BOARD MEETING

Date: Wednesday, 30 May 2018

Time: 1:30pm

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

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

Apologies:

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

Mintute Taker: Brenda Crene

Public Agenda

Item	Section 1: Routine	Ref #	Time (pm)
1.	Karakia		1:30
2.	Apologies		
3.	Interests Register		
4.	Minutes of Previous Meeting		
5.	Matters Arising - Review of Actions		
6.	Board Workplan		
7.	Chair's Report – Kevin Atkinson		
8.	Chief Executive Officer's Report – Kevin Snee	54	
9.	Financial Performance Report – Tim Evans	55	

10.	Board Health & Safety Champion's Update – Board Safety Champion	56	
	Section 2: Reports from Committee Chairs		
11.	HB Clinical Council – Co-Chairs, John Gommans and/or Andy Phillips	57	2:05
12.	HB Health Consumer Council – Chair, Rachel Ritchie	58	
13.	Maori Relationship Board – Chair, Ngahwi Tomoana	59	
14.	Pasifika Health Leadership Group – Barbara Arnott & Caren Rangi	60	
	Section 3: For Decision		
15.	Primary Care Development Partnership Governance – Ken Foote	61	2:35
	Section 4: Presentation / Discussion		
16.	National Bowel Screening Roll-out – Lynda Mockett & Malcolm Arnold	62	2:45
17.	The Place of Alcohol in Schools - Young people and under-age exposure – Kevin Snee and Rowan Manhire-Heath	63	2.55
18.	Plan to develop Kapupapa Maternal Wellbeing Health Programme – Patrick LeGeyt, Charissa Keenan & Jules Arthur	64	3.05
19.	Collaborative Pathways Update - Chris Ash and Mark Peterson	65	3:15
20.	Clinical Services Plan – Planning for Consultation – Ken Foote	66	3:25
	Section 5: Monitoring		
21.	Best Start Healthy Eating & Activity Plan update – Kevin Snee & Shari Tidswell	67	3:45
22.	Te Ara Whakawaiora – Improving First Specialist Appointment Access (local Indicator - formerly "Did not Attend) – Sharon Mason and Carleine Receveur	68	3:55
23.	Human Resources KPIs Q3 (Jan-Mar 2018) – Kate Coley	69	4:05
24.	HBDHB Performance Framework Exceptions Report Q3 (Jan-Mar 18) - HBDHB Non-Financial Performance Framework Dashboard Q3 (Jan-Mar 18)	70 71	4:15
25.	HBDHB Quarterly Performance Monitoring Dashboard Q2 (Oct-Dec17) provided by MoH	72	4:20
	Section 6: General Business		
26.	**Section 7: Recommendation to Exclude the Public** Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	**Section 8: Routine**	Ref #	**Time (pm)**
27.	Minutes of Previous Meeting (public excluded)		
28.	Matters Arising – Review of Actions		
29.	Board Approval of Actions exceeding limits delegated by CEO	73	4:30
30.	Chair's Update - verbal		
	Section 9: Decision		
31.	Annual Plan Prioritisation Workshop Outcomes from 16 May 2018	74	4:35
	Section 10: Reports from Committee Chairs		
32.	HB Clinical Council – Co-Chairs, John Gommans and/or Andy Phillips	75	4:45
33.	Finance Risk and Audit Committee – Chair, Dan Druzianic	76	4:50

The next HBDHB Board Meeting will be held at
1.30pm on WEDNESDAY 27 June 2018

Board "Interest Register" - 24 April 2018

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Kevin Atkinson (Chair)	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussion in relation to the Trust	The Chair of FRAC	Mar-11
	Active	Board Member of NZ Health Partnership Limited, *effective from 20 March 2017*	Lead, supported and owned by the 20 DHBs, NZ Health Partnerships creates efficiencies in the health sector that allow more to be spent on frontline services.	Will not take part in any decisions in relation to NZ Health Partnerships Limited where specific legal or fiduciary conflict identified.	The Chair of FRAC	22.02.17
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair of FRAC	26.10.17
Ngahiwi Tomoana (Deputy Chair)	Active	Chair, Ngati Kahungunu Iwi Incorporated (NKII)	Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB: (i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department. (ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department.	Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB.	The Chair	01.05.08
	Active	Brother of Waiariki Davis	Perceived Conflict of Interest. Non-Pecuniary interest. Waiariki Davis is employed by HBDHB and is the Health Records Manager.	Will not take part in any decisions in relation to Health Records management. All employment matters in relation to Waiariki Davis are the responsibility of the CEO.	The Chair	01.05.08
	Active	Uncle of Tiwai Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Tiwai Tomoana is employed by HBDHB and is a Kitchen Assistant in the Food and Nutrition Department at Hawke's Bay Hospital.	All employment matters in relation to Tiwai Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Uncle of Iralee Tomoana	Iralee Tomoana is employed by HBDHB and works in the Radiology Department as a clerical assistant.	All employment matters in relation to Iralee Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Brother of Numia Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Numia Tomoana is employed by Cranford Hospice and works as a palliative care assistant and, in this role, works with chaplains at Hawke's Bay Hospital.	Will not take part in any decisions in relation to the Chaplain service at Hawke's Bay Hospital.	The Chair	01.05.08
	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		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

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
	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
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 "Whahariki Trust" advised 30-8-17	Relationship and and may be contractural from time to time	No conflict	The Chair	5.12.16
	Active	Chair of Directions	Relationship and contractual	Potential Conflict as this group has a DHB Contract	The Chair	5.12.16
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 TUESDAY 24 APRIL 2018, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.30PM

PUBLIC

Present:	Kevin Atkinson (Chair) Ngahiwi Tomoana (Deputy Chair) *arrived at 3.00pm* Peter Dunkerley Diana Kirton Barbara Arnott Heather Skipworth Jacoby Poulain Ana Apatu Hine Flood
Apologies	Dan Druzianic and Helen Francis
In Attendance:	Kevin Snee (Chief Executive Officer) Members of the Executive Management Team Drs Gommans and Phillips (as co-Chairs, HB Clinical Council) Rachel Ritchie (Chair, HB Health Consumer Council) Members of the public and media Brenda Crene

APOLOGIES

Apologies were noted from Dan Druzianic and Helen Francis

3. INTEREST REGISTER

No changes to the interests register were advised.

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

4. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on 28 March 2018, were confirmed as a correct record of the meeting.

Moved: Peter Dunkerley
Seconded: Hine Flood
Carried

5. MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: **H&S Booklets –** item closed.

Item 2: **Reporting – what has changed for consumers –** comment noted, item closed

Item 3: **Clinical Governance Structure Value Assessment –** diagram contained within appendix II had been changed accordingly. Item closed.

Item 4: **Clinical Services Plan –** Workshop coverage and inclusion of MRB and Pacific members. Found to be adequately covered – item closed.

Item 5: **Establishing Health and Social Care Localities in HB –**

The following actions closed:

a) Comment received within the matters arising, incorporating the activity plan request within the September Update. Item closed
b) Te Pare and Jill Garrett will attend the May Consumer Council Meeting. (subsequently moved to the July Meeting).

The following actions remain outstanding:

c) Chris Ash will to come back on what has changed for consumers
d) The conversation between Hine and Chris remained outstanding.

6. BOARD WORK PLAN

The Board Work Plan was noted.

The Board were advised to expect a first draft of the 2018/19 budget in June to FRAC.

The Chair indicated the board were keen to hold a half day workshop around the annual plan prior to the next meeting and would discuss this with the CEO outside the meeting.

7. CHAIR'S REPORT

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

Name	Role	Service	Years of Service	Retired
Karen Roberts	Cook	Operations Directorate	29	8-Apr-18
Rose Chase	Care Associate	Older Persons & Mental Health	28	30-Apr-18

- A letter of thanks had been received from Reverend Barbara Walker on behalf of the Chaplaincy Services, thanking Board for their efforts to raise funding through LTAs and providing a grant of $20k over and above their normal contribution paid. The board hoped that the NCC and CHBDC would again consider contributing to this service in future, in line with funding support received from the Wairoa and Hastings Councils'.

8. CHIEF EXECUTIVE OFFICER'S REPORT

The CEO provided an overview of his report, in summary noting:

- The health system remained under pressure in March, with daily planning meetings occurring to speed up flow within the system. During April there had been a gradual improvement. Chris McKenna advised she will continue to focus on this area over the coming months, this was all about team work across the system.
- As the hospital being so busy continues to impact on elective surgery rates. Patients may wait slightly longer for minor surgery in the interim, but we should be back on track in May.
  The Board enquired whether there were any clinical risks for those patients not being operated on within 4 months? In response: this is seen as a short-term scenario with acute patients continuing to be prioritised.
- The Financial position had further deteriorated in March and we will likely not be able to break even this year.
- Nationally recruitment of nurses is becoming difficult, especially nurses with experience. We have 50 new nurse graduates in our system, who do require support but they are our nurses for the future.

Nurses Action (nationally):

- Nurses picketed outside the Hospital on Monday 23rd May as part of the nationwide action over pay and other matters.
- One of the key issues for nurses around the country has been the "care capacity demand" (CCDM) part of the MECA agreement. This has not always been deployed as well as it could have been in other regions. We implemented this fairly well and are now being disadvantaged. CCDMs first and major tranche was completed more speedily here in HB with further FTEs being employed over the next 18 months.
- If there is no agreement on matters nationally, strike action may occur.

9. FINANCIAL PERFORMANCE REPORT

Tim Evans, ED of Corporate Services spoke to the Financial Report for March 2018, which showed a $2.0 million variance unfavourable to plan with March being $347 thousand unfavourable for the nine months year to date. It was a huge month doing a lot of acute and high case weight work which extended services.

The unfavourable variance for the month was driven by outsourcing, a continued decrease in ACC revenue due to capacity and increased undelivered efficiency targets which were partially offset by the catch up in capitalisation of labour costs and continued detailed reviews of accruals.

Inter District flows (IDFs) are always an unknown until future months. Our savings program continues to remain at 60% of target for the financial year ended 30 June.

10. HEALTH & SAFETY BOARD CHAMPIONS UPDATE

Board Champions Dan and Jacoby had met and reviewed the strategy. Advised the report was good and identified resources required going forward.

Kate Coley was formulating a roster for Safety Tours. Other board members were welcome to attend these tours if they wished.

The Chair advised whilst in the hospital recently, he had spoken to three nursing staff independently asking whether it was a safe place to work. He had received a positive yes from all three nurses which was pleasing.

REPORT FROM COMMITTEE CHAIRS

11. HAWKE'S BAY CLINICAL COUNCIL

Co-Chair Dr John Gommans spoke to the report from the Council's meeting held 11 April 2018. He advised that several homeopaths had been invited to join the meeting for discussions. This had been very worthwhile on how we can work together for the benefit of those we are helping.

An overview of investments made in the health system (ie spending on areas considered by Councils and MRB) and it was good to see that most of the funds discussed in the prioritisation process in in had gone to the community (even though such prioritisation decisions were small in comparison to overall funding).

Received an excellent update from Information Services. They have certainly come a long way. A priority now is for the DHB to get clinical business processes in order to better focus on integration and engagement with primary care.

Quality Dashboard – input from clinical leaders nationally and locally had been provided. It was agreed that HBDHB should endorse the use of this dashboard with further development(s) pending.

Discussions around choosing wisely had resulted in the number one priority for council members, being "prescribing wisely" and "involving patients in their use and care". A joint workshop between Clinical and Consumer Council on this topic is planned for June.

12. HAWKE'S BAY HEALTH CONSUMER COUNCIL

Rachel Ritchie, Chair of Consumer Council advised the outcomes of their meeting held on 12 April 2018: noting the number of outstanding items and actions planned; advising that recruitment of the Consumer Engagement Manager and Consumer Engagement Coordinator was underway; positive feedback had been received from consumer members attending the CSP workshops held in April. Heard from Kate Coley on the framework for developing the people strategy. Looking to see how it will work in practice and benefit consumers, and how this can be measured.

Rachel advised that two new deputy chairs for Consumer Council had been appointed to support her and five new Council members were being sought publicly to replace those who had completed their third term and were not able to be reappointed – however those members retiring were able to stay on committees representing consumers.

Barbara Arnott complemented Rachel on her Report as it encapsulated and identified areas and aspects that the Board were waiting on and they shared the same concerns especially around health literacy.

Rachel referred to the analogy "opening and closing a door" and advised that when engaging with consumers, there is an expectation created by engaging with them, that management will listen to the responses and take action in response to that input. This seems obvious but too often responses are forgotten. She said the ability to implement change is a huge challenge for the DHB but to move forward and ensure ongoing consumer engagement, the system needs to be able to be 'change ready'. If nothing changes in response to consumer input, consumers' lose faith. They become 'fatigued' and cynical by consumer consultation requests, as they don't have any confidence the system will change.

13. MĀORI RELATIONSHIP BOARD (MRB)

Heather Skipworth as Deputy Chair of MRB spoke to report for the meeting held 11 April 2018 – which was tabled at the meeting and available on Diligent.

- Heather advised that MRB felt they could add value to the CSP Meetings scheduled in May and that Patrick LeGeyt would invite MRB members to attend.
- Framework for developing the People Strategy was reviewed and MRB questioned why the DHB HeART values were not used and recommended they should be highlighted on the framework poster under 'Our Values'.
- Maori and Pasifika workforce Action Plan had been reviewed and it was advised that MRB wish to have their own workforce development action plans as needs differ from those of Pasifika.
- Te Ara Whakapiri (Last Days of Life): MRB were appreciative that strategic services worked in partnership with the Māori Health Improvement team to ensure cultural sensitivities were incorporated into the Last days Care Plan and Toolkit. It was advised this had been a valuable exercise as it had provided a lot more than was expected.
- Te Ara Whakawaiora – Culturally Competent Workforce; Cardiovascular; Healthy Weight; and Breastfeeding and Establishing Health and Social Care Localities in HB - were received and feedback provided.

To enable MRB to workshop topics, a special meeting was held on Wednesday 18 April 2018.

FOR DISCUSSION / INFORMATION

14. CLINICAL SERVICES PLAN UPDATE

Ken Foote provided a verbal update of progress to date

Two of the future options workshops had been completed during April with two further workshops planned for early May. From the 31 May integrated workshop, Sapere will take information and deliver the first draft of the CSP by the end of June. In July governance groups consider to reality check this draft with the final result going through to the consultation stage. During May,

governance and advisory groups will be asked for advice on a consultation process planned for August/September, on whether we are engaging with the right people in the right place in the right way.

The Board will receive the final of the Clinical Services Plan on 31st October for endorsement.

15. WINTER & FLU PLANNING PRESENTATION

Sharon Mason introduced Sandra Bee, Emergency Management Advisor. The presentation provided an overview of stakeholder engagement; the H3N2 predominant flu strain in the northern hemisphere with the highest rate of hospitalisation reported in the 65 plus age group and the young (0-4 years). Triggers noted were an increase in staff illness, outbreaks in residential care and schools. Pre Phase work was being undertaken with an array of tools identified.

The next "Early phase" relates to surveillance, communication, coordination and training. The Disruptive phase may include EOC activation, bed, discharge, staff and alternate service delivery models.

Current work includes St John Ambulance utilising alternate models of care; community pharmacy monitoring as well as socialisation and communication of alternate plans to the Community

Discussion included:

- A lot of messaging for the community was being prepared by the Communications Department.
- Good indications are that Tamiflu can be used in hostels and/or home care facilities to lessen the severity of illness.
- Planning and processes used during the Gastro Outbreak will be implemented if required.
- If severe enough, all practices would need to divert messages to a central call centre for flu matters and advice 24/7.

16. MAORI & PACIFIC WORKFORCE ACTION PLAN – a component of Building a Diverse Workforce

Kate Coley introduced Ngaira Harker (Nurse Director), Patrick LeGeyt (Acting General Manager of Maori Health), and Talalelei Taufale (Pacific Health Improvement Manager)

It was acknowledged that Maori and Pacific populations are over represented in the determinants of health and that the workforce should reflects our populations with MoH KPIs reflecting this nationally. Action areas ensure the environment is supportive of all ethnicities and all cultures and activities flow.

The logic model was tabled by Patrick LeGeyt.

Ngaira provided further detail around the actions stating there is a huge need for Maori people in health generally and more Maori Nurse leadership nationally. It was pleasing to see that Wairoa was in a good place in this regard. Raising awareness and visibility through newsletters and other mediums to highlight the differences Maori make in the health workforce, would certainly encourage interest. This was work in progress.

Action **Jacoby enquired whether it was possible to have a point of contact (within the DHB) where enquiries for Maori (and other ethnicities), seeking employment could be directed?**

Heather Skipworth asked whether the gap in the Maori workforce presented as numbers were roles or head count?
In response, the figures presented are people (not roles). Outstanding against the current target we need 27 more employed with Maori ethnicity. For Maori if you look at how Hawke's Bay stack up against the other 19 DHBs, we have the 2nd most represented workforce in the country and other DHBs look at us for that reason. We are now in a very different place and are most definitely tracking in the right direction and will achieve our aspirations.

However for Pacific people, the same focus has not been applied and employee numbers have declined.

Talalelei Taufale relayed from a pacific perspective their concerns were similar to Maori but with a difference. The key is to create supportive environment to ensure better opportunities, and if undergoing study that there are opportunities on completion. It is the supportive environment that Pasifika people seek at this time.

It was noted that the Pasifika Health Leadership Group (PHLG) had not discussed fully this document as a team, this will occur on 12 May.

Barbara Arnott who attends and supports the PHLG, advised this discussion will be around how we model implementation of the plan and the measures to ensure success. She assumed, and then queried whether Pacific KPIs would be reported within the HR KPIs (quarterly).
In response, Kate advised the KPIs were part of quarterly HR reporting, however she would now provide a new six monthly report to better capture and track against the action plan(s) presented.

Action **"Maori and Pacific Workforce Actions against Plan (6 monthly)" will be provided. A commencement date for this report will be advised and included on the workplan.**

The following points were noted by Barbara Arnott:

- Every patient needs to have a cultural arm around them. How do we use our Patient Experience feedback to show the impact on our consumers?
- Referring to Appendix 4 (the draft action plan - capacity in workforce) which states develop a Business Case for the Pacific Workforce. This requests funding in April for a budget that needs to be signed off in June 2018. We cannot wait and see as pacific people need support.
- We need to build capability in the HR team to support the workforce action plan and agree the KPIs going forward (monitoring over four years).
- The ethnicity workforce KPIs will flow through to the Annual Plan 2018/19
- The Board hold management accountable for delivery of a collection of actions for an ethnically diverse workforce.

In response to a query by Ana Apatu - it was advised there is interest in Primary Care with the PHO wanting to implement and Totara Health are engaging also.

- Ethnic workforce diversity should filter down through all those providing health services in HB.

17. TE ARA WHAKAWAIORA / CULTURALLY COMPETENT WORKFORCE (Local Indicator)

In reference to the report, it was advised there was an evaluation underway of the training programme "Engaging Effectively with Māori".

Action: **Kate Coley to tidy up a column in the report provided, to include those who have been through training that has now expired. This will be provided in the next report when due – date tbc.**

Dr Gommans mentioned the difficulty of incorporating professional training in our statistics eg, junior doctors (as they are in HB for one or two years). We need to think of ways on how better to reflect the different groups.

It was advised the NUKA model was excellent in this regard.

18. TE ARA WHAKAWAIORA / BREASTFEEDING (National Indicator)

Chris McKenna provided an overview including:

- Area of focus - high level leaving breast feeding. There is a gap between 6 weeks and 3 months.

- There are currently pieces of work are on target to do without investing hugely. Test in the interim to ensure proof of concept therefore will not be fully operational for 16 months or so (Oct 2019).
- Have consulted widely.
- Felt should maybe target those who are pregnant, as if not engaged at this time, may have missed the boat?.
- Working with LMCs – in maternity services. HB is an accredited breastfeeding service. There are a high number leaving breastfeeding. Social indicator around whanau, family and partner support in behind this. Working closely to support Mums. A new contract is being put in place to continue that support.
- Next month Patrick LeGeyt and Jules Arthur will present the new model of care. This will assist in responding to Jacoby's query in February.

Recommendations adopted. Other councils have supported as well.

19. TE ARA WHAKAWAIORA / CARDIOVASCULAR (National Indicator)

Dr John Gommans provided a brief overview on the report provided advising the urgent area was around how we capture data and view trends. Performance has dropped. A number of issues have been identified to focus on and have us back on track – to where we were a year or two ago.

Problem is a number of the interventions are undertaken in Wellington. There have been discussions at a regional level around PCIs

Maintaining compliance (3 day) or 72 hour window for patients to receive an angiogram
Ethnicity in cardiology is not an issue. However if medical assistance is not sought early, difficulties arise.

20. TE ARA WHAKAWAIORA / HEALTHY WEIGHT (National Indicator)

Shari Tidswell spoke to the paper provided, advising we continue to have small reduction for 4 year old s, however have exceeded the target for two quarters. The discrepancy between Maori and Other – equated to one child which explained the 2-3% difference!

- There is a healthy weight environment in schools and will have a clinical person doing BMIs to ensure consistency of data. This will occur to the most vulnerable groups in high deprivation areas.
- Key message that water is the best drink. All staff on board really well. Working very very well. Recyclable cups vs drink bottles.
- Hastings District Council has removed all sugar sweetened messages from vending machines.
- Water only in CHB and Wairoa needs to receive focus to get to the top of their priority list.
- The competitive nature between councils could work magic!.

GENERAL BUSINESS

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

RESOLUTION TO EXCLUDE THE PUBLIC

RESOLUTION

That the Board

Exclude the public from the following items:

22. Confirmation of Minutes of Board Meeting
23. Matters Arising from the Minutes of Board Meeting
24. Board Approval of Actions exceeding limits delegated by CEO
25. Chair's Update
26. A Framework for Developing the People Strategy
27. HB Health Sector Leadership Forum
28. Whole of Board Appraisal (progress against actions)
29. HB Clinical Council
30. Finance Risk and Audit Committee

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

The public section of the Board Meeting closed 3.45pm

Signed: _____
Chair

Date: _____

BOARD MEETING - MATTERS ARISING
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	29/3/18	**Establishing Health and Social Care Localities in HB:** Outstanding c) Consumer Council request an update as to what has changed for consumers? d) MRB meeting 11 April: Hine will speak with Chris Ash to see if further detail can be included in that meeting.	ED Primary Care Hine Flood	May 18 asap	TePare attending the Consumer Meeting in ~~May~~ now July Not completed.
2	24/4/18	**Maori and Pacific Workforce:** a) Jacoby enquired whether it was possible to have a point of contact (within the DHB) where enquiries for Maori (and other ethnicities), seeking employment could be directed? a) "Maori and Pacific Workforce Update on actions against Plan (6 monthly)" will be provided. Commencement to be advised and included on the workplan. b) Note other comments raised by Barbara Arnott during this discussion (on page 6 of the minutes).	Kate Coley		Progressing – being considered within Maori Health Services/recruitment Date to be provided Noted the points raised
3	24/4/18	**Te Ara Whakawaiora – Culturally Competent Workforce:** Tidy up a column in the report regarding Effectively Engaging with Maori , to include those who have been through training that has now expired. This will be provided in the next report – tbc. Date to be confirmed on the TAW schedule.	Kate Coley Patrick LeGeyt		Noted

BOARD WORKPLAN

27-Jun-18	EMT Member	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	BOARD Meeting date
Implementing the Consumer Engagement Strategy	Kate Coley	13-Jun-18	13-Jun-18	10-May-18	27-Jun-18
People Plan Business Case	Kate Coley	13-Jun-18	13-Jun-18	13-Jun-18	27-Jun-18
Recognising Consumer Participation - Policy Amendment	Kate Coley	13-Jun-18	13-Jun-18	13-Jun-18	27-Jun-18
Annual Plan 2018/19 Draft (June) (DRAFT DUE TO MoH 16 JULY) - draft to committees and Boa	Chris Ash	8-Aug-18	8-Aug-18	9-Aug-19	27-Jun-18
Clinical Services Plan verbal update (May June July) - not this month for clinical-consumer	Ken Foote	13-Jun-18			27-Jun-18
Emergency Management - Whole of Board Appraisal action plan item	Sharon Mason				27-Jun-18
I.S Mobility Progress Update	Kevin Snee				27-Jun-18
Te Ara Whakawaiora - Oral Health (National Indicators)	Kevin Snee	13-Jun-18	13-Jun-18	13-Jun-18	27-Jun-18
Under 18 Free GP service Update	Chris Ash	13-Jun-18	13-Jun-18	13-Jun-18	27-Jun-18
Urgent Care Service Update (6 monthly **June** Dec 18) paper or presentation	Wayne Woolrich		13-Jun-18	13-Jun-18	27-Jun-18
Te Ara Whakawaiora "Smokefree update" (6 monthly moved to July) - board action Nov17	Kevin Snee	11-Jul-18	11-Jul-18	12-Jul-18	27-Jun-18
Finance Report (May)	Tim Evans				27-Jun-18
25-Jul-18	**EMT Member**	**MRB Meeting Date**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**BOARD Meeting date**
Alcohol Positon Statement INTERNAL and Strategy *for EMT consideration* (board action August 20	Sharon Mason	11-Jul-18	11-Jul-18	12-Jul-18	25-Jul-18
Annual Plan 2018/19 Draft (June) (DRAFT DUE TO MoH 16 JULY)	Chris Ash	11-Jul-18	11-Jul-18	11-Jul-18	25-Jul-18
Clinical Services Plan verbal update (May June **July**)	Ken Foote	11-Jul-18	11-Jul-18	12-Jul-18	25-Jul-18
He Ngakau Aotea - Strategic Priorities for MRB	Patrick LeGeyt		11-Jul-18	12-Jul-18	25-Jul-18
Planned MRI and Fluoroscopy Equipment Replacement Programme **Detailed Business Case'**	Sharon Mason		11-Jul-18		25-Jul-18
Policy on Consumer Stories	Kate Coley / John Gommans	11-Jul-18	11-Jul-18	12-Jul-18	25-Jul-18
Te Ara Whakapiri Next Steps (Last Days of Life) - MRB considered in April - moved to July for rest	Kevin Snee	11-Jul-18	11-Jul-18	12-Jul-18	25-Jul-18
Finance Report (Jun)	Tim Evans				25-Jul-18
Health and Social Care Localities (from March Report provided) What has changed for consumers?	Chris Ash			12-Jul-18	25-Jul-18
29-Aug-18	**EMT Member**	**MRB Meeting Date**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**BOARD Meeting date**
Annual Report 2017/18 First Draft	ED Fin Services				29-Aug-18
Collaborative Pathways update (May - **Aug** - Nov) Aug include Consumer and Board	Chris Ash & Mark Peterson		8-Aug-18	9-Aug-19	29-Aug-18
Matariki Regional Development Strategy and Social Inclusion Strategy	Kevin Snee	8-Aug-18	8-Aug-18	9-Aug-19	29-Aug-18
Te Ara Whakawaiora - Access 0-4 / 45-65 yrs (local indicator)	Kevin Snee	8-Aug-18	8-Aug-18	9-Aug-19	29-Aug-18
Hawke's Bay District Health Board (HBDHB) Non-Financial Performance Framework Dashboard Q4	Kevin Snee				29-Aug-18
HBDHB Performance Framework Exceptions Q4 Feb/May/**Aug 18**	Kevin Snee	8-Aug-18			29-Aug-18
HR - KPIs Q4 Apr-Jun 18 (advised board Dec17 - Revised report format after June 2017)	Kate Coley				29-Aug-18
MoH HBDHB Quarterly Performance Monitoring Dashboard Q3	Kevin Snee				29-Aug-18
Whole of Board Appraisal (progress against actions Nov 17) - Apr-**Aug**	Ken Foote				29-Aug-18
Finance Report(July)	ED Fin Services				29-Aug-18
26-Sep-18	**EMT Member**	**MRB Meeting Date**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**BOARD Meeting date**
Annual Plan 2018/19 - approved Minister timing open	Chris Ash	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-18
Heatlh Equity Report	Sharon Mason	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-18
Annual Report 2017/18 Final - issue to whom/when to be confirmed	ED Fin Services				26-Sep-18
Health and Safety: Asbestos & Hazardous Management Plans Presentation EMT FRAC for informa	Sharon Mason				26-Sep-18
Establishing Health and Social Care Localities in HB (Mar 18,**Sept)** - update on activity planned Boar	Chris Ash	12-Sep-18	12-Sep-18	12-Sep-18	26-Sep-18
Te Ara Whakawaiora - Breastfeeding (National Indicator)	Kevin Snee	12-Sep-18	12-Sep-18	13-Sep-18	26-Sep-18
Finance Report (Aug)	ED Fin Services				26-Sep-18
31-Oct-18	**EMT Member**	**MRB Meeting Date**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**BOARD Meeting date**
Te Ara Whakawaiora - Alcohol and other Drugs (National and Local Indicators)	Kevin Snee	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
Te Ara Whakawaiora - Cardiovascular (National Indicator)	Kevin Snee	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
Te Ara Whakawaiora - Did not Attend (local Indicator)	Kevin Snee	10-Oct-18	10-Oct-18	11-Oct-18	31-Oct-18
Finance Report (Sept)	ED Fin Services				31-Oct-18
28-Nov-18	**EMT Member**	**MRB Meeting Date**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**BOARD Meeting date**
Best Start Healthy Eating & Activity Plan update (for information - 6 mthly Nov-May-**Nov18**)	Kevin Snee		14-Nov-18	15-Nov-18	28-Nov-18
Te Ara Whakawaiora "Smokefree update" (6 monthly May-**Nov**) each year Board action Nov 17	Kevin Snee	14-Nov-18	14-Nov-18	15-Nov-18	28-Nov-18
Finance Report (Oct)	ED Fin Services				28-Nov-18
Hawke's Bay District Health Board (HBDHB) Non-Financial Performance Framework Dashboard Q1	Kevin Snee				28-Nov-18
HBDHB Performance Framework Exceptions Q1 **Nov 18** Feb 19 /May/Aug 19	Kevin Snee	14-Nov-18			28-Nov-18
HR - KPIs Q1 Jul-Sept 18	Kate Coley				28-Nov-18
MoH HBDHB Quarterly Performance Monitoring Dashboard Q4	Kevin Snee				28-Nov-18
19-Dec-18	**EMT Member**	**MRB Meeting Date**	**Clinical Council Meeting Date**	**Consumer Council Meeting Date**	**BOARD Meeting date**
People Plan Business Case update (6 monthly - Dec, Jun)	Kate Coley	5-Dec-18	5-Dec-18	6-Dec-18	19-Dec-18
Urgent Care Service Update (6 monthly June **Dec 18**) paper or **presentation** TBC	Wayne Woolrich		5-Dec-18	6-Dec-18	19-Dec-18
Finance Report (Nov)	ED Fin Services				19-Dec-18

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** 54
	For the attention of: **HBDHB Board**
Document Owner:	Kevin Snee, Chief Executive Officer
Reviewed by:	Not applicable
Month as at	21 May 2018
Consideration:	For Information

8

RECOMMENDATION

That the Board

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

INTRODUCTION

The pressure has lessened on the health system in part as a consequence of the good work done in Fit for Winter across primary and secondary care. This has been reflected in an improvement in the Shorter Stays in Emergency Departments (ED 6) performance and in the hospital being freed up from the gridlock that it was in a few months back. This improvement has continued into May when the whole system feels back under control having struggled over a prolonged period of time.

This month has a distinctly public health and primary care feel to it with the primary care development partnership, bowel screening, alcohol in schools, Kaupapa Māori maternal health, healthy eating and activity and collaborative pathways on the agenda.

At the time of writing we are reviewing the budget settlement for the following financial year and will be able to update the Board on what the implications are for next year.

For the Board's information I have also included a review and update on the programme of activities related to the Big Listen (appendix 1).

PERFORMANCE

Measure / Indicator	Target	Month of April	Qtr to end April	Trend For Qtr
Shorter stays in ED	≥95%	91.4%	91.4%	▲
Improved access to Elective Surgery (2017/18YTD)	100%	-	94.8%	▼

Waiting list	*Less than 3 months*	*3-4 months*	*4+ months*
First Specialist Assessments (ESPI-2)	3,566	555	146
Patients given commitment to treat, but not yet treated (ESPI-5)	1,274	255	130

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*	≥90%	92.9% (Mar 2017)	91.0% (6m to Mar 2017)	▲

Measure / Indicator	Target	Month of April	Qtr to end April	Trend For Qtr
due to Clinical Decision or Patient Choice are now excluded).				
Increased immunisation at 8 months (3 months to end of January)	≥95%	---	92%	▼
Better help for smokers to quit – Primary Care	≥90%	88.2% (15m to April)	---	▼
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%	---	75%	
Raising healthy kids (New)	≥95%	---	100% (6m to April)	▬
Financial – month (in thousands of dollars)	(369)	(1,342)	---	---
Financial – year to date (in thousands of dollars)	(2,481)	(5,489)	---	---

***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%	*20/19 = 105%%*	*89/114 = 78.1%*

The key issue of concern is elective activity which is significantly below plan. The ED6 performance, whilst it is below target, is improving and I expect it to continue to improve in May.

We continue to perform well in Raising Healthy Kids and Faster Cancer Treatment, whilst Immunisation has reduced slightly I would expect this to improve as we progress through the year.

The year-to-date result to the end of April is $3.0 million unfavourable to plan, with April $973k unfavourable.

PRIMARY CARE DEVELOPMENT PARTNERSHIP GOVERNANCE

A proposal has been generated, following discussion between the Chairs of the DHB and Health Hawke's Bay, for establishment of the governance arrangements that will give life to the Primary Care Development Partnership. Strengthened alliance working is one of the priorities outlined in this year's Ministerial Letter of Expectations. More importantly, the new arrangements will support delivery of one of the system's main stated priorities - the development of more responsive, wellness - focussed, culturally appropriate primary healthcare. The proposals build on a strong track record of innovation in Hawke's Bay, and on the strong bilateral relationship between a coterminous DHB and PHO. If supported, they will enable the Primary Care Development Partnership to operate in shadow form from July 2018.

NATIONAL BOWEL SCREENING ROLL-OUT

Work is well underway in preparation for the go-live of the National Bowel Screening Programme in Hawke's Bay in October this year, and an update on the project to ensure delivery is included on this month's agenda. The paper, and accompanying presentation, gives a flavour of the areas that are being prioritised to make a success of this new, life-saving service.

THE PLACE OF ALCOHOL IN SCHOOLS – YOUNG PEOPLE AND UNDER-AGE EXPOSURE

We are seeking the Board's endorsement of the position that 'alcohol and schools do not mix'. The paper and attached report provides a summary on alcohol use at school events attended by children. The report also provides evidence to support the position that schools' implicit or explicit support for and parental modelling of drinking at school fundraising events has a negative impact on youth drinking. Consistent with the DHB's position on reducing alcohol-related harm (signed by the Board in 2016), the DHB can show leadership by taking a strong position against the 'normalising' of alcohol use at events held on school grounds where children and young people are present. This supports our vision of 'healthy communities, family and whanau living free from alcohol-related harm and inequity.'

The report seeks to increase the number of alcohol-free settings, reduce under-age exposure to alcohol consumption and shift attitudes towards alcohol in the wider population.

The report will be circulated to school boards, trustees and other relevant parties to inform school alcohol policy development and decisions about the use of alcohol at school events. The report will be accompanied by an alcohol-free fundraising resource.

KAUPAPA MĀORI MATERNAL HEALTH PROGRAMME

HBDHB is proposing to develop a Kaupapa Māori Maternal Health programme. Led by a partnership approach between Maternity, Population Health, and Māori Health, the intent of the programme is to overcome barriers to access to maternal and child health care, and improve maternal and child health outcomes. The programme will be responsive, accessible, and culturally appropriate to meet the needs of Māori women and their whānau. Fundamental to the development of the programme and its overall success will be the integrated, and collaborative approach, between HBDHB, providers, and communities. The project is currently in the conceptual stage and is being led by a steering group with expertise and experience in maternal and child health, Māori approaches to health and service delivery, and equity.

COLLABORATIVE PATHWAYS UPDATE

A checkpoint review of the Collaborative Pathways programme is included in this month's papers. Pathways are a critical building block of an integrated health system, and an opportunity to review the Hawke's Bay approach has been generated by the withdrawal of the existing software supplier from the New Zealand market. The paper sets out options that are being actively progressed with the support of Clinical Council. The anticipated outcome will be a dynamic pathways solution, capable of integration with primary and secondary care information systems.

CLINICAL SERVICES PLAN

It has previously been agreed that consultation/engagement on the draft Clinical Services Plan (CSP) will take place during August and early September 2018. The CSP project team is currently developing a plan for this.

The attached report is seeking advice on who we should be consulting with and the best way to do it. The project team wants to make sure that this consultation/engagement process goes well, by engaging with the right groups and people, in the right place and in the right way, to gain feedback, understanding and acceptance.

BEST START HEALTHY EATING AND ACTIVITY PLAN

The Best Start Plan continues to make progress, with Councils and employers incorporating healthy eating in their settings and work happening with key community partners to deliver more programmes that support healthy weight. New resources have been developed to support whānau to implement healthy lifestyles including an updated Healthy Conversation Tool for Before School Check nurses and portion plate to reinforce healthy eating in the home. Work has been completed to identify a new measurement point for child weight, which will allow us to measure the impact of this Plan and other activity on a child's healthy weight. The small reduction in obese children at four years has been maintained and we hope the work to support an increase in breastfeeding and support for healthy weight environments in early childhood education services will see further reductions.

TE ARA WHAKAWAIORA – IMPROVING FIRST SPECIALIST ASSESSMENT ACCESS

The Te Ara Whakawaiora – Improving First Specialist Assessment (FSA) access indicator reported this month, was formerly referred to as "Did not attend" (DNA). The change of language signals the change of approach supported from the recommendations of the DNA project that was undertaken back in 2014. Strengthening the partnership approach across the health system has enhanced systems and process that support consumer access to our services. This has included the collaborative work of the Administration team and the Kaitakawaenga from Māori Health. The results are positive, with Access to First Specialist Assessment continuing to improve. This includes seeing the DNA rate for the total population tracking under the target DNA rate of 7.5 percent. Although the rates for Māori and Pacific are improving, there are still persistent disparities for these groups to be addressed. The report provides a pathway forward to improve on the gains already made.

HUMAN RESOURCES KEY PERFORMANCE INDICATORS

Slow progress being made on the Māori representation target for 2017/18 of 15.68 percent, with 14.68 percent of employees identifying as Māori at 31 March 2018. The gap to our target sits at 29 people. Comparisons to 20 DHBs, mid-sized DHBs and Central Region DHBs are favourable. Staff turnover is within the 10.0 percent annual target, with 9.18 percent in the last 12 months. Annual leave balances 2+ years are slightly higher than last year's level but we rank well against other DHBs. Sick leave is slightly higher than last year but we rank second best of the mid-sized DHBs and sixth best of the 20 DHBs.

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

We continue to be above target for Raising Healthy Kids performance, two year olds fully immunised and Faster Cancer Treatment. The number of pre-school children enrolled in DHB funded Oral Health Services was favourable for all ethnicities. However, we still have challenges meeting the Shorter Stays in Emergency Department where 89 percent of patients are admitted, transferred or discharged within six hours against a target of 95 percent.

The number of high risk patients who receive an angiogram within three days of admission decreased this quarter and is unfavourable at 55 percent with the target being 70 percent. The health target Improved Access to Elective Surgery is below target this quarter and currently sits at 96.4 percent.

CONCLUSION

The health system pressure has abated in April and I expect to see some improvement in key indicators as a consequence in May. We continue to progress our primary care and public health programmes and we are also make solid progress in developing our Clinical Services Plan.

Appendix 1

The Big Listen & The People Plan – An update

Purpose

To ensure the Board is fully informed and aware of the activities undertaken in regards to The Big Listen and the next steps in relation to developing the People Plan.

Background

In 2016 the DHB undertook a review of the Transform & Sustain programme of work and identified two core enabler programmes relating to investing in our people and the building of a new culture.

The start of that journey saw the sector participate in the Big Listen. The priority was to understand what it was like to work in the Hawke's Bay health system. At the same time we asked our consumers about their experience of being cared for by the district health board. Further feedback was also gathered through the Clinical Services Plan patient journey workshops and engagement with our Māori community through Korero Mai. This feedback has formed the foundation for the development of the People Plan.

The work done locally is in alignment with the NZ Health Strategy. One of the key areas relates to "One Team" (Kotahi te tima,) which prioritises the investment in the capability and capacity of the workforce, as does the recent Minister of Health's Letter of Expectation which outlines that *"DHBs need to be bold in their vision for change while remaining responsive to the concerns raised by the workforce".*

There is an overwhelming body of research and evidence to show that engaged staff deliver better health care. Those organisations with higher staff engagement tend to have lower patient mortality, make better use of resources and deliver stronger financial performance. [1]

Over the past few years the DHB has performed well against financial and MOH Health targets, has been able to invest in new technology and infrastructure alongside implementing a series of innovative models of care changes which are having positive impacts for our community. It is clear to ensure we sustain this performance we need to look after, invest and develop our people. Our aim is to have workforce that is engaged, motivated, highly skilled and supported to provide the best possible services that meet the needs of our community.

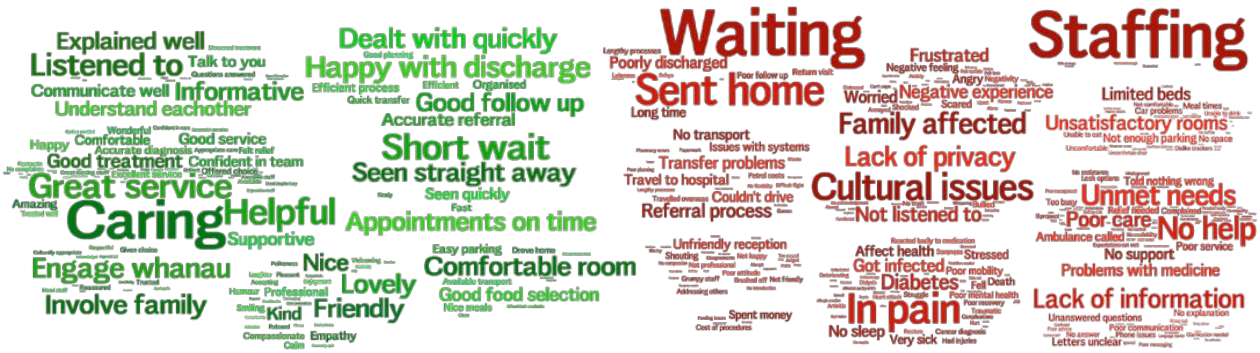
As a Board and EMT we committed to undertaking The Big Listen, hearing and understanding the challenges and personally making changes to live our values. Given our staff are expecting change the impact on not following through on this commitment would be significantly detrimental. The Big Listen identified staff believe the DHB has previously undertaken engagement surveys and little change has been implemented. The key is personally and organisationally making visible and tangible changes that directly link back to the feedback – the concept of You Said, We Did.

Our people are our biggest and most costly asset, - without them we will be unable to achieve our ambitions for the sector. The People Plan is about making sure our people are well supported, cared for and led, have the capability and resilience to cope with the challenges ahead so that they are able to deliver their best for our community.

[1] West & Dawson (2012)

What did the Big Listen Tell Us?

The Big Listen feedback identified a number of key priorities including the explicit need to live our values to ensure that we create a culture that is supportive, kind and caring to both our staff and consumers. A key part of that change will be our commitment to change and live our values.



The Clinical Services plan identified a number of issues relating to the workforce as follows:

- Lack of Capacity - People across the system are feeling strained - increasingly at risk of burn out
- Ageing workforce
- Need for greater flexibility in regards to working conditions in Primary Care
- Lack of allied health staff
- Recruitment challenges for Medical staff in primary and secondary care
- Lack of succession planning processes
- Funding Model in primary care prevents innovation
- Workforce not always working at top of scope or in their given roles due to resources
- Lack of overarching workforce development plan

Overarching themes from the Feedback

- Appreciating our staff
- Lack of Capacity - Workload and resourcing challenges
- Bullying – Issues with behaviours at all levels and people not always demonstrating and living our values –
- Behaviours impacting consumers
- Leadership and capability development
- Wellbeing
- Removing and reducing barriers

Timeline of activities / initiatives implemented since November

Month	Activities / initiatives & actions undertaken
November	• Co-Create workshops (around 150 attendees) • Launch of final results from Big Listen • Launch of new Behaviours Framework (Appendix 1)
December	• Identification and agreement of funding for quick wins from February to end June inclusive • Presentation to Board on findings and next steps
January	• Communications on Our Hub to staff – re wellbeing quick wins – Self Care in Health Care programme, continuance of free 15 minute massages, Body Balance programme subsidised, reminder re all other well-being opportunities.
February	• Co-create workshops with staff focusing on Bullying, Orientation, Performance Appraisal's and Recruitment (around 200 attendees)
March	• Ongoing wellbeing programme • Emails to all attendees at co-create workshops thanking them for participation • Ice blocks for all staff to support them coping with the summer heat • Ongoing communications re Big Listen/People Plan through Our Hub, InFocus
April	• People Plan framework shared with all governance groups/unions and leaders • People Plan framework shared with Board • Boot Camps at Swim Gym established for lunchtime sessions ($5) • Flu vaccinations launch • Health & Safety strategy endorsed by Board • Maori & Pacific Workforce Action plans endorsed • Wellbeing Steering Group established – cross professional working group to develop wellbeing framework and actions and initiatives for next five years • Ongoing communications re Big Listen/People though Our Hub and InFocus
May	• Ongoing push for Flu vaccinations, what's going on with the feedback from The Big Listen and Co-create workshops, what's coming next on Our Hub. • Development of online E-learning to use BUILD & ABC tools • Development of People Plan and business case for endorsement by EMT • Workshop with Hiring Managers to test values based recruitment information • Refreshing the Consumer Engagement strategy (Post MRB Workshop) (formally endorsed by Consumer Council in May 2018) and developing the Recognising Consumer Participation Policy for endorsement in June/July. • Development of toolkits around DHB approach to Bullying • Review of Values Based Recruitment outputs from workshops
June	• Tim Keogh – Training hiring managers around Values Based Recruitment, • Train the trainer VBR, Workshop to test DHBs approach to bullying, resources, processes and toolkits • People Plan development and feedback/input sought from all governance groups • People Plan shared with staff and unions for feedback • Continue to promote all Well-Being activities – Self Care in Health Care programme, free 15 minute massages, push Boot Camp training at lunchtimes, body balance, ergonomic assessments, paid massages within Occ Health, flu vaccinations • Source "staff support winter hampers" to be implemented throughout July, August and into September • Development of a Communication strategy to support launch and ongoing communication of the People Plan activities etc.
July	• "Launch" of People Plan – Timing TBC • Begin rollout of E-Learning BUILD Module to all staff • Test Values Based recruitment process with two new Executive Director interviews. • Launch new approach to dealing with Bullying & Unacceptable behaviours

It should be noted that all of the activities relating to well-being including free massages, ice blocks, self-care in health care workshops, Occ Health Massages and Boot Camps have been very positively received.

People Plan Development

Last month the draft people framework was presented and feedback sought from governance groups. Significant changes have been made to ensure that our values are at the core of our culture, to simplify the language and streamline the key intentions and commitments to our staff. The People Plan sets out a five year plan for the investment and development of our people.

The overarching aim of the People plan is to "Grow our People by Living our Values", thereby our staff feel trusted, valued, engaged and are skilled and well supported.

There are a number of key deliverables of the People Plan including,

- Increasing staff engagement
- Embedding and living our values
- Creating a great place to work – ensuring more Good Days
- Building our culture
- Ensure better patient outcomes – person and whanau centred care
- Enabling significant behavioural change in the organisation
- Increasing the diversity of our workforce

The below picture shows the new People Plan framework which has our values at the centre of the culture that we are trying to build. There will be a number of pieces of work that will sit within each of the values to support their embedding. For example – under Tauwhiro will be all the work around Well Being and Health & Safety. The detail of the People Plan is currently being developed and will be shared with all governance groups prior to the Board endorsement in June.

There will be a number of measures and KPIs to measure both the progress on the implementation of the People Plan and also the impact the initiatives have on key outcome measures. The KPIs will be developed once the People Plan year one priorities have been endorsed and these will be devolved to managers and leaders across the organisation. Key indicators will be reported on a quarterly basis, with a six month progress report being shared with all governance groups and staff.

Key outcome measures which will be measured annually through the engagement surveys and potentially six monthly through interim "pulse" surveys will focus on the following:

- improvement in staff engagement – improve performance in response to "I would recommend this place as a great place to work",
- Improved positive response from our Consumers in regards to them also recommending this as a place for family and friends to receive care;
- Reduction in staff stating that their health & wellbeing has been affected by their work
- Increased number of staff feeling comfortable to speak up about unacceptable behaviour
- Reduction in those who say they have felt bullied in the last six months

The People Plan will be "launched" early in the new financial year, however timing of this will be key to its success. A full communications plan will be developed during June to ensure that the launch is positively received, that there are some very visible and tangible changes made and communicated within the first three months and that ongoing there are regular

updates provided to staff (through multiple mechanisms) and to governance groups around progress that is being made and linking directly back to feedback from the Big Listen. It is acknowledged that whilst there has been a significant amount of work being undertaken perhaps in the background that we have potentially not done sufficient internal communication with all of our teams, however this will be resolved with the development of the communications plan.

The implementation of the People Plan is one of the priorities for the DHB in the coming years as this will be a key enabler to helping us as a DHB and the wider sector achieve our ambitions and the vision for the sector.

Growing Our People By Living Our Values

He tāngata, he tāngata, he tāngata.

OURHEALTH HAWKE'S BAY

OUR PEOPLE
He tāngata. He tāngata. He tāngata.

HE KAUANUANU
RESPECT

Showing ***respect*** for each other, our staff, patients and consumers.

ĀKINA
IMPROVEMENT

Continuous ***improvement*** in everything we do.

RARANGA TE TIRA
PARTNERSHIP

Working together in ***partnership*** across the community.

TAUWHIRO
CARE

Delivering high quality ***care*** to patients and consumers.

Appendix 1 – Behaviours Framework (Developed through The Big Listen)

Our shared values and behaviours

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGA TE TIRA PARTNERSHIP
TAUWHIRO CARE

HE KAUANUANU RESPECT
*Showing **respect** for each other, our staff, patients and consumers*

	✓	✗
Welcoming	Is polite, welcoming, friendly, smiles, introduce self Acknowledges people, makes eye contact, smiles	Is closed, cold, makes people feel a nuisance Ignore people, doesn't look up, rolls their eyes
Respectful	Values people as individuals; is culturally aware / safe Respects and protects privacy and dignity	Lacks respect or discriminates against people Lacks privacy, gossips, talks behind other people's backs
Kind	Shows kindness, empathy and compassion for others Enhances peoples mana	Is rude, aggressive, shouts, snaps, intimidates, bullies Is abrupt, belittling, or creates stress and anxiety
Helpful	Attentive to people's needs, will go the extra mile Reliable, keeps their promises; advocates for others	Unhelpful, begrudging, lazy, 'not my job' attitude Doesn't keep promises, unresponsive

ĀKINA IMPROVEMENT
*Continuous **improvement** in everything we do*

	✓	✗
Positive	Has a positive attitude, optimistic, happy Encourages and enables others; looks for solutions	Grumpy, moaning, moody, has a negative attitude Complains but doesn't act to change things
Learning	Always learning and developing themselves or others Seeks out training and development; 'growth mindset'	Not interested in learning or development; apathy "Fixed mindset, 'that's just how I am', OK with just OK
Innovating	Always looking for better ways to do things Is curious and courageous, embracing change	Resistant to change, new ideas; 'we've always done it this way'; looks for reasons why things can't be done
Appreciative	Shares and celebrates success and achievements Says 'thank you', recognises people's contributions	Nit picks, criticises, undermines or passes blame Makes people feel undervalued or inadequate

RARANGA TE TIRA PARTNERSHIP
*Working together in **partnership** across the community*

	✓	✗
Listens	Listens to people, hears and values their views Takes time to answer questions and to clarify	'Tells', dictates to others and dismisses their views Judgmental, assumes, ignores people's views
Communicates	Explains clearly in ways people can understand Shares information, is open, honest and transparent	Uses language / jargon people don't understand Leaves people in the dark
Involves	Involves colleagues, partners, patients and whanau Trusts people; helps people play an active part	Excludes people, withholds info, micromanages Makes people feel excluded or isolated
Connects	Pro-actively joins up services, teams, communities Builds understanding and teamwork	Promotes or maintains silo-working 'Us and them' attitude, shows favouritism

TAUWHIRO CARE
*Delivering high quality **care** to patients and consumers*

	✓	✗
Professional	Calm, patient, reassuring, makes people feel safe Has high standards, takes responsibility, is accountable	Rushes, 'too busy', looks / sounds unprofessional Unrealistic expectations, takes on too much
Safe	Consistently follows agreed safe practice Knows the safest care is supporting people to stay well	Inconsistent practice, slow to follow latest evidence Not thinking about health of our whole community
Efficient	Makes best use of resources and time Respects the value of other people's time, prompt	Not interested in effective user of resources Keeps people waiting unnecessarily, often late
Speaks up	Seeks out, welcomes and give feedback to others Speaks up whenever they have a concern	Rejects feedback from others, give a 'telling off' 'Walks past' safety concerns or poor behaviour

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report April 2018** 55
	For the attention of: **HBDHB Board and the Finance Risk and Audit Committee**
Document Owner	Tim Evans, Executive Director Corporate Services
Document Author(s)	Phil Lomax, Financial and Systems Accountant
Reviewed by	Executive Management Team
Month/Year	May, 2018
Purpose	For Information

RECOMMENDATION:

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

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

1. EXECUTIVE DIRECTOR CORPORATE SERVICES' COMMENTS

Financial Performance

The year-to-date result to the end of April is $3.0 million unfavourable to plan, with April $973 thousand unfavourable. The unfavourable variance for the month is mainly driven by the greater than planned use of nursing resources to cope with the high acuity and high volumes of patients.

Acute volumes and the slow down in outsourcing reduced elective surgery in April to 78% of planned volumes, with significant reductions in outsourced (6% of plan) and Inter District Flow outflow volumes (43% of plan). On a year-to-date basis, elective surgery is at 94.8% of planned volumes, down from 96.7% to the end of March.

Forecast

The forecast has changed only marginally from March, and remains at a $3.2 million deficit that is $4.7 million adverse to the planned $1.5 million surplus. Higher forecast nursing costs are offset by improved PHARMAC projections and lower than expected corporate costs.

Risks and mitigations to the forecast include:

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

2. RESOURCE OVERVIEW

	April				Year to Date				Year End Forecast	Refer Section
	Actual	Budget	Variance		Actual	Budget	Variance			
	$'000	$'000	$'000	%	$'000	$'000	$'000	%	$'000	
Net Result - surplus/(deficit)	(1,342)	(369)	(973)	-263.7%	(5,489)	(2,481)	(3,008)	-121.2%	(3,237)	3
Contingency utilised	890	250	(640)	-256.0%	2,055	2,500	445	17.8%	3,000	8
Quality and financial improvement	1,431	1,322	109	8.2%	5,908	8,430	(2,522)	-29.9%	7,293	11
Capital spend	2,133	1,993	140	7.0%	13,932	19,925	(5,993)	-30.1%	20,010	16
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,465	2,305	(159)	-6.9%	2,320	2,333	13	0.6%	2,326	5 & 7
	CWD	CWD	CWD	%	CWD	CWD	CWD	%	CWD	
Case weighted discharges	2,374	2,148	225	10.5%	24,468	23,540	928	3.9%	28,386	5

Contingency was utilised this month for meeting elective surgery targets and Care Capacity Demand Management (CCDM). The remaining contingency for the months of March and April were also released. This leaves $945 thousand unreleased year-to-date.

99.8% of the Quality and Financial Improvement (QFI) required savings have a plan. 70% of expected savings have been achieved April year-to-date, in comparison to the 63% achieved in March (this differs from the percentage reported last month - see section 11). Achievement against urgent care, residential care and Enliven savings plans are the reason for the improvement.

The capital expenditure plan was phased evenly across the year, as detailed project planning was not complete at the time the budget was set. The under-spend to April reflects this uncertainty in the timing of payments for building projects that make up the bulk of the underspend. Information technology has similar issues relating to the integrated communication environment (ICE) and mobility projects.

High acute demand has required 152 FTEs of additional personnel resources (more hours worked by existing staff rather than extra employees) in April, mostly in nursing, as pressure across the Emergency Department (ED), Intensive Care (ICU), and the wards required increases in staffing rosters. Year-to-date continuing allied health vacancies and medical and senior nursing vacancies earlier in the year offset the effect of high volumes over the last few months.

April experienced high case weighted discharges, with the reduction in elective volumes being more than offset by an increase in patient acuity and acute demand.

3. FINANCIAL PERFORMANCE SUMMARY

	April				Year to Date				Year End Forecast	Refer Section
$'000	Actual	Budget	Variance		Actual	Budget	Variance			
Income	44,936	45,125	(189)	-0.4%	458,887	458,883	4	0.0%	555,256	4
Less:										
Providing Health Services	22,510	21,046	(1,464)	-7.0%	224,150	218,939	(5,211)	-2.4%	269,328	5
Funding Other Providers	19,666	20,050	384	1.9%	198,668	199,318	650	0.3%	240,175	6
Corporate Services	4,100	4,097	(2)	-0.1%	39,984	39,711	(273)	-0.7%	48,137	7
Reserves	1	301	299	99.5%	1,574	3,397	1,823	53.7%	852	8
	(1,342)	**(369)**	**(973)**	**-263.7%**	**(5,489)**	**(2,481)**	**(3,008)**	**-121.2%**	**(3,237)**	

Income

The April reduction in income relates to pay equity and is fully offset by a decrease in expenditure under Funding Other Providers. Year-to-date the effect of pay equity is offset by Wairoa GP revenue, clinical trial and special fund revenue, income from other DHBs for IDFs and patient transport.

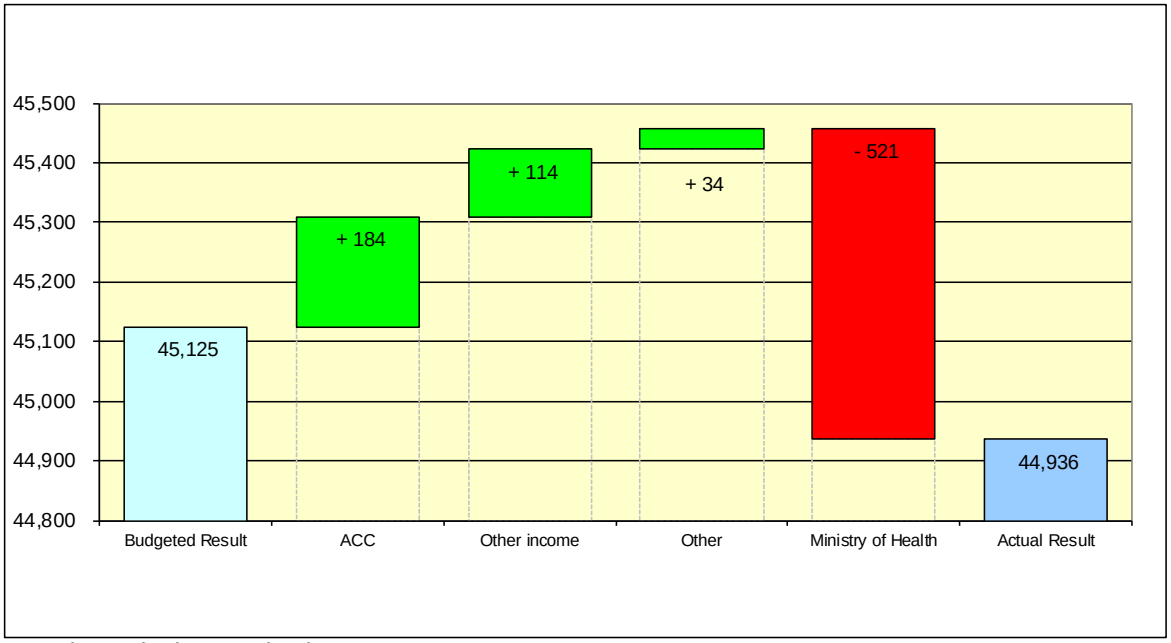
Providing Health Services
High acuity and volumes driving nursing and clinical supply costs, and undelivered savings were the main contributers to the result.

Funding Other Providers
Reduced pay equity costs and higher PHARMAC rebates are being offset by higher IDF outflows.

4. INCOME

$'000	April				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Ministry of Health	42,533	43,054	(521)	-1.2%	437,320	438,283	(962)	-0.2%	529,753
Inter District Flows	717	693	24	3.5%	7,132	6,928	203	2.9%	8,472
Other District Health Boards	382	333	49	14.7%	3,652	3,329	323	9.7%	4,324
Financing	60	74	(14)	-18.8%	684	737	(54)	-7.3%	811
ACC	600	415	184	44.4%	4,456	4,369	87	2.0%	5,192
Other Government	73	60	13	21.1%	540	370	170	45.9%	615
Patient and Consumer Sourced	78	129	(51)	-39.5%	927	1,148	(221)	-19.2%	1,128
Other Income	480	367	114	31.0%	4,152	3,653	499	13.7%	4,935
Abnormals	14	0	14	7374.1%	25	67	(42)	-63.0%	25
	44,936	**45,125**	(189)	-0.4%	**458,887**	**458,883**	4	0.0%	**555,256**

Month of April



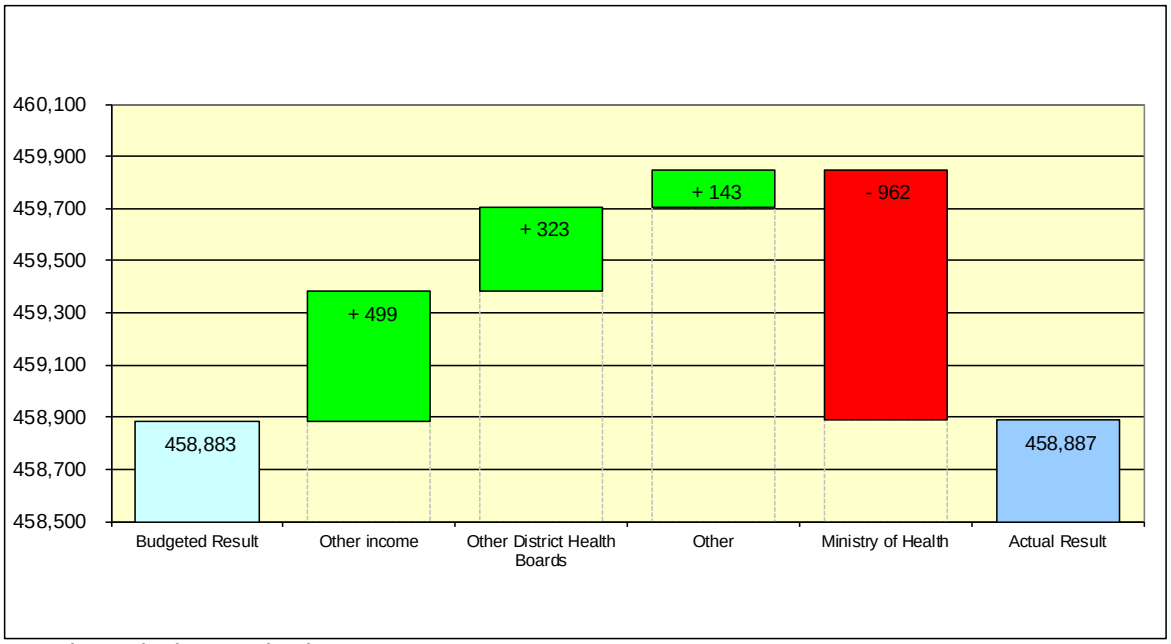
Note the scale does not begin at zero

ACC (favourable)
Rehabilitation services for ACC offsetting reduced ACC surgery to support elective health targets.

Other income (favourable)
Income into the GP Health Centre in Wairoa, clinical trial revenue, and donations.

Ministry of Health (unfavourable)
Reduction in expected reimbursement for pay equity. Offset by a reduction in the expected pay equity costs (see section 6).

Year to Date



Note the scale does not begin at zero

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

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

Ministry of Health (unfavourable)
Reduction in expected reimbursement for pay equity. Offset by a reduction in the expected pay equity costs (see section 6).

5. PROVIDING HEALTH SERVICES

	April				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure by type $'000									
Medical personnel and locums	5,015	4,745	(270)	-5.7%	51,923	52,166	243	0.5%	62,049
Nursing personnel	6,993	6,224	(769)	-12.3%	64,427	63,563	(864)	-1.4%	77,407
Allied health personnel	2,982	2,986	4	0.1%	28,259	30,318	2,060	6.8%	34,128
Other personnel	1,910	1,931	22	1.1%	19,668	19,775	107	0.5%	23,825
Outsourced services	598	646	48	7.4%	9,022	6,687	(2,334)	-34.9%	10,271
Clinical supplies	3,309	2,761	(548)	-19.9%	33,454	29,088	(4,365)	-15.0%	40,663
Infrastructure and non clinical	1,703	1,753	50	2.8%	17,398	17,340	(57)	-0.3%	20,927
	22,510	**21,046**	**(1,464)**	**-7.0%**	**224,150**	**218,939**	**(5,211)**	**-2.4%**	**269,270**
Expenditure by directorate $'000									
Medical	6,265	5,673	(592)	-10.4%	60,759	58,207	(2,552)	-4.4%	72,618
Surgical	4,836	4,405	(431)	-9.8%	50,663	47,109	(3,555)	-7.5%	60,739
Community, Women and Children	3,737	3,467	(271)	-7.8%	36,301	35,863	(438)	-1.2%	43,756
Older Persons, Options HB, Menta	2,959	2,785	(174)	-6.2%	28,807	29,133	326	1.1%	34,881
Operations	3,319	3,187	(132)	-4.1%	32,090	32,061	(29)	-0.1%	38,662
Other	1,394	1,528	134	8.8%	15,530	16,566	1,037	6.3%	18,613
	22,510	**21,046**	**(1,464)**	**-7.0%**	**224,150**	**218,939**	**(5,211)**	**-2.4%**	**269,270**
Full Time Equivalents									
Medical personnel	360.3	347.7	(13)	-3.6%	344	346	1	0.3%	345.2
Nursing personnel	1,033.6	901.8	(132)	-14.6%	949	925	(23)	-2.5%	922.3
Allied health personnel	483.4	476.7	(7)	-1.4%	456	480	24	5.1%	478.4
Support personnel	145.8	136.3	(9)	-6.9%	139	136	(2)	-1.6%	136.0
Management and administration	262.0	270.6	9	3.2%	268	273	5	1.9%	271.9
	2,285.2	**2,133.2**	**(152)**	**-7.1%**	**2,155**	**2,161**	**5**	**0.3%**	**2,153.9**
Case Weighted Discharges									
Acute	1,631	1,400	231	16.5%	16,833	16,028	805	5.0%	19,385
Elective	502	546	(44)	-8.0%	5,138	5,382	(244)	-4.5%	6,451
Maternity	193	160	33	20.6%	1,865	1,675	190	11.3%	2,000
IDF Inflows	47	42	5	11.6%	632	455	177	39.0%	550
	2,374	**2,148**	**225**	**10.5%**	**24,468**	**23,540**	**928**	**3.9%**	**28,386**

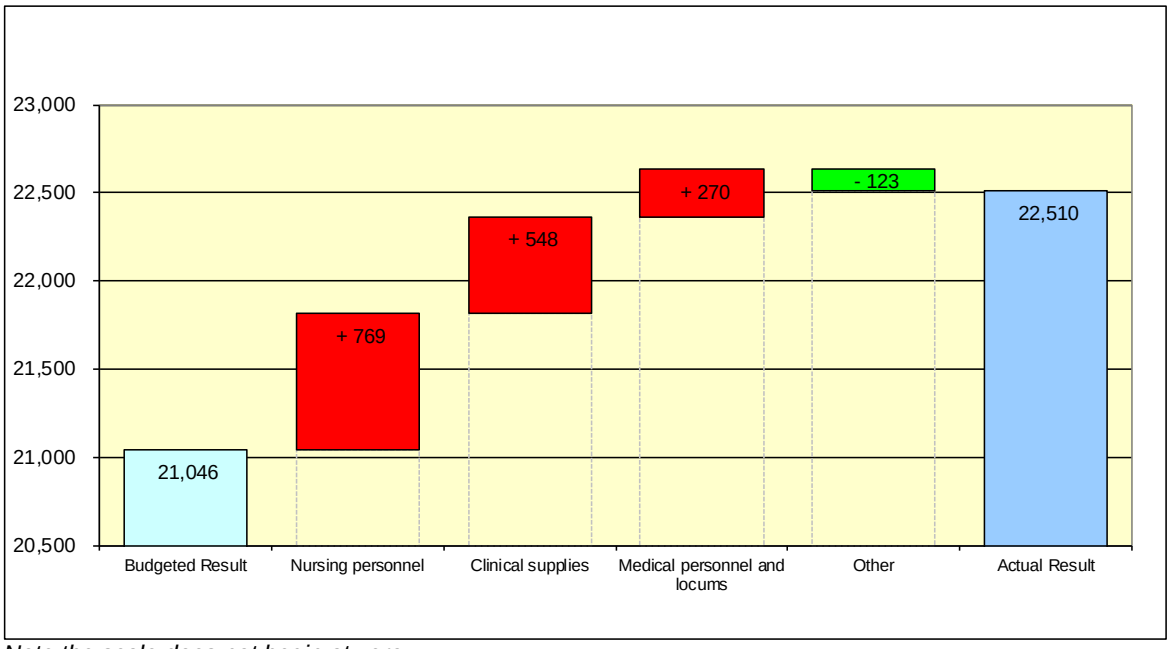
Directorates

- Surgical services – nursing and medical costs associated with Sunday acute lists, and theatre supplies driven by patient volumes. Year-to-date the result reflects the cost of attempting to meet elective surgery targets both internally and externally, and the difficulty completing efficiency plans while doing so. Note that $1.25 million of the favourable variance under reserves partly offsets surgical services unfavourable year-to-date variance.
- Medical – nursing costs reflecting high acuity and patient volumes were a major impact on the April result. Year-to-date nursing costs in April, unachieved efficiencies, outsourced radiology reads, medical leave and vacancy cover, and biologics (pharmaceuticals) all contribute to this adverse result.
- Community, Women & Children – April's adverse variance is due to high paediatric volumes and high acuity in maternity which has resulted in high nursing costs. Vacancies in medical, nursing and allied health, especially in to earlier part of the year, offset the year –to-date unidentified savings target.

Case Weighted Discharges(CWD)

Overall CWD was 4% above plan year-to-date, with high acute demand being offset by a reduction in electives. Medical, surgical, neonatal and paediatric acutes are all above plan, with neonates 24% over plan year-to-date. Elective surgery is at 95% of plan.

