HAWKE'S BAY DISTRICT HEALTH BOARD

ANNUAL PLAN 2015/16

with Statement of Intent
2015 – 2019
and
Statement of Performance Expectations
2015/16

HAWKE'S BAY
District Health Board
Whakawāteatia

Front cover photos - Te Mata Peak Tuki Tuki Spotlight and The Cape
by Ankh Photography www.ankh.co.nz

OUR VISION

"HEALTHY HAWKE'S BAY"

"TE HAUORA O TE MATAU-A-MAUI"

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

OUR VALUES / BEHAVIOURS

TAUWHIRO - delivering high quality care to patients and Consumers

RARANGA TE TIRA – working together in partnership across the Community

HE KAUANUANU – showing respect for each other, our staff, patients and consumers

AKINA – continuously improving everything we do

Hawke's Bay District Health Board
Annual Plan 2015/16

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Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

25 SEP 2015

Mr Kevin Atkinson
Chairperson
Hawke's Bay District Health Board
Private Bag 9014
Hastings 4156

Dear Mr Atkinson

Hawke's Bay District Health Board 2015/16 Annual Plan

This letter is to advise you I have approved and signed Hawke's Bay District Health Board's (DHB's) 2015/16 Annual Plan for three years.

I wish to emphasise how important Annual Plans are to ensure appropriate accountability arrangements are in place. I appreciate the significant work that is involved in preparing your Annual Plan and thank you for your effort.

The Government is committed to improving the health of New Zealanders and continues to invest in key health services. In Budget 2015, Vote Health received an additional $1.7 billion in government spending, demonstrating the Government's on-going commitment to protecting and growing our public health services.

As you are aware, a refresh of the New Zealand Health Strategy is currently under way. The Strategy will provide DHBs and the wider sector with a clear strategic direction and road map for the next three to five years for delivery of health services to New Zealanders. Thank you for your involvement to date and your continued input into the refresh.

Living Within our Means

The Government is determined to reach surplus in 2015/16. To assist with this, DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance in order to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of DHBs' operation and service delivery. Additionally, improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs.

I am pleased to see that your DHB is planning a surplus for 2015/16 and for the following three years. I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result for 2015/16.

Health Shared Services Programme

DHBs have committed to progress the shared service initiatives (Food Services, Linen and Laundry Services and National Infrastructure Platform business cases), and to include cost and benefit impacts for the Finance Procurement and Supply Chain Initiative in Annual Plans where

these are available. I expect that DHBs will deliver on these business cases within their bottom lines.

With the establishment of NZ Health Partnerships Ltd, consistent with the shareholders' agreement, I expect all DHBs to work together to ensure successful implementation of the current programmes and to identify, develop and implement future opportunities.

National Health Targets

Your Annual Plan provides a good range of actions that I am confident will support strong health target performance when implemented in 2015/16. Please ensure all health target actions identified in your Annual Plan are fully implemented to help you to continue to deliver better outcomes for your population.

As you are aware, from quarter two of 2014/15, the 62 day Faster Cancer Treatment indicator became the cancer health target with a target achievement level of 85 percent by July 2016 and then increasing to 90 percent by July 2017. I am concerned that the pace of progress needs to improve if the 85 percent target is to be achieved by July 2016. Please ensure delivery of this target remains a key priority for your teams.

System Integration

As you are aware, DHBs are expected to continue focussing on integrated healthcare and to shift services closer to home in 2015/16. Shifting services is varied based on local need, context and scalability and can range from co-locating outpatient clinics in the community, through to redesign of services.

I understand that Hawke's Bay DHB plans to maintain primary care access to radiology, and to strengthen integration in 2015/16 by:

- developing an Urgent Care service to reduce acute demand by the end of quarter two with implementation by quarter four
- integrating gerontology and community teams to primary care with an annual investment of $2.3 million
- increasing access to podiatry services with an investment of greater than $200,000
- implementing a diabetes support pathway to support best practice with an investment of $40,000
- establishing cardiac, gerontological and specialist nurse practitioners in primary care to support primary care with an investment of $230,000
- implementing six previously developed clinical pathways and developing two new pathways.

I look forward to being advised of your progress with this throughout the year. Where these services trigger the service change protocols you will need to follow the normal service change process.

Better Public Services (BPS): Results for New Zealanders

Of the ten whole-of-government key result areas, the health service is leading the following areas:

- increased infant immunisation
- reduced incidence of rheumatic fever
- reduced assaults on children.

It is important that DHBs continue to work closely with other social sector organisations, including non-governmental organisations, to achieve our sector goals in relation to these and other initiatives, such as Whānau Ora, Children's Action Plan and Youth Mental Health.

Tackling Obesity

I am pleased to note your Annual Plan includes a focus on obesity and identified a range of activities to tackle obesity. I have asked Ministry officials to look at what actions can be undertaken

to help address childhood obesity, including, advice on a possible obesity target that will be meaningful and evidence based. I will be writing to all DHBs in coming months to outline proposed next steps.

Annual Plan Approval

My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the National Health Board. I am aware you are planning a number of service reviews in the 2015/16 year. Please ensure that you advise the National Health Board as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2015/16 Annual Plan. I look forward to seeing your achievements.

Please ensure that a copy of this letter is attached to the copy of your signed Annual Plan held by the Board and to all copies of the Annual Plan made available to the public.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

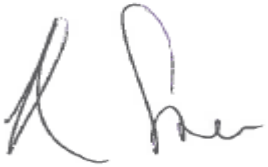
STATEMENT FROM THE CHAIR AND CHIEF EXECUTIVE

Two years on from the launch of the organisation's Transform and Sustain strategy, inroads in improving the health and well-being of our community continue as we think and act as one health system rather than a hospital a district health board or a primary care provider. We have made significant progress in some important areas, in the last 12 months. In October 2014, we published "Health Inequity in Hawke's Bay", an important piece of population health research. This has acted as a catalyst to engaging with other agencies as part of a multi-sector response to find solutions to the significant inequities highlighted in the report.

Building relationships with our providers has also taken priority in the past year with some high-trust contracts already in place. These trust based contracts will pay dividends because providers are able to more efficiently develop longer-term health programmes that benefit our community. We also launched our AIM 24/7 programme to improve acute inpatient flow through the hospital. This project wasn't about "tinkering" at the edges of managing patient care and has required transformational change. A number of work streams were developed and clinically led. There have been many achievements through this project such as, new ED observation beds and a medical day stay unit as well as a new acute assessment unit model of care. Other initiatives are in progress – the Operations Centre and the winter response plan, for example, will stand the hospital in good stead in the future when facing regular and cyclical pressures. Another key piece of work has been Operation Productivity - improving theatre productivity. This work is still in progress but is already delivering some worthwhile gains for our community, by improving operating capacity.

On the infrastructure front, our flagship mental health inpatient unit project is ahead of schedule and should be ready within the next year – a pleasing achievement after many years of planning efforts. Building has also begun on the new primary maternity birthing unit, the Napier Health Centre upgrade has been completed and plans for a new stand-alone gastroenterology facility are progressing These are just examples of some of the excellent improvement initiatives at Hawke's Bay District Health Board (HBDHB).

This annual plan focuses on the 2015/16 year which ends on 30 June 2016. An annual plan is a legal requirement and is the primary accountability document between the Minister of Health and HBDHB. We are planning to deliver our fifth consecutive surplus in 2015/16. Our baseline funding from the Ministry of Health continues to grow but, in order to fund approved investments along with additional spending needed by our various service directorates, we have a savings plan of $8.5 million (1.65% of overall expenditure) for 2015/16. This is prudent management of resources as we continue to strive for the "triple aim" that underpins our Transform and Sustain strategy. The only alternative to a focused savings programme would be to stay as we are and not keep investing in new innovations and services by delivering a surplus, but very quickly that would put us back to a situation where we wouldn't be able to provide a quality service for our community.



X _____
Dr Kevin Snee
Chief Executive - Hawke's Bay District Health Board

X _____
Kevin Atkinson
Board Chair – Hawke's Bay District Health Board

X_____
Hon. Dr Jonathan Coleman
Minister of Health

LETTER OF SUPPORT FROM THE PRIMARY HEALTHCARE ORGANISATION

As the single Primary Healthcare Organisation (PHO) in the Hawke's Bay district, Health Hawke's Bay - Te Oranga Hawke's Bay (HHB) works closely with Hawke's Bay District Health Board (HBDHB) to implement the better, sooner, more convenient policy at a local level. Our aim is to support the enrolled population in Hawke's Bay by delivering first level services through General Practices and a range of other health services providers.

Our management team actively contributes to joint planning with HBDHB through membership of the Executive, development of services in response to priority focus for which the PHO takes a lead, co-development of numerous programmes across primary care, and shared effort in respect of governance, monitoring and intelligence. In addition, our Board members take part in the bi-annual Health Sector Leadership Forum as well as ad hoc governance and strategic opportunities as they arise. Our partnership with HBDHB is formalised through an Alliance agreement and the Alliance Leadership Team has a key role in facilitating an integrated response to health sector challenges along with the Hawke's Bay Clinical Council, which is an advisory committee to the HBDHB Board. Elements of this Annual Plan, which are the specific responsibility of the PHO, are reflected in HHB planning documents too and those elements are endorsed by our Board.

We are unified with HBDHB through our common vision and values and, where possible and appropriate we work jointly and with Ngāti Kahungunu to co-produce strategic direction. In 2015/16, we look forward to another year of partnership and co-production as we work towards one health system focused on patients and whānau.

X _____

Liz Stockley
Chief Executive
Health Hawke's Bay - Te Oranga Hawke's Bay

1. INTRODUCTION & STRATEGIC INTENTIONS

1.1 EXECUTIVE SUMMARY

Hawke's Bay District Health Board (HBDHB) is a Crown Entity and is the Government's funder and provider of public health and disability services for the population in our defined district. Our vision is simple - we want everyone in Hawke's Bay district to be healthy. The funding and provision of services is guided by our statutory obligations and by priorities established at the national, regional and local levels. As an integrated health system, we rely on networks of suppliers across the spectrum of care and across New Zealand. Our organisation is the district's largest single employer making us a significant contributor to the local economy. The population of Hawke's Bay district has some unique characteristics compared to the rest of New Zealand in terms of health status and socio-demographics, and this provides us with some specific challenges.

Locally, we are guided by a health-sector strategic framework and our five year strategic programme - Transform and Sustain, which was launched in December 2013. Our three priority goals for Transform and Sustain are: responding to our population; delivering consistent high-quality care; and being more efficient at what we do. Through the programme we will contribute to the Government's priorities for the health system, which include fiscal discipline, strong clinical leadership, integration between Primary and Secondary care, achieving the National Health Targets, and tackling the key drivers of morbidity. We also work collaboratively for optimal arrangements by aligning our work to a Regional Services Plan developed on behalf of the six Central Region DHBs - Whanganui, Mid-Central, Wairarapa, Hutt Valley, Capital & Coast, and Hawke's Bay. Fiscal responsibility means that we plan for modest annual operating surpluses that enable us to invest in programmes that will deliver the necessary transformational change for ongoing quality improvement.

Our Statement of Intent outlines our strategic intentions for the next four years and shows how local outputs impact on our population and contribute to local, regional and system-level outcomes. The health system outcomes are defined by the Ministry of Health as New Zealanders living longer, healthier and more independent lives, and a cost effective health system supporting a productive economy. Over time, we will measure progress towards our vision by considering patient and whānau experiences of care, resource sustainability and life expectancy gap as headline system outcomes plus a suite of eighteen key supporting dimensions that will be evidence of impact.

Targets for service performance standards for the 2015/16 year are aligned to the New Zealand Triple Aim, which is part of our strategic framework, and are set out in the Statement of Performance Expectations grouped according to four reportable classes of outputs: Prevention Services; Early Detection and Management Services; Intensive Assessment and Treatment Services; and Rehabilitation and Support Services. A set of financial statements for the 2015 to 2019 period is also included. Actual results will be audited against those forecasts by Audit New Zealand after the end of each financial year.

X_____

Board Member

X _____

Board Member

1.2 CONTEXT

Hawke's Bay District Health Board (HBDHB) is one of 20 District Health Boards (DHBs) that were established by the New Zealand Public Health and Disability Act 2000 (NZPHD Act). HBDHB is the Government's funder and provider of public health services for the 159,600[1] people resident in the Hawke's Bay district. A map of the district, which is defined by the NZPHD Act is shown in Figure 1. In 2015/16, HBDHB's allocation of public health funds will be $482 million, including 3.96%[2] of the total health funding that the Government allocates directly to all DHBs.

Our objectives[3] are to improve, promote and protect the health, well-being and independence of our population and to ensure effective and efficient care of people in need of health services or disability support services. To achieve this, HBDHB works with consumers, stakeholder communities and other health and disability organisations to plan and coordinate activities, develop collaborative and cooperative arrangements, monitor and report on health status and health system performance, participate in training of the health workforce, foster health promotion and disease prevention, promote reduction of adverse social and environmental effects, and ensure provision of health and disability services.

Funding and Provision of Services

Each DHB has a statutory responsibility for the health outcomes of its district population as well as an objective under law to seek optimum arrangements for the most effective and efficient delivery of health services. This requires the health system to be integrated at local, regional and national levels.

As a funder, HBDHB buys health and disability services from various organisations right across New Zealand for the benefit of our population.

We fund and work very closely with Health Hawke's Bay – Te Oranga Hawke's Bay Primary Healthcare Organisation (the PHO) who coordinate and support primary health care services across the district. The PHO brings together General Practitioners (GPs), Nurses and other health professionals in the community to serve the needs of their enrolled populations. Other organisations we fund may be community-based private entities, such as residential care providers or individual pharmacists, or may be public entities, such as other DHBs. In 2015/16 we will fund over $222 million worth of services from other providers. 76.5% (2014/15 75%) of those services will be from primary care and private providers mostly based in Hawke's Bay communities and the other 23.4% will be from other DHBs for more specialised care than is provided locally. The local component is projected to grow by $8.4 million.

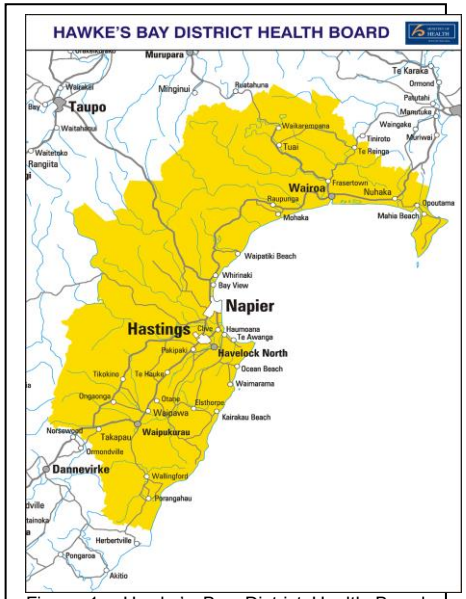


Figure 1: Hawke's Bay District Health Board District

As a provider, we supply health and disability programmes and services for the benefit of our population and on referral for other DHBs' patients. This includes a full range of services from prevention through to end-of-life care that are provided through resources owned or employed directly by us. Where we cannot provide the necessary level of care locally, we refer patients to other DHBs and larger centres with more specialised capability.

[1] Estimated by Statistics New Zealand based on assumptions specified by Ministry of Health

[2] HBDHB share has increased from 3.89% in 2014/15.

[3] DHB performance objectives are specified in section 22 of the NZPHD Act.

Because population numbers are too small to justify a full range of service provision in every district, each DHB is also part of a regional grouping that is coordinated to optimise service delivery. HBDHB is part of the Central Region along with Whanganui, Mid-Central (Manawatu), Capital and Coast (Wellington & Kapiti), Hutt Valley and Wairarapa DHBs. There are approximately 884,000 people living in the Central Region - around 19% of the total New Zealand population.

Despite this larger grouping, a small number of specialised services cannot be efficiently provided even at the regional level and these are, therefore, arranged as national services located at one or two provider hospitals for the whole of New Zealand. Examples are clinical genetics and paediatric cardiology. These services are planned and funded centrally by the National Health Board with all DHBs having access.

Organisational Overview

HBDHB has ...

- 267 doctors
- 1,419 nurses
- 531 allied health professionals
- A 400-bed secondary hospital
- An 11-bed rural hospital
- 2 community health centres

With over 2,800 employees, HBDHB is the district's largest employer. Our provider arm is known as Health Services and our frontline services are delivered to patients and consumers across the district in a number of settings. For example, we provide public health programmes in schools and community centres, inpatient and outpatient services in leased and owned health facilities, and mobile nursing services in people's homes. The main health facilities include Hawke's Bay Hospital, (Hastings Memorial), Wairoa Hospital and Health Centre, Napier Health Centre and Central Hawke's Bay Health Centre. In addition, we have significant investment in clinical equipment, information technology and other (non-clinical) moveable assets.
Corporate and clinical support services are located appropriately to provide effective back-up to our frontline services.

Our organisation is governed by a Board with eleven members, seven of whom are elected every three years (last election in 2013) and four of whom are appointed by the Minister of Health. The Board is advised by four committees that include clinical, community and consumer representation. The Board employs the Chief Executive Officer to lead an executive management team, who oversee the day-to-day operations of the organisation.

Our population

In 2015/16, the Hawke's Bay district population will grow slightly to over 159,000 people. Most of our population live in Napier or Hastings - two cities located within 20 kilometres of each other that together account for more than 80% of the total numbers. About 10% of the population live in or close to Wairoa or Waipukurau, which are relatively concentrated rural settlements, and the remaining 10% live in rural and remote locations.

Compared to New Zealand averages, there are some important differences in the makeup of our population – we have a higher proportion of Māori (25% *vs* 16%), more people aged over 65 years (18% *vs* 15%) and more people living in areas with relatively high material deprivation (27% *vs* 20%). The 2013 New Zealand Index of Deprivation (NZDep13)[4] explains how relative deprivation, as one measure of socio-economic status, is an indication of disadvantage in terms

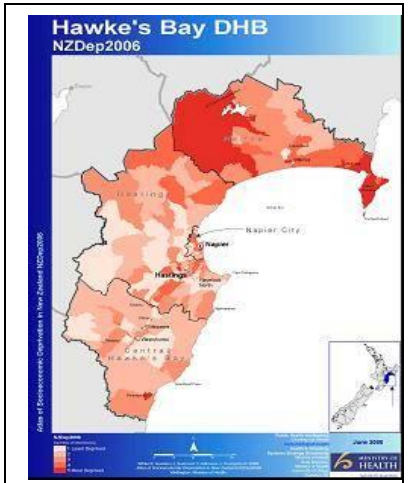


Figure 2: Hawke's Bay District relative deprivation

[4] NZDep2013 is a measure of the average level of deprivation time relative to the whole of New Zealand. The 2013 index was based on nine variables: - 2 related to income plus home ownership, family support, employment status, qualifications, living space, communications, transport. Result quoted is based on mesh-block data.

of people's opportunity to access and use the health system.
Figure 2, shows the pattern across Hawke's Bay DHB according to NZDep2006 – this is not expected to be markedly different to NZDep2013.

Health Status
In 2014 we produced an analysis and report on health status in Hawke's Bay[5]. The focus of the report was on equity because health inequities are differences in health status that are avoidable or preventable and therefore unfair.

The report finds many inequities in health in Hawke's Bay, particularly for Māori, Pasifika and people living in more-deprived areas. There are also areas where, with determined and focused effort, we have improved outcomes and reduced inequities. This demonstrates that inequities are not inevitable. We can change them if we have the courage and determination to do so.

Key findings:

- More deaths at younger ages. More Māori, more Pasifika and more people living in the most deprived parts of Hawke's Bay are dying at younger ages
- Socioeconomic conditions. Social inequity in Hawke's Bay is widening. The health impacts on children are more immediate and rates of admission to hospital for 0-14 year olds for conditions known to be strongly linked to social conditions are increasing, particularly for Pasifika and Māori children
- Tobacco use. The leading cause of avoidable deaths amongst Māori women is now lung cancer. High smoking rates amongst pregnant Māori women is a significant health issue.
- Obesity. One in three adults in Hawke's Bay is obese. Hawke's Bay men and women are less active in all age groups than their New Zealand average counterparts
- Alcohol use. One in every four adults in Hawke's Bay is likely to be harming their own health or causing harm to others through their alcohol use.
- Access to primary care. High self-reported unmet need and higher rates of avoidable hospital admissions, especially amongst 45-64 year olds, show that there continue to be access issues to primary care.

The Health Equity Report concludes that inequity affects everyone and, for a difference to be made, we must tackle this collectively and take responsibility as a community. Since release, the findings of the report have been presented to a range of groups and organisations - the DHB and PHO Boards and staff, local government bodies, Ministry of Social Development, the National Health Committee, Māori providers, clinicians, etc. The level of interest has been very positive and has led to the Hawke's Bay Intersectoral Forum[6] taking a role in putting together an action plan, with nominated sector leads, to address priority areas. This multi-agency approach aims to bring a full range of relevant providers together with public, philanthropic and private funders to implement novel opportunities to integrate efforts that will address inequity as a community.

The full Health Equity Report can be accessed from our website: www.hawkesbay.health.nz. Health status reviews rely on up-to-date population information and HBDHB conducts periodic updates with full reviews following the release of Census data. The next full review is likely to be conducted following the 2018 Census.

[5] Health Equity in Hawke's Bay, Hawke's Bay District Health Board. 2014. Available from www.Hawke'sbay.health.nz

[6] Includes Mayors, Members of Parliament, Iwi, Local and Regional Councils, Business HB, EIT, Government agencies – Housing NZ; Police, Corrections, Ministry of Social Development, Ministry of Education, Te Puni Kokiri, DHB

1.3 STRATEGIC INTENTIONS

Integrating the funding and provision of health and disability services across national, regional and local levels necessitates alignment of strategic direction in the same manner.

National

The driving goals for Government and the State Sector are that New Zealanders have greater opportunities, enjoy greater security, and experience greater prosperity. The health system contributes to these goals by working towards New Zealanders living longer, healthier and more independent lives, and by supporting New Zealand's economic growth.

Government's priorities for the health system are communicated to all DHBs through the Minister of Health's annual "Letter of Expectations"[7]. For 2015/16 the Government's investment of an extra $3.8 billion in health since 2008/09 is highlighted alongside a requirement that DHBs operate within allocated funding and drive efficiency in back-office processes and collaboration national, regional and sub-regional levels. Fostering strong clinical leadership remains a focus for DHB as well as continuing to focus on integration between primary and secondary care. There is an ongoing focus on the national health targets and the Better Public Services initiatives along with a new emphasis on tackling the drivers of morbidity with particular reference to what DHBs can do to help reduce the incidence of obesity in New Zealand. In an effort to focus DHBs on strategic direction, the Minister has promised the sector an update and refresh of the New Zealand Health Strategy while requiring all DHBs to submit refreshed Statements of Intent.

Regional:

A Regional Services Plan (RSP)[8] has been developed by the six central region DHBs to provide an overall framework for future planning around optimum arrangements and regionalisation. In the short-term, the RSP focuses on short to medium-term coordination of regional programmes, integration of vulnerable services and financial sustainability.

Local

In 2013, we published Transform & Sustain[9], our strategic plan for 2014 – 2018. Transform & Sustain provides common understanding of our direction and began with sector-wide agreement on a common 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."

Underpinning that vision are values, principles, aims, goals and strategies that are summarised in Appendix 1.

The logic that links the impact of our work locally to local, regional and national strategic intentions is shown in Figure 3 below.

[7] Minister of Health's Letter of Expectations, December 17th 2014.

[8] Regional Services Plan 2015-2016, Central Region District Health Boards, 2015. Available from www.centraltas.co.nz

[9] Available from our website: www.hawkebay.health.nz

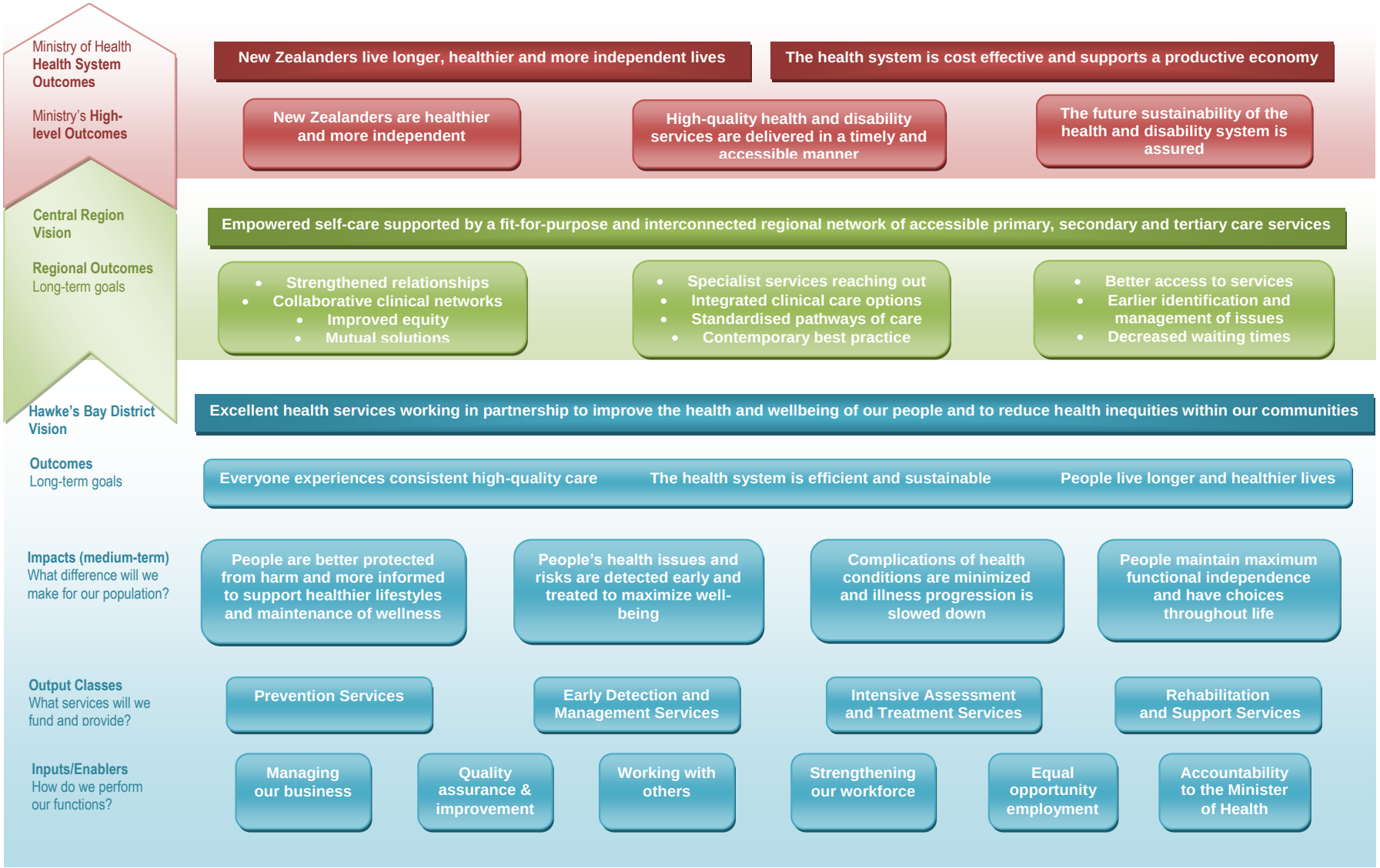


Figure 3: Connecting local activity to local, regional and national objectives

Despite the significant progress made in the recent past, our vision will remain a series of words unless we deal with the more challenging issues, such as the growth in chronic illness, our ageing population and vulnerability in a large sector of our community.

Our Challenges

Locally, our population profile is changing. Despite population growth[10] being modest, at about 2.7% in the next 10 years, we will see significant changes in age groups. In our population the over 65s will grow by 16% and the over 85s will increase by 12%. The same age group of Māori and Pasifika people will grow even faster at 51% and 106% respectively.

MĀORI & PASIFIKA	2016	2025	Growth
0-14	15,770	16,450	4.3%
15-64	28,220	30,790	9.1%
65yrs +	3,010	4,550	51.2%
85 yrs +	160	330	106.3%

Growth in the population is being driven by a younger age profile in the Māori and Pasifika population, which results in a higher birth rate, plus increased life expectancy across our whole population.

TOTAL	2016	2025	Growth
0-14	34,150	33,170	-2.9%
15-64	97,960	96,070	-1.9%
65yrs +	29,190	33,960	16.3%
85 yrs +	3,480	3,930	12.9%

[10] Statistics New Zealand, Projections prepared for Ministry of Health, October 2014.

These projected population changes emphasise the need for HBDHB to maintain our focus on improving Māori and Pasifika health and to reorient our services to address and manage age-related health issues.

Risk and Opportunity

The health of our population can be described using the diagram in Figure 3, where everyone in the population fits within one of these categories. Our focus will be to keep people healthy, to stay well and to require less hospital care.

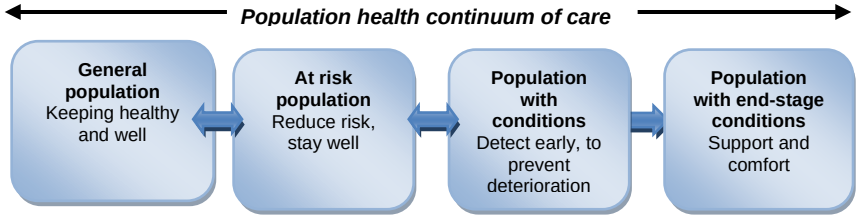


Figure 4 - Population Health Continuum of Care

An increasing burden of long-term conditions is a worldwide issue as modern medicine reduces early death. This is particularly so in places with demographics like Hawke's Bay – an ageing population with areas of significant deprivation and vulnerability. New Zealand research shows that, generally, Māori develop ageing conditions about 10 years younger than non-Māori.

Therefore, due to age-related and other long-term conditions, we need to concentrate on three main themes:

1. Helping people to stay healthy and well and able to live independently in their own home for longer
2. Ensuring that people who have complex long-term illnesses are able to live to their full potential

3. Supporting frail elderly people and their families/whānau.so that they can put in place a better plan for how they want to be cared for as the end of their life approaches (advance care planning).

This needs to be done in an integrated and coordinated way, meaning that all organisations need to work together with a focus on prevention, recognising that good health begins in the places where we live, learn, work and play, long before medical assistance is required. At the same time, by better understanding the changing needs and challenges of our ageing population and their inevitable frailty and dependency towards the end of a long life, we need to put in place better services designed to support the elderly and the changing needs of our population.

We can summarise these challenges into three priority goals:

1. Responding to our population
2. Delivering consistent high-quality health care
3. Being more efficient at what we do.

At the same time it is imperative that we remain financially robust so we are in a position to invest in programmes that will deliver transformational change.

Our Strategic Response

Considering the duties placed on us by the Treaty of Waitangi, the NZPHD Act and the national, regional and local context outlined above, HBDHB will prioritise our funding and provision of health and disability services based on our three priority goals.

Priority Goal 1: Responding to our Population

We have been too focused on the hospital when we could have been taking health services into the community. We have made progress in recent years but it has been slow, and there is still too much focus on meeting demand through secondary (hospital-based) care. We believe patients and whānau should be at the centre of health care, not a hospital or any particular care setting.

Barriers to accessing health care can occur for a number of reasons. For example, a person may be unable to get an appointment soon enough, may not have enough money to pay for an appointment at a medical centre or may not have the transport to get there. Often the services appear to be designed to suit the needs of professionals rather than patients. Our health workforce needs to have a good understanding of the people they serve; we need to have a stronger engagement with consumers. In particular, there are two main areas where we need to focus our attention.

Firstly, we must take action in regards to how we respond to the changing needs of our ageing population. We will focus on three responses:

- Recognising that many older people are well, we will develop opportunities for them to contribute valuable consumer support and advice to the care system
- We will provide care for our older people in their community with a clear intent to implement key care pathways and integrate service provision across primary and secondary settings
- Aiming to begin earlier conversations about care towards the end of life, we will lead open and honest conversations with people and whānau about decisions that affect them. By doing so, we will get a better understanding of what matters to the person and their whānau during this time and will be able to focus on supportive care that is the most appropriate for them.

Secondly, the growing Māori and Pasifika population and the persistent inequities that we see in terms of their health outcomes, means that we have to find better ways of engaging with whānau and aiga. We will:

- Create better working relationships that influence Māori and Pasifika health and well-being, acknowledging the formal and informal roles that community-based entities can bring to a partnership. These include iwi, hapū, Treaty settlement entities, Māori providers, individual marae, Pasifika community churches and key Government agencies
- Provide good cultural responsiveness training based on advice and support from experts in Māori and Pasifika cultural practices. We will

ensure that the health system workforce is well prepared and responsive and that resource allocation and service monitoring are informed through effective engagement, especially with Māori

- Work towards having a workforce that is more representative of our community. We have targeted a 10% year-on-year increase in the proportion of Māori staff employed and will focus on culturally appropriate recruitment across the system.

