BOARD MEETING

Date: Wednesday, 28 February 2017

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	1	
9.	Financial Performance Report	2	
10.	Board Health & Safety Champion's Update	3	

	Section 2: Reports from Committee Chairs		
11.	HB Clinical Council – Co-Chairs, John Gommans and/or Andy Phillips	4	2:10
12.	HB Health Consumer Council – Chair, Rachel Ritchie	5	2:20
13.	Māori Relationship Board – Chair Ngahiwi Tomoana	6	2:30
14.	Pasifika Health Leadership Group – Barbara Arnott	7	2:40
	Section 3: Decision		
15.	Clinical Portal Project – Anne Speden / Michael Sheehan	8	2:50
16.	Waipukurau Land Disposal – Sharon Mason	9	3:10
17.	Special General Meeting NZ Health Partnerships – Ken Foote	10	3:15
	Section 4: For Information / Discussion		
18.	Suicide Prevention Update – Dr Nick Jones for Penny Thompson	11	3:20
19.	Ngatahi Vulnerable Children's Workforce Development Progress – Russell Wills & Bernice Gabrielle	12	3:35
20.	HB Health Sector Leadership Forum Programme – Ken Foote	13	3.45
	Section 5: Monitoring Reports – for information		
21.	Te Ara Whakawaiora - Access 0-4 / 45-65 yrs (local indicator) – Mark Peterson	14	3.50
22.	HBDHB Performance Framework Exceptions Q2 Oct-Dec 17 – Tim Evans • HBDHB Quarterly Performance Monitoring Dashboard for Q2 • HBDHB Quarterly Performance Monitoring Dashboard (from MoH) for Q1	15	3.52
23.	Human Resource - KPIs Q2 Oct-Dec 17 – Kate Coley	16	3.55
24.	HBDHB Annual Plan 2016/17 – available on the OurHealth website and in Diligent Resources	17	-
	Section 6: General Business		
25.	**Section 7: Recommendation to Exclude the Public** Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	**Section 8: Routine**	Ref #	**Time (pm)**
26.	Minutes of Previous Meeting (public excluded)		4.00
27.	Matters Arising – Review of Actions		
28.	Board Approval of Actions exceeding limits delegated by CEO	18	
29.	Chair's Update - verbal		
	Section 9: Discussion / Decision		
30.	Integrated Communications Environment – Anne Speden	19	4.05
31.	Clinical Services Plan Update – Ken Foote	20	4.15
	Section 10: Reports from Committee Chairs		
32.	Finance Risk and Audit Committee – Chair, Dan Druzianic	21	4.30

The next HBDHB Board Meeting will be held at
1.00pm on Wednesday 28 March 2018

Board "Interest Register" - January 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. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair of FRAC	26.10.17
Ngahiwi Tomoana (Deputy Chair)	Active	Chair, Ngati Kahungunu Iwi Incorporated (NKII)	Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB: (i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department. (ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department.	Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB.	The Chair	01.05.08
	Active	Brother of Waiariki Davis	Perceived Conflict of Interest. Non-Pecuniary interest. Waiariki Davis is employed by HBDHB and is the Health Records Manager.	Will not take part in any decisions in relation to Health Records management. All employment matters in relation to Waiariki Davis are the responsibility of the CEO.	The Chair	01.05.08
	Active	Uncle of Tiwai Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Tiwai Tomoana is employed by HBDHB and is a Kitchen Assistant in the Food and Nutrition Department at Hawke's Bay Hospital.	All employment matters in relation to Tiwai Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Uncle of Iralee Tomoana	Iralee Tomoana is employed by HBDHB and works in the Radiology Department as a clerical assistant.	All employment matters in relation to Iralee Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Brother of Numia Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Numia Tomoana is employed by Cranford Hospice and works as a palliative care assistant and, in this role, works with chaplains at Hawke's Bay Hospital.	Will not take part in any decisions in relation to the Chaplain service at Hawke's Bay Hospital.	The Chair	01.05.08
Barbara Arnott	Active	Trustee of the Hawke's Bay Air Ambulance Trust	HBDHB has a partnership contract with Skyline Aviation who together operate the HB Air Ambulance Service which is supported by the Trust.	Declare this interest prior to any discussion on the HB Air Ambulance Services and Chair decides on appropriate mitigation action	The Chair	10.05.10
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	26.10.17
Dr Helen Francis	Active	Alzheimer's Napier previously a Committee member Patron and Lifetime Member	Alzheimer's Society holds a contract with the HBDHB to provide dementia specific daycare and community services.	Will not take part in any decisions or discussion in relation to HBDHB contract with Alzheimer's Society	The Chair	08.06.10 21.06.14
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.11
	Active	Contractor Hastings Health Centre	Actual Conflict of Interest. Pecuniary Interest.	Will not take part in any decisions or discussions in relation to Hastings Health Centre.	The Chair	24.01.18

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
	Active	HB Medical Research Foundation	Trustee	Declare this interest prior to any discussion in relation to the Foundation, and an appropirate mitigation action is decided on.	The Chair	20.08.14
Diana Kirton	Active	Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB.	Perceived Conflict of Interest. Non-Pecuniary interest.	Will not take part in any decisions in relation to surgical services provided by or contracted by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO	The Chair	18.02.09
	Active	Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014	Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers.	Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on.	The Chair	16.01.14
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.14
	Active	Member, Hawke's Bay Law Society Standards Committee	Law Society	No conflict perceived	The Chair	20.06.17
	Active	RENEW counselling services	Counsellor	No conflict perceived	The Chair	17.07.17
Dan Druzianic	Active	Director of Markhams Hawke's Bay Limited	Potential Conflict of Interest. Some clients may from time to time be employed by or have contracts with HBDHB	Declare an interest at any time an issue arises concerning a client, and take no further part in any decision or discussion on this matter.	The Chair	7.12.10
Jacoby Poulain	Active	Board Member of Eastern Institute of Technology (EIT)	Perceived conflict - HBDHB has a Memorandum of Understanding (MOU) with EIT relating to training and development in health related occupations.	Will not take part in any decisions or discussions in relation to the MOU between HBDHB and EIT	The Chair	14.1.14
	Active	Councillor Hastings District Council	Potential conflict as potential advocate for Hastings District population whereas HBDHB coveres whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.1.14
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumatua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust (aligned to Iron Maori Limited)	The Trust has contracts with HBDHB including the Green Prescription Contract; and the Mobility Action Plan (Muscular Skeletal)	Will not take part in any discussions or decisions relating to any actions or contracts with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15 29.03.17
	Active	Director of Kahungunu Asset Holding Company Ltd	The asset portfolio of the company in no way relates to health, therefore there is no perceived conflict of interest.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	26.10.16
Peter Dunkerley	Active	Trustee of Hawke's Bay Helicopter Rescue Trust	Actual conflict of interest. The Trust provides helicopter patient transfer services to HBDHB	Will not take part in any decision or discussion in relation to any contract or financial arrangement between HBHRT and HBDHB	The Chair	15.05.14
	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) The U-Turn Trust renamed /rebranded "Whariki 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 13 DECEMBER 2017, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.05PM

PUBLIC

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

Apology Nil

In Attendance: Kevin Snee (Chief Executive Officer)
Co-Chair, HB Clinical Council, John Gommans and Andy Phillips (part)
Members of the Executive Management Team
Brenda Crene

APOLOGY

No apologies were recorded

3. INTEREST REGISTER (discussed at noon)

Peter Dunkerley advised his interest as a shareholder of Need a Nerd and NZ Technologies, from 13 December 2017. This would be updated on the FRAC Interest Register also. **Action**

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

The Board meeting had commenced noon with the interests register considered at that time, then moved to public excluded and re-convened at 1.00pm for this public session.

11. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on 29 November 2017, were confirmed as a correct record of the meeting.

Moved: Heather Skipworth
Seconded: Peter Dunkerley
Carried

12. MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: **Chaplaincy Service Costs –** Hine Flood advised the Wairoa District Council had agreed to support the $4k sought. Item to be removed.

Item 2: **FRAC and Board timing in February –** a change in the order of the FRAC/Board meetings on 28 February was noted as follows:

FRAC Meeting	10am-12.30pm
Board Only time	12.30-1.00pm
Lunch	1.00-1.30pm
BOARD meeting	1.30pm

Item 3: **Homeopathy –** Andy Phillips following up on the letter received and will advise the outcome. This item remains open.

Item 4: **Health and Safety concerns –** had been raised with the CEO. Developments were n hand which will address the issues. Peter Dunkerley advised later in the meeting under Health and Safety update. Remove action.

Item 5: **Quality Accounts –** Advised these have been produced for 5 years now. For 3 years the HQSC reviewed them, however they no longer do so. The Accounts are not ranked but it would be a definite motivational tool for DHBs if they were. The document is valuable and beneficial for our community. If the opportunity arises for rankings in future, the Board advised they would be keen to have this explored. Remove action.

Item 6: **Matariki Regional and Social Inclusion Strategy –** Tracee TeHuia to provide feedback from the regional governance group to the Board Meeting in February 2018. This item remains open.

Item 7: **TAW / Smokefree –** patient stories / background and reasons why some still smoke will be provided to the board to enable better understanding of the real issues. Advised this is in hand and noted. The next update on Smokefree to the Board will be in May 2018 as these reports are provided 6 monthly. Remove action.

13. BOARD WORK PLAN

The Board Work Plan was noted for February 2018 with a lot of papers listed.

The workplan will be more descriptive in future.

14. 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
Maggie Nicol	Registered Nurse	Medical Directorate	34	17-Dec-17
Carol Edwards	Registered Nurse	Medical Directorate	30+	22-Dec-17
Anothoness (**Toni**) Ormsby	Registered Nurse	Medical Directorate	21	31-Dec-17

The Chair advised he had nothing further to report since the Board Meeting held two weeks prior.

15. CHIEF EXECUTIVE OFFICER'S REPORT

The CEO provided an overview of his report advising of the pressures being experienced. ED had improved slightly with more work to do and he touched on issues in relation to first outpatient appointments which should be alleviated now a Locum was in place.

Faster Cancer Treatment was above target for the 6 months but there was room for improvement as were seeing 57% of the number we would expect to see on the pathway (ie, 11 out of 19 for November). The challenges were explained by Andrew Phillips with the CEO advising that by March we need to report to the Board there has been a significant improvement, or a program needs to be provided with actions for improvement. **Action Andy Phillips**

The biggest concern this month was the financial pressure that had emerged in November at $525 thousand unfavourable. The CEO advised he would be meeting with key staff to better understand this situation before Christmas and look at resolving this quickly.

The Finance report for December would be circulated to the Board in January by the Board Administrator. **Action**

The **Urgent Care Service** within the community had commenced but has been relatively quiet to date. A tracking report on the new service will be provided to the Board in 6 months' time. **Action**

16. FINANCIAL PERFORMANCE REPORT

Ashton Kirk (Acting ED Corporate Services) spoke to the Financial Report for November 2017, which showed a $653 thousand unfavourable variance to plan with November at $525 thousand unfavourable (with the months variance improved by the release of a further $250 thousand in contingency). In the main this result was due to: Nursing (shifts and phasing of training); outsourcing; clinical supplies (high Orthopaedic, ICU and general surgery) and undelivered savings.

The team were working closely with respective areas to ensure they were on track and able to deliver. The major issue is not the in-month result, it is the trend! Currently there are limited budget management controls in place, with a focus on the unachieved savings plan which was itemised on page 35 of the finance report.

A challenge is capacity and managing the front door. Some external expertise has been brought in from other DHBs to assist, with a view to recommending other ways of working. Also making sure we manage resources to encourage an enhanced culture. The summer close down no longer exists and there are difficulties in balancing this new norm.

Auditors have commented that Hawke's Bay is one of the best DHBs for financial reporting (being one of three consistently achieving). The CEO advised we may see additional investment made into DHBs by the new Government but equally there were added pressures coming on the health system nationally.

17. HEALTH & SAFETY BOARD CHAMPION'S UPDATE

A verbal update was received from board member Peter Dunkerley, advising he had received an update from the new Health and Safety Advisor, Christine Mildon.

It was noted that **Governance Health and Safety Training** would be held in the New Year with the full board and the Executive Team undertaking half day training (20 places). An invitation would be issued - **Action**

It was suggested a Health and Safety Board Champion Terms of Reference be considered - **Ken Foote to consider and Action if required.**

Other areas moving forward included:

- First draft of DHBs Health and Safety strategic plan for next 3-5 years completed.
- In the final stages of piloting use of Safe 365 to manage high risk contractors.
- Looking at definitions of contractor risk.
- Begun training plan for the current 57 Health and Safety Champions within the organisation.
- Training Facilities team on incident investigation.
- Have begun an interim response to unresolved events relating to inappropriate behaviour.
- Incident investigation of reported sub-contractor injury (bruising). Awaiting feedback from the company concerned.

REPORT FROM COMMITTEE CHAIRS

18. HB CLINICAL COUNCIL MEETING AND JOINT WORKSHOP WITH CONSUMER COUNCIL

On behalf of co-Chair Andy Phillips and Consumer Council Chair Rachel Ritchie (who was unable to attend this Board Meeting), Dr John Gommans provided an update from the meetings held on Wednesday 6 December.

The Clinical Council met first to consider agenda items, including the approval of the Laboratory Testing Guidelines and consider other Council specific items. There was also some discussion around the **Clinical Governance Committees' Structure**. A report to the Board on this topic will be made available for their February 2018 meeting.

HB Health Consumer Council members then joined the meeting for a joint workshop on **Person & Whanau Centred Care (P&WCC).**

P&WCC was considered three years ago (early 2015) by both Clinical and Consumer Council and is fundamental to both, so much so P&WCC was incorporated into both councils Annual Plans. Both groups still agree with our original vision.

- It was recognised some work had occurred with patches of excellence but it was inconsistent and not yet "integrated" into what we do!
- Both Councils feel that timing is right to make good progress with P&WCC in 2018 through:
  - the Big Listen feedback from patients and staff
  - the Clinical Services Plan - to ensure services are anchored around meeting P&WCC needs;
  - Transform and Sustain;
  - Health system being committed to co-design, also
  - the Clinical leadership and Consumer engagement; and
  - the development of closer strategic relationships with the South Central Foundation (NUKA)
- Agreed we need P&WCC to be fully integrated into how we work and be a key Goal!

The Definition of P&WCC is a challenge and relaying one clear message is difficult. The Workshop did not determine a "definition". However the group agreed the principles and that an holistic approach was required, with services integrated with people and whanau always at the centre. It is about building trust and relationships and working with people to co-design. We need to understand and listen to ascertain what is important to the person.

The people of Hawke's Bay need to come up with an agreed terminology. Appropriate resources to implement P&WCC are required sooner rather than later (including training packages). We need to make hasty progress as it is not happening the way we want it to currently.

This was a very useful Workshop. Further work will be done via a subgroup (comprising of members of both Council's) to take P&WCC forward to the Board as a strategy in 2018.

19. PASIFIKA HEALTH LEADERSHIP GROUP (PHLG)

Barbara Arnott (Chair of CPHAC) who oversees the PHLG, advised board members were being asked to accept minor changes to the ToR for the Pasifika Health Leadership Group and also to endorse four (4) new appointments bringing membership up to eight as indicated in the ToR.

The changes noted to the ToR provided included: changing the heading from Pacific Health Leadership Group to "Pasifika" Health and incorporating the wording into the "Purpose" section wording also.
Functions: item a) had been added "Enhance engagement between Pacific communities and HB health funders and providers; and c) the wording "Provide direction" had been included at the

beginning of the paragraph. Under the "Support" section on page 2 of the ToR, the entire detail included under this heading was new.
There was some discussion around low Pacific staffing levels and attrition rates high and this resulted in board members requesting a new item be added under the "Aims" as a new item on page 1 of the ToR.

With that inclusion the Board approved the following resolution including the appointment of four new members: Iami Tukalau, Anna Marie Faavae, Ina i-te-roe Graham and Traci Tuimaseve.

RESOLUTION

That the HBDHB Board

- Accept the minor modifications to the Terms of Reference with the inclusion under the aim of the PHLGs advice on page 1 creating a new item: c) Enhance Pacific health staff resources.
- Endorse the four new appointments to the Pasifika Health Leadership Group

Moved **Barbara Arnott**
Seconded **Heather Skipworth**
Carried

FOR DISCUSSION / PRESENTATION

20. BIG LISTEN / PEOPLE STRATEGY

Kate Coley provided a presentation which since the meeting has been loaded onto Diligent for future reference.

In addition to the presentation, discussion included:

- There was a big piece of work being done around behaviours and attitudes.
- Bullying and behavioural issues amongst some staff was discussed and how this was being managed/dealt with. Following workshops held, reporting staff were more prepared to speak out.
- HB tends to be at one end of the bullying spectrum (likely to do with a number being medically trained) and also we are a big bureaucracy and employer in HB.
- Through training there have seen some immediate changes as a result of addressed some behavioural issues. Those affected had not realised how they came across (to others) and had apologised sincerely for this – and were now a lot more aware.
- No bullying should be accepted and because HBDHB are at a level consistent with other DHBs was not something to be proud of and should not be spoken about as such.
- We are training people to understand what bullying behaviour was, and what was not.
- Will be working on the INDUCTION process in this area also
- In EXIT interviews need to ask if those leaving had been bullied and provide example(s) ensuring their understanding of bullying is consistent in the first place.
- In February will co-design the approach which needs a refresh. Better to have a face to face.
- People tend to provide brilliant service when they know feedback is coming. OR that they are being watched!
- Measures and KPIs in this area (for the CEO and ED People and Quality) were noted.

TIMELINES advised for the Big Listen/People Strategy :

- Jan, Feb & March 2018 – run further co-design workshops with staff and leaders
- February –run co-design workshops with Bipartite Group and all Union Delegates
- March – share draft strategy and run co-design workshop with all leaders

- March – share draft People Strategy – co-design at Health Sector Leadership forum
- March/April – incorporate feedback and information
- April – share final draft People Strategy with all governance groups, staff and unions for feedback (Normal consultation process)
- May/June 2018 – endorsement of people strategy,

- An MRB Workshop had been held on how we measure our **patient experience feedback** – thinking about how we capture feedback through a system that is effective and quick. Kate advised that she hopes to have a clearer picture in March 2018. Want to do this well, rather than rush it.

21. CLINICAL SERVICES PLAN (CSP)

Ken Foote Project Lead for the CSP project and Project Sponsor Tracee TeHuia were in attendance for this item. The presentation provided by Ken had been included within the board papers however one inclusion at the end of the presentation was a diagram provided by Tracee, highlight how this all comes together:

This indicative timeline is for six major pieces of work, with planning occurring in January / February to confirm agreed names, purpose and confirm the timelines.

In discussion regarding the creation of the 5-10 Year Strategic Plan document (shown in red above), it was asked that this document be “simple” enough to be read by the young eg, a 12 year old boy.

With the resignation of Carina Burgess in October, a replacement “Head of Planning” was being sought with interviews to take place in January 2018.

MONITORING

22. HUMAN RESOURCES KPIs for Quarter One

Kate Coley provided an overview of the report. In 2018 Pasifika will be reported. Some identify with both Maori and Pasifika which is currently a challenge in the system, as we count only the first field.

In six months (by June 2018) this HR KPIs report will look very different. Board members suggested a traffic light one page summary at the beginning of the report as an interim measure.
Action

The public section of the Board Meeting closed 2.45pm

Signed: _____

Chair

Date: _____

BOARD MEETING - MATTERS ARISING
(Public)

5

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	29 Nov 17	**Homeopathy:** Chief Allied Health Professions Officer to follow up on letter received around Homeopathy being part of the health service and advise outcome.	Andy Phillips	Feb 18	Verbal Update
2	29 Nov 17	**Matariki Regional Economic Strategy & Social Inclusion Strategy** Comments and feedback to the Governance Group and will report back to the February Board Meeting.	Sharon Mason	Feb 18	Verbal Update
3	13 Dec 17	**Interest Register -** Update for Peter Dunkerley.	Admin	Dec 17	Actioned
4	13 Dec 17	**Faster Cancer Treatment -** a report to the Board that there has been significant improvement or a program provided with actions for improvement.	Andy Phillips	Mar 18	Included on workplan – report to Kathy 8 March 2018
5	13 Dec 17	**Finance Report for December 2018:** to be provided to the Board in mid January by email.	Admin	Mid Jan 18	Actioned
6	13 Dec 17	**Pasifika Health Leadership Group:** a) include new clause into the Terms of Reference relating to enhancing Pacific health staff resources. b) Proceed with appointment of four new appointmens to the PHLB Group.	K Foote	Feb 18	Actioned
7	13 Dec 17	**Urgent Care Service –** a tracking report on the new service will be provided in six months time.	Wayne Woolrich	June 18 and Dec 18	Included on workplan.
8	13 Dec 17	**Governance Health & Safety Training** would be arranged for the New Year (half day training)	Ken Foote	Dec 17	Training confirmed for Tues 27 Feb 2018
9	13 Dec 17	**Health & Safety Board Champion Terms of Reference** considered.	Ken Foote	Feb 18	Consider following the H&S workshop planned for 27 February
10	13 Dec 17	**HR KPI's Quarterly Reporting –** advised Board that the report will look very different by June 2018. In the interim the Board suggested a traffic light one page summary at the beginning of the Report. Reports due Feb / May 2018.	Kate Coley	Feb 18	

HAWKE'S BAY DISTRICT HEALTH BOARD – WORKPLAN

Mtg Date	Papers and Topics	Lead(s)
28 Feb	Clinical Portal Project	Anne Speden
	Disposal of Surplus Land at Waipukurau	Sharon Mason
	Leadership Forum Programme	Ken Foote
	Suicide Prevention Update (Board Action)	Sharon Mason
	Ngātahi Vulnerable Children's Workforce Development Update	Russell Wills
	HBDHB Annual Plan 2016/17 final	
	Integrated Communications Environment	Anne Speden
	Clinical Services Plan Update	Ken Foote
	Monitoring	
	HR KPIs Q2 Oct-Dec 17	Kate Coley
	Te Ara Whakawaiora – Access 0-4 / 45-56 years local indicator	Mark Peterson
	HBDHB Performance Framework Exceptions Report & Dashboard Q2 Oct-Dec 17 and the MoH dashboard Q1	Tim Evans
7 Mar	**HB Health Sector Leadership Forum** **Venue: Napier Sailing Club, Ahuriri** **9.00am to 3.00pm** (door open at 8.30am)	
28 Mar	Radiology Expansion Programme	Sharon Mason
	Feedback from Workshop held in December (by Councils) Board action	Kevin Snee
	Building Culture	Kate Coley
	Clinical Governance Value Assessment (Board Action)	Gommans/Phillips
	Collaborative Pathways Report	Mark Peterson
	Establishing Health and Social Care Localities in HB (6 mthly update)	Chris Ash
	Oncology Model of Care (from Oct)	Sharon Mason
	Audit NZ Final Management Report on the audit of HBDHB for y/e June 2017 (from Dec)	Tim Evans
	Faster Cancer Treatment (Board action Dec 17)	Andy Phillips
	Incorporating Building a Diverse Workforce and engaging well with Maori (Sept 17 Board action)	Kate Coley
	Monitoring	
	Te Ara Whakawaiora / Culturally Competent Workforce	Kate Coley
	Te Ara Whakawaiora – Breastfeeding (national indicator)	Chris McKenna
25 Apr	Mobility Action Plan Update	Andy Phillips
	Big Listen Update	Kate Coley
	Building Culture	Kate Coley
	Implementing the Consumer Engagement Strategy (from Sept 17)	Kate Coley
	Recognising Consumer Participation Policy Amendment (from July 17)	Kate Coley
	Policy on Consumer Stories (from July 17)	Kate Coley
	Whole of Board Appraisal (progress against actions)	
	Alcohol Position Statement and Strategy	Sharon Mason
	Monitoring	
	Te Ara Whakawaiora – Did not attend	Sharon Mason

30 May	Annual Plan draft 2018/19 Smoke Free Update (including Nov Board Action) Annual Plan Second Draft Best Start Healthy Eating & Activity Plan update (for information - 6 mthly Nov-May-Nov18) People Strategy / Big Listen Update ***Monitoring*** HR KPIs Q3 Oct-Dec 17 HBDHB Non-Financial Exceptions Report Q3 Jan-Mar 18 + MoH dashboard Q2	Chris Ash Sharon Mason Tracee TeHuia Tracee TeHuia Kate Coley Kate Coley Tim Evans
27 Jun	People Strategy final Consumer Experience Feedback (revised method) Q3 Youth Health Strategy (Board action June 2017) Urgent Care Service Update	Kate Coley Kate Coley Tracee TeHuia Wayne Woolrich
25 July		
29 Aug	Annual Report 2017/18 (first draft) Whole of Board Appraisal (progress against actions) ***Monitoring*** HR KPIs Q4 Apr-June 18 HBDHB Performance Framework Exceptions Report Q4 Apr-Jun 18 + MoH dashboard Q3	Tim Evans Kate Coley Tim Evans
5 Sept	**HB Health Sector Leadership Forum** **Venue: To be confirmed** **9.00am to 3.00pm** (door open at 8.30am)	
26 Sept	Approve Annual Plan 2018/19 Establishing Health and Social Care Localities in HB (6 mthly update)	Tim Evans Tracee TeHuia
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) Smokefree Update (6 monthly) ***Monitoring*** HR KPIs Q1 Jul-Sept 18 HBDHB Performance Framework Exceptions Report Q1 Jul-Sep 18 + MoH dashboard Q3	Tracee TeHuia Tracee TeHuia Kate Coley Tim Evans
12 Dec	Urgent Care Service Update	Wayne Woolrich

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** 01
	For the attention of: **HBDHB Board**
Document Owner:	Kevin Snee, Chief Executive Officer
Reviewed by:	Not applicable
Month as at	22 February 2018
Consideration:	For Information

RECOMMENDATION

That the Board

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

INTRODUCTION

The Hawke's Bay health system has been under significant pressure throughout December and January, at a time when we would normally expect the system to be quieter. This has led to a deterioration in some of our hospital performance targets and our finances. This is the general picture across health systems in New Zealand. We are currently trying to understand why this is happening. It is likely to be multifactorial, but some facts and figures are illustrative – comparing December and January with the previous year:

- Attendances at ED have increased from 127 to 132 per day a 4.0 percent increase
- Admissions to hospital via ED increased from 35.1 to 41.0 per day, a 16.8 percent increase
- Acute surgical discharges increased from 895 to 1,040, a 16.2 percent increase
- Average daily occupancy rate for adult inpatient areas increased from 88.2 percent to 90.2 percent, an increase of 2.4 percent

We will present to FRAC, this month, some long term trends and analysis to help understand why the system is under pressure and some steps we intend to take in the short and medium term to ensure we have greater resilience in place for winter.

On a more positive note, our annual plan has now been formally signed off by the Minister of Health and we had a positive meeting at the Health Select Committee.

PERFORMANCE

PERFORMANCEMeasure / Indicator	Target	Month of January	Qtr to end January	Trend For Qtr
Shorter stays in ED	≥95%	89.9%	89.9%	▼
Improved access to Elective Surgery (2017/18YTD)	100%	-	96.5%	▼

Waiting list	Less than 3 months	3-4 months	4+ months
First Specialist Assessments (ESPI-2)	2,595	451	216
Patients given commitment to treat, but not yet treated (ESPI-5)	1,044	123	96

Faster cancer treatment* *(The FCT Health Target definition has changed for 2017/18 financial year. Patients who breach the 62 day target due to Capacity Constraint are still counted against target however patients who breach the target due to Clinical Decision or Patient Choice are now excluded).*	≥90%	100% (December 2017)	94.9% (6m to December 2017)	▲
Increased immunisation at 8 months (3 months to end of January)	≥95%	---	93.3%	▼
Better help for smokers to quit – Primary Care	≥90%	90.9% (15m to December)	---	▼
Better help for smokers to quit – Maternity **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% (Quarter 2, 2017/18)	▼
Raising healthy kids (New)	≥95%	---	97% (6m to December)	▼
Financial – month (in thousands of dollars)	(4,455)	(4,830)	---	---
Financial – year to date (in thousands of dollars)	(4,455)	(5,891)	---	---

***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%	*12/19 = 63%*	*59/114 = 51.8%*

The key issues of concern are the shorter stays in emergency department (ED6) performance and the elective services patient flow (ESPI) targets. Because the acute activity has displaced our elective activity, it is proving problematic. This is requiring increased spend in the private sector to meet targets, which is in turn undermining our financial performance.

The year-to-date result to the end of January is $1.436 million unfavourable to plan, with January $374 thousand unfavourable. A recovery plan is being put in place, but we are mindful that clinical quality and the welfare of our staff will need to be maintained.

CLINICAL PORTAL PROJECT

We are now into the implementation phase of this regional project. Significant effort has been invested to now enable a progressive rollout commencing in April with a target completion date of December 2018. No additional capital or operating budget is required. HBDHB has secured a number of beneficial regional initiatives including; external review of system performance/stability, dedicated Orion team to focus on our region with a true clinically led focus to designing future capability. In addition, Orion has approached HBDHB to act as a clinical product development review site, one of only two in the country, Canterbury DHB being the other.

DISPOSAL OF SURPLUS LAND AT WAIPUKURAU

A very small parcel of land on the river bank at the bottom of the Pukeora Hill remains in HBDHB ownership. The Board's approval is required to declare this land surplus to requirements, and to approve the disposal of the land in accordance with the statutory disposal process.

NEW ZEALAND HEALTH PARTNERSHIPS

A Special General Meeting of shareholders of New Zealand Health Partnerships Ltd is to be held on 8 March 2018. A paper is included seeking the Board's formal appointment of Kevin Atkinson to be the HBDHB representative to attend and vote at that meeting.

SUICIDE PREVENTION UPDATE

Suicide Prevention provides an update on current initiatives such as the Flaxmere Planning Committee, the cross sector approach to youth suicide prevention and postvention management. Included are two noted barriers and limitations of working in suicide prevention space across sectors, services and communities. Lastly, the update provides an intended focus for the future of suicide prevention such as researching zero suicides quality framework, a by community for community approach, resources and education, post/prevention and strategy development.

NGĀTAHI VULNERABLE CHILDREN'S WORKFORCE DEVELOPMENT PROGRESS

The Ngātahi Project is a partnership of 24 health, education and social service agencies, led by Bernice Gabriel, CAFS psychologist, and Dr Russell Wills, community paediatrician. Using a bottom-up approach, the project has engaged 441 practitioners in the vulnerable children's workforce, who have mapped their development needs against an agreed framework. From this mapping exercise three priorities for developing new competencies were identified: engaging effectively with Māori, mental health and addictions, and trauma-informed practice. This workforce has high levels of fatigue, burnout and vicarious trauma, so improving systems to support the workforce is a high priority of the third work stream. An independent evaluation demonstrated high engagement of the participating agencies and practitioners.

Funding has been secured from the Ministry for Children Oranga Tamariki and Transform and Sustain to design, deliver and evaluate the workforce development programme in 2018 and 2019.

TE ARA WHAKAWAIORA – ACCESS (0-4 YEARS AND 45-65 YEARS)

For ASH rates (Ambulatory Sensitive Hospitalisations - which are a proxy for potentially avoidable admissions if there was some appropriate intervention at some point in the past) in the 0-4 age group, HBDHB is doing well against the national average. The equity gap between the rates of Māori and non-Māori is relatively small and has been closing over the last few years. Some of the reasons for this are outlined.

For the 45-64 age group we are not doing nearly as well. While our ASH rates for this age group are around the national average, the difference in the rate between Māori and non-Māori is substantial and stubbornly resistant to improvement. In the paper there are quite a number of initiatives outlined that are designed to reduce overall ASH rates and to move towards equity. Key among these are the increased utilisation of Care Pathways, which should lead to more standardised care for everyone, and for the greater use of Nurse Practitioners and Clinical Nurse Specialists in outreach models to ensure patients are receiving the most appropriate care.

HBDHB PERFORMANCE FRAMEWORK EXCEPTIONS QUARTER TWO AND MINISTRY OF HEALTH QUARTERLY PERFORMANCE MONITORING DASHBOARD QUARTER ONE

Our Raising Healthy Kids performance continues to be above target. Good progress has been made this quarter with the Faster Cancer Treatment (FCT) health target where we are favourable against target. Better help to quit smoking in primary care has continued to improve and we have achieved target for our total result. The overall Did not Attend (DNA) rates to ESPI specialist appointments have remained favourable and there has been progress in DNA for both Māori and Pacific rates of DNA. However, we continue to fall short in the health target shorter stays in emergency department where 92.2 percent of patients are admitted, transferred or discharged within six hours against a target of 95 percent. The health target improved access to elective surgery is below target this quarter.

HUMAN RESOURCES KEY PERFORMANCE INDICATORS (KPIs) QUARTER TWO

Slow progress is being made on the Māori representation target for 2017/18 of 15.68 percent, with 14.61 percent of employees identifying as Māori at 31 December 2017. The gap to our target sits at 34 positions compared to 37 at the end of September 2017. Work is underway with both the Māori and Pasifika teams to ensure we have a detailed plan to achieve and sustain these workforce KPIs. Comparisons to 20 DHBs, mid-sized DHBs and Central Region DHBs are favourable. Staff turnover is within the 10.0 percent annual target, with 9.17 percent in the last 12 months. Annual leave balances 2+ years are higher than last year's level, but we rank well against other DHBs. Sick leave is slightly higher than last year but we are working on new reports to assist managers to monitor and manage as appropriate.

INTEGRATED COMMUNICATIONS ENVIRONMENT

The current traditional telephony environment is at its end of life and a risk to the organisation. We have completed the negotiations with Spark New Zealand Limited as preferred supplier. The negotiated position includes; a significant reduction off the original RFP price, a reduced operational cost and a regional commercial construct for Central Region DHB's to leverage. The solution delivers a key step towards an integrated care platform which is scalable, resilient and supports mobility, increasing staff productivity and flexible work practices.

CLINICAL SERVICES PLAN UPDATE

An update on the Clinical Services Plan will be presented in public excluded.

CONCLUSION

We have continued to be under significant pressure as a health system, which is impacting on some key performance areas and our financial performance. As can be seen in this report however, good progress continues to be made across a number of areas.

Governance Report Overview

02

9

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report January 2018**
	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	February, 2018
Purpose	For Information
Previous Consideration Discussions	None
Summary	The year-to-date result to the end of January is $1.436 million unfavourable to plan, with January $374 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
January 2018

Author:	**Phil Lomax**
Designation:	**Financial and Systems Accountant**
Date:	**13 February 2018**

1. EXECUTIVE DIRECTOR CORPORATE SERVICES' COMMENTS

Financial Performance

The year-to-date result to the end of January is $1.436 million unfavourable to plan, with January $374 thousand unfavourable.

Senior medical officers receive annual entitlements to continuing medical education (CME) leave and associated expenses on 1 January of each year. Entitlements are usually available for three years and are forfeited at the end of that period if unused. The DHB budgets for CME entitlements but not for any forfeits. The net impact of CME payments, entitlements, and forfeits in comparison to budget in January 2018 is $843 thousand favourable. This CME effect reduces the unfavourable variance for the month from what otherwise would have been $1.217 million unfavourable.

Case weighted discharges were similar to the average over the first half of the financial year. However, they were 20% above the budget for January - the budget reflecting historical trends and the opportunity to make savings. The higher than expected acute demand in January is reflected in higher than budgeted staffing and clinical supply costs that are the major cause of the underlying $1.217 million unfavourable January result.

Forecast

The detailed review of financial performance by directorate indicates a deterioration in the forecast result by $2.2 million, from a $1.5 million planned surplus to a $0.7 million deficit.

The main drivers of the forecast variance are:

- Unachieved savings ($4.2 million)
- Additional outsourced services and clinical supplies for elective surgery ($2.5 million)
- Additional clinical supply costs related to medical acute care ($0.5 million)
- Additional patient transport costs ($0.3 million)
- Additional continence supplies ($0.2million)
- Additional depreciation expense ($0.7 million)
- Additional payments to other providers ($0.3 million)

Partly offset by:

- Additional MOH income ($0.3 million)
- Additional ACC and other government income ($0.3 million)

- Allied health vacancies ($2.2 million)
- Other personnel vacancies ($0.4 million)
- Contingency released ($3.0 million)
- Unspent IT infrastructure costs ($0.3 million)

Directorates are reviewing savings plans to identify opportunities to help mitigate the forecast result.However, the inability to make savings over the holiday period due to acute volumes makes that much more difficult. Consequently the forecast has been updated to indicate the likely result assuming no material opportunities for additional savings are identified.

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
- Costs of $0.7 million relating to Care Capacity Demand Management (CCDM) that has no funding stream identified
- 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

	January				Year to Date				Year End Forecast	Refer Section
	Actual	Budget	Variance		Actual	Budget	Variance			
	$'000	$'000	$'000	%	$'000	$'000	$'000	%	$'000	
Net Result - surplus/(deficit)	(4,830)	(4,455)	(374)	-8.4%	(5,891)	(4,455)	(1,436)	-32.2%	(653)	3
Contingency utilised	125	250	125	50.0%	875	1,750	875	50.0%	3,000	8
Quality and financial improvement	159	1,184	(1,025)	-86.6%	3,462	5,441	(1,979)	-36.4%	6,612	11
Capital spend	1,578	1,993	(414)	-20.8%	8,373	13,948	(5,575)	-40.0%	23,920	16
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,306	2,378	72	3.0%	2,280	2,327	47	2.0%	2,321	5 & 7
	CWD	CWD	CWD	%	CWD	CWD	CWD	%	CWD	
Case weighted discharges	2,427	1,989	438	22.0%	16,989	16,755	234	1.4%	28,386	5

The monthly $125 thousand of the contingency dedicated to meeting elective surgery targets was released in January, taking the total released year-to-date to $875 thousand. Only the $1.5 million for elective surgery has been allocated from the $3.0 million available contingency.

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 January 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 in January. The shortfall is mainly in Inter District Flows (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 January 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.

Higher than expected volumes for the time of year is reflected in medical (net of the CME leave entitlement effect) 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.

Higher than expected acute demand was experienced in January across surgery (25% above monthly volumes for the first half of the year, and 67% above the budget for January), medicine (6% below the first half of the year, but 10% above the January budget) and paediatrics (20% below the first half and 30% above the January budget) . Despite the acute pressure, surgical elective volumes were maintained, and on-site volumes for the elective services health target were less than 10% behind plan for the month.

3. FINANCIAL PERFORMANCE SUMMARY

	January				Year to Date				Year End	Refer
$'000	Actual	Budget	Variance		Actual	Budget	Variance		Forecast	Section
Income	46,175	46,118	57	0.1%	320,870	320,299	570	0.2%	556,270	4
Less:										
Providing Health Services	26,663	26,125	(538)	-2.1%	157,931	154,731	(3,200)	-2.1%	268,218	5
Funding Other Providers	20,009	19,800	(209)	-1.1%	139,259	139,571	311	0.2%	239,328	6
Corporate Services	4,145	4,291	145	3.4%	28,158	27,955	(204)	-0.7%	48,287	7
Reserves	187	358	**171**	**47.8%**	1,412	2,499	**1,087**	**43.5%**	1,090	8
	(4,830)	**(4,455)**	**(374)**	**-8.4%**	**(5,891)**	**(4,455)**	**(1,436)**	**-32.2%**	**(653)**	

Income
Special fund and clinical trial income (unbudgeted), additional funding for specific programmes from MOH, and higher ACC income other than from elective surgery.

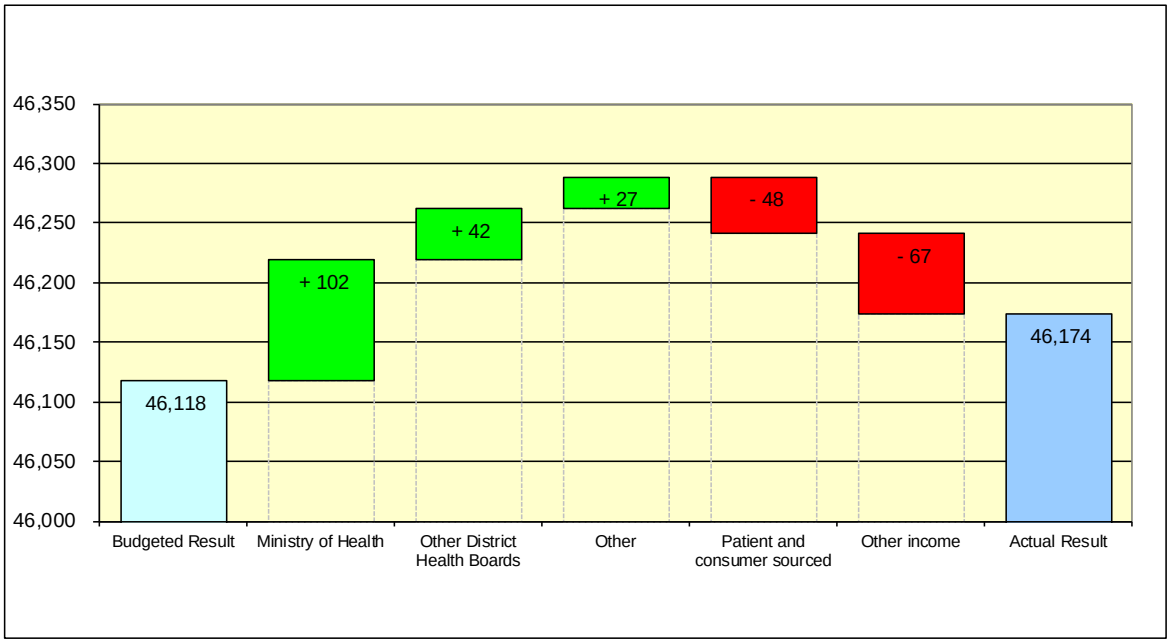
Providing Health Services
Higher than expected acute demand in January increasing nursing and clinical supply costs, reducing the ability to achieve one-off cost savings, and reducing the opportunity to earn ACC income.

Funding Other Providers
Release of provisions, wash-ups and rebates generally relating to 2016/17, were partly offset by increased spend on day relief programmes, home support, and care giver support for older people, higher than budgeted community residential mental health beds and services, and inter-district outflow provisions.

4. INCOME

	January				Year to Date				Year End
$'000	Actual	Budget	Variance		Actual	Budget	Variance		Forecast
Ministry of Health	44,187	44,085	102	0.2%	306,070	305,913	157	0.1%	531,304
Inter District Flows	715	693	22	3.2%	4,750	4,850	(100)	-2.1%	8,214
Other District Health Boards	375	333	42	12.7%	2,445	2,330	115	4.9%	4,104
Financing	73	74	(0)	-0.4%	494	516	(22)	-4.2%	812
ACC	425	415	9	2.2%	3,207	3,051	**156**	**5.1%**	5,465
Other Government	9	22	(12)	-56.8%	368	267	**102**	**38.1%**	487
Patient and Consumer Sourced	81	129	(48)	-37.0%	635	760	**(125)**	**-16.5%**	1,211
Other Income	300	367	**(67)**	**-18.1%**	2,891	2,547	**344**	**13.5%**	4,662
Abnormals	8	0	8	4363.2%	10	66	**(56)**	**-84.6%**	11
	46,175	**46,118**	57	0.1%	**320,870**	**320,299**	570	0.2%	**556,270**

Month of January



Note the scale does not begin at zero

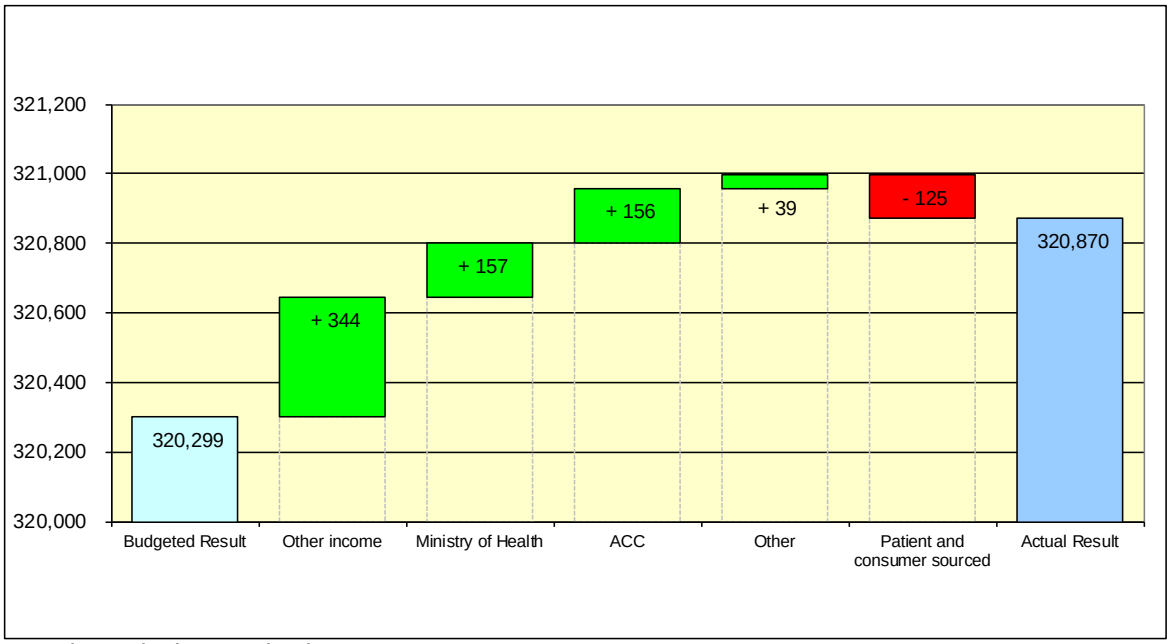
Ministry of Health (favourable)
Cancer nurse coordinator, and Say Ahh funding.

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

Patient and consumer sourced (unfavourable)
Lower than budgeted audiology patient co-payments, non-resident charges and meals on wheels.

Other income (unfavourable)
Lower than budgeted income for the Wairoa GP practices, and lower rental income.

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 Ngātahi 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.

ACC (favourable)
ACC surgery fell behind budget in January. However, this is offset by non-acute rehabilitation and community nursing that remain above budget year-to-date.

Patient and consumer sourced (unfavourable)
Audiology patient co-payments due to audiologist vacancies, non-eligible patient charges and NASC charges all behind budget.

5. PROVIDING HEALTH SERVICES

	January				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure by type $'000									
Medical personnel and locums	8,200	8,600	399	4.6%	37,315	37,612	297	0.8%	62,152
Nursing personnel	7,847	7,198	(649)	-9.0%	45,075	44,879	(197)	-0.4%	76,582
Allied health personnel	2,794	3,226	432	13.4%	19,730	21,320	1,589	7.5%	34,375
Other personnel	2,089	2,125	36	1.7%	13,815	13,983	168	1.2%	23,746
Outsourced services	858	648	(210)	-32.5%	6,435	4,622	(1,813)	-39.2%	9,507
Clinical supplies	3,260	2,646	(614)	-23.2%	23,448	20,246	(3,202)	-15.8%	40,954
Infrastructure and non clinical	1,614	1,682	68	4.1%	12,112	12,069	(43)	-0.4%	20,902
	26,663	**26,125**	(538)	-2.1%	**157,931**	**154,731**	(3,200)	-2.1%	**268,218**
Expenditure by directorate $'000									
Medical	8,105	7,487	(618)	-8.3%	42,750	41,170	(1,579)	-3.8%	71,744
Surgical	6,380	5,708	(672)	-11.8%	35,797	33,144	(2,653)	-8.0%	60,190
Community, Women and Children	4,092	4,298	206	4.8%	25,469	25,486	17	0.1%	43,262
Older Persons, Options HB, Menta	3,390	3,700	311	8.4%	20,200	20,760	560	2.7%	34,798
Operations	3,392	3,359	(33)	-1.0%	22,515	22,520	4	0.0%	38,944
Other	1,303	1,572	269	17.1%	11,200	11,651	451	3.9%	19,279
	26,663	**26,125**	(538)	-2.1%	**157,931**	**154,731**	(3,200)	-2.1%	**268,218**
Full Time Equivalents									
Medical personnel	408.3	409.5	1	0.3%	338	343	5	1.5%	345.2
Nursing personnel	976.6	922.7	(54)	-5.8%	929	924	(4)	-0.5%	918.1
Allied health personnel	400.0	470.8	71	15.0%	450	479	30	6.2%	478.4
Support personnel	140.6	137.7	(3)	-2.1%	137	136	(1)	-0.5%	136.0
Management and administration	239.9	267.5	28	10.3%	267	273	6	2.4%	271.9
	2,165.3	**2,208.0**	43	1.9%	**2,120**	**2,156**	36	1.7%	**2,149.6**
Case Weighted Discharges									
Acute	1,706	1,332	374	28.0%	11,753	11,543	210	1.8%	19,385
Elective	501	446	55	12.4%	3,556	3,696	(141)	-3.8%	6,451
Maternity	140	171	(31)	-18.3%	1,240	1,198	42	3.5%	2,000
IDF Inflows	80	39	40	102.0%	441	317	123	38.8%	550
	2,427	**1,989**	438	22.0%	**16,989**	**16,755**	234	1.4%	**28,386**

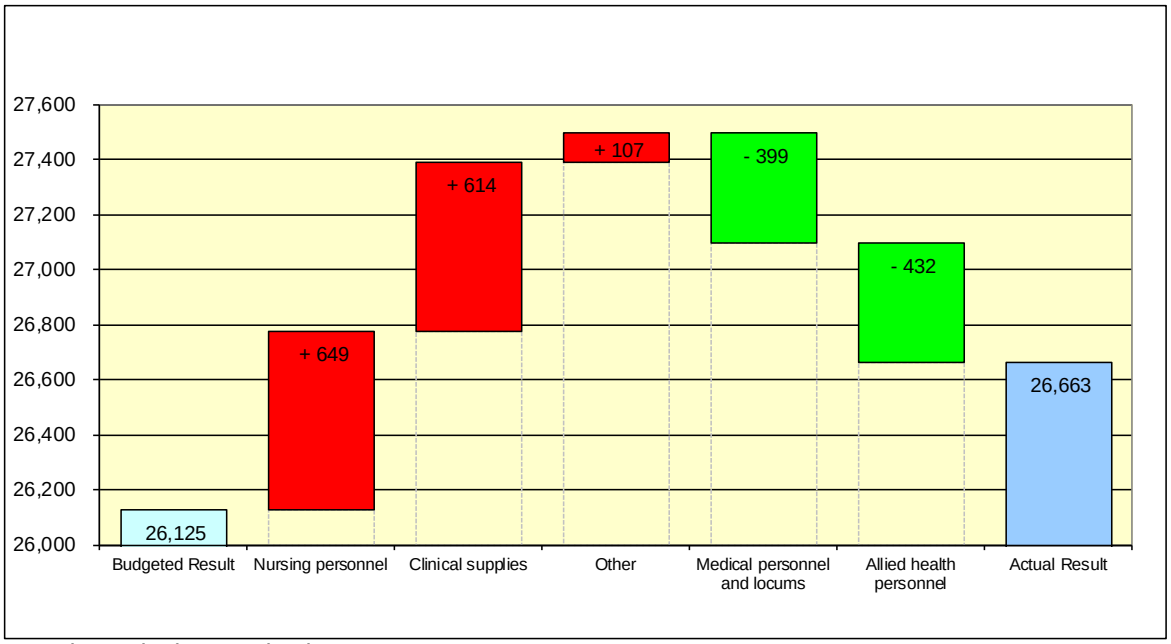
Directorates

- Surgical services – higher acute demand than planned for January increasing nursing and clinical supply costs, reducing the ability to achieve one-off cost savings, and reducing the opportunity to earn ACC income. Note that $875 thousand appearing as a 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 variance.
- Medical services – higher than expected acute volumes in January increasing nursing and clinical supply costs, and reducing the ability to achieve one-off cost savings.

Case Weighted Discharges

The hospital budgeted for reduced caseweights in January reflecting historical patterns and the opportunity to achieve efficiencies. However, the month saw high acute demand across surgery (25% above monthly volumes for the first half of the year, and 67% above the budget for January), medicine (6% below the first half of the year, but 10% above the January budget) and paediatrics (20% below the first half and 30% above the months budget). Surgical elective volumes were maintained at a reasonably high level.

Month of January



Note the scale does not begin at zero

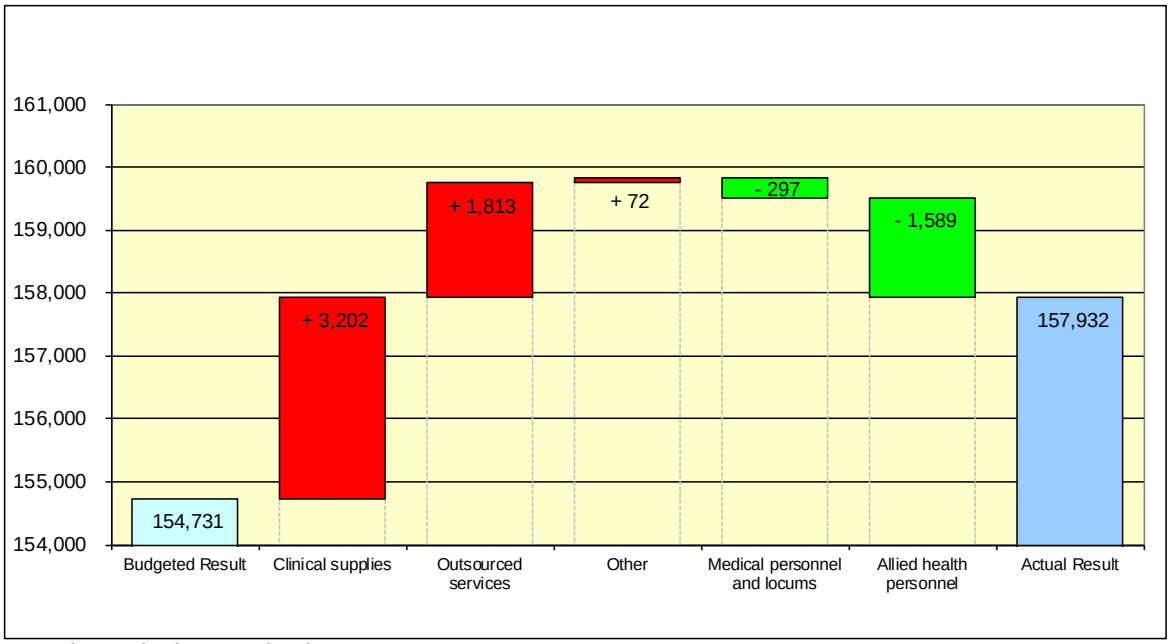
Nursing personnel (unfavourable)
Additional staff and low annual leave taken to cope with higher than expected demand.

Clinical supplies (unfavourable)
Undelivered savings for targets not yet allocated to budgets, supplies reflecting higher than expected demand (instruments and equipment, implants and prostheses, and pharmaceuticals), and patient transport costs.

Medical personnel and locums (favourable)
CME entitlements and forfeits partly offset by locum costs to cover vacancies.

Allied health personnel (favourable)
Vacancies in mental health, community services, services for women and children, and health of older people.

Year to date



Note the scale does not begin at zero

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

Outsourced services (unfavourable)
Mainly outsourced elective surgery to Royston, and higher costs and volumes for after-hours radiologist services, .

Medical personnel and locums (favourable)
Vacancies and CME adjustments offset by locums providing leave and vacancy cover.

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

Full time equivalents (FTE)

FTEs are 36 (1.7%) favourable year to date including:

Medical personnel (5 FTE / 1.5% favourable)
- Vacancies (offset in outsourced medical costs).

Nursing personnel (-4 FTE / -0.5% favourable)
- High patient volumes continuing into January, mostly surgical acutes, has more than offset the favourable variance built up from unfilled new senior nurse positions earlier in the year.

