 |
| Management Services | 5,090 |
| National Procurement Service | 4,850 |
| *Total Expenditure* | 22,543 |
| ***Surplus/ (Deficit)*** | **15** |

# Benefits

Benefits management is at the very heart of NZHP's purpose. In conjunction with our shareholders, programmes are identified, assessed, prioritised, developed and implemented with the singular purpose of delivering benefits to DHBs and contributing to the health and wellbeing of New Zealanders.

A benefit is defined as a clear financial or performance improvement. This may include building organisational capabilities, delivering efficiencies or effectiveness, or clinical improvements. Whether financial or performance-based all benefits ultimately contribute to better health outcomes. As such, "Value" is a term the better encapsulates the breadth of gains that can be made across the sector.

In 2017/18 NZHP and its shareholders will work together to develop a Value Framework. This Framework will define the problem or opportunity, the value proposition of a programme or project, as well as the standards around measuring, tracking and reporting on the gains made. The Value Framework will incorporate the existing Benefits Management Framework.

Alongside our own programmes and services, NZHP is responsible for coordinating and reporting the aggregated sector benefits based on information provided by DHBs and third party providers such as PHARMAC and Ministry of Business, Innovation and Employment (MBIE). The benefits reported by NZHP are realised and owned by the DHBs.

**BUDGETARY BENEFITS**

Budgetary benefits are defined as the incremental annual change, primarily cash, which has a clearly defined impact on the Statement of Comprehensive Income. These benefits result in a budget line reduction, compared with the prior year.

**NON-BUDGETARY BENEFITS**

Non-Budgetary benefits are defined as those that form part of the business case that do not meet the definition of Budgetary. There are three general components:

- **Cost Avoidance:** Cash that would have been spent is now totally avoided or reallocated as a result of the business case.
- **Cumulative benefits:** are those that are carried forward from previous years, whether they were originally budgetary or non-budgetary in nature.
- **Qualitative benefits:** accrue from associated activity as a result of a business case and need to be reported in some way. Also referred to as non-financial benefits, in some cases it may be too difficult to quantify these reliably.

## Benefits Estimates

Table 9: Estimated Total Benefits for Output Class 1 & 2 2017/18.

| | Estimated 2017/18 $000 |
|---|---|
| **OUTPUT CLASS 1: PROGRAMMES** | |
| ***Total Annual Benefits*** | |
| Budgetary | 0 |
| Non-Budgetary | 0 |
| | |
| **OUTPUT CLASS 2: SERVICES** | |
| **National Procurement - NZHP**[1] | |
| Budgetary | 2,500 |
| Non-Budgetary | 18,000 |
| **National Procurement – MBIE**[2] | |
| Budgetary | 0 |
| Non-Budgetary | 10,900 |
| **Food Services** | |
| Budgetary | 0 |
| Non-Budgetary | 1,810 |
| **Shared Banking** | |
| Budgetary | 0 |
| Non-Budgetary | 2,500 |
| **Collective Insurance** | |
| Budgetary | 0 |
| Non-Budgetary | 2,500 |
| **DHB Procurement**[3] | |
| Budgetary | 3,400 |
| Non-Budgetary | 8,800 |
| ***Total Annual Benefits*** | |
| Budgetary | 5,900 |
| Non-Budgetary | 44,510 |
| | |
| **TOTAL ANNUAL BENEFITS** | **50,410** |

1. National Procurement - NZHP includes the National Procurement Service provided by NZHP and PHARMAC contracts (pending the full transition of medical device procurement to PHARMAC).
2. National Procurement - MBIE includes benefits from All of Government contracts, as reported by MBIE.
3. DHB Procurement includes DHB individual and DHB collaborative procurement.

# Assessing performance

Our performance will be assessed against the following four ratings categories:

Table 10: Performance assessment ratings

| | Performance Rating | Description |
|---|---|---|
| | Achieved | On target or better. |
| | Substantially achieved | 95% to 99.9% achieved.<br>0.1%-5% away from target. |
| | Not achieved, but progress made | 90% to 94.9% achieved.<br>5.1% to 10% away from target and improvement on previous year. |
| | Not Achieved | <90% achieved.<br>>10% away from target; or 5.1% to 10% away from target and no improvement on previous year. |

The perspectives that underpin our assessment of performance are quality, financial and timeliness.

Table 11: Performance categories

| Perspective | Description |
|---|---|
| Quality | This will measure the quality of the delivery of programmes and services. Measures may be related to post-implementation reviews, quality assurance reviews, peer reviews, and stakeholder and shareholder engagement. |
| Financial | This will report performance against the projected costs and benefits for financial measures. |
| Timeliness | The programmes and services will have progress measured against agreed milestones to determine if they are delivery on schedule. |

### Reporting performance

The performance of output classes will be reported in NZHPs' Annual and Quarterly Reports to our Shareholders.

# SECTION FOUR

# FINANCIAL STATEMENTS

# Financial statements

## 1.1 Prospective Statement of Financial Performance by Output Class

**For the year ending 30 June 2018**

| | 2015/16 Actual $000 | 2016/17 Forecast $000 | 2017/18 Budget $000 |
|---|---|---|---|
| **Revenue:** | | | |
| Output Class 1: Programmes | 7,777 | 12,060 | 13,253 |
| Output Class 2: Services | 46,249 | 33,511 | 22,558 |
| Total Revenue by Output Class | 54,026 | 45,571 | 35,811 |
| **Expenditure:** | | | |
| Output Class 1: Programmes | 12,167 | 10,339 | 13,253 |
| Output Class 2: Services | 45,957 | 33,103 | 22,543 |
| Total Expenditure by Output Class | 58,124 | 43,442 | 35,796 |
| **Surplus/ (Deficit)** | **(4,098)** | **2,129** | **15** |

15

## 1.2 Prospective Statement of Comprehensive Revenue and Expense

**For the year ending 30 June 2018**

| | 2015/16 Actual $000 | 2016/17 Forecast $000 | 2017/18 Budget $000 |
|---|---|---|---|
| **Revenue:** | | | |
| Revenue from DHBs | 21,631 | 27,162 | 23,796 |
| Interest revenue - NZ Health Partnerships | 219 | 86 | 15 |
| Shared banking | 28,385 | 18,300 | 12,000 |
| Other revenue | 3,791 | 23 | 0 |
| Total revenue | 54,026 | 45,571 | 35,811 |
| **Expenditure:** | | | |
| Personnel costs | 3,205 | 3,514 | 6,771 |
| Depreciation and amortisation expense | 2,126 | 1,696 | 145 |
| Finance costs - NZ Health Partnerships | 0 | 0 | 0 |
| Shared banking | 28,362 | 18,300 | 12,000 |
| Other expenses | 24,431 | 19,932 | 16,880 |
| Total Expenditure | 58,124 | 43,442 | 35,796 |
| **Surplus/ (Deficit)** | **(4,098)** | **2,129** | **15** |
| Other Comprehensive revenue and expense | 0 | 0 | 0 |
| **Total Other Comprehensive Revenue and Expense** | **0** | 0 | 0 |
| **TOTAL COMPREHENSIVE REVENUE AND EXPENSE** | **(4,098)** | **2,129** | **15** |

## 1.3 Prospective Statement of Financial Position

**As at 30 June 2018**

| | 2015/16 Actual $000 | 2016/17 Forecast $000 | 2017/18 Budget $000 |
|---|---|---|---|
| **ASSETS** | | | |
| **Current Assets:** | | | |
| Cash and cash equivalents (incl. Shared Banking) | 110,566 | 114,683 | 98,302 |
| Receivables | 9,077 | 10,037 | 10,586 |
| Investments – DHB shared banking Facility | 120,000 | 130,000 | 150,000 |
| Prepayments | 48 | 1,504 | 1,456 |
| DHB Shared Banking Facility | 26,691 | 26,584 | 26,478 |
| Total Current Assets | 266,382 | 282,808 | 286,822 |
| **Non-Current Assets:** | | | |
| Investment - DHB Shared banking Facility | 20,000 | 0 | 0 |
| Property, plant, and equipment | 78 | 47 | 33 |
| Intangible assets | 55,757 | 55,755 | 54,706 |
| Total Non-Current Assets | 75,835 | 55,802 | 54,739 |
| **Total Assets** | **342,217** | **338,610** | **341,561** |
| **LIABILITIES** | | | |
| **Current Liabilities:** | | | |
| Payables | 10,446 | 7,165 | 7,827 |
| DHB Shared Banking Facility | 269,469 | 268,288 | 270,599 |
| Employee entitlements | 177 | 210 | 173 |
| Income in Advance | 1,307 | 0 | 0 |
| Total Current Liabilities | 281,399 | 275,663 | 278,599 |
| **Non-Current Liabilities:** | | | |
| Employee entitlements | 0 | 0 | 0 |
| Total Non-Current Liabilities | 0 | 0 | 0 |
| **Total Liabilities** | **281,399** | **275,663** | **278,599** |
| **Net Assets** | **60,818** | **62,947** | **62,962** |
| **EQUITY** | | | |
| Contributed Capital | 64,916 | 60,818 | 62,947 |
| Accumulated surplus / (deficit) | (4,098) | 2,129 | 15 |
| **Total Equity** | **60,818** | **62,947** | **62,962** |

15

## 1.4 Prospective Statement of Changes in Equity

**For the year ending 30 June 2018**

| | 2015/16 Actual $000 | 2016/17 Forecast $000 | 2017/18 Budget $000 |
|---|---|---|---|
| **Balance at 1 July** | **0** | **60,818** | **62,947** |
| Total Comprehensive Revenue and Expense for the year | (4,098) | 2,129 | 15 |
| **Owner Transactions** | | | |
| Contributed Capital | 64,916 | 0 | 0 |
| **Balance at 30 June** | **60,818** | **62,947** | **62,962** |

## 1.5 Prospective Statement of Cash Flows

**For the year ending 30 June 2018**

| | 2015/16 Actual $000 | 2016/17 Forecast $000 | 2017/18 Budget $000 |
|---|---|---|---|
| **Cash flows from Operating Activities:** | | | |
| Receipts from DHBs | 19,139 | 25,628 | 22,061 |
| Receipts from other revenue | 3,625 | 23 | 0 |
| Interest received | 28,787 | 18,386 | 12,015 |
| Payments to suppliers | (24,084) | (18,193) | (15,145) |
| Payments to employees | (3,244) | (3,514) | (6,771) |
| Interest paid | (29,607) | (18,300) | (12,000) |
| Net DHB Sweep account movements with DHBs | (223,755) | (103,873) | (121,268) |
| Goods and services tax (net) | 368 | 596 | 257 |
| Net Cash Flow from Operating Activities | (228,771) | (99,247) | (120,851) |
| **Cash flows from Investing Activities:** | | | |
| Funds from Deposit | 330,000 | 340,000 | 340,000 |
| Purchase of property, plant, and equipment | (6) | (1) | 0 |
| Purchase of intangible assets | (3,735) | (1,635) | (530) |
| Funds to Deposit | (235,000) | (235,000) | (235,000) |
| Net Cash Flow from Investing Activities | 91,259 | 103,364 | 104,470 |
| **Cash flows from Financing Activities:** | | | |
| Cash transferred | 248,078 | 0 | 0 |
| Proceeds from borrowings | 0 | 0 | 0 |
| Repayment Interest | 0 | 0 | 0 |
| Net Cash Flow from Financing Activities | 248,078 | 0 | 0 |
| **Net (decrease)/increase in cash and cash equivalents** | 110,566 | 4,117 | (16,381) |
| Cash and cash equivalents at the beginning of the year | 0 | 110,566 | 114,683 |
| **Cash and cash equivalents at the end of the year** | **110,566** | **114,683** | **98,302** |

15

# Notes to the Prospective Financial Statements

## Statement of Accounting Policies

**Reporting Entity**
NZ Health Partnerships Limited (NZHP) is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled and operates in New Zealand. The relevant legislation governing NZHP operations include the Crown Entities Act 2004. NZHP is a multi-parent Crown subsidiary, owned by the 20 District Health Boards, which have equal Class A shareholding and voting rights.

NZHP primary objective is to operate as a cooperative undertaking, and enable DHBs to collectively maximise shared services opportunities for the national good.

NZHP has designated itself as a public benefit entity (PBE) for financial reporting purposes.

**Basis of Preparation**
The prospective financial statements are based on policies and approvals in place as at 1 July 2017. The prospective financial statements set out NZHP activities and planned performance. The use of this information for other purposes may not be appropriate. These prospective financial statements have been prepared on the basis of assumptions of future events that NZHP reasonably expects to occur and associated actions that NZHP reasonably expects to take at the date that this information was prepared.

**Statement of Compliance**
These prospective financial statements have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes the requirement to comply with Generally Accepted Accounting Practice in New Zealand (NZ GAAP).

The prospective financial statements have been prepared to comply with Public Benefit Entity Standards (PBE Standards) for a Tier 1 entity.

The prospective financial statements have been prepared for the special purpose of the Statement of Performance Expectations 2017/18 of NZHP for its shareholders. They have not been prepared for any other purpose and should not be relied upon for any other purpose.

These statements will be used in our Annual Report as the budgeted figures. The Statement of Performance Expectations narrative informs the prospective financial statements and the document should be read as a whole.

The preparation of prospective financial statements in conformity with PBE FRS 42 requires the Board and management to make good judgements, estimates, and assumptions that affect the application of policies and reported amounts of assets and liabilities, income, and expenses.

The prospective financial statements were approved on 16 May 2017. The Board is responsible for the prospective financial statements presented, including the assumptions underlying the

prospective financial statements and all other disclosures. The Statement of Performance Expectations is prospective and as such contains no actual operating results. It is not intended that these prospective financial statements will be updated.

**Measurement Base**
The prospective financial statements have been prepared on a historical cost basis.

Presentation currency and rounding
The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000).

## Significant Accounting Policies

**Revenue**
Interest Revenue
Interest revenue is recognised using the effective interest method. Interest revenue on an impaired financial asset is recognised using the original effective interest rate.



**Expenditure**
Finance Costs
Borrowing costs are recognised as an expense in the financial year in which they are incurred.

**Goods and Service Tax**
All items in the financial statements are presented exclusive of goods and service tax (GST), except for receivables and payables, which are presented on a GST-inclusive basis. Where GST is not recoverable as input tax then it is recognised as part of the related asset or expense. The net amount of GST recoverable from, or payable to, Inland Revenue (IRD) is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows. Commitments and contingencies are disclosed exclusive of GST.

**Income Tax**
NZHP is a public authority and consequently is exempt from the payment of income tax. Accordingly, no provision has been made for income tax.

## Critical Accounting Judgments and Estimates

In preparing these financial statements, NZHP has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectation of future events that are believed to be reasonable under the circumstances.

## Critical Judgment in Applying Accounting Policies

Management has exercised critical judgements in applying accounting policies for the capitalisation of the National Oracle Solution (NOS) programme. Refer notes below.

## Accounting Policy

**Revenue**

**Funding from DHBs**
NZHP is funded through revenue received from the DHBs, which is restricted in its use for the purpose of NZHP meeting its objectives as specified in the Statement of Intent. The breakdown of revenue of different output class is on pages 20 and 25. Revenue is recognised as revenue when earned and is reported in the financial period to which it relates.

**Personnel Costs**

**Superannuation schemes**
Defined benefit schemes
NZHP has no obligations to contribute to any defined benefit superannuation funds.

Defined contribution schemes
Obligations for contributions to Kiwi Saver are accounted for as defined contribution superannuation schemes and are recognised as an expense in the surplus or deficit as incurred.

**Other Expenses**

**Operating leases**
An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee. Lease payments under an operating lease are recognised as an expense on a straight - line basis over the lease term. Lease incentives received are recognised in the surplus/deficit as a reduction of rental expense over the lease term.

**Cash and cash equivalents**
Cash and cash equivalents include cash on hand, deposits held at call with banks and other short-term highly liquid investments with original maturities of three months or less. All investments are held in New Zealand. These include the DHB Shared Banking sweep account and NZHP operational account.

**Receivables**
Receivables are initially measured at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment.

**Investments**
Bank term deposits
Investments in bank term deposits are initially measured at the amount invested.
After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

**Property, plant and equipment**

Property, plant and equipment consist of the following asset classes: leasehold improvements, furniture, and office equipment and information technology.

Property, plant and equipment are shown at cost, less any accumulated depreciation and impairment losses.

Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to NZHP and the cost of the item can be measured reliably.

Work in progress is recognised at cost less impairment and is not depreciated.

In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.



Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset and are reported in the surplus or deficit.

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to NZHP and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant and equipment, at rates that will write-off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of property, plant and equipment have been estimated as follows:

| Asset Type | Useful Life | Rate |
|---|---|---|
| Leasehold improvements | 5 – 14 years | 7% - 21% |
| Furniture and office equipment | 1.5 – 9.5 years | 10.5% - 67% |
| IT Hardware | 2.5 – 5 years | 20% - 40% |

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter. The residual value and useful life of an asset is reviewed and adjusted if applicable, at each financial year end.

Impairment of property, plant and equipment

Cash generating assets

NZHP does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Non-cash generating assets
Property, plant and equipment and intangible assets held at cost that have a finite useful life, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on either a depreciated replacement approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of the information.

If an asset's carrying amount exceeds its recoverable amount, the asset is regarded as impaired and the carrying amount is written-down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit. The reversal of an impairment loss is recognised in the surplus or deficit.

**Intangible assets**

Software acquisition and development
Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Staff training costs are recognised as an expense when incurred.
Costs associated with maintaining computer software are recognised as an expense when incurred.

Costs associated with development and maintenance of NZHP website is recognised as an expense when incurred. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include software development employee costs and an appropriate portion of relevant overheads.

Amortisation
The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

| Intangible Asset Type | Useful Life | Rate |
|---|---|---|
| Acquired computer software | 2.5 – 3 years | 33% - 40% |

Impairment of intangible assets
Refer to the policy for impairment of property, plant, and equipment. The same approach applies to the impairment of intangible assets.

**Critical judgement in applying accounting policies**

Capitalisation of National Oracle Solution
The National Oracle Solution (NOS, previously known as Finance Procurement and Supply Chain (FPSC)) programme is a significant part of health sectors saving initiatives. The NOS programme is set to improve the way goods and services are made available to DHBs for purchasing, ordering, delivery storage and payment. A national approach to these services will combine the purchasing power of DHBs, create visibility of stock and ensure a common financial language across the health sector.

Throughout the development of the NOS programme, the assets that are created by the programme will be held in Work in Progress (WIP). The NOS programme is not a single asset, but a bundle of assets that are both tangible such as IT hardware and intangible, such as software, policy manuals, process documentation, process maps, standard operating procedures, reference materials and intellectual property. The costs that are directly associated with the development of the NOS programme will be recognised as tangible or intangible assets when it is in the location and condition necessary for it to be capable of operating in the manner intended by management. Direct costs include project development employees, contractors, consultants and apportionment of the relevant overheads.



Indirect costs are recognised as expenses when incurred and include: depreciation, software licenses and software maintenance costs, for example.

Amortisation
The amortisation of the assets will begin once the asset is available for use (commissioned into the fixed asset register) and will cease at the date that the asset is derecognised. The carrying value of an intangible asset with a finite life is amortised on a straight line basis over its useful life. The useful lives of NOS intangible assets have been estimated to be 15 years (life of the contract).

**Payables**
Short-term payables are recorded at their face value.

**Employee entitlements**
Short-term employee entitlements
Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured at nominal values based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date and annual leave earned to but not yet taken at balance date.

A liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date, to the extent that it will be used by staff to cover those future absences.
A liability and an expense is recognised where there is a contractual obligation or where there is a past practice that has created a constructive obligation and a reliable estimate of the obligation can be made.

Long-term employee entitlements
NZHP does not have any employment agreement containing long service leave entitlements.

**Equity**
Equity is measured as the difference between total assets and total liabilities.

**Borrowings**
Borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities unless NZHP has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

**Financial Instrument Risks**
NZHP activities expose it to credit risk, cash flow risk and liquidity risk. NZHP policy does not allow any transactions that are speculative in nature to be entered into. It has policies and procedures to ensure risks are low.

NZ HEALTH PARTNERSHIPS

# Annual Plan 2017/18



# Contents



15

# Who we are

**NZHP is part of the New Zealand Health and Disability Sector.**

## Our Purpose

NZHP is a multi-parent Crown-entity subsidiary that is supported and owned by New Zealand's 20 DHBs.

As a co-operative, NZHP's purpose is to enable DHBs to collectively maximise shared services opportunities for the national good. Put another way, NZHP exists to support DHBs to serve their communities and achieve their strategic objectives.

## What we do

We collaborate with DHBs as our shareholders, co-creators and customers. In partnership we identify, develop and implement initiatives for the sector's mutual benefit.

With an aging population, increasing cost of new clinical equipment, and rising public demand, our initiatives are focused on creating financial efficiencies for DHBs.

By thinking, acting and investing collaboratively DHBs are able to achieve greater benefits than they would by operating independently.

However, what we do is about more than cost reduction. While the company's primary focus is on administrative, support and procurement activities, most of our work has direct or indirect clinical implications. Ultimately, patient outcomes are at the heart of the company and our operations.

## Governance and Accountability

NZHP works in a commercial manner within a public sector environment. The company operates under a Board, as well as programme and service governance structures with strong DHB representation. The Board comprises four regional DHB Chairs and three independent Directors. It is chaired by an independent Director.

**New Zealand Health Partnerships Board:**

- Peter Anderson (Chair)
- Deryck Shaw
- Kevin Atkinson
- Rabin Rabindran
- Jo Hogan
- Terry McLaughlin

Alongside NZHP Chief Executive, Megan Main, each programme and service has a DHB Chief Executive Sponsor. These Sponsors help drive strategic delivery and support performance through the promotion of strong stakeholder engagement.

## Strategic Partnerships

NZHP actively works to foster strategic relationships across the sector. Organisations with which we work closely include the Ministry of Health, PHARMAC, Ministry of Business, Innovation and Employment, Treasury, Department of Internal Affairs, commercial organisations and other health-sector shared services organisations.

## Statutory and Compliance Requirements

As a Crown Entity subsidiary, NZHP is required to comply with a variety of legislation including the:

- Companies Act 1993
- New Zealand Public Health and Disability
- Act 2000
- Crown Entities Act 2004
- Public Finance Act 1989
- Official Information Act 1982.

## Risk Management

NZHP recognises that risk and issue management is essential for the delivery of its programmes and services. The aims of our risk and issues management processes are to improve the quality of decision making to minimise and manage adverse impacts.

# Future direction

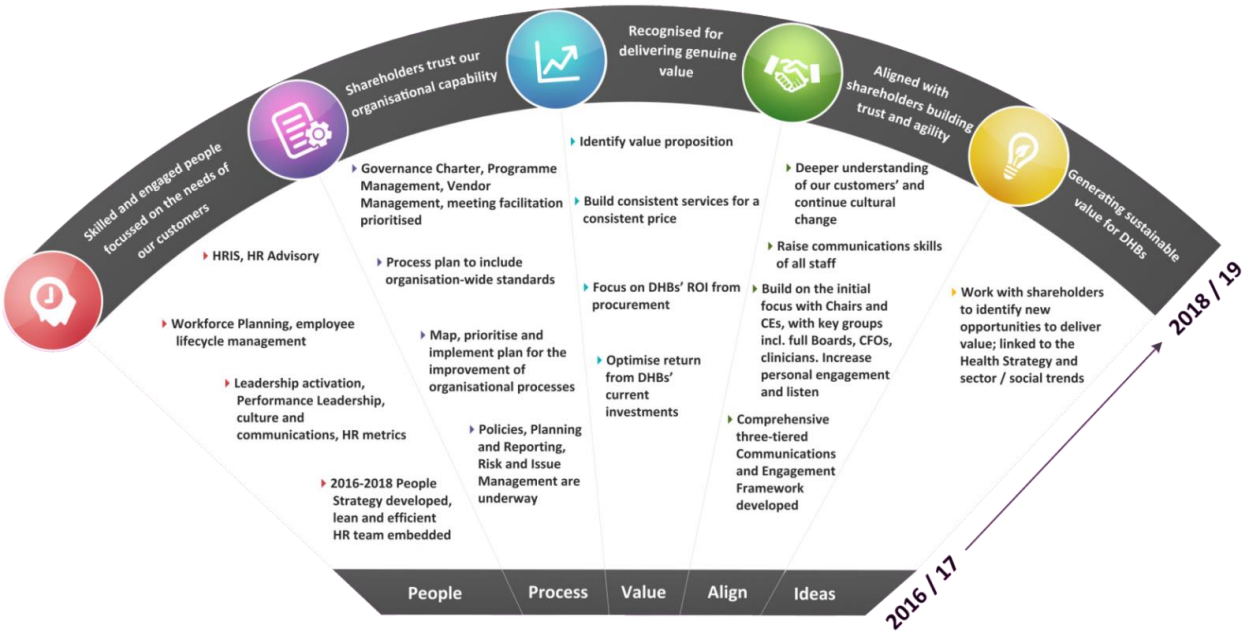
**NZHP will optimise its organisational performance and alignment with shareholders to deliver maximum value for the co-operative as a whole**

In 2015/16 NZHP conducted its first ever stakeholder survey. This was the key input into the development of NZHP's Strategic Business Plan 2016/17 - 2018/19. The Plan aims to increase our organisational performance, continue to improve alignment with our shareholders and to deliver value now and in the future.

This will be achieved through five key work streams:

1. People
2. Process
3. Value
4. Alignment
5. Opportunities.

Diagram 1 - NZHP Strategic Business Framework




### Strategic work streams

All work streams, even those ostensibly with an internal focus, are focusing on delivering value for shareholders.

### 1. People

***Outcome: Skilled and engaged people focused on the needs of our customers (DHBs)***

We will employ people with not just technical skills but the ability to build relationships and communicate clearly. We will create a culture and performance systems that ensure our people are motivated, listen to their customers and remain focussed on the commitments we make to make to our shareholders in planning documents and day-to-day interactions. We will embed and promote good workplace health and safety practices.

### 2. Process

***Outcome: Shareholders trust our organisational capability***

We will map, prioritise and implement a plan to improve all of our internal processes from risks and issues management through to working with our shareholders on the development and implementation of an agreed Decision Making Framework. The latter was discussed extensively at our March 2017 Shareholders' Meeting and the DHB directors and senior leaders present unanimously endorsed the need to prioritise this work. We are also focused on reducing our administration costs through better management practices and targeted improvement initiatives.

### 3. Value

***Outcome: Delivering genuine value now***

We will maximise the value generated from DHBs' current investment in our programmes and services by refreshing our programme and vendor management processes and through the central focus of improving DHBs' return on investment in procurement. Moving on from "benefits" to a more evolved Value Framework is another priority for this work stream. This too was prioritised at our March 2017 Shareholders' Meeting.

### 4. Alignment

***Outcome: Delivering genuine value now***

We will broaden our communications and engagement reach into full DHB Boards and senior leadership teams and will establish an effective clinical engagement model as part of work implementing the Procurement Operating Model. We will also focus on understanding the unique drivers and circumstances of each DHB to help inform the Decision Making Framework and shape value propositions particular to each of our shareholders.

### 5. Opportunities (Ideas)

***Outcome: Generating sustainable value for DHBs***

We will facilitate the development of a shared vision for how of how we want to leverage the cooperative's national scale and strength. This will include working with our shareholders to identify the challenges and opportunities that will benefit from a nationally coordinated DHB-driven response. And, without losing focus on our current work, we will engage with the sector to identify ways to innovate or leverage greater value from our current programmes and services. There may be fresh areas of opportunity to explore, although this will be a secondary focus.

## Strategic Alignment

Through our day-to-day work and by delivering on our strategic works streams we are key contributors to the government's goals of having an effective, integrated and innovative Health and Disability Sector that enables New Zealanders to live well, stay well and get well. All of programmes and services align to the five themes and goals of the refreshed New Zealand Health Strategy, as shown in Diagram 2.

Diagram 2 – NZ Health Strategy: 5 Strategic Themes

# Our programme, services and management

## Programme

With the National Infrastructure Platform programme completed in June 2017, NZHP currently manages one programme, the National Oracle Solution (NOS). NZHP manages this programme alongside DHB experts and leaders in the NOS Business Owners Forum and Programme Steering Committee.

### NATIONAL ORACLE SOLUTION

Every year, DHBs spend about $1.3 billion buying goods and services, including everything from cotton wool buds through to hospital beds. Traditionally the purchasing of these goods and services has been done in a variety of ways across the 20 DHBs, with no single register or process for handling the transactions.

NOS is a common software solution which will replace the many systems DHBs currently use to source, order, store and pay for goods and services. Once in place, for the first time the sector will have visibility of the amount all 20 DHBs spend on individual goods and services. This will enable the bulk buying power of the sector to be leveraged for procurement initiatives - ensuring value for money and the right tools for the job.

*Focus for 2017/18*

In 2017/18 the build of the technology and supporting infrastructure for NOS will be completed and tested, ready for roll out. Implementation for NOS is structured in multiple waves, with Bay of Plenty, Canterbury, Waikato and West Coast DHBs first to go live on the new system. A change programme of this magnitude is challenging. We will capture lessons learned which will be used to inform both the planning and the implementation activities for future waves. Ultimately the DHBs will lead their own implementation and change management processes, with support from NZHP as requested.

# Services

NZHP currently manages four commercial services on behalf of DHBs: Shared Banking, Collective Insurance, DHB Procurement and Food Services. These services deliver both qualitative and financial value to DHBs.

## SHARED BANKING and COLLECTIVE INSURANCE

### Shared Banking

On any given day NZHP manages a cash balance of between $300m to $1.4b for the sector. Unlike the other services where we act as a vendor manager, NZHP delivers the banking service itself. We invest funds held in a range of low risk investments to optimise the return on funds and minimise fees, while ensuring sufficient cash is available to meet all DHBs' needs.

*Focus for 2017/18*

In 2017/18 we will transition to BNZ as the new Shared Banking provider. This new contract will substantially reduce the costs of transactional banking, minimise the cost of working capital and term borrowing facilities and maximise returns for credit balances. The DHBs will receive better individualised customer service with 33 BNZ Partner Centres throughout the country.

### Collective Insurance

Collectively DHBs have assets valued around $15b. On behalf of DHBs, NZHP seeks to negotiate the best insurance deal available on a collective basis.

Working together means the sector can offer insurers a portfolio that is geographically spread with a high level of risk identification and management processes in place. Substantial cover is gained as a result from a comparatively lower premium, compared to if each DHB were to insure on an individual basis.

*Focus for 2017/18*

In 2017/18 we will negotiate a new Collective Insurance Agreement to provide services from 2018/19 and onwards. In advance of putting the tender process in place, DHBs will join the All of Government Broker Panel which will tender and negotiate a longer term collective contract. It will involve the marketplace's best pricing for Liability Package, Motor Vehicle, Travel and Personal Accident insurance policies.

# DHB PROCUREMENT SERVICE

DHB Procurement includes both implementation of the wider sector procurement operating model as well as delivery of National Procurement Service itself.

## Operating Model

In March 2017, DHB Chief Executives unanimously approved the health sector's new Procurement Operating Model. The Operating Model guides how the DHB Procurement Strategy will be operationalised. This covers approach, functions and roles within the sector.

Under the Joint Procurement Authority, NZHP will support implementation of the model over the next two to three years. Within the model, roles and responsibilities are defined for the Ministry of Business Innovation and Employment, PHARMAC, NZHP (national activity) and DHBs (working both collaboratively together or locally where DHBs purchase goods and services for their individual use).

## National Procurement Service

Under the new Operating Model, NZHP took over the healthAlliance national procurement service from 1 May 2017. This includes category and contract management, aligned planning, quality, process and standards oversight, strategic relationship management, and business information.

PHARMAC will incrementally take over medical device procurement over the next three years, while other procurement will eventually be handled collaboratively and locally. NZHP will work directly with PHARMAC and DHBs to manage this process.

*Focus in 2017/18*

In 2016, the DHB Procurement Strategy was endorsed by DHBs and approved by the NZHP Board. It represents a commitment to a collective way of working. This approach can extend the strategic reach of procurement to enable greater leverage of the national health spend and establish mutually beneficial relationships with suppliers. Savings attained through more effective sourcing and procurement practices create opportunities to reinvest in growth, personnel, facilities or other products and services.

In March 2017, DHBs approved a Procurement Operating Model including establishment of a new Procurement Service from 1 May 2017. In 2017/18 we will provide a Centre-led national procurement service for DHBs, delivering agreed procurement needs and managing contracts for the provision of clinical and non-clinical goods. It will involve contract management, clinical product co-ordination, and supplier relationship management and technology solutions to enable reductions in administrative and transactional costs.

## FOOD SERVICES

Under the Food Services Agreement (FSA), Compass Group NZ is contracted to provide patient meals, meals-on-wheels, and cafeteria services, ward supplies and optional services for six DHBs.

NZHP's focus is on ensuring appropriate governance, contract and vendor management are in place to ensure our participating shareholders receive the best service possible.

*Focus for 2017/18*
In 2017/2018 we will establish the revised FSA governance model and progress the expectations of the participating DHBs to renegotiate elements of the Terms and Conditions of the FSA to reflect the smaller participation level and maximise service delivery and commercial opportunities for all parties involved. We will commence delivery of the three year operating plan, and activate the tracking and reporting of benefits under the Compass Group NZ contract. The stated FSA benefits expectation is $1.8m per annum over the life of the contract.



# Management

## ORGANISATIONAL CAPABILITY

NZHP's work is supported by a lean team providing a range of core functions including Finance, Risk Management, Audit and Compliance; as well as Strategy, Business Performance, Human Resources, Change Management, Communications and Engagement. These are collectively known as Organisational Capability.

*Focus for 2017/18*
In 2017/18 we will implement the Communications and Engagement Strategy to ensure improved communication from all levels of the organisation, further enhance relationships with key DHB stakeholders. The execution of the People Strategy will continue to build a skilled and engaged workforce with the right capabilities, where people are focused on our strategic priorities and commitments made to our shareholders. In addition to the continuous improvement of finance, accounting, legal planning and performance processes, we will develop a range of corporate advancements including the creation of a Decision Making Framework, a new Value Framework, and a more effective Risk Management model.

# Measuring our performance

The following performance measures and targets have been developed in conjunction with NZHP's Statement of Performance Expectations (SPE) measures and should be read in conjunction with NZHP's SPE.

## Programme

The National Oracle Solution (NOS) will design and build a single financial management information system ready for DHB implementation. The programme represents a significant investment for the sector and is a critical enabler for the National Procurement Service.

### NATIONAL ORACLE SOLUTION

Table 1: NOS performance measures and targets 2017/18

| # | Performance Measure | Target | Type | When |
|---|---|---|---|---|
| The below performance measures repeat NOS SPE measures 1 to 4. | | | | |
| 1.1 | Ensure readiness of Oracle Administration Model | Key positions filled and capability in place. | Quality | 30 June 2018 |
| 2.1 | Complete Technology Build | Solution acceptance testing successfully completed. | Quality Timeliness | 31 December 2017 |
| 3.1 | Complete Solution Readiness | User acceptance testing successfully completed. | Quality Timeliness | 30 June 2018 |
| 4.1 | Preparation for First Wave DHB Implementation | Preparation for First Wave DHB implementation completed with no open action items, due to start 1 July 2018 | Quality Financial Timeliness | 30 June 2018 |

Note: Planning for NOS design and build is underway, with detailed timelines scheduled for completion 30 June 2017. In the event that of the above target dates may change, they will be updated in the NZHP Quarter One Report 2017/18.

# Services

NZHP works in a commercial manner within a public sector environment to provide high performing services that focus on creating efficiencies for DHBs with savings going back into frontline health services. Our services teams deliver qualitative and quantitative benefits to DHBs for Shared Banking, Collective Insurance, Food Services, Procurement and Organisational Capability.

## SHARED BANKING and COLLECTIVE INSURANCE

### Shared Banking

Banking and Treasury Services invests funds held in a restricted range of low risk investments to optimise returns on funds, while ensuring sufficient cash is available to meet all DHB needs. We manage a cash balance of between $300m to $1.4b through Shared Banking and Treasury functions.



Table 2: Shared Banking performance measures and targets 2017/18

| # | Performance Measure | Target | Type | When |
|---|---|---|---|---|
| Performance measure 5.1 repeats SPE measure 5 New banking service provider implemented. | | | | |
| 5.1 | New banking services provider implemented | Implementation of new banking services provider for 2017/18. | Timeliness | 31 Dec 2017 |
| Performance measures 6.1 and 6.2 support SPE measure 6 Delivery of efficient shared banking service. | | | | |
| 6.1 | Minimum deposit margin maintained | Minimum average deposit margin of 0.10% above NZs Official Cash Rate (OCR) maintained for the year. | Financial | 30 June 2018 |
| 6.2 | Minimum financial benefits to be achieved for shared banking | Total non-budgetary benefit of a minimum of $2.5m provided to DHBs for the year. | Financial | 30 June 2018 |
| Performance measures 7.1 and 7.2 support SPE measure 7 Delivery of effective shared banking service. | | | | |
| 7.1 | Independent audit of shared banking services undertaken | No issues raised in independent audit report are rated 'significant' (or equivalent) or higher. | Quality | 30 June 2018 |
| 7.2 | Customer service satisfaction rating | Minimum of 80% of all DHBs rate the customer service for the shared banking service as at least satisfactory / meets requirements. | Quality | 30 June 2018 |

### Collective Insurance

The Collective Insurance Service is responsible for managing the insurance requirements for the DHBs, various joint ventures and subsidiaries. Each insurance tender and contract is made on a fit for purpose basis. Collectively DHBs have assets valued around $15b.

Table 3: Collective Insurance performance measures and targets 2017/18

| # | Performance Measure | Target | Type | When |
|---|---|---|---|---|
| Performance measure 8.1 repeats SPE measure 8 New collective insurance agreement implemented. | | | | |
| 8.1 | New collective insurance agreement implemented | Negotiation of new collective insurance agreement completed and selected broker is in place for 2018/19. | Timeliness | 30 June 2018 |
| Performance measure 9.1 supports SPE measure 9 Delivery of efficient collective insurance service. | | | | |
| 9.1 | Minimum financial benefit to be achieved | Total non-budgetary benefit of a minimum of $2.5m provided to DHBs for 2018/19. | Financial | 30 June 2018 |
| Performance measures 10.1 and 10.2 support SPE measure 10 Delivery of effective collective insurance service. | | | | |
| 10.1 | 2018/19 insurance agreed and documented for all DHBs | All 20 DHBs have agreed insurance cover in place for 2018/19 for material damage, business disruption, professional liability, travel and motor vehicles. | Quality Timeliness | 30 June 2018 |
| 10.2 | Customer service satisfaction rating | Minimum of 80% of all DHBs rate the customer service for the collective insurance service as at least satisfactory/meets requirements. | Quality | 30 June 2018 |

## DHB PROCUREMENT SERVICE

The DHB Procurement Service ensures DHBs achieve increased value from collective procurement with a focus on clinical imperatives such as quality, safety, standardisation and sustainability; reducing overall procurement costs and increasing real return on investment; and by working with the DHBs as one team, for the national good.

Table 4: DHB Procurement Service performance measures and targets 2017/18

| # | Performance Measure | Target | Type | When |
|---|---|---|---|---|
| The below performance measures repeat DHB Procurement Services' SPE measures 11 to 16. | | | | |
| 11.1 | Implementation of structure to support operating model | Procurement capability and capacity is in place to support the procurement operating model. | Quality Timeliness | 30 November 2017 |
| 12.1 | An operational clinical engagement framework | A clinical engagement framework is developed which supports the operating model, approved by JPA and implementation is underway. | Quality Timeliness | 30 June 2018 |
| 13.1 | Aligned governance processes | Processes to support governance are in place and aligned to the procurement operating model. | Quality Timeliness | 30 June 2018 |

Table 4: DHB Procurement Service performance measures and targets 2017/18 - Continued

| # | Performance Measure | Target | Type | When |
|---|---|---|---|---|
| 14.1 | Enhance planning across multi-year processes | A rolling 3-year plan for procurement has been established, operationalised and approved by JPA. | Timeliness | 30 September 2017 |
| 15.1 | Transition of non-national contracts to DHBs | Procurement capability and capacity plans are in place to ensure DHBs are ready to receive non-national contracts, and all non-national contracts have been moved to suitable owners/managers. | Timeliness | 31 December 2017 |
| 16.1 | Delivery of efficient procurement service | Delivery of value add procurement service including achievement of $6.1m total benefits. | Financial | 30 June 2018 |

## FOOD SERVICES



Food Services provides the contract and vendor management of the Food Services Agreement with Compass Group NZ, on behalf of Auckland, Waitemata, Counties Manukau, Southern, Hauora Tairawhiti and Nelson Marlborough DHBs. Compass Group NZ provides approximately 60% of all patient meals served in New Zealand hospitals as well as other services such as Meals on Wheels.

Table 5: Food Services performance measures and targets 2017/18

| # | Performance Measure | Target | Type | When |
|---|---|---|---|---|
| The below performance measures repeat Food Services' SPE measures 17 to 20. | | | | |
| 17.1 | Transition programme to active contract management | Vendor and customer relationship management framework is in place, aligned to new Health Sector Procurement Operating Model, with active reporting and tracking of benefits realisation. | Quality<br>Timeliness | 31 December 2017 |
| 18.1 | Implement revised FSA governance model | Establishment of FSA Contract Management Group and associated strategy and operating model, with participation from all 6 DHBs. | Quality<br>Timeliness | 30 September 2017 |
| 19.1 | 3-year operating plan | Delivery and sign off of 1 to 3-year operating plan. | Quality<br>Timeliness | 30 June 2018 |
| 20.1 | Delivery of efficient food service | Delivery of value add food service including achievement of $1.8m total benefits. | Financial | 30 June 2018 |

# Management

## ORGANISATIONAL CAPABILITY

NZHP's core functions including Finance, Risk Management, Audit and Compliance; as well as Strategy, Business Performance, Human Resources, Change Management, Communications and Engagement are collectively known as Organisational Capability.

Table 6: Organisational Capability performance measures and targets 2017/18

| # | Performance Measure | Target | Type | When |
|---|---|---|---|---|
| Performance measure 21.1 supports SPE measure 21 Embed change management framework. | | | | |
| 21.1 | Support sector change required to implement the Procurement Operating Model | Develop and execute a Change Management Strategy and Plan to support implementation of the new Procurement Operating Model. | Quality | 30 June 2018 |
| Performance measures 22.1 and 22.2 support SPE measure 22 Implement Communications and Engagement Strategy. | | | | |
| 22.1 | Communication standards applied across all programme and services | Communications are planned and timely. | Quality<br>Timeliness | 30 June 2018 |
| 22.2 | Meet statutory obligations | NZ Health Partnerships meets all statutory requirements regarding OIAs and Parliamentary questions. | Quality<br>Timeliness | 30 June 2018 |
| Performance measure 23.1 repeats SPE measure 23 Decision Making Framework. | | | | |
| 23.1 | Decision Making Framework | Development and implementation of agreed Decision Making Framework. | Quality<br>Timeliness | To be confirmed |
| Performance measure 24.1 supports SPE measure 24 Implement Human Resources Strategy. | | | | |
| 24.1 | Improve key internal focus areas | Particular focus on the following areas for improvement:<br>1. Leadership<br>2. Internal Communications<br>3. Living Our Values<br>4. Reward and Recognition<br>5. Customer Focus. | Quality | 30 June 2018 |

Table 6: Organisational Capability performance measures and targets 2017/18 - Continued

| # | Performance Measure | Target | Type | When |
|---|---|---|---|---|
| Performance measures 25.1 to 25.4 support SPE measure 25 Enhance organisational capability. | | | | |
| 25.1 | Identify NZHP process suite | Complete current state assessment of NZHP process suite. | Quality | 31 Dec 2017 |
| 25.2 | Develop prioritised improvement plan for identified processes | Undertake fit for purpose reviews of identified processes; determine key improvement areas and/or gaps; develop prioritised improvement plan. | Quality | 31 December 2017 |
| 25.3 | Implement enhanced processes across NZHP | Develop and implement enhanced processes as determined in prioritised improvement plan (refer measure 25.2). | Quality | 30 June 2018 |
| Performance measures 26.1 to 26.3 support SPE measure 26 Delivery of effective Corporate Services functions. | | | | |
| 26.1 | Delivery on time of key accountability documents | SPE, Annual Plan, Annual Report and Quarterly Reports are completed, approved and published within mandated timelines. | Quality Timeliness | 30 June 2018 |
| 26.2 | Improve financial reporting to Executive Leadership Team (ELT) | Improved financial reporting template for ELT is developed and embedded. | Quality | 30 June 2018 |
| 26.3 | Enhance budgeting processes | Budgeting framework and processes revised and embedded. | Quality | 30 June 2018 |
| Performance measure 27.1 repeats SPE measure 27 Planning and Performance Framework. | | | | |
| 27.1 | Enhance planning and performance function and processes | Planning and Performance framework and processes developed and embedded. | Quality | 30 June 2018 |
| Performance measures 28.1 and 28.2 support SPE measure 28 Value Framework. | | | | |
| 28.1 | Value Framework | Value framework and processes developed and embedded. | Quality | 30 June 2018 |
| 28.2 | Customer service satisfaction rating | Minimum of 80% of all DHBs rate NZHP's performance (management and delivery of programmes and services) as at least satisfactory / meets requirements. | Quality | 30 June 2018 |
| Performance measures 29.1 to 29.3 support SPE measure 29 Delivery of effective Risk Management. | | | | |
| 29.1 | Completion of quality assurance across key programmes and services | Independent reviews or audits are undertaken across identified programmes and services. | Quality | 30 June 2018 |
| 29.2 | Embed legislative compliance checklist | Legislative compliance checklist completed and in use | Quality | 30 June 2018 |
| 29.3 | Embed Health & Safety policy and procedures | Health & Safety culture is embedded across NZHP. | Quality | 30 June 2018 |

# Benefits

Benefits management is at the very heart of NZHP's purpose. In conjunction with our shareholders, programmes are identified, assessed, prioritised, developed and implemented with the singular purpose of delivering benefits to DHBs and contributing to the health and wellbeing of New Zealanders.