Priority Goal 2: Delivering Consistent High Quality Care

We generally deliver care to a high standard and we have seen some significant improvements in recent years. However, there are still too many examples where patient experience is inadequate and where mistakes that cause harm are made. Delivering high-quality care is about making sure we use all our resources in the best way, with the patients and their family/ whānau at the centre of that care. The best quality care is appropriate, convenient and precise – the patient gets exactly what they need, delivered as soon as possible and without error or undue waiting. Every staff member should be aware of their own responsibilities in quality improvement and safety when delivering day-to-day care. Clinicians are not only responsible for the provision of high-quality patient care, their leadership is also important. Clinical participation in the leadership and governance of health services is essential for creating a culture of effective quality and safety.

Priority Goal 3: Being More Efficient at What We Do

The future will not look the same as the present and that future will require different ways of working to deliver more productive services. Reducing waste in health will make us more efficient and will ensure we get the best value from health care resources by delivering the right care to the right people in the right place, the first time. The current systems do not effectively incentivise health providers to be responsive to patient needs or for delivering high-quality care. In addition, health organisations often appear to work around the needs of the organisation rather than the needs of the population.

We know that the whole public sector in New Zealand is facing a reduced growth in funding while, at the same time, the health system must deal with increasing expectations and changing needs. Transformation will rely on better understanding of value, smarter use of resources and frank communication among all stakeholders – this includes a clear responsibility on the population to take care of themselves (where they are able), and on providers to respond to reasonable expectations and true needs.

Achieving Regular Financial Surpluses

The DHB is responsible for most of the Government's spending on health in Hawke's Bay – surpluses are planned and must be delivered according to statutory obligations. This will allow us to invest in our infrastructure and services. Over the past four years, through hard work and good management, we have managed to generate an additional investment in our infrastructure with $34 million capital investment planned over the next three years.

Where to Next?

We are stepping up to deliver on our vision through Transform and Sustain. We must continue to recognise and research our population needs, work in partnership for quality health care and become more efficient at what we do. Transformation is happening and remains necessary to move forward in these areas.

The most effective way we can respond to these challenges is by transforming our services by improving quality. Transformation must lead to increased effectiveness – a more efficient system that maximises value for the population and reduces waste.

Financial sustainability is more likely to follow from an effective transformational change programme, where we work with our community so that our services meet their needs. Over time, through that transformation, achieving financial surplus will become business as usual.

How we will Assess Performance

The National Health Board monitors DHB performance on behalf of the Minister of Health. Financial and non-financial performance frameworks are in place as part of wider accountability arrangements providing assurance to the Minister about DHB performance in terms of the legislative requirements and Government priorities. In addition, HBHDB has implemented a performance monitoring process that is closely aligned to the national frameworks and that is used to generate a monthly report so that our Board can assess and query progress against performance objectives set out in our Annual Plan and Statement of Performance Expectations.

Measuring Progress towards Our Vision

We have developed the Hawke's Bay Health Sector performance and reporting framework to measure progress on Transform and Sustain and to show our stakeholders how that will lead us towards our vision. We also align our work to the New Zealand Triple Aim[11] for quality and safety outcomes which will mean:

- Improved quality, safety and experience of care
- Improved health and equity for all populations
- Better value for public health systems

The first part of our vision refers to how the system delivers health care:
"Excellent health services working in partnership…"

The second part captures the purpose of our work as:
"… to improve the health and well-being of our people and to reduce health inequities within our community.

Figure 4 below is the Hawke's Bay Health Sector Performance Framework. Our "Vital Signs" represent the outcomes that we expect to see improving over the longer term. We measure the intended outcomes of our work as changes over time and we recognise that the health sector is not solely responsible for achieving them. However, they are all measurable and are aligned to Transform and Sustain objectives as well as NZ Triple Aim dimensions of quality improvement.

Beneath the "Vital Signs" we have a suite of indicators that make up "Supporting Dimensions" – these show the impact of health sector work contributing to the outcomes that we seek.

Appendix 1 contains a matrix of the measures that will be used over time to monitor and report on progress against this framework.

Our outcomes have been modified since our last Statement of Intent. These outcomes are more aligned to other sector frameworks and are consistent with the purposes of the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000.

[11] The New Zealand Triple Aim is adapted from the Triple Aim developed by the Institute for Healthcare Improvement, Cambridge, USA. Details available from www.hqsc.govt.nz.

MEASURING OUR VISION

OURHEALTH HAWKE'S BAY Whakawateatia

HEALTHY HAWKE'S BAY

Excellent health services working in partnership to improve the health and well-being of our people and reduce health inequities within our community

NZ TRIPLE AIM

- Improved quality and safety of care
- Best value for public health system resources
- Improved health and equity for all populations

TRANSFORM & SUSTAIN

- Delivering consistent high-quality health care
- **Being more efficient** at what we do
- Responding to our population

VITAL SIGNS

- Patient experience
- Resource sustainability
- Live healthier and longer

SUPPORTING DIMENSIONS

- Better access to specialist outpatients
- A safer hospital
- Higher-quality general practices
- More older people living independently
- Improved hospital workforce productivity
- Better **staff** engagement
- Reduced infant mortality
- Fewer premature deaths
- Healthier weight
- Reduced readmissions
- A culturally responsive workforce
- More accessible general practice
- Better infrastructure **efficiency**
- Better **staff** retention
- Care closer to home
- More heart and diabetes checks
- Faster cancer treatment
- Fewer women smoking in pregnancy

Figure 4: The Hawke's Bay Health Sector Performance Framework

2. DELIVERING ON PRIORITIES AND TARGETS

This section focuses on activity around government and regional priorities to provide a sense of our commitment of resources to implementing those priorities and how we coordinate our efforts across all priority levels.

Performance targets and activity milestones in respect of Government priorities have been set with reference to the national health targets and the Dimensions of DHB Performance (DDP). How we will report against those measures is detailed in Appendix 2. Measurement against regional priorities is discussed in the Regional Services Plan[12] (RSP) and corresponding local activity is cross-referenced in the tables below. HBDHB adds to assessment of performance by setting additional targets within our measures of Performance Expectations (Chapter 3). Chapter 3 contains our Statement of Performance Expectations and the measures contained therein will be audited and used as the basis for our Annual Report for 2015/16 and as a key input to our Quality Accounts 2015.

The Minister of Health's annual "Letter of Expectations"[13] and the National Health Board planning guidelines provide a framework for highlighting Government's priorities in respect of the public health system. The sections below are categorised according to the planning guidelines with appropriate activity shown to illustrate key initiatives that are being implemented to achieve the given measures. An intervention logic approach has been used to illustrate how activity links to achievement of results. In addition, there are details of national and local priorities for Māori health as outlined in the guidance for DHB Māori Health Plans. Our Māori Health Plan 2015/16[14] is totally integrated into this Annual Plan but will be extracted as a stand-alone document only for submission to the MoH in order to comply with the requirements of our Operational Policy Framework.

Acknowledgement

The 2015/16 planning process for this Annual Plan included setting up groups of stakeholders around each priority area. Accountability for collating each section was shared between co-leads from Health Hawke's Bay – Te Oranga Hawke's Bay (the PHO) and HBDHB to ensure that there was PHO participation in the preparation of this plan. Groups drafted sections and coordinated clinical input over the period from January to May 2015.

[12] Central Region's Regional Services Plan 2015/16

[13] Minister's Letter of Expectations, 17th December 2014

[14] Our planning priorities for Māori health in 2015/16 are aligned to the national indicators for Māori health and to our three-year Māori Health Strategy, Mai – available from our website.

2.1 *PRIORITIES & TARGETS*

2.1.1 Better Public Services

HBDHB collaborates with other Government agencies and with all other DHBs to deliver collective activity and to meet our objectives and accountabilities to the Crown. Through a national work programme some lead DHB providers are responsible for the provision and development of a national service. We are committed to national service improvement programmes that require clinicians and managers across a designated service pathway to work together on interventions to improve equity of access, quality, consistency and sustainability nationwide. Access to services at other DHBs is managed through the "Inter District Flow" (IDF) process and we have procedures to ensure effective IDF assessment, approval and monitoring. Under our Transform and Sustain key intention, "Transforming multi-agency working", we are part of a local inter-agency forum that is being developed to guide a more collaborative approach across agencies.

In Hawke's Bay, Ngati Kahungunu Iwi Incorporated (NKII) is our local Iwi/Māori health relationship partner. NKII guides the way we integrate our work with Māori through a formal Memorandum of Understanding (MoU) and membership of our Māori Relationship Board (MRB). One of our Transform and Sustain intentions is "better engagement with Māori" and we work direct with NKII and through the MRB to enhance all engagement processes so that Iwi have a strengthened role in providing oversight of the deployment of local resources and the monitoring of effectiveness.

Increasing Immunisations	
Improved immunisation coverage leads directly to reduced rates of vaccine preventable disease, and consequently better health and independence for people. The HBDHB Immunisation Steering Group provides a forum for a collaborative approach to improving the immunisation rates for Hawke's Bay children and adults. New Zealand research has found that an established relationship with a primary care provider is a critical factor in the timely delivery of immunisation and that there is a need for more effective facilitation of early engagement with primary health care providers. Early enrolment with a General Practice (GP) and Well Child/Tamariki Ora (WC/TO) enables new-born babies to receive timely immunisation and other health checks. If infants are enrolled with a GP before they are six weeks of age then they can be effectively pre-called and vaccinated on time. The NIR is a tool that supports management of both individual and population health, and information from the NIR is used to assist with planning, targeting and monitoring of immunisation services. For those families/whānau not accessing primary care providers, it is important to offer opportunities for receiving childhood scheduled vaccinations in a safe environment. The Immunisation Team will continue to work collaboratively with Māori health providers, WC/TO providers, Before School Check (B4SC) coordinator, PHO, Family Start, and midwifery staff. We continue to provide staff from Māori health providers and Tamariki Ora with resources and training to promote the importance of immunisation with their families/whānau with a strong focus of "on time every time."	
Short-term outcome	**Measure**
Maintain immunisation coverage of 8 month infants and 2 year old children at 95% or above ensuring equity of coverage between different ethnic populations	95% coverage of 8 month & 2 year old children
Activity	**Monitoring & Performance**
• Facilitate HBDHB Immunisation Steering Group which provides a forum for a collaborative approach to improving immunisation rates for Hawke's Bay children. Representation on the Steering Group of all sectors	• Quarterly meetings • 95% coverage with equity

involved with immunisation: Midwife, WC/TO, Secondary services, primary care, Māori providers, Health Hawke's Bay (HHB) PHO, HBDHB Immunisation Team, Public Health, National Immunisation Register (NIR), the Immunisation Advisory Centre (IMAC). Implement and continue strategies in the Immunisation Steering Group Action Plan – "Improving Childhood Immunisation On-Time Rates in Hawke's Bay. Action Plan 1 January 2015 – 31 December 2016" Details include: ○ Strategies for identifying and referring due and overdue children who present to hospital services ○ Strategies for monitoring and maintaining equity	maintained • On-time immunisations achieving target • Datamart reports reflect equitable coverage
• Inter-agency planning around activities to promote Immunisation Week	• Narrative report in Q3
• Practice Patient Management System (PMS) audit systems will be used to identify those children who have not received immunisations; due and overdue children will be identified. Practices will then actively recall or refer these children to outreach. The PHO will engage with Māori providers in promotional and incentive activity such as providing nappies to encourage on time immunisation	• Ongoing
• Strengthen relationships with Māori service providers	• Ongoing
Short-term outcome	**Measure**
NIR is well coordinated - NIR is used to its maximum potential and assists HBDHB to reach and maintain its immunisation targets.	95% coverage of 8 month & 2 year old children
Activity	**Monitoring & Performance**
• Datamart reports are used regularly to measure the coverage rate and identify increased numbers of declining or opt-offs or other gaps in service delivery • All live births are recorded and monitored • Working relationships with primary care providers, WC/TO providers, HHB PHO, B4SC coordinator, Family Start providers, Public Health Nurses (PHNs), parents • Liaise with other NIR coordinators • Feedback is given to primary care providers on coverage rates	• NIR provides valuable accurate data at both the personal and population health level when the database is well maintained. • Ongoing information and support
Short-term outcome	**Measure**
Increase and maintain 4 year old immunisation coverage - working toward the Ministry of Health's (MoH) indicator of 95% of 4 year olds being up to date for immunisation	• Target 90% by June 2016
Activity	**Monitoring & Performance**
• HBDHB Immunisation Steering Group will continue to facilitate a collaborative approach to improving immunisation rates for Hawke's Bay children • Quarterly meetings of HBDHB Immunisation Steering Group monitor results and agree on action • Strengthen relationships with Māori service providers to ensure appropriate service provision	• Regular distribution of datamart reports to show numbers, rates, geographical coverage, equity, etc

○ 6-monthly meetings with Tamariki Ora providers to share results and learnings • Immunisation offered/promoted at the time of B4SC with outreach provided where indicated	
Short-term outcome	**Measure**
For girls born in 2002, 65% will have received dose 3 of HPV vaccine with equity maintained between the different ethnicities.	Increasing HPV (12-year-old) immunisation rates
Activity	**Monitoring & Performance**
• Sub-group of the Immunisation Steering Group to develop and implement an Action Plan to improve uptake of the HPV vaccine ○ Promote use of online learning tools with relevant stakeholders	• Data to reflect coverage rate achieved • Equity of coverage with Māori and Pasifika
Short-term outcome	**Measure**
Increase the % of Māori ≥ 65 years having annual influenza vaccination. Baseline = 68% (as at Dec 2014)	Increase % of Māori 65 years and over having influenza vaccination
Activity	**Monitoring & Performance**
• Collaborate with Māori providers and HHB to improve uptake of the influenza vaccination for Māori ≥ 65years. • Practice PMS audit systems will be used to identify those eligible for influenza vaccination. The Practice will then actively recall these people. The PHO will engage with Māori providers in promotional activity. The General Practice facilitation team will encourage Practices to recall and campaign between March and August 2015 • Review recording of volumes delivered by providers not invoicing for individual interventions to improve accuracy of aggregate data	• 75% of Kaumatua are immunised • Increased % of Kaumatua immunised • 75% of Kaumatua are immunised Increased immunisation being provided

Reducing Rheumatic Fever	
HBDHB previously had one of the highest rates of Acute Rheumatic Fever (ARF) in the country. However, the cases were predominantly found in the Hastings suburb of Flaxmere. In 2010, HBDHB and Te Taiwhenua o Heretaunga developed and launched 'Say Ahh', a rheumatic fever prevention programme in Flaxmere. So far in 2014/15 there have been no notified cases in the Flaxmere area. Our Rheumatic Fever Prevention Plan is updated regularly and the implementation is ongoing. We will be providing the next update of our Rheumatic Fever Prevention Plan to the MoH by 20 October 2015	
Short-term outcome	**Measure**
Less hospitalisations for ARF with a concentrated effort in areas with high Māori and Pasifika populations. Hawke's Bay baseline rate (2011/12) was 4.3 hospital admissions per 100,000 population.	Hospitalisation rate per 100,000 - less than 1.9
Activity	**Monitoring & Performance**
Rheumatic Fever Prevention Programme • Implementation of new Healthy Homes programme targeting 300 annual referrals for housing improvement	Regular monitoring and reporting of: • Referrals and resultant housing improvements

• Continue to promote and participate in cross-government workshops with Ministry of Social Development (MSD) and Housing New Zealand • Regular meetings of Healthy Homes Governance Group at least bi-monthly • Regular monitoring of paediatric respiratory admissions who meet eligibility criteria • Process for regular monitoring of housing-related hospital admission data will be established with Paediatric services with a suite of measures being developed • MoH reporting requirements will be completed and will highlight the range of interventions needed to fully implement the Healthy Housing initiative • Awareness raising in other non 'Say Ahh' low decile schools will be increased • Monitor rheumatic fever prevention activities in other non-'Say Ahh' Schools • Opportunist throat swabbing services will be extended in School Based Health Services (SBHS) low decile secondary schools	• Referrals to social service providers • Workshop and meetings actions • Prevention awareness raising activities completed • Evaluation of health promotion activities completed • Number of swabs taken in SBHS
Actions to Treat Group A streptococcal Throat Infections. • Commence raising awareness and improving health literacy with a focus on high risk school children not attending 'Say Ahh' schools • Review school throat swabbing programme and implement recommendations with key providers • Continue to promote opportunities for workforce development. • Complete annual Standing Orders update • Develop and monitor wider use of Standing Orders in primary care • Use coordinated primary options approach to fund access to free rapid-response sore throat management services in General Practices	• Number of activities in high-risk schools • Number of awareness raising sessions delivered • Review completed • Number of Clinical Nurse Educator (CME/CNE) sessions held • Number of providers (GP and Hauora) using Standing Orders
Actions to Facilitate the Effective Follow-up of Identified Rheumatic Fever Cases • Continue to monitor timeliness of secondary prophylaxis. • Continue to monitor time between admission and notification of all new cases of rheumatic fever • Root cause analysis carried out in all cases informs actions ○ For each case review, provide a report to the Ministry showing actions taken and lessons learned	• % of patients receiving secondary prophylaxis within 5 days of due date • % of patients notified within 7 days of diagnosis

Children's Action Plan
HBDHB has signed the Memorandum of Understanding (MoU) between Child, Youth and Family (CYF), Police and DHBs to show our support and commitment to reducing the number of assaults on children. Our strategy in this area is aimed at reducing the health harm to children through early intervention programmes in health services. This includes putting systems in place to actively work with the most vulnerable groups, through support and education. Guidance and intersectoral advice is provided by a multi-agency group (vulnerable women's group) who focus on maternal well-being and child protection with the aim of identifying at risk families/whānau in need of support. In addition, we will work with stakeholders in the Children's Teams

demonstration sites to contribute to and adopt the lessons learned from the pilot programmes.	
Short-term outcome	**Measure**
Comply with Vulnerable Children Act	Compliance with Vulnerable Children Act
Activity	**Monitoring & Performance**
• Refer to the Workforce section below	
Short-term outcome	**Measure**
Violence Intervention Programme (VIP) quality improvements are identified, areas of improvement highlighted to improve practice, improvements are implemented.	Reducing child assaults by 5% by 2017
Activity	**Monitoring & Performance**
• Audits completed as per Auckland University of Technology (AUT) requirements, of HBDHB VIP programme ○ Implement recommendations form audit of VIP programme as per AUT requirement • Continue to implement audit recommendations • Implement worker safety checks for all new employees in the core children's workforce • Include provision for a child protection policy clause to be added to all contracts on renewal with providers • Review of HBDHB Child Protection Policy (to include new National VIP guidelines)	• Target audit score of 80/100 • % of new staff employed in child health services have safety checks completed • % of applicable contracts have clause included
Short-term outcome	**Measure**
The DHB is compliant with the National Child Protection Alert System (NCPAS) policy and standards Staff are confident to recognise signs of abuse, neglect, and enlist support to guide interventions as appropriate	100% of staff in designated areas are offered VIP training
Activity	**Monitoring & Performance**
• Continue to provide Ministry accredited training to health professionals to recognise signs of abuse and maltreatment.(6 weekly core VIP training programmes provided) • Maintain and improve NCPAS • Improvement systematic collection of data • Continue to enlist and train VIP champions within HBDHB and external providers	Quarterly reporting on: • Number of Core VIP training programmes provided • Number of child protection alerts placed on national warning system
Short-term outcome	**Measure**
Support implementation of regional Children's Teams	Support establishment of Children's Teams
Activity	**Monitoring & Performance**
• Continue to support DHBs in establishment of Children's Teams	• Ongoing
Short-term outcome	**Measure**
An effective continuum across primary and referred services to provide better support for vulnerable children and families leads to:	

Effective referrals are made for vulnerable children and families GP and WC/TO provider are notified of long-term plans and concerns	Reduction in unplanned CYFs uplifts
Activity	**Monitoring & Performance**
• Multi-agency maternal well-being and child protection group receives referrals from health professionals and provides advice for women with children up to 6 weeks of age. • Continue to deliver gateway programmes • Safety plans are put in place for all high risk families referred to CYFS by 36 weeks gestation	• Estimate 200 referrals per year • Number of women seen by Maternal Mental Health service • Number of high risk families referred to WC/TO providers by 2 weeks after birth

Whānau **Ora**	
HBDHB will continue to play a key role in supporting Whānau Ora by working with service providers and the Commissioning Agency to improve the health of whānau. HBDHB supports the Whānau Ora policy and recognises the importance of working with other public sector agencies and local health providers in addressing the health needs of the whānau. We continue to support the ongoing development of mature hauora providers to enhance whānau-centred health service delivery. We recognise whānau as the backbone of Māori (and other) communities and believe that Whānau Ora is an important approach to enhancing effective self-management and independence. Current Whānau Ora collectives within HBDHB district that are also funded health providers are: Te Taiwhenua o Heretaunga (Takitimu Ora); Te Kupenga Hauora – Ahuriri; Kahungunu Executive ki te Wairoa (Te Whare Maire o Tapuwae)	
Short-term outcome	**Measure**
Improved health outcomes for whānau through quality services that are integrated (across social sectors and within health), responsive and patient/whānau centred.	• Quarterly reporting, SI5
Activity	**Monitoring & Performance**
Support integrated and whānau centred approach to strategic service development and design • Strengthen working relationship with North Island Whānau Ora Commissioning Agency, Te Pou Matakana by identifying opportunities to collaborate in planning and working on joint projects/commissions • Continue to monitor and assess health needs among Māori communities • Involve Māori communities and local Whānau Ora collectives in outcome focused strategic planning and co-design of whānau-centred service delivery	• From Q1 • Ongoing
Short-term outcome	Measure
Community health services meet the needs and aspirations of Māori populations in defined communities	Increased access to whānau centred health services
Support implementation of integrated and whānau centred community health services • Work with other public sector agencies, Māori Health and Social Service providers and Whānau Ora collectives in addressing identified health needs through integrated community plans • Work with Bay of Plenty DHB and Lakes DHB to fulfil our role and commitment outlined in the Ngai Tuhoe Settlement Management Plan (SMP)	• Service agreements in response to Whakatu community needs assessment completed with Takitimu Ora by Q2 Quarterly reporting (SI5) on:

○ Continue to provide advice and support to Ngai Tūhoe through the exchange of ideas, identification of risks, capacity and capability building opportunities and meaningful health investment	• SMP activity
Short-term outcome	**Measure**
Improved access to community health care services for underserved families across all communities by identifying the most urgent needs and collaborating in culturally-appropriate intersectoral responses.	Establish baseline number of whānau supported
Develop and implement 'Whānau Manaaki programme' – a programme of cross-sectoral support for complex health and social needs • Carry out an assessment to determine which whānau are in most need of support, what type of support is needed and the best option for delivering that support • Work with other public sectors, Whānau Ora collectives and Māori Health and Social Service providers on a joint programme to address identified health needs	Quarterly reporting on: • Number of whānau identified • Lead agencies and number of plans supported by each
Improved capacity and capability of Whānau Ora provider collectives to maximise whānau health outcomes	More sustainable Whānau Ora providers
Activity	**Monitoring & Performance**
HBDHB will work with the three current Whānau Ora collectives to ensure they are: • Each linked to Māori communities in their localities by providing services based on local health needs assessments • Supported with Workforce Development opportunities to enhance integration of services • Integrated with primary care providers in their respective localities • Engaged in quarterly meetings that will identify and agree areas where the DHB can support capacity and capability building of the collectives to improve whānau health outcomes	• Wairoa health needs assessment completed by Q2 • Quarterly meetings with Whānau Ora providers
Short-term outcome	**Measure**
Broader health sector view on Whānau Ora implementation adopted	
• Participate in processes led by the Ministry to obtain a broader health sector view on Whānau Ora implementation, including supporting providers in using the Whānau Ora Information System.	• Levels of engagement with the MoH on issues related to Whānau Ora implementation
Short-term outcome	**Measure**
Central Region • Work with regional partners to complete and implement the Regional Whānau Ora Framework and Action Plan	• RSP Action Plan 2

Prime Minister's Youth Mental Health Project
A significant number of young people in New Zealand will experience mental health problems during adolescence. Problems such as depression, anxiety and substance abuse can have life-long consequences. The current system for addressing youth health issues has some significant gaps and there are

many barriers to access for young people. The Government has launched the Prime Minister's Youth Mental Health project in order to achieve better mental health and well-being for young people – including sub-groups of the population at comparatively higher risk of mental health issues, such as Māori and Pasifika. Aligned to our planned development of a new mental health inpatient facility, HBDHB has a significant commitment to mental health service development over the next four years. This will include a youth focus that will improve primary care responsiveness to youth with mild to moderate mental health issues.	
Short-term outcome	**Measure**
Increased access to primary care services, for youth attending decile 1-3 secondary schools, Alternative Education and Teen Parent Units and Increased availability of primary health care services in eligible education facilities	Increased referral pathways completed to mental health services Alcohol and Other Drug (AOD) and other primary care services
Activity	**Monitoring & Performance**
• Continuation of SBHS in eligible education facilities • Universal health and youth development assessments including: Home, Education/Employment, Eating, Activities, Drugs and Alcohol, Sexuality, Suicide and Depression, Safety (HEEADSS) will be offered to year 9 students and all students attending Alternative Education,& Teen Parents Units • Implement SBHS at new Teen Parent Unit in Flaxmere • HEEADSS framework will be used by RNs working with other students with complex needs in SBHS and in nurse led clinics in non SBHS secondary schools • Collaborative work with Youth Justice will continue to ensure that young people, under Youth Justice are triaged through a multi-agency advisory group and receive comprehensive health assessments	• Registered Nurse (RN) FTE working in SBHS • Ratio of RN FTE to number of students attending SBHS Education facility. 1 RN:750 student for decile 1-3 secondary schools & 1 RN:200 students for Alt Education & Teen Parent Units • Number of students receiving HEEADSS assessments • 95% of Year 9, Alternative Education and Teen Parent Unit students will receive a HEEADSS assessment • Number of Youth under Youth Justice receiving health assessments • 20% increase in the number of Youth under Youth Justice will receive a health assessment
Short-term outcome	**Measure**
All eligible schools, Alternative Education facilities and Teen Parent Units will have an active, continuous quality	High level of satisfaction in the SBHS

improvement programme in place using Youth Health Care in Secondary Schools: A framework for continuous quality improvement	will be reported in surveys by school staff and students in
Activity	**Monitoring & Performance**
• Every educational facility will have at least one 'Plan Do Study Act' (PDSA) cycle completed	• Number of PDSA cycles completed using the quality improvement framework • % of SBHS education facilities with completed PDSA cycles
Short-term outcome	**Measure**
Early identification of mental health and addiction issues, better access to timely and appropriate treatment and follow up and more equitable access for Māori, Pasifika and low-decile youth populations	Increased access to Directions (Youth one-stop shop) Increased face-to-face time with clients Target groups are reached
Activity	**Monitoring & Performance**
• Increase youth referrals to primary mental health packages of care	• Number packages used • % Māori, Pasifika & low-decile youth
• Additional investment in Flaxmere-based Wairua Tangata to support families and friends affected by suicide and self-harm	• % increase in investment
• Increased access to kaupapa Māori services for youth in Hastings	• Number of individuals referred to the service • % referrals who have contact within 7 days
• New mental health acute model of care includes separate space for youth and mother and baby	• Operational by March 2016
Short-term outcome	**Measure**
Improve integrated service provision for youth	Improve the responsiveness of primary care to youth
Activity	**Monitoring & Performance**
• Complete a review of Child Adolescent and Family Services to identify further opportunities in terms of leadership, skill mix, model of care improvements and integration	• By February 2016
• Ensure ongoing sustainability of Youth One-Stop Shop (YOSS) through funding of a 3 year contract	• Commencing July 2015
• Effect youth alliancing through relationship between Alliance Leadership Team, Health Sector Leadership Forum and Clinical Council	• Ad hoc reporting to Clinical Council

○ Monitor access to youth services and address gaps ○ Monitor increased funding from DHB and PHO for extension of community-based youth suicide programme (Wairua Tangata) in Flaxmere ○ Appoint Clinical Council and Consumer Council youth representative	• From July 2015
Short-term outcome	**Measure**
Improve follow-up in primary care of youth aged 12-19 years discharged from Child & Adolescent Mental Health Services (CAMHS) & youth AOD services and ensure that when youth are discharged they have a transition plan	PP7. 95% of clients discharged will have a transition plan
Activity	**Monitoring & Performance**
• Develop a standard transition plan document / template that will cover secondary mental health and addiction services	• By 31 July 2015
• Every clinician who has primary responsibility for a case will complete the core transition document. Transition plans completed.	• Within 24 hours of discharge
• Ensure primary care provider or primary referrer is prompted to make a follow-up appointment within 3 weeks. Transition plans communicated to primary referrer.	• Within 48 hours of discharge
Short-term outcome	**Measure**
Improve access to CAMHS and youth AOD services	PP8. 80% of clients are seen within 3 weeks PP8. 95% of clients are seen within 8 weeks
Activity	**Monitoring & Performance**
• Establish new administrative procedure to ensure that "choice" appointments (with a given time & date) are proactively offered to clients	• By 31 July 2015
• Implement process that enables and encourages clients to call the service to confirm their appointment or make a time that suits them better	• By 31 July 2015
• Establish two standard prompts to remind patients of the set appointment - telephone contact and text contact	• By 30 September 2015
• Implement robust policy for discharge after decline that re-engages the primary referrer	• By 30 September 2015
• Monitor rate of referral and uptake over time to ensure an appropriate number of appointments are offered to match referral and acceptance	• By 31 December 2015
• Implement a proactive policy to reach patients who Do Not Attend (DNA) their appointment. Monitor DNA rate and target ongoing reduction	• Reduce DNA

2.1.2 Working Together for Better, Sooner, More Convenient Health Care

We recognise that our vision will not be achieved through the efforts of HBDHB alone because the root causes of poor health often lie outside the health sector and the health system's control. Ensuring that the social and physical environment we live in is one which promotes and protects health requires partnerships with whānau, Hapū and Iwi and working intersectorally across professional and organisational boundaries.

Formal, close working relationships exist with the PHO, General Practice, private hospitals, a variety of Non-Government Organisations (NGOs), local Government, Unions and individual HBDHB employees. Part of our transformational change relies on the strength of these relationships to test new ideas and initiatives, as well as for development of expanded scopes of practice and associated training, and provision of support for aged residential care nursing and carer development in partnership with the PHO. We are working with the PHO to deliver on the national health targets, develop more integrated urgent care services, implement a primary care strategy, realign our respective health promotion services to maximise value for money, and implement broader alliances with organisations in discrete locations who can work together to benefit from efficiency and scale to transform rural care delivery. Our alliance with the PHO continues to be developed locally to drive transformational change.

More Heart and Diabetes Checks

Cardiovascular Disease (CVD) is the leading cause of death in New Zealand and we have one of the worst rates in the world for diabetes. With prevalence rising at a rate that is exceeding population growth, it is a major health burden for New Zealand now and into the foreseeable future. As the population ages, and lifestyles change, these conditions are likely to increase significantly without positive intervention. Our Health Equity Report that ischaemic heart disease is the leading cause of potential years of life lost and of avoidable mortality in Hawke's Bay. High rates for Māori and Pasifika make this a significant equity issue.

In 2013/14 the Government released new funding to support primary care to screen 90% of the target population. In response Health Hawke's Bay devised a CVD Screening Action Plan to:

- Take a whole systems approach to improving the rate of CVD risk screening and implementation of intervention to reduce population risk factors
- Systematically screen the eligible population for the risk factors and provide early intervention/treatment/management where risks are identified
- Establish a suite of options for Practices to engage with (data-mining, benchmarking, coaching, contracting of independent nurses) that will assist in targeting and reaching the eligible population
- Establish a process and data set that will enable close monitoring of each Practice and confirm the eligible population to achieve the desired screening outcomes – utilise Dr Info audit reports and tracking for achievement
- Ensure Practices have the resources/data information to achieve the desired target outcomes
- Ensure that all Practices maintain the information management to reflect the accurate utilisation of data available
- Recall when there are known risks and prescribe treatment; refer for specialist or other care, where appropriate

Health Hawke's Bay will continue with the Action Plan through the 2015/16 financial year.