Allied Health Personnel (30 FTE / 6.2% favourable)
- Vacancies including social workers, psychologists, 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 January 2018			
		Actual	Plan	Var.	%Var.
On-Site	Avastins	117	117	0	0.00%
	ENT	260	299	-39	-13.00%
	General Surgery	457	493	-36	-7.30%
	Gynaecology	293	328	-35	-10.70%
	Maxillo-Facial	128	128	0	0.00%
	Ophthalmology	533	629	-96	-15.30%
	Orthopaedics	318	334	-16	-4.80%
	Orthopaedics - Major Joints	126	153	-27	-17.60%
	Skin Lesions	119	119	0	0.00%
	Urology	300	281	19	6.80%
	Vascular	77	105	-28	-26.70%
	Surgical - Arranged	334	314	20	6.40%
	Non Surgical - Arranged	46	8	38	475.00%
	Non Surgical - Elective	28	39	-11	-28.20%
On-Site	**Total**	**3136**	**3347**	**-211**	**-6.30%**
Outsourced	ENT	56	80	-24	-30.00%
	General Surgery	186	162	24	14.80%
	Gynaecology	17	0	17	0.00%
	Maxillo-Facial	30	43	-13	-30.20%
	Ophthalmology	121	69	52	75.40%
	Orthopaedics	1	0	1	0.00%
	Orthopaedics - Major Joints	66	56	10	17.90%
	Skin Lesions	1	0	1	0.00%
	Urology	25	29	-4	-13.80%
	Vascular	16	3	13	433.30%
Outsourced	**Total**	**519**	**442**	**77**	**17.40%**
IDF Outflow	Cardiothoracic	50	42	8	19.00%
	ENT	30	22	8	36.40%
	General Surgery	33	30	3	10.00%
	Gynaecology	12	15	-3	-20.00%
	Maxillo-Facial	76	108	-32	-29.60%
	Neurosurgery	26	47	-21	-44.70%
	Ophthalmology	20	21	-1	-4.80%
	Orthopaedics	24	11	13	118.20%
	Paediatric Surgery	44	47	-3	-6.40%
	Skin Lesions	23	26	-3	-11.50%
	Urology	9	4	5	125.00%
	Vascular	7	9	-2	-22.20%
	Surgical - Arranged	88	85	3	3.50%
	Non Surgical - Arranged	34	32	2	6.30%
	Non Surgical - Elective	66	61	5	8.20%
IDF Outflow	**Total**	**542**	**560**	**-18**	**-3.20%**
TOTAL		**4,197**	**4,349**	**-152**	**-3.50%**

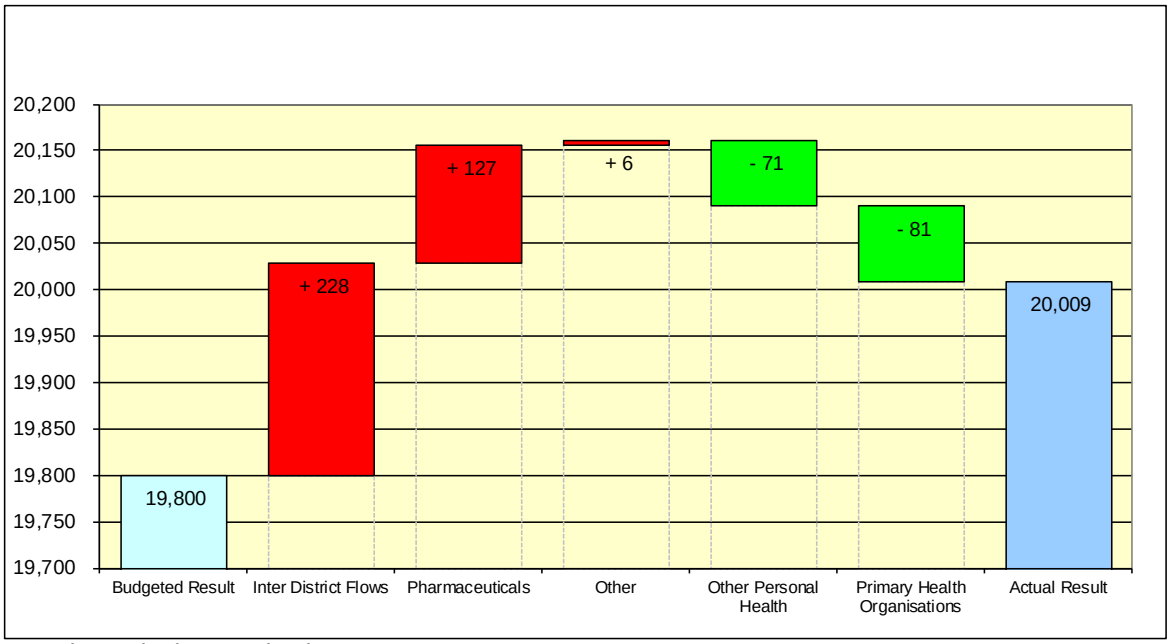
		January 2018			
		Actual	Plan	Var.	%Var.
On-Site	Avastins	17	17	0	0.00%
	ENT	54	43	11	25.60%
	General Surgery	62	71	-9	-12.70%
	Gynaecology	33	46	-13	-28.30%
	Maxillo-Facial	15	19	-4	-21.10%
	Ophthalmology	84	92	-8	-8.70%
	Orthopaedics	41	48	-7	-14.60%
	Orthopaedics - Major Joints	9	27	-18	-66.70%
	Skin Lesions	17	17	0	0.00%
	Urology	40	40	0	0.00%
	Vascular	11	15	-4	-26.70%
	Surgical - Arranged	54	46	8	17.40%
	Non Surgical - Arranged	4	1	3	300.00%
	Non Surgical - Elective	0	6	-6	-100.00%
On-Site	**Total**	**441**	**488**	**-47**	**-9.60%**
Outsourced	ENT	4	13	-9	-69.20%
	General Surgery	26	25	1	4.00%
	Gynaecology	6	0	6	0.00%
	Maxillo-Facial	7	11	-4	-36.40%
	Ophthalmology	17	7	10	142.90%
	Orthopaedics	0	0	0	0.00%
	Orthopaedics - Major Joints	14	10	4	40.00%
	Skin Lesions	0	0	0	0.00%
	Urology	4	4	0	0.00%
	Vascular	3	1	2	200.00%
Outsourced	**Total**	**81**	**71**	**10**	**14.10%**
IDF Outflow	Cardiothoracic	3	6	-3	-50.00%
	ENT	0	3	-3	-100.00%
	General Surgery	3	3	0	0.00%
	Gynaecology	1	2	-1	-50.00%
	Maxillo-Facial	7	14	-7	-50.00%
	Neurosurgery	1	7	-6	-85.70%
	Ophthalmology	2	2	0	0.00%
	Orthopaedics	0	1	-1	-100.00%
	Paediatric Surgery	2	6	-4	-66.70%
	Skin Lesions	0	3	-3	-100.00%
	Urology	0	0	0	0.00%
	Vascular	0	1	-1	-100.00%
	Surgical - Arranged	10	11	-1	-9.10%
	Non Surgical - Arranged	4	3	1	33.30%
	Non Surgical - Elective	8	6	2	33.30%
IDF Outflow	**Total**	**41**	**68**	**-27**	**-39.70%**
TOTAL		**517**	**607**	**-90**	**-14.80%**

Please Note: This report was run on 9 February 2018. Skin Lesions and Avastins are reported to plan. Data is subject to change.

6. FUNDING OTHER PROVIDERS

$'000	January Actual	January Budget	January Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Payments to Other Providers									
Pharmaceuticals	3,854	3,726	(127)	-3.4%	25,440	26,140	699	2.7%	44,092
Primary Health Organisations	2,866	2,947	81	2.7%	21,343	21,384	41	0.2%	36,464
Inter District Flows	4,528	4,300	**(228)**	**-5.3%**	30,553	30,308	(245)	-0.8%	51,681
Other Personal Health	1,858	1,929	71	3.7%	13,234	13,481	247	1.8%	24,152
Mental Health	987	931	**(56)**	**-6.0%**	6,837	6,574	(262)	-4.0%	11,498
Health of Older People	5,612	5,603	(10)	-0.2%	39,502	39,225	(277)	-0.7%	67,539
Other Funding Payments	304	364	**60**	**16.4%**	2,350	2,459	109	4.4%	3,902
	20,009	19,800	(209)	-1.1%	**139,259**	**139,571**	311	0.2%	239,328
Payments by Portfolio									
Strategic Services									
Secondary Care	4,048	3,784	**(263)**	**-7.0%**	26,955	26,840	(115)	-0.4%	45,831
Primary Care	8,073	8,185	111	1.4%	56,900	58,087	1,187	2.0%	99,149
Chronic Disease Management	-	-	-	0.0%	-	-	-	0.0%	-
Mental Health	1,239	1,251	12	1.0%	8,792	8,767	(25)	-0.3%	14,955
Health of Older People	5,921	5,914	(6)	-0.1%	41,881	41,316	(565)	-1.4%	71,279
Other Health Funding	33	33	(0)	0.0%	233	233	(0)	0.0%	400
Maori Health	569	510	**(59)**	**-11.6%**	3,605	3,463	(143)	-4.1%	6,227
Population Health	126	122	(4)	-3.1%	893	864	(29)	-3.3%	1,488
	20,009	19,800	(209)	-1.1%	**139,259**	**139,571**	311	0.2%	239,328

Month of January



Note the scale does not begin at zero

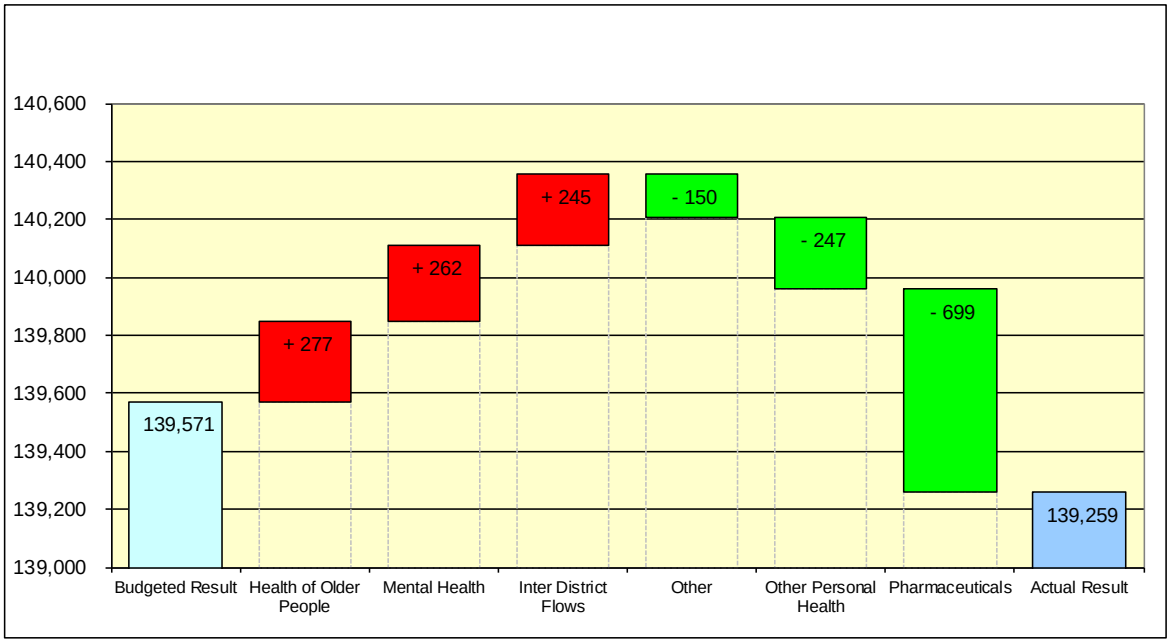
Inter district flows (unfavourable)
Higher outflows based on MOH data and information from other DHBs.

Pharmaceuticals (unfavourable)
Adjustment of the provision for pharmaceutical claims to match September to November average expenditure.

Other personal health (favourable)
Release of a number of small provisions for expenditure that have not come to charge.

Primary health organisations (favourable)
Reduced provision for free to under 18s services, to reflect payments.

Year to Date



Health of Older People (unfavourable)
Increased spend on day relief programmes, home support, and care giver support.

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

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

Other Personal Health (favourable)
Funding recoveries.

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

7. CORPORATE SERVICES

$'000	January Actual	January Budget	January Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Operating Expenditure									
Personnel	1,225	1,381	156	11.3%	9,068	9,330	262	2.8%	15,661
Outsourced services	92	68	(24)	-36.2%	533	473	(60)	-12.7%	839
Clinical supplies	291	277	(13)	-4.8%	(166)	(263)	(96)	-36.7%	(337)
Infrastructure and non clinical	693	765	73	9.5%	5,719	5,900	181	3.1%	9,576
	2,300	2,491	191	7.7%	15,154	15,441	287	1.9%	25,740
Capital servicing									
Depreciation and amortisation	1,140	1,095	(46)	-4.2%	8,047	7,579	(468)	-6.2%	14,042
Financing	-	-	-	0.0%	-	-	-	0.0%	-
Capital charge	705	705	-	0.0%	4,957	4,935	(23)	-0.5%	8,504
	1,845	1,800	(46)	-2.5%	13,004	12,514	(490)	-3.9%	22,547
	4,145	**4,291**	145	3.4%	**28,158**	**27,955**	(204)	-0.7%	**48,287**
Full Time Equivalents									
Medical personnel	0.4	0.4	0	7.9%	0	0	0	1.3%	0.3
Nursing personnel	7.4	14.5	7	48.6%	13	15	2	15.8%	14.9
Allied health personnel	0.5	0.4	(0)	-26.4%	1	0	(0)	-104.4%	0.4
Support personnel	7.8	8.9	1	12.7%	9	9	0	1.6%	9.1
Management and administration	124.4	145.8	21	14.7%	138	146	9	5.9%	146.8
	140.5	**170.0**	29	17.3%	**160**	**171**	11	6.3%	**171.5**

Depreciation is partly the acceleration of depreciation for some lower value IT assets, and earlier capitalisation of assets in 2016/17 than was estimated for depreciation budgets for 2017/18.

8. RESERVES

$'000	January Actual	January Budget	January Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Expenditure									
Contingency	125	250	125	50.0%	875	1,750	875	50.0%	-
Transform and Sustain resource	55	104	49	47.1%	492	719	227	31.6%	1,023
Other	7	4	(3)	-67.4%	45	30	(16)	-53.1%	66
	187	**358**	171	47.8%	**1,412**	**2,499**	1,087	43.5%	**1,090**

The $125 thousand monthy release of the contingency to cover the additional costs of meeting elective surgery targets was made in January. Project timelines for the national patient flow project have been extended delaying Transform and Sustain expenditure in the near term.

9. FINANCIAL PERFORMANCE BY MOH CLASSIFICATION

	January			Year to Date			End of Year		
$'000	Actual	Annual Plan	Variance	Actual	Annual Plan	Variance	Forecast	Annual Plan	Variance
Funding									
Income	43,664	43,527	137 F	302,511	302,345	166 F	525,512	525,029	483 F
Less:									
Payments to Internal Providers	22,354	22,284	(69) U	166,799	166,890	91 F	284,927	285,018	91 F
Payments to Other Providers	20,009	19,800	(209) U	139,259	139,571	311 F	239,328	239,055	(273) U
Contribution	**1,302**	**1,443**	**(142) U**	**(3,547)**	**(4,116)**	**569 F**	**1,257**	**956**	**301 F**
Governance and Funding Admin.									
Funding	274	274	-	1,921	1,921	-	3,294	3,294	-
Other Income	3	3	-	55	18	37 F	67	30	37 F
Less:									
Expenditure	214	284	71 F	1,600	1,803	202 F	3,000	3,204	204 F
Contribution	**63**	**(8)**	**71 F**	**375**	**136**	**239 F**	**361**	**120**	**241 F**
Health Provision									
Funding	22,079	22,010	69 F	164,878	164,969	(91) U	281,633	281,724	(91) U
Other Income	2,508	2,588	(80) U	18,304	17,937	367 F	30,691	30,654	37 F
Less:									
Expenditure	30,781	30,489	(292) U	185,901	183,382	(2,519) U	314,594	311,954	(2,641) U
Contribution	**(6,194)**	**(5,891)**	**(303) U**	**(2,719)**	**(475)**	**(2,244) U**	**(2,270)**	**424**	**(2,695) U**
Net Result	**(4,830)**	**(4,455)**	**(374)** U	**(5,891)**	**(4,455)**	**(1,436)** 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.

	January			Year to Date			End of Year		
$'000	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement
Funding									
Income	43,527	43,527	0 F	302,345	301,824	521 F	525,029	524,124	905 F
Less:									
Payments to Internal Providers	22,284	22,190	(94) U	166,890	166,232	(658) U	285,018	283,900	(1,118) U
Payments to Other Providers	19,800	19,747	(52) U	139,571	138,971	(600) U	239,055	238,724	(331) U
Contribution	**1,443**	**1,589**	**(146) U**	**(4,116)**	**(3,379)**	**(737) U**	**956**	**1,500**	**(544) U**
Governance and Funding Admin.									
Funding	274	274	-	1,921	1,921	-	3,294	3,294	-
Other Income	3	3	-	18	18	-	30	30	-
Less:									
Expenditure	284	280	(5) U	1,803	1,943	140 F	3,204	3,324	120 F
Contribution	**(8)**	**(3)**	**(5) U**	**136**	**(5)**	**140 F**	**120**	**(0)**	**120 F**
Health Provision									
Funding	22,010	21,916	94 F	164,969	164,311	658 F	281,724	280,606	1,118 F
Other Income	2,588	2,532	56 F	17,937	17,653	284 F	30,654	30,089	565 F
Less:									
Expenditure	30,489	30,490	1 F	183,382	183,036	(346) U	311,954	310,695	(1,258) U
Contribution	**(5,891)**	**(6,042)**	**151 F**	**(475)**	**(1,072)**	**596 F**	**424**	**-**	**424 F**
Net Result	**(4,455)**	**(4,455)**	**-**	**(4,455)**	**(4,455)**	**(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 $3.5 million of savings have been achieved against a year-to-date target of $5.4 million. Savings planned for January is 11% of the savings planned for the year, and reflects the opportunities for savings expected over the holiday period. Unfortunately acute demand did not dip as expected and consequently savings were a small fraction of plan in January.

Corporate general efficiencies are 53% of the year-to-date identified plans, down from 82% in December. The planned reduction in depreciation expense and capital charges comprise most of the shortfall.

Provider services general efficiencies are 73% of the year-to-date identified plans, down from 77% in December. The main items in the shortfall are in Surgical Services (non-recurrent schemes), Medical Services (staff management), and Community, Women and Child (vacancy management).

Strategic Planning general efficiencies are at 53% of the year-to-date identified plans, down from 75% in December. 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 quarter of the shortfall, and Urgent Care makes up most of the remainder.

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	457,433	241,330	(216,103)	53%	24%
Provider Services	4,911,000	2,482,049	1,801,543	(680,506)	73%	37%
Strategic Planning	4,598,000	2,281,946	1,208,724	(1,073,222)	53%	26%
Strategy and Health Improvement	286,000	219,286	210,177	(9,109)	96%	74%
Grand Total	**10,792,000**	**5,440,713**	**3,461,773**	**(1,978,940)**	**64%**	**32%**

12. FINANCIAL POSITION

30 June 2017	$'000	January Actual	January 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	(13,297)	(8,929)	4,369	(5,891)	(2,973)
142,345		136,454	140,822	4,369	(5,891)	146,421
	Represented by:					
	Current Assets					
16,541	Bank	13,541	12,203	(1,337)	(3,000)	15,536
1,690	Bank deposits > 90 days	1,901	1,755	(147)	212	1,755
26,735	Prepayments and receivables	19,267	22,696	3,428	(7,468)	22,951
4,435	Inventory	4,362	4,383	20	(72)	4,419
625	Non current assets held for sale	625	-	(625)	-	-
50,025		39,697	41,036	1,339	(10,328)	44,661
	Non Current Assets					
152,411	Property, plant and equipment	152,929	157,026	4,097	518	160,576
1,820	Intangible assets	1,576	2,389	812	(244)	2,962
10,701	Investments	10,987	11,621	634	286	12,105
164,932		165,492	171,035	5,543	560	175,642
214,957	**Total Assets**	**205,189**	**212,072**	**6,883**	**(9,768)**	**220,302**
	Liabilities					
	Current Liabilities					
35,447	Payables	30,863	35,446	4,583	(4,584)	35,762
34,528	Employee entitlements	35,235	33,089	(2,146)	707	35,381
69,975		66,098	68,535	2,437	(3,877)	71,143
	Non Current Liabilities					
2,638	Employee entitlements	2,638	2,714	77	-	2,739
2,638		2,638	2,714	77	-	2,739
72,612	**Total Liabilities**	**68,735**	**71,249**	**2,514**	**(3,877)**	**73,882**
142,345	**Net Assets**	**136,454**	**140,822**	**4,369**	**(5,891)**	**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.
- Employee entitlements – see below

13. EMPLOYEE ENTITLEMENTS

30 June 2017	$'000	January Actual	January Budget	Variance from budget	Movement from 30 June 2017	Annual Budget
7,853	Salaries & wages accrued	7,097	5,122	(1,976)	(755)	7,756
522	ACC levy provisions	730	292	(438)	208	501
4,869	Continuing medical education	6,422	6,341	(81)	1,554	5,553
19,819	Accrued leave	19,335	19,662	326	(484)	19,883
4,103	Long service leave & retirement grat.	4,287	4,387	100	184	4,426
37,165	**Total Employee Entitlements**	37,872	35,803	(2,069)	707	38,119

14. TREASURY

Liquidity management

The surplus cash of all DHBs is managed by NZ Health Partnerships Limited (NZHPL) 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 $5.6 million behind plan year-to-date, including the surgical expansion that is in the planning stage, and information technology that is expected to be spent later in the year.

See table on the next page.

2018 Annual Plan		*Actual $'000*	*Year to Date Budget $'000*	*Variance $'000*
	Source of Funds			
	Operating Sources			
13,625	Depreciation	8,047	7,579	(468)
1,500	Surplus/(Deficit)	(5,891)	(4,455)	1,436
9,166	Working Capital	6,216	10,697	5,731
24,290		8,371	13,820	6,699
	Other Sources			
-	Special funds and clinical trials	287	-	(287)
625	Sale of assets	-	625	(625)
625		287	625	(912)
24,915	**Total funds sourced**	**8,658**	**14,445**	**5,787**
	Application of Funds:			
	Block Allocations			
3,400	Facilities	1,634	2,158	523
3,200	Information Services	200	1,866	1,665
3,400	Clinical Plant & Equipment	2,198	1,808	(390)
10,000		4,032	5,831	1,799
	Local Strategic			
1,082	Renal Centralised Development	407	631	224
6,306	New Stand-alone Endoscopy Unit	3,136	3,677	541
134	New Mental Health Inpatient Unit Development	85	78	(7)
-	Maternity Services	7	-	(7)
500	Upgrade old MHIU	10	292	281
243	Travel Plan	63	142	79
1,555	Histology and Education Centre Upgrade	116	907	791
3,000	Surgical Expansion	-	1,749	1,749
500	Radiology Extension	-	292	292
600	Fit out Corporate Building	-	350	350
13,920		3,824	8,117	4,293
	Other			
-	Special funds and clinical trials	287	-	(287)
-	Surgical Expansion preliminary costs	103	-	(103)
-	Other	127	-	(127)
-		516	-	(516)
23,920	***Capital Spend***	***8,373***	***13,948***	***5,575***
	Regional Strategic			
995	RHIP (formerly CRISP)	286	498	212
995		286	498	212
24,915	**Total funds applied**	**8,658**	**14,445**	**5,787**

Monthly Project Board Report

Feb 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
41%	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	$ 5,377,472	Total 17/18 Spend to Date	$ 3,136,000
Percentage of Total Spend vs Budget	41%	Percentage 17/18 Spend vs Forecast	42%

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.

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	Feb-18	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

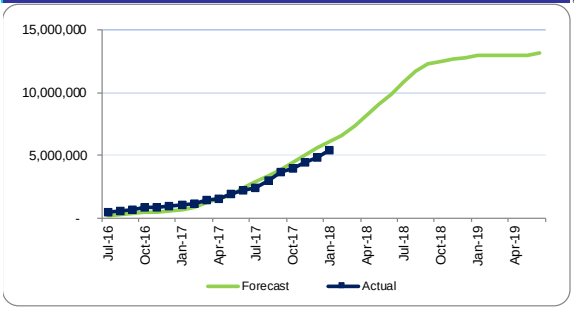
The final stage of structural steel installation is complete, All structural steel has now been delivered to site and erected. Ground floor concrete pours are now completed and all trades are proceeding to programme, revised programme has been agreed providing the completed building in September 2018 with operational activity planned from October 2018.
No accidents reported in this period, 3nd Quarter H&S GEMCO Audit completed , results pending. Independent H&S auditing by the HBDHB continues on a monthly basis.

Planned Activities next period

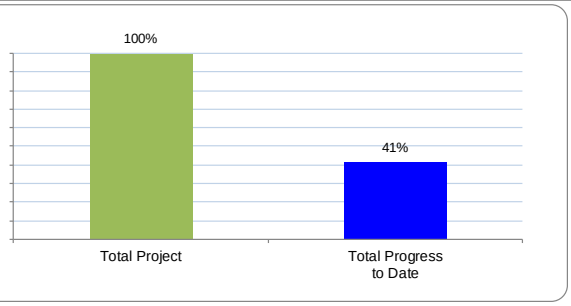
Completion of concrete floor to level 1
Completion of External cladding, services first fix and windows for Grids A through to E. Internal framing for Grids E through to K

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	January Forecast	Variance	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast	Jul Budget	Aug Budget	Sep Budget	Oct Budget	Nov Budget	Dec Budget	Jan Budget
Cash flows from operating activities															
Cash receipts from Crown agencies	47,637	45,702	1,935	45,724	42,461	43,681	42,163	53,208	44,365	43,638	52,459	44,805	48,215	44,703	45,742
Cash receipts from revenue banking	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from donations, bequests and clinical trials	(59)	-	(59)	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	(2,585)	471	(3,056)	470	445	443	445	443	440	446	440	505	447	445	471
Cash paid to suppliers	(28,072)	(27,692)	(381)	(22,482)	(26,743)	(26,295)	(25,149)	(30,597)	(28,113)	(26,670)	(29,968)	(27,677)	(27,999)	(27,464)	(27,634)
Cash paid to employees	(20,734)	(23,227)	2,493	(14,671)	(19,539)	(15,375)	(17,869)	(15,647)	(15,532)	(20,705)	(15,683)	(15,901)	(18,879)	(15,325)	(23,374)
Cash generated from operations	**(3,813)**	**(4,745)**	**932**	**9,041**	**(3,376)**	**2,453**	**(411)**	**7,408**	**1,160**	**(3,291)**	**7,249**	**1,733**	**1,784**	**2,360**	**(4,795)**
Interest received	73	74	(0)	68	75	73	75	73	74	74	74	74	74	74	74
Interest paid	-	-	-	0	0	(0)	(0)	0	-	-	-	-	-	-	-
Capital charge paid	(705)	0	(705)	-	-	-	-	(4,230)	0	0	0	0	0	(4,230)	0
Net cash inflow/(outflow) from operating activities	**(4,445)**	**(4,672)**	**227**	**9,109**	**(3,300)**	**2,526**	**(336)**	**3,251**	**1,234**	**(3,217)**	**7,322**	**1,806**	**1,858**	**(1,796)**	**(4,722)**
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	6	-	6	0	0	0	0	625	-	-	-	-	-	-	-
Acquisition of property, plant and equipment	(1,545)	(1,835)	290	(1,803)	(1,842)	(2,078)	(2,009)	(2,501)	(926)	(926)	(926)	(926)	(926)	(926)	(926)
Acquisition of intangible assets	(33)	(130)	97	(324)	(203)	(227)	(411)	(385)	(154)	(154)	(154)	(154)	(154)	(154)	(154)
Acquisition of investments	-	-	-	-	(285)	-	-	(284)	-	-	(249)	-	-	(249)	-
Net cash inflow/(outflow) from investing activities	**(1,572)**	**(1,965)**	**392**	**(2,127)**	**(2,330)**	**(2,305)**	**(2,420)**	**(2,545)**	**(1,080)**	**(1,080)**	**(1,328)**	**(1,080)**	**(1,080)**	**(1,328)**	**(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	(6,017)	(6,636)	619	6,982	(5,631)	221	(2,756)	348	154	(4,297)	5,994	727	778	(3,124)	(5,801)
Add:Opening cash	21,459	21,459	-	15,442	22,424	16,794	17,014	14,259	14,607	14,761	10,464	16,458	17,185	17,964	14,839
Cash and cash equivalents at end of period	**15,442**	**14,823**	**619**	**22,424**	**16,794**	**17,014**	**14,259**	**14,607**	**14,761**	**10,464**	**16,458**	**17,185**	**17,964**	**14,839**	**9,038**
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)	12,588	11,984	604	19,585	13,954	14,175	11,419	11,767	11,922	7,625	13,619	14,346	15,124	12,000	6,198
Short term investments (special funds/clinical trials)	2,825	2,835	(10)	2,835	2,835	2,835	2,835	2,835	2,835	2,835	2,835	2,835	2,835	2,835	2,835
Bank overdraft	25	-	25	(0)	(0)	(0)	(0)	(0)	-	-	-	-	-	-	-
	15,442	**14,823**	**619**	**22,424**	**16,793**	**17,014**	**14,258**	**14,606**	**14,761**	**10,464**	**16,458**	**17,185**	**17,963**	**14,839**	**9,037**

The operating forecasts for 2017/18 year are based on the draft budget completed in June 2017, and the forecast completed at the end of January 2018. 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.

RECOMMENDATION:

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

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

BOARD HEALTH & SAFETY CHAMPION'S UPDATE

Verbal

HAWKE'S BAY
District Health Board
Whakawāteatia

HB CLINICAL COUNCIL

11

Report

HB HEALTH CONSUMER COUNCIL

Report

12

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board (MRB)**	06
	For the attention of: **HBDHB Board**	
Document Owner:	Ngahiwi Tomoana (Chair)	
Month:	February 2018	
Consideration:	For Information	

13

RECOMMENDATIONS

That the Board:

Reviews the contents of this report, and consider the following recommendations:

- **Note** that MRB require further discussion about an Equity Committee and where the committee should be placed. MRB will respond to Clinical Council by the next meeting in April
- **Approve** MRB to develop a definition for the term 'vulnerable' and develop some measures specific to Kahungunu that is also required for the Ngātahi Project RFP of the training programme
- **Support** MRBs suggestion for a co-facilitator at the next HB Leadership Forum in March 2018 to improve facilitation and prevent a reoccurrence of the last forum

Note that MRB:

- **Noted** the progress of the Ngātahi Project in the first year
- **Noted** the approach endorsed for Years 2 and 3 of the Ngātahi Project and the forecast budget of $232,500 for 2018 and $212,500 for 2019, and that
- **Noted** the Transform and Sustain Steering Group will be asked to contribute funding of $80,000 in FY2017/2018 and FY2018/2019 for the evaluation component of the project
- **Noted** the remaining funding has been sought from the Ministry for Children Oranga Tamariki and a philanthropic funder.
- **Noted and approved** the Suicide Prevention Update Report by Penny Thompson (title) to be submitted to the HBDHB Board meeting in February 2018.

PURPOSE

The purpose of this report is to provide the Board with an overview of the matters and recommendations discussed at the Māori Relationship Board (MRB) meeting held on the 14 February 2018.

The following reports and papers were discussed and considered:

CLINICAL COUNCIL UPDATE - EQUITY COMMITTEE

An Equity Committee was discussed at the Clinical Council Meeting held in November last year including where the committee would be best placed. MRB were asked to provide their view about a

standalone committee or an equity lens across all committees, and if the committee should sit with the Clinical Council.

MRB were adamant that there is no need to create another committee. But there is a need for a 'third eye' to hold everyone to a higher level of accountability. Equity obliges people to look at their own back yards to find solutions to address the inequities. The Strategy and Health Improvement Directorate was charged with the development of the Equity Framework. Strategic facets of the framework could include a Health Equity Committee that would sit at a high level. The framework also includes training for key personnel with a whole approach across the system. There was some reservation about the Clinical Council being the Equity Champions for our whānau.

MRB agreed that further discussion is required therefore a decision could not be made at that time. MRB would endeavour to have a response to the Clinical Council by the next meeting in April regarding an Equity Committee and where it would best sit.

NGĀTAHI VULNERABLE CHILDREN'S WORKFORCE DEVELOPMENT PROGRESS

There was a lengthy discussion about the definition of 'vulnerable' and the existence of any methods to measure factors contributing to whānau becoming vulnerable. Because there is no standard definition of vulnerable, MRB agreed that further work is needed to develop a definition that will depict the Māori view of vulnerable as well as measures that would be specific to Kahungunu. In view of these matters, and that the training programme RFP requires a definition, MRB will be conducting this work to develop a definition of 'vulnerable' and measures specifically for Kahungunu.

SUICIDE PREVENTION UPDATE

The resources and the community focus 'by community, for the community' were complimented. MRB provided the following feedback for consideration:

- Refer to the 2017 Suicide Mortality Review Committee Report (SMRC) to support the report statements about the complexity of suicide and the risks. The SMRC report also talks about the reformation of the Suicide Committee
- Include self-harm to elevate the issue of suicide. If we are thinking about prevention we need to also be thinking about the continuum.

CLINICAL SERVICES PLAN VERBAL UPDATE

Ken Foote (Company Secretary) provided a brief outline about the reasons behind the decision to extend the timelines, and the new dates agreed to by EMT with a few tweaks.

Although the Clinical Services Plan (CSP) is a DHB Plan that reflects our interests, there was some concern about what reassurance there is that Sapere will have the best interests of Māori. And if there is a Māori organisation that could possibly be contracted to write a plan for Māori that would be specific to our region.

Ken will formulate the timelines for MRB to look at where engagement with Māori and community can occur.

HB Health Leadership Forum in March

MRB requested a one hour timeslot at the start of the forum to present the learnings from the Alaska trip to Southcentral Foundation by members who were part of the contingency. Presenting the learnings will help find resolutions to the issues discussed today and demonstrate how we feed into the CSP.

Concerns were raised about the use of the same facilitator following the last forum whose behaviour caused some dissatisfaction. MRB suggested a co-facilitator to prevent a reoccurrence of the previous experience.

HAWKE'S BAY District Health Board Whakawāteatia	**Pasifika Health Leadership Group** 07
	For the attention of: **HBDHB Board**
Document Owner:	Barbara Arnott, Chair of CPHAC
Document Author(s):	Caren Rangi, Chair of PHLG
Month:	February 2018
Consideration:	For Information

14

RECOMMENDATION

That the HBDHB Board

1. **Note** the contents of this report.
2. **Note** the outcome from the findings and recommendations of the PHLG Review.

INTRODUCTION

The Pasifika Health Leadership Group (PHLG) met on 12 February 2018. The four new members recently appointed to the PHLG attended the meeting. Their varying experience and Pacific backgrounds will enhance the PHLG's reach across the Hawke's Bay Pacifica population. The meeting theme predominately addressed the PHLG Review.

PHLG REVIEW

A Review was initiated mid-2017 on the value and effectiveness of the PHLG by Ken Foote, Company Secretary. During the review period, the Terms of Reference was updated and endorsed at the HBDHB December Board meeting that better now reflects the PHLG's purpose and function. At this meeting, the Board discussed the low rate of Pacific staffing and introduced an additional item to the Terms of Reference to enhance Pacific health staff resources.

These review findings were outlined and discussed at the February PHLG meeting.
The PHLG agreed to the Review recommendations and this was endorsed unanimously.
PHLG members are to engage in a supplementary meeting to formulate a Workplan for 2018-19 including liaison with the HB Health Consumer Council on a community engagement plan that will help shape the Workplan. This Workplan is to be endorsed at their May meeting.

The PHLG Review paper is attached for the Board's information.

PACIFIC HEALTH REPORT

The report was taken as read noting items:

- The National Bowel Screening Programme roll-out which Talalelei Taufale is a representative for Pacifica
- The Pacific Workforce as a key area for the PHLG to adopt as a priority for 2018
- MidCentral Pasifika Health team's visit to share best practice and map priorities for 2018
- Visit to Auckland and Waitemata DHBs to share information and develop a roadmap for all Pasifika DHBs to work with Pacific families

Governance Report Overview

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Pasifika Health Leadership Group Review**
	For the attention of: **Pasifika Health Leadership Group**
Document Owner	Ken Foote, Company Secretary
Document Author(s)	Ken Foote, Company Secretary
Reviewed by	Barbara Arnott, Chair CPHAC Caren Rangi, Chair PHLG
Month/Year	February 2018
Purpose	To consider the Review report and recommendations, and decide on appropriate actions to address identified areas for improvement
Previous Consideration Discussions	A 'self-assessment' was carried out by PHLG at the commencement of the Review in July 2017, and appropriate changes to the ToR were acknowledged in December 2017.
Summary	The Review identified that a number of 'developments' have been achieved by the PHLG since it was established in 2013, but that these have yet to have any significant positive impact on improving pacific health status and patient experience. Key issues identified for potential improvement included: • Enhanced community engagement • Improved understanding and application of effective governance • Identification of key focus areas • Provision of appropriate levels and form of HBDHB executive, management and clinical support
Contribution to Goals and Strategic Implications	Improving health and equity and enhancing patient experiences for Pacific population
Impact on Reducing Inequities/Disparities	PHLG has the potential to positively address the issue of inequity, where Pacific rates remain higher than other population groups in a number of areas.
Consumer Engagement	Limited consumer input into the Review, but need identified for PHLG to engage more with pacific communities and further develop relationship with Consumer Council.
Other Consultation /Involvement	Interviews with key stakeholders and analysis undertaken by Business Intelligence Unit
Financial/Budget Impact	No specific direct costs involved other than enhanced 'business as usual' activities. Any potential increase in support resources will require separate 'business case'.
Timing Issues	HBDHB Board endorsement 28 February 2018

Announcements/ Communications	Standard 'business as usual' communications required to ensure internal HBDHB awareness of recommendations and actions

RECOMMENDATION:

It is recommended that the Pasifika Health Leadership Group:

1. **Note** the Review Report
2. **Approve** the Report recommendations that:

- PHLG develop a 'Workplan' for itself (with clear objectives) on what it needs and wants to achieve, to deliver on its ToR
- A 'Community Engagement Plan' is developed and implemented as part of this Workplan, in liaison with HB Health Consumer Council
- The Company Secretary attend all PHLG meetings (for at least the next 12 months) to:
    - Provide clarity and 'training' on the governance role (to develop understanding and confidence).
    - Assist with the development and monitoring of the Workplan.
    - Assist and support the application of good governance practice throughout the meetings (both directly and indirectly).
- The Chair facilitates an open discussion and gains agreement around reasonable expectations of PHLG members.
- Assign timeframes and responsibilities for all items included in post-meeting action plans, to ensure timely resolution of all issues raised.
- HBDHB CEO ensures PHLG (and Pacific Health generally) is provided with the appropriate level of executive, management and clinical support, and that the roles of such staff are clearly defined.

HBDHB Pasifika Health Leadership Group Review

Author:	**Ken Foote**
Designation:	**Company Secretary**
Date:	**22 January 2018**

BACKGROUND

A review of the value and effectiveness of the Pasifika Health Leadership Group (PHLG) was initiated in July 2017. The background and terms of reference for the review are attached as **Appendix A**. The intent of the review was to answer the following:

- Is PHLG appropriately structured, supported and empowered to have the intended impact on improving the health status and patient care experience of Pacific people?
- If not, what substantive changes need to be made to governance structures, systems and processes to better achieve the desired outcomes.
- If it is, what changes to the ToR, membership, support and operation of the PHLG (if any) could further enhance this impact.

PROCESS

Although it was originally intended to consult quite widely on this review, a number of factors resulted in this being more limited:

- The initial meeting with PHLG to discuss the review, 'self-identified' many of the issues that needed to be addressed.
- The reviewer was away for all of August and prioritized onto other tasks from his return.
- The Big Listen activities were a focus for many
- The limited profile of the PHLG
- The identified need to increase/refresh the membership on PHLG.

Given the identification of key issues through discussions, analysis and reviews undertaken however, this limited consultation has not negatively impacted on the value of the Review, nor on the findings and recommendations contained in this report.

FINDINGS

Achievements: A review of PHLG related activities and the achievements over the years, highlighted the following:

2013 - PHLG established.
2014 - Pasifika Health Action Plan developed
- Sole navigator service established
- Brothers Heart Check campaign

2015 - 0.8 FTE Navigator – Totara Health
- Focus on Whanau Wellness

2016 - Workforce development programme
- Workshops on cultural competence – Le Va

2017 - Health Promoter appointed
- 2x Health Navigators appointed
- Pasifika Health Dashboard
- Pasifika Workforce Development Plan – target and plan.

PACIFIC HEALTH STATUS

Collation and analysis of relevant data and information relating to the relative health status and patient experience of Pacific people over the period 2012-2017 was undertaken. A summary of this analysis is attached as **Appendix B**.

Overall it appears that there have been some improvements in the last five years, but nothing dramatic and there have been some areas of deterioration. Inequity is still a significant factor and Pacific rates remain higher than other population groups in a number of areas.

PHLG MEETINGS / MINUTES

All the minutes of the PHLG meeting held since the first meeting held on 2 December 20132 were reviewed. Key issues/highlights identified included:

- Average of 4 meetings per year.
- Irregular attendance by some members
- Good minutes and action plans
- A number of achievements (refer above)
- Two key issues in particular raised several times over the years but not followed through:
  - Community engagement
  - Governance training.
- One meeting chaired by Pacific Health Development Manager in absence of co-Chairs.
- No apparent plan on what PHLG want to achieve themselves (as district from PHAP for Pacific population).
- Appears to be limited understanding and/or confidence in the governance role, with limited direction given and management staff 'not held to account'.
- Participation appears relatively 'passive' with the Chair carrying a significant burden given limited responses to requests for comment.

PHLG MEETING

The major findings to come out of the meeting convened to discuss the Review with PHLG were:

- Members were passionate about wanting to help Pacific communities have improved health and wellbeing.
- Wanted to know and learn how things could be done better.
- Strongly believed that they needed to engage more with Pacific communities to better understand their views and priorities, and establish mutual connections, to raise the profile and visibility of PHLG and therefore the strength and credibility of its advice to HBDHB.
- Acknowledged own weaknesses in the areas of governance, communications and planning.
- Felt that HBDHB resourcing and support to PHLG could be strengthened.
- Agreed that current structure and reporting processes for PHLG was still appropriate

UPDATED TERMS OF REFERENCE

With the need to recruit four new members in December 2017, it was deemed appropriate to update the ToR for PHLG in line with these Review findings, in advance of this Review Report, and seek HBDHB Board approval of these. This was completed and the updated ToR has been attached as **Appendix C.**

The changes to the ToR included:

- Changing the heading from Pacific Health Leadership Group to "Pasifika" Health and incorporating this wording into the "Purpose" section also.

- Adding a new function item a) "Enhance engagement between Pacific communities and HB health funders and providers; and in item c), adding the words "Provide direction" at the beginning of the paragraph.
- Adding more detail under the "Support" section on page 2

There was some discussion in the HBDHB Board Meeting around low Pacific staffing levels and high attrition rates, and this resulted in board members requesting a new item be added under the "Aims" as a new item on page 1 of the ToR.

ie, c) Enhance Pacific health staff resources.

It was generally agreed that these changes would clarify and enhance the mandate of the PHLG and deal with the major deficiencies identified in this Review. The general structure of the PHLG formally reporting through CPHAC and personally presenting to the Board every 3 – 4 months was confirmed as still appropriate.

FURTHER RECOMMENDATIONS

Although the above changes to the ToR will provide the mandate to address the key issues identified in this Review, there is still the need to develop some system and process 'tools' for PHLG to use to achieve this, as well as further support and advice to ensure the benefits are realized. It is therefore recommended that:

- PHLG develop a 'Workplan' for itself (with clear objectives) on what it needs and wants to achieve, to deliver on its ToR
- A 'Community Engagement Plan' is developed and implemented as part of this Workplan, in liaison with HB Health Consumer Council
- The Company Secretary attend all PHLG meetings (for at least the next 12 months) to:
    - Provide clarity and 'training' on the governance role (to develop understanding and confidence).
    - Assist with the development and monitoring of the Workplan.
    - Assist and support the application of good governance practice throughout the meetings (both directly and indirectly).
- The Chair facilitates an open discussion and gains agreement around reasonable expectations of PHLG members.
- Assign timeframes and responsibilities for all items included in post-meeting action plans, to ensure timely resolution of all issues raised.
- HBDHB CEO ensures PHLG (and Pacific Health generally) is provided with the appropriate level of executive, management and clinical support, and that the roles of such staff are clearly defined.

CONCLUSION

The rationale for the establishment of the PHLG remains, as does the huge challenge for HBDHB to improve the health status and improve the patient experience of our Pacific people. The HBDHB acknowledges this challenge and the Board looks to, and significantly values, the input and advice of the PHLG to help it achieve this goal.

This review has found that there are good structures and foundations in place on which to build engagements, relationships and health initiatives that will make a difference. Ongoing monitoring of performance and achievements, with further enhancements and adjustments as necessary, will still be required however.

The changes to the ToR and implementation of the other recommendations will allow us to collectively make more of a positive impact on this.

RECOMMENDATION:

It is recommended that the Pasifika Health Leadership Group:

1. **Note** the Review Report
2. **Approve** the Report recommendations that:

- PHLG develop a 'Workplan' for itself (with clear objectives) on what it needs and wants to achieve, to deliver on its ToR
- A 'Community Engagement Plan' is developed and implemented as part of this Workplan, in liaison with HB Health Consumer Council
- The Company Secretary attend all PHLG meetings (for at least the next 12 months) to:
    - Provide clarity and 'training' on the governance role (to develop understanding and confidence).
    - Assist with the development and monitoring of the Workplan.
    - Assist and support the application of good governance practice throughout the meetings (both directly and indirectly).
- The Chair facilitates an open discussion and gains agreement around reasonable expectations of PHLG members.
- Assign timeframes and responsibilities for all items included in post-meeting action plans, to ensure timely resolution of all issues raised.
- HBDHB CEO ensures PHLG (and Pacific Health generally) is provided with the appropriate level of executive, management and clinical support, and that the roles of such staff are clearly defined.

APPENDIX A

July 2017

HBDHB Pasifika Health Leadership Group Review

Background

In September 2012, a report was submitted to HBDHB Community and Public Health Advisory Committee (CPHAC), highlighting that there were many actions and interventions required to reduce the inequalities in health for the Pacific community in Hawke's Bay. This led to the development and implementation of the Pacific Health Action Plan (PHAP) which included the coordination of Pacific perspectives in the various levels and services of the health sector.

Feedback from a number of groups involved with the PHAP, subsequently indicated that in order to gain traction in the Pacific community, a structure of communication and monitoring of the status of Pacific health was required, that starts at grass roots and is linked through to Board level. Pacific leaders added to this, by suggesting that this could be best achieved through Pacific representation at a strategic or governance level within HBDHB.

Following further discussion in July 2013, the HBDHB Board approved a "CPHAC" recommendation to establish the Pacific Health Leadership Group (PHLG) as a sub-committee of CPHAC. In establishing this Group, it was acknowledged that Pacific is a term that reflects a range of different ethnic groups and cultures that currently reside in Hawke's Bay. These include: Samoan, Cook Island, Niuean, Tokelau, Tongan, Kiribati and Fijian. The name of the group was subsequently amended to Pasifika Health leadership Group

Terms of Reference

The Terms of Reference for the PHLG established by the HBDHB Board in July 2013 are attached. These were based on the ToR for the existing Māori Relationship Board (MRB). Discussions commenced within the PHLG in late 2015 about rewording d) and c) and strengthening engagement with Pacific Communities.

Review

As it is nearly four years since this group was established, it is appropriate now to review the value and effectiveness of the PHLG, and assess whether it has actually achieved the purpose for which it was created. Given the level of authority within the TOR for PHLG, it is also appropriate to conduct the review at two different levels:

- **Strategic** – "What impact has PHLG and its supporting structure had on:
  - Reducing existing health disparities and improving the health of the Hawke's Bay Pacific people
  - Enhancing the patient care experience for Pacific people through ensuring all services are accessible and responsive to meet their needs.
- **Functional** – How well has PHLG delivered on its 'functions' , as set out in the TOR

Splitting the review into these two components will better enable conclusions to be drawn on the following:

- Is PHLG appropriately structured, supported and empowered to have the intended impact on improving the health status and patient care experience of Pacific people?
- If not, what substantive changes need to be made to governance structures, systems and processes to better achieve the desired outcomes.

- If it is, what changes to the TOR, membership, support and operation of the PHLG (if any) could further enhance this impact.

Methodology

The review will be undertaken as follows:

- Collation and analysis of all data and information relating to the relative health status and patient experience of Pacific people over the period 2012-2017
- Review of PHLG minutes and reports to identify achievements and issues.
- Interviews with key stakeholders:
  - PHLG members
  - Chair of CPHAC
  - HBDHB Chair and CEO
  - Executive Director Strategy and Health Improvement
  - Staff directly / indirectly involved with PHLG and Pacific health generally
  - Consumer Council Chair and Members with specific interest in Pacific health.
  - Nuanua Pasifika Health Workforce Group
  - Pacific Health Providers
- Draft Report prepared, and reviewed by:
  - Co-Chairs PHLG
  - Chair CPHAC
  - Executive Director Strategy & Health Improvement
- Final Draft Report submitted to
  - PHLG
  - EMT
- Final Report submitted (with recommendations as appropriate) to HBDHB Board

Community Engagement

PHLG have previously identified the need to strengthen engagement with Pacific Communities. Although not formally part of the Review, trialling a community engagement process through a series of 'workshops' could help inform the Review, particularly when considering the Purpose and Function (within the ToR). To enable this, at least one such 'Workshop' will be held during the Review period, and another (incorporating any lessons learned) by the end of 2017.

General topics to be addressed in the 'Workshops' will include:

- Community views on current health services
  Strengths and weaknesses
- Community health service needs and expectations
- Alternative options / improvements identified
- Views on health service planning and leadership

Timeline

The timeline for key milestones of the Review is:

Key Milestone		Completed in 2017 by:
Pacific health data and KPIs	}	
PHLG achievements and issues	}	31 August
Interviews		30 September
Community Workshop		30 September
Draft Report prepared and reviewed		31 October

Final Draft Report reviewed	15 November
Final Report to HBDHB Board	29 November
2nd Community Workshop	31 December

NOTE : Reviewer will be absent for the whole of August 2017

Appointments

Key appointments / personnel involved with the Review are:

Sponsor	Tracee TeHuia, Executive Director Strategy and Health Improvement
Reviewer	Ken Foote, HBDHB Company Secretary
Support	Talalelei Taufale, Pacific Health Development Manager
	Kim Maitland, Executive Assistant (Minute Secretary PHLG)

APPENDIX B

Pacific People Health

The Hawke's Bay DHB Pacific population at 6,340 people is 4 % of the total 163,580 population.
The Pacific population is a young population with 42 % of the population under 20 years of age compared to 22 % in the Non Maori Non Pacific population.
Hawke's Bay DHB Pacific population is particularly impacted by socioeconomic disadvantage with 73.6 % of Pacific peoples living in areas classified as high deprivation areas (NZdep2013 Quintile 5-CAU weighted).

Pacific people age standardised emergency department attendance rates have increased over the last 5 years. However rates have stabilized in the last 12 month period. Currently Pacific rates are statistically significantly higher than Maori and Non Maori Non Pacific rates. While overall 0-4 year old Pacific Ambulatory sensitive hospitalisation rates have dropped over the last 5 years, Pacific rates remain twice Non Maori Non Pacific rates. Specific ASH conditions cellulitis, dermatitis and eczema have remained particularly high in Pacific children and have increased over the last 5 years .Respiratory conditions both upper and lower are 1.8 times the non Maori non Pacific rates have continued to increase over the last 5 years.

Pacific Ambulatory sensitive hospitalisation rates in the 45-64 year age group have continued to increase over the last 5 years. There has been specific increases in the ASH conditions angina,chest pain,myocardial infarction and COPD hospitalisations over the last 5 years. On the other hand congestive heart failure and stroke rates have improved in the last 5 years.

Significantly higher utilisation rates of the Emergency Department by Pacific people along with higher ambulatory sensitive hospitalisation rates in the 0-4 year olds and 45-64 years are indicative of issues of poor primary care access for Pacific people as well as poor long term conditions management. This is also impacted by – socio-economic issues such as poor quality housing and crowding.

Pacific acute bronchiolitis hospitalisation rates have trended upwards and are significantly higher (6 times higher) compared to Non Maori Non Pacific rates.
Pacific child oral health is poor compared to all ethnic groups and the % of Pacific 5 year olds whom are caries free have declined over the last 5 years. However on a positive note the proportion of Pacific pre school children enrolled in the oral health service have increased 5.8 % over the last 5 years. This rate remain's below target.
Pacific 4 year obesity prevalence rates have declined over the last 5 years from 12.8 % in 2011 to 9 % in 2016. Obesity rates in Pacific 4 year olds remain nearly 3 times Non Maori non Pacific children rates.

There has been a small increase in the % of Pacific women registering with a Lead Maternity Carer (LMC) by 12 weeks of their pregnancy over the last 4 years from 47 % in 2013/14 to 50 5 in 2016/17. Pacific rates remain lower than other ethnic groups

Health risk factors such as obesity are higher in Pacific population. Overall diabetes prevalence is higher in the Hawkes Bay Pacific adult population and prevalence is higher in younger age groups in the Pacific population compared to Non Maori Non Pacific. There has been little movement in the Pacific women (50-69 years) breast screening rates over the last

5 years and rates are lower for Pacific women compared to other ethnic groups and are below target.
Did Not Attend (DNA) rates for ESPI First specialist assesments have declined over the last 5 years from 21.8 % in 2012/13 to 14 % in 2016/17. Howver Pacific DNA rates are nearly 4 times the Non Maori Non Pacific rates in 2016/17.
Pacific people age standardised rates of elective surgery have increased in the last 5 years. However access rates are lower compared to Maori and Non Maori non Pacific. This may be indicative of access problems to secondary services.

While there has been an increase in % of Pacific youth access Secondary Mental Health Services in the last 4 years access rates in the Pacific adult population have declined. Pacific mental health access rates are lower compared to other population groups in both youth and adult populations .

Prepared By Lisa Jones
Business Intelligence Team
December 2017

APPENDIX C

TERMS OF REFERENCE

Hawke's Bay District Health Board
Pasifika Health Leadership Group

12 December 2017

Purpose	The purpose of the Pasifika Health Leadership Group (PHLG) is to provide appropriate advice to Hawke's Bay District Health Board (HBDHB) through the Community & Public Health Advisory Committee (CPHAC) to improve the health status of the Pacific people within the HBDHB area and reduce health disparities.
Functions	The functions of the PHLG are to a) Enhance engagement between Pacific communities and Hawke's Bay health funders and providers b) Identify and convey the needs for health and wellbeing of the Pacific people within Hawke's Bay. c) Provide direction and ensure an appropriate plan is jointly developed and maintained by HBDHB to address identified issues. d) Monitor the operational implementation of this plan. e) Monitor the strategic development and performance of HBDHB delivered and funded services, to ensure they support the reduction in disparities and are responsive to the needs of Pacific people. f) Monitor the operational performance of services targeted particularly at Pacific people. The aim of the PHLGs advice is to: a) Reduce existing health disparities and improve the health of the Hawke's Bay Pacific people. b) Enhance the patient care experience for Pacific people through ensuring all services are accessible and responsive to meet their needs. c) Enhance Pacific health staff resources.
Level of Authority	The PHLG has the authority to give advice and make recommendations to the HBDHB Board through CPHAC.
Membership	• Up to eight (8) members shall be appointed to the PHLG by CPHAC for terms of up to two (2) years, • Members may be reappointed. • General criteria for membership shall consist of a mix of: - Nominated by their community, having demonstrated relevant skills and links to that community - Knowledge and experience in the health sector - Experience of working in a multi-agency environment - Knowledge and experience of the disability sector - Governance, strategic and policy skills • At least two members of PHLG shall have attributes to 'represent' Pacific youth issues. • Remuneration will be based on the Cabinet Fees Framework for HBDHB Committee Members.

