# BOARD MEETING

**Date:** Wednesday, 28 March 2018

**Time:** 1:30pm

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

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

**Apologies:** -

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

**Mintute Taker:** Brenda Crene

**Public Agenda**

| Item | Section 1: Routine | Ref # | Time (pm) |
|---|---|---|---|
| 1. | Karakia | | 1:30 |
| 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 | 22 | |
| 9. | Financial Performance Report | 23 | |
| 10. | Board Health & Safety Champion's Update | 24 | |
| | **Section 2: Reports from Committee Chairs** | | |
| 11. | HB Clinical Council – Co-Chairs, John Gommans and/or Andy Phillips | 25 | 2:10 |
| 12. | HB Health Consumer Council – Chair, Rachel Ritchie | 26 | 2:20 |
| | **Section 3: Decision** | | |
| 13. | Clinical Governance Structure – value assessment<br>Co-Chairs, John Gommans and/or Andy Phillips | 27 | 2:30 |
| 14. | Clinical Services Plan – Ken Foote | 28 | 2.45 |
| | **Section 4: For Information / Discussion** | | |
| 15. | Go Well Travel Plan Update - *Presentation* | 29 | 3.00 |
| 16. | Providing Best Outcomes and Experience for People with Cancer – Andy Phillips | 30 | 3.10 |
| 17. | Establishing Health and Social Care Localities in HB (6monthly update)<br>– Chris Ash, and Jill Garrett | 31 | 3:25 |
| | **Section 5: General Business** | | |
| 18. | **Section 6: Recommendation to Exclude the Public**<br>Under Clause 32, New Zealand Public Health & Disability Act 2000 | | |

**Public Excluded Agenda**

| Item | Section 7: Routine | Ref # | Time (pm) |
|---|---|---|---|
| 19. | Minutes of Previous Meeting (public excluded) | | 3:40 |
| 20. | Matters Arising – Review of Actions | | |
| 21. | Board Approval of Actions exceeding limits delegated by CEO | **32** | |
| 22. | Chair's Update - verbal | | |
| 23. | Leadership Forum Reflections / follow up | | 3.45 |
| | **Section 8: Reports from Committee Chairs** | | |
| 24. | HB Clinical Council – Co-Chairs, John Gommans and/or Andy Phillips | 33 | 4:00 |
| 25. | Finance Risk and Audit Committee – Chair, Dan Druzianic | 34 | 4:05 |

**The next HBDHB Board Meeting will be held at**
**1.00pm on TUESDAY 24 April 2018**

## Board "Interest Register" - 26 February 2018

| Board Member Name | Current Status | Conflict of Interest | Nature of Conflict | Mitigation / Resolution Actions | Mitigation / Resolution Actions Approved by | Date Conflict Declared |
|---|---|---|---|---|---|---|
| Kevin Atkinson (Chair) | Active | Trustee of Te Matau a Maui Health Trust | The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders. | Will not take part in any decisions or discussion in relation to the Trust | The Chair of FRAC | Mar-11 |
| | Active | Board Member of NZ Health Partnership Limited, *effective from 20 March 2017* | Lead, supported and owned by the 20 DHBs, NZ Health Partnerships creates efficiencies in the health sector that allow more to be spent on frontline services. | Will not take part in any decisions in relation to NZ Health Partnerships Limited where specific legal or fiduciary conflict identified. | The Chair of FRAC | 22.02.17 |
| | Active | Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited. | Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines. | Will not take part in any decisions or discussions in relation to HBDHB electricity contracts.<br>Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation. | The Chair of FRAC | 26.10.17 |
| Ngahiwi Tomoana (Deputy Chair) | Active | Chair, Ngati Kahungunu Iwi Incorporated (NKII) | Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB:<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 |
| | 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 | 26.10.17 |
| Dr Helen Francis | 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 |
| | Active | Independent Consultant | To a variety of health organisations. | Will declare at the beginning of meeting(s) if there are any projects that have anything to do with items on the agenda and will not be involved in those discussions | The Chair | 26.02.18 |

| Board Member Name | Current Status | Conflict of Interest | Nature of Conflict | Mitigation / Resolution Actions | Mitigation / Resolution Actions Approved by | Date Conflict Declared |
|---|---|---|---|---|---|---|
| Diana Kirton | Active | Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB. | Perceived Conflict of Interest. Non-Pecuniary interest. | Will not take part in any decisions in relation to surgical services provided by or contracted by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO | The Chair | 18.02.09 |
| | Active | Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014 | Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers. | Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on. | The Chair | 16.01.14 |
| | Active | Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited. | Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines. | Will not take part in any decisions or discussions in relation to HBDHB electricity contracts.<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 |
| | Active | Member, Hawke's Bay Law Society Standards Committee | Law Society | No conflict perceived | The Chair | 20.06.17 |
| | Active | RENEW counselling services | Counsellor | No conflict perceived | The Chair | 17.07.17 |
| Dan Druzianic | Active | Director of Markhams Hawke's Bay Limited | Potential Conflict of Interest. Some clients may from time to time be employed by or have contracts with HBDHB | Declare an interest at any time an issue arises concerning a client, and take no further part in any decision or discussion on this matter. | The Chair | 7.12.10 |
| Jacoby Poulain | Active | Board Member of Eastern Institute of Technology (EIT) | Perceived conflict - HBDHB has a Memorandum of Understanding (MOU) with EIT relating to training and development in health related occupations. | Will not take part in any decisions or discussions in relation to the MOU between HBDHB and EIT | The Chair | 14.1.14 |
| | Active | Councillor Hastings District Council | Potential conflict as potential advocate for Hastings District population whereas HBDHB coveres whole of Hawke's Bay | Declare this interest prior to any discussion on the specific provision of services in Hastings and Chair decides on appropriate mitigation action. | The Chair | 14.1.14 |
| Heather Skipworth | Active | Daughter of Tanira Te Au | Kaumatua - Kaupapa Maori HBDHB | All employment matters are the responsibility of the CEO | The Chair | 04.02.14 |
| | Active | Trustee of Te Timatanga Ararau Trust (aligned to Iron Maori Limited) | The Trust has contracts with HBDHB including the Green Prescription Contract; and the Mobility Action Plan (Muscular Skeletal) | Will not take part in any discussions or decisions relating to any actions or contracts with the Trust or aligned to Iron Maori Limited. | The Chair | 04.02.14<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 |
| | Active | Shareholder Need a Nerd | IT support for home or business | No conflict perceived | The Chair | 13.12.17 |
| | Active | Shareholder of NZ Technologies | Technology and innovative support for businesses to grow | No conflict perceived | The Chair | 13.12.17 |
| Ana Apatu | Active | CEO of U-Turn Trust (U Turn is a member of Takitimu Ora Whanau Collective)<br>The U-Turn Trust renamed /rebranded "Whararikī Trust" advised 30-8-17 | Relationship and and may be contractural from time to time | No conflict | The Chair | 5.12.16 |
| | Active | Chair of Directions | Relationship and contractual | Potential Conflict as this group has a DHB Contract | The Chair | 5.12.16 |
| | Active | Chair, Health Promotion Forum | Relationship | No conflict | The Chair | 5.12.16 |
| Hine Flood | Active | Member, Health Hawkes Bay Priority Population Committee | Pecuniary interest - Oversight and advise on service delivery to HBH priority populations. | Will not take part in any conflict of interest that may arise or in relation to any contract or financial arrangement with the PPC and HBDHB | The Chair | 14.02.17 |
| | Active | Councillor for the Wairoa District Council | Perceived Conflict - advocate for the Wairoa District population and HBDHB covers the whole of the Hawkes Bay region. | Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action. | The Chair | 14.02.17 |

**MINUTES OF THE BOARD MEETING**
**HELD ON WEDNESDAY 28 February 2018, IN THE TE WAIORA ROOM,**
**DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS**
**AT 1.35PM**

**PUBLIC**

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

**Apology**

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

**KARAKIA**

Ngahiwi Tomoana opened the meeting with a Karakia.

**APOLOGIES**

Nil

**3. INTEREST REGISTER**

No changes to the interests register were advised.

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

**4. CONFIRMATION OF PREVIOUS MINUTES**

The minutes of the Board meeting held on 13 December 2017, were confirmed as a correct record of the meeting.

**Moved: Barbara Arnott**
**Seconded: Peter Dunkerley**
**Carried**

**5. MATTERS ARISING FROM PREVIOUS MINUTES**

Item 1: **Homeopathy:** verbal update received from Andy Phillips who had met with the author of the letter and shared views. Acknowledged that many in the community

use homeopathy and agreed she would meet with Clinical Council and also join the Grand Round. The board were pleased and asked for this action to be removed.

Item 2: **Matariki Regional Economic Strategy & Social Inclusion Strategy –** verbal update received from the CEO who advised that good progress was being made brining both strategies together and developing a set of actions. This item will be removed – with routine updates provided to the Board.

Item 4: **Faster Cancer Treatment** - An update report to be provided by Andy Phillips for Board Meeting, 28 March.

Items 3, 5, 6, 7, 8, 9 and 10 had all been actioned since the meeting held 13 December 2017.

## 6. BOARD WORK PLAN

The Board Work Plan was noted.

## 7. 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 |
|---|---|---|---|---|
| Lois Taylor | Care Associate | Communities Women & Children | 30 | 15-Oct-17 |
| Glenda Timms | Registered Nurse | Surgical Directorate | 31 | 16-Dec-17 |
| Sheryl Cushing | ACC Administration Coordinator | Corporate Services | 23 | 21-Dec-17 |
| Linda Mayo | Practice Nurse | Communities Women & Children | 33 | 12-Jan-18 |
| Karen Brooks | Team Leader Administration Coordinator | Operations Directorate | 10 | 19-Jan-18 |
| Mary Fischbach | Alcohol & Drug Clinician | Older Persons & Mental Health | 16 | 2-Feb-18 |
| Gay Brown | Clinical Nurse Manager | Medical Directorate | 38 | 4-Feb-18 |

- **Census** final day for completion was Tuesday 6 March: Some concern was expressed about the new method(s) for the collection of census information and the household response rate. A high response rate was very important as DHB funding is population dependent (and the Ministry obtain population detail via Census information received). When considering our high-needs/risk population the following methods to raise census awareness were discussed:
  - Prepare a media statement.
  - 27,000 NKII were registered and could be communicated with overnight.
  - Utilise Taiwhenua.
  - Hastings and Napier Council Communication teams would be contacted to increase exposure.
  - Attach emotion in messages as there are many await surgery.
  - It was understood that rest homes were being managed by Statistic NZ but Comms would check on this.
  - Query noted about those who do not speak English well, vision or hearing impaired.

  **Actioned following the meeting.**

- **National Bowel Screening**: There had been a statement around deferral of the national bowel screening program. The Chair clarified that Hawkes Bay remain one of the eight DHBs that will have screening implemented by November 2018. He advised the reason for the deferral of other centres was due to the availability of software. HBDHB (as have other DHBs) will be using the Pilot software.

- A letter had been received from the Chair of **Presbyterian Support Services,** suggesting a follow up meeting between the boards, as had occurred several years prior.

  **Action HBDHB Chair will discuss this to ascertain the need and whether a full board meeting was necessary, or another option(s) pursued.**

- A letter had been received from the **Civil Aviation Authority (CAA)** asking the DHB to ensure that medical practitioners and clinical leaders advise the CAA with details of any pilot licence holder that had a medical condition, under section 27c of Civil Aviation Act.
  The Board were advised by Dr John Gommans that this occurs as a matter of course.

## 8. CHIEF EXECUTIVE OFFICER'S REPORT

The CEO provided an overview of his report with comments summarised as follows.

Discussion at FRAC had explored at length the pressure the health system was under currently. Matching capacity to demand is a health system problem and has impacted on ED and waiting list targets.

Faster Cancer treatment was doing reasonably well but we do expect an improvement.

There have been significant problems with financials. Hawke's Bay were not alone with rising concern also from other DHBs many of whom are at relatively high hospital capacity for this time of year. This is of concern as we lead into the winter months and flu season.

A lot of good work has gone into the Clinical Services Plan development.

It was pleasing that the Select Committee questions were well received. The CEO thanked for the work put into the 168 questions. Hawke's Bay appears to have been held in high regard for our performance.

We have made good progress employing Māori in our workforce but need to ensure we monitor for potential candidates to move through into management positons.

## 9. FINANCIAL PERFORMANCE REPORT

Tim Evans (ED of Corporate Services) spoke to the Financial Report for January 2018. The year-to-date result to the end of January is $1.436 million unfavourable to plan, with January $374 thousand unfavourable. Most of the specific details had been captured at the FRAC meeting prior.

Finances were not as expected however Hawke's Bay did have one of the better results in the sector. We need to balance the need to contain and balance versus over-react and impact our services.

- A query around the average spend per month being $22-28m. Appears to be out of line up to $30m.
  **Action ED Corporate Services will review and provide an explanation to the Board via email.**

**RESOLUTION**

**That the Board**

**Approve** Finance to adjust the budget expectation for financial year end 30 June 2018, to break even.

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

### 10. HEALTH & SAFETY BOARD CHAMPION'S UPDATE

Most of the Board attended the Health & Safety (H&S) Governance Training day on 27th February. It was a good workshop and the prioritisation of the 5 points to keep an eye on.

**Action:** **The Chair asked for extra H&S booklets for those board members who did not attend.**

This was Helen and Peter's last time as champions. Jacoby Poulain and Dan Druzianic were now the H&S champions for the Board.

With Christine Milden now employed, the champions had more confidence in the processes.

The Health and Safety Strategy for HBDHB will come to Board in March. It was noted that the role of the Champion would be expanding by going out and discharging your due diligence responsibility.

Board's commitment to H&S was noted with the statement will being refreshed and included with the Strategy next month.

## REPORT FROM COMMITTEE CHAIRS

### 11. HAWKE'S BAY CLINICAL COUNCIL

The co-Chairs were in attendance and spoke to the report from the Council's meeting held on 14 February 2018.

The workshop around Person and Whanau Centred Care identified four key issues: language, leadership, resourcing and implementation. The key was getting the leaders together with consumer members and working with the support of staff from DHB to make sure it happens. From Consumer Council's point of view, they know what it looks and feels like but getting it to something palatable for the organisation to make changes was where the difficulty lies.

The implementation of the Clinical Portal project will see tangible improvements made that we have been waiting years for. HB had been dragging the chain but were now seen as leaders across the region. We have been learning from those who had implemented "in one hit" and we will be looking at progressive implementation instead. Consumers were looking forward to the latter stages of the project when primary care interacts with the community.

Council reflected on the value of the Clinical Governance Committee Structure with a report being provided to the Board in March.

Adverse Events – providing 6 monthly reports and find we are tracking similar to last year.

### 12. HAWKE'S BAY HEALTH CONSUMER COUNCIL

Rachel Ritchie, Chair of Council advised the outcomes of their meeting held on 15 February 2018:

An update of the Clinical Services Plan and Disability Strategy progress.

The Clinical Portal Project overview discussion and supporting paper was well received, with focus on the need for consumer input going forward. It was noted that the consumer friendly pieces of the project would occur at a later date.

The Ngātahi Vulnerable Children's Workforce Development Update was impressive with a lot of good work undertaken.

Youth Consumer Council were currently reviewing their priorities and seeking further funding.

Several areas which Consumer Council had spent time on in 2017 had been deferred due to the loss/resignation of the Consumer Engagement Manager. The pros and cons of the incumbent's position were discussed at their meeting, with feedback provided to the ED of People and Quality. It was clear that although this had been a new evolving role initially, Jeanette had clearly been very stretched.

The Board asked if an exit interview had been offered.
The ED People and Quality was reviewing how to proceed with scoping the position.

### 13. MĀORI RELATIONSHIP BOARD

Ngahiwi Tomoana spoke to the meeting held 14 February 2018.

He advised the resignation of Tracee TeHuia had altered feelings at the MRB meeting at that time.

The following was noted

- That MRB will further discuss an Equity Committee and where the committee should sit, and will respond to Clinical Council for their April Meeting

  It was noted by Dr John Gommans (co-Chair of Clinical Council) that we share equity already as it is embedded in the Triple Aim and the Terms of our Committees. Equity and health for all, and value for dollars of the public spend. This ensures all our committees explicitly have an equity lens.

  MRB believes the sector needs a clear approach and want to be part of the discussion.

  Clinicians want and need to advise on equity.

  Do we need a clinical equity advisory group? Not stand alone but plugged into the big picture. Maybe balance engagement, the big picture and technical expertise.

  **Action: The CEO and Board were keen to have the HB Health Sector Leadership Forum Programme adapted to factor in a discussion on equity.**

- MRB will look at a definition for the term 'vulnerable' and develop some measures specific to Kahungunu and would like it to be considered for the Ngātahi Project RFP of the training programme MRB noted this was a huge project and felt that Korero Mai should fit with it. MRB were looking at how they may better support this project going forward.

### 14. PASIFIKA HEALTH LEADERSHIP GROUP

Barbara Arnott (Chair of CPHAC) who is the Board Representative supporting PHLG provided an overview. It was advised that Ken Foote and Sharon Mason will both be supporting Pasifika going forward.

The PHLG review undertaken by Ken had been well received and consideration would be given to the recommendations made. As a result there was new life and more clarity. Four new PHLG members attended the meeting in February.

Workforce development was just as important to Pasifika as for Māori and we now have Pasifika workforce targets.

Ngahiwi advised that seasonal workers were going to become more static in future. Currently 5,000 coming in for work every year and we are looking at more residential longer term solutions rather than short term.

## FOR DECISION

### 15. CLINICAL PORTAL PROJECT

Anne Speden (Chief Information Officer) and Michael Sheehan (Project Manager) provided an overview of the Project.

Approval was being sought for the Clinical Portal Implementation Business Case spanning two (2) financial years - 2017/18 & 2018/19 as part of a regional solution (previously called CRISP & RHIP) from back in 2011. The Clinical Portal Implementation follows on from that decision with the implementation of Clinical Portal and Radiology Information System (RIS) components of the solution.

Key points noted included:

- No additional capital would be required. It has been agreed that the capital budget for Clinical Portal Implementation 2017/18 & 2018/19 will be funded from the IS Capital allocation.
- Oversight groups representing range of clinical specialties being contacted when guidance required. Concern was change – scale and type of change – tied in and linked to a progressive rollout. Approach to staffing has seen HB using as many internal DHB staff as possible. This has been supplemented by fixed term contracts. The IS team are motivated and focusing on getting this delivered.
- Strong partnerships/alliances have been developed with all parties engaged and understanding the need to adhere to rollout timelines.
- The Clinical Portal is a foundation platform in that it provides a base from which to develop further modules and gradually move towards the goal of a single electronic clinical record.

  Clinical Council strongly support this development.
- There will be challenges and disruptions which will be worked through to minimise impact.

**Action: ED Corporate Services to ensure Clinical Portal updates are included on the FRAC agenda monthly.**

**RECOMMENDATION:**

It is recommended that the HBDHB Board:

1. **Note** that the Clinical Portal Implementation Project implements the Regional Solution that has been co-funded by the regions DHBs
2. **Approve** the Clinical Portal Implementation Business Case.

Note the capital involved is the capital 1.84 million.

**Moved Kevin Atkinson**
**Seconded Helen Francis**
**Carried**

## 16. DISPOSAL OF SURPLUS LAND AT WAIPUKURAU

Andrea Beattie, Property and Service Contracts Manager was in attendance at the meeting advising that investigation had revealed that this land should have been dealt with when the State Highway was realigned through the Pukeora Hospital Farm land in the 1990's but was excluded in error.

It was noted that HBDHB had not paid rates on this small parcel of land which had no dedicated access and would be purchased by the Council to add to their adjoining land holding.

**RESOLUTION:**

It is recommended that the HBDHB Board:

1. **Note** that the land described as Lot 1 DP 25272 situated on State Highway 2 Waipukurau is surplus to HBDHB requirements
2. **Approve** the disposal of the land in accordance with statutory disposal processes

**Moved Barbara Arnott**
**Seconded Peter Dunkerley**
**Carried**

### 17. SPECIAL GENERAL MEETING NZ HEALTH PARTNERSHIPS

Ken Foote provided a brief overview advising that as a shareholder of NZHP Ltd, HBDHB needs to formally appoint a representative to attend and vote at this meeting on the Board's behalf

**RECOMMENDATION:**

It is recommended that the HBDHB Board:

1. **Appoint** Kevin Atkinson as the HBDHB representative to attend the NZHP Ltd Shareholders Special General Meeting to be held on 8 March 2018.

**Moved** **Helen Francis**
**Seconded** **Hine Flood**
**Carried**

## FOR / INFORMATION DISCUSSION

### 18. SUICIDE PREVENTION UPDATE

Dr Nicholas Jones was in attendance for Penny Thompson

This was a community led initiative and work in progress. Self-evident with exciting things coming up around the new Strategy. Don't often have ways of measuring evidence due to the coronial issues but confident we are making a difference.

The board were pleased with the progress made and the positive actions.

### 19. NGĀTAHI PROJECT PROGRESS REPORT END OF YEAR ONE

Russell Wills as Project Sponsor and Bernice Gabriel, Project Manager and Senior Phycologist were in attendance.

The Ngātahi Project was about Hawke's Bay health, education and social services (the "vulnerable children's workforce") working together as one to deliver excellent care and interventions to vulnerable children and their families. In this first year of the project we have been successful in meeting all our milestones.

Progress in the first year was noted with the financial impact as follows: **Y1** $250,000 - **Y2** $232,500 - **Y3** $212,500

Key points:

- In all the vulnerable children work done nationally, the key constraint on making a difference was the lack of a skilled workforce, as the specific skills were not taught in mainstream. This was noted by Russell during his term as the Children's Commissioner. He felt HB was a good place to start.
- ¾ of families with vulnerable children were Māori and those assisting them were not Māori. It became clear that the only way was to utilise a bottom up approach and also to ensure a sense of ownership. A lot of work had been undertaken with a fully funded evaluation provided.
- Showed engagement of the services was high, especially regarding trust.
- This has been the first major Intersectoral project where the project manager has been a clinician.
- Have been successful in obtaining funding from Transform and Sustain which was approved the week prior to the board meeting. Tamariki had been approved 28 February and there was also agreement from a philanthropic trust to bring in external experts.
- Research shows the workforce is fatigued and traumatised. Packages required to better support to this workforce.

- This was likely to become a pilot for a national roll out.
- The process with service providers commenced with us asking "tell us what you don't know and need to know?"

It was noted there was a lot of shared working here which was admirable. Well done. The Board admired the passion and progress made.

- A number of care givers (foster parents, grandparents etc) of vulnerable children were involved in the training and provided valuable feedback. The greatest learnings are when people are in a traumatic space.
- Clinical competence alone will not cut it. Evidence based trainers to train Caffs. Clinical application and cultural competency (prepped trainers prior on clinically and culturally sound). Huge learnings received.
- Acknowledgement that not all Māori are connected to their culture (and raised the European way). Does the training acknowledge that?
  No assumptions are made we just ASK!

Diana Kirton advised there was national recognition of the people running the programme. This is a perfect recipe for success and we are extremely lucky to have this going on in our own back yard.

Dr Russell Wills and Bernice Gabrielle were congratulated on the work undertaken and the great progress made to date.

**Action:** **Agreed an updated would be provided to the Board and Committees in one year ie, February 2019.**

### 20. HB HEALTH SECTOR LEADERSHIP FORUM PROGRAMME

The programme provided was discussed briefly and approved by the Board for issue with the inclusion of timing to discuss equity woven in with timelines adjusted accordingly.

Noted MRB's comments around facilitation were noted.

## FOR MONITORING

### 21. TE ARA WHAKAWAIORA / ACCESS 0-4 / 45/65 yrs (local indicator)

The report noted. No issues discussed.

### 22. HBDHB PERFORMANCE FRAMEWORK EXCEPTIONS Q2 (Oct-Dec 2017)

Tim Evans ED Corporate Services spoke briefly to the report provided

Performance highlights for the total population were noted in the following areas: achievements; areas of progress and areas of focus.

It was noted that there had been a drop in immunisation at 4 years – The rate for total had dropped 2.9% and currently sat at 91.3% against a target of 95%, there had also been a decrease for Māori by 6% and Pacific 10.2%. (referring to page 13 of the report provided).

The Board were appreciative of the comments within the report which were refreshed regularly. The Chair valued the work and effort put in to provide the comments. They were not repetitive but were fresh and new.

**Action:** **Staff would be complimented by ED Provider Services and ED Corporate Services**

Jacoby Poulain referred to maternity, smoking and LMCs as well as infant immunisation. She explained that she had previously been advised that a new model of engaging with Māori women and maternity was being developed, in the form of a kaupapa Māori weekend workshop/whananga, to commence in October 2017. However she was unsure whether the project had started and sought clarification as to the status.
**Action: ED Provider Services advised she and/or maternity would clarify.**

- **HBDHB Quarterly performance monitoring dashboard for Q2**

  The report was noted. No issues discussed.

- **HBDHB Quarterly performance monitoring dashboard for Q1 (from MoH)**

  Advised this had not yet been released by the Ministry of Health

### 23. HUMAN RESOURCE KPIs Q2

Kate Coley, ED People and Quality presented this report.

Traffic light cover attached to the report as requested by the Board in December. This report format will change in June/July.

