BOARD MEETING

Date: Wednesday 29 August 2018

Time: 1:30pm

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

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

Apologies: Kevin Atkinson and Dr Helen Francis

In Attendance:
Dr Kevin Snee, Chief Executive Officer
Executive Management Team members
Rachel Ritchie, Chair HB Health Consumer Council
Jill Garrett, Strategic Services Manager - Primary
Penny Rongotoa, Portfolio Manager - Integration
Lisa Malde, Sustainability Officer
Gavin Carey-Smith, Facilities Manager
Lisa Jones, Business Intelligence Team Leader
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 and Welcome to Carriann Hall, Executive Director Financial Services		
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 – Kevin Snee	110	
9.	Financial Performance Report – Carriann Hall / Ashton Kirk	111	
10.	Board Health & Safety Champion's Update – Board Safety Champion	112	
	Section 2: Presentation		
11.	HBDHB Environmental Sustainability Update ***(must be completed prior to 2:30pm)*** – Lisa Malde & Gavin Carey-Smith	113	2:00
	Section 3: Reports from Committee Chairs		
12.	HB Clinical Council – Co-Chairs, John Gommans / Andy Phillips	114	2:25
13.	HB Health Consumer Council – Chair, Rachel Ritchie	115	2:30
14.	Māori Relationship Board – Chair, Heather Skipworth	116	2:35
15.	Pasifika Health Leadership Group (verbal) – Barbara Arnott (CPHAC Chair)	117	2:40
	Section 4: For Information		
16.	Te Ara Whakapiri Next Steps (Last Days of Life) – Chris Ash, Jill Garrett & Penny Rongotoa	118	2:45
17.	Te Ara Whakawaiora - Access Rates 0-4 / 45-64 yrs (local indicator) Qtly - Jill Garrett	119	2:50
18.	18.1 HBDHB Non-Financial Performance Framework Dashboard Q4 – Lisa Jones 18.2 HBDHB Non-Financial Performance Exceptions Report Q4 18.3 HBDHB Quarterly Performance Monitoring Dashboard Q3 (from MoH)	120 121 122	3.00
19.	Clinical Services Plan update – Ken Foote	123	3:10
	Section 5: General Business		
20.	**Section 6: Recommendation to Exclude the Public** Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	**Section 7: Routine**	Ref #	**Time (pm)**
21.	Minutes of Previous Meeting (public excluded)		
22.	Matters Arising – Review of Actions (nil)		
23.	Board Approval of Actions exceeding limits delegated by CEO	124	3:12
24.	Chair's Update (verbal)		
	Section 8: Reports from Committee Chairs		
25.	HB Clinical Council Co-Chairs, John Gommans / Andy Phillips	125	3:20
26.	Finance Risk and Audit Committee – Chair, Dan Druzianic	126	3:30
	Section 9: Discussion		
27.	Whole of Board Appraisal Update – Ken Foote	127	3.40

The next HBDHB Board Meeting will be held at
1.30pm on WEDNESDAY 26 September 2018

Board "Interest Register" - 8 August 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	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
	Active	Involved with Waitangi Claim #2687 (involving Napier Hospital land) sold by the Government	Requested that this be noted on the Interest Register	Unlikely to be any conflict of Interest.	The Chair	28.03.18
Barbara Arnott	Active	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	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.11
	Active	HB Medical Research Foundation	Trustee	Declare this interest prior to any discussion in relation to the Foundation, and an appropirate mitigation action is decided on.	The Chair	20.08.14
	Active	Independent Consultant	To a variety of health organisations.	Will declare at the beginning of meeting(s) if there are any projects that have anything to do with items on the agenda and will not be involved in those discussions	The Chair	26.02.18

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Diana Kirton	Active	Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB.	Perceived Conflict of Interest. Non-Pecuniary interest.	Will not take part in any decisions in relation to surgical services provided by or contracted by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO	The Chair	18.02.09
	Active	Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014	Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers.	Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on.	The Chair	16.01.14
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.14
	Active	Member, Hawke's Bay Law Society Standards Committee	Law Society	No conflict perceived	The Chair	20.06.17
	Active	RENEW Counselling Services	Counsellor	No conflict perceived	The Chair	17.07.17
Dan Druzianic	Active	Director of Markhams Hawke's Bay Limited	Potential Conflict of Interest. Some clients may from time to time be employed by or have contracts with HBDHB	Declare an interest at any time an issue arises concerning a client, and take no further part in any decision or discussion on this matter.	The Chair	7.12.10
Jacoby Poulain	Active	Board Member of Eastern Institute of Technology (EIT)	Perceived conflict - HBDHB has a Memorandum of Understanding (MOU) with EIT relating to training and development in health related occupations.	Will not take part in any decisions or discussions in relation to the MOU between HBDHB and EIT	The Chair	14.1.14
	Active	Councillor Hastings District Council	Potential conflict as potential advocate for Hastings District population whereas HBDHB coveres whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Hastings and Chair decides on appropriate mitigation action.	The Chair	14.1.14
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumatua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust (aligned to Iron Maori Limited)	The Trust has contracts with HBDHB including the Green Prescription Contract; and the Mobility Action Plan (Muscular Skeletal)	Will not take part in any discussions or decisions relating to any actions or contracts with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 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 "Whararikí Trust" (advised 30-8-17)	Relationship and and may be contractural from time to time	No conflict	The Chair	5.12.16
	Active	Whakaraki Trust "HB Tamariki Health Housing fund"	Formed a relationship and MoU with HBDHB Child Health Team Community Women and Children's Directorate. The Trust created a "HB Tamariki Health Housing fund" to ensure warm dry homes for Hawke's Bay whanau.	Will advise at the outset of any discussions on this topic, and will not take part in any decisions / or financial discussions relating to this arrangement.	The Chair	8.08.18
Hine Flood	Active	Member, Health Hawkes Bay Priority Population Committee	Pecuniary interest - Oversight and advise on service delivery to HBH priority populations.	Will not take part in any conflict of interest that may arise or in relation to any contract or financial arrangement with the PPC and HBDHB	The Chair	14.02.17
	Active	Councillor for the Wairoa District Council	Perceived Conflict - advocate for the Wairoa District population and HBDHB covers the whole of the Hawkes Bay region.	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.02.17

MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 25 JULY 2018, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.00PM

PUBLIC

Present: Kevin Atkinson (Chair)
Ngahiwi Tomoana (Deputy Chair)
Dan Druzianic
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)
Members of the Executive Management Team
Drs Gommans and Phillips (as co-Chairs, HB Clinical Council)
Rachel Ritchie (Chair, HB Health Consumer Council)
Members of the public and media
Jacqui Sanders-Jones, Minute Taker and Executive Assistant to Executive Director of Provider Services

3. INTEREST REGISTER

No changes to the interests register were advised

No interests were recorded for any items on the agenda

4. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on 27 June 2018, were confirmed as a correct record of the meeting.

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

5. MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: **Human Resources (HR) KPIs –** Detail sought by Ngahiwi Tomoana and monthly updates to be provided around Māori workforce in hand. Remove item.

Item 2: **Interest Register –** updated – Actioned. Remove item

Item 3: **Addiction Services –** Still to be determined – no further progress – emphasise interest in this from DHB perspective and request to eventuate onto EMT Work plan. Noted that families feel they don't know what support is available and how to access. Chris

Ash confirmed a number of teams in primary care are working up a scoping report. This piece of work will be ready soon to take to committees. **Remain as Matters Arising**

Item 4: **Treaty Settlement Groups –** Actioned. **Remove item**

Item 5**:** **Alcohol at the Health Awards** – annual review in April – Actioned. **Remove item**.

Item 6: **Information Services & Mobility** - working through – **remain as Matters Arising**

Item 7: I**mplementing the Consumer Engagement Strategy** – schedule presentation to board and timings for Work plan - confirmed as Sept/Oct. Actioned. **Remove item.**

Item 8: **Recognising Consumer Participation**, Policy Amendment. All actioned**. Remove item**

Analysis request around lowering of bowel screening age in HB
An equity impact assessment has been prepared by the Ministry of Health and provided to DHBs. Andy Phillips noted that an external view on this report was being sought and feedback would be provided to the Ministry.

6. BOARD WORK PLAN

The Board Work Plan was noted.

He Ngākau Aotea report due to come to table in October – bring forward to August please - **ACTION**

7. CHAIR'S REPORT

- Helen Francis and Kevin Atkinson will be absent from August meeting – Ngahiwi Tomoana to Chair.
- 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
Elaine (Nola) Palmer	Assessor	Older Persons & Mental Health	34	4-May-18

- Letter from Peter Hughes, State Services Commissioner requesting confirmation of HBDHB maintaining appropriate processes in place in regards to CEO expenses/gifts. Assurance given by Chair.
- The first four DHB sites are running live on the NOS programme. Things are running as well as expected after the first 3 weeks.

8. CHIEF EXECUTIVE OFFICER'S REPORT

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

- Made reference to poor year end position regarding financial performance
- ED and Elective surgery – poor performance was due to acute activity being managed over last few months and how we can manage better going forward.
- Difficulties in Provider Services were not helped by contingency planning for the nurses strike.
- Good meeting with Director General recently.
- Primary Care Development partnerships need to take centre stage, alongside smoke free strategy and annual plan
- CSP – Intention is that we are ready for consultation in August/Sept 2018.
- Performance noted immunisations had strong results from Raising Healthy Kids and Faster Cancer Treatment is doing well.

9. FINANCIAL PERFORMANCE REPORT

Ashton Kirk (Acting ED of Financial Services) spoke to the Financial Report for June 2018, which showed $4.6 million unfavourable to plan reflecting high patient volumes in the month, continuation of the undelivered savings and other issues experienced in previous months, and the adjustments from forecast mentioned above.

The full year result is predicted to be $8.3 million unfavourable, attributable to difficulty achieving savings, unfavourable IDF outflows to budget, the cost of elective surgery earlier in the year, radiology after hours reads, high patient volumes in the second half of the year, and the result for the June month (see previous paragraph), partly offset by the release of the contingency, allied health vacancies, and PHARMAC rebates

Comments noted in addition to the report included:

- Challenging and difficult year financially for the DHB – especially last month.
- Capital Projects:
  - Gastro facility is in good space. Slight risk around financials of equipment.
  - Surgical Expansion project: Kevin received an approval letter on this $12m project and it can proceed with MoH authority. Seismic issues may push the timeframe out by nine months. Considering deficit we may need to borrow to attain this project potentially.
- Budget will be communicated publicly shortly.

10. HEALTH & SAFETY BOARD CHAMPION'S UPDATE

Dan Druzianic and Ana Apatu as Health & Safety Board Champions had visited Pharmacy – with the following noted:

1. Physically the design of pharmacy is challenging. The foyer from ED is cluttered. Through to the dispensary is tight for space for staff to work in. The physical closeness of staff working together is not ideal and potential for uncomfortable proximity for some. Bench tops and work areas are not conducive to productive working environment. Concern raised on how staff are safe amongst hazardous substances and their safe disposal.
2. Difficulties in recruiting staff to such a challenging physical environment.
3. Staff want to draw up aseptic drugs themselves, however this requires investment to do in house.
4. Staff are very aware of finances.
5. Stress levels for staff is a KPI. Suggestion that a team look at indicators for levels of stress for staff.

Dan suggested taking Peter Dunkerley through the Pharmacy.

It was explained there were Chief Pharmacist interviews taking place and this could be further investigated by them.

Andy Phillips commented:

- Laboratories had huge improvements over past few years.
- Formalin disposal is to be addressed.
- New histology lab will allow opportunity for revision of where hazardous substances are disposed of.
- Elaine Roberts, Pharmacy Manager, will be able to assist with addressing issues raised.

Andy further explained pharmacy robots process and whether this is an opportunity to reduce staff costs and enable reduction in risk for those staff within pharmacy environment.

Audit being carried out on medication safety. Adverse events lists 'medication safety' as an issue.

Agreed that regular review within H&S of Pharmacy is required:

1. H&S issues in Pharmacy to be reviewed and to report back next Board meeting – Anne McLeod and Colin Hutchinson -**ACTION**
2. Useful to get an understanding on the approaches available in the medium to long term to achieve a better situation – Colin Hutchinson -**ACTION**

REPORT FROM COMMITTEE CHAIRS

- **Smoke free** – no comments had been received from Clinical Council, MRB, and Consumer Council. Chair to take offline to ensure reports are working well through the various committees.

11. HAWKE'S BAY CLINICAL COUNCIL

Co-Chair John Gommans spoke to the report from the Council's meeting held on 11 July 2018.

This had been a short meeting due to Contingency planning - no commentary provided.

12. HAWKE'S BAY HEALTH CONSUMER COUNCIL

Rachel Ritchie (Chair) advised the outcomes of their meeting held on 12 July 2018:

Farewelled five consumer members. There had been a strong level of interest in filling the new positons, with nine people interviewed and five appointed.

Other discussions included:

- Reports coming through to Consumer Council are often For Information Only.
  Agreed that reports coming through Consumer Council do need to be considered appropriately.

13. MĀORI RELATIONSHIP BOARD

Ngahiwi Tomoana and Hine Flood spoke to the meeting held 11 July 2018.

- **He Ngākau Aotea** report will assist with reviewing items through MRB

  The Board Chair congratulated members on the success of the July MRB meeting. Hine agreed that mechanisms are in place (e.g. Terms of Reference) needed a refresh. MRB has reviewed where we are at, what is planned and now looking at information coming to MRB in finer detail. Recognised there is opportunity for growth and improvement especially with George Reedy's involvement.
  Agreed values and how we treat people.
  MRB – He Ngākau Aotea was received well. Will go to Ngati Kahungunu before coming back to Board. Hine stated that MRB need to know what HBDHB board want from MRB.

PASIFIKA HEALTH LEADERSHIP GROUP

Barbara Arnott (Chair of CPHAC) advised of a moving presentation from Cheryl Newman, giving an honest update re screening for Family Violence/Violence Intervention Programme at HBDHB. Discussion points followed:

- CEO will take to Tripartite as the focus in Family Violence (FV). ACC will also be involved.
- Rate of screening for HDBHB was lower than others nationally although prevalent within community.
- Noted there is no school screening programme.
- Chris Ash and Andy Phillips noted this as a priority piece of work. Intersectoral approach will make the difference. Identified importance that all these services can now interact with each other.

- Jacoby Poulain commented that she has had conversations with Hastings DC, Police, and Mayor regarding system-wide response to FV. Important that DHB role is to link up the services for the whanau to enable a co-ordinated response.
- Chris Ash felt there are a lot more resources available than we make use of. NUKA model works at destigmatising the issue of FV in healthcare. A focus on screening will be an enabler to using resources better.

FOR DECISION

14. CENTRAL TECHNICAL ADVISORY SERVICES (TAS)

RESOLUTION

That the HBDHB Board (as an A Class Shareholder)

1. **Vote** in favour of the attached resolution to alter the CTAS Constitution.

Moved: Ngahiwi Tomoana
Seconded: Ana Apatu
Carried

15. Primary Care Partnership Development Governance

RESOLUTION

That the Board

2. **Approves** the following appointments to the Primary Care Development Partnership Governance Group for the first year ending 30 June 2019:

HHB Ltd Board:	Bayden Barber
	Jason Ward
	Jeremy Harker
HBDHB Board:	Hine Flood
	Ana Apatu
	Helen Francis
Maori Relationship Board	Beverly Te Huia
Clinical Council	David Rodgers
Consumer Council	Rachel Ritchie

Moved: Barbara Arnott
Seconded: Heather Skipworth
Carried

In addition discussions included:

- Kevin Atkinson thanked those Board members who put themselves forward. Appointments would be for 12 months.
- Ken Foote will provide governance support and an EA from Health Hawke's Bay will provide secretarial services

FOR DISCUSSION / INFORMATION

16. TE ARA WHAKAWAIORA - Smoke free update *from Johanna Wilson Acting Smoke free Programme Manager & Julie Arthur, Midwifery Director*

Johanna spoke of the statistics provide within the paper.

This report shows good work done through this hospital. However there is room for improvement with Maori women and in particular, pregnant Maori women.

In addition discussions included:

- Board thanked the Smoke free team. This is greater than a health response; this is about whole community/whanau involvement in prevention of smoke related deaths. Kaumatua conversations are being held and MRB are also reviewing what they can do. Wairoa work provides stop smoking practitioners. Project team involvement in young parent programmes; providing Maternity CO smokealyzers to midwives.
- Discussion on smokealyzers in media and negative impact potential.
- Andy Phillips and Chris Ash recognised smoking as a strongly addictive drug and the need to hear voice of community. Issues like FV, P, mental health, smoking is prominent. Andy suggested conversation between population health, primary care and Maori health in order to provide greater support and resource in order to resolve problem.
- Jacoby feels that the Maternity support is fragmented and requested further update on Maternal Well Being programme – Maternity, Pop health & Maori health services should be joined in a seamless way to support our most vulnerable women.
  An up to date report on Maternal Well-being programme to be circulated to Board members. Julie Arthur/Patrick le Geyt –ACTION.
- Rachel Ritchie commented that addictive issues are interlinked by triggers and stresses. Poses a wider question of how we address these first as these are what lead to smoking. Agreed and understood that the whole picture (holistically) should be reviewed i.e. healthy home programme.
- Ngahiwi explained that status makes a difference to smoking stats. Smoking is a societal issue and involvement of professional women could make an influential difference.
- The Board requested that next steps and recommendations be included in next Board report.

FOR MONITORING

17. Annual Plan

Chris Ash provided brief update on Annual Plan – including local priorities and Clinical Services Plan

Submission of first draft will be made this week and will be circulated to Board. **Action**
Essential to ensure any specifics from Letter of Expectations from MoH (much of which was expected) are addressed and confirmed with departments to ensure activity proposed is correct. Annual Plan will have focus on Equity.
Explained priority areas – document circulated this Friday will explain steps to take the new areas forward. Includes a collaborative redesign of Mental Health and Addictions and ensures outcomes for young people and school services including specific projects.
Annual Plan also includes completion of the Clinical Services Plan and addresses HBDHB Sustainability and Carbon footprint.

Focus on Addictions has 3 and 8 week targets and includes narrative into plan from population health and Maori health in order to address these issues within communities.

Next Steps: September deadline for final submission. MoH will be engaging with DHBs prior to Christmas with any amendments.

Comments noted:

- Generally felt that focus was on the Ministry of Health expectations within this proposed Annual Plan and not focused on the people we serve. CEO explained that this year's report back to the Ministry is to specifically address the letter of expectations and the MoH template requirements, and should be considered a compliance document.

GENERAL BUSINESS

AGM of Chaplaincy Service on Thursday 13 September 2018, 3pm in the Hospital Chapel. Chair encouraged attendance from Board members. Contact Rev Barbara Walker Barbara.walker@hbdhb.govt.nz

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

18. RESOLUTION TO EXCLUDE THE PUBLIC

RESOLVED

That the Board

Exclude the public from the following items:

19. Confirmation of Minutes of Board Meeting
20. Matters Arising from the Minutes of Board Meeting
21. Board Approval of Actions exceeding limits delegated by CEO
22. Chair's Update
23. Clinical Services Plan 2nd Draft
24. Hawke's Bay Clinical Council Report
25 Hawkes Bay Consumer Council Report
26 Maori Relationship Board Report
25. Finance Risk and Audit Committee Report

Moved: **Helen Francis**
Seconded: **Ana Apatu**
Carried

The public section of the Board Meeting closed 3.32pm

Signed: _____
Chair

Date: _____

BOARD MEETING - MATTERS ARISING
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	30/5/18 25/7/18	**Human Resource (HR) KPIs – Maori Workforce** Detail sought by Ngahiwi Tomoana in June 2018. Monthly updates on Maori Workforce to be provided.	Kate Coley Kevin Snee	Sept 18	Suggest via the CEO's Report Monthly
2	27/6/18 25/7/18	**Addiction Services** Raised by Diana Kirton in June advising this does not appear on the workplan currently. To be determined A number of teams in primary care are working up a scoping report	Claire / Colin Chris Ash		Ongoing
3	27/6/18	**Information Services and Mobility** progress, the Board wish to receive presentations periodically. Topics: Business Intelligence, Clinical Portal and Mobility	Anne Speden		Separate sessions with the Board will be arranged accordingly and advised by CEO and Anne.
4	25/7/18	**He Ngākau Aotea Report** The Board wish to see this in August.		Aug 18	Subsequently advised this will be later in the year.
5	25/7/18	**Health and Safety matters noted in Pharmacy:** to be reviewed and reported back to the Board Meeting. Useful to gain an understanding on the approaches available in the medium to long term to achieve a better situation.	Anne McLeod and Colin Hutchinson Colin Hutchinson	Sept 18	Included on workplan
6	25/7/18	**Maternal Well-being Programme** (further to presentation provided in May): The Board requested an update.	Patrick LeGeyt & Charissa Keenan		Timing to be confirmed (likely October)
		Chaplaincy Services AGM is being held on Thursday 13 September at the Hospital Chapel.			

BOARD WORKPLAN

As at 21 Aug 2018

26-Sep-18	**EMT Member**	**MRB Meeting Date**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**BOARD Meeting date**
Alcohol Paper	Kevin Snee	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-18
Annual Plan 2018/19 -	Chris Ash	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-18
Clinical Services Plan Monthly Update (aug, sep, oct)	Ken Foote	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-18
Violence Intervention Programme Presentation Committees reviewed in July - EMT 28 Aug - Board Sept TBC	Colin Hutchinson/Claire Caddie	11-Jul-18	8-Aug-18	12-Jul-18	26-Sep-18
HR KPIs Q4 + Māori workforce detail monthly (via CEO's report)	Kate Coley				26-Sep-18
Matariki Regional Development Strategy and Social Inclusion Strategy update (6 mthly) **Sept**-Mar	Andy Phillips	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-18
Te Ara Whakawaiora - Breastfeeding (National Indicator)	TBC	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-18
Urgent Care (After Hours) Service Update 6mthly (Sept-Mar-Sept)	Wayne Woolrich	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-18
Finance Report (Aug)	Carriann Hall				26-Sep-18

31-Oct-18	**EMT Member**	**MRB Meeting Date**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**BOARD Meeting date**
Clinical Services Plan Monthly Update (aug, sep, oct)	Ken Foote	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
He Ngakau Aotea (following consultation with Iwi)	Patrick LeGeyt				31-Oct-18
Consumer Engagement Strategy Implementation Plan and presentation.	Kate Coley			15-Nov-18	31-Oct-18
National Mental Health Inquiry	Colin Hutchinson/Claire Caddie	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
Model of Care for Haematology and Oncology Presentation and paper (Public Excluded)	Colin Hutchinson/Claire Caddie		10-Oct-18		31-Oct-18
Maternal Wellbeing Programme Update (Board update action 25/7) other committees TBC	Patrick LeGeyt	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
Analysis of earlier bowel screening for Maori and Pasifika	Chris Ash				31-Oct-18
Planned MRI and Fluoroscopy Equipment Replacement Programme Detailed Business Case'	Colin Hutchinson/Claire Caddie		10-Oct-18		31-Oct-18
TAS Annual Plan					31-Oct-18
Using Consumer Stories Revised ... (not considered in July by governance groups - pulled at the last minute)	Kate Coley / John Gommans	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
Collaborative Pathways update (July - Oct - Feb - June)	Chris Ash & Mark Peterson		10-Oct-18	11-Oct-18	31-Oct-18
Establishing Health and Social Care Localities in HB (Mar 18,Sept) - update on activity planned Board action Mar	Chris Ash	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
HR - KPIs Q4 Apr-Jun 18 / Q1 Jul-Sept 18- new format	Kate Coley				31-Oct-18
Te Ara Whakawaiora - Alcohol and other Drugs (National and Local Indicators)	Andy Phillips	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
Te Ara Whakawaiora - Cardiovascular (National Indicator)	Colin Hutchinson/Claire Caddie	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
Te Ara Whakawaiora - Improving Access Indicator	Colin Hutchinson/Claire Caddie	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
Finance Report (Sept)	Carriann Hall				31-Oct-18

28-Nov-18	**EMT Member**	**MRB Meeting Date**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**BOARD Meeting date**
Clinical Services Plan in final form	Ken Foote	14-Nov-18	14-Nov-18	15-Nov-18	28-Nov-18
Health Equity Report	Andy Phillips	14-Nov-18	14-Nov-18	15-Nov-18	28-Nov-18
Best Start Healthy Eating & Activity Plan update (for information - 6 mthly Nov-May-Nov18)	Andy Phillips		14-Nov-18	15-Nov-18	28-Nov-18
HBDHB Non-Financial Performance Framework Dashboard Q1 - EMT/Board	TBC				28-Nov-18
HBDHB Quarterly Performance Monitoring Dashboard Q4 (produced by MoH) EMT/ Board	TBC				28-Nov-18
HBDHB Performance Framework Exceptions Q1 Nov 18 Feb 19 /May/Aug 19 (jit)	TBC	14-Nov-18			28-Nov-18
HR - KPIs Q1 Jul-Sept 18 - new format advised from June	Kate Coley				28-Nov-18
MoH HBDHB Quarterly Performance Monitoring Dashboard Q4	Anne Speden				28-Nov-18
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-Nov-Feb-May	Chris Ash	14-Nov-18	14-Nov-18	15-Nov-18	28-Nov-18
Te Ara Whakawaiora "Smokefree update" (6 monthly May-Nov) each year Board action Nov 17	Andy Phillips	14-Nov-18	14-Nov-18	15-Nov-18	28-Nov-18
Finance Report (Oct)	Carriann Hall				28-Nov-18

19-Dec-18	**EMT Member**	**MRB Meeting Date**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**BOARD Meeting date**
People Plan (6 monthly - **Dec**, Jun)	Kate Coley	5-Dec-18	5-Dec-18	6-Dec-18	19-Dec-18
Finance Report (Nov)	ED Fin Services				19-Dec-18

27-Feb-19	**EMT Member**	**MRB Meeting Date**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**BOARD Meeting date**
Collaborative Pathways update (July - Oct - Feb- Jun)	Chris Ash & Mark Peterson		13-Feb-19	14-Feb-19	27-Feb-19
HBDHB Non-Financial Performance Framework Dashboard Q2 - EMT/Board	TBC				27-Feb-19
HBDHB Quarterly Performance Monitoring Dashboard Q1 (produced by MoH) EMT/ Board	TBC				27-Feb-19
HBDHB Performance Framework Exceptions Q2 Nov 18 Feb 19 /May/Aug 19 (jit)	TBC	13-Feb-19			27-Feb-19
HR - KPIs Q2 Oct-Dec 18	Kate Coley				27-Feb-19
MoH HBDHB Quarterly Performance Monitoring Dashboard Q1	Anne Speden				27-Feb-19
Ngatahi Vulnerable Children's Workforce Development - annual progress Feb 19	Colin Hutchinson/Claire Caddie	13-Feb-19	13-Feb-19	14-Feb-19	27-Feb-19
Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-Nov-Feb-May	Chris Ash	13-Feb-19	13-Feb-19	14-Feb-19	27-Feb-19
Finance Report (Jan)	Carriann Hall				27-Feb-19

27-Mar-19	**EMT Member**	**MRB Meeting Date**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**BOARD Meeting date**
Establishing Health and Social Care Localities in HB (Mar 19,Sept) 6monthly	Chris Ash	13-Mar-19	13-Mar-19	13-Mar-19	27-Mar-19
Matariki Regional Development Strategy and Social Inclusion Strategy update (6 mthly) Sept-Mar	Kevin Snee	13-Mar-19	13-Mar-19	14-Mar-19	27-Mar-19
Urgent Care (After Hours) Service Update 6mthly (Sept-Mar-Sept)	Wayne Woolrich	13-Mar-19	13-Mar-19	13-Mar-19	27-Mar-19
Finance Report (Feb)	Carriann Hall				27-Mar-19

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** 110
	For the attention of: **HBDHB Board**
Document Owner:	Kevin Snee, Chief Executive Officer
Reviewed by:	Not applicable
Month as at	20 August 2018
Consideration:	For Information

RECOMMENDATION

That the Board

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

INTRODUCTION

In July some of the performance concerns that caused problems in the previous year continue, particularly in relation to elective activity and Emergency Department (ED). There is also evidence, in August, that influenza is upon us and causing some difficulty due to increased hospital presentations and staff sickness.

In July we saw nurses vote in favour of a new pay settlement, which means there will be no further industrial action. The settlement also brings with it some further investment into nursing staff positions.

On today's agenda there are a number of key issues to be addressed. Firstly environmental sustainability, the DHB is major source of pollution relating to transportation, waste and energy use. It is important that all DHBs play a key role in their local ecosystem. Secondly, Te Ara Whakapiri describes a toolkit to enable support for people in their last days of life which we will be using locally. Thirdly, we will be discussing quarterly performance indicators. Finally we will discuss the engagement process for the Clinical Services Plan.

PERFORMANCE

Measure / Indicator	Target	Month of July	Qtr to end July	Trend For Qtr
Shorter stays in ED	≥95%	88%	88%	-
Improved access to Elective Surgery (2017/18YTD)	100%	-	NA	-

Waiting list	Less than 3 months	3-4 months	4+ months
First Specialist Assessments (ESPI-2)	3,247	564	202
Patients given commitment to treat, but not yet treated (ESPI-5)	1,159	190	290

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% (June 2017)	88% (6m to June 2017)	-
Increased immunisation at 8 months	≥95%	---	93% (3m to July)	▼
Better help for smokers to quit – Primary Care	≥90%	--	86.8% (15m to July)	▼
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%	---	69% (3m to June)	
Raising healthy kids (New)	≥95%	---	100% (6m to June)	▬
Financial – month (in thousands of dollars)	288	300	---	---
Financial – year to date (in thousands of dollars)	288	300	---	---

***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%	*9/19 = 47%*	*92/114 = 81%*

Elective activity is a particular problem at present and I have highlighted the key issues below:

Outpatients
First Specialist Assessment (FSA or ESPI2) numbers have increased waiting beyond four months between May and July. This position will remain in August but will improve in September. It is likely we will fluctuate between red and amber for the remainder of the year. This is at least in part due to a significant increase in the numbers waiting for FSA in surgery, and there is also pressure in Ear Nose Throat (ENT) and Gynaecology. Referrals have increased from General Practice for FSAs since February 2018. This increase is being investigated at present.

- *Follow-up appointments*
  One of the consequences of a focus on FSAs is less attention is given to patients waiting for follow-up appointments – this is a national problem. This sometimes means patients have waited longer than intended for their appointment. To date there is no evidence of any long term harm as a consequence of this, but to ensure this is dealt with appropriately we are applying a tool called the Acuity Index, developed by Southern District Health Board, to all new and follow-up patients so those with greatest clinical need are seen as a priority. This will have an impact on our ability to hit the four month ESPI2 target because some follow-ups will be prioritised over new patients based on clinical need.

Elective Surgery (ESPI5)
Elective surgery is an issue. In the previous year the budget for elective surgery and outsourcing was significantly overspent and as a result outsourcing was reduced in the final financial quarter - this was done in discussion with the Ministry of Health (MoH). This led to more people waiting longer than four months for surgery; dispensation was given for not meeting the waiting time guarantee until after January 2019. Outsourcing recommenced in late July when a more appropriate plan was put in place to reduce, over the course of the year, the reliance on Royston Hospital. Use of elective day case work at the weekend has increased to help build capacity. In addition we are reprioritising the work done in certain specialties to reduce the flow of patients on to the list – this may mean an increase in thresholds, although we aim to keep this to a minimum. We also plan to use our own staff who will be deployed to external theatres. To put this plan in place requires recruitment of staff and a new contract to be placed. The consequence of the limitation in theatre and staff capacity is likely to mean that our numbers waiting beyond four months will peak in September and begin to reduce from November onwards. We are likely to be on top of this by the fourth quarter of 2019.

Ultimately our business case has been approved to enable the build of an eighth theatre but seismic strengthening in the theatre block may push this out to early 2021. This will make a significant difference to our ability to meet our elective requirements in-house.

In addition to the issues highlighted above, emergency department (ED) performance for the month remained poor at 88 percent – it is likely this will not improve significantly until quarter two. Our Faster Cancer Treatment target remains slightly below target for the six months to June, but it was 100 percent in June. We are just below target on immunisation and are exceeding the healthy weight target.

The financial result for June is $12k favourable for the month; there are, however, significant pressures within the DHB provider arm that I am investigating at present.

It is likely the current set of targets will be changed in the medium term to a broader, but perhaps more meaningful, range of targets. The indications are that some of the same targets will remain, such as ED6 and Ambulatory Sensitive Hospitalisation (ASH) rates for 0-4 year olds, but there are likely to be new targets such as smoke-free infancy, and the number of discharges relating to self-harm.

HBDHB ENVIRONMENTAL SUSTAINABILITY UPDATE

Communication from the Ministry of Health around environmentally sustainable healthcare has dramatically increased since the change in government. Facilities Management has made efforts over the past ten years to operate as sustainably as possible, but with increased expectations from the Ministry around climate change adaptation and mitigation, we need to be thinking more holistically. The sustainability presentation will summarise what other DHBs are doing, sustainability initiatives at HBDHB, potential opportunities, expectations from the Ministry and HBDHB's planned next steps.

TE ARA WHAKAPIRI (LAST DAYS OF LIFE)

Te Ara Whakapiri Hawke's Bay Care Plan and toolkit was developed for the local setting using the Ministry of Health (MoH) Te Ara Whakapiri Principles and Guidance Tool. During the establishment phases the tool went through a robust evaluation of independent reviews of models, stocktake of services, literature reviews based on evident practice and summaries of findings from family and whānau surveys. The tool has been designed reflective of Te Whare Tapa Wha.

Māori Relationship Board requested that the tool be aligned to local tikanga. As a result tikanga guidelines have been developed as an additional and integral resource to support the wider Te Ara Whakapiri Toolkit (TAWTK) – which includes:

- A self-review matrix has been developed to assist an organisation or service to self-evaluate and self-design areas for improvement
- The Matrix is with the communications team for production and publishing
- Users of Te Ara Whakapiri Toolkit will be provided with the resource once produced
- The resource was trialled with (five) Aged residential care facilities

The resource is now being promoted and distributed within the relevant health sector.

