



BOARD MEETING

Date: Wednesday 29 May 2019

Time: 1:30pm

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

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

Apologies: Ngahiwi Tomoana

In Attendance: Kevin Snee, Chief Executive Officer
Executive Management Team members
John Gommans and Jules Arthur, Co-Chairs of Clinical Council
Rachel Ritchie, Chair HB Health Consumer Council
Members of the public and media

Minute Taker: Jacqui Sanders-Jones, Board Administrator

Public Agenda

Item	Section 1: Routine	Ref #	Time (pm)
1.	Welcome and Apologies		1:30
2.	Interests Register		
3.	Minutes of Previous Meeting 24 April 2019		
4.	Matters Arising - Review of Actions		
5.	Board Workplan		
6.	Chair's Report (verbal)		
7.	Chief Executive Officer's Report – Kevin Snee 7.1 Special Editions of In Focus from CEO	43	
8.	Financial Performance Report – Carriann Hall, ED Financial Services	44	
9.	People and Quality Dashboard Q3 (Jan – Mar 19) – Kate Coley	45	

10.	10.0 Board Health & Safety Champion's Update - Board Safety Champion 10.1 H& S Action Register		
	Section 2: Governance / Committee Reports		
11.	11.0 Te Pitau Health Alliance HB Update – Wayne Woolrich 11.1 Te Pitau Health Alliance Governance Group – Ken Foote	46 47	2:00
12.	Māori Relationship Board (verbal update) – Chair, Heather Skipworth		2:05
13.	Pacific Health Leaders Group report (verbal update) – Barbara Arnott		2.10
14.	HB Health Consumer Council – Chair, Rachel Ritchie	48	2:15
15.	HB Clinical Council	49	2:20
	Section 3: For Information & Discussion		
16.	HB Health Strategy feedback session – Chris Ash/Kate Rawstron 16.0 Health Strategy cover report 16.1 Draft Health Strategy document (with comments)	50 51	2.25
17.	HBDHB Annual Plan - Chris Ash/Kate Rawstron 17.1 Annual Plan Part A 17.2 Annual Plan Part B 17.3 Population Health Annual Plan (Draft)	52	3.05
18.	HBDHB Non Financial Framework Dashboard Q3 – Chris Ash	53	3.20
19.	HBDHB Performance Framework Exceptions Q3 – Chris Ash	54	3.25
20.	Te Ara Whakawaiora CHILD HEALTH combined report – Patrick Le Gyt	56	3.30
21.	Tò Waha - A Whānau-Centred Collaborative Approach – Bernard Te Paa	57	3.40
	Section 4: For Information		
22.	After Hours Care Service update – Chris Ash	58	3.50
23.	Section 5: Recommendation to Exclude the Public Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	Section 6: Routine	Ref #	Time (pm)
24.	Minutes of Previous Meeting 24 April 2019 (public excluded)		3.55
25.	Matters Arising (public excluded) – Review of Actions		-
26.	Board Approval of Actions exceeding limits delegated by CEO	59	-
27.	Chair's Update (verbal)		
	Section 7: For Information		
28.	Finance Risk and Audit Committee – Chair, Dan Druzianic	60	4.00
	Meeting concludes		

The next HBDHB Board Meeting will be held at
1.30pm on Wednesday 26 June 2019

Our shared values and behaviours



HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGATETIRA PARTNERSHIP
TAUWHIRO CARE



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

Welcoming

- ✓ Is polite, welcoming, friendly, smiles, introduce self
- ✓ Acknowledges people, makes eye contact, smiles

Respectful

- ✓ Values people as individuals; is culturally aware / safe
- ✓ Respects and protects privacy and dignity

Kind

- ✓ Shows kindness, empathy and compassion for others
- ✓ Enhances peoples mana

Helpful

- ✓ Attentive to people's needs, will go the extra mile
- ✓ Reliable, keeps their promises; advocates for others

- ✗ Is closed, cold, makes people feel a nuisance
- ✗ Ignore people, doesn't look up, rolls their eyes
- ✗ Lacks respect or discriminates against people
- ✗ Lacks privacy, gossips, talks behind other people's backs
- ✗ Is rude, aggressive, shouts, snaps, intimidates, bullies
- ✗ Is abrupt, belittling, or creates stress and anxiety
- ✗ Unhelpful, begrudging, lazy, 'not my job' attitude
- ✗ Doesn't keep promises, unresponsive



ĀKINA IMPROVEMENT *Continuous improvement in everything we do*

Positive

- ✓ Has a positive attitude, optimistic, happy
- ✓ Encourages and enables others; looks for solutions

Learning

- ✓ Always learning and developing themselves or others
- ✓ Seeks out training and development; 'growth mindset'

Innovating

- ✓ Always looking for better ways to do things
- ✓ Is curious and courageous, embracing change

Appreciative

- ✓ Shares and celebrates success and achievements
- ✓ Says 'thank you', recognises people's contributions

- ✗ Grumpy, moaning, moody, has a negative attitude
- ✗ Complains but doesn't act to change things
- ✗ Not interested in learning or development; apathy
- ✗ "Fixed mindset, 'that's just how I am', OK with just OK
- ✗ Resistant to change, new ideas; 'we've always done it this way'; looks for reasons why things can't be done
- ✗ Nit picks, criticises, undermines or passes blame
- ✗ Makes people feel undervalued or inadequate



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

Listens

- ✓ Listens to people, hears and values their views
- ✓ Takes time to answer questions and to clarify

Communicates

- ✓ Explains clearly in ways people can understand
- ✓ Shares information, is open, honest and transparent

Involves

- ✓ Involves colleagues, partners, patients and whanau
- ✓ Trusts people; helps people play an active part

Connects

- ✓ Pro-actively joins up services, teams, communities
- ✓ Builds understanding and teamwork

- ✗ 'Tells', dictates to others and dismisses their views
- ✗ Judgmental, assumes, ignores people's views
- ✗ Uses language / jargon people don't understand
- ✗ Leaves people in the dark
- ✗ Excludes people, withholds info, micromanages
- ✗ Makes people feel excluded or isolated
- ✗ Promotes or maintains silo-working
- ✗ 'Us and them' attitude, shows favouritism



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

Professional

- ✓ Calm, patient, reassuring, makes people feel safe
- ✓ Has high standards, takes responsibility, is accountable

Safe

- ✓ Consistently follows agreed safe practice
- ✓ Knows the safest care is supporting people to stay well

Efficient

- ✓ Makes best use of resources and time
- ✓ Respects the value of other people's time, prompt

Speaks up

- ✓ Seeks out, welcomes and give feedback to others
- ✓ Speaks up whenever they have a concern

- ✗ Rushes, 'too busy', looks / sounds unprofessional
- ✗ Unrealistic expectations, takes on too much
- ✗ Inconsistent practice, slow to follow latest evidence
- ✗ Not thinking about health of our whole community
- ✗ Not interested in effective use of resources
- ✗ Keeps people waiting unnecessarily, often late
- ✗ Rejects feedback from others, give a 'telling off'
- ✗ 'Walks past' safety concerns or poor behaviour



Board "Interest Register" - 13 March 2019

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Kevin Atkinson (Chair)	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussion in relation to the Trust	The Chair of FRAC	Mar-11
	Active	Board Member of NZ Health Partnership Limited, effective from 20 March 2017	Lead, supported and owned by the 20 DHBs, NZ Health Partnerships creates efficiencies in the health sector that allow more to be spent on frontline services.	Will not take part in any decisions in relation to NZ Health Partnerships Limited where specific legal or fiduciary conflict identified.	The Chair of FRAC	22.02.17
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair of FRAC	26.10.17
Ngahiwi Tomoana (Deputy Chair)	Active	Chair, Ngati Kahungunu Iwi Incorporated (NKII)	Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB: (i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department. (ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department.	Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB.	The Chair	01.05.08
	Active	Uncle of Tiwai Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Tiwai Tomoana is employed by HBDHB and is a Kitchen Assistant in the Food and Nutrition Department at Hawke's Bay Hospital.	All employment matters in relation to Tiwai Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Uncle of Iralee Tomoana	Iralee Tomoana is employed by HBDHB and works in the Radiology Department as a clerical assistant.	All employment matters in relation to Iralee Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Brother of Numia Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Numia Tomoana is employed by Cranford Hospice and works as a palliative care assistant and, in this role, works with chaplains at Hawke's Bay Hospital.	Will not take part in any decisions in relation to the Chaplain service at Hawke's Bay Hospital.	The Chair	01.05.08
	Active	Involved with Waitangi Claim #2687 (involving Napier Hospital land) sold by the Government	Requested that this be noted on the Interest Register	Unlikely to be any conflict of Interest.	The Chair	28.03.18
	Active	Iwi Chairs involved with Treaty of Waitangi Health Claim #2575	Requested that this be noted on the Interest Register	Unlikely to be any conflict of Interest.	The Chair	19.12.18
Barbara Arnott	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	26.10.17
Dr Helen Francis	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.11
	Active	HB Medical Research Foundation	Trustee	Declare this interest prior to any discussion in relation to the Foundation, and an appropriate mitigation action is decided on.	The Chair	20.08.14
	Active	Senior Advisor Primary Care	Health system improvement & innovation, Ministry of Health	Declare interest as and when required	The Chair	13.03.19

Board Meeting 29 May 2019 - Interests Register

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Diana Kirton	Active	Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB.	Perceived Conflict of Interest. Non-Pecuniary interest.	Will not take part in any decisions in relation to surgical services provided by or contracted with HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO	The Chair	18.02.09
	Active	Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014	Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers.	Declare this prior to any discussion in relation to EIT in the area of interest, and an appropriate mitigation action is decided on.	The Chair	16.01.14
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.14
	Active	Member, Hawke's Bay Law Society Standards Committee	Law Society	No conflict perceived	The Chair	20.06.17
	Active	RENEW Counselling Services	Counsellor	No conflict perceived	The Chair	17.07.17
Dan Druzianic	Active	Director of Markhams Hawke's Bay Limited	Potential Conflict of Interest. Some clients may from time to time be employed by or have contracts with HBDHB	Declare an interest at any time an issue arises concerning a client, and take no further part in any decision or discussion on this matter.	The Chair	7.12.10
Jacoby Poulain	Active	Board Member of Eastern Institute of Technology (EIT)	Perceived conflict - HBDHB has a Memorandum of Understanding (MOU) with EIT relating to training and development in health related occupations.	Will not take part in any decisions or discussions in relation to the MOU between HBDHB and EIT	The Chair	14.1.14
	Active	Councillor Hastings District Council	Potential conflict as potential advocate for Hastings District population whereas HBDHB covers whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Hastings and Chair decides on appropriate mitigation action.	The Chair	14.1.14
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumatau - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust (aligned to Iron Maori Limited)	The Trust has contracts with HBDHB including the Green Prescription Contract; and the Mobility Action Plan (Muscular Skeletal)	Will not take part in any discussions or decisions relating to any actions or contracts with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15 29.03.17
	Active	Director of Kahungunu Asset Holding Company Ltd	The asset portfolio of the company in no way relates to health, therefore there is no perceived conflict of interest.	Unlikely to be any conflict of interest. If in doubt will discuss with the HBDHB Chair.	The Chair	26.10.16
Peter Dunkerley	Active	Trustee of Hawke's Bay Helicopter Rescue Trust	Actual conflict of interest. The Trust provides helicopter patient transfer services to HBDHB	Will not take part in any decision or discussion in relation to any contract or financial arrangement between HBHRT and HBDHB	The Chair	15.05.14
	Active	Shareholder Need a Nerd	IT support for home or business	No conflict perceived	The Chair	13.12.17
	Active	Shareholder of NZ Technologies	Technology and innovative support for businesses to grow	No conflict perceived	The Chair	13.12.17
Ana Apatu	Active	CEO of Wharariki Trust (a member of Takitimu Ora Whanau Collective)	A relationship which may be contractual from time to time	Will advise of any perceived or real conflict prior to discussion	PCDP Chair	5.12.16
	Active	Whakaraki Trust "HB Tamariki Health Housing fund"	Formed a relationship and MoU with HBDHB Child Health Team Community Women and Children's Directorate.. The Trust created a "HB Tamariki Health Housing fund" to ensure warm dry homes for Hawke's Bay whanau	Will advise at the outset of any discussions on this topic, and will not take part in any decisions / or financial discussions relating to this arrangement.	The Chair	8.08.18
Hine Flood	Active	Member, Health Hawkes Bay Priority Population Committee	Pecuniary interest - Oversight and advise on service delivery to HBH priority populations.	Will not take part in any conflict of interest that may arise or in relation to any contract or financial arrangement with the PPC and HBDHB	The Chair	14.02.17
	Active	Councillor for the Wairoa District Council	Perceived Conflict - advocate for the Wairoa District population and HBDHB covers the whole of the Hawkes Bay region.	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.02.17

**MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 24 APRIL 2019, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.30PM**

PUBLIC

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

In Attendance: Kevin Snee (Chief Executive Officer)
Members of the Executive Management Team
Dr Gommans and Julie Arthur (Co-Chairs, HB Clinical Council)
Rachel Ritchie (Chair, HB Health Consumer Council)
Members of the public and media
Jacqui Sanders-Jones, Board Administrator

APOLOGY

None

2. INTEREST REGISTER

No changes to the interests register were advised

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

3. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on Wednesday 27 March 2019, were confirmed as a correct record of the meeting.

Moved: Peter Dunkerley
Seconded: Diana Kirton
Carried

4. MATTERS ARISING FROM PREVIOUS MINUTES

- Item 1: Equity & Cultural Competency Workshops - **complete**
- Item 2: Consumer Experience facilitators – **deferred** to June as part of item on Person & Whanau Centred Care
- Item 3: Whole of board appraisal action plan – now included in the Workplan, **remove**.
- Item 4: Allied Laundry letter response – **complete**

- Item 5: Oral Health Team project –Workplan for **May**
- Item 6: Equity for Māori – discussion as part of agenda for April
- Item 7: Person & Whanau Centred Care – Workplan for **June**
- Item 8: PHLG Nurse Navigators – Workplan for **May**

5. BOARD WORK PLAN

The Board Work Plan was noted.

6. CHAIR'S REPORT

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

Name	Role	Service	Years of Service	Retired
Robin Shirkey	Clinical Pharmacist	Operations Directorate	34	26-Mar-19
Mariet Vaessen	Staff Midwife	Communities Women & Children	10	31-Mar-19

- Chair advised receipt of letter from State Services Commission on the updated Speaking Up model standards, and requested CEO to obtain feedback from management.
ACTION CEO to distribute this letter to management and feedback comments from EMT to Board.
- Correspondence received from Minister approving \$8.8m as crown entity funding injection to assist with seismic strengthening project in theatre block.

7. CHIEF EXECUTIVE OFFICER'S REPORT

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

- Reflection on industrial action with particular attention to RMO strike, noting the key issues focus on roster decision making. There is a facilitated process of mediation although unlikely in advance of this strike.
- Performance measures– recognising difficulties in some areas caused by; Short stays in ED declining figures, further impact on elective surgeries from RMO industrial action.
ACTION CEO to provide report which explains in detail HBDHB progress and timelines of expectations against these targets. (May)
CEO further explained that although HBDHB has revised annual targets there are not the same consequences as in previous years, however these targets remain equally as important for HBDHB to achieve.

RECOMMENDATION

That the HBDHB Board:

- . Note the contents of this report.

Adopted

8. FINANCIAL PERFORMANCE REPORT

Carriann Hall (ED of Financial Services) spoke to the Financial Report for March 2019, which showed a \$1.4m unfavourable variance to budget taking the year-to-date result to a \$6.2m deficit

RECOMMENDATION

That the HBDHB Board:

- . Note the contents of this report.

Adopted

9. HEALTH & SAFETY BOARD CHAMPION'S UPDATE

Board Health & Safety Champion, Barbara Arnott, provided an update on her visit to ICU.

Noted the collegial environment within the teams of ICU and that staff spoken to felt supported and safe in their positions. The following three safety concerns were raised:

- Resources – 5 ICU beds and 6 HDU beds currently available in the unit. Concerns over the appropriate use of this area as different specific healthcare requirements for ICU and HDU patients. Pressure for ICU beds has previously led to overflow of ICU patients into PACU which has led to feeling of isolation for staff and patients. Noted that this same issue was raised during 2013 external audit which resulted in a report of under resourcing.
- Storage – lacking appropriate storage for patients/families and ward resources, which could be addressed with relatively small investment.
ACTION EDPS to take forward with Facilities

Addressing the above two points, the CEO explained that although the facilities footprint could not be changed, the use of space within it can be addressed quite quickly (such as moving HDU to somewhere else in the hospital).

- Flight – patient stretchers are felt to be extremely unstable when raised. Urgent replacement suggested.

ACTION EDPS to take forward with Operations Directorate

Company Secretary confirmed that Board H&S Champions are provided with a feedback report template which, through its completion, produces actions which get fed into Quality team to address.

ACTION Board H&S action register to be included as standing monthly item for visibility

REPORT FROM COMMITTEE CHAIRS

10. TE PĀTAU HEALTH ALLIANCE (HAWKE'S BAY)

Hine Flood, as member of the Te Pātau Health Alliance, spoke on matters discussed at their meeting held Wednesday 10 April 2019, including;

Confirmation of PHO commitment (not DHB) to supporting Health Care Home initiative.

Currently no Te Pātau involvement with PHO review of funding which is being conducted through KPMG.

ACTION Hine Flood to take forward query of involvement of Te Pātau with the KPMG review of PHO funding, via Chair of Te Pātau Health Alliance, Bayden Barber

RECOMMENDATION

That the HBDHB Board:

- . Note the contents of this report.

Adopted

11. MĀORI RELATIONSHIP BOARD (MRB)

Heather Skipworth, as Chair of MRB, spoke to the workshop held Wednesday 10 April 2019.