Chair	The Chair shall be elected by the PHLG and endorsed by CPHAC.
Quorum	A quorum will be half the members if the number of members is even, and a majority if the number of members is odd.
Meetings	Meetings will be held quarterly, or more frequently at the request of the Chair. Workshops may be held from time to time. The Standing Orders adopted by HBDHB apply to PHLG meetings.
Reporting	Following each meeting, the Chair shall report on PHLG business to the CPHAC Chair, with such recommendations as the PHLG may deem appropriate.
Minutes	Minutes will be circulated to all members of the PHLG within one week of the meeting taking place. CPHAC and HBDHB Board members will be sent a copy of the minutes, on request.
Support	The PHLG shall be supported by the Executive Director of Strategy and Health Improvement and the Pacific Health Development Manager. Such support shall include the provision of regular reporting and advice on: a) Health status of Pacific people b) Performance/achievements of plans and initiatives aimed at improving health outcomes and patient experience of Pacific people c) Objectives/achievements of 'dedicated' Pacific Health services and resources and arranging regular engagement opportunities for PHLG to meet with Pacific communities

Governance Report Overview

08

HAWKE'S BAY District Health Board Whakawāteatia	**Clinical Portal Implementation Business Case**
	For the attention of: **HBDHB Board**
Document Owner	Anne Speden, CIO
Document Author(s)	Michael Sheehan, Clinical Portal Implementation Project Manager
Reviewed by	Ken Foote, Company Secretary; Keith Buckley, IS Transition Manager; Executive Management Team, HB Clinical Council and HB Health Consumer Council
Month/Year	February, 2018
Purpose	Approval of the Clinical Portal Implementation Business Case that will span two (2) financial years - 2017/18 & 2018/19
Previous Consideration Discussions	Approval from Boards across the Region to proceed with the development of a regional solution (previously called CRISP & RHIP) was provided 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 Regional Solution
Summary	The recommendation is that the Business Case is approved. This is in support of realising the benefits of the Regional Solution for the regions health care. Approval of the Business Case also realises a return on HBDHB's investment in the Regional Solution and supports progress towards a single electronic health record (eHR).
Contribution to Goals and Strategic Implications	The Project contributes to the organisational goals by: • Improving the quality of care through the presentation of patient clinical information in one portal • Improving the health of our population by having patient notes available wherever they may present • Enabling efficiencies by sharing the cost of clinical systems across the region and providing a consistent interface for clinicians to access information
Impact on Reducing Inequities/Disparities	CP version 2.3 for HBDHB is externally developed and not yet available. The Health Equity Assessment Toolkit (HEAT) would be used to explore equity considerations in further detail once the product is available to HBDHB, in second calendar quarter 2018.
Consumer Engagement	The RHIP Regional Steering Group has provided input to the design and functionality of CP and RIS. A number of consumer representatives sit on the RHIP Regional Steering Group and one of the consumer representatives is from the Hawkes Bay. As a result, there has been consumer representation and local engagement in the development of the products.
Other Consultation /Involvement	Clinical engagement & leadership continues to have significant input and involvement in CPs development. This has been led by

	Whanganui's CMO supported by a range of clinical representation from all the region's DHBs. HBDHB continues to have strong, proactive clinical & technical involvement.
Financial/Budget Impact	No additional capital is 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. This is was supported by the Executive Director Corporate Services. The IS Governance Group (chaired by Sharon Mason) are across the key program priorities which included this implementation. The capital budget for 2017/18 & 2018/19 have the support of Executive Director Corporate Services. **Capital Costs** FY 2017/18 $651,578 FY 2018/19 $633,141 Total Capital Estimate $1,284,719 The operational budget allocation for 2017/ & 2018/919 have the support of Executive Director Corporate Services and is less than the pre-project estimate of $368,000 per financial year **Operating Expenditure** FY 2017/18 $262,500 FY 2018/19 $258,544 Total Operating Estimate $521,044
Timing Issues	Current targets for the implementation of CP (including RIS) are: Dec 2017 - VPN connection to Regional Solution - Complete April '18 - Clinicians view regional clinical information in CP June '18 - Clinicians view regional & local clinical information in CP June '18 - Progressive rollout of CP functionality, including RIS, across the DHB, in consultation with Operations, Clinical Council, clinicians & IS.
Announcements/ Communications	A Communications Strategy is currently in development as an asset for the CP Project alongside monthly communications planning sessions with the HB Communications Manager. Key communications points are initially based on the April & June dates shown in the Timing section above. Further communication plans & details for activities after June will be developed once the post June project time line is completed. All communications activities are being developed in conjunction with the HBDHB communications team.

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** that the Clinical Portal Implementation Business Case implements the regional solution that has been funded by the regional DHBs including Hawke's Bay DHB
2. **Approval** of the Clinical Portal Implementation Business Case.

Approval of the Clinical Portal Implementation Business Case

Author:	**Michael Sheehan,**
Designation:	**Project Manager for Clinical Portal Implementation**
Date:	**February 2018**

PURPOSE
The purpose of this paper is to obtain approval of the Clinical Portal Implementation Business Case

BACKGROUND
The region's six DHBs have been funding the development of the Regional Solution including Clinical Portal and RIS.
Progressively from June 2016, Whanganui and Mid Central DHBs have been migrating to the Regional Solution with their completion due in February 2018. Migration planning for Wellington's three DHBs is underway and they will begin their migration processes in the first calendar quarter this year.

From June 2018, Clinical Portal & RIS will be available for Hawke's Bay DHB to implement. Planning is underway and a progressive roll out approach is being taken to distribute and minimize any potential impacts and risks. WebPAS, as the third component of the Regional Solution, will be considered after the completion of the Clinical Portal Implementation Project.

In April our clinicians will be able to view regional patient data in Clinical Portal. June will show Hawke's Bay's own patient data in Clinical Portal. This will be followed by a progressive rollout of Clinical Portal functionality across Hawke's Bay DHB. Prioritisation and timing for the rollout will take place in consultation with Operations, Clinical Council, clinicians & IS.

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.

ATTACHMENTS:
- Clinical Portal Business Case (January 2018)
- Board Minutes Extract (21 December 2011), to proceed with CRISP

Better Business Cases

15.1

Clinical Portal Implementation

Prepared by:	M Sheehan
Prepared for:	A Speden, T Evans
Date:	01 February 2018
Version:	1.0
Status:	Released for EMT

Business Cases
Clinical Portal Implementation

Document Control

Document Information

	Position
Document ID	
Document Owner	M Sheehan
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Version	Issue Date	Changes
1a	12/01/18	First draft
1b	17/01/18	Format & additional content
1c	26/01/18	Feedback & Executive Summary
1.0	01/02/18	Released for EMT

Document Review

Role	Name	Review Status
Company Secretary	Ken Foote	
Chief Information Officer	Anne Speden	
Head of Contracts	Ashton Kirk	
IS Transition Manager	Keith Buckley	
Management Accountant	Barry King	
Project Management Office Manager	Kate Rawstron	

Document Sign-off

Role	Name	Sign-off Date
Project Manager	M Sheehan	
CIO	A Speden	
ED Corporate Services	T Evans	

Contents

15.1

Executive Summary

Significant investment has taken place to deliver Clinical Portal as the future facing platform for Hawke's Bay DHB, the Region and the patients in our care. This new Regional Solution platform, agreed to in 2011 and previously known as RHIP, delivers access to patient clinical information for all clinicians across the Region. The option endorsed by this Business Case is to fund the implementation of Clinical Portal for Hawke's Bay DHB in order to deliver on the five original key investment objectives from 2011:

- Consolidated view of patient clinical information across Regional DHB providers
- Enable workforce flexibility to work across providers
- Standardise core processes and procedures
- Move to a high availability regional structure to support 24/7 operations
- Bring all providers up to minimum supported levels

These five key objectives will be enabled through the delivery of the Clinical Portal Implementation Project providing a modern, base platform from which we can advance.

The Project team has invested significant time and effort in planning the initial stages and will begin progressive rollout for Hawke's Bay DHB clinicians in April with a targeted completion in December 2018 as agreed. This progressive rollout approach has been adopted due to lessons learned from Mid Central and Whanganui where a "Big Bang" all at once approach initially proved disruptive for clinical teams and hospital operations.

No additional capital is required for the implementation of Clinical Portal. The budget for this phase of implementation was not originally scoped, defined or allocated. It has now been agreed that the capital budget for Clinical Portal Implementation 2017/18 will be funded from the IS Capital allocation. This decision was supported by the Executive Director Corporate Services. The IS Governance Group (chaired by Sharon Mason) was established in mid-2017 and are across the key program priorities for 17/18 which included this implementation.

Capital requirements for 2018/19, shown below, will again be funded from IS capital allocations.

The IS operational budgets for 2017/18 and 2018/19 has been allocated, as shown in below, and are less than the $368,000 originally indicated prior to this project being scoped.

		FY 2017/18	FY 2018/19	Totals
Capital expenditure	*Additional detail are in the Financial Case section*	**$ 651,578**	**$ 633,141**	**$ 1,284,719**
Operating expenditure		**$ 262,500**	**$ 258,544**	**$ 521,044**

The following structures and activities are in place and underway to support our Clinical Portal Implementation. These include the following:

- Project reporting to IS Senior Leadership Team, Transform and Sustain, FRAC
- Oversight structures in place with broad clinical representation
- Engaged with 32 clinical subject matter experts to inform ECA to Clinical Portal shift
- Risk mitigation and innovative communication plans underway
- A process to identify, triage and stream policy, procedure and patient safety elements to the People and Quality team has been agreed
- IS resources now fully engaged and focused on the project delivery
- New staff have been recruited to supplement and support the existing IS Team skillsets.

In addition, Hawke's Bay DHB's approach and engagement across the Region has enabled:

- An external review to advance the performance and stability of the Regional Solution
- Alignment of final Clinical Portal functionality to our progressive rollout plan
- Agreed bulk funding for Orion to enable agile development and faster delivery
- Dedicated Orion development team
- Strong supplier partner engagement and commitment to our delivery timelines
- Central Technical Advisory Service (CTAS) has agreed to fund clinically led service design workshops to define future functionality and advancements of Clinical Portal
- Orion has approached Hawke's Bay DHB to act as a clinical product development review site, one of only two in the country.

It is the recommendation of this Clinical Portal Implementation Business Case that the Board approves this Business Case to implement Clinical Portal and realise the benefits of the original investment.

15.1

Introduction

This Clinical Portal Business Case seeks formal approval from the Board to fund the Clinical Portal implementation (Clinical Portal previously known as CRISP and RHIP) for Hawke's Bay District Health Board (Hawke's Bay DHB). This follows the decision in 2011, by Boards across the Region, to proceed with the development of a regional solution (The Hawke's Bay DHB Board's "Minutes Extract 21 December 2011" is attached in the Appendices, reflecting this decision).

This business case follows the Treasury Better Business Cases guidance.

Strategic Case

The strategic context

At the time of the decision to proceed with the Regional Solution known as CRISP, the Central Regional Information Plan (2011) stated "The proposed regional system has tightly integrated patient administration and clinical workstation functionality; available through a single clinical applications portal…designed to support a single patient shared care record available to clinicians across the region at the right time and place."

The document goes on to say "The founding principle of the Portal is to provide users with a single log in to patient vitals, clinical documentation, patient demographics, patient administration and a shared care record. The system also supports the sharing of clinical information between all health care providers and the patient within a robust privacy and access model that is fully audited."

Following on from these strategic statements of intent, this Business Case for Clinical Portal Implementation is the final stage to realise the benefits, for Hawke's Bay DHB, of the original decision and gain a return on the investment in the Regional Solution with better access to patient information and improved health outcomes for our population.

The case for change

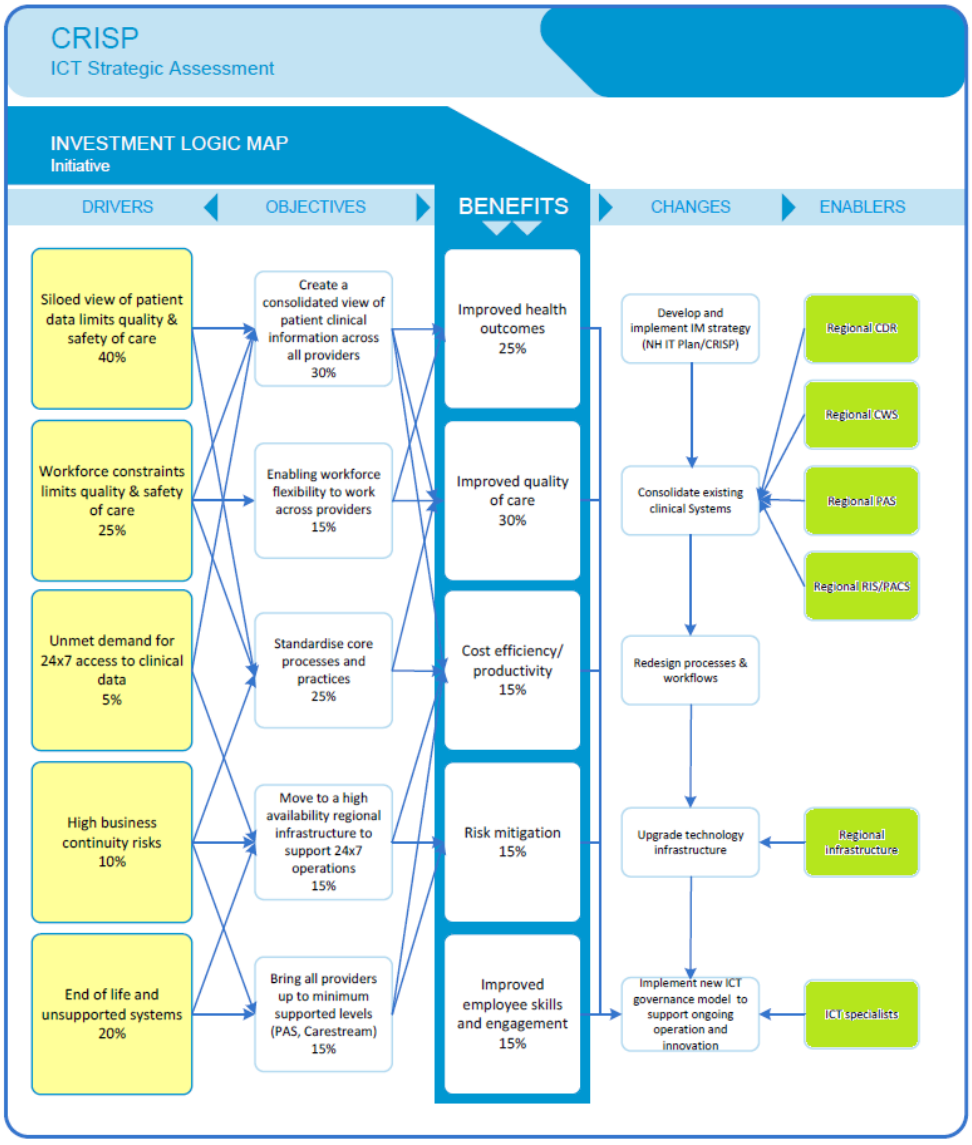
The original CRISP Phase 1 proposal highlighted the need to move the Region's DHBs from a then current state of disparate, fragmented, and in some cases obsolete, clinical and administrative information systems.

The objective was a future state of shared, standardised and fully integrated information systems that would enhance clinical practice, drive administrative efficiencies, enable regionalisation of services, reduce current operational risks and enhance patient care.

The key aims of CRISP were to deliver a clinical framework through the delivery of key enablers being:

- Regional CDR - Now available (known as medical documents, tests, results etc.)
- Regional CWS - Now available (known as the Clinical Portal))
- Regional PAS - Now available (out of scope for the Clinical Portal Implementation)
- Regional RIS/PACS - Now available
- Regional Infrastructure - Now available
- ICT Specialists - Now available

The Investment Logic Map from 2011, shown below, highlights all planned key enablers in green as now being available and operational. The Clinical Portal Implementation project for Hawke's Bay DHB takes up all enablers with the exception of Regional PAS. A significant reason to exclude PAS at this stage was the risk inherent in changing all foundational clinical systems for Hawke's Bay DHB at one time. Regional PAS may be considered for implementation after Clinical Portal rollout is complete.



In addition, the Clinical Portal Implementation provides a foundational capability for the region to improve integration across primary/community and secondary/tertiary providers, introduce mobility, interoperate with other national data repositories and implement shared care records which is also in alignment with the Transform and Sustain strategy.

Original key CRISP stakeholders identified five investment objectives for the regional development to take place:

- Consolidated view of patient clinical information across providers
- Enable workforce flexibility to work across providers
- Standardise core processes and procedures
- Move to a high availability regional structure to support 24/7 operations

- Bring all providers up to minimum supported levels

These five investment objectives will be realised through Clinical Portal Implementation.

In addition, as a secondary care facility, Hawke's Bay DHB have a number of patients that need to travel within the Region for tertiary level care. With current disparate systems, viewing clinical tests, results and discharge summaries from other facilities is challenging. With Clinical Portal, an immediate benefit will be the availability of patient information from across the Region for all clinicians involved in a patient's care. This means a Hawke's Bay DHB clinician can view and monitor a patient's treatments and progress in other Regional facilities and review tests, results, clinical notes and discharge summaries on the patient's return to their care.

Clinical Portal also provides us with a future facing extendable platform which the Region can enhance for integration with Primary Care Partners and additional modules to better serve patient and clinical needs.

Economic Case

A range of options were identified and short-listed by IS stakeholders. As a result the Hawke's Bay DHB CIO and Executive Director of Corporate Services endorse option three, below, as the preferred way forward.
The following short-listed options were selected for analysis in this business case:

Option one: Status quo of Staying on ECA (retained as a baseline comparator)
This option has Hawke's Bay DHB remain on its current ECA system.
This system has been heavily customised over many years, often to the needs of micro groups within the DHB. The interface is unique to Hawke's Bay DHB, has a steep learning curve with high training needs and is often described as unintuitive and obsolete.
In addition:

- ECA has become more brittle and will require significant efforts, and costs, to bring into alignment with modern approaches, technologies and practices
- The costs and risks associated with the ongoing support of a bespoke legacy system are likely to increase
- ECA has an internal focus and does not support the availability of patient notes, presentations, tests and results to support patients receiving appropriate care wherever they may present within the region
- Continued use of ECA keeps Hawke's Bay DHB on bespoke locally modified systems rather than meeting the objective of moving to standardised, interoperable, core Regional Solutions
- This option does not fulfil any of the original CRISP (2011) Investment Logic Map objectives.

Option two: Install a local Hawke's Bay DHB Clinical Portal
This option has Hawke's Bay DHB purchasing and installing its own stand-alone instance of Clinical Portal along with the associated infrastructure.
This allows Hawke's Bay DHB to migrate clinical functionality from ECA to a local Clinical Portal similar to the regional solution while being independent of the region. While viable, Hawke's Bay DHB would:

- Be spending additional funds on a new local portal solution that has already been funded through supporting the Regional Solution
- No longer support the visibility of patient information across the region for improved patient care and outcomes
- Be removed from the shared funding approach for advancement of the Regional Solution, placing full future development costs back on to Hawke's Bay DHB

- Become isolated from the country wide progress of moving towards a single instance of Clinical Portal per region.
- This option meets two of the original CRISP (2011) Investment Logic Map objectives for only as long as the local solution mirrors all development that takes place in the Regional Solution.

Option three: Fund the Clinical Portal Implementation (the preferred way forward)
This has Hawke's Bay DHB continuing with the 2011 agreement to bring the region on to a common and unified platform.
This also provides:

- Consolidated view of patient clinical information across providers
- Enable workforce flexibility to work across providers
- Standardise core processes and procedures
- Move to a high availability regional structure to support 24/7 operations
- Bring all providers up to minimum supported levels

This delivers on all of the original five investment objectives that drove the establishment of the Regional Solution.

Options Analysis

The three business options presented are all possible. A key point in assessing the viability of these options is the decision to fund the Regional Solution and an assumption that the Regional Solution will deliver the enablers and realise the five investment objectives as per the Investment Logic Map. An additional assumption is that Hawke's Bay DHB will want to realise a return on its investment in the Regional Solution.

Option 1 to remain on the current system will not realise any of the investment in the Regional Solution that Hawke's Bay DHB has contributed to. Nor will it deliver on any of the objectives As a result, any investment to date would be a sunk cost with no benefits or returns realised for Hawke's Bay DHB. Additional costs will be incurred in order to maintain ECA.

While being the most viable alternative to the Regional Solution, Option 2 carries costs with the need to establish a regional like solution internally for Hawke's Bay DHB. This approach would also deliver only two of the five objectives of the planned Regional Solution. These two objectives will only be fulfilled if the local solution remains in development lockstep with the Regional Solution's development. Investment to date, in the Regional Solution, would be a sunk cost and Hawke's Bay DHB would remove itself from the shared funding development model the Regional Solution offers.

The recommended option is to proceed with Option 3 as it will realise a return on the investment to date of the Regional Solution and share the costs of future enhancements. It will also align Hawke's Bay DHB, and Central Region, to the emerging common platform of Clinical Portal across New Zealand's DHBs and deliver on the five objectives of the original development efforts.

In addition, the regional RIS solution enables a regional wide workflow where the imaging/modality can be completed in one DHB with the interpretation and reporting by radiographers completed at any DHB within the region. This distributed workflow has the potential to leverage a pool of radiographers, on the proviso that the staff resources are available to meet that demand.

Commercial Case

The approach to developing the Regional Solution was defined in 2012. It is an externally hosted solution shared across six DHBs with a point of escalation for system support based out of Capital & Coast DHB. The development of the solution has been in conjunction with Orion Healthcare and with Central Technical Advisory Services (CTAS) providing Regional project management.

The procurement strategy for the Clinical Portal Implementation at Hawke's Bay DHB is to:

1. Use internal staff where possible to leverage existing knowledge and to up skill staff in the Regional Solution. This builds internal intellectual property (IP) that remains with the organisation post project completion.

2. Fixed term staff will be used to supplement internal skills where additional resources are needed for capacity reasons. Broader skill sets will also be hired, such as Project Management and training, that will address any temporary shortfalls. All hiring goes through the appropriate approval process with signoff by both the Hawke's Bay DHB CIO and ED Corporate Services as appropriate

3. Third parties will be contracted in to do specialised one off pieces of work. As an example, Orion Health are performing data analysis work in preparation for migrating Hawke's Bay DHB data into Clinical Portal, which is one of Orion's products. These third party arrangements, and any associated contracts, have been confirmed as appropriate, in consultation with Hawke's Bay DHBs' Head of Contracts.

Project Plan

Planning for the implementation of Clinical Portal and RIS has begun.

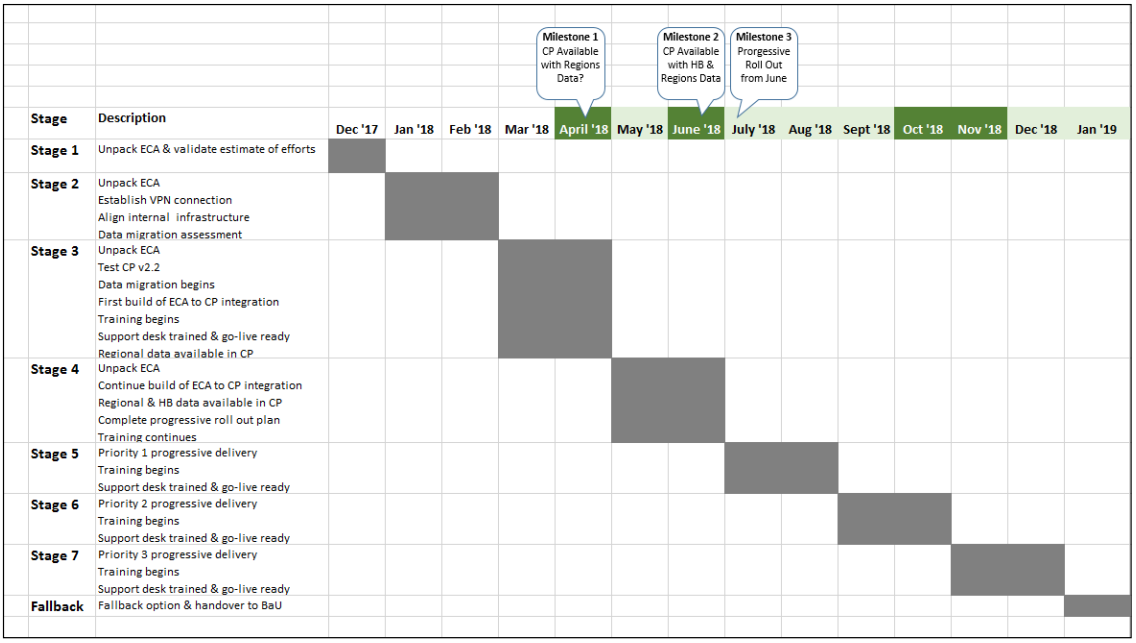
Rollout Options

Both "Big Bang" and progressive rollout options were explored. The key lessons learned from Mid Central and Whanganui, where a "Big Bang" approach was taken, were:

- Elevated patient safety concerns
- Elevated workloads for some staff
- Large amount of training for patient facing staff across tight timeframes
- Some disruption for clinical teams and the organisation
- Significant increase in peak loads on the Regional Solution

As a result of the lessons learned from Mid Central and Whanganui, a progressive rollout approach has been taken. This is to contain disruption, risks and short term negative impacts. It also has the benefits to spread the required training over a set of lower intensity sessions that have a lower impact on staffing and the organisation.

A high level view of the project plan is shown below.



High level view of the Clinical Portal Project plan

IS have committed to our Chief Executive Officer (CEO) and the Board for the delivery of three Clinical Portal Implementation milestones:

Milestone	Date	Description
Milestone 1	April 2018	Hawke's Bay DHB clinicians view available regional data in Clinical Portal
Milestone 2	June 2018	Hawke's Bay DHB clinicians view regional and Hawke's Bay DHB clinical data in Clinical Portal
Milestone 3	June through December 2018	Progressive roll out of functionality across Hawke's Bay DHB from June through December.

Note the prioritisation of the progressive role out will be made in collaboration with Operations, Clinical Council, clinicians and IS to address a range of challenges such as peak seasonal presentation times, staff availability and technical interdependencies.

Training

The progressive approach to the Clinical Portal rollout supports a lower intensity training approach. Our first Milestone of viewing Regional data in Clinical Portal provides for low impact training to cover logging on and searching for patients. This builds familiarity with the Clinical Portal interfaces. We add to this with Milestone 2 by viewing local patient data and viewing information such as tests, results and discharge summaries. This means that as we progress the rollout there will already be a level of familiarity with interfaces and menus. This forms the foundation that further progressive training builds on. This approach also allows us to bring elements of training in-house to contain costs.

Financial Case

Costs to develop the Regional Solution for the region's six DHBs were agreed to at Board level in 2011. These allocated funds have covered the solution development to Version 2.3, the version Hawke's Bay DHB is planning to implement. Implementation costs are the responsibility of each individual DHB.
The project to implement Clinical Portal will span two financial years being 2017/18 and 2018/2019 and this is reflected in the budget estimates below.

Capital and Operational Budgets

Capital Budget

No additional capital is required for the implementation of Clinical Portal.

Prior to this project, the capital budget for implementation had not been scoped, defined or allocated. It has now been agreed that the capital budget for Clinical Portal Implementation 2017/18 will be funded from the current IS capital allocation. This decision is supported by the Executive Director Corporate Services. The IS Governance Group (chaired by Sharon Mason) was established in mid-2017 and are across the key program priorities for 17/18 which included this implementation

The capital budget for Clinical Portal Implementation 2018/19 will also be funded from the IS capital allocation supported by the Executive Director Corporate Services. The IS Governance Group will prioritise key IS program activities across 18/19 in support of this high priority implementation.

Operational Budget

The operational budget for Clinical Portal Implementation in 2017/18 and 2018/19 are as shown below. The operational expenses are less than the $368,000 originally estimated, prior to this project.

Budget Estimate Details

		FY 2017/18	FY 2018/19	Totals
Capital expenditure	Description			
	Fixed Term Staff & Contractors	$ 305,839	$ 198,710	
	Existing Internal Staff	$ 194,254	$ 284,887	
	Training Planning & Coordination	$ 47,779	$ 83,544	
	Travel & Accommodation	$ 31,800	$ 43,200	
	Hardware & Services	$ 71,906	$ 22,800	
	Totals	**$ 651,578**	**$ 633,141**	**$ 1,284,719**
Operating expenditure	Description			
	Project Manager - non delivery time	$ 42,148	$ -	
	Training - Internal	$ 43,700	$ 83,544	
	Training - External	$ 63,452	$ 55,000	
	Applications / development & support backfill	$ 87,200	$ 120,000	
	Software & Support	$ 26,000	$ -	
	Totals	**$ 262,500**	**$ 258,544**	**$ 521,044**

Investment Appraisal

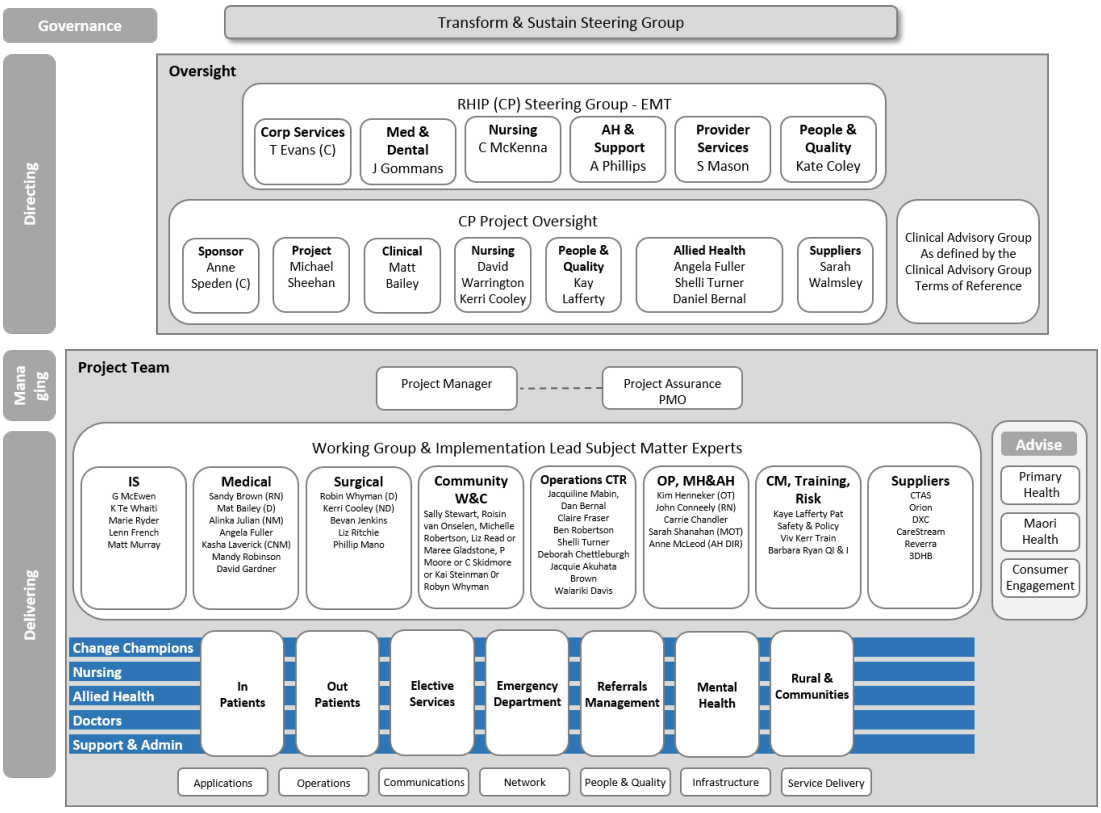
The aggregated benefits of implementing Clinical Portal across the region are the patient health outcomes, a standardised interface and the shared cost model to further enhance the new base platform the Clinical Portal project will deliver. These benefits reflect an ongoing long-term investment in supporting the Hawkes Bay's, and the wider regions, ongoing healthcare by enablement through modern and appropriate solutions.

The capital investment required for the implementation of Clinical Portal (and RIS) for Hawke's Bay DHB reflects the final stage of a program of work than began in 2011, to provide a region wide, modern digital platform. This platform sets a level across the region from which the region can drive efficiencies and clinically led enhancements for advancing patient care and outcomes.

Management Case

In the event that this Business Case receives formal approval, the project will proceed with the delivery of the regional Clinical Portal and RIS solutions. The project will be managed using the Prince2 project management methodology.

The relevant project management and governance arrangements are proposed as follows:



Project Organisational Chart

Structured Meetings

- The IS Team Leads and Project Manager meet weekly to plan, review, discuss and advance the Clinical Portal Implementation Project

- The Project Working Group & Implementation Subject Matter Experts are meeting monthly to provide detail and feedback on how ECA is used by staff
- The Clinical Portal Implementation Project Oversight Group will meet monthly from February to provide project oversight, focused Project steerage and inform solutions to challenges along the way.
- The project will consult with the Steering Group to identify their meeting requirements. This group will provide strategic oversight and influence. They will also be consulted regarding an appropriate approach to progressive roll out planning

The IS Project team has invested significant time and effort in planning the initial stages of the Clinical Portal Implementation Project. Progressive rollout for Hawke's Bay DHB clinicians will begin in April with a targeted completion in December 2018 as agreed. This progressive rollout approach has been adopted due to lessons learned from Mid Central and Whanganui where a "Big Bang" all at once approach proved disruptive and for some clinical teams

Progressive Roll Out

The progressive roll out may take the form of a function by function, group by group or service by service approach. This will be informed by technical dependencies and process sequencing bought to light by the ECA "unpacking". Once IS has a fuller understanding of the possibilities we will work with stakeholders, including Operations, Clinical Council and clinical groups, to identify the most effective approach to the rollout.

Reporting

The Project Manager provides the following reports:

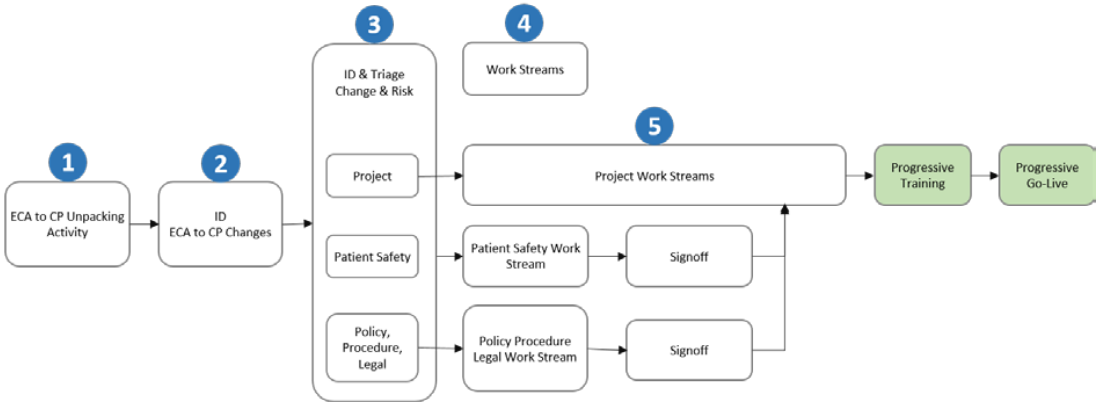
- Fortnightly reports to the IS Senior Management Team (SMT)
- Monthly reports to Transform and Sustain (T&S)
- Reports to Finance Risk and Audit Committee (FRAC)

Change

The plan for dealing with change has been scoped with the People & Quality Team. The agreed approach to be taken is:

1. Project team identifies activities in ECA by "unpacking" staff's daily activities
2. The results of "unpacking" are documented and compared to corresponding actions in Clinical Portal and identify change
3. A triage group, comprised of IS and People & Quality staff will triage all changes for policy, procedure, legal and patient safety matters
4. These changes will be streamed to the appropriate teams and people, elevating them to others as required, to be managed, approved and addressed with staff
5. These resolved change streams will then feed back into the projects training program as part of the progressive roll out.

A process flow is shown below.



Process for tracking and managing identified change

15.1

Risk

The strategy and plan for assessing and managing risk is underway. The following key risks have been identified from the initial analysis:

Main Risks	Consequence (H/M/L)	Likelihood (H/M/L)	Comments & Risk Management Strategies
Change to clinical systems and interfaces impact on patient safety as clinicians will be working with an unfamiliar product, & a new interface	H	M	The project is working with People & Quality team to identify scale & scope of change in support of Patient Safety. Once assessed, training will be built to mitigate against impacts.
Internal reputational risk with staff	M	M	Consultation & communications across our 2501 clinicians is underway. This will be followed with a range of training prior to rollout. The organisation will need to support the time & effort required of staff to ensure they are fully supported throughout training & the ECA to Clinical Portal migration.
Internal Change Management	M	M	Clinical Portal represents an elevated amount of change for staff that interact with clinical information. A process to identify change is in place to allow it to be managed at the appropriate point in the organisation e.g. clinical, policy, legal etc. This approach will be refined throughout the project to ensure it adapts the change management needs.
External business reputational risk with suppliers & partners	M	L	Clinical Portal is initially an internal facing implementation. The DHB has taken a strategic partnership approach with our suppliers & we are collectively focused on a collaborative & successfully delivery.
Community Reputational Risk	M	L	As part of the communications plan, preparation to communicate with the wider Hawke's Bay is being considered, with mitigating actions is required
If the delivery of Version 2.1 is delayed it may	M	L	The project, with the Hawke's Bay DHB CIO, are actively engaged with TAS and

impact the project's progressive rollout timeline, pushing back completion dates.			Orion Health to underpin the importance of Hawke's Bay DHB delivery timelines. All parties are committed to the milestones & the project will continue to monitor & report.

The objective is to manage risks by working collegially and collaboratively with our clinical, People & Quality and Communications teams to minimise the potential of an occurrence and mitigate any impacts if something should occur.

The Regional Solution has also had initial performance challenges. CTAS developed a "Consolidated Regional Improvement Plan" as a result of initial concerns. This action plan has delivered progressive improvements of the Regional Solution across a number of areas. The Clinical Portal Project, and Hawke's Bay DHB's IS team, will continue to monitor progress to ensure the Regional Solution is ready for Hawke's Bay DHB to on-board to and progressively go live.

Communications

An overall communications strategy is in draft format and being further developed with the Hawke's Bay DHB Communication Manager. The communications plan is aligned to the three key milestones and the progressive rollout approach.

Investment Logic Map Benefits

The original Investment Logic Map showed five benefits of proceeding with the Regional Solution. There were:

- Improved health outcomes 25%
- Improved quality of care 30%
- Cost efficiency/productivity 15%
- Risk Mitigation 15%
- Improved employee skills and engagement 15%

The shown benefits and associated percentages reflect a benefits weighting approach. This highlights that of the health benefits accrued through the Clinical Portal Implementation it is anticipated that 25% will be improved health outcomes, 30% improved quality of care etc.

Post Implementation review

The listed benefits of the Regional Clinical Portal Implementation will take time to become visible and measureable. As part of the Clinical Portal Implementation a Benefits Review Plan should be developed. We are in discussions with CTAS and the Regional project team as to whether this be led from a Regional or individual DHB perspective.

Next Steps

This Clinical Portal Implementation Business Case seeks approval from the Board to proceed with the Clinical Portal implementation as outlined and by using this Business Case's recommended option (Option 3).

Once approved, the Clinical Portal Project will continue toward the delivery of the milestones and a progressive rollout.

Appendix (Attached)

- Board Minutes Extract 21 December 2011

References

- M Sheehan (September 2017). RHIP Project Brief v1.2
- M Sheehan (2018). CP Project on Page & Charts v9.
- M Sheehan (2018). CP Project Plan – Stage 1-2.
- M Sheehan (2018). RHIP CP Project Budget Estimates.
- Health Quality & Safety Commission New Zealand (2016). Governing for Quality, A Quality & Safety Guide for District Health Boards.
- D Beesley (2016). End of Project Report, Southern DHB HCS Implementation.
- C Sullivan, A Stalb et al (2016). Pioneering digital disruption: Australia's first integrated digital tertiary hospital.
- OCG (2009). Managing Successful Projects with Prince2.

All references are available, as required, from the IS Clinical Portal Implementation Project Manager or CIO.

Extract of Board Minutes 21 December 2011

Supplied by Brenda Creene

Central Region Information System Plan

A summary paper had been distributed prior to the meeting which coordinated and summarised the papers distributed with the Agenda.

The papers were introduced by Peter Reed (Chief Financial Officer) supported by Vidhya Makam (IS Manager) and Kevin Snee (CEO).

The CFO provided a presentation on the project and covered off some of the key financial issues. Following active discussion agreement in principle was obtained with several additions/amendments requested.

The Board then resolved:

Procurement Strategy for CRISP

RESOLUTION

That the Hawke's Bay District Health Board, having considered the following matters:

- The memo from the Programme Director CRISP (dated 29 November 2011);
- the Board's view that, as discussed in the Business Case, the approach of standardising existing implementations and consolidating to a single regional instance [significantly,] reduces technical and financial risk;
- this selective procurement approach is consistent with the National Health IT Plan and has the support of the National Health IT Board;
- the finding of the State Services Commission Gateway Review report, Gate 0/1 review, April 2011, that "given the history of large projects in the public sector, the proposed solution for consolidation of currently used and proven applications is an appropriate low risk approach";
- the approval of the Business Case by the DHBs and the requirement that TAS implement Phase One of CRISP in accordance with the Business Case; and
- the Board's view that selective procurement in this case is consistent with the OAG Guidelines;

Resolves, subject to approval by the TAS Board, for TAS to engage the existing application vendors to provide the applications as specified in the CRISP Business Case, and

Resolves, subject to approval by the TAS Board, for TAS to engage in a full market request for proposal process to provide the infrastructure as specified in the CRISP Business Case.

Moved **Kevin Atkinson**

Seconded **Peter Dunkerley**

Carried

Governance Report Overview

09

HAWKE'S BAY District Health Board Whakawāteatia	**Disposal of Surplus Land at Waipukurau**
	For the attention of: **HBDHB Board**
Document Owner	Sharon Mason, Executive Director Provider Services
Document Author(s)	Andrea Beattie, Property and Service Contracts Manager
Reviewed by	Executive Management Team
Month/Year	February 2018
Purpose	Decision
Previous Consideration Discussions	N/A
Summary	Seeking approval to declare the parcel of land Lot 1 DP 25272 situated on State Highway 2 at Waipukurau surplus to HBDHB requirements, and approve the disposal of the land in accordance with the statutory disposal process.
Contribution to Goals and Strategic Implications	N/A
Impact on Reducing Inequities/Disparities	N/A
Consumer Engagement	Nil
Other Consultation /Involvement	N/A
Financial/Budget Impact	Sale Proceeds $10,000 less disposal costs
Timing Issues	Consultation with resident population and obtaining Minister of Health consent: 4-6 weeks Revocation of reserve status and pre-disposal clearances: 2-4 weeks Submit Section 40(4) Public Works Act 1981 report and recommendation: 4-8 weeks Signing of Agreement for Sale and Purchase: 1-2 weeks
Announcements/ Communications	Consultation with community – the first step requires notification to the wider community that the land is being considered for disposal Responsibility – Accredited disposal agent Mode/method – Newspaper advertising

RECOMMENDATION:

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

16

Disposal of Surplus Land at Waipukurau

Author:	**Andrea Beattie**
Designation:	**Property And Service Contracts Manager**
Date:	**20 December 2017**

PURPOSE
The purpose of this paper is to obtain approval to declare the land described as Lot 1 DP 25272 (as outlined in blue on the attached plan) surplus to HBDHB requirements and commence statutory disposal processes.

BACKGROUND
The land is a small parcel of land (7619m^2) situated between State Highway 2 and the Tukituki River at the base of Pukeora Hill, Waipukurau.

Investigation has revealed that the land ought to 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.

The land sits under Hawke's Bay District Health Board ownership meaning statutory disposal processes are to be followed as set out in Clause 43(1) of Schedule 3 of the New Zealand Health and Disability Act 2000.

The land has no legal access but is adjacent to land owned by Central Hawke's Bay District Council. The Council has agreed to purchase the land for $10,000, with the transfer being completed pursuant to Section 40(4) Public Works Act.

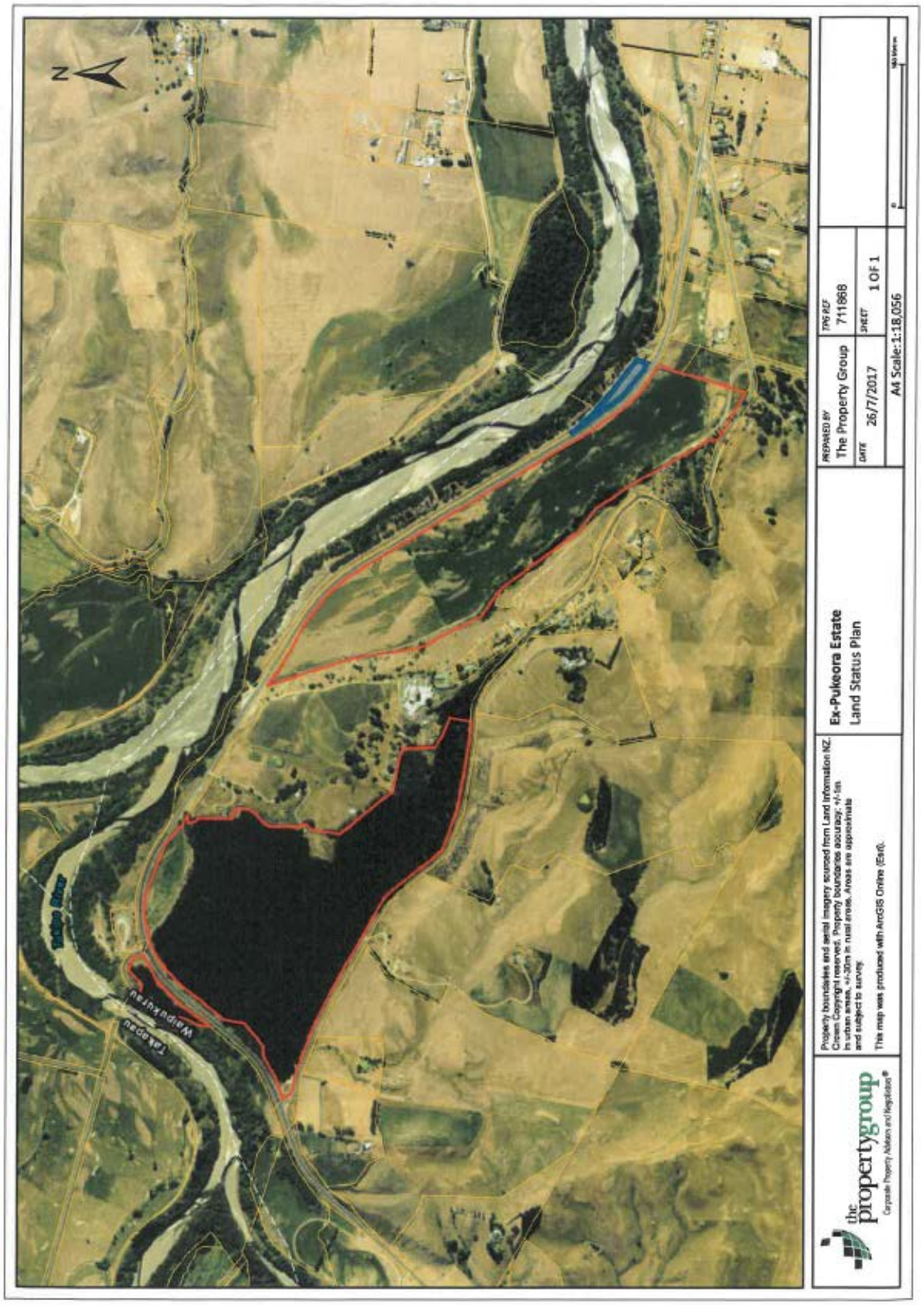
RECOMMENDATION:

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

ATTACHMENTS:

- Plan showing the land (outlined in blue)


N
Tukipo River
Waipukurau
Tuki Open
Property boundaries and aerial imagery sourced from Land Information NZ. Crown Copyright reserved. Property boundaries accuracy: +/-1m in urban areas, +/-20m in rural areas. Areas are approximate and subject to survey.
This map was produced with ArcGIS Online (Esri).
the property group
Corporate Property Advisors and Registered
Ex-Pukeora Estate
Land Status Plan
PREPARED BY
The Property Group
DATE
26/7/2017
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16

HAWKE'S BAY District Health Board Whakawāteatia	**New Zealand Health Partnerships (NZHP) - Shareholders Special General Meeting** 10
	For the attention of: **HBDHB Board**
Document Owner:	Ken Foote, Company Secretary
Month:	February 2018
Consideration:	For Decision

RECOMMENDATION

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.

17

A Special General Meeting of Shareholders of NZHP Ltd is to be held in conjunction with a DHB Chair's meeting on 8 March 2018. The purpose of the meeting is to appoint/reappoint directors of NZHP Ltd.

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.

It is recommended that the Chair, Kevin Atkinson be appointed.

HAWKE'S BAY District Health Board Whakawāteatia	**Suicide Prevention Update** 11 For the attention of: **HBDHB Board**
Document Owner:	Allison Stevenson – Acting Executive Director Provider Services
Document Author(s):	Penny Thompson – Suicide Prevention Coordinator
Reviewed by:	Allison Stevenson, Jenny Cawston and Executive Management Team, Maori Relationship Board, Clinical Council and Consumer Council
Month:	February, 2018
Purpose	• Provide Suicide Prevention update to the HBDHB Board
Previous Consideration	N/A
Summary	• Suicide Prevention Activities • Barriers and Limitations • Future Activities
Contribution to Goals and Strategic Implications	• Improving quality, safety and experience of care • Improving Health and Equity for all populations • Improving Value from public health system resources
Impact on Reducing Inequities/Disparities	• Working with Flaxmere Planning Committee • AEIOU voice over via social media
Consumer Engagement	• Community led initiative • Resource revised according to feedback
Other Consultation /Involvement	• Flaxmere Planning Committee • Clinical Advisory Services Aotearoa
Financial/Budget Impact	• Raising Awareness Campaign for December 2017 – March 2018 • Communications System
Timing Issues	N/A
Announcements/ Communications	• Clinical Advisory Services Aotearoa support initiated in late November

RECOMMENDATION

That the HBDHB Board

- Note the contents of this report and feedback, if any provided by the respective Council's and MRB

18

HAWKE'S BAY
District Health Board
Whakawāteatia

Suicide Prevention Update

Author:	Penny Thompson
Designation:	Suicide Prevention Coordinator
Date:	18 January 2018

OVERVIEW

Every year one in five New Zealanders experience some form of psychological distress or develops a diagnosable mental disorder (Ministry of Health, 2006). These numbers are increasing and will continue to do so under the current system and the way services are delivered. According to Stone et al (2017) an effective suicide prevention strategy is strengthening accessibility and improving delivery of suicide care. It is believed that improved delivery for suicide care should occur on a continuum that starts with whanau and ends with acute inpatient services. Our future initiatives will need to add significant value to existing primary and community care services with potential to reduce the economic cost of a range of Government services, as well as improving population health status across both mental and physical health.

BACKGROUND

New Zealand has one of the highest youth suicide rates in the Organisation for Economic Cooperation and Development (Ministry of Health, 2017). Māori have higher suicide rates of 21.1 per 100,000 compared to that of non-Māori recorded at 14.6 per 100,000 in 2013. (Ministry of Health, 2013). According to Gluckman (2017) of particular concern is young Māori males aged 15 to 29. The rates of suicide for 15 to 19 years of age in 2010 was recorded at 15.6 per 100,000 adolescents (Gluckman, 2017).

In Hawkes Bay, twenty nine people took their lives in 2013 (Ministry of Health, 2013). According to Coronial Services New Zealand (2017) the rates of suicide for Māori are disproportionate to that of non-Māori with a decline in non-Māori suicide rates since 1996 and although trends are hard to determine with population fluctuations, there appears to be no decline for Māori nationally.

Suicide is a complex issue and will require multi-faceted interventions to reduce or eliminate suicides such as; building resilient people and communities, creating protective environments and eliminating inequities caused by poverty or hardship (Stone et al, 2017). The social reasons behind suicide is emphasised by adverse childhood experiences suggesting that increased exposures to adverse childhood trauma such as child abuse, neglect, poverty, family violence or parent in prison can significantly increase the occurrence of depression and suicide attempts compared to those people who do not experience adverse childhood trauma (Felitti et al, 1998).

SUICIDE PREVENTION INITIATIVES - CURRENT

The HBDHB has shown a great deal of commitment to suicide prevention since the four youth suicides in December 2013. Such commitment can be seen in the management and operational leadership to drive suicide prevention activities across public sectors, allocating permanent funding, building and creating strong relationships with non-government organisations, schools and communities such as Flaxmere, Central Hawke's Bay and Havelock North. The network of

agencies participating in suicide prevention/postvention continue to improve what they do whilst looking for opportunities to do things differently. There are currently three large initiatives in progress, one working with the Flaxmere Planning committee to implement their community plan and the other being the Local Response Team (LRT), who is responsible for ensuring support is in place for those who have been impacted by suspected suicide. The LRT has extended its scope to include the youth suicide prevention space.

1. Flaxmere Planning Committee
   On the 9th October, the same week of Mental Health Awareness week, the Flaxmere Planning Committee launched a Flaxmere Wellbeing Challenge that finished on the 24th December promoting group, individual activities and events that focus on the Five Ways to Wellbeing. The challenge asked people to register and share their journeys on their Facebook page. The challenge has been driven and created by the Flaxmere Planning Committee with involvement from Flaxmere based services.

2. Youth Suicide Prevention
   The LRT youth suicide prevention work is intended to take a comprehensive cross sector approach for youth up to the age of 17, who have a child protection and suicide attempt event in the Police system. The LRT designate a lead agency, create and/or share plans. This process has taken some time to initiate and the network of agencies working in the multi-disciplinary space is continuously attempting to improve the process and outcomes. This work increasingly requires mental health clinical expertise to guide best practice.

3. Postvention (the time after a suicide occurs)
   Postvention management continues as a component of suicide prevention care. The need to coordinate support increases significantly when a suspected self-inflicted death notification for a youth is received. This is due to the impact of friend's networks, social media and the effect on schools. This year the LRT has actively been working together to support various high schools in the region with timely risk assessments, communications support, promoting services available and parent evenings.

   The suicide prevention network have been working closely with the Clinical Advisory Services Aotearoa Community Postvention Response Services (CPRS) to manage recent suspected self-inflicted death notifications for two people who knew each other. A cross sector response was initiated immediately with the timely review and development of resources, creation of a two month communications plan from December to March, ongoing guidance from CPRS and clear actions for the suicide prevention network. CPRS has commended the Hawke's Bay Suicide Prevention network for the decisive response and will continue to support the network as needed.

BARRIERS AND LIMITATIONS

There are two main barriers and limitations that could significantly improve the capacity of the suicide prevention network.

1. One communication system – patient/client management systems accessible across sectors, especially Ministry of Vulnerable Children, Police and HBDHB.

   Currently, under the guidance of the Privacy Rights and Vulnerable Children's Act, the Suicide Prevention Coordinator provides intensive administration support collating information, assigning clear actions and managing accountability for stated actions. One communication system would make the information more accessible, current for all major sectors and reduce the administrative process overall. The States Services Commission et al (2014) Working Better Together and Getting to Great reports suggest core business effectiveness and efficiencies need to be as strong as an organisations ability to react to events. However, there is no escaping the economic impact of creating one communication system, unless the costs and rewards are shared across sectors.

2. Mental Health – increased demand on services (internal and external to the DHB) could be an acknowledgement of the increased awareness of services in the community. However, the demand compared to the full time equivalents available makes timeliness to access support difficult. In conjunction, there is an increased need for mental health and addictions services available in the community.

   In contrast, there has also been some mental health specific initiatives implemented in the last 18 months that address some of the contributing factors connected to suicides

   - Te Ara Manapo – a maternal and parental mental health and addictions service that works through the parents to give the child the best start in life.
   - Mental Health Credentialing of Primary Care/Practice nurses to increase the confidence of primary care staff to manage mental health in the community
   - Day Programme at Te Harakeke involving group interventions
   - Home-based Services – managing clients care in their home
   - Resilience coaching for youth – through Health Hawke's Bay, the DHB is funding Youth Resilience programmes being delivered in schools. The programme began in Term 2 of 2017 and the feedback from schools has been very favourable.

   However to increase the level of wellbeing, resiliency and equity requires a shift in focus. We need to ensure the services have the flexibility to respond to the social complexity of people's lives. Felitti et al (1998) supports this approach understanding that adverse childhood experiences can have a significant effect on individuals and impact their overall health outcomes.

THE FUTURE OF SUICIDE PREVENTION

- Researching Zero Suicides Quality Improvement Framework
  Zero Suicides Quality Improvement Framework is growing interest in New Zealand with Canterbury and Waitemata choosing to implement. The Zero Suicides workshop for Health Professionals held in October 2017 had international presenters sharing their results such as, improved organisational performance and culture post training, improved patient/client outcomes and service specific results including reductions in restraint care, assaults on staff and disciplinary cases. Joe Rafferty of Mersey Care described the zero framework, as having revolutionised their organisation approaches and that it is not a sprint to the end but rather a journey. It is expected more research into this area is required to determine the resources needed to implement such a framework.