### 24. HBDHB ANNUAL PLAN 2017/18

The copy was received signed by the Minister.

## 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:

26. Confirmation of Minutes of Board Meeting
27. Matters Arising from the Minutes of Board Meeting
28. Board Approval of Actions exceeding limits delegated by CEO
29. Chair's Update
30. Integrated Communications Environment
31. Clinical Services Plan Update
32. Finance Risk and Audit Committee Report

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

The public section of the Board Meeting closed 3.45pm

**Signed:** _____

**Chair**

**Date:** _____

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# BOARD MEETING - MATTERS ARISING
# (Public)

| Action | Date Entered | Action to be Taken | By Whom | Month | Status |
|---|---|---|---|---|---|
| 1 | 28/2/18 | Communicaton around the importance of completing the **Census by 6 March**. Anna Kirk actioned this following the meeting. | ED Corporate Services | Mar 18 | Actioned |
| 2 | 28/2/18 | **Presbyterian Support Services** letter to the Chair seeking to meet will be responded to. | The Chair | Mar 18 | Verbal update |
| 3 | 28/2/18 | **Finance:**<br>• Adjust the budget expectation for the financial year end 30 June 2018, to break even.<br>• The average spend per month $22-28m. Appears to be out of line up to $30m. An explaination would be provided. | ED Corporate Services | Mar 18 | Actioned – refer to response below |
| 4 | 28/2/18 | **Health and Safety (H&S)**<br>Booklets issued at the H&S Governance Training Day would be provided to board members who did not attend the training. | ED People and Quality | Mar 18 | Booklets to be provided at the March meeting. |
| 5 | 28/2/18 | **HB Health Sector Leadership Forum Programme**:<br>Adapt to factor in a discussion on equity. | Company Secretary | Mar 18 | Actioned. Forum held 7 March 2018. |
| 6 | 28/2/18 | **Clinical Portal Updates**<br>Include updates on the FRAC agenda monthly. | CEO | | Included on Workplan |
| 7 | 28/2/18 | **Disposal of Surplus Land at Waipukurau**<br>Finalise in accordance with the statutory disposal process. | ED Provider Services | Mar 18 | Actioned by Andrea Beattie |
| 8 | 28/2/18 | **Ngatahi Project Progress Report** – further update at the end of year two. | Dr Russell Wills | Feb 19 | Included on workplan |
| 9 | 28/2/18 | **HBDHB Performance Framework Expectations Q2:**<br>Compliments to the staff tasked with preparing the commentary within this report. The Board fully appreciate this. | ED Provider Services<br>&<br>CEO | Mar 18 | Actioned |
| 10 | 28/2/18 | **New model of engaging with Maori women and maternity**. Feedback on status requested by Jacoby Poulain. | ED Provider Services | May 18 | A presentation will be scheduled for May (by Jules Arthur and Patrick LeGeyt). |

**In response to Item 3: Response from ED Corporate Services**

It was noted in February Board that the rolling cash flow (item 16 on the Finance report) has higher payments to suppliers in June than in all the other months of the year. Following investigation this was found to be an error.

The rolling cash flow is prepared using the latest forecast to the end of the year, and the forecast would not have changed to this extent without being noticed. That suggests the February rolling cash flow was based on an incorrect version of the forecast, and the error was not noticed because it was offset in MOH income. The March report rolling cash flow has been correctly compiled and will not show this higher payment.

# HAWKE'S BAY DISTRICT HEALTH BOARD – WORKPLAN

| Mtg Date | Papers and Topics | Lead(s) |
|---|---|---|
| **25 Apr** | Planned MRI and Fluoroscopy Equipment Replacement Programme (previously named Radiology Expansion Programme) | Sharon Mason |
| | Collaborative Pathways Report | Mark Peterson |
| | Mobility Action Plan Update | Andy Phillips |
| | Clinical Services Plan Update | Ken Foote |
| | Big Listen Update | Kate Coley |
| | Building Culture | Kate Coley |
| | Incorporating Building a Diverse Workforce and engaging well with Maori (Sept 17 Board action) | Kate Coley |
| | Whole of Board Appraisal (progress against actions) | Ken Foote |
| | Alcohol Position Statement and Strategy | Sharon Mason |
| | ***Monitoring*** | |
| | Te Ara Whakawaiora – Did not attend | Sharon Mason |
| | Te Ara Whakawaiora – Healthy Weight (National Indicator) | Sharon Mason |
| | Te Ara Whakawaiora – Cardiovascular | John Gommans |
| | Te Ara Whakawaiora / Culturally Competent Workforce | Kate Coley |
| | Te Ara Whakawaiora – Breastfeeding (national indicator) | Chris McKenna |
| **30 May** | Model of Care for Haematology and Oncology (from Oct) | Sharon Mason |
| | Smoke Free Update (6 monthly update) | Sharon Mason |
| | Maternal Wellbeing Model of Health Presentation | Sharon Mason |
| | Best Start Healthy Eating & Activity Plan update (6 monthly update) | Sharon Mason |
| | Te Ara Whakapiri (Last days of Life) Clinical Services Plan update | Chris Ash |
| | People Strategy / Big Listen Update | Kate Coley |
| | Implementing the Consumer Engagement Strategy | Kate Coley |
| | Recognising Consumer Participation | Kate Coley |
| | ***Monitoring*** | |
| | HR KPIs Q3 Oct-Dec 17 | Kate Coley |
| | HBDHB Non-Financial Exceptions Report Q3 Jan-Mar 18<br>+ MoH dashboard Q2 | Tim Evans |
| **27 Jun** | Annual Plan draft 2018/19 | Chris Ash |
| | Youth Health Strategy (Board action June 2017) | Chris Ash |
| | People Strategy final | Kate Coley |
| | Consumer Experience Feedback (revised method) Q3 | Kate Coley |
| | Clinical Services Plan Update | Ken Foote |
| | Urgent Care Service Update | Wayne Woolrich |

| | | |
|---|---|---|
| **25 July** | Clinical Services Plan Update | Ken Foote |
| **29 Aug** | Annual Plan 2018/19 Second Draft<br>Annual Report 2017/18 (first draft)<br>Whole of Board Appraisal (progress against actions)<br>Implementing the Consumer Engagement Strategy (from Sept 17)<br>Recognising Consumer Participation Policy Amendment (from July 17)<br>Policy on Consumer Stories (from July 17) AUGUST<br><br>***Monitoring***<br>HR KPIs Q4 Apr-June 18<br>HBDHB Performance Framework Exceptions Report Q4 Apr-Jun 18 + MoH dashboard Q3 | Chris Ash<br>Tim Evans<br>Ken Foote<br>Kate Coley<br>Kate Coley<br>Kate Coley<br><br><br>Kate Coley<br>TBA |
| **5 Sept** | **HB Health Sector Leadership Forum**<br>**Venue: To be confirmed**<br>**9.00am to 3.00pm** (door open at 8.30am) | |
| **26 Sept** | Approve Annual Plan 2018/19<br>Establishing Health and Social Care Localities in HB (6 mthly update) | TBA<br>Sharon Mason |
| **31 Oct** | Havelock North Gastroenteritis Outbreak Progress Report on recommendations (6 monthly) | Kate Coley |
| **28 Nov** | Best Start Healthy Eating & Activity Plan update (6 monthly)<br>Smokefree Update (6 monthly)<br>***Monitoring***<br>HR KPIs Q1 Jul-Sept 18<br>HBDHB Performance Framework Exceptions Report Q1 Jul-Sep 18 + MoH dashboard Q3 | Sharon Mason<br>Sharon Mason<br><br>Kate Coley<br>TBA |
| **12 Dec** | Urgent Care Service Update | Wayne Woolrich |

# CHAIR'S REPORT

Verbal

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Chief Executive Officer's Report** 22 |
| | For the attention of: **HBDHB Board** |
| Document Owner: | Kevin Snee, Chief Executive Officer |
| Reviewed by: | Not applicable |
| Month as at | 20 March 2018 |
| Consideration: | For Information |



**RECOMMENDATION**

**That the Board**

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

**INTRODUCTION**

The Hawke's Bay health system has continued under pressure. In order to reduce the pressure within the Health System in general, and the hospital in particular, a demand reduction task force has been set up. Led by myself the team is meeting daily with key managerial and clinical partners from the whole system. These meetings have been occurring since 20 March with the clear goal of addressing demand in the health system and improving flow through the hospital. This will improve care, reduce stress on staff and put us in a better place to address the likely demand of winter and any flu pandemic.

I attended a meeting of the DHB Chairs and CEOs nationally with the new Minister, Hon Dr David Clark, Associate Minister, Julie Anne Genter and the Acting Director-General, Stephen McKernan. We were informed about the key priorities for the government namely:

- Mental Health and Addictions
- Primary Care
- Inequalities
- Public Health

There was also a discussion, led by the Associate Minister, on the carbon footprint of the health system. The conversation about the Minister's priorities was productive and we await the Minister's Letter of Expectations which is imminent. In the conversation it became clear that any major system restructure was very unlikely before the next government election in 2020.

**PERFORMANCE**

| Measure / Indicator | Target | Month of February | Qtr to end February | Trend For Qtr |
|---|---|---|---|---|
| Shorter stays in ED | ≥95% | 90.1% | 90.0% | ▲ |
| Improved access to Elective Surgery (2017/18YTD) | 100% | - | 95.9% | ▼ |

| *Waiting list* | *Less than 3 months* | *3-4 months* | *4+ months* |
|---|---|---|---|
| ***First Specialist Assessments (ESPI-2)*** | 2,674 | 537 | 39 |
| ***Patients given commitment to treat, but not yet treated (ESPI-5)*** | 956 | 164 | 98 |

| | | | | |
|---|---|---|---|---|
| Faster cancer treatment*<br>*(The FCT Health Target definition has changed for 2017/18 financial year. Patients who breach the 62 day target due to Capacity Constraint are still counted against target however patients who breach the target due to Clinical Decision or Patient Choice are now excluded).* | ≥90% | 76%<br>(Jan 2017) | 90.7%<br>(6m to Jan 2017) | ▼ |
| Increased immunisation at 8 months<br>(3 months to end of January) | ≥95% | --- | 93.9% | ▲ |
| Better help for smokers to quit – Primary Care | ≥90% | 88.9%<br>(15m to February) | --- | ▼ |
| Better help for smokers to quit – Maternity<br>**The number of events is likely to be lower than the number of births recorded in any one quarter; however until the National Maternity Record is fully operational (approx. 2020) then reporting on this indicator will be from data collected from MMPO and DHB employed midwifes and remains developmental.* | ≥90% | --- | 73.9%<br>(Quarter 2, 2017/18) | ▼ |
| Raising healthy kids (New) | ≥95% | --- | 97%<br>(6m to February) | ▬ |
| Financial – month (in thousands of dollars) | 3,427 | 3,174 | --- | --- |
| Financial – year to date (in thousands of dollars) | (1,029) | (2,717) | --- | --- |

***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%* | *25/19 = 132%* | *75/114 = 66.0%* |

The key issues of concern remain:

- Shorter stays in emergency department (ED6) performance
- Elective services patient flow (ESPI) targets

Acute activity has displaced our elective activity which has required increased spend in the private sector to meet targets, this is in turn undermining our financial performance. We have notified the Ministry of Health (MoH) that we could only achieve our elective plan by spending significant additional resource in the private sector, which would increase our deficit. They have agreed that this is undesirable.

The year-to-date result to the end of February is $1.688 million unfavourable to plan, with February $252 thousand unfavourable.

**CLINICAL GOVERNANCE STRUCTURE – VALUE ASSESSMENT**

Clinical Council has reviewed the structure, value and workloads of proposed clinical committees and advisory groups. An updated governance structure is proposed with four clinical committees reporting to Council, which align with the pillars of clinical governance. The existing Information Services Governance committee will have revised terms of reference to include clinical governance and strengthened clinical representation. A range of advisory groups already exist within the DHB and these will expand their scope over time to fulfil sector wide clinical governance needs and obligations. Primary and community care representation will be strengthened, initially within the clinical committee structure. To help achieve equity, achieving the triple aim will be part of the terms of reference for each committee and advisory group. Clinical Council agreed the requirement for equity in the health sector's governance structure(s) but that this requires further discussion with other governance bodies. The intention is that there will be a phased implementation of the new clinical governance structure with appropriate supports from 1 July 2018.



**CLINICAL SERVICES PLAN**

An update on the Clinical Services Plan is included, outlining the recently agreed revised plan, and progress and planning completed to date. We are on track to deliver a plan for consultation in September.

**PRODUCING BEST OUTCOMES AND EXPERIENCE FOR PEOPLE WITH CANCER**

A multidisciplinary team has worked in partnership across primary, secondary and tertiary care, with corporate departments and with the Cancer Society, to improve outcomes and experience for people referred with high suspicion of cancer. The team has significantly reduced waiting times for diagnosis and treatment, introduced one-stop clinics, improved access, delivered treatments in outpatient settings previously performed in theatre. Over recent months the focus has been on increasing the number of people on the 31 and 62 day pathways. This work has included redesigning triage. For January 2018, 29 cases were submitted to the Ministry of Health (MoH). Of these, 26 met the MoH definitions for the 62 day FCT pathway and 20 were submitted as compliant – this is a significant improvement. This brings the six month rolling compliance to 90.8 percent against the 90 percent target.

**GO WELL TRAVEL PLAN**

The Board will receive a presentation providing an update on the Go Well Travel Plan including achievements and successes to date. Travel planning and work on our carbon footprint are an important priority for the Associate Minister of Health, Julie Anne Genter.

**ESTABLISHING HEALTH AND SOCIAL CARE LOCALITIES IN HAWKE'S BAY**

A commitment has been made to reinvigorate the Alliance Agreement for Hawke's Bay by means of a Primary Care Development Partnership ('PCDP'). This development has a number of crucial intersects with the Localities programme as the PCDP will rely on a strong and more coordinated local voice to drive service improvement. At the same time, there are a number of common themes (such as the development of sustainable service delivery models for rural communities) that will benefit from a more centrally-sponsored approach.

At present, the programme has focused solely on the establishment of a 'localities approach' in the rural areas of Wairoa and Central Hawke's Bay. In two relatively self-defining rural communities, this approach has generated significant early benefits. Both areas are working to a 'collective impact' model. As local arrangements mature it is anticipated that more rapid progress will follow in the areas of service integration, locally-led planning, and progression towards intersectoral enabled and whānau-led approaches. Work on the initially proposed 'Hastings' and 'Napier' localities has not, to date, been initiated - the approach will be reviewed with stakeholders, and in line with the establishment of the PCDP.

**MATARIKI REGIONAL STRATEGY, SOCIAL INCLUSION AND ECONOMIC DEVELOPMENT – FEEDBACK TO MATARIKI EXECUTIVE GROUP FOR INFORMATION**

Following on from the presentation at the last Board meeting the Matariki Governance Group and Social Inclusion Working Group have responded to the Board's feedback by reducing the number of actions in the Regional Economic Development Strategy (REDS). In addition, Social Inclusion actions have been aligned with the REDS actions. There will be a single Matariki strategy by the end of 2018. Actions are being delivered with community and business partners, i.e. employment programmes, driver licensing and business development. Engagement is planned over the next month for the Social Inclusion actions and an outcomes framework to show the progress at a whānau land regional level will be the next piece of work completed. A Summary is included as an appendix to this report.

**CONCLUSION**

The health system remains under significant pressure. We are taking urgent steps to ensure that we are ready to deal with any winter pressures. Meanwhile our key strategic programmes continue on schedule.

Appendix



## Board feedback and responses from Matariki

| Recommendations | Initial feedback (provided by presenters 29 November 2017) updated feedback from Matariki Executive Group |
|---|---|
| With the significant number of action items in the Regional Economic Development Strategy, some form of prioritisation would appear necessary if we are to make progress. | This has been done to some extent, reducing the actions to 35, each being ranked (a), (b) and (c) according to priority. Further work is underway as part of the merging of REDS and Social Inclusion Strategies |
| Two strategies currently being maintained separately. | The Governance Group supported a paper recommending the merge of the document in November 2017<br>The Strategies have now been merged to form a Matariki Regional Development Strategy, which has to sections Economic Development and Social Inclusion. Work is happening to integrate the actions and develop joint outcome measures.<br>When the Strategy is reviewed (later this year) there will be a complete re-write to produce a single fully integrated document. |
| Need to acknowledge limited resources of some of the lead agencies – may tend to over commit and under deliver. | There is no funding identified for Social Inclusion. Key partners have support the process by providing initial project lead and support to deliver the Communication Plan. |
| Need to get on and deliver or momentum will be lost. | Programme management system is now in place.<br>Workshop to engage communities are occurring in March.<br>Work has begun on developing a resource to support socially responsible employers and addressing barrier to employment. |

| Questions | Initial feedback |
|---|---|
| Are we taking the community with us on this journey – should there be a regular newsletter/communication? | There have been (and will be) significant community engagement - a communication resource has been put in place. As above community engagement workshops are being delivered in March. |
| Are community Councils/Boards receiving regular updates? | Not that Matariki Executive Group are aware of |
| What about indicators and outcomes? | Monitoring framework is noted as a high priority action for the working group.<br>Intelligence group is reconvening and will pick up this piece of work with the support of the Matariki Working Group.<br>Investigation has begun to look at existing tools which can be adapted. |

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| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Financial Performance Report February 2018** 23 |
| | For the attention of: **HBDHB Board and the Finance Risk and Audit Committee** |
| **Document Owner** | Tim Evans, Executive Director Corporate Services |
| **Document Author(s)** | Phil Lomax, Financial and Systems Accountant |
| **Reviewed by** | Executive Management Team |
| **Month/Year** | March, 2018 |
| **Purpose** | For Information |
| **Previous Consideration Discussions** | None |
| **Summary** | The year-to-date result to the end of February is $1.688 million unfavourable to plan, with February $252 thousand unfavourable. |
| **Contribution to Goals and Strategic Implications** | Not applicable |
| **Impact on Reducing Inequities/Disparities** | Not applicable |
| **Consumer Engagement** | None |
| **Other Consultation /Involvement** | None |
| **Financial/Budget Impact** | As above. |
| **Timing Issues** | Not applicable |
| **Announcements/ Communications** | Not applicable |

**RECOMMENDATION:**

It is recommended that the HBDHB Board and the Finance Risk and Audit Committee :

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

HAWKE'S BAY
District Health Board
Whakawāteatia

# Financial Performance Report
# February 2018

| | |
|---|---|
| **Author:** | **Phil Lomax** |
| **Designation:** | **Financial and Systems Accountant** |
| **Date:** | **7 March 2018** |

## 1. EXECUTIVE DIRECTOR CORPORATE SERVICES' COMMENTS

### *Financial Performance*

The year-to-date result to the end of February is $1.688 million unfavourable to plan, with February $252 thousand unfavourable. The unfavourable variance for the month is driven by a $1.18 million increase in the provision for an adverse IDF wash up, mostly offset by the unwinding of the elective surgery provision.

Case weighted discharges were similar to the average over the first seven months of the financial year, however they were 8.5% above the budget for February - the budget reflecting historical trends and the opportunity to make savings, although at a significantly lower level than in January.

### *Forecast*

The normal monthly review of the forecast has been completed, and updated in the tables below. The exercise did not indicate a material movement in the forecast result other than for Inter District Flows (IDFs), and consequently the forecast $653 thousand deficit has not been changed.

IDFs are inherently volatile so it is difficult to forecast the year end result with a high degree of precision. The impact of IDFs on the forecast will be covered in more detail at the Finance Risk and Audit Committee.

Risks and mitigations to the forecast include:

- The assumption the DHB will do its best to meet elective surgery targets while avoiding further outsourcing costs, but will not lose any MOH funding or incur any penalties as a result of not meeting the targets
- IDF volatility could improve or deteriorate the year end forecast by an unquantifiable amount.
- No allowance has been made for unidentified one-off items that could improve the forecast
- No allowance has been made for possible additional MOH contracts that could be put in place in the next five months

## 2. RESOURCE OVERVIEW

| | February | | | | Year to Date | | | | Year End Forecast | Refer Section |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | | |
| | $'000 | $'000 | $'000 | % | $'000 | $'000 | $'000 | % | $'000 | |
| Net Result - surplus/(deficit) | 3,174 | 3,427 | (252) | -7.4% | (2,717) | (1,029) | (1,688) | -164.1% | (653) | 3 |
| Contingency utilised | 180 | 250 | 70 | 28.0% | 1,055 | 2,000 | 945 | 47.3% | 3,000 | 8 |
| Quality and financial improvement | 1,238 | 2,005 | (767) | -38.3% | 4,700 | 7,446 | (2,746) | -36.9% | 10,812 | 11 |
| Capital spend | 1,525 | 1,993 | (467) | -23.5% | 9,898 | 15,940 | (6,042) | -37.9% | 23,920 | 16 |
| | FTE | FTE | FTE | % | FTE | FTE | FTE | % | FTE | |
| Employees | 2,385 | 2,372 | (13) | -0.5% | 2,293 | 2,333 | 40 | 1.7% | 2,325 | 5 & 7 |
| | CWD | CWD | CWD | % | CWD | CWD | CWD | % | CWD | |
| Case weighted discharges | 2,414 | 2,226 | 189 | 8.5% | 19,403 | 18,980 | 423 | 2.2% | 28,386 | 5 |

The monthly $125 thousand of the contingency dedicated to meeting elective surgery targets was released in February. A further $55 thousand relating to Care Capacity Demand Management (CCDM) was also released taking the total released year-to-date to $1.055 million. The $1.5 million for elective surgery and $290 thousand for CCDM have been allocated from the $3.0 million contingency leaving 1.210 million available.

99.8% of the Quality and Financial Improvement (QFI) required savings have a plan. Of the Savings Plans 64% of expected savings have been achieved February year-to-date, having slipped back as some projects have made a slow start and one-off expected savings proved difficult due to high acute volumes over the Christmas holiday period. The shortfall is mainly in IDFs and surgical slow burning schemes.

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

High volumes over the usually quiet holiday period, is reflected in medical and nursing FTEs. However continuing allied health vacancies, and medical and senior nursing vacancies earlier in the year while new positions were being filled, offsets the effect of high volumes both in the month and year to date.

Acute demand reduced to more normal levels following an unusually busy January. However maternity case-weights were well over planned volumes and underpin the February variance.

## 3. FINANCIAL PERFORMANCE SUMMARY

| | February | | | | Year to Date | | | | Year End Forecast | Refer Section |
|---|---|---|---|---|---|---|---|---|---|---|
| $'000 | Actual | Budget | Variance | | Actual | Budget | Variance | | | |
| Income | 48,431 | 48,236 | 195 | 0.4% | 369,301 | 368,535 | 765 | 0.2% | 556,078 | 4 |
| *Less:* | | | | | | | | | | |
| Providing Health Services | 21,005 | 21,045 | 39 | 0.2% | 178,937 | 175,776 | (3,161) | -1.8% | 268,303 | 5 |
| Funding Other Providers | 20,517 | 19,831 | (685) | -3.5% | 159,776 | 159,402 | (374) | -0.2% | 239,405 | 6 |
| Corporate Services | 3,619 | 3,633 | 14 | 0.4% | 31,777 | 31,587 | (190) | -0.6% | 48,093 | 7 |
| Reserves | 116 | 301 | 185 | 61.5% | 1,528 | 2,799 | 1,271 | 45.4% | 929 | 8 |
| | **3,174** | **3,427** | **(252)** | **-7.4%** | **(2,717)** | **(1,029)** | **(1,688)** | **-164.1%** | **(653)** | |

### *Income*

Additional funding for specific programmes from MOH, and higher ACC income other than from elective surgery.

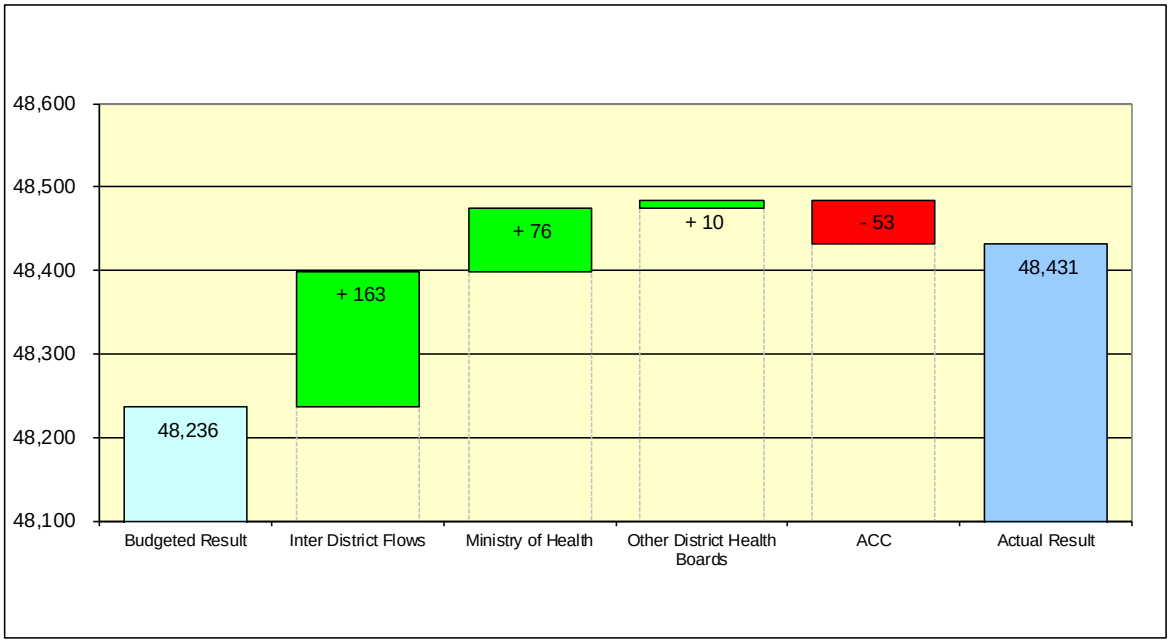
***Providing Health Services***
Radiology reads, medical vacancy cover, and undelivered savings partly offset by senior nurse and allied health vacancies.