Month of April



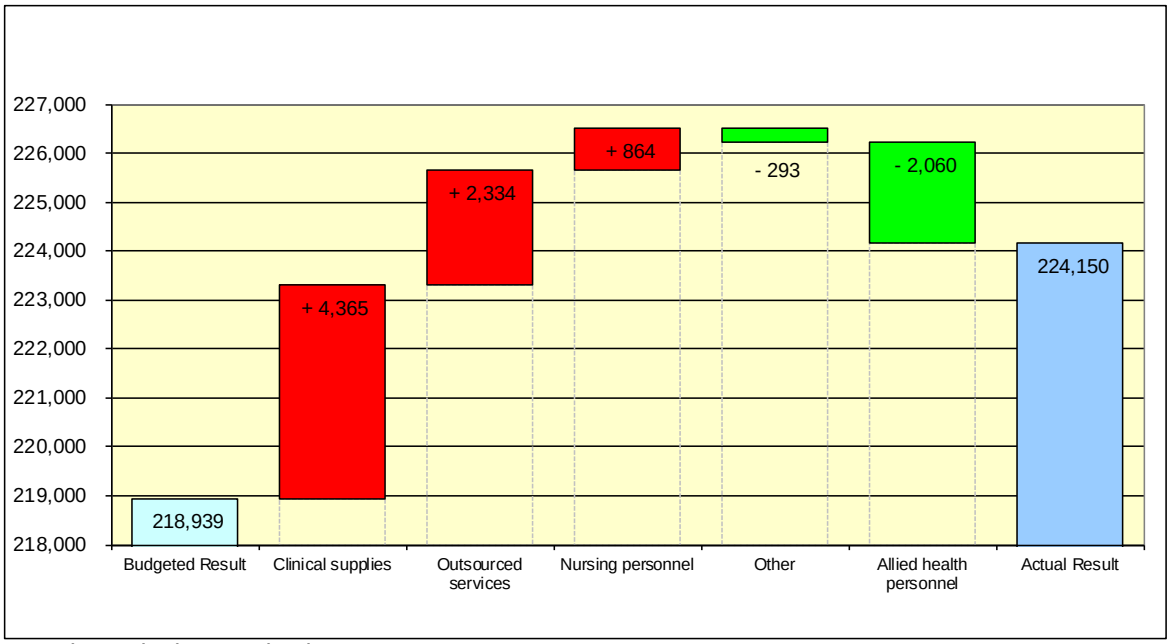
Note the scale does not begin at zero

Nursing Personnel (unfavourable)
Acute volumes, a high number of births, high cost tracheostomys and Sunday acute lists, are the main users of additional nursing resources.

Clinical Supplies (unfavourable)
Undelivered savings for targets not yet allocated to budgets is the bulk of the variance, with patient transport, and high use of renal fluids also contributing.

Medical Personnel and Locums (unfavourable)
Vacancy cover.

Year to Date



Note the scale does not begin at zero

Clinical Supplies (unfavourable)
Mainly undelivered savings for targets not yet allocated to budgets ($2.8 million). Most expense categories are unfavourable to budget driven by high patient volumes.

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

Nursing Personnel (unfavourable)
Mostly the high use of nursing resources in April to cope with volume pressure. Nursing personnel costs have been increasing throughout the year as senior nurse vacancies have been filled.

Allied Health Personnel (favourable)
Vacancies mainly in psychologists, MRTs, social workers, and laboratory technicians, and partly offset by physiotherapists.

Full Time Equivalents (FTE)

FTEs are 5 (0.3%) favourable year to date including:

Nursing Personnel (-23 FTE / -2.5% unfavourable)

- High patient acuity in April following higher patient volumes since before Christmas, are reflected in the unfavourable nursing FTE year-to-date position.

Allied Health Personnel (24 FTE / 5.1% favourable)

- Vacancies including psychologists, laboratory technicians, MRTs,and social workers.

Monthly Elective Health Target Report
Year to Date March 2018

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

		YTD April 2018			
		Actual	Plan	Var.	%Var.
On-Site	Avastins	151	151	0	0.00%
	ENT	343	382	-39	-10.20%
	General Surgery	579	636	-57	-9.00%
	Gynaecology	386	425	-39	-9.20%
	Maxillo-Facial	160	158	2	1.30%
	Ophthalmology	707	819	-112	-13.70%
	Orthopaedics	417	433	-16	-3.70%
	Orthopaedics - Major Joints	171	206	-35	-17.00%
	Skin Lesions	152	152	0	0.00%
	Urology	365	364	1	0.30%
	Vascular	86	136	-50	-36.80%
	Surgical - Arranged	444	408	36	8.80%
	Non Surgical - Arranged	60	10	50	500.00%
	Non Surgical - Elective	32	50	-18	-36.00%
On-Site	**Total**	**4053**	**4330**	**-277**	**-6.40%**
Outsourced	ENT	80	119	-39	-32.80%
	General Surgery	249	236	13	5.50%
	Gynaecology	21	0	21	0.00%
	Maxillo-Facial	40	73	-33	-45.20%
	Ophthalmology	153	90	63	70.00%
	Orthopaedics	1	0	1	0.00%
	Orthopaedics - Major Joints	88	68	20	29.40%
	Skin Lesions	2	0	2	0.00%
	Urology	40	42	-2	-4.80%
	Vascular	22	5	17	340.00%
Outsourced	**Total**	**696**	**633**	**63**	**10.00%**
IDF Outflow	Cardiothoracic	68	61	7	11.50%
	ENT	45	36	9	25.00%
	General Surgery	47	43	4	9.30%
	Gynaecology	20	22	-2	-9.10%
	Maxillo-Facial	99	156	-57	-36.50%
	Neurosurgery	43	68	-25	-36.80%
	Ophthalmology	29	31	-2	-6.50%
	Orthopaedics	34	16	18	112.50%
	Paediatric Surgery	56	68	-12	-17.60%
	Skin Lesions	34	42	-8	-19.00%
	Urology	11	6	5	83.30%
	Vascular	8	12	-4	-33.30%
	Surgical - Arranged	134	125	9	7.20%
	Non Surgical - Arranged	51	47	4	8.50%
	Non Surgical - Elective	87	97	-10	-10.30%
IDF Outflow	**Total**	**766**	**830**	**-64**	**-7.70%**
TOTAL		**5,946**	**6,271**	**-325**	**-5.20%**

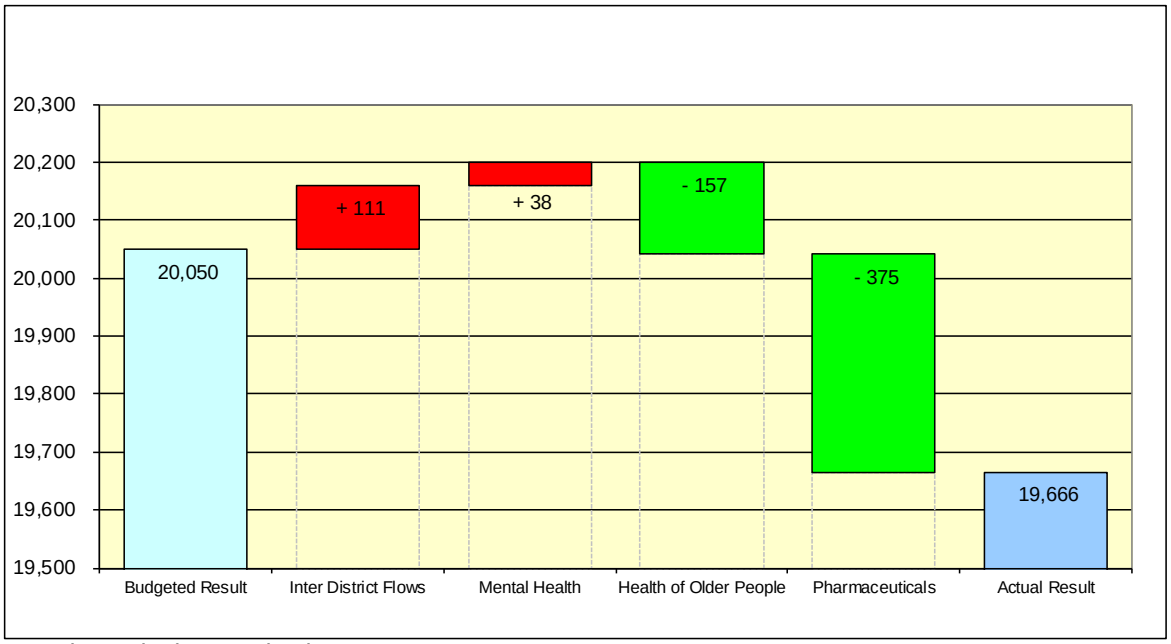
		April 2018			
		Actual	Plan	Var.	%Var.
On-Site	Avastins	17	17	0	0.00%
	ENT	46	41	5	12.20%
	General Surgery	68	71	-3	-4.20%
	Gynaecology	37	47	-10	-21.30%
	Maxillo-Facial	15	14	1	7.10%
	Ophthalmology	88	94	-6	-6.40%
	Orthopaedics	40	47	-7	-14.90%
	Orthopaedics - Major Joints	22	26	-4	-15.40%
	Skin Lesions	16	16	0	0.00%
	Urology	29	40	-11	-27.50%
	Vascular	10	14	-4	-28.60%
	Surgical - Arranged	54	44	10	22.70%
	Non Surgical - Arranged	6	1	5	500.00%
	Non Surgical - Elective	0	6	-6	-100.00%
On-Site	**Total**	**448**	**478**	**-30**	**-6.30%**
Outsourced	ENT	2	13	-11	-84.60%
	General Surgery	0	24	-24	-100.00%
	Gynaecology	0	0	0	0.00%
	Maxillo-Facial	0	10	-10	-100.00%
	Ophthalmology	0	7	-7	-100.00%
	Orthopaedics	0	0	0	0.00%
	Orthopaedics - Major Joints	1	4	-3	-75.00%
	Skin Lesions	0	0	0	0.00%
	Urology	1	4	-3	-75.00%
	Vascular	0	1	-1	-100.00%
Outsourced	**Total**	**4**	**63**	**-59**	**-93.70%**
IDF Outflow	Cardiothoracic	4	6	-2	-33.30%
	ENT	0	4	-4	-100.00%
	General Surgery	1	4	-3	-75.00%
	Gynaecology	1	2	-1	-50.00%
	Maxillo-Facial	4	16	-12	-75.00%
	Neurosurgery	4	7	-3	-42.90%
	Ophthalmology	2	2	0	0.00%
	Orthopaedics	1	2	-1	-50.00%
	Paediatric Surgery	2	7	-5	-71.40%
	Skin Lesions	2	5	-3	-60.00%
	Urology	1	1	0	0.00%
	Vascular	1	1	0	0.00%
	Surgical - Arranged	10	13	-3	-23.10%
	Non Surgical - Arranged	0	5	-5	-100.00%
	Non Surgical - Elective	4	12	-8	-66.70%
IDF Outflow	**Total**	**37**	**87**	**-50**	**-57.50%**
TOTAL		**489**	**628**	**-139**	**-22.10%**

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

6. FUNDING OTHER PROVIDERS

$'000	April Actual	April Budget	April Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Payments to Other Providers									
Pharmaceuticals	3,351	3,726	375	10.1%	36,046	37,319	1,273	3.4%	43,840
Primary Health Organisations	2,979	2,964	(15)	-0.5%	30,157	30,488	330	1.1%	36,180
Inter District Flows	4,329	4,219	(111)	-2.6%	45,315	42,920	(2,395)	-5.6%	55,112
Other Personal Health	2,228	2,240	12	0.5%	18,942	19,612	669	3.4%	23,314
Mental Health	969	931	(37)	-4.0%	9,806	9,368	(438)	-4.7%	11,673
Health of Older People	5,445	5,603	157	2.8%	55,021	56,033	1,012	1.8%	65,900
Other Funding Payments	365	367	2	0.6%	3,381	3,578	197	5.5%	4,156
	19,666	20,050	384	1.9%	**198,668**	**199,318**	650	0.3%	240,175
Payments by Portfolio									
Strategic Services									
Secondary Care	3,845	3,716	(129)	-3.5%	40,018	38,057	(1,961)	-5.2%	48,801
Primary Care	8,095	8,512	417	4.9%	81,237	83,249	2,012	2.4%	98,545
Chronic Disease Management	-	-	-	0.0%	-	-	-	0.0%	-
Mental Health	1,219	1,237	19	1.5%	12,574	12,492	(82)	-0.7%	15,080
Health of Older People	5,806	5,914	109	1.8%	58,520	58,934	415	0.7%	70,053
Other Health Funding	-	33	33	100.0%	-	333	333	100.0%	-
Maori Health	521	514	(7)	-1.4%	5,129	5,021	(108)	-2.2%	6,261
Population Health	180	122	(58)	-47.1%	1,191	1,231	41	3.3%	1,435
	19,666	20,050	384	1.9%	**198,668**	**199,318**	650	0.3%	240,175

Month of April



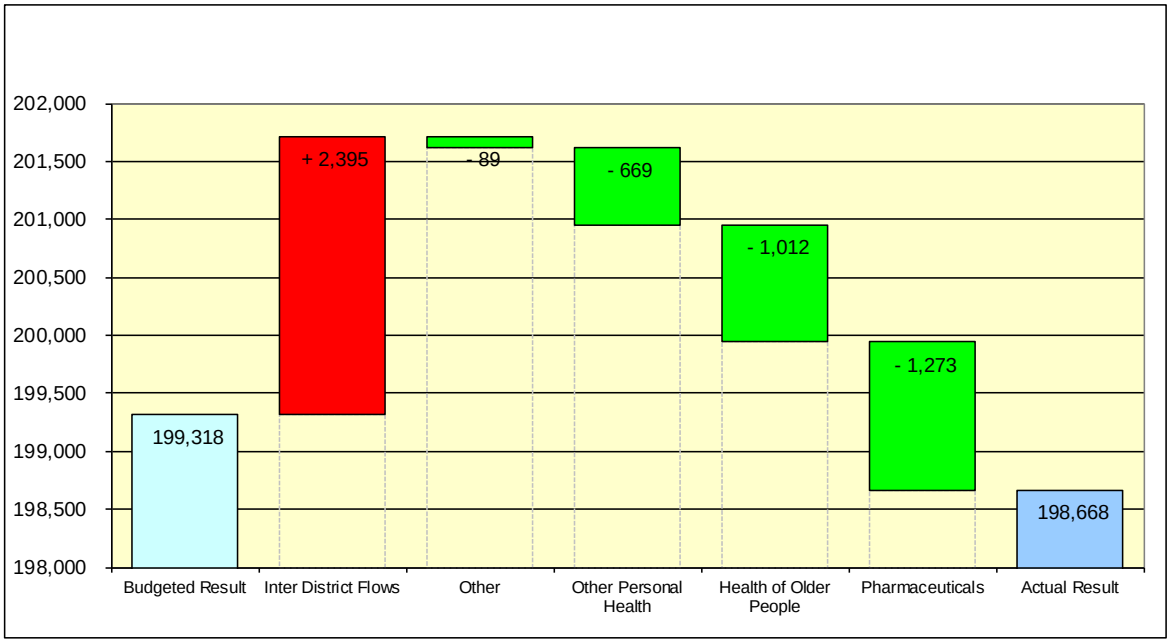
Note the scale does not begin at zero

Inter District Flows (unfavourable)
Higher outflows based on MoH data and information from other DHBs. This shows a continuing trend of high activity this year.

Health of Older People (favourable)
Ongoing reduction in the accrual for pay equity costs following updated data from MoH. Offset by associated reduction in income.

Pharmaceuticals (favourable)
Higher than planned rebate expected based on PHARMAC information.

Year to Date



Inter District Flows (unfavourable)
Some reduction has been achieved in IDF outflows, through management of referrals and investigation of data errors made by other DHBs. However, complex cases in neo natal services and paediatrics, and higher numbers of orthopaedic patients due to an aging population, have prevented achievement of the planned efficiencies.

Other Personal Health (favourable)
Funding recoveries.

Health of Older People (favourable)
Ongoing decrease in expected cost of pay equity following review by MoH.

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

7. CORPORATE SERVICES

$'000	April				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Operating Expenditure									
Personnel	1,358	1,302	(56)	-4.3%	13,181	13,275	94	0.7%	15,769
Outsourced services	103	68	(35)	-52.5%	834	676	**(157)**	**-23.3%**	956
Clinical supplies	61	111	50	44.9%	(396)	(466)	**(70)**	**-15.0%**	(398)
Infrastructure and non clinical	755	780	24	3.1%	7,939	8,234	295	3.6%	9,529
	2,278	2,261	(17)	-0.8%	21,558	21,720	162	0.7%	25,856
Capital servicing									
Depreciation and amortisation	1,117	1,132	15	1.3%	11,354	10,942	(412)	-3.8%	13,776
Capital charge	705	705	-	0.0%	7,072	7,050	(23)	-0.3%	8,504
	1,822	1,837	15	0.8%	18,426	17,991	(435)	-2.4%	22,281
	4,100	**4,097**	**(2)**	**-0.1%**	**39,984**	**39,711**	**(273)**	**-0.7%**	**48,137**
Full Time Equivalents									
Medical personnel	0.3	0.3	(0)	-17.4%	0	0	(0)	-0.4%	0.3
Nursing personnel	14.2	14.5	0	2.1%	13	15	1	9.7%	14.9
Allied health personnel	0.2	0.4	0	37.4%	1	0	(0)	-60.2%	0.4
Support personnel	9.4	9.1	(0)	-3.9%	9	9	0	0.1%	9.1
Management and administration	155.4	148.0	**(7)**	**-5.0%**	141	147	6	4.2%	147.0
	179.6	**172.3**	**(7)**	**-4.3%**	**165**	**172**	**7**	**4.3%**	**171.7**

The year-to-date variances relates to favourable results from:

- Information Services where staff vacancies were partially covered by outsourced personnel, and planned efficiencies were more than covered by reduced data network expenditure from the treatment of ICE as capital expenditure rather than an operating lease.
- Delay in primary care project expenditure as the delivery models for care pathways and health and social networks projects are reviewed.

More than offset by unfavourable results from:

- Higher than planned depreciation resulting from a greater capitalisation of assets in 2016/17 than allowed for in the budget
- Unbudgeted special fund and clinical trial expenditure
- Recruitment and consultancy costs

8. RESERVES

$'000	April				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure									
Contingency	(62)	250	**312**	**124.9%**	945	2,500	**1,555**	**62.2%**	-
Transform and Sustain resource	42	102	**60**	**58.9%**	559	1,025	**466**	**45.5%**	782
Other	22	(51)	**(73)**	**-142.7%**	70	(128)	**(198)**	**-154.4%**	70
	1	**301**	**299**	**99.5%**	**1,574**	**3,397**	**1,823**	**53.7%**	**852**

Contingency released of $1.555 million includes the year-to-date allocations for elective surgery ($1.250 million) and CCDM ($171 thousand), and the remaining unallocated contingency for March and April of $134 thousand. Project timelines for the national patient flow project have been extended delaying Transform and Sustain expenditure in the near term. The “Other” category includes the devolvement of CCDM budgets to individual directorates providing health services.

9. FINANCIAL PERFORMANCE BY MOH CLASSIFICATION

	April			Year to Date			End of Year		
$'000	Actual	Annual Plan	Variance	Actual	Annual Plan	Variance	Forecast	Annual Plan	Variance
Funding									
Income	42,116	42,544	(428) U	432,478	433,282	(804) U	523,982	525,146	(1,164) U
Less:									
Payments to Internal Providers	22,587	22,535	(52) U	236,492	236,583	91 F	284,993	285,122	129 F
Payments to Other Providers	19,666	20,050	384 F	198,668	199,318	650 F	240,175	239,078	(1,098) U
Contribution	**(137)**	**(41)**	**(96) U**	**(2,683)**	**(2,620)**	**(63) U**	**(1,187)**	**947**	**(2,133) U**
Governance and Funding Admin.									
Funding	350	298	52 F	2,819	2,819	-	3,369	3,416	(47) U
Other Income	3	3	-	62	25	37 F	67	30	37 F
Less:									
Expenditure	232	301	69 F	2,368	2,709	341 F	2,887	3,321	434 F
Contribution	**120**	**(1)**	**121 F**	**513**	**135**	**378 F**	**549**	**125**	**424 F**
Health Provision									
Funding	22,238	22,244	(6) U	233,667	233,764	(97) U	281,618	281,706	(88) U
Other Income	2,817	2,572	245 F	26,353	25,577	777 F	31,213	30,654	559 F
Less:									
Expenditure	26,379	25,143	(1,237) U	263,340	259,338	(4,002) U	315,430	311,931	(3,498) U
Contribution	**(1,325)**	**(327)**	**(998) U**	**(3,320)**	**3**	**(3,322) U**	**(2,599)**	**428**	**(3,027) U**
Net Result	**(1,342)**	**(369)**	**(973)** U	**(5,489)**	**(2,481)**	**(3,008)** U	**(3,237)**	**1,500**	**(4,737)** U

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

10. MANAGEMENT BUDGET MOVEMENTS

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

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

	April			Year to Date			End of Year		
$'000	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement
Funding									
Income	42,544	42,527	18 F	433,282	432,560	722 F	525,146	524,124	1,022 F
Less:									
Payments to Internal Providers	22,535	22,427	(108) U	236,583	235,578	(1,005) U	285,122	283,900	(1,222) U
Payments to Other Providers	20,050	20,058	8 F	199,318	198,803	(514) U	239,078	238,724	(354) U
Contribution	**(41)**	**41**	**(82) U**	**(2,620)**	**(1,822)**	**(798) U**	**947**	**1,500**	**(553) U**
Governance and Funding Admin.									
Funding	298	274	23 F	2,819	2,744	75 F	3,416	3,294	122 F
Other Income	3	3	-	25	25	-	30	30	-
Less:									
Expenditure	301	274	(27) U	2,709	2,767	58 F	3,321	3,324	3 F
Contribution	**(1)**	**3**	**(4) U**	**135**	**2**	**134 F**	**125**	**(0)**	**125 F**
Health Provision									
Funding	22,244	22,153	91 F	233,764	232,834	930 F	281,706	280,606	1,099 F
Other Income	2,572	2,516	56 F	25,577	25,125	452 F	30,654	30,089	565 F
Less:									
Expenditure	25,143	25,082	(60) U	259,338	258,620	(718) U	311,931	310,695	(1,236) U
Contribution	**(327)**	**(413)**	**86 F**	**3**	**(661)**	**664 F**	**428**	**-**	**428 F**
Net Result	**(369)**	**(369)**	**0** F	**(2,481)**	**(2,481)**	**0** F	**1,500**	**1,500**	**(0)** U

11. QUALITY AND FINANCIAL IMPROVEMENT PROGRAMME

The table below shows $5.9 million of savings has been achieved against a year-to-date target of $8.4 million. Note the table in last month's report inadvertantly included data relating to 2016/17 unachieved efficiencies, achievement of which is being managed through a separate process including savings from one-off windfall gains. The corrected table has been included below.

Corporate general efficiencies are 58% of the year-to-date identified plans, down from 60% in March. The planned reduction in depreciation expense and capital charges comprise most of the shortfall.

Provider services general efficiencies are 76% of the year-to-date identified plans, down from 77% in March. The main services with shortfalls are Community, Women & Child, Medical Services, and Surgical Services and reflect the pressures experienced with the high acute activity.

Strategic Planning general efficiencies are at 64% of the year-to-date identified plans, up from 47% in March. Urgent care, rest homes, and Enliven make up the larger part of the increase in April, and IDFoutflows make up most of the shortfall year-to-date.

April

Service	2017/18 Annual Savings Plans	YTD Savings Planned	YTD Savings Achieved	YTD Var	% YTD Planned Savings Achieved	% of Annual Plan Achieved YTD
Corporate	997,000	731,108	424,708	(306,401)	58%	43%
Provider Services	4,911,000	3,890,190	2,970,269	(919,920)	76%	60%
Strategic Planning	4,598,000	3,549,723	2,255,814	(1,293,910)	64%	49%
Strategy and Health Improvement	286,000	258,976	257,443	(1,533)	99%	90%
Grand Total	**10,792,000**	**8,429,997**	**5,908,233**	**(2,521,764)**	**70%**	**55%**

March (corrected)

Service	2017/18 Annual Savings Plans	YTD Savings Planned	YTD Savings Achieved	YTD Var	% YTD Planned Savings Achieved	% of Annual Plan Achieved YTD
Corporate	997,000	633,569	378,573	(254,996)	60%	38%
Provider Services	4,911,000	3,122,169	2,406,330	(715,840)	77%	51%
Strategic Planning	4,598,000	3,106,593	1,451,333	(1,655,260)	47%	32%
Strategy and Health Improvement	286,000	245,746	240,793	(4,952)	98%	84%
Grand Total	**10,792,000**	**7,108,077**	**4,477,029**	**(2,631,048)**	**63%**	**42%**

12. FINANCIAL POSITION

30 June 2017	$'000	April Actual	April Budget	Variance from budget	Movement from 30 June 2017	Annual Budget
	Equity					
149,751	Crown equity and reserves	149,751	149,751	-	-	149,394
(7,406)	Accumulated deficit	(12,895)	(6,954)	5,941	(5,489)	(2,973)
142,345		136,856	142,797	5,941	(5,489)	146,421
	Represented by:					
	Current Assets					
16,541	Bank	15,513	13,458	(2,055)	(1,027)	15,536
1,690	Bank deposits > 90 days	1,901	1,755	(147)	212	1,755
26,735	Prepayments and receivables	21,307	22,849	1,542	(5,429)	22,951
4,435	Inventory	4,341	4,404	63	(94)	4,419
625	Non current assets held for sale	625	-	(625)	-	-
50,025		43,687	42,467	(1,221)	(6,338)	44,661
	Non Current Assets					
152,411	Property, plant and equipment	155,255	159,203	3,948	2,844	160,576
1,820	Intangible assets	1,481	2,736	1,255	(339)	2,962
10,701	Investments	11,684	11,856	172	982	12,105
164,932		168,419	173,794	5,375	3,488	175,642
214,957	**Total Assets**	**212,107**	**216,261**	**4,154**	**(2,850)**	**220,302**
	Liabilities					
	Current Liabilities					
35,447	Payables	36,264	35,636	(628)	817	35,762
34,528	Employee entitlements	36,349	35,100	(1,250)	1,822	35,381
69,975		72,614	70,735	(1,878)	2,639	71,143
	Non Current Liabilities					
2,638	Employee entitlements	2,638	2,729	91	-	2,739
2,638		2,638	2,729	91	-	2,739
72,612	**Total Liabilities**	**75,251**	**73,464**	**(1,787)**	**2,639**	**73,882**
142,345	**Net Assets**	**136,856**	**142,797**	**5,941**	**(5,489)**	**146,421**

The variance from budget for:

- Equity reflects the amount the budgeted opening balance differs from the 2016/17 result, and the 2017/18 variance from budget;
- Prepayments and receivables are now lower than budget after the receipt of delayed MoH payments;
- Property, plant and equipment and intangible assets mainly reflect the lower than budgeted capital spend;
- Employee entitlements – see below

13. EMPLOYEE ENTITLEMENTS

30 June 2017	$'000	April Actual	April Budget	Variance from budget	Movement from 30 June 2017	Annual Budget
7,853	Salaries & wages accrued	7,419	7,245	(174)	(434)	7,756
522	ACC levy provisions	887	417	(470)	365	501
4,869	Continuing medical education	6,101	5,869	(233)	1,233	5,553
19,819	Accrued leave	20,356	19,887	(469)	537	19,883
4,103	Long service leave & retirement grat.	4,224	4,411	187	121	4,426
37,165	**Total Employee Entitlements**	38,987	37,828	(1,159)	1,822	38,119

14. TREASURY

Liquidity Management

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

Debt Management

The DHB has no interest rate exposure relating to debt.

Foreign Exchange Risk Management

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

15. CAPITAL EXPENDITURE

Capital spend is $5.7 million behind plan year-to-date (last month $6.6 million), including the surgical expansion that is in the planning stage, the histology and education centre upgrade that is now underway, and information technology that is expected to be spent before the end of the year.

See table on the next page.

2018 Annual Plan		*Actual $'000*	*Year to Date Budget $'000*	*Variance $'000*
	Source of Funds			
	Operating Sources			
13,625	Depreciation	11,354	10,942	(412)
1,500	Surplus/(Deficit)	(5,489)	(2,481)	3,008
9,166	Working Capital	8,775	11,586	4,061
24,290		14,640	20,047	6,657
	Other Sources			
-	Special funds and clinical trials	288	-	(288)
625	Sale of assets	-	625	(625)
625		288	625	(913)
24,915	**Total funds sourced**	**14,928**	**20,672**	**5,744**
	Application of Funds:			
	Block Allocations			
3,400	Facilities	2,593	3,007	414
3,200	Information Services	698	2,666	1,967
3,400	Clinical Plant & Equipment	2,839	2,657	(182)
10,000		6,130	8,330	2,200
	Local Strategic			
1,082	Renal Centralised Development	414	901	488
6,306	New Stand-alone Endoscopy Unit	6,057	5,253	(804)
134	New Mental Health Inpatient Unit Development	142	112	(30)
-	Maternity Services	7	-	(7)
500	Upgrade old MHIU	10	417	406
243	Travel Plan	124	202	78
1,555	Histology and Education Centre Upgrade	233	1,295	1,062
500	Radiology Extension	-	417	417
600	Fit out Corporate Building	-	500	500
3,000	Surgical Expansion	470	2,499	2,029
13,920		7,457	11,595	4,139
	Other			
-	Special funds and clinical trials	288	-	(288)
-	Other	57	-	(57)
-		345	-	(345)
23,920	***Capital Spend***	***13,932***	***19,925***	***5,993***
	Regional Strategic			
995	RHIP (formerly CRISP)	996	746	(250)
995		996	746	(250)
24,915	**Total funds applied**	**14,928**	**20,672**	**5,744**

Monthly Project Board Report

Apr 2018

HAWKE'S BAY District Health Board

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

Project Manager Facilities Development: Trent Fairey

Overall Project Progress	Quality & Safety Risk Status	Time Status	Financial Status
66%	G	G	G

Phase 3: Service transition & Facility Development

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

Project Budget Status

Total Approved for Capital Budget	**$ 13,095,000**	Total 17/18 Forecast Spend	**$ 7,450,000**
Total Project Spend to Date	$ 8,613,000	Total 17/18 Spend to Date	$ 6,057,000
Percentage of Total Spend vs Budget	66%	Percentage 17/18 Spend vs Forecast	81%

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

Deliverable Dates

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

Key Achievements this period

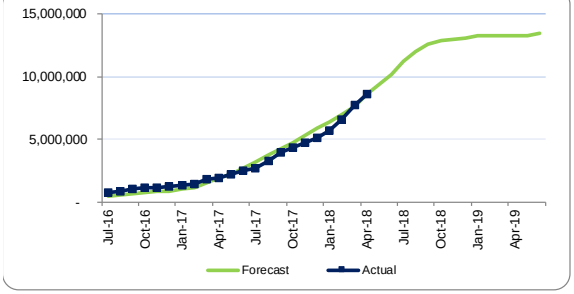
Roof and exterior cladding installations continue with the completion of all roof sections and RAB cladding. Installation of all windows has been undertaken in April and internal gib lining and 1st fix of building services continues on both levels. All trades are proceeding to programme, revised programme has been agreed providing the completed building in September 2018 with operational activity planned from October 2018.
1 incident reported in this period, strain to hamstring from lifting, worker is off through to mid May. 1st Quarter (2018) H&S GEMCO Audit completed , result 98%. Independent H&S auditing by the HBDHB continues on a monthly basis.

Planned Activities next period

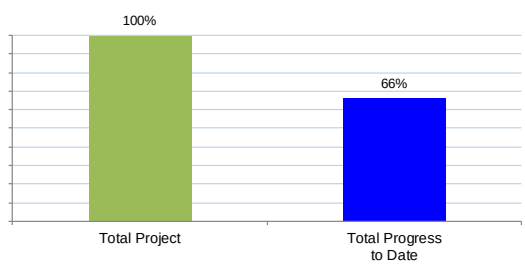
Completion of internal wall linings and services 1st fix for both levels. Installation of lift and services. Installation of external metal and aluminum cladding.

Risks & Issues of Note	Mitigation & Resolutions
Specialised Furniture, Fittings and Equipment. Procurement process delays the installation dates.	Ensure timely decision making from the clinical teams, allowing procurement from off-shore manufacturers in a controlled manner.
Furniture, Fittings and Equipment costs exceed allocated budget	Working with Gastroenterology services to ensure value across all purchases, partnering with HBDHB procurement services to ensure best practice is adhered to.

Actual Spend



Total Project Progress



16. ROLLING CASH FLOW

	Actual	April Forecast	Variance	May Forecast	Jun Forecast	Jul Budget	Aug Budget	Sep Budget	Oct Budget	Nov Budget	Dec Budget	Jan Budget	Feb Budget	Mar Budget	Apr Budget
Cash flows from operating activities															
Cash receipts from Crown agencies	45,904	44,207	1,697	47,647	48,337	44,251	43,524	52,345	44,691	48,101	44,589	45,628	47,740	44,733	44,636
Cash receipts from revenue banking	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from donations, bequests and clinical trials	42	-	42	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	3,333	427	2,906	445	439	440	446	440	505	447	445	471	477	471	471
Cash paid to suppliers	(26,041)	(25,529)	(512)	(25,927)	(27,104)	(28,113)	(26,670)	(33,468)	(27,677)	(27,999)	(27,464)	(27,634)	(24,929)	(27,883)	(27,786)
Cash paid to employees	(17,779)	(16,482)	(1,297)	(18,848)	(15,893)	(15,532)	(20,705)	(15,683)	(15,901)	(18,879)	(15,325)	(23,374)	(16,233)	(16,077)	(16,356)
Cash generated from operations	**5,459**	**2,623**	**2,836**	**3,317**	**5,779**	**1,046**	**(3,405)**	**3,635**	**1,619**	**1,670**	**2,246**	**(4,909)**	**7,056**	**1,245**	**964**
Interest received	60	64	(4)	64	64	74	74	74	74	74	74	74	74	74	74
Interest paid	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Capital charge paid	(705)	-	(705)	0	(0)	(4,230)	0	0	0	0	(4,230)	0	0	0	0
Net cash inflow/(outflow) from operating activities	**4,814**	**2,687**	**2,128**	**3,380**	**5,842**	**(3,110)**	**(3,331)**	**3,708**	**1,692**	**1,744**	**(1,910)**	**(4,836)**	**7,129**	**1,319**	**1,038**
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	21	-	21	-	(0)	-	-	-	-	-	625	-	-	-	-
Acquisition of property, plant and equipment	(2,123)	(3,092)	969	(2,210)	(3,108)	(1,282)	(1,282)	(1,282)	(1,282)	(1,282)	(1,283)	(1,283)	(1,283)	(1,383)	(1,125)
Acquisition of intangible assets	(10)	(25)	15	(565)	(540)	(154)	(154)	(154)	(154)	(154)	(154)	(154)	(154)	(154)	(154)
Acquisition of investments	(711)	-	(711)	-	(249)	-	-	(249)	-	-	(249)	-	-	(249)	-
Net cash inflow/(outflow) from investing activities	**(2,822)**	**(3,117)**	**294**	**(2,775)**	**(3,897)**	**(1,436)**	**(1,436)**	**(1,684)**	**(1,436)**	**(1,436)**	**(1,060)**	**(1,437)**	**(1,437)**	**(1,785)**	**(1,279)**
Cash flows from financing activities															
Proceeds from equity injection	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Proceeds from borrowings	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Repayment of finance leases	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Equity repayment to the Crown	-	-	-	-	(357)	-	-	-	-	-	-	-	-	-	-
Net cash inflow/(outflow) from financing activities	**-**	**-**	**-**	**-**	**(357)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Net increase/(decrease) in cash or cash equivalents	1,992	(430)	2,422	606	1,587	(4,546)	(4,767)	2,024	257	308	(2,970)	(6,272)	5,693	(467)	(240)
Add:Opening cash	15,423	15,423	-	17,415	18,020	19,608	15,062	10,295	12,319	12,576	12,884	9,914	3,642	9,335	8,868
Cash and cash equivalents at end of period	**17,415**	**14,993**	**2,422**	**18,020**	**19,608**	**15,062**	**10,295**	**12,319**	**12,576**	**12,884**	**9,914**	**3,642**	**9,335**	**8,868**	**8,628**
Cash and cash equivalents															
Cash	4	4	0	4	4	4	4	4	4	4	4	4	4	4	4
Short term investments (excl. special funds/clinical trials)	17,027	11,963	5,064	14,990	16,578	12,031	7,264	9,289	9,545	9,854	6,883	611	6,304	5,838	5,597
Short term investments (special funds/clinical trials)	2,877	3,026	(149)	3,026	3,026	3,026	3,026	3,026	3,026	3,026	3,026	3,026	3,026	3,026	3,026
Bank overdraft	(2,493)	-	(2,493)	-	-	-	-	-	-	-	-	-	-	-	-
	17,415	**17,311**	**2,422**	**18,020**	**19,608**	**15,062**	**10,295**	**12,320**	**12,576**	**12,885**	**9,914**	**3,642**	**9,335**	**8,869**	**8,628**

Changes have been made to the phasing of some major cash-flows based on best estimates of when they will occur e.g. elective services revenue, IDF wash-up and the rest home worker's pay equity settlement.

BOARD HEALTH & SAFETY CHAMPION'S UPDATE

Verbal

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Clinical Council**	57
	For the attention of: **HBDHB Board**	
Document Owner(s):	Dr John Gommans (Chair) Dr Andy Phillips (Co-Chair)	
Month:	May 2018	
Consideration:	For Information	

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RECOMMENDATION

That the Board

Review the contents of this report; and

Note that Clinical Council:

- **Endorsed** the report on The Place of Alcohol in Schools - Young people and under-age exposure.
- **Endorsed** the work being progressed on Community Prescribing for Nurses
- **Endorsed** the development of a Kaupapa Māori Maternal Health Programme
- **Supported** the scoping of an expanded CPO programme
- **Supported** the National Bowel Cancer Screening Programme Roll-out
- **Agreed** that funds for the Collaborative Pathways programme should be put on hold pending testing of the Canterbury Health Pathways by a group of GPs and Practice Nurses
- **Received** an update on implementation of the National Early Warning Score System
- **Received** an update on the Clinical Services Plan (CSP) – Planning for Consultation
- **Noted** reports provided for information only.

Council met on 9 May April 2018, an overview of matters discussed is provided below.

- **The Place of Alcohol in Schools - Young people and under-age exposure**

Rowan Manhire-Heath, population health advisor presented a paper on the place of alcohol in schools - young people and under-age exposure. Dr Nick Jones provided background regarding the concern from the Medical Director of Health receiving applications from schools for temporary licenses for events where children are present. The concern was the impact of that in modelling behaviour and exposure to alcohol in the school setting. The intention of the paper is to influence Boards of Trustees and Principals who are setting policies for their schools and making decisions around applying for a special licence for a function in the education setting. Also under the Supply of Alcohol Act, the Medical Officer of Health has the ability to object to a licence being granted. The paper supported the opposition to these licences. Discussion held re: importance of the health sector setting a good example and having a Board endorsed statement.

Clinical Council supported the paper and agreed that Alcohol has no place in schools especially when children are present.

- **Community Prescribing for Nurses**

A presentation was provided by Sally Houliston, Nurse Consultant, Workforce Development. Subsequent discussion covered a wide range of issues including e-prescribing; standing orders; laboratory services; supporting nurses in schools; auditing, monitoring and reporting by governance group and continuing competence, safety and peer review; relationship to clinical pathways, extending this to ED and outpatient clinics; equity and funding consultations with no barriers at dispensing, and funding of a nurse co-ordinator to run the programme.

Clinical council were supportive of the approach taken and agreed the value of community prescribing for nurses.

- **Co-ordinated Primary Care Options (CPO)**

Dr Mark Peterson provided background on this item. This scheme provides funding for primary care to undertake treatments that otherwise would be provided in hospital; initially focussed on avoiding hospital admission but subsequently expanded to cover other conditions. General discussion held regarding scoping to include the economics and capacity to meet demand; strength of the prioritisation mechanism and the need to be transparent and quality driven with cross sector governance; need to evaluate how effective this funding has been before further investment is made and the relationship of CPO with collaborative pathways and RN prescribing.

Council were supportive of this approach to investing in primary care and recommended that CPO scheme interventions must be supported by a collaborative pathway and transparent cross sector governance processes. Council also suggested that joint injections should be added to the list of potential CPO interventions.

- **Collaborative Pathways Update**

Dr Mark Peterson provided background on this item. Council supported the use of clinical pathways to reduce unwarranted variation in clinical practise. Council noted that Map of Medicine is to be discontinued and that a better electronic tool was required to replace this. It was considered that choosing the replacement electronic tool is an extremely important decision. There was also a need to integrate choosing wisely recommendations to give guidance to less experienced staff. Canterbury Health Pathways is now the electronic tool of choice for most DHBs.

Council's opinion was that clinical pathways are part of good decision-making and this is an important issue that we need to get right. It does need testing in primary care and will in future move towards a system, which integrates with practice software, enables e-referrals and includes primary and secondary care.

Council decided to pause work on collaborative pathways whilst Canterbury Health Pathways is tested by a group of GPs and Practice Nurses to make sure that it is fit for purpose in Hawke's Bay.

- **Early Warning Score System Update**

The Chair advised that there is a National requirement from the Health Quality Safety Commission (HQSC) to implement their deteriorating patient programme including the National Vital Signs Observation Chart and Early Warning Score (EWS) system into our hospital. It was noted that care of patients at risk of deterioration has been a feature of the DHB's annual adverse event reports. The Chair confirmed excellent progress with embedding the new chart and EWS system following its introduction on 11 April, and the required training programmes. Challenges going forward are the need to ensure data collection for monitoring purposes and that there is timely access to sufficiently experienced and skilled clinicians after hours when a patient at risk of deteriorating is identified.

It was also noted that HQSC have established a number of programmes that DHBs are required to implement, which have not come with additional resources.

- **Clinical Services Plan (CSP) – Planning for Consultation**

Ken Foote, Company Secretary provided an update on progress. The four future options workshops have now been completed with the integrated workshop planned for 31 May. In the interim two small additional workshops are planned to ensure that appropriate information from the future options workshops are fed into the integrative workshop. Council provided the Company Secretary with suggestions on how were should engage with clinicians during the wider consultation period on the draft plan planned for August/September.

- **National Bowel Cancer Screening Programme Presentation**

A presentation was provided by Dr Malcolm Arnold, Gastroenterologist and Lynda Mockett, Project Manager. Dr Arnold provided an overview of the programme, which is intended to be rolled out in Hawke's Bay from 9 October 2018. The screening programme can save lives by detecting potential cancer early and has considerable costs savings if polyps are caught early before they turn into cancer. Dr Arnold described a number of risks to meeting this start date including Pathologist capacity, participation in multidisciplinary team meetings, need to have short waiting times for endoscopy and the general demands on the health system. These risks will be continuously reviewed prior to a readiness assessment from the Ministry of Health in August. Dr Arnold noted the concern that had been expressed around equity and the discussions that had taken place between Dr Phillips and the Ministry of Health to request reducing the age of eligibility for Maori participation down to 50 years.

Council expressed strong support for the programme and thanked Dr Arnold and the project team for the work done in readiness for the roll out of the programme.

- **Maternal Wellbeing Model of Health Report and Presentation**

A presentation was provided by Patrick Le Geyt, Acting GM Maori Health, Charissa Keenan, Health Gains Advisor and Jules Arthur, Midwifery Advisor. Patrick Le Geyt provided an overview of the programme developed from the SUDI national rollout. The national programme has been modelled on the HBDHB safe sleep programme. HBDHB has been allocated additional resources to look at the social determinates of SUDI, bed sharing, smoking in pregnancy and alcohol. This has given us the opportunity to utilise a wellbeing and holistic approach and to take services to culture.

Council supported this work as an excellent example of culturally competent care and for its intent to address health inequities

Reports for information were noted from the following:

- HB Health Sector Leadership Forum Update
- HBDHB Performance Framework Exceptions Q3 Dashboard
- Te Ara Whakawaiora - Did not Attend (local Indicator)
- Best Start Healthy Eating & Activity Plan update
- HHB Clinical Advisory and Governance Committee

OURHEALTH HAWKE'S BAY Whakawateatia	**Hawke's Bay Health Consumer Council** **58**
	For the attention of: **HBDHB Board**
Document Owner:	Rachel Ritchie, Chair
Reviewed by:	Not applicable
Month:	May, 2018
Consideration:	For Information

RECOMMENDATION

That the Board

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

Consumer Council met on 10 May 2018. An overview of issues discussed and/or agreed at the meeting is provided below.

- **Maternal Wellbeing Model of Health**

Council received a copy of the paper 'Plan to Develop a Kaupapa Maori Maternal Health Programme' noting in particular that as HBDHB is a high risk area for SUDI, this is a real opportunity to do something different; to look at the issues from a wellbeing and holistic approach and to take sevices to culture. It was also noted that this is being developed as a partnership between various sevices, involves consumers and is supporting the workforce to be culturally responsive.

Following discussion, Council provided it's support for the Programme.

- **National Bowel Sceening Roll-Out Update**

Dr Malcolm Arnold provided an overview of the programme and an update on what HBDHB were doing. Council both appreciated the update and expressed it's ongoing support for the programme and the work being done locally to commence screening from October 2018.

- **The Place of Alcohol in Schools**

At the outset, there appeared to be two differing views on the proposed policy:
- Schools are places where healthy lifestyles should be promoted
- School is a place of education where role modeling can teach responsible decision making.

After considerable discussion, robust debate and a reminder of the context for this DHB policy, a consensus conclusion was reached:

'Consumer Council generally supports the intent of the paper for the DHB to encourage schools to review their policies based on the evidence provided around alcohol consumption. The Council see this issue in a much wider context, and feel that this approach is very narrow. However they appreciate this policy has a direct and particular purpose in relation to the small number of primary schools where licence applications are numerous'.

Council then formally endorsed the report.

- **Co-ordinated Primary Care Options Programme**

Council noted and supported the the scoping for an expanded CPO Programme

- **Clinical Services Plan – Planning for Consultation**

Some ideas and suggestions were provided on how best to engage with consumers, specifically noting that a full consumer ‘mail drop’ was not warranted in this instance.

- **Implementing the Consumer Engagement Strategy**

Council provided further input to, and endorsed, the latest draft of this strategy, to be presented to the Board in June/July. This is part of the suite of papers around Consumer & Whanau Centred Care that the Council is focused on progressing. Next is the Recognising Consumer Participation Policy which is to be discussed by the Council at the June meeting.

- **Information Papers**

The following papers were received, noted but not discussed:

- HB Health Sector Leadership Forum report
- Best Start Healthy Eating & Activity Plan (6 Month Update)
- HBDHB Performance Framework Exceptions Q3 Dashboard
- Te Ara Whakawaiora - Did Not Attend (Local Indicator)

- **Other**
  Hutt Valley DHB representatives attended the meeting to observe us in action - they are part way through implementing their own Consumer Council Framework.

  Recruitment of new Council members and 2 Consumer Engagement staff members is progressing.

  Appointments from within Council to the Clinical Governance Committees were confirmed - including the main " Patient Experience Committee" which will be underway soon.

OURHEALTH HAWKE'S BAY Whakawateatia	**Māori Relationship Board** 59
	For the attention of: **HBDHB Board**
Document Owner:	Heather Skipworth, Chair
Reviewed by:	Not applicable
Month:	May, 2018
Consideration:	For Information

RECOMMENDATION

That the Board

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

The Māori Relationship Board met on on 9 May 2018. An overview of issues discussed and/or agreed at the meeting is provided below.

- **Te Karere Māori Nursing Newsletter**

Ngaira Harker (Nurse Director – Māori Health) introduced "Te Karere Māori Nursing Newsletter" which was very well received by MRB.

There was general discussion about wider circulation of this newsletter including preparing and providing videos in strategic locations.

> MRB recommended that the CEO be approached and asked to issue the 'te karere Māori Nursing Newsletter' in conjunction with a CEO's Newsletter, focusing on "Māori Workforce Development".

- **Clinical Council Report**

MRB discussed Ana Apatu's role as an observer as a proxy for Kerri Nuku, who has found it difficult to attend meetings due to her demanding workload.

> MRB recommended that Ana replace Kerri until April 2019 and that MRB Chair contact Kerri to thank her for service and that Ana would step in for one year.

- **Clinical Services Plan**

Ken Foote who updated MRB on the CSP workshops that had recently been held and the integrated workshop to be held on 30 May 2018.

Ken Foote asked MRB for advice on how to best consult the community, in particular Māori, with the draft CSP plan. MRB members said they would email the Acting General Manager Māori Health with their suggestions and feedback.

- **Maternal Wellbeing Model of Health**

Charrissa Keenan, Health Gains Advisor, Māori Health, provided a presentation and an information paper on the proposed kaupapa Māori maternal health programme. The paper outlined the approach to develop the programme, and identified key actions and timeframes to deliver the programme.

MRB supported the approach and liken it to the Nuka concept of "taking services to culture". They also commented that the presentation and paper were how they would like presentations in the future.

> MRB noted the contents of the report and supported the development of a Kaupapa Māori Maternal Health Programme and proposed next steps.

- **National Bowel Screening Project**

Dr Malcolm Arnold and Lynda Mockett, Project Manager, provided a detailed presentation on the Bowel Screening Programme and explained the project process, individual eligibility criteria, and testing procedure.

MRB discussed recommending to the HBDHB Board to make strong representation to the MoH to lower the eligibility age criteria to 50 years and over for Māori. It was advised other DHBs nationally were also following this course of action.

MRB recommend the HBDHB Board strongly lobby the Ministry of Health to lower the starter age for bowel screening to 50 years and over.

- **MRB Strategic Priorities**

MRB discussed a document entitled "He Ngakau Aotea" (having an open heart and mind) that had been developed from their workshop on 18 April 2018.

MRB agreed they had learnt from delving too deep into detail and would like to be more focussed on strategic areas of Māori health improvement.

He Ngakau Aotea attempts to identify key priorities MRB would like to see traction on, including how the Nuka Model could be implemented in Hawke's Bay firstly with a pilot in Wairoa.

MRB will continue to meet and communicate to refine their strategic priorities and present these to the Board.

- **Information Papers**

The following papers were received and noted:

- Health Sector Leadership Forum Report
- HBDHB Performance Framework Exceptions Report – Q3
- Best Start Healthy Eating & Activity Plan
- The Place of Alcohol in Schools

MRB noted the following report had been amended and would be sent out to MRB members:

- Te Ara Whakawaiora - Improving Access Indicator (Did Not Attend FSA)

HAWKE'S BAY District Health Board Whakawāteatia	**Pasifika Health Leadership Group** 60
	For the attention of: **HBDHB Board**
Document Owner:	Barbara Arnott, Chair of CPHAC
Reviewed by:	n/a
Month:	May 2018
Consideration:	For Information

14

RECOMMENDATION

That the HBDHB Board

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

The Pasifika Health Leadership Group met on 14 May 2018. An overview of matters discussed is provided below.

Two presentations were received.

National Bowel Screening Programme

A detailed presentation was delivered by Malcolm Arnold with some of the NBSP project team members in attendance. Pasifika eligible for the screening programme in Hawke's Bay make up an approximate number of 430. Discussion included - the best way to engage with the Pasifika community was via families and churches. Meetings with community leaders are in progress to ascertain champions. Navigators will be available to assist clients through any stage of the process. It was requested that the information sheet be available in all Pacific languages to ensure best engagement. Any other feedback from PHLG was welcome.

Primary Mental Health Model Of Care

Trish Freer from Health Hawke's Bay was in attendance to provide a presentation of a change in model providing mental health care to youth. Any feedback on how to expand the service for Pasifika was welcome. The PHLG advocated that relationships were developed with Le Va, a Pacific NGO that has access to Pacific research and tools to support the development of specific Pacific actions and models.

PACIFIC WORKFORCE ACTION PLAN

Talalelei Taufale tabled the Action Plan for discussion. The PHLG reviewed the Plan and noted going forward:

- Funding is required to engage a Pasifika Workforce Coordinator which will be key to drive the Plan by increasing the workforce of Pasifika in areas such as the; emergency department, renal, paediatrics, midwifery etc. PHLG collectively endorsed that the Pasifika Workforce Coordinator role would be best placed within the Recruitment Team of the People & Quality Directorate. This role would provide influence over hospital recruitment, cultural equity and carry a level of influence
- PHLG will provide input into the development of a 3-year Action Plan
- Further tailoring is required of the Pasifika workforce KPIs

- PHLG will provide input to support the cultural training to be provided by LeVa "Engaging Pasifika" to specified services within the DHB

CLINICAL SERVICES PLAN
Ken Foote in attendance for this item and provided an overview of progress to date.
PHLG were asked to advise of any Pacific island community groups that should be presented to, bearing in mind the CSP is aimed at those with an understanding of wider health issues and at a strategic level.

PACIFIC HEALTH REPORT
The report was taken as read.

REPORTS FOR INFORMATION/ENDORSEMENT
The following papers were received for information/endorsement and were taken as read.
- Best Start Healthy Eating & Activity Plan update
- The Place of Alcohol in Schools - Young people and under-age exposure

CONCLUSION
The Chair spoke to the Terms of Reference and noted in moving forward that the focus remains emphasised on workforce and community engagement, advocating for what was important for Pasifika.

The PHLG endorsed that funding be sourced to engage a Pasifika Workforce Coordinator.

OURHEALTH HAWKE'S BAY Whakawateatia	**Primary Care Development Partnership Governance** 61
	For the attention of: **HBDHB and Health HB Boards**
Document Owner:	Ken Foote, HBDHB Company Secretary
Reviewed by:	CEOs of HBDHB and Health Hawke's Bay
Month:	May, 2018
Consideration:	For Decision

RECOMMENDATION

That the Boards

1. **Approve** the proposed membership of the Primary Care Development Partnership Governance Group, based on the Draft Partnership Agreement.
2. **Call for expressions of interest** for the nine core membership positons on the Governance Group for the first 12 months from 1 July 2018
3. **Appoint** the Chair's and CEOs of HBDHB and Health Hawke's Bay Ltd as an 'appointments panel' to recommend an appropriate mix of appointments, in accordance with the process set out in this report.

15

BACKGROUND

Transitioning the current Hawke's Bay Health Alliance into a 'new' Hawke's Bay Primary Care Development Partnership has been under consideration for some time. A Partnership Support Team has been meeting for some months developing terms of references for specific areas of work.

With this work underway, and a mutual desire to formalise the Partnership for the first year from 1 July 2018, getting the required Agreement and governance structures in place has now become a priority.

To advance these, a modified 'Short Form' Draft Partnership Agreement has been developed and a Discussion Paper on Governance prepared. Both of these documents are attached.

CONSIDERATION

As a starting point for considering these, a meeting was convened on Tuesday 15 May 2018, of:

- Chair and CEO of HBDHB
- Chair and CEO of Health Hawke's Bay
- Executive Director Primary Care (proposed Partnership Support Team Lead)
- Company Secretary (proposed Partnership Governance Group Support).

The outcome of the discussion at this meting was a request for this paper to be prepared for consideration by both HBDHB and Health Hawkes Bay Ltd boards, this month.

AGREEMENTS

Issues discussed and agreed at the above meeting included:

- The issues raised in the Discussion Paper were noted and endorsed, and the recommendations agreed.
- The Draft Partnership Agreement was noted and it was agreed that reviewing and gaining approval of this will be the first task of the proposed Governance Group, once established.
- The nine 'core' members of the Governance Group will be appointed and the Group established prior to 30 June 2018.
- The appointment of all members will be formally approved by both Boards.
- The terms/tenure of membership will be for twelve months with provision for reappointment, to provide for some rotation but retaining some experience.
- The Governance Group needs to have a good mix of perspectives, skills and experience.
- The Cabinet Fees Framework will be applied to all HBDHB board and advisory committee appointments (where relevant) and be paid for by HBDHB.
- Health Hawke's Bay Ltd will cover the costs of its own Board members.
- HBDHB will provide governance support to the Group through the Company Secretary, and Health Hawke's Bay Ltd will provide minute and secretarial support.

Given all the above, it was then agreed there needed to be a coordinated process for the appointment of members, and that the Chairs and CEOs of the HBDHB and Health Hawke's Bay should provide this coordination as an appointments panel to make recommendations to the two Boards for appointment.

The 'panel' will be supported by the HBDHB Company Secretary.

The proposed process for appointment included:

- Both boards need to approve the proposed membership composition
- Expressions of interest from all membership groups be invited
- HBDHB Company Secretary receives and consolidates expressions of interest
- Chairs of Clinical Council, Consumer Council and Maori Relationship Board consulted on expressions of interest received from their respective members
- Panel considers and agrees on initial membership and makes recommendations to both Boards
- Boards agree, members are appointed and the Governance Group meets prior to 30 June 2018.

RECOMMENDATIONS

The above recommendations have been developed from the above agreements and the contents of the two attached documents.

Approval of these recommendations by both boards, will allow the Governance Group to be established, and commence its work, starting with a review of the Draft Partnership Agreement and the 'shadow year' work plan being developed by the Partnership Support Team.

ATTACHMENTS

- Appendix 1: Primary Care Development Partnership Governance – Recommendations for Discussion
- Appendix 2: Draft Hawke's Bay Primary Care Development Partnership Agreement – April 2018

Appendix 1

PRIMARY CARE DEVELOPMENT PARTNERSHIP GOVERNANCE RECOMMENDATION FOR DISCUSSION

INTRODUCTION

The Primary Care Development Partnership (PCDP) is emerging as a strategic response to the inability to secure traction in the locally-led transformation of primary healthcare. Building on the Hawke's Bay Health Alliance Agreement, the PCDP will provide cross-sector governance and oversight to the collaborative design and commissioning of new care models. The scope of potential activity will relate to the $250m of services commissioned by the Primary Care Directorate, including the Back to Back Agreement with Health Hawke's Bay, and key internal provider arrangements within the integrated directorates of the DHB.

Under the current proposal, design will be achieved through clinical and consumer-led 'Service Development Groups' and 'Working Groups'. Their work will be based on a level of delegated authority (deriving from defined annual priorities), which will be approved by the Boards of HBDHB and Health Hawke's Bay (HHB) during the annual planning round. Other activities may be assigned by agreement to the PCDP from time to time.

Given the nature of the PCDP and the potential level of delegation from HBDHB and HHB, it is appropriate to establish a Governance Group with an appropriate mix of representation, perspectives, skills and experience. The draft terms of reference for this Governance Group are set out in clause 8 of the Draft PCDP Agreement.

PRINCIPLES

Some suggested principles to guide the establishment of the Governance Group within PCDP include:

- **Fit for purpose**
- Reflect the **level of delegated authority** held
- Avoid **duplication** with existing structures
- Maximise the **value of existing structures** and/or amend existing structures to achieve this
- Avoid **unnecessary layers** that do not add value
- Keep as **simple and flexible** as possible
- Ensure '**whole of system'** coverage
- Structures will require **trust and confidence** of stakeholders to be effective
- Start with a **potential end** in mind

DELEGATED AUTHORITY

Two of the more significant factors to influence the composition of the Governance Group is the agreed scope and activities of the PCDP, including the level of delegated authority the Group would have to make decisions that would be binding on both HBDHB and HHB.

The general intent on these issues is set out in Schedule 1 of the Draft PCDP Agreement:

1 The ultimate scope of our Partnership may include any/all those publically funded primary and community healthcare services and activities, within the Hawke's Bay Health Sector, where benefits and/or performance could be improved through enhanced integration of services.

2 On an ongoing basis, the scope of our Partnership will generally be determined by agreement to establish specific Service Development Groups or Working Groups. General issues may be included within the scope as agreed from time to time.

3 We will review the Scope of our Partnership and our Partnership Activities/Objectives annually, in conjunction with our annual planning processes.

In determining the scope, the levels of delegated authority for any activity can also be agreed. Scope activities that require the establishment of a Service Development Group in particular would be potentially suitable for delegated authority, given the likely transformational change identified as an outcome. Other activities may be more suited to the PCDP making recommendations to HBDHB and HHB boards.

The draft programme (scope) for the proposed first 'shadow' year of the PCDP includes:

- Mental Health in Primary Care
- Community mental Health & Addictions
- After Hours & On-Day needs
- End of Life Care Model (Palliative Care)
- Coordinated Primary Options
- Integrated Community Nursing Models
- Community Pharmacy Development
- Home Based Support and Restorative Homecare
- Aged Residential Care Transformation
- Intersectoral Health Improvement Projects
- New Investments into Primary Healthcare

Of these, three have been identified as being suitable for having delegated authority. An indicative table of the levels of delegated authority for each of these is set out below:

	DHB	3rd Party Contracts	PHO
Community Mental Health & Addictions	$12m-$18m (scope tbc)		$1.3m
Palliative Care	$0.9m	$3.3m	$0.3m
Integrated Community Nursing model	tbc	tbc	tbc

CLINICAL LEADERSHIP/CONSUMER ENGAGEMENT

One of the key principles of the various Alliance (Partnership) arrangements implemented around the country in recent years, was to ensure there was clinical leadership and input into high level decision making within regions. The Canterbury Clinical Network has been identifies as a model example for how this might be achieved.

This raises the issue of the level of clinical leadership input required on the PCDP Governance Group

Since September 2010, HBDHB has had a clinical Council in place, with a relatively wide purpose:

'*The Hawkes bay Clinical Council is the principal clinical governance, leadership and advisory group for the Hawkes Bay health system'*

Its functions are:

The Hawkes Bay Clinical Council:

- *Provides clinical advice and assurance to the Hawkes Bay health system management and governance structures*
- *Works in partnership with the Hawkes Bay Health Consumer Council to ensure Hawkes Bay health services are organised around the needs of people*

- *Provides oversight of clinical quality and patient safety*
- *Provided clinical leadership to the Hawkes Bay health system workforce.*

This mandate largely covers the clinical leadership component of the above principle, and given that the Clinical Council reports directly to both HBDHB and HHB boards (through the CEO and GM respectively), it is also able to influence decision making at the highest level.

The attached draft PCDP Agreement makes provision for this within the PCDP governance structure, as advisors to the Governance Group:

1.1 **Clinician-Led Decision Making**: We recognise that clinicians, alongside others, are in the best position to make decisions about how to apply resources to specific services to achieve the best outcomes. These decisions will involve less specification and an emphasis on quality processes and transparency of information to assure accountability and best value for money. Our Hawke's Bay Clinical Council (appointed by the Parties) will be the structure through which this is achieved.

A further advantage of using the existing Clinical Council as a structured part of the decision making process, is that the Consumer Council may be used in exactly the same way to gain a consumer perspective: ie

1. **Consumer Input into Decision Making**: We recognise that consumer input is essential in all levels of decision making. At the Partnership level, this will be achieved by ensuring all major Partnership activity decisions will involve input and support from the Hawke's Bay Health Consumer Council.

With Clinical and Consumer Councils part of the governance structure for the PCDP therefore (in exactly the same way as they work within HBDHB structures), there would appear appropriate to have representatives from these groups only on the Governance Group, rather than weighting the PCDP Governance Group with more clinicians (as in the Canterbury Clinical network).

MAORI CONTRIBUTION TO DECISION MAKING

Clause 2.3 of the draft PCDP Agreement contains the provision:

2. **Maori Contribution to Decision Making**; We acknowledge our responsibilities and desire to work with local Maori and enable them to contribute to our Partnership decision making. Given the Memorandum of Understanding between HBDHB and Ngati Kahungunu Iwi Incorporated, this will be achieved through active engagement with HBDHB Maori Relationship Board on all major Partnership decisions.

Given this, it would appear appropriate to have a representative of the Maori Relationship Board on the PCDP Governance Group, with that representative being one of the Ngati Kahungunu Iwi Inc nominees. Maori engagement and involvement at all other levels of service design and development within the PCDP, is also clearly anticipated and expected.

PARTNERSHIP AGREEMENT PRINCIPLES & COMMITMENTS

In establishing the PCDP Governance Group, it is important to acknowledge the context in which the PCDP will operate. The Partnership Principles (Part 3) and the mutual Commitments (Part 4) within the draft PCDP Agreement provide this context. Throughout these parts, there is continual reference to the true partnership nature of the PCDP, requiring the highest levels of ethical behaviour and a real commitment to sharing decision making, responsibility and accountability. This will require all groups within the PCDP to strive for consensus in an open and transparent way, on all matters.

This context also therefore needs to be taken into account in establishing and making appointments to the proposed Governance Group, in that decisions should not be influenced by issues such as 'power' or 'control'.

MEMBERSHIP PROVISIONS

Other proposed provisions within the draft PCDP Agreement that impact on the potential membership of the Governance group includes within clause 8.3:

Membership of Our Partnership Governance Group:

3. At the date of this Agreement the appointed members of our Partnership Governance Group are set out in the Key Information on page 5 of our Agreement.

4. Our Partnership Governance Group may, by agreement, add representatives from other parts of the Hawkes Bay health sector as members at any time, and may remove members as necessary.

5. We confirm that each Partnership Governance Group member may not appoint any alternate to attend our Partnership Governance Group, but may nominate another member to act by proxy in relation to any decision to be made by the Partnership Governance Group.

4 Involvement: We agree that the members' continuous involvement in and attendance at our Partnership Governance Group meetings is critical to our Partnership's success.

5 Chair: The Chair of our Partnership Governance Group shall be the Chair of the PHO

RECOMMENDATION

Taking all the above into account it is recommended that the membership of the PCDP Governance Group be:

Core members will be:

- Three Directors of Health Hawkes Bay Ltd
  - Chair
  - X
  - X
- Three Members of Hawkes Bay District Health Board
  - X
  - X
  - X
- HBDHB Maori Relationship Board NKII representative
  - X
- Hawkes Bay Clinical Council representative
  - X
- Hawkes Bay Health Consumer Council representative
  - X

As the Scope of our Partnership activities expands to cover them, representatives from other parts of the Hawkes Bay health sector may be added, eg:

- Community Pharmacy
- Aged Care
- NGOs

Appendix 2

Hawke's Bay Primary Care Development Partnership Agreement

BETWEEN

HAWKE'S BAY DISTRICT HEALTH BOARD

AND

HEALTH HAWKE'S BAY LIMITED – TE ORANGA HAWKE'S BAY

DRAFT – FOR DISCUSSION
APRIL 2018

SHORT FORM

Table of Contents

Our vision

HEALTHY
HAWKE'S BAY

TE HAUORA O
TE MATAU-Ā-MĀUI

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

Our values

Tauwhiro – delivering high quality care to patients and consumers

Rāranga te tira – working together in partnership across the community

He kauanuanu – showing respect for each other, our staff, patients and consumers

Ākina – continuously improving everything we do

Parties

(DATE) **2017**

THE PARTIES (each a **Party**) are:

Hawke's Bay District Health Board

Health Hawke's Bay Limited – Te Oranga Hawke's Bay

Key Information

1. **Commencement Date: 1 July 2018**

2. **Partnership Governance Group Members**:

Core members will be:

- Three Directors of Health Hawkes Bay Ltd
  - Chair
  - X
  - X
- Three Members of Hawkes Bay District Health Board
  - X
  - X
  - X
- HBDHB Maori Relationship Board NKII representative
  - X
- Hawkes Bay Clinical Council representative
  - X
- Hawkes Bay Health Consumer Council representative
  - X

As the Scope of our Partnership activities expands to cover them, representatives from other parts of the Hawkes Bay health sector may be added, eg:

- Community Pharmacy
- Aged Care
- NGOs

Our Agreement

In consideration of the mutual promises given and received by each of us in this Agreement, we agree that we will be bound by and perform this Partnership Agreement.
Our Agreement comprises the following parts:
Part A: Our Commitment - is a statement of our background, our commitment to a whole-of-system decision making process, our purpose, principles and commitment to success. We agree that the remainder of this Agreement will be interpreted in accordance with the statements made in Part A.
Part B: How We Will Succeed – is a statement of how we will work together, in particular, to achieve success by meeting and exceeding our Partnership Objectives in our Key Results Areas.
Part C: How We Will Work Together - details the processes that we have agreed to apply to how we will work together.

Part D: Term of This Partnership - details how long we expect to work together for and, if or when necessary, how we will wind up our Partnership.
Schedule 1 – includes the scope of our Partnership, our Partnership Activities and Objectives.

PART A: OUR COMMITMENT

Part A of this Agreement is a statement of our background, our commitment to a whole-of-system decision making process, our purpose, principles, values and commitment to success.

2. Scope of Our Partnership

2.1 **Who We Are**: We, the Parties to this Partnership, are the DHB and PHO for the Hawke's Bay district.

2.2 **Our Leaders**: We are led by our Partnership Governance Group, made up of those governance, management and clinical leaders and other key stakeholders, who can successfully lead our Partnership to achieve our Partnership Objectives.

2.3 **Our Purpose**: We have formed our Partnership to improve health outcomes for our populations, through:

2.3.1 transforming, developing and integrating primary and community healthcare services, and shifting activities closer to patients;

2.3.2 eliminating inequities in primary care access and health care delivery

2.3.3 making (and assisting the DHB to make) strategic health care decisions on a "whole-of-system" basis;

2.3.4 providing leadership within our primary and community health community;

2.3.5 assessing the primary and community health care needs of our populations;

2.3.6 planning primary and community health services in our District, to make the best use of health resources;

2.3.7 balancing a focus on the highest priority needs areas in our communities, while ensuring appropriate care across all our populations;

2.3.8 determining services to be funded from delegated funding pools

2.3.9 establishing Service Development Groups to advise on the development, delivery and monitoring of primary and community health services within the scope of the Partnership;

2.3.10 monitoring services that fall within the scope of our Partnership Activities; and

2.3.11 informing our populations and other stakeholders of our performance in achieving our objectives.

2.4 **Our Partnership Activities and Objectives**:

2.4.1 The scope of our Partnership is determined by our Partnership Activities. It is anticipated that this scope will be initially restricted to specific service areas, but will expand over time. Our Partnership, in carrying out its Partnership Activities, may not be involved in all healthcare services in our District.

2.4.2 Our Partnership also has specific Partnership Objectives that we expect to meet and exceed as part of our Partnership Activities.

2.4.3 The scope of our Partnership, our Partnership Activities and our Partnership Objectives are set out in Schedule 1.

2.5 **Our Conduct**: We will conduct our Partnership Activities and achieve our Partnership Objectives, by acting consistently with our Partnership Principles.

2.6 **What We Are Not**:

2.6.1 Our Partnership does not directly provide healthcare services although we will make decisions and recommendations on what services should be funded by the Parties.

2.6.2 Our Partnership does not have any authority over, nor responsibility for, any services provided directly by any employees of the Parties.

2.6.3 We work collaboratively but are not collectively established as a legal entity, as set out in clause 25.

3. Overview of Decision Making

3.1 **Allocation of Decision Making**: At the core of this Agreement is a decision-making process that makes clear which decisions remain with the DHB, the PHO and the Government, and which decisions are devolved to us, the Parties.

3.2 **Clinician-Led Decision Making**: We recognise that clinicians, alongside others, are in the best position to make decisions about how to apply resources to specific services to achieve the best outcomes. These decisions will involve less specification and an emphasis on quality processes and transparency of information to assure accountability and best value for money. Our Hawke's Bay Clinical Council (appointed by the Parties) will be the structure through which this is achieved.

3.3 **Maori Contribution to Decision Making**; We acknowledge our responsibilities and desire to work with local Maori and enable them to contribute to our Partnership decision making. Given the Memorandum of Understanding between HBDHB and Ngati Kahungunu Iwi Incorporated, this will be achieved through active engagement with HBDHB Maori Relationship Board on all major Partnership decisions.

3.4 **Consumer Input into Decision Making**: We recognise that consumer input is essential in all levels of decision making. At the Partnership level, this will be achieved by ensuring all major Partnership activity decisions will involve input and support from the Hawke's Bay Health Consumer Council.

3.5 **Decisions Made by Government**: The balancing side of the decision-making process is that it remains the role of the Government to determine the gross allocation of public funding, so as to achieve the best balance of outcomes for the population. Wherever possible this will involve discussion with clinicians, providers and/or the community through our Partnership but we recognise that in some cases these decisions may be taken centrally.

3.6 **Decisions Made by the DHB**: We recognise that the DHB has two roles:

3.6.1 as a Party within our Partnership, and

3.6.2 as the Government's agent, as the funder of health services in the District.

3.7 Our Partnership is intended, in part, to assist the DHB to fulfil its statutory objectives and functions as a funder of health services. The DHB will work within our Partnership to fulfil those obligations where it is appropriate and practicable to do so.