- Community
  A "By Community for Community" approach has been a focus for the suicide prevention network. We have continued to work with Flaxmere Planning Committee to guide and support them to promote wellbeing in partnership with their local community centre, waterworld, GP Practice, church groups, park features (such as disk golf), local businesses and local events. There have been some early learnings which will be discussed in more detail later in the 2018 year. The suicide prevention network in partnership with the Flaxmere Planning Committee intends to utilise a Results Based Accountability (RBA) to gauge effectiveness of a "By Community for Community" approach. In addition, alongside the Hastings District Council the next community we are working with is Havelock North, with the potential to include Omahu and Raureka.

- Resources and Education
  Recently the suicide prevention network have approved back of bus marketing over the summer holidays to further promote "it's ok to ask for help" and the 1737 telehealth service. Furthermore the "it's ok to ask for help" wallet card resource has also been reviewed. This was done as a direct response from feedback acquired from parent evenings and

presentations. The overwhelming need from community is to know what they can do. An acronym AEIOU has been added to the resource and will be included to suicide prevention education/training sessions. In addition, a video clip of AEIOU with Maori voice over has been created to be shared via social media during the summer holidays. Early stages of planning have been initiated with sessions to be held for church groups and schools (including primary and intermediates). Furthermore, we expect to have Le Va – Lifekeepers training available in 2018.

- Post/Prevention
  Lastly, postvention response is a necessary process to ensure those bereaved by suicide have support. Postvention along with the youth suicide prevention work will continue with the overwhelming consensus from LRT agencies to work better together, utilise our resources efficiently and improve outcomes for youth. This work will continue to develop and expand as required and if feasible.

- Strategy Development
  The suicide prevention network expect to focus on the development of a suicide prevention strategy, to submit to the Ministry of Health by 30th June 2018.

In summary the suicide postvention/prevention space requires flexibility to adapt or respond to the needs on any given day. The work across sectors continues to grow with the ongoing commitment of those agencies and services participating in the network. It is clear that ongoing clinical mental health expertise is required to support best practice. We look forward to completing a RBA framework to evaluate the effectiveness of working community by community.

RECOMMENDATION

That the HBDHB Board

- Note the contents of this report and feedback, if any provided by the respective Council's and MRB

Reference List

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ATTACHMENTS:

- **"**It's Ok to Ask for Help" Bus Backs
- "It's Ok to Ask for Help" Wallet Card

NEED TO TALK?

1737 Free call or text any time

Aunty Dee

Aunty Dee is a free online tool you can use on your mobile phone, tablet, laptop or personal computer

www.auntydee.co.nz

www.commonground.org.nz
www.thelowdown.co.nz
www.sparx.org.nz

SAMARITANS 0800 726 666

WHATS UP 0800 942 8787 (1-11pm)

YOUTHLINE 0800 376 633 (11-11 7 days)

DEPRESSION 0800 111 757 (24 hrs)
www.depression.org.nz

DIRECTIONS YOUTH HEALTH CENTRE
06 871 5307

Child, Adolescent & Family Mental Health Services 06 878 8109 ext 5848

COMMUNITY MENTAL HEALTH

Napier	06 878 8109	ext 4220
Hastings	06 878 8109	ext 5700
Wairoa	06 838 7099	ext 4875
CHB	06 858 9090	ext 5551

EMERGENCY MENTAL HEALTH
0800 112 334

ARE YOU CONCERNED ABOUT SOMEONE?

This is one thing you can do:

A Ask if someone is feeling suicidal. Be direct and matter-of-fact.

E Ensure immediate safety (take away means to suicide like ropes, guns, pills and knives). Don't leave them alone.

I Identify the problems that a person is trying to escape from by taking their life.

O Offer hope that there are other ways out, another way to solve the problem, that there is Hope.

U Use professional / Services / Community / Kaumatua and Kuia to help. Don't be sworn to secrecy. Don't carry this alone.

We would like to acknowledge the original designers of AEIOU Roger Shave and Te Runanga o Ngāti Pikiao

18.1

WINNING WAYS TO WELLBEING

CONNECT
TALK & LISTEN,
BE THERE,
FEEL CONNECTED

Give
Your time,
your words,
your presence

TAKE NOTICE
REMEMBER
THE SIMPLE
THINGS THAT
GIVE YOU JOY

KEEP LEARNING
EMBRACE NEW
EXPERIENCES,
SEE OPPORTUNITIES,
SURPRISE YOURSELF

BE ACTIVE
DO WHAT YOU CAN,
ENJOY WHAT YOU DO,
MOVE YOUR MOOD

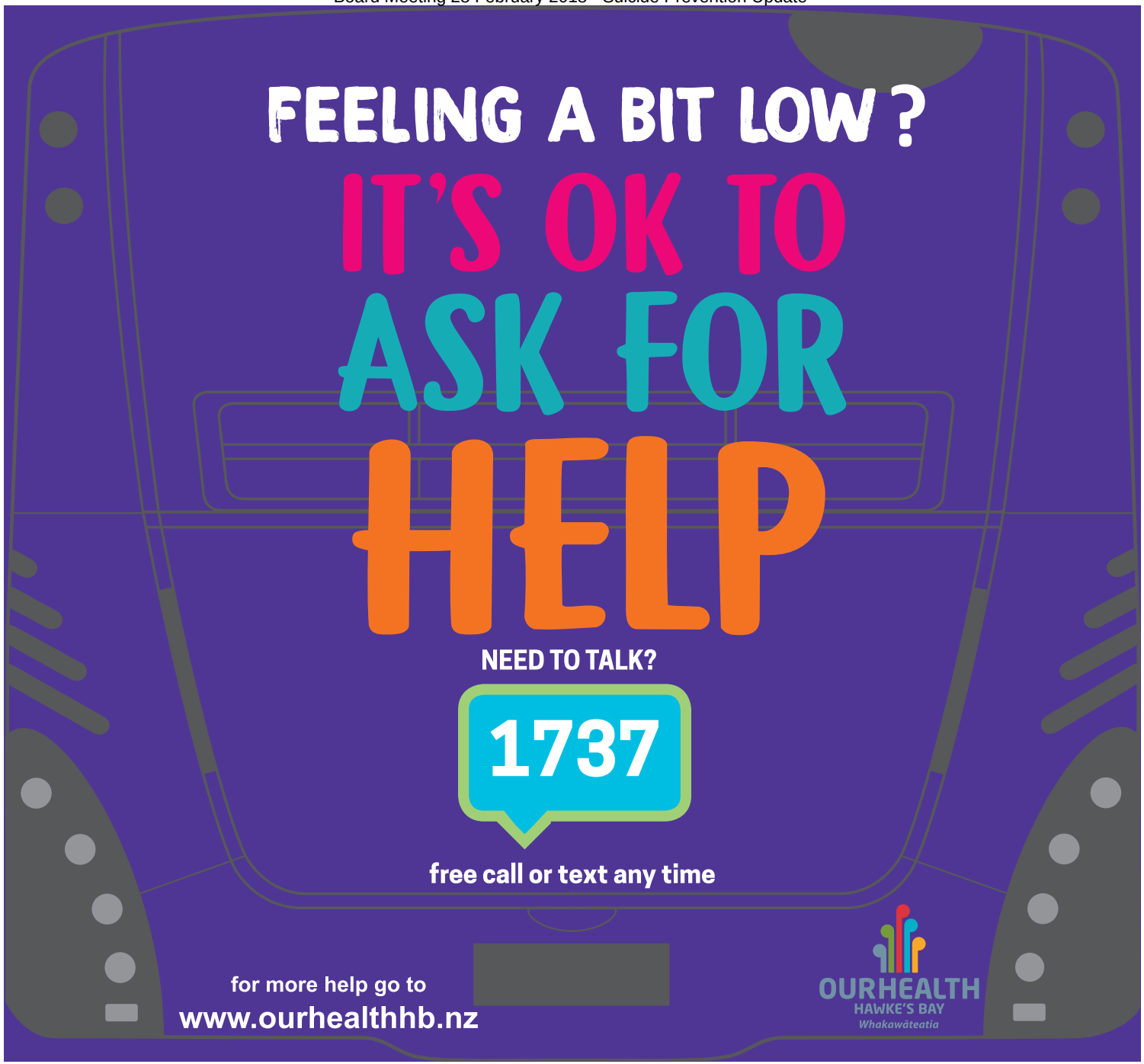
INTRODUCE THESE FIVE SIMPLE STRATEGIES INTO YOUR LIFE AND YOU WILL FEEL THE BENEFITS.

Mental Health Foundation of New Zealand
www.mentalhealth.org.nz

IT'S OK TO ASK FOR HELP

E hika mā, kei te pai noaiho, ki te pātai mō tētahi āwhina

OURHEALTH HAWKE'S BAY


FEELING A BIT LOW?
IT'S OK TO
ASK FOR
HELP
NEED TO TALK?
1737
free call or text any time
for more help go to
www.ourhealthhb.nz
OURHEALTH
HAWKE'S BAY
Whakawāteatia

18.1

FEELING A BIT LOW?

IT'S OK TO ASK FOR HELP

NEED TO TALK?

free call or text any time

for more help go to
www.ourhealthhb.nz

OURHEALTH
HAWKE'S BAY
Whakawāteatia

Governance Report Overview

12

HAWKE'S BAY District Health Board Whakawāteatia	**Ngātahi Project – progress report, end of year one**
	For the attention of: **HBDHB Board**
Document Owner	Kate Coley, Executive Director People and Quality
Document Author	Dr Russell Wills, Paediatrician, Medical Director, Quality Improvement and Patient Safety, Project Sponsor
Reviewed by	Bernice Gabriel, Project Manager; Viv Kerr, Education & Development Manager; Executive Management Team, Māori Relationship Board, Pasifika Health Leadership Group, HB Clinical Council and HB Health Consumer Council
Month/Year	February 2018
Purpose	For Information only
Previous Consideration Discussions	Previously discussed at EMT, MRB, Clinical Council, Consumer Council and the Board, who supported the project.
Summary	The Ngātahi Project has met all milestones for year one: • Agreement across 24 Hawke's Bay government and non-government health, social service and education agencies on the competencies required for practitioners working with vulnerable children (see Appendix 1 for participating agencies) • 441 practitioners completed assessments against the competencies, noting in particular those additional competencies they needed but did not yet have, or partially had • Leaders from the 24 agencies have agreed the three most important domains of practice to focus workforce development on in 2018 and 2019: Working Effectively with Māori, Mental Health and Addictions, and Trauma-Informed Care (including burnout and vicarious trauma for practitioners) • Training successfully delivered for 140 staff working in child and adolescent mental health, led by CAFS, has already shown early impacts on practice and outcomes • Three workstreams of local leaders are meeting currently to agree curriculum, who would teach, how to integrate cultural and clinical competencies, how to embed the new competencies into daily practice and evaluate the impact of these • Research report for year one received from Prof Kay Morris-Matthews (EIT) notes high engagement of workforce, exemplary leadership from Project Manager (Bernice Gabriel, CAFS psychologist), support for the competency framework and process to date, early impacts of training in CAFS and lessons learnt • Funding discussed with Deputy Chief Executive for the Ministry for Vulnerable Children for FTE for Y2-3. Project sponsor

19

	currently working to secure funding for evaluation and training costs for Y2-3. • RFP drafted for evaluation for Y2-3, focusing on process and lessons learnt (Y2) and measurable outcomes (Y3)
Contribution to Goals and Strategic Implications	Contributes to HBDHB Statement of Intent 2015-19 (p8, Fig 3): Working with Others; People better protected from harm; Health issues and risks detected early; Longer, healthier and independent lives; High quality, timely and accessible services; Sustainability. Contributes to NZ Health Strategy 2016 goals: Closer to Home; Value and High Performance; One Team; Smart System.
Impact on Reducing Inequities/Disparities	70% of vulnerable children are Māori so this project has been created with tamariki and whānau Māori at the fore: early and regular consultation with Māori providers and leaders, specific domain on Working Effectively with Māori (WEWM), co-constructed with Māori service leaders; cultural *and* clinical competency in teaching and learning; WEWM workstream to have oversight of other workstreams.
Consumer Engagement	Early consultation with caregivers of children and young people in care and with care-experienced young people, facilitated by MVCOT. Strong support for the competencies and process, no additional competencies identified. Evaluation RFP requires direct assessment of outcomes for children, young people and whānau.
Other Consultation /Involvement	MRB, Māori providers, facilitated by HBDHB Māori Health Unit. Support for project, helpful advice regarding tikanga, added several additional competencies to the WEWM domain, WEWM workstream has oversight of other domains to ensure cultural competency.
Financial/Budget Impact	Y1 $250,000 Y2 $232,500 Y3 $212,500
Timing Issues	Secure funding: February-March RFP for evaluation advertised: April Training begins mid-year Evaluation reports mid-2018, early 2019, early 2020
Announcements/ Communications	Outcomes from evaluation will be shared: Internally — Project Sponsor Dr Wills Key Stakeholders — Meetings, conferences Community — Through HBDHB communications team

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. Note the progress of the Ngātahi Project in the first year
2. **Note** the approach endorsed for Years 2 and 3 of the Ngātahi Project and the forecast budget of $232,500 for 2018 and $212,500 for 2019
3. **Note** that theTransform and Sustain Steering Group will be asked to contribute funding of $80,000 in FY2017/2018 and FY2018/2019 for the evaluation component of the project.
4. **Note** that the remaining funding has been sought from the Ministry for Children Oranga Tamariki and a philanthropic funder.

HAWKE'S BAY
District Health Board
Whakawāteatia

Ngātahi Project
Progress report - end of year one

Author:	**Dr Russell Wills**
Designation:	**Paediatrician, Medical Director, Quality Improvement and Patient Safety, Project Sponsor**
Date:	**1 February 2018**

SUMMARY
The Ngātahi Project is 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. We have:

- mapped the skills and learning needs of 441 professionals from the vulnerable children's workforce
- agreed on the three priority training areas for 2018 and 2019
- established three work streams to develop, implement and monitor training and development programmes in these three priority areas to improve the confidence and competence of the vulnerable children's workforce, and improve collaboration
- completed an independent research programme of interviews with a representative group of managers and practitioners, which provides assurance on the current direction, lessons learnt and important pointers for the following two years of the programme.

We are a step nearer to our vision of better collaboration between disciplines and sectors, sharing of effective practices, development of a common language and improved workforce capacity.

This briefing paper describes the context and progress to date. A business case for funding for 2018 and 2019 has been written and will be pitched to potential philanthropic funders.

BACKGROUND
In 2015 an expert panel reviewed Child, Youth and Family. There were a number of reasons that the care and protection system failed vulnerable children and their families[1] and recommendations were made to address these issues.

Children of parents with mental illness, addictions and in violent relationships ("vulnerable children") are at high risk of poor health, education and social outcomes. Māori are highly over-represented among these families/ whānau and the Government accepted all of the Panel's recommendations.

A new programme was created to reform the way these families are supported, including:

- changes to legislation and accountabilities of Ministry Chief Executives
- dissolution of Child, Youth and Family and creation of the Ministry for Vulnerable Children Oranga Tamariki
- implementation of multi-agency Children's Teams in ten sites
- additional funding and changes to expectations and monitoring of all agencies with a part to play in supporting such families. See Appendix Two for a roadmap of these changes.

In addition to these structural changes, the expert Panel acknowledged, *"the need for a shift from rules, compliance and timeframe-driven practice to professional judgement based on an*

evidence-based understanding of the impact of trauma on children and young people, the science of child development and attachment, and best practice approaches" (p65).

There are now many reports[2],[3],[4],[5] that recommend a focus on additional knowledge and skills ("competencies") for practitioners working with vulnerable families. These competencies include the ability to identify vulnerable whānau and families, assess both strengths and risks, formulate an assessment, design and implement a plan with families, and work collaboratively with the agencies involved.

The Ministry of Social Development Children's Action Plan Directorate therefore began a programme of work to develop a *Vulnerable Children's Core Competency Framework*, in partnership with sector leaders from education, health and social services. Hawkes Bay is piloting the Ngātahi Project, leveraging the draft Vulnerable Children's Core Competency Framework.

PURPOSE

The Ngātahi Project aims to assess the skills and development needs of health, education and social service professionals in Hawke's Bay who are working predominantly or exclusively with vulnerable children and families. Over a three year period Ngātahi and its partners will design, implement and evaluate a workforce development plan to support practitioners. By improving practitioners' competencies, including their ability to practice collaboratively and share information, in conjunction with the structural changes above, outcomes for vulnerable children and their families should improve.

PROGRESS TO DATE

Funding was obtained in 2016 from the Hawke's Bay District Health Board (HBDHB), Ministry of Social Development and Lloyd Morrison Foundation to progress the project. Bernice Gabriel, a senior psychologist at the HBDHB Child, Adolescent and Family Service (CAFS) was appointed as project manager in March 2017.

<u>HBDHB CAFS</u>

HBDHB CAFS is a multidisciplinary team of 30 staff working with children and young people (C&YP) with moderate to severe mental illness and their families. Many of these C&YP have experience of abuse, neglect, witnessing parental violence, and developmental issues such as foetal alcohol spectrum disorder. CAFS' staff work with the most complex of these children and families and accept referrals from all the other 24 agencies or services involved in the Ngātahi project.

CAFS' staff completed their competency assessment against the Ngātahi framework and the Real Skills Plus CAMHS competency framework early in 2017[6]. Priorities for staff development were identified and experienced clinician-trainers recruited to deliver training for CAFS. Trainers were asked to give particular thought to integrating clinical and cultural competence, prioritise examples of practice with Māori tamariki and whānau and advise on subsequent activities to support CAFS' staff to integrate the new competencies into everyday practice.

Peer review groups meet regularly to review cases and are the primary mechanism to integrate the new competencies into everyday practice. Four training sessions have been completed to date:

- Attachment & Trauma
- Emotional Regulation/Dialectical Behaviour Therapy*
- Acceptance & Commitment Therapy†
- Family Therapy supervision.

* Designed as a treatment for people experiencing chronic suicidal thoughts as a symptom of borderline personality, DBT is used to treat people who experience a range of chronic or severe mental health issues, including self-harm, eating and food issues, addiction, and posttraumatic stress, and borderline personality.

† ACT is an evidence-based approach for young people experiencing anxiety, depression and/or addiction.

Wider workforce

In May 2017 a hui of 72 leaders from health, education and social services, kaupapa Māori, mainstream, Government and NGO services was held at HBDHB (Appendix One).

The hui agreed on the competencies and tiers of competency that each sector required of its staff. Some competencies were added to the original framework and some were moved between tiers. The revised competency framework included 289 competencies in three tiers: Foundation, Practitioner and Leader of Practice. The original six domains and 12 sub-domains from the Vulnerable Children's Workforce Competency Framework were retained. See Appendix Three for a one-page summary of the framework. The full framework is available if required.

A Survey Monkey tool was created from the framework for practitioners to identify the competencies they did not need (N/A), already had (Y), needed and partially had (P) or needed and did not yet have (N). Staff completed the tool online or on paper in September and early October. Paper copies were entered into the Survey Monkey tool by a data administrator. Results were copied into SPSS and analysed, with a focus on the number (%) of staff in each service and across all services recording P and N responses (Table 1 below). Most practitioners also entered demographic data including discipline and years since graduation.

RESEARCH AND EVALUATION

Professors Kay Morris-Matthews and David Tipene-Leach (Eastern Institute of Technology) were contracted to provide the evaluation. Interviews were completed with staff from CAFS and the wider workforce to understand the process to date, assess manager and staff engagement, what had worked well and could be improved in this first phase of the project, and any additional themes that would inform the next steps for the project. The project manager and project sponsor have also kept logs of lessons learnt, which are reported below.

RESULTS

Qualitative research

Key themes from staff interviews have included:

- High levels of engagement of managers and staff: Both groups agreed that the competency framework worked well to identify the competencies staff needed. While the 289 competencies initially looked onerous to assess, most staff took only an hour to do so and found the process helpful.
- Value of clinical leadership: There was high agreement that the project manager, due to her clinical credibility and general approach, made the process accessible and understandable, generated high trust in the process, and that these factors were likely to generate more accurate and reliable responses, that would in turn lead to training that would be of value.
- High levels of practitioner stress: High levels of stress, burnout and fatigue were noted in many interviews. Self-care competencies were identified as a high need by many staff, which was a gap in the competency framework.

Lessons learnt

Bicultural approach

- Tamariki Māori are 70% of the target population for this project so it was agreed that tikanga Māori and Māori voices would be privileged in the project. Initial face to face meetings with Māori leaders to agree tikanga and values provided wise advice and guided the development of the project.

Engagement, values, language

- Initial face to face engagement with managers and practitioners is crucial and needs to be led by people with high degree of trust and fidelity in the region.
- Presenting to all staff in a service before mapping the competencies was crucial to get consistent messaging out and to stress values and philosophies
- Neutral, non-judgmental language was more successful in engaging staff. E.g., "mapping/needs analysis" of competencies rather than "performance appraisal"; "additional" needs, rather than "deficits".
- Stressing trust and confidentiality with practitioners.
- Honest and open acknowledgment of NGOs' difficulty with sharing resource/ intellectual property in an environment of competing for funds from the same funding pool.

Reliability of competency mapping

- Competency mapping was more reliable when done with a senior staff member who is trusted and knew staff well.
- With the Leaders of Practice tier, it would have been helpful to remind (in person and in Survey Monkey before that section) them to say N/A if not applicable to their role.
- Self-assessment on mapping is not enough, most people tend to underestimate their competencies and a very few overestimate them.

Pioneering

- Many of the lessons above were learnt from early adopter services/agencies, which changed our subsequent messaging and prevented lessons from being repeated.
- Dedicated admin and event co-ordination time/resource is crucial.

The detailed research report will be completed by 31 January 2018.

Survey Monkey: priorities for competency development

In the final analysis, 441 practitioners from 24 services mapped their competencies against all 289 competencies. The number and proportion (out of 441) of practitioners identifying that they needed but did not have (N) or partially had (P) each competency was ranked. Only those competencies with >25% of respondents N or P were further analysed. Competencies scoring highly were then grouped into themes that are naturally practised and taught together (Table below).

Table1: Highest-ranked competencies by theme (range, number responding N or P and %)

Competencies (theme)	No.	%
1. Mental health and addictions	113-258	26-59%
2. Working effectively with Maori	110-220	25-50%
3. Trauma-informed practice	112-196	26-45%
4. Professional practice, self-care, UN Convention on the Rights of the Child	109-178	25-41%
5. Child health and development, engaging effectively with children and young people,	110-164	25-37%
6. Assessment, formulation, treatment planning	114-163	26-37%
7. Networking, liaison, legislation, policy, information sharing	110-148	25-34%
8. Child protection, family violence	115-142	26-32%
9. Engaging families, whanau and caregivers	111-127	25-29%

The competency with the greatest number of practitioners identifying themselves as N or P was "Has an awareness of the legislation relating to addiction issues" (258, 59%). Addiction and mental health competencies generally were the highest-ranked by the sector overall.

DISCUSSION AND NEXT STEPS

Stakeholder interviews, surveys and our own observations suggest a high level of engagement has been achieved across sectors for the Ngātahi Project. Four hundred and forty one staff across 24 agencies or services in Hawke's Bay have identified the competencies they believe they need but do not yet have to work effectively with vulnerable children. There is high consistency in the rankings of competency needs between services. The mapping results are also consistent with the competency gaps observed in everyday practice.

On 6th November sector leaders met again to agree the training and development priorities for the Ngātahi Project in 2018 and 2019. Given that staff release time is limited and that there is a large workforce to put through the training, three areas were prioritised: Working Effectively with Māori, Mental Health and Addictions, and Trauma-Informed Practice. Self-care was agreed as needing to be the first priority of the Trauma-Informed Practice work stream.

Sector leaders joined or nominated staff to join one or more of the three work streams. Work streams are currently in the process of agreeing a chair(s), membership and terms of reference, and will commit to attending and contributing to the work stream. Work streams will be empowered to recommend what will be taught, how and by whom, follow-up activities to embed the new competencies into practice and how each competency should be assessed.

OPTIONS ANALYSIS FOR 2018 AND 2019

Three options have been identified to address the additional competencies/ development needs indicated by the mapping process:

Option one is to buy in external trainers. This is not the preferred option because:

- There is agreement among sector leaders that there is considerable expertise in the identified training areas within the participating agencies and services.
- Buying in training would be expensive.
- Buying in training would not allow for building local trainer capacity, and would not allow for the sustainability of training on an ongoing basis.

Option two is to only use local training resource. This is not the preferred option because:

- While there is considerable skill and expertise in the identified training areas, there are some training areas that are specialised and have been well-developed by experts in the field.
- Buying in some external training will reduce the work load on local trainers.

Option three (recommended) is to use a hybrid approach to training, i.e. a mixture of using external trainers where local expertise needs to be augmented (in a train-the-trainer approach to develop local capacity) and using local training resource.

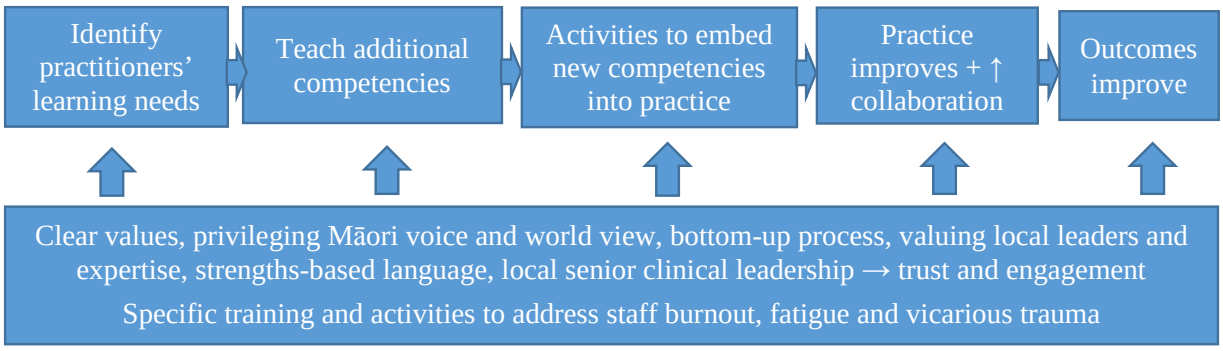
The intended approach for the roll out of training is as follows:

- Leaders chose three training areas to progress in 2018 at the hui on 6th November, i.e. Working Effectively with Māori, Mental Health and Addictions, and Trauma-Informed Practice.
- Three work streams were formed to determine the content and process of the training, how it will be embedded into practice, and how it will be evaluated. These work streams will make decisions on the internal and external resources needed.
- Working Effectively with Māori work stream members will support the other two work streams to advise on the cultural competency aspects of the training.
- Table 1 above and the detailed analysis suggests that for each programme of learning, up to 250 practitioners may wish to attend training and enter a programme to embed the new competencies into practice. Our experience in teaching assessment of child protection and family violence is that this is best achieved in small groups of no more than 20, particularly when role play is involved, so we may expect registrations for up to 12-15 courses for each theme. In 2018, the estimated number of registrants for the Working Effectively with Māori and Mental Health and Addictions training programmes are 250 each. The competency survey did not allow the estimation of the likely number of registrants for the self-care training, but the research interviews indicate that this will be high-demand training and we estimate approximately 300 registrants for 2018. This could mean approximately 250+250+300=800 registrations and 40 training programmes for groups of 20 people in 2018.

EXPECTED OUTCOMES AND BENEFITS

Hawke's Bay is the first region to undertake workforce development across the vulnerable children's workforce at this scale so we have agreed to undertake the programme in partnership with the Ministry for Children Oranga Tamariki and share the lessons we learn with all relevant ministries and other regions. The original proposal has been discussed with and is supported by leaders in MCOT, MSD, HBDHB, Special Education and NGO social services in HB working with vulnerable children, who have a well-established history of collaborative working. We believe that this project could become a template for development of the vulnerable children's workforce nationally.

Our theory of change is essentially:



Measures and indicators

Outcome sought	Demonstrated by
Engagement	Research interviews year one with practitioners and managers
Practitioners' learning needs identified	Survey Monkey results Research interviews year one with practitioners and managers
Competencies taught	Number of attendees at training, number of trainings provided Evidence of programme delivery with fidelity Pre-post self-report of competence and confidence
New competencies embedded into practice	Description of activities and attendance at these Manager report of initial practice change with examples
Practice improved	Manager report of practice change with examples Practitioner self-report of competence and confidence New evidence-based programmes delivered, description, attendance Direct observation by evaluators
Collaboration improved	Manager report of improved collaboration with examples Practitioner self-report of improved collaboration with examples Direct observation by evaluators Reports from collaborative bodies (e.g., FVIARS, Strengthening Families, High and Complex Needs Interagency Management Group, Maternal Wellbeing Programme, Intensive Wraparound Service)
Reduced staff burnout, fatigue & vicarious trauma	Practitioner self-report HR indicators, e.g. recruitment, retention, turnover Direct observation by and feedback to evaluators
Improved outcomes for children and families	Client direct feedback within services Direct observation by and client feedback to evaluators Substantiated abuse (MCOT) Police family violence (POL 1310) callouts Number of children usually resent at POL 1310 callouts Intimate partner violence convictions (Courts) Referrals for severe behaviour to MOE and HBDHB

All outcomes to be assessed by independent researchers contracted to Ngātahi Programme.
All outcomes dis-aggregated by ethnicity.

ASSUMPTIONS

- Children will continue to be a Government priority, Ministers will commit resource and require ongoing collaboration of agencies for children.
- Relationships and buy-in will continue from:
  - Ministries
  - Local executives
  - Practice leaders and agency managers
  - Practitioners
  - Families, whānau, rangatahi and tamariki
  - Other stakeholders, e.g., trades unions, registration and disciplinary bodies
- Funding and resources will be available from MoE, MCOT, HBDHB and philanthropic sources for years 2 and 3.

RISKS and MITIGATIONS

Risk	Mitigation
If agency leaders do not contribute their agency's time and skills to work streams this risks losing the mandate for that training.	At the hui on 6th November a clear message was given that it is important to engage or will not be able to influence the training. It was also made clear that all contributions are welcome
If work stream members do not agree on the content and implementation approach by the deadline this will impact negatively on the project timeline.	The work stream chairs will be supported to facilitate work stream well, value all contributions and look at best practice evidence. If no agreement in work stream this will be escalated to the governance group.

BUDGET HBDHB Ngātahi Project Financials				
Activity	**FTE**	**Amount 2018**	**Amount 2019**	**Why this is important**
Senior clinical leadership	0.5 FTE	$55,000	$55,000	Clinical leadership is required to engage managers and staff in the learning programme, identify, recruit and brief the trainer, support managers and staff to arrange peer review groups, and support the evaluation.
Event management	0.5 FTE	$27,500 ($55k pro rata)	$27,500 ($55k pro rata)	Experience this year suggests that we need event management capacity for the following: website design; online registration, tracking and reporting attendance and feedback; venue hire, IT, catering and certificates. The HBDHB EDC team is a multidisciplinary team with considerable experience in the above tasks.
External trainers		$50,000	$50,000	We would take a train-the-trainers approach with external trainers but a small budget will be required to bring in external trainers initially and for follow-up peer review.
Evaluation To be sought from HBDHB Transform and Sustain Fund		$80,000	$80,000	Ngātahi is a pilot project that, if successful, is likely to be taken up nationally. There is therefore a strong obligation to ensure the programme is evaluated independently and thoroughly, so clear documentation of lessons learnt and areas to improve are essential. Measures and indicators for 2018 and 2019 are noted above. The budget for 2017 was $80,000. We estimate that a credible evaluation could be expected for $80,000/year in 2018 and 2019.
Training costs		$20,000	$0	See table below re training costs
TOTAL COST		**$232,500**	**$212,500**	

Costs to participating services				
Activity	**FTE**	**Amount 2018**	**Amount 2019**	**Why this is important**
Training costs		$0	Contribution per agency to be determined	There will be costs for venue hire, IT, photocopying, catering and certificates. We will ask services, whenever possible, to donate venues for training and staff to bring their own lunch. Work streams will be asked, wherever possible, to identify local leaders to deliver training and support ongoing activities such as peer review. While this a cost to services (time spent training is time not spent in practice), reciprocity occurs because these services also gain from their staff attending training provided by others, and improving their practice. While we are asking for funding for the training costs in 2018, we will ask agencies/services to contribute to these costs in the 2019. The first year will give us an indication of how much we will likely need in 2019, and the contribution from each agency will then be determined.

RECOMMENDATION

That the HBDHB Board:

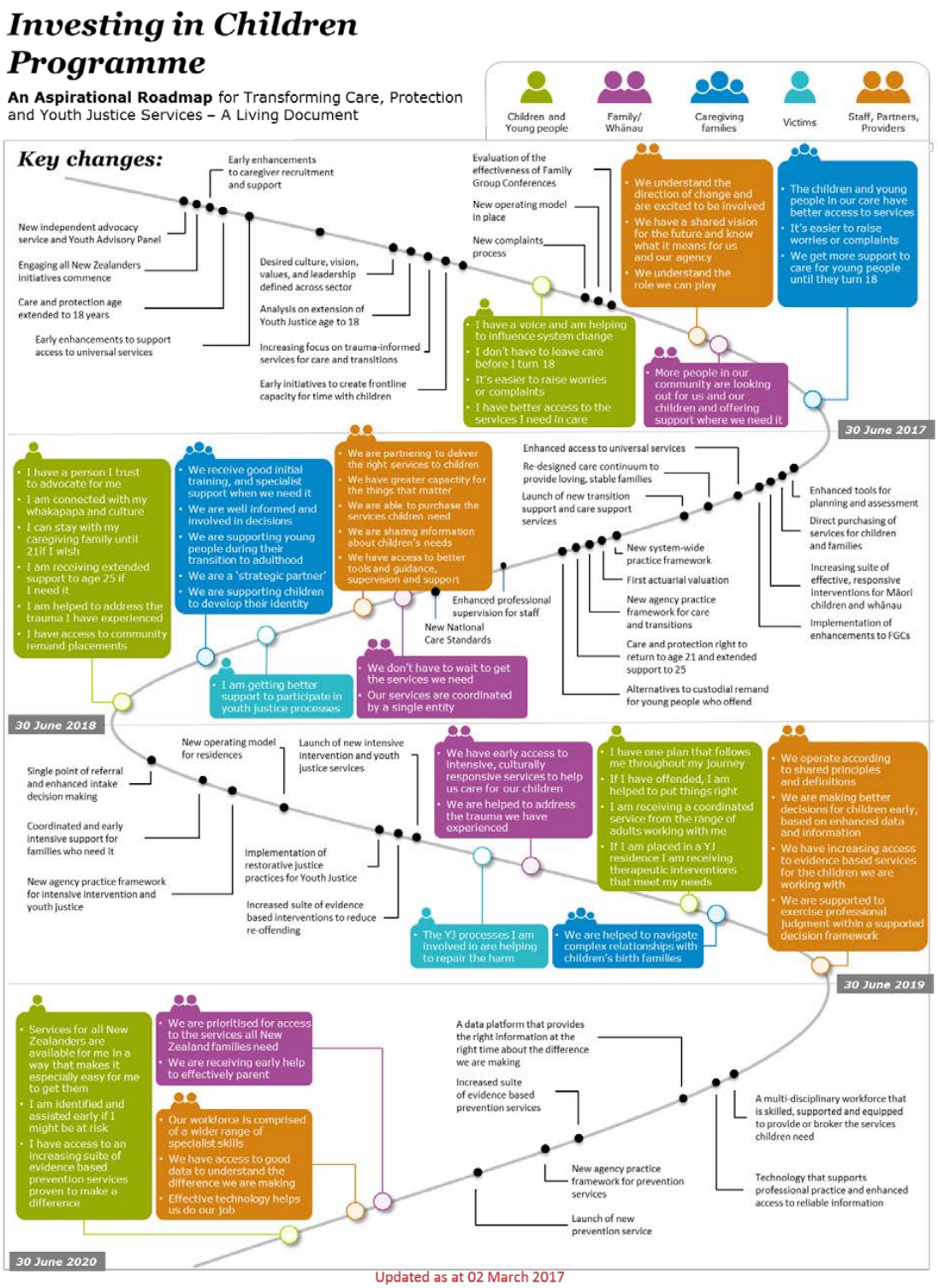
- **Note** the progress of the Ngātahi Project in the first year
- **Note** the approach endorsed for Years 2 and 3 of the Ngātahi Project and the forecast budget of $232,500 for 2018 and $212,500 for 2019
- **Note** that theTransform and Sustain Steering Group will be asked to contribute funding of $80,000 in FY2017/2018 and FY2018/2019 for the evaluation component of the project.
- **Note** that the remaining funding has been sought from the Ministry for Children Oranga Tamariki and a philanthropic funder.

Appendix 1: Agencies/Services Participating in the Ngātahi Project

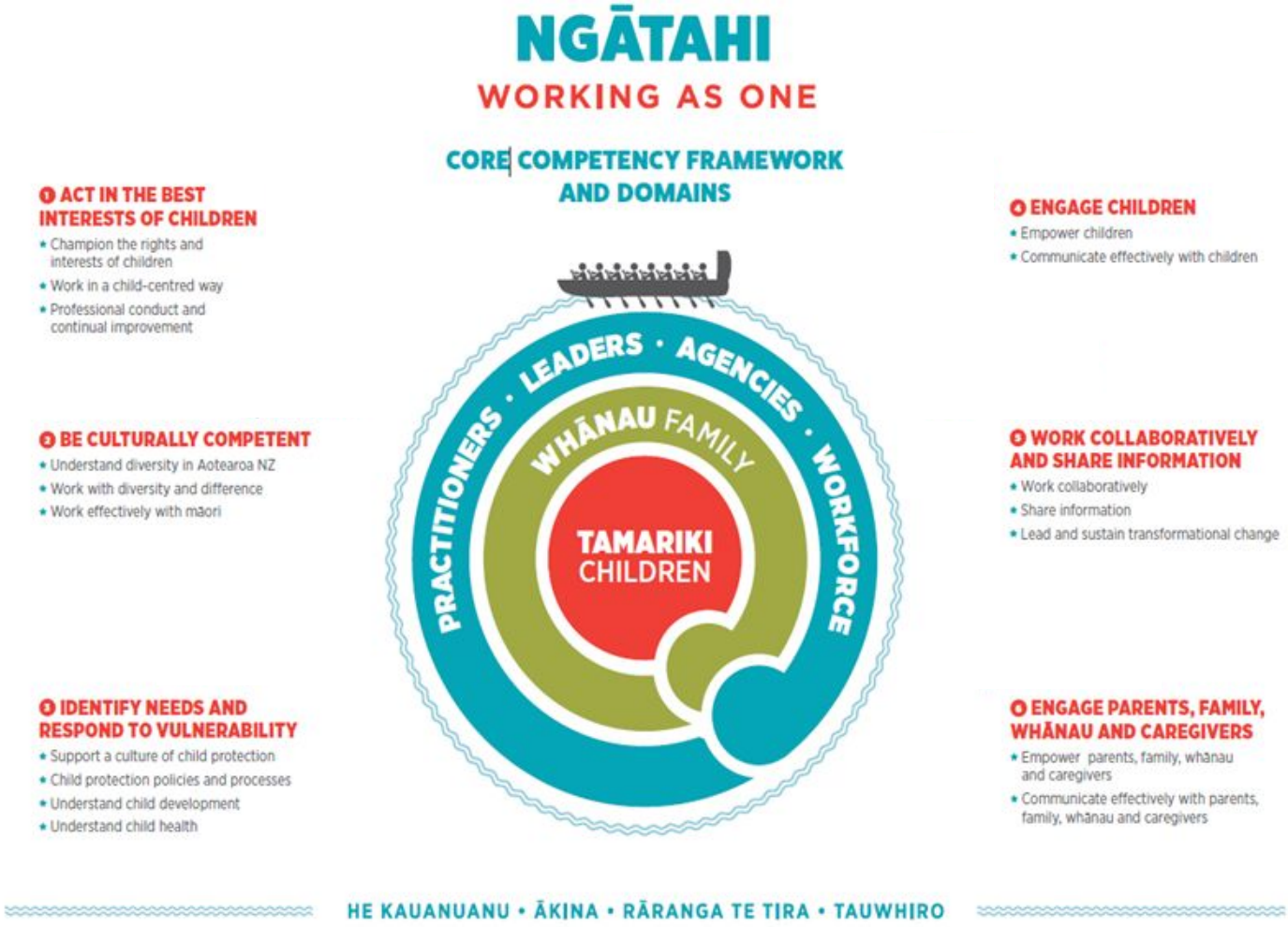
1 HBDHB – Child Development Service (CDS)
2 HBDHB - Child, Adolescent & Family Service (CAFS)
3 HBDHB – Family Violence & Child Protection Programme
4 HBDHB – NASC
5 HBDHB - Public Health Nurses
6 HBDHB – Te Ara Manapou (Parenting & Pregnancy Service)
7 Te Kupenga Hauora
8 Roopu a Iwi
9 NZ Police
10 Youth Horizons
11 Ministry of Education
12 Birthright HB Child & Family Care
13 Napier Family Centre
14 Ikaroa Rangatahi
15 Ministry for Vulnerable Children Oranga Tamariki (Napier)
16 Awhina Whanau Services
17 Open Home Foundation
18 Resource Teachers- Learning & Behaviour (RTLB)
19 Ministry for Vulnerable Children Oranga Tamariki (Hastings)
20 Directions Youth Health Service
21 Dove Hawkes Bay
22 Family Works
23 Te Taiwhenua o Heretaunga (Mental Health, Tamariki Ora, Family Start)
24 Plunket

Appendix 2: Investing in Children Aspirational Roadmap

http://www.msd.govt.nz/about-msd-and-our-work/



Appendix 3: Core Competency Framework Summary



[1] https://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/investing-in-children/investing-in-children-report.pdf
[2] Office of the Children's Commissioner. Final report on the investigation into the death of Riri-o-te-Rangi (James) Whakaruru. Wellington, Office of the Children's Commissioner, 2000
[3] Office of the Children's Commissioner. Report of the Investigation Into the Deaths of Saliel Jalessa Aplin and Olympia Maria Aplin. Wellington, Office of the Children's Commissioner, 2003
[4] Laming Lord. The Victoria Climbie Enquiry. London, HMSO, 2003. http://vcf-uk.org/wp-content/uploads/2010/07/laming-report.pdf
[5] Smith Mel. Report to the Hon. Paula Bennett Minister for Social Development and Employment. Following an Enquiry Into the Serious Abuse of a Nine Year Old Girl and Other Matters Relating to Welfare, Safety and Protection of Children in New Zealand. Wellington, Ministry of Social Development, 2011.
http://www.beehive.govt.nz/sites/all/files/Smith_report.pdf
[6] http://www.werryworkforce.org/real-skills-plus-camhs

HB Health Sector Leadership Forum
Napier Sailing Club, Ahuriri

13

Wednesday, 7 March 2018 (9.00am to 3.00pm)

Theme: **Changing the way we do things**

Aim: **To review, discuss and agree on some fundamental changes we will need to make, to develop a Hawkes Bay Health Sector that meets the equitable health and wellbeing needs of our communities.**

"Healthy Hawke's Bay - Te Hauora O Te Matau ā Māui
Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community"

Objectives:

1. To review and discuss the '2017 NKII Delegation' perspective on the **NUKA** approach
   - Discuss and agree what we in Hawkes Bay can learn and apply from this.
2. To review and discuss key findings from recent feedback processes (Big Listen, CSP Patient Journey Workshops & Korero Mai) and their relevance to **CULTURE CHANGE**
3. To identify and discus key themes that will contribute to **CULTURE CHANGE**
4. To consider and agree where and what the focus should be in the redesign and modernisation of **PRIMARY CARE**

Attendees **Forum members:**

HBDHB Board and Executive Management Team
Health Hawke's Bay Ltd Board and Executive Management Team
Māori Relationship Board
Hawke's Bay Clinical Council
Hawke's Bay Health Consumer Council
Pasifika Health Leadership Group

Facilitator Anne Pattillo

20

"Programme"

9:00am	**Workshop Opening** • Welcome	Kevin Atkinson
9:05	**Introduction to the day**	Kevin Snee & Anne Pattillo
9:10	**HB Health Sector** – The Strategic "Big Picture" Need for Change	Kevin Snee
9:20	**NUKA** – The '2017 NKII Delegation' perspective	NKII Delegation
9:50	**Group Discussion** *What can we in Hawkes Bay learn and apply from NUKA?*	Anne Pattillo
10:30	**Feedback**	Anne Pattillo
10:40	**Morning Tea**	
10:55	**CULTURE CHANGE** - Key findings/issues from recent and current feedback ▪ Big Listen ▪ CSP Patient Journey ▪ Korero Mai	 Kate Coley Ken Foote Patrick LeGeyt
11:25	**Group Discussion** *What are the key cultural change themes you would like to explore?*	Anne Pattillo
11:45	**Feedback**	Anne Pattillo
11:55	**Group Discussion** *Further develop some themes - what needs to be done by whom, when, where etc*	Anne Pattillo
12:30	**Feedback**	Anne Pattillo
12:40	**Lunch**	

1:15	**THE FUTURE OF PRIMARY HEALTHCARE** - Overview - Patient Stories	 Chris Ash Clinical Leaders
1:30	**Group Discussion** *What are the issues and themes arising from this?*	Chris Ash/Anne Pattillo
1:50	**Feedback**	Anne Pattillo
2:10	**Group Discussion** *Further develop priority themes eg, what is important to consumers, how might services need to change etc*	Chris Ash/Anne Pattillo
2:40	**Feedback**	Anne Pattillo
2:50	**Sum up**	Kevin Snee/Anne Pattillo
3:00pm	**Closure**	Kevin Atkinson

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Access (ASH Rates 0-4 & 45-64 years)** 14 For the attention of: **HBDHB Board**
Document Owner	Dr Mark Peterson, Chief Medical Officer - Primary
Document Author(s)	Charrissa Keenan, Health Gains Advisor – Māori Health Patrick LeGeyt, GM Māori (Acting), Māori Health Jill Garrett, Strategic Services Manager – Primary Care
Reviewed by	Executive Management Tea**m**; Māori Relationship Board, Pasifika Health Leadership Group, HB Clinical Council and HB Health Consumer Council
Month/Year	February, 2018
Purpose	Provide an update on the Te Ara Whakawaiora priority areas relating to Access (ASH rates 0-4 and 45-64) Māori
Previous Consideration Discussions	Six-monthly update. No previous consideration.
Summary	ASH rates 0-4 (On track) • *Respiratory* - Review of the respiratory care pathways found that care pathways for this age band require development to address service and system barriers to access. • *Immunisation* - Achieving equitable outcomes for Māori. Work however needed to provide information that leads to appropriate time frames for presentation for immunisation by whanau. • *Oral health* – Showing excellent results of improved outcomes. • *Child healthy homes program* – Achieving significant increases in referrals. • *Skin Program* – The program in its initial phase of raising awareness of skin problems, identifying key stakeholders including ECE providers. ASH 45-64 (Not on track) • *System level improvement plan* – All activities are now in place. Utilisation of CPO programs by Māori is low and will need to be addressed in Q3-4. Appointments into rolls for cardiac services are now in place. • *Collaborative Pathways* – 75 pathways developed. Utilisation increasing by full complement of health professionals. New IT platform for the pathways is being sort in partnership with Central and Midland DHBs. Still more work needed to get pathways imbedded in BAU and funded accordingly • *Continuation of the Nurse led respiratory program* – Contract hold ups has meant recommencement of the program has been delayed. Working group in place to identify target groups and attach three-monthly kick start performance indicators to address current COPD rates.

	• *Implementation of the HBDHB Long Term Conditions Framework* Focus areas for the implementation team will be work force development, care coordination and transfer of care processes. The work is multi-disciplinary and spans multiple co morbidities including; respiratory, cardiac, renal and diabetes. Pharmacy is part of the multi-disciplinary team.
Contribution to Goals and Strategic Implications	Focus is on Improving Health and Equity for Māori
Impact on Reducing Inequities/Disparities	Directly aligned to addressing inequity between Māori and Other
Consumer Engagement	(Forms part of each work stream)
Other Consultation /Involvement	Not applicable for this report
Financial/Budget Impact	Not applicable for this report
Timing Issues	Not applicable
Announcements/ Communications	None

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the content of the report
2. **Endorse** the actions being taken.

HAWKE'S BAY
District Health Board
Whakawāteatia

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

Author(s):	Charrissa Keenan, Health Gains Advisor – Māori Health Patrick LeGeyt, GM Māori (Acting), Māori Health Jill Garrett, Strategic Services Manager – Primary Care
Designations:	As above
Date:	**February, 2018**

OVERVIEW

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

UPCOMING REPORTS

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

Priority	Indicator	Champion	Reporting Month
Access *Local Indicator*	Reducing acute admissions of Ambulatory Sensitive Hospitalisations (ASH): 1. 0-4 year olds - dental decay, skin conditions, respiratory and ear, nose and throat infections 2. 45-64 year olds - heart disease, skin infections respiratory infections and diabetes	Mark Peterson	February 2018

MĀORI HEALTH PLAN INDICATOR

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

Ambulatory Sensitive Hospitalisations (ASH) reflect hospital admissions for conditions which could potentially be prevented by early access to treatment in care. In many countries ASH is used as a means to assess the performance of primary care and to identify potential barriers to access.

However, while ensuring early access to effective primary care is still likely to be of considerable value in reducing ASH, in countries such as New Zealand, where large socioeconomic and ethnic disparities in child health exist, a greater emphasis is needed to address those factors, often outside of the health sector, which drive the underlying burden of disease (e.g. household income, housing, nutrition, exposure to second hand cigarette smoke). But what this also emphasises is the necessity for the health system to be working efficiency, effectively, and equitably in every way to ensure that health does not add to the socio-economic burden of ill-health. The HBDHB is committed to non-differential targets and significant inequality is seen in this indicator. Our work programmes focus on targeting vulnerable populations to reduce hospitalisation, improving the home environment and improving consistency of practice and early access to primary care programmes and reducing inequities.

WHY IS THIS INDICATOR IMPORTANT?

System Level Measures

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

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

Each ASH band for total population is divided into; Māori, Pacific, Other[1]. Targets are derived from the DHB ASH rates for the Māori population. The base line rates for the DHB will be compared with national total population rates and targets set accordingly. These are expressed in rates per 100,000. All Māori and Pasifika data reported against for ASH will analysed by Māori vs Other to adequately examine the equity gap.

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

0 – 4 years

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

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

The 2016 top three ASH conditions for tamariki Māori 0 – 4 years were: dental conditions, asthma and respiratory infections – Upper ENT.

45-64 years

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

For the 2017-18 year the target areas as identified in the SLM-Improvement Plan are;

Using Health Resources Effectively: Reduce standardised acute hospital Bed Days per 1000 population for Māori to ≤461 (by June 2018)

Contributory Measures

- ASH rates 45-64yrs (Māori)

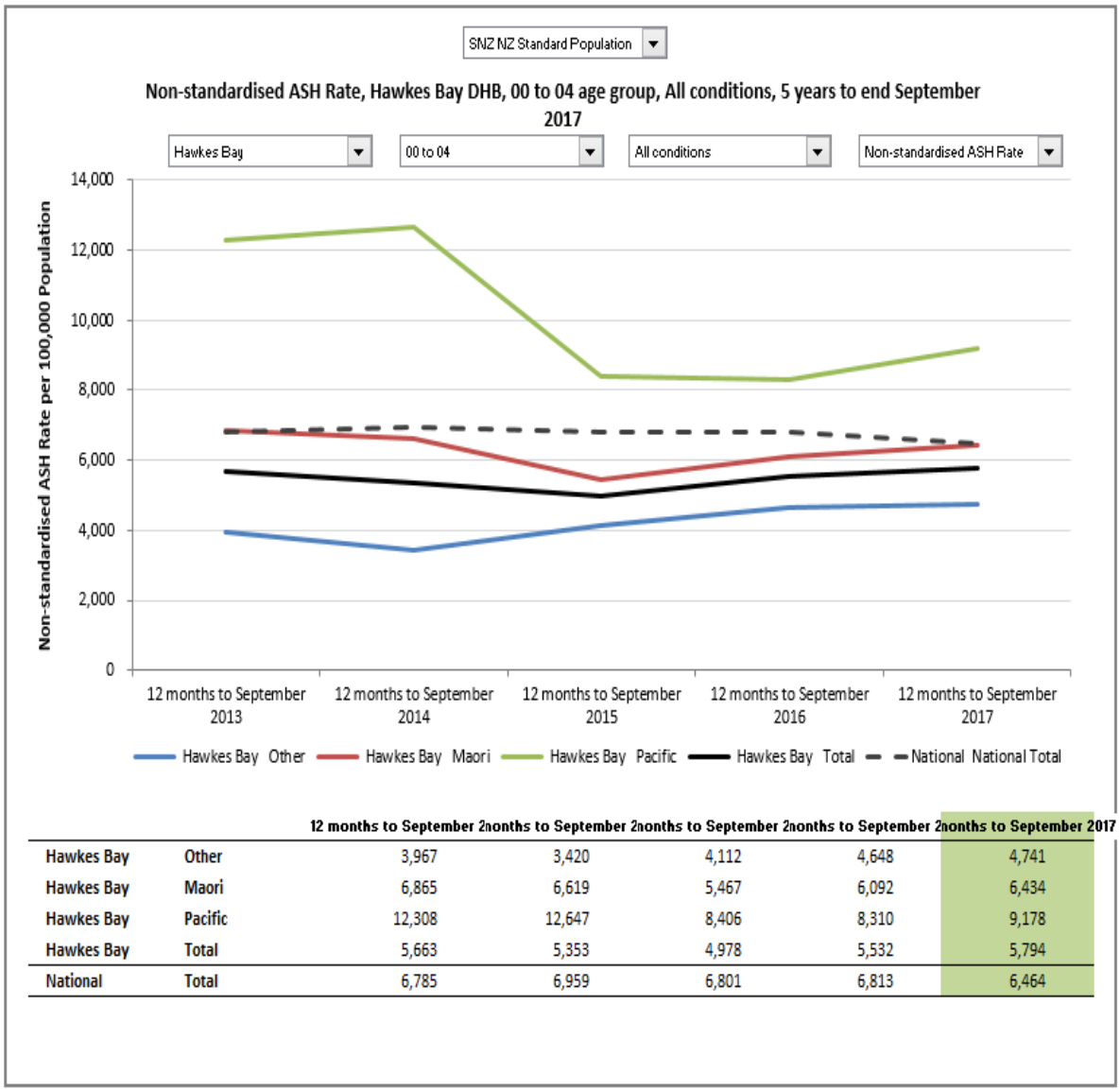
[1] MoH-System Integration SI1: Ambulatory sensitive hospitalisations.
[2] MoH-System Integration SI1: Ambulatory sensitive hospitalisations.

- Increase the number of Māori and Pasifika and Quintile 5 referred into the high needs enrolment program (PHO)
- Increase the number of referrals into the Coordinated Primary Options (CPO) program – Hospital Discharge pathway for Māori – Pasifika and Q4 and Q5.