Short-term outcome	Measure
Achieve the national health target: More Heart and Diabetes Checks, and build sustainability (System Integration and Integrated Performance Incentive Framework (IPIF) target) Prioritise Māori Men between the age of 35-45 and Māori women 45-55 years to be screened, and total population 45-69 years males and 55-69 years females	Population with risk are identified and appropriate intervention has been provided. Information will be disaggregated by Māori, Pasifika and Quintile 5
Activity	**Monitoring & Performance**
• Prioritise (Māori) promote PMS audits with a particular focus on those who are coming due for Cardiovascular Risk Assessment (CVRA). Includes those about to be coming into the cohort, those that are due, those that will require rescreening	• 90% of the eligible population have received CVRA • PMS quality/clinical audits of appropriate interventions
Short-term outcome	**Measure**
Achieving sustainable screening targets within fiscal incentives - Baseline confirmed by July 1 2015	• Improvement on Baseline
Activity	**Monitoring & Performance**
• Health Business Intelligence Team will refine predictor tools to assist Practices to manage the total cohort of their screened population • Internal benchmarking • Where appropriate, the General Practice facilitation team will work with practices to improve those outliers to achieve expected benchmark.	• 90% achieved and maintained • Increase in GPs achieving and maintaining target
Short-term outcome	**Measure**
There will be an increased opportunity for Māori Men to access primary care services by receiving CVRA in the work place	Māori men have increased access to services provided in primary care.
Activity	**Monitoring & Performance**
• Specific outreach nursing services will target workplaces where there is a high volume of Māori men in the work place, e.g. Napier Port, Ravensdown.	• Reported through Te Ara Whakawaiora & IPIF

Diabetes Care Improvement Plans (DCIP)
In Hawke's Bay, as around the world, the numbers of people living with diabetes is rising. Our Health Equity Report shows that diabetes is one of the top seven causes of death and one of the five top causes of amenable mortality in Hawke's Bay, and that there are significant equity issues in people's care. Improved access to care and better management of diabetes is cited as one of the factors that will lead to a great reduction in amenable mortality disparities. Better care and support for people with diabetes is a priority for HBDHB in order to both achieve better health and well-being for our population and to manage the rising demand for services which is a threat to sustainability. Primary care takes the lead role in the management of most long-term conditions for most people most of the time. Our focus for diabetes services is on creating a more integrated system of care where primary care providers

are supported by specialist services to provide high quality care to their patients. For example, in 2015/16 we will be redesigning our podiatry services to target better access to community podiatrists for Māori, Pasifika and people living in areas of higher relative deprivation. This will enable people with diabetes to more readily access specialist podiatry services when needed. A key focus of activity needs to be empowering patients to manage their own conditions effectively through health literacy and self-management approaches. We will embed the clinical pathways for diabetes and continue to review existing diabetes services against the National Quality Standards for Diabetes Care. More information about our overall approach to long-term conditions can be found in the long-term conditions section, above. Here we focus on how we will be working with and incentivising primary care to improve diabetes management.	
Short-term outcome	**Measure**
Improved Quality of the management of people with diabetes including those who are pre-diabetic (trend data collation including disaggregation into Ethnicity (focus on Māori) Pasifika, age, gender, disability, geographical location and deprivation).	Proportion of total population who is pre-diabetic Measure of compliance to coding.
Activity	**Monitoring & Performance**
• The PHO will use the PMS to audit the 28 Practices to identify the population cohort who have pre-diabetes indicators (HbA1c between 40 and 49 mmol/mol). This will include the specific identification of Māori within the cohort.	• Number of Practices • number of people • 28 Practice audits are completed
Short-term outcome	**Measure**
General Practice will have an increased knowledge of services available via the public health system Patients will have increased utilisation of services available via the public health system	Increased utilisation of referrals to Māori and NGO providers who provide life style support options
Activity	**Monitoring & Performance**
• Explore how teams from the PHO and the Population Health team can work more collaboratively to increase access to publicly funded services. Where appropriate (the person is overweight, has indicated a desire to change lifestyle for themselves and their whānau, there is a family history, need for increased health literacy, etc) the person will be referred to the appropriate community service. These include but are not limited to: Iron Māori Green Prescriptions (GRx), Stanford, Kahungungu Hikoi Whenua, Diabetes Hawke's Bay, seen and supported in nurse clinics • Practices will be surveyed 6 monthly to identify trends for referral pathways	• 56 survey responses • Number of collaboration sessions between Population Health team and General practice teams • Range of services utilised /referred to
Short-term outcome	**Measure**
There will be increased knowledge and understanding for practices of the people with diabetes they are serving HbA1c, blood pressure greater than 130/90,LDL and microalbumuruia	HbA1c, blood pressure greater than 130/90,LDL and microalbumuruia
Activity	**Monitoring & Performance**
• All Practices will provide a DCIP for annual sign off by 1 July 2015 • The DCIP will include how the 20 Quality standards underpin service delivery and how the Practice will provide	• 28 DCIPs signed • Practices include and report on

education on diet, exercise and introduction of self-management strategies • Practices adequately identify the diabetic population of their Practice	actual vs. expected numbers of referrals to: to exercise, self-management, Dietitian
Short-term outcome	**Measure**
Improved uptake of self-management programmes, consumer engagement, and integration across NGOs to deliver this training	
Activity	**Monitoring & Performance**
• The PHO will continue to promote the utilisation of the Stanford programme in Practices. There will be an increase in the number of Master Trainers to ensure capacity can be managed for the expanding programme. • The implementation of the co designed Māori Responsive Stanford Programme will be implemented.	• 3 new Master Trainers • Report on Stanford Māori responsiveness in Community and Māori settings
Short-term outcome	**Measure**
• Ongoing PHO enablement of improvement • Prioritisation of Māori to receive support for managing diabetes in a proactive way • People with diabetes have optimal control and avoid complications	Number of people bringing diabetes under control
Activity	**Monitoring & Performance**
• Data matching programme will be finalised by implementation 1 July 2015 • Services to Improve Access (SIA) funding will continue to be made available for Māori for Diabetes Annual Reviews as a top-up • The Rural diabetes early detection of renal complications will be fully implemented	• Data matching with the Virtual Diabetes Register (VDR) confirms actual population for Hawke's Bay • 2 programmes established Central Hawke's Bay and Wairoa

Long-Term Conditions (LTCs)	
In Hawke's Bay, as around the world, the numbers of people living with LTCs is rising. Better care and support for people with LTCs is a priority for HBDHB in order to both achieve better health and well-being for our population and to manage the rising demand for services which is a threat to sustainability. Primary care takes the lead role in the management of most LTCs for most people most of the time. Our focus is on creating a more integrated system of care where primary care providers are supported by specialist services to provide high quality care to their patients. A key focus of activity needs to be empowering patients to manage their own conditions effectively through health literacy and self-management approaches	
Short-term outcome	**Measure**
Those people in Hawke's Bay who are at risk of or who currently have LTC can access early support and intervention programmes to reduce risk, access appropriate treatment and self-management programmes. More people and their Whānau are supported to manage their identified condition better	TBA

Activity	Monitoring & Performance

• Explore how teams from the PHO and the Population Health team can work more collaboratively to increase access to publicly funded services
• Continue to implement sustainable approach by work with DHB smoking cessation team and IPIF manager to embed the policies, programme of work and expected systems changes in General Practices.
• As part of maximisation of care plus
  ○ Work with key stakeholders to agree stratification indicators
  ○ Work with Practices to understand what the Practice LTC profile looks like
  ○ Support Practices to develop a plan to address how this population will be supported to self-manage
• PHO/DHB management teams will work towards integration with the following services by understanding what is currently being provided across the sector in Diabetes, Cardio Vascular disease, and mental health, and determining an approach to support these services to work more closely with each other to support the population.
• A further three people will be trained to be Master Trainers in Stanford
• Master Trainers continue to expand the reach to work with, Māori and Pasifika communities, high needs areas, General Practice interface, MSD, Sport Hawke's Bay and support further training for lay trainers (community Leadership) and communities receiving support
	• Current network meetings established by the DHB Population Health team
	• Practices will be surveyed 6 monthly to identify trends for referral pathways
	• Initiate programme of work with 8 Practices
	• Policy development
	• Monthly Reference Group meetings
	• Guiding principles and clinical indicators will be developed
	• Stratification and data systems will be established
	• Stocktake and integration status of services provided across sector
	• Joint approach agreed and initiated
	• 3 new Master Trainers and 16 community cohorts supported for self-management

Short-term outcome	**Measure**
Reduction in Ambulatory Sensitive Hospitalisation (ASH) rates in 0-4 year olds. There will be specific focus on ASH conditions with the highest inequity – dental decay, skin conditions (dermatitis & cellulitis), respiratory (e.g. Asthma) and ear, nose and throat infections	TBA
Activity	**Monitoring & Performance**
• Monitor inequities in ASH rates • Development of a Kaupapa Māori resource for use in Kohanga Reo for promotion of skin health ○ Resource package developed in partnership with Te Kohanga Reo Regional Office • Continue to provide Healthy Homes assessments' to drive improvement in housing, particularly where there are children living in cold, damp and over-crowded conditions	• ASH rates by ethnicities • By end of Q4 • Number of eligible referrals received (by ethnicity)

• Where appropriate action plan initiated for all eligible children in Hawke's Bay	• Number of housing intervention plans signed off by families • Re-admission rates for children who have had housing intervention plans completed • Number of completed Healthy Homes action plans • 90% of referrers are satisfied with the process and feedback received • 90% of plans being implemented within 6 months of referral being received
• Increased enrolment and engagement by Community Oral Health Service ○ Better data provides earliest available information about families ○ Opportunities for engagement with services are enhanced ○ Earlier prevention messages and education to whānau ○ Identification of need for, and referral to targeted outreach service ○ Prevention and early treatment of decay leads to reduced hospital admissions for treatment under anaesthetic	• Number and % of children enrolled with Community Oral health services: age and ethnicity profiles
Short-term outcome	**Measure**
Reduction in ASH rates in 45-64 year olds. There will be specific focus on ASH conditions with the highest inequity – heart disease, skin infections, respiratory infections and diabetes	TBA
Activity	**Monitoring & Performance**
• Better screening for cardiovascular disease ○ PHO campaigns to achieve More Heart and Diabetes Checks targets ○ Focus on Māori men – provide CVD risk assessment screening in workplaces with high number of male Māori staff	• IPIF and Te Ara Whakawaiora reporting
• Earlier identification and improved self-management of diabetes ○ PHO Practice audits to identify pre-diabetics aged 40 to 49 for each member Practice ○ Increase GP referrals to available publicly funded community services supporting self-management ○ 6 monthly survey of Practices to identify referral trends and service availability	• 28 audits completed • 56 surveys completed
• Monitor recently published Chronic Obstructive Pulmonary Disease (COPD) pathway to confirm equitable access • Continue to fund the Coordinated Primary Options (CPO) programme with the objective of reducing acute hospitalisation and a focus on conditions with high ASH inequity, e.g. for adults: cellulitis; DVT	• CPO uptake partly monitored through Te Ara Whakawaiora reporting

confirmed/suspected; COPD exacerbation; pneumonia; sub-acute community support. Programme funds primary care management	

Obesity	
The Hawke's Bay Health Equity Report identified an increase in obesity across the population with significant rates for Pasifika (60%) and Māori (50%) and total population (34%) - these are all above the national averages. Obesity is recognised as a major public health problem across the country with New Zealand ranking fourth worst in the OECD for rates of obesity. National rates of obesity have increased substantially and significantly over the past 15 years. Obesity increases a person's risk of dying young, it increases the risk of cancer, heart disease, diabetes and a raft of other related medical conditions. It is significant for Hawke's Bay that there has been a decrease in physical activity that is a change in trend. High calorie, no nutrition diets and low levels of physical activity are linked to increased obesity	
Short-term outcome	**Measure**
Complete a strategic obesity document which engages cross-sector partners	
Activity	**Monitoring & Performance**
• Identify key partners to support improvements in obesity rate for Hawke's Bay particularly those able to influence Māori and Pasifika communities • Consult with key communities to identify goals and activities which will address obesity - including Māori and Pasifika groups • Draft a strategic document which support the delivery of goals to achieve reductions in obesity • Review effective tools, initiatives and programme in reducing obesity, nationally and internationally	• TBA
Short-term outcome	**Measure**
Establish a working group to support the implementation of the cross-sector plan	
Activity	**Monitoring & Performance**
• Identify key partners including those engaged with Māori, Pasifika and high deprivation communities and/or able to influence the reduction of barrier to access to health, food and physical activity • Establish a process for cross-sector planning, delivery and monitoring for the obesity strategic document • Maintain engagement with partners via meeting, work plans, shared activity and shared responsibility for outcomes. • Working group members and agencies to advocate and promote initiative via policy, promotion and raising awareness.	• TBA
Short-term outcome	**Measure**
Establish childhood obesity and reducing inequalities as DHB priority areas for delivery	
Activity	**Monitoring & Performance**
• Gain HBDHB Board endorsement for DHB approach to addressing obesity and members commitment to	• TBA

advocating this approach • Develop business cases for these programme to gain resourcing to support them • Monitor obesity rate for children via B4 School Check data • Align activity in maternal nutrition, Kahungunu Hikoi Whenua, (KHW) child health, health promoting schools • Implement the Breastfeeding Plan to support the increased breastfeeding rates, particularly for Māori and Pasifika women	
Short-term outcome	**Measure**
HBDHB to role model healthy eating and increasing physical activity	
Activity	**Monitoring & Performance**
• Promote and monitor the implementation of the Healthy Eating Policy in the DHB • Develop a physical activity policy, linking to other initiatives including 'Journeys to Work', Occupational Health and Safety activities and events • Develop a Breastfeeding policy to support staff, visitors and client to be able to breastfeed on DHB premises • Develop management engagement and supporting for Healthy Eating, Breastfeeding and Physical Activity policies • Promote three annual activities to support healthy eating and physical activity, e.g. Cancer Society 'Relay for Life' and 'Iron Māori'	• TBA

Stroke	
HBDHB will provide an organised acute stroke service for our population. The aim is that more people will receive access to organised stroke services, and stroke services will be timelier so that more patients survive stroke events and the likelihood of subsequent stroke events is reduced.	
Short-term outcome	**Measure**
All stroke patients admitted and treated in a stroke unit with an interdisciplinary Stroke team	80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway.
Activity	**Monitoring & Performance**
• Stroke data is collected and reported	
Short-term outcome	**Measure**
All eligible stroke patient have equitable access to community stroke services, regardless of age, ethnicity or geographic domicile	
Activity	**Monitoring & Performance**
• Barriers to achieving targets are identified and strategies developed to address these, e.g. patient flow practices/access to diagnostics; that facilitate admission of stroke patients to rehab within 10 days	• Proportion of patients with acute stroke who are transferred to in-patient rehabilitation service

• Continue to monitor the average Length of Stay (LoS) in rehabilitation and identify area for service improvement through the use of Australian Rehabilitation Outcome Centre (AROC) data
  ○ Functional Independence Measures (FIM) are completed by senior nursing staff on Assessment, Treatment & Rehabilitation (AT&R) ward admission and discharge
  ○ Data is captured and sent regularly to AROC at University of Woolongong, Australia
  ○ Analysis and detailed reporting including benchmarking with like-facilities is received from AROC
  ○ AROC information used to share learnings and plan improvements
• Māori and Pasifika people admitted with stroke have access to services which meet individual and whānau needs, reducing the burden of care and are provided with participation from Māori Health providers and primary care
• Recruitment of a Stroke Clinical Nurse Specialist to provide nursing expertise and leadership that ensures further development of the Transient Ischaemic Attack (TIA), acute stroke and stroke rehabilitation services of the Hawke's Bay Hospital
	• 60% of people with acute stroke who are transferred to in-patient rehabilitation service within 10 days of acute stroke admission
	• Standardised and consistent use of AROC data is utilised to determine service improvement initiatives to improve patient outcomes
	• Average LoS is monitored and measures are undertaken to address extended LoS
	• The percentage of Māori and Pasifika people presenting with stroke and who are transferred to rehab within 10 days reflects improved access to stroke services

Short-term outcome	**Measure**
All eligible stroke patients have access to thrombolysis	
Activity	**Monitoring & Performance**
• Promoted integrated thrombolysis services with emergency and ambulance services • Thrombolysis audit and review completed quarterly	• 6% of ischaemic stroke patients thrombolysed • Integrated thrombolysis service with emergency and ambulance service promoted • Clinical lead to undertake a formal update to emergency and ambulance service on thrombolysis and outline what they offer • Quarterly audit
Central Region • People experiencing acute ischaemic stroke have consistent access to quality-assured and regularly audited stroke thrombolysis services 24 hours, 7 days per week at all Central Region DHBs (either directly or via	• Workstream is developed, credentialing, audit processes, regional register, shared protocols,

support from a larger DHB) • Implement a Regional Thrombolysis Network including credentialing, audit processes, regional register, shared protocols, a regional back-up roster and regional case review.	a regional back-up roster and regional case review are established • Purchase of Telestroke equipment for sub-region is agree upon by local DHBs • An effective telephone backup set up in sub-regional areas is maintained.

Cardiac Services including Acute Coronary Syndrome	
Across the Central Region there is a commitment to improved and timelier access to cardiac services. HBDHB supports the regional programme outlined in the Regional Services Programme (RSP) and also works locally to improve access to cardiac diagnostics and specialist assessments, reducing waiting times for people requiring cardiac services, improve prioritisation and selection of cardiac surgical patients, increase cardiac surgical discharges and reduce variations in access.	
Short-term outcome	**Measure**
Provide equitable access to surgery by delivering minimum target intervention rates • For cardiac surgery a target intervention rate of 6.5 per 10,000 of population will be achieved • For percutaneous revascularisation a target rate of at least 12.5 per 10,000 of population will be achieved • For coronary angiography services a target rate of at least 34.7 per 10,000 of population will be achieved	Target intervention rates per 10,000 achieved
Activity	**Monitoring & Performance**
• Monitor and review register of cardiac surgery patients to ensure they are prioritised and treated in accordance with assigned priority and urgency timeframes ○ Score all patients using the national cardiac surgery Clinical Priority Assessment Criteria (CPAC) ○ Assign urgency based on assessment ○ Prioritise patients based on assigned urgency ○ Complete first specialist assessment within 4 months ○ Complete surgery within 4 months of First Specialist Assessment (FSA)	• Proportion scored using CPAC • Waiting times for FSA • Waiting times for cardiac surgery
Short-term outcome	**Measure**
Patients with suspected Acute Coronary Syndrome receive seamless, coordinated care across the clinical pathway as demonstrated by the percentage of patients with ACS who receive angiogram within 3 days - Baseline at Q3 2014/15: Total 63.2%; Māori 81.8%; Pasifika 100%	Target = 70%
Activity	**Monitoring & Performance**
• Implement agreed protocol for referral to regional centres for use at times when access to local angiography	

services is not feasible within 72 hours
• Explore other strategies to improve access to coronary angiography at HBDHB
  ○ Short-term: increasing access to cath lab services using weekend shift(s)
  ○ Long-term: investigate stand-alone cath lab capacity
• Continued use of the ANZACS-Q I reporting system
  ○ Assign responsibility and resource for data capture
  ○ Complete ANZACS-QI ACS and cath/PCI registry data capture within 30 days of coronary angiography (Baseline at Q3 2014/15: Total 61.1%; Māori 6.7%; Pasifika n/a)
  ○ Complete cardiac surgery registry data within 30 days of discharge following cardiac surgery
• Establish measures of ACS risk stratification and timeliness for patients to receive appropriate intervention
	• From July 2015
	
	• By September 2015
	• By March 2016
	
	• By July 2015
	• > 95%
	
	• > 95%
	• By June 2016

Short-term outcome	**Measure**
Work with primary care to develop clear patient pathways that improve access to cardiac services	
Activity	Monitoring & Performance

• Implementation of an accelerated chest pain pathway – see Shorter Stays in ED
• Following agreement of regional cardiac pathways (expected in May/June 2015), develop local components of aligned pathways for:
  ○ Non-acute chest pain
  ○ Atrial fibrillation
  ○ Heart failure
• Agree on local criteria and arrangement for transfer of patients between services
• Publish pathways to Map of Medicine
	• July – November 2015
	• By end of Q 2

Central Region
We are working with the Central Region Cardiac Network to:
• Develop minimum standards for the region for:
  ○ Chest pain assessment
  ○ Management of ACS Atrial Fibrillation
  ○ Heart failure management
  ○ Echo referral guidelines
  ○ Rehabilitation Services
• Develop regional guidelines regarding prioritisation processes for FSA appointments, including referral criteria
• Identify the appropriate mix of tertiary services to be transitioned and delivered in secondary care (including financial and clinical impact on services)
• Realign regional education programme with other regional/national initiatives concerning training and workforce
	• Complete 3 pathways by June 2016

Shorter Stays in Emergency Departments (ED) – Health Target	
Better, Sooner, More Convenient health services for New Zealanders in relation to ED means all New Zealanders can easily access the best services, in a timely way to improve overall health outcomes. A health system that functions well for people with acute care needs is one that delivers and coordinates acute care services in the hospital and community; improves the public's confidence in being able to access services when they need to; sees less time spent waiting and receiving treatment in the ED; moves patients efficiently between phases of care; and makes the best use of available resources. The ED target is not simply about ED efficiency – instead, it reflects patient flow and whole of system functioning.	
Short-term outcome	**Measure**
Achieve the national health target for shorter stays in the ED – patients admitted, discharged or transferred from the ED within six hours	Target 95%
Activity	**Monitoring & Performance**
Within our AIM 24/7 programme, that is focusing on patient flow through hospital services 24 hours per day, we have included an ED workstream. The workstream is tasked with identifying, developing, implementing and testing discrete packages of work that can assist with patient flow through the ED. For example, an early task was completion of a multi-disciplinary service agreement for management of acute admissions that was consulted on and agreed by clinical leaders in all the services with identified consistently high demand through the ED. This agreement has codified some previous conventions and ensures that all staff are clearer on expectations of process. Other Plan-Do-Study-Act cycles that are currently proposed from the working group with an expected completion date of December 2015, are: • Redesigning the ED front-of-house so that patients are expedited to the triage station • Improving reconnection with primary care for ongoing or enduring care requirements • Embedding the best use of newly established ED observation beds to maximise efficient resource allocation • Improved input of medical specialists earlier in the patient journey • Expediting surgical reviews • Reducing demand on ED by providing better options for management of acute needs	A monitoring framework has been established to support the initiatives. This is produced regularly and includes: • Health target achievement for those patients admitted to general medicine specialties • Time between arrival and review request • Use of ED observation beds • ED triage compliance • Unplanned representations within 48 hours
We currently have one of the highest rates of patient presentations per emergency medicine specialist in New Zealand. We will move to address this in 2015/16 by: • Engaging with the Australasian College of Emergency Medicine to increase our training accreditation from 6 months to 12 months in recognition of the size, scope and scale of our service and to assist with recruitment and retention • Reviewing and improving on Senior Medical Officer support for ED	• Recommendations completed by December 2015

Short-term outcome	**Measure**
Ongoing monitoring of quality and patient safety in accordance with the ED Quality framework	• ED quality improvement demonstrated
Activity	**Monitoring & Performance**

In 2014, an ED Quality team was established to provide an ongoing audit of HBDHB ED Quality Indicators. The team includes Physicians and Nurses from our ED plus one representative from our Quality Improvement and Patient Safety (QIPS) service and one from our Business Intelligence service. The team's objectives are identification, measurement and reporting of clinical quality and patient safety in the ED, and to agree on and measure corrective action plans where expected performance is not achieved. Activities include:
• Monitoring of all mandatory measures
• Increase monitoring of non-mandatory measures
  ○ Identification of at least 3 relevant non-mandatory measures by Q1
  ○ Analysis and action plan to rectify areas of concern by Q3
• Identifying data available through "business as usual" processes and systems
• Sampling for specific audits and reviews
• Communication with Health Records as necessary
• Maintenance of due process and adherence to ethical practice
• Reporting and consultation on results and consequent activity
	• Monthly quality review
	• Ongoing data capture for continuous and ad hoc audit activity
	• ED Quality team reporting and review

Short-term outcome	**Measure**
Implement accelerated chest pain pathways in ED	• Pathway implemented in ED within 6 months of regional agreement
Activity	**Monitoring & Performance**

The Central Region Cardiac Network is expected to finalise an accelerated chest pain pathway in May 2015.
• HBDHB will implement the regional accelerated chest pain pathway when approved by the Network. This will include:
  ○ Publishing a local version of the pathway within 3 months
  ○ Integrating with ED protocols within 6 months
	• Local pathway produced by end of Q1

Short-term outcome	**Measure**
Improve access to the most appropriate urgent care options across Hawke's Bay district	

Activity	Monitoring & Performance
Under our Transform and Sustain programme, and in partnership with the PHO, we have put in place a service level Urgent Care Alliance (UCA). This clinician led team have been tasked with implementing service level changes across the health sector to improve the integration of urgent care in Hawke's Bay. A part of this project will focus upon those patients currently seeking urgent care in the ED • In conjunction with stakeholders, the UCA will establish a set of service level standards for urgent care across the Hawke's Bay district that we will sign off as a social contract with our communities. The standards will set the level of response and outcome that everyone can expect when in need of urgent care • The standards will also ensure that patient understanding and self-management, cultural responsiveness, type of service, timeliness, affordability, patient risk and integrated services are at the heart of all proposed initiatives • A staged work plan of each initiative will be developed to ensure the programme is carefully structured and monitored to show impact, where applicable, on the Health target • The UCA will also assess the evidence and potential outcomes of all of the initiatives it will implement using the NZ Triple Aim and the HEAT tool to ensure that principles of equity are maintained. • The expected timeframe for this project is the Stage 1 initiatives in place by the end of 2015 with Stage 2 initiatives being in place by end of 2016.	• Monthly performance review by Clinical Council and HBDHB Project Assurance • The individual measurement of urgent care initiative deliverables across the timeframe of this project

Smokefree and Better Help for Smokers to Quit Health Target

We recognise the evidence of harm caused by tobacco and are committed to the vision of a smokefree Aotearoa by 2025. The health sector's role is to improve, promote and protect the health and well-being of the population in the district by responding to the harm of tobacco and encouraging and supporting a smokefree/tobacco free lifestyle for all. There is a momentum of change occurring at the national and district level. Examples include: increases in taxation; retail display regulations, and plain packaging - all of which have contributed to an increasing number of young people reporting that they have never tried tobacco products. Locally, NKII, the DHB, PHO, employers and local Councils have worked together well to advance the concept of smokefree environments.

Hawke's Bay prevalence of tobacco use is higher than the national average and we believe that reducing tobacco consumption remains the best opportunity to improve Māori health and reduce inequities. In 2015/16 we will continue to focus on achieving the national health targets and improving smokefree environments particularly in pregnancy and for neonates, new-borns and infants who are so negatively affected by exposure to first and second-hand tobacco smoke.

Short-term outcome	Measure
Secondary services continuously improve the clinical practice of ABC	95% of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice & support to quit smoking

Activity	Monitoring & Performance
• Monitor reporting to ensure equitable delivering of screening and cessation support - particularly for Māori and other population groups with high tobacco use rates • Support Secondary services to sustain the achievement of the "Better Help for Smokers to Quit" target as part of business as usual	• 95% of smokers are offered brief advice/cessation support • Monitoring of weekly, monthly and quarterly reports
• Complete an annual audit of ABC to highlight any barriers to clinical practice	• One audit completed per annum Audit report identifies barriers and action to address missed opportunities to best practice
• Provide staff training including nurses completing E learning Help to Stop, junior doctors Smokefree Education and health professionals secondary and primary care NRT module	• 90% of nurses and junior doctors complete 100% of Smokefree Champions • Education sessions meet the need of targeted groups
Short-term outcome	**Measure**
Maintain the Primary Care "Better Help for Smokers to Quit" Target becomes business as usual	90% of PHO patients who smoke have been offered help to quit smoking
Activity	**Monitoring & Performance**
• Reporting is monitored to identify any changes in screening and support and data is shared with relevant managers and staff.	• 90% of smokers enrolled in primary care are offered brief advice/cessation support • Monthly report - breakdown by Practice
• Smokefree policies are reviewed and support provided to develop effective policies for each Practice	• 60% of Practices have reviewed Smokefree Policies • 6 monthly report identifies those who have a robust smokefree policy
Short-term outcome	**Measure**
Midwives and maternity services maintain ABC screening	90% of pregnant women who identify

	as smokers upon registration with a DHB- employed midwife or Lead Maternity Carer (LMC) are offered brief advice & support to quit smoking
Activity	**Monitoring & Performance**
• Monitor reporting and identify trends in screening and where needed identify activities to increase screening	• 90% of pregnant women who identify as smokers upon registration with a DHB - employed Midwife or Lead Maternity Carer are offered advice and support to quit smoking. Monitoring identifies and addresses reductions in screening
• Provide training to Maternity staff including updates	• Two study days and one update
Short-term outcome	**Measure**
Increase LMC's confidence to provider Cessation support and to refer to cessation services	Percentage of Māori women who are smoke free at two weeks postnatal
Activity	
• Incentivised programme to promoted, monitored and supported via reports, regular meeting with the provider and midwives and information sharing. Targeting Young Māori woman and their whānau.	• 90% of young Māori women are referred to cessation support
• Complete Smokefree Education at Te Hapu Ora - change for children	• Full workshop attendance at 2 study days
Short-term outcome	**Measure**
Reduce numbers of smokers to support the achievement of Smokefree 2025	
Activity	
• Coordinate all plans engaged with reaching the 2025 Smokefree goal including Tobacco Control, Population Health, Coalition Work Plan and the District Annual Plan	• Plans reference each other and activities align
• Review the District-wide Smokefree Plan/strategy to re-write a plan to guide Smokefree for the next 5 years	• One new Plan supports the 2025 goal

Improved Access to Elective Surgery - Health Target	
HBDHB supports the national priority of more people receiving access to elective services in order to support New Zealanders to live longer, healthier and more independent lives. Through coordinated and integrated services, patients will have shorter waiting times for elective services meaning they receive faster access to health services, and can regain good health and independence sooner. Local projects/actions to support achievement of the elective surgery health target are focused around our 'Operation Productivity' – a clinically-led programme of work that is systematically identifying and implementing service improvements in our operating theatres and perioperative environment	
Short-term outcomes	**Measure**
1. Delivery of Elective Health Target	• 7109 surgical discharges
2. Delivery of Standardised Intervention Rates (SIR)	
a. Major Joint replacements	• 21.0 per 10,000 population
b. Cataract procedures	• 27.0 per 10,000 population
3. Achieve the waiting time targets (ESPI)	
a. No-one waiting more than 4 months for FSA	• ESPI 2
b. No-one waiting more than 4 months for elective surgery treatment	• ESPI 5
4. Patients will be prioritised for treatment using national, or nationally recognised, tools, and treatment will be in accordance with assigned priority and waiting time	• Increase uptake of latest CPAC tools
5. Achieve the standardised elective surgical inpatient length of stay target	• 1.59 days
Activity	**Monitoring & Performance**
Improving elective services productivity	• By December 2015
• Complete review and optimisation of theatre and implement recommendations	
• Complete implementation of process controls to optimise delivery of health target, e.g. theatre session cancellation solutions, outsourcing agreements, locum engagement, etc.	
• Complete implementation of process changes in theatre management to optimise theatre utilisation	
• Implement separate acute and elective flows in general surgery and orthopaedics	
• Continuation of Service Reviews to better align services with the forecast population needs and plan for mitigation of identified resource constraints	• Ongoing
Clinical Pathways	• By June 2016
• Local customisation of clinical pathways developed by the region	
Continuation of outpatient redesign projects	
• Pre-admission improvements finalised and processes fully implemented	• By December 2015
• Patient-focused booking – review current processes; agree and implement new processes across elective services	
• Prioritisation tools – all nationally agreed prioritisation tools adopted	• Ongoing

Central Region • Customise and implement Central Region clinical pathways for ORL, orthopaedic and ophthalmic services • Implement Central Region enhanced recovery after surgery processes agreed by Orthopaedic Network • Participate in Central Region telehealth business case or pilot service	• By September 2015 • SI2: Delivery of Regional Services Plans
Short-term outcome	**Measure**
National Patient Flow - patient level data is being reported into the National Patient Flow collection	
Activity	**Monitoring & Performance**
Participate in activity relating to development and implementation of the National Patient Flow system, including amending data submission as required	• Ongoing

Improved Access to Diagnostics	
HBDHB is committed to improving diagnostic services as a key enabler of a more integrated health sector. We will achieve targeted performance by more efficient use of existing resources, making improvements to referral management and patient pathways, and by investing in workforce and capacity as required. Regionally, we are participating in the development of radiology capability and capacity. Nationally, our hospital-based radiology service is participating in development and implementation of National Patient Flow (NPF) indicators by using a referrals handling process that enables compliance with NPF expectations. Much of our local improvement work in diagnostic services is in support of the regional programme, which is detailed in the RSP.	
Short-term outcome	**Measure**
Achieve the Diagnostic imaging waiting time targets – accepted referrals for Computed Tomography (CT) scans and Magnetic Resonance Imaging (MRI) will receive their scans within six weeks (42 days)	• CT 95% • MRI 85%
Activity	**Monitoring & Performance**
A "Radiology Service Improvement" project aligned to the National Radiology Service Improvement Initiative (NRSII) was commenced in October 2014 and will be completed by December 2015. The goal of the project is to facilitate the realignment of the CT and MRI service capacity with the service demands in order to improve patient access to CT and MRI services. This will result in the DHB providing a high-quality, timely and efficient CT and MRI service for the district. Key workstreams completed in the 2014/15 year include: • Demand and capacity analysis for CT and MRI • Justification and protocol review for CT and MRI • Implementation of Coronary CT • Establishing a reporting framework Having completed this preliminary work, the project will focus on implementing service improvement opportunities in the first 6 months of 2015/16 • Create improvement plan • Prepare change management plan • Implement service improvements	• By 1 July 2015 • By 31 July 2015 • July – December 2015