3.8 However, we acknowledge that the DHB's statutory and other obligations will require it to make some decisions, which may affect our Partnership, outside of our Partnership and this Agreement. Without limiting its ability to make those decisions, the DHB undertakes to make those decisions, insofar as is reasonably practicable, in good faith and having regard to our Partnership's Objectives., We agree that nothing in this Agreement limits the DHB's rights, powers, obligations or liabilities under any Law or other agreement referred to in clause 9.2.

3.9 **Decisions Made by the PHO**: Equally, we recognise that the PHO is subject to its own governance obligations. We also agree that nothing in this Agreement limits the PHO's rights or obligations, necessary to comply with its governance obligations under any Law or other agreement.

4. Our Partnership Principles

4.1 We will conduct ourselves and undertake our Partnership Activities in a manner consistent with the Hawke's Bay Health Sector Vision and Values, and our Partnership Principles and will take all reasonable steps to ensure that our employees, contractors and agents do likewise.

4.2 We agree that every part of this Agreement must be read in such a way as to be consistent with, and ensure the integrity of, our commitments to our Partnership Principles.

4.3 **Our Partnership Principles**: Our Partnership is founded on the following principles:

4.3.1 we will support clinical leadership and, in particular, clinically-led service development;

4.3.2 we will adopt a patient-centred, integrated, whole-of-system approach, and make decisions on a Best for System basis;

4.3.3 we will conduct ourselves with honesty and integrity, and develop a high degree of trust;

4.3.4 we will promote an environment of high quality, performance and accountability, and low bureaucracy;

4.3.5 we will strive to resolve disagreements co-operatively and, wherever possible, achieve consensus;

4.3.6 we will seek to make the best use of finite resources in planning and delivering health services to achieve improved health outcomes for our populations;

4.3.7 we will adopt and foster an open and transparent approach to sharing information;

4.3.8 we will monitor and report on our Partnership's achievements, including public reporting;

4.3.9 we will be collectively responsible for all decisions and outcomes of our Partnership;

4.3.10 we will operate as a unified team providing mutual support, appreciation and encouragement;

4.3.11 we will conduct ourselves in accordance with Best Practice;

4.3.12 we will support professional behaviour and leadership;

4.3.13 we will remain flexible and responsive to support an evolving health environment;

4.3.14 we will incorporate whanau ora approaches where appropriate;

4.3.15 we will develop, encourage and reward innovation and challenge our status quo;

4.3.16 we will actively support and build on our successes; and

4.3.17 we commit to fully exploring the collective sharing and management of the risks and benefits arising from our Partnership Activities. Where we cannot manage risk collectively, our principle is to allocate responsibility for each risk to those of us who can best manage it.

PART B: HOW WE WILL SUCCEED

Part B of this Agreement is a statement of how we will work together, in particular, to achieve success by meeting and exceeding our Partnership Objectives in our Key Results Areas.

5. Commitments

5.1 **Shared Decision Making**:

5.1.1 Each of us is fully committed to our Partnership and carrying out our Partnership Activities to achieve our Partnership Objectives. We acknowledge that this commitment is fundamental to our Partnership's success.

5.1.2 We will work as one team, in an innovative and open manner, to produce outstanding results.

5.1.3 We will work on an Open Book basis to help achieve the best results from our Partnership Activities.

5.2 **Shared Responsibility**:

5.2.1 We all take responsibility for our Partnership's success and our failures.

5.2.2 We all take responsibility for achieving consensus decisions within our Partnership.

5.2.3 We all take responsibility for addressing all potential disputes within our Partnership.

5.2.4 We will establish and maintain an environment within our Partnership that encourages open, honest and timely sharing of information.

5.3 **Shared Accountability**: We are both responsible collectively for identifying, managing and mitigating all risks associated with our Partnership Activities.

5.4 **Commitment to Good Faith**: We will, at all times:

5.4.1 act in good faith and be fair, honest and ethical in our dealings with each other;

5.4.2 make all decisions on a Best for System basis and when making such decisions, will give predominate weight to the interests of our Partnership over our own self-interest;

5.4.3 do everything that is reasonably necessary to enable each of us to undertake our Partnership Activities and perform our obligations under this Agreement;

5.4.4 not act in a manner that impedes or restricts each other's performance of our Partnership Activities and the performance of our obligations under this Agreement; and

5.4.5 do all things that are, or may reasonably be, expected of us so as to give effect to the spirit and intent of this Agreement and our Partnership.

5.5 **Commitment to Consultation**: We recognise that both of us may, in the course of undertaking our Partnership Activities and otherwise meeting our commitments under this Agreement, be required to consult with others who do not form part of our Partnership. We will provide a reasonable opportunity to do so in a prudent and timely manner.

6. Service Development & Working Groups

6.1 **Service Development**: Where our Partnership identifies a service within the scope of our Partnership Activities that requires transformational change, we may establish a Service Development group to:

6.1.1 recommend how the service should be delivered within the scope of our Partnership;

6.1.2 monitor and report on the performance of a service within the scope of our Partnership.

6.2 **Working Groups**: Clause 5.1 does not limit our ability to establish any other Working Groups that it considers necessary to advise it on any aspect of our Partnership Activities.

6.3 **Scope and Conditions**: A Service Development or other Working Group will operate according to any directions, conditions or restrictions established by us. This will include the lines of accountability to the appropriate body within our Partnership structures, and may include a direction to work collaboratively with Other Partnerships.

7. Services Planning

7.1 We will work together to decide how our Partnership will carry out service planning for those services within the scope of our Partnership Activities, which may include delegating decision making authority to our Partnership Governance Group and/or Clinical Council.

7.2 Our Clinical Council may, at its discretion, consult, work with or seek recommendations from a Service Development or Working Group or other appropriate party to assist with their decision making for our Partnership in relation to service planning for those clinical services within the scope of our Partnership Activities.

7.3 Our Partnership Governance Group or Clinical Council may, as a result of service planning decisions/recommendations made by our Partnership, recommend to the DHB the method and form of contracting for the delivery of the service on a Best Practice basis.

7.4 The DHB will implement our Partnership Governance Group's decisions/recommendations, subject only to its statutory requirements and its Reserved Powers, as set out in clause 2.7.

7.5 In implementing our Clinical Council and/or Partnership Governance Group's decision/recommendation, the DHB may:

7.5.1 undertake a procurement process based on the specification for the activity, work or service recommended by our Partnership;

7.5.2 enter into agreements/contracts with relevant providers, which may include Parties and/or others; and/or

7.5.3 select from the Parties and other service providers those capable of providing the activity, work or service in accordance with the specification for the activity, work or service recommended by our Partnership.

7.6 The PHO will implement our Partnership Governance Groups' decisions/recommendations for those services within our Partnership Activities for which it has direct responsibility:

PART C: HOW WE WILL WORK TOGETHER

Part C of this Agreement details the structures and processes that apply to how we will work together.

8. Leadership Structure

8.1 **General Structure**:

8.1.1 Our Partnership will be directed and lead by our Partnership Governance Group.

8.1.2 The day-to-day affairs of our Partnership will be co-ordinated by our Partnership Support Team (made up of relevant members of the management teams of the DHB and PHO) and supported by both the Clinical and Consumer Councils.

8.1.3 Our Partnership Support Team will be led by the HBDHB Executive Director Primary Care

8.2 **Service Developments**: Our Service Development groups will be led and directed by a Service Development Leadership Team, acting within a scope of authority, agreed by the Parties.

9. Partnership Governance Group Terms of Reference

9.1 **Our Partnership Governance Group**: We agree that we will have an Partnership Governance Group whose primary function will be to lead us with respect to our Partnership Activities and our Partnership, in accordance with this Agreement.

9.2 **Duties of Our Partnership Governance Group**: The duties of our Partnership Governance Group include:

9.2.1 promoting and supporting the vision, values and direction of our Partnership;

9.2.2 facilitating clinical leadership within our District through the Clinical Council;

9.2.3 establishing principles and setting challenging objectives;

9.2.4 facilitating, empowering and enabling the achievement of Partnership objectives/outcomes;

9.2.5 maintaining a coherent set of policies and procedures as necessary to undertake its duties;

9.2.6 agreeing with the DHB, in accordance with clause 6:

(a) our Key Results Areas and Partnership Objectives, including the systems and key performance indicators for assessing achievement of these;

(b) the work, activity and services to be provided to meet our Partnership Objectives within the Key Result Areas;

9.2.7 establishing and/or supporting Service Development and other Working Groups as necessary to oversee the development and delivery of services that fall within the scope of our Partnership Activities;

9.2.8 providing high level support and stakeholder interface;

9.2.9 monitoring and encouraging inter-Party relationships and stakeholder engagement;

9.2.10 agreeing and adopting transparent governance and accountability structures for our Partnership; and

9.2.11 mentoring and championing our Partnership and its Parties as reasonably required.

9.2.12 approving the allocation of delegated/devolved funding pools

9.2.13 approving system and district level measures and related allocation of incentives, in conjunction with the Clinical Council.

9.3 **Membership of Our Partnership Governance Group**:

9.3.1 At the date of this Agreement the appointed members of our Partnership Governance Group are set out in the Key Information on page 5 of our Agreement.

9.3.2 Our Partnership Governance Group may, by agreement, add representatives from other parts of the Hawkes Bay health sector as members at any time, and may remove members as necessary.

9.3.3 We confirm that each Partnership Governance Group member may not appoint any alternate to attend our Partnership Governance Group, but may nominate another member to act by proxy in relation to any decision to be made by the Partnership Governance Group.

9.4 **Involvement**: We agree that the members' continuous involvement in and attendance at our Partnership Governance Group meetings is critical to our Partnership's success.

9.5 **Chair:** The Chair of our Partnership Governance Group shall be the Chair of the PHO.

9.6 **Decision Making**: When making a decision, determination or resolution, our Partnership Governance Group (together and individually) must:

9.6.1 have regard to its duties, specified at clause 8.2 of this Agreement;

9.6.2 have regard to this Agreement;

9.6.3 consider the matter before them in good faith and use their best endeavours to facilitate a consensus decision;

9.6.4 not prevent a consensus decision being made for trivial or frivolous reasons;

9.6.5 use all relevant information in a timely fashion; and

9.6.6 actively seek and facilitate a consensus decision, determination or resolution.

9.7 **Reporting**: Our Partnership Governance Group will provide a report to the Parties following each Partnership Governance Group meeting, and an Annual Report about its performance.

9.8 **Implementing Decisions**: We will implement all decisions and directions of our Partnership Governance Group concerning our Partnership and this Agreement.

10. Service Development Leadership Team

10.1 **Service Development Leadership Team**: We agree that we may appoint a leadership team (**Service Development Leadership Team**), whose primary function will be to direct and lead a Service Development and provide guidance and leadership to us with respect to those of our Partnership Activities that are within the scope of that Service Development (**Service Activities**).

10.2 **Duties of a Service Development Leadership Team**: The duties of a Service Development Leadership Team may include:

10.2.1 providing a vision, strategic leadership and direction;

10.2.2 providing clinical leadership;

10.2.3 recommending how the services should be delivered in the District; and

10.2.4 monitoring and reporting on the performance of the service;

10.3 **Consensus Decision-Making**: Unless all of us agree otherwise, every decision, determination and resolution of a Service Development Leadership Team must be made by consensus of those present (whether in person, by telephone or videoconference), or by proxy, at the relevant meeting on a Best for System basis.

PART D: TERM OF THIS PARTNERSHIP

Part D of this Agreement details how long we expect to work together for and, if or when necessary, how we will wind up our Partnership.

11. Term

This Agreement commences upon the Commencement Date specified in the Key Information and continues in effect until:

11.1 30 June 2028

11.2 The Parties may agree to renew this Agreement from this date.

12. Suspending Partnership Activities

12.1 **Suspension by Our Partnership Governance Group**: Our Partnership Governance Group may suspend some or all of our Partnership Activities at any time.

12.2 **Suspension by the DHB**: The DHB may suspend some or all of our Partnership Activities, as a Reserved Power, if it determines that it is necessary to do so to prevent a breach of a Statutory Requirement.

12.3 **Recommencement**: We will recommence the performance of Partnership Activities only when directed to do so by our Partnership Governance Group or the DHB, under clause 22.1 or clause 22.2 as the case may be.

13. Terminating Our Partnership

13.1 **Termination by the DHB**: We agree that the DHB may, in exceptional circumstances, terminate this Agreement as a Reserved Power.

13.2 **Termination by either Party**: We agree that either Party may terminate this Agreement due to ongoing Wilful Default by the other Party.

13.3 **Termination by Agreement**: We agree that this Agreement may be terminated by mutual agreement between the Parties.

Executed as an Agreement
Executed for Health Hawkes Bay Limited by:

in the presence of

Director/Authorised Signatory

Director/Authorised Signatory

Witness signature

Full name

Occupation

Address

Executed for Hawkes Bay District Health Board by:

in the presence of

Director/Authorised Signatory

Director/Authorised Signatory

Witness signature

Full name

Occupation

Address

Schedule 1 - Scope of our Partnership, Partnership Activities & Partnership Objectives

4 The ultimate scope of our Partnership may include any/all those publically funded primary and community healthcare services and activities, within the Hawke's Bay Health Sector, where benefits and/or performance could be improved through enhanced integration of services.

5 On an ongoing basis, the scope of our Partnership will generally be determined by agreement to establish specific Service Development Groups or Working Groups. General issues may be included within the scope as agreed from time to time.

6 The initial scope of our Partnership shall include the following:

- X
- X
- X
- X

7 Our initial Partnership Activities are:

Activity
•
•
•
•
•
•

8 We will review the Scope of our Partnership and our Partnership Activities/Objectives annually, in conjunction with our annual planning processes.

9 Our Partnership Objectives are:

Partnership Objectives
• To improve the performance of primary and community healthcare in terms of: - Health and equity for all populations - Quality, safety and experience of care - Best value from health system resources • Specific SMART Objectives???
• Facilitate the development, implementation, monitoring and achievement of specific primary and community healthcare objectives as set out in the Annual Plan

HAWKE'S BAY District Health Board Whakawāteatia	**National Bowel Screening Programme Roll-out** 62
	For the attention of: **HBDHB Board**
Document Owner	Chris Ash, Senior Responsible Owner
Document Author(s)	Dr Malcolm Arnold, Clinical Lead; and Lynda Mockett, NBSP Project Manager
Reviewed by	Claire Caddie, Project Sponsor and Chris Ash, Senior Responsible Owner and Executive Management Team Presentations only provided to Maori Relationship Board, HB Clinical Council and HB Health Consumer Council.
Month/Year	May 2018
Purpose	Input/Discussion for Monitoring
Previous Consideration Discussions	Update on National Bowel Screening Programme (NBSP) implementation in Hawke's Bay
Summary	The NBSP is currently being established at HBDHB. The 'Provision of information planning and establishment for a NBSP' is set out in the MoH agreement with HBDHB. This report is to inform HBDHB Leadership Teams of the Service Schedule including: outputs; deliverables; and, performance measures and HBDHB planning and establishment status against these.
Contribution to Goals and Strategic Implications	This project is strategically aligned to the NBSP and has linkages to the Faster Cancer Treatment (FCT) target.
Impact on Reducing Inequities/Disparities	The Health Equity Assessment Tool (HEAT) has been applied to HBDHB Bowel Screening Equity Plan. The Plan focuses on equity of participation and quality throughout the screening pathway and recognises and addresses the needs of priority groups such as Māori, Pacific peoples and those living in deprived areas.
Consumer Engagement	The Programme is being informed and developed in conjunction with local consumers and key stakeholders (including, Māori, Pacific peoples and the wider community). This will have a positive impact on reducing inequity through reduced travel, more culturally responsive services, closer to home.
Other Consultation /Involvement	Consultation, support and visit has been undertaken with Hutt Valley DHB – who is HBDHB's regional support mechanism, along with other DHBs who are implementing the Programme already, e.g. Southland and Waitemata DHB. The MoH BSP Relationship Manager provides support with the BSP establishment as well.
Financial/Budget Impact	The Project has an Establishment Budget of $170 thousand. There is an indicative 2018/19 and 2019/20 budget post 'go-live' for the implementation of circa $700 thousand per annum.

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Timing Issues	'Readiness Assessment' (Audit) 15 August 2018 'go-live' 9 October 2018
Announcements/ Communications	A detailed Communication Plan has been developed outlining Hawke's Bay DHB's strategic and community engagement activity and communication approach to support the DHB's Bowel Screening programme for the period April – November 2018.

RECOMMENDATION:

It is recommended that the HBDHB Board

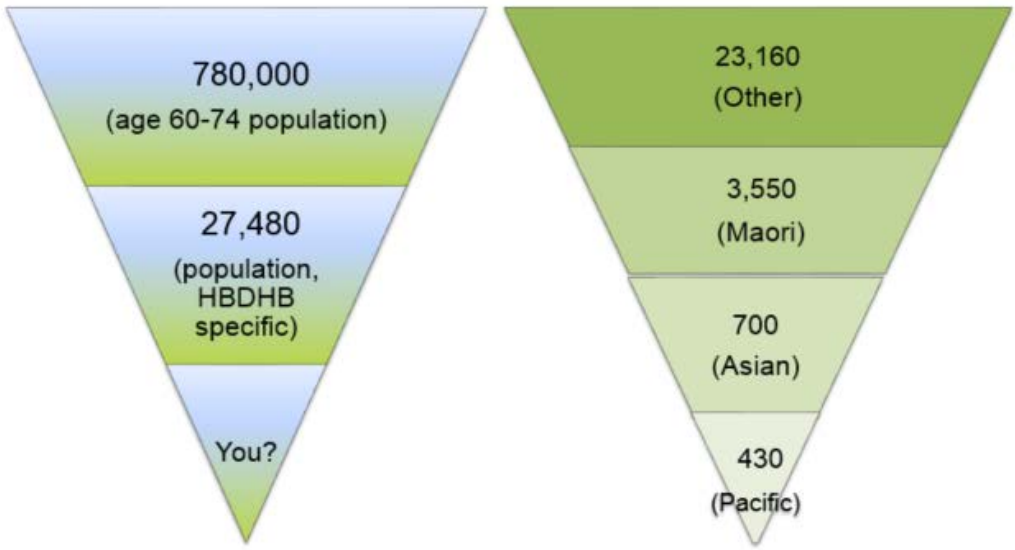
1. **Note** the contents of this report
2. **Continue to support** the planning, establishment and implementation of the National Bowel Screening Programme at HBDHB as set out in the contract agreement with MoH.

National Bowel Screening Roll-Out Programme

Authors	**Dr Malcolm Arnold, Clinical Lead and Lynda Mockett, NBSP Project Manager**
Date:	**May 2018**

BACKGROUND
HBDHB has entered into a contract with the Ministry of Health (MoH) to establish and implement NBSP.

Eligible Population in Hawke's Bay



In Hawke's Bay the eligible population is expected to increase on average 2% per annum over the next 10 years from 27,840 in 2017/18 to 33,020 by 2027/28. The Māori, eligible population is projected to increase by an average 4% per year over the next 10 years from 3,550 in 2017/18 to 5,060 by 2027/28. The Pacific eligible population is projected to increase by nearly 5% per year over the same period from 430 people in 2017/18 to 680 by 2027/28.

Bowel screening is an equity negative programme with the main population being Pakeha at 83%. 27% of the eligible population live in areas classified as socio-economically deprived, and this includes the Maori and Pacific population where 56.8% of Maori and 73.6% of Pacific peoples are socio-economically disadvantaged living in areas classified as high deprivation areas. The HEAT has been employed in the development of HBDHB Service Delivery plans and identified common inequities in terms of access to treatment and primary care, transient households, cultural identity and language and geographical location.

HIGH LEVEL PROJECTS OBJECTIVES

- Provide necessary information to MoH and HBDHB.
- Undertake initial planning for the implementation of bowel screening.
- Ensure HBDHB are adequately prepared for the implementation of the Programme and understand the implication of bowel screening.
- Ensure all systems and processes are in place to confirm HBDHB readiness to implement the NBSP for the eligible population.

PROJECT DELIVERABLES AND TIME SCHEDULE

MoH Deliverables Summary	Due date
Monthly Progress Reports	20th of each month.
Endoscopy Production Planning	20 April 18 Ongoing
Phase One	
Final - Business Case	28 February 2018 Complete
Phase Two	
Project Planning & Establishment Documents	20 April 18 - Complete
Self-Assessment	9 - 27 July 18
Audit process & performance statistics in place Readiness Assessment(s) completed and signed off	15 August
Confirmation of IT changes and integration	1 Sept 18
BSP 'Go-live'	9 October
Final Report for Phase 2 – outputs 4 to10	Go live +30 days

PROJECT APPROACH

The approach to delivering on the objectives is guided by the MoH specifications, in conjunction with the MoH NBSP Service Output, Interim Quality Standards and NBSP Service Delivery Model, and will be established and delivered by the Working Groups. The project is run with an agile framework that is underpinned with PRINCE2 methodologies. The establishment and integration of the project is supported by HBDHB PMO office where workflows and reporting functions will be managed by a centralised Project Management Software - Psoda.

PROJECT WORKING GROUPS AND KEY DELIVERABLES

Working Group	High Level Deliverables
Primary Care	Primary Care engagement plan Training activities and roles
Information Technology	Integration to MoH Interim BSP + Register Enhancements to HBDHB systems
Clinical, Treatment, Endoscopy	Workforce planning, Production Planning & Quality Standards
Diagnostics	Histopathology, Radiology & Laboratory, Multi-Disciplinary Meeting (MDM) workforce planning & Quality Standards
Equity & Engagement	Equity planning & implementation
Communication	Communication & engagement plan for eligible people

TIMING

Currently each working group is on track to delivering the key objectives in full and on time. As with any project and rollout, there may be some inter–project dependencies that could arise. A risk management plan is supporting each working group through to completion. This work includes, among others, a focus on Colonoscopy Capacity Planning by ensuring weekly monitoring and production planning is in place to help counteract wait list targets influenced by acute demand; The development of a clinical NBSP Multi-Disciplinary Team to focus on clinical pathway processes to

ensure timely clinical decisions and referral targets, as well as a focus on histology and laboratory resourcing to cope with demand.

RECOMMENDATION:

It is recommended that the HBDHB Board

1. **Note** the contents of this report
2. **Continue to support** the planning, establishment and implementation of the National Bowel Screening Programme at HBDHB as set out in the contract agreement with MoH.

ATTACHMENTS

Bowel Screening Power Point Presentation

HAWKE'S BAY District Health Board Whakawāteatia	**The place of alcohol in schools: Young people and under-age exposure** 63 For the attention of: **HBDHB Board**
Document Owner	Kevin Snee – Chief Executive Officer
Document Author(s)	Rowan Manhire-Heath, Population Health Advisor
Reviewed by	Dr Nicholas Jones – Acting Clinical Director, Population Health and Executive Management Team; Maori Relationship Board; HB Clinical Council and HB Health Consumer Council
Month/Year	May 2018
Purpose	For endorsement
Previous Consideration Discussions	Nil
Summary	This paper seeks District Health Board endorsement of the attached report on alcohol use at school events attended by children. The report will be circulated to school boards or trustees and other relevant parties to inform school alcohol policy development and decisions about the use of alcohol at school events. The report includes: • A review of scientific literature concerning the impact of exposure to alcohol in childhood • A summary of Hawke's Bay data on alcohol licenses and schools • Recommendations for actions A summary of the full report is also provided for DHB endorsement
Contribution to Goals and Strategic Implications	• Reducing alcohol related harms in Hawke's Bay by: o Addressing underlying drivers of alcohol use o Shifting attitudes towards alcohol o Delay uptake of drinking by young people o Reduce hazardous drinking in whole population
Impact on Reducing Inequities/Disparities	Will reduce indirect harms caused by exposure to alcohol, protecting young people who are affected by alcohol-related harm in their home or community. Will contribute to reducing disparities in harmful alcohol use particularly among young people.
Consumer Engagement	To be reviewed by Consumer Council and Youth Consumer Council prior to endorsement by the Board
Other Consultation /Involvement	Alcohol Harm Reduction Steering Group Māori Health Service
Financial/Budget Impact	No financial impact
Timing Issues	Not applicable

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Announcements/ Communications	A risk management plan will be developed in respect to sharing the report and will include some key messages.

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Endorse** the report and summary.

ATTACHMENTS:

- The place of alcohol in schools: Young people and under-age exposure report
- Summary – Fact Sheet : The Place of Alcohol in Schools

The place of alcohol in schools: Young people and under-age exposure

March 2018

Prepared by:	Rowan Manhire-Heath (Population Health Advisor) With support from the Hawke's Bay District Health Board Population Health and Business Intelligence teams
Please contact:	Rowan.Manhire-Heath@hawkesbaydhb.govt.nz

E whanake te rākau mahuri pokepoke, he rakau whakatangatatia

As a young sapling is moulded, that is the growth of an adult tree

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EXECUTIVE SUMMARY

Exposure to alcohol during childhood and adolescence—either through witnessing adults drinking or via alcohol marketing—has shown to increase the likelihood of a young person drinking alcohol both at an earlier age, and of drinking more hazardously.

A number of settings where alcohol promotion is pervasive—particularly in respect to the influence on children and young people—are of concern to the Hawke's Bay District Health Board and these include: supermarkets, in association with sport and online and, most significant to this report, schools and educational settings. The District Health Board's concern results from the potentially high number of children and young people exposed in these settings. This report will explore exposure to alcohol in these settings, the impact of exposure to alcohol on children and young people[1] and will present data on the prevalence of alcohol use by adults in schools and educational settings in Hawke's Bay.

The District Health Board is clear in its position: alcohol and schools do not mix. This stance is supported by a growing body of evidence showing that exposure to alcohol in childhood increases the likelihood of adolescent and hazardous drinking. 'Exposure' in the capacity of this report refers to the visual presence and modelling of drinking behaviours as opposed to the actual consumption of alcohol. This position is shared by Medical Officers of Health throughout New Zealand and is evident in Australia, where concerns have been raised about alcohol's 'distinct presence' in schools (Ward et al., 2014).

Within the recently developed Hawke's Bay District Health Board *Alcohol Harm Reduction Strategy*, 'denormalising alcohol use' is emphasised as imperative to achieving the key outcomes:

- Delayed uptake of drinking by young people
- Reduced hazardous drinking prevalence across the whole Hawke's Bay population.

Ministry of Education guidelines for schools on the sale and supply of alcohol emphasise that "…schools are a core part of our community and social structure and are important settings for promoting health and wellbeing through education, policies and modelling behaviour" (2016, p.1).

The District Health Board maintain that consumption of alcohol within the school environment reinforces the inaccurate perception that alcohol is a safe product that must be accommodated in all settings. Given the increase in alcohol availability and acceptability in New Zealand society—and the consequent increased harms that are resulting—the school environment represents one setting that must have children's wellbeing interests at the centre. This is not to downplay the role of other settings or influences on young people's attitudes and behaviour towards alcohol. However few would argue that schools and early education centres (ECEs) in particular play a very significant symbolic place in children's lives, where it is expected that children's, rather than adult's needs predominate.

Indeed within the United Nations Convention on the Rights of the Child (UNCROC)—a global human rights treaty ratified by the New Zealand government in 1993—the best interests of the child must be a primary

[1] References to children in this report include all young people under the age of 18.

consideration "in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies…". The convention goes on to state that "…parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs or psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances." It can be reasonably argued that some fundraising events in schools using children to promote the sale of alcohol could be seen as a contravention to this article and others under UNCROC.

The District Health Board has a vision that schools are recognised as significant spaces where the best interests of children are a primary consideration and that they embrace their responsibility to create healthy and safe environments for children and communities by choosing to be alcohol-free.

We encourage feedback on this report and its subject matter.

THIS REPORT SEEKS TO:

1. Highlight the evidence associated with exposure to alcohol and the harm it can cause young people
2. Share data on the prevalence of the sale and supply of alcohol to adults in schools and educational settings in Hawke's Bay
3. Provide practical recommendations for all stakeholders that support the achievement of the Hawke's Bay District Health Board's vision.

HAZARDOUS DRINKING IN HAWKE'S BAY

The Hawke's Bay population as a whole is drinking more hazardously than the rest of New Zealand. The Ministry of Health define hazardous drinking as an established pattern of drinking that carries a risk of harming physical or mental health, or having harmful social effects to the drinker or others. Hazardous drinking is defined by a score of 8 or more on the alcohol screening tool known as AUDIT, the Alcohol Use Disorders Identification Test (Ministry of Health, 2015). Of the approximately 20,000[2] young people aged 15-24 living in the region, over one in two males are drinking hazardously, and almost one in three females[3], a rate significantly higher than the national average for the same age group (one in four).

Estimates suggest that one in three young people aged 12-16 years engage in binge-drinking (Fortune, et al., 2010). Evidence also shows that young people experience more harm per drink than older adults (The Law Commission, 2010) and that the impact of alcohol on the developing brain (up to the age of 25) is enough to bring about learning and memory difficulties, depression and alcohol dependency problems later in life (Crews, He & Hodge, 2007). Positively, there appears to be a shift emerging in young people's drinking patterns, with more young people choosing not to drink yet the harmful pattern of drinking in those that choose to drink remains unchanged (Ministry of Health, 2015).

A high level of hazardous drinking exists within a region known nationally and globally for its strong and successful wine industry—a major source of employment and income for Hawke's Bay.

As such, the promotion of the benefits of alcohol production and consumption are likely conveying the message to the population of Hawke's Bay that drinking alcohol is a normal and socially accepted activity that has positive and wide-reaching consequences.

This is in spite of the stark data that shows that up to 800 New Zealanders die from alcohol-related causes each year and that alcohol misuse is associated with over 200 conditions ranging from cancer to osteoporosis and pancreatitis. Further, alcohol-related harm is more than an individual issue as the impact of alcohol consumption on others, such as families, communities and wider society is substantial and is estimated to cost an overall $6.5 billion each year.

Although the District Health Board understands that not all consequences of drinking alcohol is negative, it is important to ensure messages around safer consumption of alcohol are heard. Many drinkers for example, cannot identify a standard drink (Kerr & Stockwel, 2011).

Many myths about alcohol consumption exist. For example, it is commonly believed that low risk drinking is 'no risk', yet any consumption of alcohol carries a risk. Factors such as; the rate of drinking, body and genetic makeup, gender, age, existing health problems and any medications influence this risk. Also, there is no safe limit in pregnancy.

[2] Source data from Stats NZ Subnational population estimates (RC, AU), by age and sex at 30 June 1996, 2001, 2006-17 (2017 boundaries)

[3] 41.1% of age group 15-24 years (or 53.9% males, 30.6% females) in Hawke's Bay (2011-14) as compared with 25.6% for NZ overall for same age group

In order to reduce the prevalence of hazardous drinking—particularly by Hawke's Bay young people—it is important that the population understands the harm caused by alcohol and the impact of alcohol exposure on children and young people.

YOUNG PEOPLE AND EXPOSURE TO ALCOHOL

As previously emphasised, a growing body of evidence exists to show that exposure to parental consumption and alcohol marketing directly influences a young person's decision to start drinking alcohol and the amount of alcohol they consume (Anderson et al., 2009; Smith & Foxcroft, 2009; Ryan et al., 2010).

Exposure to parental drinking

Although little evidence exists that demonstrates the benefits of a child seeing a parent consuming alcohol, the impact of exposure to parental drinking is a highly contested topic. A popular discourse in New Zealand that supports exposure to parental drinking as a method of teaching 'responsible' drinking, references the 'European approach' to alcohol consumption, whereby children are exposed to alcohol consumption via parental drinking and may be given small amounts of alcohol from an early age. Evidence suggests that this is an inaccurate and harmful belief, and instead results in young people more likely to drink hazardously at an earlier age (Kaynak et al., 2014). The belief also precedes and undermines messaging around the harms of alcohol that children may receive through school-based health education or wider health promotion messages.

In October 2017, the Institute of Alcohol Studies Scotland released findings of a study exploring the impact of non-addicted parental drinking on children. The authors found that children who had witnessed their parent tipsy or drunk were less likely to consider their parent as a positive role model, and were more likely to experience negative impacts (such as feeling worried or embarrassed) as a result (IAS, 2017). The same children were also more likely to report a parent being more unpredictable than usual, more argumentative or being less comforting and sensitive (IAS, 2017). These results were the same across all levels of parental alcohol consumption (from low to high).

Due to the prevalence of hazardous drinking in Hawke's Bay, we can assume that many of the region's schools and early childhood education centres will include families where students will experience the consequences of harmful drinking at home. In addition to the IAS findings, evidence also exists to show an association between hazardous parental alcohol use and child abuse and neglect (Bays, 1990; Freisler, Midanik & Gruenewald, 2004). By being alcohol-free, schools and early childhood education centres can offer a 'safe haven' for these children.

Although the impact of parental drinking on children is significant, other social influences are believed to also play a role in a child's future beliefs and behaviours around alcohol. Bendsten et al. (2013) identified an association between adolescent drunkenness and the levels of alcohol consumption in their community that cannot be explained by parental drinking patterns. Such research provides evidence of the extent of the influence community behaviours have on young people, even when parents role model positive behaviours around alcohol to their children in the home.

Exposure to alcohol marketing

There is evidence of an association between young people's exposure to alcohol marketing and sponsorship, and subsequent earlier age of initiation to drinking alcohol, increased consumption and increased experience of alcohol-related harm (Bryden et al., 2012; De Bruijn, 2012: De Bruijn et al., 2012; Gordon et al., 2011; Grenard, Dent & Stacy, 2013; Lin et al., 2012).

Supermarkets

Although legislation exists that prohibits the marketing of alcohol to young people (Sale and Supply of Alcohol Act 2012), the presence of alcohol in supermarkets—an outlet regularly visited by children and young people—undermines this safeguard.

Since 1990, the sale of alcohol in supermarkets has heralded the normalisation of alcohol as a commonly used commodity. Recent research from Otago University shows how frequently children are exposed to alcohol marketing in New Zealand supermarkets, recording exposure on 85 percent of study participants' supermarket visits (Chambers et al., 2017). Further, alcohol was found to be located near staple foods such as bread and milk, reinforcing the perception of alcohol as just another ordinary food stuff.

Despite instruction on methods of reducing exposure in supermarkets within the Sale and Supply of Alcohol Act 2012 (SSAA)—such as single alcohol areas (SAA)—it is highly questionable whether the new Act has led to any reduction in exposure (Chambers et al., 2017).

Sport

What is often considered a staple of New Zealand life, sport—is yet another setting where the marketing of alcohol is widespread and participation of children and young people is high. This is in spite of the clear conflicting association of sport—a healthy activity—and alcohol—a product that causes harm.

One New Zealand study found that sports sponsorship by 'unhealthy' industries (alcohol, gambling and unhealthy foods) was twice as common as those sponsored by 'healthy' industries (Maher et al., 2006). The authors also identified rugby as the sport most commonly sponsored by the alcohol industry, a concerning result as this sport is arguably the most popular and high profile in New Zealand. Maher et al. (2006) describe the impact of such sponsorship as both obscuring the health risk of alcohol while simultaneously promoting consumption.

This phenomenon has been epitomised by a 2017 large scale review of New Zealand Rugby following a series of alcohol-fueled incidents. Although the Research and Responsibility Review received much attention, there appears to be a reluctance to relinquish alcohol sponsorship. Concerns have been raised about the impact of such sponsorship in a report by the New Zealand Law Commission who called alcohol "…an unquestioned adjunct to New Zealander's social, cultural and sporting life for many generations" (2010, p. 37).

In 2014, the Ministerial Forum on Alcohol Advertising and Sponsorship concluded the need to change the sponsorship of sporting, cultural and musical events away from alcohol to reduce youth exposure. The Forum recognised the established evidence that voluntary self-regulation codes by the alcohol industry have not been successful in reducing rates of alcohol consumption among young people (Fergusson & Boden, 2011).

Online advertising

Social media is an emerging platform for the marketing of alcohol, one that is less regulated and importantly, one that is well-used by young people. In New Zealand, advertising of alcohol on television is restricted to hours where young people are not expected to be viewing (after 10pm), there are no such restrictions on online advertising. Young people may also use social media to share stories and images of alcohol consumption and this has the potential to normalise and humourise hazardous drinking. The use of social media to promote alcohol was also highlighted by The Ministerial Forum (Ministerial Forum on Alcohol Advertising & Sponsorship, 2014) whose recommendations have yet to be actioned.

Schools

Evidence suggests that sponsorship of schools by the alcohol industry is already occurring. Sponsorship by alcohol and other 'unhealthy' industries has been identified within school fundraising programmes in New Zealand, particularly sponsorship by trusts and charity organisations, for example pub charities (gambling) and alcohol licensing trusts. Richards et al. (2005) emphasise that the value of an endorsement by schools in exchange for such sponsorship is significant and their study demonstrates the increasing global trend of corporate involvement in schools, a phenomenon that Hawke's Bay is not immune from.

According to Munro et al. (2014), schools and educational settings choose to sell alcohol for one of three purposes:

1. To generate revenue – an example - for immediate consumption at school fundraising events such as school fairs or quiz nights.
2. For celebration such as prize-giving or jubilee celebration.
3. For recreational purposes - an example - student discos, art shows or plays. Alternatively alcohol may be consumed by staff on school camps or at after work drinks.

In the case of purpose 1. above, the District Health Board are aware that schools and educational settings in Hawke's Bay sell and supply alcohol at fundraising events as an easy method of revenue generation. Given that the wine industry is a significant employer in Hawke's Bay, special deals are likely to be struck by parents who work in the industry, facilitating such fundraising opportunities.

Munro et al. (2014) reference anecdotal evidence showing that the likely effects of the presence of alcohol at school fundraising events where children are present in Australia. Notwithstanding, a basic concern is that parental drinking at such events diverts attention away from children who are (or should be) the primary focus of the event. This relates to both purpose 1. and 3. listed above. Other identified harms include:

- Disruption of children's activities and events
- Public modelling of harmful alcohol consumption
- Violent assault
- Children's embarrassment and shame resulting from parental behaviour
- Division within school communities (Munro et al., 2014).

A further pathway the District Health Board have observed through which young people are exposed to alcohol whilst at school is the sale of alcohol by fundraising students who act as a conduit for, in most cases, a local winery. Additionally, a project promoting and selling alcohol by young people for charity purposes has been celebrated as a successful Young Enterprise Scheme, a New Zealand-wide programme teaching business and enterprise skills to high school students, sponsored by the Lion Foundation.

The ethics of children being used to promote an event because alcohol will be available to consume or as a product in its own right, acting as an intermediary for the industry whether it is for charitable purposes or not, is highly questionable.

It is the Hawke's Bay District Health Board's view that schools currently fundraising by selling alcohol, both on schools grounds and through corporate fundraising schemes, would be better to seek alternative methods of revenue gathering.

School alcohol policies

As stated by the Ministry of Education, "*there is no legal reason to stop alcohol being consumed on school sites",* school Boards of

Trustees are required to provide safe environments for students (Ministry of Education, 2017a). One way of achieving this is for educational settings to create a policy on the sale, supply and consumption of alcohol.

According to Ministry of Education's guidelines (see Appendix E), an alcohol policy can:

- "outline the school's approach to the sale, supply and consumption of alcohol
- highlight the school's alcohol prevention and intervention strategies
- be developed in partnership with the school's wider community to ensure that it reflects the community values, philosophies, ethos, goals and lived experiences" (2016, p.1).

It is a vision of the Hawke's Bay District Health Board that all schools and educational settings in the region develop and implement their own 'alcohol policy'. An essential part of the development of an alcohol policy is community consultation to determine the values and views of the community in relation to alcohol.

THE POLICY SETTING

Alcohol regulation and governance within Hawke's Bay is the responsibility of the four Councils: Napier City Council, Hastings District Council, Wairoa District Council and Central Hawke's Bay District Council. Under the Sale and Supply of Alcohol Act, 2012, all Councils are encouraged to develop and implement a Local Alcohol Policy that sets in place rules around the sale and supply of alcohol in their geographical area to include; hours of sale, the location of licensed premises and conditions and restrictions on licenses where necessary[4]. As evidenced within the Tasman District Local Alcohol Policy, a discretionary rule can be included that stipulates what is deemed acceptable and unacceptable use of alcohol in school settings[5].

Councils may also choose to have an 'alcohol strategy' that provides direction for the work required to reduce alcohol-related harm. Napier City and Hastings District Councils are in the process of revising their 2011 Joint Alcohol Strategy. Listed as an objective within both versions of the strategy is to *'foster safe and responsible events and environments'*. Additionally, *'young people (including under-age drinkers)'* are listed as an 'at risk group'.

A positive example of this is the local iwi, Ngāti Kahungunu, who choose to keep all events alcohol-free as a way of enhancing the environment for whānau growth and wellbeing (as per strategic outcome 1.3 of Te Ara Toiora O Ngāti Kahungunu 2007-2026 (2006): 'Wellbeing of whānau flourishes as Kahungunu'). Such a move has not diminished the popularity or attendance and role models to the community that fun can be had without alcohol.

A further objective within Councils' Joint Strategy is to *'change attitudes towards alcohol to reduce tolerance for alcohol harms'*, a goal that is highly relevant to this report. Although changing attitudes about what is socially acceptable is challenging, encouragement and lessons can be learnt from the smokefree movement where, over the past five decades, smoking has moved from a normalised and accommodated activity, to one that is highly regulated and widely unacceptable in most settings. Strong political will and policy were critical to this attitude shift.

It is hoped that local Councils will show leadership and support the District Health Board's stance on the sale and supply of alcohol by schools and educational settings in Hawke's Bay.

Community views on alcohol

A number of data sources provide a helpful insight into the attitudes and beliefs of members in the Hawke's Bay community around alcohol access and the impact of alcohol in their community.

The recently released 'Attitudes and Behaviours Towards Alcohol – Hawke's Bay Regional Analysis' from the Health Promotion Agency reported that 35 percent of respondents agreed that 'some licensed premises are too close to public facilities like schools', demonstrating an awareness of safety issues surrounding alcohol outlets. Half of

[4] At the time of writing this report, Central Hawke's Bay are implementing their Local Alcohol Policy, while Napier City and Hastings District Councils have developed a joint provisional policy. Wairoa District Council are in the early stages of developing a Local Alcohol Policy for their area.

[5] It is writ within Tasman District Council's Local Alcohol Policy as a discretionary condition that, "*No school fate, gala or similar event held on school grounds at which the participation of children can be reasonably expected shall allow for the consumption of alcohol on the premises*" (2.3.3)

respondents agreed or strongly agreed with the statement: 'there are places I no longer go to because of others' behaviour when drinking'.

Perhaps as a response to the high level of hazardous drinking in the region, data from a Hawke's Bay regional community survey (conducted in 2015) show that almost two-thirds (62 percent) of those interviewed felt that alcohol had a negative impact on their community. Results from the same survey indicated that 56 percent want fewer bottle stores and almost 80 percent wanted more alcohol-free entertainment.

The role of the District Health Board in alcohol regulation

Under the Act, if a school (or other event holder) wishes to hold an event that sells or supplies alcohol they are required to apply for a 'special licence'. The Medical Officer of Health[6] has a statutory reporting role for licensing decisions that occur at a legislative level. As a requirement of the Sale and Supply of Alcohol Act 2012, Medical Officers of Health are required to submit a report with their views on the application to the District Licensing Committee, who ultimately make the decision on whether a licence should be granted or not.

The District Health Board is also involved with providing health promotion advice and support to schools. On receipt of an alcohol licence application[7] involving a school or educational setting, a Health Protection Officer will contact the applicant to obtain further information on whether the event is on school grounds and whether children are present. If children are present, they will talk with the applicant, questioning whether alcohol is needed at the event.

The following documents are supplied to all applicants of licenses that are connected to school grounds or an education setting:

- A letter from the District Health Board listing the resources available for schools and educational settings including contact details for further information (Appendix A)
- A guide to developing a school alcohol policy (Appendix B)
- A 'quick reference' host responsibility guide, should applicants decide to sell or supply alcohol at their event (Appendix C)
- A sample 'Host Responsibility Policy' (Appendix D)
- Ministry of Education guidelines on the sale, supply and consumption of alcohol (Appendix E).

Licence oppositions

Medical Officers of Health throughout New Zealand are unanimous in their view that alcohol consumption by adults (particularly parents) on school grounds causes indirect harm to children. Australian health officials are also concerned with this phenomenon and struggle, as health in New Zealand does, with the inconsistent and ambiguous guidelines that currently exist around alcohol use on school property (Ward et al., 2014).

Some progress has been achieved in Australia with the New South Wales policy stating firmly that:

"Alcohol must not be consumed or brought to school premises during school hours. This

[6] *Medical Officers of Health are medical doctors who have specialised in public health medicine. They are designated under the 1956 Health Act by the Director General of Health to improve, protect and promote the health of the population in their district.*

[7] *Hawke's Bay District Health Board use a database called Healthscape to record all alcohol license applications.*

includes employees, students and visitors and other people who use school premises. The consumption of alcohol is not permitted at any school function (including those conducted outside school premises) at any time when school students, from any school are present" (Ward et al., 2014).

Unfortunately, oppositions by Medical Officers of Health throughout New Zealand have had mixed results, largely due to the expectation for health professionals and communities to prove that indirect harm will occur (as opposed to the licence applicant proving that it won't).

Section 4(2) of the Sale and Supply of Alcohol Act defines harm as "…any harm to society generally or the community, directly or indirectly caused, or indirectly contributed to by any crime, damage, death, disease, disorderly behaviour, illness or injury". Although the Act emphasises both direct and indirect harm caused by alcohol in its definition of alcohol-related harm, it appears that indirect harms are poorly understood by District Licensing Committees due to the limited success of Medical Officers of Health who have objected on the grounds of the potential for the licence to cause indirect harm.

Providing evidence of direct harm, for example where there is a correlation between a licensed event and the number of associated admissions to an emergency department following an event is relatively simple. Indirect harm, such as the role modelling of adults at a school event, requires robust and peer reviewed literature to prove an association with, for example, subsequent behaviours of young people.

In 2013, Elm Grove School in Mosgiel applied for a special licence to sell alcohol gifted by a parent for the purpose of raising funds for the school. The Elm Grove School decision[8] however, demonstrates recognition by a District Licensing Committee of the indirect harm caused by the sale and supply of alcohol on school grounds. The Committee remarked that:

"It must be noted first that New Zealand is moving into a more restrictive era with regards to alcohol licensing. The object of the Act now considers not only the sale and supply of alcohol but also the consumption of alcohol. The Committee was mindful that the Act imposes tighter controls and greater responsibility on the decision makers".

The Committee noted that the views of the Medical Officer of Health concerning the adverse effects of parental modelling were supported by research. On the basis of the 'overpowering evidence' of the Medical Officer of Health, the Committee declined the application.

[8] Application no. SP-300-2013

PREVALENCE DATA

Total number of special licenses in Hawke's Bay

Table 1: Total special license applications received relating to schools or educational settings (March 2014-October 2017)

Table 1 illustrates 139 applications have been included in this analysis and the total number of special licenses granted each year. These licenses are included as they have an association with an educational setting: either the event was on school grounds or the application was submitted by a Board of Trustees, Primary Teachers Association (PTA) or staff member.

Year	Number
2014	25
2015	37
2016	45
2017	32
Total:	**139**

Applications for special licenses were received from only 50 of the 351 educational settings in Hawke's Bay, demonstrating that the majority of schools are choosing not to utilise alcohol for revenue gathering, celebration or leisure purposes (Hammond, 2014). This is a positive finding and challenges the argument that alcohol is needed for schools to host successful fundraising events.

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Type of school submitting applications for a special licence

Figures 1 and 2 illustrate when a number of educational settings are taken into account, secondary schools had the highest number of applications per education setting despite making up only 6 percent of educational settings in Hawke's Bay. Fewer applications were received from early childhood education centres, despite having the largest proportion of educational settings in Hawke's Bay (66 percent).

Figure 1: Proportion of educational settings in Hawke's Bay by type

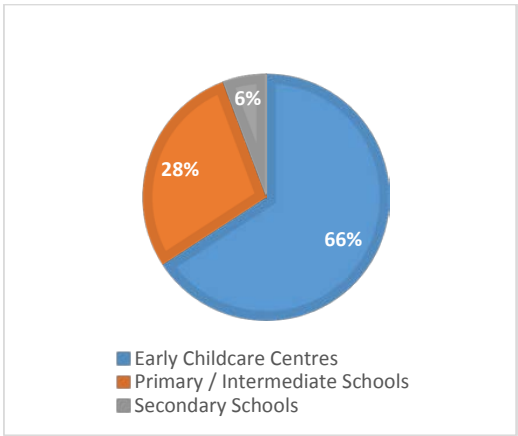
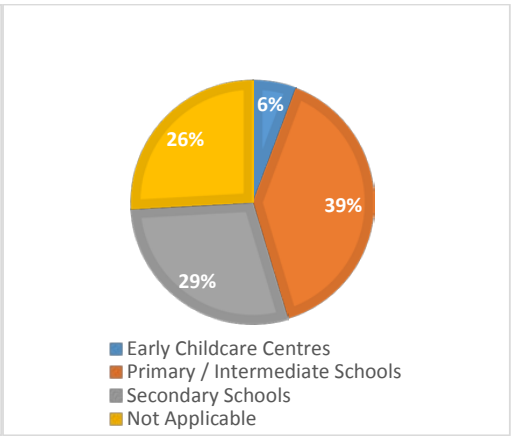


Figure 2: Proportion of applications from schools by type of educational setting



Location of schools submitting applications for a special licence

Figures 3 and 4 compare the proportion of educational settings by Territorial Local Authority (TLA) with the proportion of applications from educational settings by TLA over the four year period. As shown, although the Hastings District has the highest proportion of educational settings (51 percent), only 48 percent of applications came from the Hastings District TLA. Napier City in comparison accounts for 42 percent of applications yet only 28 percent of educational settings in Hawke's Bay in are located in this TLA. Source data is provided in Appendix A.

Figure 3: Proportion of Hawke's Bay educational settings by Territorial Local Authority

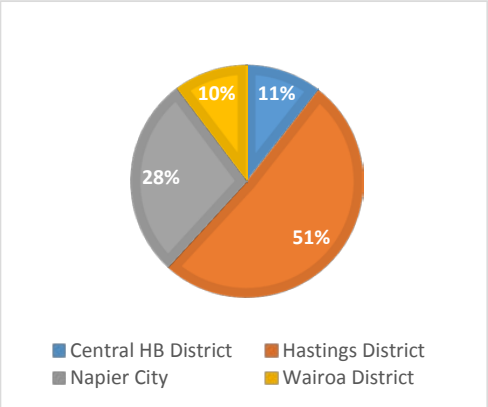
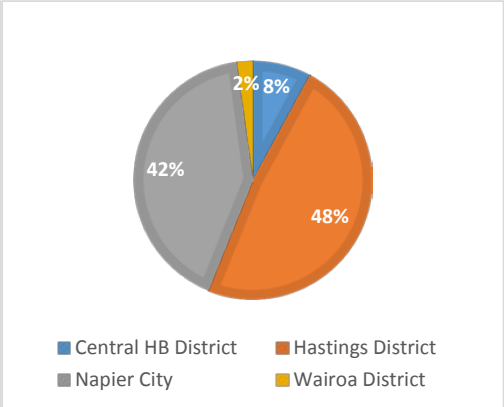
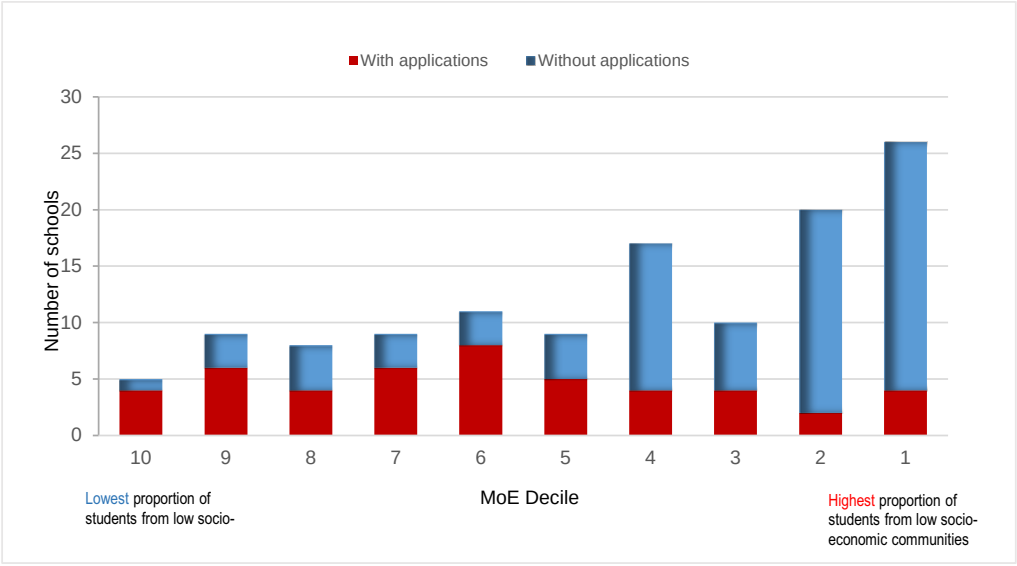


Figure 4: Proportion of applications submitted by schools by Territorial Local Authority



School decile rating and special licence applications

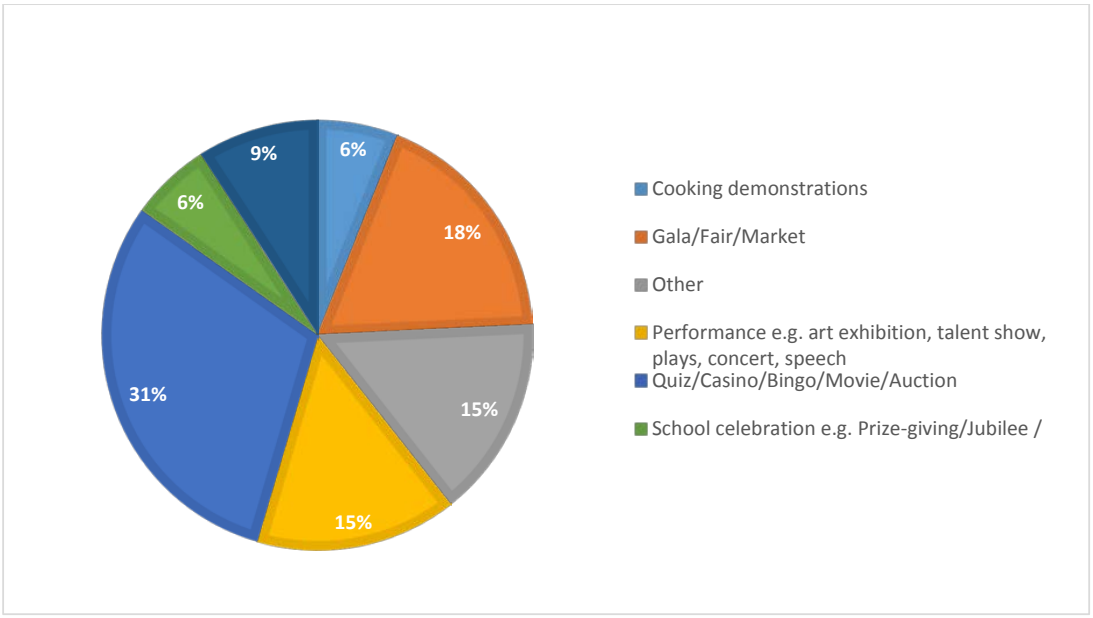
Figure 5: Number of schools with and without a history of special license applications by school decile rating



The Ministry of Education 'deciles' are a measure of the socio-economic position of a school's student community relative to other schools throughout New Zealand (Ministry of Education, 2017b). Figure 5 demonstrates the number of applications received and the corresponding decile rating of the applicant/schools (source data is provided in Appendix A). Figure 5 also shows the number of schools without any history of applying for a special licence. From this data, a trend showing higher numbers of higher decile schools applying for special licenses is apparent. It also shows the inverse of this trend for the decile rating of all primary and secondary schools with a history of no applications for special licenses (source data is provided in Appendix A). It is important to note that decile measure are used to calculate the levels of funding each school receives. Broadly put, the lower the decile, the more funding a school will receive. Whether funding pressures in higher decile schools plays a role in the pattern evident in Figure 5 is unclear and further consultation is required.

Type of event and notification of attendance by minors

Figure 6: Attendance by children for event type where alcohol licence was granted



Special licence applications were submitted for a diverse range of events. The numbers listed in Figure 6 represent events where alcohol was sold or supplied to adults. From the category of events listed in Figure 6, the most likely to expect the attendance of minors were; quiz, casino, bingo or movie nights or auctions. Although applications that explicitly state that minors (those under 18) will be attending are small, anecdotal evidence suggests that children are attending events that may not have indicated so on the special licence application form. Additionally, initial data collection did not capture this information and therefore underestimates are expected.

HAWKE'S BAY DISTRICT HEALTH BOARD OPPOSITION ACTIVITY

At the time of writing this report, a total of four applications had been opposed by a Medical Officer of Health. All events were family-focused, held on school grounds and children were in attendance. Of these oppositions, three related to the same school hosting the same event over three consecutive years. Oppositions were made on the grounds that the events were contrary to the object of the Sale and Supply of Alcohol Act 2012, relating to inappropriate consumption, nature of the event and the risk of indirect harm to young people.

Despite Medical Officer of Health's oppositions, the District Licensing Committee involved granted special licenses for all four events with similar conditions on the licenses. Examples of conditions placed on these licenses include:

i) *Persons under the age of 18 shall not be served at the beer and wine outlet (including non-alcoholic beverages)*
j) *Alcohol may be sold in the following types of containers only: - plastic vessels.*

Although only a small percentage of the total licence applications received were opposed by the Medical Officer of Health, the Medical Officer of Health and delegates have regularly proposed changes to the licence application (ergo the event) following discussions with the applicant. In most cases, further conditions were advised in order to reduce the risk of alcohol-related harm. Unfortunately, in many cases, the applicant had already promoted the event after submitting their application, creating a challenge situation to make any changes to the event.

The following is an example of advice provided by the Medical Officer of Health in response to an application for a children's art exhibition:

We requested further information from the applicant and note the following key points:

- *Whilst children are present to welcome guests and discuss their art work, we understand that they will not be directly involved in serving alcohol.*
- *Alcohol will only be sold and served from the bar area children will not be in the bar area.*
- *The ticket price includes one standard drink of any type and food/nibbles provided throughout the night.*
- *That the main focus of the event is art and not alcohol.*

Whilst we don't oppose this application for the above reasons, we do encourage the School to consider making this event alcohol free in the future. We have provided the applicant with some of our resources relating to schools and alcohol including a sample 'Host Responsibility Policy' for schools. Please find a copy of these three resources attached for your information.

The Medical Officer of Health has indicated that oppositions to applications for future events held on school grounds where children are present will increase substantially.

SUMMARY

In view of the high prevalence of hazardous drinking in Hawke's Bay, it is apparent that rangatahi (young people) are living in what McCreanor et al. (2008) call an 'intoxigenic environment'. This means an environment that normalises and accommodates alcohol consumption in all settings, allows the sale of alcohol at almost all times of day and in most premises (irrespective of who may also frequent those premises) and enables the widespread marketing of alcohol. In such an environment, it is essential that schools and educational settings are maintained as a setting where children are protected from exposure to alcohol and where their rights are paramount.

Evidence suggests that children are not only influenced by their parents and caregivers drinking patterns, but also those of the community in which they live (Bendsten et al., 2013). Schools and educational settings are an inherent part of all communities in New Zealand, and therefore have a role to play in creating a safe space for children to experience life without alcohol.

It appears that many schools in Hawke's Bay are proving that school community events can be social, fun and financially benefit the school or educational setting without the need for alcohol to be supplied.

The Hawke's Bay District Health Board intends to increase its opposition to special licence applications for events that are held on schools grounds and at which children are expected to be present as a result of this report and its findings. Positively, it appears only a small number of schools continue to hold these events, and the Hawke's Bay District Health Board are optimistic that a vision of no licenses coming from schools or educational settings can be achieved. Such events, as demonstrated by the evidence within this report, promote and normalise alcohol use and are likely causing indirect harm to children and young people. Recognising and ameliorating exposure of alcohol to children and young people in this setting will contribute to the reduction in hazardous youth drinking levels in Hawke's Bay – a key objective of the Hawke's Bay District Health Board Alcohol Harm Reduction Strategy.

Strong leadership has been demonstrated by Ngāti Kahungunu Iwi who, as mentioned earlier, maintain a strong position around alcohol and demonstrate that successful and popular events can be alcohol and tobacco free. This stance and these events provide great role-modelling for our communities and challenge other organisations to make the same commitment.

As emphasised by Hammond (2014), Boards of Trustees must recognise their role in normalising alcohol consumption through their willingness to use it to fundraise. The District Health Board acknowledge however, that schools and educational settings must be supported to be alcohol-free and understand the impact on children and young people of exposure to alcohol. Working in collaboration with the Ministry of Education, Councils and educational settings to reduce exposure to young people is essential if we are to deliver consistent messages around alcohol harms and 'turn the curve' on our poor alcohol-related health statistics in Hawke's Bay.

RECOMMENDATIONS

The District Health Board has a vision that schools in Hawke's Bay are recognised as significant spaces where the best interests of children are a primary consideration and that they embrace their responsibility to create healthy and safe environments for children and communities by choosing to be alcohol-free.

How can Hawke's Bay achieve this?

Health

- Share health information with the Hawke's Bay population on the harms caused by alcohol, with particular attention to Boards of Trustees, school staff and parents
- Continue to oppose to special license applications for events held on school grounds that children are expected to attend

Councils

- Host and advocate for more alcohol-free and family friendly events in Hawke's Bay
- Provide discounted alternative venues for schools that choose to sell and supply alcohol at their fundraising events – a great way to keep school grounds alcohol-free 24/7

Education sector

- Develop an Alcohol Policy that represents your school's community (for a template and guide visit: http://ourhealthhb.nz/healthy-communities/alcohol/alcohol-and-schools/
- Get creative with other ways to fundraise – the DHB is producing a resource to help

Everybody

- Support by attending alcohol-free events in the region
- Talk to your child's school or ECE about alcohol – does their approach fit with the values of the community?
- Share your concerns about alcohol in your region with the District Health Board. Email us at healthpromotion@hbdhb.govt.nz

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APPENDIX A: DATA TABLES

Educational setting by type

(A graph and narrative of this data is available on page 14)

Educational Setting Type	Total number of applications	Number of educational settings	Rate per 100 educational settings
Early Childcare Centres	8	231	3.5
Primary / Intermediate Schools	55	100	55.0
Secondary Schools	40	20	200.0
Not Applicable	36		
Total:	139	351	

Applications by Territorial Local Authority

(A graph and narrative of this data is available on page 15)

Territorial Local Authority	Total number of applications	Number of educational settings	Rate per 100 educational settings
Central HB District	11	37	29.7
Hastings District	67	180	37.2
Napier City	58	98	59.2
Wairoa District	3	36	8.3
Total:	**139**	**351**	

Decile rating for schools that have applied for a special license

(A graph and narrative of this data is displayed on page 15)

	Ministry of Education School Decile	Total number of applications
Lowest proportion of students from low socio-economic communities	**10**	16
	9	26
	8	12
	7	14
	6	19
	5	12
	4	12
	3	12
	2	2
Highest proportion of students from low socio-economic communities	**1**	7
	Not known	7
	Total	**139**

Decile rating for schools with a history of no applications for special licenses
(A graph and narrative of this data is displayed on page 16)

	Ministry of Education School Decile	Number of schools with NO Applications
Lowest proportion of students from low socio-economic communities	**10**	1
	9	3
	8	4
	7	3
	6	3
	5	4
	4	13
	3	6
	2	18
Highest proportion of students from low socio-economic communities	**1**	22
	Total	**77**

Type of event by attendance of minors (under 18 years of age)
(A graph and narrative of this data is available on page 17)

Event Type	Minors Attending			
	Y	N	U	Total
Cooking demonstrations	2	0	0	2
Gala/Fair/Market	6	0	1	7
Other	5	10	9	24
Performance e.g. art exhibition, talent show, plays, concert, speech	5	5	3	13
Quiz/Casino/Bingo/Movie/Auction	10	58	6	74
School celebration e.g. Prize-giving/Jubilee /	2	8	1	11
Sporting e.g. pig hunting, horse trek, 4WD	3	2	0	5
Not Known	1	0	2	3
Total:	**34**	**83**	**22**	**139**

APPENDIX B: HBDHB LETTER TO SCHOOLS AND EDUCATIONAL FACILITIES ON APPLICATION OF AN ALCOHOL LICENCE

Corporate Services

WHAKAWATEA TIA

HAWKE'S BAY
District Health Board

16 January 2015

All Principals and Board of Trustees
Hawke's Bay Schools

Dear Principals and Board of Trustees

Alcohol and Educational Facilities

The recently introduced Sale and Supply of Alcohol Act (2012) has a strong emphasis on improving New Zealand's drinking culture and reducing alcohol-related harm. The District Health Board has a key role in promoting host responsibility at functions and events where alcohol is supplied or sold.

Increasing access to and availability of alcohol are key drivers for increasing alcohol harm in our community. There is no evidence that 'normalising' drinking – even with the best intentions of promoting more 'sensible' drinking – reduces alcohol harm. From conception through to adolescence, exposure to alcohol has the potential both to cause and be associated with a range of negative outcomes for children.[1]

We have prepared a set of resources for schools and educational facilities. These aim to generate discussion within your school, including with your Board of Trustees, to develop an alcohol policy for the school and to decide if, or when, alcohol will play a part in school events.

We attach the following three documents for you:

- *School Alcohol Policy – Supporting Schools*: a guide to developing a school alcohol policy
- *Supporting Schools – Host Responsibility and Alcohol*: a quick reference host responsibility guide, should you decide to have alcohol available at events
- *Sample Host Responsibility Policy*: a template to use for events where alcohol is available.

If you would like more copies of these resources or would like to talk with us about host responsibility and alcohol use, please contact Michele Grigg, Population Health Advisor, on 06 834 1815 extension 4297. We are also more than happy to attend one of your Board of Trustees meetings.

You can find more information at www.alcohol.org.nz.

Yours sincerely

Dr Caroline McElnay
Director of Population Health/Health Equity Champion
Medical Officer of Health

[1] Law Commission. 2010. *Alcohol in Our Lives: Curbing the harm*. Wellington: Law Commission.

Population Health

Phone 06 87 8 8109. Fax 06 834 1816. Email: caroline.mcelnay@hbdhb.govt.nz
Private Bag 9014, Hastings, New Zealand. Website: www.hawkesbaydhb.govt.nz

APPENDIX C: HBDHB GUIDE TO DEVELOPING A SCHOOL ALCOHOL POLICY[9]

DEVELOPING A SCHOOL ALCOHOL POLICY

HAWKE'S BAY District Health Board Whakawateatia

Introduction

This guide provides information for developing an alcohol policy for your school or educational facility. Having a school alcohol policy means everyone is clear about if and when alcohol will be made available on your premises or at school events.

Schools have an obligation to provide a safe environment for their students. Increasing access to and availability of alcohol is a key driver in increasing alcohol harm in our community. This guide gives you tips and pointers for developing your alcohol policy.

The Hawke's Bay DHB feels very strongly that alcohol should not be on school grounds when children are present. It is widely understood that schools act as role-models for children, families and communities. Allowing alcohol to be sold or promoted in a setting where minors are present further normalises alcohol use in every day settings.

Please note that the District Health Board's Medical Officer of Health is likely to oppose a school alcohol licence application if children are likely to be present at the event for which the licence is being applied for.

We recommend your Board of Trustees works with staff, relevant school committees and the parent teacher association (PTA) to develop an alcohol policy for your school or facility. The policy should reflect the intentions of the Sale and Supply of Alcohol Act 2012.

Why have a school alcohol policy?

Educational facilities have an important role in our society. They are a core part of our community and social structure. Schools are required to provide a safe physical and emotional environment for students. They are also required to fully comply with any legislation to ensure the safety of students and employees.

While alcohol may be seen as a normal part of socialised behaviour, normalisation has led to the acceptance of excessive consumption. Alcohol consumption in the presence of minors further reinforces this. There is no evidence that 'normalising' drinking – even with the best intentions of promoting more sensible drinking – reduces alcohol harm. Instead it offers greater access to alcohol by those most likely to be affected by alcohol harm.

Your school might like to consider being both alcohol-free and smoke-free – to create a special place in your community where children will feel safe, knowing that parents and caregivers will not be drinking or smoking on school premises.
If you apply for a liquor licence we will ask to see your alcohol policy.

Produced December 2014

Points to consider

The Ministry of Education suggests that schools have an alcohol policy.[1]

You might like to discuss these questions when considering your policy:

a) Does having alcohol available on school premises or at school events have any benefit to our school community?

b) Does it have any benefit to the children in our community?

c) How does our school/educational setting contribute to reducing alcohol harm in our community?

d) What example do we want to set for our children and community?

e) How can we support the intention of the Sale and Supply of Alcohol Act 2012?

Having a policy means everyone in the school community is clear about the place of alcohol in their school/educational facility.

PROMPTS

For developing your school alcohol policy

- How does your school or educational facility promote a healthy and safe environment in relation to alcohol?
- If alcohol is provided and/or consumed, are the six key principles of Host Responsibility followed?[2]
- Is alcohol consumed when adults or staff have responsibility for student welfare?
- Will alcohol be permitted at times of the day/week when students are not on school grounds? Will it be provided if children are present?
- Is alcohol permitted at staff social functions at school? If alcohol is available, are non-alcoholic drinks, water, and food also available? Are adults asked to drink sensibly and moderately? Is alcohol served to or by students?
- Is alcohol sold on the school property for the purposes of raising money where minors have access to alcohol?
- Is alcohol offered as prizes at functions or in raffles? Note this is prohibited under the Gambling Act 2003.[3]
- Is it clear that no staff member, while acting in the capacity of a staff member, shall give alcohol to a student or enable a student to obtain alcohol?
- Do staff make sure that they do not provide students with alcohol (unless the student is their child – in accordance with the Act) or consume alcohol with students in a situation that may bring the school into disrepute?
- How frequently will the policy be reviewed?
- Who is responsible for the policy?

[9] Electronic version available online at http://ourhealthhb.nz/healthy-communities/alcohol/alcohol-and-schools/

Contacts

We are here to help. Feel free to contact us with any questions about your school alcohol policy.

Hawke's Bay District Health Board

Population Health: ph 06 834 1815, liquorlicensing@hbdhb.govt.nz

District Licensing Inspectors

Napier City Council: ph 06 834 4154, info@napier.govt.nz
Hastings District Council: ph 06 871 5000, council@hdc.govt.nz
Wairoa District Council: ph 06 838 7309, administrator@wairoadc.govt.nz
Central Hawke's Bay District Council: ph 06 857 8060, info@chbdc.govt.nz

Police

Eastern District Headquarters: ph 06 831 0700, HB.liquorlicensing@police.govt.nz

See our other guides

Supporting Schools – Host Responsibility and Alcohol: Host responsibility – a quick reference guide. December 2014. Population Health, Hawke's Bay District Health Board.

Sample Host Responsibility Policy – Schools. December 2014. Population Health, Hawke's Bay District Health Board.

Preparing a Host Responsibility Implementation Plan: A quick reference guide. April 2014. Population Health, Hawke's Bay District Health Board.

Host Responsibility and Alcohol: A guide to being a responsible host. April 2014. Population Health, Hawke's Bay District Health Board.

Host Responsibility Resources: Order form. April 2014. Population Health, Hawke's Bay District Health Board.

Supporting Safe Alcohol Use at Small Events: A quick reference guide. April 2014. Population Health, Hawke's Bay District Health Board.

Supporting Safe Alcohol Use at Large Events: A quick reference guide. Population Health, Hawke's Bay District Health Board.