HAWKE'S BAY DISTRIBUTION AND TRENDS

0-4 YEAR AGE GROUP

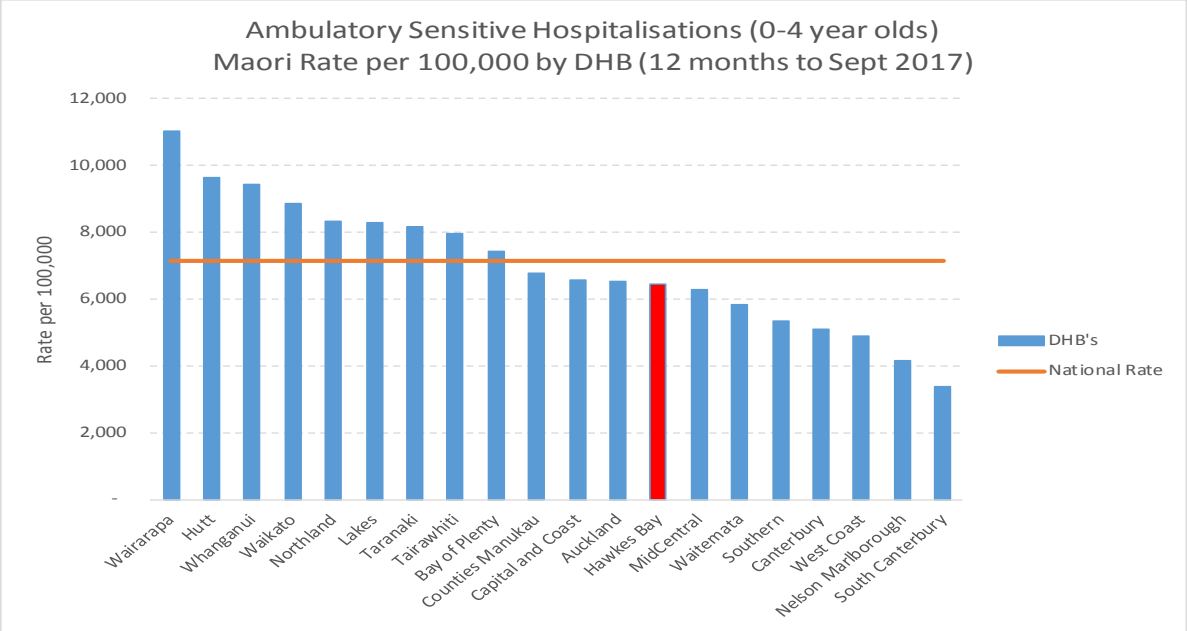
Hawke's Bay ASH rates by ethnicity 0-4 year age group – 12 months to end September 2017



		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	3,967	3,420	4,112	4,648	4,741
Hawkes Bay	Maori	6,865	6,619	5,467	6,092	6,434
Hawkes Bay	Pacific	12,308	12,647	8,406	8,310	9,178
Hawkes Bay	Total	5,663	5,353	4,978	5,532	5,794
National	Total	6,785	6,959	6,801	6,813	6,464

As at September 2017 Hawke's Bay tāmariki have lower rates of ASH compared to national rates with the total ASH Rate for HB at 5,794 compared to the national rate of 6,464. Although this is positive HB has seen its overall ASH rate increase in the latest 12 month period by 4.7% decreasing the gap between HB and the National rate by 47.7%

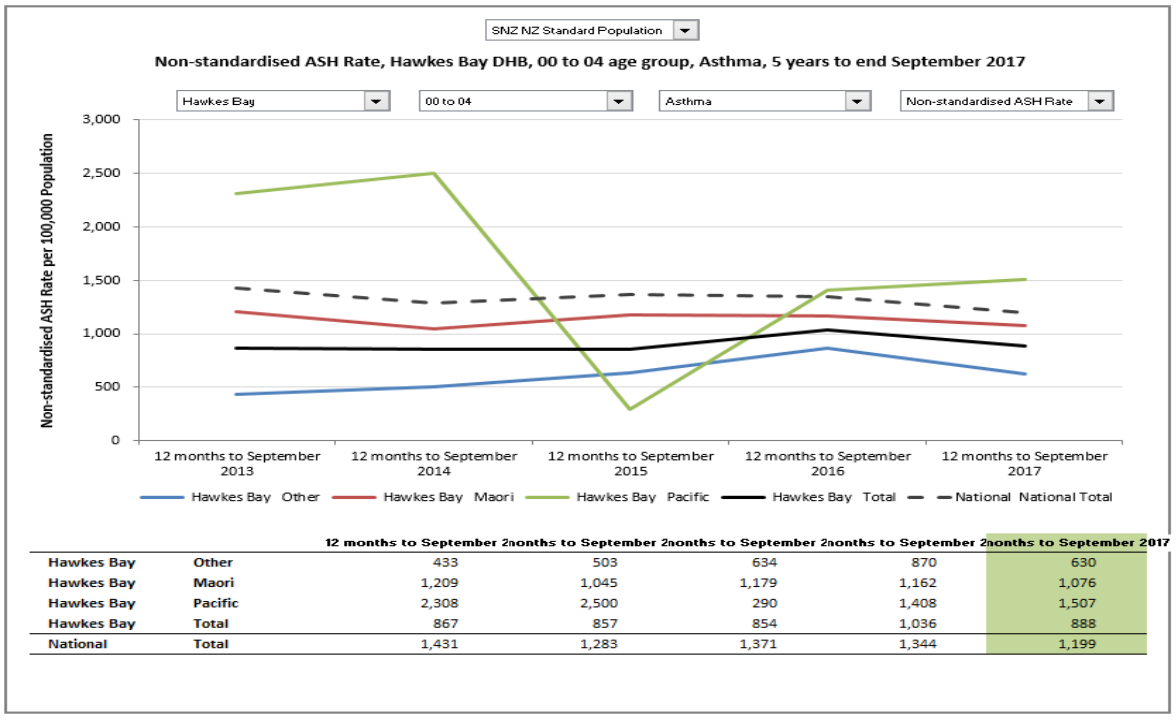
Hawke's Bay Māori ASH rates 0-4 age group 12 months to Sept 2017 – Benchmark against DHBs



In the 12 months to September 2017 the Hawke's Bay Māori rate was 99.9% of the national rate and 8th best performer of all DHB's with Māori rates, in the prior 12 month period we were the 6th best Māori performer in this age group.

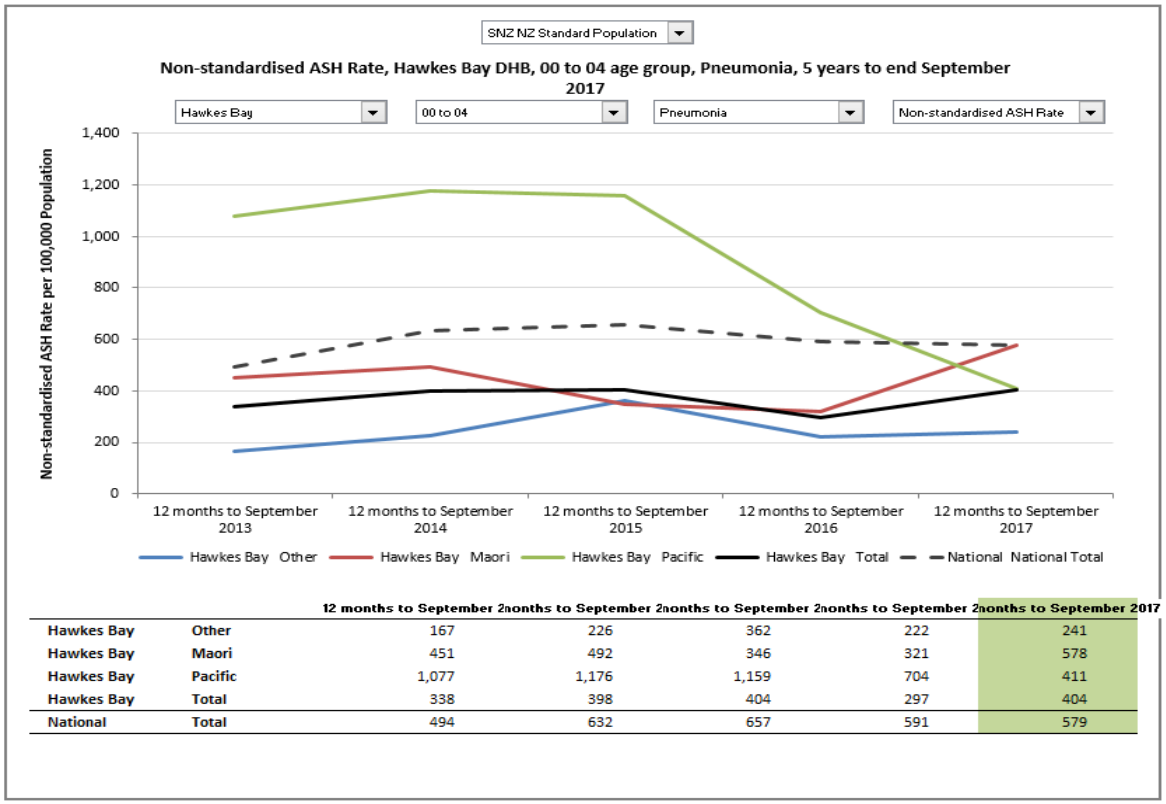
In 2017 one of the largest differences between Hawke's Bay Māori rates and national rates in the 0-4 year age group is Cellulitus, which is 29% above the nation rate.

Asthma



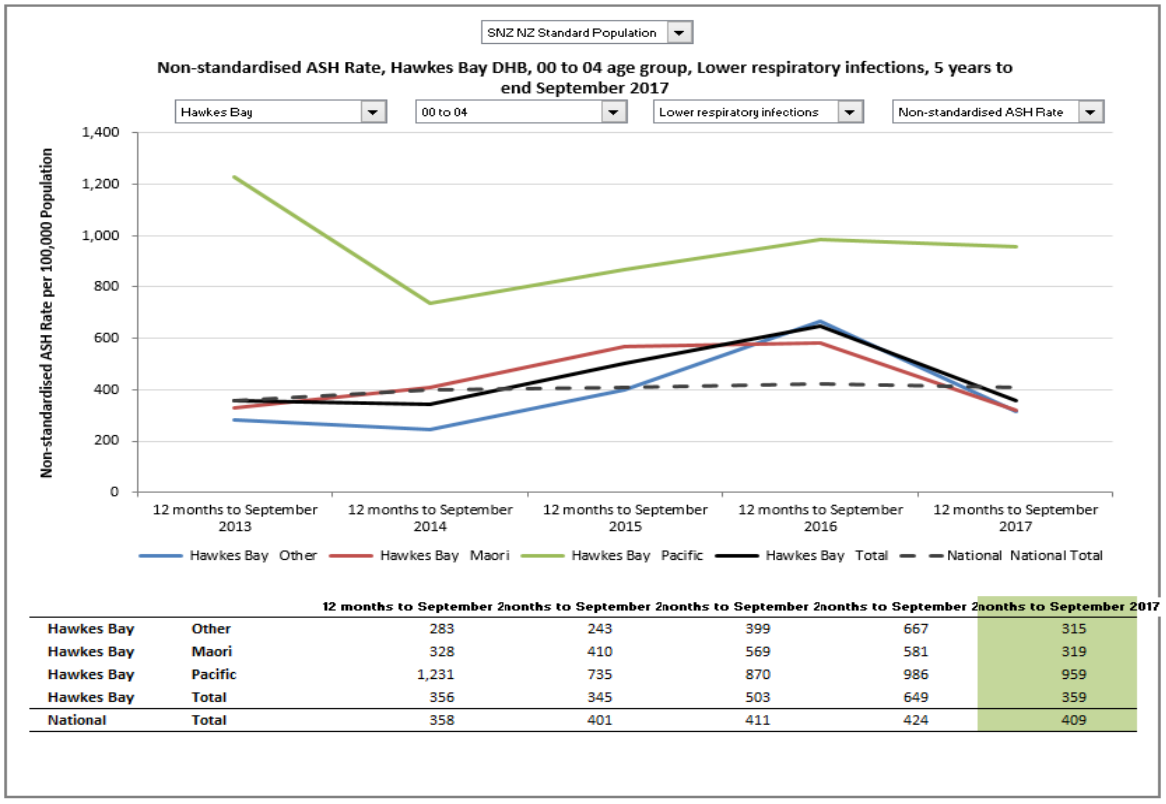
		12 months to September 2	nths to September 2	nths to September 2	nths to September 2	nths to September 2017
Hawkes Bay	Other	433	503	634	870	630
Hawkes Bay	Maori	1,209	1,045	1,179	1,162	1,076
Hawkes Bay	Pacific	2,308	2,500	290	1,408	1,507
Hawkes Bay	Total	867	857	854	1,036	888
National	Total	1,431	1,283	1,371	1,344	1,199

Pneumonia



		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	167	226	362	222	241
Hawkes Bay	Maori	451	492	346	321	578
Hawkes Bay	Pacific	1,077	1,176	1,159	704	411
Hawkes Bay	Total	338	398	404	297	404
National	Total	494	632	657	591	579

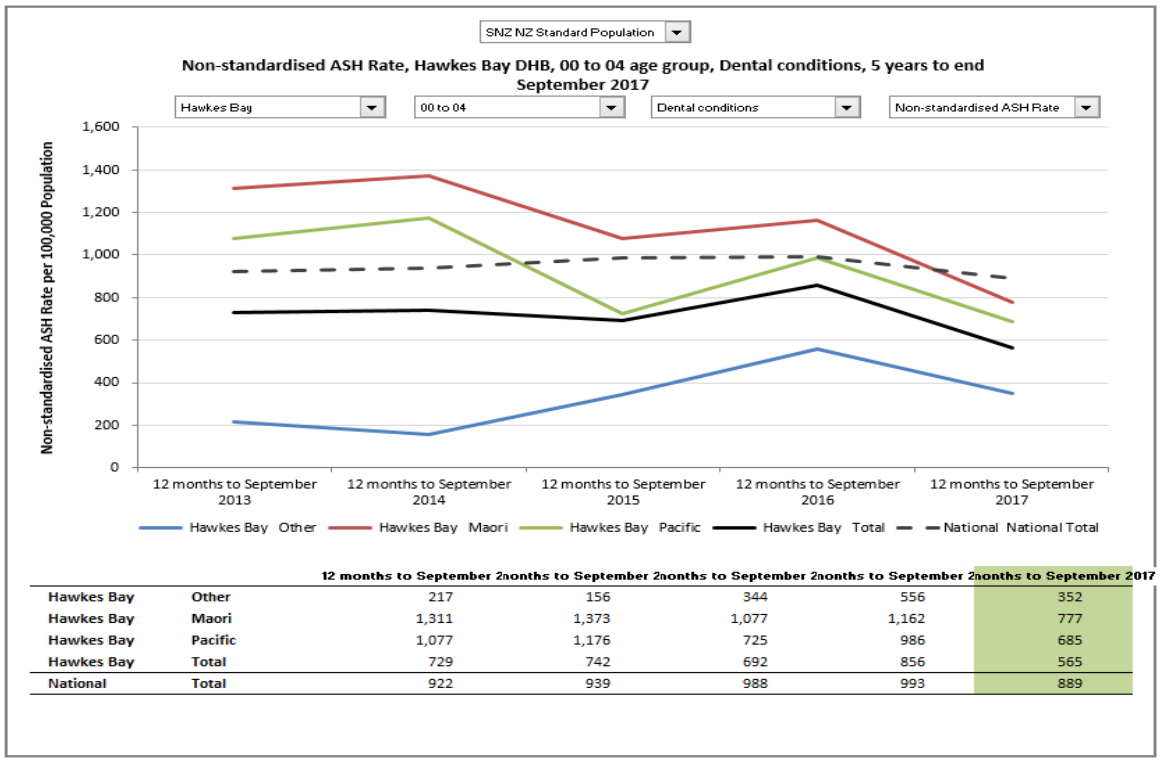
Lower Respiratory Infections



		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	283	243	399	667	315
Hawkes Bay	Maori	328	410	569	581	319
Hawkes Bay	Pacific	1,231	735	870	986	959
Hawkes Bay	Total	356	345	503	649	359
National	Total	358	401	411	424	409

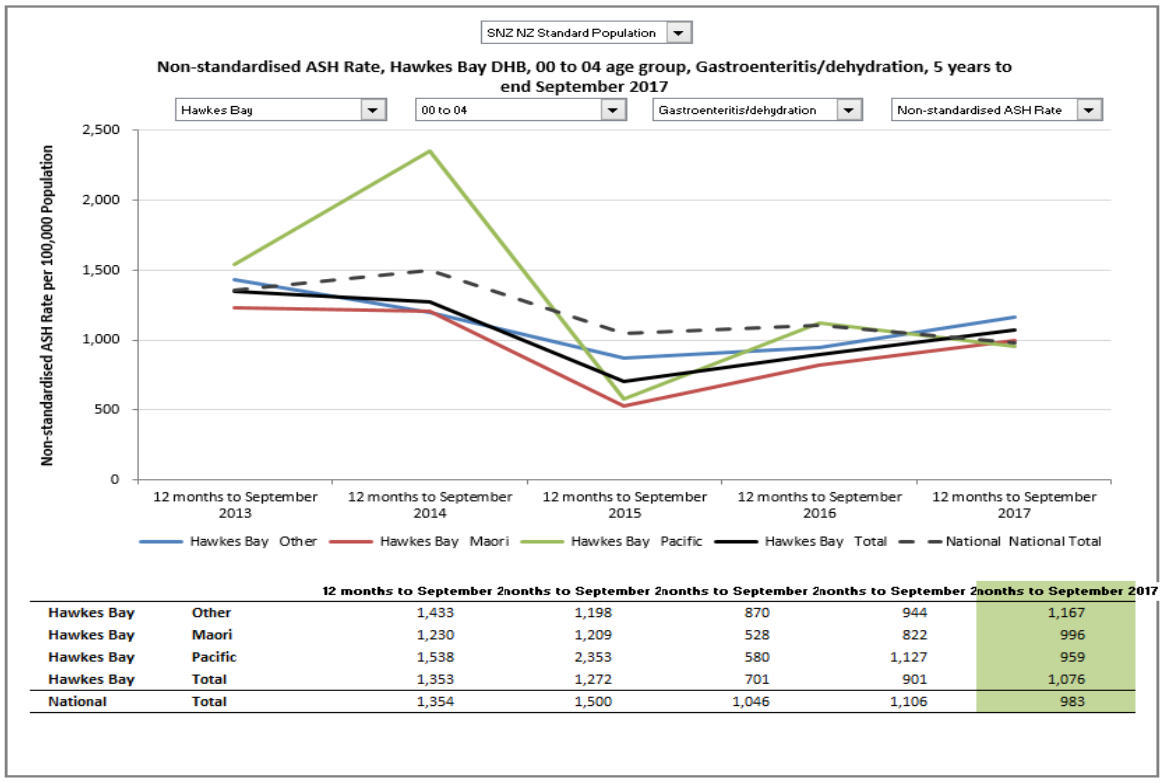
21

Dental



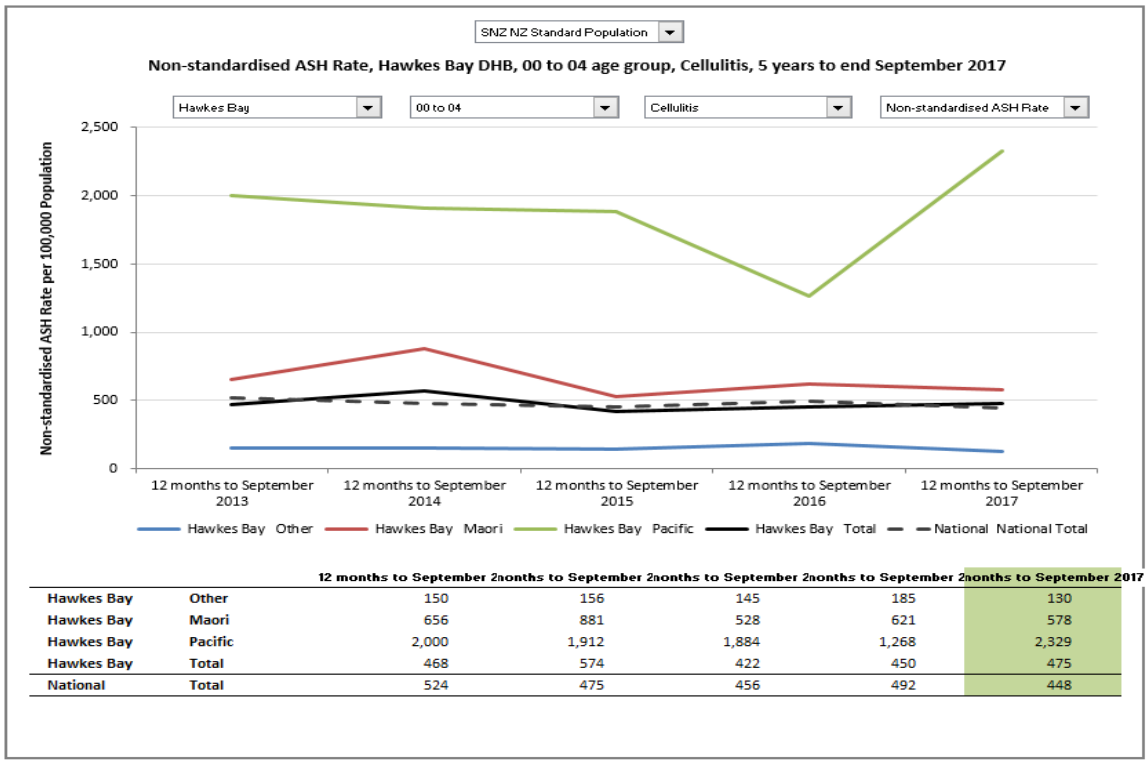
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	217	156	344	556	352
Hawkes Bay	Maori	1,311	1,373	1,077	1,162	777
Hawkes Bay	Pacific	1,077	1,176	725	986	685
Hawkes Bay	Total	729	742	692	856	565
National	Total	922	939	988	993	889

Gastroenteritis/Dehydration



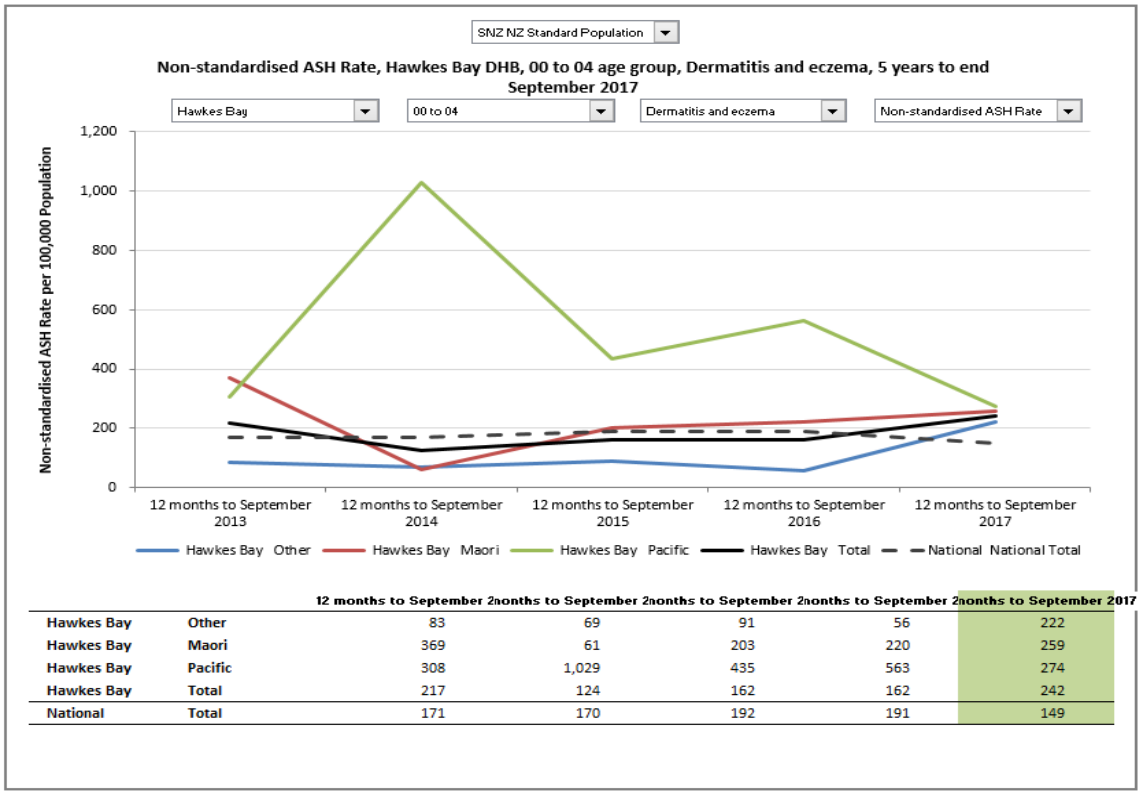
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	1,433	1,198	870	944	1,167
Hawkes Bay	Maori	1,230	1,209	528	822	996
Hawkes Bay	Pacific	1,538	2,353	580	1,127	959
Hawkes Bay	Total	1,353	1,272	701	901	1,076
National	Total	1,354	1,500	1,046	1,106	983

Cellulitis



		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	150	156	145	185	130
Hawkes Bay	Maori	656	881	528	621	578
Hawkes Bay	Pacific	2,000	1,912	1,884	1,268	2,329
Hawkes Bay	Total	468	574	422	450	475
National	Total	524	475	456	492	448

Dermatitis and Eczema



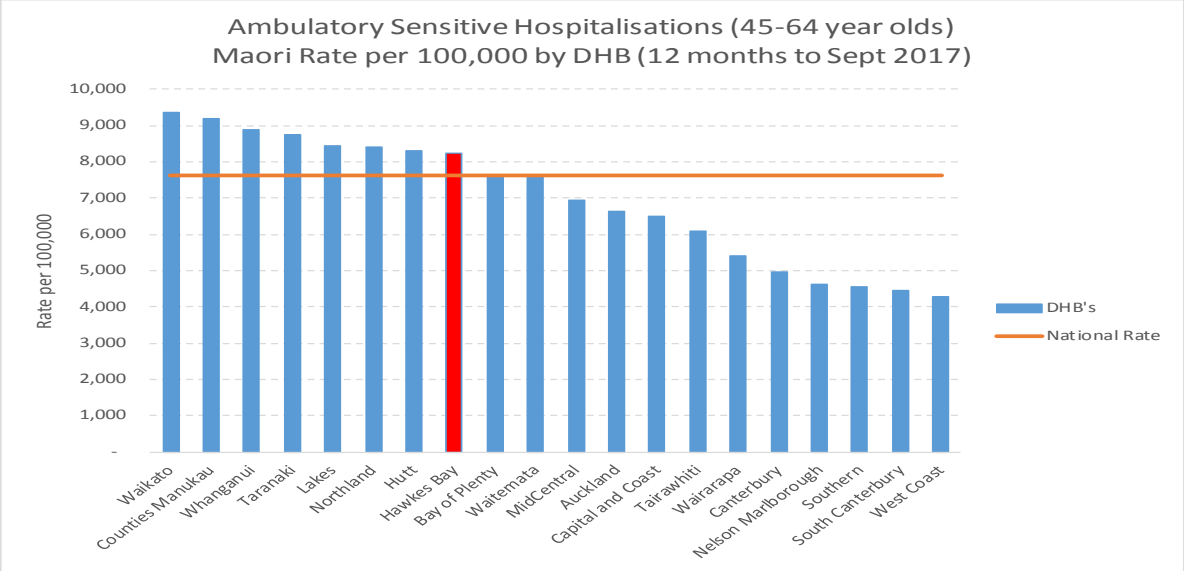
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	83	69	91	56	222
Hawkes Bay	Maori	369	61	203	220	259
Hawkes Bay	Pacific	308	1,029	435	563	274
Hawkes Bay	Total	217	124	162	162	242
National	Total	171	170	192	191	149

ASH RATES 45-64 AGE GROUP

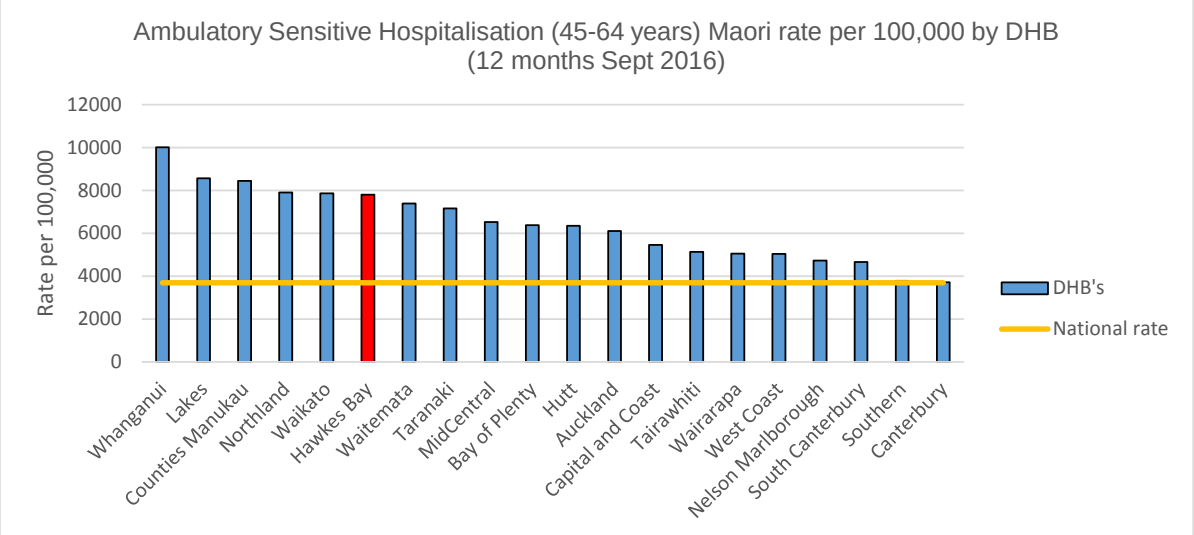
The expectation for ASH 45-64 is that there will be a minimum reduction by half of the equity gap between Māori and national total population base line data over a period of 2.5 years. Within 5% would be considered equity.[3]

Hawke's Bay Distribution and Trends

Hawke's Bay Māori ASH rates 45-64 age group 12 months to Sept 2017 – Benchmark against DHBs



Hawke's Bay Māori ASH rates 45-64 age group 12 months to Sept 2016 – Benchmark against DHBs



There are four notable points illustrated by these two graphs.

1. The National ASH rate has increased from just under 4000 in the 12 months to Sept 2016 to just under 8000 in the 12months to Sept 2017. This is statistically significant.

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

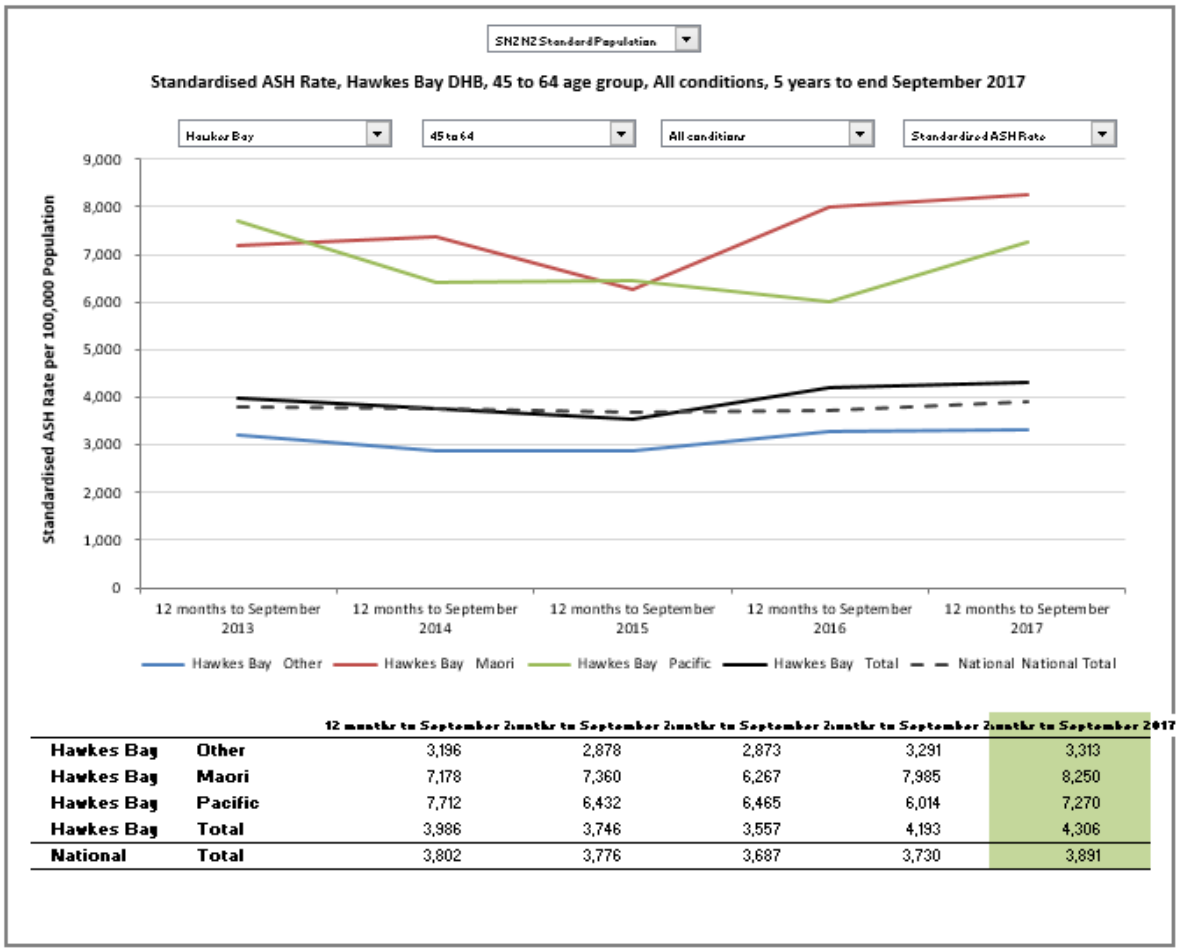
2. HBDHB rates have remained relatively static in the 24 months to Sept 17, at close to 8000.

3. The position of HBDHB has moved from 15thth to 13th position in the national benchmark.

4. All of the above demonstrate that the actions we have taken in the last 24 months have had little impact on our ASH rates. What is also of significance is that the increase in national rates demonstrate that this not peculiar to HB.

The following paragraphs detail what contributes to the ASH rate and findings for each of the top 10 conditions named as follows in order of highest contributor to lowest contributor; angina and chest pain, myocardial infarction, cellulitis, COPD, pneumonia, gastroenteritis-dehydration, kidney-urinary infection, congestive heart failure, stroke, epilepsy.

Hawke's Bay Māori ASH rates 45-64 age group 12 months to Sept 2017 – All conditions (5 Years)



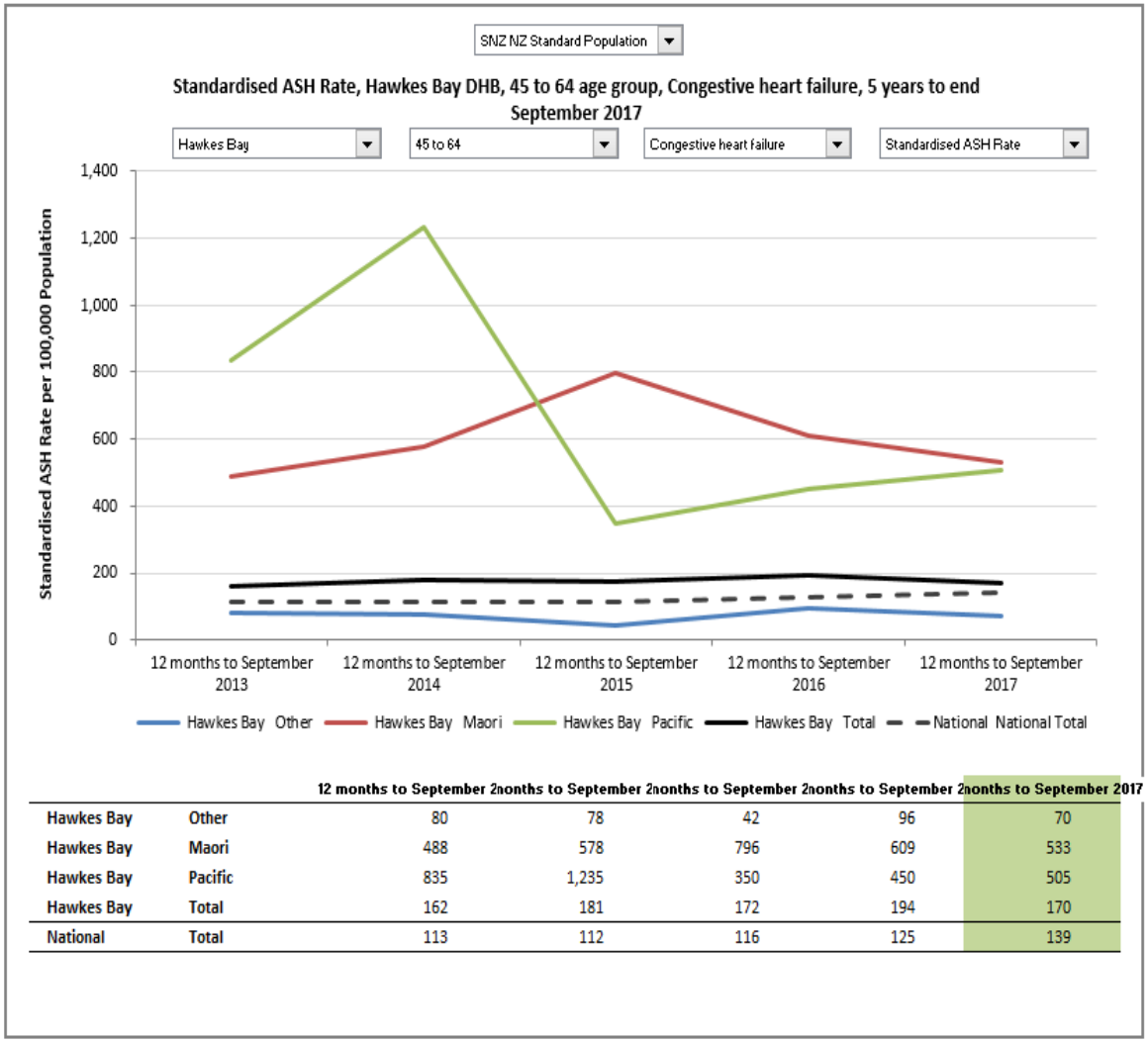
		12 months to September	2 months to September	2 months to September	2 months to September	2 months to September 2017
Hawkes Bay	**Other**	3,196	2,878	2,873	3,291	3,313
Hawkes Bay	**Maori**	7,178	7,360	6,267	7,985	8,250
Hawkes Bay	**Pacific**	7,712	6,432	6,465	6,014	7,270
Hawkes Bay	**Total**	3,986	3,746	3,557	4,193	4,306
National	**Total**	3,802	3,776	3,687	3,730	3,891

In all Top 10 conditions Māori are at least double the rate of other. In some instances e.g. COPD and Congestive Heart Failure, Māori rates are respectively 5 -7 times those of other. This is significant when Māori constitute only 22% of the population of HB. The gap in equity between Māori and Other in HB for ASH rates has increased from 4,694 per 100,000 to 4,937 per 100,000, an increase of 5.1%

Hawke's Bay DHB 45-64 ASH Rates 12 months to Sept 2017

ASH 45-64 Conditions – Contributing to Top 10 Conditions

Congestive Heart Failure



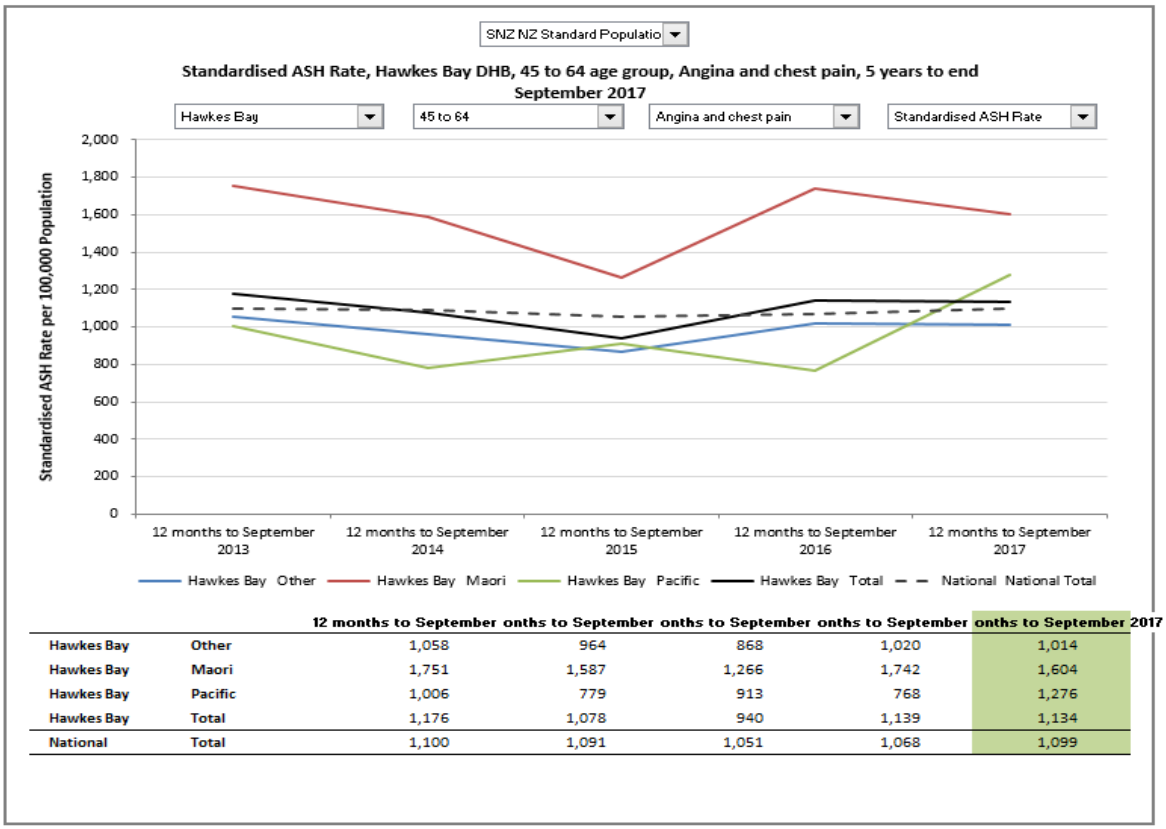
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	80	78	42	96	70
Hawkes Bay	Maori	488	578	796	609	533
Hawkes Bay	Pacific	835	1,235	350	450	505
Hawkes Bay	Total	162	181	172	194	170
National	Total	113	112	116	125	139

In the previous report CHF was ranked 5th out of all conditions contributing to ASH rates for this age group. It is now 8th in the top 10.

Table 1.0 – ASH events 45-64 Congestive Heart Failure

		12 months to September	onths to September	onths to September	onths to September	onths to September 2017
Hawkes Bay	Other	29	28	15	36	26
Hawkes Bay	Maori	35	42	59	48	43
Hawkes Bay	Pacific	7	10	3	4	6
Hawkes Bay	Total	71	80	77	88	75
National	Total	-	-	-	-	-

Angina and Chest Pain



		12 months to September	onths to September	onths to September	onths to September	onths to September 2017
Hawkes Bay	Other	1,058	964	868	1,020	1,014
Hawkes Bay	Maori	1,751	1,587	1,266	1,742	1,604
Hawkes Bay	Pacific	1,006	779	913	768	1,276
Hawkes Bay	Total	1,176	1,078	940	1,139	1,134
National	Total	1,100	1,091	1,051	1,068	1,099

The overall rate for Māori is showing a decline in the 12 month period reported.

21

Table 1.1 – ASH events 45-64 Angina and Chest Pain

		12 months to September	onths to September	onths to September	onths to September	onths to September 2017
Hawkes Bay	Other	366	335	299	355	351
Hawkes Bay	Maori	129	122	98	136	130
Hawkes Bay	Pacific	9	7	9	9	15
Hawkes Bay	Total	504	464	406	500	496
National	Total	-	-	-	-	-

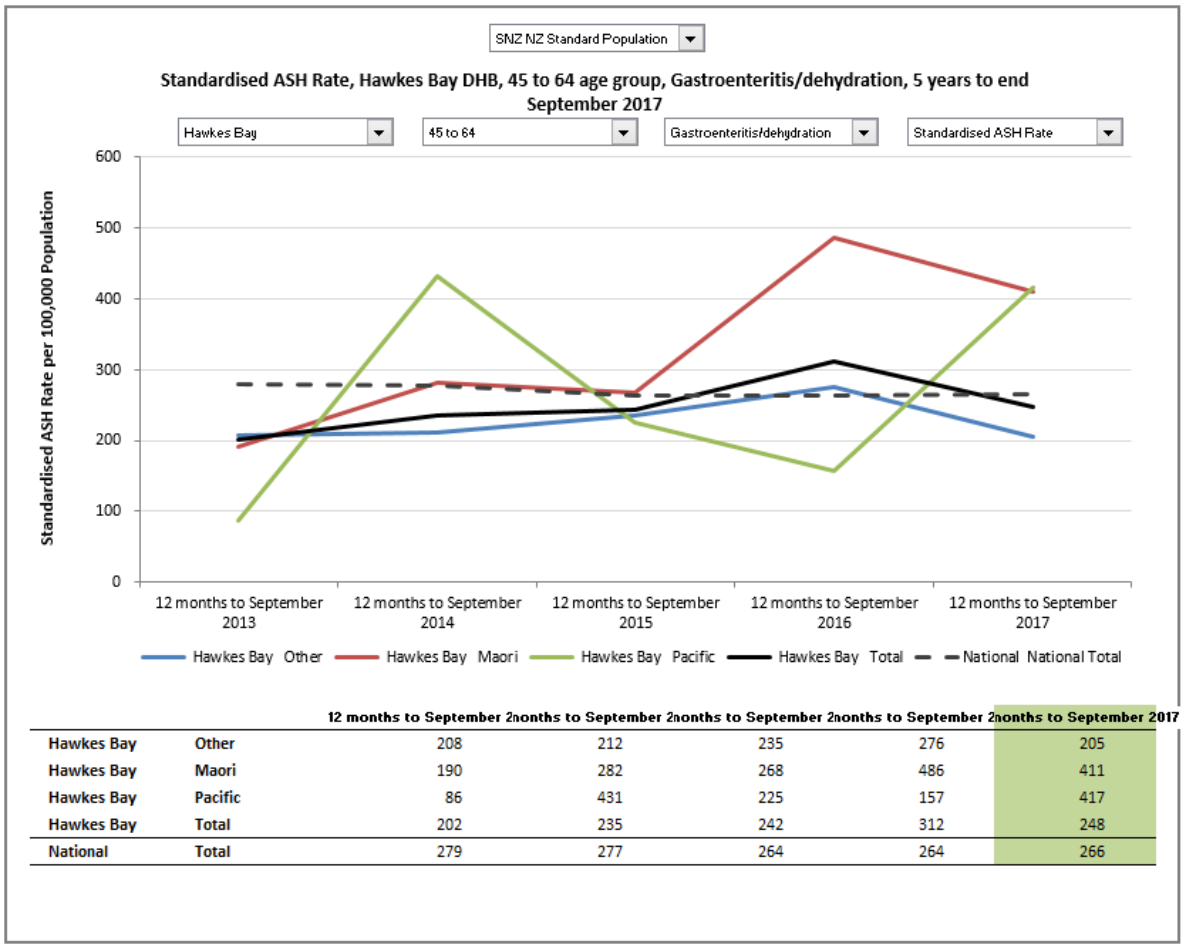
Rheumatic Fever and heart disease

The rate of Rheumatic fever and heart disease is for Māori has also shown a significant drop in the 12 months from Sept 16 to Sept 17 as depicted in table 1.2 below

Table 1.2 – ASH rates 45-64 - Rheumatic Fever

		12 months to September	onths to September	onths to September	onths to September	onths to September 2017
Hawkes Bay	Other	6	3	6	6	
Hawkes Bay	Maori	13	38	37	61	37
Hawkes Bay	Pacific					
Hawkes Bay	Total	7	10	12	17	7
National	Total	7	7	8	7	9

Gastro enteritis/Dehydration



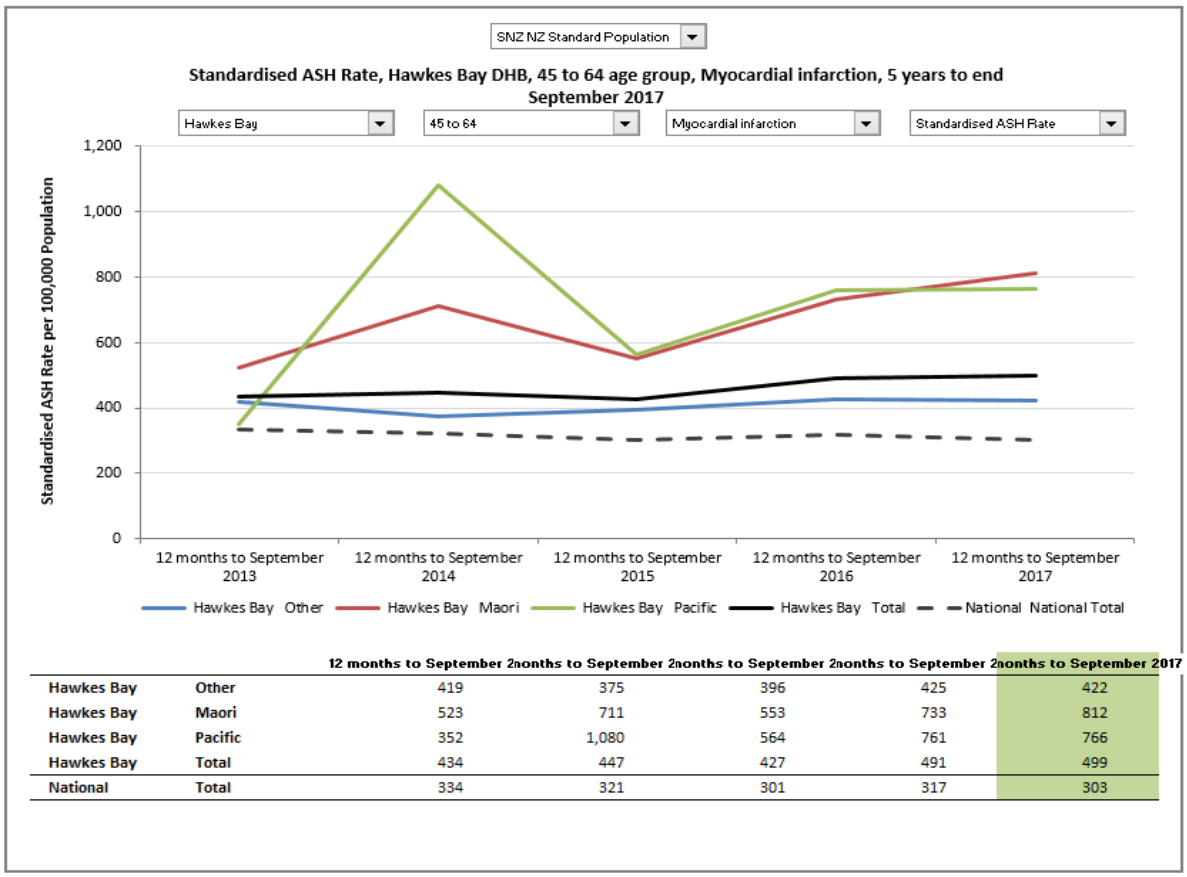
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	208	212	235	276	205
Hawkes Bay	Maori	190	282	268	486	411
Hawkes Bay	Pacific	86	431	225	157	417
Hawkes Bay	Total	202	235	242	312	248
National	Total	279	277	264	264	266

The overall rate has remained reasonably static over time. The rate for Māori is decreasing and the rate for Pasifika showing sharp increase. The pasifika spike can be attributed to the relatively small numbers. The actual events contributing to this statistic - see table 1.0 below.

Table 1.3 – ASH Events 45-64 Gastroentritis/Dehydration

		12 months to September 2	onths to September 2	onths to September 2	onths to September 2	onths to September 2017
Hawkes Bay	Other	72	73	83	96	75
Hawkes Bay	Maori	14	22	21	38	33
Hawkes Bay	Pacific	1	5	2	2	5
Hawkes Bay	Total	87	100	106	136	113
National	Total	-	-	-	-	-

Myocardial Infarction



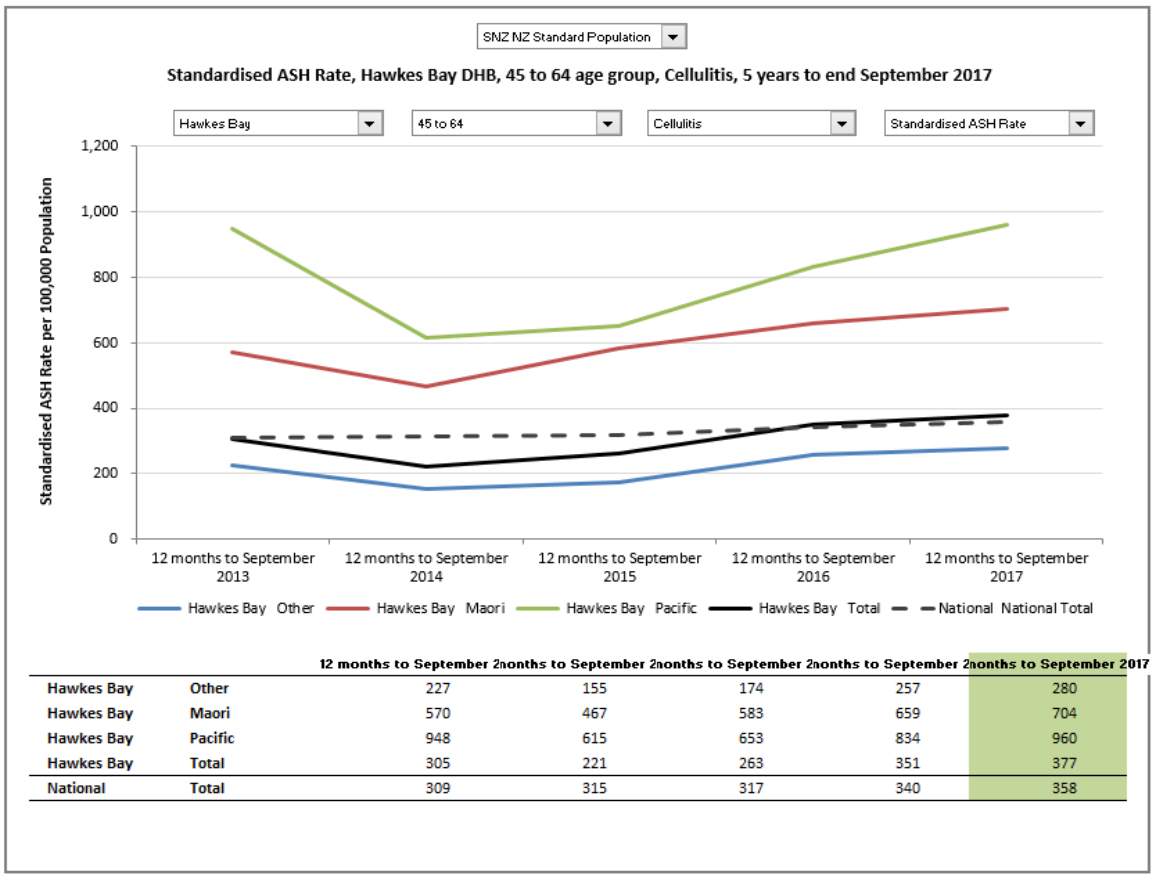
		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	419	375	396	425	422
Hawkes Bay	Maori	523	711	553	733	812
Hawkes Bay	Pacific	352	1,080	564	761	766
Hawkes Bay	Total	434	447	427	491	499
National	Total	334	321	301	317	303

The rate for Māori is twice that of Other. The rate for Māori per 100,000 is currently 812 compared with 422 for Other. The equity gap has increased by 26.6%.