• Issues resolution and refinement • Handover to business-as-usual	• October – December 2015 • From January 2016
Short-term outcome	**Measure**
Achieve waiting time targets for colonoscopy • Urgent colonoscopy: 75% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive), 100% within 30 days • Non-urgent colonoscopy: 65% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 120 days • Surveillance colonoscopy: 65% of people waiting for a surveillance or follow-up colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date, 100% within 120 days	• Monthly reporting from National Booking Reporting System • PP29: Access to diagnostics
Activity	**Monitoring & Performance**

• Ongoing use and reporting against Global Rating Scale standards
  ○ Monthly report to Endoscopy User Group who have oversight of performance
• Extend use of Provation to ensure consistent standard of clinical data capture across in-house and outsource service providers
• Monthly reporting of performance against targets to inform Service Director and Consultants of any issues requiring mitigation
  ○ Ad hoc use of idle capacity (weekends) to catch-up as necessary
  ○ Proactive outsourcing of volumes in accordance with contract protocols when appropriate
• Monitor compliance with national referral criteria for direct access and use of recently-implemented aligned eReferral process
• Regional collaboration in response to capacity and competency report due June 2015 will ensure Central Region consistency and standardisation from point of referral through end of procedure, and enable better demand management across sub-regional grouping (Whanganui, MidCentral, Hawke's Bay)
• Progress business case for stand-alone endoscopy capacity development through detailed design of service and facility changes; seek Board approval to proceed to tender
	• Monthly reporting
	• Ongoing
	• By April 2016

Short-term outcome	**Measure**
Achieve waiting time targets for Coronary Angiography - 95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months	• Monthly reporting from National Booking Reporting System • PP29: access to diagnostics
Activity	**Monitoring & Performance**
• Ongoing monitoring of performance against benchmark targets • Implement agreed protocols for faster referral of high-risk patients will improve capacity for elective angiography • Review local provision capacity to consider future demand and service response	• Monthly • Ongoing • By December 2015

Central Region
• Implement Central Region Radiology Access Criteria
  ○ Consultation with wider referring community completed
  ○ Criteria amended if necessary and aligned to clinical pathways programme for ongoing implementation (see System Integration for more detail on HBDHB Clinical Pathways programme)
• Operationalise and maintain the necessary governance, business as usual and change control systems to deliver the regional RIS and PACS work programme, including the systems delivered by Regional Health Informatic Programme
• Support the development of workforce programme for Diagnostic Imaging starting with sonography
• Work closely with Whanganui and MidCentral DHBs on implementing agreed model for access to colonoscopy
	
	• By December 2015
	• By April 2016
	
	• From July 2015

Cancer Services, Faster Cancer Treatment (FCT) Health Target and Cancer Screening	
Cancer services span the continuum from prevention and screening, through treatment and follow-up care. FCT takes a pathway approach to care, to facilitate improved hospital productivity by ensuring resources are used effectively and efficiently. Cancer treatment is provided by HBDHB through our own provider and in collaboration with a number of other providers – for example, all radiation treatments are provided for Hawke's Bay patients by MidCentral DHB, while some surgical treatments are outsourced from Capital & Coast, Hutt Valley and Auckland DHBs. There is local provision of outpatient-based chemotherapy plus coordination of all Hawke's Bay patients across and through all networked services. This requires a high level of inter-district collaboration to ensure that services are integrated and seamless for patients.	
Short-term outcome	**Measure**
Achieve the Faster Cancer Treatment Health Target - % of patients referred with a high suspicion of cancer and a need to be seen with two weeks, that wait 62 days or less to receive their first treatment (or other management)	• Target 85%
Activity	**Monitoring & Performance**

• Continue to identify and implement service improvements to support patients to receive their treatment in a timely manner
• Participate in regionally-led development of innovative approaches to improving achievement of the FCT health target, using round two of the service improvement fund
• Adjust data collection based on findings of the national survey regarding the definition of "high suspicion of cancer"
• Continue to monitor milestones that contribute to FCT
  ○ % of patients (by ethnicity) with confirmed diagnosis of cancer who receive their first cancer treatment (or other management) within 31 days of decision to treat
• Continue to improve the quality of FCT data collection and reporting providing better platforms for national datasets
  ○ Develop and add in variables indicated by tumour standards reviews
  ○ Rationalise local databases to bring together related datasets
• Implementation of priorities that were identified by bowel, lung, gynaecology and breast tumour standard reviews
	• Ongoing
	• By October 2015
	• From July 2015
	• PP30
	
	• By June 2016
	• By June 2016

○ Support development and implement action plans as agreed by regional groups and networks, e.g. develop capacity and competency aligned to bowel tumour standards review; support development of EBUS capability at Capital & Coast DHB by amending referral pathway	
Short-term outcome	**Measure**
Improve the timeliness and quality of the cancer patient pathway from time of referral through treatment to follow-up or palliative care	
Activity	**Monitoring & Performance**
• Our Health Equity report highlights higher premature mortality and lower survival rates for Māori with lung cancer. Investigate inequity of outcomes regarding lung cancer in Hawke's Bay by completing an audit of people who have presented acutely with lung cancer. Establish issues and barriers regarding earlier access to health services; consider logistics of lung cancer screening	• By June 2016
• Continue to achieve shorter waits for cancer treatment target so that all patients, ready for treatment wait less than 4 weeks for radiotherapy or chemotherapy ○ Ongoing monitoring and reporting of access ○ Develop mitigation plans around risk to service continuity	• PP30 - quarterly
• Continuing to maximise the functionality of MDMs, prioritise patients within clinical resources and seek to grow clinical resource where appropriate ○ Scope cancer nurse coordinator role across primary/community care ○ Participate in Central Region review of MDM capacity to identify opportunities to close gaps or improve the functioning of MDMs ○ Plan for capital replacement of equipment ○ Develop video-conference link with DHBs external to Central Region to improve consistency of service	• Number of patients accessing MDMs (by ethnicity) - PP24 – reported quarterly
• Align with Central Region direction on implementing the guidance on active surveillance for prostate cancer	• By June 2016
• Work with specialist palliative care providers (Hospice and Hospital palliative care teams) to implement the national specialist palliative care service specifications ○ Plan for the implementation of the model of care identified from the Palliative Care Council. 'Last Days of Life' initiative ○ Monitor pathways for factors that facilitate or act as barriers toward achieving equity of access for Māori	
• Support the Central Region initiative to scope and identify gaps in supportive care service provision by completing stock-takes and implementing consistent service access as agreed	
• Participate in Regional SMO Workforce Plan	
• Support the regional approach to implementing the Cancer Health Information Strategy	

Short-term outcome	Measure
Achieve IPIF target for women aged 25 to 69 years enrolled in the PHO who have received a cervical smear in the past 3 years	Target - 80%
Activity	Monitoring & Performance
• Continue to concentrate on Māori and Pasifika women to receive cervical screening • Continue to support non-Māori women in Quintile 5 areas to receive free screening • Promotional activity extending $20 vouchers for Māori women who are overdue for a cervical screen 2015-2016 year • Increased screening in the home • Screening on time, and reducing the years to horizon overdue to 3 years rather than a 5 year lapsed history • Increase engagement and support to Māori providers and community organisations who have smear takers • Support community events and build capacity in our rural communities • Continue to focus on supporting events where there are high numbers of Māori women present • Manage one campaign promoting cervical screening during cervical screening month	• IPIF reporting • Number of Māori women receiving vouchers • Number of women screened in the home • 2 events in community
Short-term outcome	Measure
Achieve the National Cervical Screening Programme (NCSP) and BreastScreen Aotearoa (BSA) national targets for all population groups, with special emphasis on Māori and Pasifika populations	NCSP target ≥ 80% BSA target ≥70%
Activity	Monitoring & Performance
• Regional coordination of services across the National Cervical Screening Programme and BreastScreen Aotearoa screening pathways - entailing collaborative partnerships, joint planning, coordination of services and activities, effective communication and strengthening supportive networks • Develop and implement annual Regional Action Plan for breast and cervical screening • Monitor key performance indicators for screening coverage, colposcopy services and HPV immunisation • Continue piloting and then rolling out the quality improvement initiative 'Best Practice in Primary Care' (BPPC) project, focusing on NCSP systems and processes within General Practice including improving access, service quality, data quality, patient management systems, compliance with NCSP Policies and Standards and HPV testing • Continue focus on improving data quality, e.g. data matching between NSCP, BSA and General Practices, and working with smear takers, laboratories and the NCSP Register regarding recording ethnicity data • Continue to advance competency for screening workforce: support nurses to attend smear-taker training and pass their assessments, hold annual CME/CNE sessions on BSA and NCSP programmes, support cultural competency, implement He Taura Tieke in primary care • Ongoing training for service providers on NCSP and BSA policies and standards • Continue to employ recruitment and retention strategies targeting Māori and Pasifika populations, using a mix of kanohi	• Four Steering Group meetings & six Provider meetings per annum • 80% of HB NCSP service providers represented at meetings • BPPC initiative completed in 4 General Practices • Number of data matches • % of HB General Practices data matched • Number of health professionals attending training courses • Number and % of women

ki te kanohi, settings and community development approaches • Continue to refine the referral process from primary care into colposcopy • Continue to work towards reducing DNAs for colposcopy FSA and follow-up appointment, particularly for Māori women with CIN2 and CIN3 • Support breast screening mobile unit visits at Wairoa and Waipukurau	seen outside of colposcopy guideline times • DNA rates for colposcopy FSA and follow-up • Increased number and % of new screens and re-screens compared to previous visit
Central Region **Hawke's Bay DHB will continue to be an active participant in Central Region projects and activities. This includes:** • Contribution to regional process for Round 2 of the Ministry funded FCT RFP by October 2015 and involvement in successful projects • Ongoing improvement in data collection for FCT reporting including regional aggregation • Participation in regional MDM work • Regional approach to tumour standards reviews • Implementation of National Endoscopy Quality Improvement Programme • Contribution to development of regional pathways • Participation in programmes aimed at addressing system barriers in cancer care for Māori	• RSP, Action Plan 3

Primary Care

Transform and Sustain describes the need to redesign primary and community health care services so that they become fully integrated, provide care closer to the person's home during the early stages of care and are able to provide higher quality and more expansive services. Transform and Sustain speaks to the need for services to become less hospital-centric and to redeploy resources to population and primary health care settings. This change in emphasis will bring multi-fold benefits of slowing/reducing the rate of acute hospital admissions by providing better, more accessible care before people become really unwell, slowing disease progression and supporting individuals and whānau to manage their own health.

Alliancing in Hawke's Bay

HBDHB and Health Hawke's Bay Limited (the PHO) entered into an Alliance with effect from December 2013, formalising this with an Alliance Agreement in September 2014. The Alliance activities include:

- Promote clinical leadership and support clinically led decision-making
- Create an environment in which Transform and Sustain culture, strategies and actions can be developed and implemented, as appropriate
- Determine services to be funded from the Flexible Funding Pool, and
- Select, monitor and manage district level issues relating to IPIF

These activities are mainly supported through the pre-existing Hawke's Bay Clinical Council, which had been established in 2010 with the specific purpose:

- The Hawke's Bay Clinical Council provides clinical-led decision-making and advice to the Hawke's Bay health system on resource allocation and key service changes. The Council also provides clinical leadership and oversight of clinical quality and patient safety locally. It seeks to break down boundaries across primary and secondary care to ensure that services are organised around the needs of people.

The Alliance Leadership Team (ALT) works closely with Clinical Council to deal with specific issues or barriers to achieving Alliance objectives. This may include appointment and/or coordination of service level advisory groups or working teams to support specific initiatives – particularly ensuring connection to the Clinical Council for decision-making support and to Consumer Council for patient/whānau involvement. All service level advisory groups are linked to cross-sector clinical leadership and to consumer input in this way.

HBDHB and the PHO have been working with the health sector and consumers to develop an overarching strategic framework for primary and community health services. The framework provides direction for the development of integrated and sustainable services which can meet the challenges of inequity, rising demand and spiralling costs and outlines priority activities across three focus areas:

- Improving access and equity
- Managing demand
- Service integration

The strategic framework brings together several key projects into usual business for local primary and community services. These projects include the following innovative changes to services in Hawke's Bay:

- Presence of clinical pharmacy facilitators in General Practice settings to provide expertise and support to prescribers
- Clustering of inter-disciplinary older person's services around General Practice settings
- Better communication and integration between General Practice and district nursing services in respect of common patients

The principle or concept of locality clusters and clinical networks serves to bring providers into closer working relationships to meet the needs of the communities they share.

A key local priority that has emerged, and is supported by the findings of our Health Equity report, is improving the access of disadvantaged groups to primary and community care. Barriers to care exist – these include cost, transport, geographical distance and the nature of some services in terms of providing a welcoming atmosphere. We want to ensure that all our services are accessible and that everyone who needs care is enabled and empowered to seek that care as early as possible. It is particularly important that Māori living in Hawke's Bay have access to General Practice services that are responsive to cultural difference, understand the broader determinants affecting inequitable health outcomes, and provide services to increase the opportunity for Māori to be more self-determining in managing their own health challenges.

One of the national priorities affecting primary care services in 2015/16 is the extension of free General Practice services to all enrolled children under 13 years of age. This will be done in collaboration with the PHO.

Short-term outcome	Measure
Increase enrolment in the PHO: baseline at March 2015: Total population = 95.5%; Māori = 95%; Pasifika = 88%	• Target 97.5%
Activity	**Monitoring & Performance**
• Promote enrolment at birth – automatic enrolment process • Work with Practices to update and re-enrol members whose membership is due to lapse • Encourage people to re-connect with primary care providers when attending ED	• Population level enrolment rates – by ethnicity: Quarterly • Annual GP utilisation rate by ethnicity
Short-term outcome	**Measure**
• Practices are supported to consider and respond to the particular context and paradigm of Māori accessing their services • Practices are supported to engage with, communicate and share health information in a way it can be retained and understood by Māori using their services.	• Practices self-identify where the responsiveness can be improved and are supported to implement changes • Increased appropriate utilisation of services
Activity	**Monitoring & Performance**
• Practices are engaged in a formal support and quality programme 'He Taura Tieke' to increase the responsiveness to their Māori population. A staggered approach of engagement will occur over the next 12 months ○ A self-assessment and annual plan will be completed by each participating Practice • The Health Literacy training programme will be implemented into General Practice over the next 12 months ○ Evaluation of the training and customer survey	• 18 Practices 2015-2016 • 6 monthly reporting of PHO SIA contract • 6 monthly reporting of PHO Health Promotion Plan
Short-term outcome	**Measure**
• The Self-management Programme 'Stanford' is provided in environments where Māori feel most comfortable (Marae, Māori venues) and is inclusive of protocol and process which supports Māori cultural context • Health Literacy campaign implemented (programme covers 2 years) • Whānau Wellness Programme (2nd year)	• Māori are actively participating in the programme from and with, Sport Hawke's Bay, Iron Māori, Hikoi Koutou, Patu Aotearoa, KHW • Whānau have the opportunity to manage health as a core component of living 'well'
Activity	**Monitoring & Performance**
• Māori are trained to be Master Trainers including participation from Māori NGO. Stanford will be provided in Marae settings and in places where Māori feel most comfortable. Trainers are encouraged to use Māori cultural process to deliver the programme	• Evaluation of the training and customer surveys for Stanford completed

• The priority campaign actions to support more understanding in Māori communities of identified health issues will be implemented • A recruitment programme will be initiated to bring up to 250 whānau onto the programme in the first quarter of 2015. The whānau will access 12 months of GP services free of charge while other services will be identified to ensure whole of sector support	• PHO reporting: health promotion plan • PHO reporting: SIA contract • Te Ara Whakawaiora reporting
Short-term outcome	**Measure**
Increase equitable access to General practice for children • Roll out of free GP services (daytime and after-hours) to those under 13 years old • Implement free prescription co-payments for under 13's	• PP22 • Access to free visits and prescriptions for under 13's • Disaggregate by ethnicity
Activity	**Monitoring & Performance**
• Complete contract preparation • The PHO will work with Practices choosing to implement the contract for Under 13 years old so that it is embedded into Business As Usual (BAU) for those Practices – includes daytime and after hours access • Monitor access changes	• Pre 1 July 2015 • Up to 28 Practices
Short-term outcome	**Measure**
Distribution of Rural Primary Care Funding is agreed through the ALT in accordance with the process laid out in the PHO Services Agreement.	
Activity	**Monitoring & Performance**
• Rural Practices provide proposals to address issues in respective communities – leadership development, integration of services (Multi-Disciplinary Team (MDT) approaches), and access for under-served populations • Available rural funding allocated based on proposals • Funding allocation confirmed and prioritised by ALT	• By end Q3 • By end Q4
Short-term outcome	**Measure**
Implement the National Enrolment Service (NES)	
Activity	**Monitoring & Performance**
• Support the PHO to implement the NES within local Practices ○ PHO submits quarterly registers as per status quo until NES is live ○ Transition to NES as soon as practicable	• Quarterly progress

Health of Older People (HoP)
HBDHB is investing in improved services for frail older people. Services will be coordinated to support General Practices to provide care and support patients and families with LTCs to manage their care. In older people services, we will develop clusters of Practices supported by coordinated care teams, including pharmacy facilitators, district nurses, geriatricians, allied health and mental health. Over the next three years we will build MDTs that work with General

Practice staff so staff can use their skills where they will make the biggest improvements in the health of people who are frail. Staff will have confidence to work across disciplines so we reduce the number of people involved in a patient's care.	
Short-term outcome	**Measure**
Roll out of EngAGE Services: Increased access to Allied Health and transitional care in the community	Monitor over 65 years use of ED and admissions to hospital
Activity	**Monitoring & Performance**
• The EngAGE response team in Hawke's Bay Hospital will expand to 7 days • Clusters and intermediate care services will be developed with General Practices by December 2015 • Intermediate care services will be available across Napier, Taradale, Hastings, Havelock North	• 6 cluster established in Napier, Taradale, Hastings & Havelock North • As per contract requirement
Short-term outcome	**Measure**
HoP Specialists: Increase access to geriatrician and Clinical Nurse Specialist (CNS) in General Practices	Monitor over 65 years use of ED and admissions to hospital
Activity	**Monitoring & Performance**
• Geriatrician time released to work in the community with General Practices 2.9 FTE • CNS gerontology roles aligned to General Practices	• Staff working in each cluster
Short-term outcome	**Measure**
Dementia care pathways (PP23): Implement the two new dementia care pathways developed in 2014/15 using Map of Medicine Develop service options for people under 65 years	Two pathways implemented for assessment and management
Activity	**Monitoring & Performance**
• Agreed care pathways published – dementia and cognitive impairment • Identify gaps in services and decide targeting of resources • Support GP and Specialist training on pathways • Monitor outcome for clients	• By end of Q1 • Ongoing
Short-term outcome	**Measure**
Workforce development: Consistent practice for the care of frail older people	
Activity	**Monitoring & Performance**
• CNS gerontology promote use of Waitemata Guidelines with Aged Residential Care (ARC) and support Best Practice • Joint RN and caregiver training for ARC staff, continues with local Aged Care Association. • Advance Care Planning (ACP) group continues to present to community groups to raise awareness of what ACP means and create a platform for cultural change across the community • Monitor Home Based Support Services (HBSS) level of training for Support Workers. Care Associate training will be provided by the Older Person's Mental Health team who care for people with dementia and confusion while	• Aged care association joint training - number of attendees RN and Caregiver • 2 training sessions by June 2016

they are in hospital • Pou Arahi (cultural advisors) work with ARC facilities on developing annual plans for working with Māori. Includes: ○ Training for care providers and service managers on cultural responsiveness ○ Facility/setting-based health plans focused on providing effective care services to Māori customers ○ Facilitate cultural supervision among instutitional care providers to help with quality improvement by exploring and developing policies and procedures for Korua and Kuia health plans; Whānau Ora approaches	Monitor & report on: • Number and categories of staff attending training • Number of plans developed • At least 10 institutions visited and supported by June 2016
Short-term outcome	**Measure**
Improved wrap around services for the health of older people	Report on deliverables from PP23
Activity	**Monitoring & Performance**
• Funding from the inbetween travel settlement will be transferred to contracted home and community support providers • Monitoring of the operation of the fracture liaison service • Establish team and report systems	• Number of people who are seen by the service and the treatment they receive • To be developed
Short-term outcome	**Measure**
A more unified and improved health and disability system is evidenced	• Benchmark against standards
Activity	**Monitoring & Performance**
• Continue to use InterRAI to compare performance with other Central Region DHBs ○ Monitor the number and percentage of older people who have received long-term home and community support services in the last 3 months who have had an interRAI Homecare or a Contact assessment and completed care plan • Older people referred for an interRAI assessment to access publicly funded care services will undergo an assessment and have a service allocated/declined in a timely manner • Promote the use of InterRAI assessments with Aged Care facilities and further teams in the hospital & community ○ Measure the percentage of older people in ARC by facility who have a second interRAI Long-Term Care Facility assessment (LTCF) completed 230 days after admission • Options Hawke's Bay care managers use the LTCF assessment to enable a timely response to changes in level of needs	• Quarterly reporting: PP23 • 100% of routine referrals actioned within 20 working days
Central Region Local work in HoP services is closely aligned to the Regional programme • HBDHB participates in the Regional HoP Network • HBDHB provides clinical leadership for dementia education programmes for primary health care	• Section RSP, Action Plan 1

Rising to the Challenge and Mental Health Service Development Plan	
By December 2015 the project to implement changes in mental health acute and community services will be nearing completion. This is a major project for HBDHB with investment of over $20 million in a new mental health facility and redesign of services for patients and their families. We will establish a number of new services by April 2015, while maintaining continuity of care for patients. These include: • Establishing a specialist home based treatment team • Transferring acute community based unplanned respite services to an NGO • Extending community based resiliency programmes • Developing NGO day programmes to support people to connect with their communities • Continuing productive wards in mental health inpatient unit and Te Whare Aronui to release clinician time for direct patient care	
Short-term outcome	**Measure**
Improve access and quality of acute and community mental health services	• Services established by Q1 • Measurement systems in place for teams • Services in place by Q3
Activity	**Monitoring & Performance**
• Services are monitored through a Steering Group representing stakeholders in Hawke's Bay. • Communication strategies include NGO, PHO & Justice sectors • Establishing a specialist home based treatment team • Transferring acute community based unplanned respite services to an NGO • Extending community based resiliency programmes • Developing NGO day programmes to support people to connect with their communities • Continuing productive wards in mental health inpatient unit and Te Whare Aronui to release clinician time for direct patient care • Acute hospital based services will be established in the new mental health facility from December 2015. From February 2016 the intensive day programme will be in place and the focus will be on continuous improvement	• Increase access rates • Continuity of care for patients as services transition • Increased clinical face to face time for clients
Short-term outcome	**Measure**
Improve communication between primary and secondary care	
Activity	**Monitoring & Performance**
Joint activities with Health Hawke's Bay (PHO) include: • Peer support for Psychiatrists and GPs • Development of nursing competency in primary care • Stocktake of primary mental health support in the community • Low cost primary care clinics provided in high need areas (Wairoa, Hastings & Napier) are funded by HBDHB	• Ongoing

and Health Hawke's Bay for long-term clients with mental health needs	
Short-term outcome	**Measure**
Improve physical health & well being	
Activity	**Monitoring & Performance**
• HBDHB has developed metabolic clinics to monitor weight gain and encourage healthy eating • HBDHB have employed a Dietitian to assist services users to live a healthy lifestyle • Mental Health Inpatient beds will be reduced by December 2015 and alternative community services will be in place	• Establish new services Q1 • Fully operational by Q3
Short-term outcome	**Measure**
Deliver increased access for all age groups	
Activity	**Monitoring & Performance**
• HBDHB have agreed an integrated contract with Te Taiwhenua o Heretaunga. This will target resources to Hastings Māori and youth • HBDHB provides support to 25 clients in rest home care • Mental health needs assessment provides a liaison role to work with ARC and maintain communication and support from key workers • Psychiatrists provide clinical support in the community • HBDHB will work with MoH to implement national guidelines for services for children of parents with mental illness • HBDHB runs several successful groups for both children and parents including the award winning programme 'Fostering Security'	• Clients living in the community with appropriate support
Short-term outcome	**Measure**
Increased access to flexible options for clients with high & complex needs	
Activity	**Monitoring & Performance**
• Developing individual packages for clients with multiple needs including mental health, psychogeriatric, frailty, cognitive and behavioural support • Needs assessment services work together to develop options • Work with Capital & Coast DHB to develop options for long-term community placements • Maintain clinical working group with Colwyn psychogeriatric services to develop capability to provide mental health services as well as psychogeriatric services for up to 2 clients	• At least 4 high cost clients placed in community services • Coordinated clinical oversight and support
Short-term outcome	**Measure**
Reduce the rate of Māori under Compulsory Treatment Orders (CTOs). Baseline as at December 2014 = 81.5 per 100,000 (total population)	• < 81.5 per 100,000 (total population)

Activity	Monitoring & Performance

• HBDHB will undertake an audit of patients subject to CTOs to determine factors associated with treatment under Mental Health Act in different patient groups
• HBDHB has Kaupapa Māori mental health and addiction services in place
  ○ This includes joint governance with Te Taiwhenua o Heretaunga who provide clinical and community services to over 280 clients per annum
  ○ HBDHB has an integrated contract which includes monitoring KPIs, working to increase access to services, developing whānau, integrating with primary care and developing capability in youth services
  ○ Regular meetings between hospital and community services monitor progress of individuals subject to CTOs to consider options
	• Report by Q3
	• Bi-monthly meetings and case reviews

Short-term outcome	**Measure**
Maintain a mix of NGO and Specialist services	
Activity	**Monitoring & Performance**
Over the past 5 years HBDHB has consolidated NGO providers. If management and clinical leadership are stable, contracts are for let 3 years. As a strategic partnership the integrated contract with Te Taiwhenua o Heretaunga is in place for 5 years. HBDHB are developing another integrated contract with a mental health NGO in 2015. Providers across the district specialise: • Mental health support and accommodation is provided by Te Taiwhenua o Heretaunga, Whatever It Takes, Richmond Services Limited and Centrecare Community Trust • Addiction services are provided by provider arm (Health Services), Central Health & MASH • Corrections contracts with NZ Care for addiction services • HBDHB has a system in place for Richmond to provide additional support worker time and link clients to Workbridge and pathways to employment All of these services have mental health contracts over $500,000 per annum. HBDHB encourages providers to work together to address co-existing problems and develop staff competency. In rural areas the DHB contracts with smaller providers and works with them to form partnerships with larger organisations • Kahungunu Executive ki te Wairoa provides mental health community support and day programmes. Clinical support is provided by Te Taiwhenua o Heretaunga • Manaaki House provides addiction counselling in Wairoa. Clinical support is provided by Health Services which provides all-age mental health and addiction services Price increases are not automatically passed through to providers – NGO or provider arm – unless there are sustainability issues. Consideration includes overall business models, underlying costs and strategic development with other services or providers. Prices are adjusted for additional costs in rural areas.	• PP07: Employment rates for people with low-prevalence conditions

Short-term outcome	**Measure**
Better access to forensic services	• Improved access to forensic services
Activity	**Monitoring & Performance**
• Capital & Coast DHB employs staff in community forensic services in Hawke's Bay including youth forensic services • Clinical staff work closely with forensic services • The Child and Adolescent Psychiatrist works part-time with HBHDB Child Adolescent & Family Services and Capital & Coast DHB youth forensic services	• Coordinated through the regional programme
Short-term outcome	**Measure**
Access to a range of eating disorder services	
Activity	**Monitoring & Performance**
• HBDHB employs a Dietitian and 2 community mental health staff with an interest in eating disorders. No further investment is planned	
Short-term outcome	**Measure**
Increased access to perinatal and maternal mental health services	
Activity	**Monitoring & Performance**
• Coordinated response from Maternal and Mental Health Services • Service expanded to include SMO and CNS	
Short-term outcome	
Deliver a coordinated, multi-agency response to suicide prevention and postvention so that Hawke's Bay has a clear pathway that helps to reduce the number of suicides, minimise the presence of suicidal behaviour, ensure people at risk of suicide are accessing appropriate care and builds community/workplace resilience	• Reduction in suicide numbers and rates
Activity	

• Provide a final district suicide prevention and postvention plan that includes:
  ○ Resilience building: responding to early risks, promoting mental health and well-being, preventing suicide
  ○ Competence to respond: workforce development for health workers and community gate-keepers
  ○ Specific approaches: mental health service users, males, youth, Māori
  ○ Multi-agency postvention responses: clusters, contagions
• Monitor progress against the plan; evaluate responses against expectations; improve the system
	• By July 2015
	
	• First Annual Report by June 2016

Central Region • HBDHB is well-connected to the regional programme as outlined in the RSP, Action Plan 6 • Regular, ongoing attendance and participation in regional service planning and development forums	

Maternal and Child Health	
A considerable body of evidence links adverse childhood circumstances to poor child health outcomes and future adult ill-health. These adverse health outcomes include low birth weight, infant mortality, poor dental health, poorer mental health and cognitive development and increased hospital admissions from a variety of causes. Maternity services are provided by a range of health professionals to women and families throughout pregnancy, childbirth and for the first six weeks of a baby's life. Child services continue thereafter with a number of primary, community, population-wide and hospital-based programmes aimed at ensuring that all children are regularly assessed against a raft of health and well-being indicators. Our focus in this part of the plan is on pre-pregnancy, maternal and pre-school services.	
Short-term outcome	**Measure**
Increase in the number of women who receive continuity of primary maternity care during their pregnancy (access to either a community DHB midwife or LMC)	Pregnant women receiving continuity of primary maternity care through a community or DHB LMC. Target 95%
Activity	**Monitoring & Performance**
• Promotion of early enrolment with LMC with particular focus on reducing inequity for Māori and Pasifika • Raise awareness amongst Primary Health providers around pathways for referral for LMC midwifery care • Promote a Maternity model of care that ensures women under secondary care services retain primary LMC services as far as possible • Dedicated team of DHB midwives in both Wairoa and Hastings site to provide continuity of carer for women under DHB care	• Number of women who are unbooked at time of admission for delivery • Women under team midwifery care seen by >2 midwives in postnatal period • Maternity Patient Satisfaction surveys • Complaints/Compliments
Short-term outcome	**Measure**
Timely registration with a LMC (DHB MoH target)	Women who register with an LMC do so in their 1st trimester - data broken down by ethnicity. Target 80%
Activity	**Monitoring & Performance**
Use social media and other networks to facilitate access to services: • Promotion of the "Find Your Midwife' website on DHB Maternity Services webpage and Social Media, PHO desktops • Profile LMCs • Promotion of Napier Maternity Resource Centre as a drop-in for women requiring pregnancy tests or help finding an LMC ***Pilot project to improve links with GP and LMC midwife for women:*** • Development of early pregnancy kits for GPs - providing information for GPs to facilitate women to find and book with a LMC, by Q2, 2015/16	• 80% of women are screened for pre-existing diabetes in the 1st or 2nd trimester • Number of likes on Facebook page • Consumer survey responses • GP Utilisation of the early pregnancy kits • Number of multi-professional meetings convened

• Campaign for 5 key messages in the first 10 weeks will be rolled out locally to make women aware of need for early pregnancy care • To develop and build inter-professional relationships across continuum, e.g. PHO/Pharmacists/LMC	• Campaign for 5 key messages established by Quarter 3
Short-term outcome	**Measure**
Increase in the number of women attending DHB funded pregnancy and parenting education with a focus on Māori, Pasifika, teen and for those whom English is a second language	Pregnant women completing DHB funded pregnancy and parenting education. Target > 30%
Activity	**Monitoring & Performance**

• Improve the responsiveness of antenatal education (bump, birth and baby education classes) to the needs of Māori
  ○ Explore kaupapa Māori based models of delivery
  ○ Improve booking system to facilitate easy booking for women
  ○ Liaise with provider childbirth educator course to provide supportive pathways for Māori childbirth educator students by Q2
• Raising the profile of antenatal educational services by working with primary care and LMCs to improve promotion
• Explore community based venues and models of delivery
• Feedback from client for all antenatal education services to explore trends and inform future service provision (including those who enrolled but did not complete antenatal education)
• HBDHB antenatal education services to be reviewed with a focus on being more responsive to Māori, Pasifika, teen and those for whom English is a second language
	• % and number of Māori, Pasifika, teen and those for whom English is a second language attending DHB funded antenatal education
	• Booking system updated by Q2
	• % and number of whānau supporting Māori women at DHB funded antenatal education
	• Review of antenatal education services completed by Q4

Short-term outcome	**Measure**
Ensure all new-born babies are enrolled with a PHO and registered with a GP, Well Child/Tamariki Ora (WC/TO) and Community Oral Health Services (COHS)	New-borns are enrolled with a PHO, WC/TO provider and COHS by 3 months. Target > 98%
Activity	**Monitoring & Performance**
Develop and maintain systems to enable multiple enrolment with services • Modify maternity booking form to promote automatic enrolment with “opt off” option • Standardise maternity discharge process to ensure enrolment forms are received by NIR and PHO • Maximise potential of NIR for multiple enrolment and ongoing maintenance of contact information • Follow-up whānau who decline new-born enrolment or those with no nominated WC/TO or GP primary care enrolment – PHO and GP • Educate General Practices about electronic acceptance of babies correct enrolment process and connection to other registers. General Practice Facilitation Team works with Practices to rectify breaches in enrolment	• % new-borns enrolled with PHO within 4 weeks of birth • 80% of new-borns receive 6 week