These and more information can be found at:
http://www.hawkesbay.health.nz/page/pageid/2145883919/Licensing_and_Host_Responsibility

NOTES:

[1] http://www.minedu.govt.nz/NZEducation/EducationPolicies/Schools/PropertyToolBox/StateSchools/DayToDayManagement/Alcohol.aspx Accessed November 2014

[2] See *Supporting Schools – Host Responsibility and Alcohol: Host responsibility – a quick reference guide.* December 2014. Population Health, Hawke's Bay District Health Board and *Sample Host Responsibility Policy – Schools.* December 2014. Population Health, Hawke's Bay District Health Board.

[3] The Gambling Act (2003) prohibits certain prizes from being offered. This includes alcohol, or vouchers or entitlements to alcohol, among other products including tobacco.

APPENDIX D: HBDHB SUPPORTING SCHOOLS – HOST RESPONSIBILITY AND ALCOHOL GUIDE[10]

HOST RESPONSIBILITY FOR SCHOOLS – A QUICK REFERENCE GUIDE

HAWKE'S BAY District Health Board Whakawateatia

Introduction

The Hawke's Bay DHB feels very strongly that alcohol should not be on school grounds when children are present. It is widely understood that schools act as role-models for children, families and communities. Allowing alcohol to be sold or promoted in a setting where minors are present further normalises alcohol use in every day settings.

Please note that the District Health Board's Medical Officer of Health is likely to oppose a school alcohol licence application if children are likely to be present at the event for which the licence is being applied for.

The Sale and Supply of Alcohol Act (2012) aims to improve New Zealand's drinking culture and reduce the harm caused by excessive drinking. Specifically, the object of the Act is:

- That the sale, supply, and consumption of alcohol should be undertaken safely and responsibly
- That the harm caused by the excessive or inappropriate consumption of alcohol should be minimised.

This guide aims to help educational facilities, including schools and early childhood centres, plan events where it is agreed that alcohol will be made available. It includes tips, a checklist, and contact details for the safe use of alcohol at your school event.[11]

If you decide to provide alcohol at your event(s), we can work with you to identify what's needed to make your event safe and enjoyable. We can put you on track with your planning and help you access resources.

School alcohol policy

We recommend that all schools have an alcohol policy. Having a school alcohol policy means everyone is clear about if and when alcohol will be made available on your premises or at school events.

For further information on developing a school alcohol policy, check out our guide: *Developing a School Alcohol Policy*.

Reviewed March 2018

Host responsibility

Host responsibility is based on six concepts. **A responsible host:**

1) **Prevents intoxication**
2) **Does not serve alcohol to minors**
3) **Provides and actively promotes free drinking water, low alcohol and non-alcoholic drinks**
4) **Provides and actively promotes substantial food**
5) **Serves alcohol responsibly**
6) **Arranges safe transport options.**

For further information visit: www.alcohol.org.nz/legislation-policy/host-responsibility

Alcohol and host responsibility

The management of alcohol consumption is an important component of event management that must be planned well in advance.

Key issues to consider include:

* The way alcohol is served or made available at your event
* The physical environment in which alcohol is consumed
* The ways in which the relevant regulatory frameworks are monitored and enforced.

Intoxication and transport

Host responsibility means managing and monitoring patron consumption of alcohol – not waiting until intoxication becomes evident before doing anything.

Your alcohol management procedures should aim to both manage intoxication and assist any intoxicated patrons to slow their consumption and/or consider food and non alcoholic options.

It is wise to provide a safe place for intoxicated people to sober up and consider ways to get them home. It is your responsibility to set this space up so it is adequately monitored.

Food and water

Patrons should have easy access to quality food and water before and during your event. Ensuring there is enough food conveniently available, and promoting it, are standard licence conditions.

Food outlets should be either close to alcohol outlets or integrated with them – and free water should be provided (and well publicised) at convenient, queue-free places within the venue.

If food is to be provided, check with your local council about applying for a food permit. Ensure all food is prepared and handled in accordance with Council requirements.

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[10] Electronic version available online at http://ourhealthhb.nz/healthy-communities/alcohol/alcohol-and-schools/

Your responsibilities

Your responsibilities in providing alcohol are clearly outlined in the Sale and Supply of Alcohol Act (2012)

Listed in the Act are the responsibilities of licence holders around preventing intoxication and disorderly conduct on the premises for which their licence applies (refer Part 2, Sections 248-253, pp146–148). To allow either is an offence under the Act.

The Act also requires licence holders, among other things, to provide free water for people to drink, which is easily accessible. The requirements around this are clearly spelt out in the Act (refer Part 1, Section 5 Interpretation: 'freely available to customers', p23).

✓ CHECKLIST

If you decide to provide alcohol at your event, these are the things you will need to consider in your planning:

- ○ Find out from your local Council (see Contacts) if you need a liquor licence
- ○ Providing free and easily accessible water – if your event is in a rural area you will need to work with us to check that your water supply is safe
- ○ Providing and promoting low alcohol and non-alcoholic beverages
- ○ Providing and promoting substantial food options and having these readily available[2]
- ○ How alcohol will be served, and by whom
- ○ Controlling the number of alcohol serves per person
- ○ Security may be needed for the event, especially for preventing the entry of intoxicated people
- ○ Strategies for dealing with intoxicated people, including a safe place to sober up while transport home is arranged
- ○ Ensuring you don't provide alcohol to anyone under 18 without the express consent of their parent or legal guardian[3] (unless their parent or legal guardian is also present)
- ○ The availability of safe transport options to and from the event
- ○ If there will be over 400 people at the event you will be required to provide an Alcohol Management Plan when you apply for your licence.[4]

Contacts

We are here to help. Feel free to contact us with any questions about your event.

Hawke's Bay District Health Board

Population Health: ph 06 834 1815, liquorlicensing@hbdhb.govt.nz

District Licensing Inspectors

Napier City Council: ph 06 834 4154, info@napier.govt.nz
Hastings District Council: ph 06 871 5000, council@hdc.govt.nz
Wairoa District Council: ph 06 838 7309, administrator@wairoadc.govt.nz
Central Hawke's Bay District Council: ph 06 857 8060, info@chbdc.govt.nz

Police

Eastern District Headquarters: ph 06 831 0700, HB.liquorlicensing@police.govt.nz

See our other guides

School Alcohol Policy – Supporting Schools. December 2014. Population Health, Hawke's Bay District Health Board.

Sample Host Responsibility Policy – Schools. December 2014. Population Health, Hawke's Bay District Health Board.

Preparing a Host Responsibility Implementation Plan: A quick reference guide. April 2014. Population Health, Hawke's Bay District Health Board.

Host Responsibility and Alcohol: A guide to being a responsible host. April 2014. Population Health, Hawke's Bay District Health Board.

Host Responsibility Resources: Order form. April 2014. Population Health, Hawke's Bay District Health Board.

Supporting Safe Alcohol Use at Small Events: A quick reference guide. April 2014. Population Health, Hawke's Bay District Health Board.

Supporting Safe Alcohol Use at Large Events: A quick reference guide. Population Health, Hawke's Bay District Health Board.

These and more information can be found at:
http://www.hawkesbay.health.nz/page/pageid/2145883919/Licensing_and_Host_Responsibility

NOTES:

[1] If your event is for 400 people or more, go to the HBDHB website to download a 'Supporting Safe Alcohol Use at Large Events' guide.

[2] Make sure any food is prepared and handled safely.

[3] A person supplying alcohol to anyone under 18 must do so in a 'responsible' manner (ie, under supervision, with food, with a choice of low alcohol and non-alcoholic drinks, with safe transport options in place). A person is only considered a minor's legal guardian if he/she is recognised as a guardian under the Care of Children Act 2004. 'Express consent' means a personal conversation, an email, or a text message that you have good reason to believe is genuine.

APPENDIX E: HBDHB SAMPLE HOST RESPONSIBILITY POLICY - SCHOOLS[11]

HAWKE'S BAY District Health Board Whakawateatia

SAMPLE HOST RESPONSIBILITY POLICY - SCHOOLS

Host Responsibility Policy

Our Commitment to You, Our School Community

As a responsible educational facility, we model positive and responsible behaviour around alcohol.

We have an obligation to provide a safe physical and emotional environment for our students, and to comply fully with the Sale and Supply of Alcohol Act 2012.

We want our school community to remain safe.

The Management and Staff of *[insert name of school/facility]* have a responsibility to provide an environment where alcohol and other products are served responsibly in a smokefree environment. We have therefore implemented the following Host Responsibility Policy for this event.

- **We won't serve alcohol at school fundraising events where minors are present on school grounds**
- It is against the law to sell or supply alcohol and tobacco products to minors (under the age of 18 years). If we believe you are under the age of 25, we will ask for identification. Acceptable forms of proof of age are a NZ photo driver's licence, the Hospitality NZ 18+ card, and an original, valid passport.
- It is against the law to smoke on school grounds and in school buildings. We are Smokefree at all times.
- Our aim is to provide a safe and enjoyable environment. Anyone who is intoxicated will not be served alcohol, will be asked to leave and encouraged to take advantage of safe transport options.
- We promote transport options to get you safely home. Please ask us for further information.
- We encourage you to have a lifesaver (designated driver). We will make the lifesaver's job more attractive by providing non-alcoholic drinks.
- We make sure all of our food, water and transport options are well promoted – you won't have to go looking for them.
- We will provide, and actively promote, a range of non-alcoholic drinks *[specify here the types of non-alcoholic drinks eg, fruit juices, soft drinks, tea and coffee].*
- Water is available free of charge at all times and is clearly sign-posted.
- Low alcohol drink options are available and include *[enter names here].*
- We encourage you to choose from our selection of food.

Host responsibility makes sure that everyone has a good time, and leaves in safe shape for the trip home.

Thank you for attending our event and supporting our host responsibility policy.
We hope you have an enjoyable time.

Reviewed March 2018

APPENDIX F: MINISTRY OF EDUCATION GUIDELINES FOR SCHOOLS – DEVELOPING A POLICY ON THE SALE, SUPPLY AND CONSUMPTION OF ALCOHOL[12]

MINISTRY OF EDUCATION
TE TĀHUHU O TE MĀTAURANGA

SALE, SUPPLY AND CONSUMPTION OF ALCOHOL

GUIDELINES FOR SCHOOLS

Developing a policy on the sale, supply and consumption of alcohol

Schools are a core part of our community and social structure and are important settings for promoting health and wellbeing through education, policies and modelling behaviour. This guidance provides information for schools to consider, when reviewing or developing a school policy on the sale, supply and consumption of alcohol.

Why have a policy on the sale, supply and consumption of alcohol?

Under the **National Administration Guideline** (NAG) 5 (http://www.education.govt.nz/ministry-of-education/legislation/nags/#NAG5), boards of trustees are required to "provide a safe physical and emotional environment for students" (NAG 5a) and to "comply in full with any legislation currently in force or that may be developed to ensure the safety of students and employees" (NAG 5c).

A policy on the sale, supply and consumption of alcohol will help boards of trustees, staff, parents and students to have a clear understanding of what is acceptable in terms of the sale, supply and consumption of alcohol on school grounds, at school events and in (or not in) the presence of students.

- If, as a board of trustees, you decide you do not want alcohol sold or supplied at your school, it is important to document that in a policy
- If you do want alcohol sold or supplied on school premises or during school activities, your policy should explain when alcohol will be available and at what kinds of events. You must also apply for a **special license** (http://www.legislation.govt.nz/act/public/2012/0120/latest/DLM3339490.html) when selling or supplying alcohol or charging an entrance fee to an event where alcohol is available.

A policy will:

- outline the school's approach to the sale, supply and consumption of alcohol
- highlight the school's alcohol prevention and intervention strategies
- be developed in partnership with the school's wider community to ensure that it reflects the community values, philosophies, ethos, goals and lived experiences.

Your policy will cover:

- Education Outside the Classroom (EOTC)[1] events such as school picnics, camps and offsite activities
- school events, such as galas, fundraisers and staff social events
- school balls and leavers dinners held at licensed premises or on school grounds
- sponsorship or discounted/free alcohol provided for school events
- where alcohol is available
- **serving alcohol safely** (http://alcohol.org.nz/sites/default/files/field/file_attachment/AL576 Serving Alcohol SAFELY at Workplace Events April 2014.pdf) at school events
- gifts, prizes and raffles
- external public bookings, such as weddings or parties, where non-school groups use the school under a **lease agreement** (http://www.education.govt.nz/school/property/state-schools/day-to-day-management/leasing-or-hiring-to-third-parties/)

1 *The EOTC guidelines recommend non-consumption of alcohol by parents and teachers at a school EOTC event as it impairs a person's ability to provide a high level of supervision and to respond to an emergency*

www.education.govt.nz

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[11] Electronic version available online at http://ourhealthhb.nz/healthy-communities/alcohol/alcohol-and-schools/

[12] Electronic version available online at https://www.education.govt.nz/assets/Uploads/Alcohol-Guidance-for-Schools.pdf

Legal Requirements

Your policy must comply with the **Sale and Supply of Alcohol Act 2012** (http://www.legislation.govt.nz/act/public/2012/0120/latest/DLM3339333.html).
All schools need to obtain a special licence if alcohol will be sold or supplied on a school site, at a school event and/or where an entrance fee or koha/donation for a school event is charged that covers alcohol available at the event.
A special licence must be filed at least 20 working days before an event and can take up 3-4 weeks before a decision is made by your local council's licensing committee. A special licence can be challenged by the public, police and the Medical Officer of Health and may be declined. An application **fee** (http://www.justice.govt.nz/justice-sector-policy/key-initiatives/sale-and-supply-of-alcohol/licensing/fee-system-for-alcohol-licensing/) will also apply.

The licence identifies:

- whom alcohol can be sold or supplied to
- the hours and days alcohol can be sold or supplied
- who is allowed on the premises
- conditions related to promotion and prizes, and
- the range of food and non-alcoholic drinks that will be available.

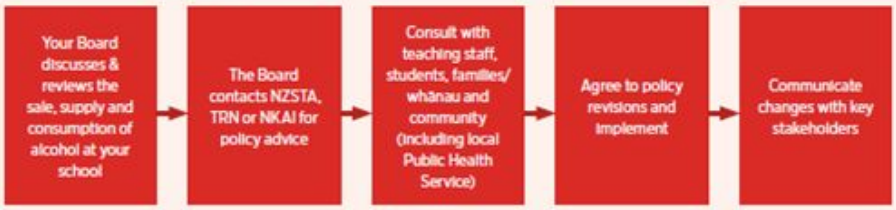
It is illegal for students under 18 years to be sold alcohol.

Under the **Gambling Act 2003** (http://www.legislation.govt.nz/regulation/public/2005/0299/latest/DLM359440.html?search=sw_096be8ed8134046a_alcohol_25_se&p=1%20-%20DLM359440), alcohol is prohibited from being offered as a prize for gambling activities (e.g. raffle prizes).

You may want to consider the following when developing your Policy

- How can we comply with the Sale and Supply of Alcohol Act 2012?
- The Sale and Supply of Alcohol Act 2012 requires a special licence to be obtained if alcohol will be sold on a school site.
- The non-consumption of alcohol by staff, parents and caregivers while students are in their care during school events.
- What steps will be taken if students, staff and parents are intoxicated at school events?
- How can we ensure that students, families and staff are safe at school and at school events?
- When does the school allow alcohol at school events? Does the school accept sponsorship from alcohol producers or providers?
- What is the school's position on the sale, supply and consumption of alcohol by the public/community groups who are using the school site?

Steps in developing your Policy



The New Zealand School Trustees Association (NZSTA), Te Rūnanga Nui (TRN) and Ngā Kura ā Iwi (NKAI) provide services to affiliated schools, to enhance their governance capability.

The following resources may also help to develop your Policy.

Click on the links highlighted in red:

Resources to help to develop your Policy

- **The Southern District Health Board: Setting the Standard** (http://www.southerndhb.govt.nz/files/17281_20160616120652-1466035612.pdf) identifies social modelling of alcohol consumption in the presence of minors, normalises alcohol use and leads to earlier initiation of alcohol consumption and heavier consumption. The **website** (http://www.southerndhb.govt.nz/index.php?page=2827) also has useful fact sheets for schools on alcohol.
- **The Ministry of Health: National Drug policy 2015-2020** (http://www.health.govt.nz/system/files/documents/publications/national-drug-policy-2015-2020-aug15.pdf) promotes a collaborative approach to reducing alcohol and other drug related harm and the role of community organisations such as schools.
- **CAYAD (Community Action Youth and Drugs): More Than Just a Policy toolkit** (http://www.healthaction.org.nz/index.php/what-we-do/cayad) is for people wishing to develop or review existing alcohol and other drug policies. The toolkit consists of a guide and a practical workbook.
- **The New Zealand Police** provide information on **Alcohol and Other Drug Guidelines** (http://www.police.govt.nz/advice/personal-and-community-advice/school-portal/information-and-guidelines/alcohol-and-other-drug) and the development of prevention policies/activities in schools.
- **The Health Promotion Agency's alcohol website** (http://alcohol.org.nz/) has useful information including advice, research and resources to help prevent and reduce alcohol-related harm
- **The University of Auckland: The health and wellbeing of secondary school students in 2012** (https://www.fmhs.auckland.ac.nz/assets/fmhs/faculty/ahrg/docs/Final%20Substance%20Abuse%20Report%2016.9.14.pdf) presents findings from 91 composite and secondary schools in New Zealand who took part in the national health and wellbeing survey.

The Ministry of Education wishes to acknowledge and thank the following people and organisations for their contribution in the development of this guideline:

- Public Health Clinical Network, Alcohol Regulatory Advisory Group
- Ministry of Health
- Health Promotion Agency
- Ngā Kura a-Iwi o Aotearoa
- Te Rūnanga Nui o Ngā Kura Kaupapa Māori o Aotearoa
- New Zealand School Trustees Association

HAWKE'S BAY District Health Board Whakawāteatia	**Plan to develop a Kaupapa Māori Maternal Health Programme** 64 For the attention of: **HBDHB Board**
Document Owner	Patrick Le Geyt, GM Māori (Acting)
Document Author(s)	Charrissa Keenan, Health Gains Advisor, Māori Health
Reviewed by	Julie Arthur, Midwifery Director, HBDHB; Shari Tidswell, Intersector Development Manager, HBDHB; Executive Management Team, Māori Relationship Board, HB Clinical Council and HB Health Consumer Council
Month/Year	May 2018
Purpose	Decision and feedback
Previous Consideration Discussions	No
Summary	It is proposed that HBDHB develop a kaupapa Māori maternal health programme ('the Programme'). The intent of the programme is to overcome barriers to access to maternal health care, eliminate inequities in maternal and child health, and improve maternal and child health outcomes. This paper outlines the approach to develop the programme, and identifies key actions and timeframes to deliver the programme.
Contribution to Goals and Strategic Implications	Improving quality, safety and experience of care; Improving Health and Equity for all populations; Improving Value from public health system resources
Impact on Reducing Inequities/Disparities	Young Māori mothers and their children experience disproportionate health inequities in terms of access to health services and health outcomes in comparison to non-Māori. The intent of the programme is to overcome barriers to access to care, eliminate inequities in maternal and child health, and improve maternal and child health outcomes.
Consumer Engagement	The partnership group has held informal and formal discussions with whānau Māori, Māori health providers, and Māori and non-Māori DHB staff about whānau concerns and aspirations for culturally appropriate services and programmes. These perspectives confirm what we already know in the data and literature about differential outcomes and dissatisfaction of Māori with current models of service delivery and the ability of mainstream services to provide a culturally appropriate programmes. There are also a number of DHB related pieces of work undertaken over the last year have involved whanau voices, and have helped shaped and guide us to this point now (i.e. Review of the

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	provision of antenatal education in HB, Review of Respiratory Care pathways, review of GA dental pathways). These reviews included whānau voices that emphasised the need for more culturally appropriate programmes.
Other Consultation /Involvement	This is a partnership approach between Māori Health Services, Population Health and Maternity Services.
Financial/Budget Impact	MOH have provided $5.1m per annum to DHBs to provide a Sudden Unexpected Death in Infants (SUDI) prevention services or enhancements that address the determinants of SUDI, such as smoking in pregnancy and bed sharing etc.
Timing Issues	None
Announcements/ Communications	None

RECOMMENDATION:

It is recommended that the HBDHB Board,

1. **Note** the content of this report
2. **Approve** the development of a Kaupapa Māori Maternal Health Programme and proposed next steps.

Proposed plan to develop a Kaupapa Māori Maternal Health Programme

Author:	**Patrick Le Geyt**
Designation:	**Acting General Manager, Maori Health**
Date:	**11 May 2018**

PROPOSED PLAN TO DEVELOP A KAUPAPA MĀORI MATERNAL HEALTH PROGRAMME

It is proposed that HBDHB develop a kaupapa Māori Maternal Health Programme ('the Programme'). The intent of the programme is to overcome barriers to access to care, eliminate inequities in maternal and child health, and improve maternal and child health outcomes. This programme plan outlines the approach to develop the programme, and identifies key actions and timeframes to deliver the programme.
The programme will be responsive, accessible, and culturally appropriate to adequately meet the needs of Māori women and their whānau. Fundamental to the development of the programme and its overall success will be the integrated, and collaborative approach between HBDHB, providers, and communities.

There are funding implications to deliver the programme. These will be identified through the development stages.

INTENDED HEALTH OUTCOMES

The intended health outcomes of the proposed programme are:

1. Improved maternal and child health outcomes for Māori mothers and their pēpi
2. A reduction in maternal and child morbidity and mortality by 2023
3. Removal of barriers to access to maternal care for Māori women, and
4. Māori women making informed decisions about their health and well-being.

AIM OF THE PROGRAMME

To provide high quality, culturally appropriate care and support to Māori women and their whanau and ultimately, equitable maternal and child health outcomes.

RATIONALE

Māori mothers experience disproportionately higher rates of poor pregnancy outcomes including maternal and perinatal mortality, pre-term birth and low birth weight compared to non-Māori mothers. These disparities occur well before pregnancy within a trajectory of disadvantage and differential outcomes that stem from infancy, childhood, adolescence, through to adulthood and older years. The evidence clearly shows that poor health in childhood is linked to poor health in adulthood, and vice versa.

Locally, Hawkes Bay has significant health inequalities, areas of high deprivation, and whanau/families living in poverty. Pēpi and tamariki Māori are especially vulnerable experiencing a disproportionate burden of ill-health and poorer health outcomes compared to non-Māori children (HBDHB, 2014). Tamariki Māori have higher rates of hospitalisation for respiratory, dental extractions, gastroenteritis, and skin conditions (HBDHB, ASH report 2018, HBDHB ASH respiratory review, 2017, HBDHB ASH dental review, 2018). These disparities continue through to adolescence,

as rangatahi Māori are over-represented in sexual health statistics such as unplanned pregnancy, sexually transmitted infections, alcohol and drug use, and depression, as well as reported unmet health need, and unable to access primary health care when they needed it (HBDHB data, 2017; Youth Survey, 2012).

The impact of poor health outcomes and the accumulative effect of disadvantage are also associated with experiences of negative stigmatization, discrimination, and racism. These feelings and experiences can have serious consequences that can prevent young people from accessing primary health care, resources, and support to make positive and informed decisions about their health and well-being. This critical life experience has lifelong implications for rangatahi as individuals, future partners, parents, and participants in society as decisions about smoking, alcohol use, dietary behavior, physical activity, and sexual health play a critical role in determining adult behavior.

Early engagement and health care experiences can determine how well (or not) a person continues to engage with health care services throughout their life. And therefore, acting on inequity during adolescence and throughout experiences such as pregnancy is a vital component to what is proposed in this paper to ensure rangatahi live to their full potential.

These disparities are also indicative of the wider social inequalities in our society and communities, and the right of Māori women and their children to access maternal health education, services, and support that is culturally appropriate, responsive, and of a high-quality standard. The burden of ill-health and subsequent life-long disadvantage is unfair, and avoidable. There is urgency for HBDHB to address these disparities.

HBDHB Maternity Services

In 2016, 40% of women that birthed in Hawkes Bay facilities were Māori, and on a yearly basis caters for a child bearing population of 28,500 women aged between 15 – 44 years old. But there are a number of other complexities that emphasize the need for HBDHB to ensure maternal and child health services are appropriately meeting the needs of Māori women. 2015 data shows that of the 1858 women that gave birth: 695 were Māori, 201 were Māori women giving birth for the first time, 102 were young Māori women aged under 20 years, 696 were Māori and Pacific women living in the most deprived areas, and 215 were whanau that were identified as high risk/vulnerable. In addition, about 460 women were classified as obese or morbidly obese, and 502 were not smoke free during their pregnancies. Inequities in maternal health care highlight that the standard of care received by Māori women and their whanau is inconsistent with HBDHB standards of maternity care which include:

- Standard 1: Provide safe, high-quality services that are nationally consistent and achieve optimal health outcomes for mothers and babies.
- Standard 2: Ensure a women-centered approach that acknowledges pregnancy and childbirth as a normal life stage.
- Standards 3: All women have access to a nationally consistent, comprehensive range of maternity services that are funded and provided appropriate to ensure there are no financial barriers to access for eligible women.

KAUPAPA MĀORI CONTEXT

The development of the programme will be based on kaupapa Māori principles of health and well-being. Central to the development and delivery of the programme is the Māori goddess Hineteiwaiwa, the deity of childbirth and female divinity. The kaupapa Māori approach of the programme recognises the identity of hine, kōhine, wāhine, and ruāhine and their intrinsic self-worth because they descend from divinity. Because of this divinity, a cultural response that fosters agency, and good decision making that encompasses their lives and realities as women and mothers is paramount. Hineteiwaiwa is also the deity of Te Whare Pora (the house of weaving); this ancient art is intrinsically related to both spiritual, and physical matters connected to whakapapa, karakia, and whānau. It acknowledges the role of Māori women as central to whānau health and well-being.
As the programme develops tikanga, cultural considerations, and relationships will be fundamental to ensure this project is responsive to the needs of Māori women and their whānau. This will be a key role of the Steering Group.

Privileging Māori
Improving equitable access to care relies on the provision of a programme that meets Māori standards and expectations. Therefore, the voices of Māori women and their whanau will be bought to the forefront to ensure their right to access health and health care is upheld, and services are culturally appropriate, responsive, and of a high-quality standard.

WHAT IS BEING PROPOSED

The proposed programme is an intervention designed to help māmā and her whānau receive appropriate information, support, and advice to help them make informed decisions about what's important to them to achieve the maximum health and wellbeing of their whānau. Engagement and exchange of information before and in the early stages of pregnancy will be essential to provide pregnant women with important information about pregnancy, birth, and parenting, but importantly, a focus on other important health issues such as, safe sleep, breastfeeding, smoking, nutrition, sexual health, and facilitating access to other health and social services to support women before, during, and post-pregnancy. The intricacies of the programme and its scope and focus will be determined and informed by the Steering Group, whānau feedback, data analysis, and sector perspectives.

PROGRAMME DEVELOPMENT

Māori Health, Maternity, and Population Health have worked collaboratively during this conceptual stage, and will continue to work in partnership to oversee the development and implementation of the programme. A Steering Group of HBDHB and Community stakeholders will be established to ensure the programme is responsive and appropriate to Māori mothers and their whanau. Steering Group members will have responsibilities and experience in maternal health care and improving Māori maternal health outcomes. The Steering Group will provide evidenced based advice and strategic direction on the development and implementation of the programme. The Group will do this by providing expert advice on:

- The development and delivery of the programme
- Priority areas of focus
- The coordination and collaboration of services and programmes
- Clinical quality, service planning, and provision
- A culturally competent workforce, and
- Advice on the integration of health services.

The Group will meet monthly initially, and then bi-monthly. Membership of the Group will comprise representation from the maternal health sector with a mix of HBDHB, provider, and community representation. Membership of the Group is still being finalized, however, proposed members so far include:

Member	Sector/representation
Nanny Tanira Te Au	Kuia
Tiwana Aranui/Hawlra Hape	Kaumatua
David Tipene-Leach	GP/Researcher/Māori health expert
Shannon Bradshaw	Māori Midwifery Consultant, HBDHB, Midwife
Michele Grant	Child Health, HBDHB
Beverley Te Huia	Ngā Maia
Rawinia Edwards	Safe Sleep, HBDHB
Jules Arthur	Director Maternity Services, HBDHB
Charrissa Keenan	Māori Health Gains Advisor, HBDHB
Shari Tidswell	Intersectoral Development Manager, HBDHB

PROJECT ACTIONS

Phase	Actions	Deliverables	Timeframe
Phase 1 Scoping	1.1 Establish Steering Group – scope terms of reference, and agree: -programme objectives and deliverables - priorities - Roopu membership - key stakeholders	• Group membership confirmed	15 May
		• Group TOR drafted	20 May
		• Advisory Group meeting held	By 1 June
		• Terms of Reference confirmed	By 1 June
Phase 2 Planning & Analysis	2.1 Gather any necessary information and conduct critical analysis of data and barriers to access to maternal health care	• Conduct a critical analysis of data and barriers to access to care	By 1 July
		• Map out current services and programmes	By 1 July
		• Write up findings and present to Steering Group outlining map, gaps, possible actions	By 1 July
	2.2 Privilege Māori voices	• Talk to Māori women, mothers, and fathers to find out what they need and want	By 31 July
		• Write up of korero and present to Steering Group for feedback	By 1 August
	2.3 Explore options for developing a culturally responsive maternal health programme for Māori women and their whānau	• Based on the critical analysis present an options paper for developing a programme	By 31 August
Phase 3 Engagement	3.1 Engagement of key sector stakeholders to: • Map the maternal health landscape • Barriers to access to maternal health care • Present proposed programme for feedback • test possible pathways and input into programme development	• Identify sector stakeholders	1 June
		• Hold workshop to introduce kaupapa and input into	By 18 June
		• Summarise korero	By 1 July
Phase 4 Development of Progamme	4.1 Deliver the programme	• Undertake a RFP process	By 31 October
		• Contract services to deliver the Programme	By 31 November

PROJECT CONSTRAINTS

- Timeframes for development
- Competing priorities

EXPECTED BENEFITS

- Māori women are fully engaged and satisfied with maternal and child health services.
- Greater awareness among Māori women and their whānau of their right to access to health care and informed decision making.
- Improved coordination of health services and programmes tailored toward whanau Māori.
- Reduction in inequities in access to health care.
- Improved maternal and child health outcomes.

- HBDHB delivering a response, culturally competent maternal health programme.

KEY RISKS

- Lack of engagement/buy-in at all levels of HBDHB.
- Inability to deliver a culturally responsive programme.
- Contracting processes.
- Establishing a kaupapa Māori programme within a non-Māori context.

KEY STAKEHOLDERS

- Maternity Services
- Paediatrics
- Lead Maternity Carer Services
- Healthy Populations
- Health Hawkes Bay
- Primary Care Practice
- DHB Maori Health Service
- Pacific health
- Māori Health Providers
- Whanake Te Kura, TTOH
- Well Child Tamariki Ora Providers
- Maternal Well-being Group
- Family Violence team
- Mental health and addictions
- Information Services
- Directions Youth Health Services
- Māori Community based Lactation Service
- Hospital based Lactation Service

INTERDEPENDENCIES

There are a number of work streams currently in progress that relate to this project. The 'Conception to 5 years' paper presented to EMT in March 2018 identifies a number of common areas and actions to improve child health outcomes and reduce disparities in child health. The paper highlights whanau voices, service coordinated, and focus on high need population groups etc. as necessary areas of focus. The newly established 'Whanake Te Kura' pregnancy and parenting education programme, proposed breastfeeding activities, Well Child Tamariki Ora, smoking cessation etc. are also relevant. This project will align with and support existing programmes to reach the desired health outcome.

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the content of this report
2. **Approve** the implementation and next steps

Appendix 1: References

1. HBDHB. 2018. Business Intelligence health reports. HBDHB

2. HBDHB. 2016. HBDHB Maternity Services Annual Clinical Report, 2016. HBDHB.

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HAWKE'S BAY District Health Board Whakawāteatia	**Collaborative Pathways** 65 For the attention of: **HBDHB Board**
Document Owner:	Chris Ash, Executive Director of Primary Care
Document Author(s):	Leigh White, Portfolio Manager - Long Term Conditions
Reviewed by:	Paul Malan, Head of Planning & Strategic Services; and Executive Management Team and HB Clinical Council
Month:	May, 2018
Purpose	• Decision • Input/Discussion
Previous Consideration Discussions	• Historical papers • An Information and Decision Paper that outlines the options, analysis and IT vendors in details can be submitted.
Summary	Pathways need to continue as they are an integral component of other system-wide programmes of work, especially when seeking to establish a more integrated and collaborative approach of care. The cross-sector co-creation of pathways brings great value in fostering relationships.
Contribution to Goals and Strategic Implications	**WHAT DO WE WANT** A strengthened programme: • A selected pathway tool that becomes respected as a "go to" platform for evidence-based clinical guidelines and localised information pertaining to our Hawke's Bay demographics • That has enough of the right resources/people involved in development • That Providers understand and disseminate the value of the collaboration and the use of pathways at the coalface • A tool that we can pursue further service integration through increased IT enablement by way of electronic decision support (e.g. e-referrals) and dynamic pathways. • That will enhance continual improvement of quality, safety, case management and increasing awareness of self-care – e.g. patient resources • Will improve value for public health system resources e.g. stop the duplication or over diagnostics
Impact on Reducing Inequities/Disparities	The work of pathways aligns to equity and tripple aim. HEAT aligns with LTC HEAT
Consumer Engagement	N/A

19

Other Consultation /Involvement	Chief Medical Officer – Primary Care
Financial/Budget Impact	$233,092 – current budget
Timing Issues	Service Agreement with map of Medincie expires June 30 2019
Announcements/ Communications	Clinical and Consumer Council

RECOMMENDATION

That the HBDHB Board note that they:

1. **Commence** robust discussions with Chief Executive Streamliners on the transitional and permanent adoption of Health Pathways
2. **Review** the budget lines for 2018/2019 to disinvest temporarily some of the Pathway budget ($233,092) but excluding HBDHB FTE as it is necessary to keep employment status due to the historical knowledge of the programme) and reinvest temporary into the development process of e-referrals and/or winter planning aligning with CPO initiatives.

Collaborative Pathways

Author:	**Leigh White**
Designation:	**Portfolio Manager - Long Term Conditions**
Date:	**March, 2018**

OVERVIEW

Business Objective – Rule out and recommended option			
HBDHB Budget for Pathway Programme 18/19	Annual: 18/19 $233,092	**Current FTE Budget (0.9FTE)**	$65,391 (Does not include LTC P/Manager or Outsourced Clinical Support)
		Option	Indicative $
Option 1: **Status quo**: We will no longer be supported by the Map of Medicine tool. ***Explanation*** MoM vendor, Hearst Group UK, is withdrawing support this year, and it is anticipated that this will occur 1 July 2018 (our contractual agreement expires 30 June 2018, but there can be an option to extend until end of year).		Not an option If extending till December	$0
Option 2: **Build an in-house tool for promulgation Explanation Comments from Jos Buurmans (IS)** **"***I would recommend against developing a bespoke solution (either alone or with Midlands) as that would not only involve a yet unknown development cost, it would also increase the risks that the HBDHB would not be able to leverage pathway work carried out nationally and that this would significantly complicate the integration with other IT solutions such as the Clinical Portal."*		Not an option	$0
Option 3: **Dispense with IT solutions & use a paper-based Explanation** This could be considered but not acceptable as it does not address key requirements including ease of pathways promulgation and updating, fit with current workflows, and integration with e-referral processes. Previous pathways, developed and shared as paper-based 'care guidelines' within Hawke's Bay have had limited uptake.		Not an option	$0

<table>
<tr><td rowspan="5">Option 4:
Procure Community Health Pathways
Explanation
• known tool - ‘tried and tested’ transition process from Map of Medicine to Health Pathways
• provides extensive knowledge based and proven model
• IS comments: “Health Pathways solution appears to be the most appropriate from a technical perspective, considering that most DHBs in New Zealand already use this, including DHBs that use the Clinical Portal that we’re migrating towards, which would simplify integration. From a business/clinical perspective, the use of Health Pathways would enable us to leverage clinical pathway work already carried out, but I understand we would need to commit to a Health Pathways ‘governance process’ that involves increasing the local pathways management team.”
Note: Additional cost implications
• Health Pathways comes with its own framework of development systems
• Variable costs are based on number of pathway development
Secondary HealthPathways are not inclusive in this costing</td><td rowspan="5">Option

Note $TBC but based on population of 159,000 in 2015

Excludes FTE Prescribed FTE is 3.5</td><td>Yr 1</td><td>$137,950</td></tr>
<tr><td>Yr 2</td><td>$99,200</td></tr>
<tr><td>Yr 3</td><td>$99,200</td></tr>
<tr><td>Yr 4</td><td>$99,200</td></tr>
<tr><td>Yr 5</td><td>$99,200</td></tr>
<tr><td colspan="4">Business Objective – Transition Option</td></tr>
<tr><td colspan="3">Put programme on hold for 6-12 months
Explanation
• Accept the previous work requires further refining pertaining to costings.
• Commence confirmative discussions with Streamliners. Informal discussions have been held and both parties agree with 6-12 months led in time for a “go live” but with agreement there is an option for users to have access to pathways (unsure if there are costs implications – this needs to be confirmed)
• IS comments: “It’s my view that we should examine clinical pathway management holistically in order to define an end-to-end solution that spans the creation and publication of clinical pathway documentation, and the execution of these pathways including referrals, and primary and secondary workflows. In my view that will lead to better care outcomes, increased efficiencies, and reduced risks of higher than necessary costs. I am currently working on a conceptual ‘integrated care’ architecture that aims to support pathways, referrals, and workflow across the various layers of care”
• Temporary reinvest the Pathway Programme funding to focus on e-referrals and winter planning aligning to CPO
Implications
• Delay of programme may cause a break in what we have now and we will lose momentum and standardisation.
• Risk of not doing pathways – will not align with strategic thinking.
• If agreed during transition, users can have access to Health Pathways but will need to be informed that they are guidance and not localised.</td><td>Consideration</td></tr>
</table>

RECOMMENDATION

It is recommended that the HBDHB Board:

1. **Commence** robust discussions with Chief Executive Streamliners on the transitional and permanent adoption of Health Pathways
2. **Review** the budget lines for 2018/2019 to disinvest temporarily some of the Pathway budget (233,092) but excluding HBDHB FTE as it is necessary to keep employment status due to the historical knowledge of the programmer) and reinvest temporary into the development process of e-referrals and/or winter planning aligning with CPO initiatives.

Hawke's Bay District Health Board

Information and Decision paper

Pathways Programme of Work

19.1

In order to achieve the expected benefits, collaboration of the workforce involved in the said system, is a critical element in managing the "system of care," as Nightingale once described. This is more vital today than ever before, for the evidenced-based medicine revolution is now causing a heightened awareness for the need for better bridges between research evidence and local clinical best-practice. Thus, the clinical pathway has emerged as an important knowledge translation strategy for promoting effective healthcare.' [Blanchet & Flarey, Jabour]

Document Information

	Position	
Document ID	Pathways – Information and decisions Paper – version 3.0	
Document Owner	Chris Ash, Primary Director/Mark Peterson, Chief Medical Officer Primary Care	
Document Writer	Leigh White, Long Term Conditions Portfolio Manager	
Issue Date	7 March 2018	21/03/2018
File Name	I:\Projects\Clincial Pathways 2018	
Classification	Commercial in Confidence	

Document History

Version	Issue Date	Changes
0.1		Shared Central Region template – but localised for HBDHB. Ongoing relationships with Midcentral, Whanganui, Midlands PHO and DHBs
1.0.	27/12/2017	Initial work.
1.1	8/01/2018	Rework
1.2	15/01/2017	Feedback from various contributors (Clinical Pathway Editors/Information Services); distributed as DRAFT 1
1.3	26/01/2017	Rework and have meet with IT Services
2.0	12/03/2018	Include feedback from others Clinical Pathway Editors/Information Services
2.1		Feedback collated ready for submissions – sent to J. Garrett, J. Buurmans, A. Speden, M. Peterson, C. McKenna and L. Dubbledam
2.2	12/03/2018	Sent to J. Garrett (QA review), J. Buurmans, A. Speden, M. Peterson, C. McKenna and L. Dubbledam (No feedback received)
3.0	21/03/2017	**FINAL DRAFT** – Sent to M. Peterson and A. Speden

Document Review

Role	Name	Review Status
Clinical Pathway Editors	Wendy Wasson and Louise Patterson	Done
Anne Speden/Jos Buurmans	IS Department	Done
Linda Dubbledam	Health Hawke's bay	Nil feedback
Jill Garrett	Strategic Services Manager – Primary care	For QA review – not completed

Document Sign-off

Role	Name	Sign-off Date
Head of Strategic Services	Paul Malan	
Primary Care Director	Chris Ash	

Setting the scene

Barbara is 80 and lives with Malcolm, who was diagnosed with dementia after being admitted to his local hospital for recurrent falls. Barbara is his main carer. Their daughter, Alice lives in Australia.

On two occasions Malcolm needed to have day surgery under general anaesthetic. Barbara received the appointment letters but forgot where she put them. Malcolm missed his appointments. Barbara's daughter was concerned that her father had not attended surgery and got frustrated over the phone with her mother, so much so that she made her mother cry. Alice noted that her mother gets very tearful and irritable of late and wonders if she is depressed by looking after her father, Malcolm. Has it all become too much for her?

Alice flew to NZ to review the situation. It was obvious they were not coping at home and her mother was making excuses for the untidiness of the house and was uncooperative when Alice asked some questions. Alice was worried her mother was depressed and drove her to see her GP.

In Appendix 1 (a): *The diagram Alzheimer Web of Care shows some of the complexity in accessing services without a clinical pathway and model of care re-design.*

In Appendix 1 (b)*: The diagram depicts the different experience an individual and family will have when a pathway is implemented as part of the wider model of care re-designed.*

Excerpt taken from Business case of Clinical pathways Programme of work – Northern Region

Table of Contents

Executive Summary

Pathways need to continue as they are an integral component of other system-wide programmes of work, especially seeking to establish a more integrated and collaborative approach of care. The cross-sector co-creation of pathways brings value in fostering relationships – e.g. key questions such as "*how will this improve the timeliness of care for the patient*?", "*who is best to treat the patient?*", "*how can we prevent this condition from occurring in the population*?", and "*how do we improve the health outcomes for Maori*? Significant business impact can be made where we make available localised pathways for prevalent conditions, for example, better use of resources, reduction in inappropriate variation in care, improved patient experiences and outcomes. It is vital that this programme remains clinically led with wide clinician engagement, ownership and support.

The Problem

The Map of Medicine static pathway has been in use in Hawke's Bay for the past three to four years. The vendor, Hearst Group UK, is withdrawing support this year, and it is anticipated that this will occur 1 July 2018 (our contractual agreement expires 30 June 2018, but there can be an option to extend until end of year). **This is the trigger for this review and information and decision paper.** Overall decisions need to be made on the continuation of the pathway programme and a replacement IT tool. The purpose of this document is to document, guide with recommendations to assist decisions and/or recommendations.

Decision

A decision needs to be sought on next steps to address the Pathways Programme otherwise:

- clinicians will not have access to workflows and pathways
- all benefits realised to date will be lost
- programme will lose momentum
- clinicians will lose faith in supporting tools
- clinicians will revert back to paper-based systems – standardisations will be lost

Description

In order for us to be able to pick the best option for Hawke's Bay, it is recommended that we need to be clear about what we want, are hoping to achieve and options as summarised in SECTION 1.

SECTION 2 describes where we have been and to date. SECTION 3 describes an analysis of differing pathway frameworks that have been explored with a focus on the technical options available for Hawke's Bay to transition and/or replace Map of Medicine. A comprehensive IT appraisal has been outlined in SECTION 3 looking at static and dynamic pathway tools in use in New Zealand.

Influencing factors are

- the value the DHB places on being part of a formalised clinical community for the development of pathways
- the risk to the pathway programme if localised pathways are no longer accessible
- for all options, an important consideration is the limited time now available.

Acknowledgement

Support for this paper in particular the review of differing pathway tools has been conducted and assisted by Midlands DHB with a collegial relationship formed with Midcentral PHO, Whanganui PHO.

SECTION ONE

1.1 Summary of business consideration

Business Objective	Priority
SUMMARY – WHAT DO WE WANT Pathways need to continue as they are an integral component of other system-wide programmes of work, especially when seeking to establish a more integrated and collaborative approach of care. The cross-sector co-creation of pathways brings value in fostering relationships. We need a tool that has the following needs: • is user friendly, easy to navigate, quick to load • functions on mobiles, tablets and desktops • is as future proof as it can be, cognisant of the wish to integrate with systems, to drive up pathway usage and to continuously improve pathways. • provides an easy to use content management system that supports an approach to developing, approving and publishing pathways, plus to receiving feedback to drive ongoing improvements The objectives are: • A strengthened programme: • a selected pathway tool that becomes respected as a "go to" platform for evidence-based clinical guidelines and localised information pertaining to our HB demographics • that has enough of the right resources/people involved in development • that Providers understand and disseminate the value of the collaboration and the use of pathways at the coal face • a tool that we can pursue further service integration through increased IT enablement by way of electronic decision support (e.g. e-referrals) and dynamic pathways. • that will enhance continual improvement of quality, safety, case management and increasing awareness of self-care – e.g. patient resources • that aligns to improving equity • will improve value for public health system resources e.g. stop the duplication or over diagnostics	Priority – Decision making – Pathways to stay or go
Business Options	**Priority**
Option 1: ***Status quo***: We will no longer be supported by the Map of Medicine tool. MoM vendor, Hearst Group UK, is withdrawing support this year, and it is anticipated that this will occur 1 July 2018 (our contractual agreement expires 30 June 2018, but there can be an option to extend until end of year).	Not an option
Option 2*: Build an in-house pathways tool or connect with Midlands Bespoke Model*: This option was explored in the original Business Case for Pathways 2014 and considered not an option at this time by IS due to the large amount of technical support. Additionally, we would be 'reinventing the wheel' to build a tool for disseminating our pathways, without any of the benefits of working with a provider and, potentially, other regions already using a tool. **Comments from Jos Buurmans (IS) "***I would recommend against developing a bespoke solution (either alone or with Midlands) as that would not only involve a yet unknown development cost, it would also increase the risks that the HBDHB would not be able to leverage pathway work carried out nationally and that this would significantly complicate the integration with other IT solutions such as the Clinical Portal".*	Not an Option
Option 3: ***Dispense with an IT solution*** and use a paper-based system, however this is considered not acceptable as it does not address key requirements including ease of pathways promulgation and updating, fit with current workflows, and integration with e-referral processes. Previous pathways, developed and shared as paper-based 'care guidelines' within Hawke's Bay have had limited uptake.	Not an Option

19.1

Business Objective	Priority
Option 4: Procure Community HealthPathways **Explanation** • known tool with 'tried and tested' transition process from Map of Medicine to Health Pathways • provides extensive knowledge based and proven model • IS comments: "*HealthPathways solution appears to be the most appropriate from a technical perspective, considering that most DHBs in New Zealand already use this, including DHBs that use the Clinical Portal that we're migrating towards, which would simplify integration. From a business/clinical perspective, the use of HealthPathways would enable us to leverage clinical pathway work already carried out, but I understand we would need to commit to a HealthPathways 'governance process' that involves increasing the local pathways management team.*" **Note: Additional cost implications** • HealthPathways comes with its own framework of development systems • Variable costs are based on number of pathway development	Option
Business – Transition Options	
Put programme on hold for 6-12 months. **Explanation** • accept the previous work requires further refining pertaining to costings. • commence confirmative discussions with Streamliners. Informal discussions have been held and both parties agree with 6-12 months led in time for a "go live" but with agreement there is an option for users to have access to pathways (unsure if there are costs implications – this needs to be confirmed) • IS comments: "*It's my view that we should examine clinical pathway management holistically in order to define an end-to-end solution that spans the creation and publication of clinical pathway documentation, and the execution of these pathways including referrals, and primary and secondary workflows. In my view that will lead to better care outcomes, increased efficiencies, and reduced risks of higher than necessary costs. I am currently working on a conceptual 'integrated care' architecture that aims to support pathways, referrals, and workflow across the various layers of care*" • Temporary reinvest the Pathway Programme funding to focus on e-referrals and winter planning aligning to CPO **Implications** • delay of programme may cause a break in what we have now and we will lose momentum and standardisation. • risk of not doing pathways – will not align with strategic thinking. • if agreed during transition, users can have access to HealthPathways but will need to be informed that they are guidance and not localised. **To minimise the negative impact of transition to a new tool** • current localised pathways continue to be available during transition • strong change management – training awareness and support • good communication and clinical leadership are provided by stakeholder	Agreement

Potential Risks

ID#	Risk description	Risk Response	Probability	Impact
R-01	Limited resourcing available to further refine costings and new work	ACCEPT The business requirements require a thorough review of costings.	20%	2

Potential Risks				
ID#	**Risk description**	**Risk Response**	**Probability**	**Impact**
R-02	The ability of the pathways programme to deliver is compromised by inadequate resourcing.	AVOID Additional resourcing requested in this paper.	80%	3
R-03	The unclear position distracts delivery and pursuit of other temporary solutions for ensuring business continuity.	AVOID Ongoing consultation	60%	4
R-04	Delays in decision making by 1 July 2018 may cause delays in implementation for HealthPathways, who have a queue of prospective customers	AVOID Pursue recommended procurement approach as soon as possible to start the connections. Use contract, relationship management and technical advisory group to reduce risk	60%	4
R-05	Secondary HealthPathways comes at a significant cost and will require further investigations	REDUCE/EXPLOIT Discuss in contractual negotiations with Streamliners re Community HealthPathways Opportunity to lobby with other members of the HealthPathways community.	60%	3
R-06	Low confidence in the integration costs which look higher than expected.	REDUCE/EXPLOIT Direct discussions between vendors re integration points will address this.	80%	2
R-07	Delivery and capability	Streamliners experience	40%	1
Legend:		**Threat**: Avoid, Reduce, Accept **Opportunity**: Exploit, Enhance, Reject	20% Rare 40% Unlikely 60% Possible 80% Likely 100% Almost Certain	1:Minimal 2:Minor 3:Moderate 4:Major 5:Extreme

1.2 Summary of Technical Option - HealthPathways

IT Platform Objective: *It is important that a tool is selected that supports rather than hinders this improvement programme*

By way of context, pathways are a core enabler. Any IT tool is simply a vehicle for organising and disseminating information to care providers. Quality improvement comes from the collaboration in development of the pathways which brings together clinicians and management to focus on specific patient journeys where the region can share knowledge, learnings and current innovations to improve the health of people in the region.

Following evaluation of six alternatives against specific criteria's and against strategies, **ONE option** is preferred. For full overview of all other alternatives please refer to Section 2:

Criteria	Technical Option – Community HealthPathways
Summary of the Option (Community HealthPathways)	HealthPathways is a very established model with established governance. The tool is used by 12 of 20 New Zealand DHBs, and offers the lowest risk for reputation and clinical engagement. 550 pathways are available national and internationally. It is a static tool based on a community managing multiple pathways.
Advantages	Joining a large clinical community with ability to create and lead pathways that are nationally adopted, plus access to large Australasian group of pathways. Access to clinical, evaluation and technical groups as part of the HealthPathways Community. Library of pathways speeds up pathway development Clinicians will be able to move to any other NZ region and many in Australia and use the same system Potential to integrated with e-Referral/work committed/discussions with Healthlink
Risks/disadvantages	Regional change management and transition Reduction in number of new pathways developed due to reallocation of resourcing to transition Technical writing per hour fee charged by HealthPathways and is a 'must' of pathway localisation. Technical writing is done by a Health Pathways team. They are able to provide quick turnarounds, but this nonetheless adds a step to the localisation process and the potential for delays outside of our control Need to follow HealthPathways recommended service model which implies an increase in programme resources and role and responsibility changes for the current team. Cannot have pathways all the way through the patient journey due to the separate secondary pathway model Cannot open pathways to public Not fully integrated but there are no vendors in NZ who are
Hard benefits	Not easily quantified plus accurate attribution of where financial benefit comes from is difficult. International evidence demonstrates cost saving benefits around pathway development and use.
Indicative timescale	Due to the demand of business HealthPathways would prefer a 6-12 month led in time. Commence with localising some and will make the remaining as PDFs on the HealthPathways site. Clinical knowledge base of 425 pathways would also be available (unlocalised but still in a NZ/Australian context).
Usability and Stakeholder support	High, as evidenced by the clinician feedback e.g. GP Registrars Clinicians' have stated the speed with which you could find info in Health Pathways Same number of clicks however layout makes it easier to find the information Mobility functions on various screen sizes
Able to replace MoM	Low risk, as is off-the-shelf
Usage	Reporting via Google Support, maintenance and hosting via SaaS Technical fit HTML and Hosted by HealthPathways
The impact of transitioning to a new tool	Medium risk, as known tool with 'tried and tested' transition process from Map of Medicine to HealthPathways User base would have to move to new tool, and there would be short term loss of functionality and integration. Would involve user change management, IS integration resource and clinical advice for transitioned pathways.
Regional/ local needs	Low risk, as HealthPathways comes with its own framework
Analysis of option	Established model with established governance. Used by 12 of 20 NZ DHBs, and offers the lowest risk for reputation and clinical engagement.

Criteria	Technical Option – Community HealthPathways				
	Downside is cost of Secondary HealthPathways.				
Option appraisal	Meets all objectives. Low risk.				
Indicative costs	Yr 1 $137,950	Yr 2 $99,200	Yr 3 $99,200	Yr 4 $99,200	Yr 5 $99,200
	Cost above exclude FTE and are based on a population of $159,000 in 2015 – TBC Cost do not include Secondary HealthPathways Ballpark cost. Further vendor engagement required to validate.				
Recommendation	RECOMMENDED - Next step – to validate costs and proceed to business case				

1.3 Feedback from HBDHB IS Department regarding technical options

"Out of the options considered to replace the Map of Medicine tool (MoM) we currently use to document and publish clinical pathways, the HealthPathways solution appears to be the most appropriate from a technical perspective, considering that most DHBs in New Zealand already use this, including DHBs that use the Clinical Portal that we're migrating towards, which would simplify integration. From a business/clinical perspective, the use of HealthPathways would enable us to leverage clinical pathway work already carried out, but I understand we would need to commit to a HealthPathways 'governance process' that involves increasing the local pathways management team.

I would recommend against developing a bespoke solution (either alone or with Midlands) as that would not only involve a yet unknown development cost, it would also increase the risks that the HBDHB would not be able to leverage pathway work carried out nationally and that this would significantly complicate the integration with other IT solutions such as the Clinical Portal.

Furthermore, it's my view that we should examine clinical pathway management holistically in order to define an end-to-end solution that spans the creation and publication of clinical pathway documentation, and the execution of these pathways including referrals, and primary and secondary workflows. In my view that will lead to better care outcomes, increased efficiencies, and reduced risks of higher than necessary costs. I am currently working on a conceptual 'integrated care' architecture that aims to support pathways, referrals, and workflow across the various layers of care that I am more than happy to discuss with you.

I suggest that we explore implementing a transition solution while defining this end-to-end solution. Options include:

- *Negotiating an extension for MoM support*
- *Retaining MoM for viewing only (we would not be creating or updating pathways in MoM anymore). This would depend on whether MoM would still be accessible from 1 July 2018.*
- *Extracting pathway documentation from MoM (e.g. as PDFs) and publishing these on a public website*
- *Advising users of MoM (e.g. GPs) to extract relevant pathways themselves"*

1.4 Delivery Capability from HealthPathways Teams

- The likely team (including any potential vendors) have a proven, successful track record relevant to the outcomes of this initiative, AND
- Strong leadership is in place, AND
- Any capability gaps can be addressed through explicit training and the use of defined support, AND
- There is a clearly defined scope and agreement of the clinical and business benefits required

1.5 Suggested Transition Process

IT tool

Community HealthPathways is recommended.

Secondary HealthPathways is an additional cost which has been de-scoped from this document for revisiting at a later point.

Note: there may be an issue of timeliness of transitioning to HealthPathways and there may need to be an interim solution as it is estimated approximately 75 fully localised pathways may take some time to complete – *this will need to be confirmed*.

- Additional resourcing of 1.0 x FTE to investigate and strengthen the Pathways Programme around pathway implementation, localisation, change management and pursuit of further IT enablement for example:
    - we can pursue further service integration through increased IT enablement of high impact pathways by way of electronic decision support and dynamic pathways
    - enough of the right resources/people are involved in pathway development as currently "light on the ground"
    - providers understand and disseminate the value of the collaboration on pathways and the use of them at the coal face
    - the pathways tool becomes a respected "go to" platform for evidence-based clinical guidelines and localised service and primary/secondary arrangements
- Approach and progress the implementation of preferred option: HealthPathways is recommended as the preferred option to replace Map of Medicine.
- Explore the following temporary solutions by way of mitigation for the risk that the HealthPathways implementation overruns:
    - make PDFs of the current localised pathways available on a website, which would still allow the Midland region to access the localised pathways electronically that contain the information for referral and management.
    - continue to liaise with our Midlands and Central Regions partners, this way we have the potential of financial benefits of a regional pricing tool with HealthPathways rather than individual
    - continue to support Facilitator and Editor FTE for transition period

Transitional milestones – dependent on approval process

	Duration:	**Target Dates 2018**
Milestones: Deadline 30 June 2018	12wks	
Additional resourcing of 1.0 x FTE to investigate and strengthen the Pathways Programme (2 year review). Ongoing programme resourcing has been identified as a critical success factor to a strengthened Pathways of Care programme that delivers on the region's needs around IT enablement (electronic clinical decision support) and around development and usage of pathways (relies on availability of local pathway development resource, plus on change management at a central regional and at a local level). Adequate resourcing for the programme is essential to its success (refer to Appendix 6)	?	
Confirm current FTE	6 weeks	By end of May
Establish discussions with Streamliners (quotes, transition planning)	5 days	
Prepare exit clause from Map of Medicine	2 days	
Retrieve Localised Pathways from Map of Medicine Tool	1 week	Done – in PDF

Catalogue current and future integration pathways	3 days	Done – Template attached
Catalogue integration needs with e-Referral System	3 days	Discussions commenced
Communications to stakeholders	4 days	

1.6 Procurement Compliance

Does this solution involve external parties/suppliers?	Yes
Is a current and relevant contract already in place for the same product/hardware/service?	?
If no contract in place, will need to engage with Procurement to discuss the Procurement activity required to ensure compliance with the Procurement and Contracts Policy?	Yes

SECTION TWO

2.0 Purpose

This document has been requested by Hawke's Bay District Health Board Clinical Council (CC), to inform and assist CC with decision making for the continuation of this on-going programme of work, but most of all the procurement of a Pathways IT tool. This document has been developed using the learnings acquired during the last three years, from the views and comments of key stakeholders and existing knowledge shared by other DHB regions.

2.1 The Problem

Hearst Group UK has announced that they are ceasing development of several of their tools: side bar and e-Referrals Map of Medicine® static pathway tool. This is due to the National Health Service (NHS) developing a national e-Referral solution which is not linked to the Map of Medicine® pathways system and makes the Map of Medicine® e-Referrals obsolete. By March 2018, any non NZ customer support will be stopped.

It is likely that by the end of June 2018, HBDHB agreement will cease however there can be an option of extension to align with Midlands's extension till September 2018. Note all of the HBDHB pathways that have been developed within the Map of Medicine product will no longer be accessible when agreement ceases.

This poses significant clinical risk:

- clinicians will not have access to the workflows and pathways
- all benefits (e.g. reductions in variations in care, quality and timeliness, unnecessary hospitalisation) realised to date will be lost
- programme will lose momentum
- clinicians will lose faith in a regionally supported tool
- clinicians will revert back to paper-based systems – standardisations will be lost

2.2 Background

HBDHB and Health Hawke's Bay (PHOs), service about 163,580 residents and have been on the pathway of development journey for more than four years using the UK evidence based pathway publishing tool "Map of Medicine".

2.3 Overall statements

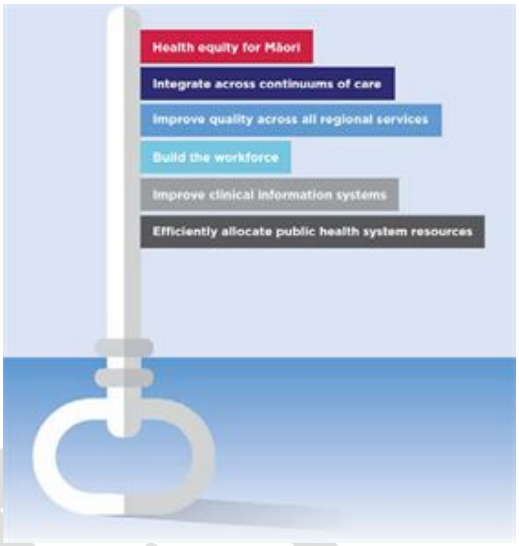
The process of creating a pathway is as essential as the outcome – it's not a cookbook that others can simply lift off the shelf!

The local "health system" benefits through less demand on acute and residential care services as patients can be better managed in the community, freeing up resources to provide more elective services and increase assistance to primary care.

As well as finding a replacement tool for Map of Medicine, an objective of this work is to improve and support central region's priorities (continue to work together).

The Pathways Programme supports the New Zealand Triple Aim Framework.

The Pathways Programme is integral to achieving all HBDHB regional objectives.



2.4 Pathways Context

Pathways can be as simple as the translation of clinical guidelines, referral criteria for clarity in a regional and local context or a fully integrated pathway transforming a person's journey. Pathways allow clinicians that face similar challenges on behalf of their patients each day to standardise and streamline clinical processes. The European Pathway Association in 2006 defined a pathway as: *"A methodology for the mutual decision making and organization of care for a well-defined group of patients, during a well-defined period"*.

An example: HBDHB Corticosteroid Pathway 2017: Radiology became overwhelmed with referrals (no capacity and identified some GPs had no capability). Referrals were assessed by Clinicans (primary/secondary) and a MDT working group. Outcomes: consultation, communication, change of process and GP education – **a success!!**

2.5 Supporting Literature

Conceptually, there are benefits in differentiating pathways from medical guidelines. The Institute of Medicine, 1990, created the most widely used definition of guidelines: "*Guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances*". While guidelines are a consensus of medical experts, pathways require a consensus among different stakeholders in the complete patient treatment process. As a consequence, pathways may deviate from guidelines on which they are based in the case where a hospital or practice does not have all the resources necessary to complete the recommended procedure (Lenz & Reichert, 2007).There are numerous other terms used for pathways: 17 different terms were identified by de Luc and Kitchiner (2001) on the concept of pathways. The most common terms besides pathway, include: care pathway, clinical pathway, integrated care pathway, care map, care protocol, anticipated pathway, care profile, collaborative care plan.

The reason for having a Pathways Programme is not so much about financial benefit but more about *"this is the right thing to do"* and will assist other models of care re-design work taking place across the health system. In relation to cost effectiveness of pathways, there have been many international studies and literature reviews that have documented a positive effect on health system costs. In the review by Van Herck et al, 82.5% of the studies reported a positive effect on reducing costs; Dautremont et al, Olson et al and Sermeus et al also came to this conclusion in their study.

International experience shows that benefits are achieved when pathways are part of a whole of system change. Literature states that pathways can be significant enablers for integrating health care across primary and secondary settings and have the potential to achieve policy objectives that are captured within the Triple Aim. That is:

- improve the quality, safety and experience of care
- improve health and equity for all populations
- gain best value for public health system resources

2.6 Key benefits of Pathways

Key Benefits	
The implementation of pathways has shown significant improvement in care both in New Zealand and internationally. Our pathways have been a vehicle to bring clinicians together as a region to focus on specific patient journeys (e.g. Faster Cancer Pathways). They have been collaborative as there has been sharing of knowledge, learnings and current innovations to improve the health of people e.g. change to Outpatient letters for Hips/Knees) region. The current approach to development of pathways predicates affordability of efficiencies through reduced duplication and through a shared ethos in pathway development.	
Strategic fit The pathways and tools are used to align with the NZ Health Strategy 2015 strategic themes with an emphasis on integration, which is critically dependent on a team approach. Integration across continuums of care is one of the HBDHB strategic objectives. A key enabler of integration is the regional partnerships. Currently, regional pathways of care are published on the international evidence based software tool 'Map of Medicine' containing up-to-date international best practice guidance.	
Other benefits	
Person-centric design making for improved quality of care and improved patient outcomes An example is reducing Radiology wait times for Corticosteroid injections	The pathway development process is a process of co-creation and highlights opportunities for service redesign, operational process improvement and possibilities to shift services closer to home, leading to better people satisfaction and outcomes. Some of the questions that may be asked as a pathway is developed include, "*how will this improve the timeliness of care for the person*?", "*who is best to treat the person*?", "*how can we prevent this condition occurring in the population*?", and "*how do we improve the health outcomes for Māori.*"

Improved communications between professionals, with patients and their family/whanau An example is people learning how to self-manage gives empowerment	The voice of the person is of central importance in the design of pathways and wherever possible this occurs to ensure that the needs of people and their carers and whānau can be included. These pathways include referrals to: • Non-governmental Organisations (NGO) • education and support resources • self-help information and information to promote independence and goal setting (e.g. ACP links)
Increased collaboration improves health outcomes and reduces inequity	The pathways of care draw together groups of clinicians and management from primary, secondary and other stakeholders to critically evaluate current pathways of care which may include inefficiencies, variation in practice, inequity and gaps in service across our region.
Create system level efficiencies and improve financial sustainability An example is reducing avoidable hospitalisation by increasing primary care options	Pathways are a key step in transforming a person's care. Many common issues are being dealt with simultaneously across sectors and this can lead to duplication of effort. Pathways support sharing of knowledge, learnings and current innovations that are occurring locally. Collaborating and taking a whole of system view across all sectors uncovers opportunities to reconfigure services to benefit both the person and the bottom line.

19.1

2.7 Supporting quality improvement

Pathways need to be implemented as part of an overall quality improvement framework by successfully communicating changes, training staff and ensuring that projects do not become IT projects, but rather clinician led projects aimed at improving quality of care for individuals.

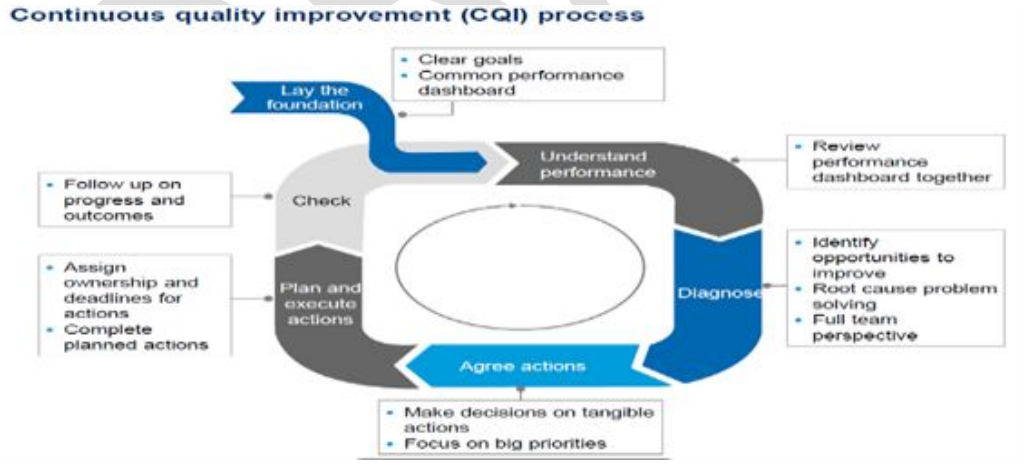


Figure above: Taken for the evaluation report of the Diabetes Care Project, McKinsey & C0, Canberra, Australia 2015

At its most complex, a pathway can act as a fully integrated information system, guiding and monitoring a person's journey of care between health professionals and across sectors. The key question is, "*Can integration improve quality and save money*?" Dr John Ovretveit states that, "*yes it can*". Dr Ovretveit provides an example of a central

problem of inappropriate referrals – delays and unnecessary referrals. The solution to this requires approaches that change referral practice.

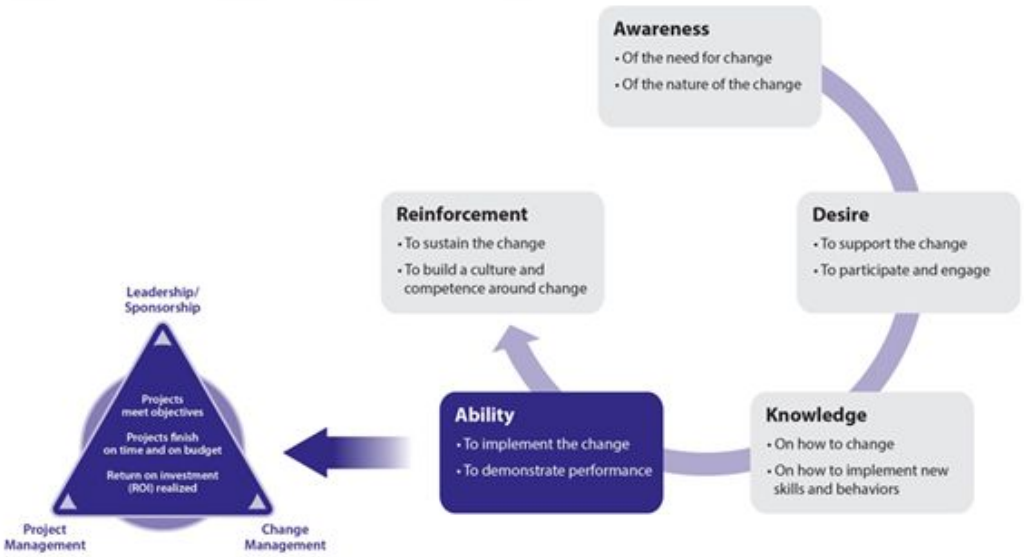
2.8 Supporting culture and transformation change

The enduring value of implementing pathways is the **culture and transformational change.** This change comes from successful implementation and understanding change management issues and barriers. Developing strategies to overcome issues and barriers are seen to be a foundational building block irrespective of the technology which could be used in the future to deliver pathways. The Pathway Programme seeks to address and minimise inequalities by ensuring that documentation and resource activities are undertaken to promote and maximise Māori and Pasifica participation (Refer to HEAT, Appendix 2). The clinicians and managers participating in the development of pathways need to consider the person's/family/ whānau and others who they meet along the way through their care journey. Some of the questions that may be asked as a pathway is developed include "*how will this improve the timeliness of care for the person*?", "*who is best to treat the person?*", "*how can we prevent this condition occurring in the population*?", and "*how do we improve the health outcomes for Maori*?"

To be successful and achieve the benefits the Pathways Program of work requires all organisations and stakeholders to work collaboratively. Primary care clinicians need to work in partnership with hospital clinicians, Health Hawke's Bay practice facilitators' need to work in partnership and the software developers need to be agile enough to respond to clinical feedback and improvement and to work with the Pathways Program team to assist with implementation. The Executive Management Team (EMT), Funders and clinicians need to support new development/ new models of care and together provide leadership in respective stakeholder organisations to work in partnership at the strategic level.

Change management is core to this initiative. Transitioning a whole region to a new tool is a significant undertaking. Why in favour of the HealthPathways option? - the tool is known and respected by clinicians across the region, some of whom have already used the tool in other regions. This will facilitate driving awareness of the nature of the change, plus the desire to change.

To roll out HealthPathways will require significant change management, potentially using the current governance framework (Clinical Council) and the current resourcing framework. An ideal would be investment and local champions that can drive localisation and usage of the pathways.