Table 1.4 – ASH events 45-64 Myocardial Infarction

		12 months to September	nonths to September	nonths to September	nonths to September	nonths to September 2017
Hawkes Bay	Other	150	133	141	156	151
Hawkes Bay	Maori	37	53	42	57	65
Hawkes Bay	Pacific	3	10	5	8	8
Hawkes Bay	Total	190	196	188	221	224
National	Total	-	-	-	-	-

Cellulitis



		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	227	155	174	257	280
Hawkes Bay	Maori	570	467	583	659	704
Hawkes Bay	Pacific	948	615	653	834	960
Hawkes Bay	Total	305	221	263	351	377
National	Total	309	315	317	340	358

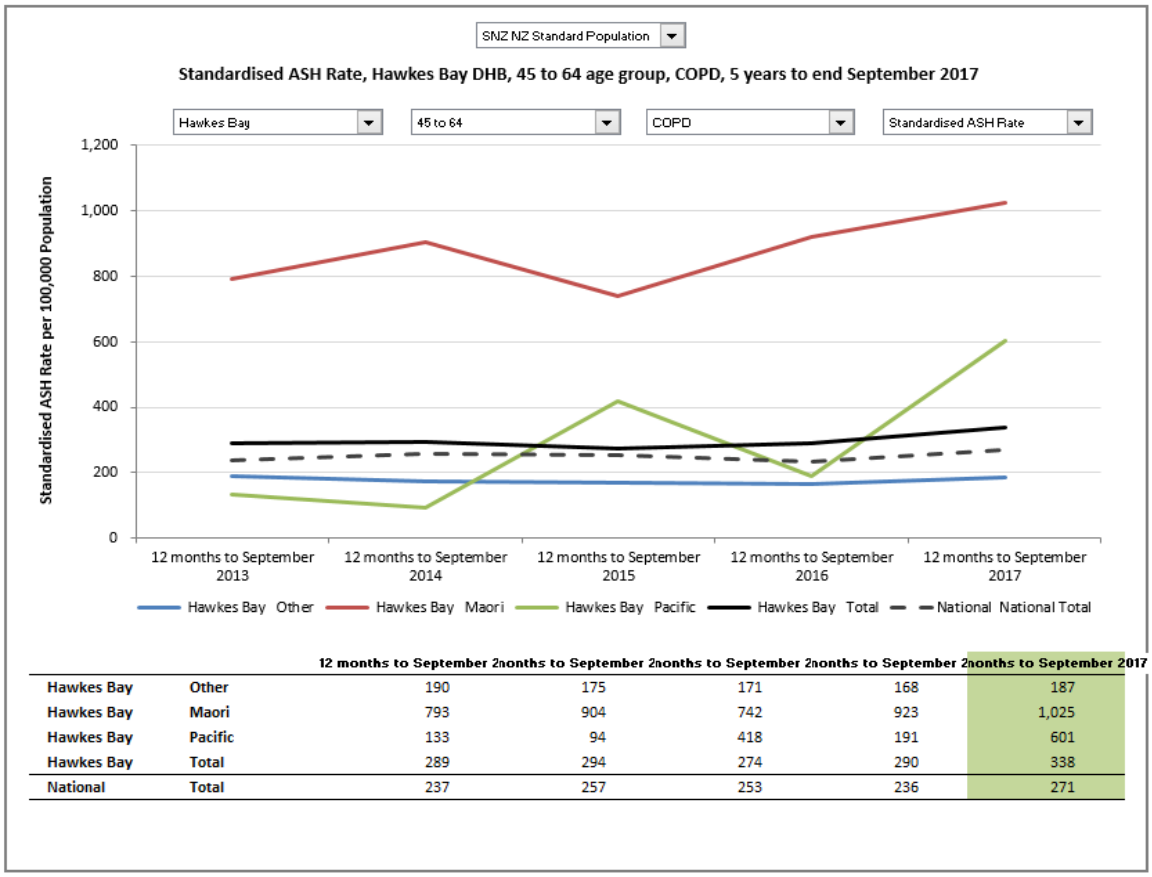
Rate for Māori have increased over the 5 year period. The utilisation rates for the cellulits pathway are showing declines and this is being addressed (see details below pg 18-19). Admissions for rural population occurs where in urban areas patients can be managed from home through the CPO program. The distance that rural patients often need to travel for follow up treatment on consecutive days, can mean that they are admitted.

There was a total of 166 admissions for the 12 month period ending September 2017 which was an increase of 10% over the previous 12 month period.

Table 1. 5 – ASH events 45-64 Cellulitis

		12 months to September 2	onths to September 2	onths to September 2	onths to September 2	onths to September 2017
Hawkes Bay	Other	77	52	61	89	98
Hawkes Bay	Maori	43	36	45	53	57
Hawkes Bay	Pacific	9	6	8	9	11
Hawkes Bay	Total	129	94	114	151	166
National	Total	-	-	-	-	-

COPD



		12 months to September 2	nonths to September 2	nonths to September 2	nonths to September 2	nonths to September 2017
Hawkes Bay	Other	190	175	171	168	187
Hawkes Bay	Maori	793	904	742	923	1,025
Hawkes Bay	Pacific	133	94	418	191	601
Hawkes Bay	Total	289	294	274	290	338
National	Total	237	257	253	236	271

Table 1.6 – ASH events 45-64 COPD

		12 months to September 2	onths to September 2	onths to September 2	onths to September 2	onths to September 2017
Hawkes Bay	Other	68	63	62	60	66
Hawkes Bay	Maori	57	66	56	69	81
Hawkes Bay	Pacific	1	1	4	2	6
Hawkes Bay	Total	126	130	122	131	153
National	Total	-	-	-	-	-

REVIEW OF CURRENT AND PLANNED ACTIVITY RELEVANT TO SUPPORT THESE INDICATORS

0-4 YEAR OLDS

Respiratory care pathways for tamariki 0 – 4 years

In 2017, a review of the ASH 0 – 4 years respiratory care pathway was undertaken to understand more about the interactions and experiences of tamariki and their whānau prior to and after they presented to ED for a respiratory related illness. The review involved a case file audit, an analysis of ASH respiratory data, a review of care pathways and referral processes, and stakeholder and whānau interviews. Three main findings of the review are:

- There is currently no clear respiratory care pathway for tamariki 0 – 4 years.
- There are no specific respiratory care programmes for children currently being delivered in the community
- The majority of tamariki and their whānau received no follow-up in the community post presentation to ED and admission to hospital.

The respiratory working group is undertaking a number of activities to progress actions to address system and service barriers to access to respiratory care for whānau. A child respiratory care pathway, with appropriate processes is being developed for primary and secondary care services. The pathway will better support information flow between services, follow up care in the community by Respiratory Nurse Champions. Paediatric respiratory training for RNCs and wider sector stakeholders took place in December. Future training is planned in 2018, and will include, the findings of the ASH respiratory review, equitable respiratory health outcomes, and health literacy considerations for both practitioners and whānau.

The Working Group is also exploring ways to improve service responsiveness to Pacific and whānau Māori, with a view to undertake a future budget bid process. Breathe HB, who are currently contracted to provide adult respiratory support across Hawkes Bay have been invited to submit a plan about how services can reach tamariki Māori and Pacific at risk of, or with, a chronic respiratory illness. The Working Group will consider this plan on 13 February 2018. Small improvements in processes is already reporting positive results. Changes to the way patient information is managed in secondary care has led to a considerable increase in the number of referrals to the Child Healthy Housing Programme. The Working Group will continue to progress actions from the review over 2018.

Increased immunisation Health Target

The 95% target for all 8-month-old infants is proving an ongoing challenge. Families/whānau seeking information and advice via online sources is delaying parent/caregiver decision making. Some families/whanau will go on to immunise their pēpi/child, but this is occurring outside the ideal timeframes. Despite this dilemma, the most recent quarterly report (October – December 2017) shows equitable coverage for Māori. There is an ongoing focus to ensure a targeted outreach service, provision of alternative venues, and opportunistic immunisations in secondary services. An example of these efforts is a short-term agreement with Kahungunu Executive to intensify immunisation support in rural remote areas. This service will help facilitate timely access to immunisation services through improved follow up of children referred to outreach. To do this a 0.2 FTE support worker will work with primary care practitioners, primary health care workers, family/whānau, and liaise with the outreach team.

Oral Health Initiative

The 'Oral health equity for tamariki 0 – 4 years' project is well underway. This is a five year project from 2016 – 2020. Over the last year, main activities have involved establishing the project, building relationships with key internal and external stakeholders, and identifying priority areas of focus. Good progress has been made in a number of areas including:

- The appointment of a Kaiawhina position within the Community Oral Health Service (COHS). Progress in the first six months shows that as a result of this new position 280 tamariki have been re-engaged with the COHS.
- COHS staff have participated in Relationship Centred Practice training.

- Well Child Tamariki Ora providers have been contracted to provide greater emphasis on oral health at Core Health checks. Funded by Māori Health, this service aims to provide whānau with appropriate oral health information and resources, and where appropriate, facilitate access to COHS appointments.
- A closer collaboration with the Early Childhood Education/Te Kohanga Reo sectors to provide staff and whānau with better oral health information and support
- The initiation of the 'water-for-kids' project which will see the Paediatric ward implementing a fizzy free environment for children in hospital from 1 March 2018.
- The establishment of Te Roopu Matua who provide valuable advice to the project group on Māori oral health perspectives and experiences, and appropriate ways to engage whānau Māori to better meet their oral health needs.
- Working with Health Hawkes Bay to increase the focus on oral health in the Whanau Wellness Programme.
- The completion of a review of the ASH dental care pathway for tamariki 0 – 4 years. The review examines the interactions and experiences of whānau prior to and after their tamaiti/child's GA dental procedure. The final report with recommendations is currently being finalised. Early findings are indicating quality improvements in early engagement, improved wait-times for children, better follow up care and support in the community, and appropriate and responsive information and support for tamariki Māori, Pacific, and children living in deprived areas.

Child Healthy Homes Programme

During 2017, there was a significant increase in referrals to the Child Healthy Housing programme (CCHP), with the greatest percentage of these referrals for whānau Māori and Pacific. The increase in referrals can be attributed to two main factors 1) the expanded criteria relating to Rheumatic Fever prevention and vulnerable children aged 0 – 5 years, which now includes pre-schoolers hospitalised for an indicator condition, at risk pregnant women/new mothers, and priority families with pre-schoolers (who have specified risk factors), and 2) the ASH Respiratory review (August, 2017) which has led to improvements to secondary care processes in discharge plans. As a result, there is better referral information flow from secondary care services to the CHHP, so whānau can be appropriately triaged and contacted to assess eligibility.

To date, a total of 811 referrals have been received since the inception of the CHHP. Whānau have received a total of 3025 interventions to promote warm dry homes and reduce transmissible diseases. These interventions have included, but not limited to, curtains (279 homes), beds (333), WINZ FACE (full and correct entitlement assessments), 160 homes insulted, and 59 families/whānau supported to relocate to warmer, dryer social or private housing. In addition, all families/whānau receive 'key tip' messages regarding sustaining a warm dry home.

Skin Programme

The HBDHB Skin Programme aims to raise awareness of skin problems, provide appropriate resources to families/whānau to care for skin, prevent skin infections and infestations, facilitate access to early treatment, enhance help-seeking behaviour, and reduce stigma and discrimination for tamariki with skin problems. A 2014 audit showed high rates of skin problems among tamariki Māori, and children living in high deprivation areas. Skin infections include, cellulitis, scabies, impetigo, infected dermatitis, and boils. HBDHB has responded with a number of activities to provide better support to tamariki and their whānau. Key activities include:

- Skin Standing Orders for Public Health Nurses and School Based Māori health provider nurses have been developed. However, these orders do not include the provision of medication, and while nurses will encourage whānau to seek help from their primary care practitioner, barriers to access to care may prevent whanau from doing so. Expanding these Standing Orders is being explored, but will require resource of time and workforce development.
- The team has been exploring ways to include early childhood education provider information on the first contact form. Currently the form does not capture this information consistently, and it is not coded. Coding this information would enable the team to identify ECEs and target resources and support accordingly.
- Development of appropriate information, and resources for early childhood education centre (ECE) staff and whānau. These resources include flip charts in te reo Māori, and Pacifica.

Relationships with Te Kohanga Reo have been strengthened, with nurses attending purapura hui, and regular ongoing hui.
- Professional training for ECE, Te Kohanga Reo, and Pacific Kohanga kaimahi at a health day in August 2017.

A survey in 2017 of ECE and Te Kohanga Reo found there is a demand among staff and whanau for more appropriate information and resources to be translated. Another area of focus, and reiterated in the 2017 survey, is the need for more face to face visits to staff and whānau. HBDHB does fund multiple visits during the year to Te Kohanga Reo and some ECE based in quintile 5 communities. However, to deliver appropriate education, key messages, and healthy skin promotion and prevention a more comprehensive approach is required. Funding support in both these areas would assist the team to make further health gain in this area.

ACTIVITY TO ADDRESS 45-64 ASH RATES

1. System Level Measures Improvement Plan

Incorporated into the improvement plan and aligned to the SLM-Reducing hospital Bed Days are the following contributory measures and activities and progress towards achieving them;

- *Increase number of Māori Pasifika and Quintile 5 referred to CPO high needs program.*
  The goal currently is to achieve 350 Māori referrals by year end. Currently not on track. As of Q2 only 59 Māori had been referred. CPO steering and management group meeting to discuss how to increase awareness of the program, the criteria for referral and the demonstration of benefits this program produces.

- *Increase number of referrals into the Hospital Discharge initiative.*
  The gaol of this program is 500 Māori referrals by year end. Currently not on track. As of Q2- only 171 Māori had been referred. As above the steering and management group will be meeting to discuss how to increase utilisation of this program.

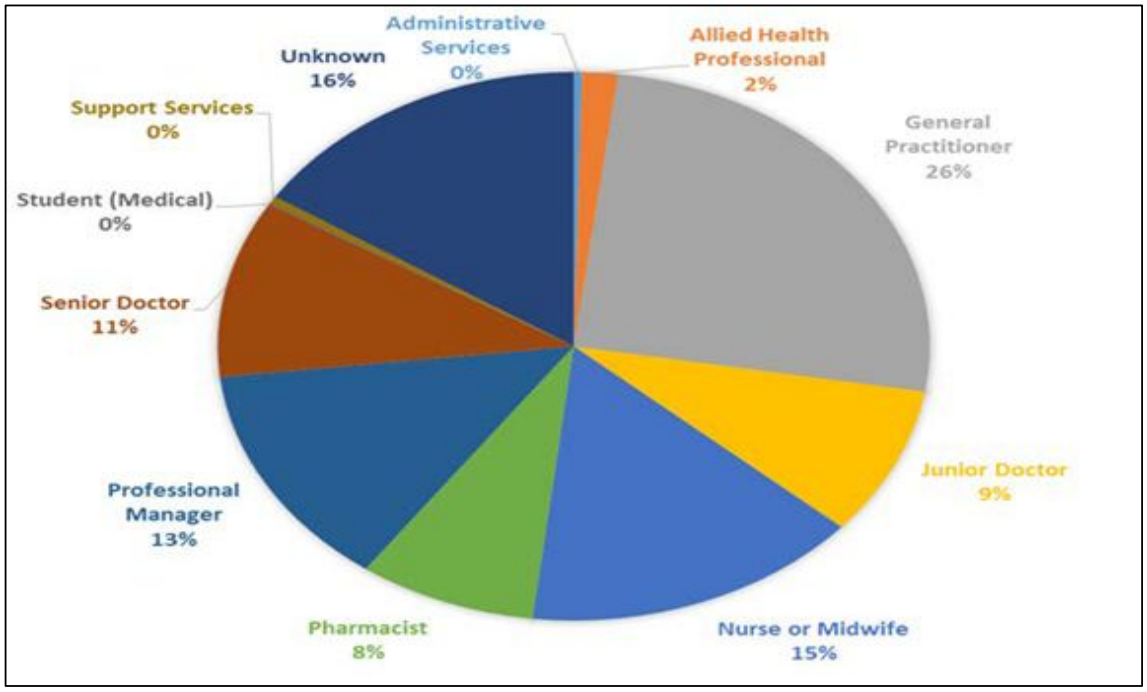
- *Recruit into the position of Nurse Practitioner for Heart Failure with a primary care focus.*
  The appointment process is now completed with preferred candidate being notified. Commencement date TBC. The candidate comes with extensive primary care experience. Recruitment to replace the retiring clinical nurse manager – cardiac has also been completed and again the preferred candidate comes with extensive primary care experience and understanding of integration of services.

- *Develop a program to implement tracer auditing to inform quality improvement (QI) initiatives.*
  The quality advisor team currently offers QI – IHI methodology training across the organisation. A more targeted approach is being implemented in Q3-4 to support the implementation of the Long Term Conditions Framework with a focus on; respiratory / cardiac, renal / diabetes service provision. This will include primary – secondary – pharmacy providers.

2. Collaborative Pathways

The Pathways Program initiated in 2014 as a pilot, with a focus on two interrelated aspects 1) development of pathways and 2) identifying the IT tool best fit for purpose. Pathways have been developed to the extent that we now have 75 pathways being used. The IT tool is under review due to the current vendor exiting the UK market. Work is underway developing a technical options paper with a partnership formed with Central and Midland DHB regions. General Practitioners are the highest users of pathways – see figure 1.0 below

Figure 1.0 – Utilisation of pathways by service provider

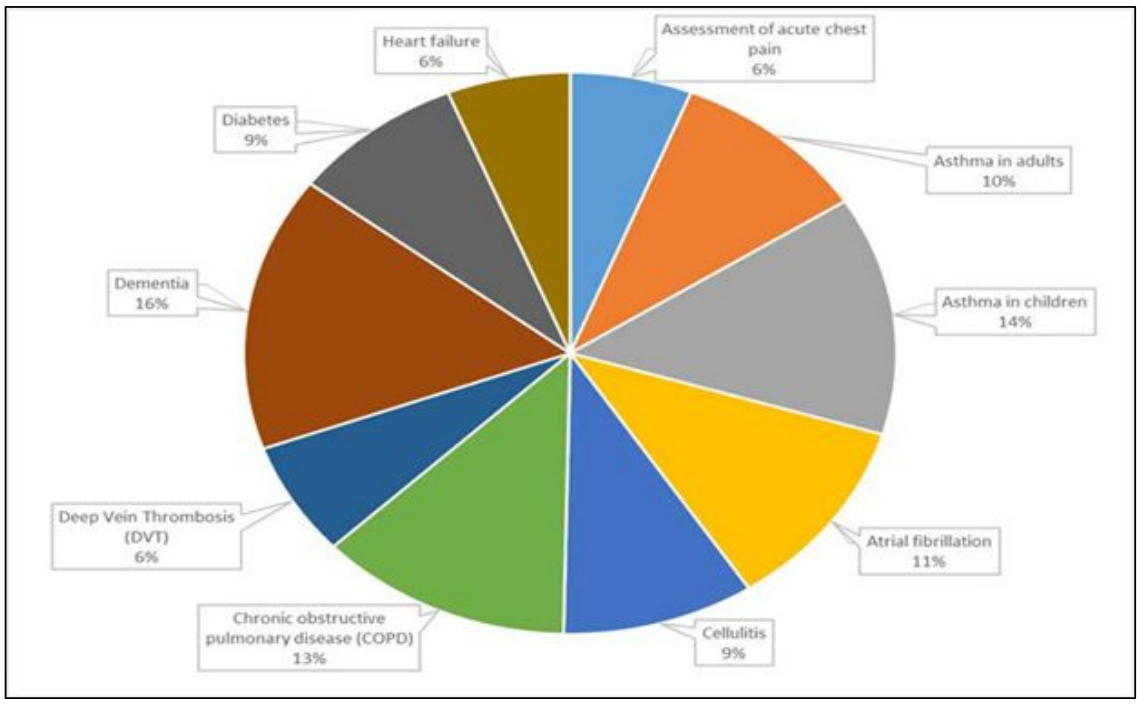


Pathways utilised that address the top 5 contributing conditions to HBDHB ASH rates (Adults)

- Cardiac: Heart Failure (6%), Atrial Fibrillation (11%), Assessment of Chest Pain (6%)
- Respiratory: COPD (11%), Asthma in Adults (10%),
- Cellulitis (9%).

21

Figure 1.2 – Utilisation rates of current pathways



A General Practitioners' point of view (Dr Alan Wright)

Clinical management pathways designed and supported across the whole local health sector are clearly the best way forward to allow timely effective clinical care to be delivered in the best place at the best time. This is what we have been trying to achieve with the Co-ordinated Primary Options (CPO) programme for the last 14 years since its inception. Pathways offers comprehensive understanding of clinical conditions and current "best-practice".

Cardiac Pathways – These pathways are being well used. A program of CME/CNE sessions in 2017 by the Clinical Leads promoted their use and supported follow up within general practice. Visibility of pathways to provider services needs further work outside of ED.

Respiratory Pathways – Partnering with the PHO, Māori and Pacific health teams work is in progress to manage the increases we are seeing in COPD presentations and admissions. (Refer section below – Continuation of the Nurse Led Respiratory Program). Tracer auditing will also form part of this work to map patient journey and experience of care from a quality improvement perspective. This work is being supported by our Quality team.

Cellulitis Pathway – low access to this pathway and increased rates in presentations indicate the need to revisit the pathway as treatment and management changes have been introduced.

Achievements and Challenges: Promotion and socialisation of all pathways is led by a small team who are becoming well known across the health sector. There are now strong links with PHO, Medical Advisors and CMO Primary Care. The team is now proactively approached by clinicians who are seeking pathway development. The challenge now is to provide greater exposure to the use of pathways in multiple provider settings.

3. Continuation of the Nurse Led Respiratory Program

The program contract has now shifted from being outputs to outcomes focused which incurred some time in its development before the contract specifications could be finalised – end of Dec 2017. The contract and program is now ready to progress. In the interim analysis of the data, and meetings with stakeholders and providers has been underway, to determine what is the best targeted approach to address a 24% decrease in the Māori accessing respiratory services.

The team that is involved is cross sector and includes ED, specialist respiratory services and general practice teams using a targeted approach to lists of patients known to general practice and or ED with a respiratory related read code, frequent presentation to ED and or admission. The program team are in the process of identifying target groups and 3 monthly targets performance indicators.

4. Implementation Plan for HBDHB Long Term Conditions Framework

An operational working group has replaced a long term conditions advisory that was formed as it was considered more appropriate to work at this level once the framework was endorsed. The working group is made up of a collective senior group of clinicians (Nursing, Allied Health, PHO and Pharmacist).

The focus of the implementation plan is AKA two of the Long Term Conditions Service Review Matrix - the dimensions of care coordination and transition of care. Areas of focus will be nursing models; Diabetes; 45-65 years COPD patients for Māori; opportunities for improved care coordination for inpatients within secondary services e.g. diabetics-podiatry-vascular; 45-65 years CHF-COPD patients with a focus on Māori, transition of care and discharge processes, and ED high user patient groups.

In addition work is underway with:

- HB Aged Residential Care Educator and linking their educational programmes to dimensions within the LTC Framework and Service Review Matrix

- The PHO Workforce coordinator to include LTC as part of CME/CNE
- Ensuring Clinical Pathway Programme links into System Level Measure activities; and
- Linking with our People and Quality Team to raise the profile of the LTC Framework when educational days on Quality aspects are planned.

RECOMMENDATIONS

	Key Recommendation	Implementation lead	Champion(s)	Time Frame
1.	Clinical pathways become part of business as usual supported by a sustainable funding resource.	Strategic Services Manager Primary Care LTC Portfolio manager	CMO Primary CMO Secondary	Dec 2018
2.	The CPO program be evaluated to inform a strategic approach to the provision of services that; • reflect national guidelines • focus on equity outcomes • use ASH rates as a success indicator and Target the unenrolled population through a range of mechanisms and programs to address unmet need.	Strategic Services Manager Primary Care Innovations and Development Manager - Health Hawke's Bay	GM Health Hawke's Bay GM Māori Health Ex. Dir. Primary Care	Dec 2018
3.	In relation to Cardiac / Respiratory & Renal / Diabetes Service plans include; • workforce development • care coordination • transition of care assessed against the LTC Service Review Matrix[4] to demonstrate progress to towards improved outcomes	Head of Planning Strategic Services Manager Primary Care LTC Portfolio Manager	Directorate Leads Chief Nursing and Midwifery Officer	Dec 2018
4.	Enhance use of CNS / NP in specific LTC, evidenced by the outcomes achieved to date by Diabetes and Respiratory CNS workforce and engagement with primary care	Directorate leads LTC Portfolio Manager	Chief Nursing & Midwifery Officer	On-going
5.	Increase the weighting that is applied to health award applications in relation to equity.	Clinical Council	CEO	July 2018

[4] LTC Service Review Matrix – the evaluation tool designed to assist with implementation of the HBDHB Long Term Conditions Framework

Comments from the Champion for ASH rates – Dr Mark Peterson CMO Primary

The results for the 0-4 age group in the last period have maintained Hawkes Bay as having lower than average rates for other DHBs. While there is still an equity gap for young children it is relatively low and closing.

The ASH rates for respiratory illness (asthma, pneumonia and lower respiratory infection) are all relatively stable and, other than for Pacifica the equity gap is relatively narrow though not closing as we would wish.

For dental admissions there has been a very significant improvement in Māori rates and the gap has closed considerably. This reflects the success of the Oral Health project and the commitment of those working in this field. Further gains are likely to be achieved once water fluoridation is reliably and consistently in place throughout the whole of the region.

The situation with ASH rates for the 45-65 age group is much less encouraging. For the most part ASH rates are not improving and the equity gap is stubbornly wide.

There are some issues with the national date available to us – most particularly I suspect in the benchmarking graphs with other DHBs. It is hard to believe that overall ASH rates have increased by close to 100% in the space of one year.

With the local graphs the Pacifica data is based on very low numbers and consequently the variation is significant between periods. Despite the data issues with the low numbers it is very hard to ignore the wide disparities between Pacific and Māori and Other.

As noted the wider use of Clinical Pathways should lead to better and more consistent care for most of the ASH conditions. Consistent use should also reduce the equity gap such that treatment offered is the same for all ethnicities.

Most of these conditions do not arise de novo at the time of admission. They are the result usually of other conditions such as diabetes, hypertension, smoking, and hyperlipidaemia. This reflects partly on access primary care and to health promotion and health literacy issues and it is clear that these are not equitable and lead on the large equity gaps in the reported rates.

Dr Mark Peterson
Chief Medical Officer - Primary

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the content of the report
2. **Endorse** the actions being taken.

Governance Report Overview 15

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Performance Framework Exceptions Report Quarter 2 2017/18**
	For the attention of: **HBDHB Board**
Document Owner	Anne Speden, Chief Information Officer
Document Author(s)	Peter Mackenzie, Business Intelligence Analyst
Reviewed by	Executive Management Team, Māori Relationship Board and the Pasifika Health Leadership Group The Dashboard only was viewed by Clinical & Consumer Council
Month/Year	February, 2018
Purpose	Monitoring
Previous Consideration Discussions	N/A
Summary	Areas of Progress: DNA Rates Areas of Focus: Health Target – Shorter Stays in ED, Mental Health – Section 29 Orders, Long Term Conditions – Diabetes Management.
Contribution to Goals and Strategic Implications	Ensuring the DHB meets/improves performance for our Ministry of Health key performance indicators and local measures outlined in the DHB Annual plan.
Impact on Reducing Inequities/Disparities	This report highlights areas of inequity, comments are provided in relation to programs of work that are underway/planned in order to positively affect equity gaps.
Consumer Engagement	N/A
Other Consultation /Involvement	Comments are supplied from various staff members throughout the DHB including service directors or their delegate, program Leaders and the PHO
Financial/Budget Impact	NA
Timing Issues	NA

RECOMMENDATION:

It is recommended that the HBDHB Board:

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

22

HBDHB PERFORMANCE FRAMEWORK
Quarter 2 2017/18

Author:	Peter Mackenzie
Designation:	Business Intelligence Analyst
Date:	February 2018

OVERVIEW
The purpose of this paper is to provide the Board with exception reporting on the Hawke's Bay District Health Board's performance on the Statement of Intent (SOI) and the District Annual Plan (DAP).

As this report ends 31st December 2017, the results in some instances may vary to those presented in other reports.

BACKGROUND
The National Health Board (NHB) facilitates DHB performance planning and monitoring within the Ministry of Health. DHB non-financial monitoring arrangements operate within wider DHB accountability arrangements including legislative requirements, obligations formalised via Crown Funding Agreements and other contractual requirements, along with formal planning documents agreed with the Minister of Health/Minister of Finance.

ANNUAL PLAN (AP) 2017/2018
The AP is a statutory requirement that includes the key actions and outputs the DHB will deliver in order to meet Government priorities and Health targets. Through the AP, the DHB has formally agreed to deliver on the performance expectations associated with the measures in the NHB-mandated monitoring framework.

STATEMENT OF PERFORMANCE EXPECTATIONS (SPE) 2017/18
The SPE is produced annually within the context of the four-year Statement of Intent (SOI) 2014-18. The SPE informs the House of Representatives of the performance expectations agreed between a Minister and a Crown Entity. Formal agreement is gained annually through the AP process and actual performance is assessed and reported through the audited HBDHB Annual Report.

HAWKE'S BAY DISTRICT HEALTH BOARD (HBDHB) PERFORMANCE FRAMEWORK
The four dimensions of the non-financial monitoring framework, which was developed by the Ministry as a mandatory framework, will reflect DHB's functions as owners, funders and providers of health and disability services.

The 4 dimensions of DHB performance are:

- *Achieving Government's priorities and targets (Policy priorities)*
- *Meeting service coverage requirements and supporting sector inter-connectedness (System Integration)*
- *Providing quality services efficiently (Ownership/Provider Arm)*
- *Purchasing the right mix and level of services within acceptable financial performance (Outputs/service performance)*

MINISTRY OF HEALTH ASSESSMENT CRITERION

Progress towards each target or measure will be assessed using the following criterion:

Rating	Abbrev	Criterion
Outstanding performer/sector leader	O	1. Applied in the fourth quarter only – this rating indicates that the DHB achieved a level of performance considerably better than the agreed DHB and/or sector expectations.
Achieved	A	1. Deliverable demonstrates targets/expectations have been met in full. 2. In the case of deliverables with multiple requirements, all requirements are met. 3. Data, or a report confirming expectations have been met, has been provided through a mechanism outside the Quarterly Reporting process, and the assessor can confirm.
Partially achieved	P	1. Target/expectation not fully met, but the resolution plan satisfies the assessor that the DHB is on to compliance. 2. A deliverable has been received, but some clarification is required. 3. In the case of deliverables with multi-requirements, where all requirements have not been met at least 50% of the requirements have been achieved.
Not achieved	N	1. The deliverable is not met. 2. There is no resolution plan if deliverable indicates non-compliance. 3. A resolution plan is included, but it is significantly deficient. 4. A report is provided, but it does not answer the criteria of the performance indicator. 5. There are significant gaps in delivery. 6. It cannot be confirmed that data or a report has been provided through channels other than the quarterly process.

KEY FOR DETAILED REPORT

Baseline	Latest available data for planning purpose
Target 2017/18	Target 2017/18
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target
U (Unfavourable)	Actual to date is unfavourable to target
Trend direction ▲	Performance is improving against the previous reporting period or baseline
Trend direction ▼	Performance is declining
Trend direction -	Performance is unchanged

Table of Contents

PERFORMANCE HIGHLIGHTS – TOTAL POPULATION

Achievements

- Health Targets – The DHB has remained favourable for the Raising Healthy Kids measure with a Total Rate of 98%, Maori at 97% and Pacific at 100% against a target of 95%.

- Health Target – For Better help to quit smoking in Primary Care we have achieved a total result of 90.9%. We have also seen slight increases in the rate for Maori 88.5% and Pacific 88.8% against the target of 90% (page 11).

- DNA – Overall we have favourably remained at 5.2% which is below the target of 7.5%.

Areas of Progress

- Health Target – For Better help to quit smoking in Primary Care we have seen slight increase in the rate for Maori 88.5% and Pacific 88.8% against the target of 90% (page 11).

- Cervical Screening – We have seen slight increases for the total population, Maori and Pacific ethnicities. The total population result is 77% against a target of 80% (page 16)

Areas of Focus

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

- Health Target – Shorter Stays in ED is currently at 92.2% against a target of 95% (page 8)

- Health Target - Elective Surgery is at 98.5% against a target of 100% (page 9)

- Immunisation at 4 years – The rate for total has dropped 2.9% and currently sits at 91.3% against a target of 95%, there have also been decrease for Maori by 6% and Pacific 10.2%. (page 13)

- Diabetes Management (HbA1c equal to or less than 64mmols) – The result for the total population is currently 43% against a target of 55%. (page 19)

- Pregnant Women Registered with an LMC by week 12 – There has been a decrease in all ethnicities for Q2 compared with Q1 and the current result for the total population is 57.9% against a target of 80%. The result for Maori is 50% and Pacific 35.3% highlighting inequity. (page 18)

PERFORMANCE HIGHLIGHTS – EQUITY

Achievements

- Immunisation of 2 year olds – The Maori rate is currently 96% and the Pacific rate is 97%, both are similar to the Total rate of 96%.

- Health Targets – The Maori is currently 97% and Pacific at 100% against a target of 95%. They are similar to the Total Rate of 98%

- Better Access to diagnostic service – The rate for Maori accepted for an urgent diagnostic colonoscopy receiving their procedure within two weeks is currently 100%, the rate for Pacific is 100% and the total rate is 94% against a target of 90%

Areas of Progress

- DNA – Both the Maori and Pacific rates of DNA have declined over the Q2 period which is pleasing to see. The Maori declined by 1.4% in Q2 and now sits at 9.1%, the Pacific rate has declined by 1% and now sit at 10.4% against a target of 7.5%.

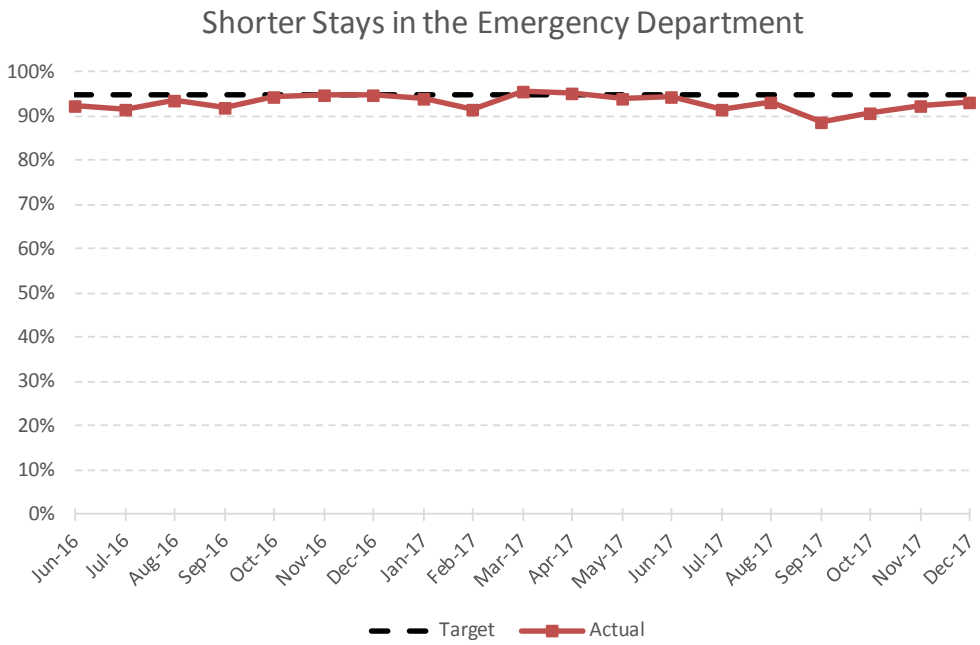
Areas of Focus

- Rate of Section 29 orders per 100,000 population – Maori Rates are currently 384 per 100,000 against the target of <81.5 and are 3 times higher than the non-Maori Rate (page 33)

HEALTH TARGETS

Health Target: Shorter stays in emergency departments
95% of all people attending the Emergency Department will be admitted, transferred or discharged within six hours

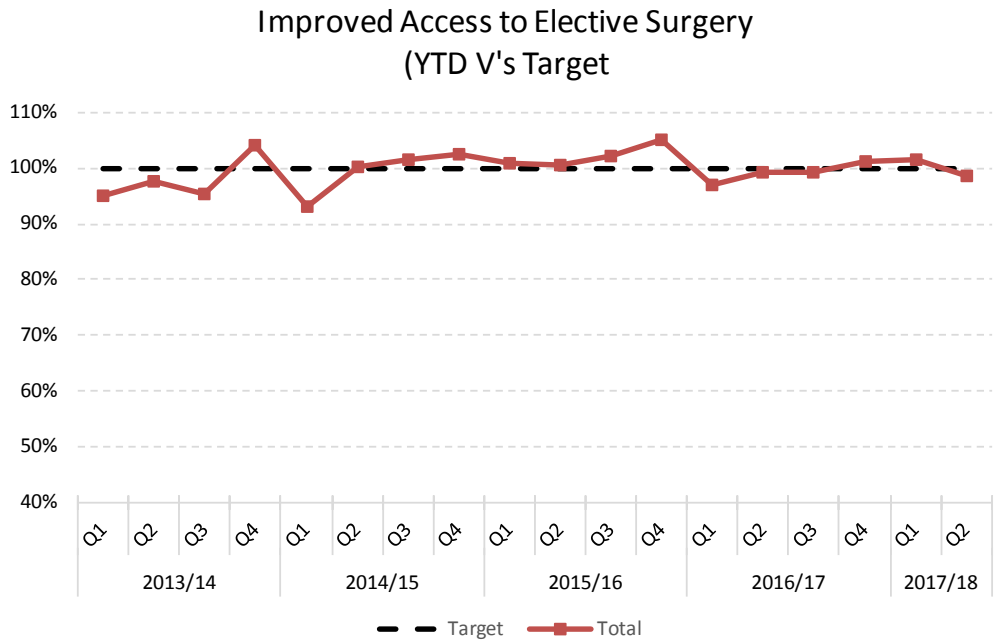
Ethnicity	Baseline [1]	Previous result [2]	Actual to Date [3]	Target 2017/18	Trend Direction
Total	94.7%	91.4% (U)	92.2% (U)	≥95%	▲
Maori	94.7%	93.8% (U)	93.5% (U)	≥95%	▼
Pacific	95.7%	95% (F)	94.1% (U)	≥95%	▼
Other	96.5%	89.8% (U)	91.3% (U)	≥95%	▲



Comments:
Several initiatives that have been introduced during the quarter include flexible opening of 10 bed inpatient ward to support periods of high demand, particularly surgical patients. Limited trial of senior nurse after hours (Mon-Fri) in AAU to provide leadership and facilitate pulling medically referred patients from ED to improve patient flow. Implementation of Primary Care model changes to Urgent Care with Registered Nurse resource being supported by St John Paramedic responder and from mid-December ED has increased the number of ED registrars to enhance leave cover and permit consistent rostered numbers across 7 days. During future months we going to increase nursing FTE as identified by CCDM programme, improving nurse: patient ratio, workload allocation and after hour's patient management. We will also ensure completion of PHO/ ED joint program (2 year duration) providing shared plans of care for patients who have high ED presentations.

1 October to December 2016
2 July to September 2017
3 October to December 2017

Health Target: Improved access to elective surgery (discharges)				
Key Performance Measures	Baseline [4]	Actual to Date [5]	Period Target	Target 2017/18 [6]
Elective Surgery	101.5%	98.5%	100%	100%
	3,751	3,684	3,742	7,574



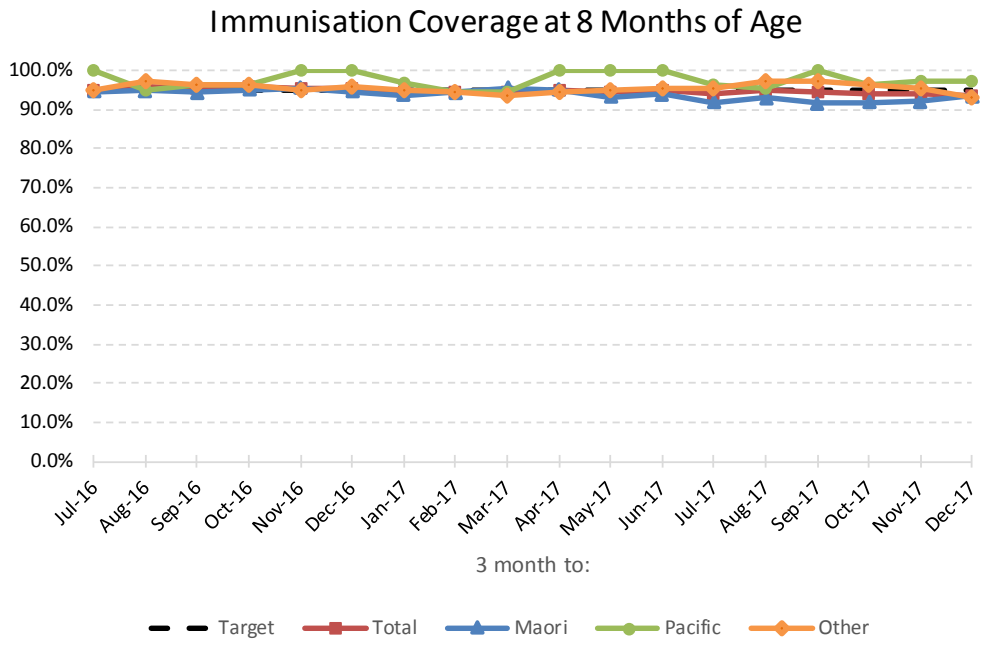
Comments:
We have in place a weekly production plan that is attended by a multi-disciplinary team. The purpose is to monitor on site operations, outsource and IDF performance in conjunction with the utilisation of theatres session usage and reviewing future bookings. We have recently taken part in a conference call with the Ministry, our themes for the year are as follows: Ophthalmology vacancy has recently been filled by locum who started late Nov 17 with an extra locum in Jan 18 and we anticipate to achieve HT in this specialty. Orthopaedic and General Surgery acute presentations continue to displace health target and we are currently using outsourcing as a mechanism to close this shortfall. An ENT vacancy has created a significant shortfall which we are regularly monitoring to see if we have sufficient resource in place to achieve specialty delivery. IDF Plastics continues under delivery and HBDHB Service Director and Clinical head of Department are arranging to meet with IDF provider to identify resolution actions required.

22

4 July to December 2016
5 July to December 2017
6 July 2017 June 2018

Health Target: Increased immunisation
% of 8 month olds fully immunised

Ethnicity	Baseline [7]	Previous result [8]	Actual to Date [9]	Target 2017/18	Trend direction
Total	95.3%	94.5% (F)	93.6% (U)	≥95%	▼
Māori	94.4%	91.5% (U)	93.4% (U)	≥95%	▲
Pacific	100.0%	100% (F)	97.1% (F)	≥95%	▼
Other	95.9%	97% (F)	93.3% (U)	≥95%	▼



Data Source: National Immunisation Register

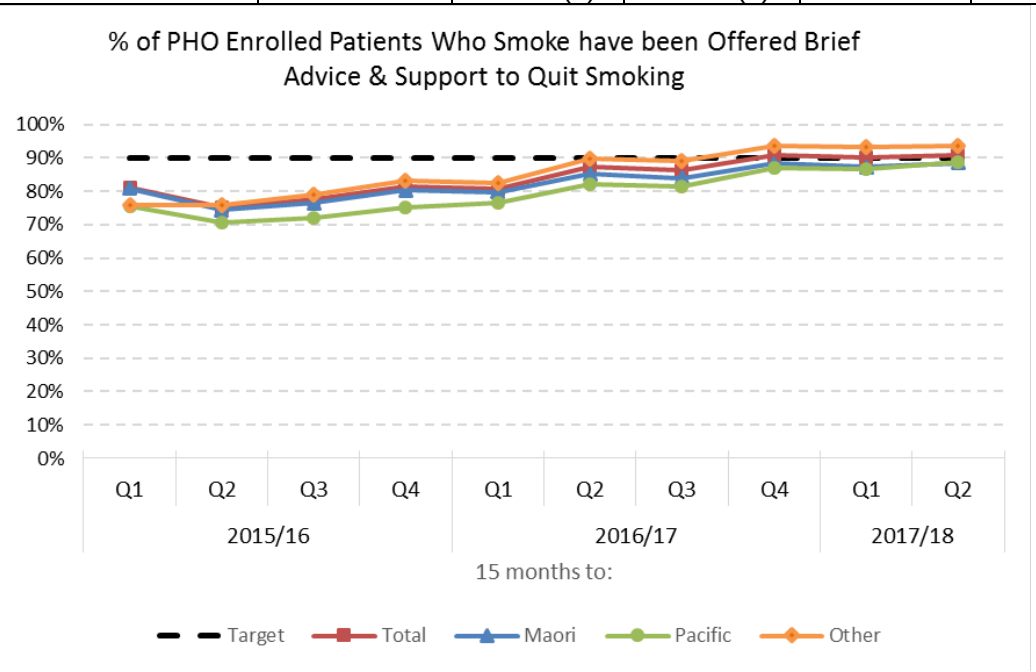
Comments:
HB is continuing to struggle to reach the 95% target for our 8 month infants however we are heartened to see that although the overall rate is down the coverage for Maori is equitable this quarter. We continue to have hesitant whanau that have been online and although some of these families do return to having their infants immunised there is often a delay so the timeframe is outside what is recommended. In December we have entered into an agreement with the Kahungunu Executive for whanau in Wairoa to have timelier follow ups when their children are referred to outreach to see if this supports the community in this rural remote area better. This agreement is in place until June 30th 2018. They have a support worker committing 1 day per fortnight to visit and improve access to primary care, answer questions, liaise with the outreach team etc.

7 October to December 2016. Source: National Immunisation Register, MOH
8 July to September 2017. Source: National Immunisation Register, MOH
9 October to December 2017. Source: National Immunisation Register, MOH

Health Target: Better help for smokers to quit – Primary Care

% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months

Key Performance Measures	Baseline [10]	Previous result [11]	Actual to Date [12]	Target 2017/18	Trend direction
Total	87.4%	90.2% (F)	90.9% (F)	≥90%	▲
Māori	85.1%	87.3% (U)	88.5% (U)	≥90%	▲
Pacific	82.2%	86.8% (U)	88.8% (U)	≥90%	▲
Other	89.9%	93.1% (F)	93.6% (F)	≥90%	▲



Source: PHO

Comments:

Activities aimed at further improving the results for quarter 2 include ensuring Smoke-free communication to practices is directed to the Practice Manager & Clinical Nurse Manager unless there is an active Smoke-free Champion within the practice. Health Hawke's Bay continues to fund the Patient Dashboard so practices can see at a glance if the presenting patient has an up-to-date smoking status and has been offered smoking brief advice and cessation support in the past 15 months. Health Hawke's Bay also funds Karo Data Management Limited to provide all 25 practices with monthly reports, which are published on or around the 10th of each month. We are also aiming towards 31 May 2018 with HBDHB and Health Hawke's Bay working together to plan local World Smoke-free Day activities.

22

10 15 months to December 2016. Source: DHB Shared Services

11 15 months to September 2017. Source: DHB Shared Services

12 15 months to December 2017. Source: DHB Shared Services

Health Target: Better help for smokers to quit – Maternity % of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking					
Key Performance Measures	Baseline [13]	Previous result [14]	Actual to Date [15]	Target 2017/18	Trend direction
Total	88.5%	81.3% (U)	73.9% (U)	≥90%	▼
Māori	78.8%	57.1% (U)	73.7% (U)	≥90%	▲
The following comment is from the Ministry of Health: *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.*					

13 October to December 2016. Source: DHB Shared Services

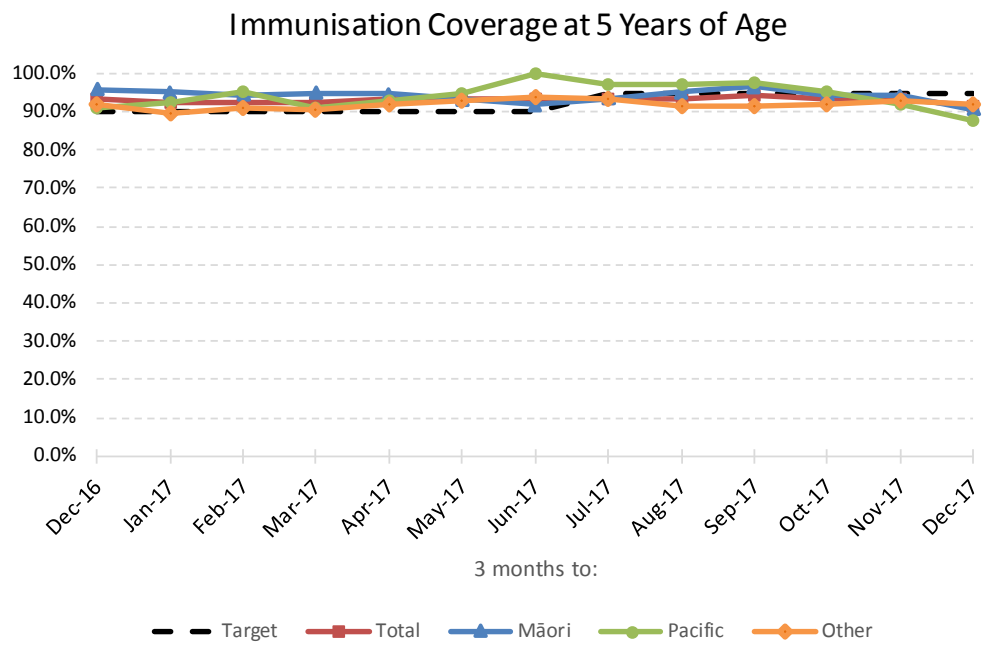
14 April to June 2017. Source: DHB Shared Services

15 July to September 2017. Source: DHB Shared Services

OUTPUT CLASS 1: PREVENTION SERVICES

Increase Immunisation
% of 4 year olds fully immunised

Key Performance Measures	Baseline [16]	Previous result [17]	Actual to Date[18]	Target 2017/18	Trend direction
Total	93.5%	94.2% (U)	91.3% (U)	≥95%	▼
Māori	95.8%	96.7% (F)	90.7% (U)	≥95%	▼
Pacific	91.2%	97.7% (F)	87.5% (U)	≥95%	▼
Other	91.8%	91.6% (U)	92% (U)	≥95%	▲



Data Source: National Immunisation Register

Comments:
We continue to try to capture these children but our resource is stretched and priority goes to the infants and 2 year olds. We struggle to get children coming from overseas with complete schedules from their original country up to date with our schedule particularly for pneumococcal and Hib. These children often come onto our radar later and take a lot of resource both in primary care and outreach. Getting any form of documented immunisation history can be a very time consuming exercise.

22

16 October to December 2016 . Source: National Immunisation Register, MOH
17 July to September 2017. Source: National Immunisation Register, MOH
18 October to December 2017. Source: National Immunisation Register, MOH

Reduced incidence of first episode Rheumatic Fever Acute rheumatic fever initial hospitalisation rate per 100,000					
Key Performance Measures	Baseline [19]	Previous result [20]	Actual to Date[21]	Target 2017/18	Trend direction
Total	1.9	-	1.9 (U)	≤1.5	*
Māori	7.3	-	4.8 (U)	≤1.5	*
Pacific	0	-	0 (F)	≤1.5	*
Other	1.9	-	1.9 (U)	≤1.5	*

Comments:
Awareness raising activities undertaken in the quarter include high levels of ongoing engagement in schools, including updates and contributing to schools newsletters. The Housing Coalition's activities include the launch and delivery of the Ready to Rent programme – which included a comprehensive session on healthy home/rheumatic fever, this programme target those on the Social Housing Register. We continue to raise awareness in all forums we engage with.

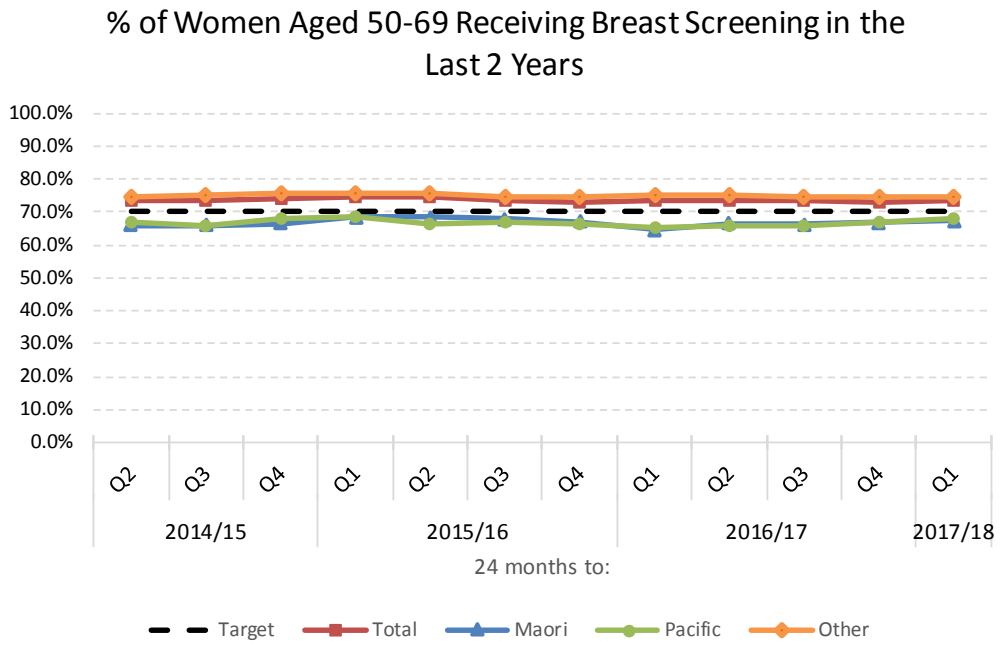
19 July 2015 to June 2016

20 July 2016 to June 2017

21 July 2017 to December 2017(YTD figure)

Improve breast screening rates
% of women aged 50-69 years receiving breast screening in the last 2 years

Key Performance Measures	Baseline [22]	Previous result [23]	Actual to Date[24]	Target 2017/18	Trend direction
Total	73.6%	73.2% (F)	73.4% (F)	≥70%	▲
Māori	64.7%	66.8% (U)	67.4% (U)	≥70%	▲
Pacific	65.4%	66.9% (U)	67.9% (U)	≥70%	▲
Other	75.0%	74.5% (F)	74.6% (F)	≥70%	▲



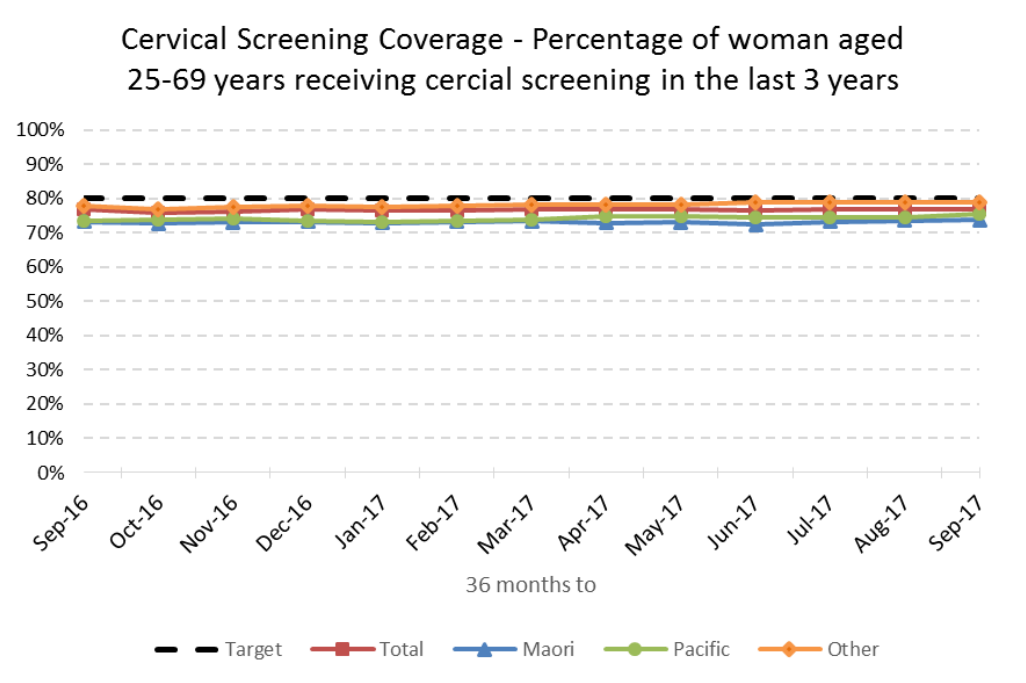
Data Source: BreastScreen Aotearoa

Comments:
The process of contacting BreastScreen Coast to Coast via phone to confirm or rearrange appointments seems to put many women off. Women who have felt discomfort when having had their mammogram talk to others about how it felt, creating a stigma around the process of having a mammogram. Fear of the unknown the result could be cancer, so they will often say they would prefer not to know. In order to improve equity all Hawke's Bay Maori and Pacific women who DNA or do not respond to their appointments for their mammogram are referred to the HBDHB Population Screening team, who then refer women to one of five independent service providers to contact the women and provide support to services, these referral outcomes are monitored every six months. A successful campaign has recently been completed to encourage Maori and Pacific 45-69 who were unenrolled or under screened on the BSA programme, gifting them a $20 Pak n Save gift card on completion of their mammogram. Planning is currently underway for the BSA Mobile visit to Wairoa late January and visit to Central Hawke's Bay in March / April 2018.