• General Practice Facilitation Team works with Practices to rectify breaches in enrolment • NIR-PHO matching within 2 weeks and PHO works closely with NIR team to catch missed enrolments and immunisations and rectify Early notification and completion of referral to WC/TO provider: • Increase administrative resource to make use of NIR information – early notification to chosen WC/TO provider based on maternity discharge information • LMC referral to WC/TO by 4 weeks +5 days. Recommend referral of high risk families to Well Child Services antenatal or within 2 weeks of the birth • WC/TO providers plan first contact and match early advice with LMC referral when received • Support whānau who have not nominated a WC/TO provider to engage with a provider of their choice Community Oral Health Service • Make use of NIR information to confirm enrolments and to reconfirm contact information periodically • Plan and complete initial appointments at appropriate age	immunisation by 8 weeks of age • Monthly audit of Patient Management Systems • Routine communication to WC/TO provider established by end Q1 • % referrals to WC/TO completed by 6 weeks
Short-term outcome	**Measure**
All children receive a B4SC, particularly children in areas of high relative deprivation	90% of 4 year olds receive a B4SC (including 90% Māori, Pasifika & high needs)
Activity	**Monitoring & Performance**
• Sustain coordinated approach to implementation of the B4SC programme • Improve B4SC timeliness by increasing early screening opportunities o Vision and Hearing Technicians (VHT) increased frequency of visits to Early Childhood Education (ECE) o VHT community clinic appointments available fortnightly o Increase parent's awareness of the need to complete all components of B4SC o Independent practitioners and Kaiwhakahaere continue consistent attempts to engage with Quintile 4 and 5 whānau in their home environment o Audit to ensure children receive hearing and vision components of B4SC o Monthly reports provided by HHB to Vision and Hearing to identify children overdue for screening	• Meet contract targets • 90% of B4SC are started before age 4½ • Children identified through audit process are followed up as soon as possible where parts of service not complete and prior to fifth birthday
Short-term outcome	**Measure**
Services for pregnant women, babies, children and families are nationally consistent	NZ Maternity Clinical Indicators
Activity	**Monitoring & Performance**
• Continue to focus on normal births for standard primips • Continue to implement Maternity Quality and Safety Programme national standards • Implement new national gestational diabetes guidelines	• Maternity annual clinical report

<table>
<tr><th>Short-term outcome</th><th>Measure</th></tr>
<tr><td>Implementation of Gestation Diabetes Mellitus (GDM) National Clinical Guidelines
• Increased awareness of impact of healthy lifestyles on GDM
• Earlier antenatal connection with diabetes service
• Improved management of GDM</td><td></td></tr>
<tr><th>Activity</th><th>Monitoring & Performance</th></tr>
<tr><td>• Every women should have a HbA1c test as a routine part of antenatal booking bloods (within first trimester ideally)
• Establish a Best Practice referral process depending on HbA1c results, including physical activity, dietary advice, blood sugar monitoring, specialised diabetes and in pregnancy care
• Deliver workforce development sessions for sector (LMCs/DHB/PHO) on new gestational diabetes guidelines and practice
• Develop pathway to establish 3 month post-partum HbA1c through GP Practice
• Clinicians that attend workforce development complete pre-and post-knowledge questionnaire
• Work in collaboration with LMCs, Specialist Diabetes Service, Secondary Obstetric Services, GPs and Community Laboratory to implement recommendations from the GDM guidelines – by Q3, 2015/16</td><td>• Number of women diagnosed with GDM in pregnancy
• Number of women attending specialist Diabetes clinic
• Number of women referred to Maternal Green Prescription programme
• Numbers of clinicians attending workforce development
• Increased knowledge based on questionnaire
• Report on progress of service implementation by Q2</td></tr>
<tr><th>Short-term outcome</th><th>Measure</th></tr>
<tr><td>Improvement in breastfeeding of pepi
<table>
<tr><th></th><th colspan="2">Māori</th><th colspan="2">Total</th></tr>
<tr><th></th><th>Jul-Dec 2013</th><th>Change since Jan-Jun 2013</th><th>Jul-Dec 2013</th><th>Change since Jan-Jun 2013</th></tr>
<tr><td>Infants are exclusively or fully breastfed at 6 weeks</td><td>61%</td><td>↓4%</td><td>72%</td><td>↑1%</td></tr>
<tr><td>Infants are exclusively or fully breastfed at 3 months of age</td><td>34%</td><td>↓8%</td><td>53%</td><td>↓2%</td></tr>
<tr><td>Infants are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)</td><td>46%</td><td>↓2%</td><td>60%</td><td>0%</td></tr>
</table>
Source: Well Child/Tamariki Ora Quality Improvement Framework March 2014, September 2014</td><td>June 2016 targets:
• 6 weeks - 75%
• 3 months of age - 60%
• 6 months of age - 65%</td></tr>
<tr><th>Activity</th><th>Monitoring & Performance</th></tr>
<tr><td>• Improve coordination of breastfeeding activities across the Hawke's Bay health sector – uses Women, Child & Youth Services, Māori Health Services and Team Mauri Ora in the PHO as key agents
• Facilitate inter-sectoral Breastfeeding Governance Group (quarterly):
○ Provide strategic direction for breastfeeding activities to increase breastfeeding rates in Hawke’s Bay</td><td>• Key stakeholder and community participation in planned breastfeeding action plan review
• KPI results card updated and</td></tr>
</table>

(attended by relevant DHB and community services/agencies) ○ Update and distribute breastfeeding KPI result card and define actions for breastfeeding programme for Māori based on the results ○ Develop a community resource providing information on breastfeeding, SUDI and Smokefree ○ Establish PHO representation on Breastfeeding Governance Group • Facilitate Hawke's Bay Breastfeeding Multi-Agency Group established under WC/TO contract to support breastfeeding workforce in Hawke's Bay ○ Includes increasing clarity for General Practice via PHO about support available for new mothers • Complete consultation with women to accessing established antenatal and postnatal breastfeeding support services (Māori, under 20, Quintile 5) to inform targeted service design and implementation ○ Use PHO and DHB Intelligence to identify those not accessing • Maintain Baby Friendly Hospital Initiative (BFHI) accreditation • Continue to deliver activities in Kahungunu Hikoi Whenua (KHW) Breastfeeding Action Plan (BFAP) and review the plan on contract expiry (December 2015) • Provide breastfeeding education and promotion through pregnancy and parenting education – increased knowledge of breastfeeding benefits and services available will lead to greater commitment to breastfeeding • Monitoring of breastfeeding results shared regularly with key stakeholders, through the PHO and reported quarterly to MRB	distributed quarterly • Community breastfeeding resource developed by end of Q3 • Consultation completed by Q3 • Number of breastfeeding pregnancy and parenting classes held each year • Number of Māori women and whānau attending breastfeeding classes • 75% of women will be exclusively breastfeeding on discharge from hospital • Number of La Lache League trained Breastfeeding Councillors Q3 • Number supported towards lactation consultant certification • Number supported toward CBE certification • Number Māori women who received breastfeeding peer support services (Piri Paua programme)
Short-term outcome	**Measure**
Sudden Unexpected Death in Infancy (SUDI) Reducing the rate of SUDI is a national priority. HBDHB is committed to reducing the rate of SUDI by decreasing the number of women smoking during pregnancy; encouraging more women to breastfeed; and increasing safe sleep knowledge and use of safe sleep devices within whānau and the wider community. In 2008-2012 there were 13 SUDI deaths among Māori (2.4 per 1,000 births), and 16 deaths among the total Hawke's Bay population (1.37 per 1,000 births). • Reduce the number of SUDI deaths	• Rate of SUDI. Target <0.5 deaths per 1,000 live births, Māori and non-Māori
Activity	**Monitoring & Performance**
Reduce the number of SUDI deaths per 1,000 live births: ***HBDHB Safe Sleep Programme***	

• HBDHB coordinates quarterly multi-sectorial Safe Sleep Action Group, including representatives from Smokefree team, Iwi, community providers, WC/TO, breastfeeding advocates and the Portfolio Advisor Women, Children and Youth – this group provides strategic guidance for SUDI activities and monitors outcomes	• Safe sleep meetings held quarterly
• Safe Sleep Coordinator promotes importance of early enrolment with LMC and WC/TO in relation to SUDI risk prevention through networks and training	
• HBDHB Safe Sleep Policy - review and update annually	• By May 2016
Continue Hospital-based Safe Sleep Coordinator Role	
Safe Sleep Champion Training – at least one per quarter	
• Continue to train safe sleep champions within and external to HBDHB (e.g. Hauora providers, Practice Nurses, independent LMC, Public Health, Child and Youth Mortality Review Committee) to increase safe sleep conversations (antenatal and postnatal) to ensure all whānau fully prepared and whānau understand the importance of a safe sleeping environment and the risk factors for SUDI	• Number and type of training provided per quarter • Profile of attendees
• Safe Sleep Champion training includes information to ensure whānau are prepared for baby outgrowing pepi pod, e.g. whānau aware that Work & Income New Zealand (WINZ) grants are available for an alternative safe sleep device	• % of pregnant women who receive safe sleep conversations
Safe Sleep Education Sessions – offered quarterly according to demand:	• % of mothers and whānau who have safe sleep conversations at discharge (annual audit completed by Q2)
• Continue to provide safe sleep education and pepi pod training to new WC/TO staff and relevant HBDHB Maternity and Child Health staff (all new staff within 3 months of start, plus annual update). Sessions support provision of accurate safe sleep information and pepi pod use to whānau, face-to-face and online with "Baby Essentials Online" and "Through the Tubes"	• % of Māori whānau provided with a pepi pod (Quarterly)
• Safe Sleep Coordinators to support community providers to develop and review safe sleep policies	
• Continue to distribute pepi pods to whānau as appropriate	
• Safe sleep education sessions include information to ensure whānau are prepared for baby outgrowing pepi pod, e.g. whānau aware that WINZ grants are available for an alternative safe sleep device	
Establish Community Safe Sleep Coordinator Role:	• Number of community based locations provided with recycled pepi pods and Safe sleep education/resources
• Provide safe sleep education and/or champion training in community settings and provide recycled pepi pods if required to PHO and General Practice staff, WINZ, Māori providers, Māori Women's Welfare, Kura Kaupapa, Marae, iwi authorities, Te Kohanga Reo, CYFS, Parenting groups, Church groups. All participants in safe sleep education and champion training complete online education: "Baby Essentials Online" and "Through the Tubes"	• Number of safe sleep promotions completed per quarter
• Offer safe sleep education and resources to all Hawke's Bay retailers selling sleeping devices for infants, recommend access to online education "Baby Essentials Online" and "Through the Tubes".	• Number of retailers provided with Safe sleep information/resources per quarter once role is established.
• Carry out activities outlined in Communications Plan (developed Q3, 2014/2015), ensuring culturally appropriate safe sleep messages are delivered, including to wider whānau members - activities include: o Promotion of safe sleep messages at local events, e.g. Iron Māori o Attend Kaupapa Māori SUDI education – Whakawhetu – by Q2	

○ In conjunction with the Hawke's Bay Breastfeeding Governance Group, develop a community resource offering information to providers on breastfeeding, smoking cessation and other SUDI information. <u>Child and Youth Mortality Review (CYMR) Committee:</u> • CYMR Committee recommendations to guide SUDI activities • Hawke's Bay CYMR Coordinator to attend the Safe Sleep Action Group • Women, Child and Youth Portfolio Advisor to attend CYMR Committee meetings <u>Reducing Risk of SUDI</u> Increasing the number of women attending pregnancy and parenting education (see separate outcome section) will help ensure more vulnerable women receive information on SUDI factors. <u>Strengthen provider awareness of Smoking Cessation Services and Referral Pathways within and external to HBDHB</u> • Promote use of HBDHB community breastfeeding resource (developed by Q3) which includes SUDI/Safe Sleep and Smoking Cessation information • Safe Sleep Coordinators to work collaboratively with HBDHB Maternal Smokefree Coordinator and Community Smoking Cessation programmes, e.g. Kaupapa Māori services • Ensure that all providers are aware of tobacco cessation support available and, as part of safe sleep conversations and pepi pod referral/distribution, give smoking cessation advice and refer as appropriate. • Activities to reduce smoking cessation in pregnancy and postnatal are outlined in the Smokefree section of the plan <u>Strengthen provider awareness of the importance of breastfeeding promotion in regards to SUDI prevention and referral pathways within and external to HBDHB for breastfeeding support:</u> • Promote use of HBDHB community breastfeeding resource which includes SUDI/Safe Sleep and Smoking Cessation information • Ensure that all Safe Sleep conversations and pepi pod referrals/distributions include support and promotion of breastfeeding as a protective factor in relation to SUDI • Ensure that all breastfeeding initiatives link breastfeeding with the prevention of SUDI	• % of Māori whānau who are not smokefree provided with a pepi pod (Quarterly)
Short-term outcome	**Measure**
All caregivers of infants are provided with SUDI prevention information at WC/TO Core Contact 1. (2013 baseline: Total population 72%; Māori 59%; Pasifika 71%)	Provision of SUDI information in Core Contact 1 – Target 100%

Activity	

• Meet quarterly with WC/TO providers in region:
  ○ Monitor performance against SUDI indicators and strengthen collaborative approach to improve performance
  ○ Include College of Midwives representative on group Q2
	• Number of WC/TO group meetings

• Safe Sleep and pepi pod training (and regular updates) made available to WC/TO providers ○ Provision of SUDI prevention information at core contact 1 to be reiterated	• Number and rate of infants receiving safe sleep information at Core 1 by ethnicity

• Participation in WC/TO regional quality improvement project:
  ○ Identify referral process procedures, maps and tools that promote seamless transition of care between WC/TO providers and referrers by Q2
  ○ Develop a consistent and valid tool in the Central Region to assess family/whānau experience of WC/TO services to identify reasons for disengagement by July 2016
	• Number of WC/TO staff members provided with safe sleep and pepi pod training (and regular updates)

• Increase completion of Core Contact 1 by 6 weeks post-birth (2013 baseline: Total 85%; Māori 75%)
  ○ Continue with quality improvement cycle (Plan, Do, Study, Act) to improve relationships with Midwife/LMC to ensure that referrals are completed to WC/TO as early as possible postnatally and in the antenatal period for the most vulnerable
  ○ Recommend referral of high risk families to Well Child services antenatal or within 2 weeks of the birth
  ○ Identify what the barriers are for Midwives/LMCs in referring to WC/TO
  ○ Continue new-born enrolment programme and pre-advice to WC/TO provider
  ○ Support internal WC/TO processes to ensure accurate and timely processing of LMC referral
	• Number and rate of infants with Core Contact 1 provided
	• A regional report into the experiences of people who disengage with WC/TO providers
	• College of Midwives involvement in quality

Short-term outcome	**Measure**
Improved sexual and maternal health for Māori women Increase access to and awareness of Sexual Health services	Reduction in under 17 year old rate of pregnancy Number of Māori accessing Sexual Health services
Activity	**Monitoring & Performance**
• Continue to co-fund CPO Sexual Health service, Directions Youth Health and SBHS increasing access to • Improve access to Sexual Health services for Māori taitama • Monitor pregnancy rates and target services accordingly • Improved access to and promotion of long-term contraception after unplanned pregnancy • Promotion of Sexual Health services-media campaign implementation	• Chlamydia rate per 100,000 is reviewed 6 monthly • % of Māori accessing Directions – Youth one stop shop • % of Māori accessing DHB Sexual Health services

	• % of Māori enlisting CPO • Number of pregnancies reported to SBHS (decile 1 to 3 schools) • CPO contract reporting PHO
Short-term outcome	**Measure**
More pre-school enrolments in the Community Oral Health Service (COHS) Baselines for calendar year 2014: Māori 65.3%; Pasifika 71.7%; Other 81.3%	90% children under 5 years of age enrolled in Community Oral Health Services
Activity	**Monitoring & Performance**
• Coordination of COHS with new-born enrolment process to improve to increase enrolments and engagement by children's first birthday • Collaborate with immunisation outreach services to provide opportunistic oral health education and facilitate access community Oral Health services. • Increase relationships with early childhood education sector using Oral Health educators based in hauora providers to facilitate these relationships • Risk profiling of pre-school children to determine review periods (6-12 months). This is for clinical activity ○ Children in Wairoa identified as not attending clinics are targeted with a home intervention to provide fluoride varnish to reduce carries at age 5 years • Monitor profiled children and engagement in services through monthly directorate reporting	• Evaluate COHS engagement after outreach intervention by Q3 • Number ECE engaged with – population health monitoring • Desktop audit of effectiveness of home interventions • % of enrolments with COHS increases
Short-term outcome	**Measure**
Pregnant women, babies, children and families have improved health outcomes WC/TO quality indicator • Number 2 - Families and Whanau are referred from their LMC to a WC/TO provider • Number 13 - Infants are exclusively or fully breastfed at 3 months • Number 21 – B4SCs are started before children are 4½ years	
Activity	**Monitoring & Performance**
• Continue to support and work in partnership with WC/TO providers in Hawke's Bay to improve maternal and child health outcomes • Utilise new Regional WC/TO Quality Improvement Project Management role to support quality improvement activities • Continue with breastfeeding quality improvement cycle (Plan, Do, Study, Act) as part of the WC/TO Quality Improvement framework • Continue with quality improvement cycle (Plan, Do, Study, Act) to improve relationships with Midwife/LMC to ensure that referrals are completed to WC/TO as early as possible postnatally and in the antenatal period for	• Number of Well Child stakeholder meetings • Levels of meeting attendance by key members • % referrals received by 6 weeks post birth by WC/TO provider • % of Infants exclusively or fully breastfed at 3 months

the most vulnerable • Further activities to improve performance in these indicators are outlined in previous sections	• % B4SCs started before children are 4½ years

Spinal Cord Impairment (SCI) Action Plan	
The SCI action plan aims to deliver better services in a timely manner across the SCI continuum (acute care through to living in the community) for people of all ages with acquired or congenital SCI that causes significant impairment. The action plan is designed to enable people with a SCI and their families/whānau to achieve better outcomes and support them to remain well and live as independently as possible in their community. Implementation of the SCI action plan is being coordinated by our Trauma Committee, which is led by senior clinicians from ED, Intensive Care Unit and Orthopaedic Surgery.	
Short-term outcome	**Measure**
Implement agreed nationally directed destination and referral processes for acute spinal cord injuries	• Agreed protocols are in place
Activity	**Monitoring & Performance**
• Disseminate information outlined in the Spinal Cord Impairment Action Plan through the Clinical Council to relevant clinical leadership • Provide a confirmation and exception report on SCI actions as requested • Work with ambulance and other providers to implement the SCI pre-hospital destination and referral pathways • Work with supra-regional services as per established protocols • Work with local rehabilitation and community services to implement post-hospital destination and referral pathways in support of SCI	• As received • Q2 and Q4

2.1.3 Working Across the System to deliver on all Government Planning Priorities

HBDHB collaborates with all other Government agencies as appropriate to ensure that we continue to identify opportunities for enhancing value from public services. In addition, there are a number of national entities and other health sector stakeholders that are key strategic partners for us in delivering a cohesive and integrated service to our population. This section highlights some of the programmes that we are involved in with other entities across the systems, where we are collectively working for system-level quality improvement.

National Entity Priority Initiatives

HBDHB is committed to working with the national entities in order to drive better economies of scale and to free up resources to move into frontline services. The table below outlines the major programmes of the national entities that we are committed to over the next year. Anticipated costs and benefits for all national programmes, where assessed and agreed, have been factored in to the HBDHB budgets for 2015/16.

Health Shared Services

HBDHB will continue to work with Health Benefits Limited and the other 20 DHBs in achieving the efficiencies available from the work completed on the four business cases. The four business cases are:

1. Finance, Procurement & Supply Chain (FPSC)
2. Food Services
3. Linen & Laundry
4. National Infrastructure Platform (NIP)

Each case is at a different stage in its development and approval and we will continue to work closely with the groups responsible for developing these cases to ensure an optimum outcome for this DHB and the sector as a whole

National Health IT Board (NHITB)

In 2015/16 HBDHB will:

- Have a business case approved for the implementation of electronic Medicines Reconciliation e(MR)
- Implement Regional Clinical Workstation (CWS) and Clinical Data Repository (CDR) in accordance with the Regional Health Informatics Plan (RHIP) timeline, currently expected to be completed by March 2016
- Commence implementation of a supported Patient Administration System (PAS) in accordance with the RHIP timeline, currently expected to be completed by December 2017
- Support the National Patient Flow work programme. HBDHB intends to be collecting Phase 2 information from July 2015 and Phase 3 information by July 2016
- Develop an implementation plan with Te Oranga Hawke's Bay – Health Hawke's Bay (the PHO), to enable individuals to have access to their own health information (patient portals)

Health Quality and Safety Commission (HQSC)

Quality and safety is one of our strategic focus areas and we have a broad programme that is closely aligned to the work of the HQSC. We are committed to complying with the expectations of our Operational Policy Framework and to continuing to develop quality and safety management systems. HQSC programmes that we support include:

- Surgical Site Infection Programme – national infection surveillance data warehouse and DHB infections management systems
- Quarterly run of the national inpatient patient experience survey and reporting system
- Ongoing links to support improvement science and increased clinical leadership
- PHO implementation of the primary care patient experience survey and reporting system

Health Workforce New Zealand (HWNZ)

Strategic workforce development programmes for HBDHB are coordinated through the Central Region regional training hub. The 2015/16 programme of work is outlined in Action Plan 11 of the RSP and HBDHB is committed to supporting the regional approach to addressing workforce requirements. The RSP action plan "…acknowledges the alliance formed between the six Central Region DHBs and HWNZ as a critical nexus in addressing workforce priorities and enabling the region to cultivate the existing collaborative and cohesive network for developing valid workforce initiatives and innovations." Strict alignment with HWNZ priorities is maintained.

National Health Committee (NHC)

HBDHB will work collaboratively with the NHC to solve sector issues by:

- Engaging with and providing advice on prioritisation and assessments including through the National Prioritisation Reference Group
- Referring technologies that are driving fast-growing expenditure to the NHC for prioritisation and assessment where appropriate
- Introducing consistently (or not introducing, where applicable) emerging technologies based on the NHC recommendations
- Holding technologies, which may be useful, but for which there is insufficient evidence, or which the NHC is in the process of assessing
- Providing clinical and business expertise and research time to design and run field evaluations where possible

Health Promotion Agency (HPA)

We will support the HPA work programme in respect of promoting the national health targets, raising public awareness about rheumatic fever, reducing consumption of alcohol during pregnancy, and increasing alcohol screening in primary settings. More detail is shown in our 2015/16 Public Health Unit Plan

PHARMAC

In 2015/16 HBDHB will:

- Continue to support PHARMAC's national contracting activity for hospital medical devices including implementing new national medical device contracts when appropriate and assisting with product evaluations where possible; and
- Support effective implementation of any product standardisation undertaken by PHARMAC during the year.

Improving Quality

Delivering consistent high quality care is one of the major themes of Transform and Sustain. In the first six months of 2013/14, the Hawke's Bay health sector developed a quality improvement and patient safety framework - Working in Partnership for Quality Healthcare in Hawke's Bay. The process identified clinical leadership and consumer partnership throughout the health sector as the most important aspect of improving quality health care and patient safety. We use our framework to align our local efforts in support of the national quality improvement work coordinated by the Health Quality and Safety Commission (HQSC). In 2014/15, we reorganised some roles within the DHB into a new Quality Improvement and Patient Safety (QIPS) team and we appointed the Director of that service to Executive Management Team (EMT) in order to further raise the profile of quality and safety at HBDHB. With a focus on consumer engagement, the QIPS team provides support for integrated quality improvement and performance across the Hawke's Bay health sector and helps clinical teams to recognise and define priority areas and to identify actions for implementation.

National Quality & Safety Markers (QSM)	Monitoring & Reporting
Meeting and/or improving HB Health sector performance against all national Quality & Safety Markers • For all QSMs, supply relevant operational teams with regular performance data from routine monitoring and audits • QIPS team members support interpretation of data, design and implementation of improvement opportunities through regular review with operational teams • Front-line ownership of improvement targets driven by Clinical Director within each directorate and overseen through regular reporting to Clinical Council, representing sector-wide (primary and secondary) clinical leadership	• HQSC quarterly QSM report on all targets
Ongoing implementation of falls minimisation activity includes continuing to monitor and evaluate all requisite areas on a monthly basis and through existing audit programmes • Stand up for Falls Programme commenced in April 2015 • Cross sector integrated approach through Falls Minimisation Group. Includes representation from primary, aged residential and secondary care patients, and NGOs. Links to activity in hospital (intentional rounding; signalling tools in wards); urgent care (fracture liaison); community (aged residential care), and primary (pharmacy; green prescription) • Falls risk assessments and care plans completed for all admissions • Investigation of events by Clinical Nurse Managers or Nurse Directors with feedback and learnings to Chief Nursing Officer and Hospital Falls Action Group	• Target - 90% of older patients are given a falls risk assessment • 98% of those at risk have an individual care plan completed
Ongoing implementation of good hand hygiene practices • Continue rollout to all clinical areas under the Provider Arm, including rural areas • Chief Nursing Officer sponsorship supports maintenance of right number of trained hand hygiene auditors and promotion of good hand hygiene practice messages to staff, patients and visitors • HBDHB has significantly increased the number of Gold Auditors to ensure front-line ownership of compliance	• Target - 80% compliance with good hand hygiene practice
Surgical safety checklist • Support the perioperative team to continue with Perioperative Harm Programme (teamwork and communication framework and VTE). This will be aligned to Theatre Productivity programme of work and includes using checklist for better communication and teamwork, plus briefing and debriefing each theatre list • Work with HQSC in supporting the new perioperative harm QSM (cohort 3) in 2015/2016	• Target – All 3 parts of WHO surgical safety checklist used in 90% of operations
Antibiotics for hip and knee replacement patients • Provide information to the prescribers, i.e. Anaesthetists and Orthopaedic surgeons of the rationale • Infectious Diseases Physician engaged in dialogue with the group • Providing updates on current practices and evidence • Visual displays as a reminder in Theatre area • Encouraging height and weight recording (pre-operatively) to enable correct dosing based on BMI	• Target - 95% of hip and knee replacement patients received surgical prophylaxis
Appropriate skin preparation for hip and knee replacement surgery • Visual displays about right skin preparation and rationale	

• Education of and provision of skin preparation solutions for patient pre-operatively at the nurse-led clinic • Patient information sheets distributed • 'Champions' in DSU and ward support the process and educate staff • Remove inappropriate skin prep solutions from the Theatres • Provide information to Orthopaedic surgeons on rationale Medication Safety • Continue to carry out medicines reconciliations and monitor and report these on a quarterly basis • Spread medicine reconciliations through paper-based systems (currently covers 73% of inpatient settings at Hawke's Bay Regional Hospital) • Perform user acceptance testing on Clinical Portal (due Quarter 2 2016) in preparation for eMeds implementation • Support implementation of electronic medicine reconciliation platform when infrastructure available (dependent on regional programme)	• Target - 100% of hip and knee replacement patients have appropriate skin prep
Open for Better Care	**Monitoring & Reporting**
HBDHB supports the HQSC-sponsored campaign by organizing and developing resources to promote the projects, auditing, providing feedback to staff and through training and education. In 2015/16 we will: • Participate in the Central Region Quality and Safety Alliance that supports the campaign across the Central Region • Support the trend analysis of central region quality indicators through data sharing • Ensure ongoing clinical ownership through the sponsorship of the QIPS Director • Participate in regional training and education and mandatory study days • Disseminate and use standardised tools	• RSP quarterly reports
Improving Patient Experience	**Monitoring & Reporting**
One of the main goals of Transform and Sustain centres on responsiveness to patients and whānau. We aim to maintain patient experience above the internal KPI target. Important activity for 2015/16 includes: • Continue to grow the Consumer Council role and interactions across a number of strategic and operational avenues • Ongoing quarterly data collection for national inpatient experience survey ○ Continue with initiative to capture correct patient details at "first point of contact", including improving collection of customer email addresses • Support implementation of the Patient Experience Survey in primary care • Opportunities for improvement will be identified, tracked and implemented • Implementation of 'Using consumer stories to improve quality of care'. This includes developing a Hawke's Bay health sector process for collecting consumer stories, identification and implementation of an analytical tool to analyse stories and data for the whole system for quality improvement purposes, development of a process for sharing this information appropriately across the sector, coordinate the HQSC consumer experience data and programmes into this process	• Quarterly report to Board • Monthly use of patient stories at governance meetings

• Development of new tools to capture the patient experience – focused on discharge feedback, feedback forms, focus groups and target focus groups • Implementation of a Patient Experience dashboard as part of the overarching QIPS dashboard • Designing and implementing clinical pathways – include patients in consultation component of pathway development • Monthly mortality data provided to all clinical areas within the DHB. Chief Operating Officer implements mortality and morbidity reviews in accordance with Operational Policy Framework requirements and provides review data to local and national stakeholders as required	
Implementing Quality Accounts	**Monitoring & Reporting**
HBDHB will continue to produce an annual set of Quality Accounts, which are publicly shared to show improvement in key quality and patient safety indicators. • Using the Hawke's Bay Clinical Council to identify, monitor and advise on key indicators of local service improvement which will lead to improved quality and safety of our hospital and community health services • Identification of key indicators of patient safety, including hospital readmissions, undertaking of mortality and morbidity reviews, length of stay, falls, etc • Development and implementation of a refined QIPS dashboard which will be provided for quarterly discussion at Clinical Council ○ Continue to focus on Māori patients and ED utilisation - Health Hawke's Bay (PHO) and the Māori Health Service will analyse data monthly, monitor trends and act as needed to facilitate enrolment and re-engagement with primary care where appropriate • Reducing the level of non-attendance at outpatient appointments, continuing to monitor and report ESPIs and DNA rates	• Quarterly report to Clinical Council

System Integration and integrated Performance Incentive Framework (IPIF)

A health system that is well integrated provides a sustainable system where people receive precisely what they need, where and when they need it. The Government's health policy, "Better, Sooner, More Convenient health care" sets out the vision for an integrated health system with patients and whānau at the centre, where care is delivered closer to home by trusted, motivated health professionals working together in an effective and efficient manner. This section provides an overview of some of the system-level initiatives that are evolving in Hawke's Bay to drive system integration. The section above on "Working together for Better, Sooner, More Convenient health care" contains highlights of initiatives from a service perspective.

The IPIF is a comprehensive performance monitoring framework that is being developed to replace the current frameworks that apply to PHOs and DHBs. Some measures for primary care were introduced in the 2014/15 year and replaced the former PHO Performance Plan (PPP). New measures are being introduced in 2015/16, some of which expand the scope of primary care performance monitoring beyond General Practice services, i.e. to pharmacy and independent midwifery. The DHB and the PHO support the implementation of the new framework.