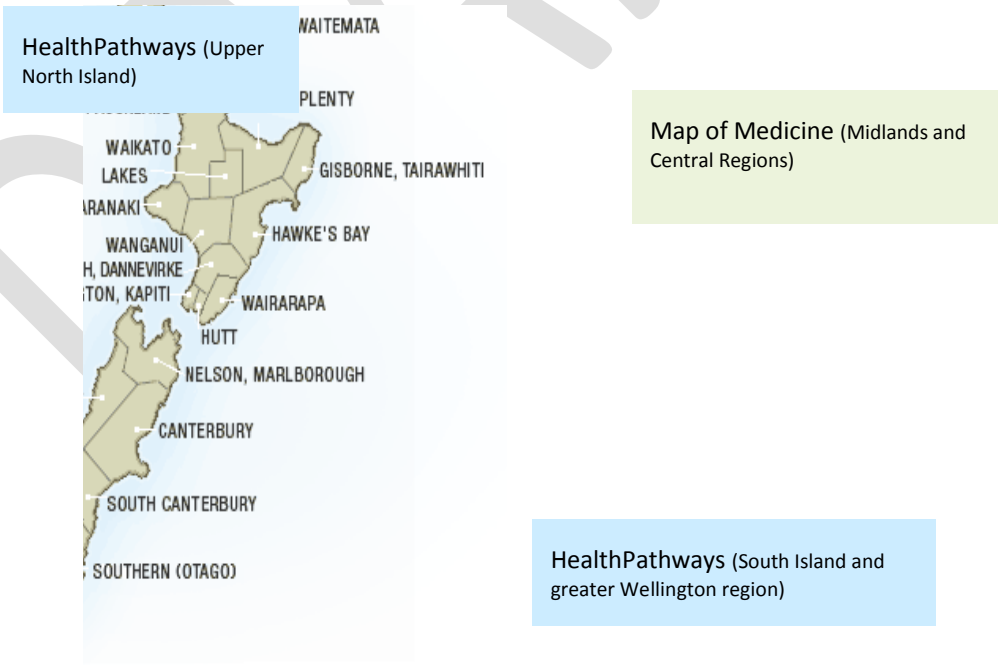
2.9 The National journey

In 2010, the National Health IT Board undertook a study to identify the 'requirements of a tool that would provide the greatest opportunity for improvements in the quality of patient care along the total health spectrum'. In defining the requirements, the study panel identified the main problems in the health sector that a pathways tool would help. These were:

- inconsistency of decision making (in diagnosis and treatment, also resource allocation, and service and capacity planning),
- difficulty in spreading the best models of care (significant duplication of effort in developing pathways that are then not shared with others, culture that entrenches current thinking),
- achieving systematic quality improvement (lack of governance and auditing mechanisms).

Despite the Health IT Board's emphasis on a single national tool, the ensuing years have seen the implementation of other tools. An example is the Canterbury Initiative, which rolled out a 'home-grown' HealthPathways tool as a localisable package of pathways and processes to all of the South Island DHBs, as well as those of the greater Wellington and Wairarapa. Health pathways (known as Streamliners) are now moving into Australia and UK. Other areas chose other vendors e.g. Map of Medicine, Health Navigator. In 2017, Auckland regions made the decision to move to HealthPathways.

***Figure below**: The distribution of Pathway tools currently in use in NZ*



2.10 The Hawke's Bay Journey

This context is important in understanding the HB region's three to four year journey with Map of Medicine. A pilot programme facilitated by MidCentral DHB was conducted in October-December 2013 to trial the pathways development process. This resulted in four completed pathways and three pathway outlines across three patient conditions. During this pilot, the Map of Medicine tool was utilised through MidCentral DHB. In July 2014, Clinical Council agreed to sponsor the establishment of Clinical Pathways within the Hawke's Bay district, focusing on two interrelated aspects:

(1) development of pathways (the collaborative process of determining best practice health care for a specified condition) and
(2) Identification of an IT tool that can promulgate pathways throughout the sector. Tool chosen Map of Medicine

2.10.1 Current Situation

In October 2017 HBDHB was given notice from Hearst group (vendors of Map of Medicine) that they were exiting out of UK. The purpose of ceasing development was due to the United Kingdom National Health System (NHS) developing a national e-Referral solution which is not linked to the Map of Medicine pathways system and makes the Map of Medicine e-Referrals obsolete. By March 2018, any non NZ customer support will be stopped.

HBDHB Map of Medicine Licence Agreement expired December 31 2017, but after renegotiation has been extended to June 2018 but with an out clause of a month's notice if decisions are made earlier.

2.10.2 Current Investment

- HBDHB patient population: 163,580
- **Fixed annual** licencing fee Cost: 18p/$0.34NZD per eligible service user
- **Variable annual** Map publishing cost: £500 - £1500/$984 -$2837.21 NZD per pathway. Some maps may hold up to eight pathways with no further cost for publishing or changing these pathways.
- For further budget breakdown and analysis refer to Appendix 3

2.10.3 Stakeholder Requirements

Primary and secondary clinicians are the key stakeholders for this programme along with other health providers, who access and use pathways to inform and streamline their recommendations of a person's care, treatment and education. A key issue for this group is gaining buy-in through empowerment and collaboration to develop, use and ultimately 'own' the pathways and the outcomes. Usability of an IT tool is an issue in that it needs to fit with current work flows and processes; these requirements are further explored and detailed in Appendix 5.

Health sector managers, both publicly and privately funded, can reasonably expect that this programme provides for a cost effective solution that delivers benefits over and above the implementation and operational costs.

Whilst consumers may not directly access the Pathways Programme, they can expect that expenditure and effort is focused on areas that will provide the most benefit. Therefore, this programme is tailored such that it impacts positively on the consumer experience in terms of waiting times, length of stay, access to procedures, choice and empowerment.

2.10.4 Our current profile

To date over 75 localised clinical pathways have been published, with a large focus on pathways that support primary care.

Figure below: demonstrates the Top 10 pathways being used for the period 1/01/2017 – 31/12/2017.

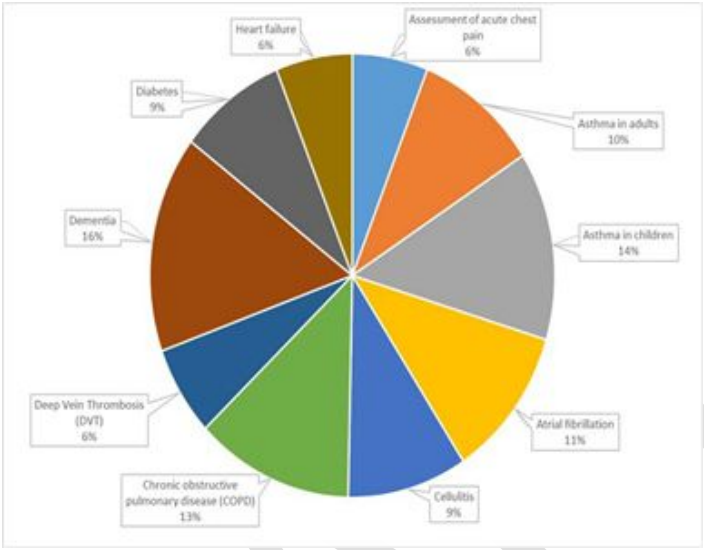


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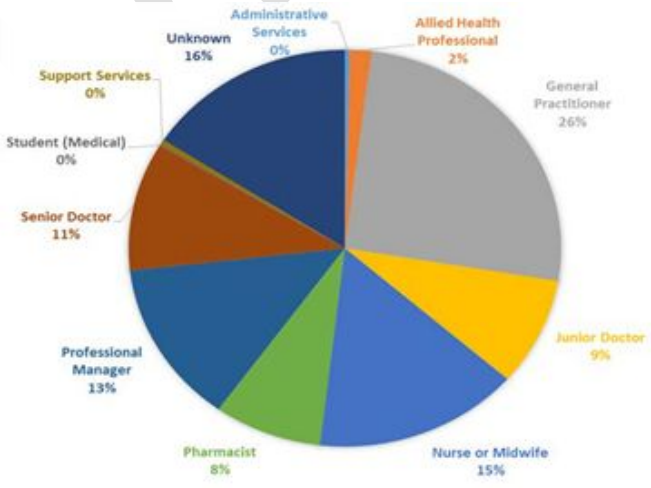
Figure below: demonstrates the users of pathways by professional groupings for the period 01/01/2017 – 31/12/2017



2.10.5 Our challenges

- confusion over whether pathways are for both primary and secondary care – a "whole of system" approach?
- pathways are not embedded 100% in clinical practice - the fact is that most GPs don't use the pathways, comments as " *not adding value to their day to day work practice - only when required scenarios, clunky to us*e"
- confusion over the "right" number of pathways to be developed? Should the aim be to maximise the number of published pathways, or focus on effectively implementing a smaller number that would make a significant difference?
- getting the right people in the room as many stakeholders require weeks' notice to attend or take part in a pathway review
- concerns about the length of time it takes to localise a pathway
- tools being too clunky to use efficiently in a consultation
- how to get the pathway used by hospital clinicians? - pathways are perceived as being weighted more towards primary care
- pathway localisation processes can vary dependent on clinicians (primary and secondary) availability to partake in development
- communication processes

2.10.6 Our effectiveness, benefits and impacts

- improved connectedness between primary and secondary
- acknowledgment that change can take years
- the strength of the approach is in how the overall change process is managed
- pathways have been integrated into the work flow of some secondary care clinicians
- time for workforce education supported by Health Hawke's Bay (HHB)
- a vehicle to assist health providers to move away from episodic care to a more holistic approach to health that puts the requirements and experience of a person at the centre of how services are planned and provided
- we have a local library of information that has been collated and sits within HHB IT systems
- the knowledge sharing aspects of pathways are arguably core to its success in changing behavior's and reducing the variation that will lead to efficiencies in care delivery and improvements in a person's outcomes. In this respect, the work by Rowe et, can be considered looking at the application of behavioural theory to health care worker practices: "***change occurs when people have personal experience of a problem and help to develop a solution***".

2.10.7 A General Practitioner's point of view (Dr Alan Wright)

"Clinical management pathways designed and supported across the whole local health sector are clearly the best way forward to allow timely, effective clinical care to be delivered in the best place at the best time. This is what we have been trying to achieve with the Coordinated Primary Options (CPO) programme for the last 14 years since its inception. Over the last few years we have been cooperating with Map of Medicine to offer some uniformity to the process. It has been a good start, but there are some significant flaws with the process and it appears now that this will be discontinued. This is a great opportunity to get on board with the "Pathways" programme that had its roots in Canterbury but has rapidly spread to become an international programme as well as its support from throughout New Zealand. I was fortunate to be invited to a meeting in 2017 where we were given an opportunity to explore this programme in some detail, and it is evident to me that this is the way forward for Hawkes Bay. Pathways offers comprehensive understanding of clinical conditions and current "best-practice" but clearly shows that there has been extensive cooperation between Primary and Secondary care with "ownership" of the relevant pathway by all involved. There appears to be widespread access to investigative services such as Radiology, which is one of our major limitations here. With these things in mind, the implementation of Pathways here in Hawkes Bay can only be successful with the following requirements:

1. Excellent clinical leadership and cooperation between Primary and Secondary care

2. Appropriate funding to remove barriers to its use

3. Regular supervision and review, both clinically and financially, to ensure ongoing relevance

4. Adherence to evidence based programmes

5. Incentives for good use of the programmes

This is a great opportunity for the HBDHB to show some sector-wide leadership and demonstrate that it has a good understanding of the rapidly changing environment of health care delivery".

2.10.8 Our Strategic Alignment

Table below: *Demonstrates alignment with key DHB and Regional Strategies*

Strategy	Investment Delivers
NZ Health Strategy	• The pathways and tools are used to align with the NZ Health Strategy 2015 strategic themes with an emphasis on integration, which is critically dependent on a team approach. For example, integrated care for a disease condition or population that improves an individual person's journey (e.g. Hepatitis C Pathway).
Our HBDHB sector vision	• "Excellent health services working in partnership to improve the health and well-being of our people and to reduce health inequities within our community"
Transform & Sustain, December 2013	• Key challenges acknowledged to be driven by an increasing burden of long-term conditions and an ageing population with areas of significant deprivation. • Highlights the need for an equity approach to our work, emphasising our Maori and Pasifika populations. • Aims to improve responsiveness to the population, deliver consistent high-quality health care, and be more efficient at what we do. • Key intentions to address the challenges: o Transforming our engagement with Maori o Transforming people involvement o Transforming health promotion and health literacy o Transforming multi-agency working o Transforming clinical quality through clinical governance o Transforming a person's experience through better clinical pathways o Transforming integration of rural services o Transforming primary health care o Transforming urgent care o Transforming out of hours hospital inpatient care o Transforming business models.
Hawke's Bay DHB Annual Plan, 2017/18	• Ensuring appropriate access across services • Engagement • Work with Central Region to apply learnings from other pathways
Central Region Regional Services Plan 2016/17	• Integration across continuums of care is one of the six HBDHB strategic objectives in the 2016-2019 regional services plan. • A key enabler of integration is the shared regional pathways. This takes a structured approach to the development of local protocols of care. Currently, regional pathways are published on the international evidence based software tool 'Map of Medicine,' which contains up-to-date international best practice guidance (e.g. NICE guidelines). Building on this best practice guidance, the pathway development process incorporates national, regional and local guidance. The publishing of a pathway allows all health providers in HB to have visibility of the international/regional/locally agreed pathways. There is a feedback mechanism within 'Map of Medicine' which can be used by clinicians to continually improve the pathways.
Interdependencies	
Alliance Framework	May affect the structure for the Pathways Program going forward.

Strategy	Investment Delivers
CRISP (Central Regional Information System Programme)	Will inform integration requirements, timing etc.
Elective and Outpatient	Will streamline all pathways where people require an elective procedure – introduces e-Referrals
Gastroenterology	Will inform any Gastro and Bowel Screening related pathways
Faster Cancer Treatment	Changing secondary pathways for all Cancer Streams
Mental Health Model of Care	Implementing new Mental Health Services pathways

SECTION THREE

3.1 Technology Enablement

Technology plays an important role in making available the pathway information at the point of care to the time-pressured clinician. The key is integrating pathway guidance into the clinicians' workflow and ensuring that: ***"The right thing to do is the easiest thing to do."***

Figure below: *illustrates the progression of pathways of care and how technology can be used to embed pathway guidance into workflow, facilitating contextual application in a person's care.*

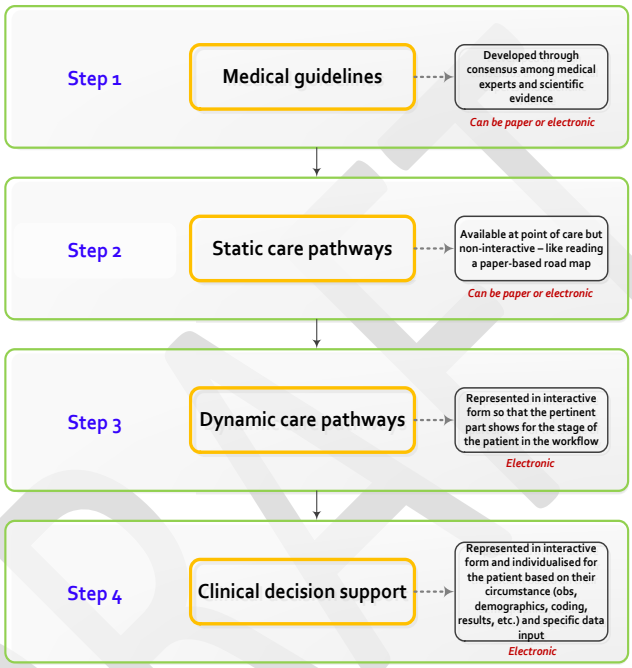
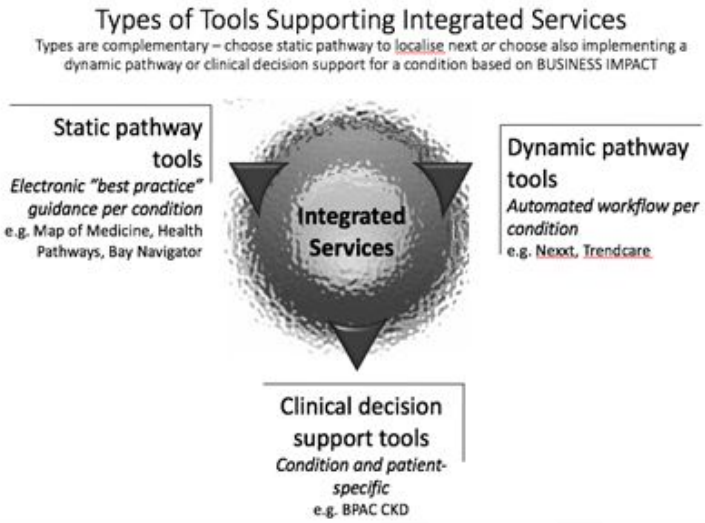


Figure above: Evolution of pathways of care

HBDHB has **reached Step 2** in the Pathway roadmap. Our pathways provide links to relevant websites for additional information, downloadable information and/or links to suitable online advice for the person or clinician. Best practice guidance and collaborative agreements are aligned. But for now the whole pathway/map is static, and the clinician is required to take the time to read through to find the pertinent information.

The next step in the journey is using technology to provide dynamic pathways of care specific to the person's presentation and their stage (e.g. diagnosis, management, and referral) in the clinical workflow, hence the trial of NexXT. This trial ceased due to a review of the pathways programme.



There is work being completed parallel to pathways and that is the work of the development of E-Referrals for the Faster Cancer Pathway. **This work sits outside the brief of this paper, however would be amiss not to mention a vision as:**

1) Continue to use a static pathway tool to support the Pathways Programme towards the integrated services goal.
2) For priority, high impact conditions, complement this with dynamic e-referral tool which also assists with decision support. Candidate conditions for this could be pathways aligning to System Level Measures (e.g. myocardial infarction, stroke, respiratory conditions, COPD, heart failure), Community Primary Options (e.g. hydration, cellulitis, and pneumonia), Faster Cancer Targets (melanoma, endometrial cancer, lung cancer, breast cancer, prostate cancer, bowel cancer) and mental health and addictions, transgender.

Support for this vision would be the importance of the co-creation process and awareness of the potential "cookbook medicine". Change management to drive usage will continue to be important, especially if the choice is to transition to a new tool and changes to e-referral systems. This would also require a robust evaluation framework for the pathway programme and support and funding for the team to continue this work.

3.2 IT Options Analysis

HBDHB has been fortunate to form a relationship with Midlands so that we could together analyse IT options. This work started mid October 2017 by Midlands DHB on behalf and in partnership with Central Region (Mid-central, Whanganui PHOs and HBDHB). Criteria was developed for a high level evaluation of the options available with the objective of 'shortlisting' preferred option(s) for further exploration of costs, benefits and implementation timelines.

Note: the National Health Information Technology Board (NHITB) criteria for evaluating pathway-related tools have been referenced in compiling this criteria and additional high level criteria have also been added to facilitate an objective assessment.

3.2.1 Evaluation Criteria

The following criteria was considered. The criteria aim is to allow for an objective high level evaluation of the options available with the objective of 'shortlisting' preferred option(s) for further exploration of costs, benefits and implementation timelines. Please note for detailed evaluation refer to Appendix 5.

Note: HBDHB has not engaged other partners in a GP survey (like other areas) as it was considered that we know the comments as outlined in our Clinical Service Plan.

#	Criteria	Description
1	**Availability and breadth of clinical content**	Current clinical content, international, national and localised.
2	**Ease of localisation**	Ability to cater for the local differences of individual DHB, PHOs and services on the pathway. The ability to edit the information easily and have updates in a timely manner.
3	**Clinical knowledge sharing**	Number of organisations contributing to the available pathways.
4	**Usability and layout**	Has a modern feel with few clicks to display and view relevant information. This also considers the ease of access to the tool, by clinicians and patients alike – e.g. how easy is it to open up the tool and use it, assist with health literacy is pertinent – by making information readily available to health consumers, it assists in the goals of increased self-management and health literacy.
5	**Mobility**	Functions on various screen sizes
6	**Integration**	Single sign on with the major clinical solutions used in the Midland region. Linked to the E-Referral system Integrated into the person's record in context
7	**Usage reporting**	The level of detail and tools used to create governance and user reports.
8	**Support, maintenance, hosting**	IS helpdesk, configuration, hosting platform or service.
9	**Confidence in vendor**	Current track record in software development, strategic direction and reputation among NZ Health community.
10	**Fit with strategy and roadmap**	Aligns with HBDHB and Regional IS strategy which is aligned with Ministry of Health's Digital Health 2020 Strategy and the Government ICT Strategy.
11	**Technical fit**	Aligns with the regional IS architectural standards.
12	**Indicative costs**	High level indicative costs of the ongoing licencing, development, configuration and upkeep of the solution. Intangible costs are also considered, such as the cost of disruption.
13	**Risks, disadvantages**	Risks to regional engagement and progress with the pathways of care programme. Negative effects of option selection.
14	**Advantages**	Positive factors of option selection
15	**Ease of transition**	Effort to transition from current electronic pathways tool to selected option

3.3 Identification of HBDHB Options for Action

Business Options	Priority
Option 1: ***Status quo***: We will no longer be supported by the Map of Medicine tool. MoM vendor, Hearst Group UK, is withdrawing support this year, and it is anticipated that this will occur 1 July 2018 (our contractual agreement expires 30 June 2018, but there can be an option to extend until end of year).	Not an option
Option 2*: Build an in-house pathways tool or connect with Midlands Bespoke Model*: This option was explored in the original Business Case for Pathways 2014 and considered not an option at this time by IS due to the large amount of technical support. Additionally, we would be 'reinventing the wheel' to build a tool for disseminating our pathways, without any of the benefits of working with a provider and, potentially, other regions already using a tool. **Comments from Jos Buurmans (IS) "***I would recommend against developing a bespoke solution (either alone or with Midlands) as that would not only involve a yet unknown development cost, it would also increase the risks that the HBDHB would not be able to leverage pathway work carried out nationally and that this would significantly complicate the integration with other IT solutions such as the Clinical Portal".*	Not an Option
Option 3: ***Dispense with an IT solution*** and use a paper-based system, however this is considered not acceptable as it does not address key requirements including ease of pathways promulgation and updating, fit with current workflows, and integration with e-referral processes. Previous pathways, developed and shared as paper-based 'care guidelines' within Hawke's Bay have had limited uptake.	Not an Option
Option 4: Procure Community HealthPathways **The HealthPathways** (HP) tool resulted from the wider Canterbury Initiative. It is a clinically-led collaborative with a purpose of addressing and resolving challenges in health care delivery within the Canterbury region. It is a web-based database of condition-specific information, together with details of service providers assembled into approximately 600 pathways plus hundreds of pages of related resources that have been developed over the last five years. It is 'localisable' to other regions and has been implemented by all DHBs in the South Island, the greater Wellington and Auckland region, and some organisations in Australia. As an initiative of the Canterbury DHB, it is owned by the New Zealand Government. A key aspect of HP is its supportive role in facilitating discourse between primary and secondary care clinicians. Features include online discussion groups, newsletters and video links that help to build the collaborative community nature that is essential to pathways development. Pathway content appears to be mostly derived from practice-based knowledge, although senior clinicians provide an over-view function and content reflects New Zealand guidelines. All subscribing regions gain access to the pathways from other regions, so it may be that localising content is all that is needed, avoiding most workflow redesign initiatives. The choice of formats – narrative or flowchart – has been voiced by some clinicians, with the wordy nature of the narrative being a negative comment. Some secondary users have commented that the product initially appeared overly focused on primary care, perceiving that an appreciation of the whole patient journey was lost and leaving little functionality for hospital-based staff, however over the later years there has been work in this sphere. Integration with primary patient management systems (PMS) has been demonstrated with MedTech and My Practice, and work is being done to integrate Health Link forms for e-referrals. It is been the collaborative effort, along with impressive improvements in service delivery that recently earned *HealthPathways* accolades from Kings Fund researchers. **Explanation** • known tool with 'tried and tested' transition process from Map of Medicine to Health Pathways • provides extensive knowledge based and proven model	Option

• IS comments: "*HealthPathways solution appears to be the most appropriate from a technical perspective, considering that most DHBs in New Zealand already use this, including DHBs that use the Clinical Portal that we're migrating towards, which would simplify integration. From a business/clinical perspective, the use of HealthPathways would enable us to leverage clinical pathway work already carried out, but I understand we would need to commit to a HealthPathways 'governance process' that involves increasing the local pathways management team.*" **Note: Additional cost implications** • HealthPathways comes with its own framework of development systems • Variable costs are based on number of pathway development	

3.4 Recommended Option

The recommended option for a Pathways tool for HBDHB is HealthPathways. This recommendation is based on the opportunity to continue our relationship with our Central Region partners and also form greater relationships with the wider NZ users.

This recommendation has several caveats:

- rationalisation of tool use across the country supports cohesiveness
- feedback informs there is a strong focus on clinician led collaborative effort, making HP feel more like an initiative, compared with other IT tools in which the vendor appears more focused on the tool
- it is recognised that there is some work to be done in order to gain integration between e-referrals (Health Link forms). This challenge exists independent of the tool we choose, as no tools have demonstrated integration with the particular cohort of IT systems in use in our district.
- what could we achieve nationally being on the same tool could further benefit MOH
- we would have local (regional, national) support when we go to transition.

3.5 Business Impact – From transitional to business as usual

Identified impacts are:

- The need to involve IS staff from the PHO, DHB and individual practices to gain access and achieve integration with other systems assuming that there is capability and capacity within these groups. Additional external support may be required, although this is probably limited to the vendors of the various software (Medtech, My Practice and HealthLink).
- Human resource input to manage the Pathways Programme implementation, governance, operations and development of individual condition-specific pathways is significant and, therefore, this may present challenges in terms of work commitments and prioritisation for existing staff or the need for additional staff or 'back fill'. This is particularly so for LTC Portfolio Manager, senior and specialist staff as this adds additional pressure. It has been recommended in previous papers that we at least appoint approximately 4-6 of each primary and secondary leads to assist with facilitation, one clinical lead and increase FTE of Editors (this has to date has not been supported as programme was "on hold").
- Initially we can expect that some training will be required for use of the pathways tool itself, however additional training for GPs and nurses to new skill development, consideration will need to be made as to what entity pays for this cost and the staffing to provide this training.
- A consequence of the 'one system' approach is that there are likely to be shifts in who does what procedures, and where. Movement of some services into community settings means that there should also be movement of funding to support it. Where there are out-right cost savings, i.e. where costs have been avoided through, say, self-management, we need to decide what happens with the savings; for example, do they contribute to

a financial surplus or are they funnelled back into further procedures? A good example is the capability of GPs performing a Pippelle Biopsy but no money to take this initiative further.

3.6 Risk Analysis

The management of risks will follow the standard HBDHB approach. See Risks and mitigations in Appendix 7.

3.7 Ongoing financing of the Pathway the Programme

Clinical Council had agreed to fund the Pathways Programme, but over the last few years there has not been full funding commitment to this Programme. Recommended on-going costs in future years will need to be budgeted for during annual processes.

3.8 Key Performance Indicators

The proposed Key Performance Indicators (KPI's) set out below are intended as an interim set until an evaluation framework and Benefits Realisation Program measures have been established. The KPIs serve to measure and evaluate the process of development/localisation of pathways, the transition of already established pathways to the new IT platform, the socialisation and communication of the pathways to clinicians and ultimately the uptake of the pathways information into individual clinician, patient consultation and management.

Socialisation - Ensures adequate representation and therefore development and socialisation

- Number of Pathways published
- Number of new Pathways localised and published
- Number of primary care clinicians taking leadership and participating in workgroups
- Number of secondary care clinicians taking leadership and participating in workgroups
- Number of Allied health clinicians that have participated in workgroups
- Number of Pharmacists that have participated in workgroups

Utilisation

- Total number of users
- Top 10 clinical pathways viewed per month
- Top 10 clinical pathways by average time on page per month

3.9 Consultation

Timeframes for options paper development and distribution are provided.

Group	Date
EMT	26 March 2018
Clinical Council	April 2018

3.10 Stakeholder consultations

Midlands have consulted on our behalf with the following vendors:

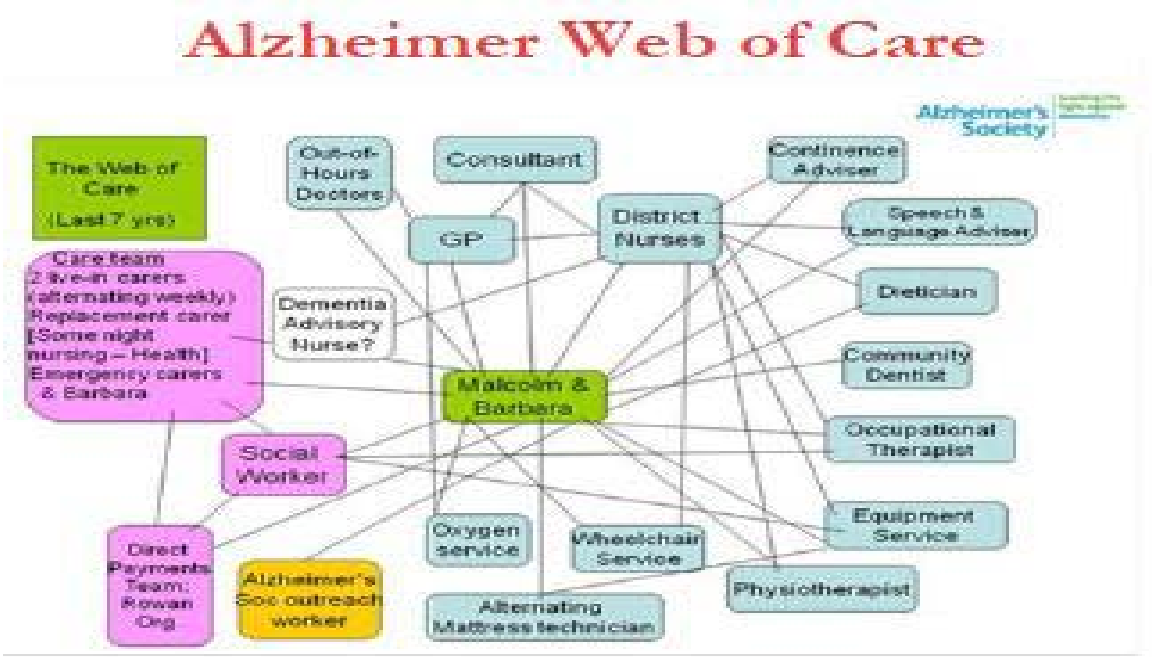
- Auckland – CM – Pathways team
- Northland GP liaison
- HealthPathways CEO
- People who have previously worked on the NexXT product
- Trendcare Rep

- Waikato DHB IS around bringing Map of Medicine here
- Awaiting information from BOP if they could scale up Bay Navigator
- Regional IS Manager – around fit and architecture
- Multiple other conversations with regional project managers, clinical leads and GP liaisons

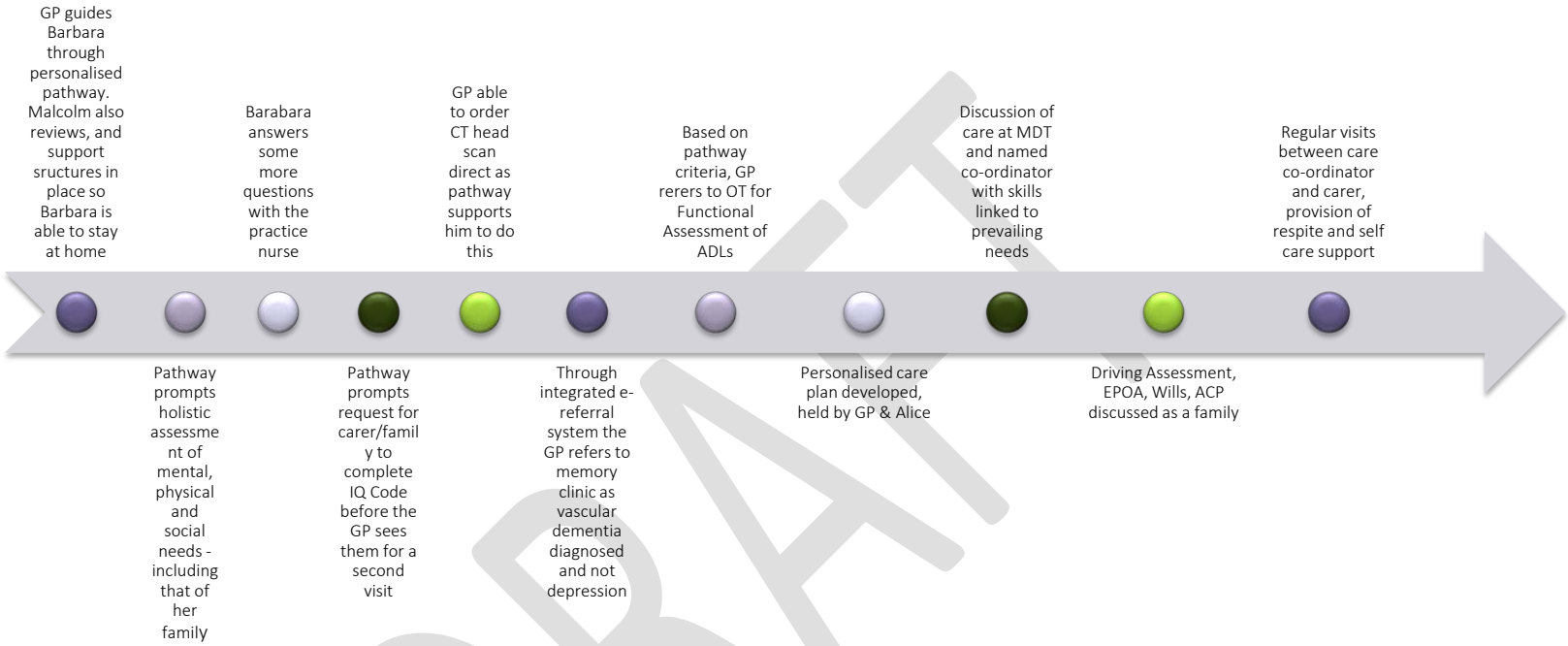
HBDHB Consultation to date:

- HealthPathways CEO and presentation by Streamlines (July/August 2017 and 22/03/2018)
- Auckland – CM – Pathways team also there feedback on NexXt
- Central Region – Midcentral and Whanganui PHOs
- Health Hawke's Bay Medical Advisor

APPENDIX 1 (a): Malcom, and Barbara's tangled web of services



APPENDIX 1 (b): Malcom and Barbara's services mapped out within a pathway



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Appendix 2: HEAT Assessment-Pathways align to Long Term Conditions Framework

Background[1]**:** Key findings from the burden of disease study 2013 tells us that people are living longer with chronic long term conditions which contributes to associated disability and or challenges that face individuals needing to access care or manage their own self-care. Hawke's Bay, has significantly higher risk factors associated with the development of a chronic condition. Māori and Pasifika are over represented within this statistic.

Understanding Health Inequalities

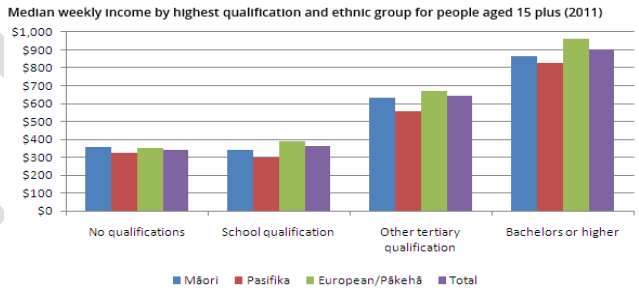
Type of Inequality	1. What inequalities exist?	2. Who is most advantaged and how?	3. Why did the inequality occur?
Consider the range of inequalities	**What do you know about inequalities in relation to this health issue?**	**Who is advantaged in relation to the health issue being considered and how?**	**What causal chain(s) lead to this inequality?**
Ethnicity[2]	Currently Māori and Pasifika people are over represented in all of our Health Risk Factors[3] which are listed in order of risk; Tobacco use, high body mass index, high blood pressure, high blood glucose level and low levels of physical activity. All of these risk factors contribute to premature mortality, increased incidence long term condition and co-morbidity rates. The disparity gap is greatest for smoking and high body mass index.	Female Non- Māori Pasifika (NMPI[4]) are least represented in the LTC (Generic) cohort, followed by Male NMPI, however this is dependent on the specific condition(s).	Educational levels of females (mothers) is identified as having a high impact on future population outcomes inclusive of health. A 15% gap exists between Māori (70%) and European females (85%) 18yr+ leaving school with NCEA L2 or above. The gap for males is 16%. Education leading to improved choice re employment, housing, lifestyle etc. Influence directly the determinants of health as identified below in this table.

[1] Adapted and taken from "Chronic Disease: Current Situation Analysis- (Prevalence, Morbidity and Mortality)" – Lisa Jones HBDHB Business Intelligence Team

[2] Ethnicity inequality – not counted twice – each separate component…

[3] Risk Factors listed are those identified in the Chronic Disease: Current Situation Analysis(Prevalence, Morbidity and Mortality) – Lisa Jones HBDHB Business Intelligence Team taken from the NZ Burden of Disease Study 2013 and the Health Equity Report – 2016.

[4] MPI-Maori Pasifika peoples vs Non Maori Pasifika (NMPI). This comparison is used to identify that the gap between MPI and NMPI is where health effort needs to be concentrated the most. By comparing MPI with total population we lose sight of the real difference that exists within population health outcomes.

Type of Inequality	1. What inequalities exist?	2. Who is most advantaged and how?	3. Consider the contributing factors that caused the inequity.
Levels of generic literacy [5]	Currently only 1:5 New Zealanders are operating at a highly effective level of literacy. The majority of Māori, Pasifika and those from other ethnic minority groups are functioning below the level of competence in literacy required to effectively meet the demands of everyday life.	Research suggests that people with high (health) literacy: • are more likely to use prevention services (such as screening) • have more knowledge of their illness, treatment and medicines • are more likely to manage their long-term/chronic condition • are less likely to be hospitalised due to a chronic condition • are more likely to use emergency services • are less vulnerable to (workplace) injury because they understand safety (precautionary) messages.	 *Source: Education Counts* Education initiatives in the last 10 yrs have focused on improving literacy (numeracy) levels with a particular focus for Māori and Pasifika as they are overly represented in the low academic achievement stats, unskilled or low skilled labour workforce, unemployment and involvement with the justice services and utilisation of assisted social services. The inclusion of non-mainstream schools, Kura Kaupapa Māori and charter schools, introduction of NCEA and NZQA standards, and literacy benchmarking attempt to address the disparity that exists going forward, however the legacy of low literacy has had an impact on our current health and quality of life indicators. Low literacy levels can contribute to a lack of confidence in navigating the health systems and social support networks. This in turn contributes to the
Health literacy[6]	56% of adult New Zealanders have poor health literacy skills, scoring below the minimum required to meet the needs of the demands of everyday life. Māori who live in a rural location have on average the poorest health literacy skills, closely followed by Māori who live in an urban location. The findings in the Korero Marama report show that overall the majority of New		

[5] Health Literacy is defined as; 'the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions' (Kickbusch et al 2005). Statistics NZ – level of Adult Literacy and http://www.healthliteracy.org.nz/about-health-literacy/health-literacy-statistics

[6] Korero Marama (2010)

Health Literacy (cont.)	Zealanders are limited in their ability to obtain, process and understand basic health information and services in order to make informed and appropriate health decisions.		inability to access the care and support that exists and that one is entitled to. Systems and processes that have been set up without consumer input in their design, use of consumer feedback post design and analysis of data that demonstrates consumer engagement with services contributes to lack of institutional awareness of the level of (health) literacy of their client base.
Socio economic factors inclusive of wider determinants of health	The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution and accessibility of resources at a personal (individual) and population health level. Addressing equity is about unequal distribution of resources in order to advantage the disadvantaged in order to create as close to a level playing field as possible.	Those who enjoy economic wellbeing and resilience gained through, stable and supportive family dynamics, good to excellent educational achievement, employment, and participation as a contributor to local and regional community (networks)	Limiting or limited access to education, employment and or social supports, at a personal or population level contributes to disadvantaged individuals and populations. Continuous and exponential increases in compromised quality of life indicators will directly impact on the 'resilience' of a family and or community to address, self-manage, create opportunity and work their way out of adversity. Lack of understanding around compounding factors that influence levels of resilience can contribute to inappropriate 'care and or self-care' being prescribed or expected of the person affected by compromised health.
Disability	With the onset of the development of a long term condition the level of ability to manage everyday life activities is affected. Those with one or more comorbidities have the greater challenges to face. Age will impact on the ability of the individual, partner and or whanau to manage the compromised health state of the consumer	Those with good family support, an able bodied partner, access to transportation to access care assistance, financially able to 'buy' assistance required or modify lifestyle to accommodate the condition(s). Those who have built resilience over time to cope with change and or changes in circumstance. Those who have developed self-managing skills that enable them or their family, network to problem solve presenting issues. Those who are not at saturation point in regard to the compromises they are having to make in-order to maintain a level of wellness that is acceptable to them.	By treating the person/family as a whole and addressing the items that 'matter to the person' instead of the 'condition or what is the matter with them' we will begin to mitigate, minimise and hopefully eliminate the impact that their change in health status has on their ability to enjoy the lifestyle of their choosing.

Type of Inequality	1. What inequalities exist?	2. Who is most advantaged and how?	3. Consider the contributing factors that caused the inequity.
Age - 65+	At the age of 35yrs the prevalence and onset of Long Term Conditions increases. This is particularly relevant to Māori (Female).		Contributing factors that lead to the onset of Long Term Conditions is believed to begin as early as pregnancy. Lifestyle influenced or compromised by low education levels, which contribute to economic well-being impact on the capacity of individuals and whanau to choose well in in terms of health choices.
Gender	There is approximately a 10% differential between (Māori) Male and female risk factors within the HBDHB demographic	Females are advantaged	Screening programs for females and the incidence of attendance of general practice by females presenting with whanau who are unwell has had an impact on female visibility to health professionals. On average attendance differentials between male and females is a 75:25 ratio. Screening is the first point of prevention, risk identification and management. Lack of screening impacts on both the identification of risk factors and the timeliness (acuity) of the person's health status when they engage in and access active management.
Mental wellness[7]	Many people with long term physical health conditions also have mental wellness issues. This can lead to significantly poorer health outcomes and reduced quality of life.	Those with a single long term condition (1:5 of the 4:5 adults who have a Long Term Condition. Those with high levels of resilience, low acuity, early stages and highly skilled in self-management. Those with high health literacy Those with good whanau support	In providing disease specific health care we overlook the holistic approach that should be engendered with Long Term Conditions. People with long term conditions and co morbid mental health problems disproportionately live in deprived areas and have access to fewer resources of all kinds. The interaction between co-morbidities and deprivation make a significant contribution to generating and maintaining equalities.
Access to health care services[8]	Those living in rural communities.	Those living within easy driving distance to services required. Those living in an area with good mobile / outreach services. Ability and desire of people to have residences in areas with easy access to services.	Residence of choice or determined by full range of health determinants. Economies of scale –as determined financially viable by the DHB Attraction and retention of staff.

19.1

[7] The King's Fund and Centre for Mental Health 2012 - https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf

[8] This section ONLY covers physical access as all other barriers to access have been identified above e.g. socio economic section/health literacy, gender et. al.

Level	Determinants with associated possible interventions (May or may not be the responsibility of the health system)
Structural:	Based on consumer and service feedback gathered in the consultation process (Refer to – LTC Framework – not inclusive in this paper) **Education -** Healthy families, confident in their own identity, able to make choices that suit their own individual context is the focus of Ka Hikitia – Māori education strategy, designed for the purpose of Māori achieving success as Māori. Literacy and numeracy project have been introduced to the education system to address underperformance of all students. Valuing kaupapa Māori education – within a Te Ao Māori framework has also been identified as mechanisms to ensure that tailored responses to differing needs within our population are needed instead of the 'one size fits all' model of thinking. **Access points – multiple and varied –** consumers consistently repeated the same messages. They want multiple access points to health care/support at varying levels. This includes hours including late nights, early mornings, weekend clinics, and the ability to phone, email, visit or have someone visit them were needed. The use of IT – web based patient portals were seen as only being advantageous. This was reaffirmed in Wairoa – by and 82 yr old male who said "My patient portal is the best thing out – time saver and ease of access to all the information I need. I'm not that stable on my feet so coming in to town can be a real issue." A recently unemployed forestry worker was quick to mention that he had no time off working in Forestry to get to the doctor as there are early morning starts and long hard days and relying on forestry transport all were factors contributing to intermittent access to care. **Utilisation of regulated health and non-health/non-regulated workforce –** the consumers wanted the right people with the right skills to support them in taking care of themselves but what was most important was the right fit of person. Diversification of our workforce (bi and multicultural) was identified as a need. The right fit also extended to what level of expertise was needed and the use of non–regulated workforce to provide levels of care appropriate to the consumer. Youth for example are wanting to engage with people with an affinity for youth issues and do not need to see a GP when their needs can be managed and or coordinated by a range of other staff such as Nurse Practitioner , Youth social worker or a Youth counsellor. Navigation of the system was identified as a need. This can be achieved through advocating for an interdisciplinary team approach to care / support. **Interdisciplinary approach to care/support – using a wellness model :** the Long Term Conditions Framework advocates for a holistic wellness approach to care based on the Four Aka. In order for care not to be focused solely on the condition but on the consumer and whanau leads to the need to have an interdisciplinary approach. - **Generic approach, not disease specific:** the incidence of consumers with co morbidities dictated to the framework that what is needed is a generic approach to care. The consumer wants a primary – centralised coordinator of their care that can provide access points to specialist care as and when needed. - **Mental health focus:** Care for large numbers of people with long-term conditions will improved by better integrating mental health support with primary care and chronic disease management programmes, with closer working between mental health specialists and other professionals. Service commissioning groups should prioritise integrating mental and physical health care more closely as a key part of their strategies to improve quality and productivity in health care.
Intermediate Pathways: *Material, psychosocial and behavioural factors. The impact of structural factors on health*	**Patient and relationship centred care:–** is the response that is needed to tailor care and support for consumers that will engender ease of access to all stages in one's healthy development. Taking into consideration quality of life measures as well as clinical measures to guide the health workforce and consumer as to 'what matters to them most' as a means of directing what type of care is needed – against an agreed set of priorities dictated by the consumer but advised and supported by the health professional.

	Raising consumer expectations:– By not accepting that health inequities is an expectation if you are Māori or Pasifika and or in a group that is not experiencing equitable health outcomes (aged , disabled, living in remote areas, male) we address the issue from the consumer demand perspectives. This can be mitigated through; - **Dis-establishing myths that** exist about conditions that you should or should not expect if you fall into a particular population or age group. - **Raising health literacy -** becoming a focus of all information that is shared in a transformational vs transactional manner with the first step of finding out what is 'known to the consumer' before exchanging information that is intended to grow that information that will lead to greater understanding and self-determination in decision making - **Creating multiple avenues to enhance self-management –** by examining and evaluating the paternal aspect to health care provision, based on the level of acuity required of the consumer at any given time, we create the opportunity for the consumer to be the decision maker in their own care. If all the above is considered in the determination of the care and support that is needed then we create the right environment to implement – co designed models of care that have had the receiver and provider of care involved in its design process.	
Health and Disability Services	**Flexible services** that can respond to variability in baseline health status and needs (mental and physical) - (see interdisciplinary teams above) **Risk mitigation:** Promotion of CQI initiatives that focus on snap shot tracer auditing that examine the pathway / care journey of the patient to identify routinely areas for improvement without them being attached to or a response to an incident – accident or death **Promoting the use of the Health and Disability advocacy service** and taking learnings from any investigations or cases	
Impact: *the impact on socioeconomic position*	• Work with national, regional and local health promotion teams • Work with ACC and other funding bodies that support employment and understanding of the determinants of health for those with a disability • Cross-sector initiatives to co-fund tailored packages of care inclusive of MSD as a funder of subsidies and benefits for consumers • Fund existing community providers to care for consumers building capacity and capability within our available work force • Work with local education providers to inform curricular content, education pathways and career pathways • Ensure step-up, step down options and the flexibility to do so within the patient journey of wellness and unwellness.	
Pathway (AKA)	**Questions**	**Responses**
Tuatahi – *Developing whānau, hapū, iwi and Māori communities*	*How have Māori been involved in the use of HEAT?* *Have Māori health inequalities been fully considered?*	The focus of the framework is to address equity and gap in health outcomes Consumer consultation was representative of our demographic profile for Hawke's Bay. Wairoa – consultation group – 70% Māori and chosen due to its high Maori population as well as high needs in relation to Long Term Conditions.

		PAG included 3 Māori members Consumer council members represented our rural isolated communities (Parongahau)
Tuarua – *Māori participation in the health and disability sector*	*How will you involve Māori in the health and disability service interventions?* *How will you build Māori workforce capability?*	Health and disability service: engage the 'right fit of person to work with the individual engaged in any service intervention. Utilise the kaitakwaenga who have recently been appointed within the Maori health team. Ensure consumers know they can request a change of person – should the right fit not be achieved (Code of Rights). Workforce development forms part of Aka toru – workforce development and enablement.
Tuatoru – *Effective health and disability services*	*How will you ensure that the health and disability service intervention(s) proposed are timely, high-quality, effective and culturally appropriate for Māori?*	Identify this in the service plans and use the driver diagram (LTC Framework figure 1.0) to ensure that activities engaged in by services align to high level outcomes and objectives; example provided is – addressing the inequality gap in health outcomes for Maori and Pasifika with the enabler identified as – prioritising work programs that address the determinants of health
Tuawhā – *Working across sectors*	*How will you work collaboratively with other sectors to reduce Māori health inequalities?*	The inter sectoral approach of the health and social care networks in conjunction with the multidisciplinary approach to providing non disease specific care to those with or at risk of having a Long Term Condition.

Questions	Responses
1. Health inequality outcomes *What are the predicted outcomes of this intervention for health inequalities?*	System level measures and contributing measures identified in Aka Tahi Use of quality of life tools to measure non clinical outcomes for consumers Reduction to within 5% of gap between Māori and non-Māori
2. Groups Benefiting *Who stands to benefit the most from this intervention?*	Those with long term conditions – who are then able to access interdisciplinary teams and increase their confidence in their self-management.
3. Unintended Consequences *Are there any unintended consequences that can be foreseen?*	By focusing on generic approach – specialised care may be impacted on. The time frame leading up to high functioning IDTs may impact on patient care coordination. Workforce capacity and capability to work in a generic approach will need lead in time and to be managed well.
4. Risk Mitigation *What needs to be done to ensure that the benefits accrue to the intended populations?*	Establish a LTC advisory group inclusive of Māori and Pasifika members Support and monitor service plans and operational management

	Work closely with the QUIPs team to ensure systems for improvement are in place Ensure clinical leads are in place to manage care and coordination of care

How will you know if inequalities have been reduced?

By ensuring that all data is presented in MPI vs NMPI (not MPI vs Total population which masks the gap)

- Outcomes measures identified and monitored against each of the "Teams of Practice" or Service targets
- Utilisation of the System Level Measures and the contributing measures to map progress towards agreed outcomes

Reduction in the gap between MPI and NMPI

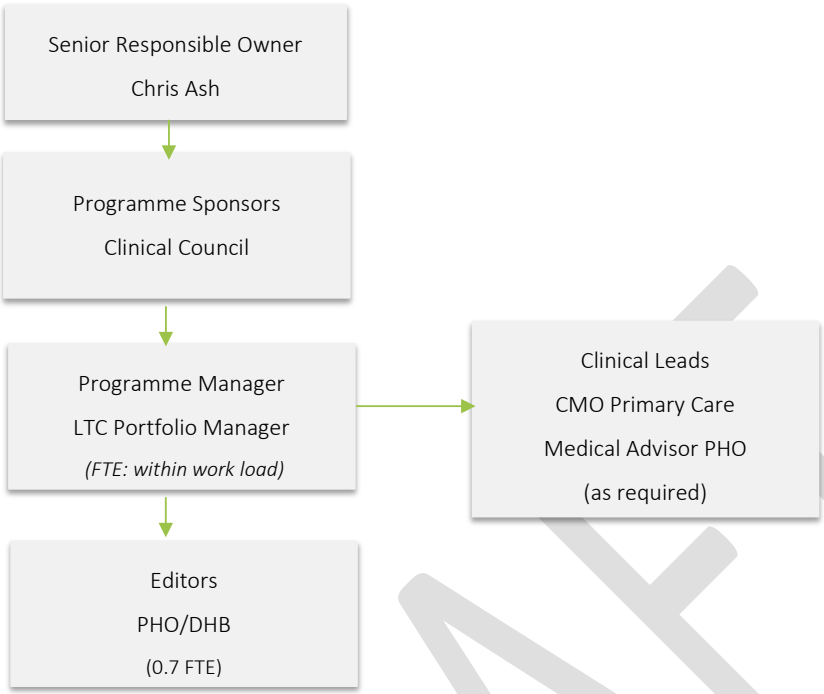
- Across the board

APPENDIX 3: Current Budget

9238 Care Pathways
Cost Centre Financial Report
For the Month Ended 28 February 2018

February Actual $	February Budget $	February Variance $	Description	Year to Date Actual $	Year to Date Budget $	Year to Date Variance $	Last Year $	Annual Budget $	
			Revenue						
			Funding - Price Volume Schedule						
-	-	-		-	-	-	-	-	
			PVS Volumes						
-	-	-		-	-	-	-	-	
			Other Income						
-	-	-	183500 - Professional & Consultancy Fees	37,083	-	37,083	-	-	
-	-	-		37,083	-	37,083	-	-	
-	-	-	**Total Income**	37,083	-	37,083	-	-	
			Expenditure						
			Personnel Costs						
			Management & Administration Personnel						
4,181	2,152	(2,029)	282400 - Professional Staff	24,025	18,474	(5,550)	18,851	27,742	
4,181	2,152	(2,029)		24,025	18,474	(5,550)	18,851	27,742	
4,181	2,152	(2,029)	**Total Personnel Costs**	24,025	18,474	(5,550)	18,851	27,742	
			Full Time Equivalent Staffing						
			Management & Administration Personnel						
0.8	*0.4*	*(0.4)*	*282400 - Professional Staff*	*0.5*	*0.4*	*(0.1)*	*0.4*	*0.4*	
0.8	***0.4***	***(0.4)***		***0.5***	***0.4***	***(0.1)***	***0.4***	***0.4***	
0.8	***0.4***	***(0.4)***	***Total FTEs***	***0.5***	***0.4***	***(0.1)***	***0.4***	***0.4***	
			Outsourced Costs						
			Outsourced - Medical Personnel						
-	667	667	310500 - Medical Fees For Service - Smo	2,151	5,333	3,183	28,156	8,000	
-	667	667		2,151	5,333	3,183	28,156	8,000	
			Outsourced - Support Personnel						
-	-	-	342001 - Interpreters	-	-	-	440	-	
-	-	-		-	-	-	440	-	
			Outsourced - Management/Admin						
-	3,200	3,200	353500 - Supervisors & Professional Staff	11,667	25,600	13,933	8,813	38,400	Off set by revenue reduced FTE with
-	3,200	3,200		11,667	25,600	13,933	8,813	38,400	
-	3,867	3,867	**Total Outsourced Services**	13,817	30,933	17,116	37,410	46,400	
			Clinical Supplies						
			Diagnostic Supplies & Other Clinical Supplies						
-	-	-	429000 - Other Diagnostic Supplies	-	-	-	0	-	
-	-	-		-	-	-	0	-	
-	-	-	**Total Clinical Supplies**	-	-	-	0	-	
			Infrastructure and Non Clinical						
			IT Systems & Telecommunications						
-	9,621	9,621	534000 - Software Charges	27,701	76,967	49,266	3,549	115,450	
1	-	(1)	535001 - Internet Connection	7	-	(7)	3	-	
1	9,621	9,620		27,707	76,967	49,259	3,552	115,450	
			Professional Fees & Expenses						
-	2,917	2,917	551000 - Consultants Fees	35,000	23,333	(11,667)	-	35,000	
-	2,917	2,917		35,000	23,333	(11,667)	-	35,000	
			Other Operating Expenses						
-	417	417	567500 - Reception And Catering	-	3,333	3,333	-	5,000	
-	292	292	570000 - Corporate Training	-	2,333	2,333	-	3,500	
-	708	708		-	5,667	5,667	-	8,500	
1	13,246	13,245	**Total Infrastructure/Non Clinical**	62,707	105,967	43,259	3,552	158,950	
4,182	19,264	15,082	**Total Expenditure**	100,549	155,375	54,825	59,813	233,092	

APPENDIX 4: Current Pathway Programme Structure, FTE, Roles and Responsibilities



Key roles and responsibilities are summarised in the following table.

Table 1: Key Roles and Responsibilities

Role	Responsibilities
Senior Responsible Owner	• Champions the Programme • Resolves issues at executive and service level • Holds/allocates Programme budget • Authorises Programme change control and communicates with the CEO and external stakeholders Ensures that the Programme remains aligned with the organisation' strategy and supports projects through internal or external approval forums.
Programme Sponsor	• Ensures business benefits are met • Responsible for programme *assurance* • Key communication point to Executive / Organisational management • Resolution of issues outside of the scope of the Programme Manager
Clinical Leads	• Represents the clinical perspectives of interest and provides a key point of contact in decisions related to clinical matters • Act as champions to socialise the Pathway • Assist to develop an education programme to inform clinicians, allied health and stakeholders of the Pathway and its use • Works with the clinical stakeholder community to resolve strategic issues within the programme which need the agreement of clinical stakeholders to ensure progress • Ensures realisation of benefits by supporting clinical change to achieve project goals • Members of the Sponsor Group (Clinical Council)
Programme Manager	• Accountable for delivery • Escalates issues to the Senior Responsible owner so no surprise • Facilitates the project management process at all points as per HBDHB project management methodology including: o Planning - Develops the work stream plan

19.1

Role	Responsibilities
Senior Responsible Owner	• Champions the Programme • Resolves issues at executive and service level • Holds/allocates Programme budget • Authorises Programme change control and communicates with the CEO and external stakeholders Ensures that the Programme remains aligned with the organisation' strategy and supports projects through internal or external approval forums.
Programme Sponsor	• Ensures business benefits are met • Responsible for programme *assurance* • Key communication point to Executive / Organisational management • Resolution of issues outside of the scope of the Programme Manager
	o Delegating –secures resources and ensures allocation of tasks to these resources that clarify what is required by when. o Monitoring – Monitors delivery ensuring that all expectations are meet o Controlling the programme – ensure all issues and risks to are identified, analysed and responded to effectively using prescribed escalation routes and change control procedures if required o Motivation of those involved to achieve objectives within the expected performance targets for time, cost, quality, scope, benefits and risks. o Formally reports to the Programme Sponsor on a regular basis including appropriate and timely escalation of issues and risks. o Relationship with Project Management Office
Programme Editors	• Accurately records Pathway information from development teams into the chosen tool editing module • Receives feedback from the consultation, collates and distributes it to the development team for consideration • Incorporates information and feedback as requested by the development team
Project management office	• Provides pro-active project assurance input to support the programme to use best practice processes to create the deliverables and appropriately follow the project management processes

APPENDIX 5: Option Analysis of differing IT tools

MAP OF MEDICINE

Map of Medicine is the current HBDHB pathway tool. It has been in use since 2013 and is integrated into the workflow of primary care, some areas in secondary care and in some NGOs. This integration has improved utilisation of the pathways and supported further clinical buy-in with the tool and pathways where the information is easily accessible.

Map of Medicine offers a comprehensive repository of evidence-based agreed local and regional guidance at the point of care. The pathways also contain tools and resources that are used in clinical assessment and supporting operational processes e.g. MOCA cognitive assessment tool on the dementia pathway. http://mapofmedicine.com/

The proposal for this option would be to align with Midlands, who may bring Map of Medicine software in-house to the Midland Region and fully support the ongoing development and maintenance of the tool. This option could be used long–term if the software is considered robust enough to be improved to meet the clinical usability requirements e.g. mobility, document layout.

The Intellectual property of the HBDHB contained in the Map of Medicine tool can be retrieved at a time prior to a decision to not pursue this option and the current Map of Medicine tool is decommissioned.

Evaluation notes

Options	Map of Medicine	Detail
Description	Static Pathway tool that has an algorithm layout. A static pathway tool.	
Availability and breadth of clinical content Usage:	330 International 75 localised Medium - general practice Low - secondary care Low – community/allied	**Coverage of clinical pathways** Map of Medicine currently holds 350 international pathways with 75 localised to the HBDHB region.
Ease of localisation	High Pathways can be localised and made available within a timeframe.	
Clinical knowledge sharing	8 NZ DHBs	**Shared community** Once the Map of Medicine is unsupported from the UK the shared clinical community could consist of the Midland region DHBs and may also include the three Central region DHBs who are currently using the Map of Medicine.
Usability Rating – the rating allocated is based on responses to clinicians survey and user experience	Medium	There is a different in opinion about whether the click through from the Map of Medicine algorithm diagrams is the quickest way to access info. The clinicians' survey, for the purpose of this options paper, showed that some liked it and some did not. The first view on Map of Medicine is the algorithm diagram, whereas on Health Pathways, you are taken straight to the reference info.
Mobility – functions on various screen sizes	No	Not usable on mobile.

Integration	High	Can integrate with Medtech32 connected care, Dashboard My Practice Medtech32 connected care $14,000 In Clinical Workflow – not in all
Usage Reporting	Granular	
Support, maintenance, hosting	Amazon Web Services or some other cloud service	IS support IS manager Mthly Amazon hosting Implementation Cost: $0 *Multiple databases for different modules with a lot of open source code used. *Developers often not willing to make changes as fragile code base and unsure of full code set. *Lack of skill in DHB resource in this area as do not currently uses these systems.
Confidence in Vendor Basis is consultation with DHBs who use the solution and their feedback	No	
Fit with Strategy and road map	Yes	**Regional Services Plan 2017-2020** The use of the Map of Medicine tool supports strategic alignment with the regional services plan Objective 2: Integrate across continuums of care. Acting as a repository of both agreed regional care pathways e.g. Lung Cancer and locally developed pathways that can be localised for each DHB e.g. Suspected Skin Cancer. One instance of the tool and therefore the pathway with localisation would assist with the issue that many common issues are being dealt with simultaneously across our region and this can lead to duplication of effort. Regional pathways enable shared knowledge, learnings and current innovations that are occurring locally to improve patients' health outcomes for the entire region.
Technical Fit	Partial Linux/SQL DB/Open Source/Java C+ Cloud hosting	
Risks, disadvantages	Feedback tells us lack of support for Map of Medicine tool Old technology/unstable code set/ability to improve layout and usability unknown/timeframe to transfer existing IP Loss of regional engagement due to the perception that the DHB who supports the system has more influence on pathway development	Loss of regional and international engagement

Advantages	Low level of transition and change management required Tool is solely owned and supported by the Midland region (NZ) Updates and changes to technology and formatting can be passed quickly Retention of existing integrations	
Ease of Transition	Easy User base could continue using current tool.	Transition is in setting up Tech team at Midlands to support in NZ
Recommendation	Not an Option	

Expenditure Type	Value	Purpose
Capital	TBA	Likely $0 as hosting will be on Amazon Web Services.
Operational	TBC Further consultation required to obtain an accurate costing.	Resource per annum: IS support resource IS management resource CP Team Hosting per annum

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Note: Further consultation would be required to confirm cost implications

HEALTH PATHWAYS

HealthPathways is an online manual used by clinicians to help make assessment, management, and specialist request decisions for over 550 conditions.

Rather than being traditional guidelines, each pathway is an agreement between primary and specialist services on how patients with particular conditions will be managed in the local context. Each health jurisdiction tailors the content of HealthPathways to reflect local arrangements and opinion, and deploys their own instance of HealthPathways to their clinical community.
https://www.healthpathwayscommunity.org

Health Pathways has two separate offerings: the community pathways element, which is widely used, and the secondary pathways element which they are currently implementing in Canterbury and promoting as another offering to other customers.

Evaluation notes

Options	HealthPathways	Detail
Description	Static Pathway tool based on a pathway community managing multiple pathways. Document layout with secondary/primary/allied and patient facing pathways. A static pathway tool.	
Availability and breadth of clinical content Usage:	550 national and international High - general practice Low - secondary care Medium – community/allied	Coverage of clinical pathways 550 conditions, separated into primary and secondary pathways.
Ease of localisation	Medium Technical writing is done by a Health Pathways team. They are able to provide quick turnarounds, but this nonetheless adds a step to the process and the potential for delays outside of our control	
Clinical knowledge sharing	13 NZ DHB, 30 Australian regions 1 UK Trust	Health Pathways place considerable value in the clinical community. There is a commitment to updating pathways. Annual fee of 5 cents per ESU for being part of this community. TBA whether there is an additional fee for the Secondary Health Pathways product.
Usability Rating – the rating allocated is based on responses to clinicians survey and user experience	High	Clinicians' rate the speed with which you could find info in Health Pathways.
Mobility – functions on various screen sizes	Yes	
Integration	Medium (future version of e-Referrals)	New integrations would need to be built: BPAC Patient Prompt Medtech Clinical Workstation My Practice Integration with e-Referrals platform.
Usage Reporting	Google	Report down to user level and page view
Support, maintenance, hosting	SaaS	Pay $6,250 per annum to Health Pathways (this is for Community Health Pathways only; cost for Secondary Health Pathways is not yet known).
Confidence in Vendor	High	The vendor has a good reputation in health. The enormity of the task they have in aligning core pathways across multiple

Basis is consultation with DHBs who use the solution and their feedback.		clients in New Zealand, the UK and Australia was noted in recent discussions with them, which might present a minor risk to the level of service they can offer.
Fit with Strategy and road map	Yes	Integrate across continuums of care. Acting as a repository of both agreed regional care pathways e.g. Lung Cancer and locally developed pathways that can be localised for each DHB e.g. Suspected Skin Cancer One instance of the tool and therefore the pathway with localisation would assist with the issue that many common issues are being dealt with simultaneously across our region. Regional pathways enable shared knowledge, learnings and current innovations that are occurring locally to improve patients' health outcomes for the entire region.
Technical Fit	Yes HTML Hosted by HealthPathway	
Risks, disadvantages	• Loss of local identity • Significant regional change management and transition • Like for like integration cost and timeframes • Reduction in number of new pathways developed due to reallocation of resourcing to transition • Technical writing per hour fee is charged by Health Pathways and is a 'must' of pathway localisation, so impacting the re-creation of the 75 existing Map of Medicine pathways as well as creation of new pathways thereon. • Need to follow Health Pathways recommended service model which implies an increase in programme resources per DHB, and so significant role and responsibility changes for the current team. Negotiation would be required with Health Pathways to this end.	A localisation process for the region would need to be established.
Advantages	• Clinicians state high level of support for Health Pathways • Joining a large clinical community with ability to create and lead pathways	

19.1

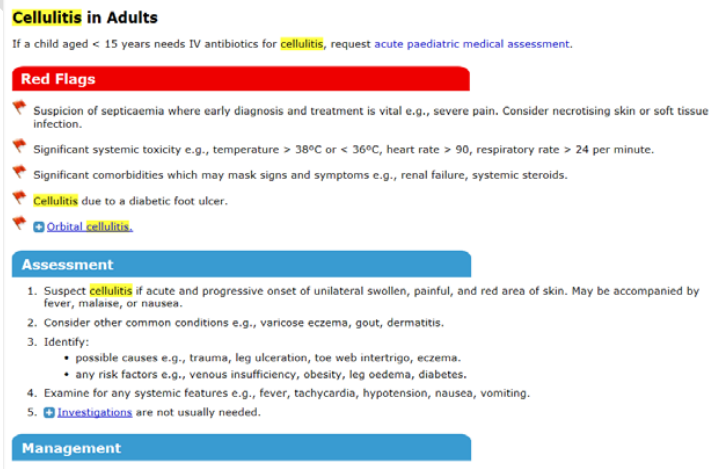
	that are nationally adopted , plus access to large Australasian clinical interest groups • Library of pathways provides starting point speeding up pathway development • Clinicians will be able to move to any other NZ region and many in Australia and use the same system	
Ease of Transition	Medium User base would have to move to new tool, and there would be short term loss of functionality.	Intangible cost of transitioning to new solution noted – in terms of user and delivery impact, which could have a negative effect on usage and productivity.
Recommendation	**Shortlisted option** Next step would be validating costs and proceeding to business case on the preferred option.	

Cost Breakdown

Expenditure Type	**Value**	**Purpose**
Capital	$0	SaaS – no cost Cost of purchasing source code TBA.
One-off Operational	$137,950 (TBC) *(2018/19 year) – based on pop of 156,000 (Northlands Agreement)*	Breakdown: Components of costs ($69,950) Training advice ,knowledge - $31,000 Website set-up - $6,250 Annual website - $6,250 HP administration systems/support - $15,000 Contribution to developments - $7,950 Breakdown: Fixed costs $71,000 Technical writing @ $115/h5 – 60 -100 pathways - $65,000 Transport, accommodation for training and advice $6,000 *Prices are nominal sums, before adjustments for CPI*
	TBC	IS resource requirement
	Not quantifiable but a risk for consideration	Intangible cost– disruption and short-term loss of productivity transitioning to a new tool

Ongoing Operational	$99,200 TBC *per annum*	Breakdown: Components of costs ($29,200) Annual website - $6,250 HP administration systems/support - $15,000 Contribution to developments - $7,950 Breakdown: Fixed costs $70,000 for technical writing Costs would need to be negotiated/confirmed with Health Pathway. According to their literature, 500 hours of technical writing will result in complete localisation of 30-40 pathways and resources, with a further 30-40 in various stages of localisation. There is an hourly charged for technical writing services. The above estimate assumes an hourly rate of up to $250 and 500 hours of technical writing per year. This may be less depending on negotiations. Ongoing costs for Health Pathways for secondary: unknown at this stage. This is a risk to adoption of this solution, so will require follow up should this be chosen as the preferred Health Pathways recommended service model implies increasing internal support resource to include an additional: 1 FTE Implementation Lead – ballpark $100,000 per annum 0.8 FTE Clinical Lead – ballpark $100,000 per annum propose retaining current complement of staff in Year 1 and then reviewing pathway editor requirements from Year 2 onwards
Total	$ $137,950 (TBC) Ongoing $ 99,200	This is an estimated cost: the first estimate includes implementation of Community only not secondary care

Note: Further consultation would be required to confirm cost implications.



Cellulitis in Adults

If a child aged < 15 years needs IV antibiotics for cellulitis, request acute paediatric medical assessment.

Red Flags

- Suspicion of septicaemia where early diagnosis and treatment is vital e.g., severe pain. Consider necrotising skin or soft tissue infection.
- Significant systemic toxicity e.g., temperature > 38ºC or < 36ºC, heart rate > 90, respiratory rate > 24 per minute.
- Significant comorbidities which may mask signs and symptoms e.g., renal failure, systemic steroids.
- Cellulitis due to a diabetic foot ulcer.
- Orbital cellulitis.

Assessment

1. Suspect cellulitis if acute and progressive onset of unilateral swollen, painful, and red area of skin. May be accompanied by fever, malaise, or nausea.
2. Consider other common conditions e.g., varicose eczema, gout, dermatitis.
3. Identify:
   - possible causes e.g., trauma, leg ulceration, toe web intertrigo, eczema.
   - any risk factors e.g., venous insufficiency, obesity, leg oedema, diabetes.
4. Examine for any systemic features e.g., fever, tachycardia, hypotension, nausea, vomiting.
5. Investigations are not usually needed.

Management

19.1

BESPOKE

One option is for the Midland region to "go it alone" and purchase their own responsible website/content management system, outsource initial set-up (e.g. development of 5 page templates) and recruit 1 FTE to complement the existing regional pathways team in maintaining the website content. HBDHB would link into this option.