A benefit is defined as a clear financial or performance improvement. This may include building organisational capabilities, delivering efficiencies or effectiveness, or clinical improvements. Whether financial or performance-based all benefits ultimately contribute to better health outcomes. As such, "Value" is a term the better encapsulates the breadth of gains that can be made across the sector.

In 2017/18 NZHP and its shareholders will work together to develop a Value Framework. This Framework will define the problem or opportunity, the value proposition of a programme or project, as well as the standards around measuring, tracking and reporting on the gains made. The Value Framework will incorporate the existing Benefits Management Framework.

Alongside our own programmes and services, NZHP is responsible for coordinating and reporting the aggregated sector benefits based on information provided by DHBs and third party providers such as PHARMAC and Ministry of Business Innovation and Employment (MBIE). The benefits reported by NZHP are realised and owned by the DHBs.

**Key Benefits Definitions**

Benefits management refers to the identification, definition, tracking, realisation and optimisation of benefits. Benefits can be made up of two parts: Budgetary and Non-Budgetary.

**BUDGETARY BENEFITS**

Budgetary benefits are defined as the incremental annual change, primarily cash, which has a clearly defined impact on the Statement of Comprehensive Income. These benefits result in a budget line reduction, compared with the prior year.

**NON-BUDGETARY BENEFITS**

Non-Budgetary benefits are defined as those that form part of the business case that do not meet the definition of Budgetary. There are three general components:

- **Cost Avoidance:** Cash that would have been spent is now totally avoided or reallocated as a result of the business case.
- **Cumulative benefits:** are those that are carried forward from previous years, whether they were originally budgetary or non-budgetary in nature.
- **Qualitative benefits:** accrue from associated activity as a result of a business case and need to be reported in some way. Also referred to as non-financial benefits, in some cases it may be too difficult to quantify these reliably.

## Benefits Estimates

Table 7: Estimated Total Benefits for Output Class 1 & 2 2017/18.

| | Estimated 2017/18 $000 |
|---|---|
| **OUTPUT CLASS 1: PROGRAMMES** | |
| ***Total Annual Benefits*** | |
| Budgetary | 0 |
| Non-Budgetary | 0 |
| **OUTPUT CLASS 2: SERVICES** | |
| **National Procurement - NZHP**[1] | |
| Budgetary | 2,500 |
| Non-Budgetary | 18,000 |
| **National Procurement – MBIE**[2] | |
| Budgetary | 0 |
| Non-Budgetary | 10,900 |
| **Food Services** | |
| Budgetary | 0 |
| Non-Budgetary | 1,810 |
| **Shared Banking** | |
| Budgetary | 0 |
| Non-Budgetary | 2,500 |
| **Collective Insurance** | |
| Budgetary | 0 |
| Non-Budgetary | 2,500 |
| **DHB Procurement**[3] | |
| Budgetary | 3,400 |
| Non-Budgetary | 8,800 |
| ***Total Annual Benefits*** | |
| Budgetary | 5,900 |
| Non-Budgetary | 44,510 |
| **TOTAL ANNUAL BENEFITS** | **50,410** |

1. National Procurement - NZHP includes the National Procurement Service provided by NZHP and PHARMAC contracts (pending the full transition of medical device procurement to PHARMAC).
2. National Procurement - MBIE includes benefits from All of Government contracts, as reported by MBIE.
3. DHB Procurement includes DHB individual and DHB collaborative procurement.

# Assessing performance

Our performance will be assessed against the following four ratings categories:

Table 8: Performance assessment ratings

| | Performance Rating | Description |
|---|---|---|
| | Achieved | On target or better. |
| | Substantially achieved | 95% to 99.9% achieved.<br>0.1%-5% away from target. |
| | Not achieved, but progress made | 90% to 94.9% achieved.<br>5.1% to 10% away from target and improvement on previous year. |
| | Not Achieved | <90% achieved.<br>>10% away from target; or 5.1% to 10% away from target and no improvement on previous year. |

The perspectives that underpin our assessment of performance are quality, financial and timeliness.

Table 9: Performance perspectives

| Perspective | Description |
|---|---|
| Quality | This will measure the quality of the delivery of programmes and services. Measures may be related to post-implementation reviews, quality assurance reviews, peer reviews, and stakeholder and shareholder engagement. |
| Financial | This will report performance against the projected costs and benefits for financial measures. |
| Timeliness | The programmes and services will have progress measured against agreed milestones to determine if they are delivery on schedule. |

# Financial Statements

## 1.1 Prospective Statement of Comprehensive Revenue and Expense

**For the year ending 30 June 2018**

| | 2015/16 Actual $000 | 2016/17 Forecast $000 | 2017/18 Budget $000 |
|---|---|---|---|
| **Revenue:** | | | |
| Revenue from DHBs | 21,631 | 27,162 | 23,796 |
| Interest revenue - NZ Health Partnerships | 219 | 86 | 15 |
| Shared banking | 28,385 | 18,300 | 12,000 |
| Other revenue | 3,791 | 23 | 0 |
| Total revenue | 54,026 | 45,571 | 35,811 |
| **Expenditure:** | | | |
| Personnel costs | 3,205 | 3,514 | 6,771 |
| Depreciation and amortisation expense | 2,126 | 1,696 | 145 |
| Finance costs - NZ Health Partnerships | 0 | 0 | 0 |
| Shared banking | 28,362 | 18,300 | 12,000 |
| Other expenses | 24,431 | 19,932 | 16,880 |
| Total Expenditure | 58,124 | 43,442 | 35,796 |
| **Surplus/ (Deficit)** | **(4,098)** | **2,129** | **15** |
| Other Comprehensive revenue and expense | 0 | 0 | 0 |
| **Total Other Comprehensive Revenue and Expense** | **0** | 0 | 0 |
| **TOTAL COMPREHENSIVE REVENUE AND EXPENSE** | **(4,098)** | **2,129** | **15** |

15

## 1.2 Organisational Capability - 2017/18 Budget

**For the year ending 30 June 2018**

| | 2017/18 Budget $000 |
|---|---|
| **Expenditure:** | |
| Employees Costs | |
| Salary & Wages | 2,392 |
| Course fess, Conference and Memberships | 176 |
| Recruitment | 65 |
| Total | 2,633 |
| Outsourced Services | |
| Contractors | 357 |
| Finance & Payroll Bureau - healthAlliance NZ | 130 |
| Information Technology - healthAlliance NZ | 90 |
| Total | 577 |
| Other Expenditure | |
| Rents, Utilities, Cleaning | 310 |
| Staff Travel | 80 |
| Staff Accommodation and Meals | 15 |
| Software leases and rentals | 97 |
| Telecommunications | 83 |
| Bank Charges | 2 |
| Audit and Legal Fees | 384 |
| Assurance Fees and Consultants | 322 |
| Insurance | 65 |
| Stationery and Supplies | 31 |
| Reception and Catering | 35 |
| Information Technology Depreciation | 145 |
| Sundry Expenses | 43 |
| Board Members Fees and Expenses | 268 |
| Total | 1,880 |
| **Total Expenditure** | **5,090** |

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Health Literacy Principles & Implementation Approach** 52 |
| | For the attention of: **HBDHB Board** |
| Document Owner:<br>Document Author: | Kate Coley, Executive Director of People & Quality<br>Adam McDonald, Health Literacy Advisor |
| Reviewed by: | Health Literacy Steering Group, Executive Management Team, Māori Relationship Board, HB Clinical Council, HB Health Consumer Council |
| Month: | May 2017 |
| Consideration: | For information |

16

**RECOMMENDATION**

**That the HBDHB Board:**

- **Note** the Health Literacy principles for the Hawke's Bay health sector
- **Note** the summary of the Quigley & Watts review report (Appendix 1 & 2). Full copy of report Appendix 3.
- **Note** the proposed action plan for the development of a set of health literacy products, tools and guidance/advisory to support the implementation of the health literacy principles

## PURPOSE

The purpose of this paper is to provide a summary of the work that has been undertaken to date in regards to health literacy, a review of the report provided by Quigley & Watts (Q&W) and to outline the approach and programme of work to begin the implementation of the health literacy principles.

## EXECUTIVE SUMMARY

The focus is to create a health literate Hawke's Bay health sector and an empowered and health literate population. This will be achieved through:

1. Reducing the health literacy demands and complexities that the health system places on people to obtain, understand and use health services and information.
2. Increasing the skills and abilities of people to access, navigate, understand and use the health system.

The ministry of health report Korero Marama (2010) found that 56% of New Zealanders have low levels of health literacy. Further to this, health literacy had a much greater impact on Māori contributing to greater health challenges and health inequities. Low levels of health literacy can impact negatively on the health of people and their whānau. International research has shown the relationship between a person's level of literacy and their health status[1] (Ministry of Health, 2010).

Phase 1 of the initial project was to undertake a stocktake of the HB health sector in regards to health literacy. A review was commissioned by Hawke's Bay District Health Board (HBDHB), on behalf of

[1] (Canadian Council of Learning 2008; Kickbusch et al 2005; Knight 2006; Korhonen 2006; Institute of Medicine 2004; Nutbeam 2008).

the sector. Quigley and Watts Ltd was commissioned to undertake a high-level strategic review of the health literacy strengths and weaknesses of the Hawke's Bay health sector. (A full copy of the report is provided in Appendix 3)

The report provided a good overview of where the HB health was at in regards to health literacy summarising our strengths, weaknesses and made a number of recommendations. (Appendix 1 & 2). These recommendations have been incorporated into the development of principles, the implementation approach and action plan detailed in this report.

The report identified the following key themes and opportunities:

- Strong leadership commitment at a strategic and senior level to health literacy
- Prioritise health literacy in a programme of work
- Focus now on the development of an overarching and co-ordinated wide action plan
- Linkages to creating a culture shift and link to the philosophy of person & whānau centred care
- Need to create an impetus to gain commitment across all levels of the sector

Since the report was finalised a number of related activities have been undertaken. The first, is the appointment of a Health Literacy Advisor who will be the Project lead for the implementation of health literacy across the sector. In addition to this appointment, the DHB has also been developing and designing training for all staff (aligned to that being offered in GP Practices) to support the improvement of health literacy. This model of Relationship Centred Practice incorporates Māori principles and frameworks including the Hui Process and is being made available to all Central region DHBs and potentially will be utilised at a national level through HQSC. Workshops and education sessions to support the building of awareness have also been taking place alongside the development of tools and guidance material for all teams across the sector. Ongoing advice and support has been provided to individuals and teams on an ad hoc basis and there has been an increase in these requests over the last few months.

The intent of the first phase of the project was to undertake a stocktake and develop a HB Health Literacy Framework. In completing this work, it is clear that health literacy is complex and it was felt that if we were going to be able to achieve the outcomes then we needed to ensure that we were not increasing the complexity with the introduction of another framework. To that end it is recommended that the HB utilises a simple model of creating a health literate organisation/system and sets out its commitment to health literacy in the form of a set of core principles. These would be easily understood by staff, patients, and the community, and will inform the programme of work.

The action plan outlines core work streams and the development of a set of products to support the roll-out of the health literacy programme of work. The work streams aim to build awareness and understanding of health literacy and develop guidelines with resources for organisations across Hawke's Bay to use to ensure a systematic approach to improving health literacy. Throughout the action plan, there is a focus on ensuring there is adequate consumer input, ensures that we build capacity across the health sector to improve health literacy and develops skills for organisations to be able to sustain the health literacy programme of work.

## BACKGROUND

## SUMMARY OF QUIGLEY & WATTS REPORT

A review was commissioned by Hawke's Bay District Health Board (HBDHB), on behalf of the sector. Quigley and Watts Ltd was commissioned to undertake a high-level strategic review of the health literacy strengths and weaknesses of the Hawke's Bay health sector and to provide findings and recommendations to inform the development of a framework and plan for health literacy within Hawke's Bay.

Information for this review was collected via face to face group discussions, telephone interviews, a literature scan and document review.

In assessing the health sector strengths and weaknesses Q&W utilised the MOH Six Dimensions framework for creating a health literate organisation and the findings are summarised below. A more detailed summary of the findings can be found in Appendix 1 & 2.

- Need for a clear and better understanding of health literacy. Health literacy often referred to as a confusing topic that contributes to the lack of clear understanding of the concept.
- Good intentions at a leadership and strategic level and some good pockets of practice, however overall there is poor and inconsistent practice across the HBDHB.
- Need for the culture within the health system to change, with re-organisation towards a more person and whānau centred system.
- Critically in the local context, this requires a health literacy framework to be underpinned by mātauranga Māori (Māori knowledge) in order to reflect the basis of New Zealand's founding relationships and to ensure the framework addresses health inequities.
- The need for the DHB to support change to make health literacy business as usual, this includes embedding health literacy into expected practice and behaviour and creating accountability.
- Workforce development and resourcing for better health literate practice for health professionals.
- Increase the Māori and Pacific health workforce.
- Effective communication from a systems to an operational level.
- Linked up clinical pathways and a health system that ensures easy access and navigation.
- More joined up and co-ordinated way of working within the health system.



Overall, whilst there is room for improvement across the six dimensions, it was Q&W's view that the HB health sector should feel optimistic about the future for health literacy as there was an absolute commitment to creating a health literat environment and it was felt that thei approach to health literacy identified in Transform & Sustain was a platform for real transformation.

## CREATING A HEALTH LITERATE SECTOR

A health literate sector makes health literacy a priority. It makes health literacy part of all aspects of service planning, design, delivery and performance evaluation to reduce the health literacy demands on consumers.

A health literate sector:

- Makes health literacy everyone's business – leaders, managers, clinical and non-clinical staff
- Designs systems, processes and services that allow consumers to access services easily
- Supports operational staff to use health literacy approaches and strategies
- Eliminates confusing communication that could prevent consumers from accessing treatment easily
- Actively builds health literacy in consumers to help them to manage their health
- Makes operational staff understand that no matter how high a consumers level of health literacy is, stress and anxiety affect their ability to understand and remember new information

Q&W recommended that the concept of health literacy should embrace:

- A dual focus - on creating both a health literate sector and an empowered and health literate population.
- A partnership approach—where individuals/whānau are partners alongside the health system and health professionals. Within the local context this includes ensuring that the principles are underpinned by mātauranga Māori (Māori knowledge).
- A population health approach—a definition of health that encompasses wellness, recognises the social determinants of health, and addresses current inequities.

Drawing on international best practice, the following six dimensions have been developed in New Zealand and describe the attributes of a health literate organisation that make it easier for people to navigate, understand and use health information and services to take care of their health. These six dimensions exemplify a health literate organisation/system and an organisation/system that embodies these dimensions creates an environment that enables people to benefit optimally from

healthcare services and information. Each dimension highlights ways in which health literacy can be embedded.

These dimensions have informed the development of a set of guiding principles and an action plan for health literacy, rather than create a framework which could potentially add greater complexity to an already complex area.

| New Zealand's Six Dimensions | | Rationale |
|---|---|---|
| 1. | **Leadership and management.** How is health literacy an organisational value, part of the culture and core business of an organisation? How is it reflected in strategic and operational plans? | Leaders and managers have a critical role in developing a health-literate organisation. They drive an organisation's health literacy culture by articulating and reinforcing goals and expectations, and by modelling expected behaviours. Leaders and managers in a health-literate health care organisation ensure that health literacy is built into all aspects of the organisation, explicitly measured and monitored, and continuously improved. |
| 2. | **Consumer involvement.** How are consumers involved in designing, developing and evaluating the organisation's values, vision, structure and service delivery? | A commitment to patient-centred care, consumer safety and quality improvement involves more than the activities of managers, clinical leaders and other staff. A health-literate health care organisation involves consumers and their families in all aspects of service delivery – not just the evaluation of consumer experience. |
| 3. | **Workforce.** How does the organisation encourage and support the health workforce to develop effective health literacy practices? Has it identified the workforce's needs for health literacy development and capacity? Has the organisation's health literacy performance been evaluated? | The health workforce plays a crucial role in communicating oral and written information to consumers and families and ensuring they understand that information. A health-literate health care organisation provides health literacy training and coaching to its entire workforce to improve communication and build health literacy. |
| 4. | **Meeting the needs of the population.** How does the delivery of services make sure consumers with low health literacy are able to participate effectively and have their health literacy needs identified and met (without experiencing any stigma or being labelled as having low health literacy)? How is meeting the needs of the population monitored? | Because health literacy is diverse and ongoing, health care organisations will find it difficult to identify who in their consumer population has low health literacy. A health-literate health care organisation adopts a universal precautions approach so that staff do not make assumptions about who might or might not need assistance. |
| 5. | **Access and navigation.** How easy is it for consumers to find and engage with appropriate and timely health and related services? How are consumers helped to find and engage with these services? How well are services coordinated and are services streamlined where possible? | Health care organisations develop and use systems that place demands on consumers and families. A health-literate health care organisation reduces the demands its systems place on consumers and families and helps them to access and navigate systems. |
| 6. | **Communication.** How are information needs identified? How is information shared with consumers in ways that improve health literacy? How is information developed with consumers and evaluated? | Health care organisations communicate with consumers and families orally, in writing and increasingly using technology. A health-literate health care organisation ensures that all communication, in all formats, is clear, easy to understand and easy for consumers and families to act on. |

## HEALTH LITERACY PRINCIPLES

Rather than utilise the MOH framework, a set of core principles (aligned to the framework) have been developed so that staff, consumers, our whānau/families and our community can easily understand them. The below outlines those principles and links to the sector wide values.

| Six Dimensions | Health Literacy Principles | HB Values |
|---|---|---|
| Leadership and management | Leadership is needed to champion a culture change to ensure that Hawkes Bay becomes a health-literate sector | He Kauanuanu<br>Ākina<br>Tauwhiro |
| Consumer involvement | Creating a health literate sector happens in partnership, where consumers and whānau are viewed as important and equal partners with health professionals. | He Kauanuanu<br>Raranga te tira |
| Meeting the needs of the population | Reducing complexities and demands of the health system is the most practical way to achieve a health literate sector | He Kauanuanu<br>Raranga te tira<br>Tauwhiro |
| Workforce | We need to invest in building skills and knowledge of our health professionals so that they with consumers build positive relationships, communicate effectively and understand one another | He Kauanuanu<br>Ākina<br>Tauwhiro |
| Communication | Communication is a critical component to ensure that health services and information is delivered so that it is understood by the consumer and can be used to make informed decisions | He Kauanuanu<br>Ākina<br>Raranga te tira<br>Tauwhiro |
| Access and navigation | Our aim is to ensure that health services and information can be easily accessed and navigated, understood and then used to improve the health and wellness of our consumers | He Kauanuanu<br>Ākina<br>Raranga te tira<br>Tauwhiro |



## HEALTH LITERACY ACTION PLAN

The action plan outlines core work streams and the development of a set of products to support the roll-out of the health literacy programme of work. The work streams aim to build awareness and understanding of health literacy and develop guidelines with resources for organisations across Hawke's Bay to use to ensure a systematic approach to improving health literacy. Throughout the action plan, there is a focus on ensuring there is adequate consumer input, ensures that we build capacity across the health sector to improve health literacy and develops skills for organisations to be able to sustain the health literacy programme of work.

| | Work streams | Proposed timeframes<br>Start | <br>End |
|---|---|---|---|
| **1.** | **Change management**<br><br>Position the health literacy programme of work within the People strategy, with the aim of shifting the culture across the HBDHB.<br><br>Collaborate and co-ordinate the health literacy programme of work with the following activities;<br>o Person and whānau centred care<br>o Workforce engagement<br>o Health equity<br>o Cultural competency | **December 2016** | **July 2018** |

| | | | |
|---|---|---|---|
| | o HBDHB values<br>o Quality improvement and patient safety<br>o Consumer and community engagement<br>o Relationship centred practice<br>o Long term conditions strategy<br>o Community and primary healthcare strategy | | |
| **2.** | **Establish a Project Advisory Roopu**<br><br>The advisory roopu is to model a partnership approach towards improving health literacy across the health sector. Given that health literacy has a greater impact on Māori and contributes towards health inequities, the group will ensure there is adequate representation from Māori consumers, workers and the community.<br><br>See Appendix 4 for the draft terms of reference and Appendix 5 for the project structure | **March 2017** | |
| **3.** | **Raise awareness for health literacy**<br>*(Process to be developed in partnership with staff and consumers)*<br><br>Develop marketing material (that is delivered through effective channels) that can effectively reach people working in the health sector and within the community to raise awareness and improve understanding of health literacy.<br><br>The marketing material may require the use of alternative titles or terminology for health literacy, given the lack of association between health literacy and what it truly means. For example – understanding healthcare (for consumers), making healthcare easy to understand (for clinicians). | **January 2017** | **May 2017** |
| **4.** | **Health literacy leadership (across sector)**<br><br>Ensure that leadership and management training programmes include creating a health literate sector.<br><br>Advise on the approach to improving organisational health literacy that contributes to the change in health sector culture. | **March 2017** | **September 2017** |

| | | | |
|---|---|---|---|
| **5.** | **Creating a health literate environment**<br><br>Develop guidelines with a set of resources for organisations (or large services) across the health sector to use to create a health literate environment*. (Potentially an e-book).* The guidelines may include the following steps;<br><br>Step 1: Complete a health literacy assessment for the six dimension of a health literate organisation. This assessment will be based on the following;<br>▪ ENLIVEN: Health literacy self-assessment tool<br>▪ Harvard University: The health literacy environment of hospitals and health centres<br>▪ Ministry of Health: Staff survey for health literacy<br><br>Step 2: Develop a health literacy action plan based on the findings from the assessment across the six dimensions of health literacy.<br><br>Step 3: Implementing toolkits and resources that improve health literacy in your service or organisation.<br>▪ Health literacy promotion / marketing<br>▪ Hawke's Bay health literacy toolkit – based on the universal precautions health literacy toolkit.<br>▪ Developing health literate communications and resources - rauemi atahwhai (in video format)<br>▪ Links to other resources including three steps to better health literacy, P.L.A.N, safe to ask (increase consumer confidence to ask questions).<br><br>Step 4: Continually improving health literacy.<br>▪ Repeat steps 1 – 3 annually | **November 2016** | **June 2017** |
| **6.** | **Workforce development (across sector)**<br><br>Develop a health literacy workforce education programme that is positioned within the HBDHB peoples and work force development strategy*. (Linkage to current RCP programme)* The programme requires coaching in effective health literacy communication methods with an emphasis on improving quality relationships with consumers | **March 2017** | **February 2018** |
| **7.** | **Consumer and community health literacy**<br><br>Create a consumer and community strategy that adopts a co-design methodology to improve consumer and community health literacy. *(Working with PHO, Staff and Consumers)* | **September 2017** | **February 2018** |
| **8.** | **Address health literacy priority areas within the HBDHB**<br><br>Health literacy innovation: Investment in projects that aim to improve health literacy across the health sector<br>Particular areas of interest, such as hospital discharge / readmission, consumer and community health literacy, Māori and Pacifica health. | **March 2017** | **July 2018** |

| | | | |
|---|---|---|---|
| **9.** | **Monitor, evaluate and continual improve health literacy**<br><br>Review, evaluate and continually improve health literacy across the Hawke's Bay region<br>▪ Ministry of health – health literacy review framework<br>▪ QIPS measures<br>▪ Health outcome and output measures<br>▪ Workforce knowledge survey<br>▪ Consumer knowledge survey<br>▪ Health literacy self-assessment | **June 2017** | **July 2018** |

## APPENDIX 1 – SUMMARY OF FINDINGS

| Dimension | Findings |
|---|---|
| Leadership | The leadership and management dimension assesses whether health literacy is an organisational value, part of the culture and core business of an organisation or service, and whether health literacy is reflected in strategic and operational plans.<br>Health literacy is a clear strategic priority for HBDHB with support from leadership and it is consistent with the values of HBDHB. Findings indicate a coordinated and thoughtful approach to developing health literacy at the strategic level thus far. As the emphasis has been on developing a strategic focus, health literacy is yet to flow into operational plans or coordinated organisational action. With the exception of Health Hawke's Bay where health literacy workforce development and initiatives for consumers have been developed action has yet to filter out to the wider health workforce. As expected at this stage of development, there is significant work required before health literacy is part of the core business of the sector but it is clear that HBDHB has, and should continue to have, a strong leadership role in this area.<br><br>Considerations for the framework include: ensuring HBDHB continues to lead health literacy work in collaboration with the rest of the sector; underpinning the framework by Māori principles; and, ensuring there is a multi-faceted, long-term approach to this work |
| Consumer Involvement | The consumer involvement dimension assesses how consumers are involved in designing, developing and evaluating the organisation's values, vision, structure and service delivery. Overall, there is a currently limited consumer involvement in health literacy work or in the strategic direction of the Hawke's Bay health system more broadly. The Consumer Council is an important step in the right direction however it is just one facet of the collaboration with consumers required for health literacy improvement. Internationally, health literacy experts acknowledge that real progress in health literacy will be limited without true collaboration with consumers, which to date has been lacking.<br><br>Considerations for the framework include: partnering with consumers in the development of the framework; importance of a patient/whānau-centred approach and the opportunities of co-design as a framework for involving consumers in service design and delivery. |
| Workforce | The workforce dimension assesses how the organisation encourages and supports the health workforce to develop effective health literacy practices, whether it has identified the workforce's needs for health literacy development and capacity, and whether the organisation's health literacy performance has been evaluated. There has been no coordinated approach to workforce development in health literacy. The focus of HBDHB has been at the strategic level thus far. There are significant workforce development needs a notable exception is Health Hawke's Bay which is in the process of undertaking workforce development for staff in primary care. While there is generally the will to up skill in this area, a key challenge will be getting all staff to see it as a priority.<br><br>Considerations for the framework include: making workforce development a priority; making health literacy as much of a priority as clinical work; creating an enabling system to support workforce change and, increasing the Māori and Pasifika workforce. |

| | |
|---|---|
| Meeting the needs of the population | Meeting the needs of the population dimension assesses how service delivery ensures that consumers with low health literacy are able to participate effectively in their care and have their health literacy needs identified and met (without experiencing any stigma or being labelled as having low health literacy). This dimension also assesses how meeting the needs of the population is monitored. There is a strategic intent to address inequities however the health system is currently unlikely to be meeting the needs of consumers with low health literacy. There is no coordinated approach to identifying health literacy need, addressing it and then monitoring whether those needs are being met. One of the biggest challenges is that the system is set up to meet the needs of those working within it and not those accessing it. Less than 50% of adult New Zealanders have adequate health literacy. Low health literacy contributes significantly to health disparities for Māori and Pacific peoples. Four out of five Māori males and three out of four Māori females have poor health literacy skills (Ministry of Health, 2010). The health system is complex and everyone struggles with it at some point even those with good health literacy.<br><br>Considerations for the framework include: a Universal Precautions approach to build the health literacy of the whole population without stigmatising those with low health literacy; a strong focus on reducing inequities particularly for Māori; monitoring mechanisms to measure whether needs are being met; and, reorienting the health system to meet the needs of the population. |
| Access & Navigation | The access and navigation dimension assesses how easy it is for consumers to find and engage with appropriate and timely health-related services, and how well these services are coordinated and streamlined. There was not as much discussion about this dimension as there was about the others but the findings indicate there is a lack of coordinated and streamlined services and impacting on access and navigation for consumers.<br><br>Considerations for the framework include having more discussion about what this dimension means and how aspects of access and navigation are addressed across the other dimensions particularly leadership and management, and communication. |
| Communication | The communication dimension assesses how information needs are identified, how information is shared with consumers in ways that improve health literacy, and how information is developed with consumers and evaluated. As with other dimensions there are pockets of good things happening but there is no coordinated approach to identifying information needs or sharing information in a way that improves health literacy. Most of the health information is written by health professionals, there is no systematic approach for assessing the readability of resources, and health practitioners have no specific tools or training to build communication skills.<br><br>Considerations for the framework include: having a coordinated approach to improving communication between health professionals and consumers with an emphasis on quality relationships; involve consumers in the development of health resources; and, think about how to improve the communication skills of both health professionals and consumers. |

## APPENDIX 2 - SUMMARY OF POTENTIAL OPPORTUNITIES

| ***Domain*** | ***Opportunity*** | ***Commentary*** |
|---|---|---|
| *Leadership* | HBDHB needs to lead the work on health literacy | Findings from interviews and groups supported a leadership role for HBDHB in collaboration with the wider sector. HBDHB also needs to lead by example and embed health literacy into the DHB first ensuring that health practitioners understand their role in improving health literacy (more about this under the 'workforce' dimension). |
| | Underpin the framework with Māori principles | The Māori Relationship Board and some interviewees felt strongly that in order for the framework to be successful, it needs to be underpinned and driven by Māori principles – tikanga and kawa – rather than Māori perspectives being reflected in the strategy. |
| | A multi-faceted, long-term approach is needed | Health literacy will not be 'fixed' quickly and the long-term nature of this work needs to be highlighted. This work should not be viewed as another project but a long term approach that is sustainable over time.<br><br>The approach needs to be multi-faceted addressing information, systems, processes and relationships relating to health literacy. |
| | Consider health literacy within the bigger issue of reorienting the health system | Creating the necessary system-wide culture change focused on wellness and patient/whānau centred care was thought to be essential but a key challenge. A key finding is that currently 'the system is set up for the system' and works for health practitioners but not necessarily for consumers. Sector culture change is required turning services around to meet customers' needs. Health literacy is only one component of this bigger issue.<br><br>*Health literacy is a part of a bigger culture change – the move to patient/whānau centred care. A whole raft of things needs to change to make that shift from how the sector has delivered services for years…… health literacy is only one part of the puzzle, working out how to piece it together is critical* (EMT).<br><br>*Health literacy issues will continue to exist until the structure changes. We have to invest money in changing the structure and supporting patient centred care. We're focused on sickness and not on wellness. Culture change is needed to create a joined up system with a wellness focus* (Staff Discussion Group). |

| | | |
|---|---|---|
| | | *Health literacy is a fundamental challenge to how we deliver services as we are very clinic based. There are power imbalances in the system. Approach needs to come from the top, be visible and observable, and align with organisational values* (Staff Discussion Group). |
| *Consumer Involvement* | Partner with consumers in the development of the framework | Many of the issues identified by participants about what is not currently working in the system will not be solved without genuine partnerships and collaboration with consumers. In a partnership approach for the development of the framework, the needs of both the service and the user can be explored, joint solutions (that a service may never think of) can be suggested, and ownership, empowerment and improving health literacy on both sides can occur. Aside from the Māori Relationship Board and the Consumer Council, there was limited discussion about involving consumers in the design of the sector or the framework. |
| | Importance of a patient/whānau-centred approach | The Māori Relationship Board emphasised that a patient/whānau-centred approach needs to be used in creating the framework and that approach should be driven by whānau to increase ownership of the process and the outcome.<br>*The system should be designed around whānau taking ownership around this initiative* (Māori Relationship Board). |
| | Co-design a useful framework for involving consumers in service design and delivery | Within a health context, co-design (also known as experience-based design or co-production) is a method of designing better experiences for patients, carers and staff. It involves patients and staff exploring the care pathway and the emotional journey patients experience along it, capturing experiences then working together to understand these experiences and improve them (Boyd, McKernon, Mullin and Old, 2012). |
| *Workforce* | Workforce development needs to be a priority within the framework/plan for health literacy | Workforce development is required to ensure understanding of the concept of health literacy and the benefits of engaging with health literacy. The staff group discussions highlighted that workforce development needs to focus on empathy, communication, understanding consumer experiences, cultural competency and feedback processes.<br>*It is hard to change practice as health professional until you are given feedback. We need an environment of feedback that allows people to change* (Staff member).<br>Staff identified the following areas as important for workforce development:<br>• the meaning of health literacy to create a shared understanding<br>• the consumer/whānau and health practitioner relationship |

| | | |
|---|---|---|
| | | • how to communicate more effectively with consumers (including culturally appropriate communication)<br>• resources/pathways that are available for consumers |
| | Getting all staff on board could be challenging | While there is a way to go in terms of up skilling staff about health literacy, staff involved in this review were very positive about health literacy, this review and the framework. They supported the DHB's role in workforce development, taking the onus off educating patients and whānau. Many of those working 'on the ground' were keen to increase their health literacy knowledge and were passionate about helping increase their patients' understanding of their own health and wellbeing. They did note though that it would be more challenging to engage some of their colleagues who may not see it as a priority. |
| | Make health literacy as much of a priority as other aspects of clinical work | Increased knowledge and skills in health literacy will assist staff in their work and could help them to see it as a priority. However, it also needs to be given priority by HBDHB. To ensure effective workforce development, changes need to be made to give health literacy and cultural competency equal value to clinical training.<br>*Health professionals' training does not support health literacy related issues or cultural practice the same way it does clinical practice. Both need to be on same level and given same priority as you can't have one without the other* (Staff member). |
| | Support workforce development with a system that values and enables change | A consistent theme at both staff groups was that health literacy workforce development cannot happen in isolation and needs to be supported by system changes that allow better communication with patients e.g. more time for appointments, health literacy champions, and access to appropriate resources, information, services and support. Adequate funding for all the components was mentioned as being important. |
| | Increase the Māori and Pasifika workforce | Several participants talked about the need to increase the Māori and Pasifika workforce to fully meet the needs of the population (more about this under the 'meeting the needs of the population' dimension). |
| *Meeting the needs of the population* | Build health literacy using a Universal Precautions approach | Rather than assessing individual patient's health literacy, many experts recommend that health professionals assume that all patients experience some degree of difficulty when in health environments and therefore apply the principle of Universal Precautions to health literacy (similar to the approach for preventing blood-borne diseases). Taking a Universal Precautions approach to health literacy involves finding out what patients already know, sharing clear |

| | | |
|---|---|---|
| | | information with patients and helping patients build their understanding of how their body works, their health issues and associated treatment (DeWalt, Callahan, Hawk, Broucksou et al, 2010).<br><br>This type of approach does not label or stigmatise those with low health literacy as it assumes everyone may have difficulty understanding. This dimension links strongly to the workforce dimension. |
| | Focus on reducing inequities particularly for Māori | Low health literacy contributes significantly to health disparities for Māori and Pacific peoples. Four out of five Māori males and three out of four Māori females have poor health literacy skills (Ministry of Health, 2010). The literature indicates health literacy is a key strategy to reduce inequities. Culturally appropriate approaches such as whānau ora need to be used, and systems and services need to be accessible and appropriate for specific communities. |
| | Create monitoring to measure whether needs are being met | It is clear that there needs to be a strong monitoring component in the framework. Levels of 'do not attends' and consumer complaints were suggested as potential measures. While useful these indicators may not specifically measure health literacy. There is also the wider question of meeting the needs of those not currently accessing health services. |
| | Reorient the health system so it is consumer focused | This would be a fundamental change to the health system however many participants mentioned the Nuka model of care in Alaska that is designed around and owned by the 'customer'. Given that HBDHB has already invested in up skilling some staff about this model, there are opportunities to further develop knowledge in this area. |
| *Communication* | A coordinated approach to improving communication between health professionals and consumers with an emphasis on quality relationships | Communication comes in all forms and while written resources are an important component, relationships are critical. Face-to-face communication was emphasised by the Māori Relationship Board especially for Māori, and communicating in ways the consumer will identify with and understand.<br><br>*Come down to whānau level and talk the basics…it's a snotty nose…how hard is it to say that he's got a 'snotty nose'* (Staff member).<br><br>Components of effective communication to consider are:<br>• use clear, plain language that reflects the audience's own common language<br>• use a range of mediums e.g. face-to-face discussions, DVDs or online video<br>• use visual prompts to explain complex issues |

| | | |
|---|---|---|
| | | *Rauemi Atawhai: A guide to developing health education resources in New Zealand* has some good advice for developing written resources (Ministry of Health, 2012). |
| | Involve consumers in the development of health resources | It is important to involve a range of consumers in the development of health resources to ensure they are being communicated with in ways that are understandable and resonate with them. This links to the 'consumer involvement' dimension above. |
| | Skills to improve communication are needed on both sides for consumers and health professionals | Communication is a two-way thing and consumers need to communicate in ways health professionals can understand as well. Ultimately though, the responsibility to ensure patient understands information should lie with the health professional. Health professionals need access to appropriate tools to aid their communication with consumers. On a practical level the Health Quality and Safety Commission's *Three Steps to Better Health Literacy* – is a useful tool. The three steps are to find out what people know, build people's health literacy knowledge and skills to meet their needs, and then check for understanding and clarity.<br><br>The Health Quality and Safety Commission's *Let's PLAN for better care* health literacy tool encourages people to plan ahead for visits to their GP or other health care professional and to ask questions when there so they fully understand their diagnosis and treatment. *Let's PLAN* is being used by the Ministry of Social Development's Work and Income case managers in Hawke's Bay to help their clients make the most of their visits to their GP and other health services. |

**APPENDIX 3 – HEALTH LITERACY STRATEGIC REVIEW**

quigley and watts
PUBLIC HEALTH SPECIALISTS

# Health Literacy Strategic Review



April 2016

Prepared for the Hawke's Bay District Health Board

By Quigley and Watts
Carolyn Watts, Kate Marsh and Jen Margaret

## Acknowledgments

Improving health literacy is central to improving the health of people living in the Hawke's Bay. This work to support health literacy was funded by the Hawke's Bay District Health Board (HBDHB) on behalf of the sector.

Our deep appreciation goes out to all the people who participated in interviews and discussion groups, including staff members, the Consumer Council, the Executive Management Team, the Māori Relationship Board and the Clinical Council. Your knowledge and experience is at the heart of this review.

The Health Literacy Leadership Group was central to the direction of this project. It was a pleasure to work with a professional and passionate group of people committed to equitable health outcomes for Hawke's Bay. Particular thanks to Jeanette Rendle, Consumer Engagement Manager and Kate Coley, Director, Quality Improvement and Patient Safety, for their support and assistance. Finally thanks to Ken Foote who led this work on behalf of the HBDHB.

Nāu te rourou, nāku te rourou ka ora ai te iwi

With your basket and my basket the people will thrive

## Contents

## Executive Summary

This review was commissioned by Hawke's Bay District Health Board (HBDHB), on behalf of the sector. Quigley and Watts Ltd was commissioned to undertake a high-level strategic review of the health literacy strengths and weaknesses of the Hawke's Bay health sector and to provide findings and recommendations to inform the development of a framework and plan for health literacy within Hawke's Bay.

Information for this review was collected via six face to face group discussions, and eighteen telephone interviews with staff, a literature scan and document review. Group discussions included two groups open to all staff which were attended by 22 people, and discussions with the Executive Management Team, Māori Relationships Board, Consumer Council and Clinical Council.

The intention of the review was to focus on health literacy however it is clear from the literature, interviews and discussion groups that health literacy is one factor in a complex suite of things that need to change within the health system.

The first section of this report is a discussion of overarching considerations which have arisen through the review process and can usefully inform the health literacy framework. This section includes discussion of critical conceptual and process issues to be considered in developing the framework.

There is debate among health literacy experts internationally and confusion generally about the boundaries of health literacy. Contributing to this is a realisation that a focus on health literacy while necessary, on its own will not be sufficient to create an equitable and sustainable health system.



*The relevant question is how consumer literate is the health sector. How well does the sector know its consumers? The definition is around the wrong way and needs to be turned on its head – what is the capacity to communicate so consumers can use information and health services to make effective decisions* (Consumer Council).

The initial steps in development of the framework are to clarify what the Hawke's Bay health sector means by health literacy and to determine the positioning of the framework in relation to other systems change intentions.

Developing a health literacy framework provides an opportunity to 'walk the talk.' The process of developing the framework is as critical as the content.

> *We believe patients and whānau should be at the centre of health care, not a hospital or any particular care setting* (HBDHB, 2014).

As the Māori Relationship Board suggested:

> *A patient/whānau centred approach should be in creating the framework – it should be whānau driven* (Māori Relationships Board).

A core component of framework development is grappling with how to measure success. A mix of tangible targets is needed at the intervention level alongside an overarching evaluation approach that recognises the complexity of health literacy.

The second section focuses on issues raised in the literature, interviews and group discussions in relation to each of the six dimensions outlined in the Ministry of Health's *Health Literacy Review – A Guide* (Ministry of Health, 2015):

**Leadership and management**

Health literacy is a clear strategic priority for HBDHB with support from leadership and it is consistent with the values of HBDHB. Findings indicate a coordinated and thoughtful approach to developing health literacy at the strategic level thus far. As the emphasis has been on developing a strategic focus, health literacy is yet to flow into operational plans or coordinated organisational action. With the exception of Health Hawke's Bay where health literacy workforce development and initiatives for consumers have been developed action has yet to filter out to the wider health workforce. As expected at this stage of

development, there is significant work required before health literacy is part of the core business of the sector but it is clear that HBDHB has, and should continue to have, a strong leadership role in this area.

Considerations for the framework include: ensuring HBDHB continues to lead health literacy work in collaboration with the rest of the sector; underpinning the framework by Māori principles; and, ensuring there is a multi-faceted, long-term approach to this work.

**Consumer involvement**

Overall, there is a currently limited consumer involvement in health literacy work or in the strategic direction of the Hawke's Bay health system more broadly. The Consumer Council is an important step in the right direction however it is just one facet of the collaboration with consumers required for health literacy improvement. Internationally, health literacy experts acknowledge that real progress in health literacy will be limited without true collaboration with consumers, which to date has been lacking.

Considerations for the framework include: partnering with consumers in the development of the framework; importance of a patient/whānau-centred approach and the opportunities of co-design as a framework for involving consumers in service design and delivery.

**Workforce**

There has been no coordinated approach to workforce development in health literacy. The focus of HBDHB has been at the strategic level thus far. There are significant workforce development needs a notable exception is Health Hawke's Bay which is in the process of undertaking workforce development for staff in primary care. While there is generally the will to upskill in this area, a key challenge will be getting all staff to see it as a priority.

Considerations for the framework include: making workforce development a priority; making health literacy as much of a priority as clinical work; creating an enabling system to support workforce change and, increasing the Māori and Pasifika workforce.

**Meeting the needs of the population**

There is a strategic intent to address inequities however the health system is currently unlikely to be meeting the needs of consumers with low health literacy. There is no coordinated approach to identifying health literacy need, addressing it and then monitoring whether those needs are being met. One of the biggest challenges is that the system is set up to meet the needs of those working within it and not those accessing it.

Considerations for the framework include: a Universal Precautions approach to build the health literacy of the whole population without stigmatising those with low health literacy; a strong focus on reducing inequities particularly for Māori; monitoring mechanisms to measure whether needs are being met; and, reorienting the health system to meet the needs of the population.

**Communication**

As with other dimensions there are pockets of good things happening but there is no coordinated approach to identifying information needs or sharing information in a way that improves health literacy. Most health information is written by health professionals, there is no systematic approach for assessing the readability of resources, and health practitioners have no specific tools or training to build communication skills.

Considerations for the framework include: having a coordinated approach to improving communication between health professionals and consumers with an emphasis on quality relationships; involving consumers in the development of health resources; and, think about how to improve the communication skills of both health professionals and consumers.

**Access and navigation**

There was not as much discussion about this dimension as there was about the others but the findings indicate there is a lack of coordinated and streamlined services and impacting on access and navigation for consumers.

Considerations for the framework include having more discussion about what this dimension means and how aspects of access and navigation are addressed across the other dimensions particularly leadership and management, and communication.

Overall, while there is considerable room for improvement across the six dimensions, HBDHB should feel optimistic about the future for health literacy as the commitment and approach to health literacy is a platform for real transformation.

**Next steps**

*To become health literate requires a system-wide culture change to creating a joined up system, focused on wellness and patient/whānau centred care. This requires this work to be valued, planned for and resourced. The approach needs to be long-term and sustainable. Cultural safety and consumer feedback/voices are critical aspects of health literacy* (Staff discussion group).

1. **Clarity on meaning**

The review found a great deal of confusion about the meaning of health literacy. This was evident in the international literature, national documents and the interviews and discussions with staff in the Hawke's Bay region. The first step in developing the framework for health literacy is to develop an agreed understanding of health literacy, including an agreed definition, scope and focus.