***Funding Other Providers***
High Inter District Flow (IDF) volumes over the holiday period, mostly offset by the release of 2016/17 provisions, wash-ups and rebates.

## 4. INCOME

| $'000 | February | | | | Year to Date | | | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | |
| Ministry of Health | 46,273 | 46,197 | 76 | 0.2% | 352,343 | 352,110 | 232 | 0.1% | 530,986 |
| Inter District Flows | 856 | 693 | **163** | **23.5%** | 5,606 | 5,543 | 63 | 1.1% | 8,377 |
| Other District Health Boards | 380 | 333 | 47 | 14.1% | 2,824 | 2,663 | **161** | **6.1%** | 4,167 |
| Financing | 61 | 74 | (13) | -17.5% | 555 | 590 | (35) | -5.9% | 809 |
| ACC | 362 | 415 | **(53)** | **-12.8%** | 3,569 | 3,466 | 103 | 3.0% | 5,326 |
| Other Government | 48 | 22 | 26 | 121.5% | 416 | 288 | **128** | **44.4%** | 589 |
| Patient and Consumer Sourced | 120 | 129 | (9) | -6.9% | 755 | 889 | **(134)** | **-15.1%** | 1,211 |
| Other Income | 331 | 373 | (42) | -11.2% | 3,222 | 2,920 | **302** | **10.3%** | 4,601 |
| Abnormals | 1 | 0 | 0 | 212.8% | 11 | 66 | **(56)** | **-83.8%** | 12 |
| | **48,431** | **48,236** | 195 | 0.4% | **369,301** | **368,535** | 765 | 0.2% | **556,078** |

***Month of February***




*Note the scale does not begin at zero*

**Inter District Flows** (favourable)
Holiday season.

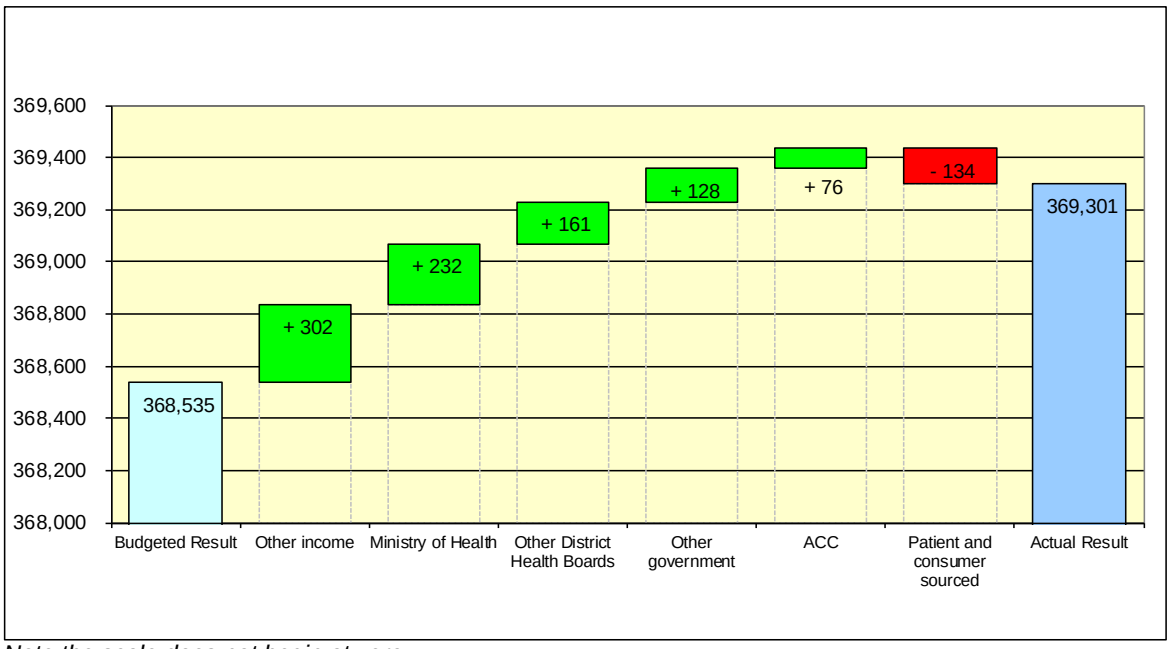
**Ministry of Health** (favourable)

Cancer nurse coordinator, and Say Ahh funding.

**ACC** (unfavourable)
Reduced ACC surgery to support elective health targets.

***Year to Date***






*Note the scale does not begin at zero*

**Other Income** (favourable)
Special fund and clinical trial income (not budgeted) and funding for the Ngatahi programme (working together for vulnerable children and their families).

**Ministry of Health** (favourable)
Specific programme funding including Say Ahh and the Supporting Raising Health Kids health target.

**Other District Health Boards** (favourable)
Mainly patient transport recoveries.

**Other government** (favourable)
Funding from the Health Research Council relating to the Havelock North Campylobacter Outbreak Study.

**Patient and consumer sourced** (unfavourable)
Audiology patient co-payments due to audiologist vacancies, NASC charges, and meals on wheels all behind budget.

## 5. PROVIDING HEALTH SERVICES

| | February | | | | Year to Date | | | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | |
| **Expenditure by type** $'000 | | | | | | | | | |
| Medical personnel and locums | 4,839 | 4,709 | (130) | -2.8% | 42,154 | 42,321 | 167 | 0.4% | 62,860 |
| Nursing personnel | 5,814 | 6,041 | 227 | 3.8% | 50,890 | 50,920 | 30 | 0.1% | 76,541 |
| Allied health personnel | 2,543 | 2,883 | **340** | **11.8%** | 22,274 | 24,203 | **1,929** | **8.0%** | 34,117 |
| Other personnel | 1,932 | 1,855 | (77) | -4.2% | 15,747 | 15,838 | 91 | 0.6% | 23,804 |
| Outsourced services | 961 | 773 | **(188)** | **-24.3%** | 7,397 | 5,396 | **(2,001)** | **-37.1%** | 9,666 |
| Clinical supplies | 3,138 | 3,018 | (121) | -4.0% | 26,586 | 23,263 | **(3,323)** | **-14.3%** | 40,463 |
| Infrastructure and non clinical | 1,777 | 1,767 | (11) | -0.6% | 13,889 | 13,835 | (54) | -0.4% | 20,812 |
| | **21,005** | **21,045** | **39** | **0.2%** | **178,937** | **175,776** | **(3,161)** | **-1.8%** | **268,263** |
| **Expenditure by directorate** $'000 | | | | | | | | | |
| Medical | 5,578 | 5,527 | (50) | -0.9% | 48,327 | 46,698 | (1,629) | -3.5% | 71,931 |
| Surgical | 4,651 | 4,680 | 29 | 0.6% | 40,448 | 37,824 | **(2,624)** | **-6.9%** | 60,244 |
| Community, Women and Children | 3,318 | 3,347 | 29 | 0.9% | 28,788 | 28,833 | 45 | 0.2% | 43,458 |
| Older Persons, Options HB, Menta | 2,720 | 2,685 | (35) | -1.3% | 22,920 | 23,445 | 525 | 2.2% | 34,974 |
| Operations | 3,021 | 3,117 | 96 | 3.1% | 25,537 | 25,637 | 100 | 0.4% | 38,647 |
| Other | 1,718 | 1,689 | (29) | -1.7% | 12,917 | 13,340 | 422 | 3.2% | 19,008 |
| | **21,005** | **21,045** | **39** | **0.2%** | **178,937** | **175,776** | **(3,161)** | **-1.8%** | **268,263** |
| **Full Time Equivalents** | | | | | | | | | |
| Medical personnel | 356.8 | 353.7 | (3) | -0.9% | 340 | 345 | 4 | 1.2% | 345.2 |
| Nursing personnel | 976.5 | 945.0 | (32) | -3.3% | 935 | 927 | (8) | -0.8% | 922.2 |
| Allied health personnel | 457.8 | 485.2 | **27** | **5.6%** | 451 | 480 | **29** | **6.1%** | 478.4 |
| Support personnel | 141.2 | 138.6 | (3) | -1.9% | 137 | 136 | (1) | -0.7% | 136.0 |
| Management and administration | 279.8 | 275.1 | (5) | -1.7% | 268 | 273 | 5 | 1.9% | 271.9 |
| | **2,212.1** | **2,197.6** | **(15)** | **-0.7%** | **2,132** | **2,162** | **30** | **1.4%** | **2,153.7** |
| **Case Weighted Discharges** | | | | | | | | | |
| Acute | 1,583 | 1,477 | **106** | **7.2%** | 13,336 | 13,020 | 315 | 2.4% | 19,385 |
| Elective | 503 | 557 | **(54)** | **-9.7%** | 4,058 | 4,253 | (195) | -4.6% | 6,451 |
| Maternity | 260 | 147 | **114** | **77.5%** | 1,500 | 1,344 | **156** | **11.6%** | 2,000 |
| IDF Inflows | 69 | 45 | 24 | 52.4% | 509 | 362 | **147** | **40.5%** | 550 |
| | **2,414** | **2,226** | **189** | **8.5%** | **19,403** | **18,980** | **423** | **2.2%** | **28,386** |

### *Directorates*

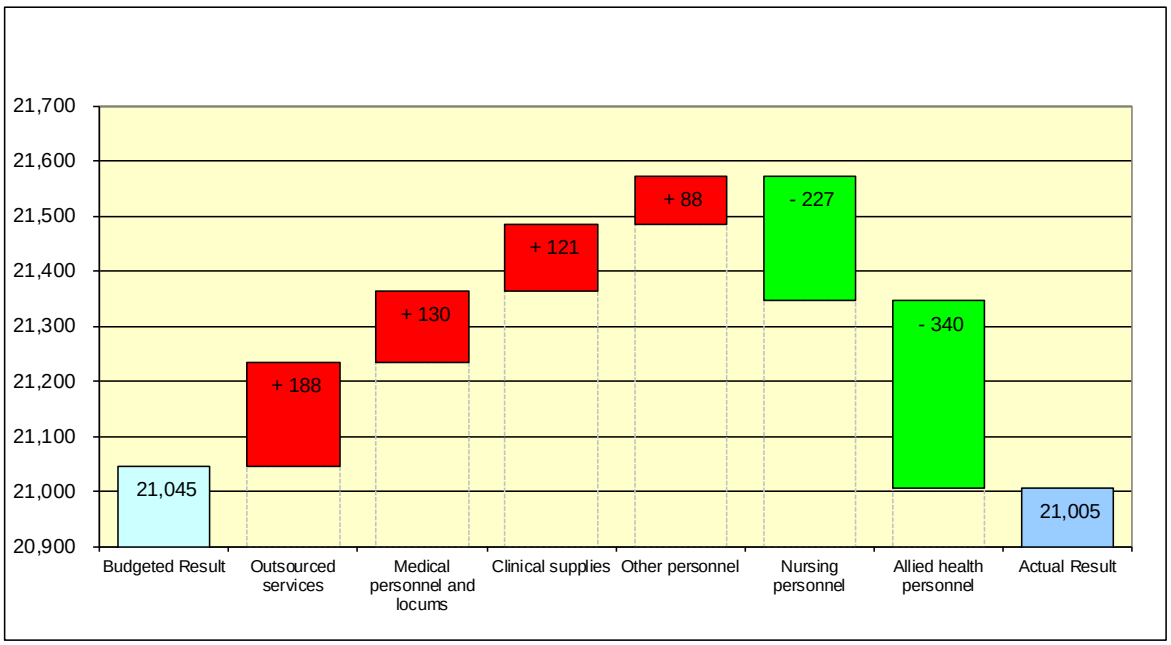
- Surgical services – lower than expected clinical supply costs helped offset unachieved efficiencies, additional elective surgery through Royston, medical vacancy and leave cover and reduced ACC income in February. Year to date the result reflects the cost of attempting to meet elective surgery targets both internally and externally, and the difficulty completing efficiency plans while doing so. Note that $1 million of the favourable variance under reserves (see section 8) has been released to cover additional costs to meet elective surgery targets. To the extent these costs have been incurred, the favourable variance in reserves partly offsets surgical services unfavourable year to date variance.
- Medical services – the cost of radiology reads is the main driver of the February result. Year to date unachieved efficiencies, outsourced radiology reads, medical leave and vacancy cover, and biologics (pharmaceuticals) contribute to the adverse result.

### *Case Weighted Discharges*

Caseweights were a similar level to the high demand in January, however there was a shift in pressure from acute surgery to maternity. Budgets are higher than January reflecting historical patterns and less opportunity to achieve efficiencies. Elective surgery caseweights were less than 90% of budget. Acute volumes were 4% to 5% above budget for medical and surgical services, and more than 30% over budget for paediatrics and neonates.



### *Month of February*




*Note the scale does not begin at zero*

**Outsourced services** (unfavourable)
Radiology reads, lithotripsy, and elective surgery all higher than budget.

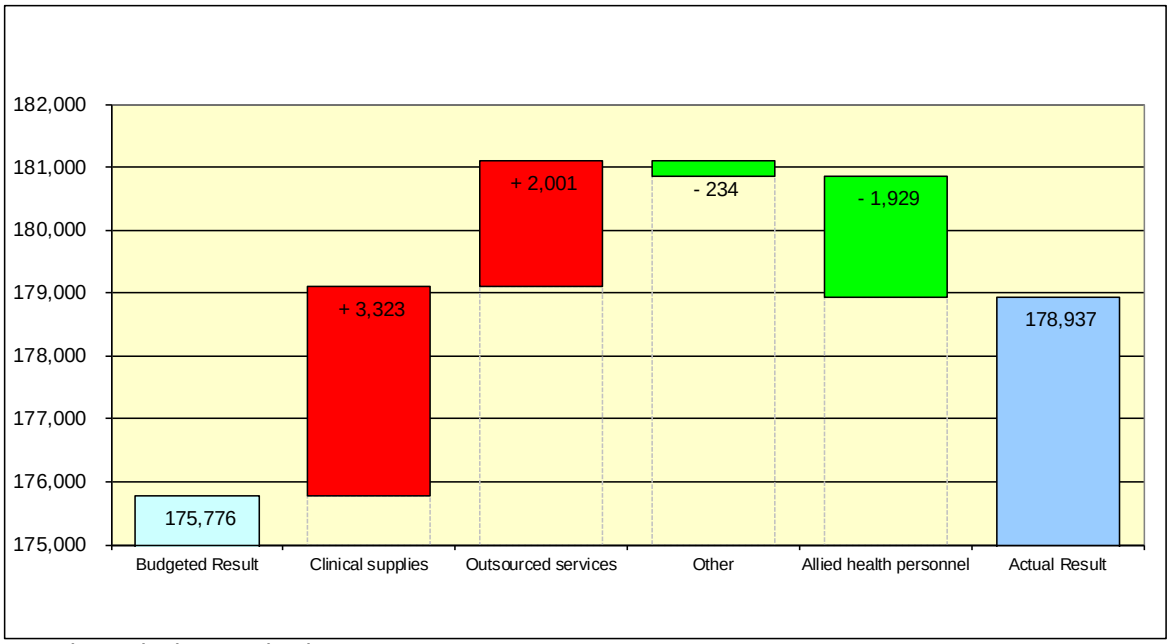
**Medical personnel and locums** (unfavourable)
Vacancy cover partly offset by a reduction in SMO fees for additional work.

**Clinical supplies** (unfavourable)
Undelivered savings for targets not yet allocated to budgets, partly offset by lower than expected implant and prostheses costs.

**Nursing personnel** (favourable)
Senior nurse vacancies.

**Allied health personnel** (favourable)
Vacancies of MRTs, psychologists, social workers, anaesthetic technicians, laboratory technicians, and occupational therapists.

***Year to date***




*Note the scale does not begin at zero*

**Clinical supplies** (unfavourable)
Mainly undelivered savings for targets not yet allocated to budgets. Patient transport, implants and prostheses, and pharmaceuticals are all above budget.

**Outsourced services** (unfavourable)
Mainly outsourced elective surgery to Royston. After-hours radiologist services, and outsourced wisdom teeth are the other main contributors.

**Allied health personnel** (favourable)
Vacancies mainly in MRTs, psychologists, social workers, and laboratory technicians.

***Full time equivalents (FTE)***

FTEs are 30 (1.4%) favourable year to date including:

**Medical personnel** (4 FTE / 1.2% favourable)
- Vacancies (offset in outsourced medical costs).

**Nursing personnel** (-8 FTE / -0.8% favourable)
- Patient volumes began to decline in February from the high volumes experience over the holiday period, however they remain over budget and are reflected in the nursing FTE year to date position.

**Allied Health Personnel** (29 FTE / 6.1% favourable)
- Vacancies including psychologists, social workers, MRTs, laboratory technicians, and occupational therapists.

## Monthly Elective Health Target Report
## Year to Date January 2018

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

| | | YTD February 2018 | | | |
|---|---|---|---|---|---|
| | | Actual | Plan | Var. | %Var. |
| On-Site | Avastins | 134 | 134 | 0 | 0.00% |
| | ENT | 300 | 339 | -39 | -11.50% |
| | General Surgery | 512 | 561 | -49 | -8.70% |
| | Gynaecology | 346 | 375 | -29 | -7.70% |
| | Maxillo-Facial | 141 | 143 | -2 | -1.40% |
| | Ophthalmology | 626 | 720 | -94 | -13.10% |
| | Orthopaedics | 362 | 382 | -20 | -5.20% |
| | Orthopaedics - Major Joints | 144 | 178 | -34 | -19.10% |
| | Skin Lesions | 135 | 135 | 0 | 0.00% |
| | Urology | 333 | 321 | 12 | 3.70% |
| | Vascular | 78 | 119 | -41 | -34.50% |
| | Surgical - Arranged | 378 | 354 | 24 | 6.80% |
| | Non Surgical - Arranged | 51 | 9 | 42 | 466.70% |
| | Non Surgical - Elective | 31 | 44 | -13 | -29.50% |
| **On-Site** | **Total** | **3571** | **3814** | **-243** | **-6.40%** |
| Outsourced | ENT | 62 | 93 | -31 | -33.30% |
| | General Surgery | 211 | 187 | 24 | 12.80% |
| | Gynaecology | 18 | 0 | 18 | 0.00% |
| | Maxillo-Facial | 40 | 53 | -13 | -24.50% |
| | Ophthalmology | 132 | 76 | 56 | 73.70% |
| | Orthopaedics | 1 | 0 | 1 | 0.00% |
| | Orthopaedics - Major Joints | 70 | 60 | 10 | 16.70% |
| | Skin Lesions | 2 | 0 | 2 | 0.00% |
| | Urology | 36 | 33 | 3 | 9.10% |
| | Vascular | 19 | 4 | 15 | 375.00% |
| **Outsourced** | **Total** | **591** | **506** | **85** | **16.80%** |
| IDF Outflow | Cardiothoracic | 56 | 48 | 8 | 16.70% |
| | ENT | 35 | 26 | 9 | 34.60% |
| | General Surgery | 37 | 34 | 3 | 8.80% |
| | Gynaecology | 15 | 17 | -2 | -11.80% |
| | Maxillo-Facial | 79 | 123 | -44 | -35.80% |
| | Neurosurgery | 33 | 54 | -21 | -38.90% |
| | Ophthalmology | 21 | 25 | -4 | -16.00% |
| | Orthopaedics | 26 | 12 | 14 | 116.70% |
| | Paediatric Surgery | 48 | 54 | -6 | -11.10% |
| | Skin Lesions | 24 | 31 | -7 | -22.60% |
| | Urology | 9 | 5 | 4 | 80.00% |
| | Vascular | 7 | 10 | -3 | -30.00% |
| | Surgical - Arranged | 102 | 98 | 4 | 4.10% |
| | Non Surgical - Arranged | 35 | 37 | -2 | -5.40% |
| | Non Surgical - Elective | 75 | 73 | 2 | 2.70% |
| **IDF Outflow** | **Total** | **602** | **647** | **-45** | **-7.00%** |
| **TOTAL** | | **4,764** | **4,967** | **-203** | **-4.10%** |

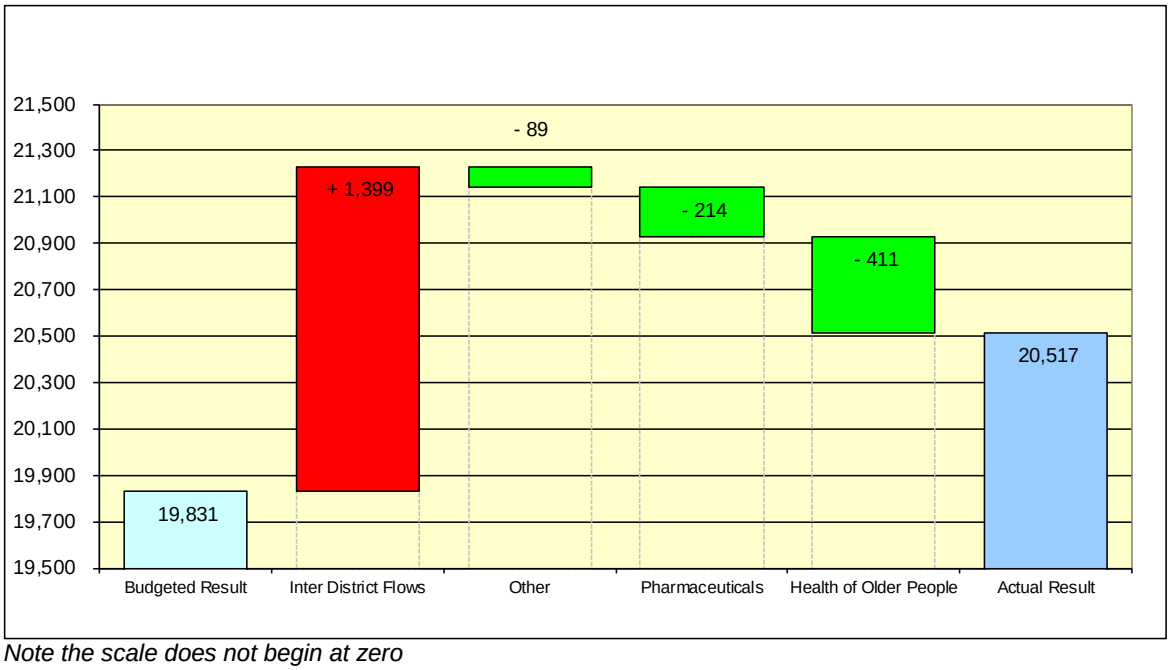
| | | February 2018 | | | |
|---|---|---|---|---|---|
| | | Actual | Plan | Var. | %Var. |
| On-Site | Avastins | 17 | 17 | 0 | 0.00% |
| | ENT | 40 | 40 | 0 | 0.00% |
| | General Surgery | 59 | 68 | -9 | -13.20% |
| | Gynaecology | 53 | 47 | 6 | 12.80% |
| | Maxillo-Facial | 13 | 15 | -2 | -13.30% |
| | Ophthalmology | 94 | 91 | 3 | 3.30% |
| | Orthopaedics | 44 | 48 | -4 | -8.30% |
| | Orthopaedics - Major Joints | 18 | 25 | -7 | -28.00% |
| | Skin Lesions | 16 | 16 | 0 | 0.00% |
| | Urology | 35 | 40 | -5 | -12.50% |
| | Vascular | 1 | 14 | -13 | -92.90% |
| | Surgical - Arranged | 47 | 40 | 7 | 17.50% |
| | Non Surgical - Arranged | 4 | 1 | 3 | 300.00% |
| | Non Surgical - Elective | 3 | 5 | -2 | -40.00% |
| **On-Site** | **Total** | **444** | **467** | **-23** | **-4.90%** |
| Outsourced | ENT | 5 | 13 | -8 | -61.50% |
| | General Surgery | 21 | 25 | -4 | -16.00% |
| | Gynaecology | 1 | 0 | 1 | 0.00% |
| | Maxillo-Facial | 4 | 10 | -6 | -60.00% |
| | Ophthalmology | 11 | 7 | 4 | 57.10% |
| | Orthopaedics | 0 | 0 | 0 | 0.00% |
| | Orthopaedics - Major Joints | 2 | 4 | -2 | -50.00% |
| | Skin Lesions | 1 | 0 | 1 | 0.00% |
| | Urology | 8 | 4 | 4 | 100.00% |
| | Vascular | 3 | 1 | 2 | 200.00% |
| **Outsourced** | **Total** | **56** | **64** | **-8** | **-12.50%** |
| IDF Outflow | Cardiothoracic | 5 | 6 | -1 | -16.70% |
| | ENT | 1 | 4 | -3 | -75.00% |
| | General Surgery | 0 | 4 | -4 | -100.00% |
| | Gynaecology | 3 | 2 | 1 | 50.00% |
| | Maxillo-Facial | 3 | 15 | -12 | -80.00% |
| | Neurosurgery | 2 | 7 | -5 | -71.40% |
| | Ophthalmology | 1 | 4 | -3 | -75.00% |
| | Orthopaedics | 1 | 1 | 0 | 0.00% |
| | Paediatric Surgery | 3 | 7 | -4 | -57.10% |
| | Skin Lesions | 0 | 5 | -5 | -100.00% |
| | Urology | 0 | 1 | -1 | -100.00% |
| | Vascular | 0 | 1 | -1 | -100.00% |
| | Surgical - Arranged | 7 | 13 | -6 | -46.20% |
| | Non Surgical - Arranged | 0 | 5 | -5 | -100.00% |
| | Non Surgical - Elective | 8 | 12 | -4 | -33.30% |
| **IDF Outflow** | **Total** | **34** | **87** | **-53** | **-60.90%** |
| **TOTAL** | | **534** | **618** | **-84** | **-13.60%** |

Please Note: This report was run on 7 March 2018. Skin Lesions and Avastins are reported to plan. Data is subject to change.