TE ARA WHAKAWAIORA – REPORTING ON AMBULATORY SENSITIVE HOSPITALISATION (ASH)[1] RATES FOR 0-4 AND 45-64 YEARS

ASH rates overall nationally are increasing, especially in the younger age group. The increased ASH rates reflect a health system under pressure. When under pressure disparities become wider and we need to do more work to understand how we should best focus in order to make the greatest gains.

The ASH rates for both 0-4 and 45-64 age groups give cause for concern. While probably not statistically significant there may be a widening inequity gap, having seen it close somewhat in the previous few years. In the 45-64 years, rates for Māori have improved in the last 12 month period, both within our own DHB and HBDHB's performance nationally, however ASH rates for Māori still remain twice the rate of "other."

There are a range of initiatives designed to improve our position, but these will take some time to demonstrate their worth.

HBDHB PERFORMANCE FRAMEWORK EXCEPTIONS QUARTER FOUR AND MINISTRY OF HEALTH QUARTERLY PERFORMANCE MONITORING DASHBOARD QUARTER THREE

We continue to be above target for Raising Healthy Kids performance, two year olds fully immunised and HPV vaccinations. Stroke patients being admitted to an organised stroke service and people waiting for urgent diagnostic colonoscopies were also favourable to target. However, we still have challenges meeting Shorter Stays in the Emergency Department, with 91 percent of patients admitted, transferred or discharged within six hours against a target of 95 percent. Improved Access to Elective Surgery at 95 percent is below the financial year target of 100 percent. The rate of Section 29 Orders is unfavourable to target across all ethnicities.

[1] Background information on National ASH rates in the NZ Medical Journal October 2016 Edition

CLINICAL SERVICES PLAN (CSP)

With the completion and approval of the draft CSP in July, the focus has shifted to preparing for and initiating the engagement process:

- An Engagement Plan has been finalised, setting out the purpose, principles and methods for this engagement, along with a schedule of meetings at which the CSP will be presented/discussed by relevant sector leaders
- The draft CSP, along with FAQ (Frequently Asked Questions), has been posted on the OURHEALTH website, with the provision for email feedback
- A 'consumer' brochure has been prepared and printed for distribution through appropriate facilities/agencies, with a 'tearoff freepost' questionnaire attached for comments/feedback
- A two minute video has been produced
- Appropriate media have been engaged
- Various presentation options have been prepared for use by sector leaders in engaging with their networks
- All feedback will be coordinated through the CSP Project Team

Potential risks and concerns about timelines and the sincerity of the engagement process, has resulted in a decision to extend the engagement process to 31 October 2018, with the final CSP now coming back through governance structures to the Board for approval in November.

CONCLUSION

The new financial year has commenced as the previous one ended, but we are continuing with our key strategic programmes and getting to grips with putting the organisation back on a sound financial footing and addressing some of our underlying service issues.

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report July 2018** 111
	For the attention of: **HBDHB Board and the Finance Risk and Audit Committee**
Document Owner	Carriann Hall, Executive Director Financial Services
Document Author(s)	Phil Lomax, Financial and Systems Accountant
Reviewed by	Executive Management Team
Month/Year	August, 2018
Purpose	For Information

9

RECOMMENDATION:

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

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

1. ACTING EXECUTIVE DIRECTOR CORPORATE SERVICES' COMMENTS

The later DHB sector annual planning process implemented from 2018/19 means some budgeting information is not available for the July report. Consequently the report is shorter than normal.

Financial Performance

The July result is $12 thousand favourable to plan.

Underlying the result are:

- A higher PHARMAC rebate for 2017/18 than expected created a favourable variance, however this was considerably offset by higher than projected payments in July, that mostly relate to June;
- Pressure on nursing resources mostly offset by allied health vacancies;
- Medical vacancies more than offset by locum cover;
- Undelivered savings (plans are in the identification stage), partly offset by lower outsourced services (mainly Royston), and the accrual of strategic savings (see comment below).

The annual plan requires the achievement of $14.1 million of savings, The budget for savings is spread evenly throughout the year, however the savings are more likely to grow incrementally as schemes are identified and implemented. The mismatch between budget and likely achievement obscures the underlying operational performance of the DHB, and savings are being accrued to overcome the issue. Progress on achieving the savings will be reported in this report each month.

Progress on identifying and making savings must be achieved over the year or an unfavourable result will occur.

2. RESOURCE OVERVIEW

	July				Year End Forecast	Refer Section
	Actual	Budget	Variance			
	$'000	$'000	$'000	%	$'000	
Net Result - surplus/(deficit)	300	288	12	4.2%	(5,000)	3
Contingency utilised	-	333	333	100.0%	4,000	8
Capital spend	1,362	-	1,362	0.0%	-	16
	FTE	FTE	FTE	%	FTE	
Employees	2,374	2,332	(41)	-1.8%	2,406	5 & 7

No contingency was released in July.

Capital spend was mostly on building projects including endoscopy surgical expansion and the histology and education centre upgrade.

The pressure on nursing resources continues, partly offset in July by allied health vacancies.

3. FINANCIAL PERFORMANCE SUMMARY

	July				Year End Forecast	Refer Section
$'000	Actual	Budget	Variance			
Income	47,654	47,891	(237)	-0.5%	569,155	4
Less:						
Providing Health Services	22,875	22,679	(197)	-0.9%	280,738	5
Funding Other Providers	19,480	20,142	662	3.3%	240,914	6
Corporate Services	4,353	4,411	58	1.3%	48,036	7
Reserves	647	372	**(274)**	**-73.7%**	4,466	8
	300	**288**	12	4.2%	**(5,000)**	

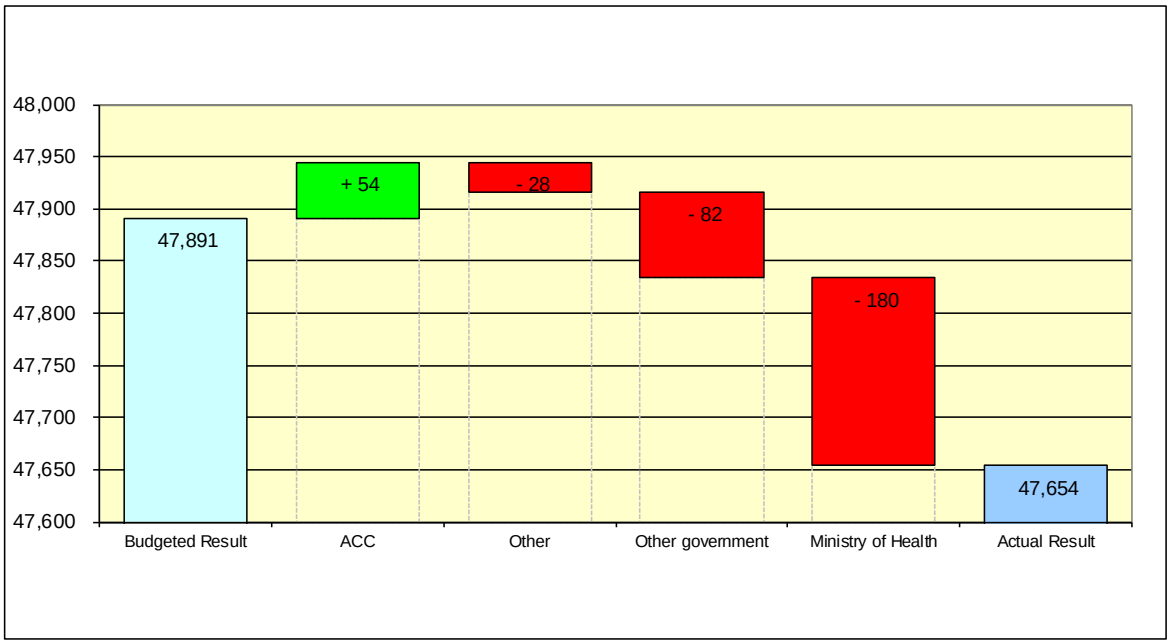
Income
Lower In-Between-Travel income than budgeted and a change in the accounting treatment of early childhood education funding.

Providing Health Services
Undelivered savings budgets (plans are in the identification stage), and nursing resources to cope with patient volumes, were partly offset by allied health vacancies and lower than budgeted outsourcing to Royston.

Funding Other Providers
Lower pharmaceutical and pay equity costs than projected in the budget.

4. INCOME

$'000	July Actual	July Budget	July Variance		Year End Forecast
Funding - Price Volume Schedule	(3)	-	(3)	0.0%	-
Ministry of Health	45,474	45,655	(180)	-0.4%	542,248
Inter District Flows	771	762	9	1.2%	9,146
Other District Health Boards	360	333	28	8.4%	3,993
Financing	50	64	(14)	-21.4%	765
ACC	467	413	**54**	**13.0%**	5,249
Other Government	(1)	82	**(82)**	**-100.8%**	673
Patient and Consumer Sourced	93	112	(20)	-17.5%	1,360
Other Income	442	470	(29)	-6.1%	5,655
Abnormals	-	0	(0)	-100.0%	67
	47,654	**47,891**	**(237)**	**-0.5%**	**569,155**



Note the scale does not begin at zero

ACC (favourable)
Income for rehabilitation services, partly offset by low elective surgery.

Other Government (unfavourable)
Change in accounting treatment for early childhood education funding. Previously income was recognised on receipt, and is now treated as income in advance.

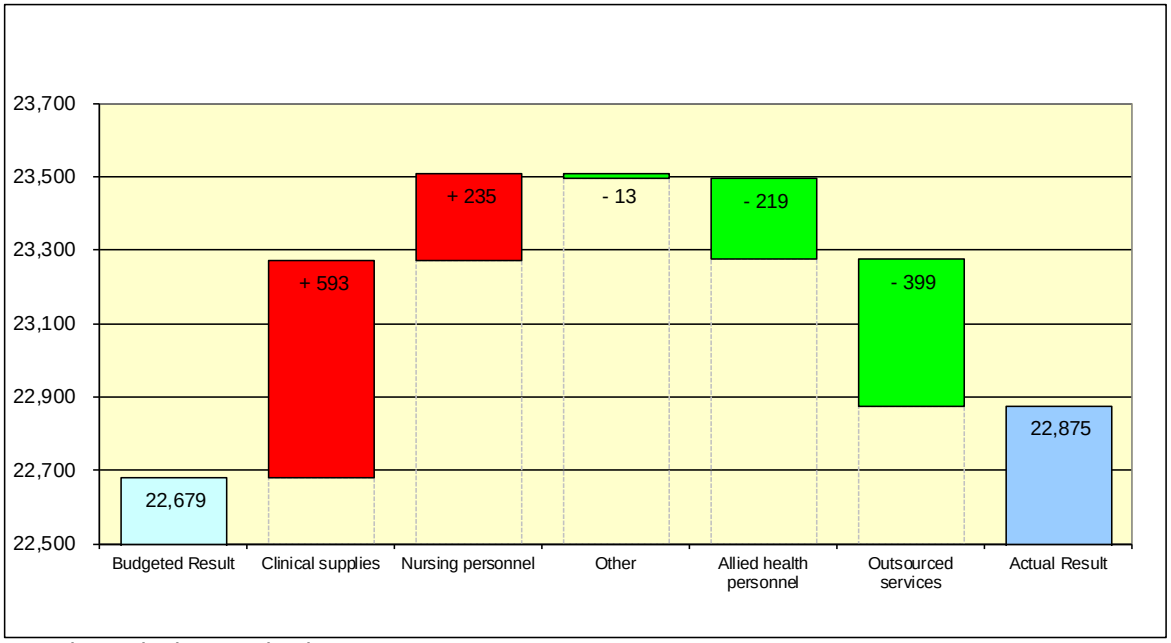
Ministry of Health (unfavourable)
Lower In-Between-Travel income than budgeted.

5. PROVIDING HEALTH SERVICES

	July				Year End
	Actual	Budget	Variance		Forecast
Expenditure by type $'000					
Medical personnel and locums	5,315	5,334	18	0.3%	67,572
Nursing personnel	6,596	6,361	(235)	-3.7%	80,903
Allied health personnel	2,981	3,201	**219**	**6.8%**	38,482
Other personnel	2,118	2,084	(34)	-1.6%	25,161
Outsourced services	604	1,003	**399**	**39.8%**	12,079
Clinical supplies	3,461	2,868	**(593)**	**-20.7%**	34,328
Infrastructure and non clinical	1,800	1,829	29	1.6%	22,215
	22,875	**22,679**	(197)	-0.9%	**280,738**
Expenditure by directorate $'000					
Medical	6,232	5,852	**(380)**	**-6.5%**	73,563
Surgical	4,830	5,022	192	3.8%	62,470
Community, Women and Children	3,727	3,578	(149)	-4.2%	44,441
Older Persons, Options HB, Menta	2,849	2,881	33	1.1%	35,623
Operations	3,252	3,257	5	0.2%	39,212
Other	1,986	2,088	103	4.9%	25,429
	22,875	**22,679**	(197)	-0.9%	**280,738**
Full Time Equivalents					
Medical personnel	346.7	354.5	8	2.2%	364.1
Nursing personnel	968.1	900.9	**(67)**	**-7.5%**	957.1
Allied health personnel	473.2	492.8	20	4.0%	496.0
Support personnel	143.0	134.9	**(8)**	**-6.0%**	138.6
Management and administration	277.9	276.0	(2)	-0.7%	276.9
	2,208.9	**2,159.0**	(50)	-2.3%	**2,232.7**

Directorates

- Medical – nursing resource costs (mainly ED and ICU) reflecting patient volumes, savings plans in the identification stage with implementation yet to begin, and pharmaceuticals costs including biologics are above budget.



Note the scale does not begin at zero

Clinical Supplies (unfavourable)
Undelivered savings and pharmaceutical expense (biologics).

Nursing Personnel (unfavourable)
High patient volumes across medical and surgical services.

Allied Health Personnel (favourable)
Vacancies.

Outsourced Services (favourable)
Lower than budgeted expenditure with Royston. Expenditure is expected to build up during the first half of the year.

Full Time Equivalents (FTE)

FTEs are 50 (2.3%) unfavourable in July including:

Nursing Personnel (-67 FTE / -7.5% unfavourable)
- High patient volumes continued into the new year.

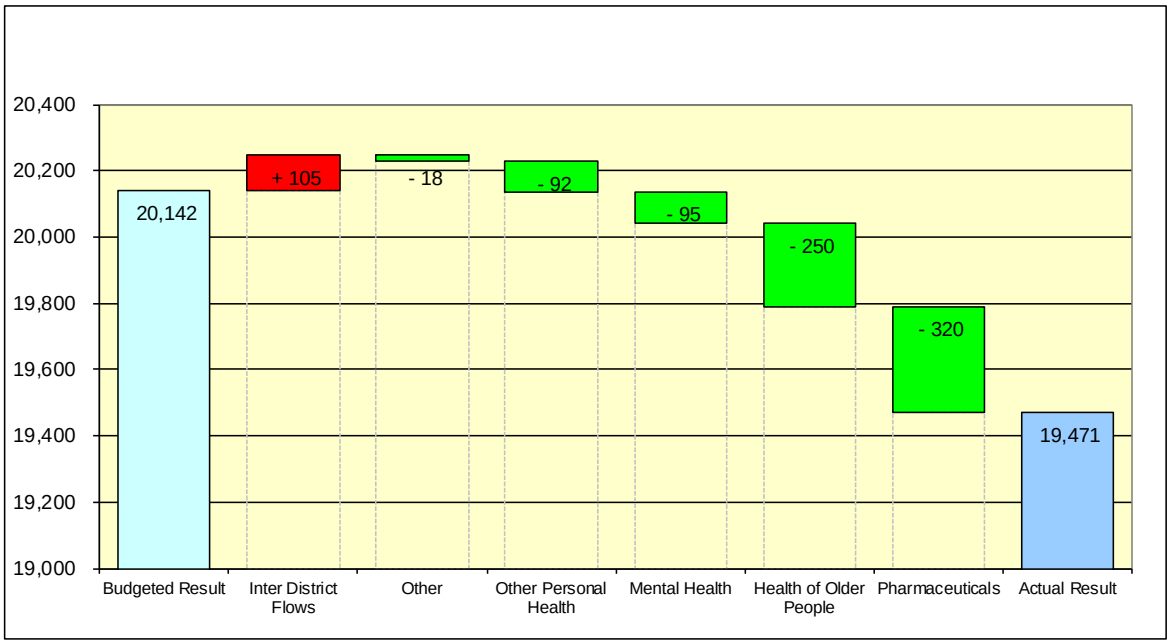
Allied Health Personnel (20 FTE / 4.0% favourable)
- Vacancies including MRTs occupational therapists, psychologists, and laboratory technicians.

Elective Health Targets

No report has been included this month as elective health targets have not yet been set.

6. FUNDING OTHER PROVIDERS

$'000	July Actual	July Budget	July Variance		Year End Forecast
Payments to Other Providers					
Pharmaceuticals	3,367	3,687	320	8.7%	44,261
Primary Health Organisations	3,256	3,256	0	0.0%	37,528
Inter District Flows	4,261	4,156	(105)	-2.5%	49,868
Other Personal Health	1,909	2,002	92	4.6%	24,826
Mental Health	973	1,067	95	8.9%	12,813
Health of Older People	5,375	5,625	250	4.4%	67,451
Other Funding Payments	331	349	18	5.1%	4,167
	19,471	20,142	671	3.3%	240,914
Payments by Portfolio					
Strategic Services					
Secondary Care	4,175	4,017	(159)	-4.0%	48,197
Primary Care	7,850	8,170	320	3.9%	97,363
Chronic Disease Management	-	-	-	0.0%	-
Mental Health	1,272	1,298	26	2.0%	15,581
Health of Older People	5,545	5,874	329	5.6%	70,454
Other Health Funding	-	133	133	100.0%	1,600
Maori Health	495	515	20	4.0%	6,106
Population Health	134	134	1	0.6%	1,613
	19,471	20,142	671	3.3%	240,914



Note the scale does not begin at zero

Inter District Flows (unfavourable)
Higher outflows based on MoH data and information from other DHBs.

Other Personal Health (favourable)
Lower than projected costs for price adjustments and miscellaneous services.

Mental Health (favourable)
Lower child and youth expenditure incurred than projected.

Health of Older People (favourable)
Lower than projected pay equity costs offset in income.

Pharmaceuticals (favourable)
Lower pharmaceutical expenditure for June than provided for as payments in July.

7. CORPORATE SERVICES

$'000	July Actual	July Budget	July Variance		Year End Forecast
Operating Expenditure					
Personnel	1,348	1,394	46	3.3%	16,497
Outsourced services	34	71	37	52.3%	855
Clinical supplies	12	(72)	**(84)**	**-116.1%**	(863)
Infrastructure and non clinical	1,233	1,243	10	0.8%	9,301
	2,627	2,636	10	0.4%	25,790
Capital servicing					
Depreciation and amortisation	1,071	1,058	(13)	-1.2%	13,652
Capital charge	655	716	**61**	**8.5%**	8,595
	1,726	1,774	49	2.7%	22,246
	4,353	**4,411**	58	1.3%	**48,036**
Full Time Equivalents					
Medical personnel	0.4	0.3	(0)	-31.3%	0.3
Nursing personnel	11.1	13.1	2	15.0%	13.4
Allied health personnel	0.2	0.4	0	38.4%	0.4
Support personnel	9.7	8.1	(2)	-20.0%	8.1
Management and administration	143.2	151.5	**8**	**5.5%**	150.7
	164.7	**173.4**	**9**	**5.0%**	**172.9**

Lower capital charges from lower equity driven by the 2017/18 result.

8. RESERVES

$'000	July Actual	July Budget	July Variance		Year End Forecast
Expenditure					
Contingency	333	333	0	0.0%	4,000
Transform and Sustain resource	(30)	35	**65**	**186.3%**	415
Other	343	4	**(339)**	**-8031.6%**	51
	647	**372**	**(274)**	**-73.7%**	**4,466**

The contingency has been accrued to budget, and will be released as the need arises. The “Other” category comprises the net costs of transactions that relate to last year, that will either be offset by wash-ups and rebates, or may require amendment to the 2017/18 result.

9. FINANCIAL PERFORMANCE BY MOH CLASSIFICATION

$'000	July Actual	July Annual Plan	July Variance
Funding			
Income	44,954	45,082	(128) U
Less:			
Payments to Internal Providers	25,752	25,752	-
Payments to Other Providers	18,702	19,520	818 F
Contribution	**500**	**(191)**	**690 F**
Governance and Funding Admin.			
Funding	290	290	-
Other Income	(4)	3	(7) U
Less:			
Expenditure	178	283	105 F
Contribution	**107**	**9**	**98 F**
Health Provision			
Funding	25,454	25,454	-
Other Income	2,619	2,719	(100) U
Less:			
Expenditure	28,380	27,704	(676) U
Contribution	**(307)**	**468**	**(776) U**
Net Result	**300**	**287**	**12** F

The table above reports the result in the classifications used by the Ministry of Health.

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. No changes were recognised to the end of July.

11. QUALITY AND FINANCIAL IMPROVEMENT PROGRAMME

Work is continuing on identifying the savings schemes that will be implemented in 2018/19.

12. FINANCIAL POSITION

30 June 2017	$'000	July Actual	July Budget	Variance from budget	Movement from 30 June 2017	Annual Budget
	Equity					
168,706	Crown equity and reserves	168,706	175,069	6,363	-	174,711
(15,982)	Accumulated deficit	(15,683)	(10,686)	4,997	300	(15,973)
152,723		153,023	164,383	11,360	300	158,738
	Represented by:					
	Current Assets					
7,444	Bank	6,916	15,095	8,179	(528)	2,313
1,885	Bank deposits > 90 days	1,862	1,901	39	(23)	1,901
25,474	Prepayments and receivables	26,046	24,648	(1,398)	572	25,045
3,907	Inventory	3,873	4,444	570	(34)	4,520
-	Non current assets held for sale	-	625	625	-	625
38,711		38,698	46,713	8,015	(13)	34,404
	Non Current Assets					
179,460	Property, plant and equipment	179,722	178,359	(1,363)	262	185,018
1,479	Intangible assets	1,442	3,079	1,636	(37)	4,147
11,573	Investments	11,504	11,684	180	(69)	11,798
192,512		192,668	193,122	453	156	200,963
231,223	**Total Assets**	**231,366**	**239,835**	**8,469**	**143**	**235,368**
	Liabilities					
	Current Liabilities					
35,817	Payables	33,431	35,361	1,930	(2,386)	36,249
40,064	Employee entitlements	42,294	37,379	(4,914)	2,229	37,579
75,881		75,724	72,740	(2,984)	(156)	73,828
	Non Current Liabilities					
2,619	Employee entitlements	2,619	2,712	93	-	2,802
2,619		2,619	2,712	93	-	2,802
78,500	**Total Liabilities**	**78,343**	**75,452**	**(2,891)**	**(156)**	**76,629**
152,723	**Net Assets**	**153,023**	**164,383**	**11,360**	**300**	**158,738**

13. EMPLOYEE ENTITLEMENTS

30 June 2017	$'000	July Actual	July Budget	Variance from budget	Movement from 30 June 2017	Annual Budget
10,004	Salaries & wages accrued	12,530	9,268	(3,262)	2,526	7,756
1,157	ACC levy provisions	1,029	201	(828)	(128)	532
5,945	Continuing medical education	5,788	5,791	3	(156)	6,456
21,348	Accrued leave	21,348	20,528	(820)	1	21,199
4,230	Long service leave & retirement grat.	4,217	4,303	86	(13)	4,438
42,683	**Total Employee Entitlements**	44,913	40,091	(4,822)	2,229	40,380

Salaries and wages accrued includes additional provisions for settlements that were not allowed for in the budget, partly recognised in last years result.

14. TREASURY

Liquidity Management

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

Debt Management

The DHB has no interest rate exposure relating to debt.

Foreign Exchange Risk Management

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

15. CAPITAL EXPENDITURE

Capital spend for the month was $1.3 million including: $777 thousand on the endoscopy project; $171 thousand on surgical expansion and $122 thousand on the histology and education centre upgrade.

No capital expenditure table has been included this month, as the capital budget is yet to be finalised.

Project reports have been removed from the Financial Performance Report as performance against plan is discussed in the Transform and Sustain Monthly Programme Overview that is presented to FRAC, and performance against budget will be covered in the capital expenditure table that will be included in this report.

16. ROLLING CASH FLOW

	Actual	July Forecast	Variance	Aug Forecast	Sep Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast	Jul Budget
Cash flows from operating activities															
Cash receipts from Crown agencies	44,851	46,720	(1,870)	46,005	46,146	51,752	46,547	46,229	46,283	46,095	46,350	46,431	46,095	46,456	46,791
Cash receipts from donations, bequests and clinical trials	(10)	-	(10)	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	2,381	495	1,886	497	493	3,092	2,064	493	496	502	496	496	502	496	495
Cash paid to suppliers	(30,114)	(28,721)	(1,393)	(26,388)	(27,433)	(27,115)	(27,632)	(35,203)	(19,125)	(24,412)	(27,553)	(27,515)	(26,034)	(28,356)	(28,873)
Cash paid to employees	(15,761)	(16,802)	1,041	(22,664)	(16,932)	(20,118)	(17,298)	(16,809)	(22,680)	(17,577)	(17,082)	(17,710)	(20,431)	(17,336)	(16,802)
Cash generated from operations	**1,347**	**1,692**	**(345)**	**(2,551)**	**2,274**	**7,611**	**3,681**	**(5,290)**	**4,975**	**4,608**	**2,211**	**1,702**	**133**	**1,260**	**1,611**
Interest received	50	64	(14)	64	54	44	34	24	14	(0)	(0)	(0)	(0)	(0)	(0)
Interest paid	-	-	-	-	-	-	-	-	-	6	16	26	36	46	56
Capital charge paid	(655)	(0)	(655)	(0)	(0)	(0)	(0)	(4,350)	(0)	(0)	(0)	(0)	(0)	(4,670)	(0)
Net cash inflow/(outflow) from operating activities	**742**	**1,756**	**(1,014)**	**(2,487)**	**2,327**	**7,655**	**3,714**	**(9,616)**	**4,988**	**4,614**	**2,227**	**1,727**	**169**	**(3,365)**	**1,666**
Cash flows from investing activities															
Acquisition of property, plant and equipment	(1,326)	(1,714)	388	(1,323)	(1,323)	(1,323)	(1,323)	(1,323)	(1,323)	(1,323)	(1,323)	(1,323)	(1,323)	(1,323)	(1,323)
Acquisition of intangible assets	(36)	(133)	97	(133)	(133)	(133)	(133)	(133)	(133)	(133)	(133)	(133)	(133)	(133)	(133)
Acquisition of investments	69	-	69	(167)	(167)	(167)	(167)	(167)	(296)	(167)	(167)	(167)	(167)	(167)	(167)
Net cash inflow/(outflow) from investing activities	**(1,293)**	**(1,847)**	**554**	**(1,623)**	**(1,623)**	**(1,623)**	**(1,623)**	**(1,623)**	**(1,753)**	**(1,623)**	**(1,623)**	**(1,623)**	**(1,623)**	**(1,623)**	**(1,623)**
Cash flows from financing activities															
Equity repayment to the Crown	-	-	-	-	-	-	-	-	-	-	-	-	-	(357)	-
Net cash inflow/(outflow) from financing activities	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**(357)**	**-**
Net increase/(decrease) in cash or cash equivalents	(551)	(91)	(460)	(4,111)	704	6,031	2,091	(11,240)	3,235	2,991	603	104	(1,455)	(5,345)	43
Add:Opening cash	9,330	9,330	(0)	8,779	4,668	5,372	11,403	13,494	2,254	5,490	8,480	9,083	9,187	7,733	2,387
Cash and cash equivalents at end of period	**8,779**	**9,239**	**(460)**	**4,668**	**5,372**	**11,403**	**13,494**	**2,254**	**5,490**	**8,480**	**9,083**	**9,187**	**7,733**	**2,387**	**2,430**
Cash and cash equivalents															
Cash	4	4	-	4	4	4	4	4	4	4	4	4	4	4	4
Short term investments (excl. special funds/clinical trials)	6,023	6,358	(335)	1,786	2,490	8,522	10,612	(627)	2,608	5,599	6,202	6,306	4,851	(494)	(451)
Short term investments (special funds/clinical trials)	2,709	2,877	(168)	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877
Bank overdraft	43	-	43	-	-	-	-	-	-	-	-	-	-	-	-
	8,779	**9,239**	**(461)**	**4,667**	**5,371**	**11,403**	**13,493**	**2,254**	**5,489**	**8,480**	**9,083**	**9,187**	**7,732**	**2,387**	**2,430**

The cash flow assumes a $4.7 million reduction in capital spend from budget for 2018/19, and a $2.0 million increase in investment in the Regional Health Informatics Programme (RHIP)

BOARD HEALTH & SAFETY CHAMPION'S UPDATE

Verbal

HBDHB ENVIRONMENTAL SUSTAINABILITY UPDATE

11

Presentation

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Clinical Council**	114
	For the attention of: **HBDHB Board**	
Document Owner:	Dr Andy Phillips (Chair)	
Month:	August 2018	
Consideration:	For Information	

12

RECOMMENDATION

That the Board

Review the contents of this report; and

Note that Clinical Council:

- **Received** the presentation on the Violence Intervention Programme
- **Received** the presentation on the Annual Plan for 2018/19
- **Received** verbal updates on the People & Quality Dashboard and Clinical Services Plan
- **Discussed** preparation for the AGM
- **Noted** the update from the Clinical Advisory & Governance Group
- **Noted** reports received for information.

Council met on 8 August 2018. An overview of matters discussed is provided below:

- **Violence Intervention Programme Presentation:**

A presentation was provided by Cheryl Newman, Family Violence Intervention Co-ordinator. Discussion took place, Council recognised this as an important issue and of the need to improve actions to prevent family harm across the sector. Council would like to see the response pathways for when a disclosure is made. Clinical leadership and the need to support DHB and primary care staff resilience is important. This is an important issue for our community and other government agencies including the Police, MSD and ACC.

- **HBDHB Annual Plan 2018/19**

A presentation was provided by Paul Malan, Head of Planning & Strategic Services. An update was provided on progress to date and the next steps, with final document required to be completed by the end of September.

- **People & Quality Dashboard**

The Chair provided a verbal update on progress with the dashboard. Members were asked what other items they would like included in the dashboard. A brief discussion took place, members advised they would like to see family violence interventions including graphs and commentary around what was being done and actions undertaken. Further discussion on the dashboard will occur at the next meeting.

- **Preparation for AGM**

The Council's AGM will take place in September together with the normal monthly business of Council. Council will be reviewing their annual plan, terms of reference and meeting agendas at that time.

- **Clinical Services Plan**

The Company Secretary provided a verbal update, advising the final draft had gone to the Board on 25 July and that the engagement process with the community will now take place during August/September. Sapere will provide the final plan, following feedback in October.

- **Clinical Advisory & Governance Group (CAG) Update**

Chris McKenna, Chief Nursing & Midwifery Officer provided an update from the last CAG meeting. CAG has been re-framed with three new GP members starting in September (from Totara Health, Hastings Health Centre and Te Taiwhenua); the PHO has developed their strategic plan and is now looking at the annual plan and work plan. CAG will be moving to six meetings per year; and branding around Health Care Homes was endorsed.

Reports for information were noted from the following:

- Te Ara Whakapiri Next Steps (Last Days of Life)
- Te Ara Whakawaiora - Access Rates 0-4 / 45-65 yrs

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Health Consumer Council** 115
	For the attention of: **HBDHB Board**
Document Owner:	Rachel Ritchie, Chair
Reviewed by:	Not applicable
Month:	August, 2018
Consideration:	For Information

13

RECOMMENDATION

That the Board

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

Consumer Council met on 9 August 2018. An overview of issues discussed and/or agreed at the meeting is provided below.

- **HBDHB Annual Plan 2018/19**

Paul Malan, Manager Strategic Services provided a presentation on the annual plan including work undertaken to date and the next steps in the process to meet this MOH compliance requirement. Members were interested in the new areas of focus around mental health, addictions and primary care access – and had questions around what changes on the ground would be seen from the new focus.

- **Primary Care Update**

Chris Ash, Executive Director, Primary Care Services, provided a presentation on the Primary Care Service Development Plan. Members were interested in this area as it is a key area of interface with consumers – but not an area that has had much exposure with the council. There was particular interest and discussion around access to primary care, measuring equity improvements, how wrap around services should be provided and relationships with other agencies.

- **Annual Plan**

Council revewed their 2017/18 work : progress has been made on the objectives set around Person & Whanau Centred care initiative, connection with Clinical Council, Youth connection, regional and national links for council and the disability focus. Encouraging the consumer voice continues with council members involved in a number of groups/ projects throughout the DHB. Input into DHB initiatives continues as they come through Council eg the People Plan and CSP.

Members workshopped the ' where to from here' for 2018/2019 and have settled on the 12 draft objectives (attached). A number of these move into the ' development or implementation' phase of an earlier initiative eg P & W CC/Consumer Engagement Strategy, Youth connections at our table, disability strategy, input into People Plan and co-design. Others – revisiting the "consumer

Stories' policy, Primary Care partnership and a focus on the consumer experience data to hand and and its use are new to the list.

- **Updates:**

  Pasifika Health

  Two Council members attended the LaVa workshops. The feedback was that Pacific needs to be visible as a specific group and that feedback is required on the Pasifika Health Plan. Diane Mara (Deputy Chair) is working with Chris Ash on this front**.**

  Disability Strategy

  This initiative from within Consumer Council is progressing. A re-grouping is currently aunderway as the brief became too broad.