Based on the findings of this review we recommend the concept of health literacy should embrace:

- **A dual focus** - on creating both a health literate sector and an empowered and health literate population. The framework should consider both sides of the health literacy equation – the capacity of individuals and the demands placed on them (NAS, 2015). Health literacy goes beyond being able to read information and navigate to appointments it includes empowerment of individuals and whānau to improve their own health (WHO, 2013).
- **A partnership approach**—where individuals/whānau are partners alongside the health system and health professionals. Within the local context this includes ensuring that the framework is underpinned by mātauranga Māori (Māori knowledge). While the onus for improving health literacy should not be placed on the individual it is important that patients and whānau are partners in any changes to improve health literacy (WHO, 2013). Engagement with consumers and their families/whānau will be pivotal to understanding where the health system is creating health literacy barriers (HQSC, 2015).
- **A population health approach**—a definition of health that encompasses wellness, recognises the social determinants of health, and addresses current inequities. The framework for health literacy at the regional level needs to be consistent with the population health approach in Transform and Sustain (Health Hawke's Bay, 2014).

2. **Clarity on purpose**

Clarifying how health literacy is conceptualised will impact on the aligning and positioning of the 'health literacy' framework. A multi-faceted approach is needed which addresses information, systems, processes and relationships. In order to achieve health literacy as an outcome, other intended transformations outlined in Transform and Sustain need to occur, likewise achieving health literacy will support the achievement of the other intended transformations.

The second step is to decide how to position health literacy in relation to other overlapping but distinct areas in Transform and Sustain (the principles, goals, strategies and intentions).

A key theme from the interviews was the importance of embedding health literacy in a cross cutting way, as part of the shift to patient/whānau centred care. Aligning health literacy with the focus on creating a culture of patient/whānau centred care was seen as means of creating an enabling environment in which current communications and access barriers may be addressed. Health literacy needs to be integrated with other quality improvement initiatives such as patient engagement, patient experience and cultural competence (NAS, 2015).

**3. Clarity on action**

While there are considerable gaps in the evidence reviewed concerning which interventions are most effective in improving health literacy (D'Eath, Barry & Sixsmith, 2012) and a need to evaluate interventions for their effectiveness (Batterham, Buchbinder, Beauchamp et al, 2014) this review has identified areas that clearly need to be addressed under each of the six dimensions.

There are specific actions that could begin immediately for which there are tools/programmes available. These include workforce development, giving staff the skills to build health literacy using a universal precautions approach outlined in the HQSC resource *Three Steps to Health Literacy*. Another area is written resources, providing comprehensive policy and support for the development of health literate resources/material for patients.

Alongside these specific actions is the deeper issue of system and culture change. Of reorienting a sector and the professionals within it to develop and provide services based on the needs of the people they serve. And to do this in an integrated way empowering individuals and whānau make effective decisions for health and wellbeing. This level of transformation requires strong leadership, clear vision and accountability mechanisms at all levels. A systems based approach is needed, yet individuals within the system must be accountable in order to create change.

# Introduction

**Purpose of this review**

This review was commissioned by Hawke's Bay District Health Board (HBDHB), on behalf of the sector. Quigley and Watts Ltd was commissioned to undertake a high-level strategic review of the health literacy strengths and weaknesses of the Hawke's Bay health sector and to provide findings and recommendations to inform the development of a framework and plan for health literacy within Hawke's Bay.

This review supports the key intention of transforming health promotion and health literacy as identified in the Hawke's Bay strategic direction for the health system, *Transform and Sustain* (2014-2017) (HBDHB, 2014).

**Report content and structure**

Information for this review was collected via six face to face group discussions, and eighteen telephone interviews with staff, a literature scan and document review. Group discussions included two groups open to all staff which were attended by 22 people, and discussions with the Executive Management Team, Māori Relationships Board, Consumer Council and Clinical Council.

Details of the data collection methodology are included in Appendix 1. The literature review to understand New Zealand and international frameworks for health literacy is included in Appendix 2.

The first section of this report is a discussion of overarching considerations which have arisen through the review process and can usefully inform the health literacy framework. This section includes discussion of critical conceptual and process issues to be considered in developing the framework. The second section focuses on issues raised in the literature, interviews and group discussions in relation to each of the six dimensions outlined in the Ministry of Health's *Health Literacy Review – A Guide* (Ministry of Health, 2015). Considerations to inform the development of an appropriate framework for improving the health literacy of the Hawke's Bay health sector and community are included under each dimension.



**Limitations**

The intention of the review was to focus on health literacy however it is clear from the literature, interviews and discussion groups that health literacy is one factor in a complex suite of things that need to change within the health system.

There is debate among health literacy experts internationally and confusion generally about the boundaries of health literacy. Contributing to this is a realisation that a focus on health literacy while necessary on its own will not be sufficient to create an equitable and sustainable health system.

# Overarching considerations

## Clarifying understandings of health literacy

**A shared responsibility**

As the concept of health literacy has evolved, it has shifted from poor health literacy being seen as an individual deficit to acknowledging the health system as a key enabler or barrier to health literacy (NAS, 2015). Rather than an either/or focus on health systems or individuals, health literacy is situated as the intersection between an individual's skills and abilities and the demands and complexity of the information and what is being asked of the individual. As illustrated by Parker (2009):


*Source:* Parker R. Measuring health literacy: what? So what? Now what? In Hernandez L, ed. *Measures of health literacy: workshop summary, Round-table on Health Literacy.* Washington, DC, National Academies Press, 2009:91–98.

A 2015 US National Academy of Science roundtable on the future of health literacy identified creating both a health-literate population and health-literate organisations as the opportunity the field should seize going forward (NAS, 2015). The final discussion of the National Academy of Science Roundtable on Health Literacy concluded, '*patients are the experts and the field must figure out how to partner with them'* (NAS, 2015).

Similarly, the Australian Commission on Safety and Quality in Health Care (2013) identifies that for consumers to contribute to a safe and high-quality health system, by making effective decisions and taking appropriate actions in relation to their health and health care, they need to have an adequate level of individual health literacy and the health literacy environment needs to support and empower them.

The shift in focus from health literacy being an individual responsibility to being one that is shared with the healthcare system is critical. While the onus for improving health literacy should not be placed on the individual it is important that consumers/whānau are partners in systems changes to improve health literacy (WHO, 2013). This requires dramatic change within the system as a whole and amongst those who make up the system.

> *Health literacy is about creating partnerships between clinicians and patients. Currently the balance is not right, the focus is on information giving not on engagement. The power imbalance is engrained, it will be a hard slog to get the systems and processes right and to change clinician behaviours* (Executive Management Team).

In moving to an understanding of health literacy as a shared responsibility, power imbalances between consumers and health professionals need to be understood and addressed. Critically in the local context, this requires a health literacy framework to be underpinned by mātauranga Māori (Māori knowledge) in order to reflect the basis of New Zealand's founding relationships and to ensure the framework addresses health inequities.

**Situating health literacy in a population health context**

The information gathered from all sources for this review highlights inconsistency in definitions and understandings of health literacy. Central to this is the definition and framing of health. Health can be viewed through the lens of health care which focuses primarily on the treatment and management of illness involving the interaction of individuals with the health system. Health can also be understood more broadly from a population health perspective as wellbeing (physical, emotional, mental and spiritual health) determined by many societal factors, mostly outside of the health system. A population health approach recognises the social determinants of health, and focuses on addressing inequities, building strong community/whānau connections, and empowering people to take control of, and improve, their own health. Central to this is understanding that many determinants of health are situated beyond the health sector (e.g. education, housing, income etc.) and responding to this by fostering collaborative cross-sectoral approaches to address social inequities which impact on health.

Importantly, the Hawke's Bay health sector, in its key strategic documents, recognises that the responsibility for health includes but extends beyond treatment to one of improving population health.

> *We need to work on better ways to support the community to stay well ….. this will mean all organisations need to work together with a focus on prevention, recognising that good health begins in the places where we live, learn, work and play, long before medical assistance is required* (Health Hawke's Bay, 2014).

The challenge, as identified in the sector's key strategic documents and the interviews, is to transform a system which is currently structured on understandings of health as healthcare and in which health literacy is in the main, understood to be a consumer deficit.

**Defining health literacy**

In addition to issues relating to the broader understanding of health literacy, the interviews highlighted that the specific term is problematic and contributes to misunderstanding. Many interviewees considered the term to be confusing jargon which leads to most health professionals focusing on the health literacy of consumers rather than the role they play as of health professionals in supporting health literacy. The word 'literacy' can also lead to a narrow focus on the reading and numeracy skills of individuals.

> *Health literacy goes beyond being able to read information and navigate to appointments it includes empowerment of individuals and whānau to improve their own health* (WHO, 2013).

Clearly defining health literacy was seen by interviewees as critical, along with ensuring the concept is understood sector-wide.

> *We are at the stage of defining the problem. All too often it is defined as 'How do we empower people out there to understand what's going on in here.' Rather than how do we empower people in here to understand what is going on out there. That is as big an issue* (Staff member).

At a framework level, a critical dimension of defining the concept of health literacy is an understanding of the systems barriers and broader transformation required. Health literacy needs to be understood in the context of not only of inequities in the determinants of health—the impacts of income, education, social capital, and living conditions on health literacy—but also the wider determinants of the health system which include: clinical expertise being valued over cultural competence, health literacy and EQ in health professionals training; the funding distribution within Vote Health (prioritisation of treatment over prevention); and, the relative value placed on health vs economic prosperity. Given this complexity, undertaking a structural analysis exercise[2] in order to aid understanding of this complex issue and support a strategic approach to systemic change could be a useful step for those involved in developing the health literacy framework.

**Embedding health literacy**

Clarifying how health literacy is conceptualised will impact on the aligning and positioning of the 'health literacy' framework. In order to achieve health literacy as an outcome, other intended transformations outlined in Transform and Sustain need to occur, likewise achieving health literacy will support the achievement of the other intended transformations.

A key theme from the interviews was the importance of embedding health literacy in a cross cutting way, as part of the shift to patient/whānau centred care. Aligning health literacy with the focus on creating a culture of patient/whānau centred care was seen as means of creating an enabling environment in which current communications and access barriers may be addressed. Health literacy needs to be integrated with other quality improvement initiatives such as patient engagement, patient experience and cultural competence (NAS, 2015). The alignment of health literacy with organisational values and existing strategies is discussed in more detail below under the dimension of leadership and management.

## Developing the framework

**Process**

Developing a health literacy framework provides an opportunity to 'walk the talk.' The process of developing the framework is as critical as the content. As the Māori Relationship Board suggested:

> *A patient/whānau centred approach should be in creating the framework – it should be whānau drive* (Māori Relationships Board).

[2] See http://awea.org.nz/spaghetti-junction for an example of a structural analysis exercise which aids problem definition.

In addition, the framework itself should be an example of a health literate document – it needs to be simple, focused and accessible. This in itself is a challenge, as the discussion in this section illustrates, health literacy is complex yet by definition demands simplicity.

**Measuring success**

One of the challenges in developing a health literacy framework is determining how to measure success. While interviewees mentioned the importance of tangible targets as a driver for change, there was recognition that multiple factors that will contribute to any particular change; some of which may be able to be attributed to the health literacy initiative and others not.

There are considerable gaps in the evidence reviewed concerning which interventions are most effective in improving health literacy (D'Eath, Barry & Sixsmith, 2012). Interventions should be evaluated for their effectiveness and used to establish a community of learning for future work (Batterham, Buchbinder, Beauchamp et al, 2014). Creativity and innovation are central to health literacy initiatives and therefore evaluation needs to encourage rather than stifle innovation.

This suggests that a mix of tangible targets is needed at the intervention level alongside an overarching evaluation approach that recognises the complexity of health literacy, for example developmental evaluation.3

Based on the findings of the review there are a number of interventions that could be undertaken as building blocks for wider transformative change for example, workforce development using the HQSC *Three Steps to Health Literacy* and a policy and process for the development of health literate resources.

**Framework structure**

As outlined above, the framework for health literacy at the regional level needs to be consistent with the population health approach in Transform and Sustain (Health Hawke's Bay, 2014). Current New Zealand frameworks and tools designed specifically for health literacy are of limited usefulness to developing a sector-wide health literacy framework for the Hawke's Bay in that they do not fully reflect a population health approach or the shared responsibility for improving health literacy. For example, a key tool, the Ministry of Health's (2015) *Framework for Health Literacy* discusses how each part of the health system can contribute to building health literacy so individuals and whānau can obtain, process and understand health materials and access and navigate appropriate, quality and timely health services. While useful to the process of organisational change, this framework does not adequately reflect a transformative agenda in which individuals, whānau and communities are seen as central and are empowered to take control of, and improve their own health, through being active in the design and delivery of health systems, organisations and initiatives.

It is beyond the scope of this review to suggest a particular model for the framework, however the following two framework examples are provided as relevant examples to stimulate thinking.

***He Korowai Oranga: The Māori Health Strategy***

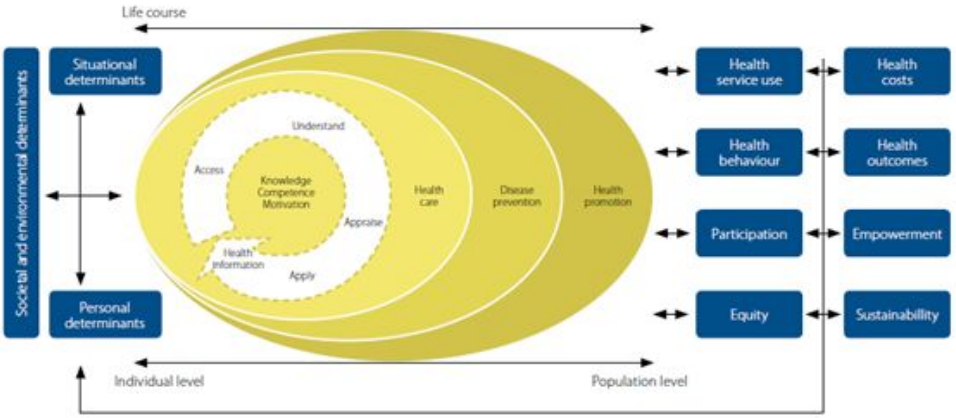
The overarching aim and three key elements of He Korowai Oranga: Māori Health Strategy (2014) provide a local, population health approach which aligns with the central tenets of health literacy and could usefully inform a health literacy framework for the Hawke's Bay.

*Pae ora [healthy futures] is a holistic concept and includes three interconnected elements: mauri ora – healthy individuals; whānau ora – healthy families; and wai ora – healthy environments. All three elements of pae ora are interconnected and mutually reinforcing. (Ministry of Health, 2014)*

***Sorensen et al's integrated model***

This international model from Sorensen et al (2012) depicts the continuum of population health from health care to health promotion. This model also recognises the personal and broader social determinants of health literacy and the situational determinants (barriers and enablers of health systems).

[3] See http://whatworks.org.nz/frameworks-approaches/developmental-evaluation/ for background.




Source: adapted from: Sørensen K et al. Health literacy and public health: a systematic review and integration of definitions and models. *BMC Public Health*, 2012, 12:80.

## Summary

The discussion above suggests that the initial steps in development the framework are to clarify what the Hawke's Bay health sector means by health literacy and to determine the positioning of the framework in relation to other systems change intentions.

Within this work it is necessary to ensure the concept of health literacy embraces:

- A focus on creating both a health literate sector and an empowered and health literate population.
- A partnership approach—where individuals/whānau are partners alongside the health system and health professionals. Within the local context this includes ensuring that the framework is underpinned by mātauranga Māori (Māori knowledge).
- A population health approach—a definition of health that encompasses wellness, recognises the social determinants of health, and addresses current inequities.

Given the complexity of the task of creating a sector-wide health literacy framework, using existing models from related contexts to stimulate thinking and undertaking a structural analysis exercise in order to aid understanding of this complex issue and support a strategic approach to systemic change may be useful early steps for those involved in developing the health literacy framework.

Developing a health literacy framework provides an opportunity to 'walk the talk.' The process of developing the framework is as critical as the content.

> *We believe patients and whānau should be at the centre of health care, not a hospital or any particular care setting* (HBDHB, 2014).

As the Māori Relationship Board suggested:

> *A patient/whānau centred approach should be in creating the framework – it should be whānau driven* (Māori Relationships Board).

A core component of framework development is grappling with how to measure success. A mix of tangible targets is needed at the intervention level alongside an overarching evaluation approach that recognises the complexity of health literacy.

## Overall assessment - the six dimensions

The six dimensions of a health-literate organisation developed as part of *Health Literacy Review: A Guide* draw on international best practice. They were designed as a New Zealand framework for a health literacy review (Ministry of Health, 2015). The dimensions overlap in content and potential solutions and should be considered as an interdependent whole.

## Leadership and management

**Summary**:

The leadership and management dimension assesses whether health literacy is an organisational value, part of the culture and core business of an organisation or service, and whether health literacy is reflected in strategic and operational plans.

Health literacy is a clear strategic priority for HBDHB with support from leadership and it is consistent with the values of HBDHB. Findings indicate a coordinated and thoughtful approach to developing health literacy at the strategic level thus far. As the emphasis has been on developing a strategic focus, health literacy is yet to flow into operational plans or coordinated organisational action. With the exception of Health Hawke's Bay where health literacy workforce development and initiatives for consumers have been developed action has yet to filter out to the wider health workforce. As expected at this stage of development, there is significant work required before health literacy is part of the core business of the sector but it is clear that HBDHB has, and should continue to have, a strong leadership role in this area.

Considerations for the framework include: ensuring HBDHB continues to lead health literacy work in collaboration with the rest of the sector; underpinning the framework by Māori principles; and, ensuring there is a multi-faceted, long-term approach to this work.

### *Sector strengths and weaknesses*

**Strategic health literacy focus evident in key documents**

The findings highlight HBDHB's evolving interest in, and commitment towards, building health literacy and becoming a more health literate sector. A strategic focus on health literacy for the Hawke's Bay health system is signalled in Transform and Sustain (HBDHB, 2014) and in Mai: Māori Health Strategy 2014-2019 (2014).

The Māori Health Action Plan 2014/15 (HBDHB, Health Hawke's Bay and Ngati Kahungunu Iwi, 2014b) and the Pasifika Health Action Plan 2014-2018 (HBDHB and Health Hawke's Bay, 2014) both build on Transform and Sustain (HBDHB, 2014) and embed the sectors commitment to health literacy.

Health literacy was identified as one of three key strategic objectives for the sector at a strategic planning workshop of the HBDHB Board, Health Hawke's Bay Ltd Board and the Māori Relationship Board, and is to be an area of focus within the 2015/16 Annual Plan (Terms of Reference Health Literacy - Framework Establishment, HBDHB, 2015).

**Health literacy is consistent with the values and key strategic documents of HBDHB**

Health literacy is consistent with the values of HBDHB.

> *Health literacy is values in action e.g. he kauanuanu (showing respect), ākina (continuous improvement)* (Executive Management Team).

Findings indicate that health literacy needs to be tied to existing frameworks, strategies and concepts e.g. Triple Aim, patient-centred care, whānau ora.

**A strong strategic platform developed to build other work off**

Findings show that health literacy is supported at a leadership level and there have been some practical steps, at the strategic level, towards addressing it. The document review revealed that the Alliance Leadership Team established the Health Literacy Leadership Group in July 2015 to develop a coordinated and collaborative approach, structure, framework, principles and communications strategy for addressing health literacy issues in Hawke's Bay. The Health Literacy Leadership Group put forward a detailed business case for this work on health literacy and funds were secured at the end of September 2015 (Health Hawke's Bay, 2015). A number of strategic development projects have been undertaken including a review of health literacy and health promotion capability (Quigley and Watts, 2014) and a health literacy information paper (Foote, 2015).

As the emphasis has been on developing a strategic focus, health literacy is yet to flow into operational plans or coordinated organisational action and filter out to the wider health workforce, with the exception of Health Hawke's Bay where health literacy workforce development and initiatives for consumers have been developed.

### *Barriers and opportunities for improvement*

**HBDHB needs to lead the work on health literacy**

Findings from interviews and groups supported a leadership role for HBDHB in collaboration with the wider sector. HBDHB also needs to lead by example and embed health literacy into the DHB first ensuring that health practitioners understand their role in improving health literacy (more about this under the 'workforce' dimension).

**Underpin the framework with Māori principles**

The Māori Relationship Board and some interviewees felt strongly that in order for the framework to be successful, it needs to be underpinned and driven by Māori principles – tikanga and kawa – rather than Māori perspectives being reflected in the strategy.

**A multi-faceted, long-term approach is needed**

Health literacy will not be 'fixed' quickly and the long-term nature of this work needs to be highlighted. This work should not be viewed as another project but a long term approach that is sustainable over time.

The approach needs to be multi-faceted addressing information, systems, processes and relationships relating to health literacy.



**Consider health literacy within the bigger issue of reorienting the health system**

Creating the necessary system-wide culture change focused on wellness and patient/whānau centred care was thought to be essential but a key challenge. A key finding is that currently 'the system is set up for the system' and works for health practitioners but not necessarily for consumers. Sector culture change is required turning services around to meet customers' needs. Health literacy is only one component of this bigger issue.

> *Health literacy is a part of a bigger culture change – the move to patient/whānau centred care. A whole raft of things needs to change to make that shift from how the sector has delivered services for years…… health literacy is only one part of the puzzle, working out how to piece it together is critical* (EMT).
>
> *Health literacy issues will continue to exist until the structure changes. We have to invest money in changing the structure and supporting patient centred care. We're focused on sickness and not on wellness. Culture change is needed to create a joined up system with a wellness focus* (Staff Discussion Group).
>
> *Health literacy is a fundamental challenge to how we deliver services as we are very clinic based. There are power imbalances in the system. Approach needs to come from the top, be visible and observable, and align with organisational values* (Staff Discussion Group).

## Consumer Involvement

**Summary**:

The consumer involvement dimension assesses how consumers are involved in designing, developing and evaluating the organisation's values, vision, structure and service delivery.

Overall, there is a currently limited consumer involvement in health literacy work or in the strategic direction of the Hawke's Bay health system more broadly. The Consumer Council is an important step in the right direction however it is just one facet of the collaboration with consumers required for health literacy improvement. Internationally, health literacy experts acknowledge that real progress in health literacy will be limited without true collaboration with consumers, which to date has been lacking.

Considerations for the framework include: partnering with consumers in the development of the framework; importance of a patient/whānau-centred approach and the opportunities of co-design as a framework for involving consumers in service design and delivery.

### *Sector strengths and weaknesses*

**There is limited consumer involvement in designing, developing and evaluating the organisation's values, vision, structure and service delivery**

The findings indicate there is limited consumer involvement in the Hawke's Bay health system at present. Most of the discussion around consumer involvement centred on consumers interactions with the health system and health professionals. Much of this discussion was focused on what is currently not working well e.g. lack of communication with consumers (this is discussed in more detail below under the 'communications' dimension). The Consumer Council discussed the paradigm shift required suggesting the real change needed was consumer literate health professionals rather than health literate consumers.

> *We need focus on consumer experience of the system and the attributes of the people they are communicating with in the system. There are a lot of changes needed* (Consumer Council).

Internationally, health literacy experts acknowledge that real progress in health literacy will be limited without true collaboration with consumers, which to date has been lacking (NAS, 2015).

**The Consumer Council is a positive step forwards**

While there is still a way to go to really involve consumers, the Consumer Council is an important step in the right direction.

> *It is big step forward having the Consumers Council. I feel we've been listened to. The journey is well and truly underway. It is evolving* (Consumer Council).

The varying levels of consumer involvement were discussed as this quote from a staff member highlights:

> *Consumer involvement is so much more than the Consumer Council although that is a good start. We need to think about the community taking ownership of this framework* (Staff member).

### *Barriers and opportunities for improvement*

**Partner with consumers in the development of the framework**

Many of the issues identified by participants about what is not currently working in the system will not be solved without genuine partnerships and collaboration with consumers. In a partnership approach for the development of the framework, the needs of both the service and the user can be explored, joint solutions (that a service may never think of) can be suggested, and ownership, empowerment and improving health literacy on both sides can occur. Aside from the Māori Relationship Board and the Consumer Council, there was limited discussion about involving consumers in the design of the sector or the framework.

**Importance of a patient/whānau-centred approach**

The Māori Relationship Board emphasised that a patient/whānau-centred approach needs to be used in creating the framework and that approach should be driven by whānau to increase ownership of the process and the outcome.

> *The system should be designed around whānau taking ownership around this initiative* (Māori Relationship Board).

**Co-design a useful framework for involving consumers in service design and delivery**

Within a health context, co-design (also known as experience-based design or co-production) is a method of designing better experiences for patients, carers and staff. It involves patients and staff exploring the care pathway and the emotional journey patients experience along it, capturing experiences then working together to understand these experiences and improve them (Boyd, McKernon, Mullin and Old, 2012).

## Workforce

**Summary**:

The workforce dimension assesses how the organisation encourages and supports the health workforce to develop effective health literacy practices, whether it has identified the workforce's needs for health literacy development and capacity, and whether the organisation's health literacy performance has been evaluated.

There has been no coordinated approach to workforce development in health literacy. The focus of HBDHB has been at the strategic level thus far. There are significant workforce development needs a notable exception is Health Hawke's Bay which is in the process of undertaking workforce development for staff in primary care. While there is generally the will to upskill in this area, a key challenge will be getting all staff to see it as a priority.

Considerations for the framework include: making workforce development a priority; making health literacy as much of a priority as clinical work; creating an enabling system to support workforce change and, increasing the Māori and Pasifika workforce.

### *Sector strengths and weaknesses*

**No coordinated approach to improving the health literacy of HBDHB's health workforce yet**

There has been no coordinated approach to improving the health literacy of the workforce yet which is no surprise given the focus of the HBDHB has been at the strategic level thus far. This means that overall, there has been little encouragement and support for the health workforce to develop effective health literacy practices, no identification of the workforces needs for health literacy development and capacity, and no evaluation of health literacy performance.

In the absence of a coordinated approach inconsistent understandings of health literacy exist. While some health professionals have a broad understanding of health literacy, many comments reflected a narrow understanding of health literacy e.g. the need to educate patients rather than looking at the systems in place that impact on a patient's ability to understand the information being imparted to them. Similarly, this has impacted health literacy practice; while there were pockets of good health literacy work happening, some of it was confused with health education i.e. focusing on distributing pamphlets to patients.

**Health Hawke's Bay is taking a coordinated workforce development approach**

Health Hawke's Bay is a notable exception in health literacy workforce development having undertaken a thorough review of health literacy workforce needs in 2015. A two-tier training programme for PHO staff has been developed based on the needs identified in the review. It was noted by an interviewee that the rest of the sector can learn a lot from the work of the PHO.

### *Barriers and opportunities for improvement*

**Workforce development needs to be a priority within the framework/plan for health literacy**

Workforce development is required to ensure understanding of the concept of health literacy and the benefits of engaging with health literacy. The staff group discussions highlighted that workforce development needs to focus on empathy, communication, understanding consumer experiences, cultural competency and feedback processes.

> *It is hard to change practice as health professional until you are given feedback. We need an environment of feedback that allows people to change* (Staff member).

Staff identified the following areas as important for workforce development:

- the meaning of health literacy to create a shared understanding
- the consumer/whānau and health practitioner relationship

- how to communicate more effectively with consumers (including culturally appropriate communication)
- resources/pathways that are available for consumers

**Getting all staff on board could be challenging**

While there is a way to go in terms of upskilling staff about health literacy, staff involved in this review were very positive about health literacy, this review and the framework. They supported the DHB's role in workforce development, taking the onus off educating patients and whānau. Many of those working 'on the ground' were keen to increase their health literacy knowledge and were passionate about helping increase their patients' understanding of their own health and wellbeing. They did note though that it would be more challenging to engage some of their colleagues who may not see it as a priority.

**Make health literacy as much of a priority as other aspects of clinical work**

Increased knowledge and skills in health literacy will assist staff in their work and could help them to see it as a priority. However, it also needs to be given priority by HBDHB. To ensure effective workforce development, changes need to be made to give health literacy and cultural competency equal value to clinical training.

> *Health professionals' training does not support health literacy related issues or cultural practice the same way it does clinical practice. Both need to be on same level and given same priority as you can't have one without the other* (Staff member).

**Support workforce development with a system that values and enables change**

A consistent theme at both staff groups was that health literacy workforce development cannot happen in isolation and needs to be supported by system changes that allow better communication with patients e.g. more time for appointments, health literacy champions, and access to appropriate resources, information, services and support. Adequate funding for all the components was mentioned as being important.

**Increase the Māori and Pasifika workforce**

Several participants talked about the need to increase the Māori and Pasifika workforce to fully meet the needs of the population (more about this under the 'meeting the needs of the population' dimension).

## Meeting the needs of the population

**Summary**:

Meeting the needs of the population dimension assesses how service delivery ensures that consumers with low health literacy are able to participate effectively in their care and have their health literacy needs identified and met (without experiencing any stigma or being labelled as having low health literacy). This dimension also assesses how meeting the needs of the population is monitored.

There is a strategic intent to address inequities however the health system is currently unlikely to be meeting the needs of consumers with low health literacy. There is no coordinated approach to identifying health literacy need, addressing it and then monitoring whether those needs are being met. One of the biggest challenges is that the system is set up to meet the needs of those working within it and not those accessing it.

Less than 50% of adult New Zealanders have adequate health literacy. Low health literacy contributes significantly to health disparities for Māori and Pacific peoples. Four out of five Māori males and three out of four Māori females have poor health literacy skills (Ministry of Health, 2010). The health system is complex and everyone struggles with it at some point even those with good health literacy.

Considerations for the framework include: a Universal Precautions approach to build the health literacy of the whole population without stigmatising those with low health literacy; a strong focus on reducing inequities particularly for Māori; monitoring mechanisms to measure whether needs are being met; and, reorienting the health system to meet the needs of the population.

### *Sector strengths and weaknesses*

**Strategic intent to address inequities but no coordinated approach across services**

Findings show there is intent at the strategic level to address inequities - this is set out in key documents and was highlighted by many participants. However, there is no coordinated approach across services to identify needs, address them and monitor whether those needs are being met. This coupled with health literacy systems barriers means that, as the system currently stands overall, consumers with low health literacy are unlikely to bet able to participate effectively in their care. As noted above, there are pockets of good things happening and some services may meet needs better than others but there is no coordinated approach across services to meet these needs.

**The system is currently set up to meet the needs of those working within it not those accessing it**

One of the biggest challenges is that the health system is not consumer focused and is set up to meet the needs of those working within it rather than those accessing it e.g. appointments are based on a fixed length rather than on patients' needs. Time was a key barrier mentioned by both consumers and health professionals.

> *If a GP is explaining things adequately then they are the ones you end up waiting to see as they take more time with their patients. Time equals money – need time and money to improve health literacy* (Consumer Council).

Transform and Sustain (2014) acknowledges *the current systems do not effectively reward health providers for being responsive to patient needs or for delivering high-quality care. In addition, health organisations often appear to work around the needs of the organisation rather than the needs of the population.*

**Everyone experiences poor health literacy at some point**

Less than half of all adults in New Zealand have the basic health literacy skills to cope with everyday demands of life and work let alone understand complex medical conditions. This means not being able to do things like read labels on medicines or workout how much medicine to give a child. Eighty per cent of Māori males and 75 per cent of Māori females have poor health literacy skills (Ministry of Health, 2010).

People with low health literacy are more likely to have ongoing difficulties in making informed health decisions, but even people with good health literacy skills can also find it difficult to understand health care information. This is especially true when a person is first diagnosed with an illness or is unwell or stressed. The Institute of Medicine report (2004) concluded that even highly skilled individuals may find the systems too complicated to understand, especially when these individuals are made more vulnerable by poor health. This was supported by participants views, even health professionals that work in the system, can experience low health literacy not just those who are most at risk.

### *Barriers and opportunities for improvement*

**Build health literacy using a Universal Precautions approach**

Rather than assessing individual patient's health literacy, many experts recommend that health professionals assume that all patients experience some degree of difficulty when in health environments and therefore apply the principle of Universal Precautions to health literacy (similar to the approach for preventing blood-borne diseases). Taking a Universal Precautions approach to health literacy involves finding out what patients already know, sharing clear information with patients and helping patients build their understanding of how their body works, their health issues and associated treatment (DeWalt, Callahan, Hawk, Broucksou et al, 2010).

This type of approach does not label or stigmatise those with low health literacy as it assumes everyone may have difficulty understanding. This dimension links strongly to the workforce dimension.

**Focus on reducing inequities particularly for Māori**

Low health literacy contributes significantly to health disparities for Māori and Pacific peoples. Four out of five Māori males and three out of four Māori females have poor health literacy skills (Ministry of Health, 2010). The literature indicates health literacy is a key strategy to reduce inequities. Culturally appropriate approaches such as whānau ora need to be used, and systems and services need to be accessible and appropriate for specific communities.

**Create monitoring to measure whether needs are being met**

It is clear that there needs to be a strong monitoring component in the framework. Levels of 'do not attends' and consumer complaints were suggested as potential measures. While useful these indicators may not specifically measure health literacy. There is also the wider question of meeting the needs of those not currently accessing health services.

**Reorient the health system so it is consumer focused**

This would be a fundamental change to the health system however many participants mentioned the Nuka model of care in Alaska that is designed around and owned by the 'customer'. Given that HBDHB has already invested in upskilling some staff about this model, there are opportunities to further develop knowledge in this area.

## Access and navigation

**Summary**:

The access and navigation dimension assesses how easy it is for consumers to find and engage with appropriate and timely health-related services, and how well these services are coordinated and streamlined.

There was not as much discussion about this dimension as there was about the others but the findings indicate there is a lack of coordinated and streamlined services and impacting on access and navigation for consumers.

Considerations for the framework include having more discussion about what this dimension means and how aspects of access and navigation are addressed across the other dimensions particularly leadership and management, and communication.

### *Sector strengths and weaknesses*

**Integrated services for seamless service delivery**

The need for better transitions between parts of the system was mentioned by many participants. Methods of communication with consumers and transitions between parts of the system were highlighted as areas for improvement. This included the relationship between the health professional and the patient, as well as getting into the system in the first place e.g. appointment letters can be difficult to understand. It was thought that pockets of the system have good communication processes but transitioning between parts of the system, with variable quality processes, meant that some patients 'dropped off'. This relates strongly to the communication dimension.

> *There is a lack of continuum of care for patients – no collaboration with other services. Services need to be connected to help with patient care* (Consumer Council).

**Improve physical access**

Interviewees discussed physical and coordination aspects that could be improved e.g. visible signage and prompts in different languages; consumers and whānau knowing where to park and what part of the hospital they need to visit to access services on time.

### *Barriers and opportunities for improvement*

**Allow for further discussion**

This dimension relates strongly to all of the other dimensions and is somewhat difficult to separate out. For instance, the concepts of seamless service delivery and transitions between services need to be led at a management and leadership level as they relate to the structure of the organisation. The physical aspects of access do need to be addressed and these strongly relate to the communication dimension. More discussion is required around this dimension and what it means for the framework.



## Communication

**Summary**:

The communication dimension assesses how information needs are identified, how information is shared with consumers in ways that improve health literacy, and how information is developed with consumers and evaluated.

As with other dimensions there are pockets of good things happening but there is no coordinated approach to identifying information needs or sharing information in a way that improves health literacy. Most of the health information is written by health professionals, there is no systematic approach for assessing the readability of resources, and health practitioners have no specific tools or training to build communication skills.

Considerations for the framework include: having a coordinated approach to improving communication between health professionals and consumers with an emphasis on quality relationships; involve consumers in the development of health resources; and, think about how to improve the communication skills of both health professionals and consumers.

### *Sector strengths and weaknesses*

**No coordinated approach to identifying information needs – for consumers and staff**

The review found no coordinated approach to identifying consumer information needs or staff information needs. Some staff talked about the lack of resources in a range of formats for them to use with their patients, which they felt limited their ability to impart all of the information required. While some staff talked at length about education resources, few talked about the need to involve consumers in the resource development process or to ask consumers about their information needs. This reflects more of an education approach rather than a partnership approach, situating the health professional as the teacher and the consumer as the student.

> *Health literacy is about creating partnerships between clinicians and patients. Currently the balance is not right, the focus is on information giving not on engagement. The power imbalance is*

> *engrained, it will be a hard slog to get the systems and processes right and to change clinician behaviours* (Executive Management Team).

**Most health information is written by health professionals with no consumer involvement**

Most of the health information was reported to be written by health professionals. Currently there is no requirement for consumers to be involved in the design or evaluation of information or resources. Health professionals were reported to assume a level of understanding that some of their colleagues even found difficult to comprehend.

> *Health professionals use a lot of terminology and we don't ask patients what they understand* (Clinical Council).

**No systematic approach for assessing the readability of resources**

While some communication staff use an assessment tool to check the readability of some resources, there is no requirement for this to happen with all resources so it happens on an ad hoc basis with no coordination within or across services.

**Health practitioners generally communicate poorly with consumers**

The poor communication between health professionals and consumers was a common theme in the review and identified as a key barrier to improving health literacy. The review findings highlight a lack of training, skills and tools available to support health professionals to improve their communication.

> *'A lot of health professionals are not as literate as we think we are. We are very bad at communicating with patients and should be better'* (Clinical Council).

### *Barriers and opportunities for improvement*

**A coordinated approach to improving communication between health professionals and consumers with an emphasis on quality relationships**

Communication comes in all forms and while written resources are an important component, relationships are critical. Face-to-face communication was emphasised by the Māori Relationship Board especially for Māori, and communicating in ways the consumer will identify with and understand.

> *Come down to whānau level and talk the basics…it's a snotty nose…how hard is it to say that he's got a 'snotty nose'* (Staff member).

Components of effective communication to consider are:

- use clear, plain language that reflects the audience's own common language
- use a range of mediums e.g. face-to-face discussions, DVDs or online video
- use visual prompts to explain complex issues

*Rauemi Atawhai: A guide to developing health education resources in New Zealand* has some good advice for developing written resources (Ministry of Health, 2012).

**Involve consumers in the development of health resources**

It is important to involve a range of consumers in the development of health resources to ensure they are being communicated with in ways that are understandable and resonate with them. This links to the 'consumer involvement' dimension above.

**Skills to improve communication are needed on both sides for consumers and health professionals**

Communication is a two-way thing and consumers need to communicate in ways health professionals can understand as well. Ultimately though, the responsibility to ensure patient understands information should lie with the health professional. Health professionals need access to appropriate tools to aid their communication with consumers. On a practical level the Health Quality and Safety Commission's *Three Steps to Better Health Literacy* – is a useful tool. The three steps are to find out what people know, build people's health literacy knowledge and skills to meet their needs, and then check for understanding and clarity.

The Health Quality and Safety Commission's *Let's PLAN for better care* health literacy tool encourages people to plan ahead for visits to their GP or other health care professional and to ask questions when there so they fully understand their diagnosis and treatment. *Let's PLAN* is being used by the Ministry of Social Development's Work and Income case managers in Hawke's Bay to help their clients make the most of their visits to their GP and other health services.

## Next Steps

*To become health literate requires a system-wide culture change to creating a joined up system, focused on wellness and patient/whānau centred care. This requires this work to be valued, planned for and resourced. The approach needs to be long-term and sustainable. Cultural safety and consumer feedback/voices are critical aspects of health literacy* (Staff discussion group).

### 1. Clarity on meaning

The review found a great deal of confusion about the meaning of health literacy. This was evident in the international literature, national documents and the interviews and discussions with staff in the Hawke's Bay region. The first step in developing the framework for health literacy is to develop an agreed understanding of health literacy, including an agreed definition, scope and focus.

Based on the findings of this review we recommend the concept of health literacy should embrace:

- **A dual focus** - on creating both a health literate sector and an empowered and health literate population. The framework should consider both sides of the health literacy equation – the capacity of individuals and the demands placed on them (NAS, 2015). Health literacy goes beyond being able to read information and navigate to appointments it includes empowerment of individuals and whānau to improve their own health (WHO, 2013).
- **A partnership approach**—where individuals/whānau are partners alongside the health system and health professionals. Within the local context this includes ensuring that the framework is underpinned by mātauranga Māori (Māori knowledge). While the onus for improving health literacy should not be placed on the individual it is important that patients and whānau are partners in any changes to improve health literacy (WHO, 2013). Engagement with consumers and their families/whānau will be pivotal to understanding where the health system is creating health literacy barriers (HQSC, 2015).
- **A population health approach**—a definition of health that encompasses wellness, recognises the social determinants of health, and addresses current inequities. The framework for health literacy at the regional level needs to be consistent with the population health approach in Transform and Sustain (Health Hawke's Bay, 2014).

### 2. Clarity on purpose

Clarifying how health literacy is conceptualised will impact on the aligning and positioning of the 'health literacy' framework. A multi-faceted approach is needed which addresses information, systems, processes and relationships. In order to achieve health literacy as an outcome, other intended transformations outlined in Transform and Sustain need to occur, likewise achieving health literacy will support the achievement of the other intended transformations.

The second step is to decide how to position health literacy in relation to other overlapping but distinct areas in Transform and Sustain (the principles, goals, strategies and intentions).

A key theme from the interviews was the importance of embedding health literacy in a cross cutting way, as part of the shift to patient/whānau centred care. Aligning health literacy with the focus on creating a culture of patient/whānau centred care was seen as means of creating an enabling environment in which current communications and access barriers may be addressed. Health literacy needs to be integrated with other quality improvement initiatives such as patient engagement, patient experience and cultural competence (NAS, 2015).

### 3. Clarity on action

While there are considerable gaps in the evidence reviewed concerning which interventions are most effective in improving health literacy (D'Eath, Barry & Sixsmith, 2012) and a need to evaluate interventions for their effectiveness (Batterham, Buchbinder, Beauchamp et al, 2014) this review has identified areas that clearly need to be addressed under each of the six dimensions.

There are specific actions that could begin immediately for which there are tools/programmes available. These include workforce development, giving staff the skills to build health literacy using a universal precautions approach outlined in the HQSC resource *Three Steps to Health Literacy*. Another area is written resources, providing comprehensive policy and support for the development of health literate resources/material for patients.

Alongside these specific actions is the deeper issue of system and culture change. Of reorienting a sector and the professionals within it to develop and provide services based on the needs of the people they serve. And to do this in an integrated way empowering individuals and whānau make effective decisions for health and wellbeing. This level of transformation requires strong leadership, clear vision and accountability mechanisms at all levels. A systems based approach is needed, yet individuals within the system must be accountable in order to create change.

## Appendix 1: Data collection methods

**Literature Review**
A brief literature review was undertaken to inform the development of a regional framework for health literacy for the Hawke's Bay region. The review focuses on identifying and assessing key tools and frameworks for health literacy.

The review is not systematic or comprehensive it is intended to be practical and help guide the next phases of the work for the framework. The selection of literature was based on seminal documents and reviews in health literacy along with the reviewer's knowledge of the literature.

The key research questions for the review were:

1. What health literacy frameworks exist that inform a strategic approach to improving health literacy at a regional level?
2. What tools are currently available to assess and build organisational health literacy particularly from a regional perspective?

**Document Review**
Documents are an important source of information about how an organisation positions and delivers on health literacy in terms of its infrastructure, policies, systems, processes, information and communications. The purpose of this high-level document review was to identify the DHB's commitment to health literacy and look at whether health literacy has been operationalised throughout the DHB and the processes through which that has happened. This was not an audit of all DHB documents, instead, the focus was on mapping out the DHB's approach to addressing health literacy through reviewing documents that explicitly referred to health literacy. This was an information gathering exercise to look at how all of the documents/information linked up rather than an assessment as such.



The document review aimed to answer the following questions:

1. How is health literacy guided and operationalised within the DHB? E.g. Is there any direction that flows through the funding on HL? Is it coordinated or random? Anything in the area of workforce? Workforce training? Communication?
2. What documents around infrastructure, policies, systems, processes, information and communications are in place within the DHB that address and support health literacy? Is there a consumer panel that all the resources go through?

The documents were located through key contacts at the DHB as well as a Google search. Two types of documents were collected and analysed:

1. Key organisational documents, which explicitly referred to health literacy.
2. Specific consumer-facing documents HBDHB had redeveloped/redesigned to be more health literate.

**Key documents:**

- Transform and Sustain: the next five years (Hawke's Bay DHB, 2013)
- Mai: Māori Health Strategy 2014-2019 (HBDHB, 2014)
- Māori Health Action Plan 2014/15 (HBDHB, Health Hawke's Bay and Ngati Kahungunu Iwi, 2014)
- Improving the Health of Pacific People in Hawke's Bay: Pasifika Health Action Plan 2014-2018 (HBDHB and Health Hawke's Bay, 2014)
- Hawke's Bay Health Consumer Council Annual Plan 2014/15 (Consumer Council, 2014)
- Health Promotion and Health Literacy Capability Report (Quigley and Watts, 2014)
- Health Literacy Information Paper – what does it mean and what can be done? (Foote, 2015)
- Health Literacy Update (Foote, 2015)
- Bay DHB Position Profile: Health Literacy Advisor (HBDHB, 2015)
- Terms of Reference - Health Literacy Framework Establishment (Health Hawke's Bay, 2015)
- Health Literacy Needs Assessment (Quigley and Watts Ltd, 2015)
- Patient-Client Information and Education Policy (Hawke's Bay DHB, 2008)

**Interviews**

Interviewees were in a range of clinical and non-clinical roles throughout the DHB and the broader health sector. They included those in senior management, clinical team leaders, iwi executives, practice managers, practice nurses, midwife, general practitioners, cultural navigators and kaitakawaenga, public health physician, publications advisors, and coordinators in particular areas of health and wellbeing e.g. breastfeeding. Many interviewees had multiple roles. In total, 12 interviewees were directly employed by the DHB and 6 interviewees were employed by service providers.