Evaluation notes

Options	**Bespoke**	**Detail**
Description	Website – move all of the pathways from Map of Medicine into website and the Midland region manages the content. Purchase responsive website/content management system and outsource development of around five web page templates (style sheets) for initial implementation. A static pathway tool.	
Availability and breadth of clinical content Usage:	All Map of Medicine pathways would be transitioned to the new solution. None.	
Ease of localisation	High Partnerships with other DHBs – although Midland region-owner solution would have full autonomy over changes.	
Clinical knowledge sharing	DHBs, and ongoing effort to develop relationships with a wider community	
Usability Rating – the rating allocated is based on responses to clinicians survey and user experience	Opportunity to feed clinicians' survey feedback into optimising a design, and also to make the website openly available and so with the same advantage as the Bay Navigator around the time-pressured clinician not needing to remember another logon and password.	E.g. provide a short summary of the pathway on first view, and ability to click through to obtain further detail.
Mobility – functions on various screen sizes	Yes	Consultation would be required around how best to present diagrams on a mobile view with consideration of usability and cost.
Usage Reporting	Google Analytics and potentially Tag Manager tool to track document downloads Google Analytics and potentially Tag Manager tool to track document downloads	Market-recognised product and straightforward to implement New integrations would need to be built: • Medtech • Clinical Workstation • My Practice • Single sign-ons would not be required, but clinical workflow integrations would. $See cost table above.

Support, maintenance, hosting	Amazon Web Services or some other cloud service	
Confidence in Vendor	Unsure	Midlands would leverage Bay Navigator lessons learned plus experience of existing in-house Map of Medicine team (management, editors, GP liaisons, etc.).
Fit with Strategy and road map	Yes	
Technical fit	HTML Cloud hosting	
Risks, disadvantages	• Uncertainty on the long term sustainability of the pathway tool supported at a regional level and competitive market • Responsibility for maintaining toolset lies with region, rather than vendor who has prior experience – do we wish to 're-invent the wheel and go it alone'? • Significant regional change management and transition • Does not benefit from shared clinical pathway community • Reduction in number of new pathways developed due to reallocation of resourcing to transition • Like for like integration cost and timeframes • One DHB IS department supporting a regional system • Can e-Referral links can be developed and incorporated • Midland region have sole ownership of solution, and more control over the pace of transition	Investigating the sustainability of this option would be a priority were it chosen as the preferred option.
Advantages	• Open access website so no barrier to pathways with no need for user registration • Lower variable OPEX • Pathways accessible to public	

	• Solution can be developed and updated regularly to meet programme need	
Ease of Transition	High Commissioning and implementing a new content-management website and recruiting a content manager for all Regional and Central DHBs make this a significant undertaking.	
Recommendation	**Is there a will to 'go it alone'?** Next step would be validating costs and proceeding to business case on the preferred option.	

Expenditure Type	**Value**	**Purpose**
Capital	TBC	Likely $0 as hosting will be an ongoing cost on Amazon Web Services.
One-off Operational	TBC	Management of transition (requirements, procurement, implementation)
Ongoing Operational	TBC	1 FTE clinical writer – 1 FTE programme coordinator Clinical manager/Editor Hosting cost – Support, maintenance contract with website/CMS vendor Ongoing enhancements to website

Note: These are estimated costs for the purpose of initial analysis.

BAY NAVIGATOR

Bay Navigator is a joint initiative between community and hospital-based health care professionals in the Bay of Plenty, designed to improve the delivery of care for patients across the region.
Bay Navigator works to increase communication and collaboration between medical professionals, with the patient at the centre of service design and pathway development to deliver better, sooner and more convenient healthcare for our community.
The Bay Navigator website was established in early 2011 as an information and communication portal for all health professionals in the Bay of Plenty, with the goal of being the Bay of Plenty's leading clinical resource.

http://baynav.bopdhb.govt.nz/pathways/

Evaluation Notes

Options	Bay Navigator	Detail
Description	Bespoke Static Pathway open website with bespoke pathway tool and algorithm display. Created by BOP DHB to support their clinicians to increase communication and collaboration between medical professionals, with the patient at the centre of service design and pathway development. A static pathway tool.	
Availability and breadth of clinical content Usage:	Map of Medicine pathways would need to be transitioned. High - general practice Low - secondary care Low – community/allied	
Ease of localisation	High Ownership is with BoP DHB and so they have full autonomy over changes.	
Clinical knowledge sharing		
Usability Rating – the rating allocated is based on responses from BOP DHB to clinicians survey and user experience	Medium - High	Positive feedback from clinicians' on tool, with a clear bonus for the time-pressured clinician being that there is no need to remember another log on and password. However it it's not well integrated into their clinical work flow. Modern user interface Layout – pictures – consistency – embed images – flexible in configuration but have to scroll Print version - info only printed Pop up boxes are CMS pages
Mobility – functions on various screen sizes	No	Pages re-size on smaller screens but do not display optimally.
Integration	Medium	New integrations would need to be built: • BPAC Patient Prompt • Medtech • Clinical Workstation • My Practice Link with some e-Referrals is already in place.
Usage Reporting	Google	

Support, maintenance, hosting	In house	
Confidence in Vendor Basis is consultation with BOP DHB who use the solution and their feedback	High	
Fit with Strategy and road map	Yes	
Technical Fit	Yes HTML	
Risks, disadvantages	• Uncertainty on the ability of existing software, infrastructure, available development resources and IS support to upscale to a regional solution • One DHB IS department supporting a regional system • Reduction in number of new pathways developed due to reallocation of resourcing to transition • Loss of regional engagement due to the perception that the DHB who supports the system has more influence on pathway development • Change management and transition – moving a number of DHBs onto a new system • Reduction in number of new pathways developed due to reallocation of resourcing to transition	
Ease of Transition	• Medium • Upscaling the platform to handle additional user base could be complex.	• Intangible cost of transitioning to new solution noted – in terms of user and delivery impact, which could have a negative effect on usage and productivity.
Recommendation	Not shortlisted – unless there is a will to investigate further Upscaling the current solution would require investment. As per bespoke option, advice sought on whether there is a will to investigate this option further.	Upscaling the current solution would require investment.

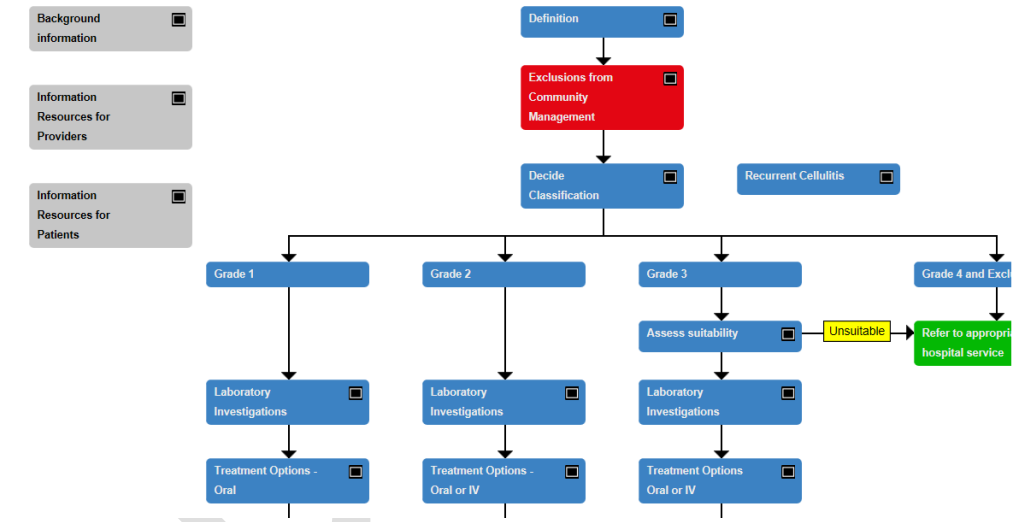
Cost breakdown

Expenditure Type	Value	Purpose
Capital	TBA	Likely $0 as hosting will be AWS.
One-off Operational	$TBC *(2018/19 year)*	Awaiting cost info from BoP. Integration costs (BPAC, Medtech, Profile, Indici, My Practice, Clinical Workstation, Hauraki Dashboard, Midlands Clinical Portal) – ballpark $100K
Ongoing Operational	$TBA *per annum*	Awaiting cost info from BoP.
Total (Year 1)	$TBC	This is an estimated cost. Further consultation required to obtain an accurate costing.

Cellulitis

Map of medicine

Print



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NEXXT

NexXt is a patient-centric Dynamic Clinical Pathway solution that supports best practice to reduce variation of care, improve quality of life for citizens and reduce pressure on healthcare budgets.
It has a cost effective Software as a Service / web architecture that scales to support clinics, regions or an entire country with a single patient-centric view

http://www.nexxtpathways.com/about/product-overview

Evaluation

NEXXT	Detail	
Description	Dynamic Pathway tool built into the workflow of general practice into the major PMS's in NZ covering the top twenty most common pathways. A dynamic pathway tool.	
Availability and breadth of clinical content Useage	20 National integrated into clinical workflow of primary care Low - general practice Nil - secondary care Nil – community/allied	Current Map numbers – 12 pathways • Cognitive Impairment • Asthma • Severe Asthma • COPD • Diabetes Type 2 • Gout • AF • Cellulitis • DVT • Dyspepsia • Iron Deficiency • Sore Throat • Full journey pathways if system integrated into secondary/allied care in region
Ease of localisation	Low Effort to implement a new automated workflow is significant.	
Clinical knowledge sharing	4 NZ DHB's	
Usability Rating – the rating allocated is based on responses to clinicians survey and user experience		Further investigation required to determine usability. By their nature, dynamic pathway tools provide workflow-specific advice to the clinician which makes them more accessible.
Mobility – functions on various screen sizes		
Integration	Low (Primary only) Low (Primary only)	Integrated with Primary Care – Medtech 32, Profile Integrated with Primary Care – Medtech 32, Profile
Usage Reporting	Granular	
Support, maintenance, hosting	SaaS	

Confidence in Vendor Basis is consultation with DHBs who use the solution and their feedback.	Low* (has been withdrawn from general practices in some regions)	
Fit with Strategy and road map	Partial	
Technical Fit	TBC	
Indicative Costs (ballpark)*	TBC	$35,000 for a 6mth pilot occurred – delivery on 2 Pathways
Risks, disadvantages	• Tool has had poor usability feedback • Effort to implement is high for single pathways and conditions • Only used in primary • Vendor appears to have halted new implementations • Loss of regional engagement due to the perception that the DHB who supports the system has more influence on pathway development • Reduction in number of new pathways developed due to reallocation of resourcing to transition • Does not have the breadth and detail of a static pathway tool • Does not benefit from shared clinical pathway community	
Advantages	• Pathway is integrated in individual patient journey	
Ease of Transition	High This would not replace but complement a static pathway tool. Transition would be complex.	
Recommendation	**Not preferred at this stage** Not currently fit for purpose as a regional electronic pathway tool	

Cost Breakdown

Expenditure Type	Value	Purpose
Capital	$0	
One-off Operational	$TBC *(2018/19 year)*	Costs would need to be elicited for all practices in region. Integration not done previously with secondary systems
Ongoing Operational	$TBC *per annum*	
Total (Year 1)		Further consultation required to obtain an accurate costing.

Note: These are estimated costs for the purpose of initial analysis.

TRENDCARE

TrendCare is a workforce planning and workload management system that provides dynamic data for clinicians, department managers, hospital executives and high level healthcare planners. Care planning components within the system ensure best practice

http://www.trendcare.com.au/

Evaluation Notes

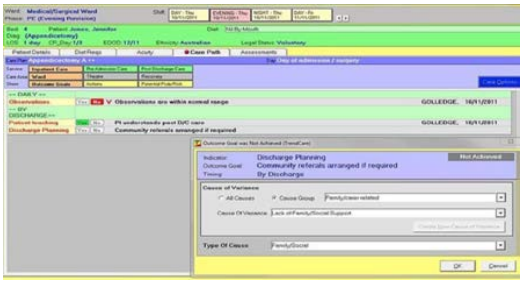
Options	Trend Care	Detail
Description	Workflow care planning tool that can be configured for local use and is commonly used in secondary nursing. A static pathway tool.	
Availability and breadth of clinical content	N/A	
Usage:	Nil - general practice High - secondary care Nil – community/allied	Nil - general practice High - secondary care Nil – community/allied
Ease of localisation	Medium Configuration is devolved to the owner, but effort to implement a new automated workflow is significant.	
Clinical knowledge sharing	1 NZ DHB *pathways are created and localised in each DHB setting	
Usability Rating – the rating allocated is based on responses to clinicians' survey and user experience		Further investigation required to determine usability. By their nature, dynamic pathway tools provide workflow-specific advice to the clinician which makes them more accessible.
Mobility – functions on various screen sizes	TBC	
Integration	Low (Secondary only)	Integrates with main secondary care PAS. No primary care integrations currently. HL7 formatted.
Usage Reporting	Granular??	
Support, maintenance, hosting	SaaS – Partial	
Confidence in Vendor	Basis is consultation with DHBs who use the solution and their feedback. Medium	

Fit with Strategy and road map	No	
Technical Fit	Yes HL7 compatible	
Risks, disadvantages	• Tool is only used in secondary care setting in nursing work flows • Effort to implement is high for single pathways and conditions • Does not have the breadth and detail of a static pathway tool • Reduction in number of new pathways developed due to reallocation of resourcing to transition • Does not benefit from shared clinical pathway community Tool has existing templates but due to high Localisation (configurability) will not support programme principle of regional consistency and equity of access to care	
Advantages	• Tool is highly configurable • Can produce workflows, care plans and patient assessments in patient context • Pathway is integrated in individual patient journey Tool is HL7 compatible – higher level of interoperability	
Ease of Transition	High This would not replace but complement a static pathway tool. Were we to consider transitioning the 75 localised pathways to an automated workflow, transition would be complex	Intangible cost of transitioning to new solution noted – in terms of user and delivery impact, which could have a negative effect on usage and productivity.
Recommendation	**Not preferred -** Not currently fit for purpose as a regional electronic pathway tool	

Cost Breakdown

Expenditure Type	Value	Purpose
Capital	TBA	Likely $0 as hosting will be AWS.
One-off Operational	$ TBC *(2018/19 year)*	Costs would need to be obtained. Integration costs (BPAC, Medtech, Clinical Portal) – ballpark $100K
Ongoing Operational	$ TBC	Costs would need to be obtained
Total (Year 1) Example for Waikato DHB only	$ TBC	This is an estimated cost – further consultation required to obtain an accurate costing for all DHBs and not just Waikato.

Note: These are estimated costs for the purpose of initial analysis.



APPENDIX 6: Example of Agreement costs with Streamliners and a DHB.

The example on the next page is an example only – *note this was the price range in 2015/ based on a population of 159,000.*

Summary key points:

- Streamliners hold the intellectual property including software and documentation (including all upgrades, updates, improvements, enhancements, modifications)
- Any intellectual property prior to agreement stays with HBDHB
- Development and implementation of pathways must meet Streamliners standards
- Pathways are hosted on the Canterbury Pathways site – hence no HBDHB IT requirements
- There may be a gap with transition planning if we go with this option if decisions are delayed
- Cost of the technical writers per hour (average 2-12 hours) – this is to advise, change and ensure meets standard formats
- Minimum requirements at HBDHB level for composition and certification
    - Contract Liaison
    - Programme Management – lead the work
    - Clinical leaders (Combined 0.3 FTE) – experienced and respected
    - GP Clinical Editors (Combined 1.2 FTE / over three people) – Purpose: identify what information is needed, engagement, correct and relevant to GP, champions the expectations, maintain overview of all information – must have training and certification
    - HealthPathways Co-Ordinator (1 FTE) Purpose: gathers non-clinical information, range of communication, supports process of editors, must have training and certification
    - Other governance groups - Purpose – support, collaboration, communications and education and undertakes audit and evaluation.
- Set-up costs:
    - Set-up of live and drafting of Canterbury Pathways – to then localise Planning Seminar led by Canterbury Team
        - one day
        - whole of system thinking and practice
        - planning and operation of work programme
        - local pathways management and customisation
        - Lessons learnt
        - Function and benefits of *HealthPathways* Community
        - Expectations of attendees: CEO – Primary/Secondary, CMOs, key clinical leaders, Operational managers, Integration Managers, those involved in the work-programme
    - Practical Workshop led by Canterbury Team
        - one day
        - modelling of the service provision of the work programme – identifying
        - understanding subject matters
        - Expectations of attendees: Work-programme Manager, Clinical leaders, Clinical Editors, *HealthPathwys* Co-Ordinator, Work-group Facilitators, Hospital Clinicians (2-5), General Practitioners (4-6), other clinicians (Allied Health, Pharmacists).
    - Extensive knowledge and transfer support via phone, video and/or email

Appendix 7: Risk Management Plan – Example of

Risk	Mitigation Strategy	Likelihood	Impact
Lack of stakeholder buy-in with competing agendas as this is a multi-dimension piece of work involving all services	• Establish meetings • Ensure membership covers all stakeholders • Regular updates	Low	High
Costs associated with implementing any tool and integrating that with the existing GP Practice PMS are higher than anticipated	• Gain agreement from new Vendor during the contract negotiation that they will work with DHB/PHO/Practice IT staff and suppliers to gain integration with existing systems, and that they will contribute to the cost of any development needed	Med	High
Reduced number of pathways. The slower rate of localisation of pathways means the utility of the platform is compromised and may affect uptake in its use by primary care	• Gain agreement on the numbers to be developed per year	Med	Med
Need robust communication available to roll out and localize.	• Important for HBDHB to be consistent with messaging and health literacy requirements • Communication resources require localisation and local launches. Need to embed equity and make appropriate for local communities.	High	High
Disconnected IT solutions can have impact into usability	• Time resources need to be included in financial planning • Involve IT	High	High
Reporting structures have not been well established – what will the impact be on resourcing	• Involve IS • Establish and monitor performance indicators and clearly publicise improvements to those indicators that are due to Pathways implementation and use (e.g. shorter wait times for elective surgery)	Med	High
Integration of new tool into GP Practice Systems or e-referrals is not possible	• Work with PHO to achieve the best work-around in order to gain a workable system • Gain tacit agreement from PHO during contract negotiation that they will work towards developing full integration within an acceptable and known timeframe	Med	Med
Clinician engagement is lower than anticipated	• Work with early adopter clinicians as Pathways champions • Provide ample and varied opportunities to engage with the initiative		

APPENIDX 8: Definitions and References

Definitions

Pathway

- the ideal journey of care that a patient should receive within a healthcare setting
- should include all aspects of health and social care, not forgetting self-care, and importantly should move the patient towards a defined positive clinical outcome
- should be based on the best clinical evidence available, from reputable evidence-based sources, e.g. NICE, Health Navigator

Static Pathway

- A pathway represented in a fixed format such as an algorithm or text on paper or in a non-interactive form on a computer.
- It is similar to viewing a paper-based road map. An individual has to pick out the shortest and most convenient route based on a picture of all the different road

Dynamic Pathway

- A pathway represented in an interactive form on a computer interface that is individualised for each patient based on specific data being input.
- It is similar to a satellite navigation system in a car. The system will regularly update you of the shortest and most convenient route however you can override its instructions

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	Clinical Services Plan – Planning for Consultation 66
	For the attention of: **HBDHB Executive Management Team; HHB Executive Management Team; Māori Relationship Board, Pasifika Health Leadership Group; HB Clinical Council; HB Health Consumer Council and HBDHB Board**
Document Owner & Author:	Ken Foote, Company Secretary & Clinical Services Plan Project Lead
Reviewed by:	Hayley Turner, Paul Malan and Executive Management Team
Month:	May 2018
Consideration:	For Advice

RECOMMENDATION:

That the governance and advisory groups:

- **Provide** advice to assist with the development of a plan for the consultation / engagement phase of the Clinical Services Plan (CSP) process, to take place over August / September 2018.

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1. PURPOSE

It has previously been agreed that consultation/engagement on the Draft CSP will take place during August and early September 2018. The CSP Project Team is currently developing a plan for this.

The purpose of this report is to seek advice from the HB health sector executive and governance groups on who we should be consulting with and the best way to do this. The Project Team wants to make sure that this consultation/engagement process goes well, by engaging with the right groups and people, in the right place and in the right way, to gain feedback, understanding and acceptance.

2. BACKGROUND

In developing a plan for consultation, it is important to remind ourselves of the background, context and process that has led to the development of the Draft CSP, on which we will be consulting. Summaries of these issues are set out below:

2.1 Why do we need a CSP?

- Planning is important to sustain a growing population and a healthier Hawke's Bay
- Need to identify the clinical services and models of care that will best meet future demand
- Need to confirm what works well, what needs improvement and new opportunities
- Take Transform & Sustain to the next level
- Planning a 10 year outlook is imperative for reducing inequity and ensuring we meet the basic and most comprehensive needs of our consumers.

2.2 What is a CSP?

A CSP will:

- Describe the current capability and capacity of services (Baseline)
- Describe the challenges and opportunities facing service provision now and in the future.
- Describe high-level options that will help meet those challenges and take advantage of those opportunities.
- Provide an indication of strategic direction and important areas for investment.
- Be able to be realistically implemented within funding projections
- Inform the next HB health sector 5 year Strategic Plan

A CSP will not:

- Address details of implementation or operational service planning
- Provide detailed financial modelling
- Provide a workforce strategy and plan
- Include a facilities Master Plan.

2.3 What else will inform the next HB health sector 5 year Strategic Plan?

- Government Policy and MoH direction
- Central Region Planning
- People Strategy (Big Listen, Korero Mai)
- Health Equity Report
- Matariki - Regional Economic Development and Social Inclusion Strategy
- Existing/Updated Plans eg,
  - Maori Health
  - Pacific Health
  - Population Health
  - Workforce
  - Information Services / Information Technology
  - Facilities
  - Finance
- Existing/Evolving Strategies eg,
  - Integration
  - Primary Care Development
  - Disability
  - Quality Framework
  - Person & Whanau Centred Care
  - Consumer Engagement/Experience
  - Clinical Leadership/Governance
  - Health Literacy / Making Health Easy to Understand
  - Health and Safety

2.4 What process has been used to develop the Draft CSP?

In June 2017, HBDHB engaged Sapere Research Group to facilitate a whole of sector, bottom up approach to the development of a CSP for the HB health system.

Over the nine month period 1 June 2017 to 28 February 2018, the process was focussed on engaging with key stakeholders to confirm ‘current state analysis’ and identify issues and challenges.

Key stakeholders significantly engaged during this time included:

- General Practice
- Community Providers
- Aged Care Providers
- HBDHB services
- Consumers
- HB health sector leadership.

During April and May 2018, the focus has been on exploring future options, with four themed workshops and an integrative workshop. The four themed workshops had health professionals and consumers working together to produce a long list of options for the future design and delivery of relevant services.

The themes for the workshops were:

- Looking after frail people in our care
- What is the character of our hospital in 10 years' time?
- Supporting our people in vulnerable situations
- Reorganising primary care for the challenge.

The Integrative Workshop to be held on 31 May 2018, will seek to integrate and prioritise the options developed at the four future options (themed) workshops.

2.5 What outputs have been produced along the way?

Output documents have been progressively produced along the way, documenting analysis and issues raised to inform the next stage of the process.

Key documents have included:

- Data Packs – July 2017
  - Population and service data analysis
  - Benchmarking
  - Demographic service volumes (demand)
- Horizon Scan – October 2017
  - Looks at trends in workforce, technology and integrated models of care that will impact on the future delivery of services and the ways people access and participate in their healthcare
- Patient Journey Workshop write ups – November 2017
  - What is working well – what isn't working so well.
  - Suggestions on how to improve
- Baseline Document – February 2018
  - Provides a summary of the current state of services delivered across general practice and other community providers, as well as district health board health services provided both in the community and hospital.
- Summary Statement – February 2018
  - Summarises findings from the *Baseline Document.* Also integrates findings from the patient journey workshops held in September 2017.

2.6 How will the Draft CSP be developed?

Sapere will use all the information collated and ideas generated from all the above, along with the options/issues agreed through the themed and integrative workshops, to produce an Initial Draft CSP by 30 June 2018.

Throughout July, all HB health sector executive and governance groups will have the opportunity to review this initial draft for accuracy, completeness, understanding and reality checking. Feedback from these reviews will be provided to Sapere. Sapere will update/amend the initial draft as appropriate and have the Draft CSP for consultation back to us by the end of July 2018.

It needs to be noted that this review during July will not involve any discussion on the merits of any of the options or suggested strategies presented, other than that necessary for a "reality check". There will be significant opportunity to review these issues during regular meetings in both August and September as well as potential time provided during the next HB Health Sector Leadership Forum Workshop currently planned for 5 September 2018.

3. CONSULTATION, OBJECTIVES & PRINCIPLES

Comment would be appreciated on the following:

3.1 Objectives

Objectives of consultation / engagement are to:

- Inform, explain, review and validate the draft CSP
- Seek feedback and comment on changes/enhancements required
- Honour our Treaty of Waitangi obligations
- Commence a process to gain understanding and acceptance of the need for change
- Listen for and note 'operational' issues/concerns raised for future detailed planning

3.2 Principles

- Acknowledge what the CSP is and what it is not – focus on strategic direction and input into the new 5 year Strategic Plan
- Draft CSP is 'owned' by HBDHB on behalf of the HB heath sector – Sapere have assisted with its development
- Acknowledge robust, objective analysis and engagement/co-design process to date
- Consultation process/engagement to be led by HBDHB
- Acknowledge the need for change – the status quo is not sustainable
- Openness and transparency – everything on the table
- Consultation/engagement is genuine - Draft can be changed
- Ensure all key stakeholders are appropriately engaged – preferably in their own environment and in ways that suit them
- Maximise use of existing forums and meetings
- Make it 'easy to understand'
- Where possible 'translate' CSP into 'what does this mean for me and my whanau/community'.

4. CONSULTATION PROCESS

As indicated above, this consultation/engagement process will only go well if we engage with the right groups and people, in the right place and in the right way.

Advice is therefore requested on all three of these factors, as well as on proposed pre-consultation briefings.

The framework and suggestions below are provided as a starting point for discussion:

4.1 Pre-Consultation Briefings:

- *Minister/Ministry of Health*
- *Members of Parliament*
- *Mayors and Chairs of Local Authorities*
- *Other 'Community leaders"*
- *Media*

4.2 Stakeholder Engagement:

- *Consumers/community*
- *Maori community*
- *Pacific Island Community*
- *HBDHB & Health HB Ltd staff*
- *HB health service providers*
  - *General Practice*
  - *Community Pharmacy*
  - *Aged Care*
  - *NGOs*
- *Community health groups*
  - *Cancer society*
  - *etc*
- *Other community groups*
  - *Aged Concern*

- *etc*

4.3 Methods:

- *Meetings/presentations*
  - *Public*
  - *groups*
- *Digital*
  - *Website*
  - *Facebook*
- *Print*
  - *Media*
    - ✓ *"News" articles*
    - ✓ *Paid advertisements*
    - ✓ *Community papers*
  - *Pamphlet*
    - ✓ *Mail drop*
    - ✓ *"Selected" availability*
  - *CEO In Focus*
    - ✓ *Special Edition*
- *Feedback*
  - *meeting notes*
  - *Pamphlet card*
  - *Email*

4.4 Leadership:

- *Overall leadership / ownership / spokesperson*
- *Delegated leadership*
- *Presenters*
  - *Coordination*
  - *Training*

4.5 Management and Administration:

- *Summaries / presentation development*
- *Programme coordination*
- *Logistics*
- *Budget / cost management*
- *Feedback collation / review / submission to Sapere*

5. CONSULTATION PLAN

Following receipt of all comments and advice from this process, the CSP Project Team and Communications Manager will develop a detailed Consultation Plan, including a full Communications Plan.

Once approved by HBDHB CEO, implementation of the Plan will commence in June, with all governance groups being provided with a copy for information. Alterations and variations to the Plan will still be possible however, where identified as necessary or desirable, and approved by HBDHB CEO.

6. COMMENTS / ADVICE

As indicated at the beginning and throughout, comments and advice on any/all issues included in this report, would be appreciated.

HAWKE'S BAY District Health Board Whakawāteatia	**Best Start: Healthy Eating and Activity Plan - Healthy Weight Strategy** 67
	For the attention of: **HBDHB Board**
Document Owner	Kevin Snee, Chief Executive Officer
Document Author(s)	Shari Tidswell, Intersector Development Manager
Reviewed by	Phil Moore (Clinical Lead) and the Executive Managment Team, Māori Relationship Board, Pasifika Health Leadership Group, HB Clinical Council and HB Health Consumer Council
Month/Year	May 2018
Purpose	The Board requested six monthly progress reports. This report provides an overview of the progress and changes impacting the Best Start Plan's delivery.
Previous Consideration Discussions	Reported six monthly.
Summary	Work delivered is part of the Best Start Plan that includes; supporting healthy eating environments, delivers prevention programmes, provides intervention pathways and supports health leadership in healthy weight. In the last six months we have worked on the final Healthy Conversation Tool for health professional working with 3 and 4-year olds, delivering increased referral places lifestyle programmes for whānau with under 5s and maintaining the effective programme delivered under this Plan.
Contribution to Goals and Strategic Implications	Health equity – Healthy weight is the second highest contributor to wellbeing. Transform and Sustain – increasing focus on prevention. Improving health outcomes for Māori and Pasifika peoples.
Impact on Reducing Inequities/Disparities	Directly aligned to addressing inequity for Māori and Pasifika.
Consumer Engagement	Delivered by the Best Start: Healthy Eating and Activity Plan Development and Delivery
Other Consultation /Involvement	Ongoing - as part of all delivery and programme development.
Financial/Budget Impact	Not applicable
Timing Issues	Not applicable
Announcements/ Communications	Will launch the new webpage and "Water Only" kit for schools.
RECOMMENDATION: **It is recommended that the HBDHB Board:** • **Note** the content of the report and **Endorse** the next step recommendations	

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Best Start: Healthy Eating and Activity Plan - Healthy Weight Strategy

Author(s):	Shari Tidswell,
Designations:	Intersector Development Manager
Date:	**May 2018**

OVERVIEW

In 2015 the Healthy Weight Strategy and in 2016 the Best Start: Healthy Eating and Activity Plan were endorsed by the HBDHB Board. These documents guide the HBDHB's work in increasing the number of healthy weight people, with a focus on children. Work is delivered across HBDHB and other sectors including primary care, councils, education, workplaces and Ngati Kahungunu Iwi Inc.

Childhood healthy weight is also being reported to the HBDHB Board via Te Ara Whakawaiora performance programme and nationally through the Raising Healthy Kids target. These reports share information and the Best Start Plan provides the direction and overview for work.

REPORTING ON PROGRESS

Below is a summary of the highlights for each of the Plan's four objectives. Appendix One provides further detail of the progress on the Plan's activities to date.

1) Increasing healthy eating and activity environments

The work undertaken with early childhood providers identified steps to support healthy weight practises. Sector representatives continue to be engaged in developing resources and creating changes in this setting. An education sector web page is under development and will provide easy access to the resources for early childhood services and schools. Planning has commenced with the Heart Foundation to support the delivery of the Healthy Heart Programme.

HBDHB have worked with Sport Hawke's Bay to support healthy weight environments in sport clubs and codes, including encouraging water only and having no treat foods. Sport Hawke's Bay now have a Healthy Clubs Coordinator to work with clubs to implement their aspirations in supporting the health and wellbeing of children and whānau.

In HBDHB secondary services, the Paediatric ward have gone "water only" – this included staff training, promotional activities and supporting ongoing implementation. This is great role modelling for children and whānau around wellbeing.

2) Develop and deliver prevention programmes

Programmes are now at the embedding stage with key messages going to wāhine and whānau during pregnancy; via Mama Aroha – messaging is consistently provided to new parents/whānau; Healthy First Foods programme is part of Well Child Tamariki Ora and Plunket services; Healthy Conversation and BESMARTER Tools are used by health

professionals engaging with 2-4 year olds and "Water is the Best Drink" messaging is consistently being used from 2 to 10 years.

3) Intervention to support children to have healthy weight

HBDHB met the Raising Healthy Kids target six months earlier than the target date and has now achieved 98% of children identified at a B4 School Check in the 98th percentile weight being referred to a primary care assessment. Further supportive pathways and tools have been developed to support whānau to make lifestyle changes which support healthy weight. This includes Active Families Under Five and the BESMARTER goal setting tool.

4) Provide leadership in healthy eating

The HBDHB continues to provide leadership across sectors to provide advice and support to implement healthy weight programmes, activities and sharing of information.

HBDHB have contributed to training events for primary care, early childhood services and HB Community Fitness Trust.

Hastings District Council has led the way by making all their facilities sugar sweetened beverage free.

WIDER CONTEXT FOR CHILD HEALTHY WEIGHT

Obesity is the second leading risk to population health outcomes in Hawke's Bay. Medium and long-term costs of not addressing obesity are very high, as obesity leads to a range of diseases with high health sector costs. A third of our adult population are obese; 48% and 68% for Māori and Pacific adult populations respectively. Childhood weight is a significant influence for adult weight and changing behaviours to increase healthy weight are more effective during childhood years.

The national target (Raising Healthy Kids) has been in place for 18 months and Hawke's Bay performs well in our consistent achievement of this target. Alongside this work is a national group who are evaluating the work delivered as part of the target. This will include investigating a second measurement point for BMI in children and collating the evaluations completed in each DHB. Progress has been slow to date and the HBDHB Best Start Advisory Group has supported HBDHB developing a measurement of 8-year olds in the school setting (see attached short report).

HB Community Fitness Trust held an event to celebrate the beginning of the building process at the HB Sports Park – this is stage one of this facility. HBDHB have been activity supporting the development within Flaxmere primary schools and early childhood providers, including liaising with the research team working alongside the programme.

NEXT STEPS

1. Establish a working group to set up a BMI measurement for 8-year olds, which will provide whānau referrals for obese children, resources for whānau and support for schools.

2. Address the identified need for a nutrition and physical activity advice/resource for early childhood education. This will reinforce key messages whānau receive via maternity services, primary care, hauora, Well Child/Plunket and B4 School Checks.

3. Develop primary school tools to support effective healthy weight environments – utilising currently engagement resources, Public Health Nurses, Health Promoting Schools and Population Health Advisor working with community partners such as; MoE East Coast, Hawke's Bay Community Fitness Centre Trust and schools.

4. Develop a pilot to support breastfeeding from 0 to 6-weeks of age to support whānau at home to maintain or re-establish breastfeeding. The pilot aims to build on the success of whanau to continue breastfeeding once they leave the care of Maternity Services.

RECOMMENDATIONS

Key Recommendation	Description	Responsible	Timeframe
Develop a pilot programme for in-home support for breastfeeding	Take the recommendations to the Best Start Advisory Group to develop actions for improvement	Jules Arthur/ Shari Tidswell	July 2018
Develop a pilot for monitoring and measuring children at 8-years	Work with the national evaluation group to determine a process/tool to track children identified at B4SC and measure change.	Child Health Team/ Shari Tidswell	November 2018

RECOMMENDATION:

It is recommended that the HBDHB Board:

- **Note** the contents of the report.
- **Endorse** the key recommendations.

Appendix One

Objective 1: Increase healthy eating and activity environments

Indicator 1a: Increase the number of schools with healthy eating policies

Indicator 1b: Increase the number of settings including workplaces, churches and marae with healthy eating policy

What the data shows

The data we have is improving, there will be a survey completed by June 2018 for all primary schools and data for the school environments has been collected with Auckland University (Informas) and reported.

Activity to deliver objective one				
	What	**How**	**Progress**	**When**
Current activity	• Work with settings to increase healthy eating including education, schools, workplaces, events, Pasifika churches, marae • Support national messaging including sugar reduction i.e. Water Only • Advocate for changes in marketing and council planning	• Healthy eating policies which reduce sugar intake in 5 ECE centres, key community events increase healthy food choices, 4 Pasifika churches have a healthy eating approaches and guidelines for marae reviewed with Ngāti Kahungunu Iwi Incorporated • Communication plan implemented for national and regional messages • Supporting the implementation of programmes and plans i.e. i Way, Active Transport, Sport HB and Ngāti Kahungunu Iwi Incorporated plans	• School water only policies reviewed by PHNs, all primary schools have policies and two secondary schools. Support is being developed for ECEs with MoH licensing staff. Four churches engaged, two are working toward reducing sugar. Hasting District Council is going sugar sweeten beverage free at their facilities. • Water only messaging promoted in schools, under 5 Healthy Food messages • DHB rep on Active Transport group, supporting Ngāti Kahungunu Iwi Inc. events to provide health messages and supplying water. • Schools project lead has established a working group including PHNs, Health Promoting Schools, Māori Health, and Pasifika Health.	July 2017

Activity to deliver objective one				
New actions	• Support education settings to implement healthy eating and food literacy- early childhood, primary schools secondary schools, • Establishing a base measure for monitoring • Engage cross-sector groups to gain support and influence to increase healthy eating environments • Investigate food security for children and their whānau identifying issues	• 50% increase in schools with "water only" policy annually • Decile 9/10 communities have a whānau co-designed programme delivered in primary schools, - trialled 2016, 5 new schools annually • All schools surveyed for status in healthy eating/water only policies • Establish a group to influence changes in the environment across Hawke's Bay • Partner with Auckland University to establish a baseline for the Hawke's Bay food environment and monitor annually	• Working group established to design a second survey for primary schools • Presented Healthy Weight Strategy to Hastings and Napier Council. • Food Environment data collection complete and report shared with stakeholders • Best Start Advisory Group has been meeting monthly to support coordination and the development of resources/programmes/project. Includes: Health HB, Child Health, Oral Health, Maori Health, Population Health, Pasifika Health, Paediatrics, Primary Care Directorate. Current work is looking at delivering an 8 year measurement for weight	Reported annually to 2020

Objective 2: Develop and deliver prevention programmes

Indicator 2a: Rates of breastfeeding at 6 weeks increase

Indicator 2b: Number of healthy weight children at 4 years remain stable or improves

What the data shows

- Child fully or exclusively breastfeeding at 6 weeks rates as 72% for total population, 66% Māori and 82% Pasifka (December 2015 Ministry of Health), these show slight increases
- 67.8% of Hawke's Bay four year olds are healthy weight, 62.7% Māori and 55.7% Pasifika (2016 Before School Check data, Health Hawke's Bay), this is 2016 data. Most recent data is obesity data with 13% of Māori, 26% Pasifika and 5.8% other four year old children in the 98th percentile for weight (June –Dec 2017 B4SC)

Actions and Stakeholders				
	What	**How**	**Progress**	**When**
Current activity	• Implementing Maternal Nutrition Programme activities- breastfeeding support, healthy first foods • Supporting settings to implement healthy eating/sugar reduction programmes/policies • Supporting health promoting schools	• Breastfeeding support resources provided via Hauora • All Well Child/Tamariki Ora providers trained in Healthy First Foods • All schools, ECE, Well Child/Tamariki Ora Providers with health eating policies are provided with information resources and advice • Health Promoting Schools health promoters are up-skilled to implement healthy eating approaches	• Complete • Complete • Information and resources shared • Meeting HPS coordinators, attended workshop with other providers. Training with Heart Foundation planned for this year. • Training is completed for Tamariki Ora and Plunket staff, LMCs and B4SC nurses. Training plan being delivered for ECEs. • Maternal Nutrition and Physical Activity programme being delivered in Wairoa – great response	July 2017
Next actions	• Extend the Maternal Nutrition programme developing programmes in ECE and resources to	• Deliver training to LMCs, Well Child providers and B4 School Check nurses to increase skills to promote healthy eating- Healthy Conversation,	• Active Families contracts in place and delivered by Iron Māori and Sport HB. Tamariki Ora and Plunket staff trained and delivering Healthy First Foods programmes.	Reported annually until 2020

Actions and Stakeholders				
	support B4 School Check providers • Supporting healthy pregnancies, via education and activity opportunities • Support the development of whānau programme (building on existing successful programme) • Develop food literacy resources including sugar reduction messages -deliver via programme and settings • Support healthy eating programmes and approaches in schools	Healthy First Foods, B4 School Check resources • Contract and support local provider/s to deliver the maternal healthy eating activity programme • Contract and support local provider/s to deliver whānau based programmes i.e. Active Families • Deliver key messages for whānau with 2–3 year olds • Develop food literacy resources for B4 School Check provider, promote Healthy First Food and heart foundation school resources • Support the co-designed programme for deprivation 9/10 communities	• Project manager appointed for school programme and working with Kimi Ora School. • Working with early childhood providers to identity resources to support healthy weight messages for whānau and children – expert group set up and reviewed current resources. • Healthy conversation tool implemented and evaluated – this includes BE SMARTER whānau plan, B4 Schools Check nurses • Working group developing the survey for all primary schools and tool to support design and delivery of healthy weight schools.	

Objective 3: Intervention to support children to have healthy weight

Indicator 3a: Increase referrals to programmes which support healthy lifestyles and whānau engagement for 4 year olds with a BMI in the 98th percentile

Indicator 3b: Increase food literacy training to targeted workforce including midwives, Well Child/Tamariki Ora, education workforces, social services and Before School Check practitioners.

What the data shows

- 119 Hawke's Bay children were identified with BMI in the 98th percentile, of these, 90 accepted a referred to a primary care follow, 2 already in care and 27 declined at referral. 98% Māori, 100% other and 100% Pasifika children received a referral to primary care. (Dec 2017 B4 School Check reported Data - MoH)
- 100 participants attended breastfeeding support training, 23 Well Child staff attended First Foods Trainer Workshops, 83 health professionals attended Gestational Diabetes updates (2015 HBDHB Maternal Nutrition Report to MoH) and 45 practice nurses attended CNE session on Raising Healthy Kids Target and whānau conversation tool/plan. 63 early childhood teaching attended an information session

Activities and Stakeholders				
	What	**How**	**Progress**	**When**
Current activity	• Screening including gestational diabetes, Well Child/Tamariki Ora and B4 School Checks • Whānau activity based programmes for under 5s • Paediatric dietetic referrals	• Monitor the screening and responding referrals • Fund Active Families under five and monitor implementation. Investigate extending to further providers • Monitor referrals and outcomes	• Monitoring provided via HBDHB Board and MoH. Raising Health Kids target has been met. • Active Families under 5 is funded and DHB has received additional funding from MoH • Majority of referrals are to Active Families which has 80% of children increasing healthy eating and activity.	July 2017 Māori Health Targets - 6 monthly to the Board
New actions	• Support screening in maternal programme, Well Child/Tamariki Ora and B4 School Checks	• Support training for health professionals completing screening - maternal, Well Child/Tamariki Ora and B4 School Checks.	• Completed WellChild/Plunket Health First Foods training, B4 School Check Conversation Tool training	Annually until 2020

Activities and Stakeholders				
	• Provide whānau based programmes to support lifestyle changes which support healthy weight i.e. Active Families • Support referrals to programmes via a range of pathways • Develop a clinical pathway from well child/primary care to secondary services • Support child health workforce, to deliver healthy conversations	• Contract community providers to take referrals for whānau with an overweight child (3-12 years) • Clinical pathway developed with key stakeholders- whānau, parents, children and health professionals • Healthy Conversation training delivered	• Active Families – delivered by Iron Māori and Sport HB. New contracts in place from Oct 2017. • Clinical pathway for B4 School Check complete. Working with diabetes pathway • Training in healthy conversation completed in 2016. Delivered the Healthy Food conversation tool 2017. Complete.	

Objective 4: Provide leadership in healthy eating

Indicator 4a: Monitor the implementation of the HB DHB Healthy Eating policy

Indicator 4b: Engage support from key partners

What the data shows

Hawke's Bay District Health Board policy has been updated and aligns with MoH guidelines and an implementation plan is in place, endorsed by EMT June 2016. Auckland University review of the policy has HBDHB ranked 3rd most effective policy for DHBs. Healthy Weight Strategy have been presented to the Intersectorial Forum, Napier and Hastings Councils, MoE East Coast, Priority Population Committee (Health HB) and internally across the DHB. Intersector Group has been established

Activities and Stakeholders				
	What	**How**	**Progress**	**When**
Current activity	• Share information, evidence and best practice and healthy weight data with key community partners • Show leadership by establish the HBDHB Healthy Eating Policy and implementing the Healthy @ Work work plan	• Regular updates provided via Maternal, Well Child/Tamariki Ora and B4 School Check forums. Regular meetings with community providers • Review and monitor the HBDHB Healthy Eating Policy and support the implementation of the Health @ Work work plan	• Strategy and Best Start Plan shared with - Sport HB, Mananui, Napier and Hastings Councils, HB Community Fitness Centre Trust, DHB staff and placed on DHB website. Communication Plan developed to increase awareness • Policy complete	July 2017
New actions	• Lead an equity focus by applying an equity lens to review this plan and delivered activity • Lead messaging and delivery to reduce sugar intake • Align HBDHB Healthy Eating Policy with national food and beverage guidelines	• Equity assessment written and finding used to refine this plan to improve response to equity • Cross-sector activity includes a sugar reduction focus • Framework/process implemented for cross-sector approach and inter-agency activity reported	• All contracts have targets for Māori and Pasifika, resources are tested with Māori and Pasifika whānau and equity lens was applied to funding. • Water only and healthy food has been delivered in event planning, Pasifika churches, workplaces and education. • Shared Healthy Eating Strategy with Intersectorial Forum – Intersector Group	Ongoing until 2020

Activities and Stakeholders				
	• Develop a process for a cross-sector approach to support healthy eating environments • Influence key service delivery stakeholders to maintain best practise and consistent messaging • Continue engagement with community particularly key influencers for Māori and Pasifika i.e. marae and church leaders	• Hauora, general practice, LMCs, contracted community providers provide national messages consistently to whānau, community and their workplace • Key activities Waitangi Day celebrations - policy/guidance document development Ngāti Kahungunu Iwi Incorporated and engagement with Pasifika church leaders	establish and setting out leadership activities • Messaging is “water is the best drink” and promoting the MoH Nutrition Guidelines • We have worked with the Te Matatini steering group and promoted water and healthy food choices (with a reduction in high fat, sugar and salt foods). The Healthy Events – Food guide material has been reviewed by Ngāti Kahungunu Iwi (events and comms staff), available on DHB website. • Partner agencies have delivered policies – HDC has “no fizzy” at the venues, Sport HB is working clubs and code to implement “water is the best drink” and healthy food options.	

Appendix Two

DRAFT
SECOND MEASUREMENT POINT FOR CHILD WEIGHT

PURPOSE

1. To provide a recommendation for a second weight measurement point for Hawke's Bay children.
2. To monitor the impact of key interventions designed to increase childhood healthy weight.

BACKGROUND

Hawke's Bay District Health Board (Hawke's Bay DHB) developed a Healthy Weight Strategy and Best Start Plan to direct and coordinate the activity supporting population increases in healthy weight for Hawkes's Bay. These documents are based on evidence (both local and international) that illustrated how early intervention, environmental changes and a range of approaches (settings, whānau programmes, screening and leadership) have the greatest impact.

The National Obesity Plan was developed (2015) and a national target implemented in (2016) by Ministry of Health. This Plan is currently being reviewed that will now better reflect the evidence. The national target – Raising Healthy Kids, is:

> *"By December 2017, 95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions." Obese children are defined as being 98th percentile and above for BMI.*

This target measures the delivery of services to obese four year old children and their whānau. To show the impact of this activity and other activities included in the Best Start Plan, an additional measurement point is required.

The weight data collected at the B4SC provides a national and regional population measurement point for four year old children, which can show over time, the impact of the activities delivered from conception to 4-years. In Hawke's Bay, 98% of children complete a B4SC and the data is collected by nurses and is monitored so provides data that is reliable and representative.

INTRODUCTION

This report will cover the following questions:

- What measure is used? Includes BMI, waist measurement and skin folds. These are regarded as the most effective weight measurement for children.
- Which age provides the most effective point for measurement for Hawke's Bay? Assessed using the following criteria – accessibility to a health professional (including reducing impact/harm for children), age prevalence of obesity, effective measurement point for population change.
- Who collects the weight data, where is the data stored and how is it used?
- How will data be collected? Population coverage – targeted groups, opportunistic versus screening approaches and which setting. To include; data collection risk and costs, consent, privacy, psychosocial risks, obligation to intervene and financial costs.

THE MEASURES

There are three measures that effectively quantify obesity; BMI. waist measurement and skin folds. Below is a comparison table.

Table 1

Measure	Effectiveness	Current use in NZ	Comparison
Waist measurement	• Generally seen as an effective anthrometric measure. • Publications (Elaine Rush) have been rigorously reviewed.	• Used for 10 years. • Project Energise Measuring impact	No opportunity to compare data in Hawke's Bay
Skin fold measures	Effective in establish fat levels	Technical process and interpreting. Not widely used.	No opportunity to compare data in Hawke's Bay
BMI	• More widely used measures provides a good population measure. • International data provides pattern for weight gain and obesity.	• Used in the B4SC • Limitation is providing information on individuals i.e. risk – does not measure the level of 'fat'. • There have been challenges in terms of relevance for Māori and Pasifika	Will provide an efficient comparison to measure change over time

(MoH – https://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/nga-tauwehe-tupono-me-te-marumaru-risk-and-protective-factors/body-size)

As noted in Table 1, BMI is the best measure for comparing data in Hawke's Bay and as a population indicator, to measure impact of Best Start activity. If we wish to use this as the screening tool there will need to be a clinical judgement made on the category and the need for referrals.

Recommendation

- Use BMI as the measure.

THE AGE GROUPS

There are three points to consider:

1. Timing in relation to the B4SC (at 4-years) - how long will it take for lifestyle changes to have an impact?
2. Developmental trends in growth - when are children more likely to be obese?
3. Interaction with a health professional - what systematic health checks/activity could support measuring BMI?

4-6 years

There is a comprehensive measure for 4-year olds (B4SC). Children require time to grow into their weight and embed lifestyle changes. International data indicates a low prevalence of obesity.
There is one scheduled check – oral health.

7-9 years

No current measure for this group. The interventions from 4-years onward should be having an effect. The prevalence of obesity would be higher so should be able to measure change.
There is one scheduled check – oral health.

10-12 years
There is no current measure for this age group, however young people in low decile schools are screened a 12-13-years via the HEADSS assessment. International evidence notes little ability to influence behaviour change or reduce obesity from 10-years onward. Prevalence of obesity is higher.
There are two checks - oral health and immunisation.

In summary, data is collated at 4-years and 12-13-years. Older age groups have a higher prevalence of obesity. 7-9-years have high levels of engagement in school. Oral health is the only consistent scheduled health check.

Recommendation
- Measure at 8-years which will allow three measurement points, but requires the implementation of a new programme.

WHO AND WHERE BMI IS COLLECTED?
Critical factors are clinical competence, ability to manage psychosocial impact, provide privacy and be able to support individuals/whānau with lifestyle changes and referrals.

There are two settings with eight year old children enrolment – schools and primary care. Given the above criteria, the person carrying out the BMI measure should be a health professional, as it is their professional conduct that will; ensure competence, understand psychosocial issues and provide a need for privacy and support.

The literature identifies schools as the most effective setting as programmes delivered in schools demonstrate high levels of participation – Rheumatic Fever Throat Swabbing, HEADSS assessments and immunisation. Primary care would provide opportunistic measurement and screening and can provide better tracking of individual weight patterns over time. Primary care also deliver the B4SC, however this is a funded programme within a national support structure.

Recommendation
- A health professional (e.g. dental nurse, public health nurse or school nurse) employed and delivering in a school setting. Work toward the individual's information going to primary care as part of the process.

HOW BMI IS COLLECTED?
To effectively implement a population-based measure the programme needs to:
- Engage schools - be a mutually beneficial programme
- Engage health professionals – include training and ongoing development. Have linked to primary care.
- Establish consent from child and whānau
- Have a programme to support and deliver – include measuring resources, conversation tool, information for child and whānau, referral pathways and school activities
- Database to collect the information and protocols for monitoring, analysing and reporting the data.
- Identify the resources to support both the screening programme and the data analysis.

Opportunistic screening will not provide the population level data needed. Universal screening or measuring will require a high level of resource investment. The middle ground is alignment with the 12-13-year old HEADSS assessment by focussing on high deprivation communities. High deprivation schools have access to a school nursing service, Public Health Nurses and Health Promoting Schools. There is the potential to look at include measuring as part of this delivery. Prevalence of obesity rates are higher in high deprivation communities (which have higher proportions of Māori and Pasifika living in them).

Currently interventions have been targeted at high deprivation communities. Screening or measuring in school in high deprivation communities will effectively measure the impact of interventions.

Developing a programme provides the structure to ensure effective measurement and the opportunity to provide individual follow-up to respond to overweight and obese children via education or referrals to programmes which support lifestyle changes. It also mean population data can be used at the schools level to inform practise.

OVERALL RECOMMENDATION

BMI measurement for children aged 4-years, 8-years and 13-years be collected via existing screening programmes (B4SC and HEADSS) and the implementation of a new school based programme for 8-year olds in high deprivation communities.

This would

- Limit increases to workloads and maximise the current data
- Target the most likely groups to have high obesity
- Provide data comparison opportunities including change over time for age groups and impact of population healthy weight activities
- Allow the Health Survey to be used that will provide cross-reference data and a way to look at equity
- Provide opportunities to further promote healthy weight activities in schools by sharing data, providing resources and supporting school outcomes.

NEXT STEPS

- Investigate delivery options and resourcing
- Establish a working group to develop the process, supporting documents and training
- Engage with schools to gain support via understanding and mutual benefit
- Deliver a trial in term four 2018, review and plan for 2019 roll out
- Roll out programme term two 2019
- Begin analysis of data in September 2019

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora: Improving First Specialist Appointment Access** 68 **(Local indicator formerly "Did Not Attend")**
	For the attention of: **HBDHB Board**
Document Owner	Sharon Mason (Executive Director of Provider Services)
Document Author(s)	Carleine Receveur (Operations Director); Jacqui Mabin (Administration Manager); Justin Nguma (Senior Health and Social Policy Advisor) and Taina Puketapu (Kaitakawaenga)
Reviewed by	Health Leadership Team, Executive Management Team, Maori Relationship Board, HB Clinical Council and HB Health Consumer Council
Month/Year	May, 2018
Purpose	Discussion for Monitoring
Previous Consideration Discussions	As per scheduled Te Ara Whakawaiora reporting and discussions
Contribution to Goals and Strategic Implications	Te Ara Whakawaiora (TAW) is an exception based report, drawn from AMHP quarterly reporting, and led by TAW Champions. Specific non-performing indicators are identified by the Māori Health Service which are then scheduled for reporting on progress from committees through to Board.
Impact on Reducing Inequities/Disparities	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
Financial/Budget Impact	Business As Usual

RECOMMENDATION:

That the HBDHB Board:

1. **Note** the contents of this report, specifically:
    - The current performance of this target
    - Review of activities to support access for First Specialist Assessments
    - Recommendations

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HAWKE'S BAY
District Health Board
Whakawāteatia

Te Ara Whakawaiora: Improving FSA Access Local indicator

Authors:	Carleine Receveur (Operations Director); Jacqui Mabin (Administration Manager) Justin Nguma (Senior Health and Social Policy Advisor) and Tania Puketapu (Kaitakawaenga)
Date:	**May 2018**

OVERVIEW

Following concerns from the National Māori General Managers (Tumu Whakarae) about the slow pace of progress on some indicators in reducing health disparities for Māori, the Hawke's Bay DHB Executive Management Team (EMT) decided to establish a championship role in 2013 for each of the indicators to spur faster traction on implementation. The Champions were tasked to provide the Board with a monthly Te Ara Whakawaiora (TAW) exceptions based report drawn from AMHP quarterly reporting highlighting the implementation progress on these indicators along with recommendations for improvement towards achievement of the annual targets and reducing health disparities. This report is from Sharon Mason, Champion for Improving FSA Access Indicator.

MĀORI HEALTH PLAN INDICATOR: Improving FSA Access

Historically Māori and Pacific people have endured lower access rates to First Specialist Assessments (FSAs) compared to other people in Hawke's Bay. This is a result of missing their FSAs. Did not attend (DNA) is a label that has been used to describe this behaviour irrespective of the circumstances in which it takes place. This label has raised concerns over the years because of the negative connotation often associated with it. Improving FSA Access has now been accepted as a new name for this indicator because in actual fact this indicator is about accessibility to health advice and or treatment services. The rates of DNA will still continue to be used as a measure of accessibility to FSAs. The higher the DNA rates the poor the levels of accessibility to FSAs.
Apparently the DNA rates for Māori and Pacific people are 3-4 times higher than those of other people in Hawke's Bay therefore they are not gaining the benefit of timely health advice and or treatment.
The indicator target for FSA DNA rate of <7.5% was introduced into the 2014 – 15 Annual Māori Health Plan (AMHP), with specific actions to implement a DNA project across all ESPI FSA clinics. It is important to note that this indicator is for FSA only, and does not include DNA's for Follow Ups.

The indicator reports on the ESPI specialties as defined by the Ministry of Health (MoH). These reports provide important information on how well DHB's are managing access to their health services.

The 18 ESPI's included in the DNA report are as follows:
Dental, Paediatric Medical, Ear Nose Throat (ENT), General Surgery, Ophthalmology, Orthopaedic Fracture, Urology, Gynaecology, Neurology, Rheumatology, Respiratory Medicine, Renal Medicine, Gastro-Entomology, Maxillo-Facial, Dermatology, General Medicine, Endocrinology and Cardiology.

WHY IS THIS INDICATOR IMPORTANT?

The indicator reflects how well our consumers are accessing services for treatment across the elective pathway at the HBDHB. Low DNA rates across all populations signify an equitable health care system that has good access for all, and ensures consumers are benefiting equally from timely health care advice and treatment. High DNA rates indicate that there are significant barriers preventing consumers from accessing services across the HBDHB, which has a negative impact on the population of Hawkes Bay. Variations in DNA across different groups of consumers in Hawke's Bay signify there are more complex issues to address that are adversely effecting some groups of the population whilst others benefit.

The DNA indicator measures and monitors Māori attendance rates in Outpatient specialist clinics and compares those rates against Pacific and Other populations. This data help us to target areas within our DHB that need more support and engagement to reduce barriers currently preventing the Māori population from accessing health care services.

The DNA rate is indicative of how efficient the elective services are currently operating. An efficient elective service ensures resources are used in the best possible way to ensure equitable health outcomes for all. Reducing DNA rates ensures full clinic and theatre utilisation, and reduced waste within the system.

CHAMPION'S UPDATE

The last TAW paper presented to the EMT, HB Health Consumer Council, and MRB by the Indicator Champion was in June 2015. In this paper the Indicator Champion highlighted a number of initiatives that had been planned and were being implemented to progress the indicator performance. These included the recommendations made in the initial assessment of the DNA problem in 2012[1]: DNA policy referrals; text to remind; the DNA project; and Kaitakawaenga DNA. We would specifically like to highlight the progress of the DNA project here because of its implications to the DNA work streams. Phase two of the DNA project commenced on 1 July 2014, targeting the nine specialties with high Māori and Pacific DNA volumes and rates. Since the beginning of 2015, the scope increased to cover the 18 ESPIs outlined above. The DNA Project Steering Group met in March 2015 and agreed to further extend the project until the end of September 2015. The DNA project focused on the following objectives:

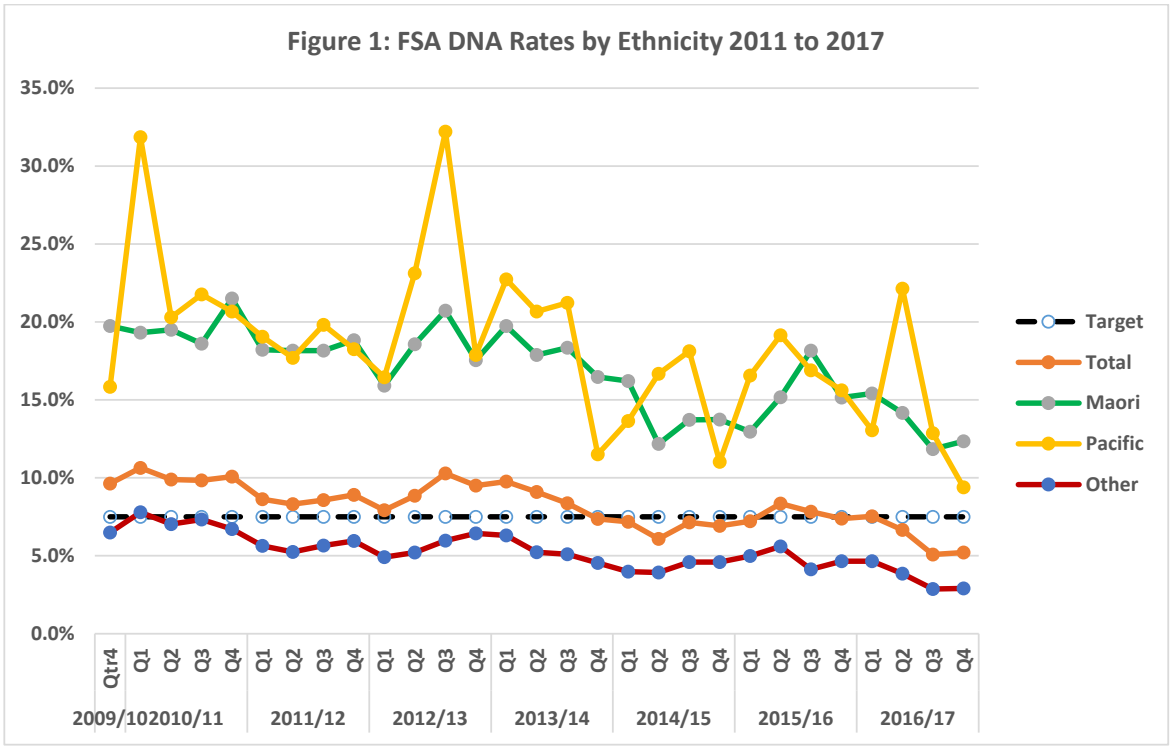
- Develop KPI and reporting systems to support effective tracking of DNA project implementation across the service
- Engage the services of two Kaitakawaenga and equip them with transport support for DNA tracing across the district.
- Review clinic information to identify speciality clinics with high variations in DNA rates for DNA tracing.
- Review and analyse patient journey within elective and out-patients environment to inform system changes that will improve the patient clinic experiences and outcomes.
- Carry out health literacy activities to promote patients and whanau understanding of health implications of DNA and encourage and support their clinic attendance for specialist appointment.
- Propose and implement system changes including staff education as needed to enhance documentation and confirmation of responsibilities/ ownership for systems that support positive patient journey and minimised DNA.
- Propose systems changes needed for sustainability beyond the project through policy, practice expectations, and related accountabilities for performance monitoring by the Board.

[1] *Paul Malan,A Report on 'Did Not Attend' Rates (DNAs) at Hawke's Bay District Health Board, May 2012*

It should be noted here that some of the objectives of the projects have been achieved while others are currently being addressed through collaboration between the Administration and Māori Health Service.

Lessons Learnt from the DNA Project Implementation

As shown in Figure 1, through the proactive role of Kaitakawaenga the DNA project made significant progress in minimizing the DNA rates since its inception in 2013/14 reducing the DNA rates among Māori from 19.7% in Q1 2013/14 to12.2% in Q2 2014/15 and trending towards the target of 7.5% within one year of operation. While the downward trend is encouraging, the disparities between Māori and non-Māori on this indicator continues to remain high which is still a major concern. Nonetheless, the work already done and continues to be done by Kaitakawaenga is to be commended and encouraged for effectively tracing and supporting the 'true' hard to reach patients to attend their FSA and follow up appointments. In the course of implementing this project however, a number of lessons/factors influencing patient behaviour were noted[2]. These are divided into two major categories: health system (i.e. poor communication with patients and whānau, and poor administrative services); and patient/whanau related factors (i.e. never got the mail, forgetting appointments, lack of transport, lack of financial resources, and competing whanau demands).



Source: Ministry of Health.

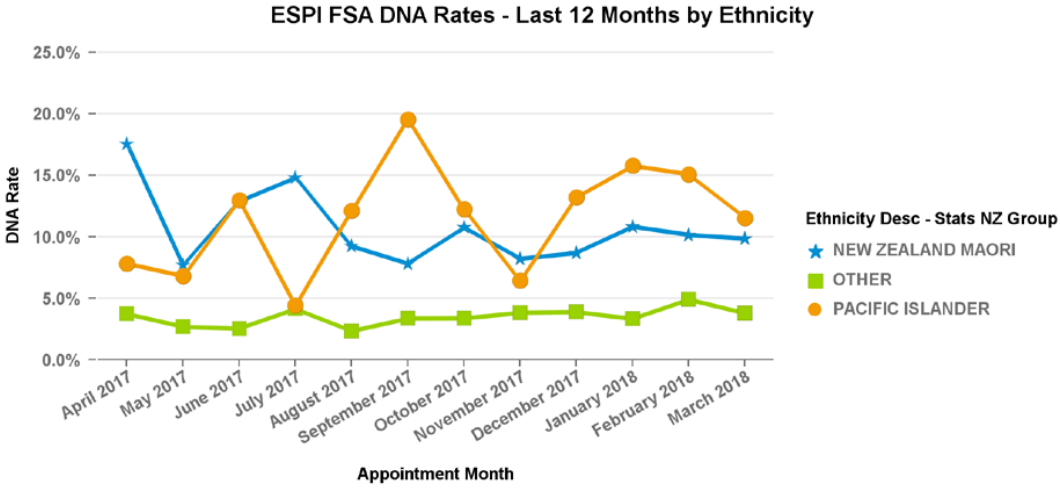
[2]*Nguma, J; Meihana, D; Raihania-White, W; Receveur, C; and Mobin, J: Policy and Health System Implications of the Hawkes Bay District Health Board (HBDHB) DNA Project, A paper presented at the Tu Kaha Conference in Wellington, 2016.*

Current Performance

Over the 2016– 17 period, the organization has made considerable improvement in strengthening communication channels and administrative services across the service. Strengthening the partnership between the Administration and Māori Health Services, for example, has been instrumental in continued improvement of access to FSA among Māori as shown in Figure 2. The Māori DNA rates now has been hovering around the 10 – 11%. Overall the total DNA is 7.1%, below the target of 7.5%.

Improving technology and clinic scheduling will be vital, along with improving relationships across the health sector and understanding of our changing consumer needs. To continue to reduce health disparity between Māori and Other populations, HBDHB needs to continue its shift into a proactive, agile state that can provide better flexibility to accommodate the changing needs of the Hawke's Bay population.

Figure: 2 FSA DNA rates by ethnicity



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CHAMPION'S REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THIS INDICATOR

1. Amalgamation of Transform and Sustain projects under DNA project

The key findings from the DNA project included poor communication with patients /whanau and poor Administration Services as the key areas contributing to the 19% DNA rate among Māori. In 2015 the HBDHB transferred the remaining DNA project work streams across to the Customer Focused Booking Project, as there was a natural alignment of goals.

2. Customer Focused Booking

Customer Focused Booking was introduced across Outpatient Booking over 2016 / 17 period following recognition that standardisation was needed across all ESPI services, and that it was critical to have the customer at the centre of the Booking process. Customer Focused Booking is now business as usual for Administration Services, who are committed towards driving efficiencies and improving communication with the Consumer.

A number of work streams were created to improve engagement and communication with HBDHB's consumers / whanau, including developing proactive processes to avoid DNA. These work streams have all had a positive impact on DNA levels. In 2017 our Māori population has seen DNA levels drop consistently to 10 – 11%. More importantly there are now mechanisms in place to ensure that the most vulnerable population remain visible, and are not falling through cracks in the system.

A number of initiatives carried out over 2016 / 17 to improve communication and Administration Services included updating desk diaries and standardising process across all booking specialties. Cross training of booking staff was carried out to ensure better cross cover and customer service. Expectations were set with the Booking team that all New Patients must be called prior to Booking FSA, and referred to Kaitakawaenga if patients were Māori and couldn't be contacted prior to their FSA.

Demographic data collection processes were reviewed and updated, with auditing and monitoring processes put in place, and a policy of 'all phones must be answered' was also introduced to ensure confirmations or cancellations were captured, and to ensure consumers were given the opportunity to talk with a person rather than be directed to voicemail.

Regular meetings with staff and Kaitakawaenga ensure a customer focus is retained and a forward looking culture driving for continuous improvement is encouraged as business as usual for the Outpatient Booking staff.

3. DNA Policy

The DNA project highlighted the need to review the DNA policy, as there were inconsistencies among staff regarding the definition of DNA. Following this observation, current efforts have focused on ensuring that all Booking staff have a uniform understanding of what constitutes a DNA, and record DNA consistently against a patient 'that does not communicate right up until the assessment is due to occur'.

The current DNA policy is a reactive and not preventative and can only come into effect once a DNA has occurred. Administration Services and Kaitakawaenga have successfully trailed and are using a preventative pathway that now needs to be captured in the new DNA policy to make the policy more effective across the HBDHB.

Outpatient Bookers refer Māori patients to Māori Health Services if they cannot be contacted prior to FSA. This allows the Kaitakawaenga an opportunity to engage before a DNA occurs, thus minimising opportunity for DNA, and ensures better utilisation of clinics. There is now a strong working partnership between Booking and Kaitakawaenga as both teams work together to take ownership to improve access to FSA appointments.

4. Text to Remind

Technical enhancements to the text to remind system have helped lead to a reduction in DNA. All clinics managed via the Outpatient Booking Centre issue a minimum of 1 text reminder requesting confirmation of the patient's attendance 72 hours prior to appointment. All bookers are monitoring responses daily and updating patient responses on the Electronic Clinical Application (ECA). This ensures clinics are fully utilised and wasted appointments minimalised.

Text replies to confirm appointments were made free of charge to consumers in 2017, following a change in contract with the HBDHB's telecommunications provider. This removed the barrier of 'lack of credit' on consumers phones, enabling consumers to text responses back to the HBDHB at no cost.

5. Regular review of the Issues Register to improve DNA results

The monthly DNA report is reviewed by the Outpatient Booking team on a monthly basis with Kaitakawaenga. This allows opportunity for all to discuss reasons behind DNA's over the last month, and as a group take ownership around how to avoid the same problem next month. The fact that DNA is a KPI for the Outpatient Booking staff helps to drive Bookers to minimise opportunity for DNA in the future.

6. Demographic Data Collection

Poor demographic data collection has been a major factor behind high DNA. A lack of policy meant a lack of consistency, expectation and guidance on the principles of demographic data collection.

A new policy was created in 2017 that provided HBDHB staff with the guiding principles of best practise when collecting demographic details from patients. Administration staff were all given training on the policy, and are continuously reminded of the importance of checking patient demographics at every opportunity.

Regular monthly auditing of Patient Demographic forms generating from the Emergency Department (ED) and the Outpatient Villas has led to an increase in quality of demographic information now being entered into ECA. Corrective action for staff members who are not accurately capturing demographic information is taken monthly if necessary.

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CHAMPION'S REPORT OF ACTIVITY THAT WILL OCCUR TO INCREASE PERFORMANCE OF THIS INDICATOR

- **Transition to a purpose built Text to Remind solution.**

Currently the text to remind system is an in-house designed system built onto ECA. It does not have the full technical capacity most text to remind systems have on the market today, and is very labour intensive for the Outpatient Booking team. An automated text to remind system that automatically updates ECA would enable the Outpatient Bookers to more clearly identify those patients who have not confirmed their bookings, and would save the Outpatient Booking team hours of searching and clicking of the mouse to manually confirm clinic appointments.

- **Review the current DNA Policy and promote an orientation towards improving access**

It is now timely to review the DNA policy to reflect the preventative pathway now firmly embedded between Outpatient Booking and Māori Health Services. This will ensure guidance and standardisation across all services at the HBDHB as well as orientating the organisation to a proactive improving access perspective.

- **Implementation of an Elective Pathway Project**

Customer Focused Booking identified a number of issues across the Elective Pathway that prohibited the roll out of the online patient booking system 'uBook'. The system currently experiences issues in relation to rescheduling, constraints in the process to book clinics and theatre lists more than 2 weeks out, and high levels of urgent appointments. Systems improvements are required to enable the implementing of the online patient booking system. This is part of a wider conversation within Health Services, recognising that this body of work is across directorate teams and would require resourcing and prioritisation.