The Workshop focused on achieving equitable outcome for Maori and included discussion points:

- funding arrangements
- recognising indigenous population
- transformed healthcare for Māori
- prioritisation for Māori
- a parallel health care system
- responsive health services
- Whanau centred approach/ Hauroa approach
- Rural community Maori and their needs
- Culturally competent leaders within the organisation

Felt to be a great discussion however no conclusions developed and therefore continuation of this workshop will be held on Monday 29 April, at Mihiroa Marae, 10am.

ACTION MRB recommendations to Board – Workplan for May (Bernard Te Paa)

12. PASIFIKA HEALTH LEADERSHIP GROUP (PHLG)

No meeting held this month.

13. HAWKE'S BAY HEALTH CONSUMER COUNCIL

Rachel Ritchie, Chair of Consumer Council advised the outcomes of the meeting held on Thursday 11 April 2019:

- Consumer facilitators are noting a demand for consumer input with a database being developed to better understand where and why consumer representation is required. Request from Board to ensure the recognition of ethnic/cultural requirements to ensure fair representation at Consumer Council.
- Confirmed that representatives from After Hours Urgent Care, Advanced Care Planning and Lab Strategy Group are feeding into Consumer Council, along with recognising that consumer outcomes need to be worked into the model of Healthy Homes.
- Consumer Council are now looking for youth representation by linking with other established 'youth groups', as Youth Council is no longer functioning as a standalone group.

RECOMMENDATION

That the HBDHB Board:

- . Note the contents of this report.

Adopted

14. HAWKE'S BAY CLINICAL COUNCIL

Co-Chairs Dr John Gommans and Julie Arthur spoke to the report from the Council's meeting held on Wednesday 10 April 2019, including:

- Engagement at clinical level for Clinical Services Plan (CSP) – approved Robin Whyman as representative onto the Health Strategy Group.
- Clinical Governance structure implementation – noted that there is not the management/administration support required to function well and that these discussions remain ongoing
- Sector wide process for reporting on clinical risk remains a concern, resulting in a workshop being held to proactively take forward this discussion.
- Development of HB Clinical Workforce Plan - ongoing development but unlikely completion before end of June 2019.
- Educational training around Triple Aim /Whanau & Person Centred Care – ongoing work with Quality team.

RECOMMENDATION

That the HBDHB Board:

- Note the contents of this report.

Adopted

FOR DISCUSSION / INFORMATION

15. Three Waters Presentation and Discussion with Napier City Council

Wayne Jack, CEO Napier City Council and Toni Goodlass, Programme Manager, gave presentation on the progress of the Three Waters Review, which involves representation from Hastings DC, Wairoa DC, Central Hawke's Bay DC, Hawke's Bay Regional Council and Napier City Council, reviewing the challenges to attaining good quality drinking water alongside the management in the delivery of the three waters;

- storm water
- waste water
- drinking water.

This review is result of national discussion stemming from Havelock North water enquiry and will consider regulatory requirements with consumer involvement and engagement through local community groups.

Review initiated by CEOs of above listed councils to review existing structure and delivery of operating models. Department of Internal Affairs (DIA) are working closely with the project team, with a limited timeframe to meet by end of 2019. Since January, the project team have assessed the current state of play, worked with stakeholders on the new service delivery model options and are currently analysing list of options for a new service delivery model. A joint Council workshop will now take place to examine the Key Principles:

- Affordability –rights and access, funding of the infrastructure
- Safe & resilient service – impact on the environment
- Meaningful role for Maori - Maori committees, through the consultation process assisted the project to establish 'one water' cultural significance

- Value of water – from a community and cultural aspect (urban and rurals). Upcoming legislation expects that ‘private’ suppliers of drinking water will require a drinking water plan approved by district councils. This affects any building supplying more than one property. I.e. maraes.

These principles are to encapsulate the new regulatory requirements and to fit with future changes.

Examples of different models of service delivery were discussed with a shortlist of three options being evaluated, including the status quo. Regulatory change is expected to increase the cost of delivery of the three waters and the project team are working with DIA for support of these options for transition to a new model.

Next steps – presenting the preferred option to key stakeholders. By the end of May the CEOs of councils involved will receive the final recommendations.

Discussion followed with points raised:

- Councils are driving this change before regulatory requirements come into effect from the government.
- HBDHB are considered a key stakeholder and feedback has been requested from Nick Jones Clinical Director for Public Health, and his team.

ACTION Nick Jones response to Napier City Council regarding Three Waters options to come through Board (May Workplan)

16. Equity Discussion

Bernard Te Paa, Executive Director of Improvement & Equity opened discussion, explaining two points:

- 1) Restructuring in Public and Population health will include a new General Manager of Population Health and a Head of Intersectoral and Special Projects. These positions will focus on addressing determinants of health.
- 2) Working in partnership with Ngati Kahungunu to develop ‘He Ngākau Aotea’. Two parts to this project including Strategic Intent and Operational Areas are being worked through. Deliverables will be ready in draft for presentation to Board in June.

Bernard acknowledged Patrick Le Geyt (General Manager, Māori Health) for his work on Te Ara Whakawaiora (TAW) reports. These will be quarterly for specific key areas, starting with Child Health indicators in May. Looking to roll this type of report for all other key areas for consolidated reports with an equity approach.

Patrick then explained the purpose of TAW reports, in that these feed into goal of achieving equity for Maori and act to identify actions to eliminate inequities. Condensing the TAW reports (Child Health, Mental Health and Adult Health), will enable a better action-based focus and provide accountability to progress on achieving equity, whilst using current resources through redistribution and thus achieve the programme outcomes.

Management were asked to identify what the *Equity statement* means for HBDHB whilst considering the Ministers letter of expectation, and whilst noting previous suggestion of ‘Equity for Maori leads to equity for everyone’, agreed a position with a focus on ‘Equity for Maori, Pacifica and those with unmet need’ and noted that Treaty obligations are honoured within this.

Discussion followed on the impact this position on equity will have on the work of HBDHB.

Bernard gave reminder of key issues from Health Equity report which have greatest effect on Māori, (which serves as a quarter of the population of Hawke’s Bay); includes Cardiovascular, suicide, Road Traffic Accidents and Lung Health.

Further discussion resulted in consensus on the following resolution:

Recommendation:

That the HBDHB Board:

- **Adopt** the core goal of '*Equity for Maori as a priority; also, equity for Pasifika and those with unmet need*'.

Adopted

17. HB Health Awards Event update

Anna Kirk, Communications Manager, gave an update on HB Health Awards including feedback on last year's event.

- Alcohol last year was available, although not funded through the ticket price . A total of \$1600 was spent on non-alcoholic drinks.
- Comms team are working with management to refresh the awards. Also working with Clinical and Consumer council to ensure plenty of stakeholder involvement.
- Reducing inequities criteria will be introduced to each category.
- **HB Health Awards will be held Friday 22 November 2019.**

18. DHB Elections 2019

Ken Foote, Company Secretary presented a paper with information and timelines for upcoming DHB board elections.

Discussion followed regarding order of names of candidates on voting papers; should alphabetic by surname be retained, or should candidates be listed by 'pseudo random' method (where names are randomly drawn once, and then printed on all voting forms in that same order). With views being split on this issues, a vote was required.

RECOMMENDATION

That the HBDHB Board:

- **Notes** that Warwick Lampp from Electionz.com has been appointed again as the HBDHB Electoral Officer, for the 2019 elections
- **Resolves** that the names of candidates on the voting documents be arranged in alphabetic order of surname
- **Requests** the Ministry of Health to actively campaign for potential candidates to stand for DHB elections.
- **Advertises and conducts** "information evenings" for potential candidates (in Hastings and Napier) prior to nominations being opened.
- **Notes** the need for 'caution' in making major decisions during the pre and post-election period.

In Favour: 5

Against: 5 (Jacoby Poulain noted)

Abstention: 1

With votes being evenly split on the issue of the order of names on the voting document, the status quo (alphabetical order) was retained.

Adopted

GENERAL BUSINESS

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

19. RECOMMENDATION TO EXCLUDE THE PUBLIC

RECOMMENDATION

That the HBDHB Board:

Exclude the public from the following items:

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

Moved: Peter Dunkerley

Seconded: Barbara Arnott

Carried

The public section of the Board Meeting closed 4.30pm

Signed: _____
Chair

Date: _____

**BOARD MEETING - MATTERS ARISING
(Public)**

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	28/11/18	Schedule Consumer Experience Facilitators to attend the May 2019 Board meeting as members would like to hear about their work.	Kate Coley	June 19	Deferred to June 19, to link with paper on Person & Whanau Centered Care
2	27/03/19	Oral Health Team project Maori Health to bring back learnings and outcomes from this Oral Health project and to consider how this model can be used to implement further programmes in addressing health issue	Bernard Te Paa/ Charrissa Keenan	May 2019	Included onto May Workplan
3	27/03/19	Person & Whanau Centred Care EMT to: Advocate for national changes and consider local changes to current funding models and other disincentives to providing PWCC in primary and community care Ensure PWCC becomes the norm; to do that, present a paper to the June 2019 Board meeting that: Enables the identification and freeing up of appropriate resources to prioritise the development of PWCC across the HB health sector Prioritises the provision of specific education and training to the HB health workforce on implementing PWCC Facilitates raising the levels of PWCC awareness within HB communities and empowering consumers to partner in their own care and contribute to service developments	Kate Coley	June 2019	For inclusion on Workplan – June 19

Action	Date Entered	Action to be Taken	By Whom	Month	Status
5	24/04/19	State Services Commission letter on 'Speaking Up – Model of Standards' CEO to obtain feedback from EMT and report to Board	CEO	May 2019	
6	24/04/19	Performance Measures CEO to provide report on HBDHB progress and timelines of expectations against health targets	CEO	May 2019	
7	24/04/19	Health & Safety Board H&S action register to be included as standing monthly item for visibility	Board Administrator	May 2019	Complete & included in agenda
8	24/04/19	Te Pitau Alliance Query involvement of Te Pitau with the KPMG review of PHO funding, via Chair of Te Pitau Health Alliance, Bayden Barber	Hine Flood	May 2019	
9	24/04/19	MRB Workshop follow up MRB Recommendations to Board following Workshops	Bernad Te Paa	June 2019	Recommendations to be further considered by MRB in June
10	24/04/19	Three Waters discussion As a stakeholder in this project, HBDHB is providing feedback from Nick Jones team on the preferred option recommendations once received from the Three Waters project team.	Nick Jones	June 2019	Recommendations from Three Waters project group not yet available for feedback. To be completed in June

Board Meeting 29 May 2019 - Board Workplan

GOVERNANCE WORKPLAN PAPERS										
21-May-19										
BOARD MEETING 29 MAY 2019		Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Annual Plan 2019/20 SPEs to Board by end of June (include committees)	BOARD must sign off by end of June 2019		Chris Ash	Robyn Richardson	4-Jun-19	12-Jun-19	12-Jun-19	13-Jun-19		29-May-19
People & Quality Dashboard Q3 (Jan-Mar 19) Feb-May-Aug-Nov (formerly HR KPI Rpt)		E	Kate Coley	Jim Scott	14-May-19				29-May-19	29-May-19
Finance Report (Apr)			Carriann Hall	Chris	14-May-19				29-May-19	29-May-19
HBDHB Non-Financial Performance Framework Dashboard Q3 - EMT/Board		E	Chris Ash	Peter MacKenzie	21-May-19					29-May-19
HBDHB Performance Framework Exceptions Q3 Feb19 /May/Aug/Nov (Just in time for MRB Mtg then to EMT)		E	Chris Ash	Peter MacKenzie	7-May-19	8-May-19				29-May-19
Te Ara Whakawaiora CHILD HEALTH combined report		E	Patrick le Geyt	Mark P/ Jill Garrett / Patrick	23-Apr-19	8-May-19	8-May-19	9-May-19		29-May-19
After Hours Urgent Care Service Update 6mthly (Sept-Mar-Sept)		E	Wayne Woolrich	Jill Garrett	30-Apr-19	8-May-19	8-May-19	9-May-19		29-May-19
To Waha - outcomes of Oral Health initiative Strategy Workstream presentations/feedback sessions (30mins + 10mins Equity discussion			Bernard Te Paa	Charrissa Keenan	30-Apr-19	8-May-19				29-May-19
			Chris Ash	Kate Rawstron		8-May-19	8-May-19	9-May-19		29-May-19
AAU/ED Centre Seismic upgrade - Business Case stage 2 & 3			John Burns	Megan Knowles	30-Apr-19				29-May-19	29-May-19
BOARD MEETING 26 JUNE 2019		Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Finance Report (May)			Carriann Hall	Chris	18-Jun-19				26-Jun-19	26-Jun-19
People Plan Progress Update Report (6 monthly - Dec, Jun 19)			Kate Coley		4-Jun-19	12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19
Consumer Experience Facilitators -update on their work (combined with PWCC update)			Kate Coley	Caryn Daum	28-May-19					26-Jun-19
He Ngakau Aotea			Bernard Te Paa		4-Jun-19	12-Jun-19				26-Jun-19
Person & Whanau Centered Care actions			Kate Coley		28-May-19	12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19
Mental Health - zero seclusion good news story			John Burns	Peta Rowden	4-Jun-19					26-Jun-19
NZ Health Partnership - SPE focus			Carriann Hall						26-Jun-19	26-Jun-19
Moving Equity Forward (MRB Workshop outcomes)			Bernard T Paa			8-May-19				29-May-19
BOARD MEETING 31 July 2019		Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Finance Report (Jun)			Carriann Hall	Chris	16-Jul-19				31-Jul-19	31-Jul-19
Te Ara Whakawaiora - Improving First Specialist Appointment Access (previously did not attend)	E		John Burns	Jacqui Mabin	2-Jul-19	10-Jul-19				31-Jul-19
Whole of Board Appraisal (progress against actions Nov 17) - Apr-Aug			Ken Foote							31-Jul-19
VIP/Family Harm report			Bernard Te Paa		25-Jun-19	10-Jul-19	10-Jul-19	11-Jul-19		31-Jul-19
BOARD MEETING 28 AUGUST 2019		Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Alcohol Harm Reduction Strategy (6 monthly update) Feb - Aug			Bernard TePaa	Rachel Eyre	13-Aug-19	14-Aug-19	14-Aug-19	15-Aug-19		28-Aug-19
Annual Plan 2019/20			Chris Ash	Robyn Richardson	6-Aug-19	14-Aug-19	14-Aug-19	15-Aug-19		28-Aug-19
People & Quality Dashboard Q4 (Apr-Jun 19) Feb-May-Aug-Nov (formerly HR KPI Rpt)	E		Kate Coley	Jim Scott	13-Aug-19					28-Aug-19
Finance Report(July)			Carriann Hall	Chris	20-Aug-19				28-Aug-19	28-Aug-19
HB Health Awards - preparation for judging 2019-2020	E		Kevin Snee	Anna Kirk	30-Jul-19		14-Aug-19	15-Aug-19		28-Aug-19
HBDHB Non-Financial Performance Framework Dashboard Q4 - EMT/Board	E		Chris Ash	Peter MacKenzie	20-Aug-19					28-Aug-19
HBDHB Performance Framework Exceptions Q4 Feb19 /May/Aug/Nov (Just in time for MRB Mtg then to EMT)	E		Chris Ash	Peter MacKenzie	13-Aug-19	14-Aug-19				28-Aug-19
BOARD MEETING 25 SEPTEMBER 2019		Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Finance Report (Aug)			Carriann Hall	Chris	17-Sep-19				25-Sep-19	25-Sep-19
Matariki HB Regional Development Strategy and Social Inclusion Strategy update (6 mthly) Sept-Mar	E		Bernard TePaa	Shari Tidswell	27-Aug-19	11-Sep-19	11-Sep-19	12-Sep-19		25-Sep-19
After Hours Urgent Care Service Update 6mthly (Sept-Mar-Sept) last one in cycle	E		Wayne Woolrich		27-Aug-19	11-Sep-19	11-Sep-19	12-Sep-19		25-Sep-19
BOARD MEETING 30 OCTOBER 2019		Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Finance Report (Sept)			Carriann Hall	Chris	15-Oct-19				30-Oct-19	30-Oct-19
Shareholder representatives for Allied Laundry and TAS meetings each year			Ken Foote		15-Oct-19					30-Oct-19
Te Ara Whakawaiora - Access Rates 45 -64 years (local indicators) ADULT HEALTH			Chris Ash	Kate Rawstron	1-Oct-19	10-Oct-19				30-Oct-19



CHAIR'S REPORT

Verbal



Chief Executive Officer's Report		43
For the attention of: HBDHB Board		
Document Owner:	Kevin Snee Chief Executive Officer	
Reviewed by:	Not applicable	
Month as at	22 May 2019	
Consideration:	For Information	

RECOMMENDATION

That the Board

1. Note the contents of this report.

INTRODUCTION

In April and early May further industrial action has again been disruptive with the only outstanding unsettled dispute with the Resident Doctor's Association. As I write this facilitation between the two parties is in train and we await the outcome. It is likely that the impact of this dispute will be felt for many months if not years in the sector because of the disruption and unhappiness caused by it.

This month there are a number of important items for discussion:

- After hours care in primary care, which remains inconsistent across Hawke's Bay
- Te Ara Whakawaiora, our approach targeting management action on issues to address inequities in health, today our focus is on child health.
- Tō Waha our work with the New Zealand Defence Force to address dental problems in populations who are unable to afford oral health care
- Our 10 year Health Strategy which is currently in draft
- Moving Equity Forward, the output from the work done with the Maori Relationship Board

UPLIFT OF A BABY FROM OUR PREMISES

I thought I would take this opportunity to clarify the recent baby uplift incident and the role DHBs play. Our maternity unit and all our hospital facilities, need to be safe sanctuaries for our patients. Patients must feel safe and secure in the knowledge that looking after them is our number one priority – which it is. This is why baby uplifts are so challenging. No-one who works in health wants to see this happen. Nothing is more sacred to all of us than our pēpi, babies. Sadly there are times when the safety of those babies is questioned and Oranga Tamari invoke custody orders issued by a court judge and the baby, child or young person is taken into the care of Oranga Tamariki.