22 24 months to December 2016 . Source: National Immunisation Register, MOH
23 24 months to June 2017. Source: National Immunisation Register, MOH
24 24 months to September 2017. Source: National Immunisation Register, MOH

Improve cervical screening rates
% of women aged 25–69 years who have had a cervical screening event in the past 36 months

Key Performance Measures	Baseline [25]	Previous result [26]	Actual to Date[27]	Target 2017/18	Trend direction
Total	76.7%	76.6% (U)	77% (U)	≥80%	▲
Māori	72.8%	72.4% (U)	73.8% (U)	≥80%	▲
Pacific	74.8%	74.4% (U)	75.5% (U)	≥80%	▲
Other	78.9%	78.9% (U)	78.9% (U)	≥80%	—



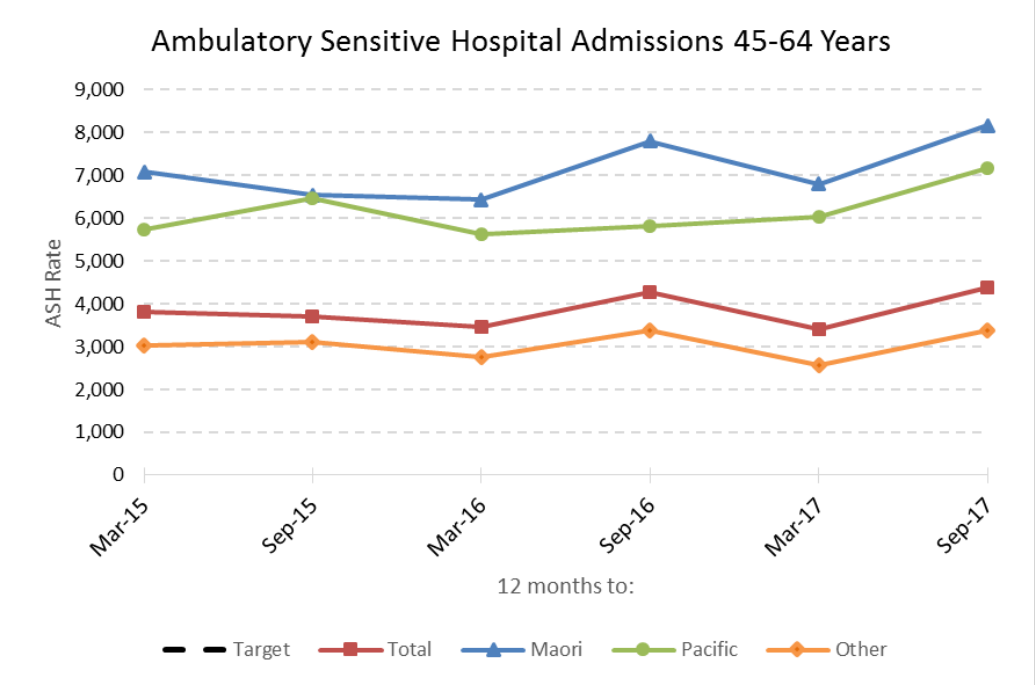
Data Source: National Cervical Screening Programme

Comments:
Opportunistic smears are to be taken in general practice with more options for women such as after hour's clinics. Some of the barriers to equity include first time women who have never engaged with their GPs and don't know anything about having their smears; they see their doctors as a place to go to only if they are sick. Also not having access to a nurse smeartaker, rather than being told to make another appointment and come back in two or three days because if a woman has decided she will have her smear it is essential that the service is offered 'now'. We are also aware that many women have had a bad experience when having their smear, which causes delays in returning for subsequent smears. In order to improve equity the Pak n Save promotional campaign funded by Health HB, all Maori, Pacific and women living in Quintile 5 will receive a Pak n Save gift card of $20 if they have their smear. HBDHB and Maori Provider Kaiawhina and Pacific community support workers are offering smears to Maori and Pacific women in their homes. Feedback from women who have been screened in their home indicates that it has made a big difference and they wouldn't have had the smear otherwise. Two staff clinics have been held on the Hospital campus, in addition to two clinics per month held at the Napier Health Centre from September to December for Maori and Pacific women.

25 26 months to December 2016
26 36 months to June 2017
27 36 months to September 2017.

OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT SERVICES

Ambulatory sensitive hospitalisation rate per 100,000 45-64 years Reduce ASH 45-64					
Key Performance Measure	Baseline	Previous result [28]	Actual to Date [29]	Target 2017/18	Trend direction
0-4 years: Total	4,129	3,967	4,373	<4,129	▼
0-4 years: Māori	7,636	7,961	8,165	-	▼



Source: Ministry of Health

Comments:
After looking at the breakdown of the information, Primary Care delivers the CPO Cellulitis pathway for adults, with children not included within this pathway, which may have an effect on the ASH rates for cellulitis. However, within the current diagnosis coding for cellulitis we only include LO3 Cellulitis within the CPO pathway. It appears that in the group of 45-64 there is a reduction in the ASH rate for Māori for cellulitis, whereas the ASH rate is higher for all, though still declining. We will require support from the DHB to understand this further and how we could impact on this further through primary care. More work can also be done with the DHB Team around the standardised evaluation that are included within the graphs.

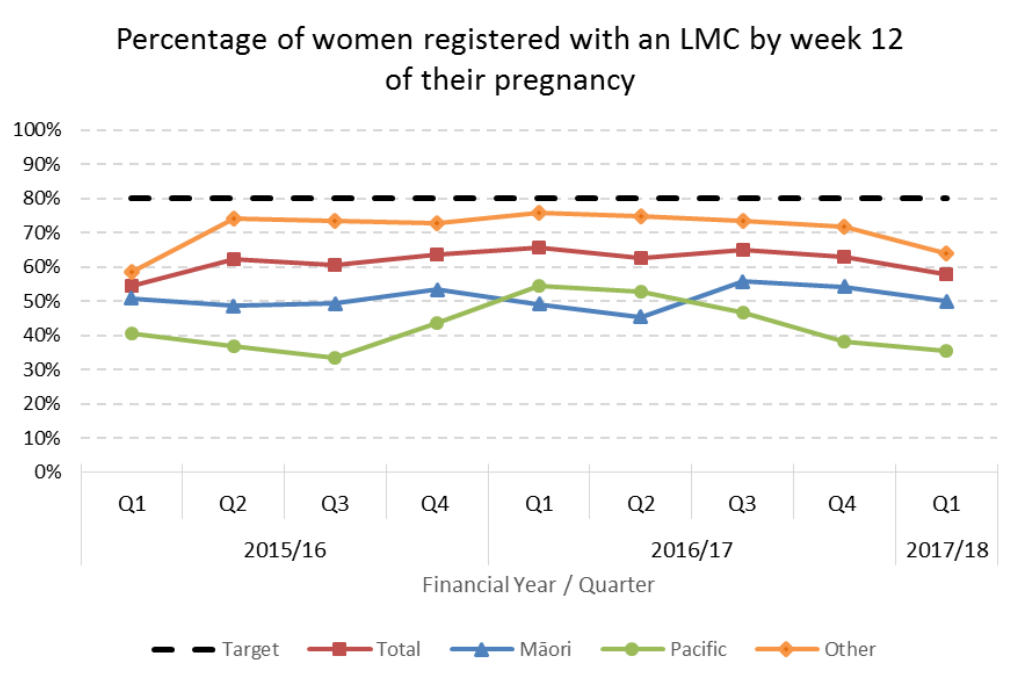
22

28 12 months to March 2017

29 12 months to September 2017

More pregnant women under the care of a Lead Maternity Carer (LMC)
% of women booked with an LMC by week 12 of their pregnancy

Key Performance Measures	Baseline [30]	Previous result [31]	Actual to Date [32]	Target 2017/18	Trend direction
Total	65.7%	63% (U)	57.9% (U)	≥80%	▼
Māori	49.2%	54.1% (U)	50% (U)	≥80%	▼
Pacific	54.5%	38.2% (U)	35.3% (U)	≥80%	▼
Other	75.9%	71.8% (U)	63.8% (U)	≥80%	▼



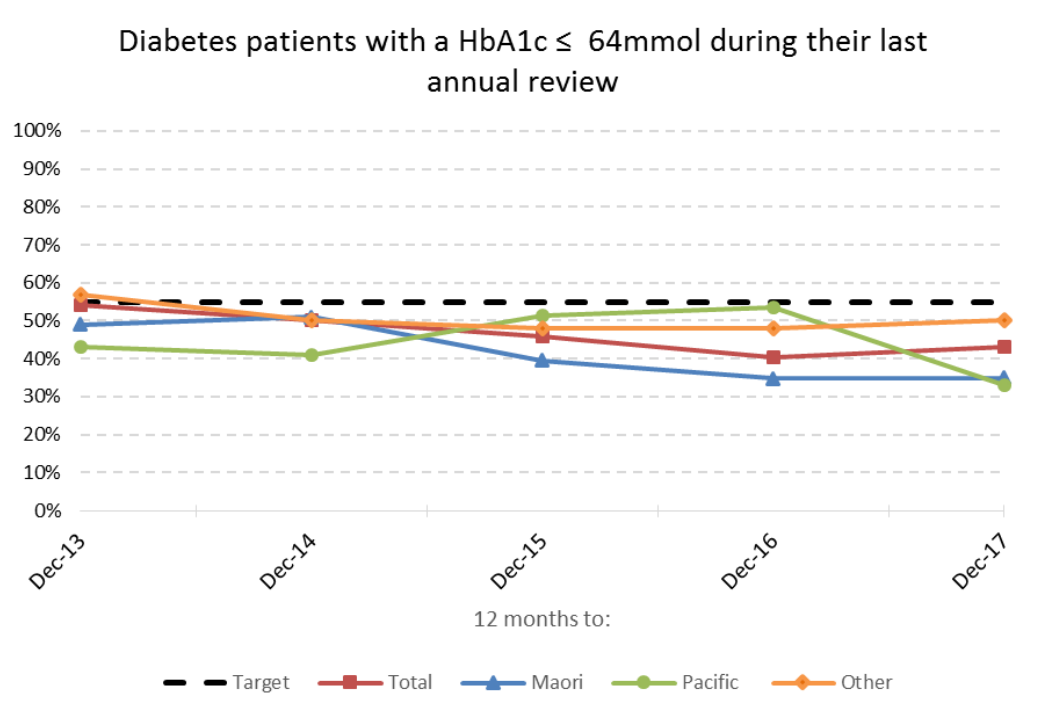
Comments:
Whilst the 'Top 5 for my baby to thrive' campaign had an initial impact in Q3 of the previous year increasing Maori engagement by 10% the results for Q1 of 17/18 remain below the target % for all ethnicities. The campaign continues with ongoing contact with PHO and GP practices across Hawke's Bay and a refresh of the find your midwife website and a DHB telephone contact for women finding it difficult to engage an LMC. A new initiative incorporating a number of equity programmes e.g. smoke free, safe sleep, breastfeeding plus early engagement with a midwife is in the planning stage with the timeline of commencement being March 2018. This works in partnership with Maori Health and our primary and community providers to raise awareness of our community to the importance of early engagement with a midwife to improve wellness and pregnancy outcome.

30 October to December *2015.*
31 April to June 2017.
32 July to September 2017

Improved management of long-term conditions (CVD, Acute heart health, Diabetes, and Stroke)

Proportion of people with diabetes who have good or acceptable glycaemic control (HbA1C indicator)

Key Performance Measures	Baseline [33]	Previous result [34]	Actual to Date [35]	Target 2017/18	Trend direction
Total	65.4%	45.9% (U)	43% (U)	≥55%	▼
Māori	46.2%	39.5% (U)	35% (U)	≥55%	▼
Pacific	39.3%	51.3% (U)	33% (U)	≥55%	▼
Other	79.2%	47.9% (U)	50% (U)	≥55%	▲



PHO: Annual Diabetes Checks Data

Comments:

There are encouraging increased referral numbers to Kia Ora Self-Management programme from general practice, processed via electronic form, also focusing on community groups. We are also running Annual diabetes reviews, Smoking cessation education (SLM) and Pre-diabetes programme (400 people to be enrolled), Local resource on nutrition has been developed and circulated to families 'Healthy Eating, Healthy Smile'. There is also new defined HbA1c reports to practices provide risk stratification of practice populations to enable focus on those outside of guidelines

33 January to December 2016

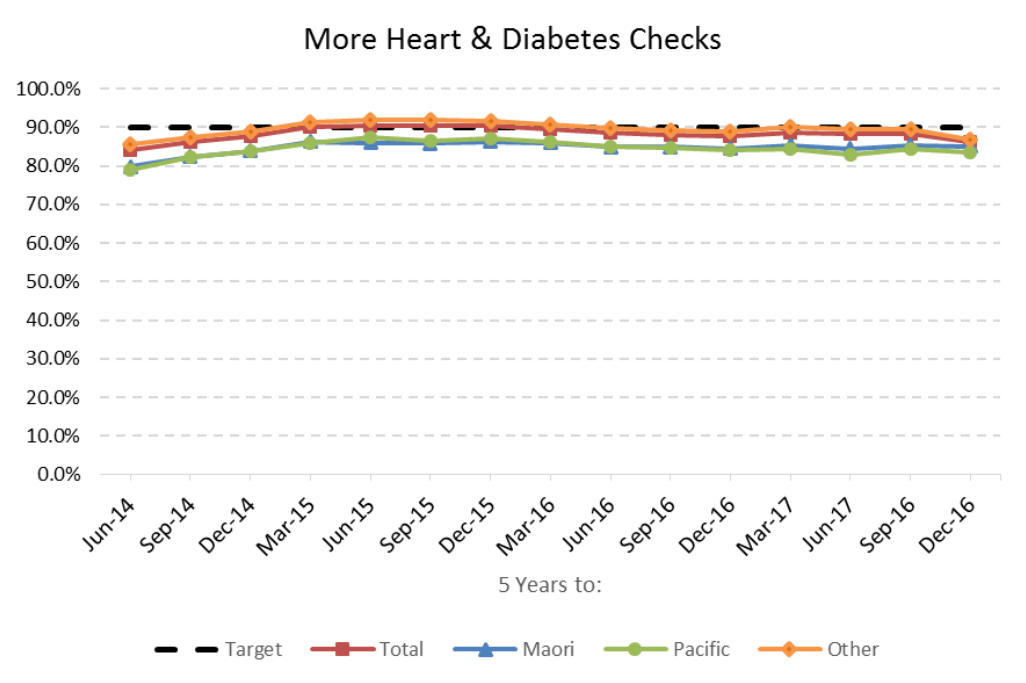
34 12 months to September 2017

35 12 months to December 2017

Improved management of long-term conditions (CVD, Acute heart health, Diabetes, and Stroke)

% of the eligible population will have had a CVD risk assessment in the last 5 years

Key Performance Measures	Baseline [36]	Previous result [37]	Actual to Date [38]	Target 2017/18	Trend direction
Total	87.8%	88.4% (U)	86.3% (U)	≥90%	▼
Māori	84.5%	85.4% (U)	85% (U)	≥90%	▼
Pacific	84.0%	84.3% (U)	83.6% (U)	≥90%	▼
Other	88.9%	89.4% (U)	86.7% (U)	≥90%	▼



Source: Ministry of Health

Comments:

Health Hawke's Bay promoted Cardiovascular Risk Assessment with a focus on Maori and Pacific Men predominately with our very low cost access (VLCA) practices. Health Hawke's Bay printed coloured A4 invitations and provided brightly coloured envelopes for them to be sent out in (with the rationale they did look like a "bill"). Each Maori and Pacific patient was offered a $20 Pak N Save Gift Card for having their "Health WOF" in their general practice. They also went into a prize-draw for $800 worth of tyres. Health Hawke's Bay funded practices $20.00 plus GST for every Maori and Pacific patient who had a CVDRA completed. Health Hawke's Bay is currently waiting for the 31 December 2017 coverage rates for both Total Population and Maori Men 35-44 years. Health Hawke's also loaned two practices our point-of-care testing equipment and fully funded the consumable products so they could carry out CVDRA's in the community. Three non-VLCA were supported to carry out Non-Face--to-Face Cardiovascular Risk Assessments on Maori and Pacific patients. Those who had recent results recorded in the patient management system had their risk calculated. A letter was then sent to each patient advising them of their result and offering them a free follow-up consult with a nurse. They also received a copy of their result and the Heart Foundation Lifestyle Advise hand-out.

Less waiting for diagnostic services

% of accepted referrals for Computed Tomography (CT) and MRI who receive their scans within 42 days (6 weeks)

36 5 years to December 2016. Source: Ministry of Health

37 5 years to September 2017. Source: Ministry of Health

38 5 years to December 2017 . Source: Ministry of Health

Key Performance Measures	Baseline [39]	Previous result [40]	Actual to Date [41]	Target 2017/18	Trend direction
CT	95.1%	96.1% (F)	92.5% (U)	≥95%	▼
MRI	48.0%	91.7% (F)	92.8% (F)	≥90%	▲

Comments:
In Quarter 2 CT maintained wait time with the exception of slight drop in December due to the increase in acute workload and Stat days (reduced scanning capacity). Overall demand and acute demand is increasing, we have seen record acute demand in December 2017 for CT, this has continued into January and February 2018. Utilising resources to meet this acute demand has put pressure on compliance of diagnostic wait time indicators. HBDHB continues to use the NRSII models and production plans to forecast and plan workload, as forecasted radiologist resourcing has been an issue during this quarter and the department is utilising strategies, such as out-sourcing and use of locums, to minimise the effect on compliance. This will continue in Q3 and Q4.

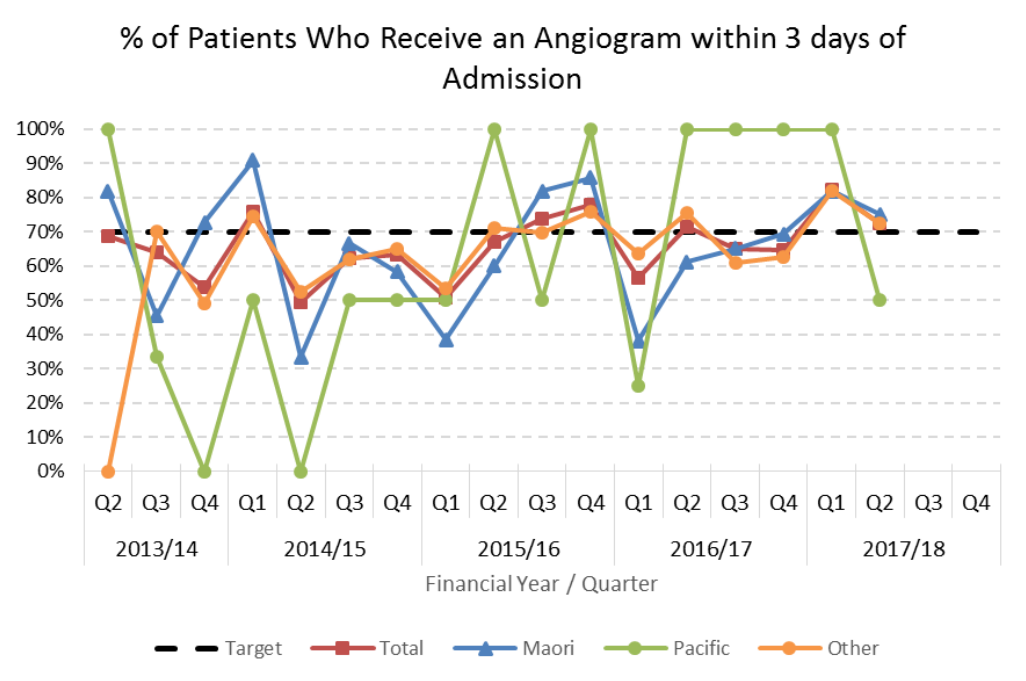
39 October to December 2015. Source: Ministry of Health

40 July to September 2016. Source: Ministry of Health

41 October to December 2016 . Source: Ministry of Health

OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT SERVICES

Patients with ACS receive seamless, coordinated care across the clinical pathway ***% of high-risk patients will receiving an angiogram within 3 days of admission.***					
Key Performance Measures	Baseline [42]	Previous result [43]	Actual to Date [44]	Target 2017/18	Trend direction
Total	71.6%	82.1% (F)	72.4% (F)	≥70%	▼
Māori	61.1%	81.8% (F)	75% (F)	≥70%	▼
Pacific	100.0%	100% (F)	50% (U)	≥70%	▼



Source: ANZACS-QI

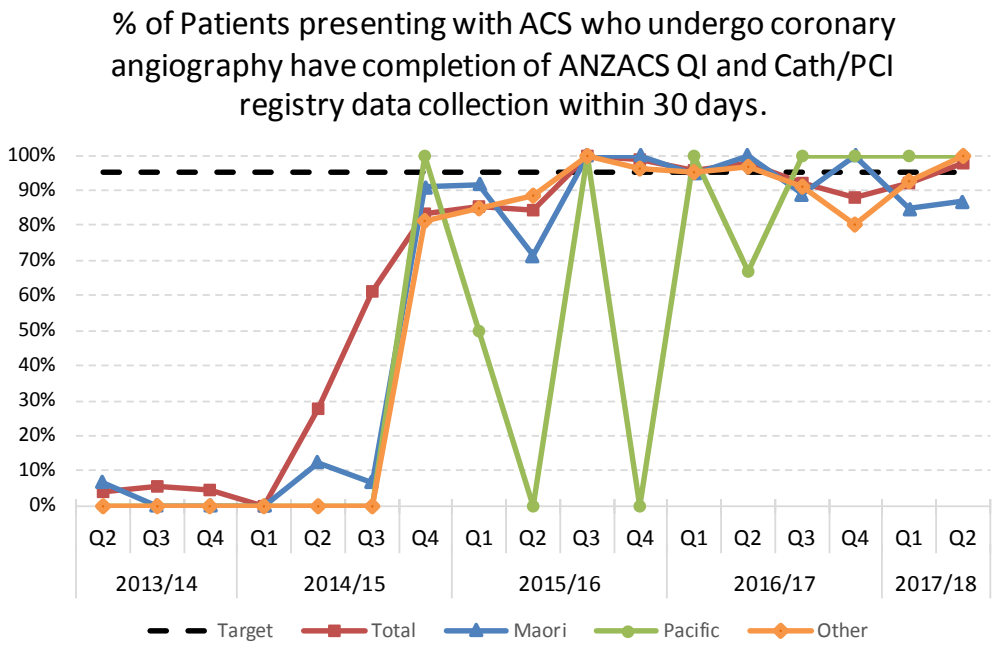
Comments:
Overall the DHB is on target for this indicator. Small numbers for Maori and Pacific result in variability with quarterly performance

42 October to December 2016. Source: Ministry of Health
43 July to September 2017. Source: Ministry of Health
44 October to December 2017 . Source: Ministry of Health

Patients with ACS receive seamless, coordinated care across the clinical pathway

% of patients undergoing cardiac surgery at the regional cardiac centres who have completion of Cardiac Surgery registry data collection within 30 days of discharge

Key Performance Measures	Baseline [45]	Previous result [46]	Actual to Date [47]	Target 2017/18	Trend direction
Total	97.7%	92% (U)	97.5% (F)	≥95%	▲
Māori	100.0%	84.6% (U)	86.7% (U)	≥95%	▲
Pacific	66.7%	100% (F)	100% (F)	≥95%	▬



Source: ANZACS QI

Comments:
Overall the DHB is on target for this indicator. Small numbers for Maori and Pacific result in variability with quarterly performance, 1 more patient for Maori would have pushed them over target. We will keep monitoring cases that do not meet target and ensure lessons are taken forward.

22

45 October to December 2016. Source: Ministry of Health

46 June to August 2017. Source: Ministry of Health

47 September to November 2017 Source: Ministry of Health

Equitable access to care for stroke patients
% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway

Key Performance Measures	Baseline [48]	Previous result [49]	Actual to Date [50]	Target 2017/18	Trend direction
Total	88.1%	84.2% (F)	75.6% (U)	≥80%	▼
Māori	-	-	92.3% (F)	≥80%	*
Pacific	-	-	72% (U)	≥80%	*

Source: HBDHB

Comments:
It is not always clinically appropriate to move patients to the stroke unit, we regularly audit the cases of patients who do not get admitted to the stoke ward to ensure the appropriate care was given. There has been an introduction of monthly emergency policy stroke education meetings with staff, this is with the hope of identifying stroke patients early in their journey through the hospital.

Equitable access to care for stroke patients
% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission

Key Performance Measures	Baseline [51]	Previous result [52]	Actual to Date [53]	Target 2017/18	Trend direction
Total	-	71% (U)	58% (U)	≥80%	*
Māori	-	-	80% (F)	≥80%	*
Pacific	-	-	50% (U)	≥80%	*

*This is a new indicator and a time series chart will be provided one there are enough data points.

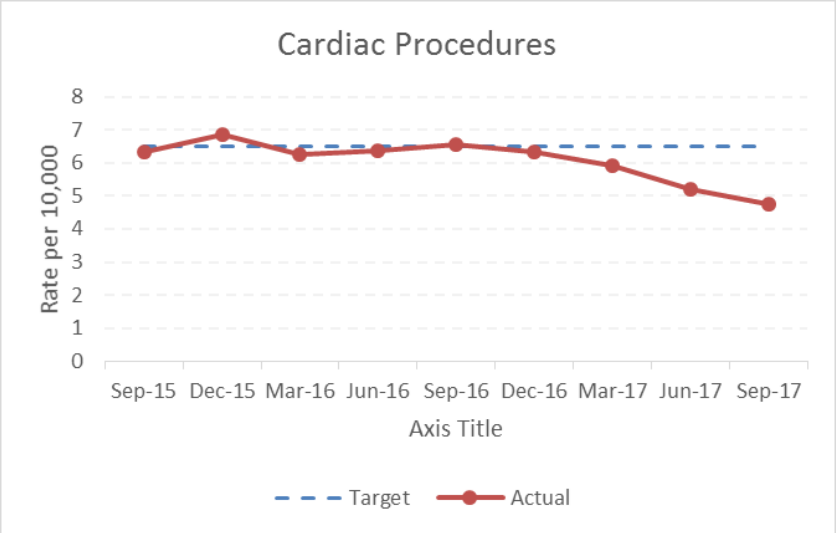
Comments:
There was a confirmed gastro-intestinal outbreak for the month of October through to the month of November which left the stroke ward on lock-down increasing length of time to rehab/discharge.

Equitable access to surgery -Standardised intervention rates for surgery per 10,000 population

Key Performance Measures	Baseline[54]	Previous result[55]	Actual to Date [56]	Target 2017/18	Trend direction
Major joint replacement	21.5	21.8 (F)	22.9 (F)	≥21	▲
Cataract procedures	58.7	46.4 (F)	49.7 (F)	≥27	▲
Cardiac procedures	6.6	5.2 (U)	4.7 (U)	≥6.5	▼
Percutaneous revascularization	13.1	12.2 (U)	12 (U)	≥12.5	▼
Coronary angiography services	21.5	21.8 (F)	22.9 (F)	≥21	▲

*Charts only supplied for the Cardiac Procedure as this is the only one that is significantly below the national average.

48 October to December 2015. Source: Ministry of Health
49 July to September 2016. Source: Ministry of Health
50 October to December 2016 . Source: Ministry of Health
51 October to December 2015. Source: Ministry of Health
52 July to September 2016. Source: Ministry of Health
53 October to December 2016 . Source: Ministry of Health
54 12 months ending December 2015. Source MoH
55 12 months ending September 2015. Source MoH
56 12 months ending December 2016. Source MoH



Source: Ministry of Health

Comments:
Cardiac procedures are demand driven and HB is reliant on Capital & Coast to accept/ pull patients for cardiac surgery and pacemaker implants

22

Quicker access to diagnostics					
Key Performance Measures	Baseline [57]	Previous result [58]	Actual to Date[59]	Target 2017/18	Trend direction
% accepted referrals for elective coronary angiography completed within 90 days	-	89.3% (U)	87.8% (U)	≥95%	▼
% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive),	91.7%	96.2% (F)	93.5% (F)	≥85%	▼
% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)	93.9%	81% (U)	59% (U)	≥85%	▼
% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date	98.1%	97% (F)	77% (F)	≥70%	▼

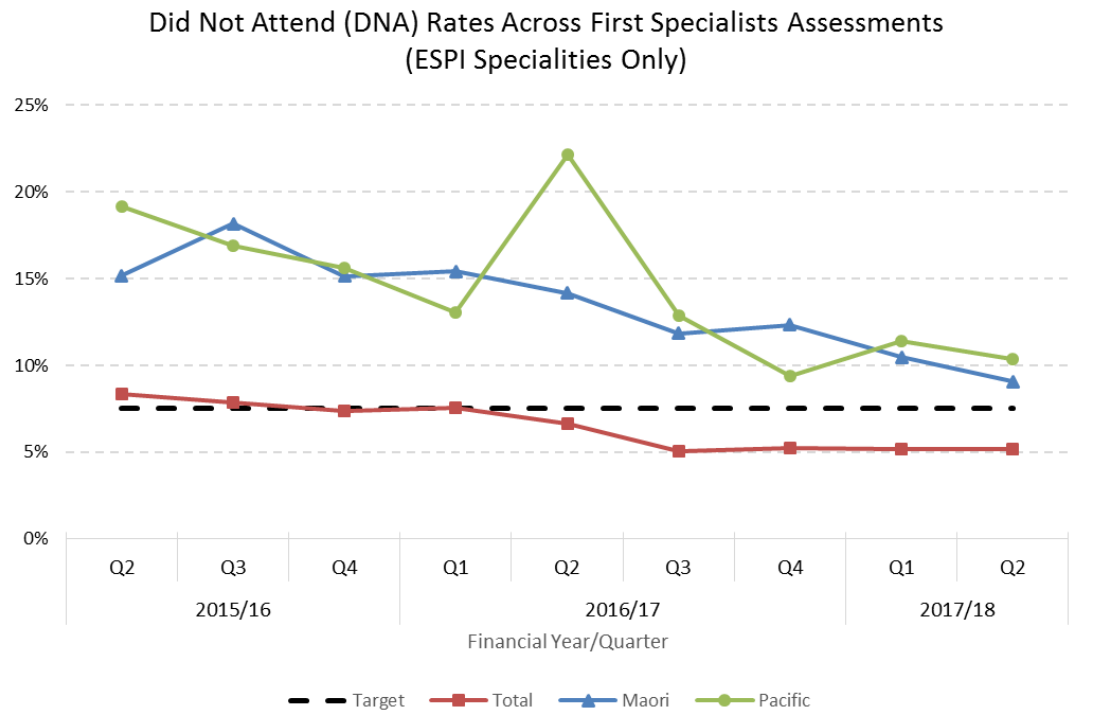
Comments:
We have had an increase in patients requiring anaesthetic support for their procedures which has impacted our semi-urgent targets overall. What we have seen is more patients coming through with higher co-morbidities, older in age and requiring pre & post support for their procedure. These patients require anaesthetic support (compared to the norm of sedation only). Due to the current anaesthetic resourcing this has impacted on us scheduling these patients within the target timeframe. To begin resolving this issue we have planned to have a weeks' worth of anaesthetic cases which is currently taking place 19.02.2018 to 23.02.2018. We have already identified that we will need to do another week of anaesthetic cases to meet our increased demand which we are planning for 12.03.2018 to 16.03.2018. The demand on our endoscopy services have remained high over the summer period with a demand for many urgent cases and a steady flow of semi-urgent cases coming through. Taking into account the public holidays we have identified that we need to do some additional lists for our sedation patients. We have booked x2 additional weekend lists in February with a total of 10 patients as well as a list of 10 patients on Waitangi Day. We are looking at our volumes and targets for the next few months ahead and are already beginning to plan further additional lists so that we can reach the 70% target.

57 December 2015.

58 March 2016.

59 June 2016

Fewer missed outpatient appointments ***Did not attend (DNA) rate across first specialist assessments***					
Key Performance Measures	Baseline [60]	Previous result [61]	Actual to Date [62]	Target 2017/18	Trend direction
Total	6.7%	5.2% (F)	5.2% (F)	≤7.5%	▬
Māori	14.2%	10.5% (U)	9.1% (U)	≤7.5%	▲
Pacific	22.1%	11.4% (U)	10.4% (U)	≤7.5%	▲
Other	3.8%	3.2% (F)	3.6% (F)	≤7.5%	▼



Source: HBDHB

Comments:
The Total DNA rate this quarter is well below our target rate of 7.5%, currently hovering just above 5%. PI continue to flux at around 10% to11% due to the low volume of numbers being seen. What is of particular significance this quarter is the continued decline in DNA rate for Maori, now sitting below 10%. This is a fantastic achievement that is real credit to the Kaitakawaenga and Booking Department.

Key initiatives behind a more equitable DNA rate:

- The newly appointed Kaitakawaenga has established some good preventative DNA process now that he has a good understanding of DHB internal systems.
- Maturity in working relationships between Kaitakawaenga and other key members across the DHB and in the community, in order to target those customers that are having real trouble accessing the DHB services.
- Demographics being monitored more closely – with monthly audits across the DHB, to ensure Demographic details are being updated and confirmed with customers at every presentation.
- Evening phone calling and in many cases Bookers calling customers more than once to confirm their appointments

22

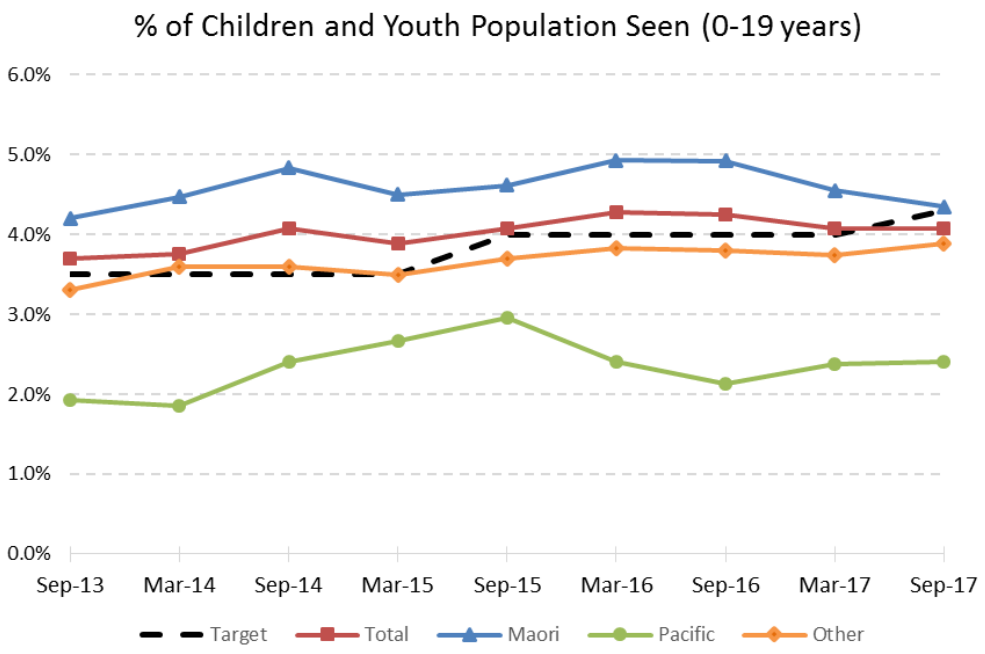
60 October to December 2016. Source: Ministry of Health
61 July to September 2016. Source: Ministry of Health
62 October to December 2016 . Source: Ministry of Health

Whilst we celebrate a good quarter for DNA, we recognise there are several areas that need to be addressed over the coming year in order to reduce DNA further. The 3 key areas where current process needs to be reviewed are:

- Dental - remains the most problematic specialty to access services for Maori and PI, due to the financial element involved.
- School holidays are a real barrier for Maori to access DHB services
- Demographics – how to keep more accurate demographic records for our more transient customers.

Administration services and Maori Health will continue to work in partnership to review the above areas and identify what changes can be made to reduce current barriers and sustain a Maori DNA rate of 7.5% or less.

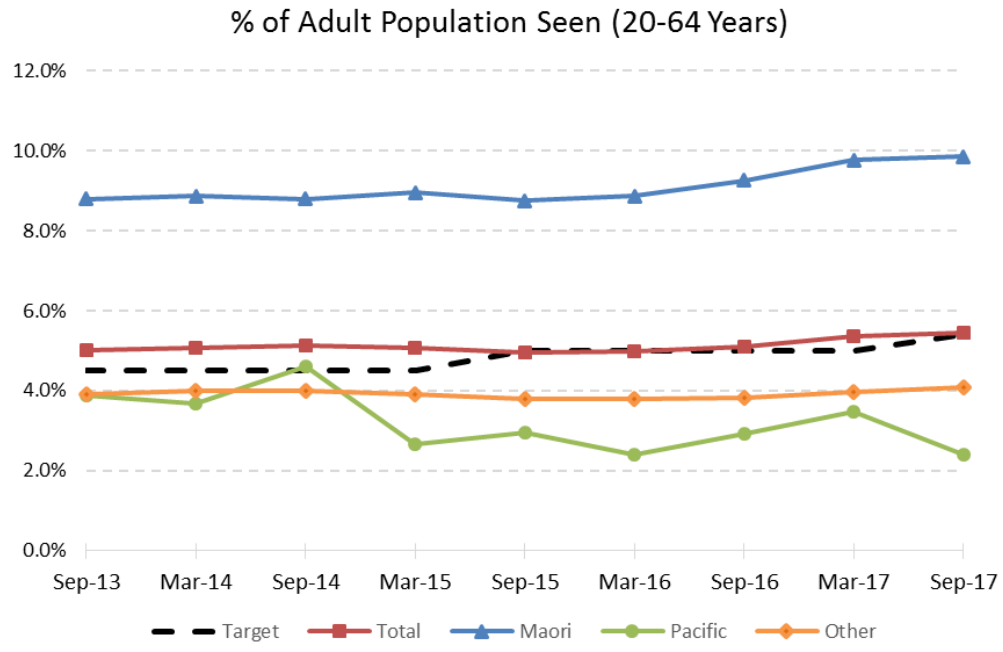
Better mental health services, Improving access, Better access to mental health and addiction services Proportion of the) population seen by mental health and addiction services					
Key Performance Measures	Baseline [63]	Previous result [64]	Actual to Date [65]	Target 2017/18	Trend direction
Child & youth (0-19)					
Total	4.3%	4.08% (F)	4.07% (F)	≥4%	▼
Māori	4.9%	4.55% (F)	4.34% (F)	≥4%	▼
Pacific	2.1%	2.38% (U)	2.4% (U)	≥4%	▲
Other	3.8%	3.74% (F)	3.88% (F)	≥4%	▲
Adult (20-64)					
Total	5.1%	5.35% (F)	5.46% (F)	≥5%	▲
Māori	9.3%	9.76% (F)	9.85% (F)	≥5%	▲
Pacific	2.2%	3.47% (U)	2.4% (U)	≥5%	▼
Other	3.8%	3.98% (U)	4.08% (U)	≥5%	▲
Older adult (65+)					
Total	1.1%	1.13% (F)	1.14% (F)	≥1.15%	▲
Māori	1.2%	1.09% (F)	1.25% (F)	≥1.15%	▲
Pacific	1.0%	1.29% (F)	0.65% (F)	≥1.15%	▼
Other	1.1%	1.14% (F)	1.13% (F)	≥1.15%	▼

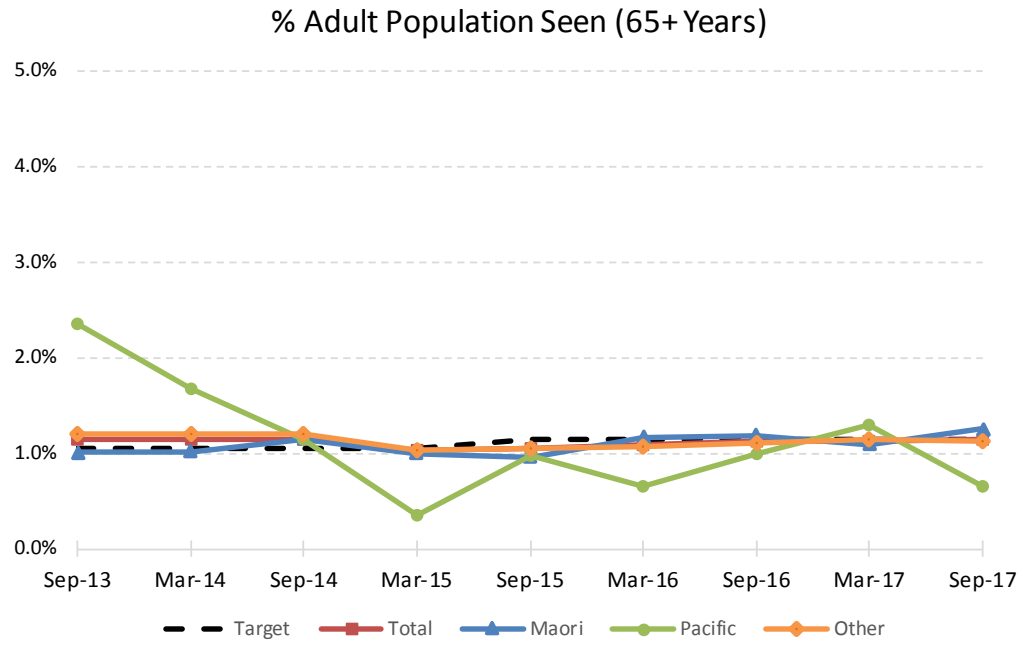


63 12 months to September 2016

64 12 months to June 2017

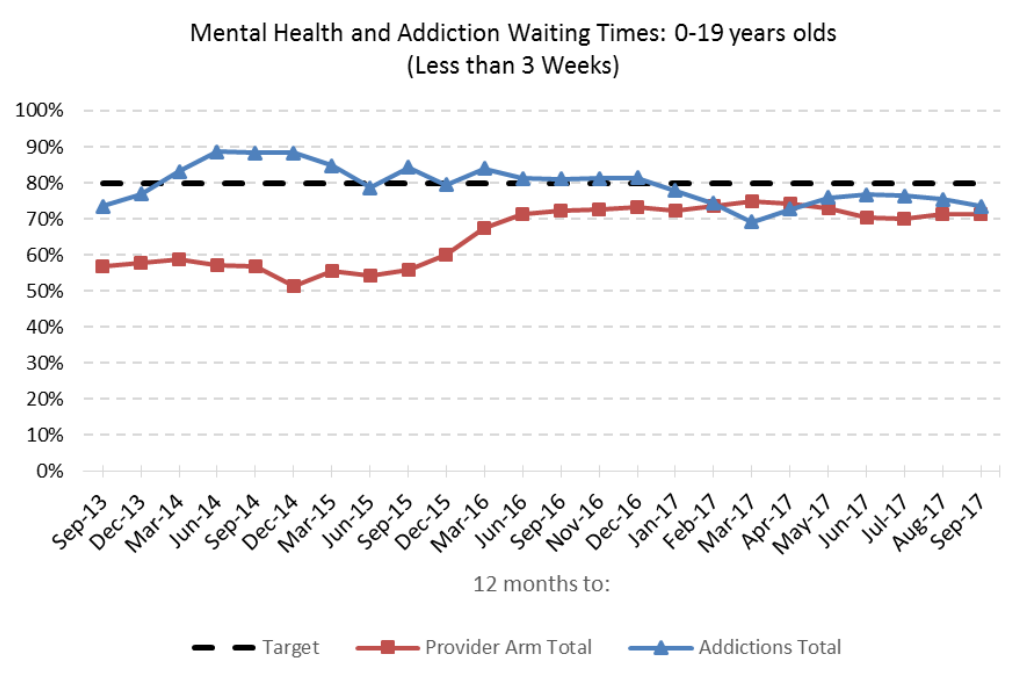
65 12 months to September 2017

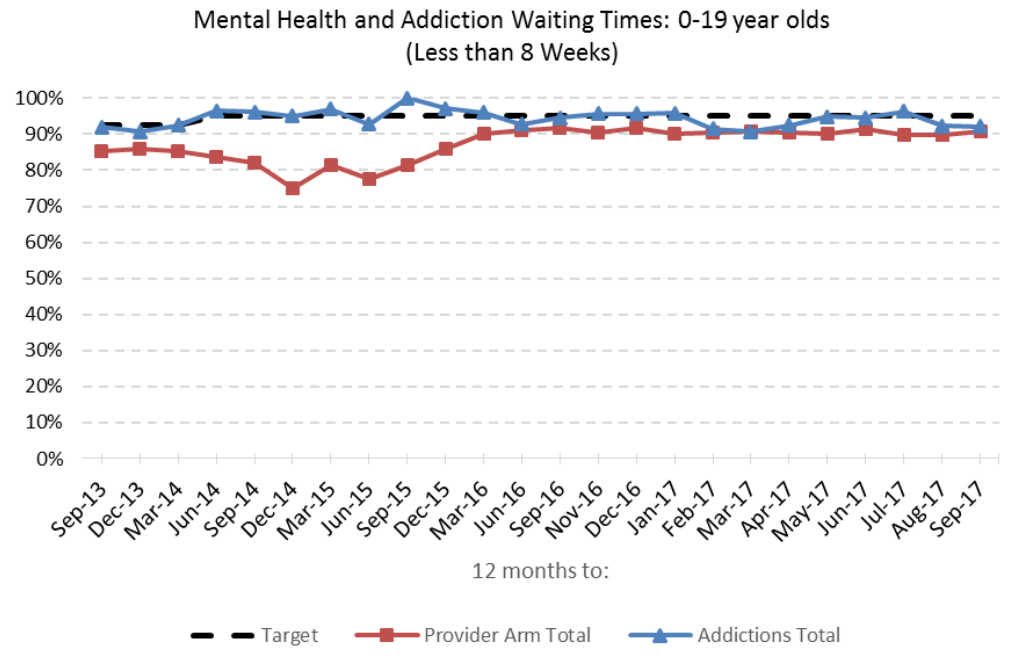




Comments:
While we have not met the current target (which has increased since the last quarter) we have remained fairly constant in our access rates. We continue to meet with relevant stakeholders to ensure access rates are optimised and we are engaging in scoping exercises with populations that have low access rates. Our Maori access rates continue to meet the targets, our Pacific access rates have historically been low and we are working with the HBDHB Pacific Health Team to identify potential barriers to Pacific youth accessing our mental health service.

Reducing waiting times Shorter waits for non-urgent mental health and addiction services for 0-19 year olds					
Key Performance Measures	Baseline [66]	Previous result [67]	Actual to Date [68]	Target 2017/18	Trend direction
Mental Health Provider Arm: Age 0-19					
<3 weeks	72.3%	71.5% (U)	71.3% (U)	≥80%	▼
<8 weeks	91.7%	89.8% (U)	90.9% (U)	≥95%	▲
Addictions (Provider Arm & NGO): Age 0-19					
<3 weeks	81.1%	75.4% (U)	73.4% (U)	≥80%	▼
<8 weeks	94.6%	92.3% (U)	92.2% (U)	≥95%	▼





22

6612 months to December 2016

67 12 months to June 2017

68 12 months to September 2017

Source: Ministry of Health

Comments:
While we have not achieved the mental health and addictions targets this quarter, neither are more than 10% variance from the target and in particular, the addictions wait time has improved. All the same issues noted by outgoing CAFS manager, Joe Melser, are still affecting our wait times:

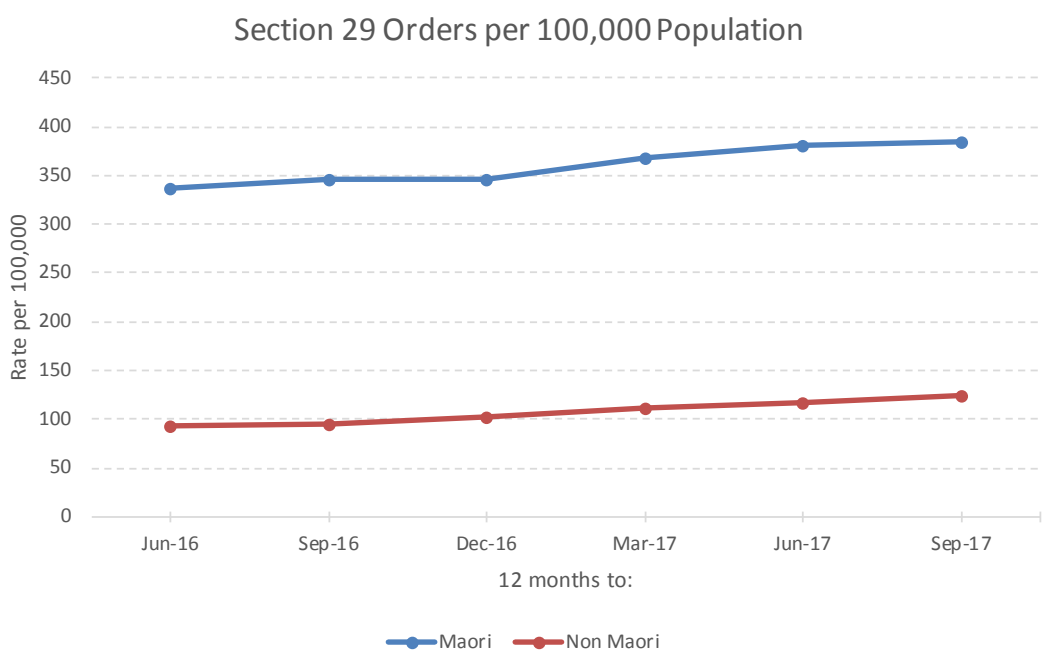
- DNA's, families rescheduling appointments and families unavailability, especially over the Christmas period
- It appears that family contact do not trigger the KPI
- Increase in referral volumes
- Capacity and demand continue to be a mismatch. We have an extra 2.5 FTE in place but staff retention continues to be a problem.

We continue to make telephone contact with families and see young people and their families in a variety of settings to maximise early engagement with our service.

Increasing consumer focus, More equitable use of Mental Health Act: Section 29 community treatment orders

Rate of s29 orders per 100,000 population

Ethnicity	Baseline [69]	Previous result [70]	Actual to Date [71]	Target 2017/18	Trend direction
Non- Māori	95	117.4 (U)	124.1 (U)	≤81.5	▼
Māori	338	381 (U)	384 (U)	≤81.5	▼



Comments:

This is a large difference in rates, though that may represent greater need in Maori consumers, which is being appropriately met through the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992. There is no evidence that the provisions of the MHA with regard to section 29 are being inappropriately used. Therefore due to the statutory requirement of certain criteria in order for a section 29 compulsory treatment order to be made by a Judge the contributing factors to the difference in rates must be that proportionally more Maori patients have mental disorder and at the same time pose a serious danger to the health or safety of themselves or others and/or have a seriously diminished capacity to take care of themselves. For Mental disorder all patients, Maori or non-Maori have access to the best possible treatment for mental disorder. This includes Kaupapa Maori mental health and addictions services. No local study has been carried out into presentation and response to treatment rates in the local population comparing Maori to others.

For dangerousness or incapacity for self-care: The Whanau Tahi one assessment and collaborative Go To Plan allow for recording of risks and mitigating actions to be taken. All patients can be referred to the Needs Assessment and Support Co-ordination (NASC) service for community support services, including support workers and supported accommodation. It may not be appreciated that risk can remain in the long term, even when someone is currently relatively well, either because of the natural history of a particular mental disorder or because the patient has no ability to appreciate that they suffer from a mental disorder and would therefore not accept treatment were it not for the section 29 compulsory treatment order. Again no local study of degree of insight in relation to the use of the mental health act comparing Maori to non-Maori has been carried out. Provider arm services are not resourced to carry out such studies which would need to be academically robust in order to have true value in planning interventions.

69 October to December 2016

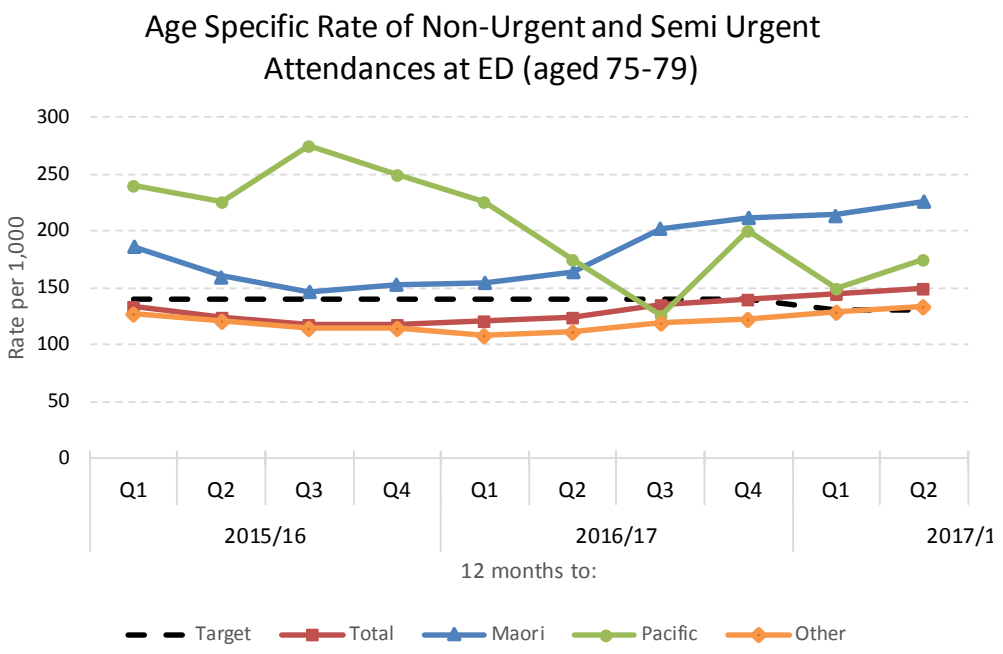
70 12 months to June 2017

71 12 months to September 2017

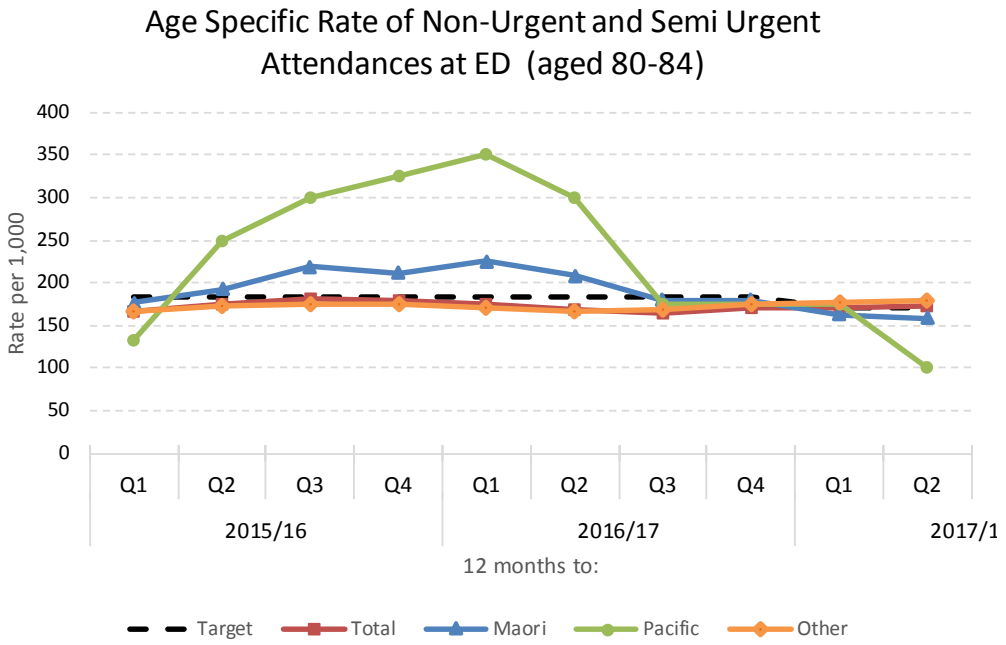
OUTPUT CLASS 4: REHABILITATION AND SUPPORT SERVICES

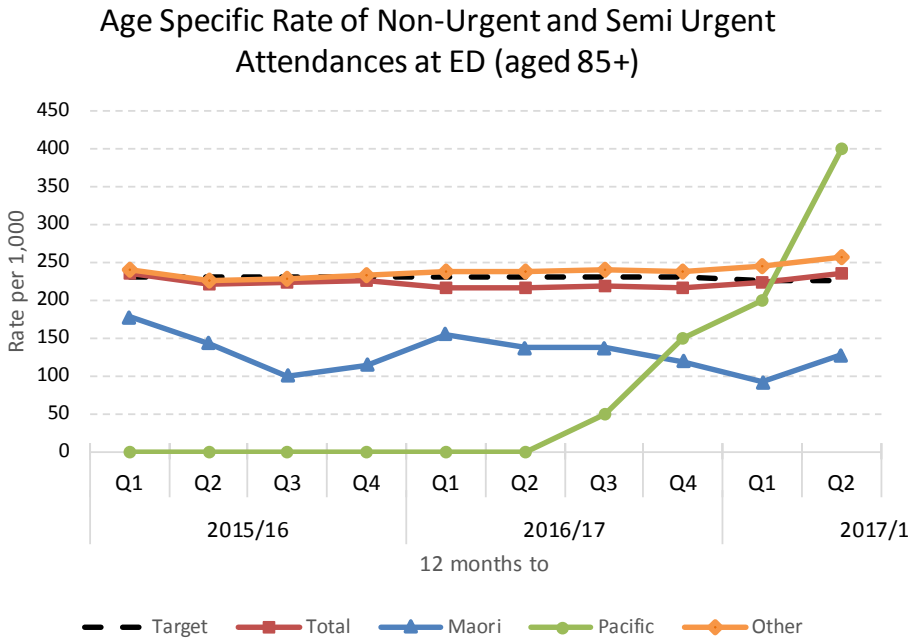
Better access to acute care for older people
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population)

Age Band	Baseline [72]	Previous result [73]	Actual to Date [74]	Target 2017/18	Trend direction
Age 75-79					
Total	124	144.5 (U)	149.9 (U)	≤130	▼
Maori	164.3	214.3 (U)	226.3 (U)	≤130	▼
Pacific	175	150 (U)	175 (U)	≤130	▼
Other	111.2	129.2 (F)	133.8 (U)	≤130	▼
Age 80-84					
Total	208.3	171.7 (U)	173.6 (U)	≤170	▼
Maori	300	162.5 (F)	158.3 (F)	≤170	▲
Pacific	167	175 (U)	100 (F)	≤170	▲
Other	167.8	176.1 (U)	179.5 (U)	≤170	▼
Age 85+					
Total	216.6	222.3 (F)	234.6 (U)	≤225	▼
Maori	136.4	90.9 (F)	127.3 (F)	≤225	▼
Pacific	0	200 (F)	400 (U)	≤225	▼
Other	237.7	243.9 (U)	255.2 (U)	≤225	▼



72 12 months to December 2016
73 12 months to October 2017
74 12 months to December 2017.