- **Te Ara Whakawaiora – Access 0-4/45-65 years**
- **Te Ara Whakapiri Next Steps (Last Days of Life)**

The progress updates provided in these papers were noted

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board** 116 For the attention of: **HBDHB Board**
Document Owner:	Heather Skipworth, Chair
Reviewed by:	Not applicable
Month:	August, 2018
Consideration:	For Information

RECOMMENDATION

That the Board

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

Note that the Maori Relationship Board:

- **Received** the HBDHB Annual Plan 2018/19 presentation.
- **Received** HBDHB Performance Framework Exceptions Report Q4, requesting further detail
- **Received an update** on He Ngakau Aotea and where to from here
- **Received an update** on progress with the Clinical Services Plan
- **Noted and discussed** the Te Ara Whakawaiora Access rates 0-4 / 45-64 years Q4 report. **Endorsed** the actions being taken; **Supported** recommendations made by EMT including future quarterly updates. **Noted** there are limited formal systems in place that address "equity", with a need to focus more on this area.

The Māori Relationship Board met on 8 August 2018. An overview of issues discussed and/or agreed at the meeting is provided below.

MRB received a report from the GM Māori Health covering Māori Health Services which included and overview of the third iwi led delegation to **South Central Foundation, Alaska** (to gain insights and attend the Core Concepts Training and the **8th Annual Nuka System of Care**; other aspects included within the report included:

- ✓ Te Ara Whakawaiora Review
- ✓ New Sudi Initiative
- ✓ Kaupapa Māori Maternal Health Programme Update
- ✓ Regional Sexual Health Plan Update
- ✓ HBDHB Draft Sustainability Policy
- ✓ Energy and Carbon Management
- ✓ Sustainable Waste Management
- ✓ Sustainable Water Management
- ✓ Sustainable and Efficient Buildings and Site Design
- ✓ Sustainable Transportation and Travel Management
- ✓ Maori Workforce Development Action Plan
- ✓ Māori Nursing Workforce; and the Ngātahi Workshop.

An additional item raised was **Health Care Homes (HCH)**. Chris Ash and Wayne Woolrich were in attendance and advised they would be happy to bring this through Committees (in a coordinated way). They advised that the **South Central Foundation's Nuka System of Care** was far broader and all

encompassing, and what was being achieved within "Nuka" was significantly larger than "Health Care Homes" which was seen as a component only. Some General Practices within HB had already introduced a form of HCH's themselves.

He Ngakau Aotea: A presentation entitled He Ngakau Aotea had been provided by George Mackey to the 11 July MRB meeting. George and Trish Giddens had subsequently presented this to the NKII Board (in Dannevirke) several weeks prior and advised they had received positive feedback. It was suggested this now be socialised within Māori, prior to presentations/plans being provided to the PHO (Health Hawke's Bay) and the HBDHB Board.

"He Ngakau Aotea" (meaning: **"**open hearts and minds to new opportunities"). This is uniquely ours and we want our people to have input so they have ownership and come along with us for the journey. This is Inspirational, Aspirational and uplifting for Māori!

It was suggested He Ngakau Aotea could feed into the Clinical Services Plan which had been through extensive consultation within the health sector (including Māori), and the Plan had been well received by MRB when the first draft was reviewed on 11 July. OR do we use "He Ngakau Aotea**"** as a source document to inform the 5 year strategy, as much of what has been presented are "key drivers" and already included within the CSP?

Clinical Services Plan update: MRB were advised a Consultation Plan was being developed, brochures printed, PowerPoints prepared (for presentation to groups), and a video developed to ensure as many mediums/platforms as possible were used to ensure consultation with the public of Hawke's Bay is far reaching. This include the offer to assist and/or go out directly and present to groups.

Subsequently the Final CSP document timeline was extended to be completed in November 2018.

HBDHB Annual Plan 2018/19 Presentation: noted the draft had been provided to the MoH on 27 July 2018. No feedback provided by MRB. However they noted that Annual Plan was essentially a MoH compliance document for this financial year.

HBDHB Performance Framework Exceptions Report Q4 – was received with MRB requesting further detail on why the "Did Not Attend" rates had slipped for the quarter? Colin Hutchinson advised he would follow this up with the Customer Focussed Booking Team and also look further into automated IT solutions.

Te Ara Whakawaiora – Access (Ambulatory Sensitive Hospitalisation) Rates 0-4 / 45/65 years: The report was received which showed an improvement for 0-4 year olds but what wasn't discussed was the 45/65 year group where the results were not so good, noting there is still considerable work that needs to be done to reduce "inequity".

There are limited formal systems in place that address "equity", those in place include: Te Ara Whakawairoa (TAW); the HEAT assessment, and System Level Measures (SLMs) which are beginning to take a more targeted approach to equity. The TAW reports show there are some good things happening but in some cases progress is slow. It was emphasised that programmes that are in place, need time to embed. Those that are having the biggest impact are those where strong Māori Health and Population Health input sits alongside clinical leadership.

Also discussed again was the need to cease to focus on reducing equity and focus on "eliminating equity". Recognition of shifts towards achieving 'equity' as a means to getting more people on board was also discussed. More focus is required in this area.

Nationally there is a shift to putting "Equity" at the forefront of DHB operations and have clear deliverable outcomes documented for regions populations. There is a need to build understanding around the determinants of health and the determinants of inequitable health outcomes.

The **2018 Health Awards** were discussed around how they align to our values and behaviours, with a strong weighting on "equity".

Nursing Entry to Practice (NEtP) Programme: Due to the higher numbers of Maori participating in the accredited nursing programme, it is envisaged that higher levels of support are required. As noted the month prior, four on the programme had resigned due to varying pressures.

PASIFIKA HEALTH LEADERSHIP GROUP

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakapiri (Last Days of Life)** 118 For the attention of: **HBDHB Board**
Document Owner(s)	Patrick Le Geyt, General Manager Maori Health Chris Ash, Executive Director of Primary Care
Document Author	Penny Rongotoa, Portfolio Manager - Integration
Reviewed by	Jill Garrett – Strategic Services Manager, Primary Care, HB Clinical Council, HB Health Consumer Council. Received a favourable response from MRB in April 2018. MRB identified that the Plan was perfect in relation to effectively engaging with Māori whānau.
Month/Year	August 2018
Purpose	For information only
Previous Consideration Discussions	MRB endorsed the Te Ara Whakapiri HB Care Plan and toolkit. MRB suggested the paper be shared with other committees, for information only.
Summary	Reviewed by Maori Relationship Board in April 2018, as suggested now circulating to the Council's and the Board
Contribution to Goals and Strategic Implications	Improved equity, communication, co-ordination and integration of services are a major health goal of the New Zealand Government as a means to driving improvements in quality, efficiency and cost control
Impact on Reducing Inequities/Disparities	Māori whānau advise that discussing future healthcare needs and, in particular end of life care can be a tapu (sacred) subject. Therefore, consideration is needed whether patients feel comfortable talking about this subject.
Consumer Engagement	Consultation with team of developers and others MRB feedback
Other Consultation /Involvement	Completed
Financial/Budget Impact	N/A
Timing Issues	Ongoing
Announcements/ Communications	N/A

RECOMMENDATION:

It is recommended that the HBDHB Board

1. **Note** the work completed to date that supports the implementation of the HBDHB Last Days of Life - Care Plan and Toolkit

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HAWKE'S BAY
District Health Board
Whakawāteatia

Te Ara Whakapiri (Last Days of Life)

Author:	Penny Rongotoa, Portfolio Manager - Integration
Reviewers:	Jill Garrett – Strategic Services Manager, Primary Care
Date:	July 2018

RECOMMENDATION

- Information update ONLY

1.0 Context

This paper responds to feedback from MRB regarding the HBDHB Te Ara Whakapiri HB Care Plan and toolkit

- The need for cultural responsiveness in a local context
- To pilot with Māori
- Include as a resource, tikanga guidelines in respect of the tool.

2.0 Background:

Te Ara Whakapiri HB Care Plan and toolkit was developed for the local setting using the MoH Te Ara Whakapiri Principles and Guidance Tool.

During the establishment phases of the MoH Te Ara Whakapiri Principles and Guidance Tool, the tool went through a robust evaluation of independent reviews of models/stocktake of services, literature reviews based on evident practice/summaries of finding from family/whānau survey. The tool has been designed reflective of Te Whare Tapa Wha.

3.0 Responding to feedback

A small working group was reconvened to work on the approach of the above request. Robust discussion was held and it was clear that when we are talking about the different dimensions that we cannot attempt to put a symptom under one dimension of Te Whare Tapa Wha, for example pain is just not physical and therefore not just under the dimension of Te Taha Tinana.

The working group wanted to ensure there was guidance for nurses and other health professionals. The purpose of the guidance is to align to the Care Plan tool.

As a result Tikanga guidelines have been developed as an additional and integral resource to support the wider Te Ara Whakapiri Tool Kit (TAWTK) - refer Appendix One below.

- A self-review matrix has been developed to assist an organisation or service to self-evaluate and self-design areas for improvement.
- The Matrix is with the communications team for production and publishing
- Users of Te Ara Whakapiri Tool Kit will be provided with the resource once produced.
- The resource was trialled with (5) Aged residential care facilities. The resource and will be promoted to the wider sector once distributed.

Appendix One: Te Ara Whakapiri Tool Kit – Tikanga Guidelines

Traditional Origins[1] e aku Rangatira e whakanui nei i a au, tēnā koutou, tēnā koutou, tēnā koutou – You, my superiors, bidding me welcome, I salute you, Greetings

Traditional Māori origins track back through genealogies from the present, through human generations to the demigod Māui, and further back to guardians, deities, gods and goddesses, and finally to the Skyfather (Ranginui) and Earthmother (Papatūānuku). There is the belief of a single ancestor who became earth and sky from whom all things descend biologically and genealogically;

"Kotahi anō te tupuna o te tangata Māori,
Ko Rangi-nui e tū nei, Ko Papa-tū-ā-nuku
E takoto nei, ki ēnei korero. Ki ta te
Pākehā ki tāna tikanga, na Te Atua anake
Te tangata, me Rangi, me Papa, me ngā mea katoa"

"There is but one ancestor of the ordinary human,
Great Sky Standing above here, and Earth spread surface lying here,
To the Pākehā or European, according to their belief, it is God alone,
Who created people, Sky, Earth, and all things"

Papatūānuku, Earth Mother, or Planet Earth (Gaia) is the ancestress of all things. She and her children are the guardians or the progenitors of everything on and under the earth, sea and skies. The two grandchildren of Papatūānuku, Hineahuone and Hinerauwhārangii were the first to receive human form and were empowered by the guardians and gods to be the receptacles of all knowledge which they then transferred genealogically and genetically through demigods and demigoddesses to Māori. All this encapsulates the holistic connection between whenua (land), humans, gods, guardians and everything in the universe. It underlies the relationship between Māori people and all things.

All this also gives deeper meanings to the word 'Whenua'. For Māori, whenua has an added meaning, being the human placenta or afterbirth. Through various birth ceremonies the placenta is returned to the land, and that results in each Māori person having personal, spiritual, symbolic and sacred links to the land where their whenua (placenta) is part of the whenua (land). The words "nōku tēnei whenua" (this is my land) is given a much stronger meaning because of the above extensions. Having ancestral and birth connections, the above is also translated as "I belong to this land, so do my ancestors, and when I die, I join them so I too, will be totally part of this land".

Assessment:

For Māori, there is sentiment attached to the voice and face-to-face communication *(kanohi ki kanohi);* hence the emphasis is on conversation (1). Whānaungatanga (relationship) is a relationship that develops as a result of sharing whakapapa (kinship links), commonalities and shared experiences which provides people with a sense of connection, belonging and comfort but most importantly, it opens the door to open communication (2). Māori whānau advise that discussing future healthcare needs and, in particular end of life care can be a tapu (sacred) subject. Therefore, consideration is needed whether patients feel comfortable talking about this subject in the presence of kai (food).

Caution should be taken not to make assumptions about whether Maori speak te reo (language), know their whakapapa (heritage, ancestors) or practice tikanga and kawa (cultural practices) (1).

> Most, if not all of the information you need for your assessment can come from a conversation and listening for cues and insights into the person, who they are, where they come from and what matters to them. Direct questions may not illicit the answers you are looking for.

Care Planning:

The table below is intended to illustrate that no careplan issue can be considered from one single dimension of health or wellbeing. Physical well-being is intertwined with spiritual, emotional and family well-being (1). During your assessment and care planning processes, an understanding and consideration of Māori world views and the ways in which tikanga can be incorporated can enhance the relationship with the person and whanau, and the efficacy of the care plan interventions. The following principles provide a foundation for this:

[1] *Hohepa, P, 1995, The Taking into Account of Te Ao Māori in Relation to Reform of the Law of Succession, Law Commission, Wellington, New Zealand*

End of Life – Collective Principles

Tikanga (custom lore)

Custom lore provides the basis of all important decisions for tribal groups as well as individuals. It remains valuable as a guiding principle and a source of wisdom.

Mana (authority, status, prestige)

A person gains authority through displaying the qualities of integrity, generosity, bravery, humility, respect, commitment to the community, using history, stories and legends to explain things, facilitating rather than commanding.

Whakapapa (genealogy)

A common ancestry provides a platform for identity, common histories, and similar understandings of the material world.

Wairuatanga (spirituality)

The spiritual world is important part of reality which is integral to day to day activities and necessary for successful endeavours.

Kaumatuatanga (respect for elders)

Elders play a crucial role in keeping families and the community together and offer both guidance and advice.

Utu (reciprocity and restoring balance)

Maintaining balance and harmony through "give and take", reciprocal obligations, honesty in all things and the exchange of gifts are still essential practices which increase the welfare of the community

Kaitakitanga (the duty of care, for people and the environment)

People should acknowledge their spiritual responsibility to the resources they work with, ensuring health and safety in any endeavour, and pursuing quality and excellence.

Whakawhanaungatanga (family responsibilities)

Family bonds should take priority over all other considerations in deciding what actions we will take.

Manakitanga (generosity and hospitality)

Manaaki is derived from the power of the word as in mana-a-ki and means to express love and hospitality towards people – your contribution, my contribution will provide sufficient for all.

Whakarite Mana (Agreements – contracts)

An agreement is a statement if intention to form a lasting relationship, and the elements of the agreement should be open to review as circumstances change. The objective is to provide long-term satisfaction for both parties, rather than relying on "the letter of the law".

Hui (tribal meetings)

Full and active participation in decision-making is important

Care-Plan Pathways

Focus from Care Plan	**Te Taha Tinana** (Bodily well-being)	**Te Taha Hinengaro** (emotional well-being)	**Te Taha Wairua** (spiritual well-being)	**Te Taha Whanau** (family well-being)
Pain *Mamae/pouri/tangi*	Mirimiri (massage) Visual pain measure Karakia can help a person through painful procedures	Sometimes a reluctance to disclose (private experience to outsiders) (whakama) (3). Pāmamae - be hurt, in pain, feel sad, upset. traumatic, upsetting, distressing.	Pain can be cause by a spiritual unrest and will not be resolved with medication. For some, pain or disease relates to punishment from God or a higher power	May advocate for the patient and tell staff what they see. May need/want to stay with their loved one to protect them and observe treatments or procedures
Agitation *takawairore*	The treatment of physical causes of agitation/ restlessness may impact the person's ability to process spiritual causes	Place of care may impact the person's ability to be at peace	May involve working through/communicating with those that have already passed on – Tohu or symbolic occurrences	Whanau may understand what is happening for their loved one
Respiratory Tract Secretions				
Nausea and Vomiting	The desire to be part of pleasurable whanau dining experience may override nausea or vomiting that occurs as a result			Can affect the person's ability/ desire to eat affecting social relations
Dyspnoea				
Food/Fluids	Food is not passed over the head.		Keeping separate from food anything that comes into contact with the body or body fluids	Often preferred to be a group experience – shared.
Mouthcare				
Bowel Care	The storage of bedpans or urinals should be in designated area	Position of commode may influence if the person uses it. E.g. near to dining area	Tapu	Not always appropriate to ask in front of family/whanau/visitors
Micturition *mimi*		Urinal bags to be kept covered at all times	Tapu	
Medication	Rongoa (treatment, solution, tonics) may be preferred/used alongside			
Mobility/Pressure Area Care		Consult with the tūroro on all aspects of care in relation to his/her body	Consult with tūroro if there is a need to use separate pillows or towels for the lower body and head support	May be preference for a whanau member to wash or care for the person
Psychological Support	Eating, sleeping and carrying out ablutions in the same bed can be a source of distress. The use of te reo is valuable. Correct pronunciation is important – ask if unsure	A Kaumatua or Kuia may be needed as support. Waiata	Taonga (treasure) are extremely important to Māori and have much more significance than just sentimental value. Understanding whakapapa and	Identify a key spokesperson from the whanau and confirm this with the patient. Check in with that person on their well-being regularly. The patient may want someone with them during doctor/nurse visits. Maori express love and respect through visiting in large numbers. Be inclusive in your interactions with tūroro and whānau
Religious/spiritual support	The head is sacred. Privacy of the body is sacred (2)	The person may prefer to keep beliefs private from anyone outside of the whanau, hapu, iwi	May be spiritual and/or religious practices e.g. karakia. Hahi (church). Allow time for the karakia process to occur. Do not rush or interrupt. Waiata	After death, whanau and visitors may use water to cleanse

Tikanga Principles

The major principle is 'tika'. Tika can cover a range of meaning, right and proper, true, honest, just personally and culturally correct or proper to upright. From tika comes the term tikanga – customary, traditional and cultural aspects which are true and honest and just. Tikanga Māori goes beyond Māori culture, or Māori custom, to mean also the true, honest and proper cultural ways. Tikanga Māori encapsulates all accepted Māori principles.
When a person is born, creation binds the two parts of the body and spirit of his/her being together. Only the mauri can join them together. When a person dies, the mauri is no longer able to bind those parts together and thereby give life – and the physical and spiritual parts of a person's being are separated. This is expressed in the following saying:

The heart provides the breath of life, but the mauri has the power to bind or join. Those who die have been released from this bond and the spirit ascends the pinnacle of death. The mauri enters and leaves at the veil which separates the human world from the spirit realm.

References

1) Te Poari Hauora ā o te tai tokerau. (2015). *He Waka Kakarauri; guidelines for engaging Māori in Advance Care Planning Conversations.*
2) Magnusson, J.E., & Fennel, J.A. (2011). Understanding the role of culture in pain: Māori practitioner perspectives relating to the experience of pain. *The New Zealand Medical Journal. 124:* 1328
3) Magnusson, J.E., & Fennel, J.A. (2011). Understanding the role of culture in pain: Māori practitioner perspectives of pain descriptors. *The New Zealand Medical Journal. 124:* 1328
4) Johnston Taylor, E., Simmonds, S., Earp, R., & Tibble, P. (2014). Maori perspectives on hospice care. *Diversity and Equality in Health and Care. 11:* 61-70
5) Moeke-Maxwell, T., Waimarie Nikora, L., & Te Awekotuku, N. (2014). End-of-life care and Māori Whānau Resilience. *Mai Journal. 3,* 2, 140-152
6) Ministry of Health. (2014). Palliative Care and Māori from a health literacy perspective. Wellington. MoH
7) Barton, P., & Wilson, D. (2008). Te Kapunga Putohe (The Restless Hands). A Māori Centred Nursing Practice Model. *Nursing Praxis in New Zealand. 24*, 2, 6-15
8) Te Whare Tapa Wha….
9) Te Ara Whakapiri….
10) Health Hawke's Bay. (2014). MAI: Maori Health Strategy.

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora (TAW): Access (Ambulatory Sensitive Hospitalisations) (ASH) Rates 0-4 & 45-64 years** 119 For the attention of: **HBDHB Board**
Document Owner	Dr Mark Peterson, Chief Medical Officer - Primary
Document Author(s)	Marie Beattie, Portfolio Manager - Integration Jill Garrett, Strategic Services Manager – Primary Care
Reviewed by	Executive Management Team, Māori Relationship Board, HB Clinical Council and HB Health Consumer Council
Month/Year	August 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 – a targeted approach over the winter period has been implemented. Further considerations are required to sustain this going forward. • Immunisation – despite some challenges this quarter equity in immunisation rates has been maintained. • Oral health – carries free statistics have been sustained over the past 12 months and utilisation of services has improved slightly. Addressing patient experience and engagement with services has been key in shifting the performance within this programme. • Child healthy homes programme – referrals continue into the programme with the addition of external stakeholders providing supplementary services. • Skin Programme – proactive approach to reducing presentations is in progress. Extra support required to close equity gaps in this area- see recommendations. **ASH 45-64**: rates for Māori have improved in the last 12 month period both within our own DHB and the Hawke's Bay District Health Board (HBDHB) performance nationally, however ASH rates for Māori still remain twice the rate of "Other." There is still significant work to be done to address this inequity. • ASH will remain a measure with associated activities as part of the System Level Measure (SLM) Improvement Plan. The focus has been to provide a range of initiatives to support Māori in engaging with a/their primary care provider and having support in place to sustain a good relationship for continuity of care.

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	• There is a need to examine patient journeys in greater depth to understand trends in the utilisation of services, readmission patterns; the menu of services that the patient does or does not have a relationship with and where coordination of care can be more greatly enhanced using Multi-Disciplinary Team (MDT) approaches. This work is beginning to take shape, and forms part of the programme of work listed under the SLMs Improvement Plan. More detail of specific programmes of work is provided in the body of this report. • The work of the people and quality team in building capacity across the organisation in Institute of Healthcare Improvement (IHI) methodology tools, inclusive of tracer auditing, will assist in using patient journeys of care to reinforce areas of best practice and highlighting areas for improvement. Linking this with patient experience survey data will be helpful in the future as it is made more available to DHB. • Review of the Coordinated Primary Options (CPO)[1] programme and scoping of a revised and expanded model will be presented to the Executive Management Team (EMT) the first week in August. The draft has already been completed. Key areas that the paper highlights is the need to have a focused approach to equity if the programme is to be beneficial in significantly contributing to reduced ASH rates (across all age bands). • Collaborative Clinical Pathways provide the foundation of best practice that underpins CPO and work in Long-term Conditions (LTCs). HBDHB has secured access to an interim tool provided through the Midlands Network that provides continued access to pathways while a replacement vendor to Map of Medicine is selected. HBDHB will form part of the Central Region Request For Proposal (RFP). The aim is to be operating off the new pathways platform in January 2019. • There is now a Nurse Practitioner Heart Failure (Intern) in role. Working relationships with primary care is commencing and alignment with respiratory initiatives has begun. Cardiac conditions have shown little improvement with the exception of Congestive Heart Failure in the last 12 month period. • The Nurse Led Respiratory Programme continues to reinforce a MDT approach and a whānau based approach to care. Significant shifts have been achieved for Māori in relation to COPD in the past 12 months. • Formalised planning for the implementation of the HBDHB LTCs framework was delayed due to recruitment into the Portfolio Manager role, however operational work with renal, diabetes, respiratory services have continued with targeted approaches to

[1] Coordinated Primary Options CPO is the delivery of services, by a recognised health professional within a primary care or community care setting, that would otherwise have been delivered by a secondary-hospital based service inclusive of outpatient services, ED provided services, and inpatient delivered services. Established in 2003 as an initiative to reduce hospital admissions by providing alternative management options in primary care. In 2009 utilised as a vehicle for the transition of services from secondary to primary care and from 2015 the addition of integrated (HHB and HBDHB) services. CPO supports and is supported by collaborative clinical pathways. Thus they are mutually beneficial – one team, smart system, mitigating risk associated with parallel/isolated clinical process.

	care coordination, transitioning of care supported by Clinical Nurse Specialists (aka two – LTC framework)
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:

That the HBDHB Board:

1. **Note** the content of the report
2. **Endorse** the actions being taken.
3. **Support** recommendations made by EMT (31 July 2018)

   Provide quarterly updates against activities that:
   - contribute to the Te Ara Whakawaiora indicators;
   - are reported against as part of the System Level Measures Improvement Plan
     - Keeping Children out of Hospital and Using Health Resources Effectively.

HAWKE'S BAY
District Health Board
Whakawāteatia

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

Author(s):	Marie Beattie. Portfolio Manager - Integration Jill Garrett, Strategic Services Manager – Primary Care
Designations:	As above
Date:	**July 2018**

OVERVIEW

Te Ara Whakawaiora (TAW) is an exception based report, drawn from Approved Mental Health Professional (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 ASH Hospitalisations: 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	July 2018

MĀORI HEALTH PLAN INDICATOR

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

ASH reflect hospital admissions for conditions which could potentially be prevented by early access to treatment in primary 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 socio-economic 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).

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?

SLMs

The Introduction of the SLMs; 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. ASH rates are included in two SLMs.

- ASH 00-04yrs is reported against under the SLM - 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[2]. 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 two to five 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) [3]

0 – 4 years

For the 2017 year the contributory measures regarding the SLM of Reduced ASH rates for 0-4 years as agreed by Health Hawke's Bay (HHB) and HBDHB 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 Chronic Obstructive Pulmonary Disease (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)
- 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 CPO programme – Hospital Discharge pathway for Māori – Pasifika and Q4 and Q5.

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

1. HAWKE'S BAY DISTRIBUTION AND TRENDS

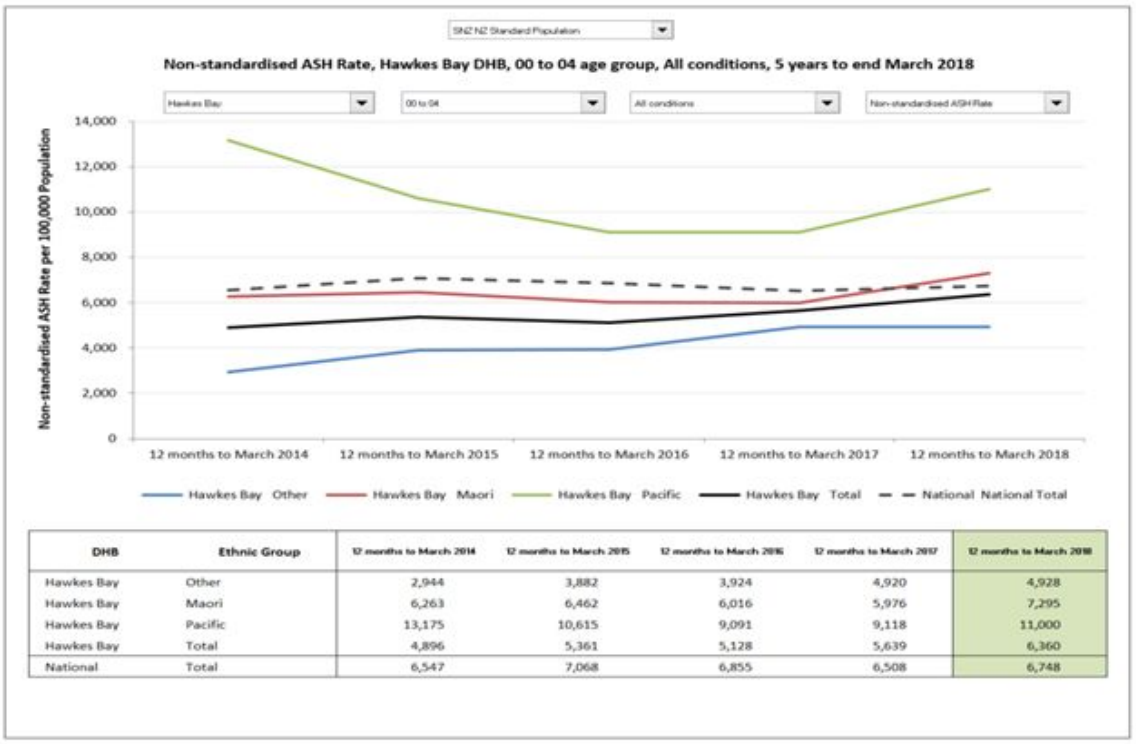
0-4 YEAR AGE GROUP

For the 2017-18 year the contributory measures regarding the SLM of Reduced ASH rates for 0-4 years as agreed by HHB and the HBDHB are:

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

The 2018 top three ASH conditions for tamariki Māori 0 – 4 years were: Upper and ENT respiratory Infections, Gastroenteritis/dehydration and asthma.

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



DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	2,944	3,882	3,924	4,920	4,928
Hawkes Bay	Maori	6,263	6,462	6,016	5,976	7,295
Hawkes Bay	Pacific	13,175	10,615	9,091	9,118	11,000
Hawkes Bay	Total	4,896	5,361	5,128	5,639	6,360
National	Total	6,547	7,068	6,855	6,508	6,748

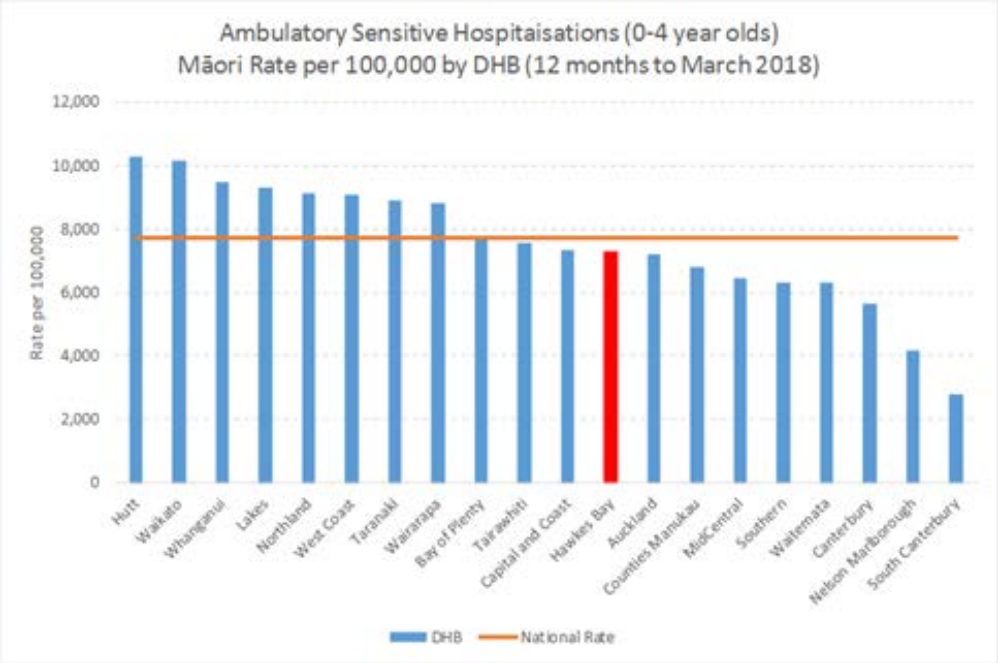
Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	179	231	226	276	272
Hawkes Bay	Maori	305	316	293	297	364
Hawkes Bay	Pacific	83	69	60	62	77
Hawkes Bay	Total	567	616	579	635	713
National	Total	-	-	-	-	-

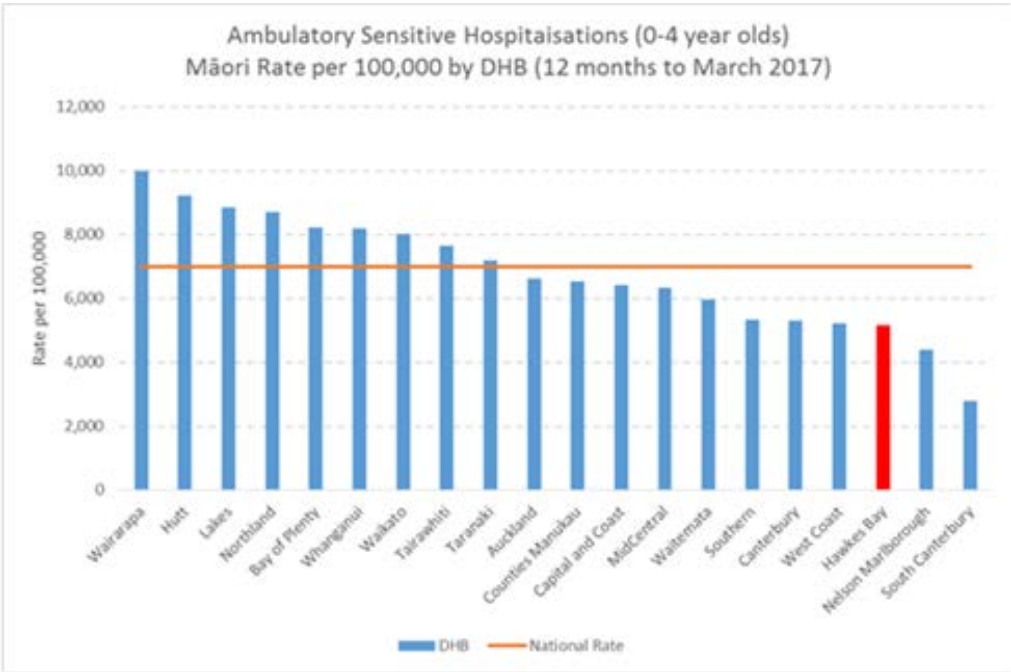
Data Analysis

As at March 2018 Hawke's Bay tāmariki have lower ASH compared to national rates with the total ASH Rate for HB at 6,360 compared to the national rate of 6,784. Although this is positive HB has seen its overall ASH rate increase in the past 12 months by 11%.