When a Custody Orders is executed the DHB must maintain its patient care but it is unable to override, and neither would it be appropriate, the powers conferred by Sections 104(2) and 104 (3) of the Oranga Tamariki Act 1989. In this recent case the DHB did not prevent the mother of the child's midwife from entering our buildings – it had to follow the instruction of Oranga Tamariki and Police exercising their powers under the legally binding Custody Order.

The DHBs social workers were not involved in this incident. Despite trying we were not able to get the support of Oranga Tamariki and Police to let the mother's midwife or other whānau into the hospital. The interventions the DHB did organise were support from Maori Health Kaitakawaenga at the time and to facilitate and host a hui to work on resolving the stand-off and finding a way forward. Utilising the district health board's Maori Health whare, Mihiroa, a Hui with all parties, including whānau, supported the whanau voice to be heard and reached a solution to support mother and baby together.

New legislation coming into effect from July 1 will hopefully minimise similar situations from occurring. We need to continue to work together with whānau, iwi and all other organisations to support better parenting. The statistics in Hawke's Bay for babies and young person's being taken into care by Oranga Tamariki are dreadful. This is not something that can be resolved overnight but as a community it is something we all need to change.

I would like to thank my staff who were involved in this incident. This has been deeply disturbing for many of them especially being publically blamed for an issue they had no authority over. I know many have taken heart from the Hui and that a resolution was found. We are continuing to work in partnership with Iwi, whānau and many local and national organisations to ensure a culturally responsive approach will be adopted so better solutions can be found. This will include discussing with Oranga Tamariki how this practice is better managed, thereby reducing its impact upon our patients, services and organisation and supporting how we live our values.

MATCHING CAPACITY TO DEMAND

In April and May I began a programme of work to ensure we cope with increased demands of winter hospital presentations as well as addressing some of the long standing difficulties the hospital campus is experiencing relating to patient flow and delivering our capacity.

There are several things to be addressed in the short and medium term. We need to target investments that will improve flow, increase capacity and reduce length of stay.

The changes we make must be aligned with our Clinical Services Plan as it will help us move in a direction to enable more work to be done outside the hospital. More intensive and increasingly shorter stay work must be done within the hospital 24/7. It is increasingly outmoded and inefficient to see our hospital as primarily a 9 to 5, Monday to Friday service for many aspects of our work.

I recognise there will funding implications in relation to capital and operational spend, however many of the initiatives will take the form of invest to save and will prevent increases in costs down the line. There are already resources available that can be redeployed e.g., the outsourcing spend can be redirected to deliver internal elective capacity more efficiently, and PHO savings from services funded by the DHB can be used to accelerate the modernisation of primary care.

I have appended the two most recent In Focus Special Editions, which cover the actions we are taking

PERFORMANCE

Measure / Indicator	Target	Month of April	Qtr to end April	Trend For Qtr
Shorter stays in ED	≥95%	84.7%	84.7%	▼
Improved access to Elective Surgery (2018/19YTD)	100%	68.5%	YTD 87.5%	—
Waiting list <i>(Patients who breach the 62 day target due to Capacity Constraint are still counted against target however patients who breach the target due to Clinical Decision or Patient Choice are now excluded).</i>	Less than 3 months	3-4 months	4+ months	
	First Specialist Assessments (ESPI-2)	2,981	574	
	Patients given commitment to treat, but not yet treated (ESPI-5)	942	68	
Faster cancer treatment – 62 day indicator*	≥90%	70% March	87% 6m to March	▼
Faster cancer treatment - 31 day indicator	≥85%	76% March	86% 6m to March	—
Increased immunisation at 8 months	≥95%	---	91% 3m to April	—
Better help for smokers to quit – Primary Care	≥90%		79% 15m to April	—
Raising healthy kids (New)	≥95%		96% 6m to April	▼
Financial – month (in thousands of dollars)	(1,037)	(1,522)	---	---
Financial – year to date (in thousands of dollars)	(3,652)	(7,679)	---	---

*Based on the expected annual cancer registrations for the DHB supplied by the Ministry, the DHB is expected to identify at least 228 people a year (19 a month) as patients with a high suspicion of cancer.

Faster Cancer Treatment Expected Volumes v Actual	Target	Month Actual / Expected	Rolling 6m Actual / Expected
	100%	13/19 = 68%	102/114 = 89%

A number of hospital performance areas remain relatively poor. Elective activity, in particular, has been adversely effected by the five day RMO strike. Steps are being taken to address the current activity gap. Faster Cancer Treatment has also been adversely effected in month but over the 6 month period it is only slightly off target. ED performance is also poor, but a number of planned investments to improve flow and increase capacity should help to address this problem. It is noteworthy that the immunisation figure is holding up well at a time when in other similar populations it is falling significantly because of the ill-informed, anti-vaccination movement.

Financial performance in month was an adverse variance of \$485k. Our year-to- date position is an adverse variance of \$4.26m. Whilst this is a further deterioration of our position it is not out of step with the sector. This excludes any adjustment made for the Holidays Act and other national issues.

AFTER HOURS CARE SERVICE UPDATE 6 MONTHLY

A process is underway to review the current Primary Care After Hours service model. A new interim model was implemented in December 2017 after a long process of review, with a commitment to take stock in 18 months and conduct a wider set of improvements in partnership with consumers and providers. Overall, the Napier based overnight service is considered to be relatively efficient and cost effective, but there is no overnight service in Hastings apart from the Hospital's Emergency Department (ED). Indications are that there is a high Primary Care element to ED presentations and attendance by

residents of suburbs surrounding the Hospital is very high. Issues such as location, confidence and affordability are understood to be key. An approach to develop the new service model has been proposed, and endorsed by the After Hours Governance Group. The approach to codesign has received an initial discussion at all of the main system governance forums.

TE ARA WHAKAWAIORA

The Te Ara Whakawaiora reporting for Maori health has been refined to consist of four reports over the year, furnished quarterly. The first report focuses on those Child health related indicators, with the following three reports focussing on adult health, mental health and cultural responsiveness.

The Child health indicators we measure are Ambulatory Sensitive Hospital (ASH) rates (0 - 4 years), Child oral health, breastfeeding rates and the Child health weight target. We continue to perform well achieving the healthy weight programme target, as we do for preschool enrolments, our breastfeeding rates for Maori and Pacific continue to improve, but are still below target, and we are not closing the equity gap for our ASH rate targets. We are looking to improve performance in that area by instigating the recommendations from the ASH review carried out in the previous year.

TŌ WAHA – A WHANAU-CENTRED COLLABORATIVE APPROACH

The Tō Waha initiative was a collaborative oral health initiative between NZ Defence Force, HBDHB, oral health providers and the community. It demonstrates what can be achieved when activities are established on whānau-centred, kaupapa Māori principles and practices, and the HBDHB core values. When this happens, a model is created where whānau are empowered, staff are working as one team, and equitable health gains are made. Over 700 people were provided with dental intervention mostly from the Māori and Pacific community over a two week period

DRAFT HEALTH STRATEGY WORKSTREAM FEEDBACK SESSION

Work is entering its final stages to draft the Hawke's Bay Health Strategy. The document, which will replace Transform & Sustain, will have a 10-year horizon. It has been founded on, but not limited to, three main source documents (Clinical Services Plan, Health Equity Report and People Plan) that were themselves the subject of wide consultation and engagement. Following the Health Sector Leadership Forum in March we have been working with our governance committees to develop six strategic goals. At their May meetings feedback was provided to an initial draft of the document. Elements of that feedback are now being considered and, where possible, incorporated. A further round of engagement with governance committees will be undertaken in June, prior to a final draft of the document returning on route to the July Board meeting.

Following sign-off of the strategy, intensive work will begin on implementation planning, which will be heavily co-designed with patients, whānau, clinicians and the local communities they serve.

At the meeting held on Friday 17 May 2019, a presentation was given by the Planning & Strategic Projects Team outlining the progress of our 2019/20 Annual Planning package. The Annual Plan is a compliance document that ensures the DHB's committed activities address the baseline requirements in the Minister's Letter of Expectations. Due to very tight internal timeframes and interdependent deadlines, the contents of the draft Annual Plan have not been available as a paper prior to the Board meeting. However, opportunities will be extended to Board members for more detailed briefings, should they be required, prior to submission on 21st June.

MOVING EQUITY FORWARD

Māori Relationship Board (MRB) held equity workshops on the 10th and 29th April 2019 to discuss gaps and opportunities for improving equity across HBDHB, and to explore and agree draft recommendations to HBDHB's Board to strengthen the organisation's commitment to prioritise equity for Māori at all levels of the health system. MRB has identified six key recommendations to achieve these aims, and propose they be presented to HBDHB Board for consideration.

CONCLUSION

This has been another difficult month with strikes causing disruption to our services. However, we are putting in place a set of measures that should help us cope better for winter and beyond whilst we put in place our long term plans

SPECIAL EDITION

News & views about Our Health from Hawke's Bay DHB
Chief Executive Dr Kevin Snee



7.1

IN FOCUS: CEO News Update

May 2019



I have asked my management team to quickly address areas of difficulty Hawke's Bay Hospital is experiencing to match service capacity to demand.

The first focus will be on funding initiatives to manage winter flow so we can match capacity to demand over the winter months.

We haven't suddenly found a lot of money to be able to implement new initiatives and improve infrastructure, however we have decided to invest in a number of areas to drive improvement. We believe in backing you and what you have told us you need so you can improve the way healthcare is delivered. We believe this in turn will reap the benefit of improving hospital flow and improving the quality of care to our patients.

Work has already begun on some short term solutions to improve our internal patient capacity and flow by recruiting additional staff in the following areas:

- Increasing inpatient medical capacity over winter by increasing resourced beds in AT&R. The beds will be fully resourced with additional medical, nursing and allied health staff.

- Extra weekend rounds of senior medical officers (SMO) and house officers will be put in place for the next 6 months to help improve patient flow over the weekends.
- Extra beds will be resourced on A2 to support the Surgical Directorate with sufficient bed capacity.

The current relief team will be used to support short notice absenteeism. Recruitment has already begun.

Recurrent funding for these positions will be made available so staff can be recruited where appropriate into permanent contracts. This will also help the recruitment process, with the funding redirected into the initiatives highlighted below over time.

The three targeted areas of focus over the coming weeks will be:

- infrastructure
- management capacity
- patient length of stay.

IN FOCUS: CEO News Update**May 2019**

These initiatives will help us deliver improved quality of care and patient safety.

There are other solutions that can be implemented to help us move forward quickly. As these all come with funding implications, in many cases we will be investing to achieve long term goals and create greater efficiencies.

Focus for next 6 months

Management and administrative capacity and capability

John Burns has been appointed **locum Executive Director Provider Services**. He will start with us 13 May. John is a very experienced Australasian manager who will work closely with existing managers and clinical leaders to build on skill levels and work to streamline processes and system issues.

John will be with us until we recruit permanently to the position of Executive Director Provider Services.

He and the management team will be paying particular attention to strengthening management capacity and capability within the hospital.

Claire Caddie will remain as Deputy Executive Director Provider Services, until at least the end of June. As we have already announced, we are very pleased Colin Hutchison will continue to support key hospital projects as the Deputy Chief Medical and Dental Officer.

We will work with clinical leaders to bring the **Cognitive Institute programmes relating to Speaking Up for Safety and Promoting Professional Accountability** to HBDHB. This was identified in the People Plan, as these programmes are being used in other DHBs and are having a positive impact on both staff and patient safety. Alongside this we will put in place a range of initiatives to build on the work we have done to-date to improve our culture. These initiatives

are designed to reinforce our values and improve both patient and staff safety.

We will be undertaking a **review of administrative support required for clinicians**. There will be a significant investment to upgrade voice recognition software. In addition we will review the administrative support needed within each service and make necessary investments to ensure clinicians are properly supported.

Service issues

The **Acute Assessment Unit will become a Medical Assessment Unit**, as was always intended. Nursing staff will increase over time so the unit can function more effectively with a 1 in 3 ratio of nurses to patients throughout the day and early evening.

I have asked for a business case for this to be worked up with urgency. I expect steps to be made towards this over the next 2 months, with the unit fully functional by September.

A surgical assessment unit will be established. We are working with the Surgical Leadership Team on this. This will require agreement about the model of care, location, function and oversight. I will ensure this work is done swiftly.

We recognise there is a need to increase our HDU capacity by an additional four beds. The surgical and ICU leadership teams are working on solutions for this. Again I expect this to be concluded swiftly.

To enable more efficient medicine reconciliation we have agreed to **recruit more pharmacy staff**. This will ensure we address our local target for medicine reconciliation and contribute to improved patient safety.

Managing capacity

We will reduce length of patient stay by:

- recruiting more pharmacy staff so discharging can be done more effectively

IN FOCUS: CEO News Update**May 2019**

- investing in better use of acute admission and ICU/ HDU capacity
- managing frail patients better.

In addition we will undertake an urgent analysis, specialty-by-specialty, of waiting lists and cases being denied surgery so we can put in place measures to address gaps.

Helping managers manage

Clinical nurse managers have too many direct reports making it impossible for them to manage as effectively as they want.

To help overcome this I have asked managers and HR to work with CNMs to better define their roles and consider different management structures to help ease this burden. This work is to be completed by July.

Managing frailty

More investment will be made in community-based initiatives to help support older people remain independent in their own homes through reducing beds in AT&R, in keeping with the recommendations from the Clinical Services Plan.

We will also put in place better support for the medical management of all frail surgical patients by increasing senior medical staff to support an interdisciplinary team.

A priority will be ensuring all patients have an estimated date of discharge upon admission.

Infrastructure medium term**Theatres**

Seismic strengthening has slowed down our planned build of a new theatre and expansion of the theatre block. However, I have asked for both the Theatre Procedure Room **in the existing theatre block and the third endoscopy suite in Ruakopito to be brought quickly on-line as**

additional minor theatres. This should take no more than 6-9 months. Both these areas could be used for a range of specialties including ophthalmology, ENT and urology who all struggle for space.

We are also **reviewing the commissioning of an additional clip-on theatre** and a number of other initiatives to help us increase our internal capacity and meet the demand on our surgical services.

Emergency Department

We will be working with facilities to **address the problem of lack of space in ED** in order to create more clinical space.

Intensive Care Unit

We intend to ensure our ICU/ HDU is appropriately sized. I have already mentioned we are working with the surgical and ICU leadership teams to manage capacity for these units in the long term.

Pharmacy

We are working with pharmacy and facilities to consider how we best meet their needs and in doing so find more space for acute services.

Primary care

We have agreed a programme with Health Hawke's Bay (PHO) to put in place **Healthcare Home** and other learnings from Nuka, where **community based services work together to support patients with chronic conditions** and help prevent long hospital stays. I have asked that we speed this up to roll-out over 2 years, not the 3 that is currently planned. This will also enable more same day access to our primary care services.

Out-of-hours services will be refined for greater consistency across Napier and Hastings.

7.1

IN FOCUS: CEO News Update

May 2019

Summary

This is a high level overview of work that we are addressing with urgency whilst we continue to build our long term strategy to deliver the Clinical Services Plan. There are many details we have yet to work through. However, I wanted to ensure everyone was aware work is happening with pace to address some of the issues we have as winter approaches.

Each fortnight I will provide an update, through this special edition InFocus, of where those plans have got to so everyone is well connected and aware of the work happening.

Thank you for your efforts. The year has been challenging with the number of issues we have had to address, along with industrial action.

I look forward to updating you over the coming weeks with progress and any feedback you may have.

Please give me a call or email me if there is anything you would like to address directly with me.



Kevin Snee
Chief Executive,
Hawke's Bay District Health Board

SPECIAL EDITION

News & views about Our Health from Hawke's Bay DHB
Chief Executive Dr Kevin Snee



7.1

IN FOCUS: CEO News Update 1

May 2019



The past fortnight has seen us manage and cope well with strike action from the Resident Doctors' Association thanks to the support of our senior doctors, allied health professionals, bookers, midwives, nurses, primary care and all of our associated services. Thank you to everyone for your support during this time.

In this newsletter I would also like to make special mention of maternity services who have been the focus of a lot of public attention, because of a baby uplift initiated through a court order to take place in Ata Rangi under the jurisdiction of Oranga Tamariki.

I would like to congratulate maternity staff for their dedication and focus on continuing to care for mother and baby - not only those directly affected but everyone else in their care throughout the very difficult two days it took before a solution was reached.

With the support of security, duty managers and Māori Health services we were able to continue to provide care to our maternity patients.

A whānau hui was also coordinated with Oranga Tamariki, police and our staff. Thankfully a solution was found.

A lot of people have had public input into this - many without the full knowledge of the facts of this case. This has been very difficult for staff and

I congratulate them all for maintaining such a high standard of professionalism.

On Sunday we celebrated International Nurses Day. Every day we see the wonderful work and care nurses provide to everyone they come into contact with. I'd like to acknowledge all our nurses and midwives and thank them for the work they do for the Hawke's Bay community.

In my last newsletter I provided an overview of initiatives we are undertaking to help hospital services manage flow and capacity to match demand over the winter months.

This newsletter will provide an update to those initiatives and where we are placed in the short to medium term.

To recap, the three targeted areas of focus over the coming weeks will be:

- infrastructure
- management capacity
- patient length of stay.

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These initiatives will help us deliver improved quality of care and patient safety.

Management and administrative capacity and capability

John Burns started work with us this week as **locum Executive Director Provider Services**. John has only been with us a matter of days but his focus will be on hospital flow from ED through to the wards and appropriate discharge. Robust winter planning is part of this key work, based on our past trends of increased patient presentations and increased staff sickness.