RECOMMENDATIONS FROM TARGET CHAMPION

Key Recommendation	Description	Responsible	Timeframe
Transition to a purpose built Text to Remind solution	Automated text to remind system that automatically updates ECA would enable the Outpatient Bookers to more clearly identify those patients who have not confirmed their bookings,	IS and Administration services	To be confirmed (dependent on IS prioritisation)
Review and update the current DNA Policy	Amend the policy to include an orientation towards improving access to FSA and proactive management	Maori Health and Administration services	Draft completed by Q2 18/19
Implementation of an Elective Pathway Project	Improvement of patient flow	Partnership approach with Surgical, Medical and Operations Directorate	Commence planning Q2 18/19

RECOMMENDATION:

That the HBDHB Board:

1. **Note** the contents of this report, specifically:
    - The current performance of this target
    - Review of activities to support access for First Specialist Assessments
    - Recommendations

HAWKE'S BAY District Health Board Whakawāteatia	**Human Resource KPIs (Quarter 3 January-March 2018)** 69
	For the attention of: **HBDHB Board**
Document Owner: Document Author:	Kate Coley, Executive Director of People & Quality Jim Scott, Workforce Analyst
Reviewed by:	Executive Management Team
Month:	May 2018
Consideration:	Monitoring

RECOMMENDATION

That the HBDHB Board:

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

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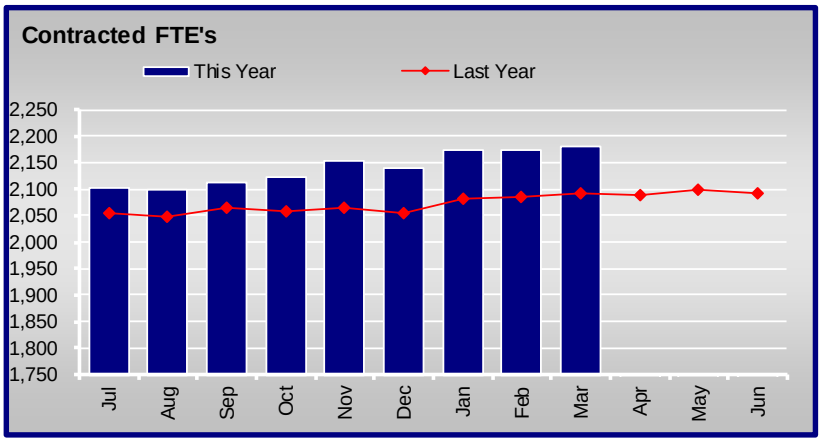
Summary of KPI progress

The following is a summary of the status of each of the KPI measures in this report. For full details refer to the appropriate page. Mid-sized DHBs are Hawkes Bay, Bay of Plenty, Hutt Valley, MidCentral, Nelson Marlborough and Northland.

KPI Measure	Status	Comment	20 DHB Ranking (1 – best)	6 mid-sized DHB ranking (1 = best)
Headcount and positions	Amber	Increases over last year which are within budget. This will need to be considered in conjunction with the Financial result.		
Sick Leave	Amber	Slightly higher than last year. Ongoing monitoring and reporting. Currently testing additional reporting to identify extended sick leave, ACC etc. within the nursing workforce which will be rolled out across all professional groups so that managers are able to support staff and ensure relevant processes are followed.	6	2
Lost Time Injuries	Green	Improvement on last year. Work continues to ensure that we support our staff with injuries and that return to work programmes are implemented in conjunction with the individual and their manager.		
Staff Turnover	Green	Within quarterly and yearly targets.		
Accrued Annual Leave 2+ years	Amber	Percentage similar but numbers 4 employees higher than last year. Ranked 5th best of 20 DHBs.	5	2
Accrued Annual Leave 1 to 2 years	Amber	Percentage similar but numbers higher than last year.		
Maori representation	Amber	Improvement on last year but still some way off 2017/18 target. Rank well compare to other DHBs. The Maori workforce action plan was endorsed by Board in April and regular reporting on progress will be completed on a 6 monthly basis alongside the key indicators agreed.	3	1
Pacific representation	Amber	Down slightly on last year but only 5 employees off achieving 2017/18 target.		

Headcount and positions

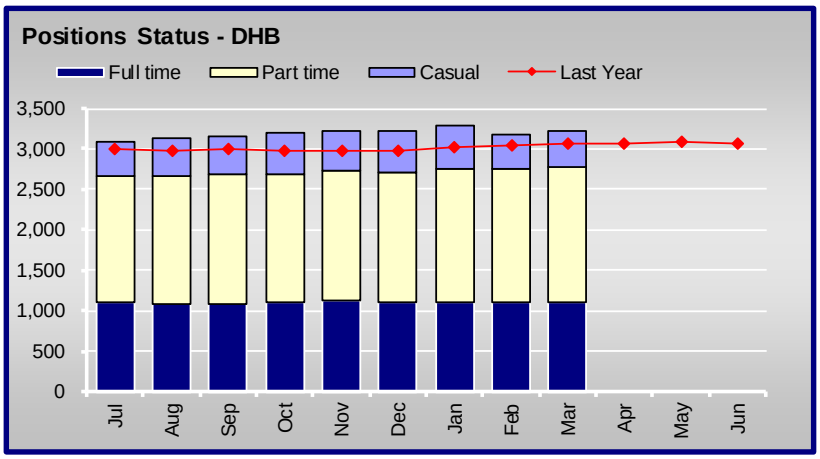
Reporting on headcount/ positions is a snapshot in time rather than an average for the month or year.



Contracted FTEs
2179.8 at 31 Mar. 2018
2091.4 at 31 Mar. 2017
= 4.2% increase

Overall increases/ (decreases)

	FTE	
Medical	17.3	6.7%
Nursing	48.7	5.7%
Allied Health	15.4	3.5%
Support	3.1	2.5%
Mge. & Admin	3.9	1.0%
Total	**88.4**	**4.2%**



Positions filled:
3216 at 31 Mar. 2018
3062 at 31 Mar. 2017
= 5.0% increase (154 positions)

Of the 3216 positions (last year in brackets):
35% are full-time (36%)
51% are part-time (51%)
14% are casual (13%)

Overall increases/ (decreases) –

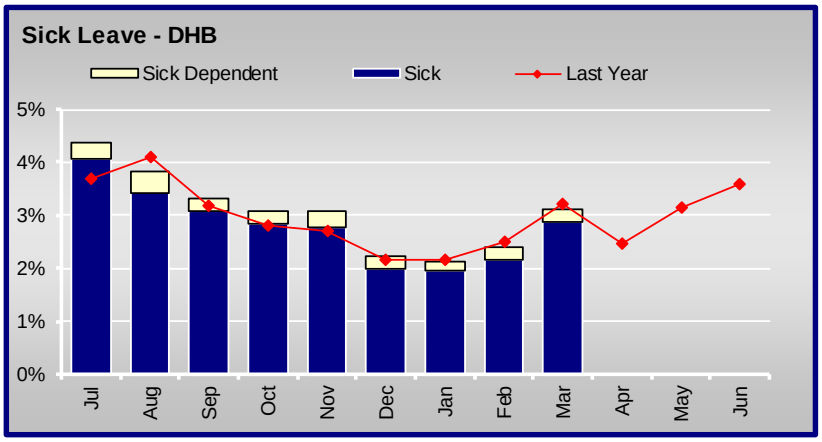
	Full time	Part time	Casual	Total	% change
Medical	13	5	3	21	7.1%
Nursing	6	54	24	84	5.5%
Allied Health	(3)	22	(3)	16	2.8%
Support	(4)	14	6	16	8.5%
Management & Admin	8	(2)	11	17	3.6%
Totals	**20**	**93**	**41**	**154**	**5.0%**

Sick Leave

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

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

Target is 2.00%



Mar. 2018 = 3.10%
Mar. 2017 = 3.23%

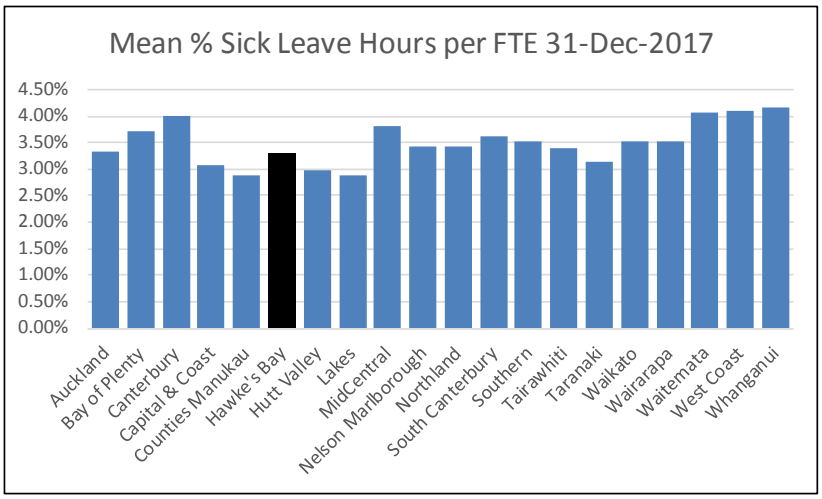
YTD Mar. '18 = 3.05%
YTD Mar. '17 = 2.95%

DHBSS have taken over reporting of the 20 DHB Comparisons and report on the mean % sick leave hours (quarter ended 31 December 2017).

Hawke's Bay DHB rank:

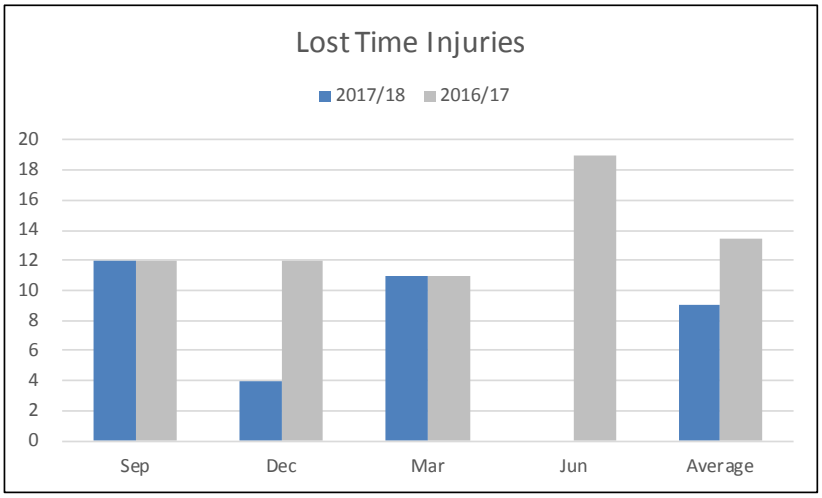
6th lowest of 20 DHBs.

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



Lost Time Injuries

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



Breakdown by quarter:

	2017/18	2016/17
Sept	12	12
Dec	4	12
Mar	11	11
Jun		19
Total	**27**	**54**
Average	*9*	*14*

Average days lost

	2017/18	2016/17
Sept	15.3	15.0
Dec	30.4	13.3
Mar	14.5	16.8
Jun		28.6
Average	*17.2*	*19.8*

Breakdown by Occupational Group – Year to date ending March

	2017/18	2016/17
Medical	0	1
Nursing	13	23
Allied Health	3	4
Support	9	5
Management & Admin	2	2
Total	**27**	**35**

Breakdown by reason for injury – Year to date ending March

	2017/18	2016/17
Being hit by object	3	3
Being hit, struck or bitten by person	2	3
Falls	4	5
Hitting objects	1	3
Muscular stress	15	19
Other	2	2
Total	**27**	**35**

There is a significant decrease in reported injuries in by Nursing. This may be because staff have not had time to report with the continued high workload due to patient numbers and complexity. There has been no peaks and lulls over the last year, as has been the norm in the past.

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

- The staff physiotherapist seeing staff for on-site treatment, and early intervention
- On-site doctor available to staff.
- Free massages for staff
- Locally based case manager, and HBDHB staff managing simple claims has enabled early, effective face to face communication ensuring staff feel cared for and supported.
- Managers aware of resources available on site for staff to access.

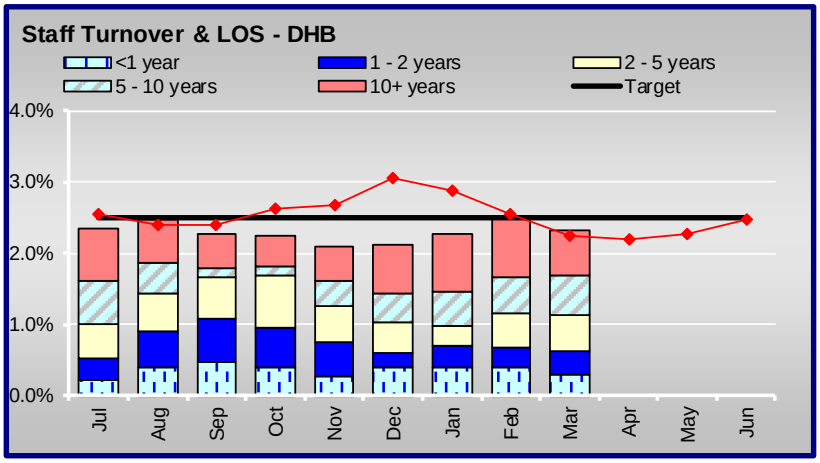
Staff Turnover

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

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

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

Target is 2.50% per quarter.



3 months ended Mar '18 = 2.30% which is below the target of 2.50%.

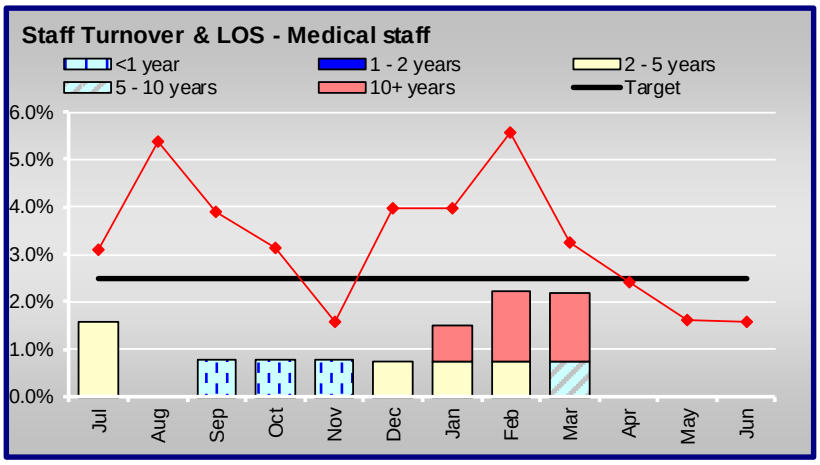
12 months to Mar '18 = 9.18% which is below the 10% annual target. See reasons for leaving below.

2387	Staff at 1 Jan '18
74	New Staff
(62)	Staff resignations
8	Change of status – mostly fixed term to permanent
2407	Staff at 31 Mar '18

Reasons for leaving included in Staff Turnover	**Quarter**	**Last 12 months**
Moving to a position outside HBDHB	19	72
Relocating outside HB	4	23
Retirement	8	37
Not returning from parental leave	2	3
Personal	7	20
Family reasons	6	12
Further education	2	3
Other reasons	7	37
Unknown reason		6
Total	**55**	**213**

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

Staff Turnover – Medical Staff



3 months ended Mar '18 = 2.19% which is below the 2.50% target.

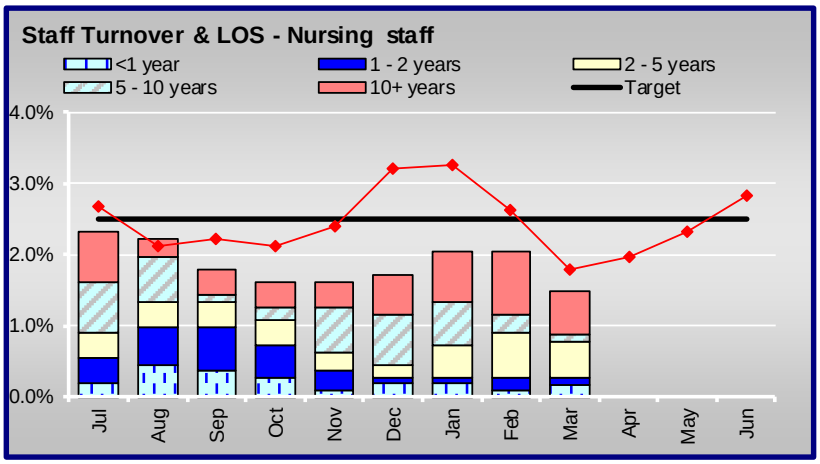
12 months to Mar '18 = 5.51% which is below the 10% annual target. See reasons below.

137	Staff at 1 Jan '18
6	New Staff
(3)	Staff resignations
0	Change of status – fixed term to permanent
0	Trf other staff group
140	Staff at 31 Mar '18

Reasons for leaving included in Staff Turnover	**Quarter**	**Last 12 months**
Moving to a position outside HBDHB	1	3
Relocating outside HB		
Retirement		
Personal		1
Family Reasons	1	1
Other reasons	1	2
Unknown reason		
Total	**3**	**7**

23

Staff Turnover – Nursing Staff



3 months ended Mar '18 = 1.48% which is below the target of 2.50%.

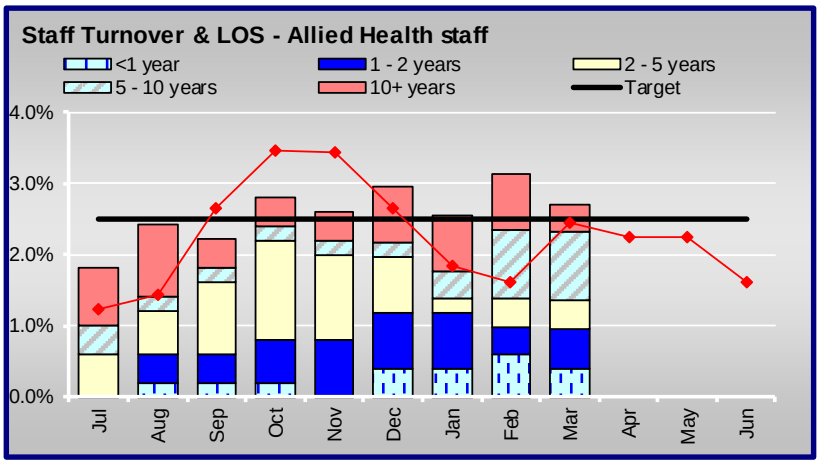
12 months to Mar '18 = 7.75% which is below the 10% annual target.

1152	Staff at 1 Jan '18
29	New Staff
(20)	Staff resignations
11	Change of status – mostly fixed term to permanent
1	Trf other staff group
1173	Staff at 31 Mar '18

Reasons for leaving included in Staff Turnover	**Quarter**	**Last 12 months**
Moving to a position outside HBDHB	3	22
Relocating outside HB		11
Retirement	3	16
Not returning from parental leave	1	1
Personal	3	9
Family reasons	2	3
Further Education	1	1
Other reasons	4	19
Unknown reason		6
Total	**17**	**88**

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

Staff Turnover – Allied Health Staff



3 months ended Mar '18 = 2.69% which is above the 2.50% target.

12 months to Mar '18 = 9.68% which is below the 10% annual target.

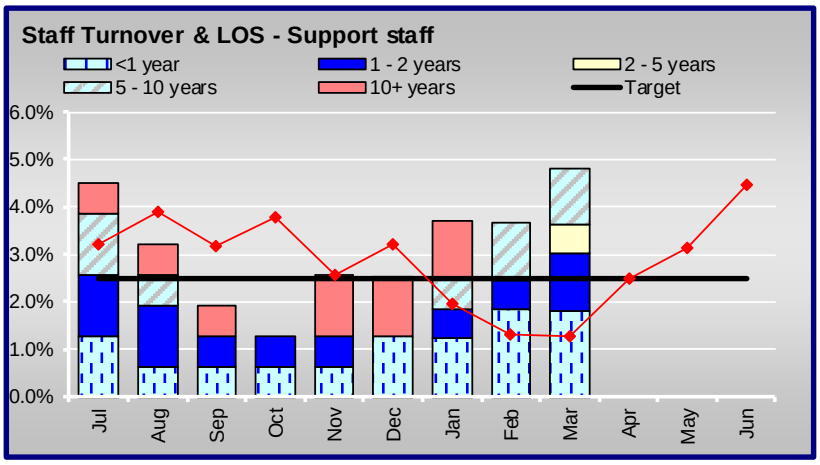
520	Staff at 1 Jan '18
16	New Staff
(16)	Staff resignations
3	Change of status – fixed term or casual to permanent
(2)	Trf other staff group
521	Staff at 31 Mar '18

Reasons for leaving included in Staff Turnover	Quarter	Last 12 months
Moving to a position outside HBDHB	3	17
Relocating outside HB	3	8
Retirement	2	6
Not returning from parental leave	1	1
Personal	1	2
Family reasons	2	4
Further education	1	2
Other reasons	1	8
Unknown reasons		
Total	**14**	**48**

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

23

Staff Turnover – Support Staff



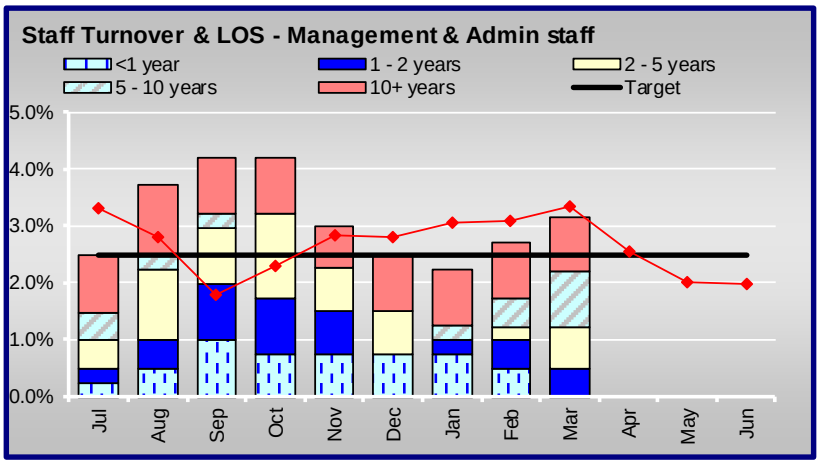
3 months ended Mar '18 = 4.82% which is above the 2.50% target.

12 months to Mar '18 = 14.01% which is above the 10% annual target. See reasons below.

166	Staff at 1 Jan '18
10	New Staff
(8)	Staff resignations
(1)	Change of status – fixed term to permanent
(1)	Trf. other staff group
166	Staff at 31 Mar '18

Reasons for leaving included in Staff Turnover	Quarter	Last 12 months
Moving to a position outside HBDHB	5	8
Relocating outside HB	1	2
Retirement		6
Not returning from parental leave		1
Personal	2	4
Family reasons		1
Further education		
Other reasons		
Unknown reason		
Total	**8**	**22**

Staff Turnover – Management & Administration Staff



3 months ended Mar '18 = 3.16% which is above the 2.50% target.

12 months to Mar '18 = 11.88% which is above the 10% annual target. See reasons below.

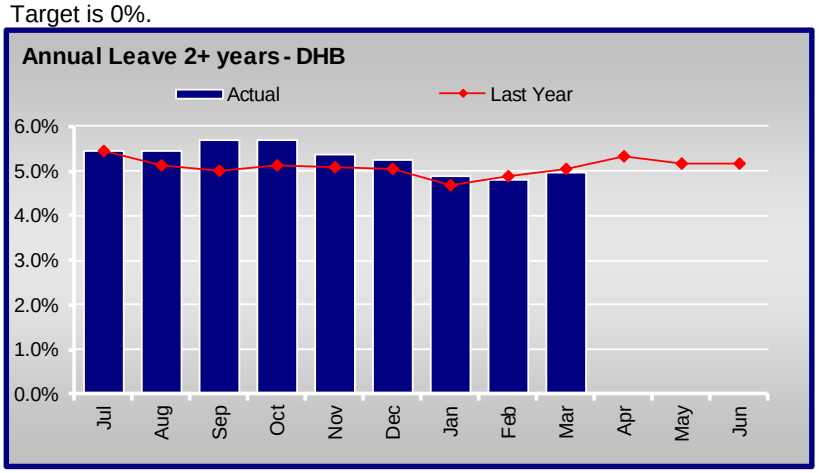
412	Staff at 1 Jan '18
13	New Staff
(15)	Staff resignations
(5)	Change of status – mostly fixed term to permanent
2	Trf from other groups
407	Staff at 31 Mar '18

Reasons for leaving included in Staff Turnover	Quarter	Last 12 months
Moving to a position outside HBDHB	7	22
Relocating outside HB		2
Retirement	3	9
Personal	1	4
Family reasons	1	3
Further education		
Other reasons	1	8
Unknown reason		
Total	**13**	**48**

Accrued Annual Leave (2+ years)

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

Target is 0%.



Mar '18 = 4.98% (138 staff)
Mar '17 = 5.04% (134 staff)
Increased by 4

The total liability at 31 March 2018 was $19.139m compared to $19.474m at 30 June 2017. This $335k improvement is made up of:

1. $395 favourable driven by a reduction in the hours owing.
2. ($60k) unfavourable driven by an increase in the average rates.

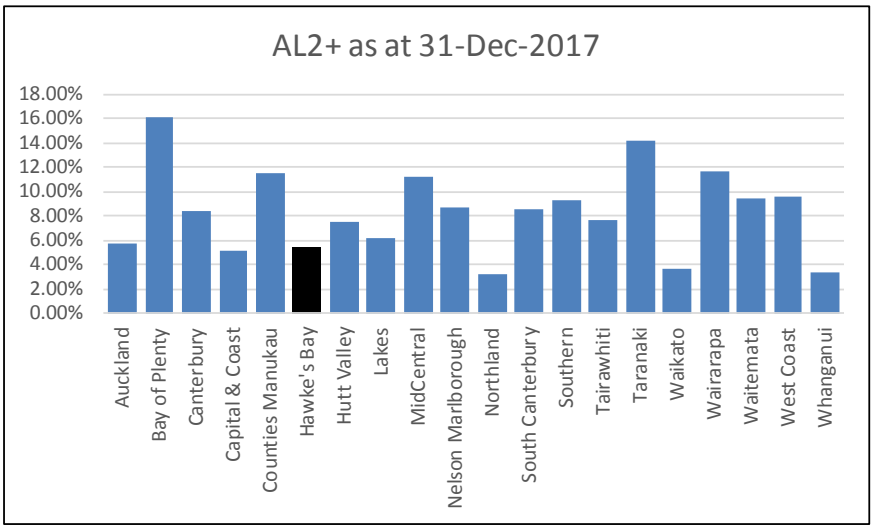
The total leave hours owed (includes statutory lieu leave etc.) has increased in the last year as has the number of employees and the average leave balance per employee:

	Total Hours Owed	Employees with leave balance	Average Leave balance (hours)
Mar. 2018	453,685	2775	163.49
Mar. 2017	433,081	2661	162.75

DHBSS have taken over reporting of the 20 DHB Comparisons and report on the annual leave percentage of employees with 2+ years of annual leave owing (at 31 December 2017). Hawke's Bay DHB rank:

5th lowest of the 20 DHBs.

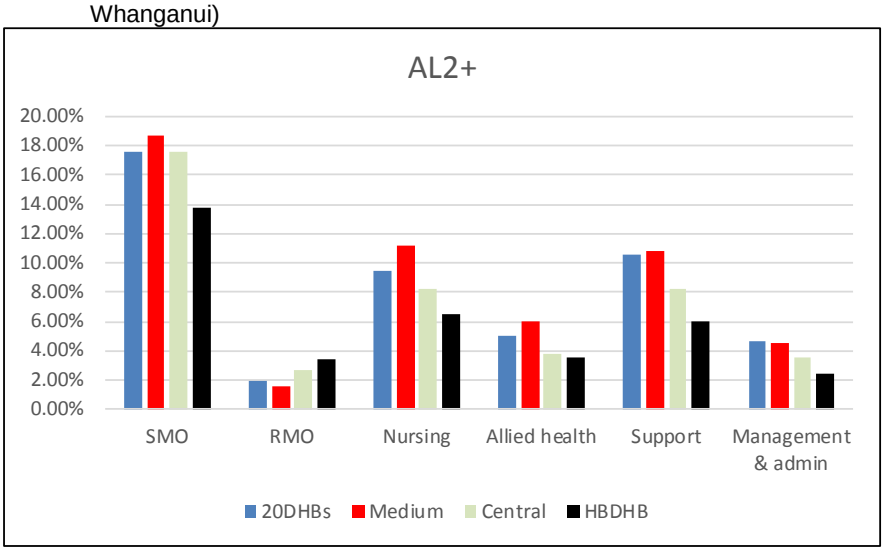
2nd lowest of the 6 mid-sized DHBs (BOP, HB, Hutt Valley, MidCentral, Nelson Marlborough and Northland)



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

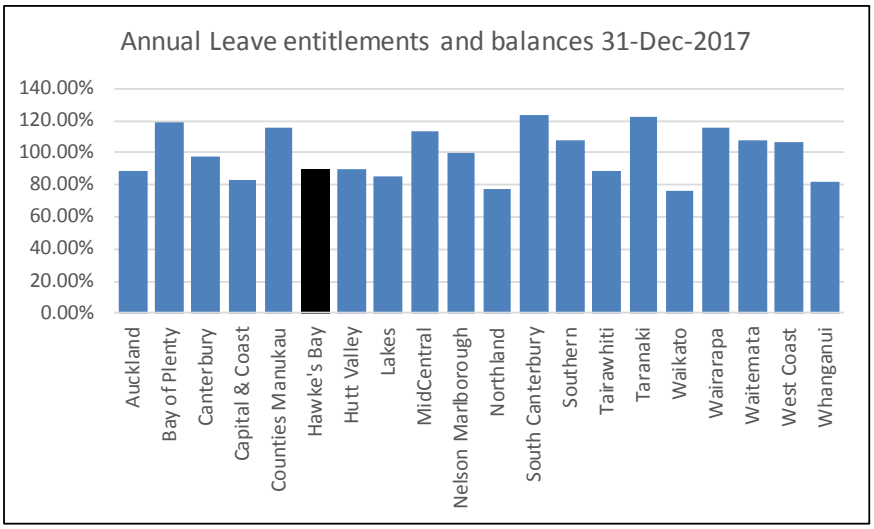
Comparsion against:

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



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

- 8th best of 20 DHBs
- 2nd best of mid sized DHBs (BOP, HB, Hutt Valley, MidCentral, Nelson Marlborough and Northland)

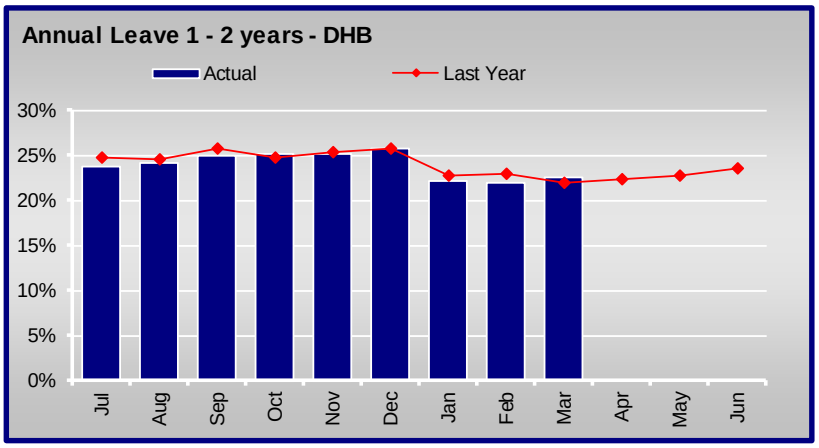


23

Accrued Annual Leave (1 – 2 years)

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

Target is 15%.



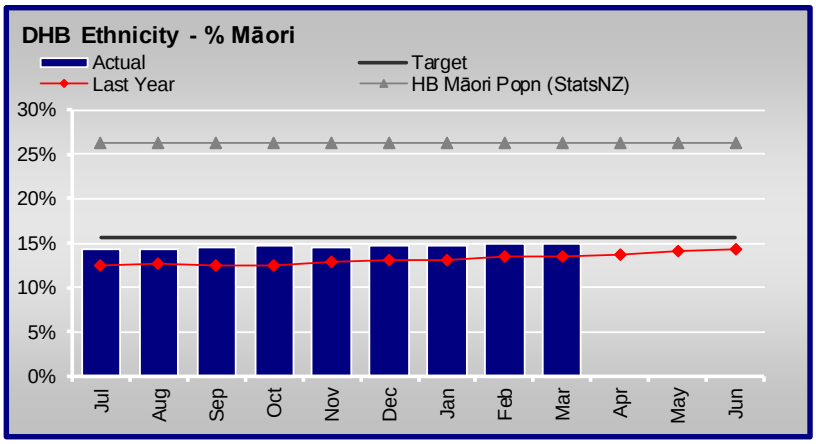
Mar '18 = 22.48% (623 staff)
Mar '17 = 21.97% (584 staff)
Slight increase in percentage of total staff with 1 to 2 years owing and 39 more employees with 1 to 2 years Annual Leave owing.

Staff Ethnicity

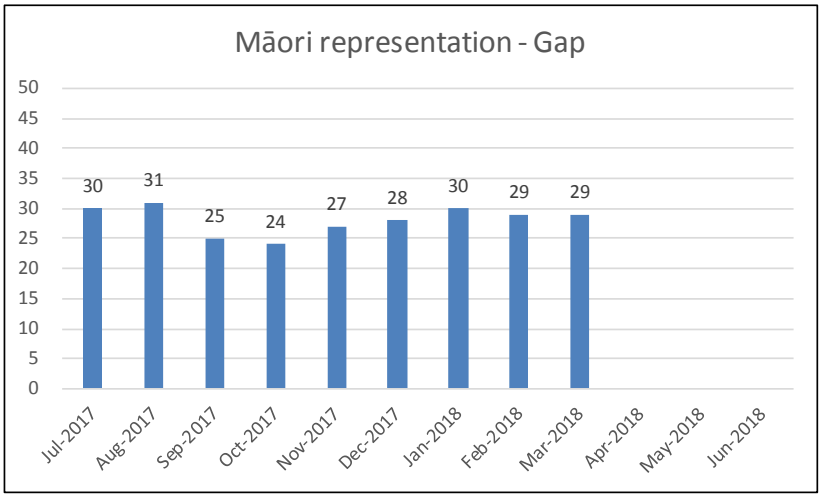
Māori representation
Measure the number of positions at HBDHB where the incumbents identify themselves as Māori

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

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



Note – at 31 March 2013 the percentage of Māori staff was 9.8% compared to 14.8% at 31 March 2018.



Māori staff representation in the Workforce:

	People	Positions
Mar. '18	14.68%	14.80%
Mar. '17	13.86%	13.46%

Mar. 2018 breakdown:

	Positions filled	% of Total
NZ & European	2347	72.98%
Maori	476	14.80%
Pacific Islands	41	1.27%
Asian	189	5.88%
Other	109	3.39%
Not known	54	1.68%
Total	**3216**	

Support staff (36.76%), and Management & Admin staff (17.42%) exceed the DHB target.

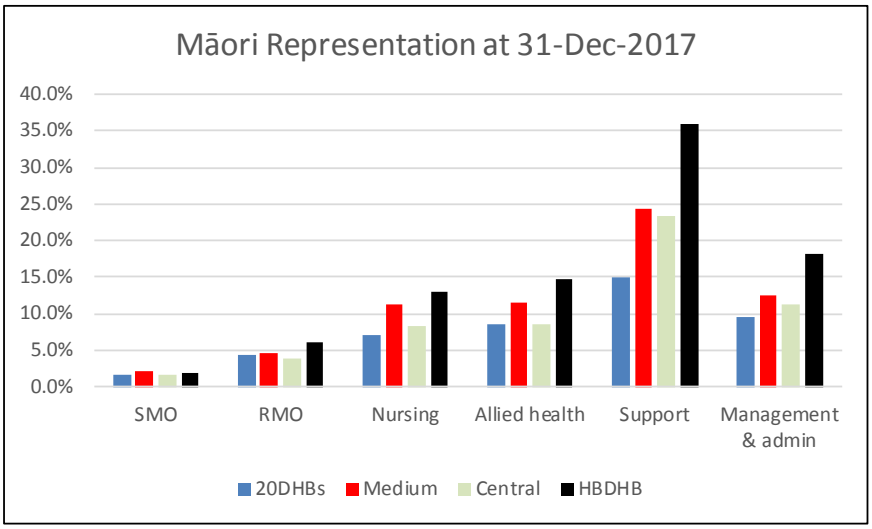
Medical (4.72%) Nursing staff (13.19%) and Allied Health staff (14.90%) are below the target.

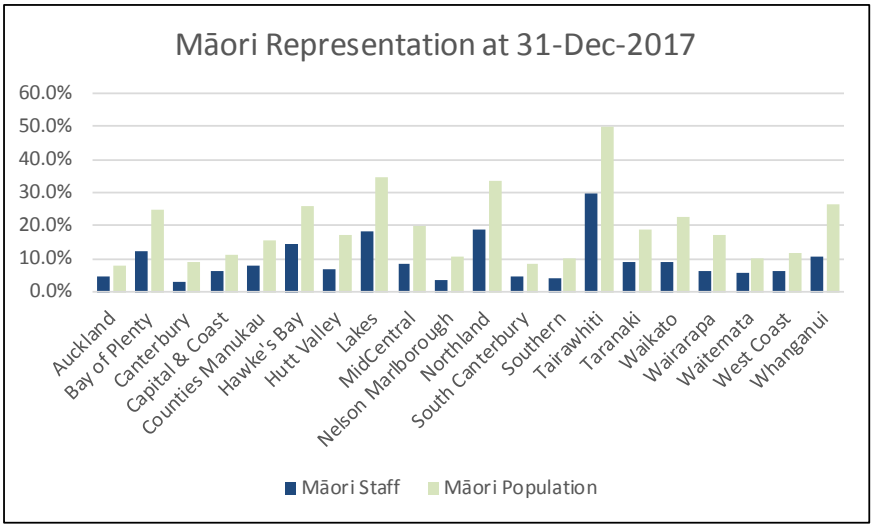
We currently have a gap of 29 people to achieve the 2017/18 target.

471	Māori Staff - 1 Jan. '18
32	New Staff
(27)	Staff resignations
0	Changes to ethnicity
476	Māori Staff – 31 Mar. '18

DHBSS have taken over reporting of the 20 DHB Comparisons and report on Ethnicity figures (to 31 December 2017). The first chart shows that Hawke's Bay DHB compares favourably against:

- 20 DHB average
- Medium sized DHBs
- Central Region DHBs





The above chart shows how DHB staffing compares against the Māori population. At 31 December 2017 Hawke's Bay DHB had 14.6% of employees identifying as Māori against the HB Māori population of 25.8%

Looking at DHBs with the highest Māori Population we rank 5th highest behind Tairawhiti, Lakes, Northland and Whanganui. Looking at DHBs with the highest Māori staffing percentages we rank 4th behind Tairawhiti, Northland and Lakes.

Summary of figures at 31 December 2017:

DHB	Maori Staff	Maori Population	Maori Representation	Rank
Tairawhiti	29.5%	50.1%	58.8%	1
Waitemata	5.7%	9.9%	57.5%	2
Hawke's Bay	14.6%	25.8%	56.5%	3
Auckland	4.5%	8.0%	55.7%	4
Northland	18.7%	33.7%	55.4%	5
Capital & Coast	6.2%	11.4%	54.5%	6
South Canterbury	4.5%	8.5%	53.2%	7
Lakes	18.4%	34.6%	53.1%	8
West Coast	6.3%	11.9%	52.8%	9
Counties Manukau	7.9%	15.7%	50.3%	10
Bay of Plenty	12.2%	24.9%	48.9%	11
Taranaki	9.1%	19.1%	47.6%	12
MidCentral	8.4%	19.9%	42.2%	13
Southern	4.1%	10.0%	40.5%	14
Hutt Valley	6.9%	17.3%	40.0%	15
Whanganui	10.6%	26.5%	39.9%	16
Waikato	8.8%	22.7%	38.9%	17
Wairarapa	6.5%	17.3%	37.6%	18
Nelson Marlborough	3.8%	10.4%	36.7%	19
Canterbury	2.9%	9.0%	32.5%	20

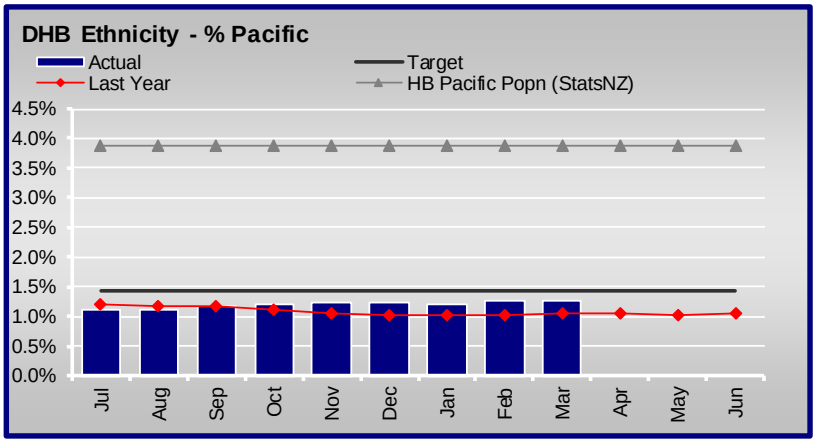
As you can see there is quite a variation in the levels of Māori staff and also quite a variation in levels of Māori Population. Table above shows how close each DHB is to their Māori Population.

Pacific representation

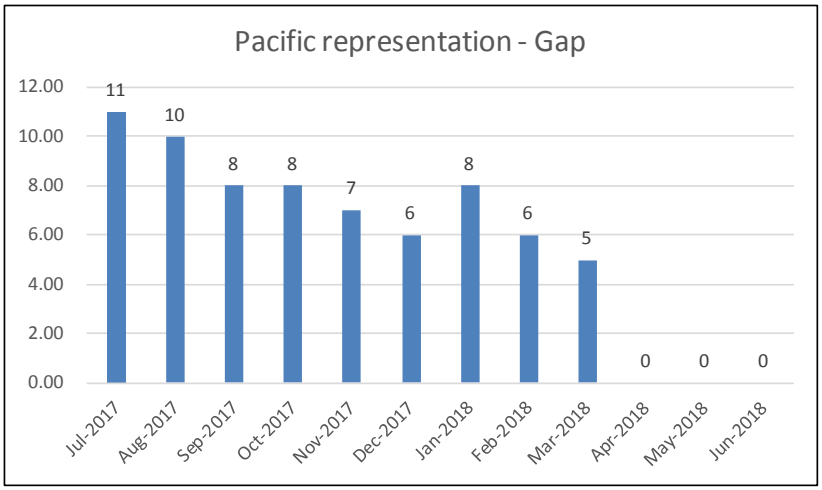
Measure the number of positions at HBDHB where the incumbents identify themselves as Pacific

Target is set at 1.44% for 2017/18. The Pacific population for HB is 3.9%

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



Note – at 31 March 2013 the percentage of Pacific staff was 1.27% the same as it is at 31 March 20187.



Pacific staff representation in the Workforce:

	People	Positions
Mar. '18	1.38%	1.27%
Mar. '17	1.16%	1.05%

Management & Admin staff (2.05%) exceed the DHB target.

Medical (0.63%) Nursing staff (1.23%), Allied Health staff (1.20%) and Support staff (0.98%) are below the target.

We currently have a gap of 5 positions to achieve the 2017/18 target.

40	Pacific Staff - 1 Jan. '18
4	New Staff
(3)	Staff resignations
	Changes to ethnicity
41	Pacific Staff 31 Mar. '18

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Performance Framework Exceptions Report Quarter 3 2017/18** 70
	For the attention of: **HBDHB Board**
Document Owner	Anne Speden, Executive Director, Corporate Services
Document Author(s)	Peter Mackenzie, Business Intelligence Analyst
Reviewed by:	Executive Management Team and Maori Relationship Board
Month/Year	May, 2018
Purpose	Monitoring
Previous Consideration Discussions	n/a
Summary	Areas of Progress: Women registered with and LMC by week 12 of pregnancy. Areas of Focus: Health Target – Shorter Stays in ED. Mental Health – Section 29 Orders. Acute Coronary Syndrome - high-risk patients receiving an angiogram within 3 days of admission.
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

24

HBDHB Performance Framework
Quarter 2 2017/18

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

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

As this report ends 31st March 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 98%, Māori at 97% and Pacific at 100% against a target of 95%.

- Number of pre-school children enrolled in DHB funded Oral Health Services – We achieved target for all ethnicities with the total rate being 8% which is below favourable to the target of <10%.

- Time from referral receipt to initial Cranford Hospice contact within 48 hours – We continue to achieve the target of 80% with this quarter's results at 94%

- DNA – Overall we have favourably remained at 5.7% which is below the target of 7.5%.

Areas of Progress

- Women registered with and LMC by week 12 of their pregnancy – We have improved overall from 57.9% to 67.1% in quarter 3, there is also improvement in the Māori result from 50% to 52.4% and Pacific 35.3% to 50%

Areas of Focus

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

- Health Target – Shorter Stays in ED is currently at 89.0% against a target of 95% (page 8)

- Improved Management for Long Term Conditions – The number of high-risk patients who receive an angiogram within 3 days of admission decreased this quarter from 72.4% to 55% (page 23)

- Rate of Section 29 orders – Rates have increased again this quarter and we have an overall rate of 129.1 against a target of <81.5 (page 32)

PERFORMANCE HIGHLIGHTS – EQUITY

Achievements

- Immunisation of 2 year olds – The Māori rate is currently 95% and the Pacific rate is 100%, both are similar to the rate for Other 92.9%.

- Equitable care for stroke patients – The Māori is currently 90% and Pacific at 77.6% against a target of 80%. They are similar to the Total Rate of 79.4%

Areas of Progress

- Oral Health MDFT score (Missing, Decayed, Filled Teeth) – Māori is mean scored at 1.04 which is an improvement from the previous year 1.10, this is still unfavourable to the target of <0.96. The mean score for the Other ethnicity is 0.53.

Areas of Focus

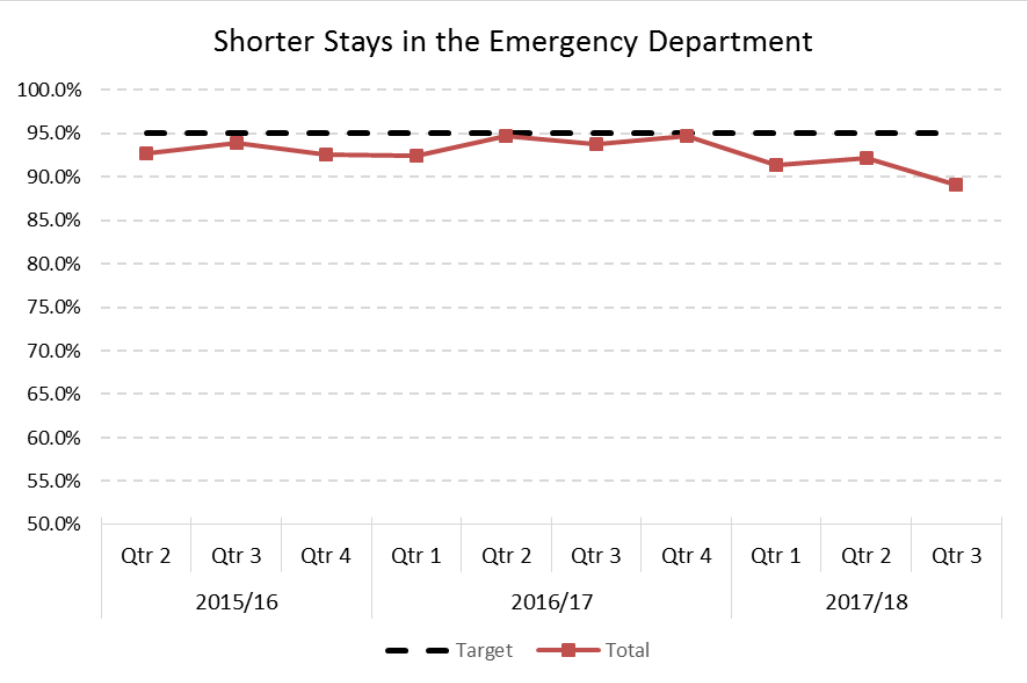
- Rate of Section 29 orders per 100,000 population – Māori Rates are currently 398 per 100,000 against the target of <81.5 and are 3 times higher than the non-Māori Rate (page 32)

- Breastfeeding at 3 months – Māori is currently at 41% compared to the total rate of 51%, the target 60%

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

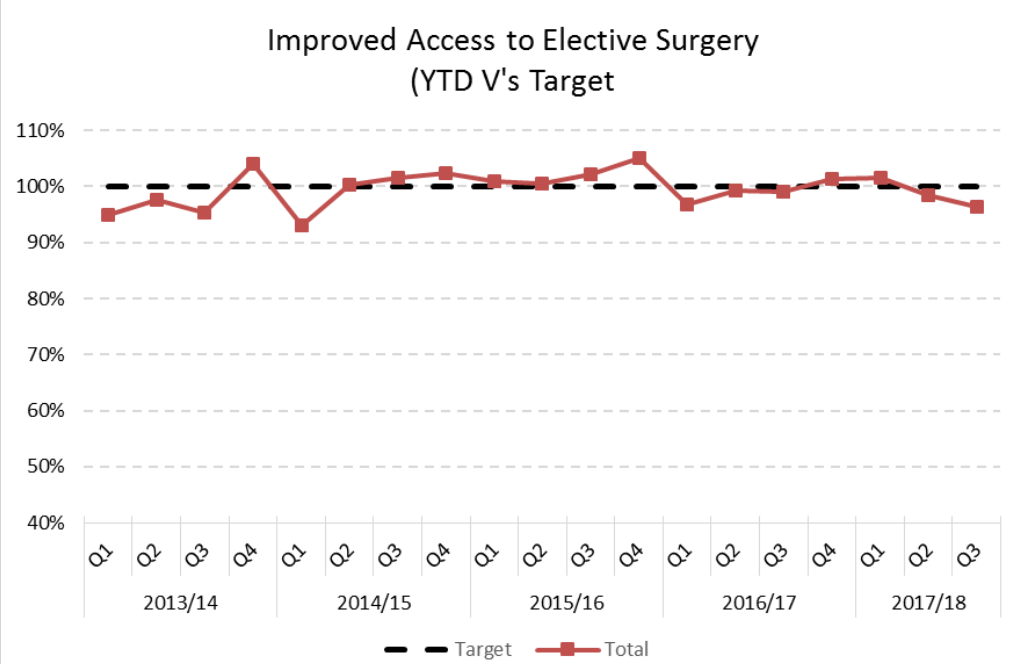
Ethnicity	Baseline [1]	Previous result [2]	Actual to Date [3]	Target 2017/18	Trend Direction
Total	94.7%	92.2% (U)	89.0% (U)	≥95%	▼
Māori	94.7%	93.5% (U)	89.9% (U)	≥95%	▼
Pacific	95.7%	94.1% (U)	92.9% (U)	≥95%	▼
Other	96.5%	91.3% (U)	88.2% (U)	≥95%	▼



Comments:
To support the Shorter Stays in EDs health target the DHB have Implemented a 3rd Nurse Practitioner to independent practice. This enables additional coverage and extended hours of a fast track role at front of house on limited basis. The extended NP hours provides early senior nursing assessment and decision making but is dependent on resource increase. The DHB also increased RMO numbers in ED for both MECA compliance and to resource a revised roster model which more reliably matches resources to known patterns of activity. Due to issues with specialty responsiveness to ED referrals there in ongoing development of a new model of care for general medicine and work being undertaken within Surgical Services to focus upon improving the timeliness and effectiveness of the specialty response to acute presentations. High levels of hospital bed occupancy (including ICU/HDU) are constraining acute patient flow and increasing ED length of stay. Many streams of work are being undertaken under executive level sponsorship including 'stranded' patient initiative (identifying/addressing barriers for people with excessive LOS), implementation of Criteria-based discharge processes across acute ward areas and continued evolution of Integrated Operations Centre activity.

1 October to December 2016
2 October to December 2017
3 January to March 2018

Health Target: Improved access to elective surgery (discharges)				
	Baseline [4]	Actual to Date [5]	Period Target	Target 2017/18 [6]
Elective Surgery	105.1%	96.4%	100%	100%

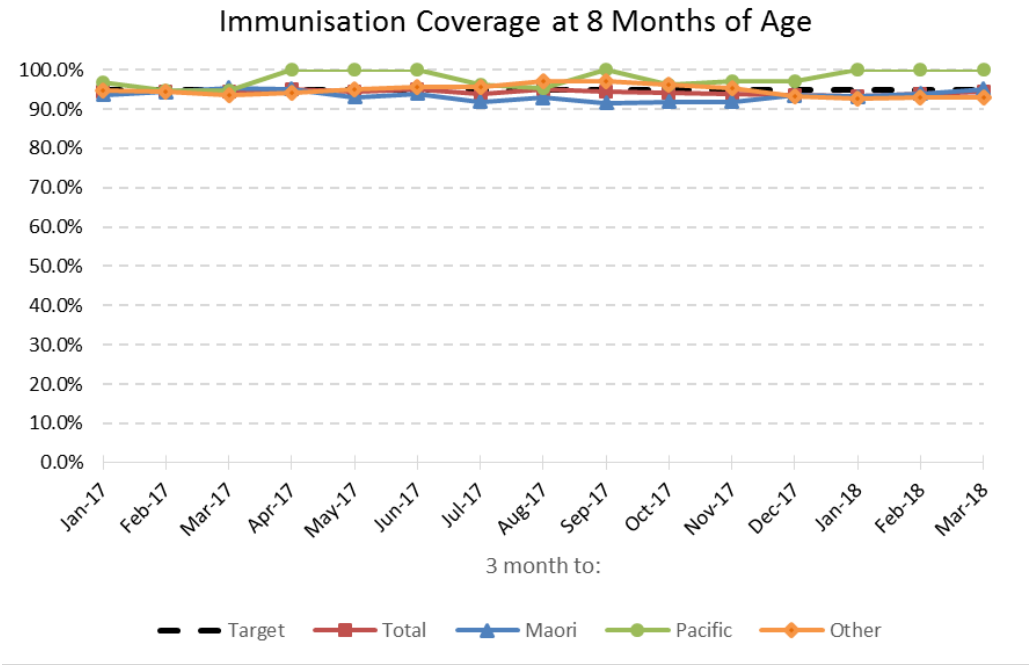


Comments:
We are looking to maximise our onsite resource whilst ensuring that acute receive timely operations, especially with winter approaching. This has presented challenges in what our next steps are to both maintain patient safety and our patients who have been given certainty for surgery timely access to elective surgery. We are proposing a series of options to our Executive Management Team throughout May and June which will help set a structure to move forward into 2018/19.

4 2016/17 Financial Year
5 July 2017 to March 2018 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	95.3%	93.6% (U)	94.3% (U)	≥95%	▲
Māori	94.4%	93.4% (U)	95.0% (F)	≥95%	▲
Pacific	100.0%	97.1% (F)	100% (F)	≥95%	▲
Other	95.9%	93.3% (U)	92.9% (U)	≥95%	▼



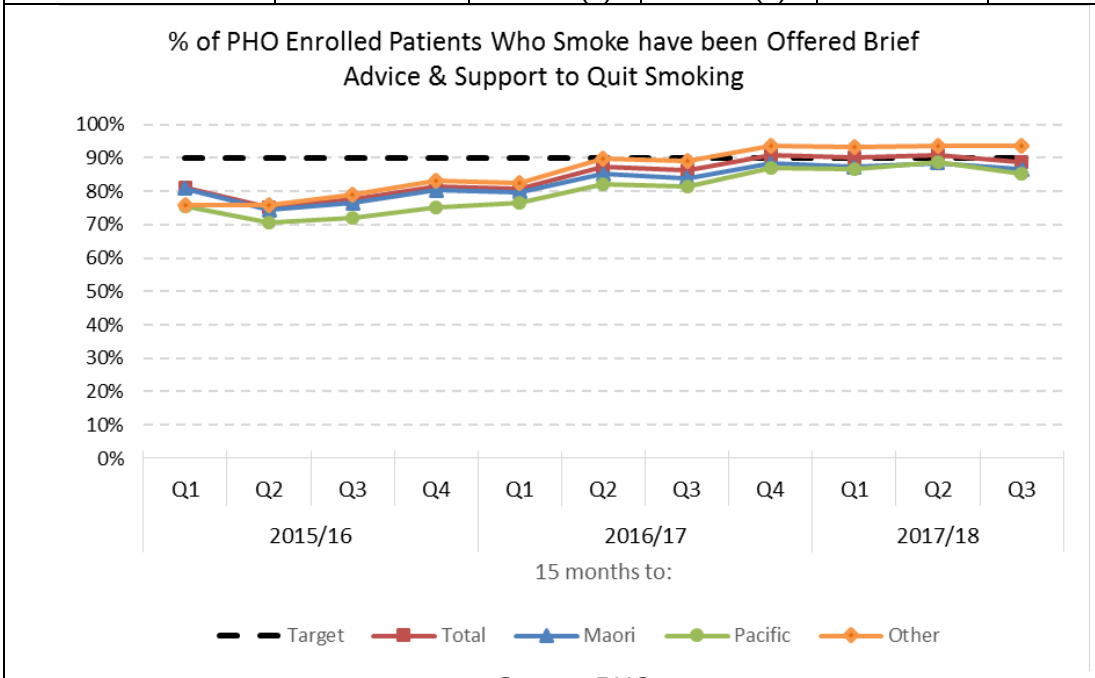
Data Source: National Immunisation Register

Comments:
We are pleased that we have achieved 94.3% overall for this target with equity maintained. We continue to have good communication between all immunisation providers which helps us achieve this result. It continues to be a struggle with hesitant whanau and these families take up a lot of time ensuring that they have opportunity for information and immunisation if wanted. Having a very efficient outreach team allows us the flexibility to vaccinate children within a short time frame if needed.

7 October to December 2016. Source: National Immunisation Register, MOH
8 October to December 2017. Source: National Immunisation Register, MOH
9 January to March 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	87.4%	90.9% (F)	88.9% (U)	≥90%	▼
Māori	85.1%	88.5% (U)	86.5% (U)	≥90%	▼
Pacific	82.2%	88.8% (U)	85.4% (U)	≥90%	▼
Other	89.9%	93.6% (F)	93.6% (F)	≥90%	—



Source: PHO

Comments:
We currently have several activities ongoing to help improve the numbers given advice and we are actively dedicated to Support ABC Activities in General Practice. We have purchasing smoke-free merchandise to support smoke-free health promotion activity in general practice and advertising Smoke-free training opportunities on Health Hawke's Bay Information Portal and Health Hawkes Bay receiving reporting on who has completed the on-line Ministry of Health "Helping People to Stop Smoking". There is a contracted Independent Nurse working with 10 practices, a DHB Smokefree Coordinator in Wairoa contacting and updating patient smoking status in Wairoa practices. The contracted Independent Nurse has worked with 10 practices through Quarter 3, contacting patients on behalf of the practice, updating their smoking status, offering them smoking brief advice, referring to cessation support services and providing Quit Cards.

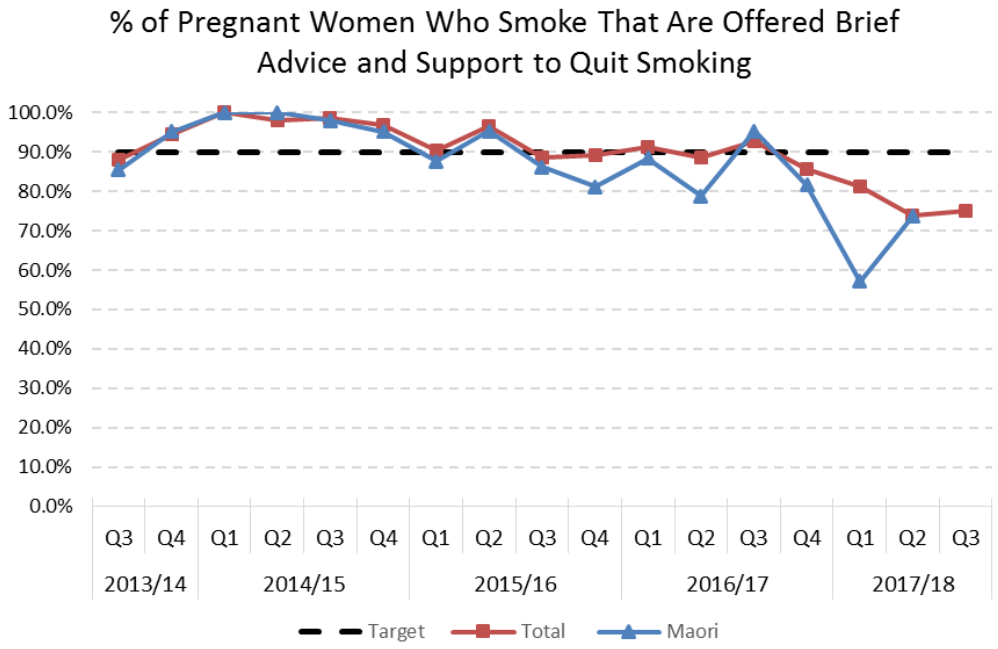
24

10 15 months to December 2016. Source: DHB Shared Services
11 15 months to December 2017. Source: DHB Shared Services
12 15 months to March 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	88.5%	73.9% (U)	75% (U)	≥90%	▲
Māori	78.8%	73.7% (U)	-	≥90%	*



Comments:

The 2017 statistics collected for smokefree status at booking with a Midwife in the Hawkes Bay reveal 48% of pregnant Māori women are not smokefree at booking compared to 12.9% NZE and 14.6% Pacific Island. Of the total referrals received (antenatal, postnatal and whanau) 67% of them were Māori and of those who engaged with the 12 week Wahine Hapu (Increasing Smokefree Pregnancy Programme), 69% were Māori. Breaking the cycle for Māori smoking can be a difficult process as many women are surrounded by Whanau and friends who are not smokefree. Often they are having babies at the age when they are most likely to smoke (18-24). 62% of those who completed the 12 week programme were in the 26 years and over category, this is often a time when women no longer want to smoke socially, the habit is becoming unaffordable and they are recognising this is something they cannot do on their own and are ready and willing to have support to quit. Emails have been sent to the HBDHB midwives and LMCs to remind them of the Wahine Hapu (Increasing Smokefree Pregnancy Programme) and to encourage their referrals early in pregnancy and also reminding the midwives to utilise the carbon monoxide monitor in their smokefree education. The HBDHB team has a newly appointed Smokefree Stop Smoking Practitioner to help with engagement with our stop smoking programme (Wahine Hapu) and the Tame Your Taniwha challenge which has women and whanau enrolled into both programmes. The Maternity Clinical Educator would like all her staff to have a smokefree education update this year and a need for a face to face approach for staff smokefree education has been identified, this has commenced and the Midwives have found this informative. A World Smokefree Day 31st May Quiz will be sent out to DHB staff, regarding the HBDHB Smokefree Policy and Nicotine Replacement Therapy to raise smokefree awareness

13 October to December 2016. Source: DHB Shared Services

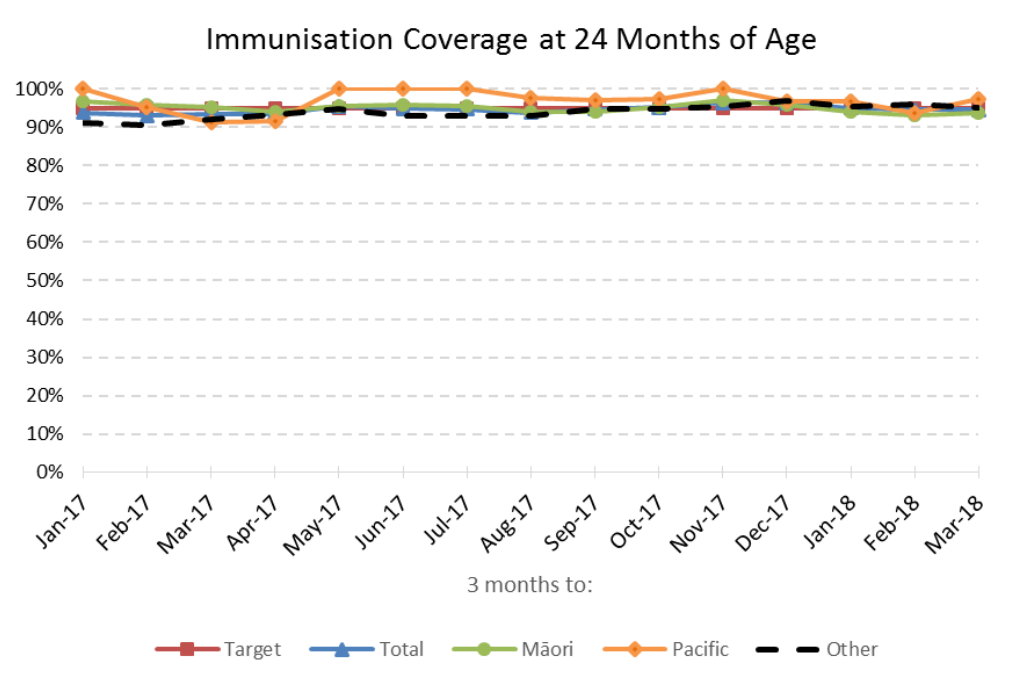
14 October to December 2017. Source: DHB Shared Services

15 January to March 2018. Source: DHB Shared Services

and also a meeting will be held in June with the HBDHB Smokefree Team to discuss the current Wahine Hapu programme, successes, barriers and innovations.

OUTPUT CLASS 1: PREVENTION SERVICES

Increase Immunisation: % of 2 year olds fully immunised					
Key Performance Measures	Baseline [16]	Previous result [17]	Actual to Date[18]	Target 2017/18	Trend direction
Total	94.7%	96.4% (F)	94.5% (F)	≥95%	▼
Māori	95.4%	95.8% (F)	93.8% (U)	≥95%	▼
Pacific	100.0%	96.7% (F)	97.3% (F)	≥95%	▲
Other	93.6%	96.9% (F)	94.9% (F)	≥95%	▼



Data Source: National Immunisation Register

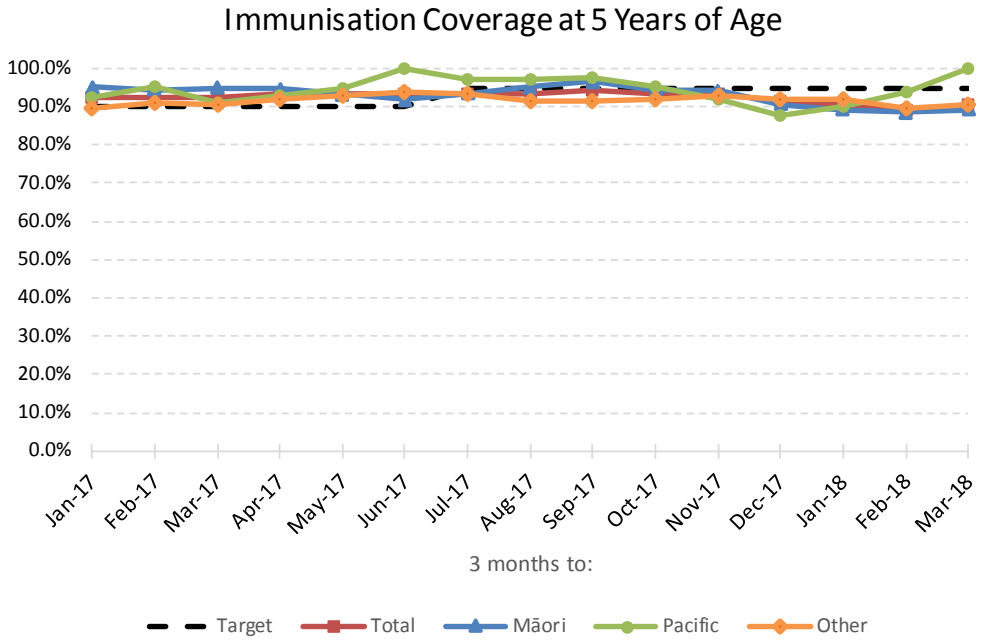
Comments:
We are pleased that we have achieved 94.5% overall for this target with equity nearly maintained. We continue to have good communication between all immunisation providers which helps us achieve this result .It continues to be a struggle with hesitant whanau, these families take up a lot of time ensuring that they have opportunity for information and immunisation if wanted. Having a very efficient outreach team allows us the flexibility to vaccinate children within a short time frame if needed.

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

17 October to December 2017. Source: National Immunisation Register, MOH

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

Increase Immunisation: % of 4 year olds fully immunised					
Key Performance Measures	Baseline [19]	Previous result [20]	Actual to Date[21]	Target 2017/18	Trend direction
Total	93.5%	91.3% (U)	90.3% (U)	≥95%	▼
Māori	95.8%	90.7% (U)	89.1% (U)	≥95%	▼
Pacific	91.2%	87.5% (U)	100% (F)	≥95%	▲
Other	91.8%	92% (U)	90.3% (U)	≥95%	▼



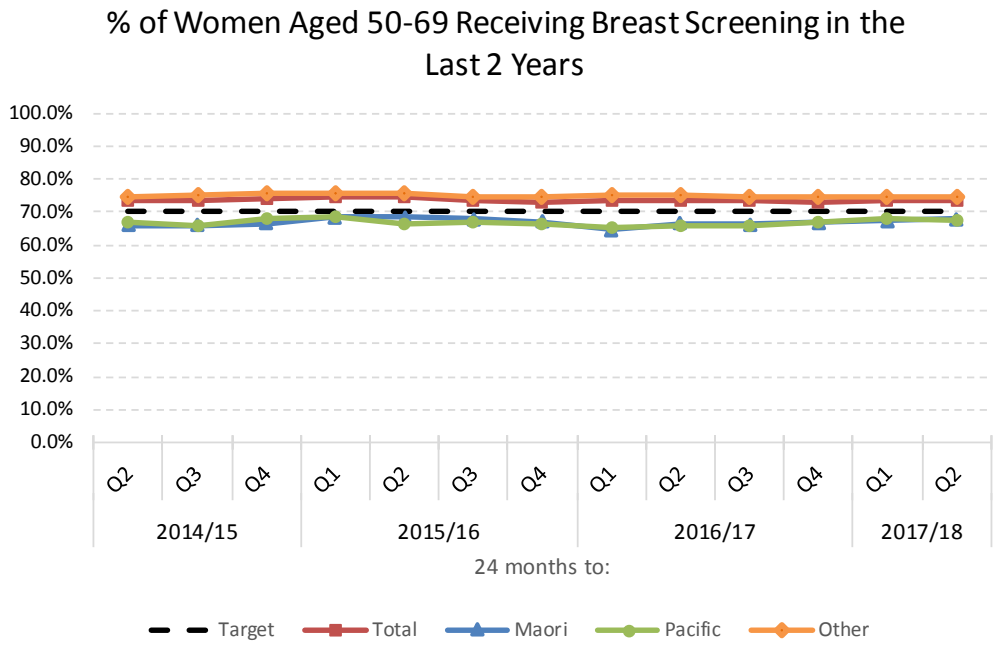
Data Source: National Immunisation Register

Comments:
This has dropped slightly this quarter as we have had less time to put into our 4 year olds due to schedule changes and the need to provide education around this and influenza planning, implementation, cold chain and a heavier workload with pharmacists. We are seeing many overseas children who require lots of work regarding education of the families for catch up immunisations and getting records etc.