Comments:
The engAGE service continues to work with older people in their homes through our community teams to maintain their independence and to prevent unnecessary hospitalisations. Our ORBIT team work in ED/AAU 7am-7pm, 7 days per week. ORBIT arrange early, safe discharge for older people presenting to hospital who are able to return home with increased support. engAGE Intermediate Care beds allow 'step-down' from hospital for older inpatient who are medically well enough to discharge, but who require further medical and allied health input to regain their independence for home. At present there are no engAGE community teams in Wairoa or Central Hawkes Bay.

RECOMMENDATION:

It is recommended that the HBDHB Board:

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

ATTACHMENT:

- HBDHB Quarterly Performance Monitoring Dashboard Q2

HBDHB PERFORMANCE FRAMEWORK RESULTS – QTR 2, 2017/18

Health Targets:	Target	Baseline	Total		Maori		Pacific		Other	
Shorter Stays in ED	≥ 95%	95%	92%	*	94%		94%		91%	*
Improved Access to Elective Services	≥ 100%	100%	99%	-	-	-	-	-	-	-
Faster Cancer Treatment	≥ 90%	65%	95%	-	78%	-	100%	-	98%	-
Increased Immunisation	≥ 95%	0%	94%		93%	*	97%		93%	
Better Help for Smoker to Quit (Primary Care)	≥ 90%	99%	91%	*	89%	*	89%	*	94%	*
Better Help for Smoker to Quit (Pregnant Women)	≥ 90%	89%	Awaiting data from Ministry of Health							
Raising Health Kids	≥ 95%	40%	98%	*	97%	*	100%	*	100%	*

Output Class 1: Prevention Services	Target	Baseline	Total		Maori		Pacific		Other	
Better Help for Smoker to Quit (Secondary Care)	≥ 95%	99%	96%		97%		97%		91%	
% of 2 year olds fully immunised	≥ 95%	95%	96%	*	96%	*	97%		97%	*
% of 4 year olds fully immunised	≥ 95%	93%	91%		91%		88%		92%	*
Acute rheumatic fever initial hospitalisation rate per 100,000	≤ 1.5	1.9	1.9	*	4.8	*	-	*	-	-
% of women aged 50-69 years receiving breast screening in the last 2 years	≥ 70%	74%	73%	*	67%	*	68%	*	75%	*
% of women aged 25–69 years who have had a cervical screening event in the past 36 months	≥ 80%	77%	77%	*	74%	*	76%	*	79%	

Output Class 2: Early Detection and Management Services	Target	Baseline	Total		Maori		Pacific		Other	
% of the population enrolled in the PHO	≥ 90%	97%	98%	*	97%		90%		98%	*
Ambulatory sensitive hospitalisation rate per 100,000 0-4 years	≤ 6822	-	5794		6434		9178		4741	
Ambulatory sensitive hospitalisation rate per 100,000 45-64 years	≤ 4129	-	4373		8165		7168		3388	
% of women booked with an LMC by week 12 of their pregnancy	≥ 80%	66%	58%		50%		35%		64%	
Proportion of people with diabetes who have good or acceptable glycaemic control (HbA1C indicator)	≤ 65%	40%	43%		35%	*	33%		50%	
% of the eligible population will have had a CVD risk assessment in the last 5 years	≥ 90%	88%	86%		85%		84%		87%	
% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks)	≥ 95%	95%	93%		-	-	-	-	-	-
% of accepted referrals for MRI scans who receive their scans within 42 days (6 weeks)	≥ 90%	48%	94%	*	-	-	-	-	-	-

Key:

Within 0.5% or Greater than Target
Within 5% of Target
Greater than 5% from Target

*	Favourable Trend from Previous Quarter

OUTPUT CLASS 3: Intensive Assessment and Treatment Services	Target	Baseline	Total		Maori		Pacific		Other	
% of high-risk patients will receiving an angiogram within 3 days of admission.	≥ 70%	72%	72%		75%		50%		72%	
% of patients undergoing cardiac surgery at the regional cardiac centres who have completion of Cardiac Surgery registry data collection within 30 days of discharge	≥ 95%	98%	98%	*	87%	*	100%		100%	*
% of potentially eligible stroke patients who are thrombolysed 24/8	≥ 8%	8%	7%		15%		6%		0%	
% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	≥ 80%	84%	76%		92%		72%	*	0%	-
% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	≥ 80%	58%	58%		80%	*	50%		0%	-
Major joint replacement	≥ 21	21.5	22.90	*	No Ethnicity Data Available					
Cataract procedures	≥ 27	58.7	49.70	*						
Cardiac surgery	≥ 6.5	6.6	4.70							
Percutaneous revascularisation	≥ 12.5	13.1	12.00							
Coronary angiography services	≥ 34.7	39	36.60	*						
Length of stay Elective (days)	≥ 1.47	1.56	0.00	-						
Length of stay Acute (days)	≥ 2.3	2.4	0.00	-						
% accepted referrals for elective coronary angiography completed within 90 days	≥ 95%	98%	88%							
% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive),	≥ 90%	92%	94%		100%		100%		92%	
% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)	≥ 70%	94%	59%		58%		75%		59%	-
% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date	≥ 70%	98%	77%		No Ethnicity Data Available					
Did not attend (DNA) rate across first specialist assessments	≤ 8%	7%	5%	*	9%	*	10%	*	4%	
Proportion of the population seen by mental health and addiction services: Child & Youth (0-19)	≥ 4%	4%	4.1%		4.3%		2.4%	*	3.9%	*
Proportion of the population seen by mental health and addiction services: Adult (20-64)	≥ 5%	5%	5.5%	*	9.8%	*	2.4%		4.1%	*
Proportion of the population seen by mental health and addiction services: Older Adult (65+)	≥ 1%	1.1%	1.1%	*	1.3%	*	0.6%		1.1%	
% of 0-19 year olds seen within 3 weeks of referral: Mental Health Provider Arm	≥ 80%	72%	71%		74%	*	65%	*	71%	
% of 0-19 year olds seen within 3 weeks of referral: Addictions (Provider Arm and NGO)	≥ 80%	81%	73%		62%		100%		86%	
% of 0-19 year olds seen within 8 weeks of referral: Mental Health Provider Arm	≥ 95%	91%	91%	*	92%	*	87%	*	90%	*
% of 0-19 year olds seen within 8 weeks of referral: Addictions (Provider Arm and NGO)	≥ 95%	95%	92%		92%	*	100%		97%	
% of clients discharged will have a quality transition or wellness plan	≥ 95%	0%	0%	-	0%	-	0%	-	0%	-
Rate of s29 orders per 100,000 population	≤ 81.5	90.1	-	-	384		-	-	124.1	

22.1

Document Owner: **Tim Evans,** GM Planning Informatics & Finance

November 2017
Section 4
1

OUTPUT CLASS 4: Rehabilitation and Support Services	Target	Baseline	Total		Maori		Pacific		Other	
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 75-79 years	≤ 130	124	149.90		226.30		175.00		133.80	*
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 80-84 years	≤ 170	208.3	173.60		158.30	*	100.00	*	179.50	
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 85+ years	≤ 225	216.6	234.60		127.27		400.00		255.16	
% of older people who have received long-term home and community support services in the last three months who have had an interRAI Home Care or a Contact assessment and completed care plan	≥ 95%	100%	100%		100%		100%		100%	
Clients with a CHESS score (Change in Health, End-stage disease, signs and symptoms) of 4 or 5 at first assessment	≤ 14%	10%	12%		No Ethnicity Data Available					
Time from referral receipt to initial Cranford Hospice contact within 48 hours	≥ 80%	100%	98%							
% of older patients given a falls risk assessment	≥ 90%	97%	98%							
% of older patients assessed as at risk of falling receive an individualised care plan	≥ 98%	98%	96%							

Non Reported in Q2

Number of babies who live in a smoke-free household at six weeks post natal	≥ -	No data provided
% of pregnant women who are smokefree at 2 weeks postnatal	≥ 95%	
% of girls fully immunised – HPV vaccine	≥ 75%	Reported in quarter 4
% of 65+ year olds immunised – flu vaccine	≥ 75%	
% of infants that are exclusively or fully breastfed at 6 weeks	≥ 75%	No data provided
% of infants that are exclusively or fully breastfed at 3 months	≥ 60%	
% of eligible pre-school enrolments in DHB-funded oral health services	≥ -	Reported in quarter 3
% of children who are carries free at 5 years of age	≥ -	
% of enrolled preschool and primary school children not examined according to planned recall	≤ -	
% of adolescents(School Year 9 up to and including age 17 years) using DHB-funded dental services	≥ -	
Mean 'decayed, missing or filled teeth (DMFT)' score at Year 9	≤ -	
Acute readmissions to hospital	≤ TBC	Currently not reported
Acute readmission rate: 75 years +	≤ -	
Number of day services	≥ -	No data provided

HBDHB QUARTERLY PERFORMANCE MONITORING DASHBOARD Q1

Provided by MoH

Late Paper

22.2

HAWKE'S BAY District Health Board Whakawāteatia	**Human Resource KPIs (Q2 October-December 2017)** 16
	For the attention of: **HBDHB Board**
Document Owner: Document Author:	Kate Coley, Executive Director of People & Quality Jim Scott, Workforce Analyst
Reviewed by:	Executive Management Team
Month:	February 2018
Consideration:	Monitoring

RECOMMENDATION

That the HBDHB Board:

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

23

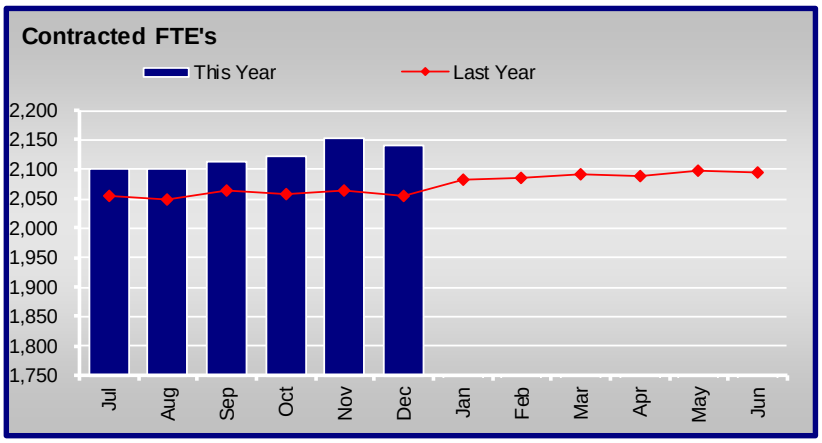
Summary of KPI progress

The following is a summary of the status of each of the KPI measures in this report. For full details refer to the appropriate page:

KPI Measure	Status	Comment	20 DHB Ranking (1 – best)	6 mid-sized DHB ranking (1 = best)
Headcount and positions	Amber	Increases over last year which are within budget. This will need to be considered in conjunction with the Financial result.		
Sick Leave	Amber	Slightly higher than last year. Ongoing monitoring and reporting. Currently working on additional reporting to identify extended sick leave, ACC etc within the nursing workforce which will be rolled out across all professional groups so that managers are able to support staff and ensure relevant processes are followed.	7	1
Lost Time Injuries	Green	Improvement on last year. Work continues to ensure that we support our staff with injuries and that return to work programmes are implemented in conjunction with the individual and their manager.		
Staff Turnover	Green	Within quarterly and yearly targets.		
Accrued Annual Leave 2+ years	Amber	Percentage similar but numbers higher than last year. Ranked 4th best of 20 DHBs. Whilst over the Christmas and New Year period there is a focus on enabling as many staff to take annual leave this is proving to be challenging in the current operational climate.	4	2
Accrued Annual Leave 1 to 2 years	Amber	Percentage similar but numbers higher than last year.		
Maori representation	Amber	Improvement on last year but still some way off 2017/18 target. Rank well compare to other DHBs. A diversity action plan will be presented to Board in March detailing a number of activities to be implemented to ensure that we achieve the target and continue to sustain and grow the Maori and Pasifika workforce in the DHB.	2	1
Pacific representation	Amber	Down slightly on last year but only 6 employees off achieving 2017/18 target.		

Headcount and positions

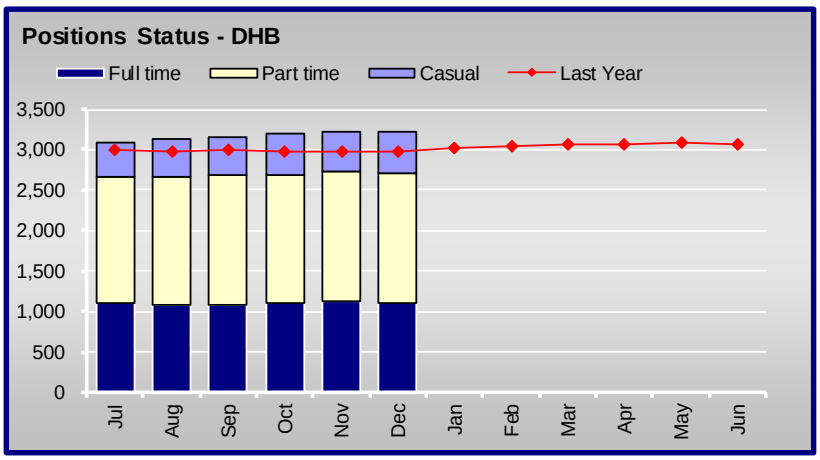
Reporting on headcount/ positions is a snapshot in time rather than an average for the month or year.



Contracted FTEs
2138.9 at 31 Dec. 2017
2055.9 at 31 Dec. 2016
= 4.0% increase

Overall increases/ (decreases)

	FTE	
Medical	17.0	6.7%
Nursing	36.7	4.3%
Allied Health	18.4	4.2%
Support	5.2	4.1%
Mge. & Admin	5.7	1.4%
Total	**83.0**	**4.0%**



Positions filled:
3223 at 31 Dec. 2017
2972 at 31 Dec. 2016
= 8.4% increase (251 positions)

Of the 3223 positions (last year in brackets):
34% are full-time (36%)
50% are part-time (51%)
16% are casual (13%)

Overall increases/ (decreases) –

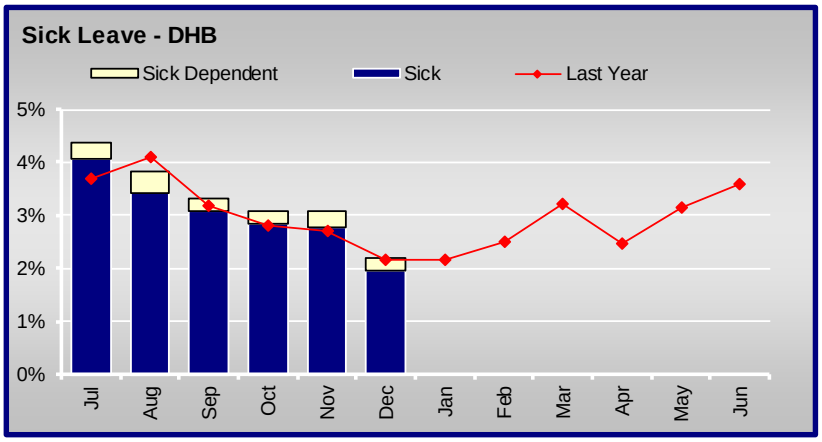
	Full time	Part time	Casual	Total	% change
Medical	18	1	3	22	7.6%
Nursing	(5)	60	129	184	12.5%
Allied Health	(7)	27	2	22	4.0%
Support	1	10	5	16	8.5%
Management & Admin	10	(4)	1	7	1.5%
Totals	**17**	**94**	**140**	**251**	**8.4%**

Sick Leave

The percentage of sick leave taken hours (paid and unpaid) to accrued FTE hours.

Note: as this KPI is reported early in the month, not all sick leave for the previous month has been recorded as yet. Figures and the graph will be adjusted in the following month.

Target is 2.00%



Dec 2017 = 2.20%
Dec 2016 = 2.18%

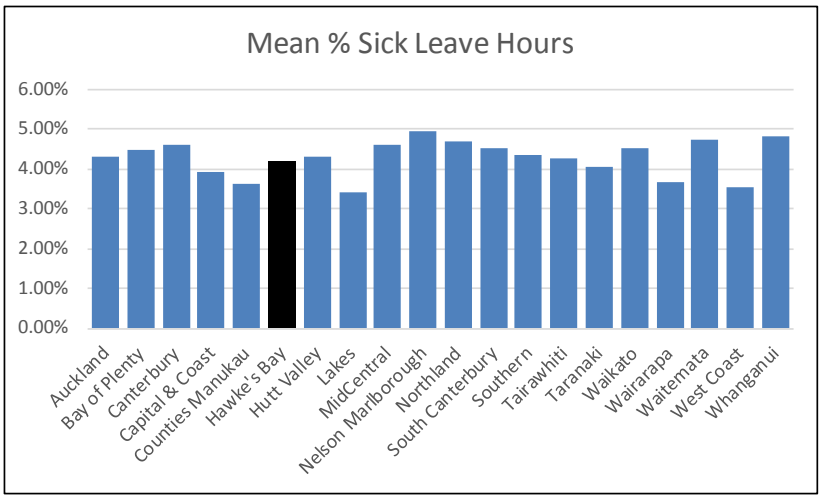
YTD Dec '17 = 3.30%
YTD Dec '16 = 3.10%

DHBSS have taken over reporting of the 20 DHB Comparisons and report on the mean % sick leave hours (quarter ended 30 September 2017).

Hawke's Bay DHB rank:

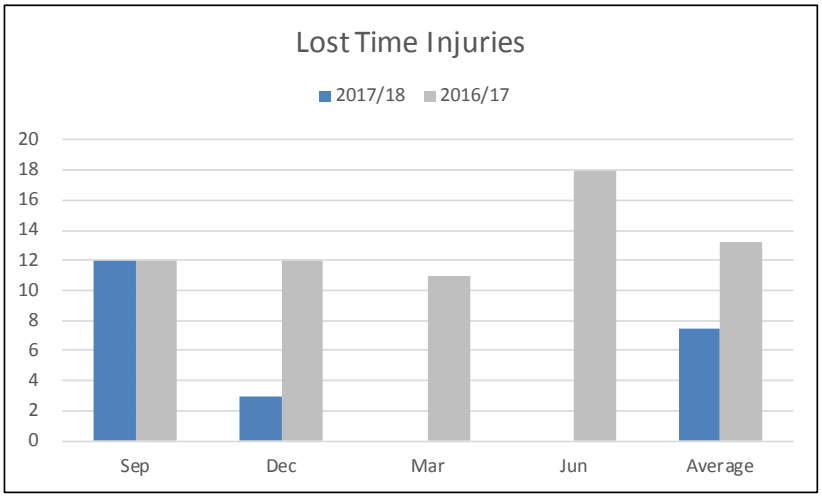
7th lowest of 20 DHBs.

Lowest of the 6 mid-sized DHBs (BOP, HB, Hutt Valley, MidCentral, Nelson Marlborough and Northland)



Lost Time Injuries

Measure the incidences of work time lost due to injury or occupational illness associated with the workplace.



Breakdown by quarter:

	2017/18	2016/17
Sept	12	12
Dec	3	12
Mar		11
Jun		18
Total	**15**	**53**
Average	*8*	*13*

Average days lost

	2017/18	2016/17
Sept	14.7	15.0
Dec	11.5	13.3
Mar		16.8
Jun		24.7
Average	*14.0*	*18.3*

Breakdown by Occupational Group – Year to date ending December

	2017/18	2016/17
Medical	0	1
Nursing	9	15
Allied Health	1	3
Support	4	4
Management & Admin	1	1
Total	**15**	**24**

Breakdown by reason for injury – Year to date ending December

	2017/18	2016/17
Being hit by object	1	1
Being hit, struck or bitten by person	1	2
Falls	3	4
Hitting objects	1	3
Muscular stress	8	12
Other	1	2
Total	**15**	**24**

The reduction of lost time injuries is a significant positive for DHB staff. Contributing factors may be;

- The staff physiotherapist continuing to be well utilized with her services being oversubscribed as the demand for on-site services continues at a high level
- Safe Handling training re-commenced
- Increased communication that there is an on-site doctor available to staff.
- Having a locally based case manager, and HBDHB staff managing simple claims has enabled early, effective face to face communication ensuring staff feel cared for and supported.
- Managers continuing to support staff who are returning to work and have an increased understanding of the importance of communicating to occupational health when a staff member is off work with an injury.

It is important to note that even though the number of injuries has reduced, it is important to know how that equates to lost time days, to really understand the severity of the injuries that occur.

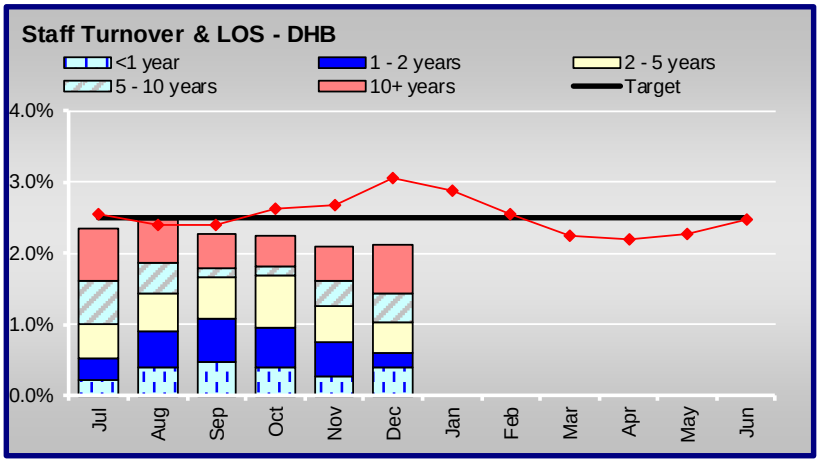
Staff Turnover

Incidence of staff resignations in an organisation. #Voluntary resignations ÷ Total headcount at the beginning of the period. Period is a rolling 3 Months

Note: Junior Doctors (RMOs), Temporary (fixed term) employees and casual employees are excluded from this measure. Employment terminations due to redundancy, death, dismissal and medical grounds are excluded.

A table has been included in the notes for each section to show total headcount at the beginning of the period, new starts, resignations, transfer and changes of status to reconcile to total headcount at the end of the quarter.

Target is 2.50% per quarter.



3 months ended Dec '17 = 2.11% which is below the target of 2.50%.

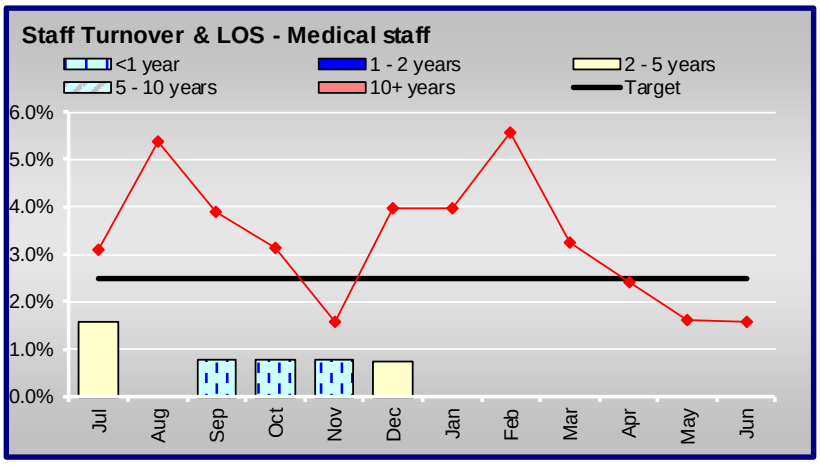
12 months to Dec '17 = 9.17% which is below the 10% annual target. See reasons for leaving below.

2322	Staff at 1 Oct '17
55	New Staff
(51)	Staff resignations
61	Change of status – mostly fixed term to permanent
2387	Staff at 31 Dec '17

Reasons for leaving included in Staff Turnover	**Quarter**	**Last 12 months**
Moving to a position outside HBDHB	17	67
Relocating outside HB	4	34
Retirement	9	34
Not returning from parental leave		2
Personal	3	18
Family reasons	3	8
Further education		3
Other reasons	13	37
Unknown reason		6
Total	**49**	**209**

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

Staff Turnover – Medical Staff



3 months ended Dec '17 = 0.74% which is below the 2.50% target.

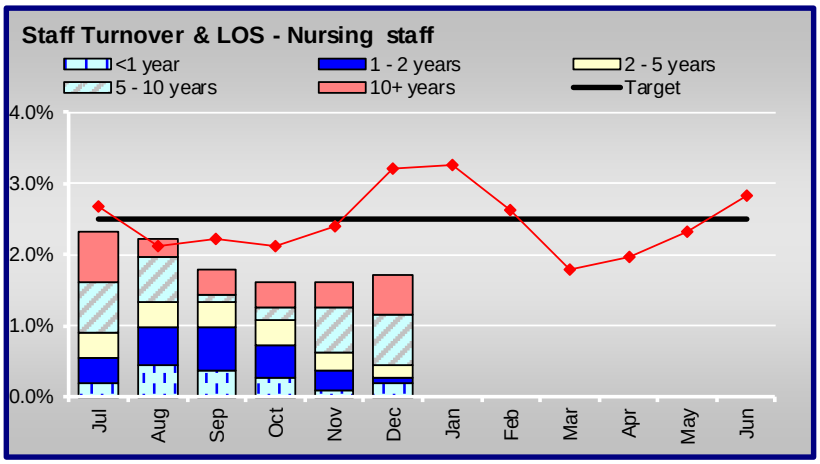
12 months to Dec '17 = 6.50% which is below the 10% annual target. See reasons below.

135	Staff at 1 Oct '17
2	New Staff
(1)	Staff resignations
1	Change of status – fixed term to permanent
0	Trf other staff group
137	Staff at 31 Dec '17

Reasons for leaving included in Staff Turnover	**Quarter**	**Last 12 months**
Moving to a position outside HBDHB	1	4
Relocating outside HB		2
Retirement		
Personal		1
Other reasons		1
Unknown reason		
Total	**1**	**8**

23

Staff Turnover – Nursing Staff



3 months ended Dec '17 = 1.70% which is below the target of 2.50%.

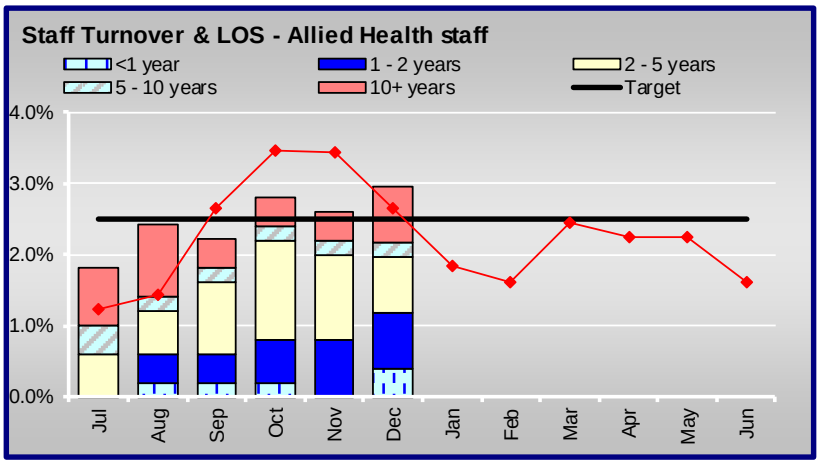
12 months to Dec '17 = 8.15% which is below the 10% annual target.

1118	Staff at 1 Oct '17
21	New Staff
(20)	Staff resignations
33	Change of status – mostly fixed term to permanent
0	Trf other staff group
1152	Staff at 31 Dec '17

Reasons for leaving included in Staff Turnover	**Quarter**	**Last 12 months**
Moving to a position outside HBDHB	6	26
Relocating outside HB		19
Retirement	6	14
Not returning from parental leave		1
Personal	2	8
Family reasons		1
Other reasons	5	17
Unknown reason		5
Total	**19**	**91**

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

Staff Turnover – Allied Health Staff



3 months ended Dec '17 = 2.95% which is above the 2.50% target.

12 months to Dec '17 = 9.37% which is below the 10% annual target.

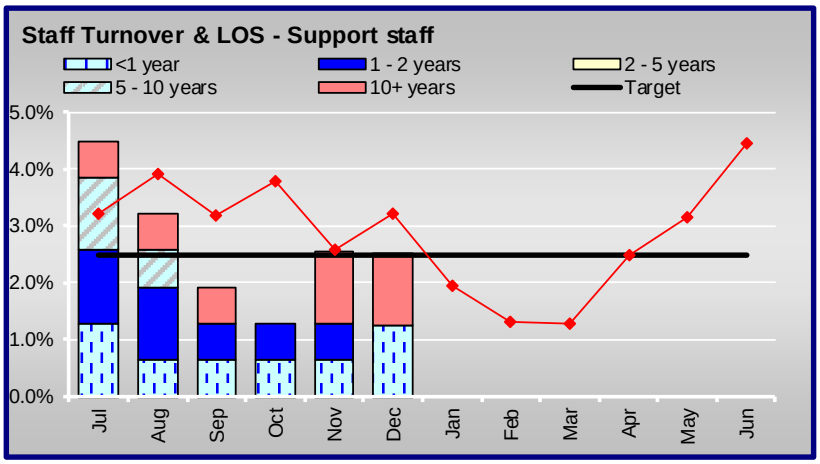
508	Staff at 1 Oct '17
13	New Staff
(15)	Staff resignations
12	Change of status – fixed term or casual to permanent
2	Trf other staff group
520	Staff at 31 Dec '17

Reasons for leaving included in Staff Turnover	**Quarter**	**Last 12 months**
Moving to a position outside HBDHB	5	14
Relocating outside HB	3	9
Retirement		5
Not returning from parental leave		
Personal		3
Family reasons	2	2
Further education		2
Other reasons	5	11
Unknown reasons		
Total	**15**	**46**

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

23

Staff Turnover – Support Staff



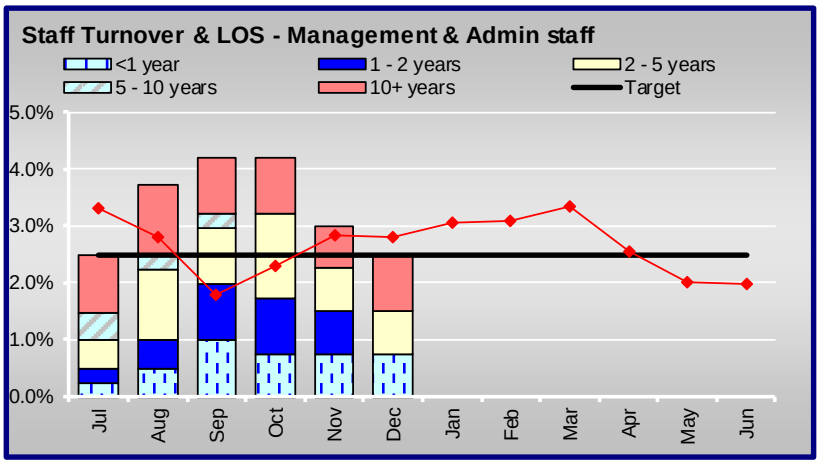
3 months ended Dec '17 = 2.52% which is above the 2.50% target.

12 months to Dec '17 = 10.19% which is above the 10% annual target. See reasons below.

159	Staff at 1 Oct '17
8	New Staff
(4)	Staff resignations
5	Change of status – fixed term to permanent
(2)	Trf. other staff group
166	Staff at 31 Dec '17

Reasons for leaving included in Staff Turnover	**Quarter**	**Last 12 months**
Moving to a position outside HBDHB	1	4
Relocating outside HB		1
Retirement	2	7
Not returning from parental leave		1
Personal	1	2
Family reasons		1
Further education		
Other reasons		
Unknown reason		
Total	**4**	**16**

Staff Turnover – Management & Administration Staff



3 months ended Dec '17 = 2.49% which is below the 2.50% target.

12 months to Dec '17 = 12.28% which is above the 10% annual target. See reasons below.

402	Staff at 1 Oct '17
11	New Staff
(11)	Staff resignations
10	Change of status – mostly fixed term to permanent
0	Trf from other groups
412	Staff at 31 Dec '17

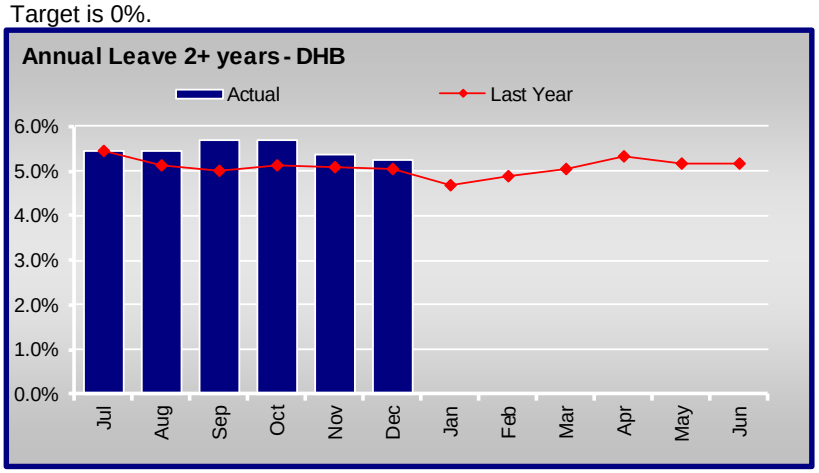
Reasons for leaving included in Staff Turnover	**Quarter**	**Last 12 months**
Moving to a position outside HBDHB	4	19
Relocating outside HB	1	3
Retirement	1	8
Personal		4
Family reasons	1	4
Further education		1
Other reasons	3	8
Unknown reason		1
Total	**10**	**48**

23

Accrued Annual Leave (2+ years)

The percentage of employees where accrued annual leave balance is greater than 2 years annual leave entitlement.

Target is 0%.



Dec '17 = 5.26% (143 staff)
Dec '16 = 5.04% (131 staff)
Increased by 12

The total liability at 31 December 2017 was $19.541m compared to $19.474m at 30 June 2017. This $67k deterioration is made up of:

1. $49k favourable driven by a reduction in the hours owing.
2. ($116k) unfavourable driven by an increase in the average rates.

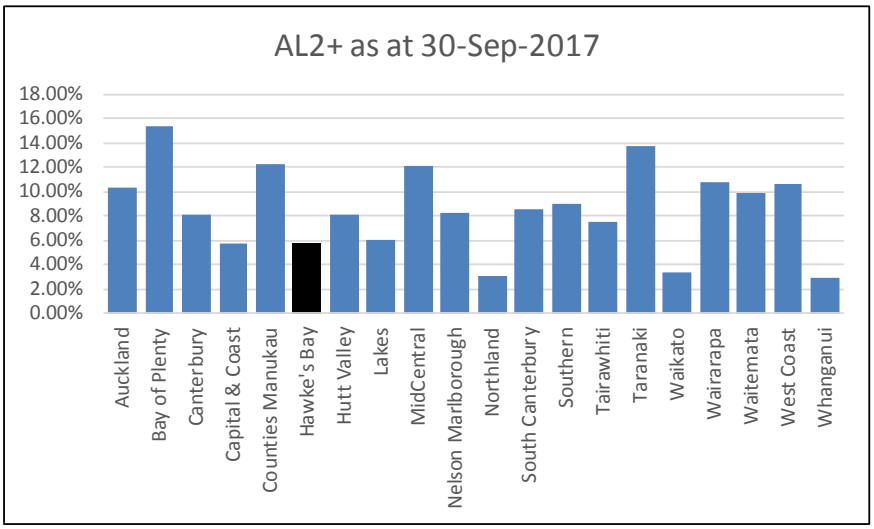
The total leave hours owed (includes statutory lieu leave etc.) has increased in the last year as has the number of employees but the average leave balance has decreased slightly:

	Total Hours Owed	Employees with leave balance	Average Leave balance (hours)
Dec. 2017	459,216	2720	168.83
Dec. 2016	444,839	2602	170.96

DHBSS have taken over reporting of the 20 DHB Comparisons and report on the annual leave percentage of employees with 2+ years of annual leave owing (at 30 September 2017). Hawke's Bay DHB rank:

4th lowest of the 20 DHBs.

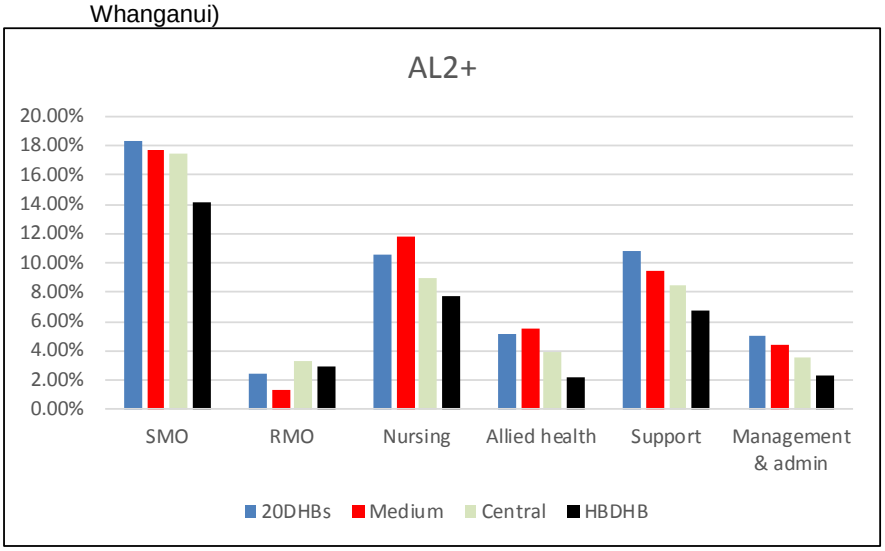
2nd lowest of the 6 mid-sized DHBs (BOP, HB, Hutt Valley, MidCentral, Nelson Marlborough and Northland)



Hawke's Bay also rank well when compared by occupational group and when comparing balance to entitlement:

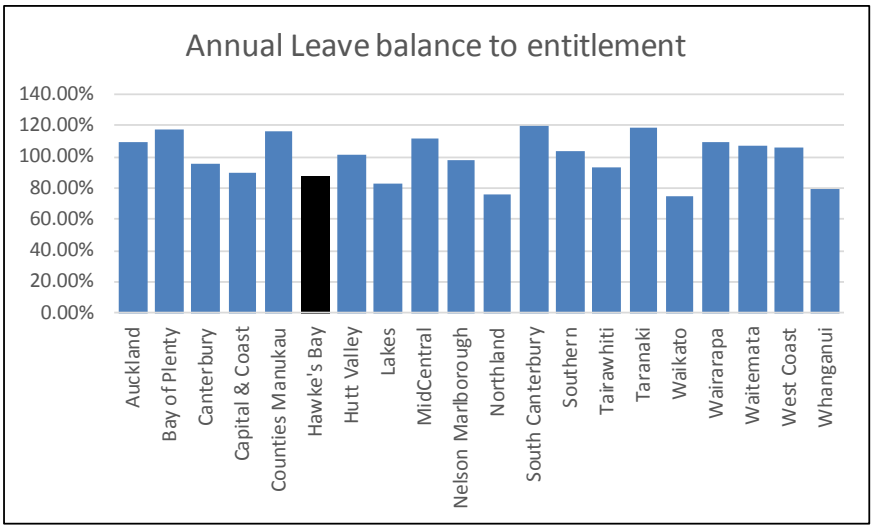
Comparsion against:

- 20 DHBs
- Mid sized DHBs (BOP, HB, Hutt Valley, MidCentral, Nelson Marlborough and Northland)
- Central Region DHBs (Capital & Coast, HB, Hutt Valley, MidCentral, Wairarapa and Whanganui)



Ratio of annual leave balances to annual leave entitlement per FTE. Hawke's Bay sitting at 87.4% ranks at:

- 5th best of 20 DHBs
- 2nd best of mid sized DHBs (BOP, HB, Hutt Valley, MidCentral, Nelson Marlborough and Northland)

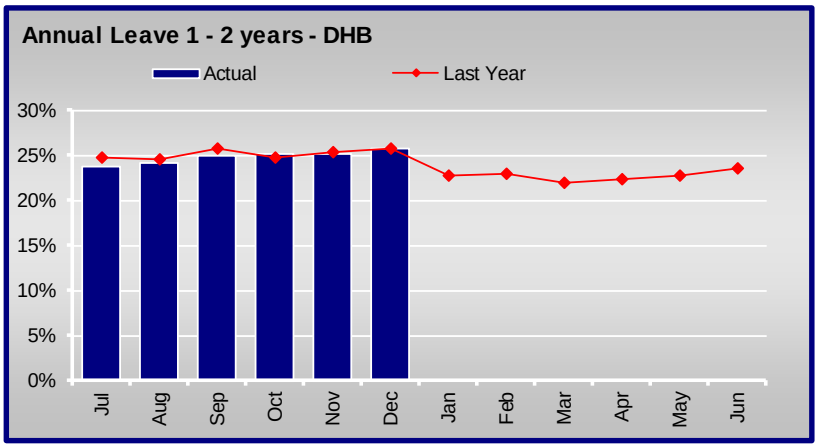


23

Accrued Annual Leave (1 – 2 years)

The percentage of employees where accrued annual leave balance is between 1 and 2 years annual leave entitlement.

Target is 15%.



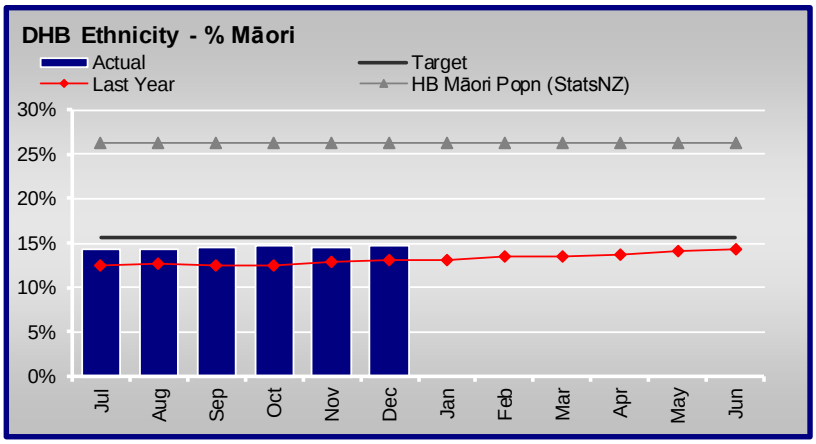
Dec '17 = 25.79% (701 staff)
Dec '16 = 25.63% (666 staff)
Slight increase in percentage of total staff with 1 to 2 years owing and 35 more employees with 1 to 2 years Annual Leave owing.

Staff Ethnicity

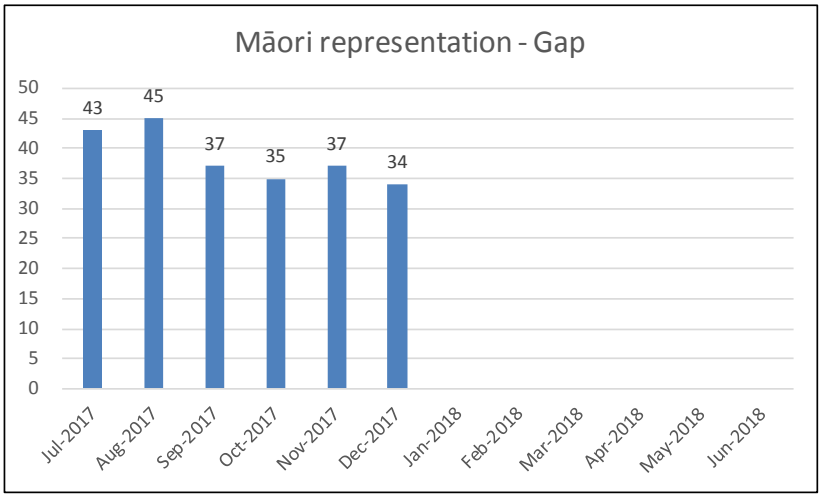
Māori representation
Measure the number of positions at HBDHB where the incumbents identify themselves as Māori

Target is set at 10% improvement on previous year. 2017/18 target = 15.68%. The Māori population for HB is 26.2%

Note - We generally report on positions so we can break our numbers down for reporting purposes by Occupational Group, Service, and Department etc. Some employees have more than one position in more than one Department, Service or occupational group



Note – at 31 December 2012 the percentage of Māori staff was 10.2% compared to 14.7% at 31 December 2017.



Māori staff representation in the Workforce:

	People	Positions
Dec. '17	14.72%	14.61%
Dec. '16	13.43%	13.02%

Dec. 2017 breakdown:

	Positions filled	% of Total
NZ & European	2358	73.16%
Maori	471	14.61%
Pacific Islands	40	1.24%
Asian	189	5.87%
Other	108	3.35%
Not known	57	1.77%
Total	**3223**	

Support staff (34.80%), and Management & Admin staff (17.58%) exceed the DHB target.

Medical (4.82%) Nursing staff (13.08%) and Allied Health staff (14.73%) are below the target.

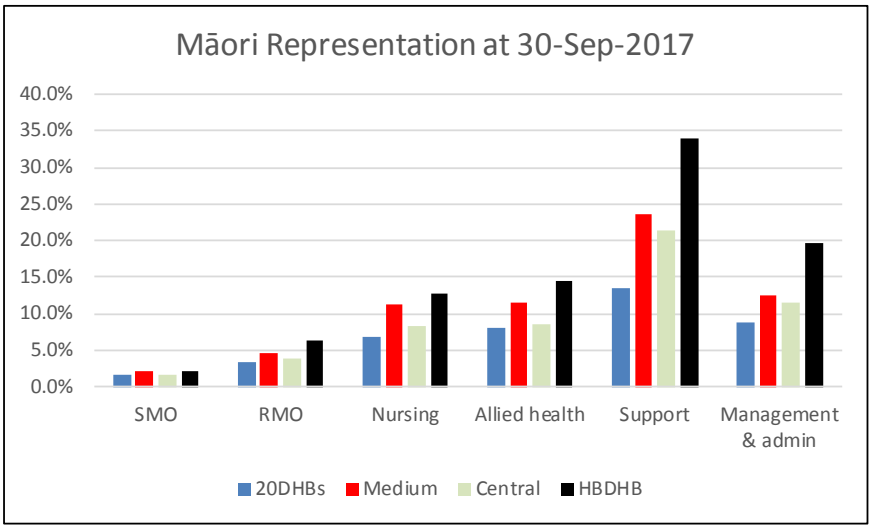
We currently have a gap of 34 positions to achieve the 2017/18 target.

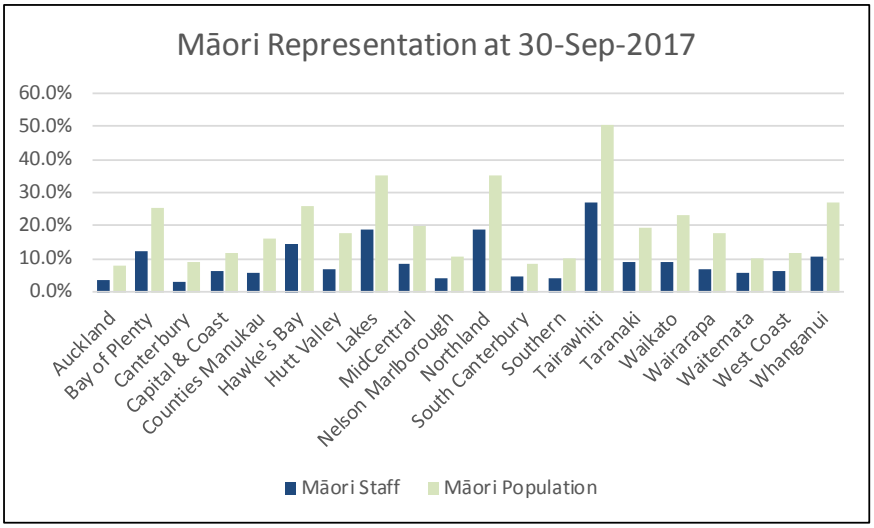
459	Māori Staff - 1 Oct. '17
31	New Staff
(19)	Staff resignations
0	Changes to ethnicity
471	Māori Staff – 31 Dec. '17

23

DHBSS have taken over reporting of the 20 DHB Comparisons and report on Ethnicity figures (to 30 September 2017). The first chart shows that Hawke's Bay DHB compares favourably against:

- 20 DHB average
- Medium sized DHBs
- Central Region DHBs





The above chart shows how DHB staffing compares against the Māori population. At 30 September 2017 Hawke's Bay DHB had 14.6% of employees identifying as Māori against the HB Māori population of 26.1%

Looking at DHBs with the highest Māori Population we rank 5th highest behind Tairawhiti, Lakes, Northland and Whanganui. Looking at DHBs with the highest Māori staffing percentages we rank 4th behind Tairawhiti, Lakes and Northland.

Summary of figures at 30 September 2017:

DHB	Maori Staff	Maori Population	Maori Representation	Rank
Waitemata	5.7%	10.0%	56.6%	1
Hawke's Bay	14.6%	26.1%	55.8%	2
West Coast	6.6%	11.9%	55.3%	3
Capital & Coast	6.2%	11.5%	53.7%	4
Northland	18.7%	34.9%	53.6%	5
Tairawhiti	27.0%	50.4%	53.5%	6
Lakes	18.8%	35.4%	52.9%	7
South Canterbury	4.4%	8.5%	51.9%	8
Bay of Plenty	12.4%	25.2%	49.1%	9
Taranaki	9.0%	19.1%	46.9%	10
Auckland	3.8%	8.2%	45.9%	11
MidCentral	8.2%	20.1%	40.9%	12
Hutt Valley	7.1%	17.5%	40.3%	13
Whanganui	10.8%	26.8%	40.1%	14
Southern	4.0%	10.2%	39.1%	15
Waikato	9.0%	23.0%	39.1%	16
Wairarapa	6.6%	17.7%	37.1%	17
Nelson Marlborough	3.9%	10.5%	37.0%	18
Counties Manukau	5.5%	15.9%	34.6%	19
Canterbury	2.9%	9.2%	31.4%	20

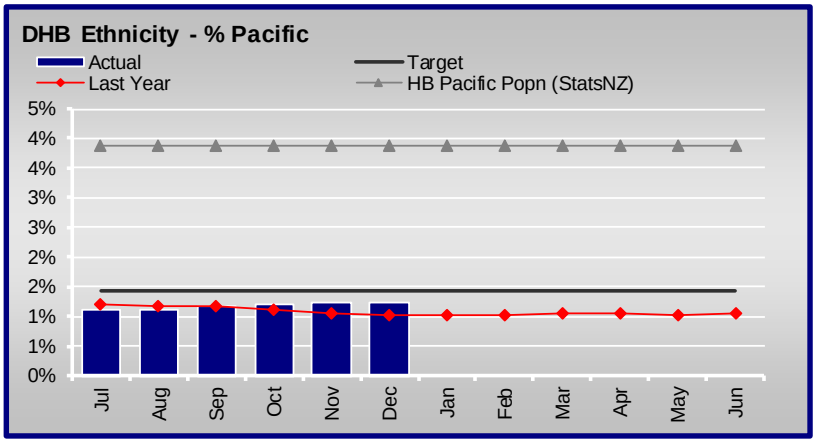
As you can see there is quite a variation in the levels of Māori staff and also quite a variation in levels of Māori Population. Table above shows how close each DHB is to their Māori Population.

Pacific representation

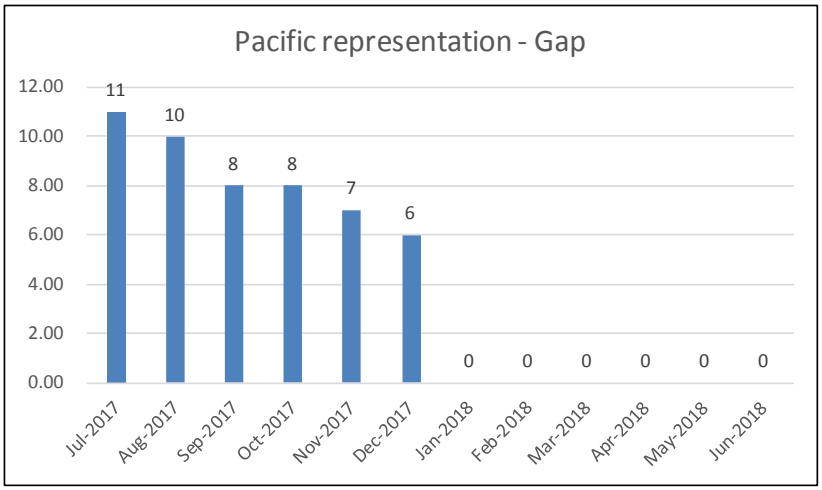
Measure the number of positions at HBDHB where the incumbents identify themselves as Pacific

Target is set at 1.44% for 2017/18. The Pacific population for HB is 3.9%

Note - We generally report on positions so we can break our numbers down for reporting purposes by Occupational Group, Service, and Department etc. Some employees have more than one position in more than one Department, Service or occupational group



Note – at 31 December 2012 the percentage of Pacific staff was 1.27% compared to 1.24% at 31 December 2017.



Pacific staff representation in the Workforce:

	People	Positions
Dec. '17	1.33%	1.24%
Dec. '16	1.11%	1.01%

Support staff (1.96%), and Management & Admin staff (2.12%) exceed the DHB target.

Medical (0.64%) Nursing staff (1.15%) and Allied Health staff (0.87%) are below the target.

We currently have a gap of 6 positions to achieve the 2017/18 target.

37	Pacific Staff - 1 Oct. '17
6	New Staff
(3)	Staff resignations
	Changes to ethnicity
40	Pacific Staff 31 Dec. '17

HBDHB ANNUAL PLAN 2016/17 FINAL

Signed by MoH

Available on Our Health Website
http://www.hawkesbay.health.nz/about-us/meeting-agendas-and-minutes/board-meetings-2018/

& Diligent Boardbooks Resource Centre

HAWKE'S BAY
District Health Board
Whakawāteatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

That the public now be excluded from the following parts of the meeting, namely:

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

The general subject of the matter to be considered while the public is excluded, the reason for passing this resolution in relation to the matter and the specific grounds under Clause 32(a) of the New Zealand Public Health and Disability Act 2000 for the passing of this resolution are as follows:

- Official Information Act 1982 9(2)(ba) to protect information which is subject to an obligation of confidence.
- Official Information Act 1982 9(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions between the organisation, board and officers of the Minister of the Crown.
- NZPHD Act 2000, schedule 3, clause 32(a), that the public conduct of the whole or relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982).