The HBDHB sent out an email informing interviewees about the project and giving them advance notice that they may be contacted for an interview. Interviewees were then contacted by email and a follow up phone call if necessary where they were asked to participate in 30 minute phone interview. They were informed that:

- they could stop the interview at any time
- the interview would be recorded for note-taking purposes
- their name would not be used in the report but their role may be referred to so anonymity could not be guaranteed
- they would be provided with the interview questions prior to the interview
- they would have access to the final report

**Group meetings**

Half hour group meetings were undertaken with the following groups:

- Executive Management Team
- Clinical Council
- Māori Relationship Board
- Consumer Council

These groups were emailed the questions prior to the discussion and the groups were recorded for note-taking purposes. In order to capture the views of other DHB staff interested in health literacy, an email was sent out to all staff inviting them to attend one of two group meetings which were attended by 22 people in various roles throughout the hospital. Prior to the discussions, the project was introduced and participants were informed that the discussion would be recorded for note-taking purposes, their name would not be used in the report but their role may be referred to so anonymity could not be guaranteed, and they would have access to the final report.

## Appendix 2: Literature review

# LITERATURE REVIEW TO INFORM THE DEVELOPMENT OF A REGIONAL FRAMEWORK FOR HEALTH LITERACY

## Introduction

This brief literature review was undertaken to inform the development of a regional framework for health literacy for the Hawke's Bay region. The review focuses on identifying and assessing key tools and frameworks for health literacy.

The review is not systematic or comprehensive it is intended to be practical and help guide the next phases of the work for the framework. The selection of literature was based on seminal documents and reviews in health literacy along with the reviewer's knowledge of the literature.

The key research questions for the review were:

3. What health literacy frameworks exist that inform a strategic approach to improving health literacy at a regional level?
4. What tools are currently available to assess and build organisational health literacy particularly from a regional perspective?

## Background



In New Zealand, health literacy has been defined as 'the capacity to obtain, process and understand basic health information and services in order to make informed and appropriate health decisions' (Ministry of Health 2010). In this definition the focus is most obviously on consumer capability. However, internationally support is growing for a stronger focus on how health systems, health care providers and practitioners can support consumers to access and understand health services (Ministry of Health, 2015).

Definitions for health literacy vary internationally and there is no unanimously accepted definition of the concept or its constituent dimensions (Sorensen et al 2012). The World Health Organization definition of health literacy identifies *capacity* as 'the social and cognitive skills which determine motivation and ability' (ref).

Sorensen et al 2012 argue making informed and appropriate health decisions' requires the ability to put information into context, understanding which factors are influencing it, and knowing how to address them. This requires the simultaneous use of a complex and interconnected set of abilities, such as reading and acting upon written health information, communicating needs to health professionals, and understanding health instructions (Sorensen et al, 2012).

Health literacy is also dynamic requiring an individual to continuously learn new information and discard what is out of date or no longer relevant. An individual's health literacy may also change over their life course as their skills set becomes subject to different information processing demands. To reflect this, a recent Canadian Expert Panel adopted the following definition of health literacy:

*The ability to access, understand, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course* (D'Eath, Barry & Sixsmith, 2012).

As the concept of health literacy has evolved it has shifted from seeing poor health literacy as an individual deficit to acknowledging the health system as key enabler or barrier to health literacy. Systemic issues exist across New Zealand's healthcare system. In many cases the system is primarily organised to meet the needs of the system not the user. For consumers to contribute to a safe and high-quality health system by making effective decisions and taking appropriate actions in relation to their health and health care, they need to have an adequate level of individual health literacy and the health literacy environment needs to support and empower them. This means that responsibility for addressing health literacy rests with policy makers, healthcare providers and consumers (Australian Commission on Safety and Quality in Health Care, 2013).

This fits with the concept of health literacy as a shared responsibility between consumers and health professionals (within the overarching system). Acknowledging the important role health professionals play in communicating effectively and supporting the development of patient's health literacy.

There is now a growing focus on the demands health services and systems place on people using them. A new understanding has emerged that patients and health professionals cannot address health literacy needs independently. Healthcare services and systems need to support health professionals to build patient health literacy by reducing the demands placed on patients and by supporting health professionals to communicate more effectively with patients (Lambert, Luke, Downey et al, 2014).

*The relationship between people as citizens, consumers or as patients with the institutions that affect their health is significantly influenced by two interacting factors: their levels of health literacy and the willingness of such institutions to recognize diversity and share or give power for more equal, inclusive and accountable relationships. A high level of health literacy allows for an expansion of decisions and actions through control over resources and decisions that affect one's life* (WHO, 2013).

Evidence internationally and in New Zealand shows:

1. Navigating increasingly complex health care systems is a major challenge for patients and their families.
2. Patients face multiple literacy requirements and increasingly difficult decisions.
3. Health information materials are often poorly written and literacy demands are excessive.
4. Health providers' written and spoken communication has insufficient clarity and quality.
5. New "business" models can create new obstacles.
6. Health literacy affects the use of health services (WHO, 2013).

Becoming a health-literate organisation is a long-term commitment. Leaders of health-literate organisations make health literacy a priority and integrate health literacy in all aspects of service planning, design, delivery and performance evaluation.

Health-literate organisations:

- redesign systems, processes and services to remove barriers to consumer access
- address communication problems that exist at all stages of the patient journey – such as confusing treatment pathways and jargon-filled discussions with health practitioners
- make health literacy everyone's business, including leaders, managers, clinical and non-clinical staff
- take an active role in building health literacy with consumers in order that consumers can better manage their health and achieve improved health outcomes
- take into account that consumers, who might usually have good health literacy, will have less health literacy knowledge and fewer health literacy skills when they are unwell or receive a new diagnosis
- support operational staff to use health literacy approaches and strategies.

Some definitions for health literacy have explicitly included a population health approach arguably widening the remit for health literacy. For example the definition developed by the European Health Literacy Consortium in 2012 (WHO, 2013):

*Health literacy is linked to literacy and entails people's knowledge, motivation and competences to access, understand, appraise and apply health information in order to make judgements and take decisions in every-day life concerning health care, disease prevention and health promotion to maintain or improve quality of life during the life course.*

Realising the goals in *Transform and Sustain* of keeping the general population well and healthy, enabling those with complex conditions to live well and supporting older people at the end of their lives will require a transformational change to the 'health system' (Watts, Murphy & Quigley, 2014).

Health literacy as a determinant of health is closely related to other social determinants of health such as general literacy, education, income and culture (WHO, 2013).

One of the challenges of this work will be the scope. At one end of the spectrum the DHBs role in health literacy can be seen as primarily as an access issue to treatment (access to information and access to services) at the other end of the spectrum is a population health approach, including treatment but extending to staying well and disease prevention. A population health approach to health literacy would place the DHB as a partner with individuals, whānau and communities to strengthen people's ability to take responsibility for their own health as well as their family health and community health.

## Context

This work will support Hawke's Bay strategic direction for the health system *Transform and Sustain* (2014-2017) (Hawke's Bay District Health Board, 2013). *Transform and Sustain* guides service planning and development.

Transform and Sustain outlines three main challenges:

- *Responding to our population: We believe patients and whānau should be at the centre of health care, not a hospital or any particular care setting, and we need to have a stronger engagement with consumers and their families/whānau.*
- *Delivering consistent high-quality health care: The best quality care is appropriate, convenient and precise – the patient gets exactly what they need, delivered as soon as possible without error or undue waiting.*
- *Being more efficient at what we do: Reducing waste in health will make us more efficient and ensure we get the best value from health care resources by delivering the right care to the right people in the right place, the first time.*



The strategy acknowledges "*the current systems do not effectively reward health providers for being responsive to patient needs or for delivering high-quality care. In addition, health organisations often appear to work around the needs of the organisation rather than the needs of the population.*"

The DHB's responsibility for health includes but extends beyond medical treatment to one of improving population health.

*We need to work on better ways to support the community to stay well ….. this will mean all organisations need to work together with a focus on prevention, recognising that good health begins in the places where we live, learn, work and play, long before medical assistance is required (Health Hawke's Bay, 2014).*

A population health approach to health literacy requires a partnership with the people of Hawke's Bay.

Transform and Sustain recognises the need for a broad definition and framework for health literacy*:*

*Improved health literacy is needed so that people can actively participate in their welfare, support self-management of their care and use health services better (Hawke's Bay DHB, 2014).*

## Summary and recommendations

- There is no unanimously accepted definition of health literacy (Sorensen, 2012).
- The Ministry of Health defines health literacy as 'the capacity to obtain, process and understand basic health information and services in order to make informed and appropriate health decisions' (Ministry of Health, 2015).
- Making informed and appropriate health decisions' requires the ability to put information into context, understanding which factors are influencing it, and knowing how to address them (Sorensen et al 2012).
- Health literacy is dynamic requiring an individual to continuously learn new information and discard what is out of date or no longer relevant (D'Eath, Barry & Sixsmith, 2012).
- As the concept of health literacy has evolved it has shifted from seeing poor health literacy as an individual deficit to acknowledging the health system as key enabler or barrier to health literacy (NAS, 2015).
- Health professionals play an important role in communicating effectively and supporting the development of patient's health literacy (Ministry of Health 2015a).

- For consumers to contribute to a safe and high-quality health system by making effective decisions and taking appropriate actions in relation to their health and health care, they need to have an adequate level of individual health literacy and the health literacy environment needs to support and empower them (Australian Commission on Safety and Quality in Health Care, 2013)
- Some definitions for health literacy have explicitly included a population health approach, including treatment but extending the concept of health to staying well and disease prevention (WHO, 2013)
- Transform and Sustain recognises the need for a broad population health definition and framework for health literacy*:*
  *Improved health literacy is needed so that people can actively participate in their welfare, support self-management of their care and use health services better (Hawke's Bay DHB, 2014).*

**Recommendations**

The framework for health literacy has a:

- Population health approach acknowledging health extends beyond treatment and the 'health system' and health organisations to include staying well and preventing disease.
- Partnership approach to health literacy seeing the health system and health professionals as partners with people and whānau.
- Equity approach to health literacy ensuring the needs of those currently not experiencing good health or accessing services are given priority.
- Partnership with Māori, Iwi and Hapu to accelerate the performance of Māori health.

## Frameworks and tools

Internationally health literacy is moving from an either/or focus on health systems or individuals to seeing health literacy as the intersection between an individual's skills and abilities and the demands and complexity of the information and what is being asked of the individual. A 2015 US National Academy of Science round table on the future of health literacy identified creating both a health-literate population and health-literate organisations as the opportunity the field should seize going forward that (NAS, 2015).

Experts at the round table acknowledged that real progress in health literacy would be limited without true collaboration with consumers, which to date had been lacking in the USA. They also believed to get traction health literacy and cultural competence needed to be seen as an essential part of patient safety (NAS, 2015).

There is significant activity across New Zealand in the area of health literacy and also in areas directly related to health literacy. This is occurring at a national, regional and organisational level. In 2015 the Ministry of Health published two documents *A framework for health literacy* (Ministry of Health, 2015a) and *Health Literacy Review: A Guide* (Ministry of Health, 2015b).

A number of District Health Boards have also commenced programmes of work in health literacy. Counties Manukau DHB has a commitment to health literacy action within its Annual Plan for 2015/16 and Statement of Intent agreement with the Government (Counties Manukau Health, 2015) as does Hawke's Bay DHB (Hawke's Bay DHB, 2014). We found no integrated regional strategies for health literacy spanning sectors of health in New Zealand.



For health literacy initiatives to be of maximum effectiveness they need to be based on evidence, implemented in a coordinated and sustainable way and evaluated.

*Addressing health literacy in a coordinated way has potential to increase the safety, quality and sustainability of the health system by building the capacity of consumers to make effective decisions and take appropriate action for health and health care, and building the capacity of the health system to support and allow this to occur* (Australian Commission on Safety and Quality in Health Care, 2013).

## Frameworks

Framework: the basic structure of something - a set of ideas or facts that provide support for something. Three broad levels of frameworks have been identified:

1. Population health level

These frameworks focus on improving health literacy in order to improve population health at all levels including health promotion, disease prevention, treatment of illness and end of life care. They acknowledge the important role of the health system and institutions within it and also that health occurs in everyday life and not in institutions or systems.

2. Health system level

These frameworks focus on health literacy at the level of the health system. The system is primarily viewed as the institutions and health professionals that diagnose and treat illness.

3. Health organisation level

These frameworks focus on health literacy at the level of institutions that diagnose and treat illness.

## New Zealand frameworks

### Population health level

No existing frameworks located.

### Health system level

**A Framework for health literacy**

This framework reflects how each part of the health system can contribute to building health literacy so that all New Zealanders can make informed decisions about managing their health, or the health of those they care for (Ministry of Health, 2015b).

The framework was developed by the Te Kete Hauora with consultation from the health sector. The framework outlines expectations for the health system, health organisations and all of the health workforce to take action that:

- supports a 'culture shift' so that health literacy is core business at all levels of the health system
- reduces health literacy demands and recognises that good health literacy practice contributes to improved health outcomes and reduced health costs.

The framework sets out three key areas for action with outcomes and actions identified at the levels of the health system, health organisations and the health workforce:

Leadership and management

Championing health literacy and taking the lead on a 'culture shift' towards a health-literate health system.

Knowledge and skills

Improving our knowledge of how health literacy demands can be reduced and health equity achieved.

Health system change

Being committed to a 'culture shift' so that change occurs at all levels of the health system, leading to better health outcomes for individuals and whānau and reduced health costs.

### Health organisation level

**Health Literacy Review: A Guide**

The Guide sets out an approach for reviewing a health service or organisation's current performance based on a framework identifying six key dimensions of health literacy in the New Zealand context. The framework was developed by the authors from an extensive review of national and international tools and frameworks. The New Zealand six dimensions framework is modelled on the US Ten Attributes framework (Brach et al 2012) which encompasses the seminal work of three earlier tools (Rudd and Anderson 2006; Jacobson et al 2007; Agency for Healthcare Research and Quality 2010).

From the Ten Attributes Framework, the following Six Dimensions were developed for the New Zealand context. These Dimensions form the framework for this Guide.

1. **Leadership and management.** How is health literacy an organisational value, part of the culture and the core business of an organisation? How is it reflected in strategic and operational plans?
2. **Consumer involvement.** How are consumers involved in designing, developing and evaluating the organisation's values, vision, structure and service delivery?
3. **Workforce**. How does the organisation encourage and support the health workforce to develop effective health literacy practices? Has it identified the workforce's needs for health literacy development and capacity? Has the organisation's health literacy performance been evaluated?
4. **Meeting the needs of the population.** How does service delivery make sure that consumers with low health literacy are able to participate effectively and have their health literacy needs identified and met (without experiencing any stigma or being labelled as having low health literacy)? How is meeting the needs of the population monitored?
5. **Access and navigation**. How easy is it for consumers to find and engage with appropriate and timely health and related services? How are consumers helped to find and engage with these services? How well are services coordinated and are services streamlined where possible?
6. **Communication**. How are information needs identified? How is information shared with consumers in ways that improve health literacy? How is information developed with consumers and evaluated?

The Six Dimensions are applied to examine how staff, consumers and families interact, and to review relevant policies, processes, structures and culture in a particular health service or health care organisation. The aim of these activities is to identify the causes of health literacy barriers and opportunities for improvement.

The following table provides the rationale for each dimension.

| New Zealand's Six Dimensions | | Rationale |
|---|---|---|
| 1. | **Leadership and management.** How is health literacy an organisational value, part of the culture and core business of an organisation? How is it reflected in strategic and operational plans? | Leaders and managers have a critical role in developing a health-literate organisation. They drive an organisation's health literacy culture by articulating and reinforcing goals and expectations, and by modelling expected behaviours. Leaders and managers in a health-literate health care organisation ensure that health literacy is built into all aspects of the organisation, explicitly measured and monitored, and continuously improved. |
| 2. | **Consumer involvement.** How are consumers involved in designing, developing and evaluating the organisation's values, vision, structure and service delivery? | A commitment to patient-centred care, consumer safety and quality improvement involves more than the activities of managers, clinical leaders and other staff. A health-literate health care organisation involves consumers and their families in all aspects of service delivery – not just the evaluation of consumer experience. |
| 3. | **Workforce.** How does the organisation encourage and support the health workforce to develop effective health literacy practices? Has it identified the workforce's needs for health literacy development and capacity? Has the organisation's health literacy performance been evaluated? | The health workforce plays a crucial role in communicating oral and written information to consumers and families and ensuring they understand that information. A health-literate health care organisation provides health literacy training and coaching to its entire workforce to improve communication and build health literacy. |
| 4. | **Meeting the needs of the population.** How does the delivery of services make sure consumers with low health literacy are able to participate effectively and have their health literacy needs identified and met (without experiencing any stigma or being labelled as having low health literacy)? How is meeting the needs of the population monitored? | Because health literacy is diverse and ongoing, health care organisations will find it difficult to identify who in their consumer population has low health literacy. A health-literate health care organisation adopts a universal precautions approach so that staff do not make assumptions about who might or might not need assistance. |
| 5. | **Access and navigation.** How easy is it for consumers to find and engage with appropriate and timely health and related services? How are consumers helped to find and engage with these services? How well are services coordinated and are services streamlined where possible? | Health care organisations develop and use systems that place demands on consumers and families. A health-literate health care organisation reduces the demands its systems place on consumers and families and helps them to access and navigate systems. |
| 6. | **Communication.** How are information needs identified? How is information shared with consumers in ways that improve health literacy? How is information developed with consumers and evaluated? | Health care organisations communicate with consumers and families orally, in writing and increasingly using technology. A health-literate health care organisation ensures that all communication, in all formats, is clear, easy to understand and easy for consumers and families to act on. |



## International frameworks

### Population health level

**WHO European Conceptual Model**

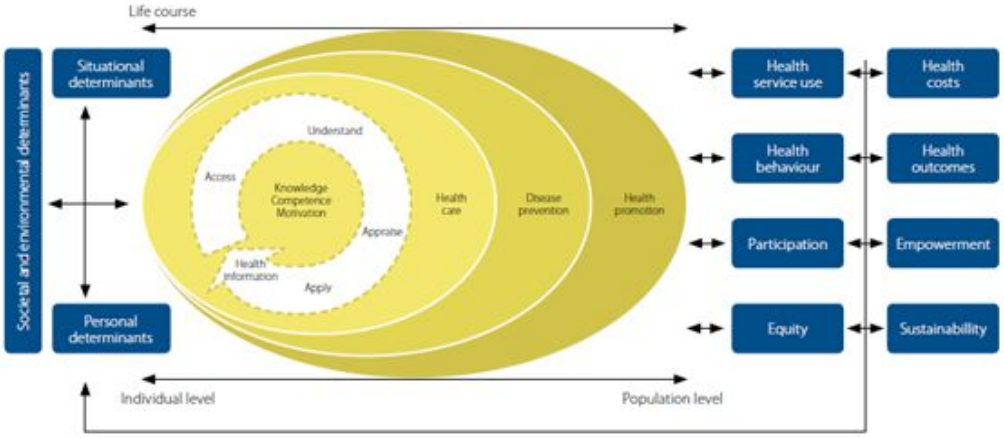
In 2013 the WHO Regional Office for Europe published Health Literacy: The Solid Facts (WHO, 2013). The publication presents a review of the evidence for interventions in health literacy. It supports a relational concept of health literacy that considers both an individual's level of health literacy and the complexities of the contexts within which people act (Figure 1). Both need to be measured and monitored (WHO, 2013).

**Figure 1: Interactive Health Literacy Framework (WHO, 2013)**


*Source:* Parker R. Measuring health literacy: what? So what? Now what? In Hernandez L, ed. *Measures of health literacy: workshop summary, Round-table on Health Literacy.* Washington, DC, National Academies Press, 2009:91–98.

The conceptual model seen as most comprehensive and based on evidence is shown below in figure 2. It is adapted from Sorensen et al 2012 and integrates medical and public health views of health literacy. The model was developed through a systematic literature review and content analysis of 17 peer-reviewed definitions and 12 conceptual models (frameworks) found in extensive literature reviews.

**Figure 2: Conceptual Model of Health Literacy**



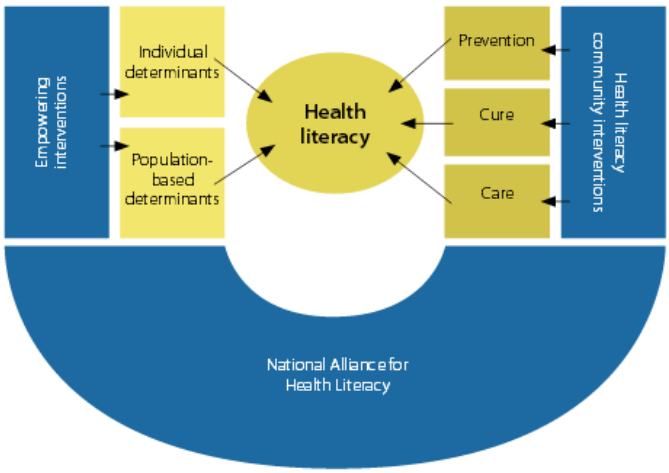

*Source:* adapted from: Sørensen K et al. Health literacy and public health: a systematic review and integration of definitions and models. *BMC Public Health*, 2012, 12:80.

This model is a population level model enabling a person to navigate three domains of the health continuum being ill or as a patient in the healthcare setting, as a person at risk of disease in the disease prevention system, and as a citizen in relation to the health promotion efforts in the community, where people live, play, work and learn (Sorensen et al, 2012).

**Netherlands Model**

In the Netherlands, the Alliance for Health Literacy found a combined effort of empowerment of individuals or communities with improvement of health sector communication yields the best results in improving health literacy. Tackling health literacy in the Netherlands is based on a strong lobby for patients' rights, which resulted in clear legislation as well as longstanding programmes for improved communication in the health care sector (WHO, 2013).

**Figure 3: Netherlands Model**




Source: Netherlands National Alliance for Health Literacy (WHO, 2013)

### Health organisation level

**ISLHD Health Literacy Framework: A Plan for Becoming a Health Literate Organisation 2012 – 2015**

(Illawarra Shoalhaven Local Health District (ISLHD), (2014))

The Framework sets out the following five key goals to guide the ISLHD to becoming a health literate organisation:

1. Embed health literacy into high-level systems and organisational policies and practices
2. Integrate health literacy into planning and evaluation for clinical and quality improvement
3. Have plain English health information that is easy to access, read, understand and use
4. Partner with consumers in the evaluation of health information and access and navigation of services
5. Have effective and evidence based health literacy strategies in interpersonal communication

An Action Plan with specific strategies and monitoring was developed and continues to guide action in 2016. An example of the action plan strategies for goal 5 is shown below in Figure 4:

**Figure 4**: **GOAL 5: Have Effective and Evidence Based Health Literacy Strategies in Interpersonal Communication**

| Strategies | Measurement | Timeframe | Progress |
|---|---|---|---|
| a) Develop and implement a consistent Teach-back training program in line with best practice for all ISLHD staff | i. Teach-back information presented to all new staff at Corporate Orientation | 2013 Ongoing | Achieved, 2013 |
| | ii. 100% of all new staff attending Corporate Orientation receive basic training in health literacy and the 'teach-back' communication | | Achieved, 2013 |
| | iii. ISLHD Teach-back training program developed (including audio-visual and written resources) | 2013 ongoing | Video resources developed, 2013 |
| | iv. Teach-back training calendar developed | 2014/2015 | |

**Optimising Health Literacy (Ophelia) Victoria, Australia**

Ophelia is a partnership between two Universities, eight service organisations and the Victorian Government. The project is designed to assist agencies to identify and respond, in a planned way, to the varied health literacy needs of their clients. The project will assess the potential for targeted, locally developed health literacy interventions to improve access, equity and outcomes (Batterham, Buchbinder, Beauchamp et al, 2014).

The Ophelia project uses a methodological foundation of three systems:

1. Intervention Mapping (IM)

IM is a tool for the planning and development of health promotion interventions. It maps the path from recognition of a need or problem to the identification of a solution. Although Intervention Mapping is presented as a series of steps, Bartholomew and colleagues (2011) see the planning process as iterative rather than linear. Program planners move back and forth between tasks and steps. The process is also cumulative: Each step is based on previous steps, and inattention to a particular step may lead to mistakes and inadequate decisions.

The Ophelia project uses IM steps of:

a) Needs Assessment
   HLQ and semi-structured interviews, assess health literacy needs, and organisational assessment to determine contextual enablers and barriers.
b) Identify performance objectives, determinants and change objectives
   Structured workshop format to engage key stakeholders, consider data and needs and possible ideas to meet needs
c) Selection of interventions
   Each site generates program logic and selects appropriate interventions to test. Communities of practice formed.
d) Detailed design and planning of interventions
   Create, test and evaluate interventions using Plan-Do-Study-Act (PDSA) cycles
e) Adoption and implementation of interventions
   PDSA cycles are implemented and results considered
f) Implementation trial
   Conduct trials and evaluate those pilot interventions demonstrating potential to improve health literacy

2. Quality Improvement Collaboratives (QIC)

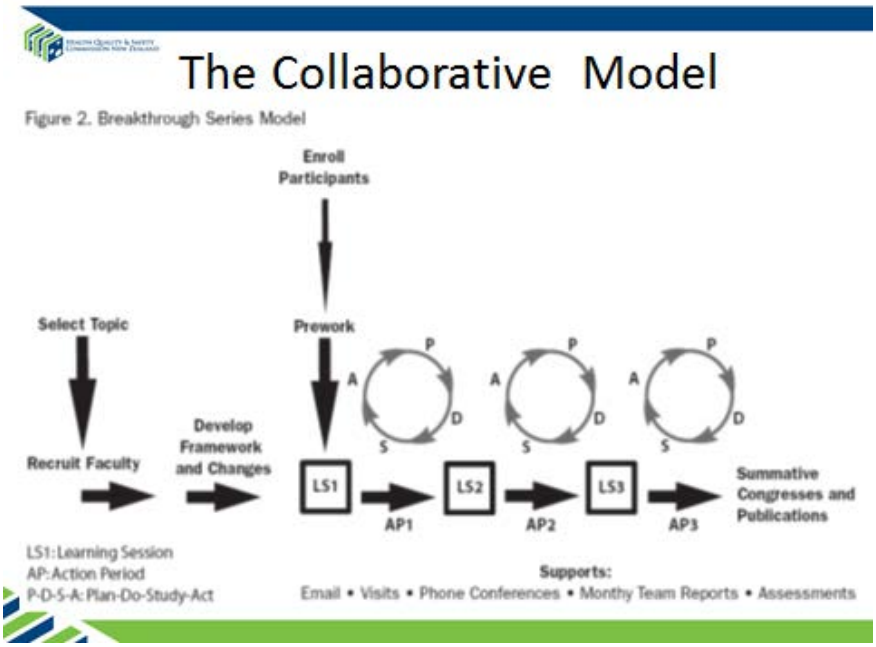
QIC (Figure 5) is a quality improvement methodology that "brings together groups of practitioners from different healthcare organisations to work in a structured way to improve one aspect of the quality of their service. It involves a series of meetings to learn about best practice in the area chosen, about quality methods and change ideas, and to share their experiences of making changes in their local settings" HQSC, 2012).

QIC have been shown to be effective in primary care delivering some real improvements in the systems of care for people with long-term conditions and a change in culture among participating practices in New Zealand (Palmer, Bycroft, Healey et al 2102). HQSC also advocates the use of QIC (HQSC, 2012) and has set these up to work on different issues, for example the safe use of opioids collaborative project (HQSC, 2014).

QIC essential components include:

- Ensuring leadership commitment
- Setting clear aims (including changes to be spread, target level of performance, target population, and time frame)
- Identifying and packaging proved ideas and practices
- Developing and executing a plan to communicate and implement the ideas
- Creating a system for measuring progress
- Establishing a process for refining the plan in response to learning during implementation (HQSC, 2012).

**Figure 5: Quality Improvement Collaboratives**




3. Realist synthesis

*Realist synthesis* is an increasingly popular approach to the review and *synthesis* of evidence, which focuses on understanding the mechanisms by which an intervention works (or not).The realist approach is particularly suited to the synthesis of evidence about complex implementation interventions (Rycroft-Malone, McCormack, Hutchinson et al, 2012).

## Tools

**Health Literacy Questionnaire**

This is a validated tool containing 44 questions across nine domains:

1) Feeling understood and supported by healthcare providers
2) Having sufficient information to manage my health
3) Actively managing my health
4) Social support for health
5) Appraisal of health information
6) Ability to actively engage with healthcare providers
7) Navigating the healthcare system
8) Ability to find good health information
9) Understand health information well enough to know what to do

The HLQ domains cover a broad range of issues pertinent to an individual's life and can be interpreted as intrinsic and extrinsic dimensions of health literacy. Some domains more strongly reflect: a) the capability of an individual to understand, engage with, and use health information and health services; or b) more strongly reflect the capability of an organisation to provide services that enable a person to understand, engage with and use their health information or services. The latter is based on the users' lived experience of using health services (Osborne, Batterham, Elsworth et al, 2013).

There are considerable gaps in the evidence reviewed concerning which interventions are most effective in improving health literacy. Further research is needed on the impact of health literacy interventions in the public health field, paying particular attention to evaluating communication about communicable diseases, and determining the most effective strategies for meeting the needs of population groups with low literacy levels, and those who are vulnerable, disadvantaged and hard to reach (D'Eath, Barry & Sixsmith, 2012).

### Health literacy tools for improving communication

A number of tools/resources have been developed to assist communication for health professionals and for consumers. These include:

**Three Steps to Health Literacy**

Developed by the Health Quality and Safety Commission in 2014 *Three steps to better health literacy* combines a range of practical tools including *Teach Back* and *Ask Me 3* for the New Zealand context.

http://www.hqsc.govt.nz/assets/Consumer-Engagement/Resources/health-literacy-booklet-3-steps-Dec-2014.pdf

**Let's PLAN**

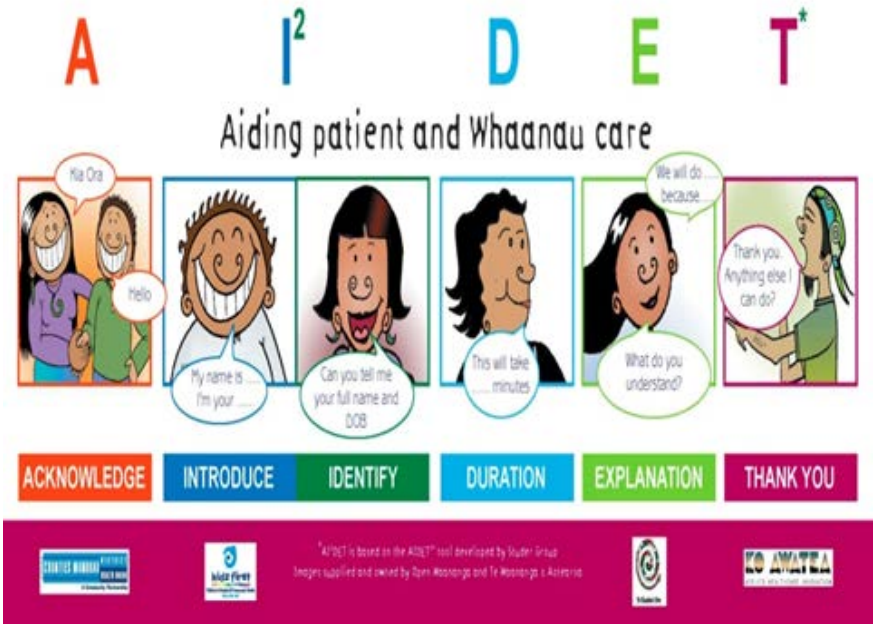
*Let's PLAN* is a health literacy initiative to help consumers prepare well for their visit to the GP or other primary care health professional.

The A4 flyer, with an accompanying promotional poster, encourages people to plan ahead for practice visits and to ask questions when there so they fully understand their diagnosis and treatment. It also suggests questions they can ask pharmacy staff when they pick up their medicine. Available for HQSC http://www.open.hqsc.govt.nz/patient-safety-week/publications-and-resources/publication/1826/.

**Aiding Patient and Whānau Care (AI$^2$DET)**

(Counties Manukau DHB, nd)

AI2DET is a communication tool adapted by Counties Manukau DHB to improve face-to-face engagement experiences for patients and whānau using services.






AI2DET emerged through the establishment of an Operational Group focusing on Patient and Family Centred Care. This led to the development of a number of workstreams, of which one was Face-to-Face Patient and Whānau Engagement.

## Tools and frameworks from related areas

There are a number of quality improvement areas related to health literacy which are important to consider in a framework for health literacy. We have covered some of these below however recommend the DHB consider other work in the area of cultural competence, consumer experience and patient safety. Many of the frameworks or models sit under the area of consumer engagement. The Health Quality and Safety Commission has a stream of work dedicated to consumer engagement called *Partners in Care*. *Partners in Care* includes health literacy, co-design, patient and family centred care and shared decision making.

Cultural competence is a key area in health literacy, both at the system level and the level of health professionals. It overlaps with the several key dimensions of health literacy, particularly communication. Cultural competence is also central to addressing indigenous health inequalities.

### Cultural Competence

The Indigenous Health Framework developed by the University of Otago translates the principles of cultural competency and safety into an approach that health practitioners can use in everyday practice. The framework consists of the *Hui Process* for enhancing the doctor-patient relationship and the *Meihana Model* to guide the interaction (Pitama, Huria & Lacey, 2014).

### Framework for consumer engagement

Health literacy is fundamental to patient engagement. If people cannot obtain, process and understand basic health information, they will not be able to look after themselves well or make sound health-related decisions (HQSC, 2015).

**Figure 6: A New Zealand framework for consumer engagement (HQSC, 2015)**


### Patient and family centred care (PFCC)

The core elements of patient and family centred care are:

- **Dignity and Respect.** Health care practitioners listen to and honour patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
- **Information Sharing.** Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
- **Participation.** Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.
- **Collaboration.** Patients, families, health care practitioners, and hospital leaders collaborate in policy and program development, implementation, and evaluation; in health care facility design; and in professional education, as well as in the delivery of care (Boon, 2012).

Patient and Family-Centred Care (PFCC) is a method of improving health care quality that changes the perspective of staff delivering care, and helps them reconnect with their values and motivation for working in health care. PFCC is a simple, low-technology health care quality improvement approach designed to tackle two parallel aspects of health care: processes of care and staff–patient interactions. Together, these have a profound effect on how patients and staff experience health care (Kings Fund, nd).

PFCC helps tackle issues in:

- the organisation of care (care 'transactions' – how care is delivered)
- 'relational' aspects of care (the human interactions that take place between patients and families, and their professional carers).

Rather than blaming staff when things go wrong, PFCC seeks to understand where care systems and processes prevent them from providing the kind of care they would wish for themselves or their families. This understanding helps staff to see where improvements are possible, and enables them to reconnect with their motivation for working in health care, promoting a new workforce culture (Kings Fund, nd).

Patient and whānau centred care is a key element of the Hawke's Bay health strategy:

*We believe patients and whānau should be at the centre of health care, not a hospital or any particular care setting, and we need to have a stronger engagement with consumers and their families/whānau* (Hawke's Bay DHB, 2014).

### Patient and family centred care toolkits

**Bay of Plenty DHB**

The Bay of Plenty DHB (Bay of Plenty DHB, nd) has an online toolkit for PFCC containing:

- Literature Review
- Facilitators Guide
- Organisation Leaders Self-Assessment
- Organisational Self-Assessment Templates
- Stakeholder & Communication Plan
- Getting Internal Stakeholders Involved 01
- Getting Internal Stakeholders Involved 02
- Volunteer Patient Advisor Information
- Volunteer Patient Advisor Application Form
- Orientation for Patient Advisors

**Kings Fund**

The Kings Fund (Kings Fund, nd) has an online toolkit, tools available in the PFCC toolkit:

- **Process mapping** – A process map is a visual representation of what happens to the patient at each stage of their care experience. It enables teams to identify which steps in the care process add value for patients and who is responsible for each step.
- **Shadowing** – This method forms the core part of the PFCC approach. It involves accompanying a patient throughout their care experience – for example, from arriving at reception to leaving at the end of the day – and taking notes and discussing experiences with patients. It is this aspect of the PFCC approach that has had the greatest impact on staff.
- **Patient stories** – This approach involves interviewing patients to gather their insights into the service they have received. It is a useful adjunct to shadowing.
- **Driver diagrams** – These are used to identify the 'drivers', or main influences, on patients' experiences. This then helps to identify the aspects of care that need to be influenced if improvements in patients' experiences are to be achieved. A driver diagram is a conceptual framework that helps teams to set an aim and then identify the key drivers (main areas of focus) and subsequent interventions they need to put in place that will align to support the achievement of the overall goal.
- **Measurement** – Measurement is an essential part of any quality improvement initiative. It must be carried out beforehand, to set the baseline, and then again at stages throughout and following the intervention. This enables you to demonstrate the impact and to identify any aspects that may need tweaking during the project.
- **The model for improvement** – This well-established approach to improvement incorporates Plan, Do, Study, Act (PDSA) cycles – also known as small tests of change, or rapid cycle improvement – which make it possible to test interventions on a small scale, and to tweak these, before rolling out more widely.
- **Snorkelling** – A group activity that enables a wide variety of health care staff to think creatively and develop their own ideas for changes that will improve patients' care experiences.

### Co-design

Patient experience is positively associated with clinical effectiveness and patient safety which supports the inclusion of patient experience as one of the central pillars of quality in health care (Doyle, Lennox & Bell, 2013).

The HQSC has a co-design programme under *Partners in Care* which offers a co-design course based on the NHS Experience-based design approach (NHS, 2009). Further information about the course is available at http://www.hqsc.govt.nz/our-programmes/partners-in-care/work-streams/co-design-partners-in-care/.

Waitemata DHB has developed a toolkit and guide for co-design, *Health service co-design: working with patients to improve healthcare services* available on line at http://www.healthcodesign.org.nz/.

Many service improvement projects have patient involvement but co-design focuses on understanding and improving patients' experiences of services as well as the services themselves.

This toolkit includes a framework and tools for undertaking co-design:

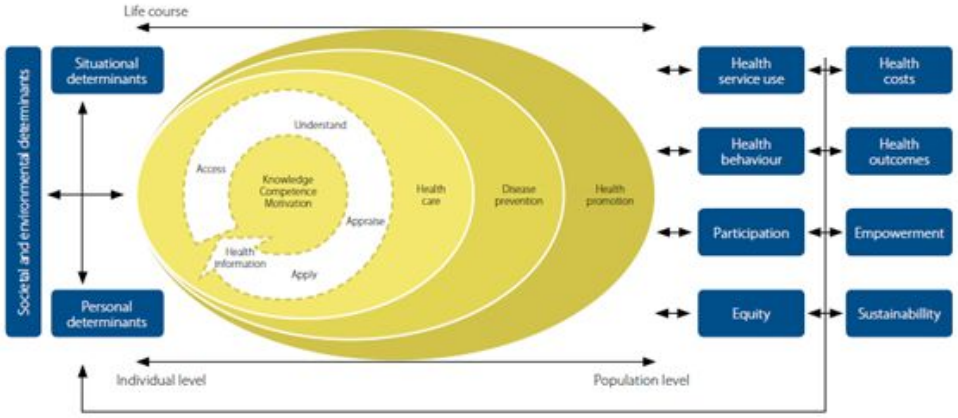
- Understanding the patient experience:
- Patient shadowing - identifying what happens during a patient visit to a service
- Patient journey mapping - summarising the service experiences patients have over time
- Experience-based surveys - learning about patients' reactions to services based on their journeys
- Patient stories - assessing patients' service experiences in their life context (Boyd, McKearnon & Old, 2010).

## Summary and recommendations

- The framework should consider both sides of the health literacy equation – the capacity of individuals and the demands placed on them (NAS, 2015).
- While the onus for improving health literacy should not be placed on the individual it is important that patients and whānau are partners in any changes to improve health literacy (WHO, 2013).
- Engagement with consumers and their families/whānau will be pivotal to understanding where the health system is creating health literacy barriers (HQSC, 2015).


*Source*: Parker R. Measuring health literacy: what? So what? Now what? In Hernandez L, ed. *Measures of health literacy: workshop summary, Round-table on Health Literacy*. Washington, DC, National Academies Press, 2009:91–98.

- The framework for health literacy at the regional level needs to be consistent with the population health approach in Transform and Sustain (Health Hawke's Bay, 2014).
- A good starting point is the conceptual model adapted from Sorensen et al 2012. This model is based on evidence and integrates medical and public health views of health literacy.




*Source*: adapted from: Sørensen K et al. Health literacy and public health: a systematic review and integration of definitions and models. *BMC Public Health*, 2012, 12:80.

- Health literacy goes beyond being able to read information and navigate to appointments it includes empowerment of individuals and whānau to improve their own health (WHO, 2013).
- Health literacy needs to be integrated with other quality improvement initiatives such as patient engagement, patient experience and cultural competence (NAS, 2015).
- There are considerable gaps in the evidence reviewed concerning which interventions are most effective in improving health literacy (D'Eath, Barry & Sixsmith, 2012).
- Any interventions should be evaluated for their effectiveness and used to establish a community of learning for future work (Batterham, Buchbinder, Beauchamp et al, 2014)..
- The framework should drive the workstreams (actions) of the DHB to address health literacy. These could include:
  - ✓ Providing leadership/champions for health literacy.
  - ✓ Raising awareness and building the skills of the workforce about health literacy.
  - ✓ Raising awareness and building the skills of the consumers and their families/whānau about health literacy.
  - ✓ An internal commitment to build health literacy into all DHB decisions, processes and policies.

- ✓ A comprehensive policy and support for the development of health literate resources/material for patients.
- ✓ Training for health professionals using effective and evidence based health literacy strategies in interpersonal communication.
- ✓ Guidance and support for services and organisations within the region on how to assess the degree to which they are supporting health literacy (integrating the *Health Literacy Review: A guide* and the Ophelia model including the Health Literacy Questionnaire)
- Guidance and support for services and organisations on the co-design of new processes/interventions to address health literacy.
- Oversight and guidance on the evaluation of changes made to improve health literacy (possibly using the quality improvement collaboratives (QIC) model).

## References


Australian Commission on Safety and Quality in Health Care. Consumers, the health system and health literacy: Taking action to improve safety and quality. Consultation Paper. Sydney: ACSQHC, 2013.

Bay of Plenty District Health Board. (nd) Patient and Family Centred Care Toolkit. Retrieved from: http://www.bopdhb.govt.nz/your-dhb/quality-and-patient-safety/patient-and-family-centred-care/toolkit/

Boon A. (2012) Excellence Through Patient and Family Centred Care: Literature Review. Bay of Plenty District Health Board and HQSC.

Boyd H, McKernon S, Old A. (2010). Health Service Co-design: working with patients to improve healthcare services. Auckland: Waitemata District Health Board.

Brach C, Keller D, Hernandez LM, et al. (2012). *Ten Attributes of Health Literate Health Care Organizations*. Washington, DC: Institute of Medicine of the National Academies.

Counties Manuaku Health. (2015). *Counties Manukau District Health Board Annual Plan 2015/16*. Auckland: Counties Manukau Health.

D'Eath M, Barry MM, Sixsmith J. (2012). *A rapid evidence review of interventions for improving health literacy.* Stockholm: European Centre for Disease Prevention and Control.

Doyle C, Lennox L, Bell D. (2013) A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ* Open.

Hawke's Health Bay DHB. (2014) Transform and Sustain: the Hawke's Bay Health System (updated). http://www.hawkesbay.health.nz.

HBDHB, Health Hawke's Bay and Ngati Kahungunu Iwi. (2014). Mai: Māori Health Strategy 2014-2019. http://www.hawkesbay.health.nz.

HBDHB, Health Hawke's Bay and Ngati Kahungunu Iwi. (2014b). The Māori Health Action Plan 2014/15. http://www.hawkesbay.health.nz.

HBDHB and Health Hawke's Bay. (2014). Pasifika Health Action Plan 2014-2018. http://www.hawkesbay.health.nz.

Health Quality and Safety Commission. (2012). Quality Improvement Collaboratives. Powerpoint presentation retrieved from https://www.hqsc.govt.nz.

Health Quality and Safety Commission. (2014). Breakthrough series collaborative on safe use of opioids in hospitals. Wellington: HQSC.

Health Quality and Safety Commission. (2015). Engaging with consumers: a guide for district health boards. Wellington: HQSC.