## 6. FUNDING OTHER PROVIDERS

| $'000 | February Actual | February Budget | February Variance | | Year to Date Actual | Year to Date Budget | Year to Date Variance | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| **Payments to Other Providers** | | | | | | | | | |
| Pharmaceuticals | 3,512 | 3,726 | 214 | 5.7% | 28,952 | 29,866 | 914 | 3.1% | 44,451 |
| Primary Health Organisations | 2,966 | 2,964 | (2) | -0.1% | 24,309 | 24,348 | 39 | 0.2% | 36,453 |
| Inter District Flows | 5,699 | 4,300 | (1,399) | -32.5% | 36,252 | 34,608 | (1,644) | -4.8% | 52,138 |
| Other Personal Health | 1,800 | 1,924 | 123 | 6.4% | 15,034 | 15,404 | 370 | 2.4% | 23,629 |
| Mental Health | 990 | 931 | (58) | -6.2% | 7,826 | 7,506 | (321) | -4.3% | 11,556 |
| Health of Older People | 5,192 | 5,603 | 411 | 7.3% | 44,694 | 44,828 | 134 | 0.3% | 67,017 |
| Other Funding Payments | 358 | 384 | 25 | 6.6% | 2,708 | 2,843 | 135 | 4.7% | 4,160 |
| | 20,517 | 19,831 | (685) | -3.5% | **159,776** | **159,402** | (374) | -0.2% | 239,405 |
| **Payments by Portfolio** | | | | | | | | | |
| Strategic Services | | | | | | | | | |
| Secondary Care | 5,106 | 3,784 | (1,322) | -34.9% | 32,061 | 30,624 | (1,437) | -4.7% | 46,203 |
| Primary Care | 8,223 | 8,196 | (27) | -0.3% | 65,123 | 66,283 | 1,160 | 1.8% | 99,562 |
| Chronic Disease Management | - | - | - | 0.0% | - | - | - | 0.0% | - |
| Mental Health | 1,270 | 1,251 | (19) | -1.5% | 10,061 | 10,017 | (44) | -0.4% | 14,974 |
| Health of Older People | 5,625 | 5,914 | 289 | 4.9% | 47,506 | 47,230 | (276) | -0.6% | 70,936 |
| Other Health Funding | (233) | 33 | 267 | 800.3% | - | 267 | 267 | 100.0% | 100 |
| Maori Health | 526 | 530 | 4 | 0.8% | 4,131 | 3,993 | (138) | -3.5% | 6,257 |
| Population Health | (0) | 122 | 123 | 100.1% | 893 | 987 | 94 | 9.5% | 1,374 |
| | 20,517 | 19,831 | (685) | -3.5% | **159,776** | **159,402** | (374) | -0.2% | 239,405 |

### *Month of February*




*Note the scale does not begin at zero*

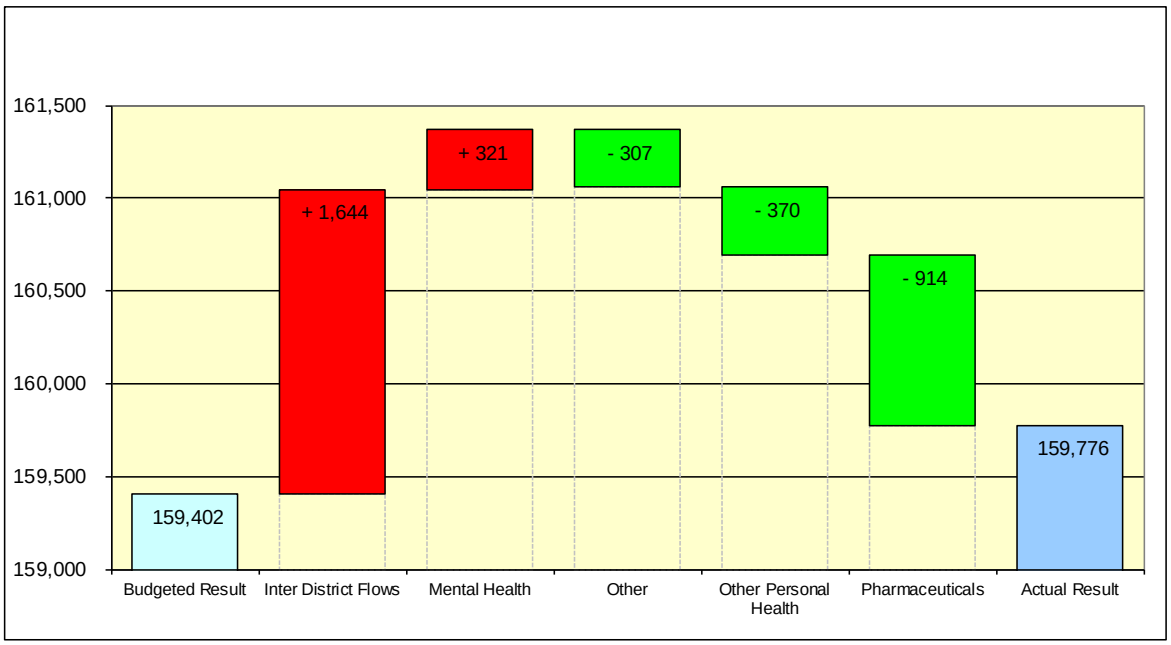
**Inter district flows** (unfavourable)
Higher outflows based on MOH data and information from other DHBs. The sudden increase may reflect delayed coding over the holiday period at some DHBs.

**Pharmaceuticals** (favourable)
Updated to reflect actual PHARMAC rebate received.

**Health of Older People** (favourable)
Short month compared to a budget based on 1/12th of annual costs..

***Year to Date***






**Inter District Flows** (unfavourable)
Provision based on information from MOH and other DHBs.

**Mental Health** (unfavourable)
Increased spend in community residential beds and services.

**Other Personal Health** (favourable)
Funding recoveries.

**Pharmaceuticals** (favourable)
Higher 2016/17 wash-up and rebate than expected, and improving 2017/18 rebate.

## 7. CORPORATE SERVICES

| $'000 | February Actual | February Budget | February Variance | | Year to Date Actual | Year to Date Budget | Year to Date Variance | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| **Operating Expenditure** | | | | | | | | | |
| Personnel | 1,315 | 1,254 | (61) | -4.9% | 10,383 | 10,584 | 201 | 1.9% | 15,740 |
| Outsourced services | 92 | 68 | (24) | -36.1% | 626 | 541 | **(85)** | **-15.6%** | 870 |
| Clinical supplies | (258) | (268) | (11) | -4.0% | (424) | (531) | **(107)** | **-20.2%** | (338) |
| Infrastructure and non clinical | 727 | 766 | 39 | 5.1% | 6,446 | 6,666 | 220 | 3.3% | 9,427 |
| | 1,876 | 1,819 | (57) | -3.2% | 17,031 | 17,260 | 229 | 1.3% | 25,700 |
| **Capital servicing** | | | | | | | | | |
| Depreciation and amortisation | 1,038 | 1,109 | **71** | **6.4%** | 9,085 | 8,688 | (397) | -4.6% | 13,889 |
| Financing | - | - | - | 0.0% | - | - | - | 0.0% | - |
| Capital charge | 705 | 705 | - | 0.0% | 5,662 | 5,640 | (23) | -0.4% | 8,504 |
| | 1,743 | 1,814 | 71 | 3.9% | 14,747 | 14,327 | (419) | -2.9% | 22,393 |
| | **3,619** | **3,633** | **14** | **0.4%** | **31,777** | **31,587** | **(190)** | **-0.6%** | **48,093** |
| **Full Time Equivalents** | | | | | | | | | |
| Medical personnel | 0.2 | 0.3 | 0 | 19.3% | 0 | 0 | 0 | 3.3% | 0.3 |
| Nursing personnel | 16.8 | 15.1 | (2) | -11.5% | 13 | 15 | 2 | 12.6% | 14.9 |
| Allied health personnel | 0.2 | 0.4 | 0 | 52.1% | 1 | 0 | (0) | -86.2% | 0.4 |
| Support personnel | 9.4 | 9.2 | (0) | -2.1% | 9 | 9 | 0 | 1.2% | 9.1 |
| Management and administration | 146.5 | 149.9 | 3 | 2.2% | 139 | 147 | **8** | **5.5%** | 146.8 |
| | **173.2** | **174.9** | **2** | **1.0%** | **162** | **172** | **10** | **5.6%** | **171.5** |

High medical officer recruitment costs in February, partly offset by Nursing Entry to Practice (NETP) training programmes (offset in income). Depreciation in February reflects the low number of days in the month.

## 8. RESERVES

| $'000 | February Actual | February Budget | February Variance | | Year to Date Actual | Year to Date Budget | Year to Date Variance | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| **Expenditure** | | | | | | | | | |
| Contingency | 70 | 250 | **180** | **71.9%** | 945 | 2,000 | **1,055** | **52.7%** | 235 |
| Transform and Sustain resource | 45 | 101 | **56** | **55.3%** | 537 | 820 | **283** | **34.5%** | 884 |
| Other | 0 | (51) | **(51)** | **-100.5%** | 45 | (21) | **(66)** | **-317.3%** | (190) |
| | **116** | **301** | **185** | **61.5%** | **1,528** | **2,799** | **1,271** | **45.4%** | **929** |

Contingency releases of $125 thousand towards elective surgery targets, and $55 thousand for CCDM were made in February. Project timelines for the national patient flow project have been extended delaying Transform and Sustain expenditure in the near term. The “Other” category includes the devolvement of CCDM budgets to individual directorates providing health services.

## 9. FINANCIAL PERFORMANCE BY MOH CLASSIFICATION

| | February | | | Year to Date | | | End of Year | | |
|---|---|---|---|---|---|---|---|---|---|
| $'000 | Actual | Annual Plan | Variance | Actual | Annual Plan | Variance | Forecast | Annual Plan | Variance |
| **Funding** | | | | | | | | | |
| Income | 46,050 | 45,775 | 275 F | 348,561 | 348,119 | 441 F | 525,290 | 525,048 | 243 F |
| *Less:* | | | | | | | | | |
| Payments to Internal Providers | 23,049 | 23,049 | - | 189,848 | 189,939 | 91 F | 284,927 | 285,018 | 91 F |
| Payments to Other Providers | 20,517 | 19,831 | (685) U | 159,776 | 159,402 | (374) U | 239,405 | 239,078 | (328) U |
| Contribution | **2,484** | **2,895** | **(410) U** | **(1,063)** | **(1,221)** | **158 F** | **958** | **952** | **6 F** |
| **Governance and Funding Admin.** | | | | | | | | | |
| Funding | 274 | 274 | - | 2,195 | 2,195 | - | 3,294 | 3,294 | - |
| Other Income | 3 | 3 | - | 57 | 20 | 37 F | 67 | 30 | 37 F |
| *Less:* | | | | | | | | | |
| Expenditure | 242 | 275 | 33 F | 1,842 | 2,078 | 235 F | 2,968 | 3,204 | 236 F |
| Contribution | **35** | **2** | **33 F** | **410** | **137** | **272 F** | **393** | **120** | **273 F** |
| **Health Provision** | | | | | | | | | |
| Funding | 22,775 | 22,771 | 4 F | 187,653 | 187,740 | (87) U | 281,633 | 281,706 | (72) U |
| Other Income | 2,379 | 2,463 | (84) U | 20,683 | 20,400 | 283 F | 30,720 | 30,654 | 66 F |
| *Less:* | | | | | | | | | |
| Expenditure | 24,498 | 24,703 | 205 F | 210,399 | 208,085 | (2,314) U | 314,357 | 311,931 | (2,426) U |
| Contribution | **655** | **530** | **125 F** | **(2,064)** | **55** | **(2,119) U** | **(2,004)** | **428** | **(2,432) U** |
| **Net Result** | **3,174** | **3,427** | **(252)** U | **(2,717)** | **(1,029)** | **(1,688)** U | **(653)** | **1,500** | **(2,153)** U |

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

## 10. MANAGEMENT BUDGET MOVEMENTS

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

The major changes between revenue and expense lines are usually due to health provision savings programmes, or unbudgeted new funding received during the year and the associated expenditure.

| | February | | | Year to Date | | | End of Year | | |
|---|---|---|---|---|---|---|---|---|---|
| $'000 | Mgmt Budget | Annual Plan | Movement | Mgmt Budget | Annual Plan | Movement | Mgmt Budget | Annual Plan | Movement |
| **Funding** | | | | | | | | | |
| Income | 45,775 | 45,641 | 134 F | 348,119 | 347,465 | 655 F | 525,048 | 524,124 | 924 F |
| *Less:* | | | | | | | | | |
| Payments to Internal Providers | 23,049 | 22,955 | (94) U | 189,939 | 189,187 | (752) U | 285,018 | 283,900 | (1,118) U |
| Payments to Other Providers | 19,831 | 19,759 | (72) U | 159,402 | 158,729 | (672) U | 239,078 | 238,724 | (354) U |
| Contribution | **2,895** | **2,927** | **(32) U** | **(1,221)** | **(452)** | **(769) U** | **952** | **1,500** | **(548) U** |
| **Governance and Funding Admin.** | | | | | | | | | |
| Funding | 274 | 274 | - | 2,195 | 2,195 | - | 3,294 | 3,294 | - |
| Other Income | 3 | 3 | - | 20 | 20 | - | 30 | 30 | - |
| *Less:* | | | | | | | | | |
| Expenditure | 275 | 272 | (3) U | 2,078 | 2,214 | 137 F | 3,204 | 3,324 | 120 F |
| Contribution | **2** | **5** | **(3) U** | **137** | **1** | **137 F** | **120** | **(0)** | **120 F** |
| **Health Provision** | | | | | | | | | |
| Funding | 22,771 | 22,681 | 90 F | 187,740 | 186,992 | 748 F | 281,706 | 280,606 | 1,099 F |
| Other Income | 2,463 | 2,407 | 56 F | 20,400 | 20,060 | 340 F | 30,654 | 30,089 | 565 F |
| *Less:* | | | | | | | | | |
| Expenditure | 24,703 | 24,593 | (110) U | 208,085 | 207,629 | (456) U | 311,931 | 310,695 | (1,236) U |
| Contribution | **530** | **495** | **36 F** | **55** | **(577)** | **632 F** | **428** | **-** | **428 F** |
| **Net Result** | **3,427** | **3,427** | **(0)** U | **(1,029)** | **(1,029)** | **(0)** U | **1,500** | **1,500** | **(0)** U |

## 11. QUALITY AND FINANCIAL IMPROVEMENT PROGRAMME

The table below shows 99.8% of the $10.8 million of general efficiency plans have been identified to date, and that $4.7 million of savings have been achieved against a year-to-date target of $7.5 million.

Corporate general efficiencies are 62% of the year-to-date identified plans, up from 53% in January. The planned reduction in depreciation expense and capital charges comprise most of the shortfall.

Provider services general efficiencies are 68% of the year-to-date identified plans, down from 73% in January. The main services with shortfalls are Community, Women and Child, Medical Services, and Surgical Services and reflect the pressures experienced over the holiday period.

Strategic Planning general efficiencies are at 54% of the year-to-date identified plans, up from 53% in January. IDF outflows makes up nearly half of the shortfall and reflects the lead time for referral practice changes. Residential care increased volumes and pay equity distortions comprise another 15% of the shortfall, and Urgent Care makes up further 13%.

| Service | 2017/18 Annual Savings Plans | YTD Savings Planned | YTD Savings Achieved | YTD Var | % YTD Planned Savings Achieved | % of Annual Plan Achieved YTD |
|---|---|---|---|---|---|---|
| Corporate | 997,000 | 552,147 | 343,906 | (208,242) | 62% | 34% |
| Provider Services | 4,911,000 | 3,918,285 | 2,653,635 | (1,264,650) | 68% | 41% |
| Strategic Planning | 4,598,000 | 2,739,963 | 1,478,653 | (1,261,310) | 54% | 31% |
| Strategy and Health Improvement | 286,000 | 235,183 | 224,266 | (10,916) | 95% | 77% |
| **Grand Total** | **10,792,000** | **7,445,578** | **4,700,460** | **(2,745,118)** | **63%** | **37%** |

## 12. FINANCIAL POSITION

| 30 June 2017 | $'000 | February Actual | February Budget | Variance from budget | Movement from 30 June 2017 | Annual Budget |
|---|---|---|---|---|---|---|
| | **Equity** | | | | | |
| 149,751 | Crown equity and reserves | 149,751 | 149,751 | - | - | 149,394 |
| (7,406) | Accumulated deficit | (10,123) | (5,502) | 4,621 | (2,717) | (2,973) |
| 142,345 | | 139,628 | 144,249 | 4,621 | (2,717) | 146,421 |
| | **Represented by:** | | | | | |
| | Current Assets | | | | | |
| 16,541 | Bank | 12,488 | 14,843 | 2,354 | (4,052) | 15,536 |
| 1,690 | Bank deposits > 90 days | 1,901 | 1,755 | (147) | 212 | 1,755 |
| 26,735 | Prepayments and receivables | 25,319 | 22,747 | (2,572) | (1,417) | 22,951 |
| 4,435 | Inventory | 4,318 | 4,390 | 71 | (116) | 4,419 |
| 625 | Non current assets held for sale | 625 | - | (625) | - | - |
| 50,025 | | 44,652 | 43,735 | (917) | (5,373) | 44,661 |
| | Non Current Assets | | | | | |
| 152,411 | Property, plant and equipment | 153,445 | 157,763 | 4,318 | 1,034 | 160,576 |
| 1,820 | Intangible assets | 1,543 | 2,506 | 963 | (277) | 2,962 |
| 10,701 | Investments | 10,987 | 11,607 | 620 | 286 | 12,105 |
| 164,932 | | 165,975 | 171,875 | 5,901 | 1,043 | 175,642 |
| **214,957** | **Total Assets** | **210,627** | **215,610** | **4,984** | **(4,330)** | **220,302** |
| | **Liabilities** | | | | | |
| | Current Liabilities | | | | | |
| - | Bank overdraft | - | - | - | - | - |
| 35,447 | Payables | 33,392 | 35,509 | 2,117 | (2,055) | 35,762 |
| 34,528 | Employee entitlements | 34,969 | 33,133 | (1,836) | 441 | 35,381 |
| 69,975 | | 68,361 | 68,642 | 281 | (1,614) | 71,143 |
| | Non Current Liabilities | | | | | |
| 2,638 | Employee entitlements | 2,638 | 2,719 | 82 | - | 2,739 |
| 2,638 | | 2,638 | 2,719 | 82 | - | 2,739 |
| **72,612** | **Total Liabilities** | **70,999** | **71,361** | **362** | **(1,614)** | **73,882** |
| | | | | | | |
| **142,345** | **Net Assets** | **139,628** | **144,249** | **4,621** | **(2,717)** | **146,421** |

The variance from budget for:

- Equity reflects the amount the budgeted opening balance differs from the 2016/17 result, and the 2017/18 variance from budget;
- Property, plant and equipment mainly reflect the lower than budgeted capital spend;
- Payables reflects the release or re-estimate of provisions and accruals in the first half of the year, partly offset by higher accrauls for inter district flows, pharmaceuticals and other provider payments.
- Employee entitlements – see below

## 13. EMPLOYEE ENTITLEMENTS

| 30 June 2017 | $'000 | February Actual | February Budget | Variance from budget | Movement from 30 June 2017 | Annual Budget |
|---|---|---|---|---|---|---|
| 7,853 | Salaries & wages accrued | 7,138 | 5,122 | (2,017) | (715) | 7,756 |
| 522 | ACC levy provisions | 804 | 334 | (470) | 282 | 501 |
| 4,869 | Continuing medical education | 6,477 | 6,184 | (293) | 1,608 | 5,553 |
| 19,819 | Accrued leave | 18,978 | 19,818 | 840 | (841) | 19,883 |
| 4,103 | Long service leave & retirement grat. | 4,210 | 4,395 | 185 | 107 | 4,426 |
| 37,165 | **Total Employee Entitlements** | 37,606 | 35,852 | (1,754) | 441 | 38,119 |

## 14. TREASURY

***Liquidity management***

The surplus cash of all DHBs is managed by NZ Health Partnerships Limited under a sweep arrangement facilitated by BNZ. 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 DHB has no interest rate exposure relating to debt.

***Foreign exchange risk management***

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

## 15. CAPITAL EXPENDITURE

Capital spend is $6.3 million behind plan year-to-date, including the surgical expansion that is in the planning stage, the histology and education centre upgrade that is now underway, and information technology that is expected to be spent later in the year.

See table on the next page.

| *2018 Annual Plan* | | *Actual $'000* | *Year to Date Budget $'000* | *Variance $'000* |
|---|---|---|---|---|
| | Source of Funds | | | |
| | **Operating Sources** | | | |
| 13,625 | Depreciation | 9,085 | 8,688 | (397) |
| 1,500 | Surplus/(Deficit) | (2,717) | (1,029) | 1,688 |
| 9,166 | Working Capital | 3,528 | 8,154 | 5,876 |
| 24,290 | | 9,896 | 15,813 | 7,167 |
| | **Other Sources** | | | |
| - | Special funds and clinical trials | 287 | - | (287) |
| 625 | Sale of assets | - | 625 | (625) |
| 625 | | 287 | 625 | (912) |
| **24,915** | **Total funds sourced** | **10,184** | **16,438** | **6,254** |
| | Application of Funds: | | | |
| | **Block Allocations** | | | |
| 3,400 | Facilities | 1,946 | 2,441 | 495 |
| 3,200 | Information Services | 210 | 2,132 | 1,922 |
| 3,400 | Clinical Plant & Equipment | 2,371 | 2,091 | (280) |
| 10,000 | | 4,527 | 6,664 | 2,137 |
| | **Local Strategic** | | | |
| 1,082 | Renal Centralised Development | 414 | 721 | 307 |
| 6,306 | New Stand-alone Endoscopy Unit | 4,017 | 4,202 | 186 |
| 134 | New Mental Health Inpatient Unit Development | 123 | 89 | (33) |
| - | Maternity Services | 7 | - | (7) |
| 500 | Upgrade old MHIU | 10 | 333 | 323 |
| 243 | Travel Plan | 88 | 162 | 74 |
| 1,555 | Histology and Education Centre Upgrade | 129 | 1,036 | 908 |
| 500 | Radiology Extension | - | 333 | 333 |
| 600 | Fit out Corporate Building | - | 400 | 400 |
| 3,000 | Surgical Expansion | 147 | 1,999 | 1,852 |
| 13,920 | | 4,933 | 9,276 | 4,343 |
| | **Other** | | | |
| - | Special funds and clinical trials | 287 | - | (287) |
| - | Other | 150 | - | (150) |
| - | | 438 | - | (438) |
| ***23,920*** | ***Capital Spend*** | ***9,898*** | ***15,940*** | ***6,042*** |
| | **Regional Strategic** | | | |
| 995 | RHIP (formerly CRISP) | 286 | 498 | 212 |
| 995 | | 286 | 498 | 212 |
| **24,915** | **Total funds applied** | **10,184** | **16,438** | **6,254** |

# Monthly Project Board Report

## Mar 2018

HAWKE'S BAY District Health Board

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

**Project Manager Facilities Development: Trent Fairey**

| Overall Project Progress | Quality & Safety Risk Status | Time Status | Financial Status |
|---|---|---|---|
| 48% | G | G | G |

**Phase 3: Service transition & Facility Development**

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

### Project Budget Status

| | | | |
|---|---|---|---|
| **Total Approved for Capital Budget** | **$ 13,095,000** | Total 17/18 Forecast Spend | **$ 7,450,000** |
| Total Project Spend to Date | $ 6,258,472 | Total 17/18 Spend to Date | $ 4,017,000 |
| Percentage of Total Spend vs Budget | 48% | Percentage 17/18 Spend vs Forecast | 54% |

Project initiation was completed on the 27th February 2017 on approval of the site specific safety plan. Project total spend is now tracking inline with initial predictions. The addition of the level 1 variation to contract for an approved $1,300,000 has been integrated into the total project costs. Total cost and timeframe reporting has changed to take into account this variation. Project spend will track in a similar range to the current predictions with the variation costs coming into the project in the first quarter of 2018/19 financial year. Project spend continues to track well with proposed cashflow projections, total variations to date are inline with RLB predictions.