Hawke's Bay Māori ASH rates 0-4 age group 12 months to March 2018 – Benchmark against DHBs



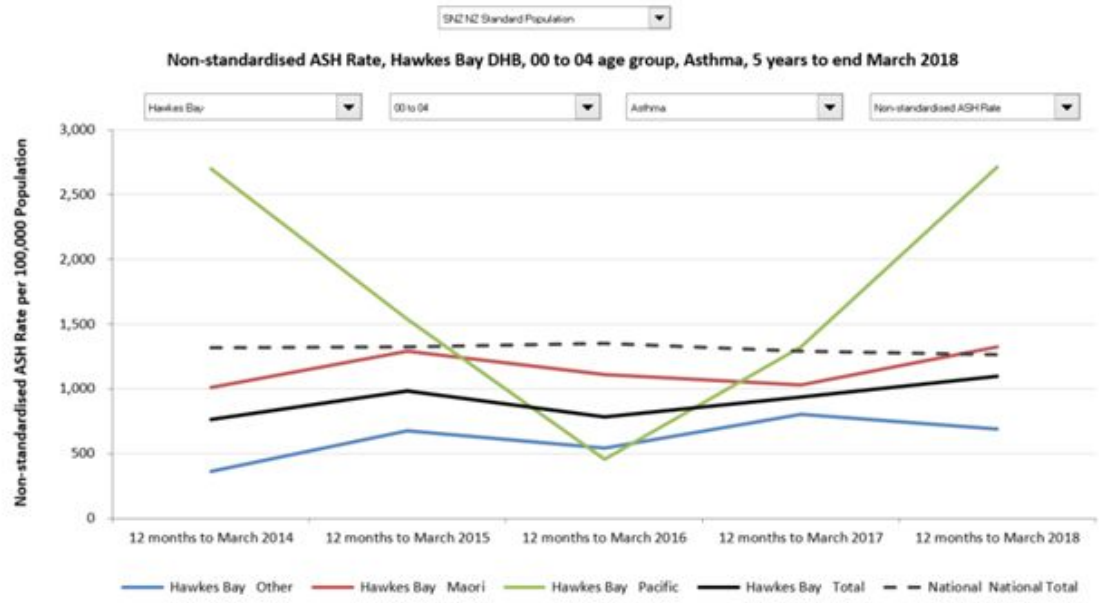
Hawke's Bay Māori ASH rates 0-4 age group 12 months to March 2017 – Benchmark against DHBs



Data Analysis

In the 12 months to September 2018 the Hawke's Bay Māori rate was 94% of the National Rate which is an improvement from the previous 12 month period of 99.9% of the national rate. We have remained the 9th 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.

Asthma



DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	362	672	538	802	688
Hawkes Bay	Maori	1,006	1,288	1,109	1,026	1,323
Hawkes Bay	Pacific	2,698	1,538	455	1,324	2,714
Hawkes Bay	Total	760	983	779	933	1,097
National	Total	1,318	1,323	1,350	1,286	1,264

Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	22	40	31	45	38
Hawkes Bay	Maori	49	63	54	51	66
Hawkes Bay	Pacific	17	10	3	9	19
Hawkes Bay	Total	88	113	88	105	123
National	Total	-	-	-	-	-

Data Analysis

Hawke's Bay ASH rates for Asthma has increase by 17.6% or 18 cases. Both Māori (1,323) and Pacific (2,714) are both above the national rate of 1,264. Although small numbers for Pacific, the 19 cases over the 12 month period is more than double from the previous period.

Pneumonia

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	148	235	313	303	127
Hawkes Bay	Maori	493	429	390	423	421
Hawkes Bay	Pacific	1,111	1,231	1,515	441	429
Hawkes Bay	Total	345	374	416	364	277
National	Total	531	633	669	561	587

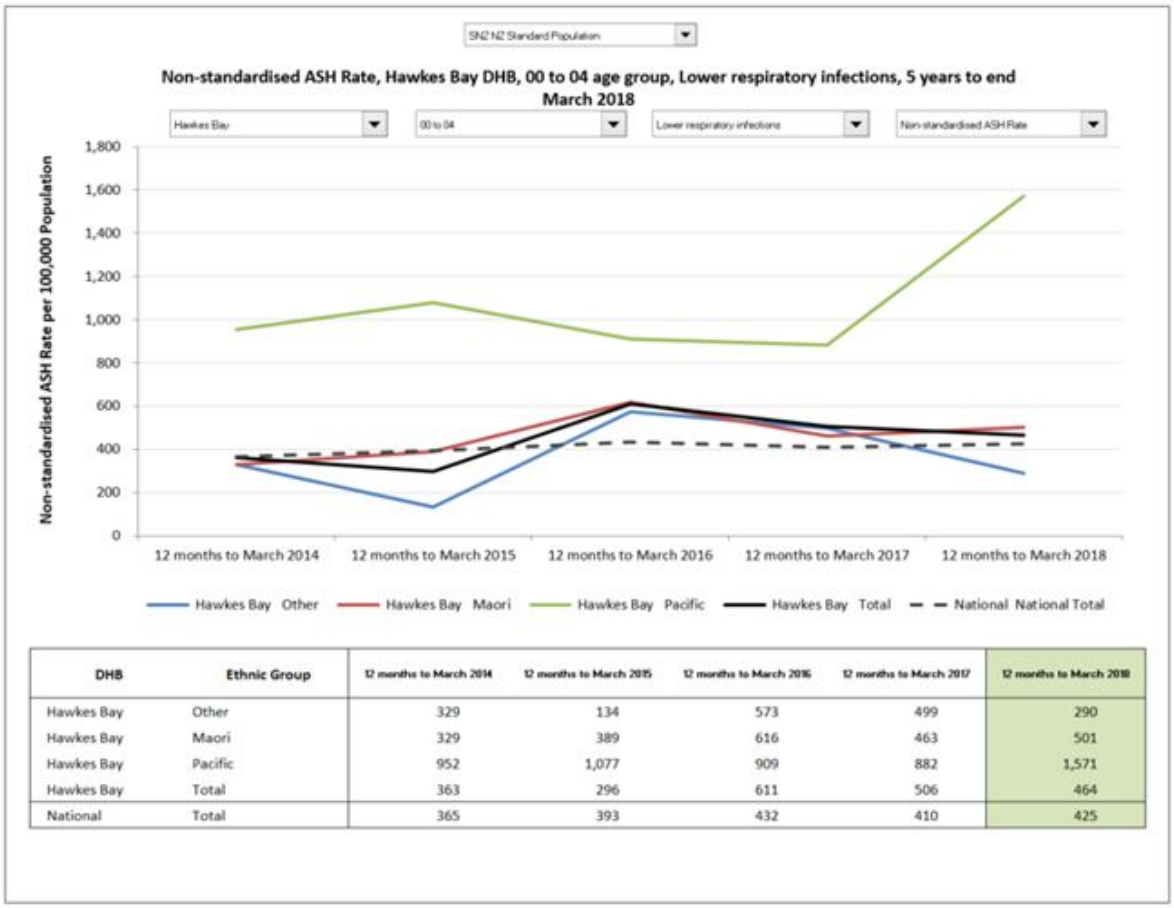
Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	9	14	18	17	7
Hawkes Bay	Maori	24	21	19	21	21
Hawkes Bay	Pacific	7	8	10	3	3
Hawkes Bay	Total	40	43	47	41	31
National	Total	-	-	-	-	-

Data Analysis

Hawke's Bay ASH rate for Pneumonia (277) is below the national rate (578). The number of events has dropped from 41 cases in the 12 month period to March 2017 to 31 in the 12 month period to March 2018.

Lower Respiratory Infections



DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	329	134	573	499	290
Hawkes Bay	Maori	329	389	616	463	501
Hawkes Bay	Pacific	952	1,077	909	882	1,571
Hawkes Bay	Total	363	296	611	506	464
National	Total	365	393	432	410	425

Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	20	8	33	28	16
Hawkes Bay	Maori	16	19	30	23	25
Hawkes Bay	Pacific	6	7	6	6	11
Hawkes Bay	Total	42	34	69	57	52
National	Total	-	-	-	-	-

Data Analysis

The Hawke's Bay ASH rate for Lower Respiratory Infections (464) is above the National rate (425). The Hawke's Bay rate has decreased by 8% however the number of Pacific cases doubled from the previous period from 6 to 11.

Programme Analysis

Child Healthy Homes Programme (CHHP): *Susan Stewart – Team Leader Child Health Team*
The Child Healthy Housing team continues to provide a quality programme with positive feedback from whānau regarding: their homes being warmer, drier and healthier; children being sick less often; increased knowledge about how to keep their home warmer and dryer. More housing interventions and services have been sourced and established, such as Tumu timbers supply of firewood, Alsco linen supplies, as well as the extensive support form established housing suppliers, such as curtain bank, Christian Love link, and insulation provider.

All respiratory ED and paediatric discharge summaries as well all appropriate ICD codes are triaged for eligibility, as a result there is better referral information flow from secondary care services to the CHHP.

To date, a total of 974 referrals have been received since the inception of the CHHP. Whānau have received a total of 3497 interventions to promote warm dry homes and reduce transmissible diseases. These interventions have included, but not limited to: curtains (320 homes); beds (363); 234 WINZ Full and Correct Entitlement Assessments (FCEA); 177 homes insulated; and, 68 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.

HBDHB/Housing coalition funding has been approved to undertake a pilot programme (75 families) 2018/19 with Habitat for Humanity to undertake minor housing repairs as well as complete building structural assessments as appropriate.

Respiratory Programme (0-4): *Charrissa Keenan Māori Health Gains Adviser*
Māori Health have developed a package of health initiatives to provide added support to tamariki Māori and their whānau via Well Child/Tamariki Ora Services ('WC/TO'). These initiatives include: a community-based Māori lactation service, an Oranga Niho[4] support service focusing on oral health education and facilitating access to dental care, and a respiratory support service for tamariki under 5 years old and their whānau. WC/TO services are positioned well to deliver such support because of their relationships with whānau and strong linkages across the health, education, and social sectors. Underlying this package of health initiatives is HBDHB's commitment to reduce inequities in hospital admissions for tamariki aged under five years and to improve Māori child health outcomes.

Increased Respiratory Support for tamariki and their whānau
The WC/TO Respiratory Support Service ('the Service') was developed following recommendations by the ASH Respiratory Working Group (RWG) to improve access for young children at risk of, or experiencing, a respiratory illness. This recommendation was based on a 2017 review of ASH respiratory care pathways that identified: 1) there is no specific child respiratory service currently delivered in Hawke's Bay; 2) children are 'bolted on' to the adult respiratory programme; and, 3) there is a general lack of confidence among the primary care workforce when providing respiratory care to young children. Despite this gap in service delivery, the ASH RWG has been advised that there is no funding available to invest in a children's respiratory support service.

To minimise the impact of respiratory illness on young children over the winter period, Māori Health, with input and direction from the ASH RWG, is working with WC/TO services to provide added respiratory support. The service targets Māori and Pacific tamariki, and children living in high deprivation areas. The focus of the service is to: 1) prevent hospital admissions by identifying tamariki with respiratory needs via the WC/TO Core Check; and, 2) provide increased support to whānau whose tamaiti has been admitted to hospital for a respiratory related illness. The Service provides in-home respiratory education and support for whānau to help manage their child's respiratory illness. The service also establishes linkages between whānau with their primary care provider, and where needed, referral to specialised respiratory support services. Due to limited funding the service is presently only short term till October 2018.

Immunisation 0-4: *Fiona Jackson Immunisation Co-ordinator*
We are pleased that we have achieved 94% overall for this target with equity maintained. We continue to have good communication between all immunisation providers which helps us achieve this result. It has been a hard quarter with the schedule change and influenza vaccinating impacting on General Practice and all immunisation providers. This has limited families' access to General Practice in some instances. Of the 31 children declined or not complete - 12 identified as Māori, 15 European and 2 Pacific with the opt-off ethnicities unknown.

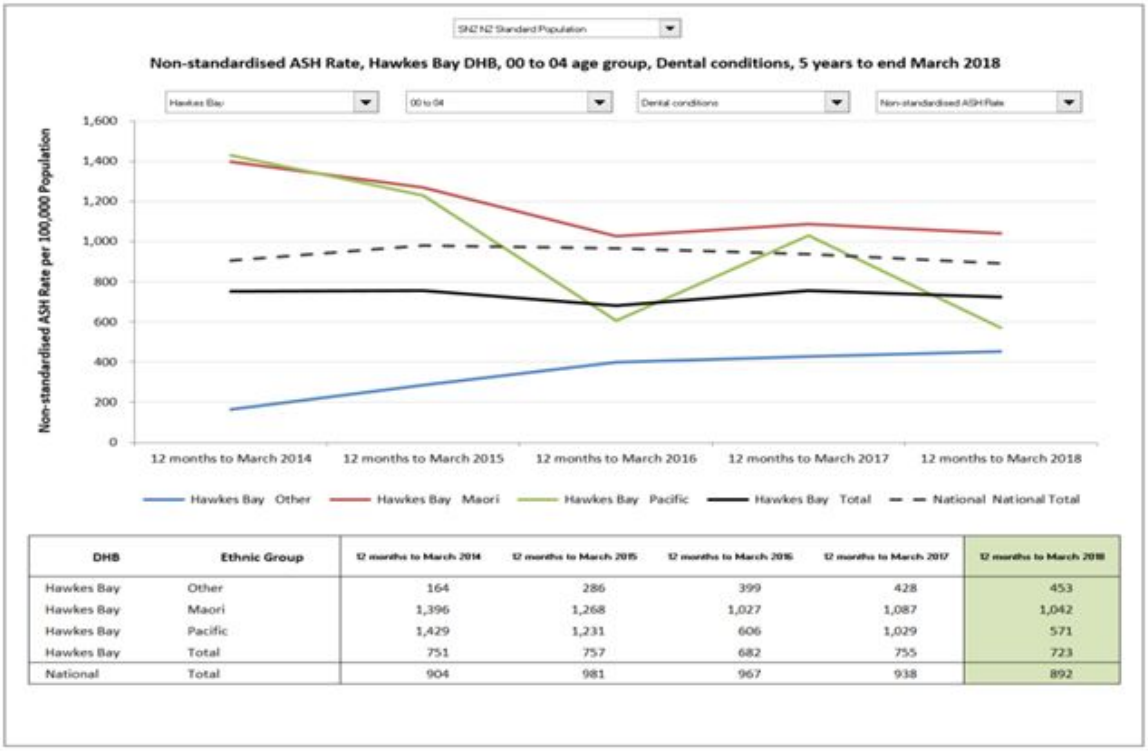
This quarter we have had 15 whānau decline immunisations. All of the above families have had conversations with trusted health professionals or the HBDHB Immunisation team to assist them with their decision-making. Housing is having an impact on finding whānau for the outreach team

[4] Dental programme for children.

and this is impacting being able to get children immunised as efficiently as we'd like. We do have a number of transient families that take time to locate.

High pneumococcal immunisation coverage in children under five will be having a significant impact on the declining admissions for pneumonia in the 0 – 4 year age group. While hospitalisations for respiratory infections aged under 5 years have been increasing in New Zealand, hospitalisations for pneumonia has declined significantly since the implementation of the pneumococcal conjugate vaccine programme.

Dental



DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	164	286	399	428	453
Hawkes Bay	Maori	1,396	1,268	1,027	1,087	1,042
Hawkes Bay	Pacific	1,429	1,231	606	1,029	571
Hawkes Bay	Total	751	757	682	755	723
National	Total	904	981	967	938	892

Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	10	17	23	24	25
Hawkes Bay	Maori	68	62	50	54	52
Hawkes Bay	Pacific	9	8	4	7	4
Hawkes Bay	Total	87	87	77	85	81
National	Total	-	-	-	-	-

Data Analysis

The ASH rates for Pacific (571), Other (453) and Total (723) are all below the national rate of 892. Māori is currently 16.8% higher than the National rate and has decrease slightly from the previous period.

Programme Analysis

Oral Health: *Wietske Cloo – Acting Service Director Community Women and Children*
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:

- Progress in the year shows that as a result of the appointment of a Kaiawhina position within the Community Oral Health Service (COHS) 515 tamariki have been re-engaged with the COHS

- WC/TO 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. There is great collaboration between services. Oral health is now part of WC/TO Quality improvement framework (supported by TAS)

- Close collaboration with the Early Childhood Education/Te Kohanga Reo/ Pasifika language nests to provide staff and whānau with better oral health information and support, inconjuction with healthy start strategy and plan to reduce obesity. Building on B4SC resources

- The 'water-for-kids' project which has made the Paediatric ward implement a fizzy free environment for children in hospital from 1 March 2018- evaluation is underway

- The Te Roopu Matua – Māori consumer, community leaders group 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 Hawke's Bay to increase the focus on oral health in the Whānau Wellness Programme, and planning to implement 'Lift the Lip' in two high needs GP practices
.
- 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 general anaesthetic dental procedure. The final report with recommendations is finalised. Findings 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.

- In general, Pasifika research results also inform the project for year 2, data monitoring of progress has improved and with that enrolment ethnicity data. The gains made in Carries Free has been sustained and utilisation of services has improved slightly.

Next steps

- Community champions supporting kaiawhina
- Fluoride varnish standing order for more practitioners
- Increasing awareness of the service
- Water only policies in settings - e.g. churches, Early Childhood Education (ECE)
- Collaborate with primary care and population health & Māori Health & WC/TO

Gastroenteritis/Dehydration

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	872	1,328	694	1,248	1,304
Hawkes Bay	Maori	780	1,186	678	946	962
Hawkes Bay	Pacific	1,111	2,308	758	1,176	1,000
Hawkes Bay	Total	846	1,323	691	1,110	1,133
National	Total	1,270	1,520	1,020	994	1,082

Events

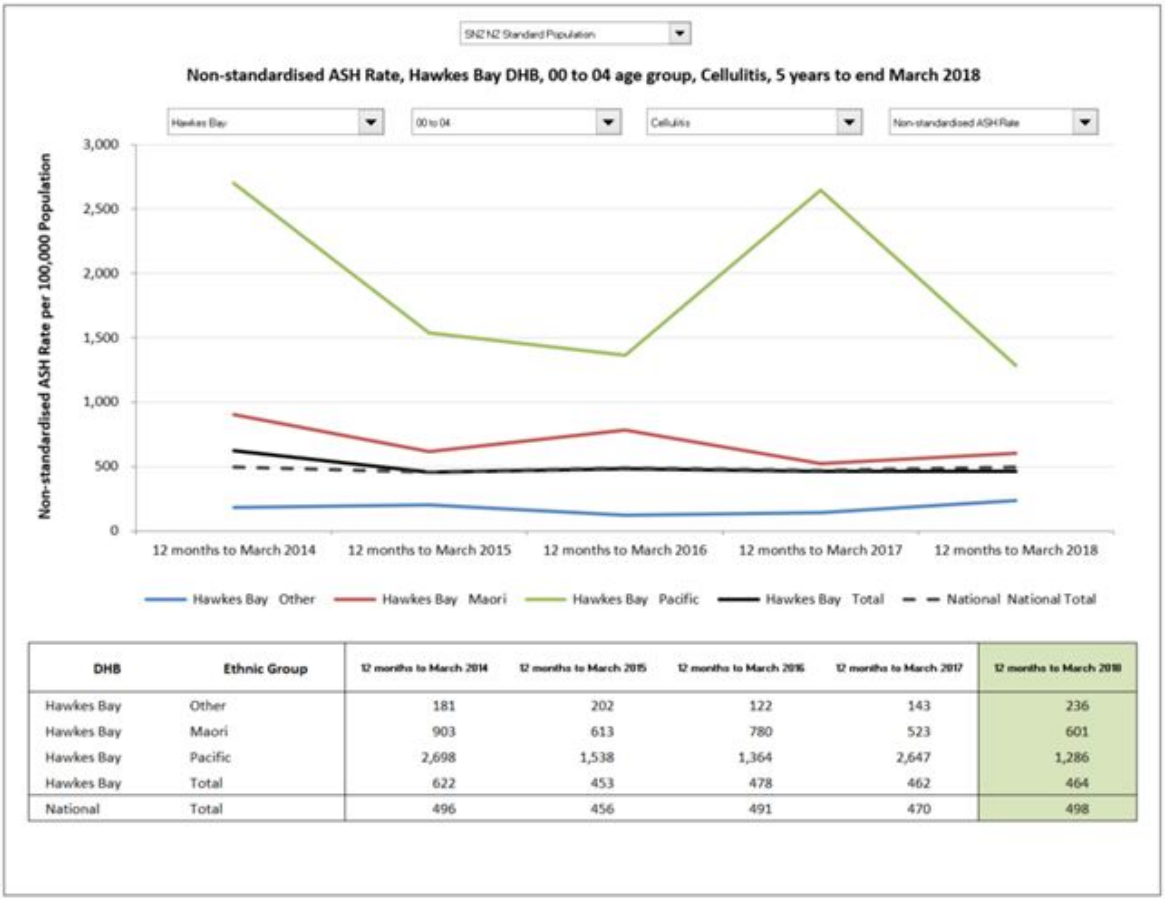
DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	53	79	40	70	72
Hawkes Bay	Maori	38	58	33	47	48
Hawkes Bay	Pacific	7	15	5	8	7
Hawkes Bay	Total	98	152	78	125	127
National	Total	-	-	-	-	-

Data Analysis: **(Peter)**

Hawke's Bay ASH rate for Gastroenteritis/Dehydration (1,133) is above the national rate of 1,082. The rate for Hawke's Bay has increased slightly to 1,133 from the previous period 1,110, this was an aditinoal 2 cases over the time period.

Strategies to address this particular ASH rate were mooted however, concerns were raised. Space constaints in primary care facilities to carry out intravenous rehydration of children under five and clinical concerns from departmental paediatricians meant this was not progressed.

Cellulitis



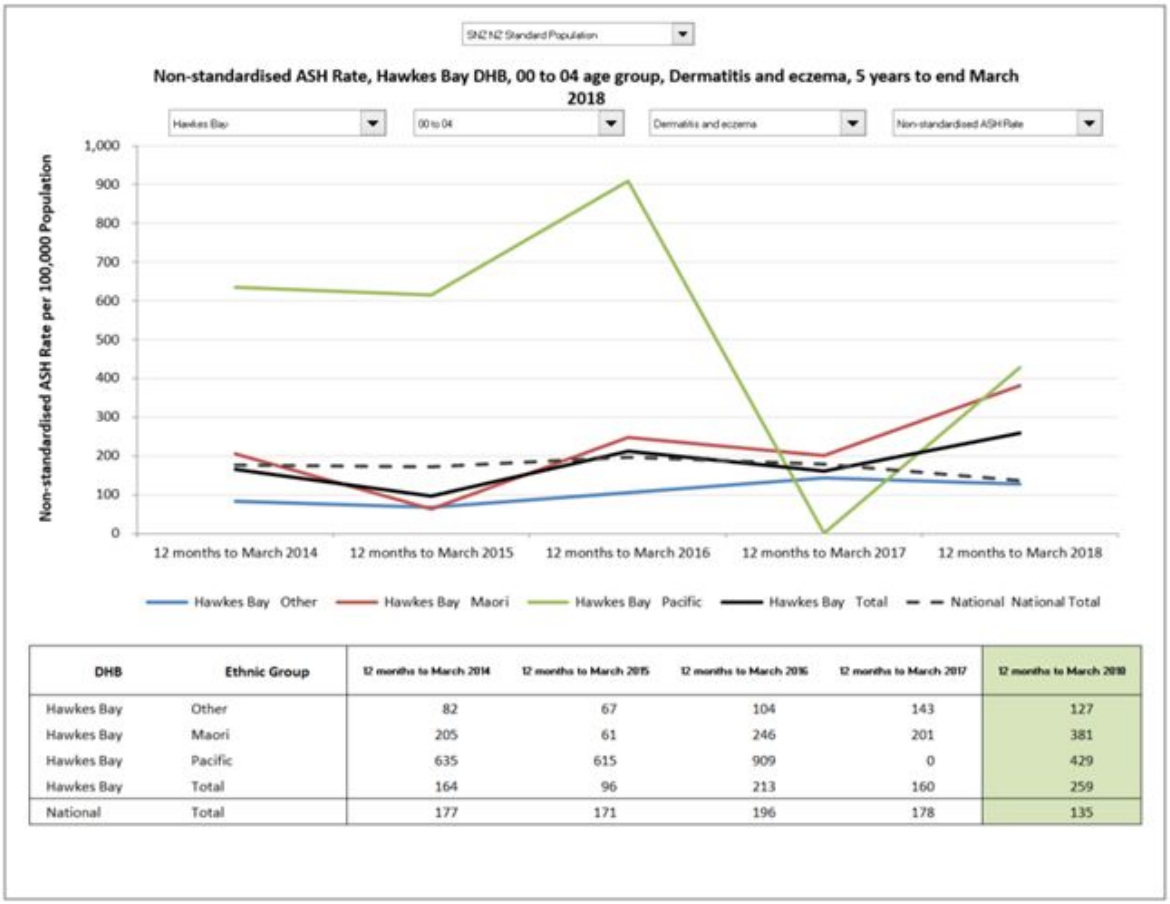
DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	181	202	122	143	236
Hawkes Bay	Maori	903	613	780	523	601
Hawkes Bay	Pacific	2,698	1,538	1,364	2,647	1,286
Hawkes Bay	Total	622	453	478	462	464
National	Total	496	456	491	470	498

Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	11	12	7	8	13
Hawkes Bay	Maori	44	30	38	26	30
Hawkes Bay	Pacific	17	10	9	18	9
Hawkes Bay	Total	72	52	54	52	52
National	Total	-	-	-	-	-

Data Analysis: **(Peter)**
Hawke's Bay ASH rate for Cellulitis (464) is below the National Rate (498). The total number of cases has stayed the same compared to the previous period however Pacific have seen cases reduce by 50% from 18 cases to nine.

Dermatitis and Eczema



DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	82	67	104	143	127
Hawkes Bay	Maori	205	61	246	201	381
Hawkes Bay	Pacific	635	615	909	0	429
Hawkes Bay	Total	164	96	213	160	259
National	Total	177	171	196	178	135

Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	5	4	6	8	7
Hawkes Bay	Maori	10	3	12	10	19
Hawkes Bay	Pacific	4	4	6	0	3
Hawkes Bay	Total	19	11	24	18	29
National	Total	-	-	-	-	-

Data Analysis

Hawke's Bay ASH rate for Dermatitis and Eczema (259) is above the national rate (135) with the total number of cases for HB in the 12 month period to March 2018 being 29. The rate for Māori (281) is 3 times higher than Other (127) with the number of cases for Māori going from 10 to 19.

Programme Analysis

Skin Programme: *Linda St George, Nurse Educator Child Health Team*

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, and reduce stigma and discrimination for tamariki with skin problems.

During 2017-2018, key activities have included:

- Public Health Nurses and School Based Māori health provider nurses continue to utilise Skin Standing Orders which enable them to supply treatment for impetigo, boils, cellulitis, head lice and scabies
- ECE provider information is still needing to be included on the first contact form to identify if and where children attend. Currently, demographic information is not accurately captured to support targeted service delivery. The programme leader has sought support for this to happen from the Portfolio Manager, Integration
- There has been significant development of appropriate skin resources for ECE staff and whānau involving robust consultation. These resources include flip charts and talk cards and posters in Te Reo Māori and Samoan. This is in response to a survey in 2017 of ECE centres that found there is a demand among staff and whānau for more appropriate information and resources to be translated.
- Professional training for ECE centres, Te Kohanga Reo, and Pacific Language Nests kaimahi took place at a health promotion event in August 2017. A further Before School Health Hui for this audience is being planned for later in 2018 where the Skin Programme and resources will be promoted further.
- Designated Public Health Nurse skin roles for ECE centres, Te Kohanga Reo, and Pacific Language Nests have strengthened relationships and supported service delivery of the skin programme with these centres.

Going forward in 2018

- We have requested support from the newly-appointed Ministry of Health (MoH) Registrar to be responsible for an audit and analysis of the ASH rates of skin admissions to hospital, allowing the skin programme to progress further towards effectively closing equity gaps.

RECOMMENDATIONS: 0-4 yrs

	Key Recommendation	Implementation lead	Champion(s)	Time Frame
1.	Introduction of a field on the first contact form identifying ECE provider and school attended. This will enable a targeted approach to ensure the reduction in presentations for this ASH rate.	Marie Beattie - Portfolio Manager Helen August - Nurse Practitioner Intern	Phillip Moore Paediatrician	Dec 2018
2.	Recommend MoH registrar be engaged to audit and analyse 0-4 admissions to hospital for skin conditions to assist in addressing prevailing equity issues.	Marie Beattie - Portfolio Manager	Nicolas Jones - Medical Officer of Health	March 2019

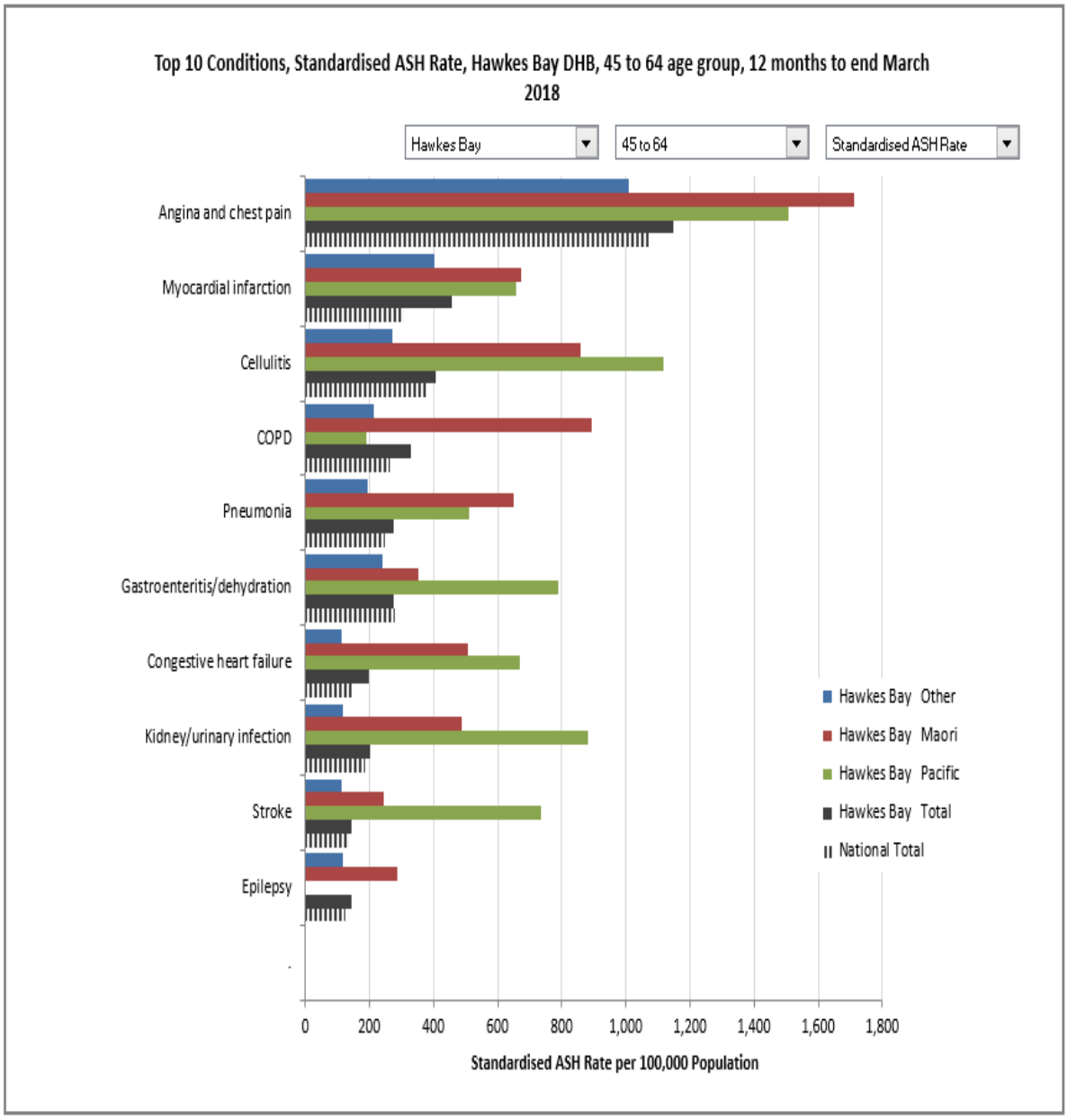
2. HAWKE'S BAY DISTRIBUTION AND TRENDS

45-64 YEAR 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.[5]

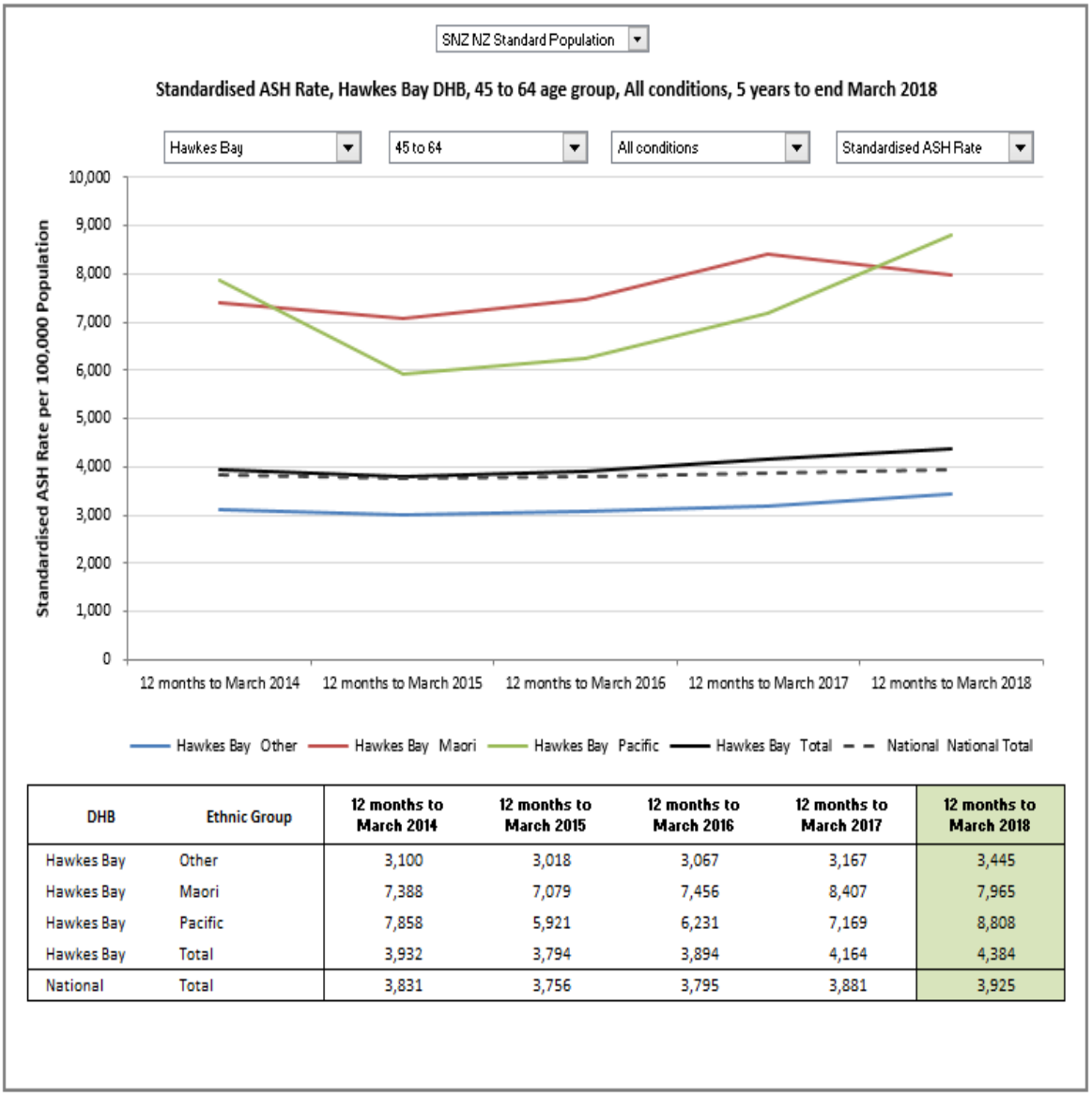
The focus of this report is on progress against reducing: Cardiac; Respiratory and Cellulitis related admissions; the highest contributors to Hawke's Bays top 10 ASH conditions. (See graph 1.0 below)

Graph 1.0 - Top 10 Conditions – HBDHB 12 months to end March 2018



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

Over time the HBDHB rates for **ALL Conditions** over 5 years has not significantly altered.



DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	3,100	3,018	3,067	3,167	3,445
Hawkes Bay	Maori	7,388	7,079	7,456	8,407	7,965
Hawkes Bay	Pacific	7,858	5,921	6,231	7,169	8,808
Hawkes Bay	Total	3,932	3,794	3,894	4,164	4,384
National	Total	3,831	3,756	3,795	3,881	3,925

Data Analysis

The Māori rate has dropped from 8,407 to 7,965 but is still over twice the rate of Other.

The Hawke's Bay ASH rate for **All Conditions/Total Population** has increased by 5% from the previous period and is currently above the national rate.

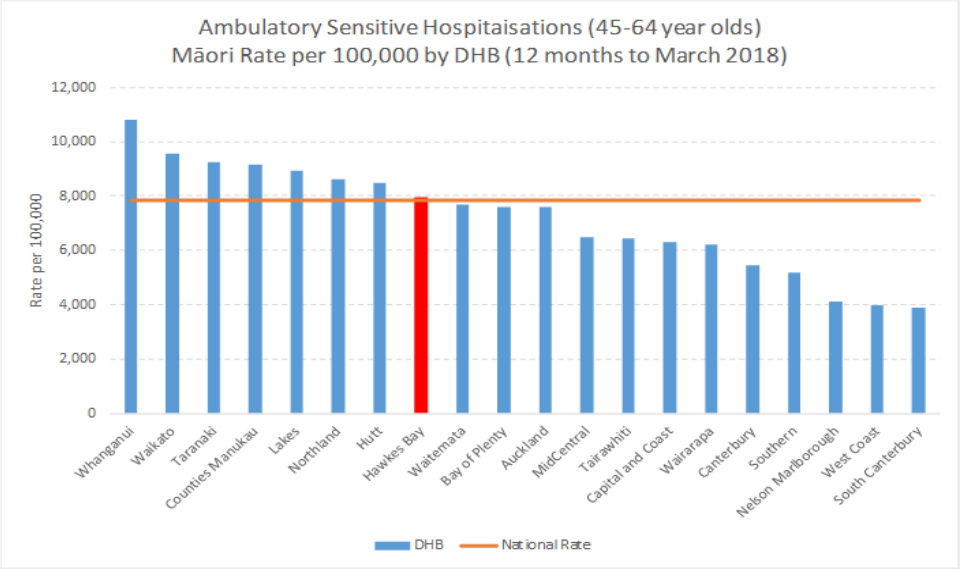
This chart and data is comparing the Māori rate with the Overall National rate, the charts on the next page are comparing the Hawke's Bay Māori rate to the Māori rates of the Other DHB's.

HOW WE COMPARE TO OTHER DHBS

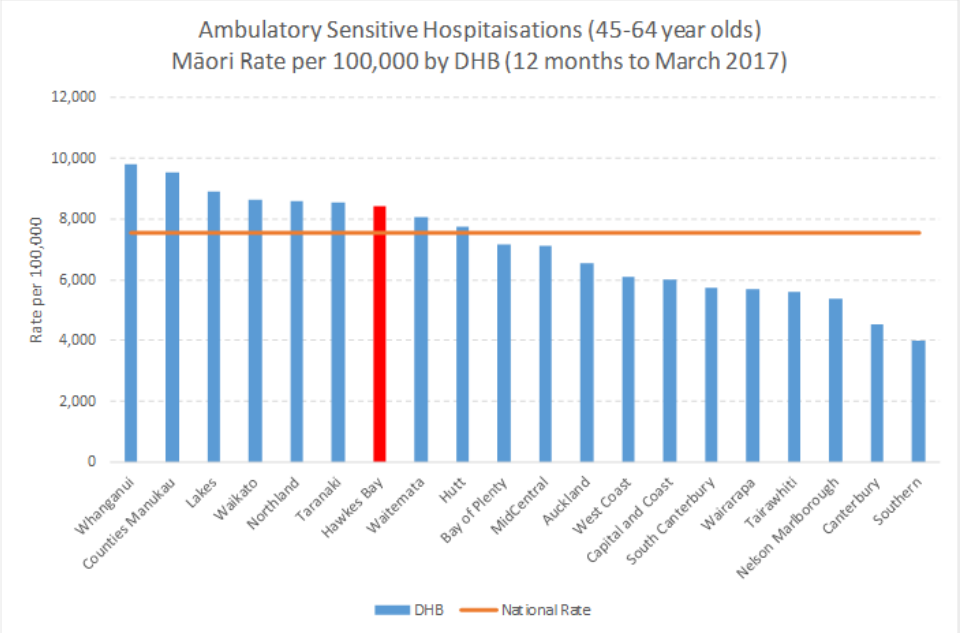
The Māori ranking of HBDHB has improved from seventh highest to eighth highest compared to the other DHB Māori Rates.

The Hawke's Bay Māori rate has reduced from 8,407 (111% of the National Māori Rate), to 7,964 (101% of the National Māori Rate).

Hawke's Bay Māori ASH rates 45-64 age group 12 months to March 2018 – Benchmark against DHBs



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

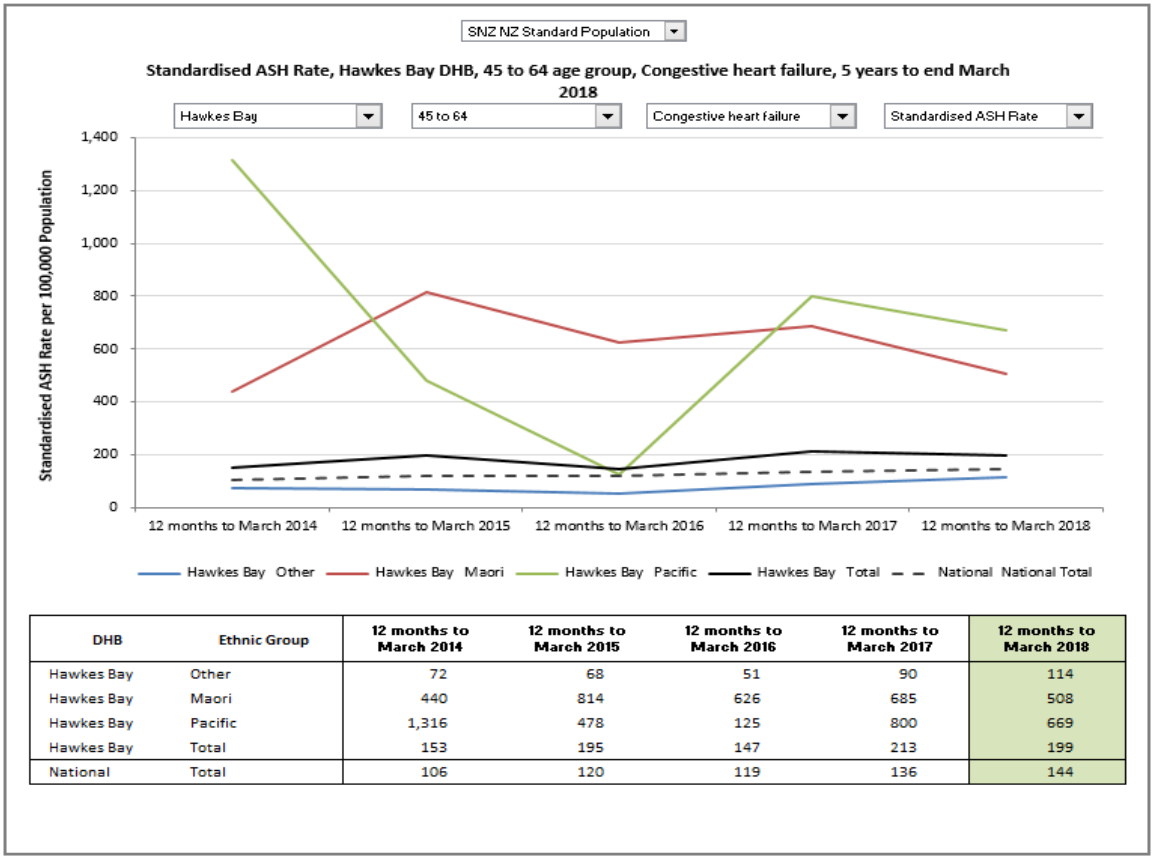


Cardiac and Respiratory Conditions, and Cellutis are the main focus areas for ASH 40-65yrs
The following graphs provide detail on the conditions that have been targeted as part of the 2017-19 SLM Improvement Plan (SLMIP). Each graph is followed by analysis by the Business Intelligence team.

A full narrative of activities aligned to the actions listed against the Te Ara Whakawaiora plan for ASH 45-65 is provided in the subsequent section - **Activity to Address 45-64 ASH Rates**.

The ASH 45-64 Cardiac Conditions are: Congestive Heart Failure; Hypertensive Disease,; Angina and Chest Pain and Myocardial infarction.

Congestive Heart Failure (CHF)



DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	72	68	51	90	114
Hawkes Bay	Maori	440	814	626	685	508
Hawkes Bay	Pacific	1,316	478	125	800	669
Hawkes Bay	Total	153	195	147	213	199
National	Total	106	120	119	136	144

Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	26	24	19	33	43
Hawkes Bay	Maori	31	58	46	53	39
Hawkes Bay	Pacific	10	4	1	8	8
Hawkes Bay	Total	67	86	66	94	90
National	Total	-	-	-	-	-

Data Analysis

Hawke's Bay ASH rate for Congestive Heart Failure (199) is above the national rate (144). The rate for Māori (508) is four times higher than the rate for Other (114), Pacific is currently 669 which over four times the rate of Other.

Hypertensive Disease

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	16	17	26	28	36
Hawkes Bay	Maori	25	41	92	106	114
Hawkes Bay	Pacific	167		79	149	368
Hawkes Bay	Total	24	21	40	46	58
National	Total	28	34	36	38	39

Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	6	6	9	10	13
Hawkes Bay	Maori	2	3	7	8	9
Hawkes Bay	Pacific	2	0	1	2	4
Hawkes Bay	Total	10	9	17	20	26
National	Total	-	-	-	-	-

Data Analysis

The Hawke's Bay ASH rate for Hypertensive Disease (58) is above the rate for national (39). Other ethnicity rate is 36 compared with Māori (114) and Pacific (368). The number of cases for Pacific doubled from two to four over the 12 month period.

Angina and Chest Pain

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	1,033	955	927	1,064	1,008
Hawkes Bay	Maori	1,631	1,502	1,515	1,619	1,710
Hawkes Bay	Pacific	909	1,007	979	923	1,505
Hawkes Bay	Total	1,132	1,064	1,022	1,160	1,149
National	Total	1,120	1,080	1,078	1,122	1,069

17

Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	356	331	318	371	356
Hawkes Bay	Maori	120	115	113	124	135
Hawkes Bay	Pacific	8	9	10	11	17
Hawkes Bay	Total	484	455	441	506	508
National	Total	-	-	-	-	-

Myocardial Infarction rates

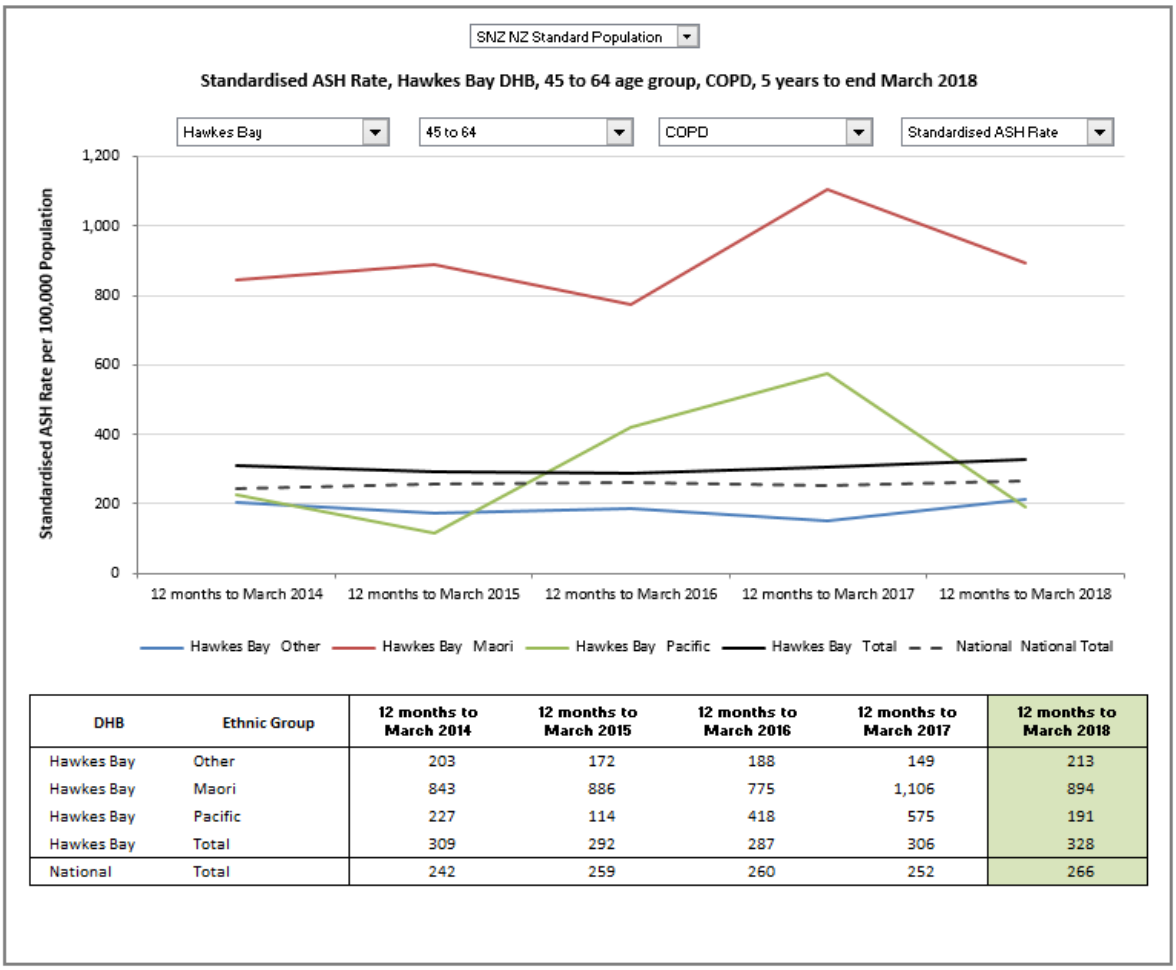
DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	145	142	156	132	149
Hawkes Bay	Maori	48	46	61	60	52
Hawkes Bay	Pacific	4	8	7	9	7
Hawkes Bay	Total	197	196	224	201	208
National	Total	-	-	-	-	-

Data Analysis

The Hawke's Bay ASH rate for Angina and Chest Pain (1,149) is the above the National Rate (1,069). The rate for Māori (1,710) and Pacific (1,505) have increased from the prior period with Māori being 1.7 times greater and Pacific 1.5 times greater that Other ethnicities. Overall Myocardial Infarction has remained the same as the previous 12 month period.

The ASH 45-64 Respiratory Conditions contributing to the ASH rate are: COPD, and Pneumonia.[6]

COPD



DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	203	172	188	149	213
Hawkes Bay	Maori	843	886	775	1,106	894
Hawkes Bay	Pacific	227	114	418	575	191
Hawkes Bay	Total	309	292	287	306	328
National	Total	242	259	260	252	266

Events

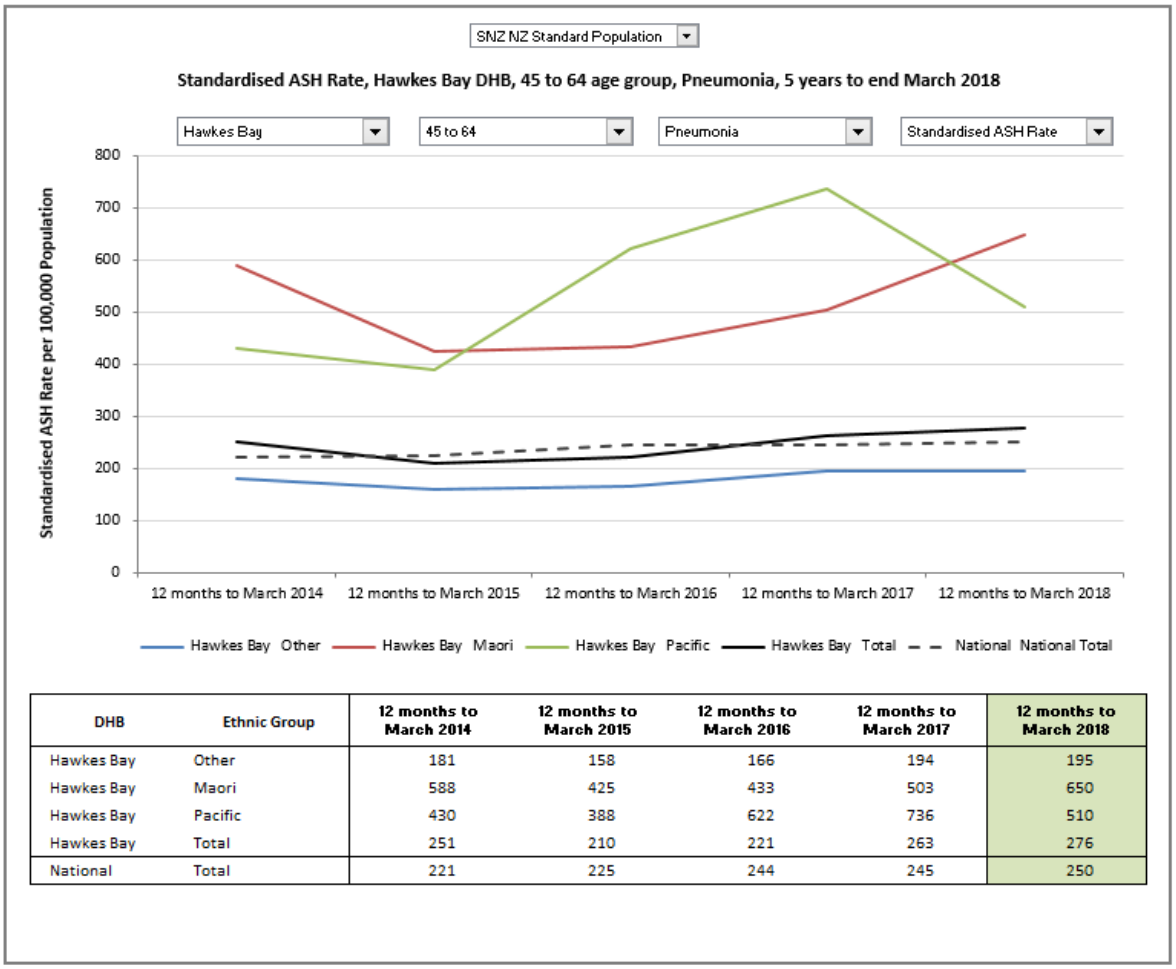
DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	72	63	68	53	77
Hawkes Bay	Maori	60	65	56	80	70
Hawkes Bay	Pacific	2	1	4	5	2
Hawkes Bay	Total	134	129	128	138	149
National	Total	-	-	-	-	-

Data Analysis

The Hawke's Bay ASH rate for COPD (328) is above the national rate (266) and has increase from the previous period from 306. The Moari rate (894) is four times greater than Other ethncities (213). Overall there were 11 more cases than preivous 12 month period.

[6] Asthma Rates per 1000 are low with event rates totally 42 per annum. This is considered too low numbers to be reporting against as the contribution to ASH is not statistically significant.

Pnuemonia



DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	181	158	166	194	195
Hawkes Bay	Maori	588	425	433	503	650
Hawkes Bay	Pacific	430	388	622	736	510
Hawkes Bay	Total	251	210	221	263	276
National	Total	221	225	244	245	250

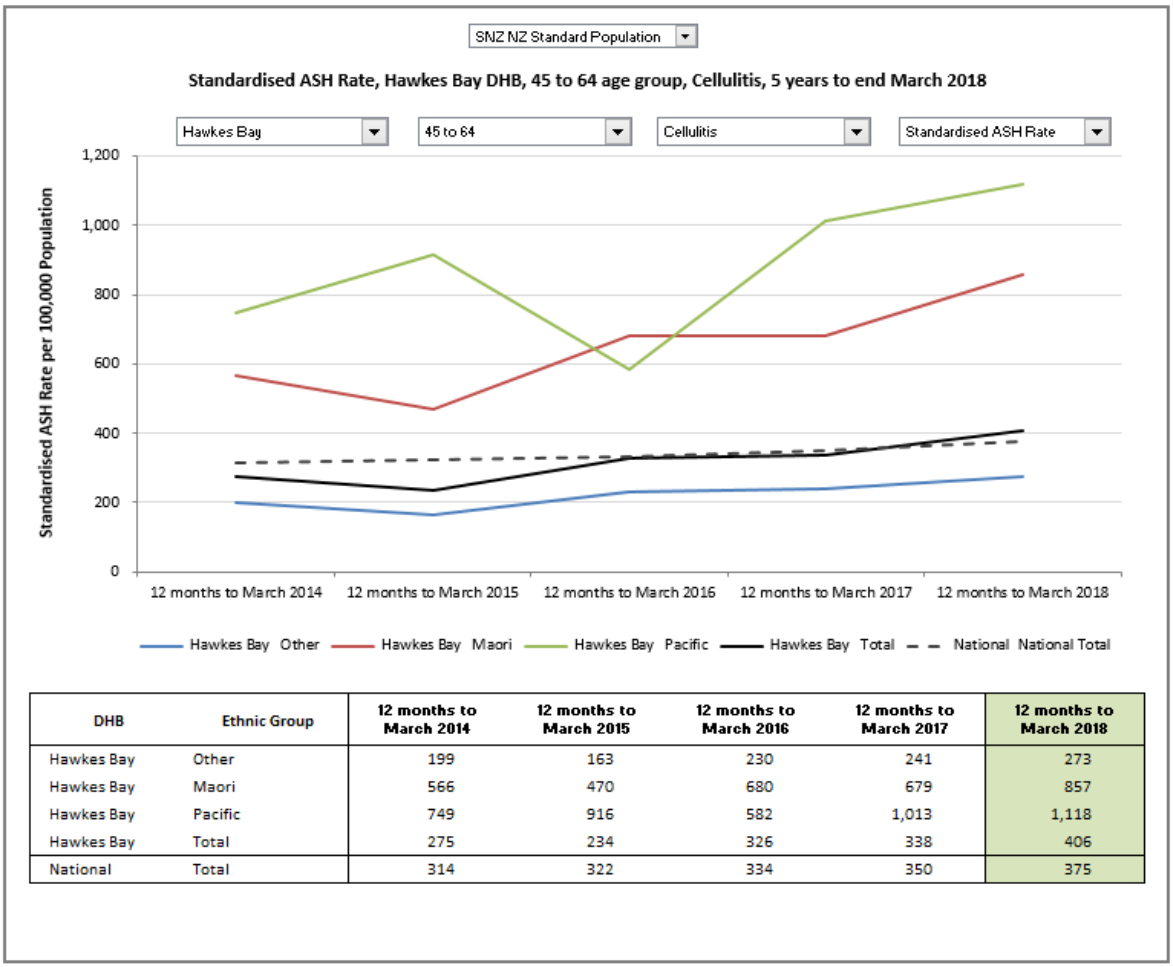
Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	64	55	58	70	70
Hawkes Bay	Maori	41	31	32	38	50
Hawkes Bay	Pacific	4	4	6	8	5
Hawkes Bay	Total	109	90	96	116	125
National	Total	-	-	-	-	-

Data Analysis

The Hawke's Bay ASH rate for Pnuemonia (276) is above the national rate (250). The Māori rate (650) is 3.3 times higher than the Other ethnicity and has increase from 503 in the preivous 12 month period.

The ASH 45-64 Cellulitis



DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	199	163	230	241	273
Hawkes Bay	Maori	566	470	680	679	857
Hawkes Bay	Pacific	749	916	582	1,013	1,118
Hawkes Bay	Total	275	234	326	338	406
National	Total	314	322	334	350	375

Events

DHB	Ethnic Group	12 months to March 2014	12 months to March 2015	12 months to March 2016	12 months to March 2017	12 months to March 2018
Hawkes Bay	Other	67	56	81	83	96
Hawkes Bay	Maori	42	35	52	53	68
Hawkes Bay	Pacific	7	9	7	10	13
Hawkes Bay	Total	116	100	140	146	177
National	Total	-	-	-	-	-

Data Analysis

The Hawke's Bay ASH rate for Cellulitis has gone from being below the national rate in the previous period to now sitting above the national rate. Māori (857) and Pacific (1,118) are 3.1 times and four times above the rate of the Other ethnicity (273).

ACTIVITY TO ADDRESS 45-64 ASH RATES

1. SLM 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 enrolment programme. Māori Base line 167. Māori Goal 350: Achieved: 91 Māori referrals (44 % of total referrals)

- The high needs enrolment programme is designed to address unmet need. Currently 97% of the population is enrolled in General Practice. Activities designed to engage the 3% of whānau who are not enrolled include:

    - ED identification of persons who register as 'GP unknown' with follow up by the PHO of the NHI listed and to either re-engage with their General Practice. Use of the high needs enrolment programme is offered and reinforced within ED for those without a GP

    - Encouraging whānau to enlist in the whānau wellness programme through the PHO, which provides free access to General Practice services and pharmacy over a 12 month (calendar year) period. This programme is made available to 250 whānau/families (not individuals) for the High Needs enrolled population. For the current 2018 cohort there are 525 individuals who have identified as Māori.

- In lieu of the range of programmes now in place to support high need enrolment, the ceiling that now seems to have been reached with this programme and the resources assigned to it, it is now time to consider the most effective use of resources to support enrolment for Māori.

- The reason why enrolment still needs to be a high focus is that without engagement with a primary health care home, all other early interventions and preventative approaches will struggle.

Increase number of referrals into the Hospital Discharge initiative
Base line was 300. Goal 500: Achieved 377 referrals

- The Criteria for referral to this programme has changed over time and in so doing has created lack of clarity for those referring from ED and in patient services. Steering Group discussions have been held on numerous occasions regarding the criteria and the need to continue to reinforce key messages about eligibility.

- The programme was reinforced during the period of industrial action and re clarification on eligibility criteria again provided. Continuing to reinforce the programme's focus on Māori and Pasifika, is a constant within management and steering group meetings.

- It is a valuable programme that requires greater publicity and visibility within hospital services. Greater efforts are in place to close the follow-up loop to ensure patients are followed-up and support to attend their post discharge appointment. A tracking mechanism to do this is underdevelopment.

- The Hospital discharge programme is managed through the CPO 7 programme. The full complement of initiatives included in the CPO programme is currently being reviewed. The Northland and Canterbury models for CPO are being used to scope the direction for the future HB model. The Northland model has a strong equity focus and the Canterbury model has proven results in reducing presentations to ED and ASH rates. The scoping paper for CPO is in its final draft and due to go to EMT in the first week of August.

[7] The Coordinated Primary Options Programme is being reviewed in its entirety currently, with the intention of extending its scope. Improving the Hospital Discharge component will form part of this review.

Rec*ruit into the position of Nurse Practitioner for heart failure with a Primary Care focus*

- Appointment has been made into this role. Work is underway to align the role closely with Primary Care and ensure there a close linkages with the PHO and General Practice teams.

- Close linkages are also being made with the Clinical Nurse Specialist (CNS) - Respiratory, and work that is being done through the Respiratory programme (see below).

Develop a programme to implement tracer auditing to inform Quality Improvement (QI) initiatives

- Tracer auditing has been utilised in demonstrating patient journeys, service involvement in care and highlighting areas across the sector for improvement. A selection of NHIs were traced and the findings used to demonstrate service utilisation and gaps in access to services. This proved extremely beneficial to clinical leads. The findings of which are being used to look at admission and readmission data, coordination of care and transition of care planning, both in and across inpatient and primary care settings. The lead who provided this support is no longer with the DHB, however there are members in the quality advisor team who are trained in tracer auditing. This has been flagged with the people and quality team as an area of work that provides great benefit to service design and planning.

- Basic IHI methodology training is the first step to being trained in tracer auditing methodology. This is being offered across the organisation and to external teams, e.g. community pharmacy.

2. *Collaborative Pathways*

- There are currently 75 Collaborative Pathways in place. Map of Medicine, the vendor for the pathways IT platform has now exited the market. The pathways continue to be available via an interim tool that the DHB has access to. This is a temporary measure while the new platform is put in place. An RFP is in play to identify a suitable vendor. The DHB is involved in that collective RFP for the Central Region.

- Pathways provide an integral part of care improvement and standards implementation. They are the platform on which CPO programme is based. The revision of the CPO programme, its focus on equity and the collection of evidence to demonstrate impact on ED presentations and admissions, and early and timely intervention in the provision of care, in the primary health care setting will be a priority within the revised CPO programme.

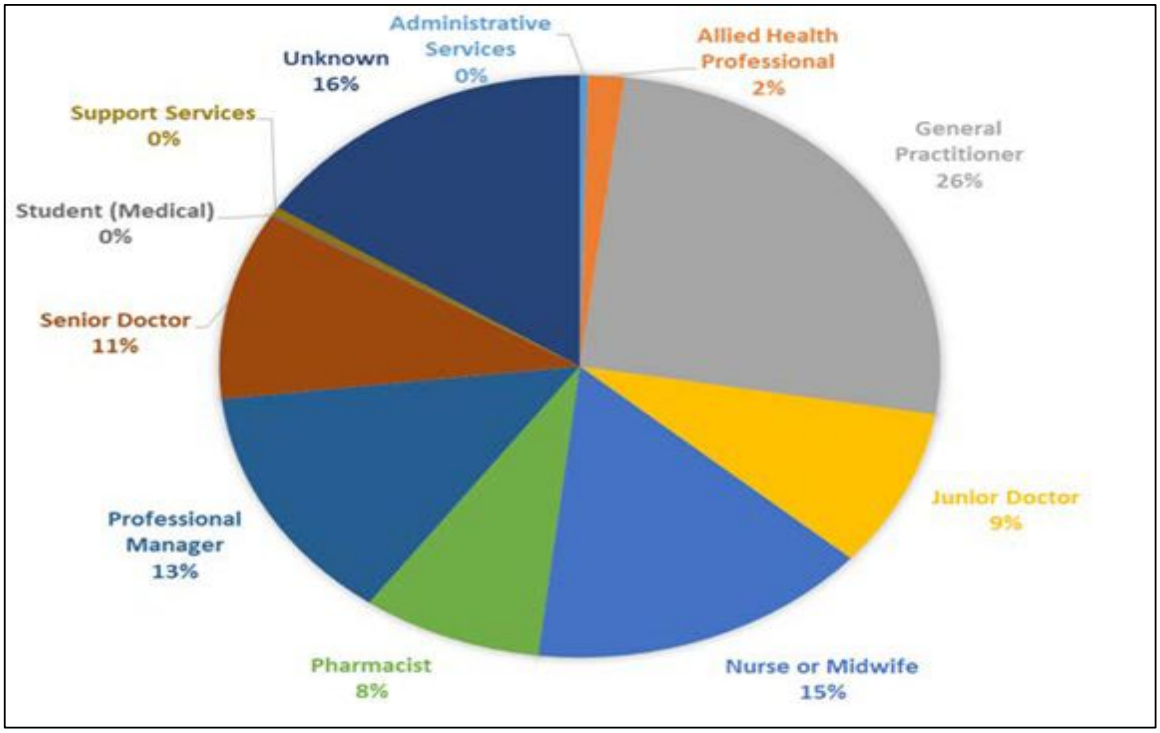
  "Collaborative clinical pathways are essential to the provision of an effective and efficient CPO pathway. Clinical pathways provide the mechanism for guiding adherence to best practice, the ability to inform clinical auditing and provide confidence in services that can be delivered through the CPO Programme.

  A priority for the DHB should be to develop systems and intelligence for a simple collection and interpretation of baseline CPO data both at the practice level but also at the ED and the hospital admission point. At present this data from ED/admissions is not coded under CPO conditions. The PHO data collection is based around claim data that is reliant on the GP filing a claim. There is very little, if any, patient journey data and this needs to be improved.

  The data needs to be able to show that the current CPO programme and the proposed expansion in the CPO programme reduces demand on ED, clinics and hospital admissions while improving the patient experience."