Illawarra Shoalhaven Local Health District (ISLHD). (2014) *ISLHD Health Literacy Framework: A Plan for Becoming a Health Literate Organisation 2012 – 2015*. Illawarra: NSW Government.

Kings Fund. (nd) Patient and Family Centred Care. Retrieved from: http://www.kingsfund.org.uk/projects/pfcc

Lambert, M, Luke, J, Downey, B et al. (2014) Health literacy: health professionals' understanding and their perceptions of barriers that indigenous patients encounter. BMC Health Services Research 14:614.

Ministry of Health. (2015). *Health Literacy Review: A guide*. Wellington: Ministry of Health.

Ministry of Health. (2015b). A Framework for Health Literacy. Wellington: Ministry of Health.

Ministry of Health. (2012) Rauemi Atawhai: A guide to developing health education resources in New Zealand. Wellington: Ministry of Health.

Ministry of Health. (2010) Kōrero Mārama: Health literacy and Māori. Wellington: Ministry of Health.

Ministry of Health. He Korowai Oranga Framework updated 2013/14. http://www.health.govt.nz/our-work/populations/Māori-health/he-korowai-oranga

The National Academies of Sciences, Engineering, and Medicine. 2015. *Health literacy: Past, present, and future: Workshop summary.* Washington, DC: The National Academies Press.

National Health Service (2009) The EBD Approach: Using patient and staff experience to design better healthcare services. Retrieved from http://www.hqsc.govt.nz/assets/Consumer-Engagement/Partners-in-Care-Resource-page/NHS-EBD-Guide-30.1.2009.pdf.

Osborne RH, Batterham RW, Elsworth GR, Hawkins M, Buchbinder R. (2013). The grounded psychometric development and initial validation of the Health Literacy Questionnaire (HLQ). BMC Public Health 13:658.

Pitama S, Huria T & Lacey C. (2014). Improving Māori health through clinical assessment: Waikare o te Waka o Meihana. *NZMJ* 127(1393): 107-119.

Rycroft-Malone J, McCormack B, Hutchinson AM et al. (2012) Realist synthesis: illustrating the method for implementation research *Implementation Science*, 7:33 http://www.implementationscience.com/content/7/1/33

Sørensen K, Van den Broucke S, Fullam J et al. (2012). Health literacy and public health: A systematic review and integration of definitions and models. *BMC Public Health* 12:80 http://www.biomedcentral.com/1471-2458/12/80.

World Health Organization. (2103). Health Literacy: The Solid Facts. Copenhangen, Denmark: WHO Regional Office for Europe.

## APPENDIX 4 – PROJECT ADVISORY GROUP DRAFT TERMS OF REFERENCE

**Health Literacy Project Advisory Roopu – Terms of Reference**

**Background**

Health literacy is about health organisations ensuring health services and information are easy for people to find, understand and use to make effective decisions for their health. Health literacy has come into focus after the Ministry of health reported that 56% of New Zealander's and a majority of Māori have difficulties understanding the healthcare that the health system delivers.
HBDHB has taken action to improve health literacy. A review was commissioned that uncovered a number of areas that we need to address. With these recommendations in mind, the health literacy project team has adopted a number of health literacy principles that will help to guide the health literacy work (see appendix A). Furthermore, we are using these principles to help our local health organisations look at the health literacy environment, to assess where they need to make changes, so that healthcare is easy for whanau to understand and use.

**Purpose**

This roopu has been established to look at how we can advise organisations in Hawke's Bay to improve health literacy. This will involve a number of ways, including how organisations approach health literacy to find out where and what it is they need to do to make improvements. Then, how can we provide them with resources that make it easy for them to make the changes to deliver health information and services to whanau that is easy to find, access, understand and use.



**Role and responsibilities**

The people in this roopu will be expected to:

- Provide advice and expertise on how the health system can make it easier for people and whanau to find, access, understand and use healthcare
- Provide direction to the project manager to achieve the goals of the health literacy project
- Provide advice into the process and products needed to improve organisational health literacy and the overall health literacy environment
- Communicate progress to key stakeholders and other interested parties
- Provide final endorsement of the process and products developed to improve the health literacy environment

**Scope**

The project includes:

- Positioning health literacy within the HBDHB peoples strategy and overall objectives of 'changing the culture' within the DHB
- How we communicate health literacy across the health sector, which is easy to understand, provides some clarity and direction on how we go about improving health literacy
- Developing a process and a set of products that help organisations to review / audit their health literacy status (or current performance), how they go about improving health literacy performance with resources to assist them in this process.
- Educating the workforce about health literacy and the impact of poor health literate practice on whanau, utilising health literacy specific strategies including the Universal precautions approach, effective communication and building quality relationships with whanau
- Advising the health sector on innovative ways to increase consumer and community health literacy skills and knowledge
- Addressing particular health literacy problem areas
- Understanding how we evaluate the health literacy programme of work to ensure we achieve the objectives and goals of the project.

And excludes:

- Decisions regarding the distribution of financial or human resources
- implementing of products into organisational BAU

**Each member will have:**

- Knowledge and breadth of experience with or within the health system
- Connections with whanau and people living in Māori / Pacific communities or areas of high deprivation
- Demonstrated leadership capability

**Members will be appointed from the following categories:**

- The health workforce
- Māori health providers, experts, academics and kaimahi
- Consumers and whanau
- Key stakeholder groups

**Responsibilities of members**

Project manager:

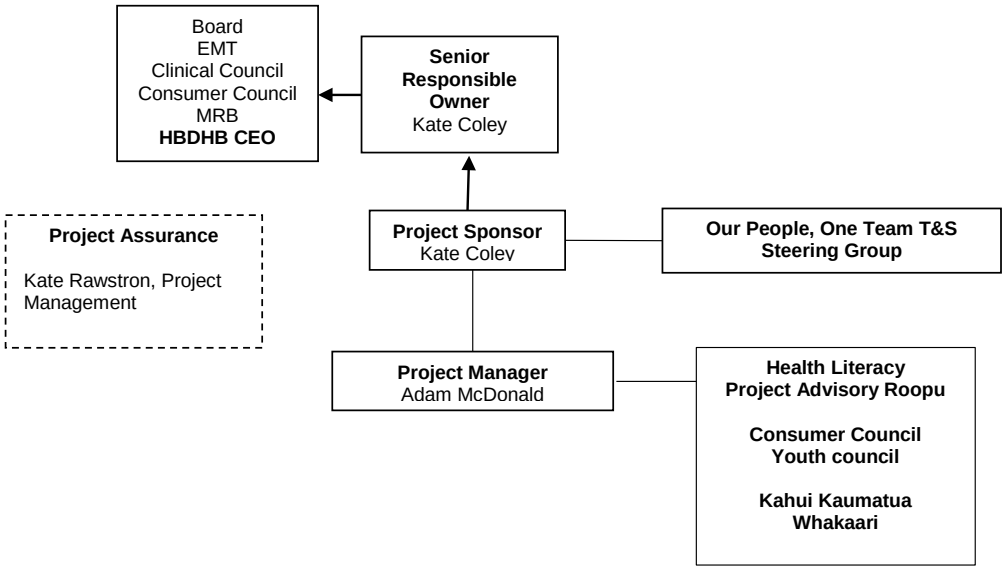
- Leads meetings effectively
- Sets and adheres to meeting protocols and ground rules
- Ensures that minutes properly reflect the input of members.
- Ensure meetings are organised and facilitated effectively
- Prepare and disseminate agenda and related papers, schedule of meetings
- Meeting records; documents required for approval
- Collate feedback from consultation

**All advisory roopu members will:**

- contribute positively and openly to the work of the group
- maintain regular attendance
- respond to communications
- be prepared and informed
- consult with and report to, as appropriate, the stakeholders they represent

Meetings will be held monthly until the project is completed.

## APPENDIX 5 – PROJECT MANAGEMENT TEAM STRUCTURE



| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Best Start: Healthy Eating and Activity Plan- Healthy Weight Strategy** 53 |
| | For the attention of: **HBDHB Board** |
| Document Owner:<br>Document Author(s): | Tracee Te Huia, ED Strategy, Health & Improvement<br>Shari Tidswell, Team Leader/Population Health Advisor |
| Reviewed by: | Executive Management Team, HB Clinical Council, HB Health Consumer Council and Māori Relationship Board |
| Month: | May 2017 |
| Consideration: | For information |

**RECOMMENDATION:**

**That the HBDHB Board**

- **Note** progress in the implementation of this Plan.

17

## 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 Whakawairoa and 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***

There has been progress in collecting data to provide benchmarks to measure change in healthy eating environments. Schools were contacted re 'water only policies' and the school environments mapped (part of Auckland University Informus Programme). This work was completed by the Public Health Nurses.

***2) Develop and deliver prevention programmes***

Prevention resources and staff training have been delivered. The breastfeeding resource is systematically provided to all whānau birthing at Hastings Hospital. This resource integrates key maternal messages (i.e. breastfeeding, smokefree, safe sleep) and is well received by whānau and staff supporting whānau. Healthy First Food resource and education sessions are business as usual for WellChild and Plunket. A new healthy food resource for 3-5 year olds and their whānau supports

conversations and co-creating a whānau healthy weight plan. This included training for B4 School Check nurses.

***3) Intervention to support children to have healthy weight***

Screening for gestational diabetes, WellChild Checks and B4 School Checks is supported. Tools are provided to support whānau with healthy weight messages and behaviours at these screening points. Maternal Green Prescription and Active Families continue to have high levels of referrals. These programmes show good outcomes with 80% of families completing Active Families programme increasing healthy eating and activity. All children with a BMI in the 98$^{th}$ percentile at the B4 School Check are receiving a healthy eating conversation and support to develop a whānau plan – whānau feedback is positive.

***4) Provide leadership in healthy eating***

HBDHB Board endorsed the reviewed Healthy Eating Policy and this now aligns with the MoH's guideline. Food Services have completed a review of food served in Zacs café and are leading the roll-out to comply with the 'traffic light' system in the policy. The Strategy has been shared widely and there has been support from a range of sectors. The work with the B4 School Check programme demonstrates an effective HBDHB-led collaboration with primary care.

## CHANGING CONTEXT FOR CHILDHOOD HEALTHY WEIGHT

Since HBDHB endorsed the Plan, 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) reports on referrals to a health professional for children in the 98$^{th}$ weight percentile.

This MoH direction aligns with or was planned for in the Best Start Plan. However, has meant reprioritisation of the Best Start Plan's work and will now impact on planned work with the early childhood education sector, primary schools pilot programme and engagement with new settings.

HBDHB entered into a Memorandum of Understanding with the Hawke's Bay Community Fitness Centre Trust that was established in November 2016. This 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. HBDHB have been invited to attend the launch and workshops delivered by the Trust with HBDHB sharing their information and plans with the Trust.

Again this aligns with the Best Start Plan and will require that the activities are coordinated. To achieve this, we are working closely with Sir Graeme Avery and others engaged with the HB Community Fitness Trust. In the planning phase, we have contributed to the information and discussion forum. Moving forward we will be actively involved in the research projects and collaborating on the schools based programme by integrating programmes developed by the Trust with the primary schools programme.

## CONCLUSION

Overall, we are on track with some adjustment made to respond to 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. 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, WellChild/Plunket and B4 School Checks.

2. Continue the work to develop a primary schools programme – working with community partners, MoE East Coast, Health Promoting Schools, Hawke's Bay Community Fitness Centre Trust and schools.

3. 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.

Appendix One

## Objective 1: Increase healthy eating and activity environments

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

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

**What the data shows**

The data we have is improving, there is now policy information recorded in HealthScape showing an increase in school policies and data for the school environments has been collected with Auckland University (Informas).

| Activity to deliver objective one | | | | |
|---|---|---|---|---|
| | **What** | **How** | **Progress** | **When** |
| **Current activity** | • Work with settings to increase healthy eating including education, schools, workplaces, events, Pasifika churches, marae<br>• Support national messaging including sugar reduction i.e. Water Only<br>• Advocate for changes in marketing and council planning | • Healthy eating policies which reduce sugar intake in 5 ECE centres, key community events increase healthy food choices, 4 Pasifika churches have a healthy eating approaches and guidelines for marae reviewed with Ngāti Kahungunu Iwi Incorporated<br>• Communication plan implemented for national and regional messages<br>• Supporting the implementation of programmes and plans i.e. i Way, Active Transport, Sport HB and Ngāti Kahungunu Iwi Incorporated plans | • School water only policies reviewed by PHNs, all primary schools have policies and two secondary schools. Support is being developed for ECEs with MoH licensing staff. Four churches engaged, two are working toward reducing sugar. Hasting District Council is going water only.<br>• Water only messaging promoting in schools, under 5 Healthy Food messages<br>• DHB rep on Active Transport group, supporting Ngāti Kahungunu Iwi Inc. event to provide health messages. | July 2017 |
| **New actions** | • Support education settings to implement healthy eating and food literacy- early childhood, primary schools secondary schools, | • 50% increase in schools with "water only" policy annually<br>• Decile 9/10 communities have a whānau co-designed programme delivered in primary schools, - trialled 2016, 5 new schools annually | • Exceeded with all primary schools having a water only policy<br>• Project lead in place, workshop held<br>• Presented Healthy Weight Strategy to Hastings and Napier Council.<br>• Food Environment data collection complete | Reported annually to 2020 |

| Activity to deliver objective one | | | | |
|---|---|---|---|---|
| | • Establishing a base measure for monitoring<br>• Engage cross-sector groups to gain support and influence to increase healthy eating environments<br>• Investigate food security for children and their whānau identifying issues | • All schools surveyed for status in healthy eating/water only policies<br>• Establish a group to influence changes in the environment across Hawke's Bay<br>• Partner with Auckland University to establish a baseline for the Hawke's Bay food environment and monitor annually | | |

## Objective 2: Develop and deliver prevention programmes

### Indicator 2a: Rates of breastfeeding at 6 weeks increase

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

**What the data shows**

- Child fully or exclusively breastfeeding at 6 weeks rates as 72% (Dec 2015) for total population, 66% Māori and 78% Pasifka (December 2015 Ministry of Health), these sho slight increases
- 76.5% of Hawke's Bay four year olds are healthy weight, 65.2% Māori and 66.9% Pasifika (2014 Before School Check data, Health Hawke's Bay), this will be refreshed with 2016 data at the end of the year.

| Actions and Stakeholders | | | | |
|---|---|---|---|---|
| | **What** | **How** | **Progress** | **When** |
| **Current activity** | • Implementing Maternal Nutrition Programme activities- breastfeeding support, healthy first foods<br>• Supporting settings to implement healthy eating/sugar reduction programmes/policies<br>• Supporting health promoting schools | • Breastfeeding support resources provided via Hauora<br>• All Well Child/Tamariki Ora providers trained in Healthy First Foods<br>• All schools, ECE, Well Child/Tamariki Ora Providers with health eating policies are provided with information resources and advice<br>• Health Promoting Schools health promoters are up-skilled to implement healthy eating approaches | • Complete<br>• Complete<br>• Information and resources shared<br>• Meeting HPS coordinators, attended workshop with other providers | July 2017 |
| **Next actions** | • Extend the Maternal Nutrition programme developing programmes in ECE and resources to support B4 School Check providers | • Deliver training to LMCs, Well Child providers and B4 School Check nurses to increase skills to promote healthy eating- Healthy Conversation, Healthy First Foods, B4 School Check resources | • Healthy Conversation workshops delivered for LMCs and others engaging with whānau and young children. Session delivered for B4 School Check nurses and GPs.<br>• Active Families contracts in place and delivered by Iron Māori and Sport HB. | Reported annually until 2020 |

| Actions and Stakeholders | | | | |
|---|---|---|---|---|
| | • Supporting healthy pregnancies, via education and activity opportunities<br>• Support the development of whānau programme (building on existing successful programme)<br>• Develop food literacy resources including sugar reduction messages -deliver via programme and settings<br>• Support healthy eating programmes and approaches in schools | • Contract and support local provider/s to deliver the maternal healthy eating activity programme<br>• Contract and support local provider/s to deliver whānau based programmes i.e. Active Families<br>• Deliver key messages for whānau with 2–3 year olds<br>• Develop food literacy resources for B4 School Check provider, promote Healthy First Food and heart foundation school resources<br>• Support the co-designed programme for deprivation 9/10 communities | • 3-5 year old messages developed – Healthy Food resource- food choices, portion size and promoting water.<br>• Resources launched with B4 Schools Check nurses<br>• Project manager appointed. | |

## Objective 3: Intervention to support children to have healthy weight

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

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

**What the data shows**

- 55 Hawke's Bay children were identified with BMI over 21, of these, 47 were referred to interventions including Pre-school Active Families and the remaining 8 were given advice. Of the referrals 55% were Māori, 29% other and 19% Pasifika. (2015 B4 School Check Clinical Data- Health Hawke's Bay)
- 57 participants attended breastfeeding support training, 23 Well Child staff attended First Foods Trainer Workshops, 83 health professionals attended Gestational Diabetes updates (2015 HBDHB Maternal Nutrition Report to MoH) and 45 practice nurses attended CNE session on Raising Healthy Kids Target and whānau conversation tool/plan.

| Activities and Stakeholders | | | | |
|---|---|---|---|---|
| | **What** | **How** | **Progress** | **When** |
| **Current activity** | • Screening including gestational diabetes, Well Child/Tamariki Ora and B4 School Checks<br>• Whānau activity based programmes for under 5s<br>• Paediatric dietetic referrals | • Monitor the screening and responding referrals<br>• Fund Active Families under five and monitor implementation. Investigate extending to further providers<br>• Monitor referrals and outcomes | • Monitoring provided via HBDHB Board and MoH. Raising Health Kids target is on track to reach target in quarter 4.<br>• Active Families under 5 is funded and Health HB will support with additional funding<br>• Majority of referrals are to Active Families which has 80% of children increasing healthy eating and activity. | July 2017<br>Māori Health Targets - 6 monthly to the Board |
| **New actions** | • Support screening in maternal programme, Well Child/Tamariki Ora and B4 School Checks | • Support training for health professionals completing screening - maternal, Well Child/Tamariki Ora and B4 School Checks. | • Completed WellChild/Plunket Health First Foods training, B4 School Check Conversation Tool training<br>• Active Families – delivered by Iron Māori and Sport HB | Annually until 2020 |

| Activities and Stakeholders | | | | |
|---|---|---|---|---|
| | • Provide whānau based programmes to support lifestyle changes which support healthy weight i.e. Active Families<br>• Support referrals to programmes via a range of pathways<br>• Develop a clinical pathway from well child/primary care to secondary services<br>• Support child health workforce, to deliver healthy conversations | • Contract community providers to take referrals for whānau with an overweight child (3-12 years)<br>• Clinical pathway developed with key stakeholders- whānau, parents, children and health professionals<br>• Healthy Conversation training delivered | • Reviewing pathway development – potentially included in Long Term Conditions pathway<br>• Delivered the Health Food conversation tool. Investigating new training opportunities | |

## Objective 4: Provide leadership in healthy eating

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

### Indicator 4b: Engage support from key partners

**What the data shows**

Hawke's Bay District Health Board policy has been updated and aligns with MoH guidelines and an implementation plan is in place, endorsed by EMT June 2016. Healthy Weight Strategy have been presented to the Intersectorial Forum, Napier and Hastings Councils, MoE East Coast, Priority Population Committee (Health HB) and internally across the DHB.

| Activities and Stakeholders | | | | |
|---|---|---|---|---|
| | **What** | **How** | **Progress** | **When** |
| **Current activity** | • Share information, evidence and best practice and healthy weight data with key community partners<br>• Show leadership by establish the HBDHB Healthy Eating Policy and implementing the Healthy @ Work work plan | • Regular updates provided via Maternal, Well Child/Tamariki Ora and B4 School Check forums. Regular meetings with community providers<br>• Review and monitor the HBDHB Healthy Eating Policy and support the implementation of the Health @ Work work plan | • Strategy and Best Start Plan shared with - Sport HB, Mananui, Napier and Hastings Councils, HB Community Fitness Centre Trust, DHB staff and placed on DHB website<br>• Policy has been replaced with one aligning with the national Food and Nutrition Policy and for implementation in place | July 2017 |
| **New actions** | • Lead an equity focus by applying an equity lens to review this plan and delivered activity<br>• Lead messaging and delivery to reduce sugar intake<br>• Align HBDHB Healthy Eating Policy with national food and beverage guidelines | • Equity assessment written and finding used to refine this plan to improve response to equity<br>• Cross-sector activity includes a sugar reduction focus<br>• Reviewed policy reflects the healthy eating guidelines<br>• Framework/process implemented for cross-sector approach and inter-agency activity reported | • All contracts have targets for Māori and Pasifika, resources are tested with Māori and Pasifika whānau and equity lens was applied to funding.<br>• Water only and healthy food has been delivered in event planning, Pasifika churches, workplaces and education.<br>• HBDHB policy review is complete and aligns to MoH Nutrition Guidelines. | Ongoing until 2020 |

| Activities and Stakeholders | | | | |
|---|---|---|---|---|
| | • Develop a process for a cross-sector approach to support healthy eating environments<br>• Influence key service delivery stakeholders to maintain best practise and consistent messaging<br>• Continue engagement with community particularly key influencers for Māori and Pasifika i.e. marae and church leaders | • Hauora, general practice, LMCs, contracted community providers provide national messages consistently to whānau, community and their workplace<br>• Key activities Waitangi Day celebrations - policy/guidance document development Ngāti Kahungunu Iwi Incorporated and engagement with Pasifika church leaders | • Shared Healthy Eating Strategy with Intersectorial Forum<br>• Messaging is “water only” and promoting the MoH Nutrition Guidelines<br>• We have worked with the Te Matatini steering group and achieved promoting water and healthy food choices (with a reduction in high fat, sugar and salt foods). The Healthy Events – Food guide material has been reviewed by Ngāti Kahungunu Iwi (events and comms staff). | |

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **HBDHB Performance Framework Exceptions Quarter 3 2016/17** 54<br>**HBDHB Quarterly Performance Monitoring Dashboard Quarter 2 2016/17** |
| | For the attention of:<br>**HBDHB Board** |
| Document Owner:<br>Document Author: | Tim Evans, Executive Director of Corporate Services<br>Peter Mackenzie, Operational Performance Analyst |
| Reviewed by: | Executive Management Team |
| Month: | May 2016 |
| Consideration: | Monitoring |

**RECOMMENDATION**

That the Board:

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

18

**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 March 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) 2016/2017**

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

**STATEMENT OF PERFORMANCE EXPECTATIONS (SPE) 2016/17**

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

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

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

The 4 dimensions of DHB performance are:

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

KEY FOR DETAILED REPORT AND DASHBOARD

| | |
|---|---|
| **Baseline** | Latest available data for planning purpose |
| **Target 2016/17** | Target 2016/17 |
| **Actual to date** | Actual to date |
| **F (Favourable)** | Actual to date is favourable to target |
| **U (Unfavourable)** | Actual to date is unfavourable to target |
| **Trend direction ▲** | Performance is improving against the previous reporting period or baseline |
| **Trend direction ▼** | Performance is declining |
| **Trend direction -** | Performance is unchanged |

# Table of Contents

## PERFORMANCE HIGHLIGHTS

### *Achievements*

- Stroke Services: For "6% of potentially eligible stroke patients thrombolysed" we achieved 8.2%. For "percentage of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway" we achieved 83.6% against a target of 80%.

- Immunisation at 5 Years: Target was achieved for all ethnicities for the period 3 months to March 2017 with Maori being the best performing ethnicity at 94.9% and the overall rate 92.6% against a target of 90%.

- Average Length of Stay Elective: Our result for the period was 1.57 days which is favourable against the target of <1.58 days.

### *Areas of Progress*

- Elective Surgery: We are currently at 99.1% against a target of 100%. We have plans in place and a forcast to meet target by year end. (page 7)

- Faster Cancer Treatment: Results have improved 3.9% this quarter and we are currently at 69.4% against a target of 85%. (page 8)

- Raising Healthy Kids: Results have improved for all ethnicities in quarter 3, the total population results have increased 41.1% and is now 81% against a target of 95%. (page 12)

- DNA (Did not attend): DNA rates reduced for all ethnicities in quarter 3. The overall rate was 5.1% against the target of <7.5%, Maori saw a 2.2% reduction in DNA to 11.8% this quarter. (page 29)

- Oral Health: Caries Free at 5 years of age rates have improved for all ethnicities with Maori improving by 8%, further progress is required to achieve the target of 67% with Maori currently 44% and total 59%.(page 16)

### *Areas of Focus*

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

- Acute Coronary Syndrome: In registering patents promptly we have gone from being favourable in quarter 2 to unfavourable for this quarter. Maori are now at 88.9% and the total population is at 88.9% versus a target of 95%.(page 18)

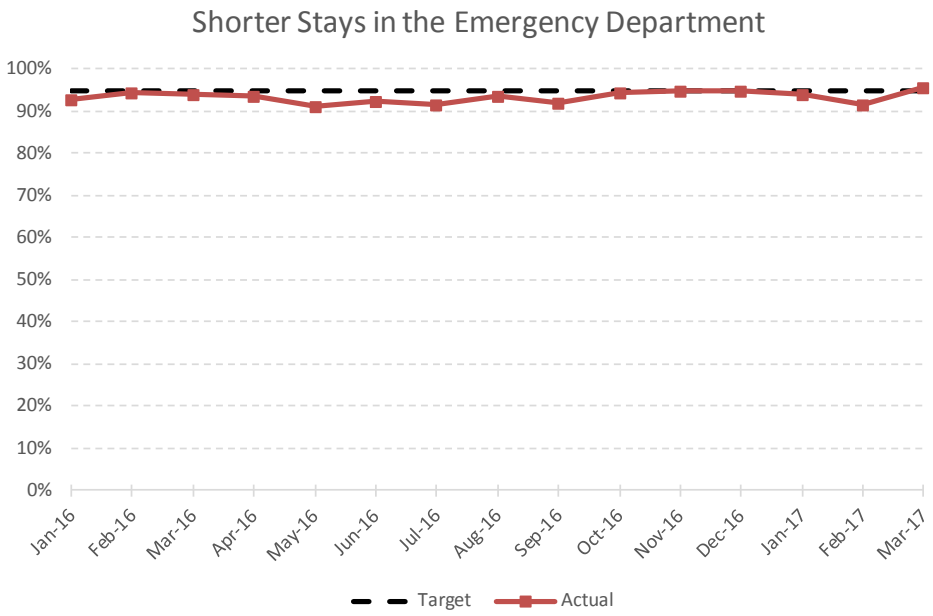
- Rheumatic Fever: We are above our financial year target for the number of cases. Overall we have a rate of 3.1 per 100,000 people against a target of <1.5 per 100,000. However the nature of the cases does not reflect poorly on our plans for systematic prevention. (page 21)

## DIMENSION 1 – ACHIEVING GOVERNMENT PRIORITIES AND TARGETS

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

| Ethnicity | Baseline [1] | Previous result [2] | Actual to Date [3] | Target 2016/17 | Progress against Previous Result |
|---|---|---|---|---|---|
| Total | 94.7% | 94.7% (F) | 93.8% (U) | ≥95% | ▼ |
| Maori | 94.8% | 95.7% (F) | 95.6% (F) | ≥95% | ▼ |
| Pacific | 94.8% | 96.5% (F) | 95% (F) | ≥95% | ▼ |
| Other | 91.6% | 94.1% (U) | 92.9% (U) | ≥95% | ▼ |

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



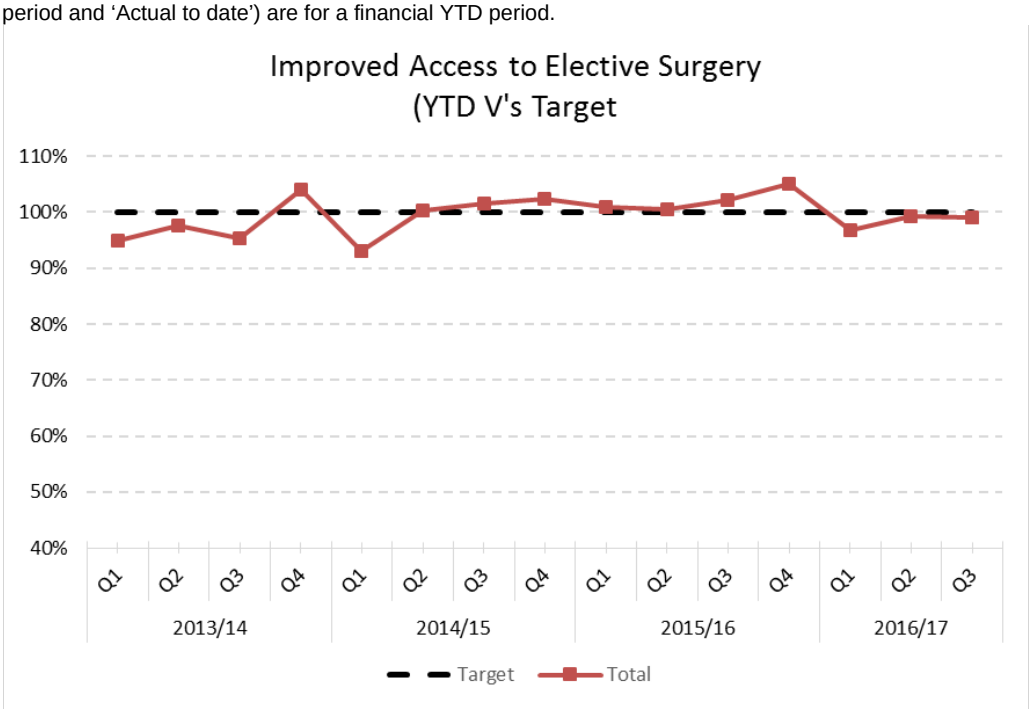

*Comments:*
This quarter there have been several factors which have impacted on the result including ongoing delays with specialty team reviews for referred patients, particularly high medical registrar workload when multiple referrals occur. There is a plan to improve the process to allow for a more timely transfer to AAU for acute medical referrals. To address increasing presentation volumes there is ongoing work with the primary care sector to develop a model for more effective Urgent Care provision and development of a revised Fast Track model of care.

The DHB has carried out several pieces of work this quarter to support the Shorter Stays in EDs health target, these include the introduction of Internal Professional Standards (IPS) and review of data to identify pressure points either under or outside of ED control. There is ongoing focus by the ED SMO group, Duty Nurse Managers, Senior Nurses and Leadership team on ED length of stay and assessment and referral of patients as well as a focussed approach to identify barriers and streamline process.

1 *October to December 2015*
2 *October to December 2016*
3 *January to March 2017*

| Health Target: Improved access to elective surgery (discharges) | | | | |
|---|---|---|---|---|
| **Key Performance Measures** | **Baseline** [4] | **Actual to Date** [5] | **Period Target** | **Target 2016/17** [6] |
| Elective Surgery | 5,866 | 5,585 (U) | 5,635 | ≥6,012 |

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




*Comments:*
There is a plan in place to ensure we deliver the health target for 2016-17. We are currently at 99.1%. We need to action an average of 17 elective discharges internally daily till June and expect to do closer to 19.

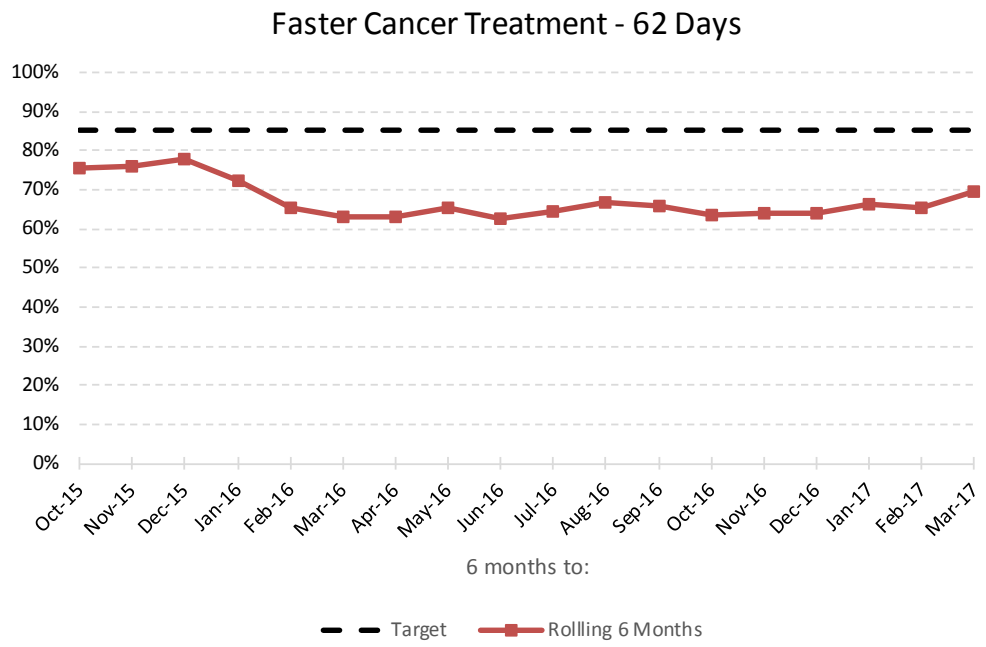
18

*4 2014/15 target*

*5 July 2016 to March 2017 Source: Ministry of Health*

*6 July 2016 to June 2017 Source: Ministry of Health*

| Health Target: Faster Cancer Treatment - patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline [7]** | **Previous result [8]** | **Actual to Date [9]** | **Target 2016/17** | **Trend direction** |
| Total | 77.6% | 65.5% (U) | 69.4% (U) | ≥85% | ▲ |




*Comments:*
The HBDHB development of internal FCT (Faster Cancer Treatment) standards/indicators for referral to MDM (multi-disciplinary meetings) 28/7 and referral for CT to CT Report continue to be validated. The FCT Governance group plan to develop further reports monitoring referral to prioritisation as well as HSCan & 2W identification at referral triage, by consultant. This type of information will facilitate data capture of patients identified for the FCT pathway and enable prospective tracking.

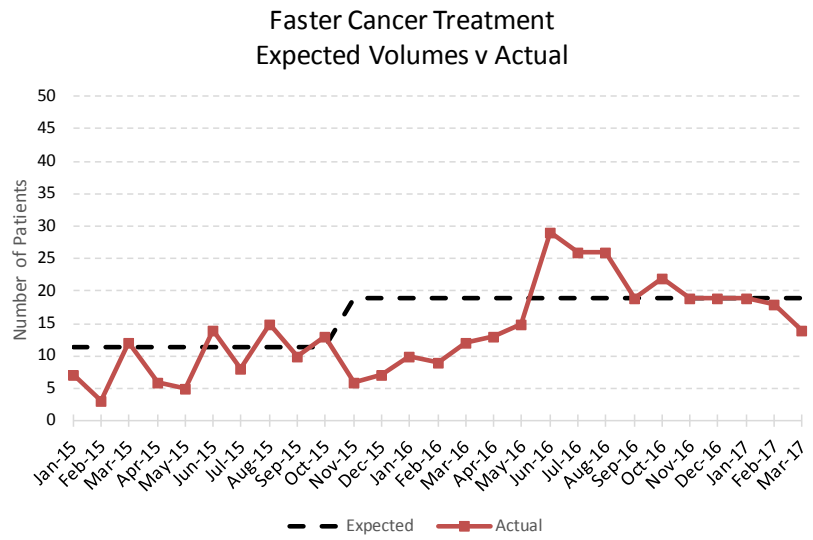
Resourced Capacity remains the most urgent challenge. The March results reflected the delays that occurred for December referrals to access surgical treatment over the January and February months. HBDHB is committed to support the realisation of the FCT challenge as evidenced by their investment plans for radiology infrastructure and staffing, a histology laboratory replacement, the new Gastroenterology suite opening August 2018, and the commencement of the plan for surgical expansion.
Learning from our ADHB colleagues, the FCT governance team has started a rebranding exercise with the question “Is it OK to wait?” The PMS will have a FCT icon for patients on the 62/7 pathway identifying the breach date. A monthly report to the Board, a weekly case meeting and surgical capacity discussion plan, highlights barriers and facilitates access to diagnostics and treatments. The Map of Medicine Project outputs are FCT aligned to enable essential clinical business rules to facilitate efficient referral management pathways. The completed pathways will be interfaced with the HBDHB electronic referral system to support the primary care referral process. The Quality team have undertaken a review of possible opportunities for improvement looking at primary and secondary drivers to identify change ideas to be prioritised for action. The meeting with the MoH Advisors has been helpful to clarify the HBDHB direction to meet the cancer health target.
The FCT team is well supported by the HBDHB exec to realise compliance with the 62 day target for cancer treatments.

7 6 *months to December 2015*

8 *6 months to December 2016*

9 *6 months to March 2017*

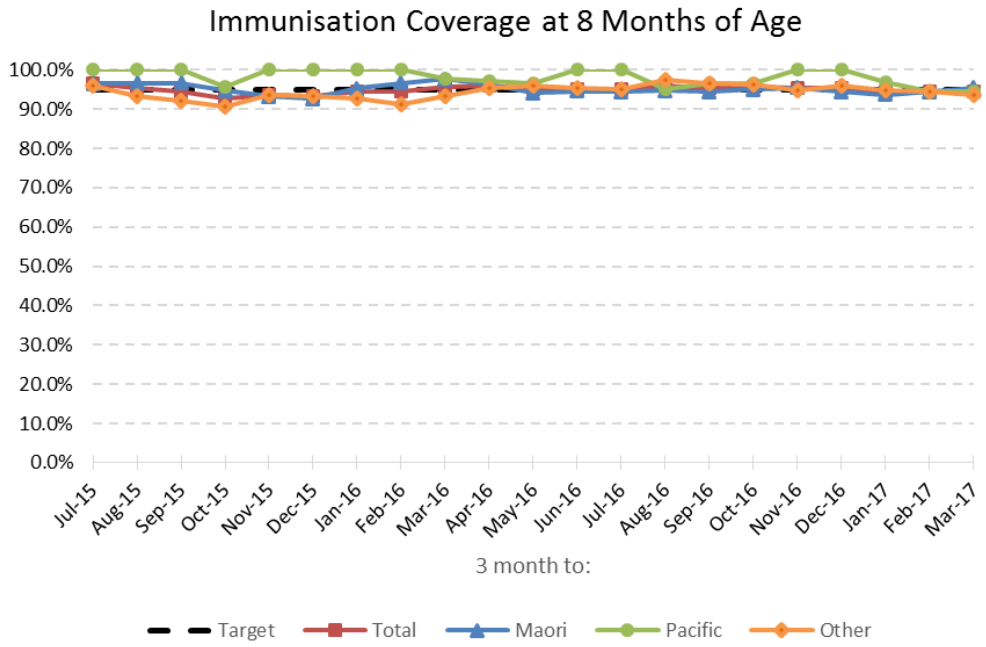
*Based on the expected annual cancer registrations for the DHB supplied by the Ministry, the DHB is expected to identify at least 228 people a year (19 a month) as patients with a high suspicion of cancer.




18

**Health Target: Increased immunisation**
**95% of 8 month olds will have had their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2016**

| Ethnicity | Baseline [10] | Previous result [11] | Actual to Date [12] | Target 2016/17 | Trend direction |
|---|---|---|---|---|---|
| *Total* | 93.3% | 95.3% (F) | 94.4% (U) | ≥95% | ▼ |
| *Māori* | 92.6% | 94.4% (U) | 95.4% (F) | ≥95% | ▲ |
| *Pacific* | 100.0% | 100% (F) | 94.6% (F) | ≥95% | ▼ |
| *Other* | 93.3% | 96.2% (F) | 93.5% (U) | ≥95% | ▼ |

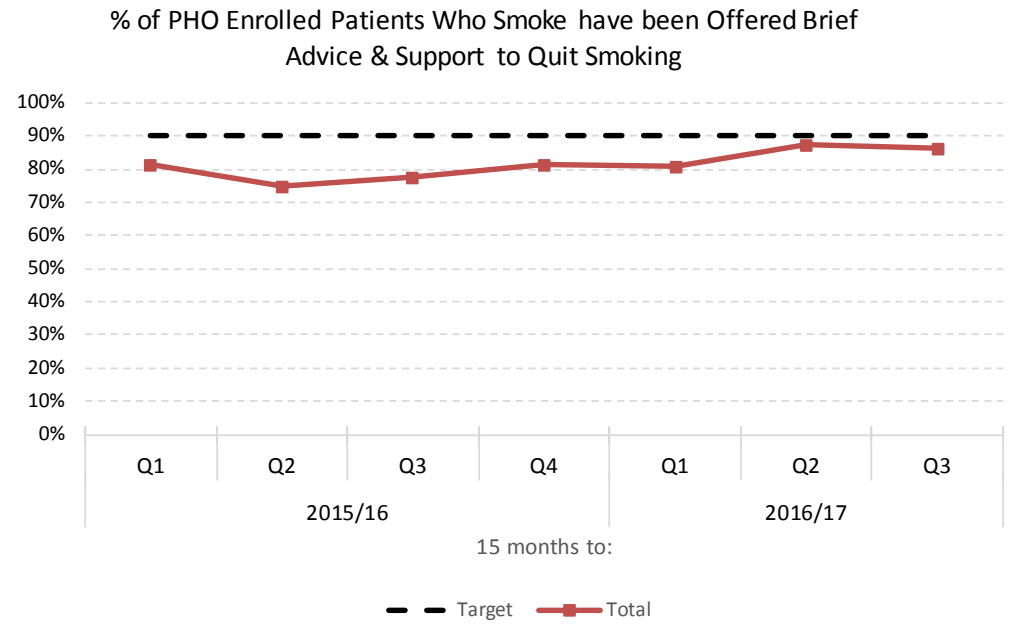



*Comments:*
We were pleased with achieving 94.4% this quarter, with 95.4% coverage for Maori infants. Although the decline rate was 3.7% we have had difficulty getting infants over the line prior to 8 months, there is a fine line as to how many approaches are made to families whose infants are not up to date. 1 child has come in from overseas not up to date after 8 months of age another transferred into our area from elsewhere in the country in December not up to date and due to staff holidays and the Christmas break was not captured in time. If we had gathered these in we would have been on track. With continually increasing workload for our Immunisation team and the intense pressure on NIR in March and April it is very difficult to be tracking infants in a timely way.
From March with the introduction of Cold Chain Standards and with pharmacists now being able to vaccinate certain eligible populations, extra resource has been needed to ensure that cold chain is appropriate - this has placed a big pressure on our team because there is no extra resource! These are great things to be occurring but management of change is essential if we are not to lose the gains that we are already achieving.

10 *October to December 2015. Source: National Immunisation Register, MOH*
11 *October to December 2016. Source: National Immunisation Register, MOH*
12 *January to March 2017. Source: National Immunisation Register, MOH*

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

| Key Performance Measures | Baseline [13] | Previous result [14] | Actual to Date [15] | Target 2016/17 | Trend direction |
|---|---|---|---|---|---|
| *Total* | 81.2% | 87.4% (U) | 86.4% (U) | ≥90% | ▼ |




Source: Ministry of Health

*Comments:*

Health Hawke's Bay has identified Smoke-free Champions in each practice and actively work with these individuals on a regular basis. There are also several initiatives in place to improve rates;

1. **Active, Dedicated Management To Support ABC Activities In General Practice**
   Health Hawke's Bay have contracted a number of independent registered nurses to work in general practices contacting patients on their behalf, updating their smoking status and offering smoking brief advice and cessation support.
2. **Reminder, Prompting And Audit Tools**
   Health Hawke's Bay fund Dr Info for all My Practice and Med-Tech practices – 23 out of 27. The updated Monthly reports are published in the first week of each month. Health Hawke's Bay contract Kato Data Management Limited to provide monthly reporting. The updated Monthly reports are published on or around 10th of each month.
3. **Systems And Processes That Make Life Easier For Health Professionals**
   Health Hawke's Bay funds patient dashboard, which uses a traffic light system to identify if a patient is a current smoker so they can be offered smoking brief advice.
4. **PHO Activities to Increase Delivery of ABC in General Practice?**
   Health Hawke's Bay contact each practice after the Karo report comes out to encourage them to follow-up on people who are recorded as a current smoker but have not been offered smoking brief advice and cessation support in the past 12 months. Health Hawke's Bay are currently developing a "Checklist" to ensure staff know how to record smoking brief advice and cessation support properly.