### Deliverable Dates

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

**Key Achievements this period**

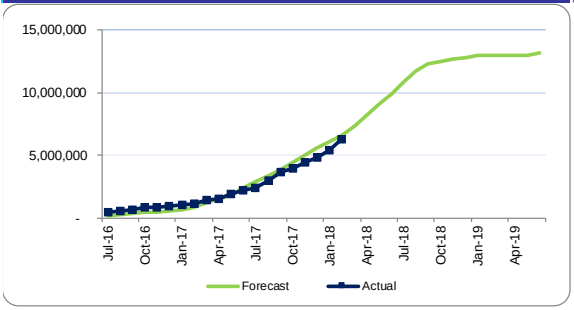
The final stage of structural steel installation is complete, All structural steel has now been delivered to site and erected. Floor concrete pours are now completed on ground and level 1. All trades are proceeding to programme, revised programme has been agreed providing the completed building in September 2018 with operational activity planned from October 2018.
No accidents reported in this period, 4th Quarter (2017) H&S GEMCO Audit completed , results pending. Independent H&S auditing by the HBDHB continues on a monthly basis.

**Planned Activities next period**

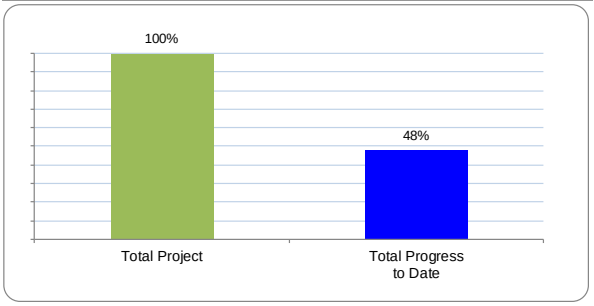
Completion of roof structure and external cladding in Early April
Services first fix and windows for all remaining Grids. Internal framing for Grids E through to K

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

**Actual Spend**




**Total Project Progress**



## 16. ROLLING CASH FLOW

| | Actual | February Forecast | Variance | Mar Forecast | Apr Forecast | May Forecast | Jun Forecast | Jul Budget | Aug Budget | Sep Budget | Oct Budget | Nov Budget | Dec Budget | Jan Budget | Feb Budget |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cash flows from operating activities** | | | | | | | | | | | | | | | |
| Cash receipts from Crown agencies | 41,838 | 45,724 | (3,886) | 47,899 | 44,410 | 47,892 | 48,266 | 44,365 | 43,638 | 52,459 | 44,805 | 48,215 | 44,703 | 45,742 | 47,854 |
| Cash receipts from revenue banking | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Cash receipts from donations, bequests and clinical trials | 79 | - | 79 | - | - | - | - | - | - | - | - | - | - | - | - |
| Cash receipts from other sources | 414 | 470 | (56) | 431 | 425 | 443 | 436 | 440 | 446 | 440 | 505 | 447 | 445 | 471 | 477 |
| Cash paid to suppliers | (25,637) | (22,482) | (3,155) | (26,930) | (26,324) | (26,190) | (26,472) | (28,113) | (26,670) | (33,468) | (27,677) | (27,999) | (27,464) | (27,634) | (24,929) |
| Cash paid to employees | (16,287) | (14,671) | (1,616) | (16,086) | (16,488) | (18,714) | (16,339) | (15,532) | (20,705) | (15,683) | (15,901) | (18,879) | (15,325) | (23,374) | (16,233) |
| **Cash generated from operations** | **407** | **9,041** | **(8,634)** | **5,313** | **2,023** | **3,431** | **5,893** | **1,160** | **(3,291)** | **3,749** | **1,733** | **1,784** | **2,360** | **(4,795)** | **7,170** |
| Interest received | 61 | 68 | (7) | 64 | 64 | 64 | 64 | 74 | 74 | 74 | 74 | 74 | 74 | 74 | 74 |
| Interest paid | - | 0 | (0) | - | - | - | - | - | - | - | - | - | - | - | - |
| Capital charge paid | 0 | - | 0 | 0 | 0 | 0 | (4,230) | 0 | 0 | 0 | 0 | 0 | (4,230) | 0 | 0 |
| **Net cash inflow/(outflow) from operating activities** | **468** | **9,109** | **(8,641)** | **5,377** | **2,087** | **3,494** | **1,726** | **1,234** | **(3,217)** | **3,822** | **1,806** | **1,858** | **(1,796)** | **(4,722)** | **7,243** |
| **Cash flows from investing activities** | | | | | | | | | | | | | | | |
| Proceeds from sale of property, plant and equipment | 5 | 0 | 5 | - | - | - | (0) | - | - | - | - | - | 625 | - | - |
| Acquisition of property, plant and equipment | (1,525) | (1,803) | 278 | (2,159) | (3,092) | (2,895) | (3,639) | (926) | (926) | (926) | (926) | (926) | (926) | (926) | (926) |
| Acquisition of intangible assets | - | (324) | 324 | (48) | (25) | (55) | (15) | (154) | (154) | (154) | (154) | (154) | (154) | (154) | (154) |
| Acquisition of investments | - | - | - | (249) | - | - | (249) | - | - | (249) | - | - | (249) | - | - |
| **Net cash inflow/(outflow) from investing activities** | **(1,520)** | **(2,127)** | **607** | **(2,455)** | **(3,117)** | **(2,950)** | **(3,903)** | **(1,080)** | **(1,080)** | **(1,328)** | **(1,080)** | **(1,080)** | **(703)** | **(1,080)** | **(1,080)** |
| **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 | (1,052) | 6,982 | (8,035) | 2,921 | (1,030) | 545 | (2,535) | 154 | (4,297) | 2,494 | 727 | 778 | (2,499) | (5,801) | 6,164 |
| Add:Opening cash | 15,442 | 15,442 | - | 14,390 | 17,311 | 16,281 | 16,826 | 14,291 | 14,445 | 10,148 | 12,643 | 13,369 | 14,148 | 11,648 | 5,847 |
| **Cash and cash equivalents at end of period** | **14,390** | **22,424** | **(8,035)** | **17,311** | **16,281** | **16,826** | **14,291** | **14,445** | **10,148** | **12,643** | **13,369** | **14,148** | **11,648** | **5,847** | **12,011** |
| **Cash and cash equivalents** | | | | | | | | | | | | | | | |
| Cash | 4 | 4 | 0 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Short term investments (excl. special funds/clinical trials) | 11,497 | 19,585 | (8,088) | 14,281 | 13,251 | 13,796 | 11,261 | 11,415 | 7,118 | 9,612 | 10,339 | 11,117 | 8,618 | 2,817 | 8,980 |
| Short term investments (special funds/clinical trials) | 2,863 | 2,835 | 28 | 3,026 | 3,026 | 3,026 | 3,026 | 3,026 | 3,026 | 3,026 | 3,026 | 3,026 | 3,026 | 3,026 | 3,026 |
| Bank overdraft | 26 | (0) | 26 | - | - | - | - | - | - | - | - | - | - | - | - |
| | **14,390** | **22,424** | **(8,035)** | **17,311** | **16,281** | **16,826** | **14,291** | **14,446** | **10,149** | **12,643** | **13,370** | **14,148** | **11,649** | **5,848** | **12,011** |

Changes have been made to the phasing of some major cash-flows based on best estimates of when they will occur e.g. elective services revenue, IDF wash-up and the rest home worker's pay equity settlement. Cash flows in February reflect a large increase in debtors, expected to partially reverse in March.

**RECOMMENDATION:**

It is recommended that the Board and FRAC:

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

# BOARD HEALTH & SAFETY CHAMPION'S UPDATE

Verbal

| | | |
|---|---|---|
| OURHEALTH HAWKE'S BAY Whakawateatia | **Hawke's Bay Clinical Council** | 25 |
| | For the attention of:<br>**HBDHB Board** | |
| Document Owner: | Dr John Gommans (Chair)<br>Dr Andy Phillips (Co-Chair) | |
| Month: | March 2018 | |
| Consideration: | For Information | |

11

**RECOMMENDATION**

**That the Board**

Review the contents of this report; and

**Note that Clinical Council:**

- **Approved in principle** the proposed Clinical Governance Structure Value Assessment
- **Approved** the Clinical Governance of Investigation of Results Policy
- **Discussed** the HB Health Sector Leadership Forum and provided feedback on the day
- **Received** and agreed to implement the Choosing Wisely Campaign
- **Received** the Clinical Services Plan Sector Update
- **Noted** reports provided for information only.

Council met on 14 March 2018, an overview of matters discussed is provided below.

**Clinical Governance Structure Value Assessment:**

A paper is on the Board agenda this month. Following discussion at the February meeting and subsequent discussion at EMT, changes were made to the structure. Clinical governance oversight for clinical risk and equity were discussed at length. Council approved the proposed clinical committees and advisory group structure subject to some small changes which have been included in the Board paper.

**Clinical Governance of Investigation of Results Policy:**

The governance and ownership of diagnostic test results is a key issue which sparked vigorous discussion. Final feedback on the draft policy was received and the policy was approved.

**Choosing Wisely Presentation:**

A presentation was provided. The Choosing Wisely campaign has been supported by the Medical Colleges in New Zealand and they are clear that this is not about rationing, it is about quality of care, getting the best value and encouraging conversations between health professions and consumers. Key principles for clinicians are that interventions need to be: supported by evidence; not duplicative of other tests or procedures; free from harm and truly necessary.

Following discussion Clinical Council agreed to support implementation of this work in Hawkes Bay. It was agreed that implementation of Choosing Wisely will be taken forward with urgency and haste. A joint meeting with the Consumer Council will be organised. Members agreed to identify three actions to focus on implementing first.

**Clinical Services Plan – Sector Update:**

An overview of progress to date was provided with a summary of the revised timeframes.

**HB Health Sector Leadership Forum Reflections:**

Members gave their feedback on the day.

**Reports for information were noted from the following:**

- Establishing Health and Social Care Localities in HB
- HHB Clinical Advisory and Governance Committee

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| OURHEALTH HAWKE'S BAY Whakawateatia | **Hawke's Bay Health Consumer Council** 26 |
| | For the attention of: **HBDHB Board** |
| Document Owner: | Rachel Ritchie, Chair |
| Reviewed by: | Not applicable |
| Month: | March, 2018 |
| Consideration: | For Information |

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**RECOMMENDATION**

**That the Board**

1. **Note** Council's endorsement of the Clinical Governance Structure Report
2. **Note** the contents of this report.

Consumer Council met on 15 March 2018. All members were present. An overview of issues discussed and/or agreed at the meeting is provided below.

**The following updates were considered:**

- **Youth Consumer Council (YCC) Report**

YCC are in the process of finalising an education project focussed on why young people are using drugs and alcohol. This is being developed in liaison with HBDHB Population Health Team and is based on direct input from tamariki and listening to them about their pressures in life. Council fully supported this work and also the proposed application to the Hastings District Council for community grant funding.

- **Clinical Services Plan**

Council noted and appreciated the various invitations to participate in the Future options Workshops.

- **Clinical Governance Structure – Value assessment**

Council noted the progress to date with this review, and acknowledged again the specific inclusion of consumer representation on each of the four committees (with 4 consumer council and 4 clinical council representatives making up the Patient Experience Committee). It was agreed that representation on the Advisory Groups will depend on the Terms of Reference and the ability of consumer reps to actually 'add value'.

The discussion on equity was noted, with acknowledgement that equity was not just a Maori and pacific Island issue. Consumer Council need to have a role in whatever structure is put in place for equity, given Council represents all consumers.

Council endorsed the Report.

- **Establishing Health and Social Care Localities in HB**

Whilst progress was noted, Council were still concerned that as yet, very little has 'changed for the consumer on the ground' and that the report doesn't measure progress in terms of a consumer perspective or ' what has changed for the consumer'.

- **CEO Update**

Dr Kevin Snee, HBDHB CEO, provided an update on the HB health sector, based largely on the presentation he had recently provided to the Health Select Committee. In particular, Council noted the 3 key development phases the CEO had identified:

- Providing a clear focus for the organisation/sector and good performance management (completed)
- Moving the DHB to provide a whole of system leadership, management, systems and service culture (completed or near completed)
- Working with parties outside the health system (next)

Council also noted the plans being put in place to address one of their major concerns, being the overloaded and exhausted staff, with influenza season still to come.
The information update was greatly appreciated and very useful for the council to have context of the wider picture.

**Council also discussed two other topics:**

- **Hawkes Bay Health Sector Leadership Forum Workshop – Reflections**

Members still appreciate and value being part of this group and workshop activity, with this being acknowledged with 14 of the 16 members in attendance. This was the largest representation from consumer council at this Forum.

Reflections and feedback was generally positive, in that the sector appeared to be heading in the right direction and that the 'issues that matter' are being openly discussed 'in partnership'. The consistent theme and language throughout the day of around the Nuka model and whanau centred care is seen as progress from previous forum where that language and focus was more intermittent the creation of a smaller group to lead this work was seen as positive as a way to spearhead progress.

Some concerns however were expressed, including:

- Primary care still need to make changes to 'make a difference for consumers'.
- Equitable access and fairness is key
- The value of the NUKA visits, given it appeared that most of the lessons learned, could have been learned right here in Hawkes Bay
- The need for constructive dialogue between all participants at these venues would give consumers more confidence in the sector and its willingness to embrace change
- Difficult to hear a lot of the conversations at the venue

- **Consumer Engagement**

General concern was expressed and discussed, about the apparent slow rate at which consumer engagement was being embraced within the sector and translating to changes on the ground for consumers to experience. The recent resignation of the Consumer Engagement Manager, and the ongoing delays in progressing the 'Consumer Engagement Strategy' and 'Recognising Consumer Participation' at the governance level (now both due in May 2018) are also of concern given these areas are of significant interest to the council. There was concern from members about the point at which consumer input is sought in a number of projects brought to the council - and that the council

feel they can add value at an earlier point. The proposed revised approach of a 3 stage process where projects are brought to the council for initial input then a second  draft for comment, followed by a 3rd submission for approval, was well received.

It was acknowledged that the general level and nature of engagement at the Chair/Council level was now quite good, but at the service and project level, there is still significant room for improvement. I expect the council will discuss this further.

## Governance Report Overview

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Clinical Governance Structure – Value Assessment** 27 |
| | For the attention of: **HBDHB Board** |
| **Document Owner** | John Gommans and Andy Phillips, Co-Chairs |
| **Document Author(s)** | John Gommans and Andy Phillips, Co-Chairs |
| **Reviewed by** | Executive Management Team, HB Clinical Council and HB Health Consumer Council |
| **Month/Year** | March, 2018 |
| **Purpose** | For Approval |
| **Previous Consideration Discussions** | Clinical Council (December 2017 and February 2018) |
| **Summary** | • At the request of the HBDHB Board. Clinical Council were asked to review the structure, value and workloads of Council's proposed clinical committees and advisory groups.<br>• EMT has discussed clinical council recommendations and the following incorporates EMT feedback<br>• A governance structure is proposed with<br>- Four Clinical Committees reporting to Council, which align with the four pillars of clinical governance.<br>- An information management committee will not be set up to report to clinical council since there is already an IS Governance committee in existence with strong clinical representation<br>- A range of advisory groups that already exist within the DHB but these will expand their scope over time to fulfil sector wide clinical governance needs and obligations<br>• Primary & community care representation will be strengthened within the clinical committee structure<br>• Equity is reflected in the governance structure and reporting lines. To help achieve this, achieving the triple aim will be part of the terms of reference for each committee and advisory group - the simultaneous pursuit of Improved quality, safety and experience of care for individuals; improved health and equity for all populations; and best value for public health system resource<br>• Clinical Council agreed the requirement for equity in the health sector's governance structure(s) but that how this is best achieved while also meeting clinical governance needs requires further discussion with other governance bodies<br>• A technical clinical advisory group on equity will be formed once a new Executive Director with this in their portfolio is recruited. |

| | |
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| | • The issue of integration within the governance structure will be on hold pending agreement of the updated Alliance structure<br>• Primary Care (PHO) Clinical Advisory and Governance Group will report directly to council as well as the PHO<br>• The final recommendations of clinical council will be presented to the March 2018 HBDHB Board meeting<br>• It will be necessary to develop a business case for the costs of supporting the clinical governance structure. This will include estimated admin support costs of $95K plus costs for enabling primary & community care clinicians participation on Advisory Groups<br>• The intention is that the clinical governance structure will be implemented with appropriate supports by 1 July 2018. |
| **Contribution to Goals and Strategic Implications** | • Improving Value from public health system resources through the prudent use of clinicians within clinical governance structures<br>• Improving quality, safety and experience of care through effective clinical governance<br>• Improving Health and Equity for all populations through establishing equity with clinical governance structures |
| **Impact on Reducing Inequities/Disparities** | The intention of embedding equity within the clinical governance structure is to ensure that staff at all levels are aware of their responsibility to abolish health inequity |
| **Consumer Engagement** | Nil to date |
| **Other Consultation /Involvement** | Nil to date |
| **Financial/Budget Impact** | Additional cost for supporting the clinical governance structure and backfilling for primary care representation |
| **Timing Issues** | • March Clinical Council meeting for final recommendation<br>• Recommendation to March 2018 Board meeting<br>• Implement new structure by 1 July 2018 |
| **Announcements/ Communications** | Communication to HB health system following March 2018 Board meeting |

**RECOMMENDATION:**

It is recommended that HB Clinical Council

1. Approve the proposed clinical committees and advisory group structure
2. Note the intention to present clinical council's recommendations to the March 2018 HBDHB Board meeting
3. Note the intention for phased increase in primary & community care representation on Clinical Committees to ensure a whole of sector approach
4. Note the intent for clinical governance training to be provided for all members of Advisory Groups and Clinical Committees

5. Note the incorporation of triple aim in Terms of Reference for all elements of the governance structure and the intent to set up a technical advisory group on equity pending recruitment of an Executive Director
6. Note that an overarching governance committee on equity will be subject to further discussion with other governance bodies.
7. Note the reporting line for the Primary Care (PHO) Clinical Advisory and Governance Group
8. Note that the issue of integration within the governance structure is on hold pending agreement of the Alliance structure
9. Note that it will be necessary to develop a business case for the costs of supporting the clinical governance structure
10. Note that the intention is that the clinical governance structure will be implemented with appropriate supports by 1 July 2018.

HAWKE'S BAY
District Health Board
Whakawāteatia

# Ensuring Best Value From the Hawkes Bay Health System Clinical Governance Committee Structures

| | |
|---|---|
| **Author(s):** | **John Gommans and Andy Phillips, Co-Chairs of HB Clinical Council** |
| **Date:** | **7 March 2018** |

## PURPOSE

At the request of the HBDHB Board, Clinical Council were asked to review the structure, value and workloads of Council's proposed clinical committees and advisory groups. The intention is that these can be implemented with appropriate supports by 1 July 2018. Clinical Council has reviewed the implications of this structure in terms of their value, the function of and need for each separate advisory group in terms of the Councils role in 'clinical governance', ensuring that their purpose did not conflict with other governance structures or processes, and resource implications including clinician and management time plus administrative support.

A panel undertook an initial review. At its December and February meetings Clinical Council identified and endorsed a number of proposed changes and these are presented for ratification by council in this paper

## CLINICAL GOVERNANCE

Clinical Governance is defined as "*the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimizing risks and fostering an environment of excellence in care for consumers, patients, community*"

Good clinical governance is essential to ensure continuous improvement in the safety and quality of care; and makes certain that there is accountability and creates a 'just' culture that is able to embrace reporting and support improvement i.e. key functions of clinical governance include monitoring of quality and safety, and provision of clinical advice.

In 2001, the Institute of Medicine described quality health care as safe, effective, patient-centred, timely, efficient, and equitable. Delivering good clinical governance requires attention to each of these domains.

## CLINICAL COUNCIL

Clinical Council is the principal clinical governance, leadership and advisory group for the Hawkes Bay health system. The structure agreed by clinical council in June 2017 is show in Appendix 2. Its functions are to:

- Provide clinical advice and assurance to the HB health system management and governance structures
- Work in partnership with the HB Health Consumer Council to ensure the HB health system is organised around the needs of people
- Provide oversight of clinical quality and patient safety
- Provide clinical leadership to the HB health system workforce
- Co-ordinate and manage this clinical governance structure

## CLINICAL COMMITTEES

**There will be the four clinical committees** aligned to the domains of safety and quality. These are:

- Professional Standards and Performance Committee – to provide assurance that all essential requirements relating to credentialing, professional standards, clinical training and research are actively promoted and maintained
- Clinical Effectiveness & Audit Committee – to provide advice and guidance to ensure that quality clinical practice is delivered by all publicly funded health service, diagnostic, pharmaceutical and therapeutic providers.
- Patient Safety & Risk Management – to provide assurance that all matters relating to patient safety and clinical risk are effectively monitored and managed
- Patient Experience – to jointly develop and recommend strategies, systems, policies, processes and actions that will contribute to the continuous improvement of patient's experience within the HB health system



**The PHO Clinical Advisory and Governance Committee reports directly to the PHO Board with a reporting line to Clinical Council**

## CLINICAL ADVISORY GROUPS

Supporting the governance work of and reporting to the five clinical committees there will be 19 Clinical Advisory Groups (AGs). Most of these already exist to some extent within the DHB but have not been well aligned with clinical council and/or are not well integrated across the sector. Hospital services are currently well represented within the AGs which will be expanded to include cross sector representation and particularly from community and primary care. This will demonstrate that primary care contribution is valued by the sector. This will require additional resource to enable primary care clinician's engagement e.g. so that backfill can be provided. This remuneration will be at a level not less than the cost of providing backfill. There is currently variable expertise in governance within clinical committees and advisory groups, and training is required.

## THE PLACE OF EQUITY IN CLINICAL GOVERNANCE

Although there are inequities related to age, gender, and income the most consistent and compelling inequities in NZ are between Māori and non-Māori. The causes of this are multifactorial including

- Differential access to the determinants of health and exposures leading to differences in disease incidence
- Differential access to health care
- Differences in quality of care received.

Under the New Zealand Public Health and Disability Act 2000, DHBs have a statutory responsibility to "reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders":

The NZ healthcare triple aim explicitly acknowledges this with the simultaneous pursuit of iimproved quality, safety and experience of care for individuals, improved health and equity for all populations and best value for public health system resource.

To deliver on this, equity is a sector wide responsibility with several other groups already working in this space, including Population and Public Health Services, Maori Relationship Board and Pacifica working groups. Clinical Council debated and agreed a recommendation for the position of equity within the clinical governance structure.

Council agreed that equity is an important element of service quality and that health equity should be everyone's business. In recognition of this, the triple aim will be explicitly part of each Terms of Reference. It is proposed that a technical equity advisory group reporting to Clinical Effectiveness and Audit Committee is set up once a new Executive Director is appointed. The function of this Advisory Group is the provision of advice to clinical researchers and clinical services to support equitable outcomes from health services and systems. The Equity Technical Advisory Group will support services to deliver equitable, value for money, sustainable services and systems which are person and whānau centered, effective, safe, timely, accessible and efficient.

Appropriate Governance of equity at a high level is required for the Hawkes Bay Health System and how this is best addressed requires engagement with other governance bodies. Clinical Council believes that a high level governance committee is required which will need to include clinical governance of equity as an important element of delivering clinical quality within its remit.