Short-term outcome	Measure
Improving the integration of services to ensure patients receive more effective and coordinated services closer to home. At the macro-level, HBDHB has a commitment to "pulling back" resources from tertiary and out of area secondary care to local secondary care; from local secondary care to community and primary care; and from primary and community care to population health. A shift of investment is being monitored over time. Please refer to "Shifting Resources" in Chapter 5 below.	• Changes in resource deployment
Activity	**Monitoring & Performance**
• Continue with Clinical Council endorsement of principle of shifting resources • Consult annually on prioritisation criteria with sector groups • Run annual "investment/disinvestment" process to include funder proposals being developed in consultation with stakeholders and formal endorsement of resulting impact from Clinical Council and Board	• Annually in March/April
Short-term outcome	**Measure**
Shifting services: Through our Transform & Sustain programme we have commenced a number of programmes aimed at more integration and the shifting of services towards community settings. This is ongoing. Examples of some individual service shifts that are planned for the 2015/16 year include:	
Activity	Monitoring & Performance
Enhancing professional support • engAGE Services – services for frail older people investment strategy. Providing additional Geriatrician resource in the community; Clinical Nurse Specialist (Gerontology) and community teams aligned to General Practices; access to transitional beds in the community and MDTs; District Nurses aligned to General Practices. ○ Q1 2015 $1.0m; Q2 $0.9m; Q3 $1.4m Simplifying access • Increasing targeted access to community-based podiatry services. RFP completed Q2; services established Q3 • Implementation of diabetes pathways – support for roll-out; implemented by Q1 • Extend free primary care for all 13-17 year olds in Wairoa; investigate targeted access to primary care across Hawke's Bay Quintile 4 and 5 13-17 year olds Substituting skills • Establish Heart Failure Nurse Practitioner, Health of Older Persons Nurse Practitioner and Specialist Clinical Nurse for cardiac rhythm management in primary care: develop more detailed business case by Q2; implement from Q3	• 2015/16 investment: $2.3m • 2015/16 investment: >$200,000 • 2015/16 investment: $40,000 • 2015/16 investment: up to $500,000 • 2015/16 estimate: $230,000
Short-term outcome	**Measure**
Implementation of the National Radiology Access Criteria (NRAC) for community-rerferred diagnostics	
Activity	**Monitoring & Performance**
• Work with the Central Region Radiology Group and GMs responsible for planning and funding to agree on a	

regional approach • Align clinical pathways work with radiology access criteria as part of ongoing clinical pathways development • Implement the NRAC or Central Region Radiology Access Criteria, as applicable	• From July 2015 • By June 2016
Short-term outcome	**Measure**
• Improve management of acute demand and ensure better integration of services across primary and urgent care	
Activity	**Monitoring & Performance**
Acute demand management in the hospital. Our Acute Inpatient Management programme – AIM 24/7 – was launched in September 2014 to focus on improving the acute patient journey from community into hospital and out to the community again. Improvements have included changes to care settings, care processes and protocols, and to staffing mix in some wards and departments. The programme will continue in 2015/16 with ongoing focus on: • Coordinating care using a centralised function with oversight of real-time patient flow information • Improving discharge coordination to ensure that return to the community is efficient and well-supported • Better understanding and response to deteriorating patients in the wards • Better response to acute surgical patient needs	• Monthly progress report to executive and clinical council
Acute demand management in the community. We have re-initiated a focus on urgent care through formation of a service level Urgent Care Alliance to address issues in respect of supply and demand of Urgent Care services across Hawke's Bay. The alliance will engage a clinically led, consumer based and health sector wide group of stakeholders to design and implement a two-stage programme with 3 major workstreams: • Improving preventative measures for urgent care – communication, transport, in-home needs assessments • Improving community based urgent care in hours – same-day appointments, better use of pharmacies, oral health • Improving urgent care 24/7 – GP out of hours, ED/GP interface, timely access to data, aged residential care, rural patient access, ambulance services, cost of access, use of alternative practitioners, access to diagnostics	• Stage 1: May – December 2015 • Stage 2: January – December 2016 • Monthly progress report to Executive and Clinical Council
Short-term outcome	**Measure**
Develop clinical pathways to: speed up referral to definitive care; provide up-to-date, localised, evidence-based overview of the standard of care that can be offered following an assessment or diagnosis; reduce inequities; and provide a vehicle for better liaison across the system	
Activity	**Monitoring & Performance**
A two-year project to pilot the implementation of clinical pathways at HBDHB was completed in June 2015. The project was overseen by our Clinical Council and was managed by the PHO. We have elected to use "Map of Medicine" as our clinical pathways tool and have developed a process that commences with an "Expression of Interest" and ends with implementation of a clinical pathway following extensive consultation and agreement with local providers across primary and secondary care. Through the pilot project, 9 pathways were developed and implemented locally. The process will be established as "business-as-usual" from 2015/16 • Embed clinical pathway development programme within funder arm functions	• From 1 July 2015

• Establish overarching governance programme for maintaining and updating local pathways • Link in with regional work to ensure compatibility with regional pathways • Monitor establishment of recently published COPD pathways • Publish dementia, rhinosinusitis, gout, chest pain, atrial fibrillation and heart failure pathways • Develop and consult on asthma and obstructive sleep apnoea pathways • Review skin lesion and melanoma pathways and update if appropriate • Prioritise Q3 and Q4 developments • Run "Expressions of Interest" (EoI) process as appropriate	• From July • Q1 • Q2 • Q2 • Q3 and Q4 • Ongoing
Short-term outcome	**Measure**
Work with the PHO to implement the HQSC patient experience survey (when developed) for primary care	
Activity	**Monitoring & Performance**
• Quality Improvement & Patient Safety team support implementation of the primary care patient survey	• See Improving Quality below
Short-term outcome	**Measure**
New IPIF measures are introduced successfully	
Activity	**Monitoring & Performance**
• The PHO and DHB work collaboratively with General Practice and patients to identify and embed new performance measures across the sector as appropriate • Contributory measures will be tested and agreed on locally once a library of validated measures is available	

Actions to Support Delivery of Regional Priorities

Our strategic intentions are aligned to those of our regional partners, as depicted in Figure 4 above. Delivery of regional programmes is carried out at regional and sub-regional level based on assessment of the most appropriate approach. Our commitment to regional collaboration is driven through membership of all major governance committees within the regional structure and by participation in clinical networks. DHB personnel are supported to participate in regional forums and regularly contribute to the development of plans and initiatives. The 2015/16 RSP implementation plans[15] were presented to our Clinical Council for review and input before being presented to our Board for approval – this process ensures that our staff have good opportunity to contribute to developments and to prepare for the local impact of any change. We have outlined activity in support of regional priorities within the service actions above and the financial impact of those activities is provided for in operational budgets and within the core funding that HBDHB contributes to the operations of Central TAS as the Central Region's Technical Advisory Service (CR TAS)

[15] Central Region Regional Services Plan 2015/16, Action Plans.

Regional activity not outlined elsewhere	Monitoring & Reporting
Major Trauma HBDHB is committed to the regional programme in respect of Major Trauma. There is a national objective of improving the survival and post-treatment impacts of major trauma by offering patients a more comprehensive and coordinated response.	
Short-term outcome	**Measure**
• Creation of Central Region Major Trauma Working Party will be established • An approved major trauma work plan will be developed for year one and priorities established for years 2 and 3 • Improve patient experience for those with a medium/major trauma	
Activity	**Monitoring & Performance**

• Provide HBDHB staff member to be on the Major Trauma Working Party
• The regional plan for the collection and reporting of a nationally consistent dataset is implemented
  ○ National collection and reporting of nationally consistent major trauma dataset.
  ○ implementation of local and regional major trauma systems
  ○ Datasets received by New Zealand Major Trauma Minimum Dataset (NZMTMD) from the Central Region DHBs support the collection and reporting of a nationally consistent major trauma dataset
• Identify a designated clinical lead for major trauma
• Establish a coordinator function. This will enable the identification of those patients who meet the criteria indicating major trauma and the capture of relevant data
• Rollout patient identification and data collection system
• Align local trauma definitions with those use in NZMTMD
• Local data collection of on all trauma patients with an Injury Severity Score (ISS) of 12 or over
• Completion of local audit of medium/major trauma cases to ensure continuity of care and continuous improvement
	• By 31 December 2015
	
	• By August 2015
	• From 1 July 2015
	
	• October 2015
	• From 1 July 2015
	
	• Quarterly reporting

Hepatitis C The MoH is working with regional groupings to deliver a Hepatitis C service to ensure continuity of care for patients. It is expected that Central Region pilot sites at Capital & Coast and Hutt Valley DHBs are transitioned to a full regional service within the 2015/16 year.	
Short-term outcome	
Hepatitis C service at pilot sites is transitioned to a full regional service	
Activity	**Monitoring & Performance**
• Implement regional Hepatitis C service locally	• From April 2016

2.1.4 Living within our Means

Workforce

HBDHB is faced with challenges relating to the ageing workforce, skill mix and the ability to retain skills and knowledge. These issues are heightened by increased patient expectations and, with a highly mobile workforce, by the availability of potentially better opportunities outside of New Zealand. From an organisational perspective, there is a need to develop more integrated sector-wide health service pathways making use of expanded scopes of practice in nursing, medical and allied health professional groups. We continue to develop new roles and changed roles as a result of new models of care. Our Transform and Sustain programme will continue to have an impact on the employees and health profession workforce across the district.

Similar challenges exist at the regional level and HBDHB is committed to the regional workforce plans as detailed in the RSP (Section 11), and to the workforce plans outlined within each of the regional priority service plans. We work closely with the Regional Training Director, all other Central Region DHBs, primary and community organisation to advance regional workforce plans.

Short-term outcome	**Measure**
Meet Government expectations for pay and employment conditions in the State Sector	
Activity	**Monitoring & Performance**
All DHB single employer bargaining arrangements and individual employment arrangements that will be put in place in the 2015/16 years will: • Deliver organisation and sector performance improvement, foster continuous improvement, advance our Transform and Sustain strategy and support effective employee engagement to deliver DHB outcomes • Enable the DHB to recruit and retain highly capable staff	

By the start of the 2015/16 year we will have implemented all the requirements for a safe and competent workforce in terms of the Vulnerable Children's Act 2014. At the time of development of this plan, the full details of the implications of the Act are unknown and the National General Managers of Human Resources (GMs HR) are working with Police and others to develop approved and agreed processes. Those processes will meet the requirements for vetting and screening (including worker safety checks) of new and current employees. We will implement all requirements with effect from 1 July 2015.

Short-term outcome	**Measure**
Meet the requirements of the Vulnerable Children's Act	
Activity	**Monitoring & Performance**
• All requirements implemented	• Effective from 1 July 2015

Māori Workforce & Cultural Competence

There is a general intention in Hawke's Bay to increase the Māori workforce across all government agencies. This is a district priority for health services because, under the organisational development component of Transform and Sustain, we intend to increase Māori staff representation in the health system too. At June 2013, the proportion of Māori employed by HBDHB was 9.9% of total staff numbers. This has increased slowly and at the end of Quarter 2 2014/15, the proportion was 11.6% against a target for the year of 12.9%. The target increases by 10% each year. In addition, we have raised the expectation of cultural competence across the workforce to ensure that services become more responsive to our Māori population in our quest for driving out inequity.

Short-term outcome	**Measure**
The proportion of Māori employed by HBDHB increases steadily by 10% year-on-year. Improved recruitment and retention of Māori employees in areas with high proportion of Māori customers	• 2015/16 target: 14.3%
Activity	**Monitoring & Performance**

• Increase support for Māori nursing workforce through the Nursing Entry to Practice (NEtP) Programme
• Maintain target focus and promote recruitment of Māori to all hiring managers
• Monitor increase of Māori recruited in Wairoa and in Allied Health roles
• Use Māori and other relevant networks to promote vacancies to Māori
  ○ Investigate Māori placements into services of high utilisation
• Connect Māori students with opportunities for health sector careers and career development through Turuki Māori Health Workforce and Incubator programmes
  ○ Establish summer school paid positions
  ○ Scholarships offered to Kahungunu students
• Carry out a mid-term evaluation of Turuki Māori Health Workforce strategy
• Align Kia Ora Hauora students into DHB
• Mandatory cultural awareness training incorporated into new staff orientation process as standard
	• NEtP % Māori
	• Number new Māori staff
	• All schools with high Māori rolls engaged in Incubator programme
	• By April 2016

Short-term outcome	**Measure**
All staff working in the health sector have completed an approved course of cultural responsiveness training. Improve Māori cultural competencies among non-Māori employees	• 100% of staff
Activity	**Monitoring & Performance**
• Continue to promote the "Engaging effectively with Māori" training package that was launched in 2014 • Promote online cultural competence training through PHO and NGOs • Explore cross-agency experiential learning for non- Māori for up to 3 months at a time	• % of staff completing, by employment group • Number of non- Māori employees engaged in learning
Central Region • HBDHB is supporting the Central Region development of a region-wide Māori Cultural Training Programme	RSP, Action Plan 2

Clinical Governance and Leadership

HBDHB actively fosters Clinical Governance and Leadership in a number of ways. At the Governance level, our Board is advised by a Clinical Council that is made up of a number of primary care and secondary care clinicians with a balance of doctors, nurses and allied health representation. The Clinical Council meets monthly to consider proposals, reflect on performance and to clarify expectations from a clinical point-of-view. Our service level alliances are given effect through relationships and reference to our Clinical Council. Furthermore, Clinical Council has an important role in resource prioritisation and, for this 2015/16 Annual Plan, the Council initiated a specific process for input and influence over investment and disinvestment decisions within the overarching budgeting function. Other ways that we foster clinical leadership is through participation of clinicians in sector-wide leadership forums, regional and national clinical networks, and at the executive management table. In our provider arm, each directorate is led by a triumvirate that includes a Service Director, a Clinical Director and a Nurse Director. As a result, most clinical staff have a professional reporting line for supervision and professional support in addition to their usual managerial reporting line for personnel functions.

Information Systems (IS)

HBDHB IS programmes are aligned to the work of the National Health IT Board (see National Entities above), the Central Region Information Services Plan – CRISP (See RSP, Section 10 Information Technology), and to Transform and Sustain. We work closely with the PHO to ensure health data and information is accurate, secure and appropriately available. Data quality is a national Māori health priority, particularly in respect of the accuracy of ethnicity reporting in primary care patient management systems. Our commitment to accelerating Māori health and well-being means that we must have good data to gauge progress. The only way to be sure that ethnic disparities are reducing is by measuring indicators across ethnicities. Good ethnic data also enables us to target resources appropriately and to contribute to health research. We have made a commitment to the principle that all our measures should be provided by ethnicity and so we aim to disaggregate our monitoring and reporting increasingly over time. HBDHB is not considered a "Pasifika DHB" for the purposes of national Pasifika monitoring and reporting. However, in recognition of the disparities raised in our Health Equity Report and in other research, we have requested inclusion in the national Pasifika data analysis.

Short-term outcome	**Measure**
Improve the collection and reporting of Māori ethnic data.	• Quarterly progress
Activity	**Monitoring & Performance**

Primary care ethnicity data quality
• Ensure correct ethnicity is collected and recorded
  ○ General Practices ensure forms and interview protocols enable self-identification of ethnicity
  ○ PHO implementing the Primary Care Ethnicity Data Audit Toolkit
  ○ Increase workforce ability and confidence to ask about ethnicity and collect full information
• Work with providers to ensure monitoring of correct ethnicity data quality – regular reporting back to Practices on missing and incomplete ethnicity data following routine patient information updates
• Investigate and provide workforce development opportunities
	• Ongoing
	• <1% "unknown" - reviewed quarterly
	• Number attending workforce development

Capital

Regional capital investment approaches are outlined in the RSP, section 10. HBDHB is committed to working with the regional capital committee on the development of our local plans and assisting our regional colleagues in development of the regional capital plan and its implementation.

Formal asset management planning is undertaken at HBDHB. Our asset values will be updated by a Registered Valuer as at the 30 June 2015. Our Asset Management Plan has also been updated in 2014-15 incorporating a ten year plan for expenditure on our assets. Approvals at regional and national level are sought depending on the threshold of any proposed investment to help ensure that there is some national consistency in development of the health assets. We will continue to work nationally with the development of the various national initiatives and regionally on the development of a regional solution for our information technology applications.

Major Strategic Asset Expenditure 2015-19				
	2015-16	2016-17	2017-18	2018-19
Mental Health Inpatient Unit	5,654	1,000	-	
Maternity development	2,035	227	-	
Napier Health Centre	81			
New stand-alone endoscopy	848	5,000	3,700	
Renal centralised development	665	1,400	-	
Oncology upgrade			200	800
Upgrade old MHIU	100	2,000	3,000	2,900
Ambulatory Care				2,000
Xray equipment	598	1,520		
Angio equipment		2,040		
MRI			2,460	
Laboratory	600	-		
Central Region IS Programme	1,391			
Health Benefits Limited				

A business case for the development of a new Mental Health Inpatient Unit was approved by the Minister of Health in April 2013 and construction commenced in the 2014/15 financial year. The total budget is $19.8 million and this will be financed from a combination of depreciation, borrowings and operating surplus. The facility is due to open in January 2016.

Procurement

The Ministry of Business, Innovation and Employment (MBIE) Government Rules of Sourcing (Rules) became mandatory for the public health sector on 1 February 2015. HBDHB intends to comply with the requirements set out in the Rules to the greatest extent that is practicable. Compliance with the Rules is subject to any statutory or similar obligation applying in respect to procurement e.g. pharmaceuticals from the pharmaceutical schedule (PHARMAC), being a requirement of s.23(7) of the NZ Public Health and Disability Act; in-scope procurement via Health Alliance (hA), being procurement covered by arrangements consented to by the Minister under s.24 of the NZPH&D Act.

3. STATEMENT OF PERFORMANCE EXPECTATIONS

This section includes information about the measures and standards against which Hawke's Bay District Health Board (HBDHB) service performance will be assessed. For the purpose of our Statement Performance Expectations (SPE), our services are grouped into four reportable Output Classes: Prevention Services; Early Detection and Management Services; Intensive Assessment and Treatment Services; and, Rehabilitation and Support Services.

The SPE describes information in respect of the first financial year of our Statement of Intent and the performance measures are forecast to provide accountability. The outputs and measures presented are a reasonable representation of the full range of services provided by the organisation. Where possible, we have included past performance (baseline data) along with each performance target to give the context of what we are trying to achieve and to enable better evaluation of our performance.

Service Performance

Explaining the contribution that our services make towards achieving the population and system level outcomes and impacts outlined in our Statement of Intent above, requires consideration of service performance. For each output class, we will assess performance in terms of the New Zealand Triple Aim (Figure 2). Maintaining a balance of focus across the Triple Aim is at the core of the Health Quality and Safety Commission's drive for quality improvement across the health sector.

FIGURE 2: THE NEW ZEALAND TRIPLE AIM

The system dimension: Best value for public health system resources

For each output class we show expected funding and expenditure to demonstrate how output class performance will contribute to the outcome of a financially sustainable system.

The population dimension: Improved health and equity for all populations

Services may target the whole population or specified sub-populations. In either case we select measures that apply to the relevant group. These measures usually refer to rates of coverage or proportions of targeted populations who are served and are indicative or responsiveness to need.

The individual dimension: Improved quality, safety and experience of care

Ensuring quality and safety, within hospitals and wider health services, is a fundamental responsibility of DHBs. Measurements in this dimension indicate how well the system responds to expected standards and contributes to patient and consumer satisfaction.

Note: all targets are an annual target or, where monitored quarterly, show the expected performance by the end of quarter four. Targets are set at the total population level and monitored, where appropriate, across different population groups to gauge the equity of results. A detailed technical description of each indicator is available in a data dictionary maintained by our information services.

The HBDHB Statement of Performance Expectations for the 2015/16 year follows:

X _____ Board Member

X _____ Board Member

3.1 OUTPUT CLASS 1 – PREVENTION SERVICES

Prevention Services are publicly funded services that protect and promote good health in the whole population or identifiable sub-populations comprising services designed to enhance the health status of the population, as distinct from treatment services which repair or support health and disability dysfunction. Prevention Services address individual behaviours by targeting population-wide physical and social environments to influence health and well-being. Prevention Services include: health promotion and education services; statutory and regulatory services; population based screening programmes; immunisation services; and, well child and school services.

On the continuum of care, Prevention Services are population-wide and are designed to focus attention on wellness of the general population and on keeping the "at risk" population healthy. It is important to emphasise that the concept of wellness extends to the entire population, including those who already have a health condition or disability.

Objective: People are better protected from harm and more informed to support healthier lifestyles and maintenance of wellness

Through collective action with communities and other sectors, we aim to protect the general population from harm and keep them informed about good health so that they are supported to be healthy and empowered to take control of their well-being. We aim to reduce inequities in health outcomes as quickly as practicable and we recognise that they often arise out of issues that originate outside the health system. Prevention programmes include the use of legislation, policy, education and community action to increase the adoption of healthy practices amongst the population and to overcome environmental barriers to good health.

How will we assess performance?

System Dimension

The expected revenue and proposed expenses in respect of this output class are shown in Figure 5.

Prevention Services	2014 Actual $'m	2015 Forecast $'m	2016 Projected $'m	2017 Projected $'m	2018 Projected $'m	2019 Projected $'m
Ministry of Health	11.4	6.1	10.0	6.5	6.9	7.3
Other sources	0.4	0.4	0.1	0.1	0.1	0.1
Income by source	**11.8**	**6.5**	**10.1**	**6.6**	**7.0**	**7.4**
Less:						
Personnel	1.3	1.4	1.4	1.5	1.5	1.5
Clinical supplies	0.1	0.1	0.1	-	-	-
Infrastructure and non clinical supplies	0.3	0.3	0.3	0.3	0.3	0.3
Payments to other providers	8.3	8.2	8.3	8.7	9.1	9.3
Expenditure by type	**10.0**	**10.0**	**10.1**	**10.5**	**10.9**	**11.1**
Net Result	**1.8**	**(3.5)**	**-**	**(3.9)**	**(3.9)**	**(3.7)**

Figure 5 - Funding and Expenditure for Output Class 1: Prevention Services

Population and Individual Dimensions

Description	INDICATOR	Baseline	2015/16 TARGET	NATIONAL AVERAGE
More smokers are given help and advice to quit	***Health Target: Better help for smokers to quit*** ➢ *% hospitalised smokers offered advice to quit* ➢ *% of PHO enrolled smokers offered advice to quit* ➢ *% of pregnant women offered advice and support to quit*	 98.2%[16] 96.0%[16] 98.1%[16]	 ≥95% ≥90% ≥90%	 95% 89%
Fewer pregnant women are smokers	• *% of pregnant Māori women that are smokefree at 2 weeks postnatal*	58%	≥86%	65%
More children are immunised	***Health Target: Increased immunisation*** • *% of 8 month olds who complete their primary course of Immunisations* • *% of 2 year olds fully immunised* • *% of 4 year olds fully immunised by age 5*	 96.0%[16] 94.4%[16] 90.6%[16]	 ≥95% ≥95% ≥95%	 94%
More girls receive all three HPV immunisations	• *% of girls that have received HPV dose three*	NEW	≥65%	
The impact of rheumatic fever is reduced	• *Rheumatic fever hospitalisation rate per 100,000*	2.6	≤1.9	
More vulnerable elderly receive influenza vaccinations	• *% of high needs 65 years olds and over influenza immunisation rate*	67.9%[17]	≥75%	
More women are screened for cancer	• *% of women aged 50-69 years receiving breast screening in the last 2 years* • *% of women aged 25-69 years receiving cervical screening in the last 3 years*	75.8%[18] 76.9%[19]	≥70% ≥80%	
Reduce the rate of Sudden Unexplained Death of Infants (SUDI)	• *Rate of SUDI deaths per 1,000 live births*	1.37	≤0.5	0.9
Better rates of breastfeeding	• *Infants are exclusively or fully breastfed* ➢ *at 6 weeks of age* ➢ *at 3 months of age* • *Infants are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)*	 68%[20] 52%[20] 58%[20]	 ≥75% ≥60% ≥65%	 75% 55% 66%
Delay conception in early teenage years	• *% of youth accessing CPO sexual health service who are Māori*	NEW	>50%	

[16] Oct-Dec 2014
[17] Jan-Dec 2014
[18] 24 months to Dec 2014
[19] 3 years to Dec 2014
[20] 6 months to Dec 2014

3.2 OUTPUT CLASS 2 – EARLY DETECTION AND MANAGEMENT SERVICES

Early Detection and Management services are delivered by a range of health and allied health professionals in various private, not-for-profit and Government service settings to individuals and small groups of individuals. The Output Class includes primary health care, primary and community care programmes, child and adolescent oral health and dental services, pharmacist services, and community referred tests and diagnostic services. The services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the district.

On the continuum of care these services are mostly concerned with the "at risk" population and those with health and disability conditions at all stages.

Objective: People's health issues and risks are detected early and treated to maximise well-being

For people who are at risk of illness and or injury, we will undertake activities that raise awareness and recognition of risky behaviours and practices and improve the opportunity of early detection of health conditions. If people are assisted to identify risk early, and those at risk are screened to detect health conditions early, then behavioural changes and treatment interventions are often easier with less complications and greater chances of returning to a state of good health or of slowing the progression of the disease, injury or illness. Targeting environmental barriers to good health and connecting people with health services earlier is the intention because early detection of health issues or risks leads to better opportunities to influence long-term outcomes.

How will we assess performance?

System Dimension

The expected revenue and proposed expenses in respect of this output class are shown in Figure 6.

Early Detection and Management	2014 Actual $'m	2015 Forecast $'m	2016 Projected $'m	2017 Projected $'m	2018 Projected $'m	2019 Projected $'m
Ministry of Health	86.5	90.1	92.7	94.7	99.4	103.0
Other District Health Boards	2.8	2.9	2.8	2.8	2.9	2.9
Other sources	4.5	4.0	3.4	3.4	3.5	3.6
Income by source	**93.8**	**97.0**	**98.9**	**100.9**	**105.8**	**109.5**
Less:						
Personnel	5.1	5.3	5.6	5.7	5.8	5.9
Outsourced services	0.1	0.1	-	-	-	-
Clinical supplies	0.5	0.4	0.5	0.4	0.4	0.4
Infrastructure and non clinical supplies	1.4	1.4	1.4	1.5	1.5	1.5
Payments to other District Health Boards	2.4	2.6	2.5	2.5	2.5	2.6
Payments to other providers	81.9	86.5	88.3	92.4	96.2	98.9
Expenditure by type	**91.4**	**96.3**	**98.3**	**102.5**	**106.4**	**109.3**
Net Result	**2.4**	**0.7**	**0.6**	**(1.6)**	**(0.6)**	**0.2**

Figure 6 –Funding and Expenditure for Output Class 2: Early Detection and Management Services

Population and Individual Dimensions

Description	INDICATOR	Baseline	2015/16 TARGET	NATIONAL AVERAGE
More enrolment with primary care	• Proportion of the population enrolled in the PHO	97.3%[21]	≥97%	
More pregnant women under the care of a Lead Maternity Carer (LMC)	• % of women booked with an LMC by week 12 of their pregnancy	51.4%[22]	≥80%	
Hospital service users are reconnected with primary care	• Rate of high intensive users of hospital ED as a proportion of Total ED visits	5.5%[23]	≤5.4%	
More checks for people at risk of long-term conditions	***Health Target: More heart and diabetes checks*** • % of the eligible population having had a CVD risk assessment in the last 5 years	87.7%[24]	≥90 %	87%
Better oral health	• % of eligible pre-school enrolments in DHB-funded oral health services • % of enrolled preschool and primary school children not examined according to planned recall • % of adolescents using DHB-funded dental services • % of children without decay at 5 years of age • Mean 'decayed, missing or filled teeth' score at Year 8	73.9%[25] 4.0%[25] 84.5%[25] 56.5%[25] 1.08[25]	≥90% ≤5% ≥85% ≥66% ≤0.87	73% 57%
Improved management of long-term conditions	• *Proportion of people with diabetes who have good or acceptable glycaemic control*	49.2%[26]	≥55%	
Less waiting for diagnostic services	• *% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days* • % of accepted referrals for MRI scans who receive their scans within 6 weeks	92.6%[27] 61.3%[27]	≥*95%* ≥*85%*	
Avoidable hospitalisation is reduced	• *Ambulatory sensitive hospitalisation rate 0-4 years* • *Ambulatory sensitive hospitalisation rate 45-64 years*	TBC TBC	TBA TBA	
More pre-schoolers receive Before School Checks	• *% of 4-year olds that receive a B4 School Check*	81%[28]	≥90%	91%

[21] Mar 2015
[22] Jul-Sep 2014
[23] Dec 2014
[24] 5 Years to Dec 2014
[25] 2014 Calendar Year
[26] 12 months to Dec 2014
[27] Dec 2014
[28] Apr 2015

3.3 OUTPUT CLASS 3 – INTENSIVE ASSESSMENT AND TREATMENT SERVICES

Intensive Assessment and Treatment Services are delivered by a range of secondary, tertiary and quaternary providers to individuals. This Output Class includes: Mental Health services; Elective and Acute services (including outpatients, inpatients, surgical and medical services); Maternity services; and, Assessment, Treatment and Rehabilitation (AT&R) services. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment, such as a 'hospital', and they are generally complex in nature and provided by specialists and other health care professionals who work closely together. There are also important links with community-based services before people come into hospital services and after they are discharged – these links must be well coordinated and work as seamlessly as possible.

HBDHB provides most of this Output Class through the Provider Arm, Health Services. However, some more specialised hospital services are funded by HBDHB to be provided by other DHBs, private hospitals, or other providers. Where this happens, other providers are monitored in terms of the Operational Policy Framework or specific contracts and in accordance with industry standards. On the continuum of care these services are at the complex end of "conditions" and are focussed on individuals with health conditions and prioritised to those identified as most in need.

Objective: Complications of health conditions are minimised and illness progression is slowed down

People who are suffering from injury or illness will be diagnosed accurately and offered the most effective treatment available as early as possible. We will coordinate activities that support people to reduce the complications of disease, injury and illness progression so that they have better health, in terms of survival, and are also able to participate effectively in society and be more independent. It is important that identified disparities are also reduced as quickly as practicable

How will we assess performance?

System Dimension

The expected revenue and proposed expenses in respect of this output class are shown in Figure 7.

Intensive Assessment and Treatment	2014 Actual $'m	2015 Forecast $'m	2016 Projected $'m	2017 Projected $'m	2018 Projected $'m	2019 Projected $'m
Ministry of Health	295.1	303.3	313.8	319.5	322.6	325.5
Other District Health Boards	5.8	6.1	5.7	5.9	5.9	6.1
Other sources	10.1	10.0	9.5	9.6	9.7	9.8
Income by source	**311.0**	**319.4**	**329.0**	**335.0**	**338.2**	**341.4**
Less:						
Personnel	158.7	165.1	175.1	180.3	183.2	186.2
Outsourced services	15.7	13.1	10.6	11.0	11.2	11.3
Clinical supplies	43.3	39.9	42.1	35.5	33.3	34.1
Infrastructure and non clinical supplies	40.5	40.2	38.3	40.2	43.4	43.5
Payments to other District Health Boards	43.9	47.4	45.8	46.1	46.4	46.6
Payments to other providers	11.9	10.9	14.2	14.8	15.3	15.8
Expenditure by type	**314.0**	**316.6**	**326.1**	**327.9**	**332.8**	**337.5**
Net Result	**(3.0)**	**2.8**	**2.9**	**7.1**	**5.4**	**3.9**

Figure 7 –Funding and Expenditure for Output Class 3: Intensive Assessment and Treatment Services

Population and Individual Dimensions

Description	INDICATOR	Baseline	2015/16 TARGET	NATIONAL AVERAGE
Less waiting for ED treatment	***Health Target: Shorter stays in EDs*** • *% of patients admitted, discharged or transferred from an ED within 6 hours*	91.5%[29]	≥95%	94%
Faster cancer treatment	***Health Target): Faster Cancer Treatment*** • *% of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks*	61.5%[29]	≥85%	66%
More elective surgery	***Health Target: Improved access to elective surgery*** • *Number of elective surgery discharges[30]*	6,103[31]	≥7,109	
Better long-term conditions management	• *Acute coronary syndrome* ➢ *% high-risk patients receiving an angiogram within 3 days* ➢ *% of angiography patients whose data is recorded on national databases* • *Stroke* ➢ *% of potentially eligible patients who are thrombolysed* ➢ *% of patients admitted to the demonstrated stroke pathway*	 50.7%[32] 12.3%[32] 6%[32] 82.1%[32]	 ≥70% ≥95% ≥6% ≥80%	
Equitable access to surgery	• *Standardised intervention rates for surgery (per 10,000 population)* ➢ *Major joint replacement* ➢ *Cataract procedures* ➢ *Cardiac surgery* ➢ *Percutaneous revascularisation* ➢ *Coronary angiography*	 21.3[33] 52.1[33] 5.7[33] 10.9[33] 36.2[33]	 ≥21.0 ≥27.0 ≥6.5 ≥12.5 ≥34.7	

[29] Oct-Dec 2014
[30] Health Target Elective Discharges is a number of publicly funded, casemix included, elective and arranged discharges for people living within the DHB district.
[31] 12 months to Jun 2014
[32] Oct-Dec 2014
[33] 12 months to Dec 2014

Shorter stays in hospital	• *Average length of stay (days)* ➢ *Elective* ➢ *Acute*	 1.74[34] 2.79[34]	 1.59 2.79	 1.67 2.64
Fewer readmissions	• *Acute readmissions to hospital*	7.6%	Reduce	7.8%
Quicker access to diagnostics	• *% coronary angiography completed within 90 days* • *Diagnostic colonoscopy* ➢ *% urgent cases performed within 14 days* ➢ *% diagnostic cases performed within 42 days* • *Surveillance colonoscopy* ➢ *% waiting less than 84 days beyond planned date*	89.8%[35] 92.6%[35] 39.7%[35] 50.7%[35]	≥95% ≥75% ≥65% ≥65%	
Fewer missed outpatient appointments	• *Did not attend (DNA) rate across first specialist assessments*	7.2%[36]	≤7.5%	
Better mental health services ➢ Improving access	***Better access to mental health and addiction services*** • *Proportion of the population seen by mental health and addiction services* ➢ *Child & youth (0-19)* ➢ *Adult (20-64)* ➢ *Older adult (65+)*	 4.1%[37] 5.1%[37] 1.15%[37]	 ≥4% ≥5% ≥1.15	
➢ Reducing waiting times	***Shorter waits for non-urgent mental health and addiction services for 0-19 year olds*** • *% of people seen within 3 weeks of referral* ➢ *Mental Health Provider Arm* ➢ *Addictions (Provider Arm and NGO)* • *% of people seen within 8 weeks of referral* ➢ *Mental Health Provider Arm* ➢ *Addictions (Provider Arm and NGO)*	 56.7[37] 88.3%[37] 82.0[37] 96.1%[37]	 ≥80% ≥80% ≥95% ≥95%	
➢ Improving access and coordination	***Improving mental health services using discharge planning*** • *% children and youth with a transition (discharge) plan*	 24.0%[38]	 ≥95%	
➢ Increasing consumer focus	***More equitable use of Mental Health Act: Section 29 community treatment orders*** • *Rate of s29 orders per 100,000 population*	 81.5%[38]	 ≥80%	

[34] 12 months to Sep 2014
[35] Dec 2014
[36] Oct-Dec 2014
[37] 12 months to Sep 2014
[38] Oct-Dec 2014

3.4 OUTPUT CLASS 4 – REHABILITATION AND SUPPORT SERVICES

This output class includes: Needs Assessment and Service Coordination (NASC); palliative care; rehabilitation; home-based support; aged residential care; respite care and day care for adults. Many of these services are delivered following a 'needs assessment' process and involve coordination of input from a range of providers. Rehabilitation and Support services assist people with enduring conditions and disabilities to live independently or to receive the support that they need either temporarily or over the rest of their lives. HBDHB provides NASC services through Options Hawke's Bay - a unit that reports to our General Manager, Integrated Care Services. Other services are provided by our Provider Arm, General Practice and a number of community-based NGOs and private organisations. On the continuum of care these services provide support for individuals who have complex, complicated or end-stage conditions.