  Exerts from the draft: Scoping the expansion of the current Hawke's Bay DHB CPO Programme. Nicky Skerman 2018

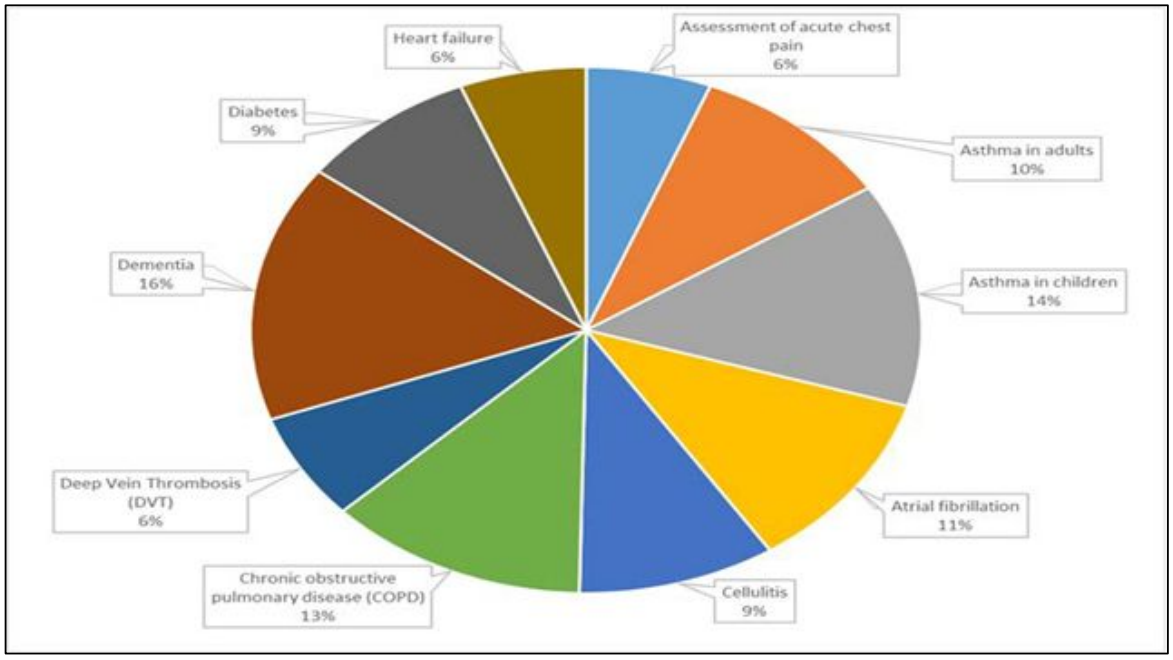
Figure 1.0 – Utilisation of pathways by service provider[8]



Pathways utilised that address the top five 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%).

Figure 1.2 – Utilisation rates of current pathways



[8] Not altered since previous report

3. Continuation of the Nurse Led Respiratory Programme: *Sue Ward - CNS Respiratory*

- The Respiratory programme continues to evolve, and education with all health care professionals cross sector continues to remain high priority. There is a MDT. The aim of this coordinated team is to ensure at every touch point for the patient this is a respiratory related contact being made with that whānau. The aim is to capitalise on every touch point available. The MDT includes: St John Ambulance; ED; Primary Care; Elderly Care; HHB; School Based Health Services; Public Health and Community Pharmacy.

- Lack of access to lung function results (due to primary care and secondary care not operating off a shared care record) means that evidence based treatment and management can sometimes be delayed for the patient. This is frequently commented on within clinical notes. The clinical portal development should address this gap.

- The health status review of 2017 for Central Hawke's Bay (CHB) highlighted high ASH COPD rates for CHB, with a 1.7 higher incident rate for Māori. This was tabled at the CHB Health Liaison Group Governance meeting and identified as an area of focus. A working group has been identified, led by the CNS Respiratory, CHB Health Centre Clinical Nurse Manager (CNM) and Clinical Nurse Lead of Te Taiwhenua o Heretaunga (TToH) CHB. It is recognised that this is a long-term programme using a collective impact multi-sector approach. The programme leads recognise the need to address the determinants of health, as well as coordinated clinical management. The Working Group is newly-formed and includes: healthy homes; nutrition; employment; pharmacy; Māori health providers; Council, education; and, primary care et.al. It is the aim of the Group to use existing resources to provide a connected and coordinated approach to prevention early intervention, and management. The programme will be focused on an outcome of respiratory well whānau/households across the age bands.

3. Implementation Plan for HBDHB LTCs Framework

- An operational working group was formed in February to advise on activities for the implementation of the LTCs framework. The Portfolio Manager leading this work resigned her position and the replacement was seconded into the role. Due to delays in recruitment to back fill this position, this work has only recently resumed.

- The focus for the implementation of the strategy will continue to be: Care Coordination; and, Transitions of Care. The service teams most directly involved in this work are Renal and Diabetes, Cardiac and Respiratory.

- The services are beginning to use recently obtained readmission data to examine the care coordination activities that will lead to reduced readmission rates. Focus will be on those with between two to four readmissions within a 12 month period. This work has only just commenced.

- A submission to Health Work Force NZ – Development Fund has been made by the DHB. This is directed at the development of a LTC workforce within the primary care workforce supported by clinical specialist support, using a multidisciplinary approach. If successful the grant will provide for four positions over a three year period. The model is based on a previous version submitted by the DHB for a health research grant that was unsuccessful. The model was adopted in Queensland, Australia and has been in place for the past 12 months.

Status of Quarter 2 - Recommendations (45-65 yrs)

	Key Recommendation	Implementation lead	Champion(s)	Time Frame	Status
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	DHB commitment to Interim tool for Clinical pathways confirmed. Jan 2019 new platform to be identified
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[9] 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	Not uniform part of service planning as yet Lead Portfolio manager recruitment delay has caused delays
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	Newly recruited Portfolio Manager to lead this work.
5.	Increase the weighting that is applied to health award applications in relation to equity.	Clinical Council	ED Equity and Health Improvement	July 2018	Being discussed: Increase weighting in each of the data sections or include in each category "Commitment to reducing Inequities"

Key Recommendation	Implementation lead	Champion(s)	Time Frame
Retain ASH 45-65 as contributory measure with activities to address within the SLM Improvement Plan	Medical Directorate Leads Portfolio Manager – Integration Innovation and Dev Mgr PHO	Exec. Director Primary Care	Quarterly
Present CPO scoping paper to committees and support a focus on addressing equity as the top line priority.	Emergency Department and Medical Directorate Leads Senior Commissioning Mgr. Innovation and Development Manager - PHO	Exec. Director Primary Care	December 2018
LTC Framework implementation plan to include formalised use of medical directorate clinical leads to influence activities directly relating to reducing ASH	Medical Directorate Leads Portfolio Manager – Integration Innovation and Dev Mgr PHO	Mark Peterson, CMO Primary	On confirmation into roles (Sept 2018)

[9] 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

The ASH rates for both 0-4 and 45-64 age groups give cause for some concern. While overall the equity gap in both age groups has not changed significantly there is now a trend towards a wider gap again having seen it close somewhat in the last few years.
This is within an environment where ASH rates overall nationally are increasing, especially in the younger age group.
It is disappointing to see both the increased rates of admission but more disappointing to see the Hawkes Bay DHB drop in "ranking" among other DHBs.
As detailed in the body of the report there are multiple interventions happening across the sector which ideally should be leading to lower rates of ASH and to a reduction in the disparity between Maori and the rest of the population.
The increased ASH rates overall reflect a health system under pressure. When under pressure it seems that the disparities become wider and we need to do more work to understand the drivers behind that change.

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
3. **Support** recommendations made by EMT (31 July 2018)

   Provide quarterly updates against activities that;

   - contribute to the Te Ara Whakawaiora indicators
   - are reported against as part of the System Level Measures Improvement Plan
     - Keeping Children out of Hospital and Using Health Resources Effectively

HBDHB PERFORMANCE FRAMEWORK RESULTS – QTR 4, 2017/18

Health Targets:	Target	Baseline	Total		Maori		Pacific		Other	
Shorter Stays in ED	≥ 95%	95%	91%	*	94%	*	92%		89%	
Improved Access to Elective Services	≥ 100%	105%	95%		No Ethnicity Data					
Faster Cancer Treatment	≥ 90%	65%	88%		94%	*	100%		86%	
Increased Immunisation	≥ 95%	95%	94%		95%		98%		91%	
Better Help for Smoker to Quit (Primary Care)	≥ 90%	81%	89%	*	87%	*	86%	*	91%	
Better Help for Smoker to Quit (Pregnant Women)	≥ 90%	97%	69%		73%		-		-	
Raising Health Kids	≥ 95%	40%	100%	*	100%	*	100%	-	100%	-

Output Class 1: Prevention Services	Target	Baseline	Total		Maori		Pacific		Other	
Better Help for Smoker to Quit (Secondary Care)	≥ 95%	99%	97%		97%	*	100%	*	97%	-
% of 2 year olds fully immunised	≥ 95%	95%	96%	*	95%	*	97%		96%	*
% of 4 year olds fully immunised	≥ 95%	96%	93%	*	90%	*	91%		95%	*
% of girls fully immunised – HPV vaccine	≥ 75%	-	76%	*	85%	*	88%	*	70%	*
% of women aged 50-69 years receiving breast screening in the last 2 years	≥ 70%	74%	73%		69%	*	68%		74%	
% of women aged 25–69 years who have had a cervical screening event in the past 36 months	≥ 80%	77%	77%		75%		78%		79%	

Output Class 2: Early Detection and Management Services	Target	Baseline	Total		Maori		Pacific		Other	
% of the population enrolled in the PHO	≥ 100%	97%	98%	*	99%	*	92%	*	98%	*
Ambulatory sensitive hospitalisation rate per 100,000 0-4 years	≤ 7388	5272	6360		7259		11000		4928	
Ambulatory sensitive hospitalisation rate per 100,000 45-64 years	≤ 4129	4063	4384		7965	*	8808		3445	
% of women booked with an LMC by week 12 of their pregnancy	≥ 80%	66%	68%	*	50%		35%		65%	
% of adolescents(School Year 9 up to and including age 17 years) using DHB-funded dental services	≥ 85%	69%	67%		No Ethnicity Data					
Proportion of people with diabetes who have good or acceptable glycaemic control (HbA1C indicator)	≥ 55%	65%	43%		49%		31%		35%	
% of the eligible population will have had a CVD risk assessment in the last 5 years	≥ 90%	88%	85%		84%		83%		86%	
% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks)	≥ 95%	95%	92%		No Ethnicity Data					
% of accepted referrals for MRI scans who receive their scans within 42 days (6 weeks)	≥ 90%	48%	85%		No Ethnicity Data					

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%	73%	59%	*	60%		67%		58%	
% 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%	96%	98%		90%		100%		100%	
% of potentially eligible stroke patients who are thrombolysed 24/8	≥ 8%	10%	5%		17%		-		6%	
% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	≥ 80%	88%	83%		75%		-		-	
% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	≥ 80%	58%	95%	*	-		-		-	
Major joint replacement	≥ 21	21.5	47.54	*	No Ethnicity Data					
Cataract procedures	≥ 27	58.7	21.78							
Cardiac surgery	≥ 6.5	6.6	5.36	*						
Percutaneous revascularisation	≥ 12.5	13.1	11.64							
Coronary angiography services	≥ 34.7	39	35.91							
Length of stay Elective (days)	≥ 1.47	1.56	1.55	*						
Length of stay Acute (days)	≥ 2.3	2.48	2.39							
Acute readmissions to hospital	≤ TBC	7%	12%	*						
% accepted referrals for elective coronary angiography completed within 90 days	≥ 95%	98%	94%	*						
% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive),	≥ 90%	92%	96%							
% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)	≥ 70%	94%	55%							
% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date	≥ 70%	98%	78%	*						
Did not attend (DNA) rate across first specialist assessments	≤ 8%	7%	7%		12%		17%		4%	
Proportion of the population seen by mental health and addiction services: Child & Youth (0-19)	≥ 4%	4%	3.9%		4.1%		2.1%		3.7%	
Proportion of the population seen by mental health and addiction services: Adult (20-64)	≥ 5%	5%	5.4%		9.8%		2.1%		4.0%	
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%	72%		76%		80%		69%	
% of 0-19 year olds seen within 3 weeks of referral: Addictions (Provider Arm and NGO)	≥ 80%	82%	73%		64%		50%		90%	*
% of 0-19 year olds seen within 8 weeks of referral: Mental Health Provider Arm	≥ 95%	92%	92%	*	94%	*	96%		91%	
% of 0-19 year olds seen within 8 weeks of referral: Addictions (Provider Arm and NGO)	≥ 95%	95%	93%	*	94%	*	100%		100%	*
Rate of s29 orders per 100,000 population	≤ 81.5	90.1	130		398		159		-	-

Document Owner: Anne Speden Chief Information Officer

November 2017
Section 4
1

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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	147.00		197.90		120.00	*	145.30	
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 80-84 years	≤ 170	167.8	178.80		160.00		300.00		180.80	*
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 85+ years	≤ 225	216.6	237.10		225.00		300.00	*	237.20	
% of older people who have received long-term home and community support services in the last three months who have had an interRAI Home Care or a Contact assessment and completed care plan	≥ 95%	100%	100%		No Ethnicity Data					
Clients with a CHESS score (Change in Health, End-stage disease, signs and symptoms) of 4 or 5 at first assessment	≤ 13.8%	14%	11%							
Time from referral receipt to initial Cranford Hospice contact within 48 hours	≥ 80%	100%	99%							
Number of day services	≥ 21791	0	21,830							
% of older patients given a falls risk assessment	≥ 90%	97%	92%							
% of older patients assessed as at risk of falling receive an individualised care plan	≥ 98%	98%	89%							

Not Reported in Q4

Number of babies who live in a smoke-free household at six weeks post natal	≥ 0	-	No New Data available
% of pregnant women who are smokefree at 2 weeks postnatal	≥ 95%	-	
% of infants that are exclusively or fully breastfed at 6 weeks	≥ 75%	-	No New Data available
% of infants that are exclusively or fully breastfed at 3 months	≥ 60%	51%	
% of eligible pre-school enrolments in DHB-funded oral health services	≥ 95%	95%	No New Data available
% of children who are carries free at 5 years of age	≥ 64%	64%	
% of enrolled preschool and primary school children not examined according to planned recall	≤ 10%	3%	
Mean 'decayed, missing or filled teeth (DMFT)' score at Year 9	≤ 96%	81%	No New Data available
% of 65+ year olds immunised – flu vaccine	≥ 75%	-	No New Data available

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Performance Framework Exceptions Report Quarter 4 2017/18** 121 For the attention of: **HBDHB Board**
Document Owner	Anne Speden, Chief Information Officer, Information Services
Document Author(s)	Peter Mackenzie, Business Intelligence Analyst
Reviewed by	Executive Management Team
Month/Year	August, 2018
Purpose	Monitoring
Previous Consideration Discussions	N/A
Summary	Areas of Success: Health Target – Raising Healthy Kids, Immunisations at 2 years of age. Areas of Progress: Health Target – Shorter Stays in ED Areas of Focus: 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
Announcements/ Communications	NA

RECOMMENDATION:

It is recommended that the HBDHB Board:

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

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HBDHB PERFORMANCE FRAMEWORK
Quarter 4 2017/18

Author:	Peter Mackenzie
Designation:	Business Intelligence Analyst
Date:	August 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 30st June 2018, 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

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PERFORMANCE HIGHLIGHTS – TOTAL POPULATION

Achievements

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

- The number of B4 school checks carried out for the year exceeded the target at 100%

Areas of Progress

- Health Target – Shorter Stays in ED has improved from 89% in the previous quarter to 91% however this is still below the target of 95% (page 8)

- Immunisation at 4 years – The overall rate has increase by 1.3% and is currently 93% compared to the target of 95% (page 14)

Areas of Focus

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

- Diabetes Management (HbA1c equal to or less than 64mmols) – The result for the total population is currently 43% against a target of 55%. (page 20)

- DNA – Overall we have favourably remained at 6.5% which is below the target of 7.5% however both Maori (12.3%) and Pacific (16.6%) have increased over the previous 2 quarters and sit significantly above the target. (page 24)

- Better access to Mental Health – There has been a decline in access across the age groups 0-19 and 65+. 0-19 is currently 3.86% against the target 4% and 65+ is currently 1.12% against the target of 1.15%. (page 25)

PERFORMANCE HIGHLIGHTS – EQUITY

Achievements

- Immunisation of 2 year olds – The Maori rate is currently 95% and the Pacific rate is 98%, both are above to the Total rate of 94%.

- Health Targets Healthy Kids – The Maori is currently 100% and Pacific at 100% against a target of 95%. They are the same at the Total Rate of 100%

- Access to Mental Health: Maori results for all age groups (0-19, 20-64, 65+) are favourable to target

Areas of Progress

- Health Target – Shorter Stays in ED increase from 90% in the previous quarter to 94%, narrowly missing the 95% Target (page 8)

Areas of Focus

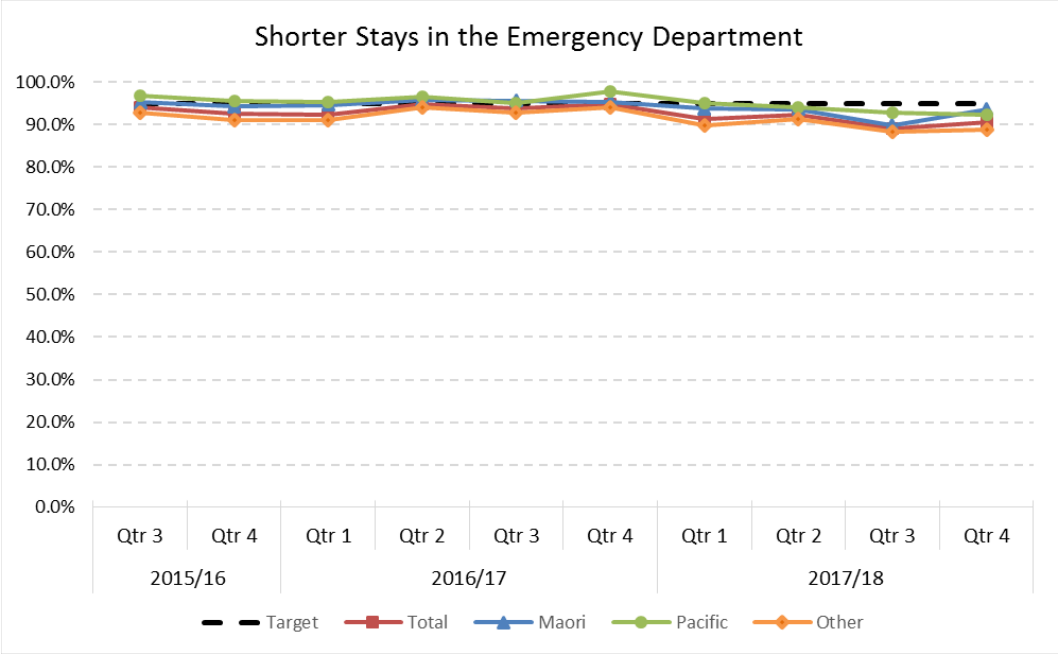
- Rate of Section 29 orders per 100,000 population – Maori Rates are currently 398 per 100,000 against the target of <81.5 and are 3 times higher than the non-Maori Rate (page 27)

- DNA – Both the Maori and Pacific rates of DNA have increased over the Q4 period which is disappointing to see. The Maori increased by 2.1% in Q4 and now sits at 12.3%, the Pacific rate has increased by 2.6% and now sit at 16.6% against a target of 7.5%.

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%	89% (U)	91% (U)	≥95%	▲
Maori	94.8%	90% (U)	94% (U)	≥95%	▲
Pacific	94.8%	93% (U)	92% (U)	≥95%	▼
Other	91.6%	88% (U)	89% (U)	≥95%	▲



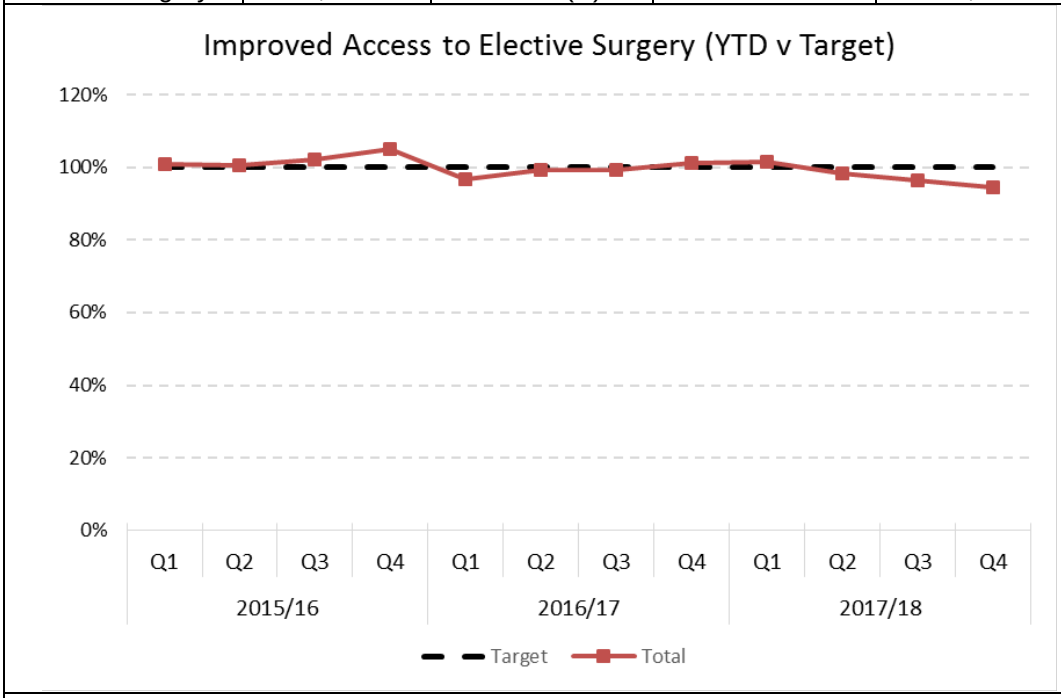
Data Source: HBDHB

Comments:
The work the DHB has done this quarter to support the Shorter Stays in ED's health target includes the recruitment, orientation and implementation of 4th Nurse Practitioner (NP) to independent practice. This enables additional coverage and extended hours of the Fast track role at front of house on an extended basis but does not provide 7 day a week extended hours. The extension of NP hours provides early senior nursing assessment and decision making, improving patient clinical safety in the waiting room when the department is at or over capacity. There has been funding to open an additional 10 bed inpatient ward to support periods of high demand, particularly surgical patients. Also additional nursing FTE (as an outcome of CCDM – Care Capacity Demand Management program) has enabled introduction of after-hours senior nurse in Acute Assessment Unit (Mon-Fri) focusing on pulling acute medical patients from ED and development of cross-team relationships after hours. There is ongoing daily monitoring and reporting of ED6 breaches and collaborative analysis by specialty groups. There is also renewed organisational focus on acute patient flow with executive sponsorship of a Fit for Winter program. Stronger organisational focus on specialty response to ED and discharge processes including the provision of senior

1 October to December 2016
2 January to March 2018
3 April to June 2018

nursing resource into the discharge lounge and re-establishment of the long-stay patient rounds also aims to tackle the ongoing issues.

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	7,469	94.5% (U)	100%	7,574



Comments:
In the previous year the budget for elective surgery and outsourcing was significantly overspent so outsourcing was very significantly reduced in the final quarter – this was done in discussion with the MoH and reduced delivery by 400 procedures.

18

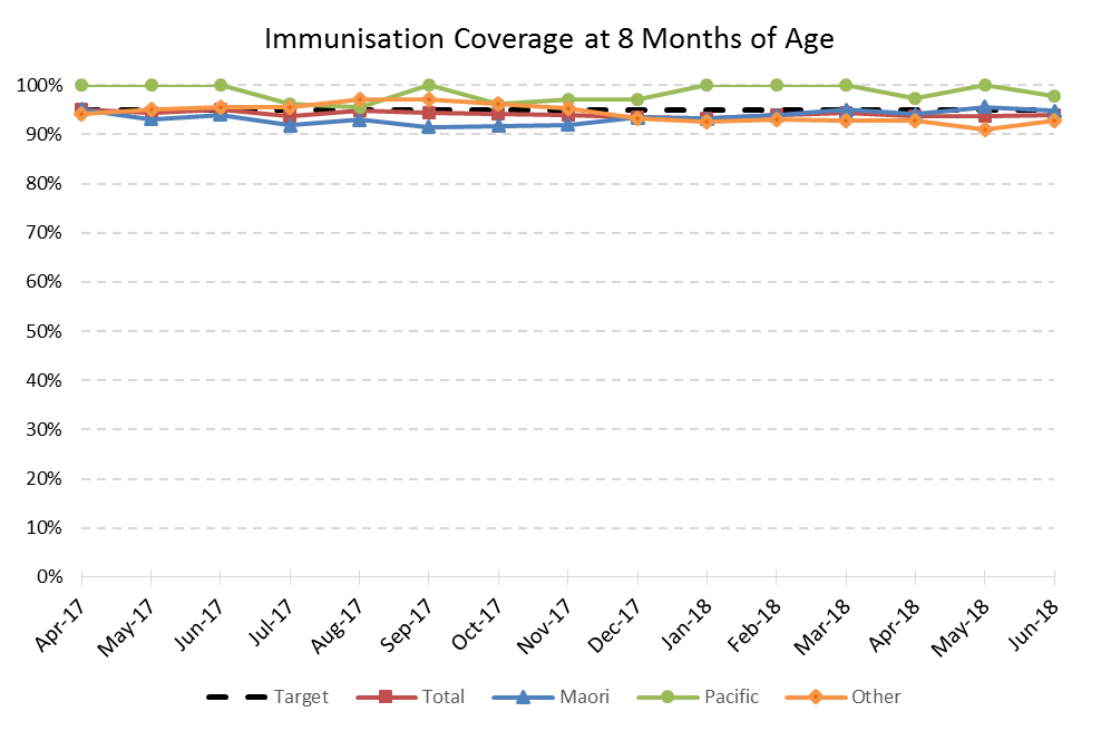
4 2015/16 target

5 July 2016 to June 2017 Source: Ministry of Health

6 July 2017 to June 2018 Source: Ministry of Health

Health Target: Increased immunisation
% of 2 year olds fully immunised

Ethnicity	Baseline [7]	Previous result [8]	Actual to Date [9]	Target 2017/18	Trend direction
Total	93.3%	94% (U)	94% (U)	≥95%	—
Māori	92.6%	96% (F)	95% (F)	≥95%	▼
Pacific	100.0%	100% (F)	98% (F)	≥95%	▼
Other	93.3%	91% (U)	91% (U)	≥95%	—



Data Source: National Immunisation Register

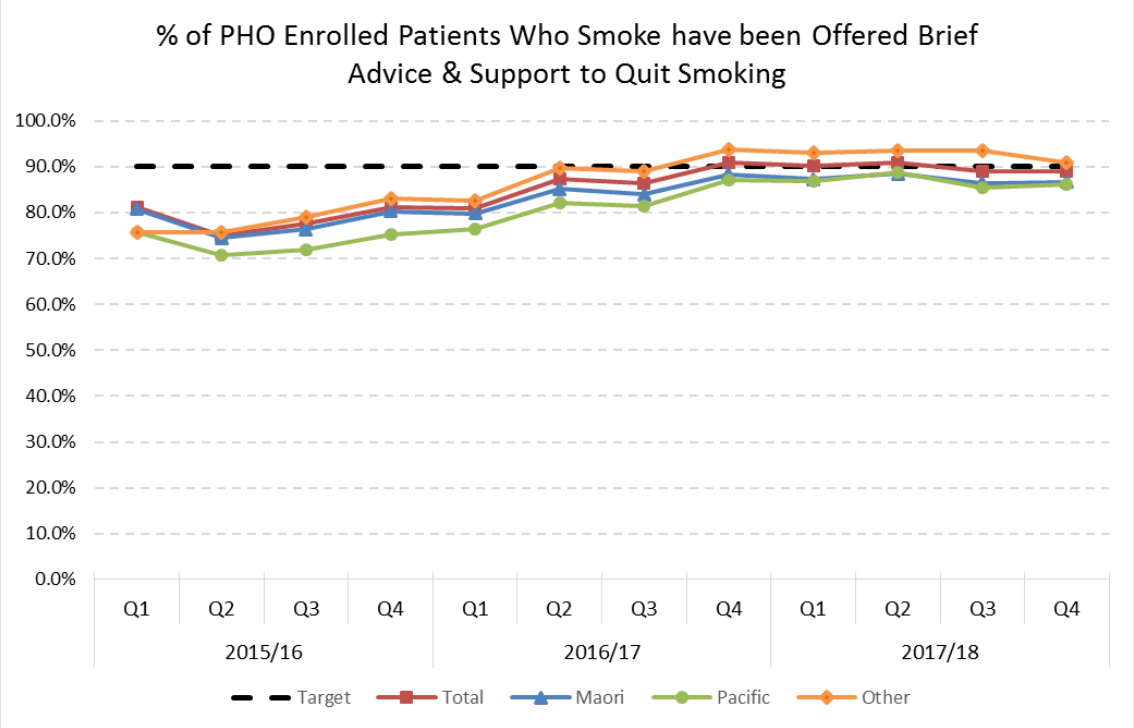
Comments:
We are pleased that we have achieved equity again this quarter, however we are slightly under the Ministry target. We continue to have good communication between all immunisation providers which helps us achieve this result. It has been a hard quarter with the schedule change and influenza vaccinating impacting on general practice and all immunisation providers. All families have who declined have had conversations with trusted health professionals or the HBDHB Immunisation team to assist them with their decision making.

7 October to December 2016. Source: National Immunisation Register, MOH
8 January to March 2018. Source: National Immunisation Register, MOH
9 April to June 2018. 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	81.2%	88.9% (U)	89.0% (U)	≥90%	▲
Māori	80.8%	86.5% (U)	86.7% (U)	≥90%	▲
Pacific	75.7%	85.4% (U)	86.2% (U)	≥90%	▲
Other	75.7%	93.6% (F)	90.9% (F)	≥90%	▼



Source: PHO

Comments:

Health Hawke's Bay Health Intelligence Team have developed patient lists of current smokers who have not had smoking brief advice recorded in the last nine months so practices can identify patients before they become overdue. Health Hawke's Bay ran a "Smoking Cessation Promotion" in General Practice to encourage doctors and nurses to update smoking status and offer smoking brief advice and cessation support in May and June and the practice that sent in the most cessation support forms got Pak n Save vouchers. The main barrier is being unable to contact people, of those unable to be updated, 44% unanswered phone call attempts, 26% disconnected phone, 21% not phone number and 3% living elsewhere.

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

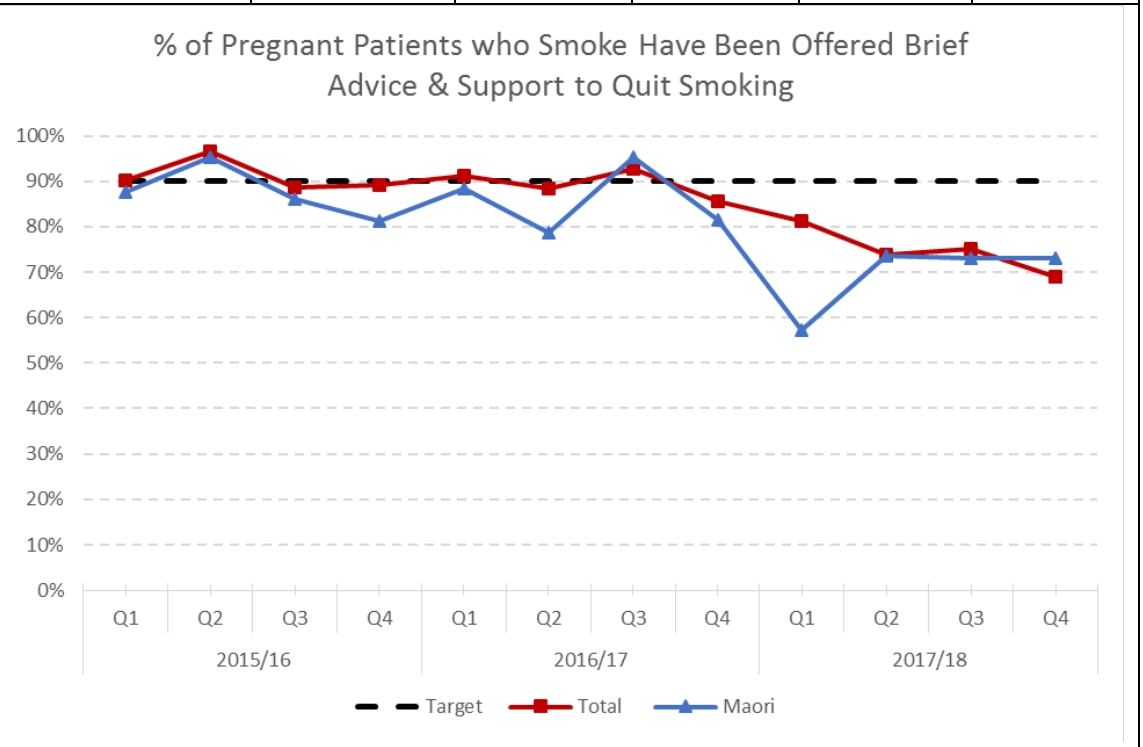
11 15 months to March 2018. Source: DHB Shared Services

12 15 months to June 2018. 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	96.5%	75% (U)	69% (U)	≥90%	▼
Māori	95.2%	73% (U)	73% (U)	≥90%	—



Comments:

The Smokefree Coordinator for Maternal and Child Health has continued communication via email and at two Maternity Refresher days in the last six months with the DHB Midwives and LMCs in Hastings and Wairoa Hospitals about the importance of ensuring all boxes are ticked on the Maternity Booking Form: 1-Smokefree Status 2-Brief Intervention Given and 3 -Referred to Quit Services. Reviewing the data has highlighted that a small number of Midwives are failing to tick the Brief Intervention Given box, yet answer the Referred to Quit Services box. This indicates a smokefree conversation was conducted and Brief Intervention given. The issue could be the word "Intervention" which suggests Nicotine Replacement Therapy given or a referral sent rather than having a conversation. This quarter we have ran several initiatives/activities including Tame Your Taniwha 8 week team challenge ran from 2nd April to 31st May. Smokefree presentations at 2 Maternity Refresher day courses for DHB Midwives and LMCs and weekly Maternity ward visits encouraging referrals to the Wahine Hapu programme

13 October to December 2016. Source: DHB Shared Services

14 January to March 2018. Source: DHB Shared Services

15 April to June 2018. Source: DHB Shared Services

OUTPUT CLASS 1: PREVENTION SERVICES

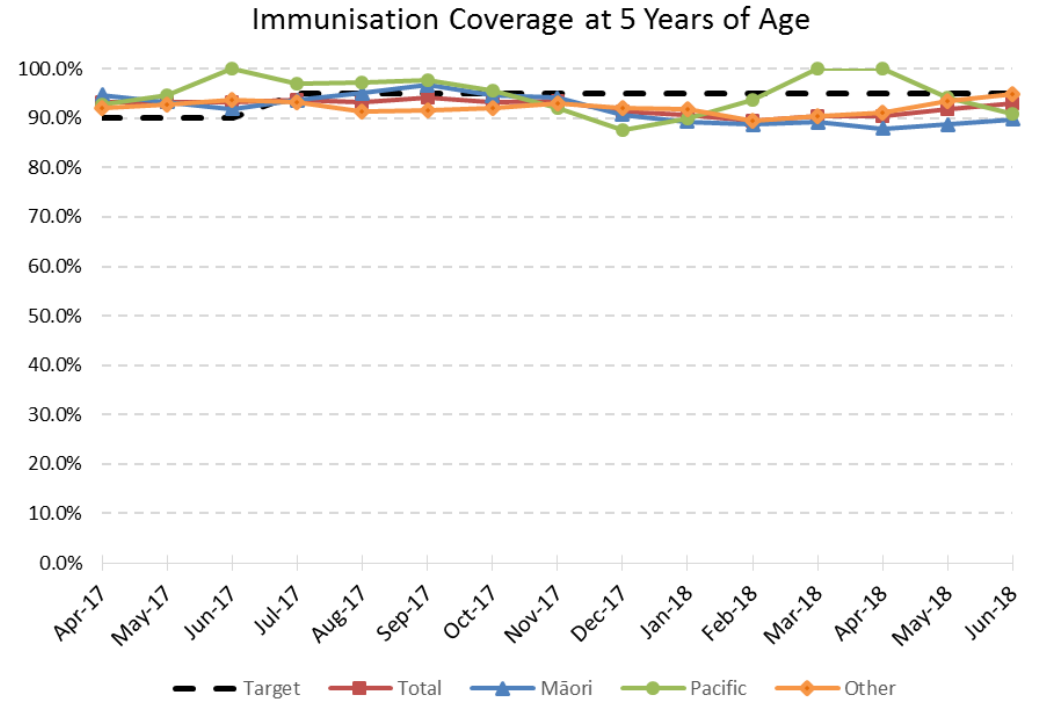
Better Help for Smokers to Quit Number of babies who live in a smoke-free household at six weeks post-natal					
Key Performance Measures	Baseline [16]	Previous result [17]	Actual to Date [18]	Target 2017/18	Trend direction
Total	65.0%	68%	66%	-	▼
Māori	41.0%	47%	41%	-	▼
Pacific	71.0%	67%	65%	-	▼
Other	85.0%	87%	84%	-	▼
Comments: This indicator is new for 2017/18 and is intended to set up a baseline for the next financial year as a SLM (system level measures). It has been included in the report for reference only.					