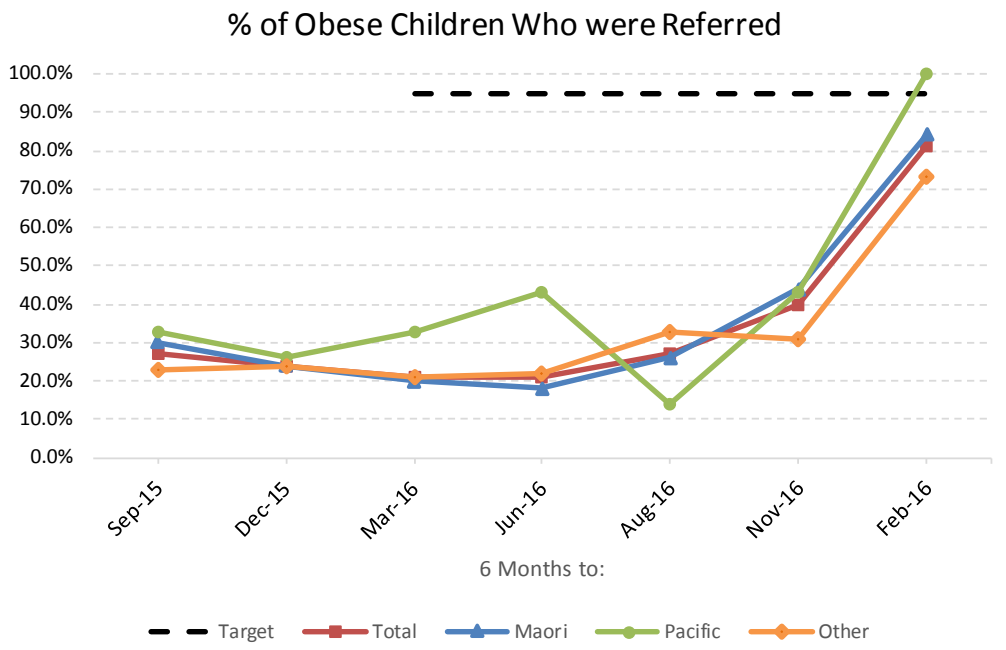
13 October to December 2015. Source: DHB Shared Services

14 October to December 2016. Source: DHB Shared Services

15 January to March 2017. Source: DHB Shared Services

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

| Key Performance Measures | Baseline [16] | Previous result [17] | Actual to Date [18] | Target 2016/17 | Trend direction |
|---|---|---|---|---|---|
| *Total* | 27.0% | 40% (U) | 81% (U) | ≥95% | ▲ |
| *Māori* | 30.0% | 44% (U) | 84% (U) | ≥95% | ▲ |
| *Pacific* | 33.0% | 43% (U) | 100% (F) | ≥95% | ▲ |
| *Other* | 23.0% | 31% (U) | 73% (U) | ≥95% | ▲ |




Source: Ministry of Health

*Comments:*
Progress in all these areas is on track with referrals acknowledged, referral pathways are established and activity used, workshops to engage key partners have been delivered and, the conversation tool is now available in all practise and is being used.

- Referral acknowledgement is at 100% -(either referral acknowledged or declined)
- Pathway is established and referrals continue to increase (moving from 52% quarter two to 81% quarter three) indicating that the pathway is working. Workshops and practise visits are supporting this increase.
- Activities includes the delivery of a conversation tool to support practitioners and whānau to discuss healthy weight, a healthy planning tool – this set key goals with whānau and resources to support these changes including Active Families referrals. Also two workshops have been delivered to support B4 School Check practitioners. This is backed up with practise visits to support practitioners. Activity to target Māori include training in Healthy First Foods and Healthy Conversations prioritised provider delivering to Māori whanau. Providers contract to deliver programme (Active Families Under 5, Maternal Healthy Weight, breastfeeding support) have targets for Māori and Pasifika engagement and these are being met, and resources developed have been tested with Māori whanau.

HBDHB has a Hawke's Bay Health Weight Strategy endorsed by the Board, this includes cross sector activity – including engaging with education, workplaces, retailers, events and local government. To support the implementation of the Strategy the Best Start: Health Eating and Activity Plan was developed, focusing on children from conceptions to 10 years and their whānau. This supports coordination across health services including guiding annual planning. The Strategy and Plan provide also provides a summary of best practise and current information about obesity which supports wider aligned practise and planning.
For example ensuring consistent messaging – healthy food choices, portion sizes, water, healthy snacks and oral health. These messages are delivered with age appropriate content i.e. breastfeeding, healthy first foods and healthy foods (3 and 4 year olds). They all align with MoH Nutrition and Physical Activity Guidelines.

16 *6 months to September 2015. Source: DHB Shared Services*
17 *6 months to November 2016. Source: DHB Shared Services*
18 *6 months to February 2017. Source: DHB Shared Services*

| Improving mental health services using transition (discharge) planning (PP7) | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline** [19] | **Previous result** [20] | **Actual to Date** [21] | **Target 2016/17** | **Trend direction** |
| *Total* | 36.2% | 84% (U) | 93% (U) | ≥95% | ▲ |
| *Due to the change in definition at the start of the financial year there are currently not enough data points for a chart.* | | | | | |
| *Comments:*<br>Transition Plans has been a focus, with regular reporting being undertaken and working to correct any errors. Low achievement historically has been largely driven by reporting issues, rather than transition planning not occurring. This regular monitoring has led to improving performance over time, which we anticipate will continue. | | | | | |

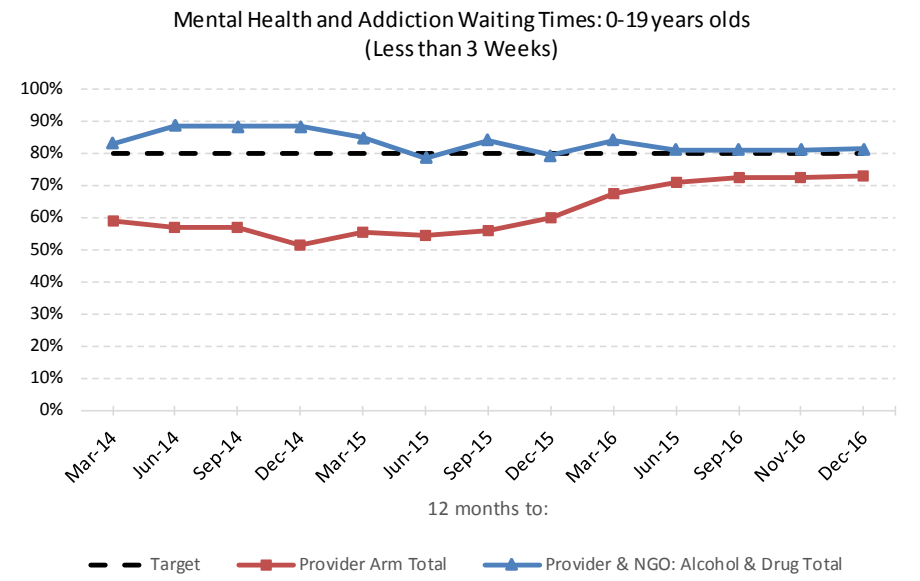


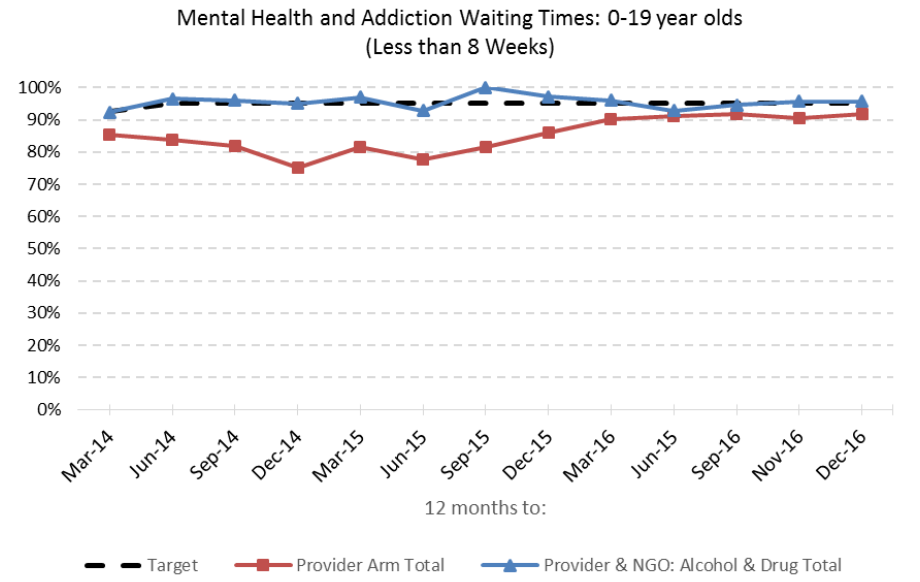
*19 January 2015 to December 2015.*

*20 July to September 2016.*

*21 October to December 2016..*

| Shorter waits for non-urgent mental health and addiction services (PP8): Mental Health Provider Arm | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline [22]** | **Previous result [23]** | **Actual to Date [24]** | **Target 2016/17** | **Trend direction** |
| **Mental Health Provider Arm: Age 0-19** | | | | | |
| <3 weeks | 60.1% | 72.3% (U) | 73.2% (U) | ≥80% | ▲ |
| <8 weeks | 81.5% | 91.7% (U) | 91.9% (U) | ≥95% | ▲ |
| **Addictions (Provider Arm & NGO): Age 0-19** | | | | | |
| <3 weeks | 84.2% | 81.1% (F) | 81.4% (F) | ≥80% | ▲ |
| <8 weeks | 99.5% | 94.6% (F) | 95.7% (F) | ≥95% | ▲ |




Source: Ministry of Health

*Comments:*
While there has been some improvement, we do note that wait times are quite directly linked to staffing and referral volumes. Wait times drop over quieter periods and tend to increase over busy periods, or when we have vacancies.

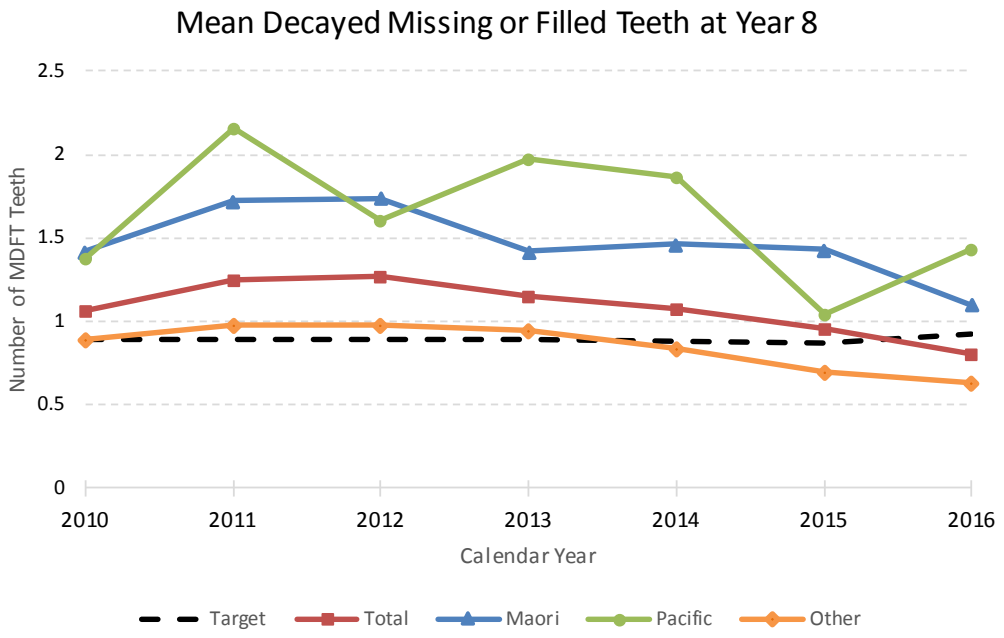
*22 12 months to December 2014*

*23 12 months to September 2016*

*24 12 months to December 2016*

In terms of strategies, we use the CAPA model, which facilitates matching demand with capacity. We are also trialling a consult liaison role within CAFS to attempt to link more effectively with our NGO partners, which may facilitate an increase in capacity over time. We are also increasing relative capacity at our front end, meaning that we can ideally see people sooner, and direct treatment more effectively.

| Oral Health MDFT score at year 8 (PP10) | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline** [25] | **Previous result** [26] | **Actual to Date**[27] | **Target 2016/17** | **Trend direction** |
| *Total* | 96.0% | 0.96 (U) | 0.81 (F) | ≤0.92 | ▲ |
| *Māori* | 143.0% | 1.43 (U) | 1.1 (U) | ≤0.92 | ▲ |
| *Pacific* | 104.0% | 1.04 (U) | 1.43 (U) | ≤0.92 | ▼ |
| *Other* | 70.0% | 0.7 (F) | 0.63 (F) | ≤0.92 | ▲ |



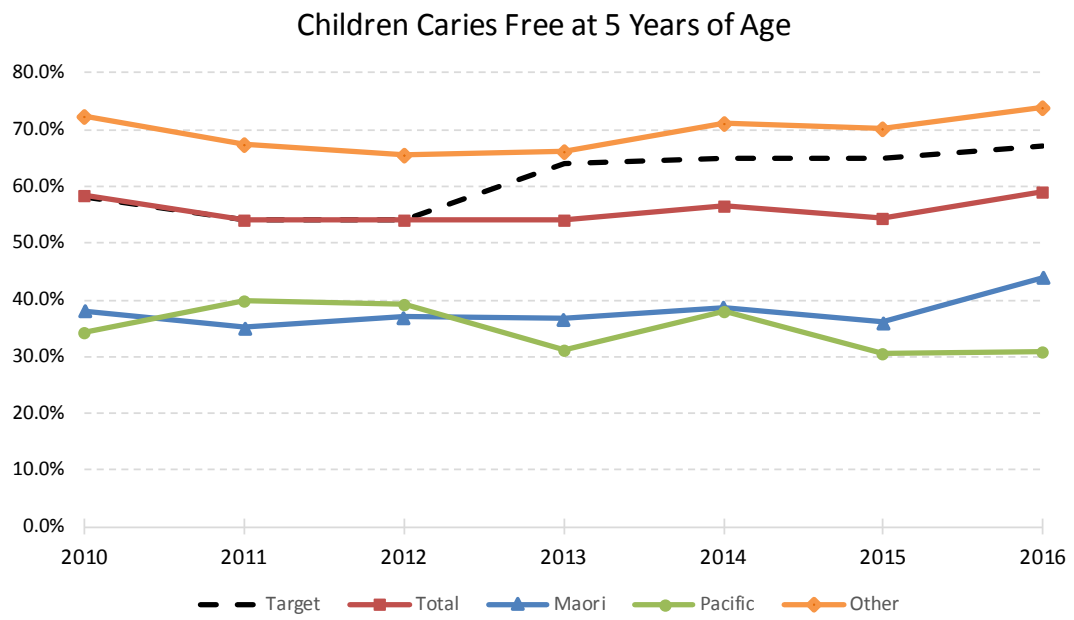

***Comments:***
HBDHB is implementing a much stronger focus on preventive dental care in the community oral health service. This involves 3 quality indicators for clinical practice - fluoride varnish applied by 4 years, bitewing films taken by 6 years, and fissure sealants by 8 years. The DHB has a number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

*25 Calendar Year 2014*

*26 Calendar Year 2015*

*27 Calendar Year 2016*

| Children caries free at 5 years of age (PP11) | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline** [28] | **Previous result** [29] | **Actual to Date** [30] | **Target 2016/17** | **Trend direction** |
| *Total* | 54.4% | 54.4% (U) | 59% (U) | ≥67% | ▲ |
| *Māori* | 36.0% | 36% (U) | 44% (U) | ≥67% | ▲ |
| *Pacific* | 30.5% | 30.5% (U) | 31% (U) | ≥67% | ▲ |
| *Other* | 70.1% | 70.1% (F) | 74% (F) | ≥67% | ▲ |



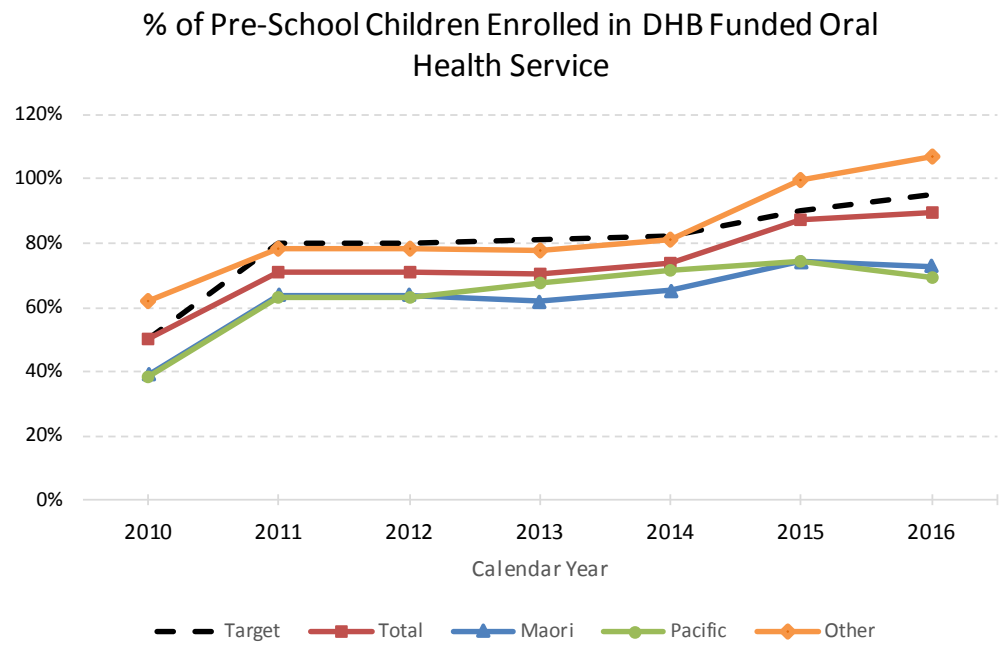

***Comments:***
HBDHB is implementing a much stronger focus on preventive dental care in the community oral health service. This involves 3 quality indicators for clinical practice - fluoride varnish applied by 4 years, bitewing films taken by 6 years, and fissure sealants by 8 years. The DHB has a number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

*28 Calendar Year 2014*

*29 Calendar Year 2015*

*30 Calendar Year 2016*

| Number of pre-school children enrolled in DHB funded Oral Health Services (PP13) | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline [31]** | **Previous result [32]** | **Actual to Date [33]** | **Target 2016/17** | **Trend direction** |
| Total | 73.9% | 87.1% (U) | 89.2% (U) | ≥95% | ▲ |
| Māori | 65.3% | 74.1% (U) | 72.7% (U) | ≥95% | ▼ |
| Pacific | 71.7% | 74.2% (U) | 69.1% (U) | ≥95% | ▼ |
| Other | 81.3% | 99.8% (F) | 107% (F) | ≥95% | ▲ |




Data Source: Titanium Oral Health System

***Comments:***
The quality indicators already show improvement in access to the Prevention programme by Māori high risk clients. Overall 40% increase at 4 yrs from 30% with Māori 60% at 4 yrs and Non Māori 25 % at 4 yrs.

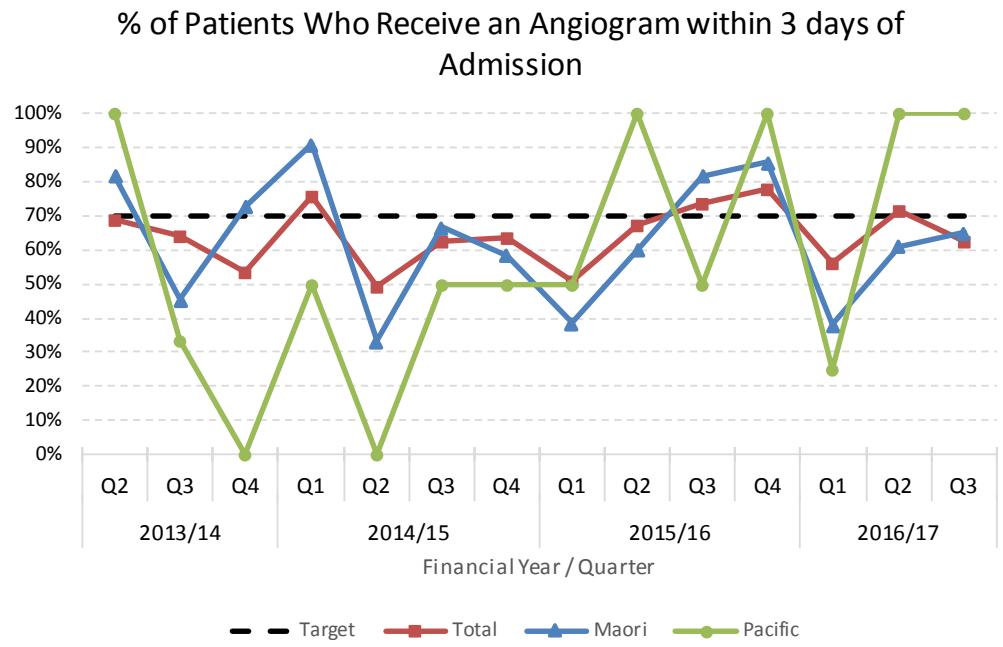
18

*31 2012 Calendar Year*

*32 2015 Calendar Year*

*33 2016 Calendar Year*

| **Improvement management for long term conditions (PP20) Cardiovascular Disease: 70% of high-risk patients will receive an angiogram within 3 days of admission** | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline [34]** | **Previous result [35]** | **Actual to Date [36]** | **Target 2016/17** | **Trend direction** |
| Total | 68.7% | 71.6% (F) | 62.5% (U) | ≥70% | ▼ |
| Māori | 60.0% | 61.1% (U) | 65% (U) | ≥70% | ▲ |
| Pacific | 100.0% | 100% (F) | 100% (F) | ≥70% | — |



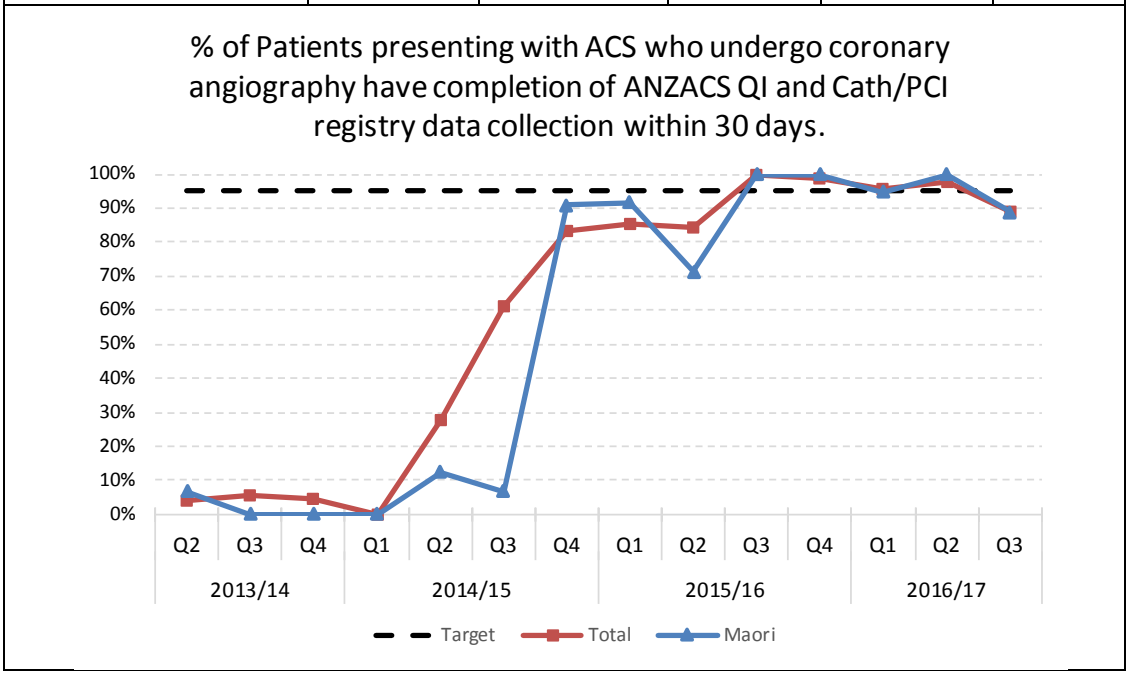

*Comments:*
It was commented during a teleconference with the Ministry of Health that there are challenges in accessing beds at Capital & Coast. A report has been created and was discussed as it shows the waiting time along the patient's journey. We are going to follow this up and distribute latest report during the next quarter. It was discussed with the MoH that there is not good visibility of patients who are waiting six days and longer. This is a potential risk as it would be good to understand if this is an issue.

34 *October to December 2015*

35 *October to December 2016*

36 *January to March 2017*

| Improvement management for long term conditions (PP20) Cardiovascular Disease: Over 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline [37]** | **Previous result [38]** | **Actual to Date [39]** | **Target 2016/17** | **Trend direction** |
| Total | 84.1% | 97.7% (F) | 88.9% (U) | ≥95% | ▼ |
| Māori | 71.4% | 100% (F) | 88.9% (U) | ≥95% | ▼ |
| Pacific | 50.0% | 66.7% (U) | 100% (F) | ≥95% | ▲ |

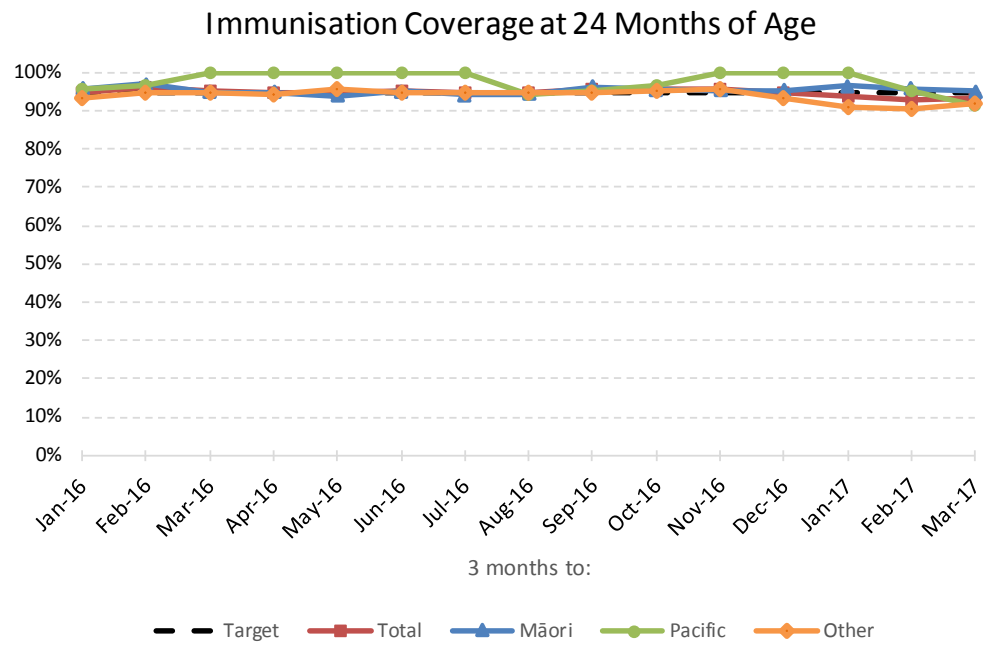



37 *October to December 2015*

38 *October to December 2016*

39 *January to March 2017*

| Key Performance Measures | Baseline [40] | Previous result [41] | Actual to Date [42] | Target 2016/17 | Trend direction |
|---|---|---|---|---|---|
| **Immunisation coverage (PP21) – 95% of 2 year olds are fully immunised** | | | | | |
| Total | 93.9% | 94.7% (F) | 93.2% (U) | ≥95% | ▼ |
| Māori | 92.6% | 95.4% (F) | 95.1% (F) | ≥95% | ▼ |
| Pacific | 100.0% | 100% (F) | 91.3% (U) | ≥95% | ▼ |
| Other | 93.3% | 93.6% (U) | 92% (U) | ≥95% | ▼ |




Source: National Immunisation Register

*Comments:*

We are disappointed that coverage is at 93.2% this quarter, although Maori coverage is 95.1%. Pacific coverage is lower at 91.3% but this is a much smaller cohort of children with only 23 Pacific children eligible and 2 not completed. We have had a high decline rate within this cohort at 5.8% so we were never going to achieve the target. We try to ensure that all families have had a discussion with a health professional and if there are barriers to access immunisation services alternatives services are always available. With continually increasing workload for our Immunisation team and the intense pressure on NIR in March and April it is very difficult to be tracking infants in a timely way. From March with the introduction of Cold Chain Standards and with pharmacists now being able to vaccinate certain eligible populations, extra resource has been needed to ensure that cold chain is appropriate - this has placed a big pressure on our team because there is no extra resource! These are great things to be occurring but management of change is essential if we are not to lose the gains that we are already achieving.

*40 October to December 2015. Source: National Immunisation Register, MOH*

*41 October to December 2016 Source: National Immunisation Register, MOH*

*42 January to March 2017. Source: National Immunisation Register, MOH*

| Key Performance Measures | Baseline [43] | Previous result | Actual to Date | Target 2016/17 | Trend direction |
|---|---|---|---|---|---|
| **Reducing Rheumatic fever (PP28) (Rate per 100,000)** | | | | | |
| Total | 0.6 | 2.48 (U) | 3.1 (U) | ≤1.5 | ▼ |
| Maori | 2.48 | 7.23 (U) | 9.64 (U) | ≤1.5 | ▼ |
| Pacific | - | 16.47 (U) | 16.47 (U) | ≤1.5 | ▬ |

*Comments:*

Whilst Hawke's Bay is seeing an increase in Rheumatic Fever cases compared to last year, there have been no ARF cases in throat swabbing schools who had a GAS sore throat in the four weeks previous.

We are interested in knowing whether this trend of seeing cases with increased complexity (e.g. presenting with chorea) and young adults, which is being investigated nationally, will identify whether this represents a genuine national trend as overall rheumatic fever rates decline.

| Key Performance Measures | Baseline [44] | Previous result [45] | Actual to Date [46] | Target 2016/17 | Trend direction |
|---|---|---|---|---|---|
| **Improving waiting time for diagnostic services (PP29)** | | | | | |
| Coronary Angiography | 89.8% | 97.7% (F) | 92.9% (U) | ≥95% | ▼ |
| Computed Tomography (CT) | 84.4% | 95.1% (F) | 96.4% (F) | ≥95% | ▲ |
| Magnetic Resonance Imaging (MRI) | 31.0% | 48% ( U ) | 59% ( U ) | ≥85% | ▲ |
| 82.4% | 82.4% | 91.7% (F) | 84.8% (F) | ≥85% | ▼ |
| Diagnostic Colonoscopy: Non-Urgent | 87.1% | 93.9% (F) | 94.9% (F) | ≥85% | ▲ |
| Surveillance Colonoscopy | 79.3% | 98.7% (F) | 98.1% (F) | ≥70% | ▼ |

*Comments:*

Coronary Angiogram: The availability of Locum Interventional Cardiologists at HB have enabled additional angiogram sessions which will assist in achieving the target.

MRI: A radiology business case has been approved that will extend working hours for MRI services - from a 5 day service to a 7 day service from July 2017. This will create additional scanning capacity and enable us to meet the indicator by early 2018. This business case has approved additional radiologist resources (2.4 FTE) that will increase reporting capacity. Additionally an MRI trainee position has also been approved for 2018 to maintain and future proof MRI workforce in HBDHB.



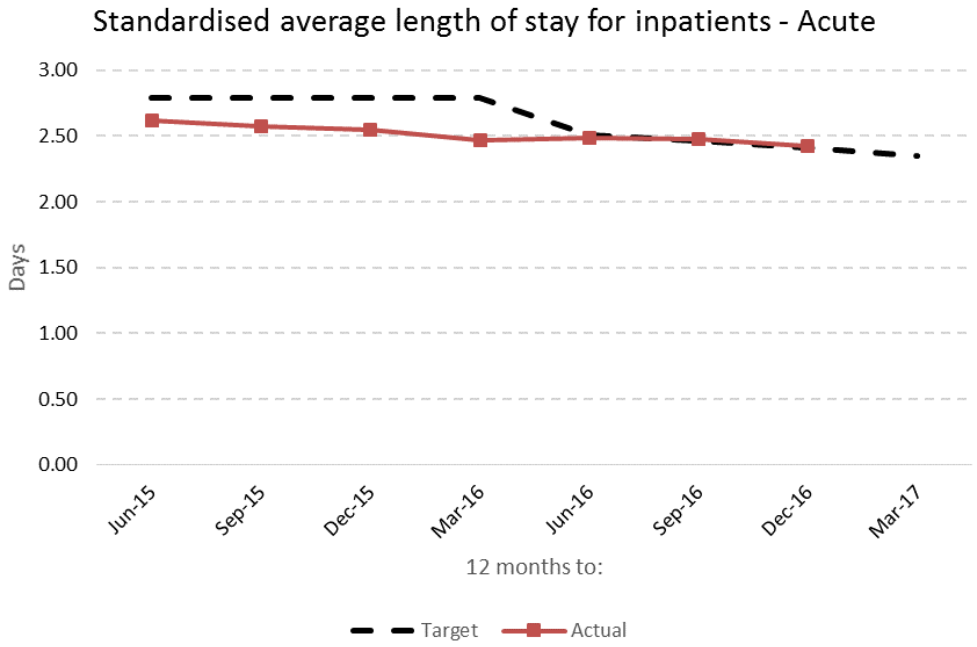
*43 October to December 2012.*

*44 December 2015.*

*45 March 2016.*

*46 June 2016*

| Inpatient Average Length of Stay (ALOS) - Acute (OS3) | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline** [47] | **Previous result** [48] | **Actual to Date** [49] | **Target 2016/17** | **Trend direction** |
| Days | 2.55 | 2.48 ( U ) | 2.42 (U) | ≤2.41 | ▲ |




Source: Ministry of Health

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

*Comments:*
We were very close to achieving target this quarter and have identified the specialties where the most progress can be made as General Medicine, General Surgery and Orthopaedics.

*47 12 months to December 2015*

*48 12 months to September 2016. Source: Ministry of Health*

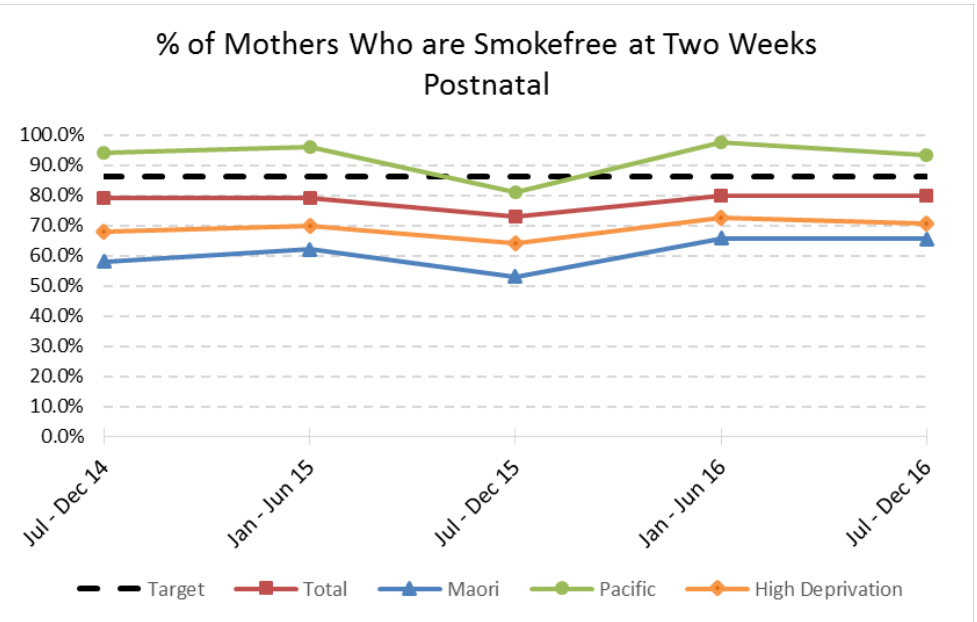
*49 12 months to December 2016. Source: Ministry of Health*

## DIMENSION 4 – SERVICE PERFORMANCE

### PREVENTION SERVICES

**Percentage of Pregnant Māori woman that are Smokefree at 2 weeks postnatal**

| Ethnicity | Baseline [50] | Previous result [51] | Actual to Date [52] | Target 2016/17 | Trend direction |
|---|---|---|---|---|---|
| Total | 73.0% | 79.9% (U) | 80% (U) | ≥95% | ▲ |
| Māori | 53.0% | 65.6% (U) | 65.6% (U) | ≥95% | — |
| Pacific | 81.0% | 97.7% (F) | 93.5% (U) | ≥95% | ▼ |




*Comments:*
The earlier we can engage with all women who are not Smokefree the better the success of maintaining a Smokefree status. HBDHB maternity and Smokefree team work in collaboration to engage with GP Practices to increase referrals at point of pregnancy confirmation to the Increasing Smokefree Pregnancy Programme (ISPP). 20 / 28 GP Practices have received training and resources to support early referrals to ISPP, an initiative that started in November 2016.

*50 2013 Calendar Year*

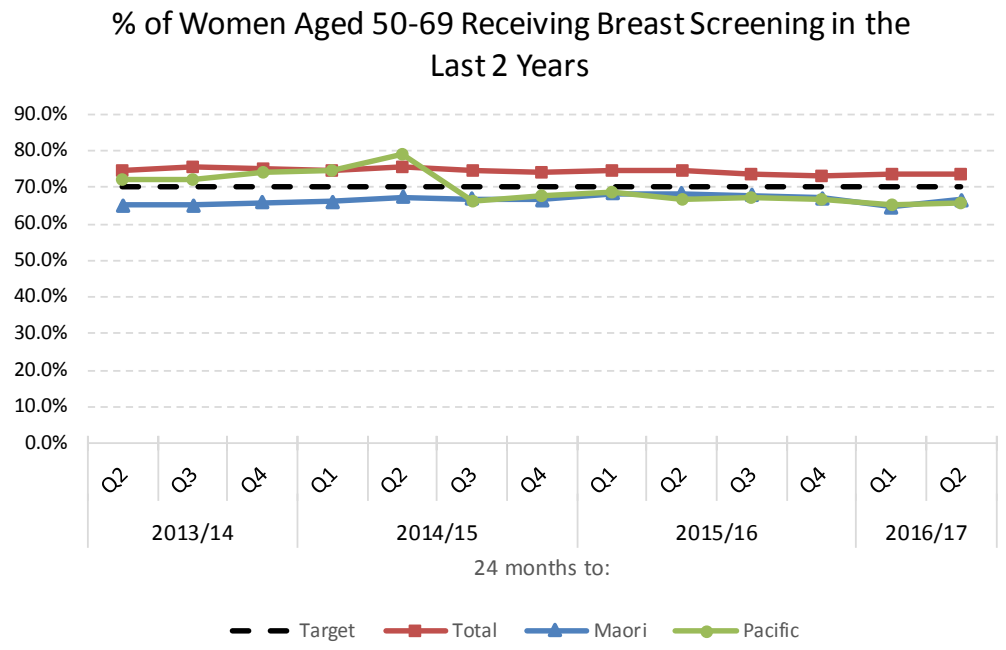
*51 2013 Calendar Year*

*52 2014 Calendar Year*

## PREVENTION SERVICES – POPULATION BASED SCREENING SERVICES

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

| Key Performance Measures | Baseline [53] | Previous result [54] | Actual to Date [55] | Target 2016/17 | Trend direction |
|---|---|---|---|---|---|
| Total | 74.7% | 73.6% (F) | 73.4% (F) | ≥70% | ▼ |
| Māori | 68.4% | 64.7% (U) | 66.7% (U) | ≥70% | ▲ |
| Pacific | 66.5% | 65.4% (U) | 65.8% (U) | ≥70% | ▲ |
| Other | 76.0% | 75% (F) | 74.9% (F) | ≥70% | ▼ |




Source: Breast Screen Coast to Coast

*Comments:*

Coverage data to the end of March has not been released by Breast Screening Aotearoa. The Breast Screening mobile has been present in Wairoa.

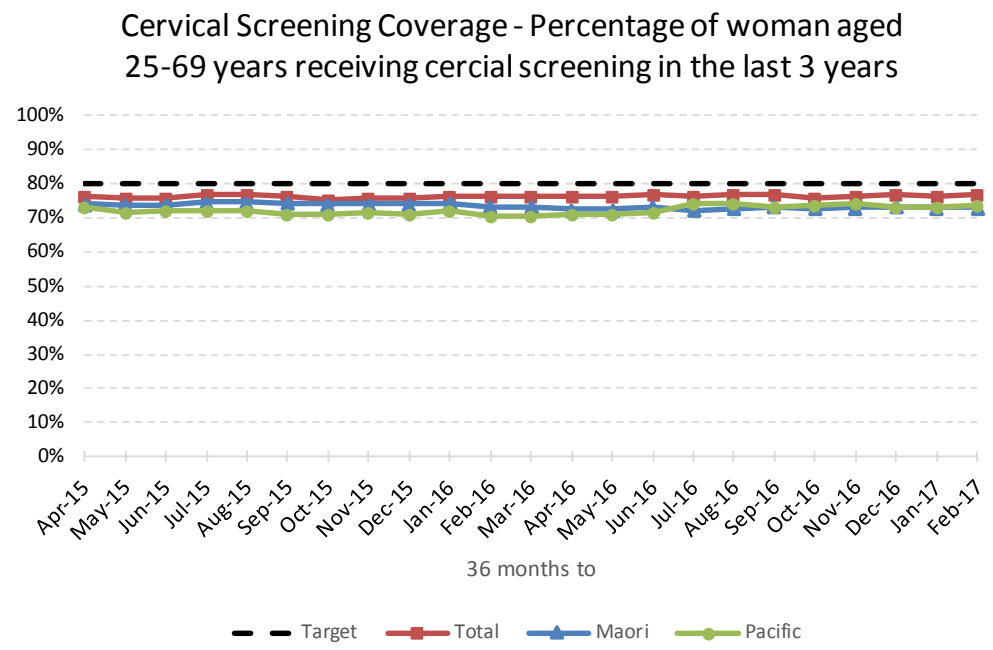
The new process agreed with Breast Screening Coast to Coast for priority women who do not respond to recall when receiving an appointment for the BSA mobile to be referred to an ISP was implemented. This new referral process implemented for the visit to Wairoa will be evaluated and information will be available for the next quarter

*53 24 months to December 2015. Source: Breast Screen Coast to Coast*

*54 24 months to September 2016. Source: Breast Screen Coast to Coast*

*55 24 months to December 2016 . Source: Breast Screen Coast to Coast*

| Percentage of women aged 25-69 years receiving cervical screening in the last 3 years | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline** [56] | **Previous result** [57] | **Actual to Date** [58] | **Target 2016/17** | **Trend direction** |
| Total | 75.8% | 76.7% (U) | 76.6% (U) | ≥80% | ▼ |
| Māori | 74.1% | 72.8% (U) | 73.1% (U) | ≥80% | ▲ |
| Pacific | 71.2% | 74.8% (U) | 73.6% (U) | ≥80% | ▼ |
| Other | 76.5% | 78.9% (U) | 77.8% (U) | ≥80% | ▼ |




Source: National Screening Unit

We remain 1st in coverage for Māori women out of the 20 DHB's, but the increase in coverage is slow. The number of smears taken in the Health Centres has increased this quarter and is favourable to the same period as last year. This may be due a large number of letters sent in this quarter to Māori for the Pak n Save campaign. We continue to work in collaboration with Totara Health, with our Kaiāwhina supporting a nurse smeartaker from the Practice offering smears in the community. Since this initiative began we have seen the benefit in our coverage for Māori. We have employed a Pacific Community Support worker on a fixed term contract from early May to the end of June and have collaborated with Choices so we can increase to two days a week offering smears to Priority women. Providing smears in the community is intensive and requires significant time to engage and encourage the women to been screened, but we are encouraged with the feedback received from the women who tell us 'they have only had the smear because it was offered to them in the home'.
Recent population projections released by the National Screening Unit show that in the next five years (2016-2021) Hawke's Bay's NCSP eligible Māori and Pacific populations will increase by 7% and the Asian population will increase by 16%. A challenge to the sector.

*56 36 months to December 2015. Source: National Screening Unit*

*57 36 months to December 2016. Source: National Screening Unit*

*58 36 months to February 2017. Source: National Screening Unit*

| **Breastfeeding Rates** | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline** [59] | **Previous result** [60] | **Actual to Date** [61] | **Target 2016/17** | **Trend direction** |
| **Full or Exclusive at 6 Weeks** | | | | | |
| Total | 68.0% | 73% (U) | 72% (U) | ≥75% | ▼ |
| Māori | 58.0% | 67% (U) | 66% (U) | ≥75% | ▼ |
| Pacific | 74.0% | 82% (F) | 82% (F) | ≥75% | — |

| Key Performance Measures | Baseline 62 | Previous result 63 | Actual to Date 64 | Target 2016/17 | **Trend direction** |
|---|---|---|---|---|---|
| **Full or Exclusive At 3 Months** | | | | | |
| Total | 54.0% | 53% (U) | 51% (U) | ≥60% | ▼ |
| Māori | 46.0% | 39% (U) | 39% (U) | ≥60% | — |
| Pacific | 62.0% | 63% (F) | 46% (U) | ≥60% | ▼ |
| **Full, Exclusive or Partial At 6 Months** | | | | | |
| Total | 56.0% | 58% (U) | 61% (U) | ≥65% | ▲ |
| Māori | 46.0% | 48% (U) | 50% (U) | ≥65% | ▲ |
| Pacific | 57.0% | 66% (F) | 67% (F) | ≥65% | ▲ |

Source: Tamariki Ora Quality Improvement Framework

*Comments:*
Breastfeeding rates for Māori at 6 weeks remain at similar levels compared to June 2015. Māori are currently at 66% compared with an 'Other' ethnicities rate of 78% and a target of 75%.