**ADMINISTRATIVE SUPPORT**

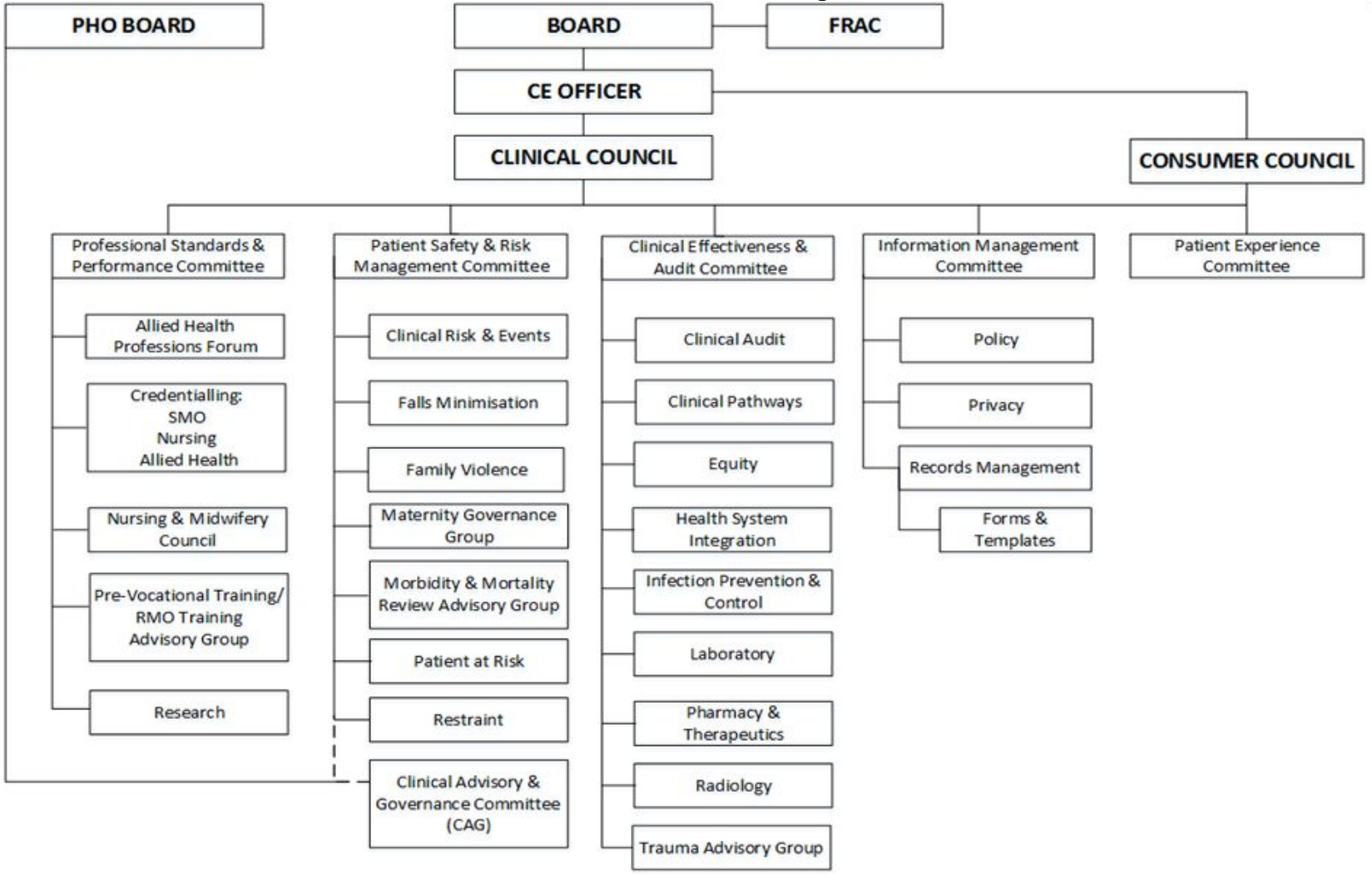
The company secretary reviewed the administrative support required for effective operation of the governance structure. This is shown in appendix 3. It is noted that a business case will need to be constructed to request funding.

**RECOMMENDATION:**

It is recommended that HB Clinical Council

1. **Approve** the proposed clinical committees and advisory group structure
2. **Note** the intention to present clinical council's recommendations to the March 2018 HBDHB Board meeting
3. **Note** the intention for phased increase in primary & community care representation on Clinical Committees to ensure a whole of sector approach
4. **Note** the intent for clinical governance training to be provided for all members of Advisory Groups and Clinical Committees
5. **Note** the incorporation of triple aim in Terms of Reference for all elements of the governance structure and the intent to set up a technical advisory group on equity pending recruitment of an Executive Director
6. **Note** that an overarching governance committee on equity will be subject to further discussion with other governance bodies.
7. **Note** the reporting line for the Primary Care (PHO) Clinical Advisory and Governance Group
8. **Note** that the issue of integration within the governance structure is on hold pending agreement of the Alliance structure
9. **Note** that it will be necessary to develop a business case for the costs of supporting the clinical governance structure
10. **Note** that the intention is that the clinical governance structure will be implemented with appropriate supports by 1 July 2018

**APPENDIX 1 – CLINICAL GOVERNANCE COMMITTEE STRUCTURE – Original version as at June 2017**

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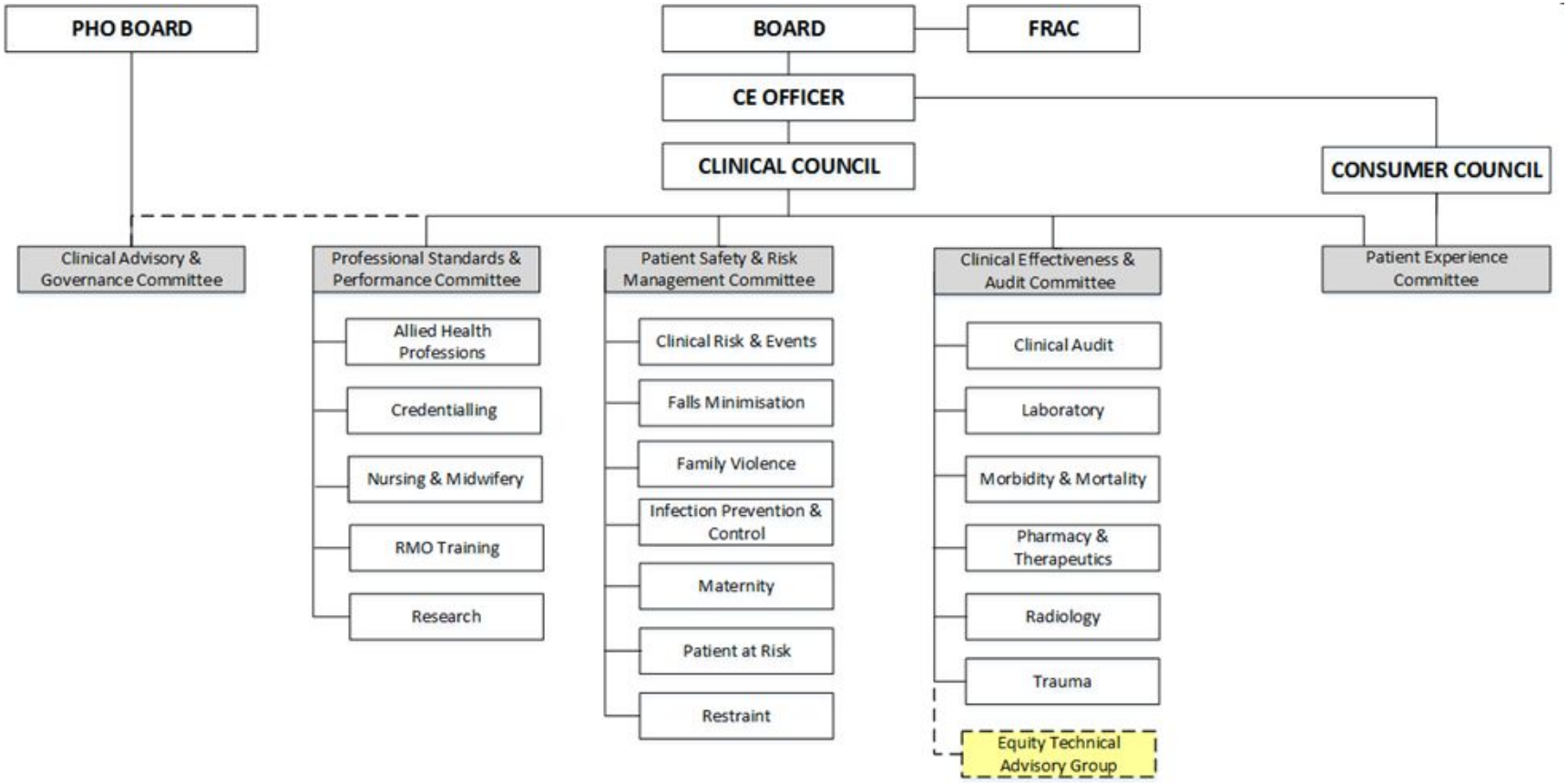
**APPENDIX 2 – CLINICAL GOVERNANCE COMMITTEE STRUCTURE – Proposed revised version March 2018**




***Pending appointment of new Executive Director***

## APPENDIX 3: CLINICAL GOVERNANCE STRUCTURE - MANAGEMENT & ADMINISTRATION REQUIREMENTS

### 1. CURRENT SUPPORT FOR CLINICAL AND CONSUMER COUNCILS

#### 1.1 Management

- Ken Foote (Company Secretary)
  Governance and administration, including maintenance of ToR, work plans, membership, tenure, payments, cost centre, ensuring appropriate agendas, minutes and reports are prepared etc.
- Kate Coley (ED People & Quality)
  Operational support and guidance, including submission of reports, actioning outcomes, coordinating activities, responding to request etc.
- Consumer Engagement Manager key contact / support for Consumer Council



#### 1.2 Administration

- Brenda Crene – Board Administrator and PA
- Maintenance of ToRs, membership schedules, contacts, interests, coordination of workflow (linked to Corporate governance), payment of fees and expenses, Diligent Boardbooks, filing of agendas and minutes etc
- Tracy Fricker – EA to ED People & Quality
- Preparation of agendas, Diligent Boardbooks, minutes and board reports.

#### 1.3 Other

Current support for existing committees is provided by some members of the quality team, EAs and PAs of current chairs/members, and other service based administrative resources.

### 2. SUPPORT FOR THE AGREED CLINICAL GOVERNANCE STRUCTURE

The clinical governance structure will require administrative support to ensure that it is both effective and delivering good “value”.
Good governance practice requires the following:

#### 2.1 Management Leadership Responsibility

- Structures and processes to be appropriately designed, implemented, monitored and adequately resourced
- An environment is created such that clinical governance is visible and valued by all key stakeholders.
- Roles, responsibilities, accountabilities and expectations are clear and well understood.
- Trust and mutual respect is developed, with Clinical, Consumer and Management leaders working in partnership to ensure the “structure” achieves the desired outcomes.
- Develop outcome measures / measures of success.

#### 2.2 Management Responsibility / Resources (Whole structure)

- Terms of reference to be maintained, updated and amended as necessary
- New appointments/reappointments to be appropriately approved and membership schedules maintained
- Chairs appointed/briefed and ‘trained’ as necessary
- Details of any payments to members and approval processes to be agreed, documented and actioned
- Management of budget and cost centre
- Workplans to be coordinated and maintained
- Ensure appropriate reports are prepared, submitted, distributed and filed as appropriate
- Committee/Advisory group secretaries to be appointed, coordinated and ‘trained’ as necessary

- Standard templates developed for minutes/actions plans/reports etc.
- Overall coordination/management of structure.

**2.3 Administration Responsibility/Resources ((Individual advisory groups/committees)**

- Meetings to be set up/rooms booked etc
- Agendas prepared and distributed
- Attendance registers completed
- Any payments to members to be actioned
- Minutes to be taken, approved and distributed
- Action plans to be recorded, followed up and completed actions noted.
- Liaison with Advisory group/Committee Chair maintained
- Reports to be written/presented as required.

**2.4 Minutes**

- 'Action Minutes' templates to be developed/distributed
- Training for minute taking to achieve standardisation, efficiency and effectiveness

**2.5 Communication Plans**

- How to advise health sector that this is happening
- Encourage nominations/participation/ownership/confidence
- Ensure effective flow of information and sharing of learnings.

## 3. SECTOR WIDE RESPONSIBILITY

Two of the principal strategic changes to be embedded into this updated clinical governance structure are:

- Expanding the mandate of each committee and advisory group to be sector wide (where appropriate).
- Including consumer representation on all committees and relevant advisory groups.

These changes will have implications as follows:

- The timings and venues for meetings will need to take account of primary care clinician and consumer involvement
- Relevant policies will need to be updated/developed to recognise this involvement with appropriate payments/compensation.

## 4. RESOURCE REQUIREMENTS

To implement appropriate 'good governance practice' to ensure the new structure is both effective and efficient, it has been identified that the following support / resources will be required.

- Company Secretary and ED People & Quality continue to provide management leadership
- Board Administrator continues with overall responsibility for Administrative issues
- A new positon is created (Clinical Governance Administrator) to assume responsibility for directly supporting Clinical and Consumer Councils and Whole of Structure' management and administration (estimated $50k per annum)
- Members of the quality team EA & PAs and other service based administrative resources continue to provide secretarial support to individual committees and advisory groups with 'system' support guidance and coordination from the Board and Clinical Governance Administrators.
- Budget allowance for fees and expenses of 'primary care' (non-HBDHB/HHB staff) and consumers (on approval of new policy) will need to be provided (estimated $45k per annum.

A business case will need to be developed to seek approval for this additional $95k per annum budget.

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Clinical Services Plan (CSP) Update** 28 |
| | For the attention of: **HBDHB Board** |
| Document Owner: | Kevin Snee, CEO |
| Document Author: | Ken Foote, Company Secretary |
| Reviewed by: | Executive Management Team |
| Month: | March 2018 |
| Consideration: | For Information |



**RECOMMENDATION**

**That the HBDHB Board**

1. **Note** the revised CSP Plan and Timelines
2. **Note** the progress and planning completed to date

**BACKGROUND**

The Clinical Services Plan (CSP) process has been underway for some months now, with progress reports and relevant documents delivered and posted to the Our Health website.

An initial draft of the CSP was planned for late March 2018. However, with general workload pressures, and to ensure feedback from workshops were well reflected within the initial draft, a decision was made late last year to dedicate more time to this crucial stage of the project, to make sure we "get it right".
In late January, a revised plan and timeline was agreed between Hawke's Bay District Health Board's Executive Management Team, Consultant group Sapere and the CSP project team, to complete the first draft by 30 June 2018 ready for extensive sector and community consultation with the final CSP tabled to Hawke's Bay District Health Board for approval at its October 2018 meeting.

**REVISED PLAN**

A summary of the revised plan includes:

- Baseline document and summary statement approved 28 February 2018
- Documentation for future options workshops distributed mid-March 2018
- Future options workshops to be held early April 2018
- Integrated workshop held early May 2018
- First draft completed 30 June 2018
- Draft CSP reviewed and updated July 2018
- Wide sector and community engagement on draft CSP – August / September 2018
- Final CSP completed early October 2018
- Final CSP adopted by HBDHB Board 31 October 2018

**BASELINE DOCUMENT & SUMMARY STATEMENT**
Two background development documents have recently been completed.

The *Baseline Document* provides a summary of the current state of services delivered across general practice and other community providers, as well as district health board health services provided both in the community and hospital.

The *Summary Statemen*t summarises findings from the *Baseline Document*. It also integrates findings from the patient journey workshops held in September 2017.

Both of these documents (together with a cover note to provide background within the overall context of the CSP) have been distributed widely throughout the health sector.Further copies are being made available on request.

**FUTURE OPTIONS WORKSHOPS**
Four key themes have been identified for workshops in April/May, that will have health professionals and consumers working together to produce a long list of options for the future design and delivery of relevant services. These themes and workshop dates are:

- Looking after frail people in our care – 9 April 2018
- What is the character of our hospital in 10 years' time? – 10 April 2018
- Supporting our people in vulnerable situations – 2 May 2018
- Reorganising primary care for the challenge – 3 May 2018

These workshops will be led by our senior clinicians and will be limited to 30 participants each. Discussions will be informed by the above documents, along with other reference material and personal experience.

The output from these workshops will feed into the Integrative Workshop, to be held on 31 May 2018.

**SECTOR AND COMMUNITY ENGAGEMENT**
There will be comprehensive engagement both within the health sector and with the wider Hawke's Bay community once we have a draft CSP. Consultation will take place throughout August and September 2018 and details of how this will occur will be extensively promoted once we are closer to a finalised draft CSP.

**CLINICAL SERVICES PLAN (CSP)**

Just a reminder, the CSP will:

- Describe the current capability and capacity of services (Baseline)
- Describe the challenges and opportunities facing service provision now and in the future.
- Describe high-level options that will help meet those challenges and take advantage of those opportunities.
- Provide an indication of strategic direction and important areas for investment.
- Inform Hawke's Bay Health Sector new five year strategic plan

The CSP will not:

- Address details of implementation
- Provide detailed financial modelling
- Provide a workforce strategy and plan
- Include a facilities master plan

HAWKE'S BAY
District Health Board
Whakawāteatia

# GO WELL TRAVEL PLAN UPDATE

Presentation

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|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Providing Best Outcomes and Experience for People with Cancer** 30 |
| | For the attention of: **HBDHB Board** |
| **Document Owner:** | Andy Phillips, Chief Allied Health Professions Officer |
| **Document Author(s):** | Andy Phillips, Elaine White, Paula Jones and Mandy Robinson |
| **Reviewed by:** | Executive Management Team (EMT) |
| **Month:** | March, 2018 |
| **Purpose** | For Discussion |
| **Previous Consideration Discussions** | Nil |
| **Summary** | • This paper provides a quarterly report on progress with improving our services for people with cancer<br>• EMT, Finance Risk and Audit Committee (FRAC) and Board have been concerned at the low numbers of patients reported on the 62 day Faster Cancer Treatment (FCT) pathway<br>• FRAC also required clarity on the issue of patients 'declined for capacity reasons'. |
| **Contribution to Goals and Strategic Implications** | • Providing better care for people with cancer<br>• Delivering the 62 day FCT Health Target |
| **Impact on Reducing Inequities/Disparities** | • There remains significant inequity throughout the cancer pathway<br>• This paper describes progress in reducing inequity |
| **Consumer Engagement** | Regular forum with people living with and beyond cancer |
| **Other Consultation /Involvement** | Patient journey workshop |
| **Financial/Budget Impact** | No financial impact described in this paper |
| **Timing Issues** | Presented at March 2018 Board |
| **Announcements/ Communications** | Regular reporting to Ministry of Health (MoH) that has press interest |

**RECOMMENDATION:**

That the HBDHB Board:

1. **Note** the numbers of patients reported on the 62 day FCT pathway
2. **Note** progress in improving services for people with cancer
3. **Note** the ongoing challenges particularly in respect of attendance at Multidisciplinary Meetings
4. **Note** the narrative around patients declined First Specialist Assessment (FSA) for 'capacity reasons'

## SITUATION

Significant work and actions have been implemented to improve the service Hawke's Bay District Health Board (HBDHB) offers people with cancer. The actions implemented are seeing results for patients. This includes:

- Significant reduction in waiting times for reduced waiting times for diagnosis and treatment,
- One-stop clinics,
- Treatments delivered in outpatient settings previously performed in theatre.
- Multidisciplinary team working in partnership across primary, secondary and tertiary care, and with the Cancer Society

HBDHB is now delivering much improved wait times, with 90 percent of patients having treatment within 62 days of being referred with a high suspicion of cancer.

This paper provides a quarterly report on progress with improving our services for people with cancer.

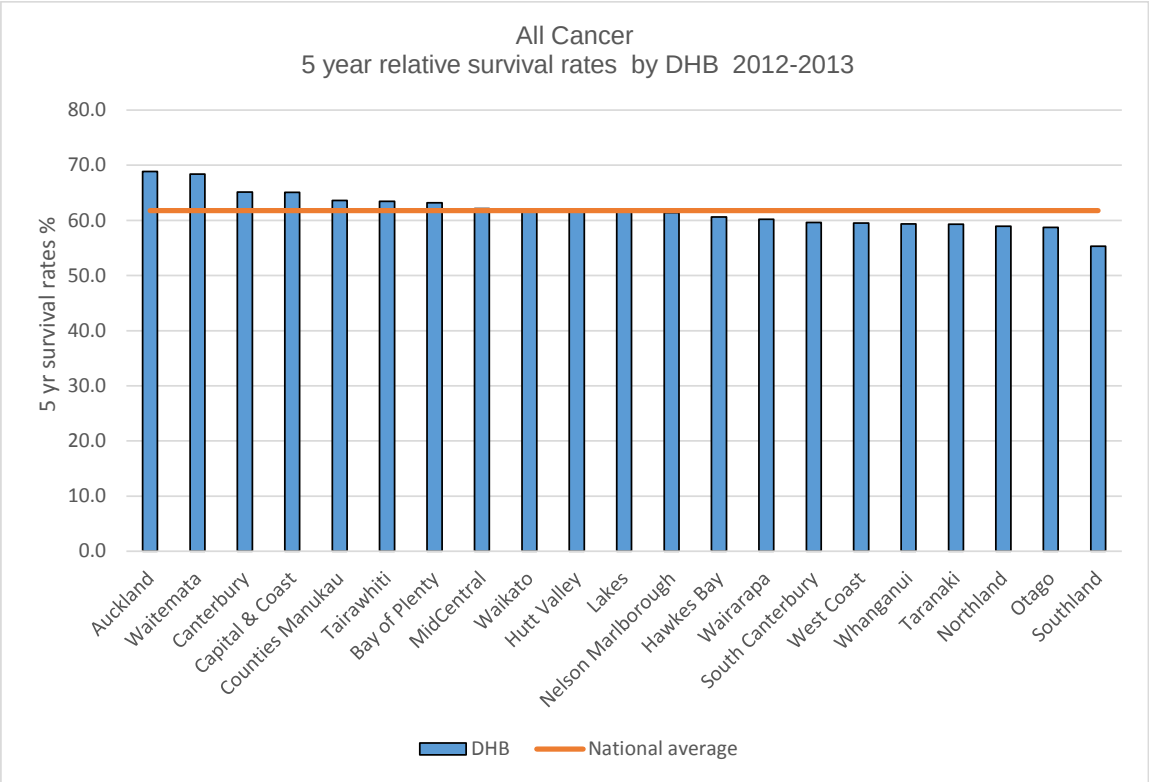
## BACKGROUND

Outcomes for people with cancer are better when there is early detection, diagnosis and treatment of cancer. Survival rates for people in Hawke's Bay show that HBDHB cancer patients have similar five year relative survival rates compared to other mid-sized DHBs. This is slightly lower than the national average in 2012-13 which was the latest year for which data is available. In Hawke's Bay, 60.6 % of all cancer patients survive five years after diagnosis compared to the DHB average of 61.8 % (Figure 1).

It should be noted that survival rates are generally higher for people residing close to tertiary cancer centres. It is anticipated that the work done to improve timeliness of cancer treatment over the past year will substantially improve outcomes for people in Hawke's Bay.

The Faster Cancer Treatment (FCT) health target is that patients receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks. From July 2017, the FCT target for patients meeting the criteria is 90%.

Figure 1 : All Cancer Five year survival rates by DHB (2012-13)






**ASSESSMENT**

For January 2018, 29 cases were submitted to the MoH. Of these, 26 met the MoH definitions for the 62 day FCT pathway and 20 were submitted as compliant. Further review has identified that 22 out of the 26 cases were compliant. This brings the 6 month rolling compliance to 90.8 % against the 90% target (Figure 2).

Around 900 people in Hawke's Bay will develop cancer each year or 76 per month. The MoH sets specific guidelines relating to which patients with cancer should be included within the FCT health target. This applies to people who are referred to the hospital from General Practice who are considered on triage to have high suspicion of cancer and need to be seen within two weeks. People who have cancer who are excluded from the 62 day FCT health target include: those whose first treatment for cancer was undertaken privately, people with recurrent cancer, people who have undergone screening for cancer, those who have entered treatment through presentation at the Emergency Department, people ineligible for treatment in New Zealand or treatment pathway that began outside New Zealand and many others. Another exclusion would be people with high suspicion of slow growing tumours who do not need to be seen within 2 weeks. Other people whose details are amongst the 900 per year entered onto the cancer registry may never be referred into secondary care.

The MoH estimate across New Zealand was that 25 % of people with cancer would meet the data definitions for the 62 day indicator. This means that there is an expectation for 19 people from Hawke's Bay per month will be reported on the FCT 62 day indicator of the 76 per month who develop cancer. Figure 3 shows the numbers of people included in the 31 day and 62 day targets over time.

A more complete picture of people with cancer accessing secondary care services in Hawke's Bay is given by the 31 day indicator. The eligible estimation for 31 day indicator of around 62 people per month was based on analysis undertaken by Central Cancer Network (CCN) Missing Patients Project.