16 6 months to December 2016. Source: DHB Shared Services

17 6 months to June 2017. Source: DHB Shared Services

18 6 months to December 2017. Source: DHB Shared Services

Increase Immunisation % of 4 year olds fully immunised					
Key Performance Measures	Baseline [19]	Previous result [20]	Actual to Date[21]	Target 2017/18	Trend direction
Total	93.9%	91.7% (U)	93% (U)	≥95%	▲
Māori	95.1%	88.66% (U)	89.8% (U)	≥95%	▲
Pacific	96.2%	94.1% (U)	90.9% (U)	≥95%	▼
Other	92.9%	93.5% (U)	94.9% (F)	≥95%	▲



Data Source: National Immunisation Register

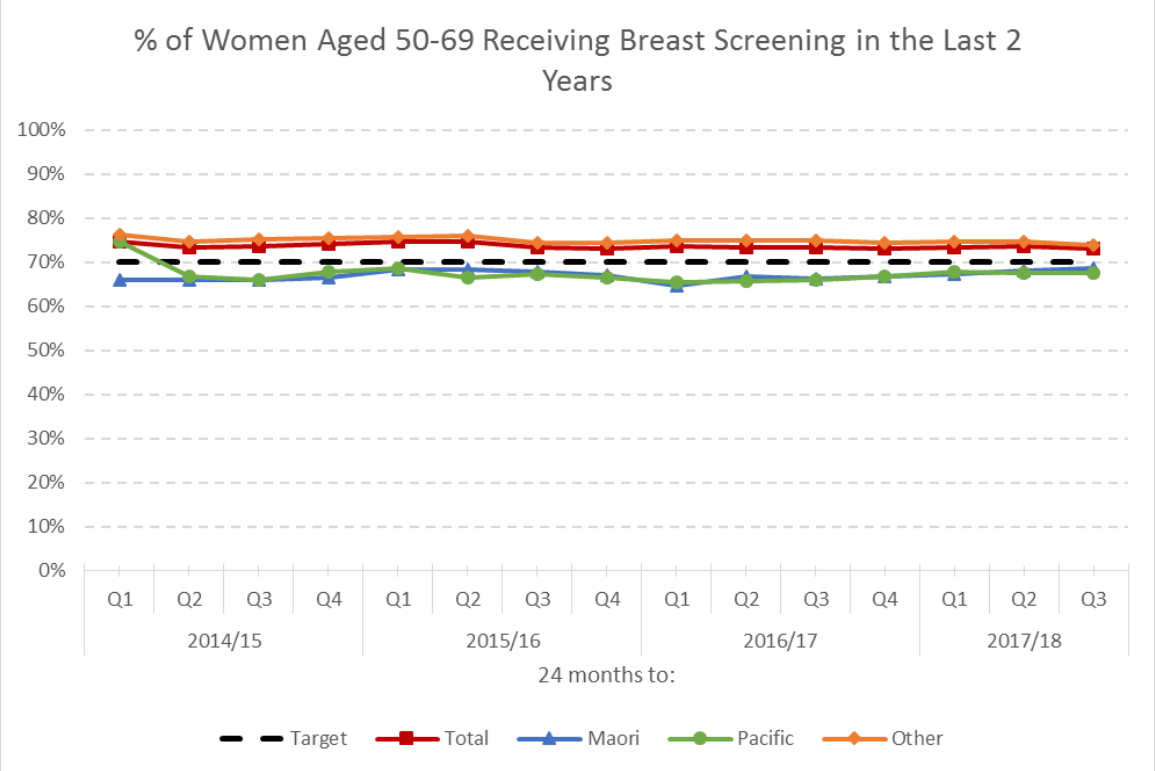
Comments:
There has been improvement this quarter however inequity remains for Maori. We continue to have less time to put into our 4 year olds due to schedule changes and influenza. Tracking 4 year olds continues to be challenging - we work closely with B4SC but due to resource we struggle to increase coverage for this group of children.

19 October to December 2016 . Source: National Immunisation Register, MOH

20 January to March 2018. Source: National Immunisation Register, MOH

21 April to June 2018. Source: National Immunisation Register, MOH

Improve breast screening rates % of women aged 50-69 years receiving breast screening in the last 2 years					
Key Performance Measures	Baseline [22]	Previous result [23]	Actual to Date[24]	Target 2017/18	Trend direction
Total	74.7%	74% (F)	73% (F)	≥70%	▼
Māori	68.4%	68% (U)	69% (U)	≥70%	▲
Pacific	66.5%	68% (U)	68% (U)	≥70%	—
Other	76.0%	75% (F)	74% (F)	≥70%	▼



Data Source: BreastScreen Aotearoa

Comments:

The Breast Screening mobile visited Wairoa for two weeks late January / February, and then it was in Waipukuaru for 6 weeks from early March through to April. Planning for these visits began in September last year with Michelle Quinn from BSCC and Annette Davis, Team Leader Population Screening meeting with the team from Kahunugunu Executive – Wairoa and Te Taiwhenua o Heretaunga – Waipukurau to discuss the pending visits. Priority women 45-69 from Wairoa and Waipukurau identified as unscreened were sent invite letters to enrol and have a mammogram whilst the BSA mobile was in town and if they did on confirmation, they would receive a grocery gift card. Forty five Maori women enrolled in Wairoa and 23 in Waipukurau plus three Pacific women. BSCC sent through the lists of priority women who hadn't confirmed their appointments (DNR) to the Population Screening team, these were then forwarded to the relevant ISP, plus daily DNA lists were forwarded on. In both areas the BSA Mobile visit was a success, Wairoa had a DNA rate of 6% and Waipukurau 4%. We continue to receive referrals for priority women who have DNA'd their appointment at the fixed sites, and these are in most cases referred on to our ISP providers. Michelle Quinn, Primary Nurse Co-ordinator regularly attends our ISP meetings and Steering Group meetings, plus we are in regular contact with Susan Cook, Data Manager at BSCC and her team. Although the official data only cover the period up to March 2017 we are aware that we have achieved coverage for Maori in April.

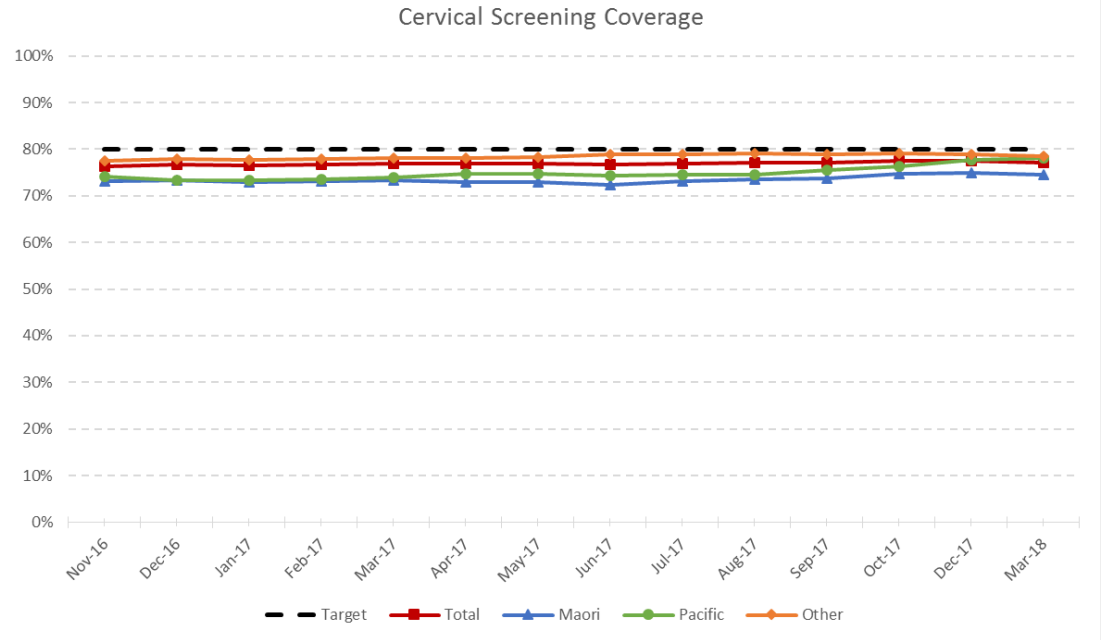
22 24 months to December 2016 . Source: National Immunisation Register, MOH

23 24 months to December 2017. Source: National Immunisation Register, MOH

24 24 months to March 2018. 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	75.8%	77% (U)	77% (U)	≥80%	—
Māori	74.1%	75% (U)	75% (U)	≥80%	—
Pacific	71.2%	78% (U)	78% (U)	≥80%	—
Other	76.5%	79% (U)	79% (U)	≥80%	—



Data Source: National Cervical Screening Programme

Comments:

We participated in the International Cultures day, promoting both breast and cervical screening, HPV and smoke free messages. We're continuing to find avenues to connect with our Asian community here in Hawke's Bay. We have launched twice monthly cervical screening clinic at the Napier Health Centre, advertising via the DHB Facebook page, and our local community paper and He Ngakau Hou, offering free smears to women 30 and over never or lapsed screening. The only queries we received were from over 70 year olds querying if they needed to continue screening. We have returned to contacting Maori and Pacific women on the lists from Maraenui Medical Centre and the Doctors Napier, plus we now have a list of 300 Pakeha women who are 30 and over and either unscreened or under screened to contact. We met with the Clinical Nurse Manager and Lead Nurse smear taker at The Doctors-Napier to discuss recalling at 33 months plus a referral process for Maori and Pacific who haven't responded by 35 months. The implementation of recall at 33 months is in place but supporting and referring women on who haven't responded by 35months would entail too heavy a burden to administer. Focus will continue to support priority women who are unscreened or under screened. We are still engaging with first time women who have never engaged with their GPs and don't know anything about having their smears or have not received a recall; they see their doctors as a place to go to only if they are sick. We are still running 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, or with the women's general practice. Feedback from women screened in their home, is

25 26 months to December 2016

26 36 months to December 2017

27 36 months to March 2018.

continuing to tell us that they are feeling, safe, more relaxed and finding the experience better all round and they state that it has made a big difference and they wouldn't have had the smear otherwise.

OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT SERVICES

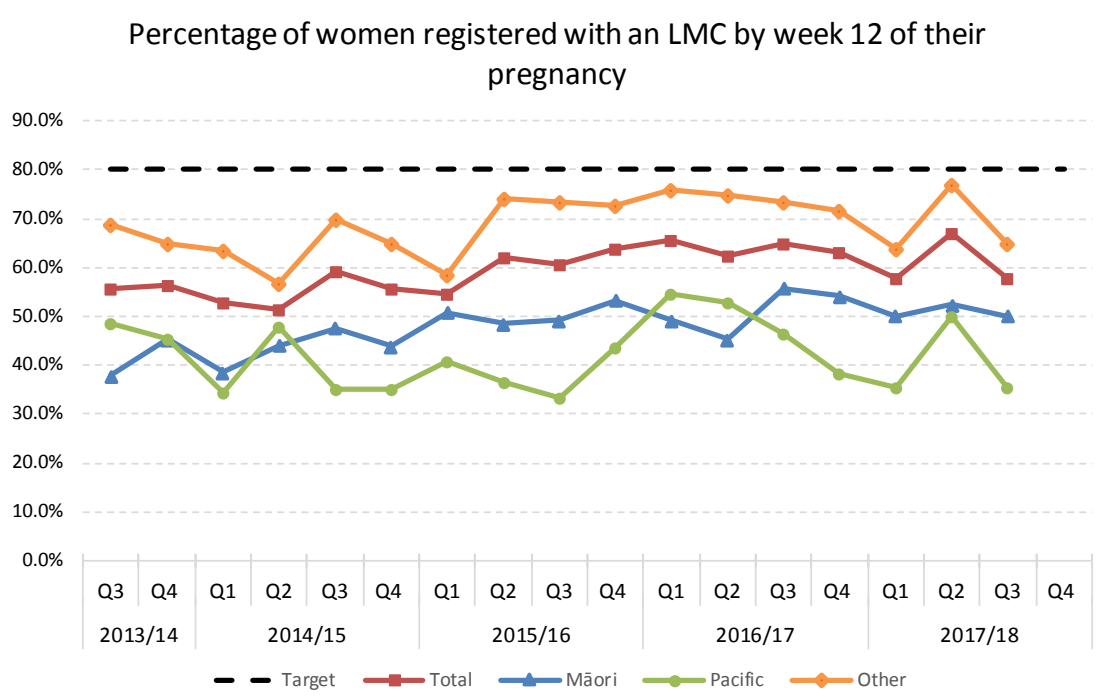
Reduce ASH 45-64 Ambulatory sensitive hospitalisation rate per 100,000 45-64 years					
Key Performance Measure	Baseline	Previous result [28]	Actual to Date [29]	Target 2017/18	Trend direction
45-64 years: Total	3510	4373 (U)	4384 (U)	-	▼
45-64 years: Māori	6310	8165 (U)	7965 (U)	≤3510	▲
Source: Ministry of Health					
Comments: Overall 45-64 ASH rates for Maori has improved within the last 12 month period and the DHBs national ranking improved (for Maori). Equity gap still sits at 3 times that of other for Maori however and the overall rate is still higher than the national rate. All activities are tracking against planned actions. Success areas in the 0-4 ASH are being used to inform project approaches. Extension of the CPO programme is currently being proposed to assist in building capacity and recognising capability within primary care.					

28 12 months to September 2017

29 12 months to March 2018

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	54.5%	67% (U)	68% (U)	≥80%	▲
Māori	50.7%	52% (U)	50% (U)	≥80%	▼
Pacific	40.6%	50% (U)	35% (U)	≥80%	▼
Other	58.5%	77% (U)	65% (U)	≥80%	▼



Comments:
The 'Top 5 for my baby to thrive' 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 commenced in 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 *2016.*
31 January to March 2018.
32 April to June 2018

Better oral health % of adolescents (School Year 9 up to and including age 17 years) using DHB-funded dental services					
Key Performance Measures	Baseline [33]	Previous result [34]	Actual to Date [35]	Target 2017/18	Trend direction
Total	68.8	68.8 (U)	66.6% (U)	≥85%	▼

Comments:
Additional volumes of adolescent oral health patients in 2017 seen by Te Taiwhenua o Heretaunga Oral Health Service were 480 and by the DHB oral health service in Wairoa were 254. Overall 734 adolescents were seen in addition to the 6333 seen by contracting dental providers through the CDA. Additional volumes seen by Te Taiwhenua were significantly lower than in 2016 and they have advised this was primarily the result of workforce issues. They advertised unsuccessfully for an experienced oral health therapist for their service and eventually recruited a new graduate oral health therapist who required a lot of support and affected productivity. Connectivity issues with their mobile dental IT system has also affected productivity. They advise that YTD results for 2018 are better and should yield a higher volume seen in 2018. Numbers at Wairoa seen by the COHS oral health service were also slightly lower than historically and appear the result of workforce shortages in the COHS and a slightly lower roll number at Wairoa College. The COHS saw 70% of the enrolled Y9-13 adolescents at Wairoa College in 2017. The numbers seen by contracting providers through the CDA were up slightly to 6333 - 119 higher and reflect some of the work being done by the adolescent oral health coordinator (AOHC) to identify practices where transferred numbers are not translating to adolescents being seen and with high schools where low attendance numbers are identified through the Proclaim data. The AOHC is increasingly using the data now available from Proclaim to inform discussion with dental providers to increase attendances.

33 January to December *2016.*

34 January to December 2016.

35 January to December 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 [36]	Previous result [37]	Actual to Date [38]	Target 2017/18	Trend direction
Total	41..4%	43% (U)	43% (U)	≥55%	▬
Māori	37.8%	49% (U)	49% (U)	≥55%	▬
Pacific	45.5%	30% (U)	31% (U)	≥55%	▲
Other	91.7%	35% (U)	35% (U)	≥55%	▬

PHO: Annual Diabetes Checks Data

Comments:

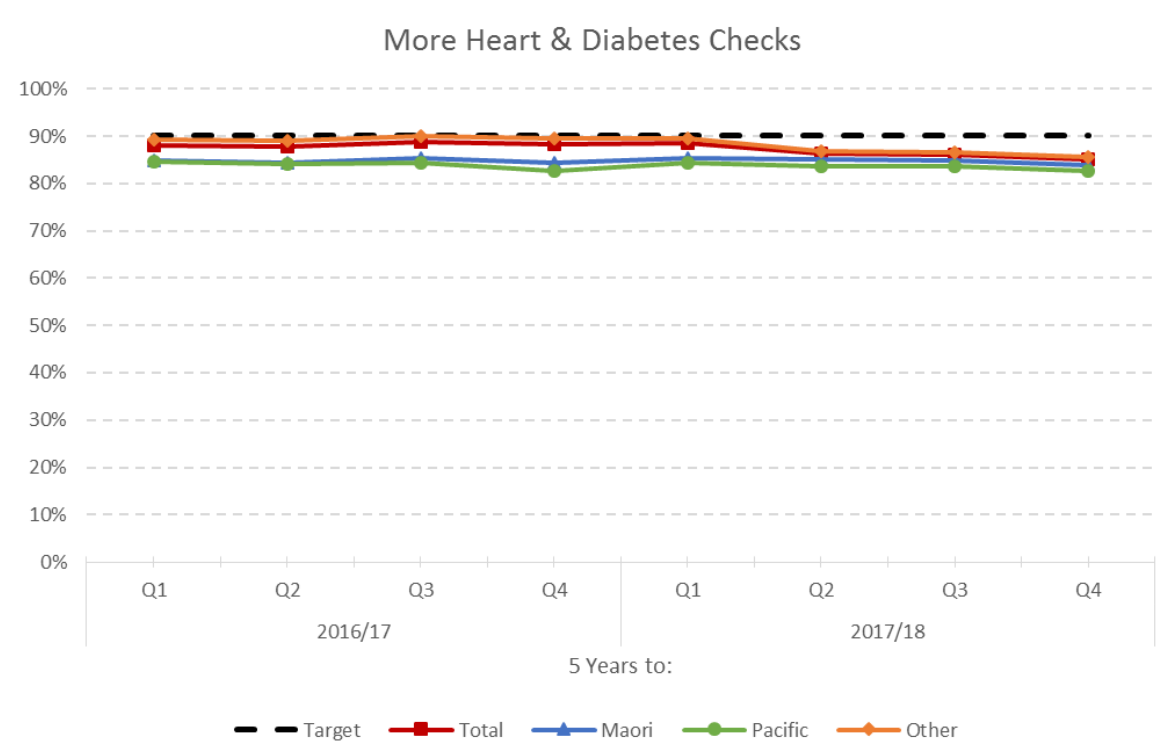
HHB (Health Hawkes Bay DHB) have delivered 8 courses this last six months with a focus on Long Term conditions, Diabetes, of which Pre - Diabetes programme 117 participants have been canvased to attend Kia Ora programme. Currently discussing possibilities of developing diabetes repository to capture data from retinal screening and podiatry services which are currently received by HBDHB. All Practice DCIP plans have been finalised and approved October 2017 as part of annual process. Two quarterly Practice Nurse Champion's meetings have been held and a further Education Sessions are currently being planned for October 2018. All practices receive monthly reporting providing an update of HbA1c bandings for their practice diabetes population which include details of patient due for annual review, overdue, coming due HBDHB Specialist services have completed a review of CNS capacity and capability. A paper has been prepared for funding to support additional resources

36 January to December 2016

37 12 months to March 2018

38 12 months to June 2018

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 [39]	Previous result [40]	Actual to Date [41]	Target 2017/18	Trend direction
Total	90.3%	86% (U)	85% (U)	≥90%	▼
Māori	86.3%	85% (U)	84% (U)	≥90%	▼
Pacific	87.0%	84% (U)	83% (U)	≥90%	▼
Other	91.7%	87% (U)	86% (U)	≥90%	▼



Source: Ministry of Health

Comments:
Health Hawke's Bay's PHO Performance Manager is participating in the Quality Commission PHO Quality Improvement Programme. The chosen project focus is "Increasing Equity for Maori Men: Cardiovascular Risk Assessment and Cardiovascular Disease". The aim of the project is to achieve a 10% increase in cardiovascular risk assessment rates for Maori men 35-74 year enrolled within two of the larger practices. Partnering with Work and Income to provide on-site checks has also formed part of an extended strategy to improve screening rates. 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 handout.

39 5 years to December 2016. Source: Ministry of Health

40 5 years to March 2018. Source: Ministry of Health

41 5 years to June 2018 . 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	68.7%	55.2% (U)	58.9% (U)	≥70%	▲
Māori	60.0%	66.7% (U)	60% (U)	≥70%	▼
Pacific	100.0%	100% (F)	66.7% (U)	≥70%	▼
Other	75.0%	63% (U)	58.1% (U)	≥70%	▼
Source: ANZACS-QI					
Comments: Improvements in almost all areas noted, however underperformance due to ongoing capacity and IDF continue to negatively influence this. Regional contingency plans are in place to continue to manage blowouts, and equity of care is being addressed in these plans.					

Shorter stays in hospital Length of stay (days)					
Key Performance Measures	Baseline [45]	Previous result [46]	Actual to Date [47]	Target 2017/18	Trend direction
Acute	2.55	2.39 (U)	2.39 (U)	≤2.3	▬
Elective	1.66	1.52 (U)	1.55 (U)	≤1.47	▼
Source: Ministry of Health					
Comments: We are disappointed to see that the acute ALOS has remained the same as the previous period and Elective has increase slightly. Length of stay for general medicine and orthopaedic specialties had the greatest number of excess bed days. We continue to work on several initiatives within the hospital looking at reducing the length of stay with 'FLOW' and previously '4000 bed Days'. Improving our systems and process to discharge patients from our inpatient wards by focusing on increased earlier in the day discharges and how we manage patients who have longer stays and Ensuring our processes are effective in managing patients with frailty from presentation in ED, through their patient journey on to discharge.					

42 October to December 2016. Source: Ministry of Health

43 January to March 2018. Source: Ministry of Health

44 April to June 2018 . Source: Ministry of Health

45 12 months to September 2016. Source: Ministry of Health

46 12 months to December 2017. Source: Ministry of Health

47 12 months to March 2018 .Source: Ministry of Health

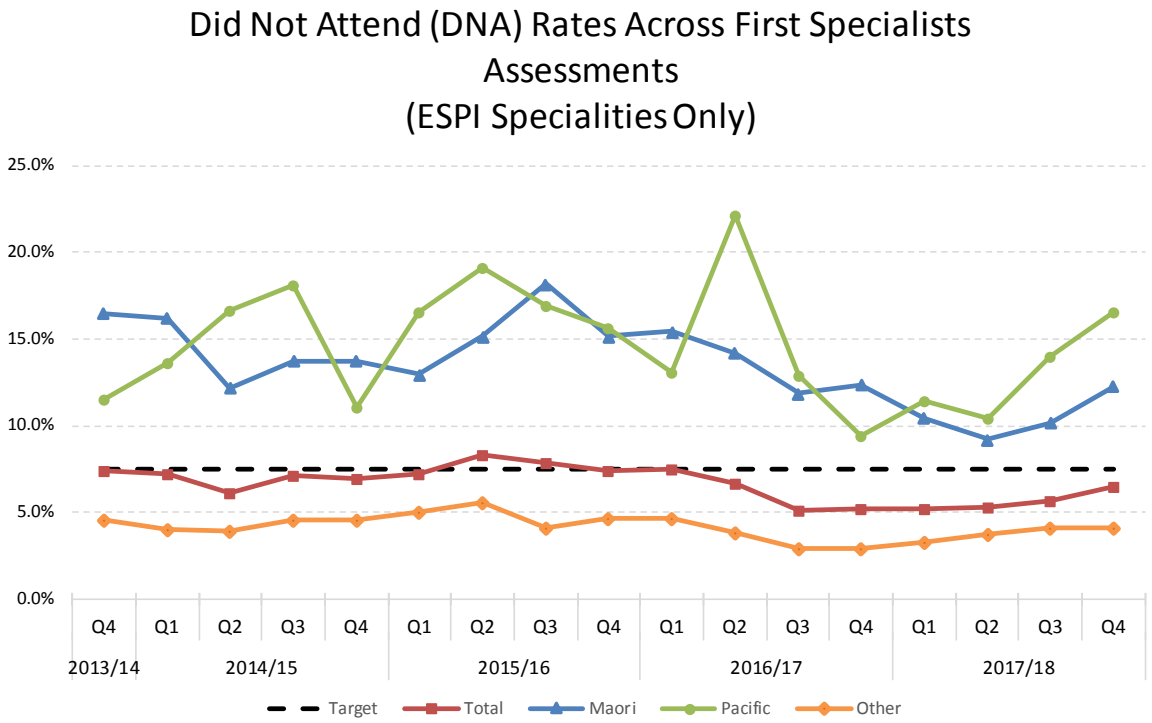
Quicker access to diagnostics					
Key Performance Measures	Baseline [48]	Previous result [49]	Actual to Date[50]	Target 2017/18	Trend direction
% accepted referrals for elective coronary angiography completed within 90 days	69%	88% (U)	94% (U)	≥95%	▲
% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive),	82.4%	97% (F)	96% (F)	≥85%	▼
% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)	87.1%	82% (U)	55% (U)	≥85%	▼
% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date	79.3%	68% (U)	78% (F)	≥70%	▲
Comments: HBDHB continues to be compliant with urgent colonoscopy within 14 days and Surveillance within 84 days. The demand volumes for the colonoscopy's triaged as semi urgent is increasing due mainly to the introduction of the NBSP (National Bowl Screening Program) and also to the natural growth in demand. The limitations of the current unit produce a mismatch of demand with capacity. The transition to the new facility in mid-October will enable the team to manage the current demand and the increase of colonoscopies volumes due to the NBSP implementation. The gastroenterology service has a recovery plan in place to bring the service delivery outputs in line with the production targets by December 31 2018.					

48 December 2016.

49 March 2018.

50 June 2018

Fewer missed outpatient appointments ***Did not attend (DNA) rate across first specialist assessments***					
Key Performance Measures	Baseline [51]	Previous result [52]	Actual to Date [53]	Target 2017/18	Trend direction
Total	8.1%	5.7% (F)	6.5% (F)	≤7.5%	▼
Māori	14.9%	10.2% (U)	12.3% (U)	≤7.5%	▼
Pacific	18.3%	14% (U)	16.6% (U)	≤7.5%	▼
Other	5.3%	4.1% (F)	4.1% (F)	≤7.5%	—



Source: HBDHB

Comments:
High work levels for Outpatient Bookers means they have less time to engage with patients, thus phoning and confirming / reminding patients of their bookings is slowly becoming a lower priority for the Booking team. Unfortunately Switchboard are no longer assisting the Outpatient Booking team with evening calling to remind patients of appointments – and this may also now be impacting negatively on the DNA rates. Dental, General Surgery and Paediatrics continue to be the problem areas for DNA and generally children will continue to be rebooked following a DNA, and there are examples this quarter where children have been counted as DNA multiple times in dental and Paediatrics. As part of Customer Focused Booking, a working group has been formed and is currently analysing the data behind the DNA patients over the last year to better understand the profile of our patients who continue to DNA. Next steps are to survey this group, to get a better understanding from our target group as to what the real barriers are from the patient perspective that is stopping them from utilising the services at the HBDHB.

51 October to December 2016. Source: Ministry of Health
52 January to March 2018. Source: Ministry of Health
53 April to May 2018 . Source: Ministry of Health

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 [54]	Previous result [55]	Actual to Date [56]	Target 2017/18	Trend direction
Child & youth (0-19)					
Total	4.1%	4.07% (F)	3.86% (U)	≥4%	▼
Māori	4.6%	4.3% (F)	4.12% (F)	≥4%	▼
Pacific	3.0%	2.4% (U)	2.12% (U)	≥4%	▼
Other	3.7%	3.88% (F)	3.67% (U)	≥4%	▼
Adult (20-64)					
Total	4.9%	5.46% (F)	5.39% (F)	≥5%	▼
Māori	8.8%	9.84% (F)	9.78% (F)	≥5%	▼
Pacific	3.0%	2.4% (U)	2.12% (U)	≥5%	▼
Other	3.8%	4.08% (U)	4.02% (U)	≥5%	▼
Older adult (65+)					
Total	1.0%	1.14% (F)	1.12% (U)	≥1.15%	▼
Māori	1.0%	1.25% (F)	1.33% (F)	≥1.15%	▲
Pacific	1.0%	0.64% (U)	0.58% (U)	≥1.15%	▼
Other	1.1%	1.13% (F)	1.09% (U)	≥1.15%	▼
Data Source: HBDHB					
Comments: While we have not met the current target across all ethnicities Maori have remained favourable to target. We have remained fairly constant in our access rates and 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 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.					