John will also support surgical services to manage acute demand while at the same time work with teams to meet elective targets.

John says he has felt very welcomed and is impressed with how teams are looking for new ways to improve hospital flow.



***"I'm here
to help you
– not to tell
you how to
do your
job."***

John Burns

Thank you all for making John feel so welcomed.

Administration support

The Executive Management Team (EMT) has supported an investment in voice recognition/transcription services through a solution called Winscribe. Planning for this has started and will see the rollout of the software begin in three phases from July. This solution will

see significant improvement and streamlined administration services with the ultimate aim to support better patient outcomes.

Service issues

Discussions with our clinical teams and service directorates are already underway to make sure **patients with acute surgical conditions** are rapidly assessed, receive diagnostic interventions and are then operated on rapidly. To facilitate this, a **surgical assessment unit will be established**. We are looking at a range of options including how we manage surgical assessments.

Managing capacity

A steering group has been established led by Andy Phillips, Hospital Commissioner, and Carriann Hall, Executive Director of Finance. The purpose of this group is to make sure we increase capacity in a synchronised way so the best benefits can be achieved. We are working closely with senior clinicians and looking to them for innovative ideas and solutions, including changing the way we have always done things.

Recruitment

Recruitment is well underway for extra nurses in AAU, ED and HDU. The recruitment team has been very busy and I'd like to thank them for going above and beyond to help support recruitment requirements.

Initially for AAU there will be a 1:4 increase in nursing to patient ratio. This will be reviewed down the track to see if we need to go further to a 1:3 ratio for assessment patients. These changes support the Care Capacity Demand Management (CCDM) FTE calculation findings in 2018.

Changes in the **Acute Assessment Unit** may also include **rapid access clinics for GPs** so patients can be assessed far more quickly.

The Medical Directorate is developing a case for increased capacity to include an HDU within the

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Post Anaesthetic Care Unit (PACU) with appropriate resourcing for nursing. This would relieve current pressures on ICU and prevent access issues for surgical patients. Approval has been given to increase bed numbers in ATR by 10 for 3 months for medical overflow patients.

Approval has also been given to increase the number of surgical beds by five.

Helping managers manage

To support nursing we are looking at reviewing the nursing management structure, and how it could improve, so senior nurses are able to focus more on leadership. We will keep you up-to-date as these discussions progress.

Security

Both locally and at a national level we are unfortunately seeing increasing rates of both verbal and physical abuse of our teams by patients and their families. We need to make sure you all have a safe environment to work in. There have been some high profile incidents, including a significant one in Ngā Rau Rakāu late last year. I'd like to acknowledge the significant amount of work being undertaken to improve safety by the Security team, Health and Safety Manager Christine Mildon, Mental Health Service Director David Warrington, with the support of the directorate leadership team. In addition, we have brought together a group of staff, leaders and union representatives to identify safety issues. This will help us mitigate risk to our teams. This work encompasses all of our teams – Hastings, community, Wairoa, Napier and Central Hawke's Bay. There will be further updates as we progress this piece of work.

Theatres

Next month new laparoscopic towers for theatres will arrive. The new \$929,000 towers include state-of-the-art technology and will mean fewer

surgeries will be postponed because of maintenance issues. They will also enable theatres to operate without having to stagger surgeries due to lack of laparoscopic equipment. The improved technology will also enable more complex surgery.

A meeting has been held with our orthopaedic surgical team and an action plan agreed. The first initiative we are looking at the feasibility of increasing acute theatre space by allowing one of the theatres to run until 7.30pm, rather than 4.30pm. We will update you as this progresses.

The review of **additional theatre** capacity is underway. How we best use our overall capacity, such as endoscopy, is being closely looked at in conjunction with the surgical expansion project team.

Emergency Department

Working on space requirements is being considered along with reconfiguration of space needs in other acute areas.

Pharmacy

Recruitment for more pharmacists is underway to develop medicine reconciliation which will improve the quality of our care and reduce length of stay for patients.

Frailty

Discussions are continuing in a number of areas and across the health sector to improve the service for our older frail patients.

Hoki Te Kainga

Hoki Te Kainga is a new outreach service being developed to support older people to leave hospital earlier. This new service will mean older people will be able to return home sooner with support provided to them, in their own home, for a period of time to suit that patient's needs. This will involve establishing a new restorative programme with a dedicated team in the

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community working seven days a week. This new service is expected to be up and running later this year.

Primary care

In addition to the work to improve care outside of hospital for acutely unwell patients, we are considering a range of actions so people are treated in primary care rather than hospital. Expression of Interest documents to implement Healthcare Home have been sent out. Health Hawke's Bay (PHO) will be supporting those general practices that wish to implement the innovative model. Healthcare Home's particular focus is helping support people with chronic conditions, remain well and prevent hospital presentations.

Kevin Snee

Chief Executive,
Hawke's Bay District Health Board

Summary

If you have a question you would like the management team to answer, we have set up an email address askemt@hbdhb.govt.nz. These questions, and who we receive them from, will be anonymous and answered through Our Hub

We are happy to answer any questions that have been niggling away at you that you'd like an answer to. It may be you would like some clarification on an issue, or to find out whether there is any truth to a rumour that has been circulating.

I look forward to updating you over the coming weeks with progress and any feedback you may have.

Please give me a call or email if there is anything you would like to address directly with me.

	Financial Performance Report April 2019
For the attention of: Finance, Risk and Audit Committee	
Document Owner	Carriann Hall, Executive Director Financial Services
Document Author	Phil Lomax, Financial and Systems Accountant
Reviewed by	Executive Management Team
Month/Year	May, 2019
Purpose	For Information

RECOMMENDATION:

That the HBDHB Finance, Risk and Audit Committee:

- Note** the contents of this report

EXECUTIVE DIRECTOR FINANCIAL SERVICES COMMENTS***Financial Performance***

As shown in the table below, the result for the month of April is \$0.5m unfavourable to plan, taking the year-to-date (YTD) result to \$7.7m deficit, which is \$4.0m adverse to plan. The forecast remains at \$10.9m deficit.

April's result is driven by non-achievement of planned savings, and overspends in medical vacancy cover, patient transport, blood requirements, and nursing costs in acute services. These were partly offset by reductions in provisioning for clinical training expenditure and Inter District Flows.

\$000	April			Year to Date			Year End Forecast	Refer Appendix
	Actual	Budget	Variance	Actual	Budget	Variance		
Income	50,243	48,499	1,743 3.6%	487,307	482,016	5,291 1.1%	584,281	1
Less:								
Providing Health Services	25,035	24,198	(837) -3.5%	244,202	239,590	(4,612) -1.9%	295,322	2
Funding Other Providers	21,603	20,736	(867) -4.2%	208,255	203,866	(4,389) -2.2%	250,444	3
Corporate Services	4,317	3,977	(340) -8.5%	42,882	40,895	(1,987) -4.9%	51,634	4
Reserves	810	626	(184) -29.4%	(354)	1,316	1,670 126.9%	(2,210)	5
	(1,522)	(1,037)	(485) -46.8%	(7,679)	(3,652)	(4,026) -110.2%	(10,909)	

Key Drivers

The detail of the variances are covered in the appendices to the report. The key drivers of the YTD position have not changed, being:

- Income (Appendix 1)

In-Between-Travel (IBT) and pay equity funding from Ministry of Health (MOH). Offset by expenditure in Funding Other Providers (refer appendix 3).

- Providing Health Services (Appendix 2)
Overspends from medical vacancy cover, savings not achieved, pay settlements over planning assumption, higher than planned nursing resource use, pharmaceuticals (biologics), patient transport costs and blood, were partly offset by medical and allied vacancies and underspending in outsourced elective surgery.
- Funding Other Providers (Appendix 3)
The cost of pay equity (residential care) and In-Between-Travel (home support), both offset under income, and savings not achieved. Partly offset by Pharmac rebates, non utilisation of the new investment reserve and provider recoveries.
- Corporate Services (Appendix 4)
Strike action, capital charges (offset in income), unfunded cost increases, and savings not achieved.
- Reserves (Appendix 5)
Prior year provisioning not required.
- Savings Plans (Appendix 8)
Shortfall on savings plans of \$6.9m are included in the YTD position and discussed further below.

Forecast

Work continues on mitigating cost pressures that have arisen this year such as Microsoft licence and new helicopter service costs. Other factors driving the \$10.9m forecast deficit (\$5.9m forecast overspend against plan) include the cost of the strikes to date, the impact of unfunded pay awards (including Public Service Association (PSA) clerical), Inter-District Flows (IDF), Senior Medical Officer (SMO) vacancy cover, and difficulty achieving savings programmes.

Our forecast excludes:

- Further MECA/SECA (Multi and Single Employer Collective Agreements) settlements above levels assumed in the budget and potential flow-on effect to contracts;
- The cost of any future strikes, should they occur;
- Impairment review of the \$2.7m investment in the Health Finance, Procurement and Information Management System (FPIM), formerly National Oracle Solution (NOS), as a result of the FPIM business case (awaiting FPIM decision from Cabinet);
- Impairment review of the \$1.6m investment in web-based patient administration system (WebPAS), part of the Regional Health Information Project (RHIP);
- Potential for increased provisioning for employee entitlements as a result of the Holidays Act and other pay related liabilities;
- Provision for IBM Service Credits liability

It also assumes that our total combined pharmaceutical budget expenditure will be in line with the PHARMAC forecast.

The revaluation of buildings completed last year, will be updated at 30 June 2019. The movement in building costs in Hawke's Bay, seismic issues and likely changes to the DHB's master buildings plan, coupled with expectation of stronger direction from MoH as a part of the National Asset Management Plan, all indicate that the carrying value of the buildings may no longer reflect their fair value to the DHB. The revaluation is likely to be recognised in other comprehensive revenue and expense, rather than the deficit, and no impact has been included in the forecast as a result.

Other Performance Measures

	April				Year to Date				Year End Forecast	Refer Appendix	
	Actual		Budget		Variance		Actual		Budget		
	\$'000	\$'000	\$'000	%	\$'000	\$'000	\$'000	%	\$'000	\$'000	
Savings plans	368	1,179	(811)	-68.8%	4,921	11,793	(6,872)	-58.3%	6,049	8	
Capital spend	1,368	1,270	98	7.7%	13,091	15,354	(2,264)	-14.7%	17,933	12	
Employees	2,482	2,356	(125)	-5.3%	2,414	2,419	5	0.2%	2,441	2 & 4	
Case weighted discharges	2,480	2,306	174	7.5%	25,205	24,335	870	3.6%	29,395	2	

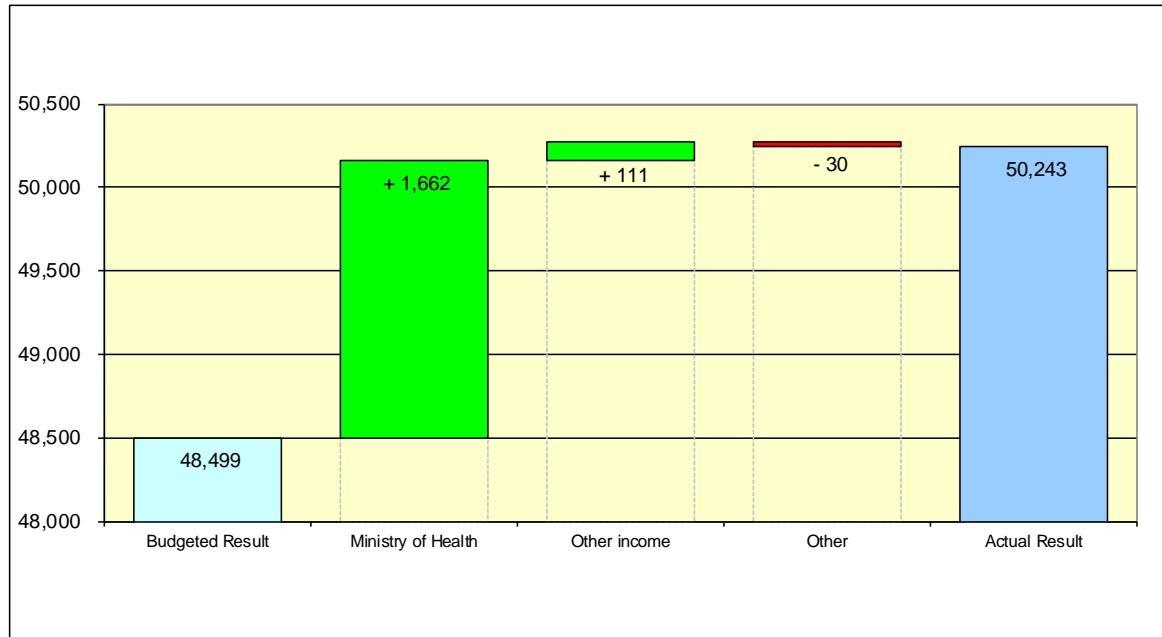
- Savings Plans (Appendix 8)
 - Delivering our \$14.2m saving plan has been a significant issue. Savings plans have been identified for \$11.7m (83%). The identified savings removed from operational budgets amounts to \$5.7m (unchanged from last month). On a straight line basis, YTD savings of \$11.8m should have been achieved by the end of April, and \$4.9m has been made.
- Capital spend (Appendix 12)
 - Capital spend is behind budget in the block allocations, and more than offsets the relatively small additional costs relating to strategic projects. Capital spend (excluding the FPIM investment) is expected to be close to plan at year end.
- Cash (Appendices 11 & 13)
 - The cash balance improved during the month from a low point of \$12.0m overdrawn on 3 April to a low point of \$8.5m overdrawn on 3 May. We are forecasting to be \$13.6m overdrawn by year end, with a low point of \$14.4m on 3 July, well within our current statutory limit of \$27m. Interest is expected to come in \$0.3m less than planned as a result.
- Employees (Appendices 2 & 4)
 - Employee numbers are favourable YTD reflecting challenges filling vacancies in medical and allied health positions. The vacancies are mostly offset by high use of nursing resources.
- Activity (Appendix 2)
 - YTD case weighted discharge (CWD) are ahead of plan, although acute demand is driving greater weighting to acute CWD and limiting the capacity available for elective activity.
 - Elective discharges show a shortfall on achieving the Ministry of Health target. However, we have assumed the DHB will meet its case weighted discharge (CWD) target and receive all of the base elective surgery funding as a result.

APPENDICES

1. INCOME

\$'000	April			Year to Date			Year End Forecast
	Actual	Budget	Variance	Actual	Budget	Variance	
Ministry of Health	47,891	46,229	1,662 3.6%	464,484	459,337	5,147 1.1%	557,001
Inter District Flows	747	762	(15) -2.0%	7,357	7,622	(264) -3.5%	8,887
Other District Health Boards	318	354	(36) -10.3%	3,478	3,519	(41) -1.2%	4,203
Financing	19	55	(36) -65.6%	274	552	(279) -50.4%	297
ACC	458	422	36 8.4%	4,381	4,469	(88) -2.0%	5,154
Other Government	72	82	(9) -11.4%	452	586	(134) -22.8%	539
Abnormals	-	-	- 0.0%	(0)	-	(0) 0.0%	(0)
Patient and Consumer Sourced	128	106	22 20.3%	1,037	1,049	(12) -1.1%	1,226
Other Income	600	489	111 22.8%	5,261	4,865	396 8.1%	6,263
Abnormals	10	-	10 0.0%	581	17	564 3320.2%	711
	50,243	48,499	1,743 3.6%	487,307	482,016	5,291 1.1%	584,281

Month of April



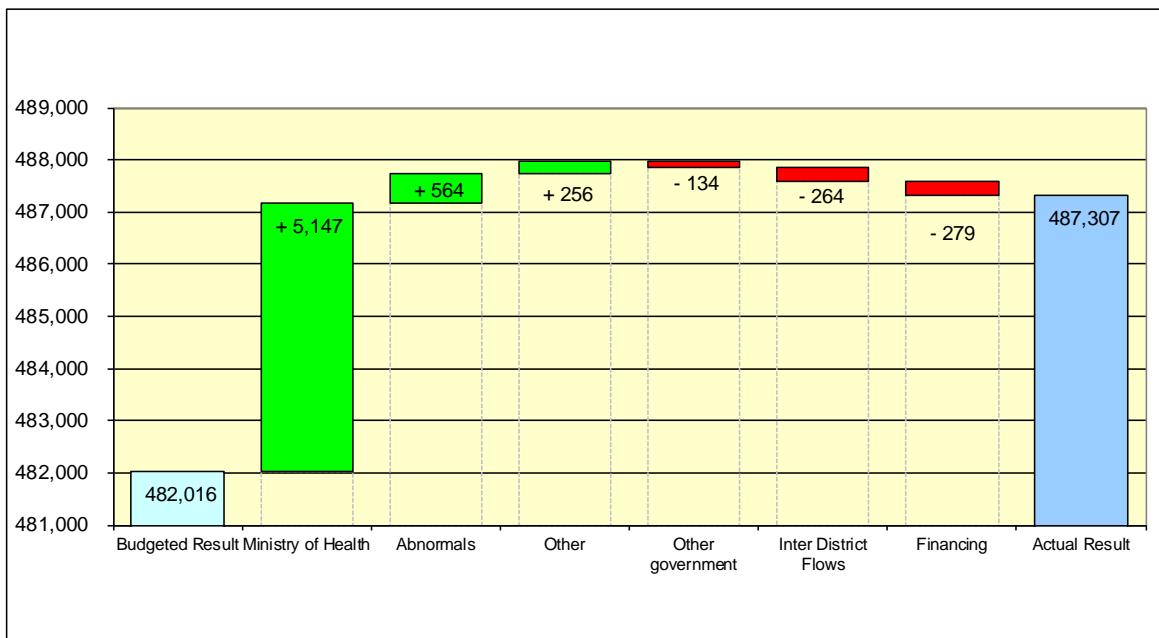
Note the scale does not begin at zero

Ministry of Health (favourable)

Mainly In-Between-Travel (home support), and pay equity (residential care) additional income offset in related expenditure (Appendix 4). Also includes capital charge funding relating to the 2017/18 land and buildings revaluations.