Figure 2: HBDHB Compliance with FCT Health Target

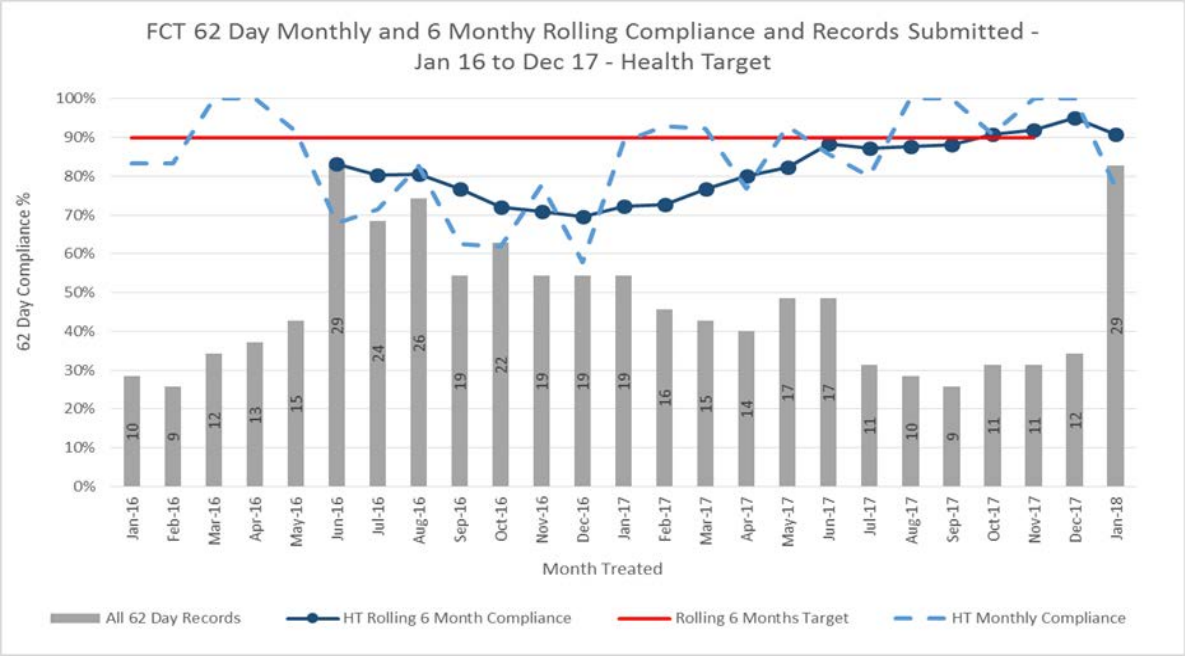
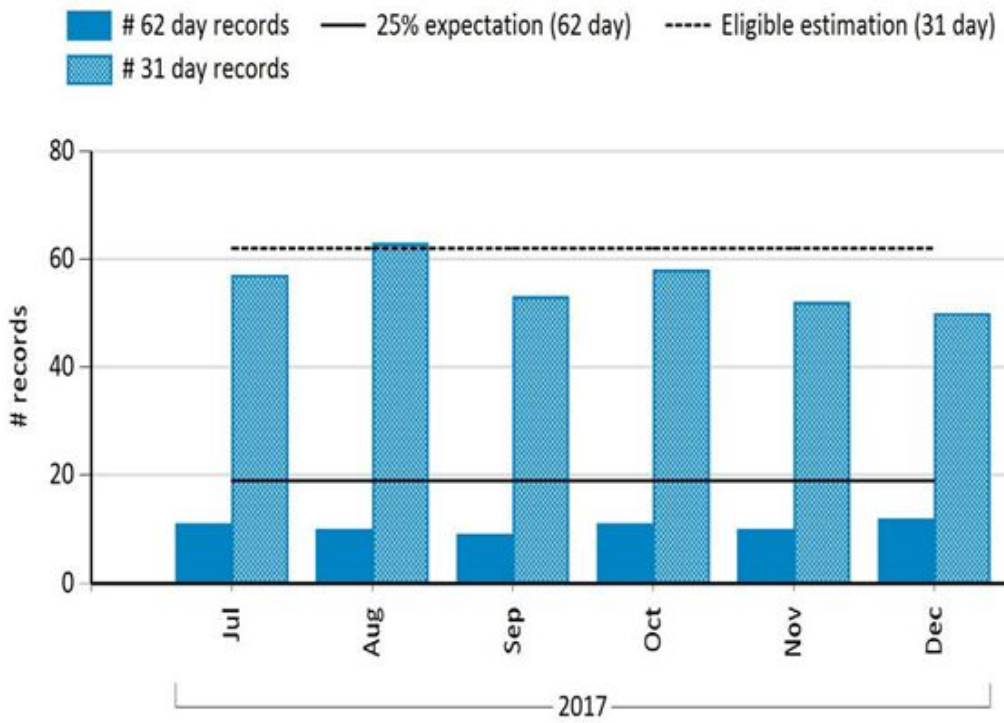



Figure 3: Numbers of people with cancer included in 31 day and 62 day targets



Significant work has been undertaken to ensure data submitted meets the MoH data definitions. It should be noted that data definitions are subject to interpretation. Data submitted to MoH is subject to rigorous scrutiny prior to submission and retrospective audit with changes made to the data record as required. Where there is ambiguity, guidance is sought from MoH regarding application of the data definitions.

Over recent months the focus has been on increasing the number of people on the 31 and 62 day pathways. This work has included redesigning the triage sheets to ensure that people fitting the criteria of high suspicion of cancer and needing to be seen within two weeks are closely managed. A measure of success has now been achieved with the number of people on the 62 day pathway increasing to 29 in January.

**CURRENT AREAS OF FOCUS**

Appendix 2 shows comparative performance data across central region. Table 1 shows significantly improved FCT performance across Central Region DHBs over the past 6 months and maintaining this is a priority for the Regional Services Plan. Table 2 shows the reasons for non-compliance with the target. A particular issue for HBDHB is 'capacity constraints' relating to HBDHB people seen in tertiary centres. An example of this is that we rely on MidCentral DHB (MDHB) for radiation oncology and medical oncology and whereas only 9% of MDHB were due to capacity constraints this was 43% for HBDHB breaches. This theme is picked up in figure 5 which shows that 'capacity delays' in MDHB providing medical oncology, radiation oncology and combined radiation/medical oncology to Hawke's Bay residents are responsible for the overwhelming majority of breaches. There is ongoing dialogue with MDHB both in respect of management of individual cases and wider service delivery.



A further area of focus relating to our relationship with MDHB and other external providers is attendance at MDM meetings where treatment options are decided for individual patients. Appendix 3 gives details of an audit recently undertaken that shows variable or poor attendance at MDMs particularly in respect of radiation and medical oncologists employed by MDHB. Part of the exchange of recent letters between HBDHB and MDHB related to MDHB desire to have single Regional MDMs and this not being suitable for many HBDHB clinicians. Further discussions are required with both external providers and HBDHB clinicians to resolve this urgently.

Figure 6 demonstrates that although the gap has closed, there continues to be inequity in the FCT pathway with Maori less likely to have diagnosis or treatment within FCT indicator times than others. There are numerous actions being taken including travel assistance, management of multiple comorbidities, cancer nurse coordinator support

**REFERRALS DECLINED FOR REASONS OF CAPACITY**

Appendix 4 shows the MoH information relating to elective referral into secondary care. No patients with suspected cancer are declined a first specialist appointment on the grounds of insufficient capacity.

HBDHB patients with suspected cancer or those who require treatment for cancer are given highest priority. An example of this is in elective surgery where cancer operations continue to be completed within short timescales despite competing pressures.

## Appendix 1: Extract from Report Prepared by Lisa Jones Hawke's Bay DHB Cancer Relative Five year survival rates

### BACKGROUND

The 2010 Global Burden of Disease study found cancer to be the leading cause of health loss (both fatal and non-fatal loss) in New Zealand. Cancer is an older person's disease and as the population has aged the number of new cancer registrations have increased 31% since 2000 and this increase is likely to continue as the older population 65 years and over is projected to increase 72 % between 2016 and 2043. Cancer survival rates have also increased and the numbers of cancer survivors are increasing and therefore living with the complications and health issues as result of cancer. This will also place additional cancer related demand on the health system.

The following paper quantifies the trends in relative survival rates of cancer in Hawke's Bay. The source data was compiled by the MOH Analytical Services in March 2017.

What is cancer survival?

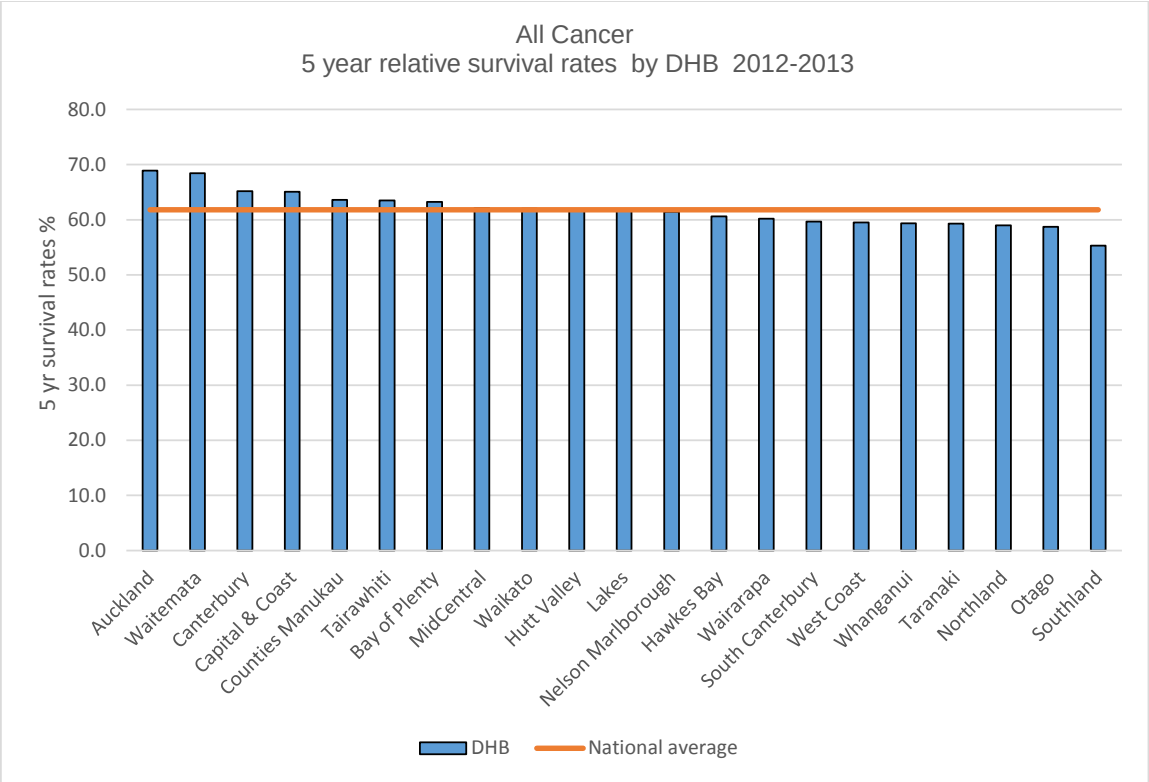
Survival' refers to the length of time lived after an initial diagnosis of cancer. Survival is one of the key indicators of the impact of cancer on society. It is a valuable way of measuring the success of cancer control. A number of different statistical procedures can be used to derive survival figures.

How is survival measured?

All survival estimates in this paper are relative survival ratios. Relative survival is the observed survival in the cancer patient group divided by the expected survival of a matched group in the general population. It is defined as a ratio, but expressed as a percentage. Relative survival is cancer survival in the absence of other causes of death. It represents the proportion of patients within a particular group alive after a certain number of years of follow-up, most commonly five years, and attributes all the 'excess' mortality of the group to the cancer in question. For example, a relative survival of 75% means that the cancer reduces the likelihood of surviving five years after diagnosis by 25%. A relative survival of 100% indicates that cancer patients experience mortality rates equivalent to those in a comparable group from the general population. If a relative survival rate exceeds 100%, this indicates that cancer patients have better observed survival than is expected for people in the general population. (Ministry of Health (2015) Cancer Patient survival 1994-2011. extracted MOH website 2/2/2018)

The following outlines regional five year relative survival rates for the most common cancers diagnosed in New Zealand.

**All cancer: 5 year relative survival rates**



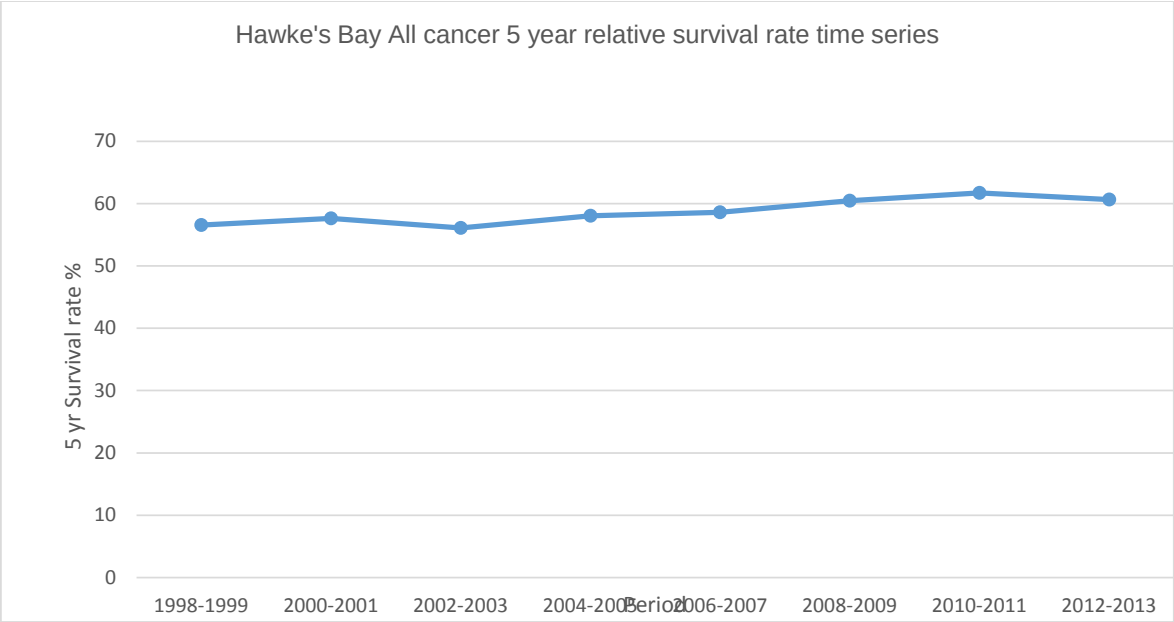

**Source: National Cancer Registry Note: Five-year survival is based on patients diagnosed in different years and their survival experience observed during the specific follow-up period (2012–2013).**

Hawke's Bay DHB cancer patients have slightly lower 5 year relative survival rates compared to the national average in 2012-13

60.6 % of all cancer patients survive 5 years after diagnosis compared to the DHB average of 61.8 %. Hawke's Bay DHB is ranked 13th of all DHB's in terms on 5 year relative survival for all diagnosed cancer patients in the 12-13 follow up period .

16

**Trends in relative all cancer survival rates**

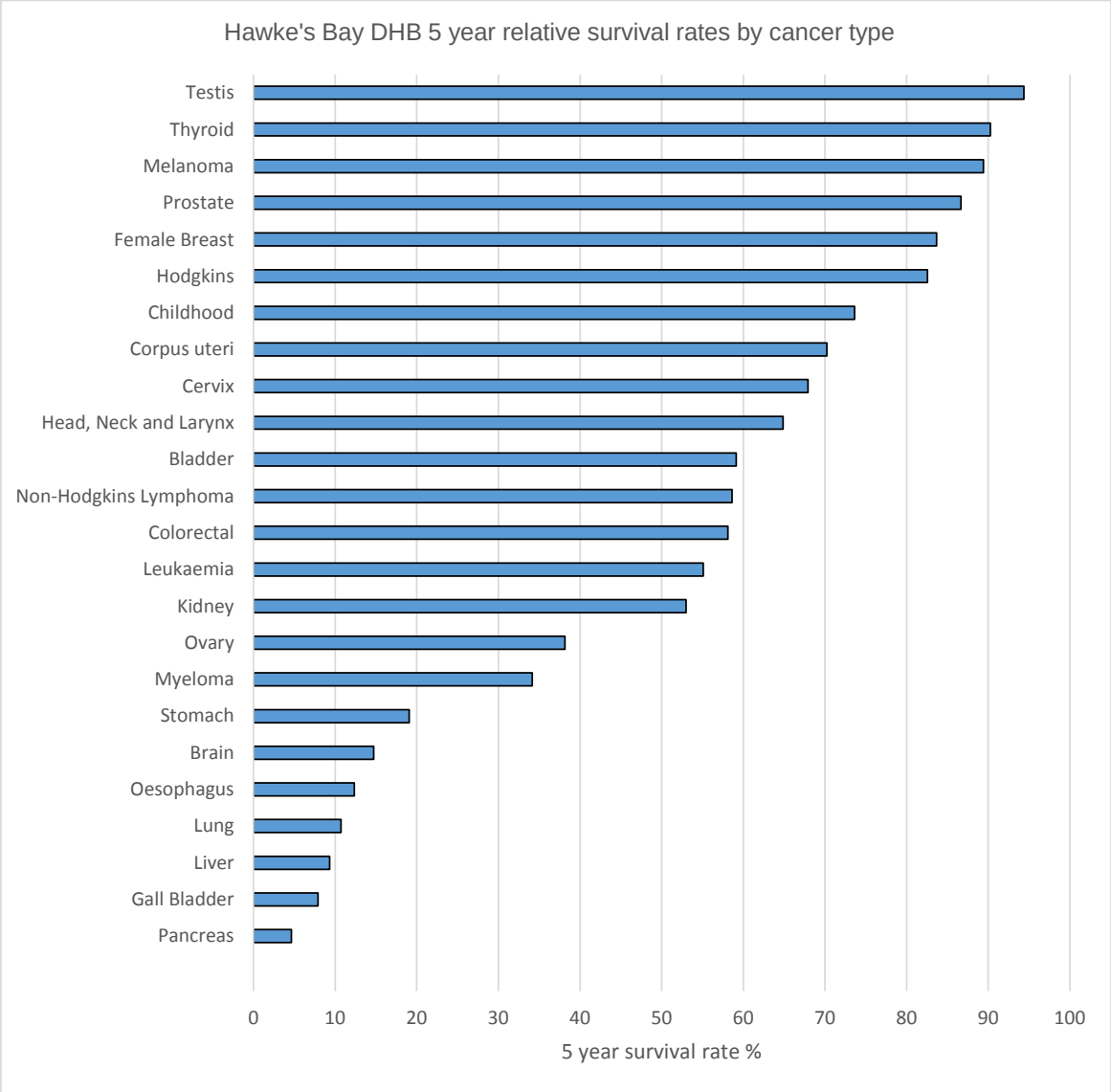



**Source: National Cancer Registry**

Five year survival for all cancers has improved over time from 56.5 % in 1998-1999 to 61.7 % in 2010-2011 and the rate dropped slightly in 2012-2013.

The following table relates to Survival rates in the period 1994 to 2014 based on patients diagnosed in a specific period who were followed up for five complete years.

5 year relative survival rates by DHB region, 1994-2014




This graph shows that cancer survival varies considerably between type and sites of cancer for Hawke's Bay cancer patients. Five year relative survival ranges from 94 % for testicular cancer to 4.7 % for pancreatic cancer. Hodgkin lymphoma, female breast, prostate, melanoma, thyroid and testicular cancer all have 5 year survival rates of more than 80 %. Cancers with low 5 year survival rates post diagnosis below 10 % are pancreatic, gall bladder and liver cancer.

## Appendix 2: Central Cancer Network Comparative Data

**Table 1: Publicly reported numerator and denominator for the 62 day and 31 day indicator achievement, CCN Region, Jul 2017 - Dec 2017**

| DHB of domicile | 62 day indicator | 31 day indicator |
|---|---|---|
| Capital & Coast DHB | 91% | 91 % |
| Hawke's Bay DHB | 95% | 89 % |
| Hutt Valley DHB | 93% | 93 % |
| MidCentral DHB | 96% | 87 % |
| Taranaki DHB | 91% | 86 % |
| Wairarapa DHB | 92% | 88 % |
| Whanganui DHB | 88% | 95 % |
| **CCN Region** | **92%** | **90 %** |

**Figure 2: Breakdown (percentage) of delay code reporting for records that breached 62 days, CCN Region DHBs, Jul 2017 - Dec 2017**

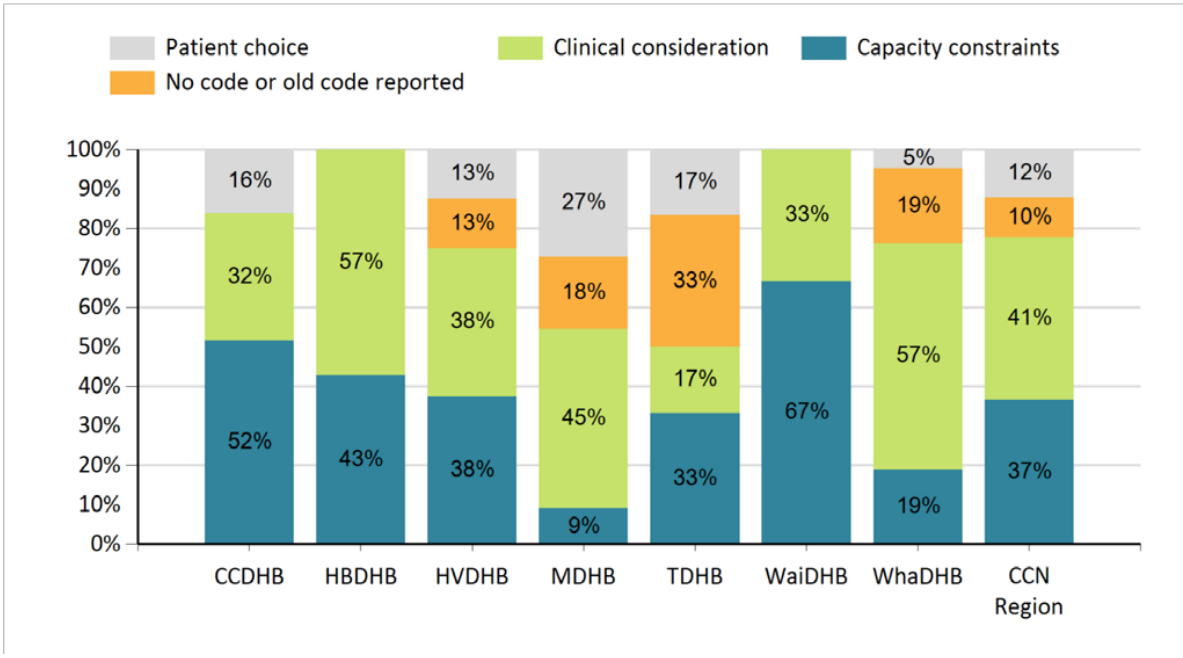


**Figure 3: Breakdown (percentage) of delay code reporting for records that breached 62 days by ethnicity, CCN Region, Jul 2017 - Dec 2017**

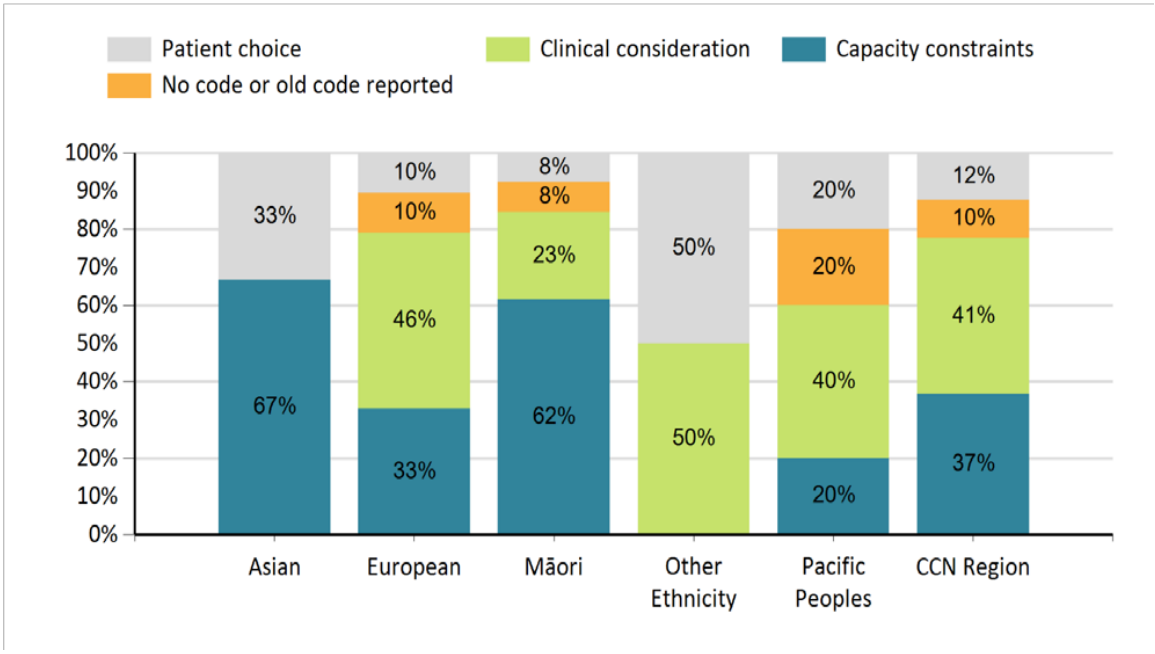



**Figure 4: Achievement of the 62 day FCT health target by tumour stream, Hawke's Bay DHB and CCN Region, Jul 2017 - Dec 2017**