Objective: People maintain maximum functional independence and have choices throughout life.

Where returning to full health is not possible we will work with our stakeholders to support and care for people so that they are able to maintain maximum function with the least restriction and the most independence. For people in our population who have end-stage conditions, it is important that they and their family or whānau are supported to cope with the situation, so that the person is able to live comfortably and to die without undue pain or suffering.

How will we assess performance?

System Dimension

The expected revenue and proposed expenses in respect of this output class are shown in Figure 8.

Rehabilitation and Support	2014 Actual $'m	2015 Forecast $'m	2016 Projected $'m	2017 Projected $'m	2018 Projected $'m	2019 Projected $'m
Ministry of Health	66.1	68.0	69.1	74.0	77.2	79.7
Other District Health Boards	3.0	3.1	3.0	3.0	3.1	3.1
Other sources	0.4	0.4	0.3	0.3	0.3	0.3
Income by source	**69.5**	**71.5**	**72.4**	**77.3**	**80.6**	**83.1**
Less:						
Personnel	5.7	6.0	6.3	6.5	6.6	6.7
Outsourced services	0.1	0.1	0.1	0.1	0.1	0.1
Clinical supplies	0.7	0.7	0.7	0.6	0.6	0.6
Infrastructure and non clinical supplies	1.7	1.7	1.7	1.8	1.8	1.9
Payments to other District Health Boards	3.7	4.0	3.9	3.9	3.9	3.9
Payments to other providers	55.6	56.0	59.2	62.0	64.5	66.3
Expenditure by type	**67.5**	**68.5**	**71.9**	**74.9**	**77.5**	**79.5**
Net Result	**2.0**	**3.0**	**0.5**	**2.4**	**3.1**	**3.6**

Figure 8 –Funding and Expenditure for Output Class 4: Rehabilitation and Support Services

Population and Individual Dimensions

Description	INDICATOR	Baseline	2015/16 TARGET	NATIONAL AVERAGE
Better access to acute care for older people	• *Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population)* ➢ *75-79 years* ➢ *80-84 years* ➢ *85+ years* • *Acute readmission rate: 75 years +*	 139.5[38] 183.1[38] 254[38] 10.9[39]	 ≤139.5 ≤183.1 ≤231.0 <10%	 10.7%
Better community support for older people	• *% of people receiving home support who have a comprehensive clinical assessment and a completed care plan*	100%[39]	≥95%	
Increased capacity and efficiency in needs assessment and service coordination services	• *Average time from assessment to coordination (65 years and over)* • *Number of needs assessments completed (Disability services)* • *Average time from referral to assessment (Disability services)*	7.3 days[40] 618[40] 6.5 days[40]	<7.3 days >600 <10 days	
Prompt response to palliative care referrals	• *Time from referral receipt to initial Cranford Hospice contact within 48 hours*	92.0%[41]	>80%	
More day services	• *Number of day services*	20,754[42]	≥21,791	
More older patients receive falls risk assessment and care plan	• *% of older patients given a falls risk assessment* • *% of older patients assessed as at risk of falling receive an individualised care plan*	91.8%[43] 76.0%[43]	90% 98%	

[38] Oct-Dec 2014
[39] 12 months to Sep 2014
[40] Dec 2014
[41] Oct to Dec 2014
[42] 12 months to Sep 2014
[43] Oct-Dec 2014

4. FINANCIAL PERFORMANCE

The MoH reports consolidated DHB sector financial information to Treasury for incorporation into the Financial Statements of the Crown. These financial statements are published and inform Ministers, Members of Parliament, the financial markets and the public of how the Government is tracking financially compared with its forecasts. Planning regulations require the DHB's Annual Plan to contain detailed financial budgets, and information on how the DHB's performance both as a funder and as a provider of services will be demonstrated. HBDHB monthly financial reporting to the Board complies with these requirements and the Finance, Risk and Audit Committee (FRAC) advises the Board on any emergent issues. This module contains audited financial statements for the 2013/14 financial year, forecast financial statements for 2014/15, and projected financial statements for the 2015 to 2019 period. Separate financial performance statements for the funding of services, providing of services, and governance and funding administration are also included for each of these periods. Performance against the 2015/16 financial year projections will be reported in the 2015/16 Annual Report.

4.1 PROJECTED FINANCIAL STATEMENTS

Introduction

Hawke's Bay District Health Board is planning to deliver a surplus of $3.99 million in each of the plan years. This is consistent with the DHB's recent track record, and enables us to fund a proportionate capital programme, including in the plan period the completion of major mental health, maternity, endoscopy and renal facilities associated with service redesign.

The financial numbers are also consistent with the DHB's "Transform and Sustain" strategy. Resource deployment and assumed efficiencies are focussed on our three strategic challenges: responding to our population and patients; systematically ensuring quality in all of our services; and increasing our productivity.

Projected Financial Statements

Reporting entity

The financial statements of the DHB comprise the DHB, its 25% interest in Allied Laundry Services Limited, and its 16.7% interest in Central Region's Technical Advisory Services Limited. The DHB has no subsidiaries.

Cautionary Note

The prospective financial information presented in this section is based on one or more hypothetical but realistic assumptions that reflect possible courses of action for the reported periods concerned, as at the date the information was prepared. Actual results achieved for the period covered are likely to vary from the information presented, and the variations may be material.

The underlying assumptions were adopted on 28 May 2015.

Accounting Policies

The projected financial statements in this plan have been prepared in accordance with generally accepted accounting practice in New Zealand (NZ GAAP) that applies for periods beginning on or after 1 July 2014. They comply with Public Benefit Entity Standards (PBE Standards) issued by the New Zealand Accounting Standards Board (NZASB) of the External Reporting Board (XRB). The forecast financial statements have been prepared on a consistent basis.

The DHB prepared its financial statements for the year ended 30 June 2014 in accordance with NZ GAAP that applied at that time. They comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), and other financial reporting standards, as appropriate for public benefit entities.

The terminology used in the financial statements is that of the PBE Standards.

The accounting policies applied in the projected financial statements are included as Appendix 2.

Projected Statement of Comprehensive Revenue and Expense

in thousands of New Zealand Dollars

For the year ended 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Ministry of Health - devolved funding	446,490	454,030	481,942	490,978	502,232	511,629
Ministry of Health - non devolved contracts	12,646	13,541	3,700	3,758	3,818	3,878
Other District Health Boards	11,613	12,078	11,548	11,724	11,903	12,085
Other government and Crown agency sourced	6,375	6,661	6,578	6,682	6,787	6,894
Patient and consumer sourced	1,718	1,471	1,479	1,502	1,526	1,550
Other	7,355	6,667	5,166	5,226	5,308	5,393
Operating income	486,197	494,448	510,414	519,870	531,574	541,429
Employee benefit costs	170,779	177,815	188,426	194,000	197,094	200,259
Outsourced services	15,925	13,308	10,654	11,141	11,252	11,364
Clinical supplies	44,641	41,109	43,432	36,463	34,272	35,137
Infrastructure and non clinical supplies	43,872	43,585	41,717	43,917	47,056	47,287
Payments to non-health board providers	207,758	215,630	222,194	230,359	237,910	243,392
Operating expenditure	482,975	491,448	506,424	515,880	527,584	537,439
Surplus for the period	3,222	3,000	3,990	3,990	3,990	3,990
Revaluation of land and buildings	-	41,232	-	-	-	-
Other comprehensive income for the period	-	41,232	-	-	-	-
Total comprehensive income for the period	**3,222**	**44,232**	**3,990**	**3,990**	**3,990**	**3,990**

Table 1 – Projected Statement of Comprehensive Revenue and Expense

Projected Statement of Changes in Net Assets/Equity

in thousands of New Zealand Dollars

For the year ended 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Equity as at 1 July	**46,277**	**49,142**	**93,017**	**96,650**	**100,283**	**103,916**
Total comprehensive income for the period:						
Funding of health and disability services	11,165	2,947	3,990	3,990	3,990	3,990
Governance and funding administration	120	139	-	0	0	0
Provision of health services	(8,062)	(86)	-	-	-	-
Revaluation of land and buildings	-	41,232	-	-	-	-
	3,222	44,232	3,990	3,990	3,990	3,990
Repayments to the Crown (equity repayments)	(357)	(357)	(357)	(357)	(357)	(357)
Equity as at 30 June	**49,142**	**93,017**	**96,650**	**100,283**	**103,916**	**107,549**

Table 2 - Projected Statement of Comprehensive Revenue and Expense and Projected Statement of Changes in Net Assets/Equity

Projected Statement of Financial Position

in thousands of New Zealand Dollars

As at 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Equity						
Paid in equity	37,586	37,229	36,871	36,515	36,158	35,801
Asset revaluation reserve	31,744	72,976	72,976	72,976	72,976	72,976
Asset replacement reserve	14,437	15,627	-	-	-	-
Accumulated deficit	(34,625)	(32,815)	(13,198)	(9,208)	(5,218)	(1,228)
	49,141	**93,017**	**96,650**	**100,283**	**103,916**	**107,549**
Represented by:						
Current assets						
Cash	8	7	7	7	7	7
Short term investments	17,000	7,474	10,469	4,667	7,655	16,041
Short term investments (special funds/clinical trials)	3,064	3,172	3,172	3,173	3,173	3,173
Receivables and prepayments	17,516	17,774	18,133	18,502	18,885	19,262
Loans (Hawke's Bay Helicopter Rescue Trust)	11	12	13	13	14	15
Inventories	3,713	3,768	3,845	3,922	4,003	4,083
Assets classified as held for sale	1,744	1,275	-	-	-	-
	43,056	33,482	35,639	30,284	33,737	42,581
Non current assets						
Property, plant and equipment	110,389	160,830	165,876	175,584	178,648	176,730
Intangible assets	3,757	3,870	4,721	5,739	5,881	5,714
Investment property	153	140	140	140	140	140
Investment in associates	4,030	5,414	6,805	6,805	5,636	4,467
Other long term investments	-	-	-	-	-	-
Loans (Hawke's Bay Helicopter Rescue Trust)	67	55	42	-	-	-
	118,395	170,308	177,583	188,268	190,305	187,051
Total assets	**161,451**	**203,790**	**213,223**	**218,552**	**224,042**	**229,632**
Less:						
Current liabilities						
Payables and accruals	35,027	33,274	33,982	34,669	35,388	36,096
Employee entitlements	32,219	32,639	32,660	33,599	34,658	35,820
Loans and borrowings	10,268	-	-	6,000	11,500	-
	77,514	65,914	66,642	74,268	81,546	71,916
Non current liabilities						
Employee entitlements	2,295	2,360	2,431	2,501	2,580	2,667
Loans and borrowings	32,500	42,500	47,500	41,500	36,000	47,500
	34,795	44,860	49,931	44,001	38,580	50,167
Total liabilities	**112,309**	**110,774**	**116,573**	**118,269**	**120,126**	**122,083**
Net assets	**49,141**	**93,017**	**96,650**	**100,283**	**103,916**	**107,549**

Table 3 - Projected Statements of Financial Position

Projected Statement of Cash Flows

in thousands of New Zealand Dollars

For the year ended 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Cash flow from operating activities						
Cash receipts from MOH, Crown agencies & patients	483,371	496,499	509,033	523,377	535,173	545,178
Cash paid to suppliers and service providers	(285,591)	(304,738)	(290,079)	(310,224)	(313,462)	(319,389)
Cash paid to employees	(168,618)	(175,281)	(188,334)	(188,724)	(192,970)	(195,487)
Cash generated from operations	**29,162**	**16,480**	**30,620**	**24,429**	**28,741**	**30,302**
Interest received	1,246	1,364	1,008	582	270	339
Dividends received	60	60	60	60	60	60
Interest paid	(2,531)	(2,510)	(2,089)	(2,575)	(2,575)	(2,575)
Capital charge paid	(3,664)	(3,923)	(4,055)	(4,354)	(4,566)	(4,908)
Cash flow from investing activities	24,273	11,470	25,544	18,142	21,930	23,218
Proceeds from sale of property, plant and equipment	(1,839)	-	1,275	-	-	-
Acquisition of property, plant and equipment	(10,815)	(19,278)	(23,923)	(22,025)	(17,310)	(13,425)
Acquisition of intangible assets	(266)	(944)	(1,500)	(1,562)	(1,275)	(1,050)
Acquisition of investments	(92)	(1,391)	(1,379)	-	-	-
Cash flow from financing activities	(13,013)	(21,613)	(25,527)	(23,587)	(18,585)	(14,475)
Proceeds from borrowings	-	-	5,000	-	-	-
Repayment of borrowings	-	-	-	-	-	-
Repayment of finance lease liabilities	(375)	(268)	-	-	-	-
Equity repayment to the Crown	(357)	(357)	(2,022)	(357)	(357)	(357)
	(733)	(625)	2,978	(357)	(357)	(357)
Net increase/(decrease) in cash and cash equivalents	10,527	(10,768)	2,995	(5,802)	2,988	8,386
Cash and cash equivalents at beginning of year	9,330	19,857	9,090	12,085	6,283	9,271
Cash and cash equivalents at end of year	19,857	9,090	12,085	6,283	9,271	17,657
Represented by:						
Cash	8	7	7	7	7	7
Short term investments	19,849	9,082	12,078	6,276	9,264	17,650
	19,857	9,090	12,085	6,283	9,271	17,657

Table 4 - Projected Statement of Cash Flows

Projected Funder Arm Operating Results

in thousands of New Zealand Dollars

For the year ended 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Income						
Ministry of Health - devolved funding	446,490	454,030	481,942	490,978	502,232	511,629
Inter district patient inflows	8,647	8,015	7,483	7,595	7,709	7,825
Other income	145	137	93	95	96	98
	455,282	**462,182**	**489,518**	**498,668**	**510,037**	**519,552**
Expenditure						
Governance and funding administration	3,002	2,781	3,140	3,298	3,172	3,203
Own DHB provided services						
Personal health	197,837	206,380	215,584	216,270	219,538	222,853
Mental health	24,537	24,366	25,005	25,084	25,462	25,845
Disability support	10,003	9,161	14,677	14,725	14,946	15,172
Public health	562	502	4,327	4,339	4,407	4,475
Maori health	418	414	601	603	612	622
Other DHB provided services (Inter district outflows)	233,357	240,824	260,194	261,021	264,965	268,967
Personal health	44,342	48,370	46,784	47,071	47,360	47,649
Mental health	2,394	2,428	2,398	2,412	2,427	2,442
Disability support	3,307	3,210	3,000	3,019	3,037	3,056
Public health	-	-	-	-	-	-
Maori health	-	-	-	-	-	-
Other provider services	50,043	54,009	52,182	52,502	52,824	53,147
Personal health	88,074	89,857	97,312	102,935	107,795	111,144
Mental health	10,133	10,467	10,994	11,640	12,195	12,578
Disability support	54,236	56,109	56,409	57,793	59,418	60,705
Public health	1,457	1,515	1,515	1,621	1,705	1,762
Maori health	3,815	3,674	3,782	3,868	3,973	4,056
	157,715	161,622	170,012	177,857	185,086	190,245
Total Expenditure	**444,118**	**459,235**	**485,528**	**494,678**	**506,047**	**515,562**
Net Result	**11,165**	**2,947**	**3,990**	**3,990**	**3,990**	**3,990**

Table 5 - Projected Funder Arm Operating Results

Projected Governance and Funding Administration Operating Results

in thousands of New Zealand Dollars

For the year ended 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Income						
Funding	3,002	2,781	3,140	3,298	3,172	3,203
Other government and Crown agency sourced	-	-	-	-	-	-
Other income	5	8	30	8	8	8
	3,007	2,789	3,170	3,306	3,180	3,211
Expenditure						
Employee benefit costs	858	716	1,044	1,010	1,020	1,030
Outsourced services	392	410	507	437	442	446
Clinical supplies	2	(0)	1	-	-	-
Infrastructure and non clinical supplies	708	591	685	916	765	773
	1,961	1,717	2,237	2,363	2,227	2,249
Plus: allocated from Provider Arm	927	933	933	943	953	962
Net Result	**120**	**139**	**-**	**0**	**0**	**0**

Table 6 - Projected Governance and Funding Administration Operating Results

Projected Provider Arm Operating Results

in thousands of New Zealand Dollars

For the year ended 30 June	2014 Audited	2015 Forecast	2016 Projected	2017 Projected	2018 Projected	2019 Projected
Income						
Funding	233,357	240,824	260,194	261,021	264,965	268,967
Ministry of Health - non devolved contracts	12,646	13,541	3,700	3,758	3,818	3,878
Other District Health Boards	2,965	4,063	4,065	4,129	4,194	4,260
Accident Insurance	5,903	6,143	6,164	6,261	6,359	6,459
Other government and Crown agency sourced	472	518	414	421	428	435
Patient and consumer sourced	1,718	1,471	1,479	1,502	1,526	1,550
Other income	7,205	6,522	5,043	5,123	5,204	5,287
	264,267	273,082	281,060	282,215	286,494	290,836
Expenditure						
Employee benefit costs	169,920	177,099	187,382	192,990	196,074	199,229
Outsourced services	15,533	12,898	10,148	10,704	10,810	10,918
Clinical Supplies	44,639	41,110	43,431	36,463	34,272	35,137
Infrastructure and non clinical supplies	43,164	42,994	41,032	43,001	46,291	46,514
	273,256	274,100	281,993	283,158	287,447	291,798
Less: allocated to Governance & Funding Admin.	927	933	933	943	953	962
Surplus for the period	(8,062)	(86)	-	-	-	-
Revaluation of land and buildings	-	41,232	-	-	-	-
Net Result	(8,062)	**41,146**	-	-	-	-

Table 7 – Projected Provider Arm Operating Results

4.2 SIGNIFICANT ASSUMPTIONS

General

- Revenue and expenditure has been budgeted on current Government policy settings and known health service initiatives.
- No allowance has been made for any new regulatory or legislative changes which increase compliance costs.
- No allowance has been made for the costs of unusual emergency events e.g. pandemic or earthquake.
- Allowance has been made for the implementation costs of and net savings from regional and national entity initiatives as advised by the Ministry of Health.
- No allowance has been made for any additional capital or operating costs that may be required by the Finance, Procurement and Supply Chain (FPSC) shared service project previously managed by Health Benefits Limited (HBL).
- Allowance has been made for net additional costs arising from the Central Regional Information Services Project (CRISP) of $0.7 million in 2015/16 with full implementation complete by June 2016.
- Catch-up demographic funding for 2015/16 has reduced the pressure for material performance improvement actions in 2015/16. However $4.3 million of new investment in service provision and the full year impact of ongoing transformation expenditure has required an $8.5 million efficiency programme for the 2015/16 year.

Revenue

- Crown funding under the national population based funding formula will be $452.4 million for 2015/16. Funding for the 2016/17, 2017/18 and 2018/19 years will include nominal increases of $12.2 million, $10.8 million and $8.9 million respectively.
- Crown funding for non-devolved services of $28.7 million is based on agreements already in place with the appropriate Ministry of Health directorates. Increases of 1.6% have been allowed for 2016/17, 2017/18 and 2018/19.
- Revenue banking of $0.8 million (of the $5 million funding left with the Ministry of Health in 2011/12 due to sales proceeds from the Napier Hill site sale) is to be drawn down in 2015/16.
- Inter district flows revenue is in accordance with Ministry of Health advice. Increases of 1.5% have been allowed for each of 2016/17, 2017/18 and 2018/19.
- Other income has been budgeted at the District Health Board's best estimates of likely income. Increases of 2.075%, 2.0% and 2.0% have been allowed for 2016/17, 2017/18 and 2018/19 based on Treasury forecasts for CPI inflation (30 June Year composite rates based the 31 March rates in the Half Year Economic and Fiscal Update 2014 published 16 December 2014 and updated 14 January 2015).

Personnel Costs and Outsourced Services

- Workforce costs for 2015/16 have been budgeted at actual known costs, including step increases where appropriate. Increases to Multi Employer Collective Agreements have been budgeted in accordance with settlements, or where no settlement has occurred, at the District Health Board's best estimate of the likely increase. Increases of 0.7% per annum have been allowed for 2016/17, 2017/18 and 2018/19, which is the District Health Board's best estimates of likely increases.
- Establishment numbers for management and administration staff have been capped by the Minister of Health at 417 FTEs, the same as 2014/15. The District Health Board is managing internally to a cap of 400 FTEs.

Supplies and Infrastructural Costs

- The cost of goods and services has been budgeted the DHB's best estimates of likely cost.
- No allowance has been made for cost increases/decreases relating to fluctuations in the value of the New Zealand Dollar.
- Increases of 2.075%, 2.0% and 2.0% have been allowed for 2016/17, 2017/18 and 2018/19 based on Treasury forecasts for CPI inflation (30 June Year composite rates based the 31 March rates in the Half Year

Economic and Fiscal Update 2014 published 16 December 2014 and updated 14 January 2015).

Services Provided by Other DHB's

- Inter district flows expenditure is in accordance with MoH advice. Increases of 0.6% have been allowed for each of 2016/17, 2017/18 and 2018/19.

Other Provider Payments

- Other provider payments have been budgeted at the DHB's best estimate of likely costs. Costs increases have been included for 2016/17, 2017/18 and 2018/19 at 2.0%, 2.5% and 2.0% respectively.

Capital Servicing

- Depreciation has been calculated to write off the cost or fair value of property, plant, and equipment assets, and amortisation has been calculated to write off the cost or fair value of intangible assets (software) less their estimated residual values, over their useful lives. The investments in HBL and CRISP give the DHB a right to use the systems they provide, so they are considered to have indefinite lives, and consequently no amortisation has been allowed for.
- Interest rates of 4.925%, 5.175% and 5.250% have been applied for new borrowings and from maturity for expiring facilities in 2016/17, 2017/18 and 2018/19 respectively based on 15 points above Treasury forecasts for 10 year bonds (30 June Year composite rates based on the 31 March interest rates in the Half Year Economic and Fiscal Update 2014 published 16 December 2014 and updated 14 January 2015).
- The capital charge rate remains at 8%.

Investment

- The purchase of class B shares in Health Benefits Limited (HBL), relating to the Finance, Procurement and Supply Chain shared service, was completed in 2014/15 and took the total investment to $2,504,071. No allowance has been made for any further investment. No allowance has been made for any impairment of the asset over the time horizon of the plan.
- The investment in CRISP has been included at $1,391,000 for 2015/16, taking the total investment to $5,844,000. No allowance has been made for any impairment of the asset over the time horizon of the plan.
- No collaborative regional or sub-regional initiatives have been included other than CRISP.
- No increase in funding for existing associate organisations, Allied Laundry Services Limited and Central Technical Advisory Services have been allowed for.
- Property, plant, equipment, intangible asset expenditure, and investments in other entities are in accordance with the table below (note this excludes $990 thousand of additional funding that is likely to be invested in property, plant and equipment):

Investment	2015/16 $'m	2016/17 $'m	2017/18 $'m	2018/19 $'m
Buildings and Plant	9,383	9,627	6,900	5,700
Clinical Equipment	5,200	8,060	6,360	3,900
Other Equipment	3,775	2,775	2,775	2,775
Information Technology	3,000	3,125	2,550	2,100
Capital Investment	**21,358**	**23,587**	**18,585**	**14,475**
Investment in HBL	-	-	-	-
Investment in CRISP	1,391	-	-	-
Total Investment	**22,749**	**23,587**	**18,585**	**14,475**

Capital Investment Funding

- Capital investment will be funded from a number of sources including working capital in accordance with the following table:

Investment Funding	2015/16 $'m	2016/17 $'m	2017/18 $'m	2018/19 $'m
Total Investment	22,749	23,587	18,585	14,475
Funded by:				
Depreciation and amortisation	14,206	14,823	15,736	16,956
Operating surplus	3,000	3,000	3,000	3,000
Property disposal	1,200	-	-	-
Borrowings	5,000	-	-	-
Cash holdings	(657)	5,764	(151)	(5,481)
Capital Investment Funding	**22,749**	**23,587**	**18,585**	**14,475**

Property, Plant and Equipment

- Hawke's Bay District Health Board is required to revalue land and buildings when the fair value differs materially from the carrying amount, and at least every five years. A revaluation as at 30 June 2015 has been included based on preliminary figures provided by the valuer. No adjustment has been made for the effect of any other revaluation over the time horizon of the plan. Property, plant and equipment relating to Chatham Islands services has been excluded as these assets will transfer by Order in Council to Canterbury District Health Board on 1 July 2015.

Debt and Equity

- Debt will be at the levels in the table below. Loans and borrowings are included in the table at face value. This differs from the projected financial statements (see above) in which these instruments are carried at fair value as required by PBE standards.

Debt	2015/16 $'m	2016/17 $'m	2017/18 $'m	2018/19 $'m
Borrowing	47.5	47.5	47.5	47.5
Finance leases	-	-	-	-
Total debt	**47.5**	**47.5**	**47.5**	**47.5**
Debt/(Debt+Equity) Ratio	*33.0%*	*32.1%*	*31.4%*	*30.6%*

- Debt funding from the Crown will increase $5 million to $47.5 million in 2014/15 as the DHB draws down the debt facility relating to the Napier Hill site sale. There are no banking covenants relating to the debt.

Key Lenders	Facility	Limit $'m	Termination Date
Crown	Term Debt	$47.5 million	31 December 2021

- Equity movements will be in accordance with the table below.

Equity	2015/16 $'m	2016/17 $'m	2017/18 $'m	2018/19 $'m
Opening equity	93.0	96.7	100.3	103.9
Surplus	4.0	4.0	4.0	3.9
Equity repayments (FRS3)	(0.3)	(0.4)	(0.4)	(0.3)
Closing equity	**96.7**	**100.3**	**103.9**	**107.5**

Additional Information and Explanations

Disposal of Land
Disposal of land is subject to current legislative requirement and protection mechanisms. HBDHB is required to notify land declared surplus to previous owners for offer back prior to offering it to the Office of Treaty Settlements, and before any sale on the open market.

5. STEWARDSHIP & ORGANISATIONAL CAPABILITY

In order to make progress against our strategic outcomes, we have put in place our 'Transform and Sustain' programme, which in time will transform the whole Hawke's Bay health system. Some work is already underway and we are building on those successes and we are using the New Zealand Triple Aim as a guide to ensure we keep change in balance.

Delivering on Transform and Sustain will mean people in Hawke's Bay will experience:

- A health system that is responsive to need
- Consistent high-quality health care
- A more efficient health system

We are also implementing some cultural and structural changes to the system to support transformation and align it with the values that underpin our vision:

- TAUWHIRO: delivering high-quality care to patients and consumers
- RĀRANGA TE TIRA: working together in partnership across the system
- HE KAUANANU: showing respect for each other, our staff, patients and consumers
- ĀKINA: continuously improving everything we do.

QUALITY

Transform and Sustain is providing:

- An organisational development programme to support our workforce so they are empowered and valued to make the biggest contribution they can
- A means of reviewing progress in the three aims we have identified
- A model to measure, target and report our expenditure so we move our resources to where we bring about transformational change.

The Sustain programme consolidates the improvements we make in order to support the Transform programme that, together, will significantly improve the value of our services to the people of Hawke's Bay.

Creating Headroom for Change

Over the recent past, individuals across the health system have worked extremely hard to make the improvements that have been necessary. It is important we recognise those efforts and create the right environment and culture for ongoing change that links quality improvement and system integration. While we know we can't make change everywhere at once, we need to identify those services that could lead and support others.

The objectives of the programme cannot be achieved in one year, but readying the whole system for transformation is not something that we could put off. Rather, we have attempted to free-up some systems and processes so those who are ready can make a start. Time and energy continues to be invested in establishing, strengthening and maintaining relationships for better liaison across the system. The transformation agenda has taken time to initiate, but the momentum is gathering as people's expectations change and we respond to patients' needs in different ways.

In the first instance, we attempted to pinpoint opportunities that could easily be implemented in order to release some time and create the space for everyone to come together to design innovative solutions. That included identifying better administrative processes and more flexible budgeting, removing obstacles, facilitating better working partnerships and supporting the generation of new ideas while spending less time on non-essential tasks.

Fundamentally, teams at all levels are being encouraged to make more time to discuss, plan, implement and review improvement opportunities. Managers and team leaders are being supported to make this happen.

5.1 ORGANISATIONAL DEVELOPMENT

Workforce
The health system needs skilled clinical leaders, team leaders and managers in place to support team performance so that we can achieve transformation. Our teams must continually focus on providing excellent services, improving health and well-being, working in partnership and reducing inequities, and they must be empowered to try new ways of doing things. This applies to service delivery and support functions. We are working together to support and develop the workforce and the organisations.

Organisational development programmes are focusing on the following:

- Embedding our new Service Directorate structure of Service Director, Medical/Surgical Director and Nurse Director
- Clinical leadership and engagement
- Talent Management Programme including succession planning
- Transformational management and leadership capability
- Increasing staff engagement, health and well-being
- High performing teams, including re-skilling and up-skilling of staff
- Building capability, through structured development of current staff and recruitment of high calibre individuals
- Increasing Māori staff representation and increasing effective engagement with Māori
- Maintaining high levels of Union engagement
- Continued development of smart systems and reporting
- Robust health and safety systems including hazard identification and mitigation
- Enhanced blended and on-line learning and development programmes for clinicians and staff

Our Child Protection Policies comply with the requirements of the Vulnerable Children Act, 2014. A copy is available from our website: www.Hawke'sbay.health.nz

Communications
We are committed to ongoing innovation in our communications to staff, our consumers and our community, and to improving the way we promote our vision, services, challenges, successes and solutions. We are also engendering a safe and trusting environment in which people can propose changes and new ideas plus some extra focus on communicating and celebrating successful initiatives already implemented.

Health Information
In transforming the health system, one of the biggest challenges we face is developing an information system that matches our ambitions for service integration. We are working with our regional partners to deliver a regional health informatics strategy to support improvements in Information Communication Technology (ICT) over the outlook period. The Central Region ICT vision is about the efficient delivery of the right information to the right people at the right time, on an anywhere, anyhow basis to achieve the desired health outcomes and improved organisational performance

Achieving the region's vision for health informatics will contribute to improved consumer experience, better support for clinicians and other health professionals and more integrated care.

There are many areas that require better ICT support and we recognise the importance of rigorous investment to achieve this. We have developed and information systems strategy and a business intelligence work plan to underpin and complement Transform and Sustain.

5.2 KEY INTENTIONS

We have described what our core challenges are:

1. Responding to our population - we believe patients and whānau should be at the centre of health care, not a hospital or any particular care setting, and we need to have a stronger engagement with consumers and their families/whānau
2. Delivering consistent high-quality health care - the best quality care is appropriate, convenient and precise – the patient gets exactly what they need, delivered as soon as possible without error or undue waiting
3. Being more efficient at what we do - reducing waste in health will make us more efficient and ensure we get the best value from health care resources by delivering the right care to the right people in the right place, the first time.

Transform and Sustain includes a number of key intentions that, when implemented, will support us to address our core challenges.

- **TRANSFORMING OUR ENGAGEMENT WITH MĀORI**
- **TRANSFORMING PATIENT INVOLVEMENT**
- **TRANSFORMING HEALTH PROMOTION AND HEALTH LITERACY**
- **TRANSFORMING MULTI-AGENCY WORKING**
- **TRANSFORMING CLINICAL QUALITY THROUGH CLINICAL GOVERNANCE**
- **TRANSFORMING PATIENT EXPERIENCE THROUGH BETTER CLINICAL PATHWAYS**
- **TRANSFORMING THROUGH INTEGRATION OF RURAL SERVICES**
- **TRANSFORMING PRIMARY HEALTH CARE**
- **TRANSFORMING URGENT CARE**
- **TRANSFORMING OUT-OF-HOURS HOSPITAL INPATIENT CARE**
- **TRANSFORMING BUSINESS MODELS**

PROCESSES FOR ACHIEVING REGULAR FINANCIAL SURPLUSES

Closing the gap between planned expenditure and expected income is normal business in the health system. As the world economic environment puts even more pressure on all Government spending, Hawke's Bay DHB, as the lead Government agent for the Hawke's Bay public health budget, must continually look for ways to live within an expectation of lower funding growth.