Other income (favourable)

Wairoa GP income.

Year to Date

Note the scale does not begin at zero

Ministry of Health (favourable)

Unbudgeted pay equity and In-Between-Travel income offset in related expenditure (Appendix 4). Also includes immediate relief funding, Care Capacity Demand Management (CCDM) funding (nurses agreement), and capital charge funding.

Abnormals (favourable)

Prior year wash-ups and accruals no longer required that were recognised in September.

Other government (unfavourable)

Income from the Health Research Council of NZ for the Havelock North Campylobacter Outbreak Study.

Inter District Flows (unfavourable)

Lower than projected visitors to Hawke's Bay, mainly last winter, only partly caught up over the summer months.

Financing (unfavourable)

Reduced interest income relating to lower cash holdings.

2. PROVIDING HEALTH SERVICES

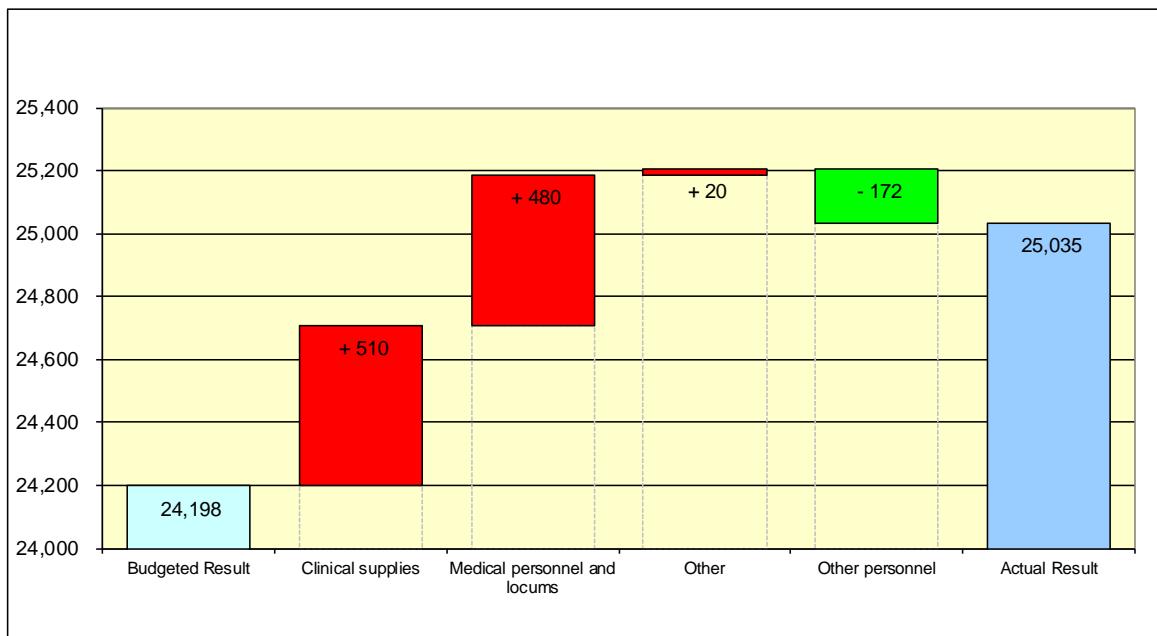
	April			Year to Date			Year End Forecast
	Actual	Budget	Variance	Actual	Budget	Variance	
Expenditure by type \$'000							
Medical personnel and locums	5,711	5,231	(480) -9.2%	57,019	56,109	(910) -1.6%	68,159
Nursing personnel	7,234	7,102	(132) -1.9%	71,437	69,196	(2,241) -3.2%	86,641
Allied health personnel	3,341	3,300	(41) -1.2%	30,335	32,370	2,035 6.3%	36,450
Other personnel	2,293	2,466	172 7.0%	21,287	21,011	(276) -1.3%	25,531
Outsourced services	955	962	7 0.8%	8,521	10,085	1,564 15.5%	11,491
Clinical supplies	3,786	3,276	(510) -15.6%	36,967	32,476	(4,491) -13.8%	44,701
Infrastructure and non clinical	1,715	1,860	145 7.8%	18,637	18,342	(295) -1.6%	22,350
	25,035	24,198	(837) -3.5%	244,202	239,590	(4,612) -1.9%	295,322
Expenditure by directorate \$'000							
Medical	6,758	6,465	(292) -4.5%	68,475	64,496	(3,979) -6.2%	82,667
Surgical	5,567	5,253	(315) -6.0%	53,448	53,087	(361) -0.7%	65,839
Community, Women and Children	3,928	3,883	(45) -1.2%	38,810	38,674	(136) -0.4%	46,984
Mental Health and Addiction	1,795	1,727	(68) -3.9%	17,693	17,313	(379) -2.2%	21,316
Older Persons, NASC HB, and Alli	1,341	1,353	12 0.9%	13,097	13,632	535 3.9%	15,764
Operations	3,987	3,520	(467) -13.3%	35,644	34,324	(1,320) -3.8%	42,931
Other	1,658	1,996	338 16.9%	17,036	18,064	1,028 5.7%	19,822
	25,035	24,198	(837) -3.5%	244,202	239,590	(4,612) -1.9%	295,322
Full Time Equivalents							
Medical personnel	369.6	354.7	(15) -4.2%	355	366	10 2.8%	366.6
Nursing personnel	1,018.0	920.6	(97) -10.6%	1,004	966	(38) -3.9%	980.1
Allied health personnel	478.8	485.7	7 1.4%	465	491	26 5.4%	494.9
Support personnel	147.0	140.1	(7) -4.9%	144	138	(6) -4.4%	139.2
Management and administration	286.9	278.1	(9) -3.1%	272	276	4 1.6%	277.9
	2,300.4	2,179.3	(121) -5.6%	2,240	2,237	(3) -0.1%	2,258.8
Case Weighted Discharges							
Acute	1,751	1,451	300 20.7%	18,584	16,506	2,077 12.6%	19,957
Elective	434	663	(229) -34.5%	4,561	5,797	(1,235) -21.3%	7,006
Maternity	241	160	81 50.5%	1,804	1,675	129 7.7%	2,000
IDF Inflows	53	32	21 66.6%	256	357	(101) -28.3%	432
	2,480	2,306	174 7.5%	25,205	24,335	870 3.6%	29,395

Directorates YTD

- Medical (YTD) – nursing resource use, medical vacancy cover, pharmaceuticals (mainly biologics), and radiology reads (radiologist vacancies);
- Surgical (April) – anticipated ramp up of theatre capacity, including extra sessions on Saturdays;
- Operations (April) – patient transport costs, blood, salary settlements (over planning assumption) including equalisation payments (timing impact);
- Other (April and YTD) – reduced provisioning for clinical training expenditure and unfunded MECA settlements, and allied health vacancies.

Case Weighted Discharges

Acute discharges are above plan both month and YTD, including general medicine, general surgery, and orthopaedics. Correspondingly, electives are below plan in April, and remain below plan YTD across all specialties constrained by capacity, acute demand and impact of industrial action. IDF inflows picked up in April after a slow March, but remain well below budget YTD.

Month of April

Note the scale does not begin at zero

Clinical supplies (unfavourable)

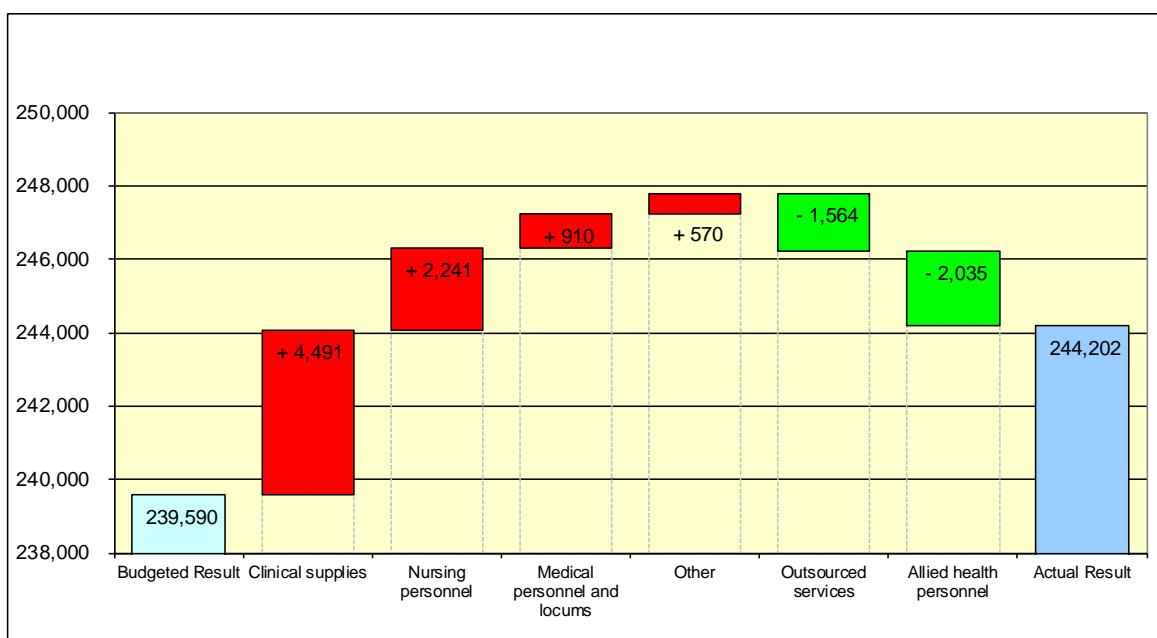
Savings plans, patient transport, and blood.

Medical personnel and locums (unfavourable)

Vacancy cover and adjustment to the provisioning for MECA settlements.

Other personnel (favourable)

Pharmacy settlement more than offsetting vacancies in-month.

Year to Date

Note the scale does not begin at zero

Clinical supplies (unfavourable)

Planned efficiencies, patient transport, pharmaceuticals including biologics, and treatment disposables including blood and blood intragam, marginally offset by lower health promotion costs.

Nursing personnel (unfavourable)

Overall, the volume and cost of hours worked are greater than planned, driven by a number of factors including patient volume and acuity, clinical practice and vacancies. However, following focussed effort from managers, the run rate on nursing personnel overspend has improved in recent months. The main issue now is the challenge of meeting leave savings without backfill.

Medical personnel and locums (unfavourable)

Locum costs for vacancy cover exceeding the cost reduction from vacancies.

Outsourced services (favourable)

Elective surgery volumes below plan, partly offset by radiology reads.

Allied health personnel (favourable)

Continuing national issue with recruitment and retention.

Full Time Equivalents (FTE)

FTEs are 3 (0.1%) unfavourable YTD including:

Medical personnel (10 FTE / 2.8% favourable)

- Vacancies in radiology, Wairoa GPs, psychiatrists, orthopaedics and emergency medicine.

Nursing personnel (-38 FTE / -3.9% unfavourable)

- Higher than budgeted staffing in acute areas (ED, ICU and General Medicine), and the surgical inpatient wards.

Allied health personnel (26 FTE / 5.4% favourable)

- Vacancies in therapies, medical radiation technologists (MRTs), social workers, psychologists, pharmacists, community support workers, health promotion workers, and laboratory technicians.

MONTHLY ELECTIVE SURGICAL DISCHARGES REPORT

YTD To April 2019

	April 2019				YTD April 2019				Full Year Plan
	Actual	Plan	Variance	%	Actual	Plan	Variance	%	
Anaesthetics	0	0	0	0.0%	0	0	0	0.0%	4
Cardiothoracic	8	10	-2	0.0%	82	98	-16	0.0%	119
Avastins	18	17	1	5.9%	184	163	21	12.9%	201
ENT	43	64	-21	-32.8%	468	604	-136	-22.5%	740
General Surgery	74	114	-40	-35.1%	965	1080	-115	-10.6%	1324
Gynaecology	38	61	-23	-37.7%	498	579	-81	-14.0%	708
Maxillo-Facial	20	43	-23	-53.5%	277	411	-134	-32.6%	507
Neurosurgery	3	8	-5	0.0%	68	77	-9	0.0%	95
Ophthalmology	97	114	-17	-14.9%	1020	1082	-62	-5.7%	1328
Orthopaedics	81	99	-18	-18.2%	944	933	11	1.2%	1145
Paediatric Surgery	11	7	4	0.0%	57	68	-11	0.0%	85
Skin Lesions	2	22	-20	-90.9%	150	205	-55	-26.8%	254
Urology	35	53	-18	-34.0%	412	501	-89	-17.8%	618
Vascular	17	29	-12	-41.4%	177	272	-95	-34.9%	333
Non Surgical - Arranged	2	12	-10	-83.3%	103	117	-14	-12.0%	144
Non Surgical - Elective	7	13	-6	-46.2%	115	122	-7	-5.7%	148
TOTAL	456	666	-210	-31.5%	5520	6312	-792	-12.5%	7753

Please Note: This report was run on 7 May 2019

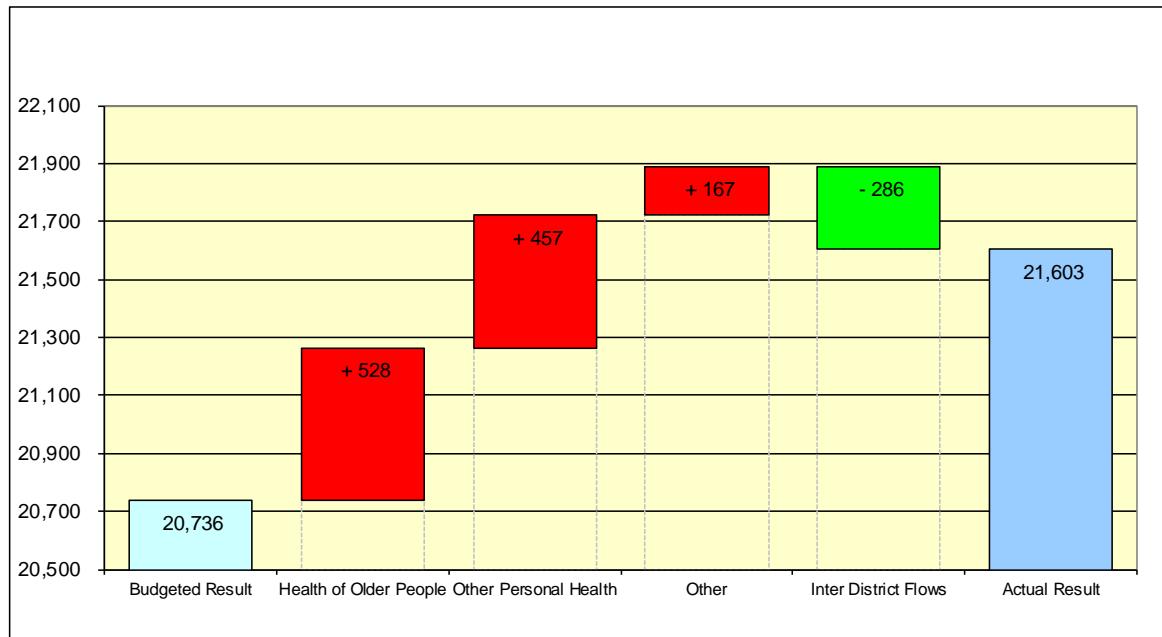
The volumes by specialty now include both elective and arranged discharges rolled into one.

Data is subject to change.