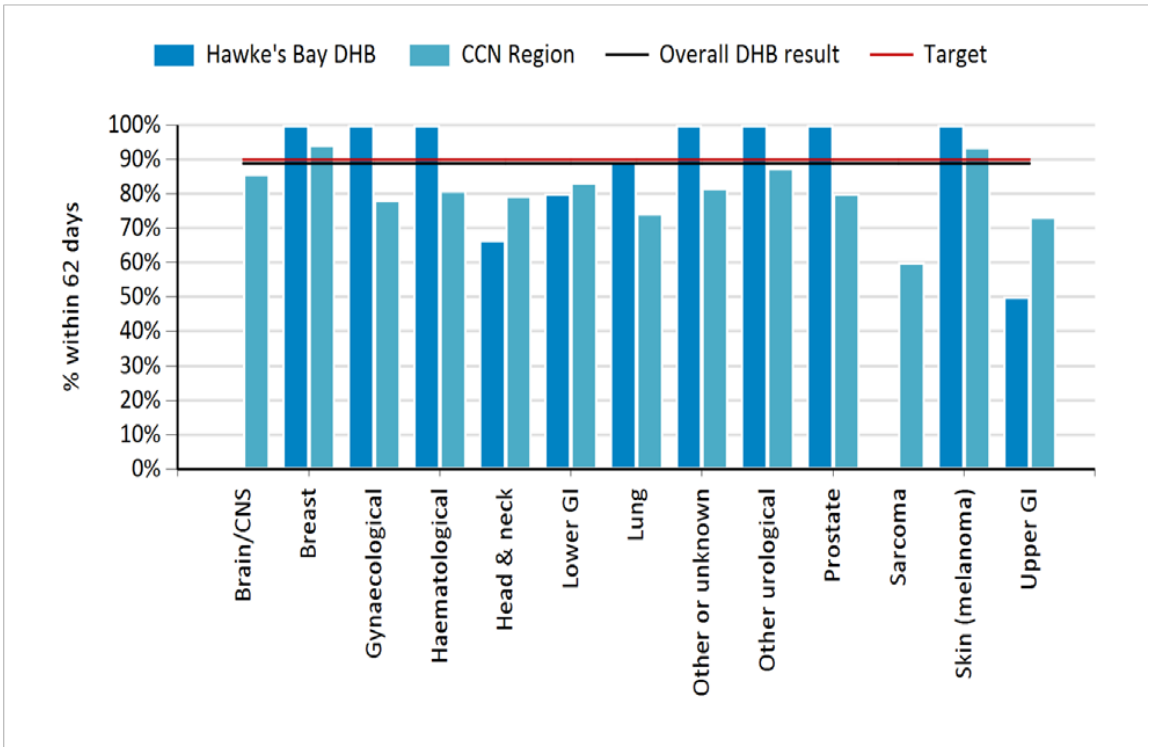


**Figure 5: Achievement of the 62 day FCT health target by first treatment, Hawke's Bay DHB and CCN Region, Jul 2017 - Dec 2017**

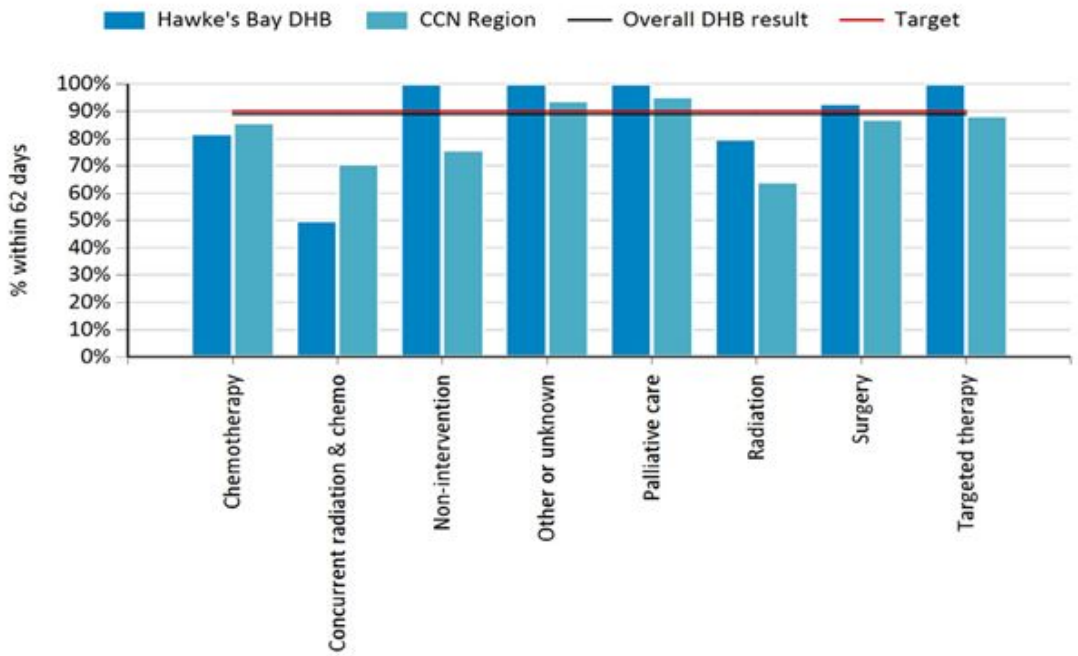
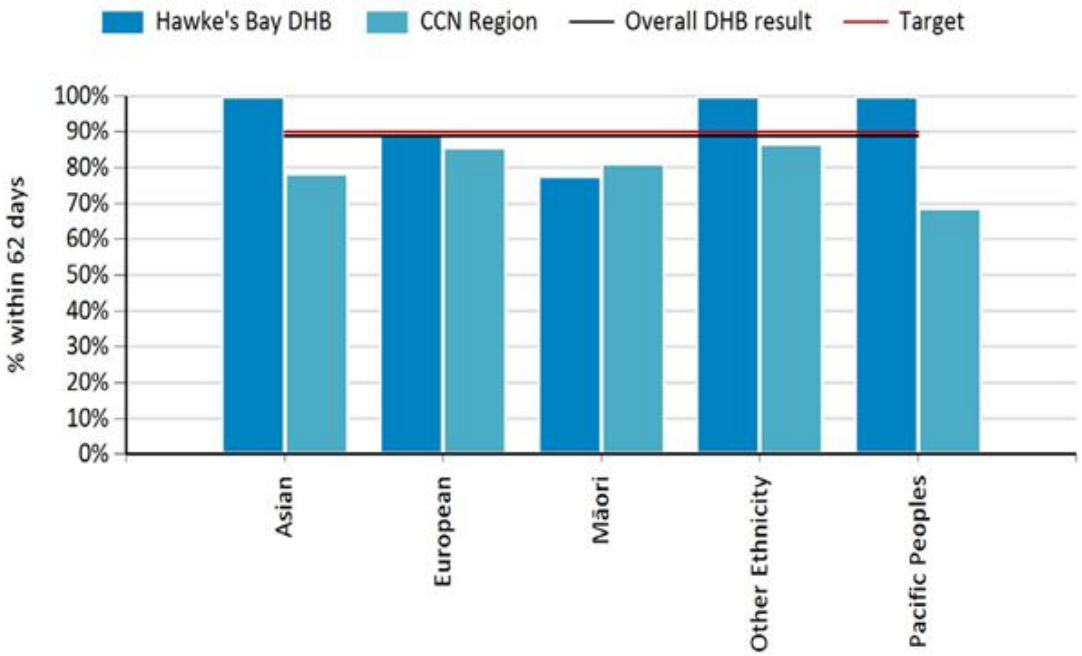



**Figure 6: Achievement of the 62 day FCT health target by ethnicity, Hawke's Bay DHB and CCN**

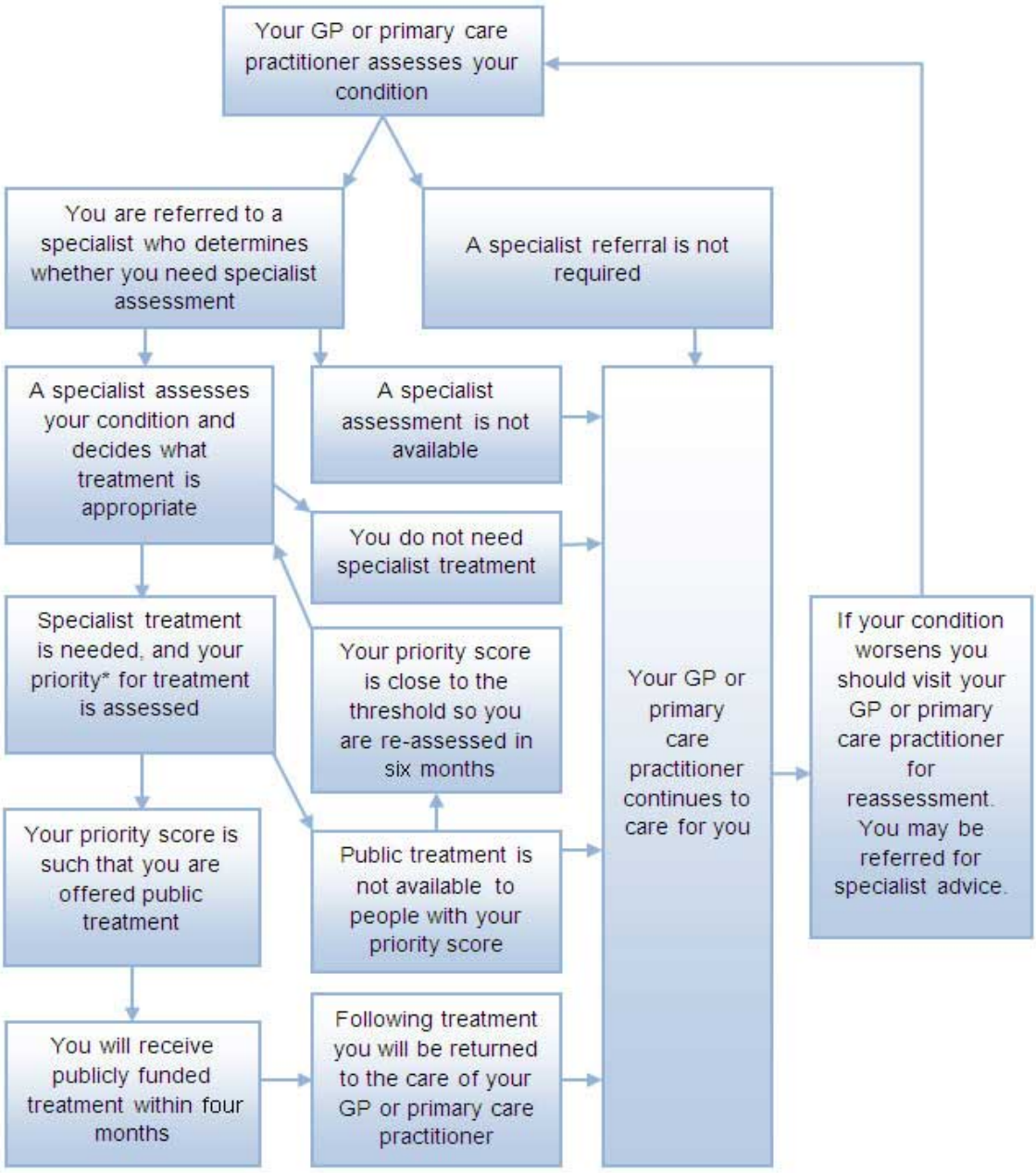


## Appendix 3 : February 2018 HBDHB MDM Representation by Specialty as per Ministry of Health Terms Of Reference Guidelines

| **February 2018 Summary:** | | |
|---|---|---|
| | | |
| **Cancer Stream:** | **Held MDM's:** | **Planned MDM's** |
| Melanoma (MDM cancelled, no surgeons available) | 1 | 2 |
| Colorectal | 4 | 4 |
| Breast Onc | 4 | 4 |
| Respiratory | 4 | 4 |
| Breast Bx | 4 | 4 |
| Urology (No Patients for discussion) | 0 | 1 |
| ENT (No Consultants available) | 0 | 1 |
| Cancelled MDM's: 3 | | |
| **Total MDM's Held:** | **17** | **20** |
| | | |
| **Specialty:** | **Present:** | **Absent:** |
| Med Onc | 11 | 8 |
| Rad Onc | 8 | 9 |
| Surgeon (General & Specialist) | 28 | 2 |
| Surgical Registrars | 4 | 3 |
| Pathologist (1 x not req'd) | 16 | 4 |
| Radiologist (2 x not req'd. 1 x PACS unavailability) | 14 | 3 |
| CNS | 17 | |
| Dermatologist | | 1 |
| Palliative Care Specialist - Unavailable at HBDHB at this time | | 17 |

## Appendix 4 : MoH Description of How the Electives process works

1. **The patient pathway** is the time from when you develop a condition needing treatment to the time the problem is either resolved or under control. This flow diagram outlines the basic steps in the Electives care process.




*Your priority score is an assessment of your level of need and ability to benefit compared to other people.

**2. When a problem first develops**

If you have a condition you think may need treatment you should first see your primary care provider such as your GP, nurse, Māori health provider, optometrist or physiotherapist. They will assess your condition and discuss the best options with you, including whether to refer you to a specialist.
The specialist may be from a public hospital or you could be referred to a private specialist if you are prepared to pay for a private consultation.

**3. Being referred to a specialist**

If you are referred to a specialist at a DHB public hospital, the DHB's local clinical staff will first assess how urgent your referral is. DHBs have different ways of deciding about urgency, but the levels are broadly as follows:

4. further specialist assessment is needed immediately
5. further specialist assessment is needed urgently
6. further specialist assessment is needed semi-urgently
7. the further assessment requested is for a routine condition and not urgent
8. further assessment by a specialist is not needed.

The hospital should inform you and your GP (or primary care provider) in 15 calendar days or less about whether you will see a specialist.



**9. How long will you wait to see a specialist?**

If you do need to see a specialist, DHBs should provide your appointment within 4 months of the day the hospital received your referral. Your GP (or primary care provider) will continue caring for you while you wait for your specialist appointment.
Sometimes you will be asked to get some other tests done (eg, blood tests) before seeing the specialist.
Your first visit to a specialist is called a First Specialist Assessment (or FSA). Sometimes a Non-Contact First Specialist Assessment (ncFSA) occurs. This is where a specialist assesses you on the basis of your records and test results without you being present. There could even be a consultation over the internet. The specialist will then develop a Plan of Care for you and give it to your GP (or primary care provider). This may include preparation for surgery or other treatment, or a long-term management plan if an elective procedure is not the best option for your condition.

**10. What the specialist will do**

The specialist will assess your condition and recommend the best option of care for you.
There are a number of possible outcomes depending on how urgent your condition is and what resources the hospital has available.

- The specialist may arrange for more tests to be done before the best decision can be made.
- You may be prescribed a course of medical treatment (eg, drugs) after which you may need a follow-up appointment.
- It may be decided the best thing for you is surgery. If this happens you will be given a priority score to determine how quickly you will receive the surgery. Your priority score will depend on how urgently you need it and how much you will benefit from it compared to other people. The DHB will determine whether it can provide treatment, depending on your priority score and available resources. If it can, treatment should be given within 4 months of confirmation it is available.
- If your condition is not yet urgent enough that you need specialist care within 4 months, but it may get worse, you may be given the status of Active Review. This means the hospital must re-assess you at least every 6 months for up to 18 months. If your condition does not get any worse you will be returned to the care of your General Practitioner (GP) (or primary care provider) and advice will be given to them about what to do if your condition gets worse.

- The specialist may decide that a service is not available to you, even though you would benefit from it. If this happens, you and your GP (or primary care provider) will be informed, and they will discuss with you your best options of care.

**11. How long will you have to wait for treatment?**

If the DHB confirms it can provide treatment, it should provide that treatment within 4 months. However, if you are waiting for surgery and your condition gets worse, you should see your GP (or primary care provider) to have your priority score reassessed.

**12. What does it mean if my referral was declined?**

Health resources are not unlimited and we have to make decisions to give one patient priority over another. This is not new or unique to New Zealand. Our aim is to be fair in the way people are treated. Decisions about who gets access are based on each person's level of need and ability to benefit, compared to others. Those with the greatest priority get access first. If your referral was declined, you will be sent back to your GP (or whomever referred you initially) who will continue to monitor your condition. From here, there are a number of options to consider:

- you may benefit from other health interventions, such as physiotherapy, weight loss management and exercise programmes. Please seek advice from your GP about what alternative care options may be suitable for you
- you are entitled to seek a second opinion, or provide further information in your referral if you believe the original referral did not adequately describe your condition
- if your condition changes, you may be re-referred for an assessment, and may go on to access publicly-funded care.

**13. If you don't agree**

If you don't agree with a decision that you will not be given a publicly funded FSA or treatment, you should talk to your GP (or primary care provider) who will explain why the decision was made and what options are available to you. These may include referral to a private specialist for treatment, or a clinical review of your condition, either by the original specialist or by another clinician (a 'second opinion'). You have the right to ask for a clinical review, but the original decision may still stand.

You should also check that all information has been given to the specialist, including the impact your condition has on your life.

DHBs often have a process for addressing patient concerns – please visit your DHB's website.

**14. If your condition gets worse**

If at any time your condition worsens you should see your GP (or primary care provider). They will ask the specialist to reassess you, which may mean your priority score for treatment changes.

**15. Using the private system**

You may choose to see a private specialist and/or have the surgery done privately, but you will need to pay for this yourself or through your private health insurance.

A private specialist may offer you surgery in a public hospital if you don't want to pay for private surgery. If this happens you will be given a priority in the same way as someone who was referred to a public specialist. Some hospitals may still require you to see a public specialist

## Governance Report Overview

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Update on Establishing Health and Social Care Localities in Hawke's Bay** 31 |
| | For the attention of:<br>**HBDHB Board** |
| **Document Owner** | Chris Ash – Executive Director Primary Care |
| **Document Author(s)** | Jill Garrett – Strategic Services Manager – Primary Care<br>Te Pare Meihana - Manager, Wairoa Hospital and Health Centre |
| **Reviewed by** | Executive Management Team, Clinical and Consumer Council<br>**Māori Relationship Board (April), Pasifika Health Leadership Group** (May) |
| **Month/Year** | March, 2018 |
| **Purpose** | For Information |
| **Previous Consideration Discussions** | Regular update for monitoring |
| **Summary** | This paper outlines:<br>• Progress in the two existing localities over the last 6 months<br>• Planned activities over the coming 6 month period<br>• Commentary on how the Health & Social Care Localities programme is being aligned with broader work relating to Primary Care Development |
| **Contribution to Goals and Strategic Implications** | Improving Health and Equity for all populations<br>Improving value from public health system resources |
| **Impact on Reducing Inequities/Disparities** | Focus of the work in localities is on eliminating and preventing the inequity gap within health outcomes – whole of population |
| **Consumer Engagement** | Consumer representation within both locality groups |
| **Other Consultation /Involvement** | Not applicable |
| **Financial/Budget Impact** | Not applicable |
| **Timing Issues** | Not applicable |
| **Announcements/ Communications** | Not applicable |

**RECOMMENDATION**

It is recommended that the HBDHB Board:

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

HAWKE'S BAY
District Health Board
Whakawāteatia

# Update on Establishing Health and Social Care Localities in Hawke's Bay

| | |
|---|---|
| **Author(s):** | **Jill Garrett – Strategic Services Manager – Primary Care**<br>**Te Pare Meihana - Manager, Wairoa Hospital and Health Centre** |
| **Date:** | **February, 2018** |

## 1.0 Locality Development in the Context of Primary Healthcare Development

1.1 A commitment has been made to reinvigorate the Alliance Agreement for Hawke's Bay by means of a Primary Care Development Partnership ('PCDP'). The need for this development has been identified on the back of longstanding and widely-held frustrations about the inability to secure care integration and modernisation at pace in primary healthcare.

1.2 As the draft working plan for the PCDP has become clearer, it is increasingly evident that there are a number of crucial intersects with the Localities programme. The PCDP will rely on a strong, and increasingly stronger and more coordinated local voice to drive prioritisation, community leadership, and the adoption and spread of best practice. At the same time, there are a number of themes common to development in a number of localities (such as the development of sustainable service delivery models for rural communities) that will benefit from a more centrally-sponsored approach.

1.3 At present, the programme has focused solely on the establishment of a 'localities approach' in the rural areas of Wairoa and Central Hawke's Bay. In two relatively self-defining rural communities, this approach has generated significant benefits. Work on the proposed 'Hastings' and 'Napier' localities has not, to date, been initiated. The approach will be reviewed in consultation with stakeholders, and in line with the establishment of the PCDP.

1.4 In both existing locality areas, however, the breadth and depth of the work undertaken has been markedly different. This has largely fallen into the domain of three core activities, those being:

- Integration of local provider management arrangements, supported by devolved decision rights for DHB services, with the goal of transformation in the delivery of clinical services
- Progressing and supporting local innovation in support of community health and wellbeing priorities, particularly in the intersectoral sphere
- Promoting an enhanced local dimension to health planning, funding and market development

1.5 Collective impact modelling has been used in both localities, Wairoa and Central Hawke's Bay (CHB) to build form and function into the task of preparing localities to drive local developments, and as a framework to evaluate progress to date. Implementing collective impact focuses on four key areas, namely, governance and infrastructure, strategic planning, community involvement and evaluation and improvement. However, in the context of 1.4 (above), collective impact does not define the breadth of the endeavor to which it is applied.

1.6 Under the framework, there are five stages on the road to achieving full collaboration.

## The Five Levels of **Collaboration**

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| | **Networking** | **Cooperation** | **Coordination** | **Coalition** | **Collaboration** |
| **Relationship Characteristics** | • Aware of organisation loosely defined roles.<br>• Little communication.<br>• All decisions are made independently. | • Provide information to each other.<br>• Somewhat defined roles.<br>• Formal communication.<br>• All decisions are made independently. | • Share information and resources.<br>• Defined roles.<br>• Frequent communication.<br>• Shared decision making. | • Share ideas.<br>• Share resources.<br>• Frequent and prioritised communication.<br>• All members have a vote in decision making. | • Members belong to one system.<br>• Frequent communication is characterised by mutual trust.<br>• Consensus is reached on all decisions. |

Source: Frey, B.B., Lohmeier, J.H., Lee, S.W., & Tollefson, N. (2006). Measuring collaboration among grant partners. American Journal of Evaluation, 27, 3, 383-392

1.7 In Wairoa, the emergence of the Community Partnerships Committee (He Reo Ngātahi: One Voice, Our Voice) pushes the overall assessment of progress towards Level 3 of the model, with some evidence of function at Level 4. Particularly important has been the definition of the community vision that 'All whānau in Wairoa are thriving', and the solid commitment of leadership from iwi, government agencies, and local community organisations to the work of the committee. In the primary healthcare service integration space, intensive activity is taking place to secure rapid progression from Level 2.

1.8 In CHB, assessment across all four areas of the model places overall progress at Level 2 of the model, with some aspects of Level 3 exhibited. CHB is growing its governance function, using strategic planning to create direction and vision, has strong community involvement, and now with greater emphasis on data sharing will be better positioned to plan health improvement initiatives.



### 2.0 Wairoa

2.1 Activity Completed (Last 6 months)

- Established senior nursing roles – The Rural Nurse Specialist and Clinical Nurse Specialist (Long Term Conditions) roles will support innovation in primary healthcare model development.
- Health of Older Persons stakeholder meetings – These support identification of local service gaps and guide development and resourcing of the care pathway.
- Case management and governance – Work is progressing with sector partners to join up approaches to supporting local whānau who are most in need of services and support.
- Integrated renal service model – Planning is underway to relocate the existing renal chairs.
- General Practice alliance agreements – These continue to evolve, and have supported project work to deliver free under 18 care, diabetes support and Cornerstone accreditation.

2.2 Activity in Progress (Next 6 months)

- Progress towards a single integrated general practice model for Wairoa
- Continued focus on more integrated primary and secondary care patient pathway
- Extension of EngAGE to include Wairoa, as part of strategy for rural provision of this service
- Further develop senior nursing opportunities, including establishment of a shared care model across providers, and a nursing workforce development approach for Wairoa.

- Achieve a "go live" date for Oranga Whānau single case management and governance within services for vulnerable tamariki and whānau
- Join up health projects and strengthen rangatahi leadership, in support of the wellbeing of young people in Wairoa
- Project to reduce the incidence of diabetes through a collaborative initiative between general practice and Kahungunu Executive.

### 3.0 Central Hawke's Bay

3.1 Activity Completed (Last 6 months)

- Choose Well
  - Signage and local materials now developed and in use in Waipawa and Waipukurau
  - Flyers and fridge magnets advertising Health Services have been developed by the Health Liaison Group and distributed to households, schools and services within CHB
- Whānau Wellness – The first programme in CHB is now in place with 58 individuals signed up in December 2017. Of those registered, 15% live in Porangahau, 15% in Waipawa, and the remaining 70% in Waipukurau.
- Workplace Wellness – A population health-based programme of support has been developed and provided to the largest employer in CHB (Silver Fern Farms).
- Shared electronic health record – This is now available to support collaborative patient management across general practice, pharmacy and the hospital services

3.2 Activity in Progress (Next 6 months)

- In-depth analysis of the CHB Health Status review to inform priorities for 2018-19 and potential operational partnerships to achieve improved health outcomes.
- VMR network enabling virtual health clinics to be provided in outreach settings.
- Extension of EngAGE to include CHB, as part of strategy for rural provision of this service
- Creation of an Lead Maternity Carer (LMC) Hub in CHB.
- Extending workplace wellness programme to support five major local employers.
- Supporting the Ministry of Education Communities of Learning (COLs) with their local achievement of health and wellbeing-related objectives (linked to readiness for learning).

**RECOMMENDATION**

It is recommended that the HBDHB Board:

**Note** the content of this report**.**

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:

19. Confirmation of Minutes of Board Meeting - Public Excluded
20. Matters Arising from the Minutes of Board Meeting - Public Excluded
21. Board Approval of Actions exceeding limits delegated by CEO
22. Chair's Update
23. Leadership Forum Reflections / follow up
24. HB Clinical Council
25. Finance Risk and Audit Committee

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).