Hawke's Bay DHB continues with its strategic direction to provide a $3m year-on-year surplus. This surplus is required to enable us to continue to invest in various infrastructure initiatives required to meet the needs of our community.

We continue with our strategy of responsible reduction in our cost base by

- Stopping doing things that are clinically ineffective of for which there is insufficient supporting evidence
- Doing things more efficiently by redesigning processes to drive out waste or errors
- Embracing opportunity to enhance quality by providing better care with the available resources

Our focus on reducing our cost base together with opportunities to increase our revenues will produce additional resources for our transformation program.

SHIFTING RESOURCES

To ensure that our change in focus is also matched by a shift of resources, we have agreed measures to monitor changes in deploying resources over time. Figure 3 illustrates a model for measuring and managing a shift of resources. The aim is to measure, monitor and realign expenditure in these categories and to shift resources purposely.

The shape of the curve will change, with the care models fundamentally transformed to enable more effective deployment of resources. This is not

about shifting resources from one provider to another, but rather it is about changing the service model.

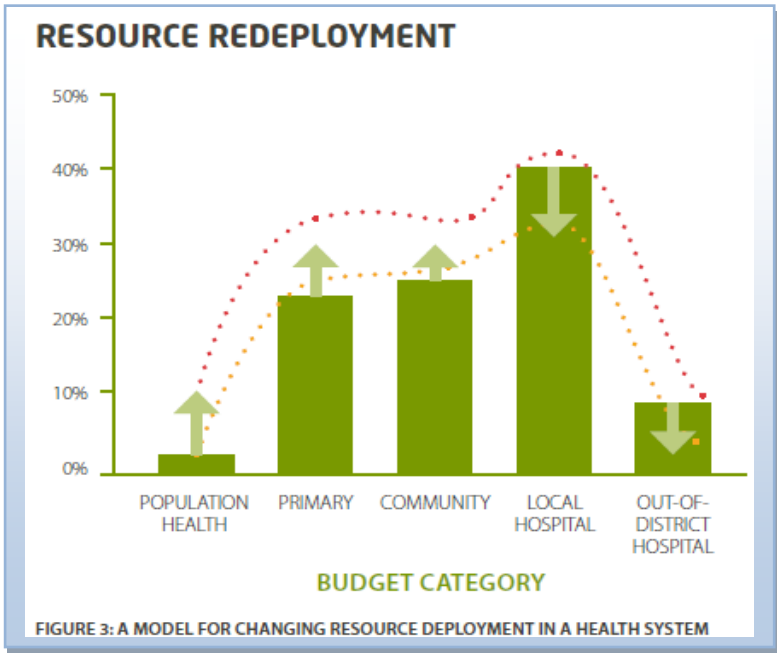


FIGURE 3: A MODEL FOR CHANGING RESOURCE DEPLOYMENT IN A HEALTH SYSTEM

SUMMARY

Our transform and sustain programme is already showing good results. We are making significant improvements in delivering services for patients, achieving more equitable health outcomes and improving staff engagement. Initiatives such as Acute Inpatient Management 24/7 (AIM 24/7) and others focusing on our after-hours services, theatre productivity, mental health model of care and health of older persons services, are all delivering significant improvement across our the sector. These improvements are being achieved within our current funding. In addition, our engagement with and commitment to the Health Quality and Safety Commission's programmes – specifically, Quality and Safety Markers (QSMs), Quality Accounts, and Patient Experience Indicators – provide the public with evidence and transparent links comparing our performance to national benchmarks and declarations about the quality of the services we fund and provide.

Note A: Subsidiary Companies and Investments

Currently, there are no subsidiary companies in which HBDHB has a controlling interest[44] and HBDHB has no plans to acquire shares or interests in terms of section 100 of the Crown Entities Act 2004. HBDHB has an interest in one multi-parent subsidiary: Allied Laundry Services Limited. Other shareholders are MidCentral DHB, Taranaki DHB and Whanganui DHB. Allied Laundry Services Limited has an exemption from producing a Statement of Intent (SOI). MidCentral DHB will report on Allied Laundry Services Limited in its SOI, on behalf of Hawke's Bay, Taranaki and Whanganui DHB

Note B: HBDHB is permitted and empowered under Section 25 of the New Zealand Public Health and Disability Act 2000 (the Act) to negotiate and enter into any service agreements (and amendments to service agreements) which it considers necessary in fulfilling its objectives and/or performing its functions pursuant to the Act.

Note C: HBDHB has a Health and Safety Policy detailing our commitment to providing a safe and healthy environment for all persons on our sites and business. The policy incorporates the Board-approved Health and Safety Statement and is updated every 2 years. The last update was in April 2014.

[44] As defined in section 58 of the Companies Act 1993

6. SERVICE CONFIGURATION

6.1 SERVICE COVERAGE AND SERVICE CHANGE

The Minister explicitly agrees to the level of service coverage for which the MoH and DHBs are held accountable. Service coverage information demonstrates how Government policy is to be translated into the required national minimum range and standards of services to be publicly funded. In the current environment of increasing resource constraints and rising demand, it is likely that the level of services provided in some locations and the standard of some services will be adjusted and that access to some services may have to be modified. Service and care pathway reviews will specifically address the issue of coverage and access as will national, regional and local integrated planning. HBDHB does not expect any exceptions to service coverage. In terms of performance measure SI3 (refer Appendix 2), should any unintended gaps in service coverage be identified by the DHB or MoH then the DHB will report progress achieved during the quarter towards resolution of exceptions.

In accordance with the Operational Policy Framework procedure regarding service change, early discussions have been held with the DHB's Relationship Manager about our service improvement plans. The table below is a high-level indication of some anticipated change.

Change	Description	Expected Benefits
Chatham Islands	As from July 1 2015, responsibility for health and disability services in the Chatham Islands transfers to Canterbury DHB. HBDHB will no longer fund services delivered to the Chatham Islands population.	Closer alignment between DHB planning and funding functions and DHB service delivery.
Bariatric surgery	Review of how and where bariatric surgery is provided for HBDHB population.	TBC
Plastic & reconstructive surgery	Reconfigure the current delivery model for plastic & reconstructive surgery	More local provision in collaboration with a regional service team. Less travel for HBDHB patients
Urgent & unplanned care	Implement the recommendations of a Service Level Alliance team that has been formed to consider changes that are necessary. May include changes to existing after hours and overnight arrangements at some locations around the district	More consistent and effective access to appropriate urgent care across the district. Reduce hospital admissions and improve equity.
Mental health & addictions	A programme linked to the commissioning of the new acute mental health inpatient facility currently under construction.	Enhanced acute functions with a range of evidence-based treatment options. Enhanced community care functions.
Telehealth	Introduce more telehealth options.	More integrated care and better access for rural and remote clients. Reduce the need to travel for some outpatient services.
Reorientation of some Māori health services	Centralisation of Kaitakawaenga resource within DHB Māori health services	Enhance coordination of outreach roles and response.

7. APPENDICES

APPENDIX 1A Our Strategic Framework

APPENDIX 1B Measures for the Health Sector Performance Framework

VITAL SIGNS	Measure
Patient Experience	Partient Experience Survey
Resource Sustainability	Financial Surplus DHB - Breakeven PHO
Live Longer & Healthier Lives	Premature deaths under 50 years

SUPPORTING DIMENSIONS	Measure
Better Access to Specialist Outpatients	Did not attend (DNA) rate across first specialist assessments
A Safer Hospital	Standardised Hospital Mortality Rate
Higher Quality General Practices	Cornerstone Accreditation
Reduced Readmissions	Standardised Readmission Rate
A Culturally Responsive Workforce.	Staff Ethnicity - % Maori
More Accessible General Practice	Ambulatory-sensitive hospitalisations
Older People Living Independently	Over 85s Living Independently
Productivity	Case Weight per Health Service FTE
Better Staff Engagement	Staff Engagement Survey
Better Infrastructure Efficiency	Infrastructure Efficiency
Better Staff Retention	Staff Turn-over
Care Closer to Home	Resource Deployment Index
Reduced Infant Mortality	Infant Mortality
Fewer Premature Deaths	All Cause Mortality < 75
Healthier Weight	Obesity Rate
More Heart and Diabetes Checks	Better diabetes and cardiovascular services
Faster Cancer Treatment	Faster Cancer Treatment
Better Help for Smokers to Quit	Better Help for Smokers to Quit - Hospital
	Better Help for Smokers to Quit - Primary Care

APPENDIX 2 Notes to the Financial Statements

REPORTING ENTITY

HBDHB is a DHB established by the New Zealand Public Health and Disability Act 2000. The DHB is a crown entity as defined by the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. The DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

The HBDHB's primary objectives are the funding and provision of health, disability and mental health services to the people of Hawke's Bay. Accordingly the DHB is a public benefit entity, as defined under XRB A1.

The projected financial statements of the HBDHB comprise the DHB, its 25% interest in Allied Laundry Services Limited, and its 16.7% interest in Central Region's Technical Advisory Services (CR TAS) Limited which is jointly controlled by the six DHBs in the central region.

BASIS OF PREPARATION

Statement of Compliance

The financial statements of the DHB have been prepared in accordance with the requirements of the Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004, which include the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP). The financial statements comply with Public Benefit Entity Standards (PBE standards), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

These financial statements are the first set of prospective financial statements presented in accordance with PBE standards.

The accounting policies set out below have been applied consistently to all periods presented in these financial statements.

Measurement Base

The projected financial statements have been prepared on a historical cost basis, except where modified by the revaluation of land and buildings.

The preparation of financial statements in conformity with PBE standards requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making the judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Judgements made by management in the application of PBE standards that have significant effect on the financial statements and estimates with a significant risk of material adjustment in the next year are discussed in the assumptions.

Functional and Presentation Currency

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars unless otherwise specified. The functional currency of the DHB is New Zealand dollars (NZ$).

Changes in Accounting Policy

PBE standards are to be applied by public benefit entities for periods beginning on or after 1 July 2014. Earlier application is not permitted. Other than the change to PBE standards, there have been no changes in

accounting policies since publication of the DHB's 2013/14 Annual Report. The DHB has not applied any transitional provisions in any PBE standard.

Basis for Consolidation

Subsidiaries

HBDHB has no subsidiaries.

Associates

Associates are those entities in which HBDHB has significant influence, but not control, over the financial and operating policies.

The projected financial statements include HBDHB's share of the total recognised gains and losses of associates on an equity accounted basis, from the date that significant influence commences until the date that significant influence ceases. The investment in an associate is initially recognised at cost and the carrying amount is increased or decreased to recognise the DHB's share of the surplus or deficit of the associate after the date of recognition as an associate. When the DHB's share of losses exceeds its interest in an associate, the carrying amount is reduced to nil and recognition of further losses is discontinued except to the extent that the DHB has incurred legal or constructive obligations or made payments on behalf of an associate. If the associate subsequently reports surpluses, the DHB will resume recognising its share of those surpluses only after its share of the surpluses equals the share of deficits not recognised. Distributions received from the associate reduce the carrying amount of the investment.

Where the DHB transacts with an associate, surplus or deficits are eliminated to the extent of the interest in the associate.

Dilutions gains or losses arising are recognised in the surplus or deficit.

Joint Ventures

Joint ventures are those entities over whose activities HBDHB has joint control, established by contractual agreement. The financial statements include the DHB's interest in joint ventures, using the proportionate method, from the date that joint control commences until the date that joint control ceases.

Foreign Currency

Transactions in foreign currencies are translated at the foreign exchange rate ruling at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to NZD at the foreign exchange rate ruling at that date. Foreign exchange differences arising on translation are recognised in the surplus or deficit.

Budget Figures

The budget figures are those approved by the DHB in its Annual Plan and included in the Statement of Intent tabled in parliament. The budget figures are prepared in accordance with NZGAAP, using accounting policies that are consistent with those adopted by the DHB for the preparation of these financial statements

SIGNIFICANT ACCOUNTING POLICIES

Revenue

Revenue is measured at the fair value of consideration received or receivable.

Crown Funding

The HBDHB is primarily funded through revenue received from the Crown under a Crown Funding Agreement. The funding is restricted in its use for the purpose of meeting the DHB' objectives as specified in the statement of intent.

Revenue from the Crown is recognised as revenue when earned and is reported in the financial period to which it relates, unless and to the extent any conditions imposed by agreements with the Crown are not yet met.

Revenue from other DHBs

Inter district patient inflow revenue occurs when a patient treated within the HBDHB region is domiciled outside of Hawke's Bay. The MoH credits HBDHB with a monthly amount based on estimated patient treatment for non Hawke's Bay residents within Hawke's Bay. An annual wash-up occurs at year end to reflect the actual non-Hawke's Bay patients treated at HBDHB.

ACC Contracted Revenue

ACC contract revenue is recognised as revenue when eligible services are provided and any contract conditions have been fulfilled.

Sale of goods

Revenue from goods sold is recognised when HBDHB has transferred to the buyer the significant risks and rewards of ownership of the goods and the DHB does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

Provision of Services

Revenue derived through the provision of services to third parties is recognised in proportion to the stage of completion at the balance sheet date. The stage of completion is assessed by reference to surveys of work performed.

Vested Assets

Where a physical asset is gifted to or acquired by the HBDHB for nil or nominal cost, the fair value of the asset received is recognised as income when control over the asset is obtained.

The activities of the HBDHB are reliant on services provided by volunteers. Volunteers services received are not recognised as revenue or expenditure by the DHB due to the difficulty of measuring their fair value with reliability.

Rental Income

Rental income from investment property is recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives granted are recognised as an integral part of the total rental income over the lease term.

Interest Income

Interest income comprises interest received and receivable on funds invested calculated using the effective interest rate method.

Expenses

Operating Lease Payments

Payments made under operating leases are recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives received are recognised in the surplus or deficit over the lease term as an integral part of the total lease expense.

Finance Lease Payments

Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding liability. The finance charge is allocated to each period during the lease term on an effective interest basis.

Borrowing Costs

Financing costs comprise interest paid and payable on borrowings calculated using the effective interest rate method, and losses on hedging instruments that are recognised in the surplus or deficit.

The interest expense component of finance lease payments is recognised in the surplus or deficit using the effective interest rate method.

Capital charge

The capital charge is recognised as an expense in the financial year to which the charge relates.

Cash and Cash Equivalents

Cash and cash equivalents comprises cash balances, call deposits and deposits with a maturity of no more than three months from the date of acquisition. Bank overdrafts that are repayable on demand and form an integral part of HBDHB's cash management are included as a component of cash and cash equivalents for the purpose of the statement of cash flows.

Debtors and Other Receivables

Short-term debtors and other receivables are recorded at their face value, less any provision for impairment. Long-term debtors are initially recognised at fair value and subsequently stated at amortised cost using the effective interest method, less impairment losses.

A provision for impairment of receivables is established when there is objective evidence that HBDHB will not be able to collect all amounts due according to the original terms of receivables. The amount of the provision is the difference between the receivable's carrying amount and the present value of estimated future cash flows, discounted using the effective interest method. The amount of the loss is recognised in the surplus or deficit.

When the receivable is uncollectible, it is written off against the provision for receivables. Overdue receivables that have been renegotiated are reclassified as current (that is, not past due).

Investments

Bank Deposits

Investments in bank deposits are initially measured at fair value plus transaction costs. After initial recognition investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

For bank deposits, impairment is established when there is objective evidence that the DHB will not be able to collect amounts due according to the original terms of the deposit.

Derivative Financial Instruments

Derivative financial instruments are occasionally used to manage exposure to interest rate and foreign exchange risks arising from HBDHB's operational activities. The DHB does not hold or issue derivative financial instruments for trading purposes. The DHB has not adopted hedge accounting.

Derivatives are initially recognised at fair value on the date a derivative contract is entered into are subsequently re-measured at their fair value at each balance date with the resulting gain or loss recognised in the surplus or deficit.

The full fair value of a forward foreign exchange derivative is classified as current if the contract is due for settlement within 12 months of balance date; otherwise, foreign exchange derivatives are classified as non-current.

Inventories

Inventories Held for Distribution

Inventories held for distribution, or consumption in the provision of services, that are not issued on a commercial basis are measured at cost, adjusted where applicable for any loss of service potential. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

Inventories Held for Sale

Inventories held for sale or use in the production of goods and services on a commercial basis are valued at the lower of cost and net realisable value. The cost of purchased inventory is determined using the weighted average cost method.

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in the surplus or deficit in the period of the write-down.

Non-current Assets held for Sale

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale, are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit. Any increase in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-current assets held for sale are not depreciated or amortised while they are classified as held for sale.

Property, Plant and Equipment

Property, plant and equipment consists of the following asset classes:

- Freehold land
- Freehold buildings
- Clinical equipment
- Information technology
- Motor vehicles
- Other equipment
- Work in progress.

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation and impairment losses. All other asset classes are measured at cost, less accumulated depreciation and impairment losses.

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every five years. The carrying value of land and buildings are assessed annually by an independent Valuer to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the asset class will be revalued. Land and building revaluation movements are accounted for on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive income and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive income but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive income. Surplus property is carried at the book value on the date the property was declared surplus until it is disposed of.

Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the DHB and the cost of the item can be measured reliably. Work in progress is recognised at cost, less impairment, and is not depreciated.

In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired at no cost, or for a nominal cost, it is recognised at its fair value as at the date of acquisition.

Disposals

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

Subsequent Costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to HBDHB and the cost of the item can be measured reliably. The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

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

Class of Asset	Estimated Life	Depreciation Rate
• Buildings	3 to 40 years	2.5% to 33%
• Clinical equipment	3 to 23 years	4.3% to 33%
• Information technology	3 to 10 years	10% to 33%
• Motor vehicles	3 to 20 years	5% to 33%
• Other equipment	3 to 40 years	2.5% to 33%

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter.

The residual value and useful life of an assets is reviewed, and adjusted if applicable, at each financial year end.

Intangible Assets

Software Acquisition and Development

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

Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include software development, employee costs and an appropriate portion of relevant overheads.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred. Costs associated with the development and maintenance of the DHB's website are recognised as an expense when incurred.

Amortisation

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

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

Type of Asset	Estimated Life	Amortisation Rate
• Acquired computer software	3 to 15 years	6.7% to 33%
• Developed computer software	3 to 15 years	6.7% to 33%
• Class B Shares in HBL	Indefinite	Nil
• Interest in CRISP	Indefinite	Nil

Impairment of Property, Plant and Equipment and Intangible Assets

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

Value in use is depreciated replacement cost for an asset where the future economic benefits or service potential of the asset are not primarily dependent on the asset's ability to generate net cash inflows and where the HBDHB would, if deprived of the asset, replace its remaining future economic benefits or service potential.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For revalued assets, the impairment loss is recognised in other comprehensive income to the extent that the impairment loss does not exceed the amount in the revaluation reserve in equity for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit.

For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss on a revalued asset is credited to other comprehensive income and increases the asset revaluation reserve for that class of asset. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit.

For assets not carried at a revalued amount the reversal of an impairment loss is recognised in the surplus or deficit.

Investment Properties

Investment properties are properties which are held either to earn rental income or for capital appreciation or for both. Investment properties are stated at fair value. If there is evidence supporting a material difference in value, an external, independent valuation company, having an appropriate recognised professional qualification and recent experience in the location and category of property being valued, will provide an assessment of the fair value of the properties. The fair values are based on market values, being the estimated amount for which a property could be exchanged on the date of valuation between a willing buyer and a willing seller in an arm's length transaction after proper marketing where the parties had each acted knowledgeably, prudently and without compulsion.

Any gain or loss arising from a change in fair value is recognised in the surplus or deficit. Rental income from investment property is accounted for as described in the accounting policy on rental income (see above).

When an item of property, plant and equipment is transferred to investment property following a change in its use, any differences arising at the date of transfer between the carrying amount of the item immediately prior to transfer and its fair value is recognised directly in equity if it is a gain. Upon disposal of the item the gain is transferred to retained earnings. Any loss arising in this manner is recognised immediately in the surplus or deficit.

If an investment property becomes owner-occupied, it is reclassified as property and its fair value at the date of reclassification becomes its cost for accounting purposes of subsequent recording. When HBDHB begins to redevelop an existing investment property for continued future use as investment property, the property remains an investment property, which is measured based on the fair value model, and is not reclassified as property, plant and equipment during the redevelopment.

Interest-bearing Loans and Borrowings

Interest-bearing loans and borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, interest-bearing

loans and borrowings are measured at amortised cost using the effective interest method.

Borrowings are classified as current liabilities HBDHB has an unconditional right to defer the settlement of the liability for at least 12 months after balance date. Borrowings where the DHB has an unconditional right to defer the settlement of the liability for at least 12 months after balance date are classified as current liabilities if the DHB expects to settle the liability within 12 months of the balance date.

Creditors and Other Payables

Creditors and other payables are recorded at their face value.

Employee Benefits

Short-term Employee Entitlements

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

These include salaries and wages accrued up to balance date, annual leave and continuing medical education leave earned, but not yet taken at balance date, retiring and long service leave entitlements expected to be settled within 12 months, and sick leave.

The liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward on balance date, to the extent that it will be used by staff to cover those future absences.

The liability and an expense are recognised for bonuses where it is a contractual obligation or where there is a past practice that has created a constructive obligation.

Long-term Employee Entitlements

Employee benefits that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on:

- Likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement and contractual entitlements information; and
- The present value of the estimated future cash flows.

Superannuation Schemes

Defined contribution Schemes

Obligations for contributions to Kiwisaver and the Government Superannuation Fund are accounted for as defined contribution superannuation schemes and are recognised as an expense in the surplus or deficit as incurred.

Defined benefit Schemes

The HBDHB makes employer contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme, the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme.

Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present legal or constructive obligation as a result of a past event, it is probable that an outflow of future economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a discount rate that reflects

current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense and included in financing costs.

Restructuring

A provision for restructuring is recognised when an approved detailed formal plan for the restructuring has either has been announced publicly to those affected, of for which implementation has already commenced.

ACC Partnership Programme

The HBDHB belongs to the ACC Partnership Programme whereby the DHB accepts the management and financial responsibility for employee work related illnesses and accidents. Under the full self-cover plan the DHB is liable for all its claims costs up to a stop loss limit of 250% of risk (levy rate x total liable payroll x loss ratio).

The liability for the ACC partnership programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to balance date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries. Expected future claims and injuries are discounted using market yields on government bonds at balance date with terms to maturity that match, as closely as possible, the estimated future cash outflows.

Goods and Services Tax (GST)

All amounts in the financial statements are presented exclusive of goods and services tax (GST), except for receivables and payables that are presented on a GST inclusive basis. Where GST is not recoverable as an input tax, it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) is included as part of receivables or payables in the statement of financial position.

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

GST relating to revenue from the Crown is recognised when the income is accrued in accordance with section 9(7) of the Goods and Services Tax Act 1985.

Commitments and contingencies are disclosed exclusive of GST.

Income Tax

HBDHB is a crown entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CB3 of the Income Tax Act 2007.

Income and Cost Allocation

Output Classes

Income and expenditure for each output class funded or provided by the HBDHB and reported in the statement of service performance, has been derived using the allocation system outlined below.

Direct income and costs are those directly attributable to an output class. Indirect income and costs are those costs that cannot be identified in an economically feasible manner with a specific output class.

Direct income and costs are charged directly to output classes. Indirect costs are charged to output classes using appropriate cost drivers such as the historical mix of purchase unit production. Indirect income is allocated to each output class based on the cost of purchase units provided.

Critical Accounting Estimates and Assumptions

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

have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below.

Employee Entitlement Provisions

The calculation of long service leave, retirement gratuities, sabbatical leave and sick leave liabilities are based on demographic assumptions and discount rate estimates. Demographic assumptions relating to life expectancy and future earnings potential are inherently uncertain as are discount rate estimates based on government stock rates over long periods of time

Workplace Accident Self-insurance

The liability for the ACC partnership programme is measured at the value of anticipated future payments to be made in respect of the employee injuries and claims using actuarial techniques. Expected future wage and salary levels and the incidence of employee claims and injuries are inherently uncertain.

Critical Judgements in Applying Accounting Policies

In the process of applying HBDHB's accounting policies, management makes various judgements that can significantly affect the amounts recognised in the projected financial statements. Management has not yet exercised any critical judgements in applying accounting policies for the year ended 30 June 2016.

APPENDIX 3 Dimensions of DHB Performance

Summary Table: 2015/16 Performance Expectations

The DHB monitoring framework aims to provide the Minister with a rounded view of performance using a range of performance markers. Four dimensions are identified that reflect DHBs functions as owners, funders and providers of health and disability services. The four identified dimensions of DHB performance cover:

- Achieving Government's priority goals/objectives and targets or 'Policy Priorities'
- Meeting service coverage requirements and supporting sector inter-connectedness or 'System Integration'
- Providing quality services efficiently or 'Ownership'
- Purchasing the right mix and level of services within acceptable financial performance or 'Outputs'.

It is intended that the structure of the framework and associated reports assists stakeholders to 'see at a glance' how well DHBs are performing across the breadth of their activity, including in relation to legislative requirements, but with the balance of measures focused on Government priorities. Each performance measure has a nomenclature to assist with classification as follows:

Code	Dimension
PP	Policy Priorities
SI	System Integration
OP	Outputs
OS	Ownership
DV	Developmental – establishment of baseline (no target/performance expectation is set)

Performance Measure	2015/16 Performance expectation/target			
Policy priorities PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19		≥4%	
	Age 20-64		≥5.0%	
	Age 65+		≥1.15%	
Policy priorities PP7: Improving mental health services using transition (discharge) planning and employment	Long-term clients		Provide a report as specified	
	Child and Youth with a Transition (discharge) plan		At least 95% of clients discharged will have a transition (discharge) plan.	
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	Mental Health Provider Arm			
	Age	<= 3 weeks	<=8 weeks	
	0-19	80%	95%	
	Addictions (Provider Arm and NGO)			
	Age	<= 3 weeks	<=8 weeks	
	0-19	80%	95%	
PP10: Oral Health- Mean DMFT score at Year 8	Ratio year 1		≤0.87	
	Ratio year 2		≤0.86	
PP11: Children caries-free at five years of age	Ratio year 1		≥66%	
	Ratio year 2		≥67%	
PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)	% year 1		≥86%	
	% year 2		≥87%	
PP13: Improving the number of children enrolled in DHB funded dental services	0-4 years - % year 1		≥90%	
	0-4 years - % year 2		≥95%	
	Children not examined 0-12 years % year 1		≤4.9	

	Children not examined 0-12 years % year 2	≤4.8
PP20: improved management for LTCs (CVD, diabetes and Stroke) Focus area 1: LTCs	Report on delivery of the actions and milestones identified in the Annual Plan.	
Focus area 2: Diabetes Care Improvement Packages and Diabetes Management (HbA1c)	Narrative quarterly report on DHB progress towards meeting its deliverables for Diabetes Care Improvement Packages (DCIP) identified in the 2015/16 annual plans Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control	≥55%
Focus area 3: Acute coronary syndrome services	70 percent of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0')	≥70%
	Over 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days.	>95%
	Over 95 percent of patients undergoing cardiac surgery at the five regional cardiac surgery centres will have completion of Cardiac Surgery registry data collection with 30 days of discharge.	>95%
	Report on delivery of the actions and milestones identified in the Annual Plan, including actions and progress in quality improvement initiatives to support the improvement of ACS indicators as reported in ANZACS-QI	NA
Focus area 4: Stroke Services	6 percent of potentially eligible stroke patients thrombolysed	≥6%

	80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	≥80%
	Report on delivery of the actions and milestones identified in the Annual Plan.	NA
PP21: Immunisation coverage	IPIF Healthy Start - Percentage of two year olds fully immunised	≥95%
	Percentage of five year olds fully immunised	≥95%
	Percentage of eligible girls fully immunised with three doses of HPV vaccine	≥65% for dose 3
PP22: Improving system integration	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP23: Improving Wrap Around Services – Health of Older People	Report on delivery of the actions and milestones identified in the Annual Plan.	
	The % of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan	
PP24: Improving Waiting Times – Cancer Multi-Disciplinary Meetings (MDT)	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP25: Prime Minister's Youth Mental Health Project	Initiative 1: SBHS in decile one to three secondary schools, teen parent units and alternative education facilities. 1. Quarterly quantitative reports on the implementation of SBHS, as per the template provided. 2. Quarterly narrative progress reports on actions undertaken to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS. Initiative 3: Youth Primary Mental Health 1. Quarterly narrative progress reports with actions undertaken in that quarter to improve and strengthen youth primary mental health (12-19 year olds with mild to moderate mental health and/or addiction issues) to achieve the following outcomes: • Early identification of mental health and/or addiction issues	

	• Better access to timely and appropriate treatment and follow up • Equitable access for Māori, Pasifika and low decile youth populations. Initiative 5: Improve the responsiveness of primary care to youth 1. Quarterly narrative reports with actions undertaken in that quarter to ensure the high performance of the youth SLAT(s) (or equivalent) in your local alliancing arrangements. 2. Quarterly narrative reports with actions the youth SLAT has undertaken in that quarter to improve the health of the DHB's youth population (for the 12-19 year age group at a minimum) by addressing identified gaps in responsiveness, access, service provision, clinical and financial sustainability for primary and community services for the young people, as per your SLAT(s) work programme.	
PP26: The Mental Health & Addiction Service Development Plan	Report on the status of quarterly milestones for a minimum of eight actions to be completed in 2015/16 and for any actions which are in progress/ongoing.	
PP27: Delivery of the children's action plan	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP28: Reducing Rheumatic fever	Provide a progress report against DHBs' rheumatic fever prevention plan	
	Hospitalisation rates (per 100,000 DHB total population) for acute rheumatic fever are 55% lower than the average over the last 3 years	≤1.9 per 100,000
PP29: Improving waiting times for diagnostic services	1. Coronary angiography – 95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)	≥95%
	2. CT and MRI – 95% of accepted referrals for CT scans, and 85% of accepted referrals for MRI scans will receive their scan within than 6 weeks (42 days)	CT ≥95% MRI ≥85%
	3. Diagnostic colonoscopy a. 75% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days b. 65% of people accepted for a non urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 120 days	≥75% ≥65%

	c. Surveillance colonoscopy 65% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days	≥65%
PP30: Faster cancer treatment	Part A: Faster Cancer Treatment – 31 day indicator	< 10 percent of the records submitted by the DHB are declined.
	Part B: Shorter Waits for Cancer Treatment – radiotherapy and chemotherapy	All patients ready-for-treatment receive treatment within four weeks from decision-to-treat.

SI1: Ambulatory sensitive (avoidable) hospital admissions		TBC
		TBC
SI2: Delivery of Regional Service Plans	Provision of a single progress report on behalf of the region agreed by all DHBs within that region (the report includes local DHB actions that support delivery of regional objectives	
SI3: Ensuring delivery of Service Coverage	Report progress achieved during the quarter towards resolution of exceptions to service coverage identified in the Annual Plan , and not approved as long-term exceptions, and any other gaps in service coverage	
SI4: Standardised Intervention Rates (SIRs)	Major joint replacement	An intervention rate of 21.0 per 10,000 of population
	Cataract procedures	An intervention rate of 27.0 per 10,000
	Cardiac surgery	A target intervention rate of 6.5 per 10,000 of population
	Percutaneous revascularisation	A target rate of at least 12.5 per 10,000 of population

	Coronary angiography services	A target rate of at least 34.7 per 10,000 of population
SI5: Delivery of Whānau Ora	Provision of a qualitative report identifying progress within the year that shows that the DHB has delivered on its planned Whānau Ora activity and what the impact of the activity has been	
SI6: IPIF Healthy Adult - Cervical Screening	80% of eligible women have received cervical screening services within the last 3 years	
OS3: Inpatient Length of Stay	Elective LOS	1.59 days
	Acute LOS	2.79 days
OS8: Reducing Acute Readmissions to Hospital	Total population	Improve on baseline performance
	75 plus	Improve on baseline performance
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections Focus area 1: Improving the quality of identity data	New NHI registration in error	>1% and ≤3%
	Recording of non-specific ethnicity	>0.5 and ≤2%
	Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5 and ≤2%
	Invalid NHI data updates % tbc	TBC
Focus area 2: Improving the quality of data submitted to National Collections	Neurobehavioral Rating Scale (NBRS) links to National Non-admitted Patients Collection (NNPAC) and National Minimum Data Set (NMDS) Greater than or equal to 97% and less than 99.5%	≥97% to <99.5 %
	National collections file load success	≥98% to <99.5 %
	Standard vs edited descriptors	≥75% to <90%
	NNPAC timeliness	≥95% to <98%
Focus area 3: Improving the quality of the programme for Integration of Mental Health data (PRIMHD)	PRIMHD data quality	Routine audits undertaken with

		appropriate actions where required
Output 1: Mental health output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction services is within: a) Five percent variance (+/-) of planned volumes for services measured by FTE b) Five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and c) Actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan	
Developmental measure DV4: Improving patient experience	No performance target set	