3. FUNDING OTHER PROVIDERS

\$'000	April			Year to Date			Year End Forecast
	Actual	Budget	Variance	Actual	Budget	Variance	
Payments to Other Providers							
Pharmaceuticals	3,546	3,584	37 1.0%	33,874	35,824	1,950 5.4%	40,919
Primary Health Organisations	3,331	3,360	28 0.8%	32,846	32,625	(221) -0.7%	39,838
Inter District Flows	4,511	4,797	286 6.0%	48,331	47,970	(360) -0.8%	57,834
Other Personal Health	2,507	2,049	(457) -22.3%	19,238	17,887	(1,351) -7.6%	23,583
Mental Health	1,233	1,058	(176) -16.6%	10,592	10,578	(13) -0.1%	12,720
Health of Older People	6,094	5,566	(528) -9.5%	59,669	55,667	(4,002) -7.2%	71,149
Other Funding Payments	380	323	(57) -17.7%	3,706	3,315	(391) -11.8%	4,400
	21,603	20,736	(867) -4.2%	208,255	203,866	(4,389) -2.2%	250,444
Payments by Portfolio							
Strategic Services							
Secondary Care	4,038	4,236	197 4.7%	43,896	42,357	(1,539) -3.6%	52,490
Primary Care	9,062	8,539	(524) -6.1%	82,147	81,863	(284) -0.3%	99,691
Mental Health	1,426	1,343	(82) -6.1%	13,156	13,435	279 2.1%	15,884
Health of Older People	6,398	5,864	(534) -9.1%	62,732	58,547	(4,185) -7.1%	74,801
Other Health Funding	-	133	133 100.0%	-	1,333	1,333 100.0%	-
Maori Health	540	495	(44) -9.0%	4,999	5,031	32 0.6%	5,985
Population Health	139	126	(13) -10.4%	1,324	1,300	(24) -1.8%	1,593
	21,603	20,736	(867) -4.2%	208,255	203,866	(4,389) -2.2%	250,444

Month of April



Note the scale does not begin at zero

Health of Older People (unfavourable)

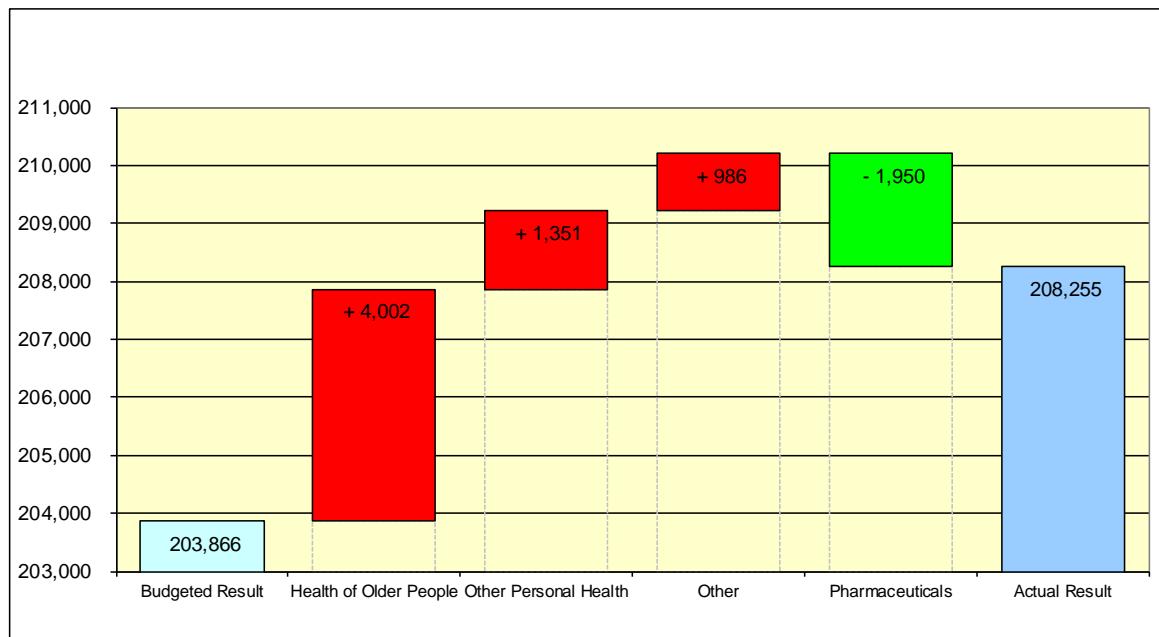
Higher than budgeted residential care and home support costs reflecting increases in volumes. Also includes pay equity and In-Between Travel costs offset by additional revenue (refer appendix 1).

Other Personal Health (unfavourable)

Efficiencies not yet achieved, partly offset by recoveries from providers for unperformed services, and the unutilised new investment reserve.

Inter District Flows (favourable)

Review of the provision for IDFs base on MOH data.

Year to Date**Health of Older People** (unfavourable)

Increasing residential care and home support costs, partly offset by funding for pay equity (residential care) and In-Between-Travel (home support) under income (refer appendix 1).

Other Personal Health (unfavourable)

Efficiencies not yet achieved, partly offset by recoveries from providers for unperformed services, and the unspent new investment reserve that will not be utilised.

Pharmaceuticals (favourable)

Pharmaceutical rebates in line with PHARMAC forecasts.

4. CORPORATE SERVICES

\$000	April			Year to Date			Year End Forecast
	Actual	Budget	Variance	Actual	Budget	Variance	
Operating Expenditure							
Personnel	1,473	1,442	(32) -2.2%	15,498	14,657	(840) -5.7%	18,885
Outsourced services	69	70	1 2.0%	714	709	(5) -0.7%	860
Clinical supplies	13	(9)	(22) -243.2%	94	(120)	(214) -177.8%	115
Infrastructure and non clinical	674	629	(46) -7.3%	8,360	7,831	(529) -6.8%	9,833
Capital servicing							
Depreciation and amortisation	2,229	2,132	(98) -4.6%	24,665	23,077	(1,588) -6.9%	29,693
Financing	1,117	1,190	73 6.2%	10,900	11,268	368 3.3%	13,170
Capital charge	-	-	- 0.0%	-	-	- 0.0%	-
	971	655	(315) -48.2%	7,317	6,551	(766) -11.7%	8,771
	2,087	1,845	(242) -13.1%	18,217	17,818	(398) -2.2%	21,941
	4,317	3,977	(340) -8.5%	42,882	40,895	(1,987) -4.9%	51,634
Full Time Equivalents							
Medical personnel	0.3	0.3	(0) -9.3%	0	0	0 2.7%	0.3
Nursing personnel	13.4	14.0	1 4.3%	13	16	3 18.5%	16.0
Allied health personnel	0.2	0.4	0 47.0%	0	0	0 49.0%	0.4
Support personnel	8.1	7.9	(0) -2.7%	8	8	(0) -4.6%	8.0
Management and administration	159.1	154.5	(5) -3.0%	152	158	6 3.7%	158.0
	181.2	177.1	(4) -2.3%	174	182	9 4.7%	182.7

Unfavourable YTD personnel costs reflects the cost of strike action, mainly staff cover. The clinical supplies variance relates mainly to planned efficiencies yet to be achieved. The infrastructure and non-clinical variance is across corporate business units and relates to software costs, telecoms, corporate training and legal. It should be noted there have been significant unfunded in-year increases managed across corporate directorates, such as Microsoft license costs.. The additional capital charges both in-month and YTD relate to the June 2018 land and buildings revaluation, and is offset by the accrual of additional MOH income in appendix 1.

5. RESERVES

\$000	April			Year to Date			Year End Forecast
	Actual	Budget	Variance	Actual	Budget	Variance	
Expenditure							
Contingency	-	23	23 100.0%	-	581	581 100.0%	-
Other	810	603	(207) -34.4%	(354)	735	1,089 148.2%	(810)
	810	626	(184) -29.4%	(354)	1,316	1,670 126.9%	(2,210)

The contingency budget reduces when Executive Management Team (EMT) approves expenditure where no source of funding has been identified. Contingency can still be released for unusual or unexpected events up to the remaining balance of the contingency, currently \$700k.

Transfers out of the original \$4m contingency YTD include:

- New nursing initiatives \$1m;
- Executive Director Provider Services contingency \$300k; and
- Cost pressure adjustments to budgets \$2m.

The forecast reflects further mitigations including structured leave management and nursing rosters.

The “Other” category comprises the net impact of an ongoing review of accruals relating to the prior year. If the variance remains favourable it will be a one-off benefit.

6. FINANCIAL PERFORMANCE BY MOH CLASSIFICATION

\$'000	April			Year to Date			End of Year		
	Annual Plan			Annual Plan			Annual Plan		
	Actual	Plan	Variance	Actual	Plan	Variance	Forecast	Plan	Variance
Funding									
Income	47,562	45,625	1,937	459,920	454,779	5,141	551,771	537,477	14,294
Less:									
Payments to Internal Providers	24,678	24,437	(241)	258,498	257,732	(766)	311,335	309,025	(2,310)
Payments to Other Providers	20,773	20,115	(658)	200,408	197,650	(2,758)	240,770	233,452	(7,319)
Contribution	2,112	1,073	1,038	1,014	(604)	1,618	(335)	(5,000)	4,665
Governance and Funding Admin.									
Funding	276	276	-	2,870	2,870	-	3,424	3,383	40
Other Income	3	3	-	25	25	-	30	30	-
Less:									
Expenditure	315	287	(28)	2,720	2,980	260	3,325	3,413	88
Contribution	(37)	(8)	(28)	175	(85)	260	129	-	129
Health Provision									
Funding	24,402	24,161	241	255,628	254,862	766	307,912	305,542	2,370
Other Income	2,581	2,776	(194)	26,402	26,251	150	31,328	30,594	734
Less:									
Expenditure	30,580	29,039	(1,541)	290,897	284,079	(6,818)	349,940	336,136	(13,804)
Contribution	(3,597)	(2,102)	(1,495)	(8,868)	(2,966)	(5,902)	(10,700)	-	(10,700)
Net Result	(1,522)	(1,037)	(485)	(7,679)	(3,655)	(4,024)	(10,906)	(5,000)	(5,906)

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

7. MANAGEMENT BUDGET MOVEMENTS

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

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

\$'000	April			Year to Date			End of Year		
	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement
Funding									
Income	45,625	44,721	904	454,779	447,838	6,941	546,225	537,477	8,748
Less:									
Payments to Internal Providers	24,437	24,271	(166)	257,732	256,305	(1,427)	310,784	309,025	(1,759)
Payments to Other Providers	20,115	19,566	(549)	197,650	194,266	(3,385)	237,932	233,452	(4,480)
Contribution	1,073	884	189	(604)	(2,733)	2,129	(2,491)	(5,000)	2,509
Governance and Funding Admin.									
Funding	276	276	-	2,870	2,830	40	3,424	3,383	40
Other Income	3	3	-	25	25	-	30	30	-
Less:									
Expenditure	287	283	(4)	2,980	2,847	(133)	3,554	3,413	(140)
Contribution	(8)	(4)	(4)	(85)	8	(93)	(100)	-	(100)
Health Provision									
Funding	24,161	23,987	174	254,862	253,391	1,470	307,360	305,542	1,819
Other Income	2,776	2,720	55	26,251	25,655	596	31,301	30,594	706
Less:									
Expenditure	29,039	28,624	(415)	284,079	279,976	(4,103)	341,071	336,136	(4,934)
Contribution	(2,102)	(1,917)	(185)	(2,966)	(930)	(2,037)	(2,409)	-	(2,409)
Net Result	(1,037)	(1,037)	(0)	(3,655)	(3,655)	(0)	(5,000)	(5,000)	(0)

8. QUALITY AND FINANCIAL IMPROVEMENT PROGRAMME

Savings plans are transferred to operational budgets as they are agreed. Living within budget will indicate that directorates are achieving their savings targets.

The table below shows \$11.7m of savings have been identified, and \$5.7m of identified savings has been removed from operational budgets. There is no change from February. We are working through the recurrency of savings as a part of 2019/20 budget setting. Savings targets have been budgeted evenly through the year at directorate level.

Division	Target 2018/19 Savings Target \$'000	Current Year Identification				Savings Delivered / Forecast				
		2018/19 Identified Saving \$'000	%	2018/19 Budget Adjusted	2018/19 Savings WIP	2018/19 Un- identified Savings	YTD Actual	YTD Plan	Var	2018/19 Forecast
Strategic	-	-	- %	-	-	-	-	-	-	-
Primary Care Provider Services	4,673	4,809	103 %	869	3,940	(136)	1,945	3,894	(1,949)	2,105
Medical	1,820	1,866	103 %	1,634	232	(46)	382	1,517	(1,135)	524
Surgical	1,450	807	56 %	766	41	643	199	1,208	(1,009)	250
CWC	1,049	804	77 %	804	-	245	407	874	(468)	489
OPMH	865	1,100	127 %	1,100	-	(235)	716	721	(5)	902
Operations	893	564	63 %	298	267	329	62	744	(682)	161
Facilities	232	246	106 %	246	-	(14)	147	193	(46)	178
COO	235	(1,170)	(498)%	(1,370)	200	1,405	41	196	(155)	83
Total Provider Services	6,544	4,216	64 %	3,476	740	2,328	1,955	5,453	(3,499)	2,586
Hl&E	402	435	108 %	435	-	(33)	261	335	(74)	305
People & Quality	105	126	120 %	124	3	(21)	83	88	(4)	107
Information Services	254	272	107 %	18	254	(18)	15	212	(197)	60
Financial Services	1,430	1,238	87 %	158	1,080	192	129	1,192	(1,063)	243
Executive	112	28	25 %	28	-	84	6	93	(87)	11
Capital Servicing	632	632	100 %	632	-	-	527	527	-	632
Totals	14,152	11,757	83 %	5,740	6,016	2,395	4,921	11,793	(6,872)	6,049
<i>Annual Leave Savings Total</i>		1,499		1,499	-	-	453	1,233	(779)	606

9. FINANCIAL POSITION

30 June 2018	\$'000	April			Annual Budget	
		Actual	Budget	Variance from budget		
164,706 (15,982)	Equity Crown equity and reserves Accumulated deficit	164,706 (23,659)	175,069 (14,628)	(10,363) (9,032)	- (7,677)	174,711 (15,973)
148,723		141,046	160,441	(19,395)	(7,677)	158,738
	Represented by:					
7,444	<u>Current Assets</u>					
1,885	Bank	837	5,929	(5,092)	(6,607)	2,313
25,474	Bank deposits > 90 days	1,855	1,901	(46)	(30)	1,901
3,907	Prepayments and receivables	26,883	24,972	1,911	1,410	25,045
2,293	Inventory	4,010	4,507	(497)	102	4,520
-	Investment in NZHP	2,638	-	2,638	345	-
	Non current assets held for sale	-	625	(625)	-	625
41,003		36,223	37,934	(1,711)	(4,781)	34,404
175,460	<u>Non Current Assets</u>					
1,479	Property, plant and equipment	177,456	183,936	(6,480)	1,996	185,018
9,280	Intangible assets	1,541	3,919	(2,378)	61	4,147
	Investments	10,072	11,798	(1,726)	791	11,798
186,220		189,069	199,653	(10,584)	2,849	200,963
227,223	Total Assets	225,291	237,587	(12,295)	(1,932)	235,368
	Liabilities					
-	<u>Current Liabilities</u>					
35,817	Bank overdraft	6,610	-	(6,610)	(6,610)	-
40,064	Payables	31,719	36,088	4,369	4,098	36,249
	Employee entitlements	43,297	38,347	(4,951)	(3,233)	37,579
75,881		81,626	74,434	(7,192)	(5,746)	73,828
2,619	<u>Non Current Liabilities</u>					
	Employee entitlements	2,619	2,712	93	-	2,802
2,619		2,619	2,712	93	-	2,802
78,500	Total Liabilities	84,245	77,146	(7,099)	(5,746)	76,629
148,723	Net Assets	141,046	160,441	(19,395)	(7,677)	158,738

Crown equity and reserves includes changes in the 2017/18 result subsequent to the preparation of the 2018/19 budget. It also includes the \$4m reduction to the 30 June 2018 revaluation reserve due to the seismic upgrades required in the theatre block.

Bank and bank deposits > 90 days reflects special funds and clinical trials, and the bank overdraft reflects the operating cash position at the end of the month.

Lower than budgeted non-current assets reflects the reclassification of the investment in New Zealand Health Partnerships (NZHP) to current assets, and the reduction in planned capital spend from the annual plan to the current management budget.

Payables have reduced reflecting payment of outstanding amounts by Mid Central Health and the Clinical Training Agency. The increase in employee entitlements reflects the impact of settlements on entitlement balances.

10. EMPLOYEE ENTITLEMENTS

30 June 2018	\$'000	April				Annual Budget
		Actual	Budget	Variance from budget	Movement from 30 June 2018	
10,004	Salaries & wages accrued	11,046	8,228	(2,818)	(1,042)	7,756
1,157	ACC levy provisions	1,769	894	(875)	(612)	532
5,945	Continuing medical education	6,083	6,929	846	(139)	6,456
21,348	Accrued leave	22,561	20,669	(1,892)	(1,213)	21,199
4,230	Long service leave & retirement grat.	4,457	4,339	(119)	(227)	4,438
42,683	Total Employee Entitlements	45,916	41,058	(4,858)	(3,233)	40,380

Leave balances (hours) have been reduced by 1% across all major staff categories since the beginning of the financial year. However, the value of the liability has increased 6% mainly reflecting settlements since that date.

11. TREASURY

Liquidity Management

The surplus cash of all DHBs is managed by New Zealand Health Partnership (NZHP) under a sweep arrangement facilitated by BNZ. The DHB provides forecast cash flow information to NZHP to allow it to invest the funds at the most advantageous rates, and uses the same information to ensure the DHB has the funds to meet its obligations as they fall due.

The cash low point for each month is generally incurred immediately prior to receipt of MOH funding on the 4th of the month. April's low point was a \$12.0m overdraft incurred on 3 April, and next month's low point is likely to be higher than the \$8.5m overdraft that occurred on 2 May. The forecast low for the end of the financial year is \$13.6m overdraft, which is within our statutory limit of \$27m.

Debt Management

The DHB has no interest rate exposure relating to debt.

Foreign Exchange Risk Management

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

12. CAPITAL EXPENDITURE

Capital spend year-to-date is under budget, mainly in the block allocations for facilities, information services and clinical plant and equipment. However, the budget approved by the Board in June assumed even phasing across the year, whereas expenditure is likely to be more randomly spread reflecting immediate needs and procurement lead times. The block allocations are expected to be close to budget at year end.

See table on the next page.