54 12 months to September 2016

55 12 months to September 2017

56 12 months to March 2018

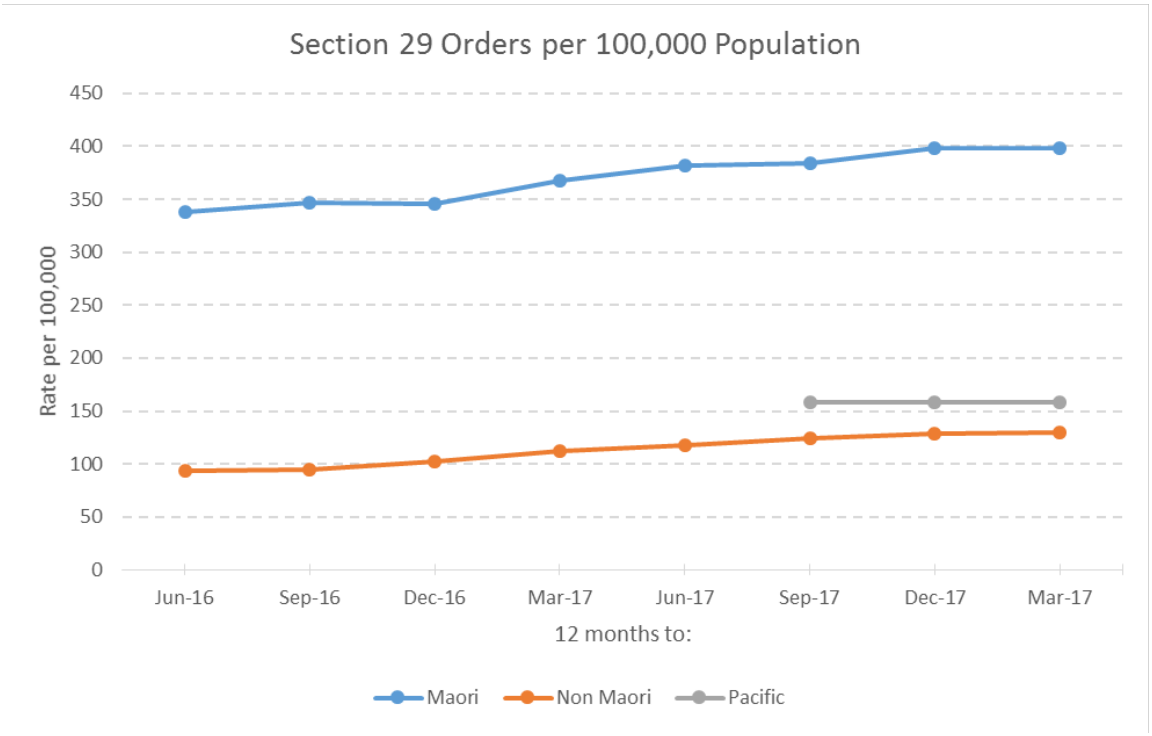
Reducing waiting times Shorter waits for non-urgent mental health and addiction services for 0-19 year olds					
Key Performance Measures	Baseline [57]	Previous result [58]	Actual to Date [59]	Target 2017/18	Trend direction
Mental Health Provider Arm: Age 0-19					
<3 weeks	60.1%	74.6% (U)	72.2% (U)	≥80%	▼
<8 weeks	81.5%	92.1% (U)	92.2% (U)	≥95%	▲
Addictions (Provider Arm & NGO): Age 0-19					
<3 weeks	84.2%	74.5% (U)	73.2% (U)	≥80%	▼
<8 weeks	99.5%	91.5% (U)	92.8% (U)	≥95%	▲
Source: Ministry of Health					
Comments: We have started to refine our processes by creating more appointments slots so that we can meet the demand and we are also refining our pathways to make it easier for clients to be seen faster (<3Wks).Improvements in our processes to reduce DNA rates (DNA's impact on our waiting times) are also aimed at having a positive impact on the results. We are working closely with Pacific and Maori cultural teams to reduce DNA rates and we are actively trying to recruit more staff.					

5712 months to December 2016

58 12 months to September 2017

59 12 months to March 2018

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 [60]	Previous result [61]	Actual to Date [62]	Target 2017/18	Trend direction
Non- Māori	97	129 (U)	130 (U)	≤81.5	▼
Māori	196	398 (U)	398 (U)	≤81.5	—
Pacific	93.4	159 (U)	159 (U)	≤81.5	—



Data Source: Ministry of Health

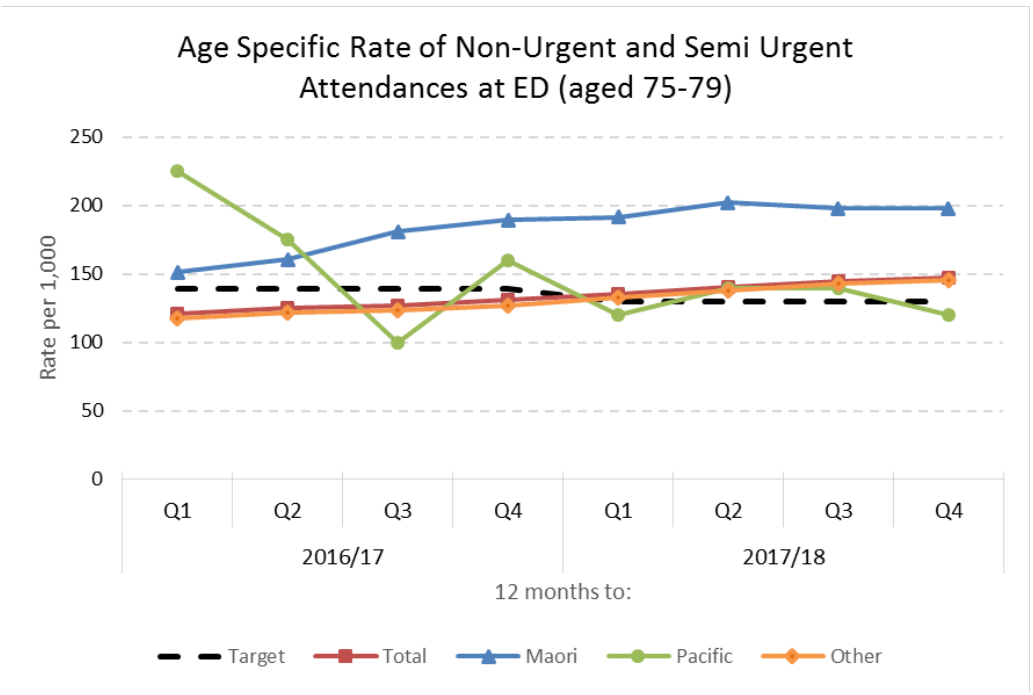
Comments:
I would expect a slight reduction for Hawkes Bay over the next Quarter as we have just done an intensive review of all clients on a CTO (compulsory treatment order) at TTOH, putting an additional 0.5 FTE for one month into TTOH. There were 43 clients under a community treatment order out of the 215 clients open to TTOH, which is 20% of their population. We managed to bring this number down to 35. This is still a considerable number of clients but we are in the process of starting a multidisciplinary review of all cases both in TTOH and in the DHB community teams on an indefinite community treatment order with the aim to reduce the number of clients under the MHA. To get through all clients involved we probably will require about a year. The process will involve a multidisciplinary approach with a strong cultural and social focus, with family involvement.

60 October to December 2016
61 12 months to September 2017
62 12 months to March 2018

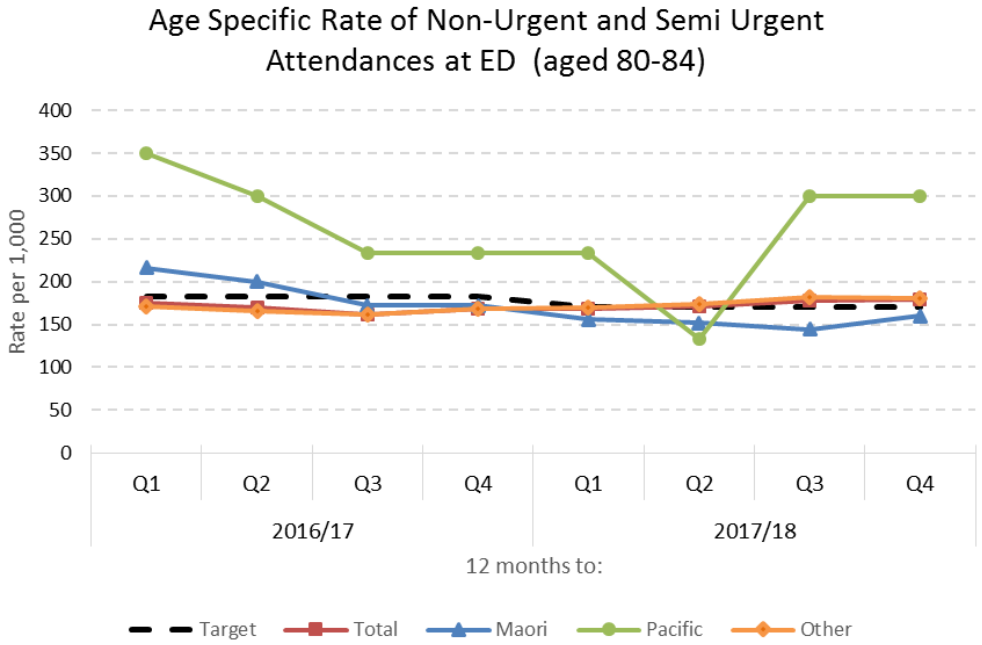
OUTPUT CLASS 4: REHABILITATION AND SUPPORT SERVICES

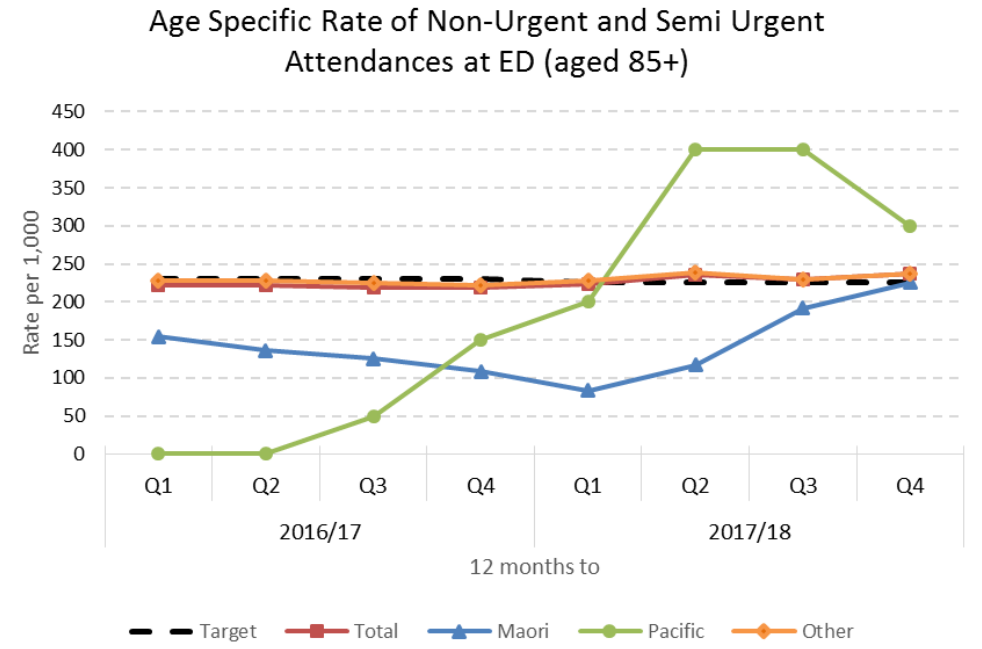
Better access to acute care for older people
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population)

Age Band	Baseline [63]	Previous result [64]	Actual to Date [65]	Target 2017/18	Trend direction
Age 75-79					
Total	136.5	145 (U)	147 (U)	≤139.5	▼
Maori	144.4	197.9 (U)	197.9 (U)	≤139.5	—
Pacific	-	140 (U)	120 (F)	≤139.5	▲
Other	-	143.3 (U)	145.3 (U)	≤139.5	▼
Age 80-84					
Total	178.9	178.3 (F)	178.8 (F)	≤183.1	▼
Maori	208	144 (F)	160 (F)	≤183.1	▼
Pacific	-	300 (U)	300 (U)	≤183.1	—
Other	-	181.4 (F)	180.8 (F)	≤183.1	▲
Age 85+					
Total	229.2	228.7 (F)	237.1 (U)	≤231	▼
Maori	153.8	191.7 (F)	225 (F)	≤231	▼
Pacific	-	400 (U)	300 (U)	≤231	▲
Other	-	229 (F)	237.2 (U)	≤231	▼



63 12 months to December 2016
64 12 months to March 2018
65 12 months to June 2018.





Comments:
Once again, the graphs show an upward trend in ED attendances in the 75-79 year age group with ED presentations in 80-85 and 85+ being largely stable. Services across the health sector are stretched, and anecdotally there is a feeling that numbers of people with complexity of medical and social conditions is increasing. The stability of ED attendances for 80+ may be due to the work which engAGE is doing with to support older people in the community, preventing them from presenting to ED in crisis as they are better supported to manage at home.

18

RECOMMENDATION:

It is recommended that the HBDHB Board:

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

ATTACHMENT:

- HBDHB Quarterly Performance Monitoring Dashboard Q3

Quarter three 2017/18 performance for the DHB population of Hawke's Bay

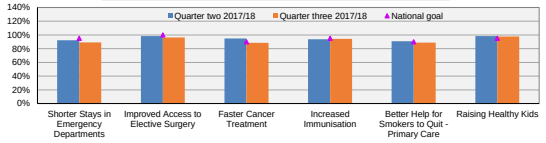
Monitoring Status Standard Monitoring

MINISTRY OF HEALTH MANATŪ HAUORA

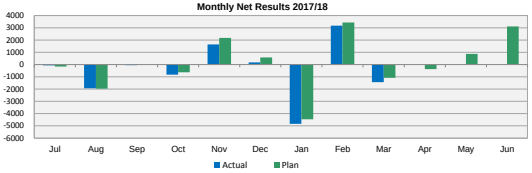
System Level measures: Implementation of the Improvement Plan

- The DHB reports it is on track to implement its SLM plan for four of the six SLMs.
- It is off track on implementing the actions for acute hospital bed days and ASH rates for 0-4 year olds. There is no evidence of the reflective thinking needed to determine the reason for losing momentum and the DHB needs to develop effective mitigation activities to get back on track.
- The alliance functions at an average level.
- The DHB needs to:
- Continue to strengthen its alliance and ensure the appropriate resources are allocated to ensure it can effectively use quality improvement science.
- broaden its membership to include other perspectives such as ambulance, pharmacy and community providers to provide a whole of system focus for the district.

Health Targets

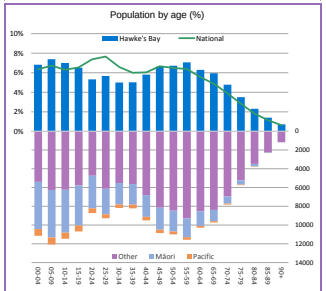


Financial Management



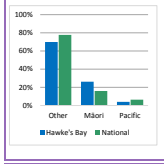
Net Result: YTD-Mar 2018
Actual: (4,148)
Plan: (2,112)
Variance: (2,035)

DHB POPULATION OVERVIEW

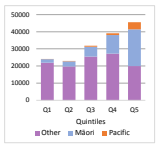


Hawke's Bay age distribution by ethnicity (number)

Population by ethnicity (%)



Hawke's Bay ethnicity by deprivation quintile



Conversation Opportunities

Conversations are currently underway with all DHBs on challenges and issues informing annual plans and performance for 2018/19 and out-years. These discussions are expected to support the development of a joint understanding of each DHB's key priorities, challenges and strategic direction.

PERFORMANCE

People Powered

*T	M	O	
●	●	●	Reducing rheumatic fever
△			Improving mental health services using wellness and transition planning
◆	◆	◆	Improving breastfeeding rates
			Regional:
●			Health Workforce

Key priority response actions:
Not reported in this quarter

DHB nominated highlights:
Our Clinical Services Plan continues with planning completed for four Future Options workshops in April/May. Emphasis has been placed on having workshops comprised of at least 15% consumers.

Regional nominated highlights:
Mental health and addiction:
- Key data regularly sourced providing a clearer view of how people are accessing and using services.
- Tangata Whaiora positions within regional leadership group.
- Access rates and wait times are measured to provide knowledge of how people are able to access services.

Closer to Home

*T	M	O	
●			Implementing the Healthy Ageing Strategy
NA			Improved management for long term conditions
△	△	△	Improved management for cardiovascular health
NA			Improved management for diabetes services
△	NA	NA	Improved management for acute heart services
△	NA	NA	Improved management for stroke services
NA	NA	NA	Improving breast screening rates
NA	NA	NA	Improving cervical screening coverage
			Regional:
△			Cardiac services
△			Stroke services

Key priority response actions:
Not reported in this quarter

DHB nominated highlights:
Transition to a stepped up model of care for mental health services in primary care was initiated in February.

Regional nominated highlights:
Mental health and addiction:
- Residential AOD model of care supports people to receive care in their own community rather than distant services.
- Youth Acute Response supports visibility of a continuum of services for young people to support service development and access.

Value and High Performance

*T	M	O	
●			Prime Minister's youth mental health project
●			Rising to the Challenge - Primary mental health
●			Rising to the Challenge- Improve outcomes for children in mental health
●			Rising to the Challenge-District suicide prevention and postvention
△			Shorter waits for non-urgent mental health and addiction services for 0-19 year olds
	△		Reducing the rate of Māori under Mental Health Act section 29 community treatment orders
△			Improving wait times for diagnostic services - Coronary angiography
△			Improving wait times for diagnostic colonoscopy - Urgent (<14 days), Non-Urgent(<42 days), Surveillance(<84 days)
△	◆	●	Immunisation coverage at 2 & 5 years old
NA	NA	NA	Human papillomavirus immunisation
NA	NA	NA	Influenza immunisation at age 65+
●	●	NA	Better help for smokers to quit in public hospitals
△			Inpatient average length of stay - elective
△			Inpatient average length of stay - acute
Regional:			
△			Elective services

Key priority response actions:
Not reported in this quarter

DHB nominated highlights:
CPO funding options have been reviewed and are currently being consulted on.

Regional nominated highlights:
Mental health and addiction:
- Survey to update regional service guide completed.
- Regional Service Data Gap Analysis completed.
- The Regional AOD Service Model utilises Tiers of Care to clarify roles. SACAT has implemented a clear role pathway.

One Team

*T	M	O	
●			Improving wait times for diagnostic services - CT and MRI scans (<42 days)
●	●	●	Faster cancer treatment (31 days)
●			Supporting vulnerable children
			Regional:
●			Cancer services- overall rating
●			Cancer services- Workplan delivery
●			Cancer services- Support for health target
△			Major trauma
●			Mental health and addiction services
●			Hepatitis C
●			Healthy ageing
△			Quality and Safety

Key priority response actions:
The Regional Medical Leaders are collaborating with the National interRAI service to make information more clinically relevant and available to in-hospital health professionals.

DHB nominated highlights:
Our Primary Care Development Partnership is in establishment phase. During Q3 we have met fortnightly with PHO and DHB colleagues from the provider and funder arm, to consider the scope, organisation and governance of the shadow year (2018/19). We are on track for a 1 July start .

Regional nominated highlights:
Mental health and addiction:
- Perinatal Mental Health services exemplar document of a Regional Support Model to be used within CREDS (Eating Disorders) to enhance service quality.
- The national workforce action plan actions prioritised, and initial actions developed.

Smart System

*T	M	O	
			Regional:
●			IT critical priorities- Overall Rating
●			IT critical priorities- Implement regional RIS/PACS
●			IT critical priorities- Clinical workstation (CWS) and clinical data repository (CDR)
●			IT critical priorities- Patient Administration Systems progress
●			IT critical priorities- Regional operating model

Key priority response actions:
The region published an infographic highlighting the characteristics of older people receiving home care assessments (interRAI). The use of this data within the region helps to benchmark DHB performance over a rolling 18 month period to inform conversations about improvement.

DHB nominated highlights:
Implementation work on clinical portal project has moved forward considerably this quarter with launch date set for HBDHB in April 2018.

Regional nominated highlights:
Mental health and addiction:
- Utilisation of the Scoping Regional Workstream process has led to improvement priority identification.
- Work regarding mental health and addiction ICT solutions based on service user pathways.

DHB Performance Challenges

Regarding Better help for smokers to quit at primary care, the DHB's drop in result is due to issues with patient outreach. The PHO has employed an independent registered nurse who provides clinical practices with their smoking brief advice coverage rates, and offers support to improve their engagement with patients.

Continued efforts are required from the DHB to meet the breastfeeding target rate for the total population. This will be particularly challenging given that the national target for exclusive or fully breastfeeding at 3 months has increased to 70%.

The Ministry will continue to work with the DHB to enhance access to and improve waiting times for elective services.

Equity Challenges

Implementing further strategies to increase immunisation rates for Māori children at age 4 years is a key priority area for the DHB.

Further work is required to meet the breastfeeding target rate for both Māori and Pacific women in the DHB. This will be particularly challenging given that the national target for exclusive or fully breastfeeding at 3 months has increased to 70%.

Regional Performance Challenges

Cardiac Secondary Services – The actual delivery of cardiac surgery procedures is 24% below plan and intervention rates for angiography and cardiac surgery remains low.

Stroke Services – The region did not reach their ASU target, however changes to after-hours admission processes should lead to an improvement.

Quality and Safety – There are delays in establishing the new group merging the Quality Managers Group and CRQS Alliance. Progress is expected in the next report.

OWNERSHIP VIEW

Standardised Intervention Rates of Procedures

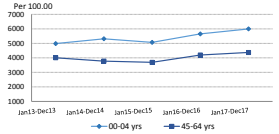
12 month period ending in December of the year

	2013	2014	2015	2016	2017	National Target
Angiography	36.47	34.66	36.66	39.14	36.44	34.70
Angioplasty	11.48	10.39	12.08	13.08	11.85	12.50
Cardiac Surgery	4.82	5.49	6.54	6.30	4.82	6.50
Cataracts	46.49	49.08	43.55	56.83	46.57	27.00
Major Joints	18.10	20.28	18.19	20.32	22.43	21.00

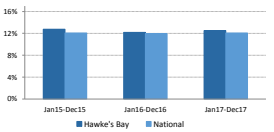
Service Coverage Delivery NA

Not reported in this quarter

Ambulatory Sensitive Hospitalisation Rates



Acute Readmission Rates (standardised)



Patients Waiting for FSA

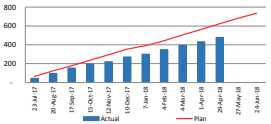
	Dec	Jan	Feb	Mar	Last mnth	4 mnths
ESPI 2	167	216	39	149	110	-18
ESPI 2 %	5.0%	6.7%	1.2%	4.4%	3.2%	-0.6%

Patients Waiting for Treatment

	Dec	Jan	Feb	Mar	Last mnth	4 mnths
ESPI 5	45	83	84	59	-25	14
ESPI 5 %	3.5%	6.9%	7.2%	4.9%	-2.3%	1.4%

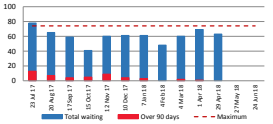
Regional Delivery of Cardiac Surgery

CAPITAL & COAST DHB OF SERVICE
Performance Against Plan: 77%
Variance: -145



Regional Wait List for Cardiac Surgery

CAPITAL & COAST DHB OF SERVICE
Total Regional Waiting list: 63
% of National Waiting List: 21%



Patient Experience

Quality and Safety Markers

	Goal	Performance	
Falls risk assessment (Oct-Dec17)	90%	98%	●
Hand hygiene (Jul-Sep17)	80%	88%	●

	Goal	Performance	
Surgical site infections (Jul-Sep 2017):			
Antibiotic administered in the right time	100%	99%	▲
Patients receive cefazolin or cefuroxime	95%	98%	●

How to read this dashboard

This dashboard shows a summary of most aspects of DHB performance. It combines indicators of DHB performance, as agreed in the 2017/18 Annual Plan, as well as complementary information such as financial management, hospital indicators and other priorities. The structure has been designed to display DHB information using an 'at-a-glance' approach. It is not to be used for general publication. Local and regional **Performance Measures** (https://nsfl.health.govt.nz/accountability/performance-and-monitoring/performance-measures/final-draft-performance-measures) are grouped by the **New Zealand Health Strategy** themes that include *People Powered, Closer to Home, Value and High Performance, One Team and Smart System* (http://www.health.govt.nz/publication/new-zealand-health-strategy-2016). The DHB population overview is included on the dashboard to provide contextual information to performance challenges, and is not performance information itself. Population data are sourced from Statistics New Zealand population projections (2016 based).

Most indicators are accompanied by a traffic light colour to represent the perceived risk to a DHB or a region achieving their target for the year. Traffic lights are applied to * **T -total population, M -Māori population, O -Pacific population unless indicated.** Where a rating for M or O is empty, this indicates that rating for that measure is applied to total population only.

The DHB is on track to achieve target	
Some aspects still need development / or the DHB is not tracking to target but has an appropriate resolution plan.	
The information available suggests the DHB is not on track to meet the target and does not have an appropriate resolution plan.	
To date, the DHB has provided no report.	NR
Not Applicable	NA

Quality & Safety markers use a traffic light scheme to mimic that used by the Health Quality and Safety Commission:

Performance at or above the goal level	
Performance within 10/15% of the goal level (depending on the marker)	
Performance more than 10%/15% below the goal level (depending on the marker)	

Definitions of each indicators are explained as below. (Definitions for health target indicators are provided in the health target summary table. Definitions for regional indicators are provided in the regional dashboards. Both definitions have been sent to DHBs each quarter and therefore are not repeated here.)

Supporting Better Public Services result 2 Healthy Mums and Babies	Highlights of progress against agreed actions to support the target of 90% of pregnant women are registered with a LMC in the first trimester by 2021, an interim target of 80% by 2019, with equitable rates for all population groups.
Supporting Better Public Services result 3 Keeping Kids Healthy	Highlights of progress against agreed actions to support the target of a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0-12 years by 2021, an interim target of 15% by 2019
System Level Measures- implementation of the Improvement Plan	This indicator shows if DHB and their alliances are on-track to implement their Improvement Plans, including whether they have provided appropriate corrective actions if not on track.
Financial Management	Overview of the financial performance of the DHB based on data provided by the DHBs in monthly financial templates
Immunisation coverage at 2 & 5 years old	At least 95 percentage of children who have completed their age-appropriate immunisations measured at age 2 years and age 5 years. The rating - indicated by the traffic light colour - is based on the DHB's performance for both the 2- and 5-year-old milestones. The dashboard population for 'Other' includes Pacific only.
Human papillomavirus immunisation	At least 75 percentage of eligible girls fully immunised with human papillomavirus (HPV) vaccine. For 2017/18 it is the 2004 birth cohort measured at 30 June 2018). The dashboard population for 'Other' includes Pacific only. This measure is reported yearly in quarter four.
Influenza immunisation at age 65+	At least 75 percent of the population aged 65 years and over are immunised against influenza annually (measured at 30 September). The dashboard population for 'Other' includes Pacific only. This measure is reported in quarter one.
Reducing rheumatic fever	A progress report against the DHB's rheumatic fever prevention plan. Ratings are only applied to DHBs who are required to submit exception reports.
Improving mental health services using wellness and transition planning	95% of people treated in mental health and addiction services for more than 3 months will have a quality wellness plan or have had a transition plan at discharge.
Reducing the rate of Māori under Mental Health Act section 29 community treatment orders	DHBs will reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.
Improving breastfeeding rates	Breastfeeding is defined as exclusive or fully breastfed at 3 months. This measure is reported in quarters one and three.
BreastScreening Aotearoa (BSA) - initial rescreen	Number of women rescreened within 20-27 months of their previous screen as a percentage of the number of women eligible for a rescreen. Target 75 percent or more of women who attend for their first screen within the programme are rescreened within 20-27 months (50-67 years only). The dashboard population for 'Other' includes only Pacific woman. Performance on this indicator is rated in quarters two and four.
Implementing the Healthy Ageing Strategy	DHBs are expected to report on delivery of the actions and milestones as identified in the 2017/18 annual plans for health of older people services including falls and fracture prevention and rehabilitation services, future models of home and community supports (HCSS), regularisation of the HCSS workforce, use of interRAI assessment tool, an action to improve equity and one locally prioritised action to progress implementation of the Healthy Ageing Strategy
Improved management for long term conditions (Cardiovascular health, diabetes, acute heart and stroke services)	DHBs are expected to report on delivery of the actions and milestones as identified in the 2017/18 annual plans for long term conditions (LTC), diabetes services, cardiovascular (CVD) health, acute heart services and stroke services. Improved management for long term conditions and diabetes are reported in quarters two and four.
Improving breast screening rates	Number of women screened in the 24 months period as a percentage of women eligible. Target: 70 percent or more screening coverage for all eligible women (50-69 years only). The dashboard population for 'Other' includes only Pacific woman. This measure is reported in quarters two and four.
Improving cervical screening coverage	The proportion of women aged 25-69 years who have had a cervical smear in the previous three years. Target: 80% or more screening coverage for all ethnic groups. The dashboard population for 'Other" includes Asian women. The denominator is derived from Statistics New Zealand's DHB population projections, adjusted for the prevalence of hysterectomy. This measure is reported in quarters two and four. However, data is updated monthly, and is found on the following: https://minhealthnz.shinyapps.io/nsu-ncsp-coverage/.
Prime Minister's youth mental health project	Reports on progress towards achieving three initiatives in the Project:1: School Based Health Services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities. 3: Youth Primary Mental Health reported under Rising to the Challenge. 5: Improve the responsiveness of primary care to youth. Initiative 6 is reported under Shorter waits for non-urgent mental health and addiction services for 0-19 year olds, and Initiative 7 is reported under Improving mental health services using wellness and transition (discharge).
Rising to the Challenge - Primary mental health	This measure is to monitor access to evidence-informed psychological therapies for mental health and additions issues in primary care.
Rising to the Challenge- Improve outcomes for children in mental health	Reports on the actions identified in the annual plan for improving outcomes for children in mental health.
Rising to the Challenge-District suicide prevention and postvention	Progress against the agreed 2015-2017 Suicide Prevention Plan is reported by describing highlights, exceptions and milestones for three of the actions, and noting any completed actions.
Improving wait times for diagnostic services - Coronary angiography	Performance against the waiting time indicators for Coronary Angiography.
Inpatient average length of stay (elective and acute)	Reports are against two inpatient average length of stay (ALOS) measures – Part One: Elective surgical inpatient ALOS, Part Two: Acute inpatient ALOS
Improving wait times for diagnostic services - CT and MRI scans	Performance against the waiting time indicators for Computed Tomography (CT) and Magnetic Resonance Imaging (MRI). Waiting time targets are people accepted for CT or MRI receiving the scan within 42 days.
Improving wait times for diagnostic colonoscopy - Urgent, Non-Urgent, Surveillance	Performance against the waiting time indicators for Colonoscopy that include urgent, non-urgent and surveillance colonoscopy. Waiting time targets are people accepted for an urgent, non-urgent or surveillance colonoscopy receiving the procedure within 14 days, 42 days or 84 days respectively.
Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	All DHBs are expected to reach 80% of people referred for non-urgent mental health or addiction services are seen within three weeks and 95% of people are seen within 8 weeks this year.
Faster cancer treatment (31 days)	The 31-day indicator is the maximum length of time a patient should have to wait from date of decision-to-date to receive their fist treatment (or other management) for cancer.
Supporting vulnerable children	Actions or initiatives to reduce deaths and hospitalisations due to assault, neglect or maltreatment of children and young people
Better help for smokers to quit in public hospitals	95 percent of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.
Standardised intervention rates of procedures	The DHB's level of intervention relative to their population, standardised to take account of variations in the population demographics (age, gender, ethnicity and deprivation) allowing for comparison between different DHBs. Green shows performance is significantly above the national target, grey is no significant variation and red is significantly below the national target.
Service coverage delivery	Self-reported confirmation & exception report. DHBs must ensure service coverage expectations are met, or demonstrate resolution of service coverage gaps by providing an appropriate resolution plan, and adequate progress is being made against the plan. This measure is reported in Q2 and Q4.
Ambulatory sensitive hospitalisation rates	Ambulatory Sensitive Hospitalisations (ASH) result from diseases and conditions sensitive to prophylactic or therapeutic interventions deliverable through primary care and are, therefore, avoidable. The ASH rates are derived by the total number of 12-month ASH for DHB patients aged 0-4 and 45-64 as the numerators and the same age population of the DHB as the denominators respectively. Rates for 45-64 age group are age standardised using national population as a standard. Performance on this measure is rated in quarters two and four.
Acute readmission rates	Acute readmission rates are the number of unplanned acute readmissions to hospital within 28 days of a previous inpatient discharge that occurred within the 12 months to the end of the quarter, as a proportion of inpatient discharges in the 12 months to the end of the quarter. Mental health hospitalisations are excluded from the measure, while acute maternity hospitalisations are not recognised for readmission purposes. The rates are standardised by patient population characteristics, deprivation, rurality, patient health conditions, comorbidity and surgery, using 3 years rolling national patient population as a 'standard'. Indirect standardisation using logistic regression method is applied to derive the rates.
Patients waiting for FSA (ESPI 2)	The total number on the waiting list waiting longer than four months for a first specialist assessment (FSA) for the last four months, and the number waiting as a % of the total list. ESPIs are the set of elective services patient flow indicators
Patients waiting for treatment (ESPI 5)	The total number on the waiting list waiting longer than four months for treatment for the last four months, and the number waiting as a % of the total list. ESPIs are the set of elective services patient flow indicators.
Regional delivery of cardiac surgery and wait list	Regional cardiac provider delivery against plan. Regional cardiac provider total waiting list against the waiting list target including those waiting over 90 days and proportion of regional to national waiting list. DHBs submit four-weekly reports.
Patient Experience	Average rating out of 10 for inpatient experience across the four domains of communication, partnership, coordination of their care, and having physical and emotional needs met, based on results from the national patient experience survey. The survey covers patients in hospital during the second month of each quarter.
Quality and Safety Markers	Progress toward the markers set by the Health Quality and Safety Commission. These include older patients receiving a falls assessment, compliance with good hand hygiene practice, and two surgical site infection measures: hip and knee replacement patients receiving 2g or more of cephazolin and antibiotic administered in the right time.
Key priority response actions	A response to the delivery of an action and milestone agreed in the annual plan for each Government planning priority, this is an opportunity to showcase achievements.
Nominated highlights	A DHB (or a region) nominated highlight of an action, an initiative or an activity that reflects a NZ Health Strategy theme and is delivered within the quarter. No performance assessment is made.
Performance challenges	A performance measure that is assigned a red diamond indicator against performance will have a text comment providing further detail about the resolution path.
Equity challenges	Population and equity assessment is against the expectations agreed in the annual and regional plans, and highlights progress towards equity. A red diamond indicator against progress towards equity will have a text comment providing further detail about the resolution path.
Conversation opportunities	Conversation opportunities are included to provide useful triggers for internal DHB conversations, Ministry officials visits to the DHB and, monitoring and intervention framework (MIF) meetings. The bullet points include both achievements and concerns based on the performance dashboard information and emerging issues identified by Ministry DHB Relationship Managers. The conversation opportunities is not an exhaustive list.

CLINICAL SERVICES PLAN

Verbal Update

HAWKE'S BAY
District Health Board
Whakawāteatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

That the public now be excluded from the following parts of the meeting, namely:

21. Confirmation of Minutes of Board Meeting - Public Excluded
22. Matters Arising from the Minutes of Board Meeting - Public Excluded
23. Board Approval of Actions exceeding limits delegated by CEO
24. Chair's Update
25. HB Clinical Council
26. Finance Risk and Audit Committee
27. Whole of Board Appraisal

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).