19 October to December 2016 . Source: National Immunisation Register, MOH
20 October to December 2017. Source: National Immunisation Register, MOH
21 January to March 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	73.6%	73.4% (F)	73.6% (F)	≥70%	▲
Māori	64.7%	67.4% (U)	68% (U)	≥70%	▲
Pacific	65.4%	67.9% (U)	67.5% (U)	≥70%	▼
Other	75.0%	74.6% (F)	74.8% (F)	≥70%	▲



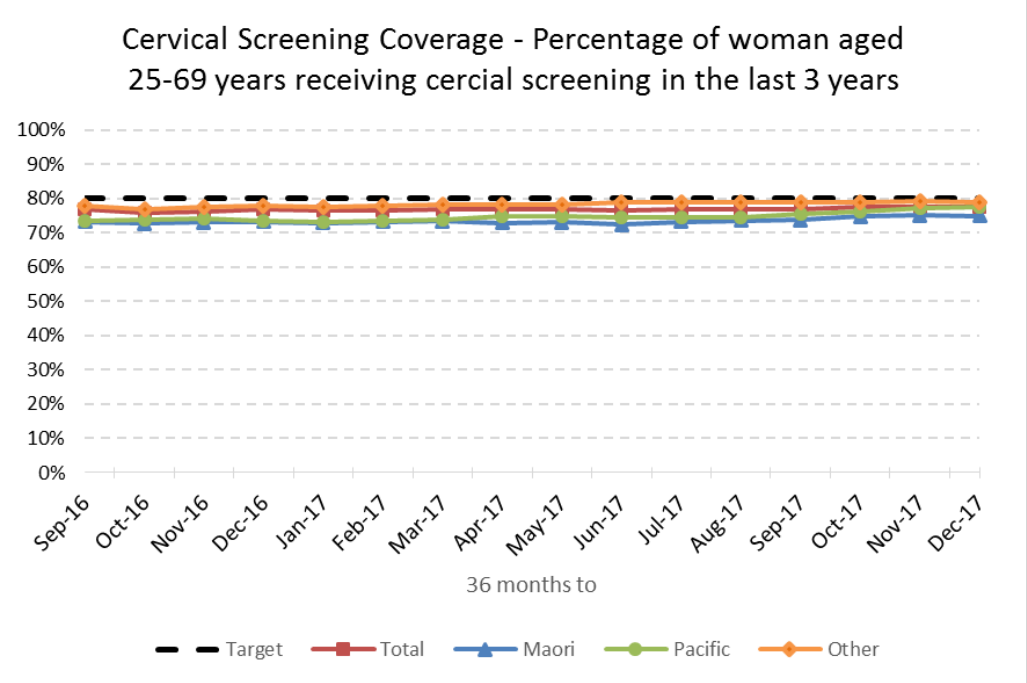
Data Source: BreastScreen Aotearoa

Comments:
The process of contacting BreastScreen Coast to Coast via phone to confirm or rearrange appointments seems to put many women off. Women who have felt discomfort when having had their mammogram talk to others about how it felt, creating a stigma around the process of having a mammogram. There is fear of the unknown or the result could be cancer, so they will often say they would prefer not to know. We continue to refer Māori and Pacific women to one of the five Independent Service Providers when a woman has either not confirmed they will attend their appointment or has DNA. The Breast Screening mobile visited Wairoa for two weeks January to February and the visit was very successful. Lists of registered Māori and Pacific women 45-69 were obtained from the three general practices and Kahungunu Executive, they were data matched against the BSA Register identifying the women who were unenrolled and not screened. These women received a letter inviting them to have enrol and have a mammogram whilst the mobile was present and they would be gifted a $20 Pak n Save card. 41 Māori enrolled and had a mammogram 78% more than in 2016, plus an addition 57 women were screened in comparison to 2016. Support to services were given by the Kahunugunu Executive team and overall there was a 6% DNA. The mobile visited CHB in March and April so far it is progressing well.

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

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

Key Performance Measures	Baseline [25]	Previous result [26]	Actual to Date[27]	Target 2017/18	Trend direction
Total	76.7%	77% (U)	77.4% (U)	≥80%	▲
Māori	72.8%	73.8% (U)	74.9% (U)	≥80%	▲
Pacific	74.8%	75.5% (U)	77.7% (U)	≥80%	▲
Other	78.9%	78.9% (U)	78.9% (U)	≥80%	—



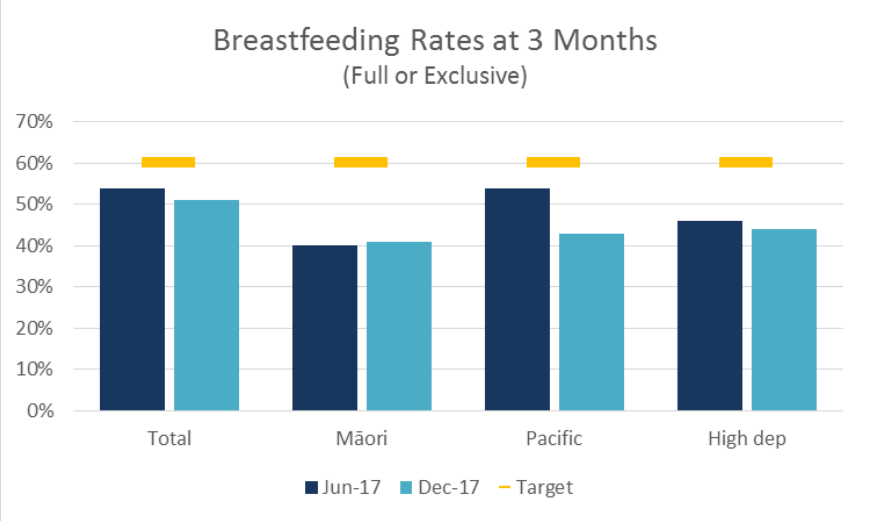
Data Source: National Cervical Screening Programme

Comments:
The availability of opportunistic smears is not as readily available as we would like it to be and the option of when you can have a smear is becoming limited in some practices due to other health demands that need to be covered. Some of the barriers to equity include first time women who have never engaged with their GPs and don't know anything about a smear and why they need to have a smear. Another barrier is time, many of the women we are providing a smear too in their home can take up to 40minutes to explain why they need a smear and what the procedure is, feedback from the women indicates that the time they have been giving in these home visits has made them feel more comfortable and at ease. In order to improve equity the Pak n Save promotional campaign funded by Health HB, all Māori, Pacific and women living in Quintile 5 will receive a Pak n Save gift card of $20 if they have their smear. The Population Screening team have set up two cervical screening clinics per month at the Napier Health Centre, these are for our Māori and Pacific women and women 30 and over who haven't had a smear or it's been more than five years since their last. The Population Screening Kaiawhina and Pacific Community Support worker continue to work in collaboration with Te Taiwhenua o Heretaunga and Choices Outreach nurses offering smears in the community and our Kaiwhakarere works in the community.

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

Better rates of breastfeeding
% of infants that are exclusively or fully breastfed at 3 months

Key Performance Measures	Baseline [28]	Previous result [29]	Actual to Date[30]	Target 2017/18	Trend direction
Total	51.0%	54% (U)	51% (U)	≥60%	▼
Māori	39.0%	40% (U)	41% (U)	≥60%	▲
Pacific	46.0%	54% (U)	43% (U)	≥60%	▼



Data Source: Tamariki Ora Quality Improvement Framework

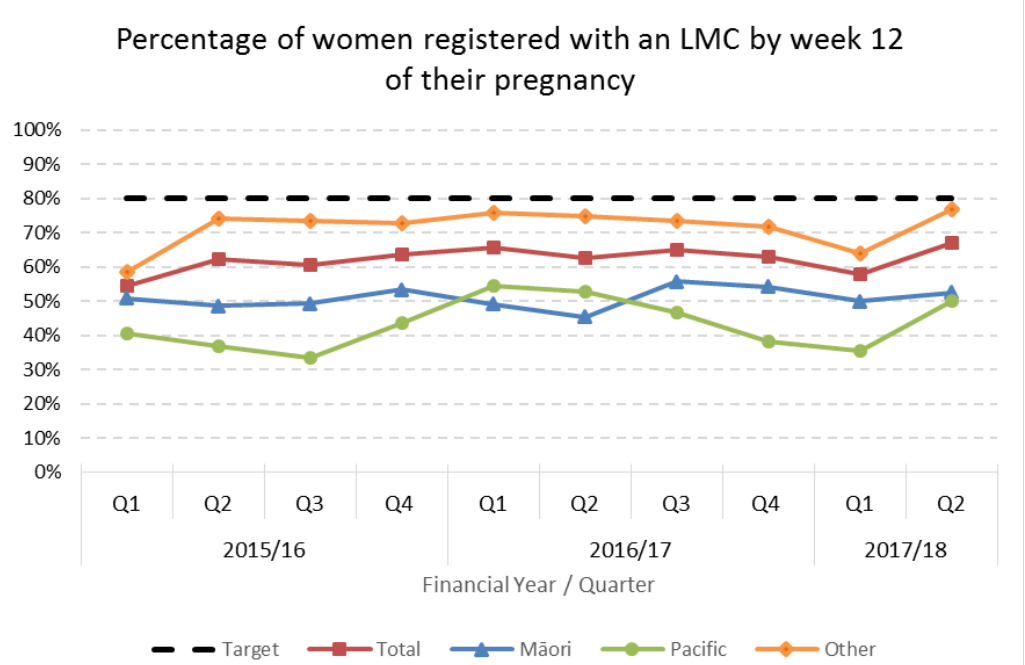
Comments:
Māori Health, Maternity Services and Population Health have worked together over the last 12 months to investigate locally and internationally practises to improve breastfeeding rates. From this, services have been reviewed with Māori Health redesigning the contract for 6 week to 6 months and Maternity Services redesigning breastfeeding support from birth to 6 weeks. Both programmes target Māori whanau with the desired outcome of decreasing the equity gap. We will be monitoring the Pasifika rates closely to respond to any continued downward trend. Overall breastfeeding rates need to improve so we are continuing to work with the community (workplaces, early child education, cafes) to create a supportive breastfeeding culture.

28 6 months to December 2016.
29 6 months to June 2017.
30 6 months to December 2017.

OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT SERVICES

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

Key Performance Measures	Baseline [31]	Previous result [32]	Actual to Date [33]	Target 2017/18	Trend direction
Total	65.7%	57.9% (U)	67.1% (U)	≥80%	▲
Māori	49.2%	50.0% (U)	52.4% (U)	≥80%	▲
Pacific	54.5%	35.3% (U)	50.0% (U)	≥80%	▲
Other	75.9%	63.8% (U)	76.9% (U)	≥80%	▲

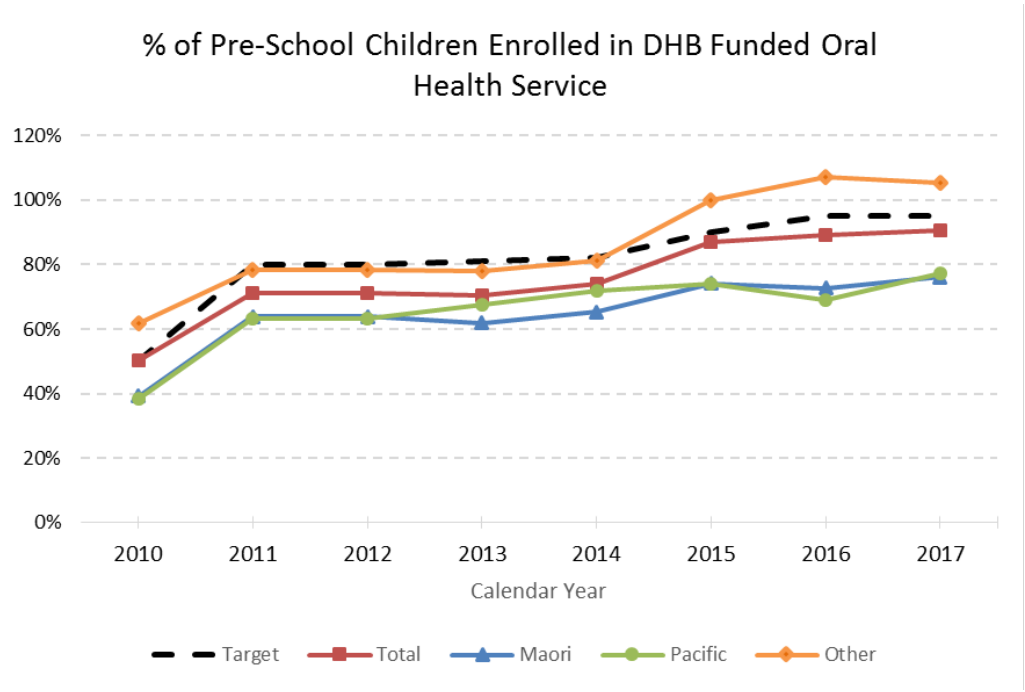


Comments:
Quarter 2 reporting on this target shows evidence of an increase in early engagement across all ethnicities; in particular an improvement in pacific island women booking within the 12 weeks, minimal movement is noted for our Māori women in this quarter. Two changes to note since the last quarter are the addition of the DHB maternity services contact number on the find your midwife Hawke's Bay page to support those women who may be having difficulty finding a midwife available when they are due. Also there are an increasing number of primary women with social complexities either being handed over to DHB community team or booking late with our community midwifery team as unable to find an LMC. There are a series of questions be asked as part of the ongoing quality improvement initiative for Hawke's Bay maternity services.

31 October to December 2016.
32 July to September 2017.
33 October to December 2017.

Better oral health: Pre-school enrolments
% of eligible pre-school enrolments in DHB-funded oral health services

Key Performance Measures	Baseline [34]	Previous result [35]	Actual to Date [36]	Target 2017/18	Trend direction
Total	89.2%	89.2% (U)	90.5% (U)	≥95%	▲
Māori	72.7%	72.7% (U)	76.1% (U)	≥95%	▲
Pacific	69.1%	69.1% (U)	77.1% (U)	≥95%	▲
Other	107.0%	107% (F)	105.2% (F)	≥95%	▼



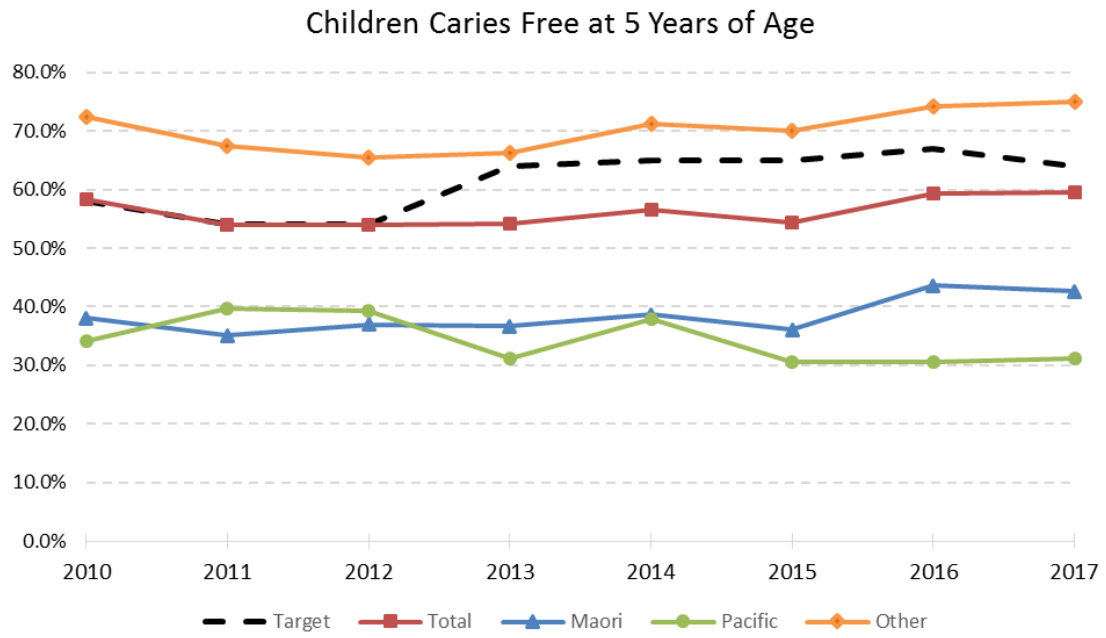
Data Source: Titanium Oral Health System

Comments:
The Hawke's Bay DHB operates a quadruple enrolment system for new born children (primary care, well child, immunisation and oral health). We are pleased to have further grown the enrolled population by 234 children to 10,131 and 90.5%. Māori and Pacific enrolments have increased to 76.1% and 77.1% (from 72.7% and 69.1%). However, the Other enrolments have remained at 105% despite substantial work to ensure correct coding and prioritisation of ethnicity, which leaves us concerned at the denominators provided for calculation of this indicator. We have employed a kaiawhina within the oral health service and in 6 months she has reengaged over 280 preschool children with our community oral health service and we are working with our Roopu Matua and meetings with teenage parents to engage the community and harder to reach whanau.

34 January to December 2016.
35 January to December 2016.
36 January to December 2017

Better oral health: Caries Free
% of children who are carries free at 5 years of age

Key Performance Measures	Baseline [37]	Previous result [38]	Actual to Date [39]	Target 2017/18	Trend direction
Total	59.0%	59.4% (U)	59.5% (U)	≥64%	▲
Māori	44.0%	43.6% (U)	42.6% (U)	≥64%	▼
Pacific	31.0%	30.5% (U)	31.3% (U)	≥64%	▲
Other	74.0%	74.1% (F)	75% (F)	≥64%	▲



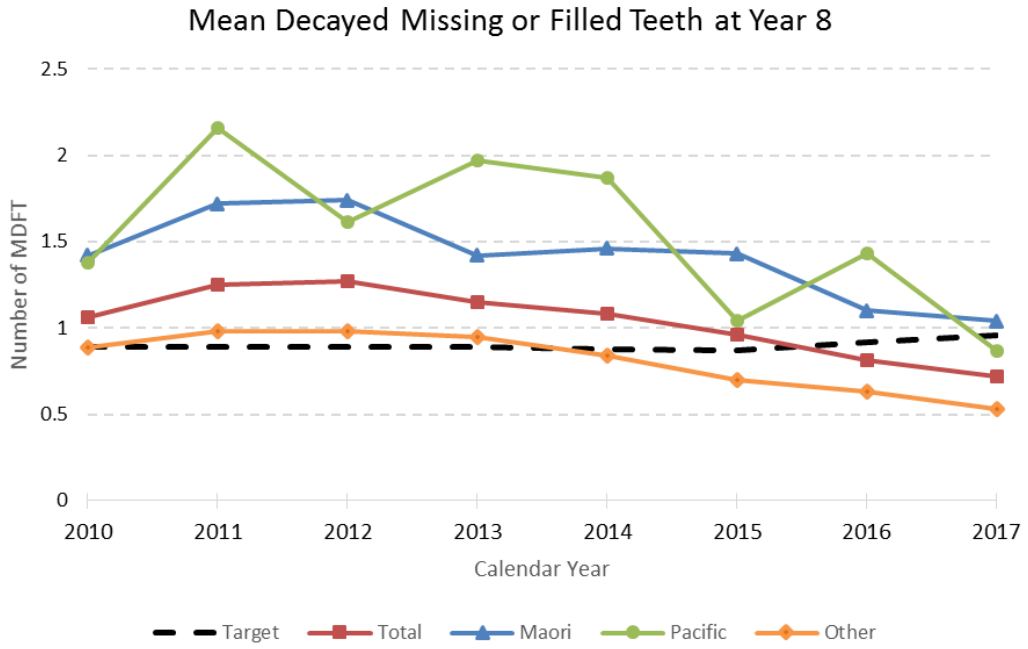
Data Source: Titanium Oral Health System

Comments:
Overall 5 year old results are almost the same in 2017 and for 2016, but pleasingly the gains achieved in 2016 from earlier years appear to have been held. The result for Other children at 75% caries free is well above the target of greater than 64% but Māori and Pacific children are below the target. Hawke's Bay DHB are putting in substantial effort with a project focussed on equity of outcomes for 5 year old children. In 2017 this project has established a Roopu Matua as well as other forms of consumer engagement for example focus groups with teen parents. Partnered with population health to include oral health messages in overall obesity strategy, support tools for B4SC includes water is the best drink and brushing 2x day. The national campaign “Baby Teeth matter” has also been supported locally, a Kaiawhina started in the Dental Service in July 2017 and has been able to bring 282 preschool children back into the service in the first 6 months. They worked in collaboration with other providers for early childhood such as B4SC, Health Hawkes Bay, Well Child Tamariki Ora providers, Child Health Team, Early Childhood Education & Kohanga Reo and Outreach Immunisation teams to reduce the siloed nature of oral health services delivery.

37 January to December 2015..
38 January to December 2017.
39 January to December 2017.

Better oral health: MDFT Score
Mean 'decayed, missing or filled teeth (DMFT)' score at Year 8

Key Performance Measures	Baseline [40]	Previous result [41]	Actual to Date [42]	Target 2017/18	Trend direction
Total	0.81	0.81 (F)	0.72 (F)	≤0.96	▲
Māori	1.1	1.1 (U)	1.04 (U)	≤0.96	▲
Pacific	1.43	1.43 (U)	0.87 (F)	≤0.96	▲
Other	0.63	0.63 (F)	0.53 (F)	≤0.96	▲



Data Source: Titanium Oral Health System

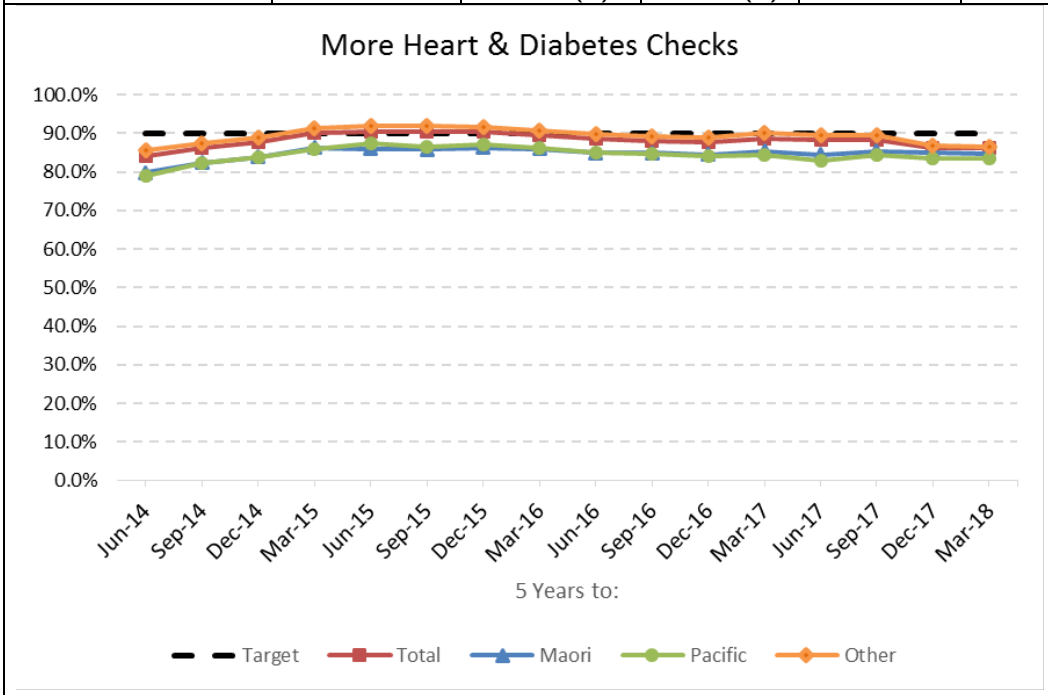
Comments:
Overall Year 8 has again improved in 2017 and is now 0.72 (previous year 0.81). Inequity persists, however Māori have improved to 1.04 (previous year 1.1), Pacific have improved substantially to 0.87 (previous year 1.43) but numbers are small and Other improved to 0.53 (previous year 0.63). Notably the DMFT for children with caries is almost the same suggesting that in each group the overall result is a consequence of more children caries free. Hawke's Bay DHB has introduced strong clinical quality indicators focussed on prevention - fluoride varnish by 4 years, bitewing films by 6 years and fissure sealants by 8 years and is measuring these and reporting to staff 6 monthly. The DHB is also operating a project to address equity of oral health outcomes for children under 5 years and these initiatives do appear to be slowly influencing the Year 8 outcomes.

40 January to December *2016.*
41 January to December 2016.
42 January to December 2017

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

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

Key Performance Measures	Baseline [43]	Previous result [44]	Actual to Date [45]	Target 2017/18	Trend direction
Total	87.8%	86.3% (U)	86.1% (U)	≥90%	▼
Māori	84.5%	85% (U)	84.8% (U)	≥90%	▼
Pacific	84.0%	83.6% (U)	83.5% (U)	≥90%	▼
Other	88.9%	86.7% (U)	86.6% (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. Close monitoring is in place to map progress towards the target with additional scope to further incentivise the program if results are not achieved. The Kaupapa of the program was inspired by a cohort of consumers, and VLCA practice staff.

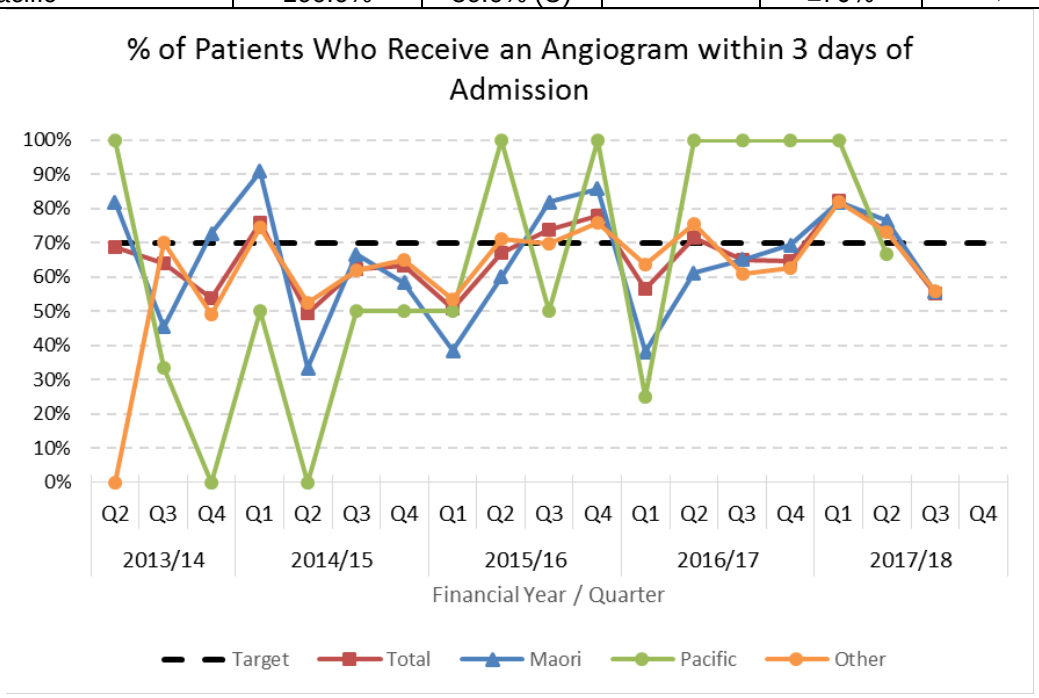
43 5 years to December 2016. Source: Ministry of Health

44 5 years to December 2017. Source: Ministry of Health

45 5 years to March 2017 . Source: Ministry of Health

OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT SERVICES

Patients with ACS receive seamless, coordinated care across the clinical pathway ***% of high-risk patients will receiving an angiogram within 3 days of admission.***					
Key Performance Measures	Baseline [46]	Previous result [47]	Actual to Date [48]	Target 2017/18	Trend direction
Total	71.6%	72.4% (F)	55.0% (U)	≥70%	▼
Māori	61.1%	75.0% (F)	55.6% (U)	≥70%	▼
Pacific	100.0%	50.0% (U)	-	≥70%	▼



Source: ANZACS-QI

Comments:
January had a reduction in capacity of 2/9 lab days due to holiday period and lack of cover. February had 8 sessions fully utilized for the month, and March had a reduction in capacity of 1/9 lab days due to technical issues with the radiology equipment (list cancelled). This required rescheduling of both the outpatient and inpatient lists, extending time to Rx.

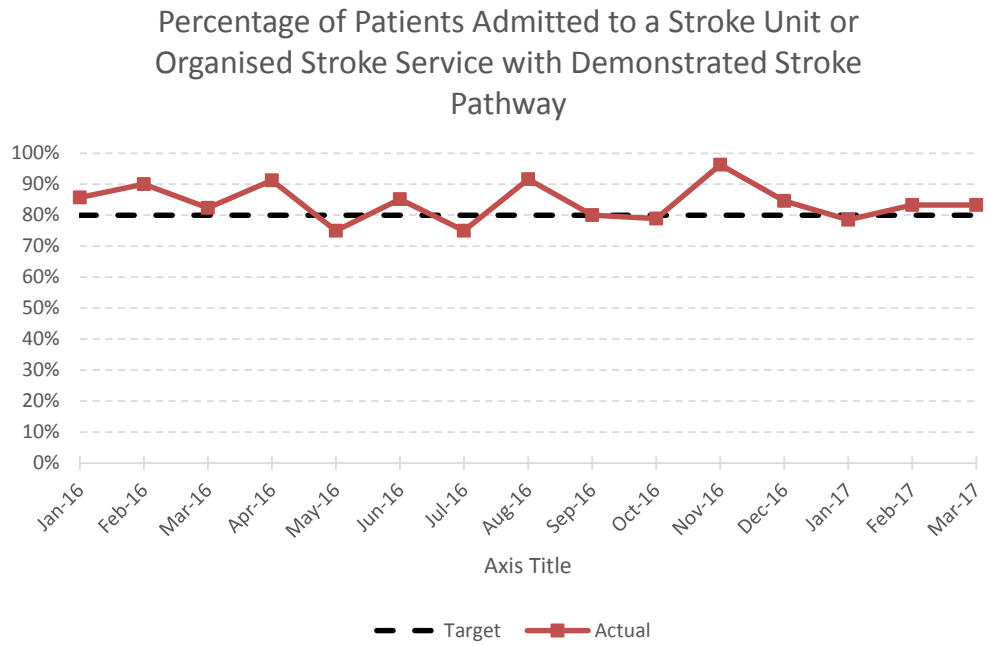
24

46 October to December 2016. Source: Ministry of Health
47 October to December 2017. Source: Ministry of Health
48 January to March 2018. Source: Ministry of Health

Equitable access to care for stroke patients

% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway

Key Performance Measures	Baseline [49]	Previous result [50]	Actual to Date [51]	Target 2017/18	Trend direction
Total	88.1%	75.6% (U)	79.4% (U)	≥80%	▲
Māori	-	92.3% (F)	90.0% (F)	≥80%	▼
Pacific	-	72% (U)	77.6% (U)	≥80%	▲



Source: HBDHB

Comments:
We were 1 patient short of making the target for this indicator. Patients who do not go onto the pathway are treated in other areas of the hospital as clinically appropriate.

49 October to December 2015. Source: Ministry of Health

50 October to December 2017. Source: Ministry of Health

51 January to March 2018. Source: Ministry of Health

Equitable access to care for stroke patients ***% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission***					
Key Performance Measures	Baseline [52]	Previous result [53]	Actual to Date [54]	Target 2017/18	Trend direction
Total	-	58% (U)	37.5% (U)	≥80%	▲
Māori	-	80% (F)	100% (F)	≥80%	▼
Pacific	-	50% (U)	28.6% (U)	≥80%	▼
*This is a new indicator and a time series chart will be provided one there are enough data points.					
Comments: Patients who are not transferred within the 7 days are reviewed as part of the quarterly reporting process. This quarter we had several patients who were kept on the stroke ward for longer than 7 days for clinical reasons and we continue to review cases.					

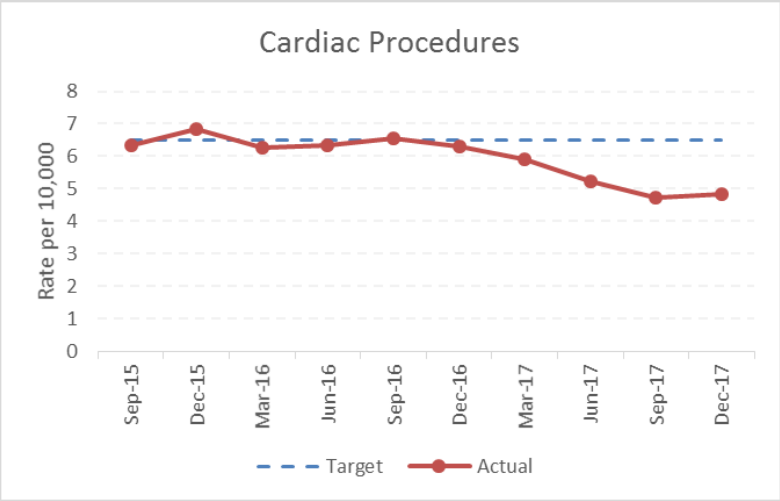
52 October to December 2015. Source: Ministry of Health

53 October to December 2016. Source: Ministry of Health

54 January to March 2018 . Source: Ministry of Health

Equitable access to surgery -Standardised intervention rates for surgery per 10,000 population					
Key Performance Measures	Baseline[55]	Previous result[56]	Actual to Date [57]	Target 2017/18	Trend direction
Major joint replacement	21.5	22.9 (F)	22.4 (F)	≥21	▼
Cataract procedures	58.7	49.7 (F)	46.6 (F)	≥27	▼
Cardiac procedures	6.6	4.7 (U)	4.8 (U)	≥6.5	▲
Percutaneous revascularization	13.1	12 (U)	11.9 (U)	≥12.5	▼
Coronary angiography services	39	36.6 (F)	36.4 (F)	≥34.75	▼

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

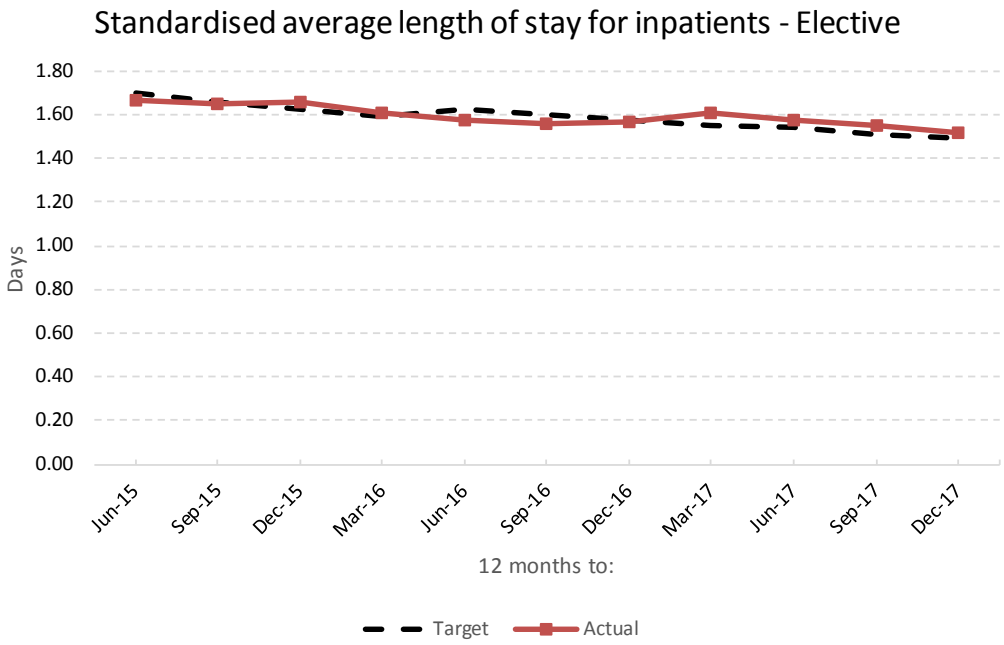


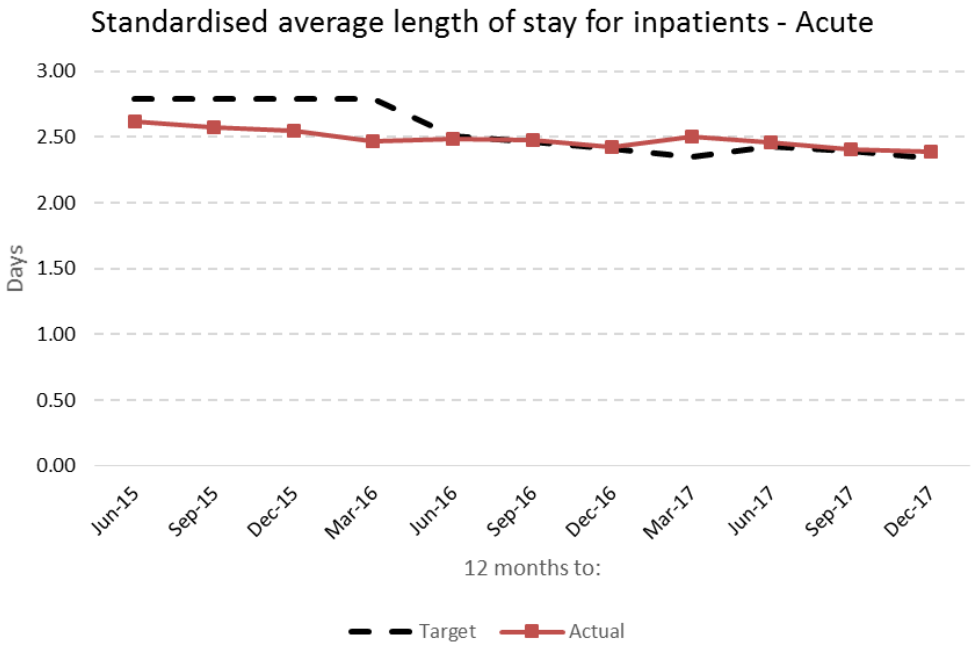
Source: Ministry of Health

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

55 12 months ending December 2015. Source MoH
56 12 months ending September 2017. Source MoH
57 12 months ending December 2017. Source MoH

Shorter stays in hospital Length of stay (days)					
Key Performance Measures	Baseline [58]	Previous result [59]	Actual to Date [60]	Target 2017/18	Trend direction
Acute	2.41	2.41 (U)	2.39 (U)	≤2.34	▲
Elective	1.51	1.55 (U)	1.52 (U)	≤1.49	▲





Source: Ministry of Health

Comments:

58 12 months to September 2016. Source: Ministry of Health

59 12 months to September 2017. Source: Ministry of Health

60 12 months to December 2017 .Source: Ministry of Health

24

We are pleased to see that both acute and elective average length of stay rates have reduced further to 2.39 and 1.52 respectively however we are still not meeting the MoH targets. 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 '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.

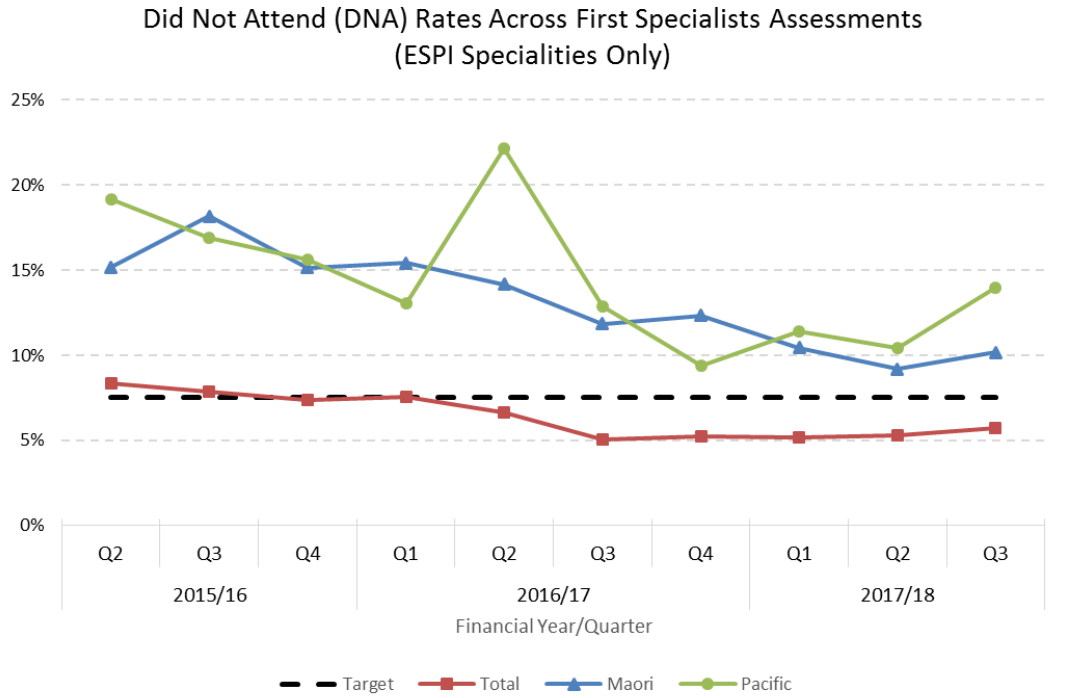
Quicker access to diagnostics					
Key Performance Measures	Baseline [61]	Previous result [62]	Actual to Date[63]	Target 2017/18	Trend direction
% accepted referrals for elective coronary angiography completed within 90 days	-	87.8% (U)	86.8% (U)	≥95%	▼
% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive),	91.7%	93.5% (F)	97.1% (F)	≥85%	▲
% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)	93.9%	59% (U)	82% (U)	≥85%	▲
% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date	98.1%	77% (F)	68% (U)	≥70%	▼
Comments: HBDHB continues to be compliant with urgent colonoscopy within 14 days. The semi urgent referrals (to be seen within 42 days) improved in February and March over the January result. The surveillance patient group has been compromised in order to address the urgent referrals as a priority, and the semi urgent demand. Resourced capacity is a challenge and the plan for the 4th quarter is to undertake extra sessions and develop a production plan to facilitate understanding of the demand flows and identify the necessary resources to meet clinical demand and production targets.					

61 December 2016.

62 December 2017.

63 March 2018.

Fewer missed outpatient appointments ***Did not attend (DNA) rate across first specialist assessments***					
Key Performance Measures	Baseline [64]	Previous result [65]	Actual to Date [66]	Target 2017/18	Trend direction
Total	6.7%	5.3% (F)	5.7% (F)	≤7.5%	▼
Māori	14.2%	9.2% (U)	10.2% (U)	≤7.5%	▼
Pacific	22.1%	10.4% (U)	14% (U)	≤7.5%	▼
Other	3.8%	3.7% (F)	4.1% (F)	≤7.5%	▼

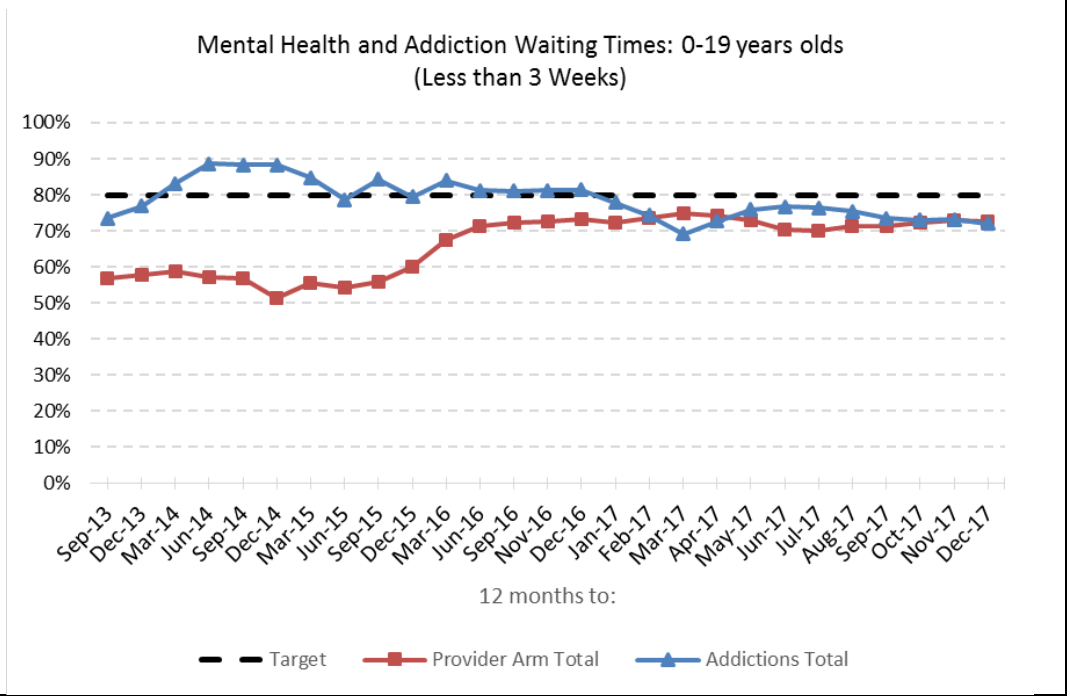


Source: HBDHB

Comments:
For the last Quarter the DNA rate for Māori has consistently trended downwards from 10.9% in Jan to 9.9% in Mar, despite a slight increase in total DNA over the Feb period. The total DNA rate increased by .9% over Feb period, to then fall at 5.4% for March – well under our 7.5% target. Dental and General Surgery continue to be the more difficult specialties for our patients to access this quarter with Paediatrics also showing high DNA for Māori. Due to high volumes of bookings the general surgery booker has been unable to call her new patients. The Administration Service is currently looking to address this issue, and will be monitoring closely to see if it makes a difference in the next quarter results. For Paediatrics and Dental the Bookers call and confirm all FSA's. For both Dental and Paediatrics, on a number of occasions that Bookers are instructed to continue to re-book appointments for repeat DNA patients (children). Unlike other services where after two DNA strikes the patients are referred back to their GP, for Paediatrics and Dental (if its children), appointments continue to be made for patients who DNA. This means there are occasions whereby one patient is responsible for multiple DNA's against the service. Finally the financial costs associated with Dental continue to provide a barrier for certain patients.

64 October to December 2016. Source: Ministry of Health
65 October to December 2017. Source: Ministry of Health
66 January to March 2018 . Source: Ministry of Health

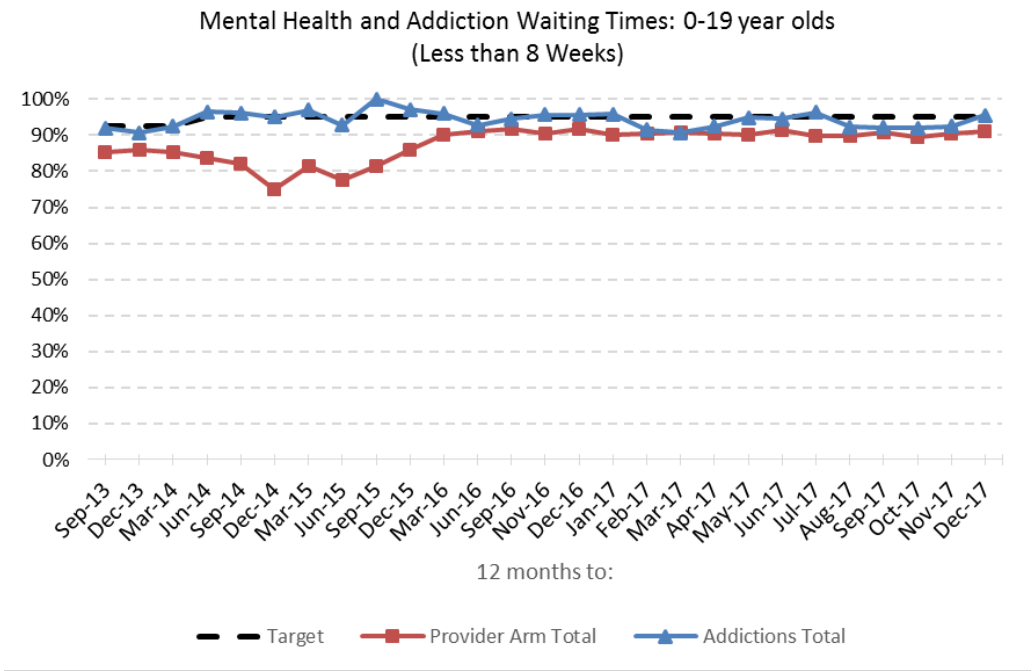
Reducing waiting times Shorter waits for non-urgent mental health and addiction services for 0-19 year olds					
Key Performance Measures	Baseline [67]	Previous result [68]	Actual to Date [69]	Target 2017/18	Trend direction
Mental Health Provider Arm: Age 0-19					
<3 weeks	72.3%	71.3% (U)	72.5% (U)	≥80%	▲
<8 weeks	91.7%	90.9% (U)	91.2% (U)	≥95%	▲
Addictions (Provider Arm & NGO): Age 0-19					
<3 weeks	81.1%	73.4% (U)	72.1% (U)	≥80%	▼
<8 weeks	94.6%	92.2% (U)	95.6% (F)	≥95%	▲



67 12 months to December 2016

68 12 months to September 2017

69 12 months to December 2017



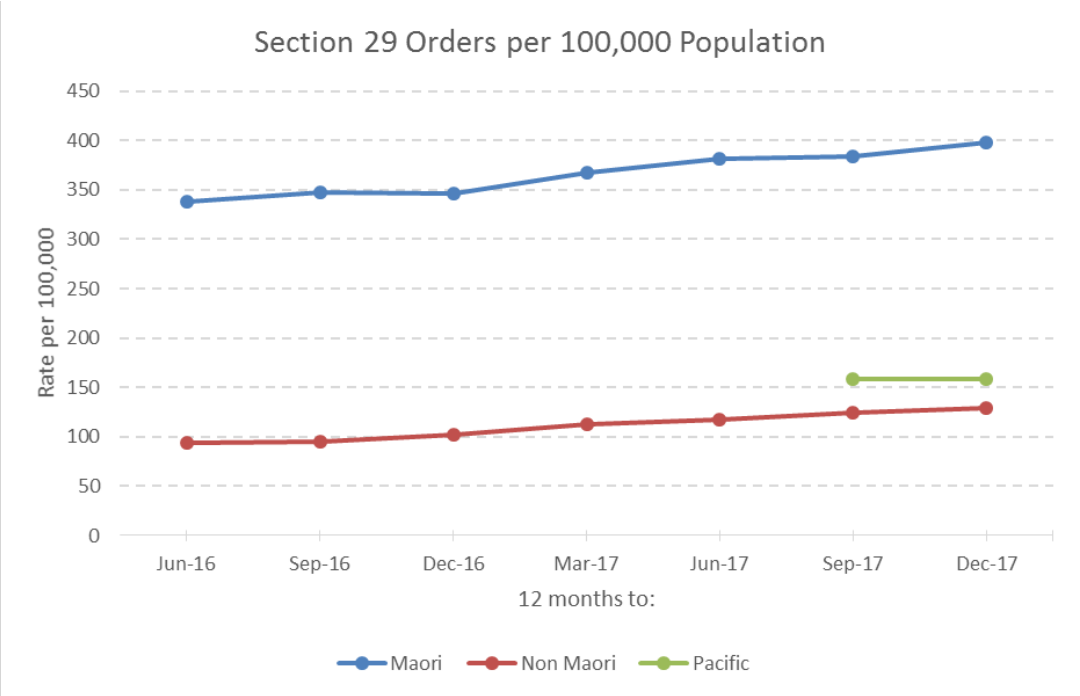
Source: Ministry of Health

Comments:
While we have not achieved the target our deficit has been less than 10 % variance of the target, we want to meet the MOH target but we continue to meet a few challenges around DNA's and increased referrals that continue to impact on our KPI's. Since the last quarter, several strategies have been put in place to alleviate this and improve our response times. We have continued to work collaboratively with the family to find appointment times that suit for everyone including the family and young person. Additionally, our electronic record system sends a reminder to the family 24 hours before the appointment to ensure they attend the appointment. This has reduced DNA rate but in other cases families have not received the reminders because their contact details were not entered in format that allows the system to send an automatic reminder. We have also continued to collaborate with NGOs early and have joint clinics in the communities where the families reside. This has improved access due to increased accessibility. Another system related issue that may impact on our wait times is that seeing a family without the young person is not recorded as a contact/encounter with the young person, thus this will show as if we have not met the young person but we have met with the family to understand his presenting problems before arranging another meeting to meet with the young person. The alcohol and drug service did not meet the <=3 week wait time target of 80%. For the 0-19 age range the wait time was 72.7 percent. However, the Alcohol and Drug service met the wait target for 3-8 weeks. The target is 95% and the wait time for Alcohol and drugs was 95.5%. Similar challenges as discussed above continue to affect our KPI's. We have 1.8FTE for drug and alcohol but cases/referrals continue to rise. Similar strategies mentioned above are being implemented to bring the waiting times to or above the MOH targets. We hope to achieve this in the next quarter.

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 [70]	Previous result [71]	Actual to Date [72]	Target 2017/18	Trend direction
Non- Māori	95	124.1 (U)	129.1 (U)	≤81.5	▼
Māori	338	384 (U)	398.2 (U)	≤81.5	▼
Pacific	0	158.7 (U)	158.7 (U)	≤81.5	—



Data Source: Ministry of Health

Comments:
We continue to monitor and use services to reduce the rate of all patients particularly Māori. We have a number of new services in place that support early intervention such as Home based treatment, Te Ara Manapou and our local response teams. We are setting set up a review panel made up of clinicians and consumers to discuss, review and look at other ways to support people who no longer require CTO support. We also negotiating a police liaison position with police.

RECOMMENDATION:
It is recommended that the HBDHB Board

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

ATTACHMENT:

- HBDHB Quarterly Performance Monitoring Dashboard Q3

70 October to December 2016

71 12 months to September 2017

72 12 months to December 2017

HBDHB PERFORMANCE FRAMEWORK RESULTS – QTR 3, 2017/18

Health Targets:	Target	Baseline	Total		Maori		Pacific		Other	
Shorter Stays in ED	≥ 95%	95%	89%		90%		93%		88%	
Improved Access to Elective Services	≥ 100%	105%	96%		-		-		-	
Faster Cancer Treatment	≥ 90%	65%	91%		85%	*	100%		91%	
Increased Immunisation	≥ 95%	95%	94%	*	95%	*	100%	*	93%	
Better Help for Smoker to Quit (Primary Care)	≥ 90%	87%	89%		87%		85%		94%	
Better Help for Smoker to Quit (Pregnant Women)	≥ 90%	89%	75%		-					
Raising Health Kids	≥ 95%	40%	98%		97%		100%		100%	

Output Class 1: Prevention Services	Target	Baseline	Total		Maori		Pacific		Other	
Better Help for Smoker to Quit (Secondary Care)	≥ 95%	99%	96%	*	97%	*	95%		95%	*
% of 2 year olds fully immunised	≥ 95%	95%	95%		94%		97%	*	95%	
% of 4 year olds fully immunised	≥ 95%	96%	90%		89%		100%	*	90%	
% of women aged 50-69 years receiving breast screening in the last 2 years	≥ 70%	74%	74%	*	68%	*	68%		75%	*
% of women aged 25–69 years who have had a cervical screening event in the past 36 months	≥ 80%	77%	77%	*	75%	*	78%	*	79%	
% of infants that are exclusively or fully breastfed at 3 months	≥ 60%	51%	51%		41%	*	43%		-	-

Output Class 2: Early Detection and Management Services	Target	Baseline	Total		Maori		Pacific		Other	
% of the population enrolled in the PHO	≥ 90%	97%	98%		98%	*	90%	*	98%	
% of women booked with an LMC by week 12 of their pregnancy	≥ 80%	66%	67%	*	52%	*	50%	*	77%	*
% of eligible pre-school enrolments in DHB-funded oral health services	≥ 95%	95%	91%	*	76%	*	77%	*	105%	
% of children who are carries free at 5 years of age	≥ 64%	64%	60%	*	43%		31%	*	75%	*
% of enrolled preschool and primary school children not examined according to planned recall	≤ 10%	3%	8%		6%		6%		10%	
Mean 'decayed, missing or filled teeth (DMFT)' score at Year 9	≤ 0.96	0.81	0.72		1.04		0.87		0.53	
% of the eligible population will have had a CVD risk assessment in the last 5 years	≥ 90%	88%	86%		85%		84%		87%	
% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks)	≥ 95%	95%	97%	*	No Ethnicity Data Available					
% of accepted referrals for MRI scans who receive their scans within 42 days (6 weeks)	≥ 90%	48%	97%	*	No Ethnicity Data Available					

Key:

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

*	Favourable Trend from Previous Quarter

OUTPUT CLASS 3: Intensive Assessment and Treatment Services	Target	Baseline	Total		Maori		Pacific		Other	
% of high-risk patients will receiving an angiogram within 3 days of admission.	≥ 70%	72%	55%		56%		0%		Data not available	
% of patients undergoing cardiac surgery at the regional cardiac centres who have completion of Cardiac Surgery registry data collection within 30 days of discharge	≥ 95%	98%	99%	*	93%	*	100%			
% of potentially eligible stroke patients who are thrombolysed 24/8	≥ 8%	8%	6%		30%		2%			
% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	≥ 80%	84%	79%	*	90%		78%	*		
% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	≥ 80%	58%	38%		100%	*	29%			
Major joint replacement	≥ 21	21.5	22.40		No Ethnicity Data Available					
Cataract procedures	≥ 27	58.7	46.60							
Cardiac surgery	≥ 6.5	6.6	4.80	*						
Percutaneous revascularisation	≥ 12.5	13.1	11.90							
Coronary angiography services	≥ 34.7	39	6.40							
Length of stay Elective (days)	≥ 1.47	1.56	2.39							
Length of stay Acute (days)	≥ 2.3	2.4	1.52							
% accepted referrals for elective coronary angiography completed within 90 days	≥ 95%	98%	88%							
% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive),	≥ 90%	92%	97%	*	100%				96%	*
% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)	≥ 70%	94%	82%	*	69%	*			83%	*
% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date	≥ 70%	98%	68%		No Ethnicity Data Available					
Did not attend (DNA) rate across first specialist assessments	≤ 8%	7%	6%		10%		14%		4%	
% of 0-19 year olds seen within 3 weeks of referral: Mental Health Provider Arm	≥ 80%	72%	73%	*	76%	*	83%	*	70%	
% of 0-19 year olds seen within 3 weeks of referral: Addictions (Provider Arm and NGO)	≥ 80%	81%	72%		61%		100%		86%	
% of 0-19 year olds seen within 8 weeks of referral: Mental Health Provider Arm	≥ 95%	91%	91%	*	94%	*	91%	*	89%	
% of 0-19 year olds seen within 8 weeks of referral: Addictions (Provider Arm and NGO)	≥ 95%	95%	96%	*	94%	*	100%		100%	*
Rate of s29 orders per 100,000 population	≤ 81.5	90.1	129.10		398.2		158.7		-	-

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	145.00		198.00	*	140.00		143.00	
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 80-84 years	≤ 170	208.3	178.00		144.00	*	300.00		181.00	
Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 85+ years	≤ 225	216.6	229.00	*	192.00		400.00		229.00	*
% of older people who have received long-term home and community support services in the last three months who have had an interRAI Home Care or a Contact assessment and completed care plan	≥ 95%	100%	100%		100%		100%		100%	
Clients with a CHESS score (Change in Health, End-stage disease, signs and symptoms) of 4 or 5 at first assessment - Home	≤ 14%	10%	9%	*	No Ethnicity Data Available					
Clients with a CHESS score (Change in Health, End-stage disease, signs and symptoms) of 4 or 5 at first assessment - Hospital	≤ 14%	10%	8%	*						
Time from referral receipt to initial Cranford Hospice contact within 48 hours	≥ 80%	100%	98%							
% of older patients given a falls risk assessment	≥ 90%	97%	96%							
% of older patients assessed as at risk of falling receive an individualised care plan	≥ 90%	98%	91%							

Non Reported in Q3

% of girls fully immunised – HPV vaccine	≥ 75%	Result will be published in Q4
% of 65+ year olds immunised – flu vaccine	≥ 75%	Result will be published in Q4
Ambulatory sensitive hospitalisation rate per 100,000 0-4 years	≤ 6822	Result will be published in Q4
Ambulatory sensitive hospitalisation rate per 100,000 45-64 years	≤ 4129	
% of adolescents(School Year 9 up to and including age 17 years) using DHB-funded dental services	≥ 85%	Result will be published in Q4
Proportion of people with diabetes who have good or acceptable glycaemic control (HbA1C indicator)	≤ 55%	Result will be published in Q4
Proportion of the population seen by mental health and addiction services: Child & Youth (0-19)	≥ 4%	Result will be published in Q4
Proportion of the population seen by mental health and addiction services: Adult (20-64)	≥ 5%	
Proportion of the population seen by mental health and addiction services: Older Adult (65+)	≥ 1%	
% of clients discharged will have a quality transition or wellness plan	≥ 95%	Result will be published in Q4
Number of babies who live in a smoke-free household at six weeks post natal	≥ 0	No New Data From the Ministry
% of pregnant women who are smokefree at 2 weeks postnatal	≥ 95%	No New Data From the Ministry

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

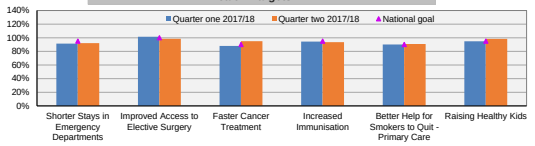
Monitoring Status Standard Monitoring

Supporting Better Public Services Results 2 Healthy Mums and Babies
The DHB is working with PHOs and general practices to facilitate seamless transition of care from Primary Care to Lead Maternity Carers.

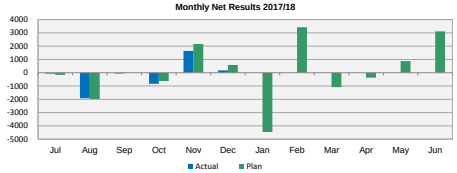
Supporting Better Public Services Results 3 Keeping Kids Healthy
The DHB is continuing to implement an oral health project focusing on developing a collaborative approach to reducing ASH 0-4 through early primary care intervention and more coordinated advice and support for Māori, Pacific and low-decile populations.

System Level measures: Implementation of the Improvement Plan

Health Targets

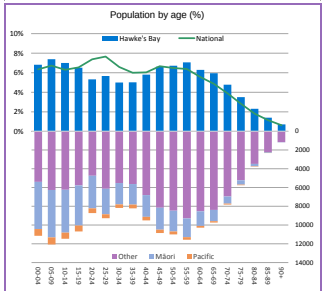


Financial Management



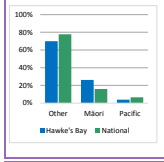
Net Result: YTD-Dec 2017
Actual: (1,061)
Plan: 0
Variance: (1,061)

DHB POPULATION OVERVIEW

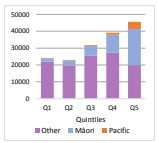


Hawke's Bay age distribution by ethnicity (number)

Population by ethnicity (%)



Hawke's Bay ethnicity by deprivation quintile



PERFORMANCE

People Powered

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

Key priority response actions:
Reducing Unintended Teenage Pregnancy: Hawke's Bay have trained 100% of school based health service nurses to use advanced standing orders for contraception.

DHB nominated highlights:
The Matariki (Regional Economic Development) Strategy and Social inclusion Strategies have been presented to our HBDHB governance committees and are being socialised amongst the health sector

Regional nominated highlights:
Mental health and addiction:
The Connecting the Dots forum is open to all and a portion of participants in 2017 identified as peers.
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
			Improved management for long term conditions
			Improved management for cardiovascular health
			Improved management for diabetes services
NA	NA		Improved management for acute heart services
NA	NA		Improved management for stroke services
			Improving breast screening rates
			Improving cervical screening coverage
			Regional:
			Cardiac services
			Stroke services

Key priority response actions:
Childhood Obesity Plan: Hawke's Bay DHB has contracted local providers to deliver a maternal nutrition and activity programme, Active Families and Green Prescription, with an equitable health outcomes focus. The DHB is also supporting schools to deliver 'water only' policies.

DHB nominated highlights:
The Oral Health project for under 5s is showing gains in terms of whānau accessing dental care

Regional nominated highlights:
Mental health and addiction: Connecting the Dots 2018 will draw people from across the region to discuss ways to work together for common goals around improving physical wellbeing of this population.
Connecting the Dots 2017 and 2018 were designed to address the physical wellbeing of people using services.

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
NR			Improving wait times for diagnostic colonoscopy - Urgent (<14 days), Non-Urgent(<42 days), Surveillance(<84 days)
		NA	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:
Child Health: Hawke's Bay is working on its Ngātahi programme, mapping staff skills to key competencies to identify gaps and opportunities to improve skills and knowledge to work effectively for families, especially tamariki/rangatahi Māori and their whanau. They are also working on expanding its Maternal Wellbeing and Child Protection Multiagency Group to cover up to 2 years of age and implement the Parenting and Pregnancy.

DHB nominated highlights:
April Strategy UK has provided feedback on the Big Listen (staff from HBDHB and PHO and consumers attending workshops to provide feedback). Further workshops have been conducted on how to make change to improve our performance across the DHB and the wider health sector.

Regional nominated highlights:
Mental health and addiction:
Survey to update regional service guide completed. This will guide an enhanced document for referrers.
Regional Service Data Gap Analysis completed. This will guide additional service measurements to be developed.

Conversation Opportunities

This revised performance dashboard for 2017/18 is a first initial step towards a stronger focus on performance for the DHB population and on reducing inequality. It also presents an explicit view of performance framed around the themes of the New Zealand health strategy.

In future quarters this area of the dashboard is intended to include triggers for conversation opportunities both internally within the DHB, and with the Ministry. The intention is to support conversations that help to make meaningful connections between the DHB's performance and its population characteristics. We would be pleased to receive your feedback to how the conversation opportunities section can be used to provide value for you.

One Team

*T	M	O	
			Improving wait times for diagnostic services - CT and MRI scans (<42 days)
		NA	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:
Disability support services: Hawke's Bay DHB has worked to ensure representatives for physical and sensory disability and also for intellectual and neurological disability are members of their Consumer Council.

DHB nominated highlights:
Feedback from Sapere Consulting post 8 patient journey workshops completed with staff from across the health sector and consumers, has now been received and presented for feedback

Regional nominated highlights:
Mental health and addiction Perinatal Mental Health services:
Perinatal Mental Health services developed an exemplar document of a Regional Support Model to enhance others support models.

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:
DHB – IT: Hawkes Bay DHB is on track with delivery of key 2017/20-18 initiatives and are engaging with TAS on the implementation timeline for the regional clinical portal.

DHB nominated highlights:
The DHB's IS team has visited Canterbury DHB to view HealthOne which plugs into Clinical Portal and provides a consolidated view of patient records captured through GP systems, pharmacy systems, and hospital information systems.

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

The DHB did not provide a narrative report as required regarding the measure of Improved management of diabetes services in this quarter. Reporting as required on this measure is expected in the following quarters.

The Ministry is working closely with the DHB on recovery plans to ensure that patients receive first specialist assessments (FSA) within expected time frames.

Equity Challenges

The DHB has failed to meet the target in this quarter for Māori patients regarding the Better help for smokers to quit in public hospital measure. A continued focus on Māori patients is needed to meet the target at hospital setting.

The DHB is continuing with improving early intervention type services and improving service responses to children across ethnicities which the DHB expect to have an impact on community treatment order rates in future. The DHB has no focus on what might be done to reduce the current high rate of Māori under community treatment orders.

For the three years to 30 Sep 2017 the DHB has cervical screening coverage below 75% for both Māori and Asian women. The DHB needs to work intensively with primary care to facilitate a team approach to improving coverage and provide opportunistic screening, or refer Māori and Asian women to alternative providers.

Regional Performance Challenges

For Cardiac Secondary Services, the actual delivery of cardiac surgery procedures is 23% below plan and intervention rates for angiography and cardiac surgery remains low for the most recent data. For Electives Services, only four Central DHBs have met their Electives health target for Q2. The partially achieved rating is also due to waiting times performance for October and November.

The partially achieved rating for Major Trauma is due to the inability to report Central region data submitted to the National MT Registry and the lack of timely data submission by MidCentral DHB. Action is being taken to address both issues. For Hepatitis C Service, the partially achieved rating is also due to MidCentral DHB submitting incomplete data.

OWNERSHIP VIEW

Standardised Intervention Rates of Procedures

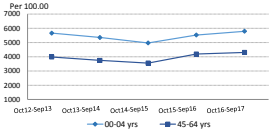
12 month period ending in September of the year

	2013	2014	2015	2016	2017	National Target
Angiography	34.99	33.58	37.20	37.89	36.55	34.70
Angioplasty	11.23	10.32	11.68	12.39	11.96	12.50
Cardiac Surgery	5.11	5.58	6.00	6.31	4.73	6.50
Cataracts	41.86	49.91	47.26	49.53	49.67	27.00
Major Joints	18.96	21.05	16.25	20.09	22.87	21.00

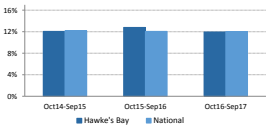
Service Coverage Delivery

This quarter the DHB provided an update on its delivery plan for Te Ara Whakapiri: Principles and guidance for the last days of life. However it did not provide a requested update on sharps disposal services in the community.

Ambulatory Sensitive Hospitalisation Rates



Acute Readmission Rates (standardised)



Patients Waiting for FSA

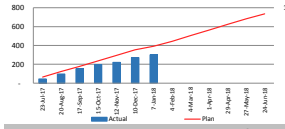
	Sep	Oct	Nov	Dec	Last mnth	4 mnths
ESPI 2	3	68	71	167	96	164
ESPI 2 %	0.1%	2.1%	2.2%	5.0%	2.8%	4.9%

Patients Waiting for Treatment

	Sep	Oct	Nov	Dec	Last mnth	4 mnths
ESPI 5	9	31	8	52	44	43
ESPI 5 %	0.8%	2.7%	0.7%	3.9%	3.2%	3.1%

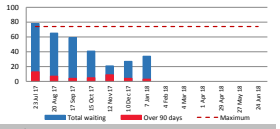
Regional Delivery of Cardiac Surgery

CAPITAL & COAST DHB OF SERVICE
Performance Against Plan: 77%
Variance: -92



Regional Wait List for Cardiac Surgery

CAPITAL & COAST DHB OF SERVICE
Total Regional Waiting list: 61
% of National Waiting List: 23%



Patient Experience

Quality and Safety Markers

	Goal	Performance
Falls risk assessment (Apr-Jun17)	90%	100%
Hand hygiene (Apr-Jun17)	80%	88%

Surgical site infections (Jan-Mar 2017):	Goal	Performance
Antibiotic administered in the right time	100%	100%
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 4.
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.
Reducing rheumatic fever	A progress report against the DHB's rheumatic fever prevention plan.
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.
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.
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 resolution plan.
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.

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:

27. Confirmation of Minutes of Board Meeting - Public Excluded
28. Matters Arising from the Minutes of Board Meeting - Public Excluded
29. Board Approval of Actions exceeding limits delegated by CEO
30. Chair's Update
31. Annual Plan Prioritisation Workshop Outcomes from 16 May 2018
32. HB Clinical Council
33. Finance Risk and Audit Committee

The general subject of the matter to be considered while the public is excluded, the reason for passing this resolution in relation to the matter and the specific grounds under Clause 32(a) of the New Zealand Public Health and Disability Act 2000 for the passing of this resolution are as follows:

- Official Information Act 1982 9(2)(ba) to protect information which is subject to an obligation of confidence.
- Official Information Act 1982 9(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions between the organisation, board and officers of the Minister of the Crown.
- NZPHD Act 2000, schedule 3, clause 32(a), that the public conduct of the whole or relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982).