2019 Updated Plan (Sep 18)		Year to Date		
		Actual \$'000	Budget \$'000	Variance \$'000
13,652	Source of Funds			
(5,000)	Operating Sources			
11,688	Depreciation	10,900	11,268	368
	Surplus/(Deficit)	(7,677)	(3,655)	4,023
	Working Capital	11,091	7,871	(3,220)
20,340		14,314	15,484	1,170
-	Other Sources			
-	Special Funds and Clinical Trials	47	-	(47)
-	Funded Programmes	4	-	(4)
-		51	-	(51)
20,340	Total funds sourced	14,365	15,484	1,119
	Application of Funds:			
	Block Allocations			
3,347	Facilities	1,847	2,803	956
3,400	Information Services	2,265	2,835	570
3,225	Clinical Plant & Equipment	1,803	2,658	855
9,972		5,915	8,297	2,381
	Local Strategic			
100	Replacement Generators	-	67	67
26	Renal Centralised Development	24	26	2
2,872	Endoscopy Building	3,093	2,857	(236)
350	Travel Plan	338	292	(47)
1,263	Histology and Education Centre Upgrade	1,306	1,263	(43)
150	Radiology Extension	19	50	31
50	Fit out Corporate Building	-	30	30
500	High Voltage Electrical Supply	66	350	284
700	Seismic Upgrades	-	400	400
1,950	Surgical Expansion	2,047	1,724	(324)
7,961		6,894	7,058	164
	Other			
-	Special Funds and Clinical Trials	47	-	(47)
-	Funded Programmes	4	-	(4)
-	Other	231	-	(231)
-		282	-	(282)
17,933	Capital Spend	13,091	15,354	2,264
	Regional Strategic			
1,945	RHIP (formerly CRISP)	929	129	(800)
1,945		929	129	(800)
	National Strategic			
462	NOS (Class B shares in NZHPL)	345	-	(345)
462		345	-	(345)
20,340	Total funds applied	14,365	15,484	1,119

13. ROLLING CASH FLOW

	Actual	April Forecast	Variance	May Forecast	Jun Forecast	Jul Forecast	Aug Forecast	Sep Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Apr Forecast
Cash flows from operating activities															
Cash receipts from Crown agencies	49,428	47,235	2,193	46,959	47,624	50,036	49,240	55,490	49,684	49,788	49,418	49,522	49,326	49,544	49,669
Cash receipts from donations, bequests and clinical trials	91	-	91	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	445,920	66	(67)	508	506	450	450	450	450	450	455	448	450	450	450
Cash paid to suppliers	(31,559)	(28,911)	(2,648)	(26,739)	(29,255)	(29,254)	(28,435)	(28,635)	(28,617)	(29,205)	(29,276)	(28,046)	(26,043)	(28,996)	(29,062)
Cash paid to employees	(15,834)	(17,224)	1,390	(20,634)	(17,783)	(23,118)	(17,993)	(17,907)	(21,230)	(18,672)	(17,579)	(25,233)	(18,066)	(18,151)	(22,349)
Cash generated from operations	2,572	1,613	959	94	1,091	(1,886)	3,263	9,399	287	2,361	3,019	(3,308)	5,667	2,847	(1,291)
Interest received	19	13	6	12	11	7	7	7	7	7	7	7	7	7	7
Interest paid	-	(4)	4	(84)	(84)	(14)	(15)	201	(7)	(69)	(90)	(16)	4	178	(4)
Capital charge paid	0	(0)	0	(0)	(4,015)	0	0	0	0	0	0	(4,314)	0	0	0
Net cash inflow/(outflow) from operating activities	2,591	1,622	969	22	(2,997)	(1,893)	3,255	9,607	288	2,300	2,936	(7,631)	5,679	3,032	(1,288)
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	10	0	10	0	480	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)
Acquisition of property, plant and equipment	(1,038)	(1,756)	719	(1,536)	(2,405)	(1,899)	(1,899)	(1,899)	(1,899)	(1,899)	(1,899)	(1,899)	(1,899)	(1,899)	(1,899)
Acquisition of intangible assets	(331)	(85)	(246)	(108)	(78)	(173)	(173)	(173)	(173)	(173)	(173)	(173)	(173)	(173)	(173)
Acquisition of investments	528	-	528	-	-	-	-	-	-	-	-	-	-	-	-
Net cash inflow/(outflow) from investing activities	(830)	(1,841)	1,011	(1,644)	(2,003)	(2,078)	(2,078)	(2,078)	(2,078)	(2,078)	(2,078)	(2,078)	(2,078)	(2,078)	(2,078)
Cash flows from financing activities															
Equity repayment to the Crown	-	-	-	-	(357)	-	-	-	-	-	-	-	-	-	-
Net cash inflow/(outflow) from financing activities	-	-	-	-	(357)	-	-	-	-	-	-	-	-	-	-
Net increase/(decrease) in cash or cash equivalents	1,761	(219)	1,980	(1,622)	(5,357)	(3,971)	1,177	7,529	(1,790)	222	858	(9,709)	3,601	955	(3,366)
Add:Opening cash	(5,671)	(5,671)	-	(3,910)	(5,532)	(10,889)	(14,860)	(13,683)	(6,154)	(7,944)	(7,722)	(6,863)	(16,572)	(12,971)	(12,017)
Cash and cash equivalents at end of period	(3,910)	(5,890)	1,980	(5,532)	(10,889)	(14,860)	(13,683)	(6,154)	(7,944)	(7,722)	(6,863)	(16,572)	(12,971)	(12,017)	(15,383)
Cash and cash equivalents															
Cash	4	4	0	4	4	4	4	4	4	4	4	4	4	4	4
Short term investments (excl. special funds/clinical trials)	(4,217)	(8,771)	4,554	(8,226)	(13,583)	(17,555)	(16,378)	(8,848)	(10,639)	(10,417)	(9,558)	(19,267)	(15,666)	(14,712)	(18,078)
Short term investments (special funds/clinical trials)	2,687	2,877	(190)	2,690	2,690	2,690	2,690	2,690	2,690	2,690	2,690	2,690	2,690	2,690	2,690
Bank overdraft	(2,393)	-	(2,393)	-	-	-	-	-	-	-	-	-	-	-	-
Cash Low Point (before the 4th of the following month)	(3,918)	(5,890)	1,972	(5,532)	(10,889)	(14,860)	(13,683)	(6,153)	(7,944)	(7,722)	(6,863)	(16,572)	(12,971)	(12,017)	(15,383)
Cash Low Point (before the 4th of the following month)	(8,459)	(8,459)	-	(8,226)	(17,505)	(18,060)	(16,600)	(12,351)	(10,814)	(10,887)	(9,558)	(19,477)	(17,306)	(24,046)	(18,258)

The forecast to June is based on the forecast based on April YTD performance. The remaining months are based on the Draft 2019/20 Annual Plan sent to the Ministry on 5 April. The higher cash shortfall (negative investments with NZHP) reflects the latest capital programme incorporated into the draft annual plan, but excludes the expected capital equity injection, due to uncertainty over timing. This may significantly improve the cash position in 2019/20.

People & Quality

Dashboard



Key Highlights

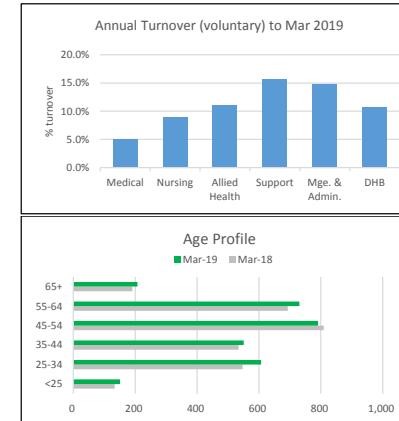
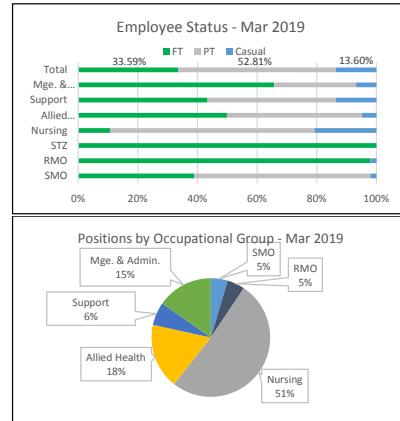
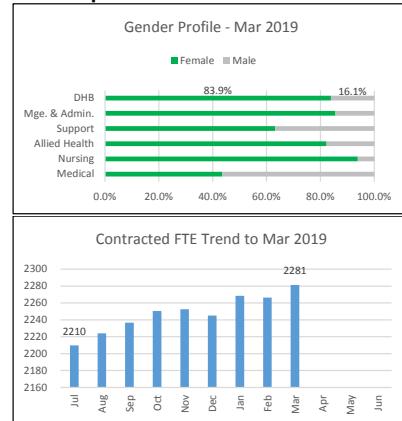
Employee status over the last year shows an increase in part-time and a reduction in full-time and casual.

Annual Turnover has increased but reasons for leaving show no particular cause for concern. We will continue to monitor the situation.

	Year end March 2019	Year end March 2018
Medical	5.0%	5.5%
Nursing	9.0%	7.8%
Allied Health	11.1%	9.7%
Support	15.7%	14.0%
Mge. & Admin.	14.7%	11.9%
Total	10.7%	9.2%

Contracted FTE shows a 4.7% increase since March 2018.

Our People



Key Highlights

Requisitions 499 YTD compared to 377 for the same period last year (32% increase)

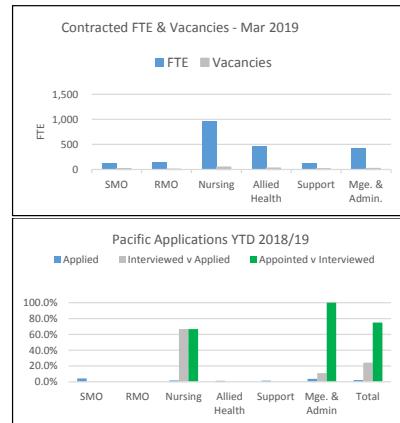
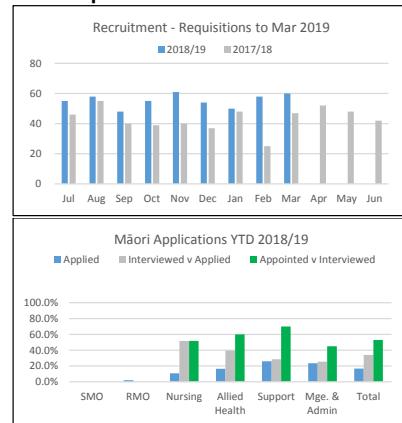
Average recruitment costs below last year (except for SMOs).

Applicants progress through recruitment process:

	Māori	Pacific
% of applications received	16.8%	2.3%
% interviewed v applied	34.0%	24.2%
% hired v interviewed	53.0%	75.0%

So of the Māori/ Pacific applicants who get to interview stage 53.0% of Māori get hired and 75.0% Pacific get hired.

Our People Recruitment



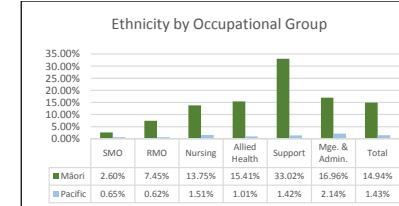
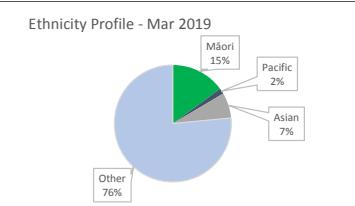
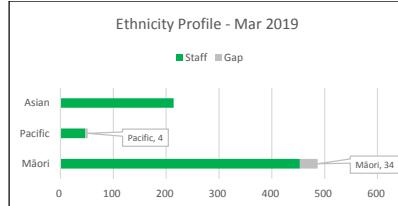
Key Highlights

Ethnicity gap to meeting our targets for 2018/19:

Māori 34
Pacific 4

HBDHB's Māori representation figures (Māori staff as % of Māori population) compare favourably with other DHBs:
Central Region = 1st
Mid-sized DHBs = 2nd
20 DHBs = 5th

Our People's Diversity



Key Highlights

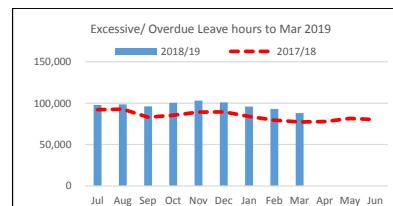
Annual Leave 2+ years =
145 (5.0%) compared to
138 (5.0%) at March last year.

Excessive/ overdue leave balances increased over last year (71.6 hours per employee compared to 66.3 hours last year)

Year to date sick leave 2.9% compared to 3.0% for same 9 months last year.

EAP new referrals:
2018/19 YTD = 169
2017/18 YTD = 160

Our People's Wellbeing



Key Highlights

Lost time Injuries – average days lost
YTD 2018/19 = 21.5 days
YTD 2017/18 = 20.8 days





10

BOARD HEALTH & SAFETY CHAMPION'S UPDATE

Verbal

**BOARD HEALTH & SAFETY
ACTION REGISTER
(Public)**

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	24/4/19	ICU report Storage – Investigate provision of appropriate storage for patients/families and ward resources with Facilities Flight – Urgent replacement of low stretchers requested	EDPS	May 2019	

10.1

	Te Pītau Health Alliance Governance Group	46
	For the attention of: HBDHB Board	
Document Owner:	Bayden Barber, Chair	
Author:	Chris Ash, Executive Director of Primary Care	
Month:	May, 2019	
Consideration:	For Information	

11

RECOMMENDATION

That the HBDHB Board:

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

The Health Alliance Governance Group met on Wednesday 8 May 2019.

Significant issues discussed and agreed included:

COMMUNICATIONS PLAN

A dedicated communications resource is to be finalised.

END OF LIFE CARE REDESIGN UPDATE

Programme redesign (integrating Treaty of Waitangi principles and Mauri Compass), key objectives, co-design, collaboration and decision-making of this two-phased approach was discussed. Redesign implementation date is 01/07/20.

The redesign is to align with Aged Related Residential Care (ARRC), i.e. End of Life Care (last one-thousand days of life) and how we focus on our most vulnerable communities, and link to unplanned hospitalisations for people over 80 years of age.

To encourage whānau voice, palliative care community groups/stakeholders will be involved.

Te Pītau Governance Group members agreed to an initial End of Life Care Roadshow (to include Advance Care Planning), with clinical representation and involvement of Ministers of religion, as necessary.

Expressions of Interest close on 28/06/19.

NAPIER/HASTINGS AFTER HOURS SERVICE REVIEW

The After Hours Steering Group have endorsed the process to review the current Primary Care After Hours service model alongside a review of existing contracted After Hours services.

Background information, key issues, and involvement of HBDHB's Business Intelligence team, stakeholders (to include community aspirations), and alignment to the Clinical Services Plan was received.

Strengths and weaknesses of the current After Hours model and three main theoretical model options were discussed. An intertwined nurse-led After Hours/Urgent care service was favoured. Location to be determined.

Clinical governance oversight is to be explored, and progress reports will be received from respective working groups. Outline of proposed framework is to be confirmed.

SYSTEM LEVEL MEASURES PROPOSED APPROACH

Te Pītau Governance Group members approved the proposed approach, and next steps for System Level measures (SLMs).

Te Pītau Health Alliance will manage overall accountability of SLMs from 01/07/19.

 OURHEALTH HAWKE'S BAY <i>Whakawāteatia</i>	Te Pitau Health Alliance Governance Group 47
For the attention of: HBDHB Board	
Document Owner:	Ken Foote, Company Secretary
Document Author(s):	Ken Foote, Company Secretary
Reviewed by:	Te Pitau Health Alliance Appointments Panel
Month:	May 2019
Consideration:	For Decision

11.1

RECOMMENDATION

That the HBDHB Board:

- **Approve** the extension of the term of the initial appointees to the Te Pitau Health Alliance Governance Group from June 2019 to December 2019.
- **Agree** that the first 'annual review' of the Governance Group membership be undertaken with effect from December 2019.

BACKGROUND

The initial members of the Te Pitau Health Alliance Governance Group (then known as the Primary Care Development Partnership) were appointed by the Boards of HBDHB and Health Hawke's Bay Ltd (HHB) in July 2018. In accordance with the draft Agreement at the time, these appointments were for one year, with their term expiring 30 June 2019.

Clause 8.3.3 of the Alliance Agreement states:

Membership of our Alliance Governance Group shall be reviewed annually by an Appointments Panel made up of the Chairs and CEOs of the DHB and PHO, who shall consider the level of interest in membership, the benefits of some rotation balances with retaining some experience, and the need to maintain a good mix of perspectives, skills and experience.

Technically therefore, this first 'annual review' should take place with effect from 1 July 2019.

Given that the Te Pitau Health Alliance Agreement was not finally agreed and signed until December 2018, much of the work of the initial governance group in the first six months was procedural, just getting initial thinking and processes set up and sorting out a name etc. This group has therefore had only six months to actually get into activities of the Alliance and the governance processes required to support it.

ANNUAL REVIEW

Rather than undertaking a full 'annual review' as technically required, the Appointments Panel are recommending that the existing Governance Group terms be extended to December 2019, and that the first formal 'annual review' (as required by clause 8.3.3 of the Agreement) be undertaken with effect from then. The reasons for this include:

- The six month 'gap' between appointing the initial Governance Group and signing the Alliance Agreement.
- Provides more time for the existing Governance Group to 'bed in' the initial Alliance activities and processes.
- HBDHB elections come up in October 2019 (there could be some changes on the Board)
- There is potential for some changes on the HHB board from the AGM in November, given a significant number of retirements by rotation (acknowledging that all could be available for reappointment)

Shifting the 'annual review' month to December will also take these issues into account in future years.

MEMBERSHIP

Current members of the Governance Group are:

HBDHB Ltd Board:	Bayden Barber Jason Ward Jeremy Harker
HBDHB Board:	Hine Flood Ana Apatu Helen Francis
Māori Relationship Board:	Beverly Te Huia
Clinical Council:	Peter Culham
Consumer Council:	Rachel Ritchie

All Governance Group members have indicated a willingness to have their current terms extended.

RECOMMENDATION

The Alliance Appointments Panel recommend that the HBDHB Board:

- **Approve** the extension of the term of the initial appointees to the Te Pitau Health Alliance Governance Group from June 2019 to December 2019.
- **Agree** that the first 'annual review' of the Governance Group membership be undertaken with effect from December 2019.



MAORI RELATIONSHIP BOARD CHAIR'S REPORT

12

Verbal



PACIFIC HEALTH LEADERS GROUP CHAIR'S REPORT

Verbal

13

	Hawke's Bay Health Consumer Council	48
For the attention of:		
HBDHB Board		
Document Owner:	Rachel Ritchie (Chair)	
Month:	May 2019	
Consideration:	For Information	
RECOMMENDATION		
<p>That the HBDHB Board:</p> <p>Note the content of the report.</p>		

14

Council met on Thursday 9 May 2019. An overview of matters discussed is provided below:

YOUTH REPRESENTATIVE

Having explored a number of options following the demise of the Youth Consumer Council, an approach to the Hastings District Council Youth Council had been accepted to appoint one of their members to be a youth representative on Consumer Council. The person appointed is Daisy Hill. Daisy will join the Consumer council from June 2019.