There is no improvement in Māori breastfeeding at 3 months. Breastfeeding rates at 3 months sit at 39% for Māori, compared to a total rate of 51%, and significantly below the target of 60%.

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

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

Te Ara Whakawaiora indicator report tabled this quarter contains a set of recommendations to review the current breastfeeding service to better support Māori and Pacific whānau post discharge from Maternity Services and consider options for disinvestment to reinvest. Update on progress expected by quarter 4.
New investment is also under contract via Māori Health to provide lactation consultation community support to address identified equity issues.

*59 October to December 2013.*

*60 January to June 2015.*

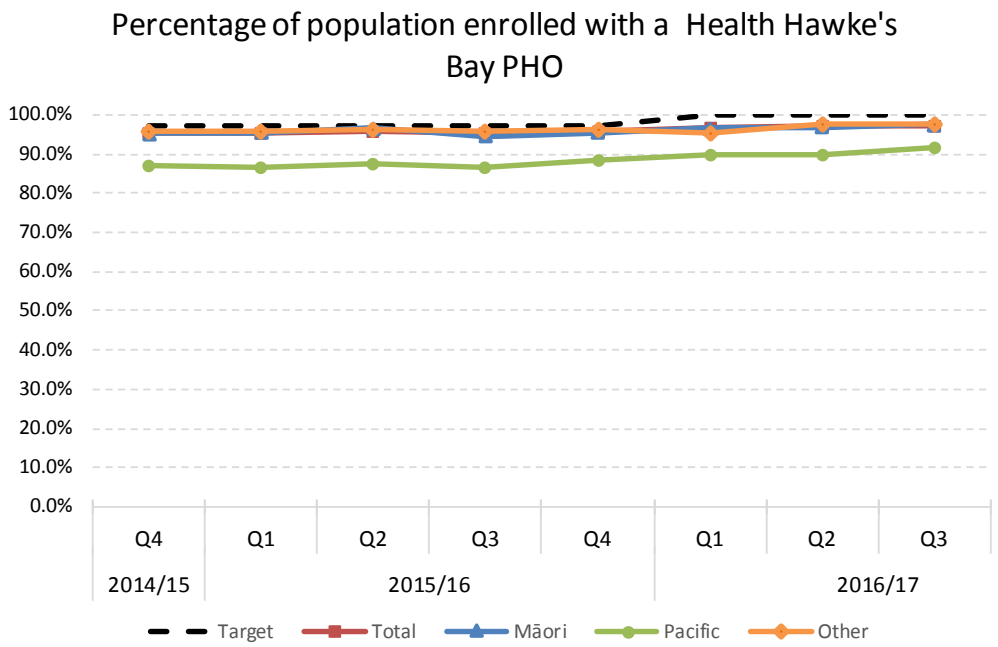
*61 July to December 2015.*

*62 January to June 2015*

*63 July to December 2015*

*64 January to June 2016.*

| Proportion of the population enrolled in the PHO | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline** [65] | **Previous result** [66] | **Actual to Date** [67] | **Target 2016/17** | **Trend direction** |
| Total | 96.4% | 97.1% (U) | 97.3% (U) | ≥100% | ▲ |
| Māori | 97.2% | 96.8% (U) | 97.5% (U) | ≥100% | ▲ |
| Pacific | 88.7% | 89.8% (U) | 91.7% (U) | ≥100% | ▲ |
| Other | 96.5% | 97.5% (U) | 97.6% (U) | ≥100% | ▲ |




Source: Ministry of Health

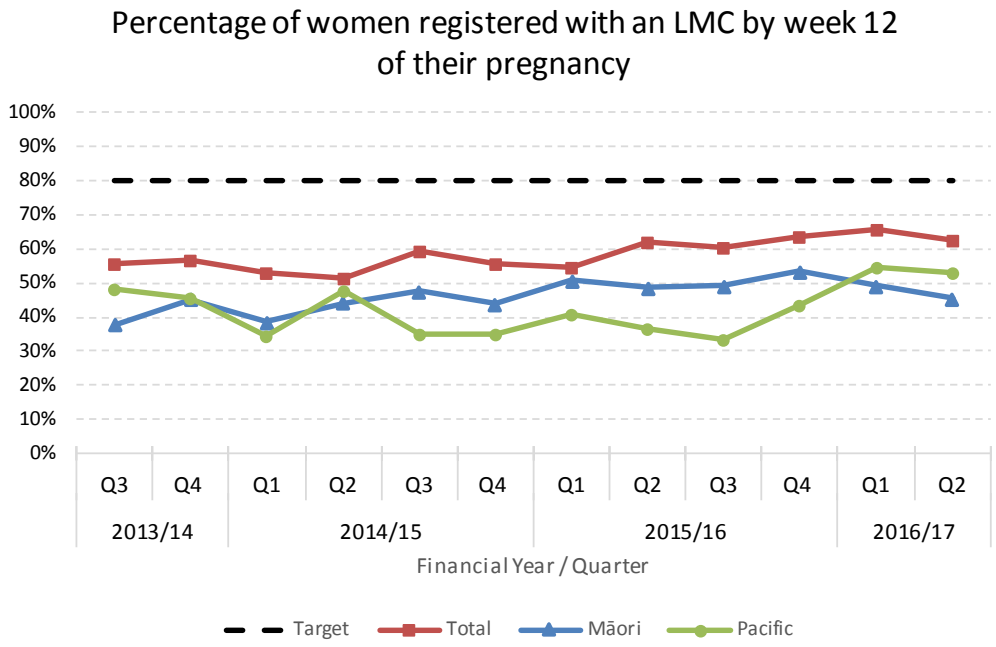
*Comments:*
Although the enrolment percentage this quarter appears to be low there has been a slight increase of 0.9% of Māori enrolled.
The High Needs Enrolment programme is still available for those consumers who are not enrolled to become enrolled and receive a 1 hour nurse consultation and a 15 minute doctor consultation.
Quarter 3 – 59 people enrolled with a General Practice under the High Needs Enrolment Programme. 33 of those people identify as Māori (56%)
HHB will continue to promote the programme to encourage enrolment with HHB General Practices.

*65 October to December 2014.*

*66 October to December 2016.*

*67 January to March 2017.*

| Percentage of women registered with an LMC by week 12 of their pregnancy | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline** [68] | **Previous result** [69] | **Actual to Date** [70] | **Target 2016/17** | **Trend direction** |
| Total | 54.5% | 65.7% (U) | 62.5% (U) | ≥80% | ▼ |
| Māori | 50.7% | 49.2% (U) | 45.3% (U) | ≥80% | ▼ |
| Pacific | 40.6% | 54.5% (U) | 52.8% (U) | ≥80% | ▼ |
| Other | 58.5% | 75.9% (U) | 74.9% (U) | ≥80% | ▼ |




*Comments:*

These figures are prior to the shared early engagement campaign with our Smokefree colleagues, this commenced in October last year and 12 GP practices have now been visited and resources given in relation to finding a midwife and Smokefree conversations. A public campaign is about to be launched with the women's resources regarding "the top5 for my baby to thrive". It will be rolled out across the district, inclusive of media and visual poster displays (buses, billboards).

Feedback from women continues to identify reasons for not engaging early:

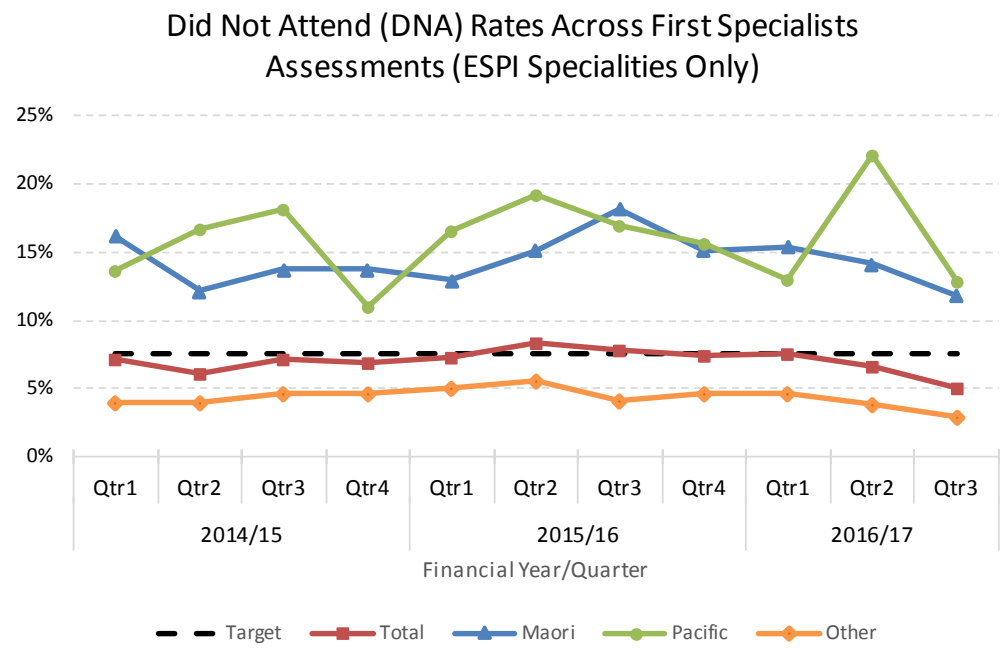
- Didn't know about midwives
- Didn't know why they should engage early
- Little support to find a midwife

*68 October to December 2015.*

*69* April to June 2016.

*70* October to December 2016.

| Did not attend (DNA) rate across first specialist assessments[71] | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline [72]** | **Previous result [73]** | **Actual to Date [74]** | **Target 2016/17** | **Trend direction** |
| Total | 8.1% | 6.7% (F) | 5.1% (F) | ≤7.5% | ▲ |
| Māori | 14.9% | 14.2% (U) | 11.8% (U) | ≤7.5% | ▲ |
| Pacific | 18.3% | 22.1% (U) | 12.9% (U) | ≤7.5% | ▲ |
| Other | 5.3% | 3.8% (F) | 2.9% (F) | ≤7.5% | ▲ |




*Comments:*
Our DNA rate for ESPI Specialties continues to decline across all areas largely as a result of a more customer focused booking process. The top three offenders for DNA continue to be the surgical specialties; Dental, ENT and General Surgery that account for over half of all the DNA rates across the ESPI Specialties.

The inconsistencies across the DHB with following DNA policy, and adhering to the agreed DNA tracing process, particularly with Maori patients continues. Customer Focused Booking hope to address this when a new project manager is assigned in July.

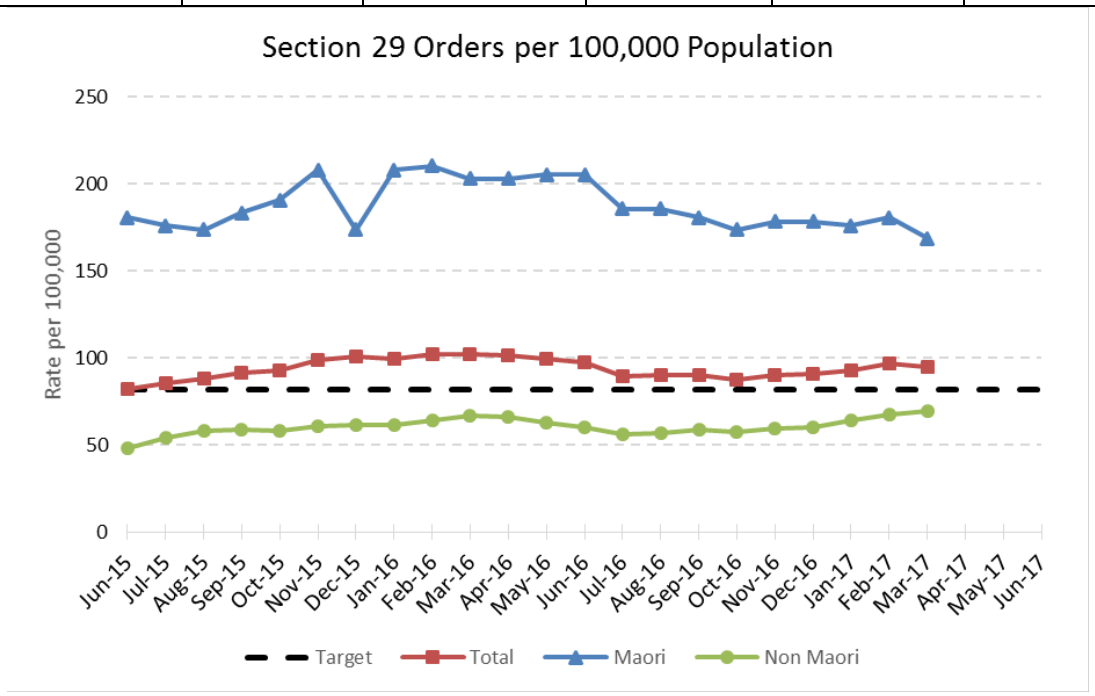
*71 ESPI specialities only*

*72 October to December 2014*

*73 January to March 2016*

*74 April to June 2016*

| Rate of Section 29 orders per 100,000 | | | | | |
|---|---|---|---|---|---|
| **Ethnicity** | **Baseline [75]** | **Previous result [76]** | **Actual to Date [77]** | **Target 2016/17** | **Trend direction** |
| Total | 97 | 89.3 (U) | 94.9 (U) | ≤81.5 | ▼ |
| Māori | 196 | 176.7 (U) | 175.1 (U) | ≤81.5 | ▲ |
| Other | 93.4 | 59 (F) | 67.1 (F) | ≤81.5 | ▼ |




*Comments:*
The inequity in this measure remains evident. Work that has been done this quarter to focus on this issue are closer working with Health Hawke's Bay PHO, partnering with their new model of care, continue to work closely with Police, whose referrals to the service continue to increase.
Further to this there is renewed commitment to work together across the sector. This includes: engaging whānau through the home-based treatment team; communication through the central coordination service for all providers; implementation of the intensive day treatment programme; reduction of restrictive care practices; increasing group interaction options in the community; and more referral and liaison with community providers.

75 *October to December 2015*

76 *October to December 2016*

77 *January to March 2017*

| Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital emergency department attendances (per 1,000) | | | | | |
|---|---|---|---|---|---|
| **Age Band** | **Baseline** [78] | **Previous result** [79] | **Actual to Date** [80] | **Target 2016/17** | **Trend direction** |
| Age 75-79 | | | | | |
| Total | 136.5 | 124 (F) | 135.1 (F) | ≤139.5 | ▼ |
| Maori | 144.4 | 164.3 ( U ) | 202.4 ( U ) | ≤139.5 | ▼ |
| Pacific | - | 175 ( U ) | 125 (F) | ≤139.5 | ▲ |
| Other | - | 111.2 (F) | 119.9 (F) | ≤139.5 | ▼ |
| Age 80-84 | | | | | |
| Total | 178.9 | 167.8 (F) | 164.9 (F) | ≤183.1 | ▲ |
| Maori | 208 | 208.3 ( U ) | 179.2 (F) | ≤183.1 | ▲ |
| Pacific | - | 300 ( U ) | 175 (F) | ≤183.1 | ▲ |
| Other | - | 167 (F) | 167.6 (F) | ≤183.1 | ▼ |
| Age 85+ | | | | | |
| Total | 229.2 | 216.6 (F) | 218.3 (F) | ≤231 | ▼ |
| Maori | 153.8 | 134.6 (F) | 136.4 (F) | ≤231 | ▼ |
| Pacific | - | - | 50 (F) | ≤231 | * |
| Other | - | 237.7 ( U ) | 239.4 ( U ) | ≤231 | ▼ |
| *Comments:*<br>Other monitoring has already highlighted the pressure that the emergency department has been under during Q3 and that has meant generally higher volumes. Although many of the lines above show a worsening trend, they are still mostly favourable compared to target and compared to baseline. The notable exception is in the 75-79 year-old Maori population. We have recently started identifying those general practices whose enrolled population are high users of ED and we are sharing that information with the practices in an effort to reconnect those people with primary care. | | | | | |



*78 October to December 2014*

*79 January to December 2016*

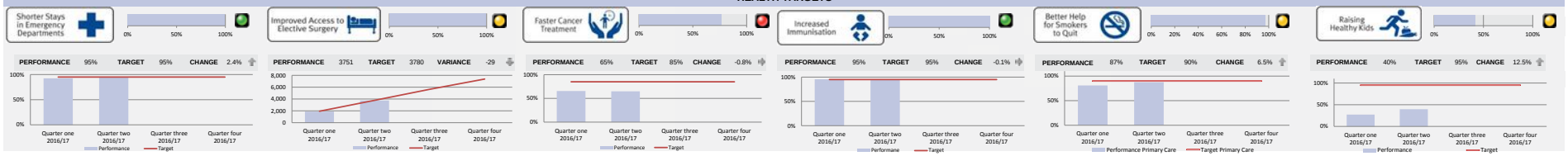
*80 April 2016 to March 2017.*

MINISTRY OF HEALTH
MANATŪ HAUORA

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

**Monitoring Status** Standard Monitoring

## HEALTH TARGETS




## IMPROVING SYSTEM INTEGRATION

### Service Reconfiguration

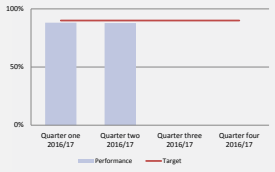
The DHB continues to invest in transforming primary and community services, including extending their rapid response teams to 7 days cover.

### System Level Measures

**Improvement Plans**

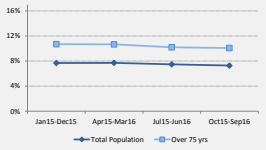
- Ambulatory sensitive hospitalisations per 100,000 for 0-4 years old
- Acute hospital bed days per capita
- Patient experience of care
- Amenable mortality rates

### More Heart and Diabetes Checks

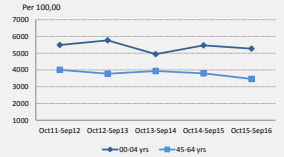



## OWNERSHIP VIEW

### Acute Readmission Rates (standardised)




### Ambulatory Sensitive Hospitalisation Rates

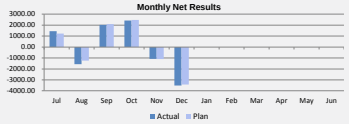



## FINANCIAL MANAGEMENT

**Financial Performance Rating:** Needs Watching

**NET RESULT:** YTD-Dec 2016

| Actual | (275) | Plan | 50 | Variance | (324) |
|---|---|---|---|---|---|




## 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% | 94% |
| **Human papillomavirus immunisation** | 70% | NA |

## WAITING TIMES

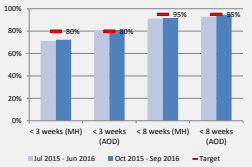
### Diagnostic waiting times

| | Goal | Performance |
|---|---|---|
| **Coronary angiography** (<90 days) | 95% | 97.7% |
| **Radiology** | | |
| CT Scan (<42 days) | 95% | 95.1% |
| MRI Scan (<42 days) | 85% | 48.0% |

| | Goal | Performance |
|---|---|---|
| **Colonoscopy** | | |
| Urgent colonoscopy (<14 days) | 85% | 91.7% |
| Non-urgent colonoscopy (<42 days) | 70% | 93.9% |
| Surveillance colonoscopy (<84 days) | 70% | 98.1% |

### Mental Health

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




### Patients Waiting For FSA and Treatment

**PATIENTS WAITING FOR FSA**

| | Oct | Nov | Dec | last mnth | 3 mnths |
|---|---|---|---|---|---|
| ESPI 2 | 6 | 7 | 49 | 42 | 43 |
| ESPI 2 % | 0.2% | 0.2% | 1.4% | 1.2% | 1.2% |

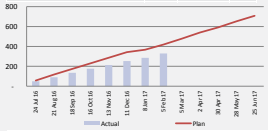
**PATIENTS WAITING FOR TREATMENT**

| | Oct | Nov | Dec | last mnth | 3 mnths |
|---|---|---|---|---|---|
| ESPI 5 | 5 | 29 | 45 | 16 | 40 |
| ESPI 5 % | 0.5% | 2.7% | 3.9% | 1.1% | 3.4% |

### Regional Provision Cardiac Surgery Delivery

**REGIONAL DELIVERY - CAPITAL & COAST DHB OF SERVICE**

PERFORMANCE AGAINST PLAN 79% VARIANCE -90




**WAITING LIST - CAPITAL & COAST DHB OF SERVICE**

| TOTAL REGIONAL WAITING LIST | 79 |
|---|---|
| % OF NATIONAL WAITING LIST | 26% |


### SERVICE COVERAGE DELIVERY

DHBs made commitments to implement the prostate cancer management and referral guidance in 2016/17 Annual Plans. This quarter the DHB confirmed progress towards implementation, providing an overview of key actions that demonstrate the DHB is integrating prostate cancer management and referral guidance into clinical pathways for prostate cancer.

## REGIONAL SERVICE DELIVERY

Quarter two 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**

### Regional Performance Highlights

The Central region received achieved ratings for eight out of eleven of its national priorities in Q2, a slight improvement in overall performance since the last quarter.

For Stroke Services, the Central region's achievements in improving stroke services is impressive. The regional implementation of the telestroke service following the pilot is excellent, supporting the delivery of equitable acute stroke care in the region.

In IT Services, the Regional Health Informatics Programme (RHIP) is still progressing on track and has moved into an implementation phase. The WebPAS functional build has been completed and planned milestones will be set for MidCentral, Whanganui & Wairarapa DHBs' implementation. The Ministry looks forward to seeing the region's progress next quarter, particularly in relation to the Clinical Portal.

### Regional Performance Issues

For Cancer Services, the Central region DHBs have not yet reached 85% (or 90%) average achievement of the Faster Cancer Treatment Health Target, therefore a partially achieved rating has been given. Current work towards this is noted by the Ministry, however further effort is required especially given that Central DHBs' average achievement rate is below the national average.

For Cardiac Secondary Services there were 1-2 patients waiting longer than 120 days in 10 weeks of Q2 and actual delivery of cardiac surgery procedures remains considerably below plan (-94). Intervention rates for angiography and cardiac surgery also remain low. The Ministry acknowledges the work the region has undertaken with the Cardiac Network, including developing the Cardiac System of Care Strategy 2016 - 2021.

The results show Capital and Coast, Hawkes Bay, Hutt Valley and Wairarapa DHBs are all behind their Electives Health Target for Q2.

The partially achieved rating is also due to waiting times performance in October and November. The Ministry looks forward to an improvement in the Central region's waiting time performance in future quarters.

## CROSS-AGENCY PRIORITIES

### Rising to the challenge

- Primary mental health
- District Suicide Prevention and Postvention

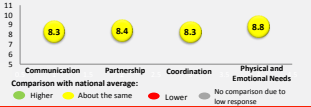
### Reducing Rheumatic fever

### Supporting vulnerable children

### Quality and Safety Markers

| | Goal | Performance | | Goal | Performance |
|---|---|---|---|---|---|
| Falls risk assessment (Jul-Sep16) | 90% | 100% | Surgical site infections (Apr-Jun 2016): | | |
| Hand hygiene (Jul-Sep16) | 80% | 88% | Antibiotic administered in the right time | 100% | 100% |
| | | | Patients receive cefazolin or cefuroxime | 95% | 99% |

### Patient Experience




### PERFORMANCE HIGHLIGHTS

The DHB has achieved the Shorter stays in emergency departments and Increased immunisation health targets this quarter. The DHB have also achieved the immunisation target at age 2 years.

The DHB has provided a comprehensive work plan regarding District suicide prevention and postvention.

### PERFORMANCE ISSUES

The DHB's achievement for the faster cancer treatment health target has not improved this quarter. The result of 65 percent places the DHB at the bottom of the DHB rankings. Strong support from senior management is needed to implement system-wide improvements to improve the quality and timeliness of cancer care.

While the region has not consistently managed the cardiac surgical waiting list in line with expectations, a partial rating has been provided overall as the Ministry acknowledges the work the Central region is undertaking to improve access to cardiac services. The Ministry look forward to improvement in future quarters.

## Delivery of the New Zealand Health Strategy - DHB Highlights for the Quarter

**People-Powered**
The Mobility Action Programme has been developed and is due to be implemented in Q3. This programme has been co- designed to meet the needs of high needs population

**Closer to Home**
The Hawke's Bay Intersectoral group Social Inclusion Draft Strategy has been developed and is currently going through a consultation period.

**Value and High Performance**
Palliative care strategy for coordinated services across HB has been developed with key stakeholders. It is currently out for consultation in community.

**One Team**
A collaborative clinical pathway for Cellulitis was developed with joint input from primary and secondary care. It has been well received in the community and in ED to changed practice and keen cellulitis admissions to a minimum.

**Smart System**
17 practices have implemented NES (National Enrolment Service). 1,562 patients have taken up patient portal.

## Delivery of the New Zealand Health Strategy - Regional Highlights for the Quarter

**People-Powered**
Mental health and addiction - Regional forum planning is including service users and whanau workers as well as DHB, NGO and Primary Care representatives to enhance people powered approaches.

**Closer to Home**
Mental health and addiction - Model of care development is enabling the delivery of services that are closer to people's homes.

**Value and High Performance**
Mental health and addiction - Scoping of all work streams is underway to identify regional priorities. Further analysis regarding wait time measure will provide additional views into this area of the sector.

**One Team**
Mental health and addiction - NGOs, Primary Care and DHBs have planned much of the first physical wellbeing forum for people with high and complex needs. This will involve multiple view point speakers to connect up the sectors.

**Smart System**
Mental health and addiction - To gain a more complete picture access data for eating disorder services is being drawn from three areas; PRIMHD, NMDS and local community team data.

18.1

## How to read this dashboard

This dashboard shows a summary of most aspects of DHB performance. It combines indicators of DHB performance, as agreed in the 2016/17 Annual Plan, as well as complementary information such as financial net results, hospital indicators and other priorities. The structure has been designed to display DHB information using an 'at-a-glance' approach. It is not to be used for general publication. It groups information according to the following areas:

| | |
|---|---|
| **Health targets** | Shows the progress made by the DHB against the health targets. The top bar chart show relative performance to target for each measure, while the time series charts absolute performance throughout the year. |
| **Improving System Integration** | This area displays information related to the progress DHBs are achieving in the implementation of the System Integration Programme. |
| **Waiting Times** | This area summarises an array of indicators that show DHB progress towards reducing waiting times. |
| **Other Priorities** | Emerging priorities such as the District Suicide Prevention and Postvention. |
| **Service coverage** | Self-reported confirmation & exception report. DHBs must ensure service coverage expectations are met, or demonstrate resolution of service coverage gaps by providing an appropriate resolution plan, and adequate progress is being made against the resolution plan. |
| **Financial Management** | Overview of the financial performance of the DHB based on data provided by the DHBs in monthly financial templates. |
| **Regional Service Delivery** | A qualitative and quantitative assessment of a progress report on behalf of the region agreed by all DHBs within that region. The report focuses on the actions agreed by each region as detailed in its RSP implementation plan. |

Each area includes one or more indicators. Definitions for those are as follow: (Definitions for health target indicators are shown in the health target summary table 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. |
| **Supporting vulnerable children** | Actions or initiatives to reduce deaths and hospitalisations due to assault, neglect or maltreatment of children and young people. |
| **Delivery of the New Zeeland Health Strategy** | All DHBs made strong commitments to the New Zealand Health Strategy in their annual plans. Each DHB and region has highlighted an action or initiative that provides an example of activity in the quarter in relation each strategy theme. |
| **Diagnostic waiting times** | Performance against the waiting time indicators for Coronary Angiography, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), and Colonoscopy. |
| **District suicide prevention and postvention** | Progress against the agreed 2015-2017 Suicide Prevention Plan is reported by describing highlights, exceptions and milestones for three of the actions, and noting any completed actions. |
| **Human papillomavirus immunisation** | Percentage of eligible girls fully immunised with human papillomavirous (HPV) vaccine. For 2016/17 the measure is the 2003 birth cohort measured at 30 June 2017. This measure is reported yearly in quarter four. |
| **Immunisation coverage at 2 and 5 years of age** | The percentage of children who have completed their age-appropriate immunisations by the age of 2 years and by the age of 5 years. The rating - indicated by the traffic light colour - is based on performance for both the 2- and 5-year-old milestones. |
| **Improved management for long term conditions** | DHBs are expected to report on delivery of the actions and milestones as identified in the 2016/17 annual plans for long term conditions (LTC), diabetes services, cardiovascular (CVD) health, acute heart service and stroke services. |
| **Improving wrap around services -Health of Older People** | DHBs are expected to report on delivery of the actions and milestones as identified in the 2016/17 annual plans for health of older people services including home and community support services, InterRAI, dementia care pathways, HOP specialists and fracture liaison services. |
| **More heart and diabetes checks** | Proportion of the eligible adult population that have had their cardiovascular disease risk assessment in the last five years. The population are PHO enrolled adults. |
| **Patient Experience** | Average rating out of 10 for inpatient experience across the four domains of communication, partnership, coordination of their care, and having physical and emotional needs met, based on results from the national patient experience survey. |
| **Patients waiting for FSA (ESPI 2)** | The total number on the waiting list waiting longer than four months for a first specialist assessment (FSA) for the last three months, and the number waiting as a % of the total list. ESPIs are the set of elective services patient flow indicators. |
| **Patients waiting for treatment (ESPI 5)** | The total number on the waiting list waiting longer than four months for treatment for the last three months, and the number waiting as a % of the total list. ESPIs are the set of elective services patient flow indicators. |
| **Primary mental health** | This measure is to monitor access to evidence-informed physiological therapies for mental health and additions issues in primary care. |
| **Quality and Safety Markers** | Progress toward the markers set by the Health Quality and Safety Commission. These include older patients receiving a falls assessment, compliance with good hand hygiene practice, and two surgical site infection measures: hip and knee replacement patients receiving 2g or more of cephazolin and antibiotic administered in the right time. |
| **Reducing rheumatic fever *** | A progress report against the DHB's rheumatic fever prevention plan (the regional plan for the South Island), plus hospitalisation rates per 100,000 DHB total population for acute rheumatic fever are 40% reduction from baseline (2009/10-2011/12). |
| **Regional delivery - cardiac** | Regional cardiac provider delivery against plan. DHBs submit four-weekly reports. |
| **Waiting list - cardiac** | Regional cardiac provider total waiting list against the waiting list target including those waiting over four months. Proportion of regional to national waiting list. DHBs submit four-weekly reports. |

| | |
|---|---|
| **Performance highlights** | Brief analysis of areas where a DHB is performing above expectations by achieving/exceeding a performance expectation, making significant progress from their base position, or implementing/leading an innovation process that will lead to performance improvement. |
| **Performance issues** | Brief analysis of areas where a DHB is performing below expectations, and actions being taken to resolve the issue(s) |

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

**** West Coast result of health target *raising healthy kids* is based on low volumes, 6 children identified as obese were not referred.**

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

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

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

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

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Annual Māori Health Plan Q3 (Jan- Mar 17) Dashboard Report** 55 |
| | For the attention of: **HBDHB Board** |
| Document Owners: | Tracee Te Huia, ED, Strategy & Health Improvement |
| Document Author(s): | Patrick Le Geyt, Acting General Manager Māori Health<br>Justin Nguma, Senior Health & Social Policy Advisor<br>Peter Mackenzie, Operational Performance Analyst |
| Reviewed by: | Executive Management Team; HB Clinical Council and HB Health Consumer Council |
| Month: | May 2017 |
| Consideration: | For Monitoring |

**RECOMMENDATION**

**That HBDHB Board:**

Note the contents of this report.

19

## OVERVIEW

The purpose of this paper is to provide MRB, HB Clinical Council, HB Consumer Council and the HBDHB Board with exception report for Quarter 3 on the implementation of the 2016 – 2017 Annual Māori Health Plan. A quick reference summary dashboard will be supplied prior to the meeting and shows our position as at the end of Quarter 3 for all indicators. The dashboard uses traffic light methodology with detailed information and symbols for all indictors. For example, in a situation where the performance of the indicator for the current quarter is higher than the previous quarter this symbol '▲' will be used to show an upward trend while an opposite symbol '▼' will be used to show a downward trend. In cases where the variance to the annual target for the indicator is greater than 0.5% this symbol **'U'***(indicated on the dashboard in red)* will be used to indicate unfavourable trend and **'**F' for favourable trend*(indicated on the dashboard in green colour)*toward the annual target *(see the table below).*

## KEY FOR DETAILED REPORT AND DASHBOARD

| | |
|---|---|
| **Baseline** | Latest available data for planning purpose |
| **Target 2015/16** | Target 2016/17 |
| **Actual to date** | Actual to date |
| **F (Favourable)** | Actual to date is favourable to target |
| **U (Unfavourable)** | Actual to date is unfavourable to target |
| **Trend direction ▲** | Performance is improving against the previous reporting period or baseline |
| **Trend direction ▼** | Performance is declining |
| **Trend direction -** | Performance is unchanged |
| | |

## 2016-2017 ANNUAL MĀORI HEALTH PLAN QUARTER 3 PERFORMANCE HIGHLIGHTS

### *Achievements*

1. Immunization rates for 8 months old Māori for Q3 have increased from 94.4% in Q2 to 95.4% in Q3, trending above the expected target of ≥ 95%. There is no disparity gap for Māori in Q3 with non-Māori at 93.5%.

   This success is attributed to primary care and the Outreach Immunisation Services (OIS). OIS effective use of NIR database to track down children that are due for immunisation, collaboration across the sector and effective engagement with whānau, ensures children are immunised on time.

### *Areas of progress*

1. Māori children with BMI in 98th percentile at B4SC referred to a health professional for nutritional advice increased rapidly from 44% in Q2 to 84% in Q3 and is trending towards the expected target of ≥ 95% by Q2 2017/18. There is no disparity gap for Māori in Q3 with non-Māori at 73%.

   Progress is due to 100% of referrals acknowledged, referral pathways established, workshops to engage key partners delivered and nutrition tools now available in all practices are being used. Activities to target Māori are well developed. Provider contracts to deliver activity and nutrition programmes (Active Families Under 5, Maternal Healthy Weight, breastfeeding support) have targets for Māori engagement and resources developed have been tested with Māori whanau.

2. The number of Māori enrolled with HHB PHO increased slightly from 96.8% in Q2 to 97.5% in Q3 and trending positively towards the target of ≥ 100%. This brings the disparity gap between Māori and non-Māori for Q3 to 0.1%.

   The enrolment increase over the last 12 months is attributed to the High Needs Enrolment programme for those consumers who are not enrolled. HHB will continue to promote the programme to encourage enrolment with HHB General Practices.

3. Cancer screening services for Māori women are moving steadily towards the expected targets and the disparity gap narrowing. Cervical screening for 25-69 year old Māori women for Q3 was 73.1% up from 72.8% in Q2 remaining beneath the expected target of ≥ 80%. The disparity gap is 4.7% between Māori and non-Māori compared to 6% recorded in Q2.

   The increased coverage in cervical screening is attributed to health sector collaboration, cervical screening campaigns and use of Māori providers.

4. Breast screening for 50-69 year old Māori women for Q3 was 66.7% up from 64.7% in Q2 and is trending positively towards the target of ≥ 70%. The disparity gap between Māori and non-Māori in Q3 was 8.2% compared to 10.3% recorded in Q2.

   Coverage to the end of March has not been released by Breast Screening Aotearoa. Efforts are, however, focused on improving services through Breast Screening mobile vans as agreed with Breast Screening Coast to Coast for priority women.

5. Access to referral services for Alcohol and Other Drugs for 0-19 year old Māori within 3 weeks remained at 74.1% in Q3 and under the expected target of ≥ 80%. Access to referral services for Alcohol and Other Drugs for 0-19 year old Māori within 8 weeks decreased from 93.6% in Q2 to 92% in Q3 and remains under the expected target of ≥ 95%. There is no disparity gap between Māori and non-Māori in Q3 with non-Māori at 72.3% (3 weeks) and 91.8% (8 weeks) respectfully.

   Mental Health Services continue to work closely with other providers to improve and maintain results through staffing and capacity building for NGO and primary sector.

6. SUDI rates per 100,000 for Māori children decreased from 2.09 in Q3 2015/16 to 1.34 in Q3 2016/17. The disparity gap between Māori and non-Māori was 0.53 in Q3 of 2016/17 compared to 1.5 recorded in Q3 of 2015/16.

7. Māori Workforce grew by less than 0.5% from 13% in Q2 to 13.5% in Q3 trending towards the expected target of 13.75% or 9 employees to the target of 409 Māori staff.

Māori Workforce Recruitment Steering Committee, which has oversight for recruitment of Māori, is currently implementing a Māori workforce recruitment plan. Monthly progress reports are sent to EMT, HS directorates and nursing and allied health management for information and action as needed.

***Challenges***

1. Acute hospitalization for Rheumatic Fever has risen from 7.3 in Q1 to 9.64 in Q3 and trending away from the expected target of ≤1.5. The disparity gap between Māori and non-Māori in Q3 was 6.54 up from 4.82 in Q1 (Figure 1).

   There has been one case in an area outside of the screening campaign localities. A Rheumatic Fever Community Awareness Campaign is being implemented in Q4 in Māori, Pacific and high needs communities that aims to improve health literacy and service navigation.

2. Breastfeeding rates for Māori remain stagnant. Breastfeeding at 6-weeks was 66% in Q3 and remains below the expected target of ≥ 75%. Similarly, the 3 month result in Q3 of 39% remains below the ≥ 60% target and the 6 month result in Q3 of 50% remains below the ≥ 65% target. The disparity gap between Māori and non-Māori in Q3 was 6% at 3 weeks, 12% at 3 months and 11% at 6 months (Figure 2).

   Te Ara Whakawaiora Champion's report, tabled this quarter, contains a set of recommendations to improve breastfeeding support services for Māori post discharge from Maternity Services. An update on progress is expected by quarter 4.

3. Pre-school oral health enrolment rates for Māori children slipped by 1.4% over the last 12 months bringing the Māori enrolment rates to 72.7% against an expected target of ≥ 95%. The disparity gap between Māori and non-Māori currently stands at 34.3% (Figure 3).

4. The percentage of Māori women who are smoke free at two weeks postnatal (data from the Well Child/Tamariki Ora Quality Indicator) remained at 65.6% as per Q2 data which was received by DHB in February in Q3 (Figure 4).

   HBDHB maternity and smokefree teams are currently working in collaboration to engage GP Practices to increase referrals at point of pregnancy confirmation through Increasing Smokefree Pregnancy Programme (ISPP). 20 / 28 GP Practices have received training and resources to support early referrals through ISPP, an initiative that started in November 2016.

5. Māori under Mental Health Act compulsory treatment orders (CTO) has decreased slightly from 179.9 per 100,000 population in Q2 to 175.1 in Q3. However, the indicator is tracking behind the expected target of ≤ 81.5 with a disparity gap of 108 between Māori and non-Māori in Q3 compared to 118.1 in Q2 (Figure 5).

   Improvement efforts are focused on working with Health Hawke's Bay PHO in their new model of care; and partnering with police, whose referrals to the service continue to increase. There are also some renewed commitment to work together across the sector.

6. The Māori staff cultural competency training remained relatively stagnant across all occupational groupings and consequently as a whole grew only 0.2% from 80.7% in Q2 to 80.9% in Q3. Medical and Support Staff remain well below the expected target of ≥ 100% with 37.5% and 64.9% respectively (Figure 6).

   The engaging effectively with Māori training is fully available to all staff and all new staff are supported to attend as part of their orientation package.

**Please note:**

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

**ANNUAL MĀORI HEALTH PLAN, QUARTER 3 JANUARY – MARCH 2017 DASHBOARD REPORT**

## Immunisation

| Indicator | Baseline | Prior period result | Actual to date Maori | Actual to date Other | Period target | Individual Numbers to Target (approx) | Time Series Trend (12 months) | Desired Trend |
|---|---|---|---|---|---|---|---|---|
| Immunisation at 8 Months (3m) | 92.6% | 94.4% | 95.4% | 93.5% | ≥ 95% | 1 | | ↑ |
| 65+ Influenza (12m) | 68.0% | 56.5% | - | - | ≥ 75% | - | | ↑ |

## Rheumatic Fever

| Indicator | Baseline | Prior period result | Actual to date Maori | Actual to date Total | Period target | Individual Numbers to Target (approx) | Time Series Trend (12 months) | Desired Trend |
|---|---|---|---|---|---|---|---|---|
| Hospitalisation rate (6m) | 2.48 | 7.23 | 9.64 | 3.1 | ≤ 1.5 | -1 | | ↓ |

## Breastfeeding

| Indicator | Baseline | Prior period result | Actual to date Maori | Actual to date Total | Period target | Individual Numbers to Target (approx) | Time Series Trend | Desired Trend |
|---|---|---|---|---|---|---|---|---|
| QIF Data (6m) | | | | | | | | |
| At 6 Weeks | 58.0% | 67.0% | 66.0% | 72.0% | ≥ 75% | - | | ↑ |
| At 3 months | 46.0% | 39.0% | 39.0% | 51.0% | ≥ 60% | - | | ↑ |
| At 6 months | 46.0% | 48.0% | 50.0% | 61.0% | ≥ 65% | - | | ↑ |

## SUDI

| Indicator | Baseline | Prior period | Actual to date Maori | Actual to date Other | Period target | Individual Numbers | Time Series Trend | Desired Trend |
|---|---|---|---|---|---|---|---|---|
| Rate per 100,000 (12m) | 2.09 | 2.09 | 1.34 | 0.81 | ≤ 0.4 | | | ↓ |
| Caregivers given SUDI Prevention Info (12m) | 72.8% | 72.8% | - | - | ≥ 100% | | | ↑ |

## Oral Health

| Indicator | Baseline | Prior period | Actual to date Maori | Actual to date Other | Period target | Individual Numbers | Time Series Trend | Desired Trend |
|---|---|---|---|---|---|---|---|---|
| Pre-school enrolment rate (12m) | 65.3% | 74.1% | - | - | ≥ 95% | - | | ↑ |
| % Caries Free at 5yrs (12m) | 36.0% | 36.0% | 44.0% | 74.0% | ≥ 67.0% | -200 | | ↑ |

## Tobacco

| Indicator | Baseline | Prior period | Actual to date Maori | Actual to date Other | Period target | Individual Numbers | Time Series Trend | Desired Trend |
|---|---|---|---|---|---|---|---|---|
| Smokefree 2 weeks postnatal (6m) | 53.0% | 65.6% | 65.6% | 80.0% | ≥ 95.0% | -126 | | ↑ |

## Mental Health & Addictions

| Indicator | Baseline | Prior period | Actual to date Maori | Actual to date Other | Period target | Individual Numbers | Time Series Trend | Desired Trend |
|---|---|---|---|---|---|---|---|---|
| Mental Health Act community treatment orders (per 100,000) (3m) | 196 | 176.7 | 175.1 | 67.1 | ≤ 81.5 | - | | ↓ |

## Access to Care

| Indicator | Baseline | Prior period result | Actual to date Maori | Actual to date Other | Period target | Individual Numbers to Target (approx) | Time Series Trend (12 months) | Desired Trend |
|---|---|---|---|---|---|---|---|---|
| PHO Enrolment (3m) | 97.2% | 96.8% | 97.5% | 97.6% | ≥ 100% | -1041 | | ↑ |

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

## ASH Rates

| Indicator | Baseline | Prior period result | Actual to date Maori | Actual to date Other | Period target | Individual Numbers to Target (approx) | Time Series Trend (12 months) | Desired Trend |
|---|---|---|---|---|---|---|---|---|
| 0-4 years (6m) | 82.1% | 84.9% | - | - | ≤ 82.0% | - | | ↓ |
| 45-64 years (6m) | 172.0% | 211.3% | - | - | ≤ 138% | - | | ↓ |

## Cancer

| Indicator | Baseline | Prior period | Actual to date Maori | Actual to date Other | Period target | Individual Numbers | Time Series Trend | Desired Trend |
|---|---|---|---|---|---|---|---|---|
| Cervical screening (25-69 yrs) (3m) | 74.1% | 72.8% | 73.1% | 77.8% | ≥ 80.0% | -627 | | ↑ |
| Breast screening (50-69 yrs) (3m) | 68.4% | 64.7% | 66.7% | 74.9% | ≥ 70.0% | -56 | | ↑ |

## Maori Workforce

| Indicator | Baseline | Prior period result | Actual to date Maori | Period target | Individual Numbers to Target (approx) | Time Series Trend | Desired Trend |
|---|---|---|---|---|---|---|---|
| Medical | 2.9% | 4.2% | 4.7% | ≥ 13.8% | | | |
| Management & Administration | 16.5% | 17.2% | 19.1% | ≥ 13.8% | | | |
| Nursing | 10.6% | 11.3% | 11.6% | ≥ 13.8% | | | |
| Allied Health | 12.6% | 13.5% | 13.2% | ≥ 13.8% | | | |
| Support Staff | 28.2% | 28.2% | 29.3% | ≥ 13.8% | | | |
| Māori staff - HBDHB (3m) | 12.3% | 13.0% | 13.5% | ≥ 13.8% | - | | ↑ |

## Cultural Responsiveness

| Indicator | Baseline | Prior period result | Actual to date | Period target | Individual Numbers to Target (approx) | Time Series Trend | Desired Trend |
|---|---|---|---|---|---|---|---|
| Medical | 19.2% | 37.7% | 37.5% | ≥ 100.0% | | | |
| Management & Administration | 79.1% | 88.4% | 88.5% | ≥ 100% | | | |
| Nursing | 70.0% | 85.4% | 85.6% | ≥ 100% | | | |
| Allied Health | 77.3% | 89.2% | 89.9% | ≥ 100% | | | |
| Support Staff | 35.6% | 64.9% | 64.9% | ≥ 100% | | | |
| HBDHB (3m) | 65.6% | 80.7% | 80.9% | ≥ 100% | - | | ↑ |

## Obesity

| Indicator | Baseline | Prior period result | Actual to date Maori | Actual to date Other | Period target | Individual Numbers to Target (approx) | Time Series Trend | Desired Trend |
|---|---|---|---|---|---|---|---|---|
| Referred for Nutrition (3m) | 30.0% | 44.0% | 84.0% | 73.0% | ≥ 95.0% | -9 | | ↑ |
| Bariatric Surgery (3m) | 7 | 0 | 0 | 0 | - | 0.00 | | - |

## Alcohol and Other Drugs

| Indicator | Baseline | Prior period result | Actual to date Maori | Actual to date Other | Period target | Individual Numbers to Target (approx) | Time Series Trend | Desired Trend |
|---|---|---|---|---|---|---|---|---|
| % of 0-19 year olds seen within 3 weeks of referral (3m) | 63% | 74.1% | 74.1% | 72.3% | ≥ 80% | - | | ↑ |
| % of 0-19 year olds seen within 8 weeks of referral (3m) | 86.5% | 93.6% | 92.0% | 91.8% | ≥ 95.0% | - | | ↑ |

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Human Resource KPIs (Q3 January-March 2017)** 56 |
| | For the attention of: **HBDHB Board** |
| Document Owner:<br>Document Author: | Kate Coley, Executive Director of People and Quality<br>Jim Scott, Workforce Analyst |
| Reviewed by: | Executive Management Team |
| Month: | May 2017 |
| Consideration: | Monitoring |

**RECOMMENDATION**

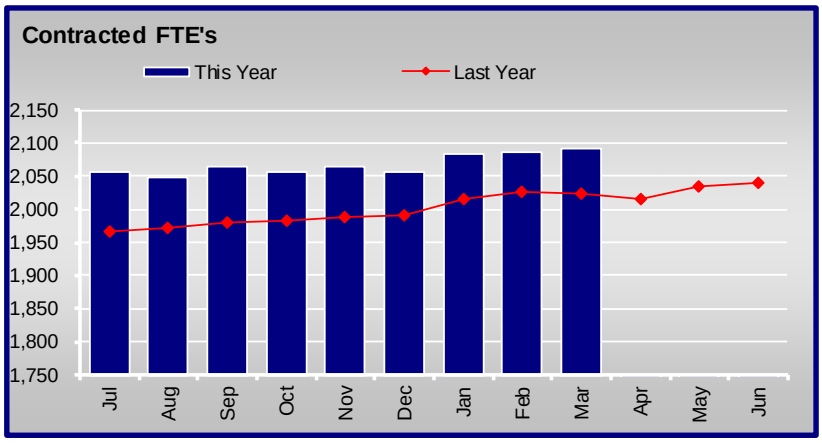
**That the HBDHB Board:**

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

20

## Headcount and positions

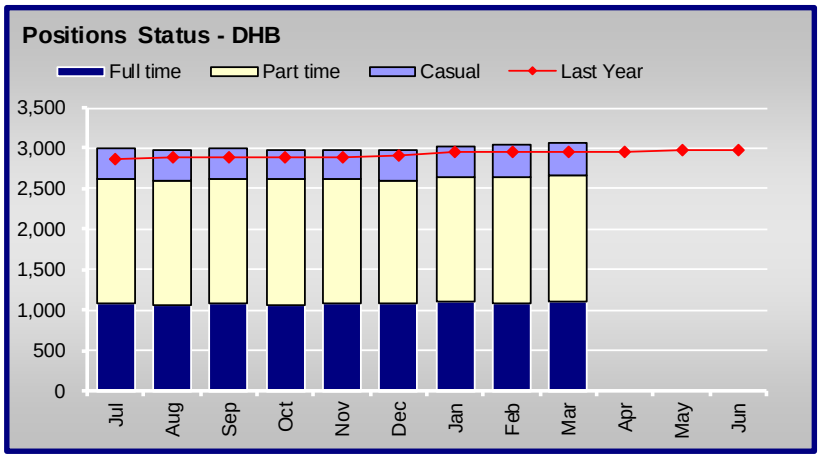
Reporting on headcount/ positions is a snapshot in time rather than an average for the month or year.




Contracted FTEs
2091.4 at 31 Mar. 2017
2022.3 at 31 Mar. 2016
= 3.4% increase

Overall increases/ (decreases)

| | FTE | |
|---|---|---|
| Medical | 17.7 | 7.3% |
| Nursing | 22.7 | 2.7% |
| Allied Health | 12.1 | 2.8% |
| Support | 0.0 | 0.0% |
| Mge. & Admin | 16.6 | 4.4% |
| **Total** | **69.1** | **3.4%** |




Positions filled:
3062 at 31 Mar. 2017
2948 at 31 Mar. 2016
= 3.9% increase (114 positions)

Of the 3062 positions (last year in brackets):
36% are full-time (36%)
51% are part-time (51%)
13% are casual (13%)

**Overall increases/ (decreases) – breakdown of 3.9% increase**

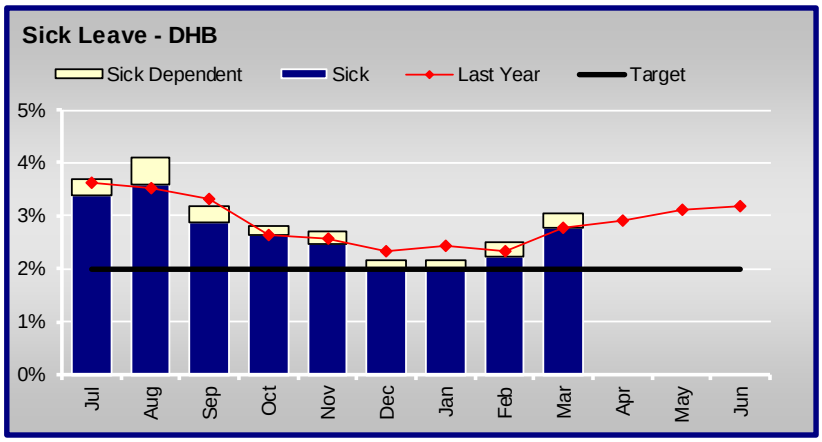
| | Full time | Part time | Casual | Total | % change |
|---|---|---|---|---|---|
| Medical | 23 | (7) | 3 | 19 | 6.8% |
| Nursing | (2) | 37 | 15 | 50 | 3.4% |
| Allied Health | 10 | 2 | 9 | 21 | 3.8% |
| Support | 0 | 1 | (2) | (1) | (0.5%) |
| Management & Admin | 4 | 18 | 3 | 25 | 5.6% |
| **Totals** | **35** | **51** | **28** | **114** | **3.9%** |

## Sick Leave

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

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

Target is 2.00%



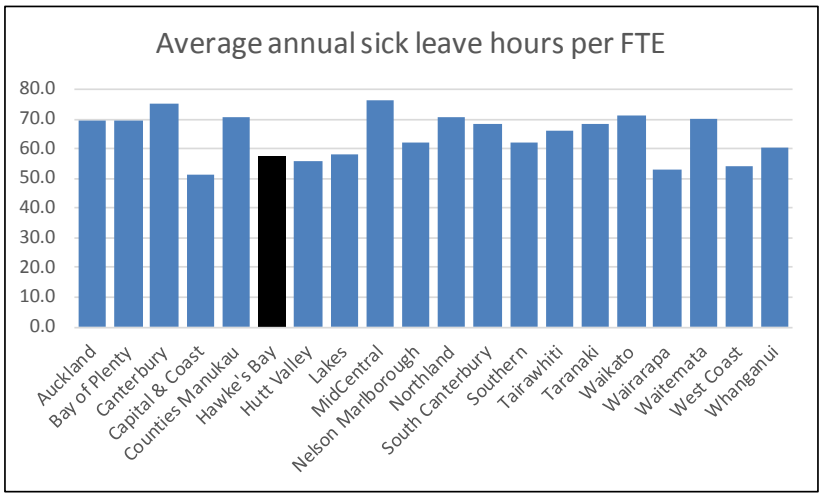

Mar 2017 = 3.03%
Mar 2016 = 2.78%

YTD Mar '17 = 2.93%
YTD Mar '16 = 2.83%

DHBSS have taken over reporting of the 20 DHB Comparisons and report on the average annual sick leave hours per FTE (to 31 December 2016). Hawke's Bay DHB rank:

5th lowest of the 20 DHBs.

2nd lowest of the 6 mid-sized DHBs




20

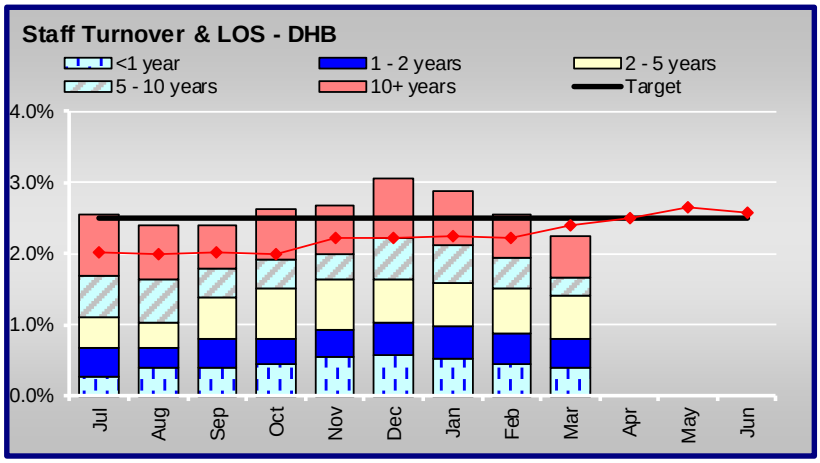
## Staff Turnover

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

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

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

Target is 2.50% per quarter.




3 months ended Mar '17 = 2.24% which is within the target of 2.50%.

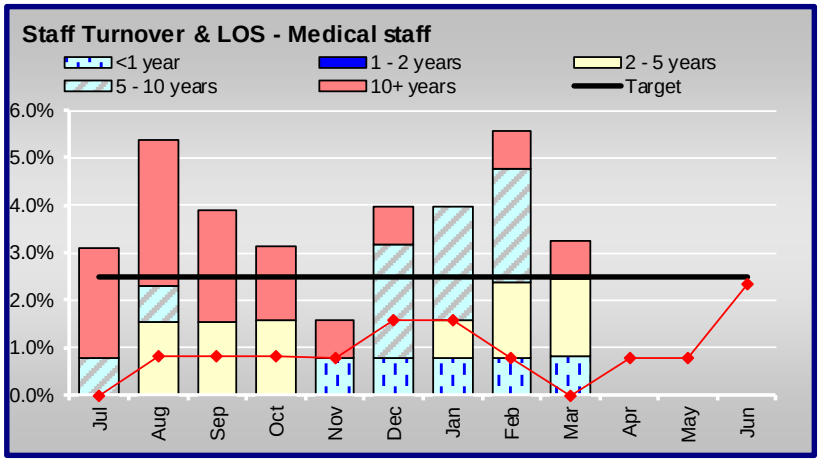
12 months to Mar '17 = 10.31% which is above the 10% annual target. See reasons below.

| | |
|---|---|
| 2278 | Staff at 1 Jan '17 |
| 68 | New Staff |
| (54) | Staff resignations |
| 27 | Change of status – mostly fixed term to permanent |
| 2319 | Staff at 31 Mar '17 |

| Reasons for leaving included in Staff Turnover | Quarter | Last 12 months |
|---|---|---|
| Moving to a position outside HBDHB | 13 | 58 |
| Relocating outside HB | 13 | 39 |
| Retirement | 6 | 50 |
| Not returning from parental leave | 0 | 8 |
| Personal | 5 | 14 |
| Family reasons | 2 | 10 |
| Further education | 2 | 4 |
| Other reasons | 8 | 27 |
| Unknown reason | 2 | 22 |
| **Total** | **51** | **232** |

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

## Staff Turnover – Medical Staff




3 months ended Mar '17 = 3.25% which is above the 2.50% target. See reasons below.

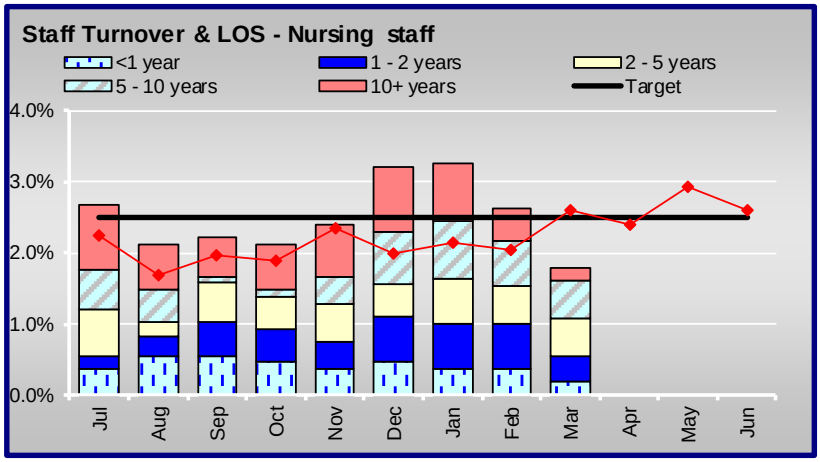
12 months to Mar '17 = 13.18% which is above the 10% annual target. See reasons below.

| | |
|---|---|
| 123 | Staff at 1 Jan '17 |
| 7 | New Staff |
| (4) | Staff resignations |
| 1 | Change of status – casual to permanent |
| 0 | Trf other staff group |
| 127 | Staff at 31 Mar '17 |

| Reasons for leaving included in Staff Turnover | Quarter | Last 12 months |
|---|---|---|
| Moving to a position outside HBDHB | 2 | 7 |
| Relocating outside HB | 2 | 2 |
| Retirement | | 5 |
| Personal | | 1 |
| Other reasons | | 1 |
| Unknown reason | | 1 |
| **Total** | **4** | **17** |

20

## Staff Turnover – Nursing Staff




3 months ended Mar '17 = 1.79% which is below the target of 2.50%.

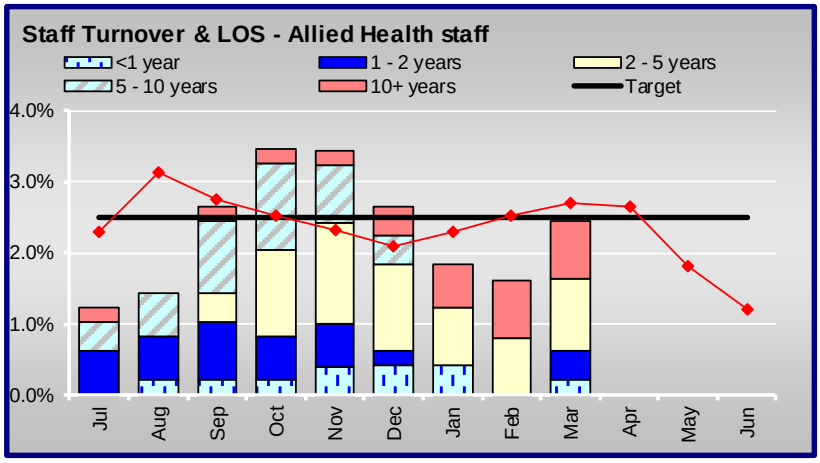
12 months to Mar '17 = 9.91% which is below the 10% annual target.

| | |
|---|---|
| 1116 | Staff at 1 Jan '17 |
| 27 | New Staff |
| (20) | Staff resignations |
| 14 | Change of status – mostly fixed term to permanent |
| (2) | Trf other staff group |
| 1135 | Staff at 31 Mar '17 |

| **Reasons for leaving included in Staff Turnover** | **Quarter** | **Last 12 months** |
|---|---|---|
| Moving to a position outside HBDHB | 5 | 22 |
| Relocating outside HB | 7 | 21 |
| Retirement | 2 | 26 |
| Not returning from parental leave | 0 | 5 |
| Personal | 2 | 5 |
| Family reasons | 0 | 5 |
| Other reasons | 3 | 15 |
| Unknown reason | 1 | 8 |
| **Total** | **20** | **107** |

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

## Staff Turnover – Allied Health Staff




3 months ended Mar '17 = 2.44% which is below the 2.50% target.

12 months to Mar '17 = 8.91% which is below the 10% annual target.

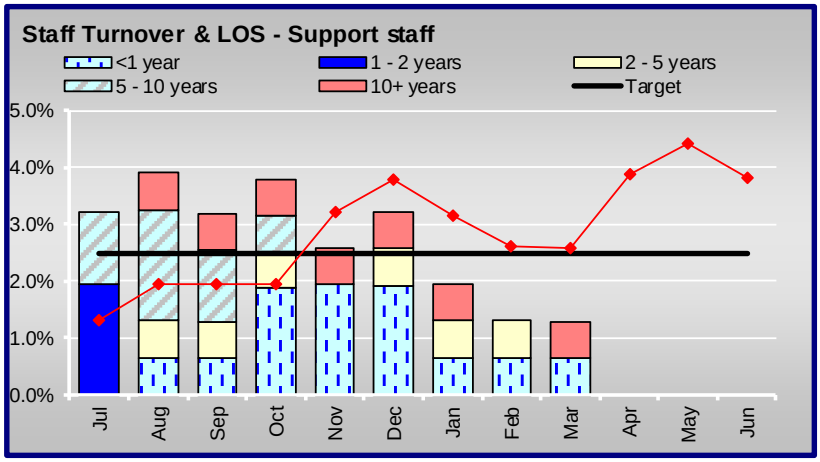
| | |
|---|---|
| 491 | Staff at 1 Jan '17 |
| 14 | New Staff |
| (14) | Staff resignations |
| 4 | Change of status – fixed term or casual to permanent |
| 1 | Trf other staff group |
| 496 | Staff at 31 Mar '17 |

| **Reasons for leaving included in Staff Turnover** | **Quarter** | **Last 12 months** |
|---|---|---|
| Moving to a position outside HBDHB | 1 | 10 |
| Relocating outside HB | 3 | 9 |
| Retirement | 1 | 5 |
| Not returning from parental leave | 0 | 2 |
| Personal | 2 | 4 |
| Family reasons | 0 | 2 |
| Further education | 1 | 1 |
| Other reasons | 4 | 7 |
| Unknown reasons | 0 | 4 |
| **Total** | **12** | **44** |

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

20

## Staff Turnover – Support Staff



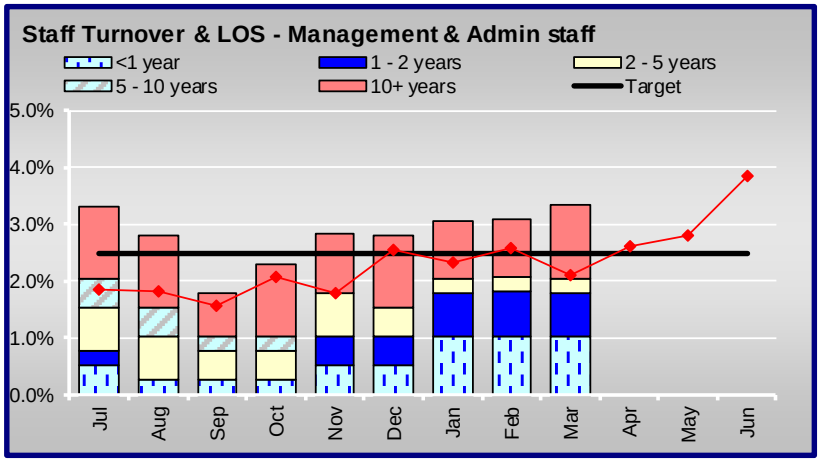

3 months ended Mar '17 = 1.27% which is below the 2.50% target.

12 months to Mar '17 = 11.46% which is above the 10% annual target. See reasons below.

| | |
|---|---|
| 157 | Staff at 1 Jan '17 |
| 3 | New Staff |
| (2) | Staff resignations |
| (1) | Change of status – casual to permanent |
| 0 | Trf. other staff group |
| 157 | Staff at 31 Mar '17 |

| Reasons for leaving included in Staff Turnover | Quarter | Last 12 months |
|---|---|---|
| Moving to a position outside HBDHB | 1 | 6 |
| Relocating outside HB | | 2 |
| Retirement | 1 | 2 |
| Not returning from parental leave | | 1 |
| Personal | | 2 |
| Family reasons | | 1 |
| Further education | | 1 |
| Other reasons | | 1 |
| Unknown reason | | 2 |
| **Total** | **2** | **18** |

## Staff Turnover – Management & Administration Staff




3 months ended Mar '17 = 3.32% which is above the 2.50% target. See reasons below.

12 months to Mar '17 = 11.76% which is above the 10% annual target. See reasons below.

| | |
|---|---|
| 391 | Staff at 1 Jan '17 |
| 17 | New Staff |
| (14) | Staff resignations |
| 9 | Change of status – mostly fixed term to permanent |
| 1 | Trf from staff groups |
| 404 | Staff at 31 Mar '17 |

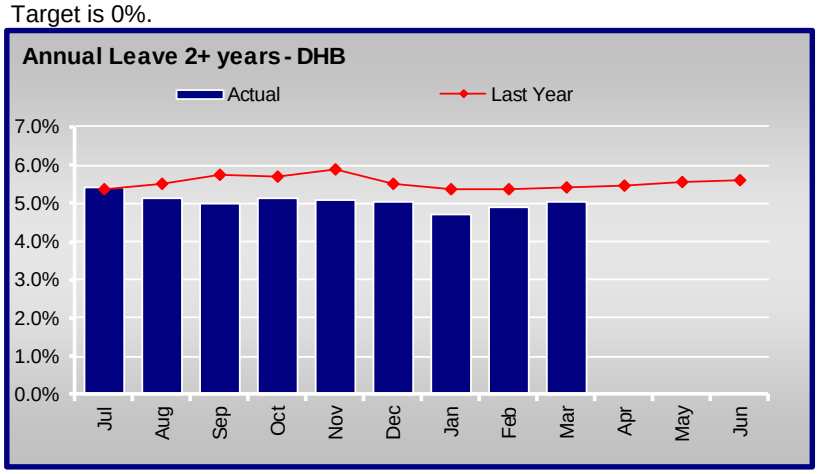
| Reasons for leaving included in Staff Turnover | Quarter | Last 12 months |
|---|---|---|
| Moving to a position outside HBDHB | 4 | 12 |
| Relocating outside HB | 1 | 5 |
| Retirement | 2 | 13 |
| Personal | 1 | 2 |
| Further education | 1 | 2 |
| Other reasons | 3 | 5 |
| Unknown reason | 1 | 7 |
| **Total** | **13** | **46** |

20

## Accrued Annual Leave (2+ years)

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

Target is 0%.




Mar '17 = 5.04% (134 staff)
Mar '16 = 5.43% (140 staff)
Decreased by 6

The total liability at 31 March 2017 was $18.338m compared to $18.776m at 30 June 2016. This $437k improvement is made up of:

1. $549k favourable driven by a decrease in the hours owing.
2. ($112k) unfavourable driven by an increase in the average rates.

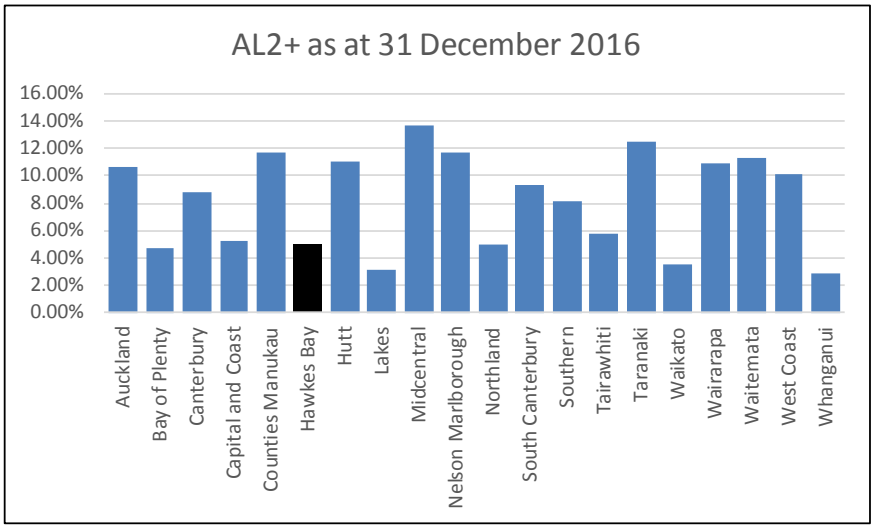
Note also that while the total leave hours owed (includes statutory lieu leave etc.) has increased in the last year, the average leave balance has reduced:

| | Total Hours Owed | Employees with leave balance | Average Leave balance (hours) |
|---|---|---|---|
| Mar. 2017 | 433,081 | 2661 | 162.75 |
| Mar. 2016 | 426,098 | 2581 | 165.09 |

DHBSS have taken over reporting of the 20 DHB Comparisons and report on the annual leave percentage of employees with 2+ years of annual leave owing (at 31 December 2016). Hawke's Bay DHB rank:

6th lowest of the 20 DHBs.

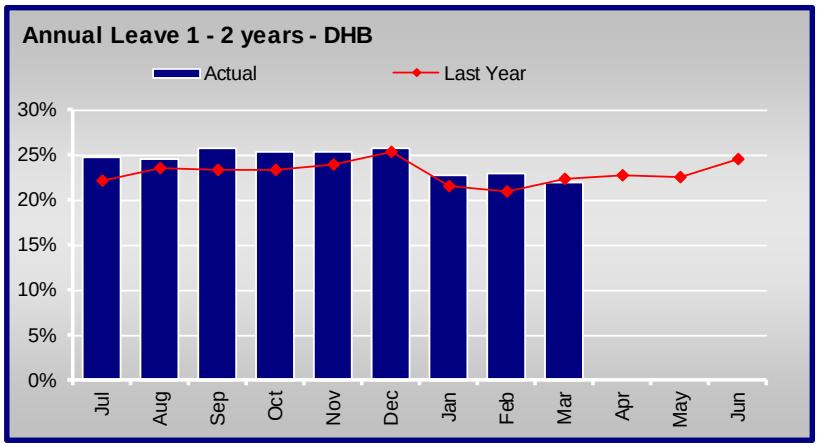
3rd lowest of the 6 mid-sized DHBs



## Accrued Annual Leave (1 – 2 years)

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

Target is 15%.




Mar '17 = 21.97% (584 staff)
Mar '16 = 22.24% (573 staff)
Increased by 11 but the percentage of total staff decreased.

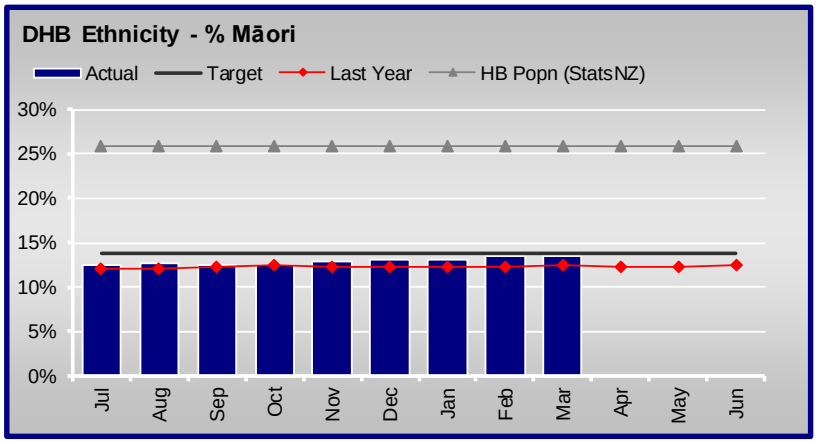
20

## Staff Ethnicity

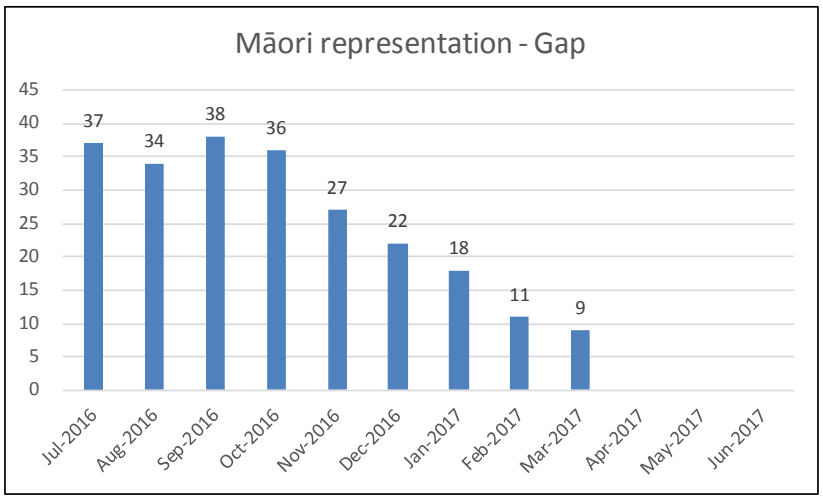
*Measure the number of positions at HBDHB where the incumbents identify themselves as Māori*

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

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




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




Māori staff representation in the Workforce:

| | People | Positions |
|---|---|---|
| Mar. '17 | 13.86% | 13.46% |
| Mar. '16 | 12.89% | 12.38% |

March 2017 breakdown:

| | Positions filled | % of Total |
|---|---|---|
| NZ & European | 2292 | 74.85% |
| Maori | 412 | 13.46% |
| Pacific Islands | 32 | 1.04% |
| Other | 260 | 8.49% |
| Not known | 66 | 2.16% |
| **Total** | **3062** | |

Support staff (29.26%) and Management & Admin staff (19.11%) exceed the DHB target.

Allied Health (13.20%) Medical (4.71%) and Nursing staff (11.57%) are below the target.

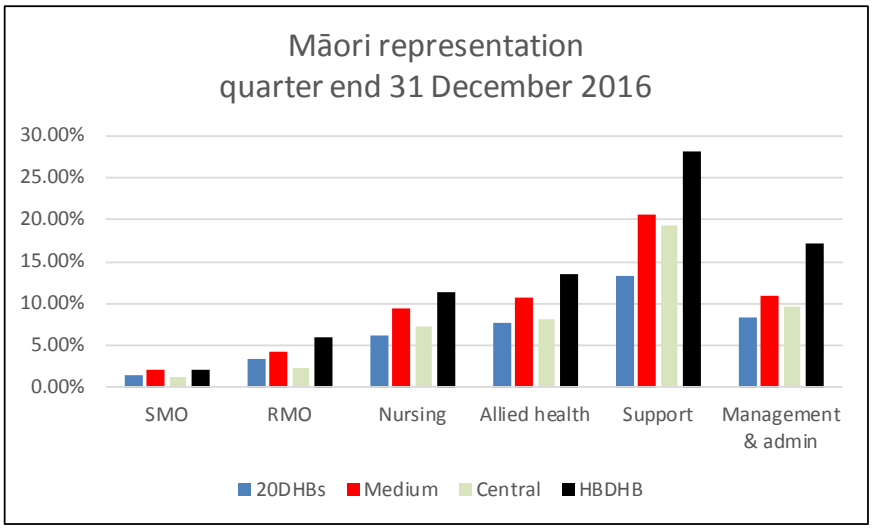
The gap to our target sits at 9 at 31 March 2017 (4 at 30 April 2017).

| | |
|---|---|
| 387 | Māori Staff - 1 Jan. '17 |
| 38 | New Staff |
| (15) | Staff resignations |
| 2 | Changes to ethnicity |
| 412 | Māori Staff – 31 Mar. '17 |

DHBSS have taken over reporting of the 20 DHB Comparisons and report on Ethnicity figures (to 31 December 2016).

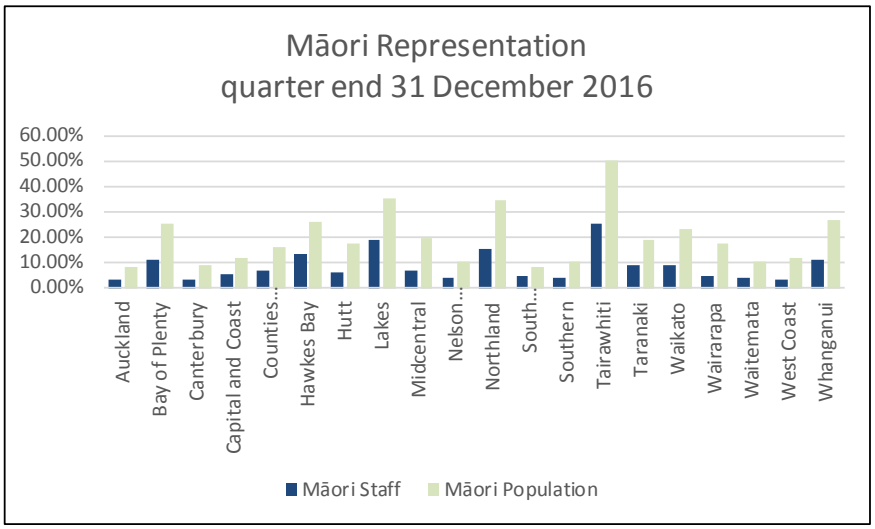
The first chart shows that Hawke's Bay DHB compares favourably against:

- 20 DHB average
- Medium sized DHBs
- Central Region DHBs






The next chart shows how DHBs compare against the Māori population. At 31 December 2016 Hawkes' Bay DHB had 13.02% of employees identifying as Maori against the HB Māori population of 25.9% so was 50.3% representative. This ranked Hawke's Bay at 4th best of the 20 DHBs.



| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Te Ara Whakawaiora: Access (ASH Rates 45-64 years)** 57 |
| | For the attention of: **HBDHB Board** |
| Document Owner: | Dr Mark Peterson, Chief Medical Officer - Primary |
| Document Author(s): | Jill Garrett, Strategic Services Manager – Primary Care |
| Reviewed by: | Paul Malan, Acting Strategic Services Manager and the Maori Relationship Board |
| Month: | May 2017 (Addendum to March report) |
| Consideration: | For Monitoring |

**RECOMMENDATION**

**That the HBDHB Board**

Note the contents of this report, in relation to the report received in March 2016

**Summary of actions to address recommendations of March Te Ara Whakawaiora Report - ASH rates 45-64**

21

In the March report the following recommendations were made to address the equity gap within the ASH indicators 45-64 pertaining to; Cardiac conditions, Respiratory and Cellulitis.

Progress against these recommendations and actions is documented below.

**Cardiac:**

Heart Failure:
An Intern Nurse Practitioner role description is being scripted by a nurse consultant engaged by the cardiac services. The recruitment will take place post July 1st spend freeze. The role will be shared between primary and secondary care to facilitate cardiac management across the sector. Leading this recruitment is the clinical nurse manager of the cardiology service. Issues arose in identifying candidates working at the scope of the original role description for a Nurse practitioner. Building capacity within the service using existing and growing expertise was considered when recruitment was unsuccessful.

Smoking cessation:
Mandatory fields within the practice management system have been created to ensure Smoking Brief Advice (SBA) is part of the routine consult within primary care. Currently the smoking cessation for SBA is 86% vs a target of 90%.

| Target Performance | Practice numbers |
|---|---|
| Achieved target | 12 |
| > 10% of target | 12 |
| < 10% of target | 4 |
| Total Practices within Health Hawke's Bay | 28 |

Consolidated work is underway with 4 practices who remain outside the 10% Target range. Independent nurses have been contracted to work with 9 practices to update 549:3250 current smoker status and offering brief advice.

Prevention and early Intervention:

- Screening of the eligible population for CVRA (Cardio Vascular Risk Assessment is on track at 89% with a target of 90%.
- Collaborative (Clinical) Pathways work continues familiarising primary and secondary care with not only clinical guidelines to management but linking into patient self-management strategies. The congestive Heart Failure pathway has been developed and socialised.
- A CME/CNE session on CHF was co facilitated by the HBDHB Cardiologist, General Practitioner, and LTC Portfolio Manager. It was very well attended and has generated good feedback.

Management:

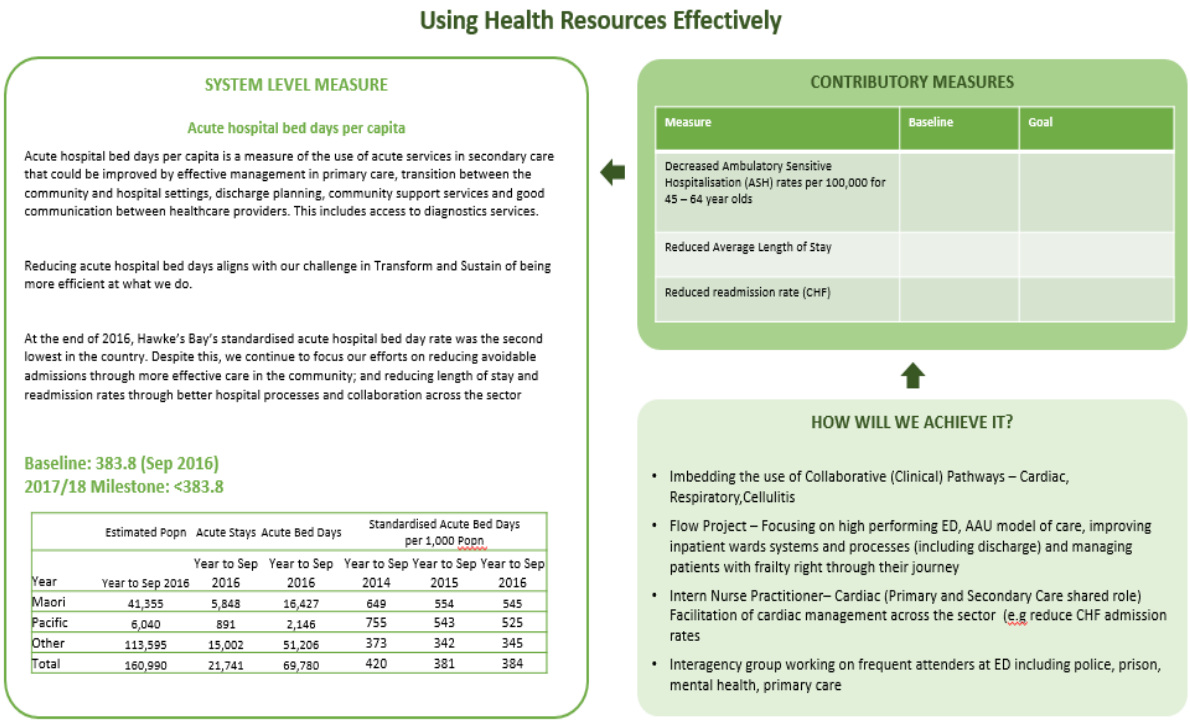
- As shown in the Te Ara Whakawaiora cardiology report presented last month the DHB has, over the last few months, met or been close to the target for timely angiography in Acute Coronary Syndrome across all ethnicity groups. Downstream this improved access to interventions should reduce the heart failure complications of chronic ischaemia but this will take quite a number of years to become apparent.

**System Level Measures:**

Planning and reporting:

- Inclusion of the activities within the Acute Hospital Bed Days indicator map against addressed ASH rates for this age band and include the flow project, interagency work in relation to presentations to ED inclusive of a dedicated team looking at specific health initiatives that target proactive management of ED utilisation rates.

Figure 1.0 – (Draft) inclusion within the HBDHB SLM Improvement Plan 2017-18



**Respiratory:**
Respiratory program: Sustainable funding has now been assigned to continue and enhance the work of the respiratory program. The service has been fully integrated into a multi-disciplinary approach with a focus on patient self-management. Self-Management models used now are based on a whanau based approach vs working with individual consumers and or their care givers. Alternatives to being transported to ED are now provided by emergency services and are working well.

Two respiratory training sessions held, October ’16 and March ’17 supporting practice in primary care. The training is provided by Breathe Hawke’s Bay. Both well attended. Respiratory Nurse champions within primary care meet regularly based on peer review structures. This is working well in building confidence within this workforce especially for the 45-64 age group.

Flu vaccination is now available through pharmacies in the community as alternative, additional provider to primary care.

**Cellulitis:**
The pathway has been developed socialised and recently updated. The change of clinical practice has been socialised with primary care providers. The work was led by the Infectious Diseases Physician (SMO Physician) and Primary Care lead. This pathway is one of the top 5 pathways accessed in secondary care.

**In addition:**

The Long Term Conditions Framework will be launched as planned - 30th May.
Attached to the framework is the Long Term Conditions Service Review Matrix (LTC-SRM).

The LTC SRM is a self - review tool designed to;

- Provide a mechanism for uniform evaluation across multiple services both secondary and primary

- Assist in service planning and reporting (directorate and service planning)

- Create the opportunity to shine the light on high performance for the purpose of sharing learnings across services

- Support a culture of continuous quality improvement, by providing an agreed continuum of excellence

- Provide a strategic evaluation of services across the health system that will assist in prioritising investment in areas identified as requiring additional support.

**Extract from March Report - Page 13**

## RECOMMENDATIONS FROM TARGET CHAMPION

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

### ASH 45-64

| | | | | |
|---|---|---|---|---|
| **Cardiac – Chronic Heart Failure** | | | | |
| **Building capability with the workforce – quality improvement initiative** | | | | |
| **Phase of initiative** | **Initiative** | **Description** | **Responsible** | **Phase** |
| Underway | Recruitment and appointment of Cardiac CNS | Working across both primary care and secondary services to build capability within existing workforce and improve systems for the transfer of patient care | Cardiology – Secondary services | Current[1] |
| Scoping | Specialist Physician support - primary care | Develop formal process for the provision of specialist support to primary care in the medical management of CHF patients | ASH Champion – GM Primary Care / Head of Cardiology | Scoping |
| Ongoing | Smoking cessation initiatives | Primary smoking brief advice | Primary care | Ongoing |
| **Respiratory** | | | | |
| **Model of care development based on best practice** | | | | |
| **Phase of initiative** | **Initiative** | **Description** | **Responsible** | **Phase** |
| Imbedded | Respiratory Program | Workforce development CNS and Nurse Practitioner levels of competency<br><br>Nurse-led clinics and co-ordination and self-management.<br><br>Emphasis on early detection and timely management of chronic conditions<br><br>Focus on Q4 and 5 patients representing 45% Māori accessing<br><br>Working in tandem with first line emergency services and pharmacy | Secondary – respiratory Service<br><br>Primary Care LTC coordinator | Ongoing |
| Extension[2] | Respiratory Program | Focus on whānau vs the individual, | Health Hawke's Bay - Equity | In place - ongoing implementation |

[1] Initial preference was for a Nurse practitioner already with skill set required in the role. Due to recruitment issues it has been agreed that building on the skill set within existing candidates at CNS level the position could be filled. Awaiting on cardiology department to initiate recruitment and appointment process.
[2] Refer body of report for more detail – ***Continuation of the Nurse-Led Respiratory Program***

| | | | | |
|---|---|---|---|---|
| | | Shift emphasis to review rather than initial diagnosis<br><br>Connected care coordination inclusive of R-CNS - practice nurse champions - Māori health workers Direct liaison by St John service with primary care for the management of patients instead of being transported to ED | Projects Manager | |
| Ongoing | Influenza vaccination | Routine flu vac for eligible population | Primary care Public Health (Pharmacy) | Ongoing<br><br>Will be extended to pharmacy |

**CONCLUSION**

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

Clinical Pathways development to include and integrated platform that reads back to patient records will assist with providing uniform clinically guided treatment and management, demonstrating uptake and adherence and the causal link that may have to the ASH 45-64 conditions.



Dr Mark Peterson
**Chief Medical Officer - Primary**

HAWKE'S BAY
District Health Board
Whakawāteatia

# Recommendation to Exclude the Public

## *Clause 32, New Zealand Public Health and Disability Act 2000*

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

23. Confirmation of Minutes of Board Meeting
    - Public Excluded

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

25. Board Approval of Actions exceeding limits delegated by CEO

26. Chair's Update

27. Cranford Hospice

28. Finance Risk and Audit Committee Report

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

- Official Information Act 1982 9(2)(ba) to protect information which is subject to an obligation of confidence.

- Official Information Act 1982 9(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions between the organisation, board and officers of the Minister of the Crown.

- NZPHD Act 2000, schedule 3, clause 32(a), that the public conduct of the whole or relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982).