Options for a representative from the 18 – 24 age group are still being considered.

CONSUMER EXPERIENCE FACILITATORS REPORT

A very positive story of an effective feedback loop having a significant positive impact was provided. After a consumer fed back about the distress and shock experienced upon receiving an appointment card from the 'Heart Failure Clinic', the name of a clinic was changed to the 'Heart Function Clinic'. The change of name reduced the distress felt and has had the impact of slashing appointment cancellations/ DNA rates for this clinic.

The Facilitators report highlighted the work being undertaken to promote the importance of consumer experience feedback and 'What Matters to You'. System feedback to date hasn't been visible to consumers who need assurance of action and real change in the system, so the plan is that these new processes provide that assurance. The example above is a great example of closing the loop and the significant impact a simple change can make.

COMMITTEE REPRESENTATIVE FEEDBACK

Feedback was provided by representatives on:

- Te Pitau Health Alliance Governance Group

HAWKES BAY HEALTH STRATEGY

Council reviewed and discussed the latest draft of the Strategy presented at the meeting, and appreciated the opportunity to provide input. It was generally agreed that the 6 headline goals were the right direction of travel, but there was some work to do around how these headline goals were framed up and the development of the 'Key Objectives' under these heads. Some of the concerns raised included:

- Whilst the words used 'on the page' in the body of the document can be seen as detail they do matter - they drive the context, the focus and ultimately impact how the document will inform the Implementation Plan and action further down the line. For example; Satisfaction measures for services should be changed from the services they 'Received' to the services 'Sought'.
- Feel there is not enough recognition of diversity within the statement of *Equity*; Sub groups (Long Term Conditions, Disabled, Mental Health) could feel excluded with the strategy focus being on Maori and Pasifika as they are not carried through into the Key Objectives and the 'body' of the section.
- Weave more 'unmet need' population into the document; e.g. the needs of the homeless and mentally ill; frail and elderly
- There was recognition that to enable change there is a requirement to be bold in this document and that the system and leaders need to 'do something different' - to that extent the strategy is on the right track.
- Embed Person & Whanau Centered Care headline goal – it would be good to see the objectives more aligned to the implementation of change in the system e.g. 'Embed a change focused feedback system', and 'prioritise where changes to the service models are best made for better health outcomes'; linkages between primary and secondary care for a more seamless service.
- The objectives around changing funding resources appears in this document without context or reference from previous documents or any evidence based work up of how health outcomes change as a result.

Having had limited time to review this draft of itself and in connection with its source reports (CSP, People Plan etc.), members were invited to send further individual feedback through via email. It appeared that a further round of review would take place.

AFTER HOURS CARE UPDATE

Council received a verbal report on after hours care and were asked to comment on where in Hastings an after-hours care service would be best placed. Feedback was that cost is a major determinant of utilising this service and that was a bigger issue than venue within Hastings. Some detail of the service in Napier was discussed. Further paper summary of the presentation was to be forwarded to members for further update and consideration of the issues in this area.

PASIFIKA HEALTH SERVICE NURSE NAVIGATORS

Following a presentation and discussion on this topic, Council noted the good work being done by the small team, and supported the requirement to grow the service with an additional 1.00 FTE Nurse Navigator.

TE ARA WHAKAWAIORA CHILD HEALTH

The indicators within the consolidated report were reviewed and noted. Council supported the intention to establish a Child Health kaupapa to bring a more cohesive and collaborative approach to track progress and improve effectiveness in child health activities across the organisation.

	Hawke's Bay Clinical Council	49
	For the attention of: HBDHB Board	
Document Owner:	Dr John Gommans (Co-Chair) Jules Arthur (Co-Chair)	
Month:	May 2019	
Consideration:	For Information	

RECOMMENDATION

That the HBDHB Board

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

15

HB Clinical Council met on 8 May 2019. A summary of matters discussed is provided below:

COMMITTEES & REPRESENTATIVES REPORTS TO COUNCIL

Reports were received from:

- Clinical Advisory Governance Group (PHO)
 - Currently considering an appropriate appointment to Clinical Council
- Te Pitau Health Alliance
 - First meeting for new representative – Peter Culham

COLLABORATIVE PATHWAYS UPDATE

Collaborative pathways is currently parked as there is no consensus amongst the central region PHOs on a system to be used, and they waiting to see what happens nationally.

Some of the existing pathways are currently being converted to electronic. Embedding into electronic referrals is being investigated.

HB HEALTH STRATEGY

Along with all other governance groups, Council received and discussed the latest draft of the Hawkes Bay Health Strategy.

In general there was agreement with the layout and approaches. Some suggestions were however made on how the objectives could reflect more of what we want to achieve, eg:

- Clinical themes not directly mentioned, particularly aging population
- Commitment to co-design and community leadership needs strengthening
- Need to think about how to quantify smart objectives
- Acute demand not mentioned and the adverse impact of not addressing this
- Not sure how the strategy objectives link to health gain – needs to be more clear

TE ARA WHAKAWAIORA CHILD HEALTH COMBINED REPORT

The Clinical Council noted the report and supported the approach of consolidating the indicators under four categories.

TO WAHA – A WHANAU CENTRED COLLABORATIVE APPROACH

Council appreciated an update on this initiative, and noted that the ‘local’ success of this was due to the collaborative approach between the DHB and community providers. It also demonstrated that community led approaches can lead to better health outcomes and collaborative efforts working across the health system can produce better outcomes.

Council requested a letter of thanks from Clinical Council be sent to the Community Dentists who gave their time for free.

AFTER HOURS SERVICE UPDATE

Council noted the Update and also the presentation on the issues and approaches to be taken, to address the problem. Council is now keen to hear the feedback from the various groups on the proposals outlined.

PRIMARY CARE WORKFORCE SURVEY

The Hawke’s Bay PHO Workforce Analysis “snapshot” conducted September 2018 to March 2019 was presented to Council. The presentation included RNZCGP National Survey 2018 data; rationale; results; Hawke’s Bay PHO workforce survey and analysis; deductions and assumptions and next steps. Of particular concern to all, were the results from the RNZCGP National Survey 2018:

- Over the next five years, 27% of GPs intend to retire. Over the next 10 years, 47% intend to retire
- Increasing numbers of GPs say they work in practices that have a GP vacancy (31% percent in urban areas and 39% of rural practices)
- GP burn-out rates are increasing (26%, compared to 22% in 2016)

Council were particularly pleased to see the data that had been gathered, the initial analysis and the planned next steps, grouped around strategies to grow, recruit, train, develop and sustain the whole of the primary and community care workforce.

General discussion noted the increasing part time GP workforce which has an impact on patient experience and ability to deliver patient and whanau centred care. Healthcare Home is a model to reform general practice, free up time for GPs, nurses doing work GPs don’t need to do; different models for chronic and acute care. Once this work has been done, extended care teams can be introduced.

Council offered their full support to the PHO in coordinating this vital work.

PASIFIKA NURSE NAVIGATORS

Council were briefed on the current comparative operation of the HBDHB Pacific Navigation team and the identified need for additional nurse navigator resource. The general discussion that followed acknowledged that the current team is small but it is making a big difference.

Council supported the direction the Pacific Health Team are taking.

 OURHEALTH HAWKE'S BAY <i>Whakawāteatia</i>	Hawke's Bay Health Strategy Document – Draft Document for feedback	50
	For the attention of: HBDHB Board	
Document Owner:	Kevin Snee - Chief Executive Officer	
Document Author:	Hayley Turner –Planning and Strategic Projects Kate Rawstron – Head of Planning and Strategic Projects	
Reviewed by:	Health Sector Leadership Forum Core Leaders Group	
Month:	May 2019	
Consideration:	For Review and Feedback	

16

RECOMMENDATION:

That the HBDHB Board:

1. **Review** the Draft HB Health Strategy Document
2. **Provide feedback** at the meeting for a further and final iteration

Purpose of this paper

The purpose of this paper is to provide the context for the document and a summary of the process to date, and seek feedback to complete a final “copy” version of the HB Health Strategy for sign off from **HBDHB Board on 26 June 2019.**

Attached is the second Draft HB Health Strategy (one with comments and one clean) for your review and feedback. Feedback is particularly requested on:

- Does it read as a cohesive Strategy for the Health System and fulfil the purpose of a strategy?
- Do you feel the Strategy reflects the feedback provided to date?
- Are there ways the strategy can be enhanced/refined to better connect with stakeholders? (acknowledging that different resources will be used to communicate with our various audiences)

CONTEXT

In conducting your review and providing feedback, it is important to remember some key contextual points:

The Purpose of the HB Health Strategy:

- A strategy sets the compass to guide us and allows us to communicate our vision and shared purpose with our people and our partners across the system
- The HB Health Strategy should therefore set the direction and paint the future that has been identified by our health sector and community through previous initiatives such the CSP and People Plan in a single view that easy to understand by all – everyone should be able to connect and see themselves within this document.
- It should support Hawke's Bay Health sector as a whole system to work together more effectively on the most important things by identifying our core Strategic Goals and objectives to address our system challenges as identified through the *CSP, Big Listen and Health Equity Report.

**This is not a complete list of inputs*

How is this different from the CSP?

- Just a reminder, the CSP provided us with a range of options setting our direction for future services. It did not address the "How" we would get there or "What" we needed to start our journey.
- The HB Health Strategy document brings existing core documents, combines the key strategies and brings them up a level in a single document

What is and isn't included in HB Health Strategy:

- It is not an Implementation plan but will drive that activity and output – see appendix 1
- This will not include detailed solutions – these will sit within our Implementation Plan - see appendix 1
- It does not replace a Health Outcomes Framework – this will be part of the implementation planning activity which must be aligned to the Strategic objectives set out in this document, but the document must show linkage.
- Does not include specifics on how we will develop and embed a Person and Whānau Centred culture, this will fall as part of the activity that follows, but lays out the approaches that we will take to get there.
- Does not answer how we will manage the change, bringing our system and people on one journey. This activity is set out in workstream 1 – Kuaka Change Framework – see appendix 2 and is an enabler for all change including culture

The Process of the HB Strategy Development to date:

- Key input of strategic documents brought together at a higher level
- Input/feedback through workshops, meetings, governance forums to build on initial content and develop and refine the key areas of the Strategy:
 1. Vision and Mission
 2. System Goals
 3. System level Strategic objectives
 4. Approaches
 5. Dependencies
 6. Investment Principles

Note:

- 1& 2 - *newly developed but informed by existing work*
- 3 – 6 – developed by combining and refining existing strategic documents raising them up to the strategic level of this document



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Next steps:

- Incorporate feedback for MRB, Clinical Council, Consumer Council, Pasifika Health Leadership Group, Board and PHO Leadership Team for a further iteration - **May**
- Complete any gaps as identified in this version of the document attached or highlighted from feedback received in – **May**
- Complete a cross reference exercise of the HB Health Strategy against the source documents to verify alignment – **May**
- Review for easy readability and understanding - **May**
- Produce a final version of the document for sign off in **June 2019**
- Print copy and launch – **post sign off**

Note:

This document will drive the five year implementation plan which will follow **2019/20**

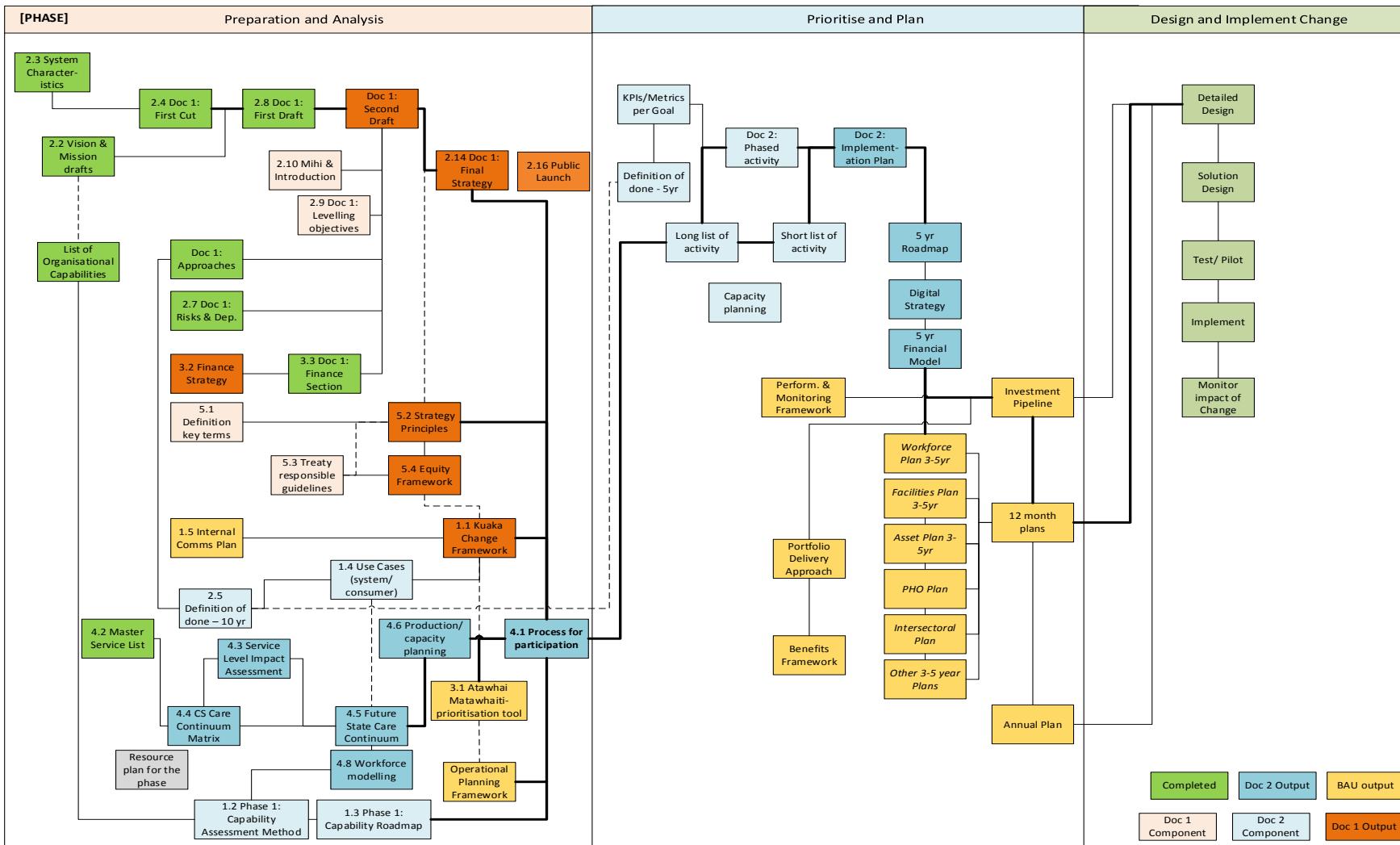
Appendix 1 Strategy Development Network Diagram

We are not just producing a document (HB Health Strategy).

There is a huge amount of work under the bonnet taking place to get the system ready to do things in a different way

This Strategy Development Network Diagram highlights the key activities required to develop the Strategy and Implementation Plan with integrated planning processes and activity leading to the final phase of execution – Making the change! It also illustrates the relationship between each of these activities so that we understand key inputs and outputs.

Our goal is to be organisationally and system ready to deliver the transformational change as set out in our HB Health Strategy.



Appendix 2 Phase 1- Preparation and Analysis Workstream Delivery

The five delivery workstreams currently underway with activity identified in the Strategy Network Diagram – appendix 1.

	Workstream 1	Workstream 2	Workstream 3	Workstream 4	Workstream 5
Delivery Stream	Change Management: Our Journey Together kaupapa	Doc 1: HB Health Strategy	Finance	Doc 2: Data Modelling Doc 2: Implementation Plan	Quality & Equity
Purpose	To develop a change management strategy, framework and engagement plan to enable the successful change deliver and to support all other workstreams providing a framework and toolkit so that we deliver consistent key messages and support our people through the whole process	To develop and write the new strategy document including V&M, goals and strategic objectives	To develop the financial strategy that includes cost modelling and investment decision making to enable the implementation planning process (Workstream 4)	To develop data driven modelling to inform the scenario planning and decision making and prioritisation required to develop the implementation plan To develop an integrated implementation planning framework and plans to execute the HB Health Strategy	To lead and deliver the equity framework and other tools, support all other workstreams to ensure that all outputs are aligned to achieving equitable health outcomes
Strategic Planning Team: Kate Rawstron & Hayley Turner Responsible for delivery, co-ordinating and supporting the strategic planning effort					
Treaty of Waitangi: MOU - Relationship Manager – Patrick Le Geyt					
Teams & Deliverables *SWG member	Deliverables: 1.1 Kuaka Framework (HT) 1.2 Phase 1 Capability Assessment Method (HT) 1.3 Phase 1 Capability Roadmap (HT) 1.4 Use cases (system/Consumer Journey)(JB) 1.5 Internal Communication Plan (AK)	Deliverables: 2.1 Design principles (CA) 2.2 Vision & Mission (CA) 2.3 System Characteristics (CA) 2.4 Doc 1 First Cut (KR) 2.5 Definition of Done- 10 Years (KR) 2.6 Objectives (KR) 2.7 Dependencies (KR) 2.8 Doc 1 First Draft (KR) 2.9 Levelling of Approaches (CA) 2.10 Mihi and introductions (BTP) 2.11 Translations (Māori & Pasifika)(BTP) 2.12 Doc 1 Final Draft (KR) 2.13 Artwork (BTP) 2.14 Doc 1 Final Version (KR) 2.15 Public Engagement (ST) 2.16 Strategy Public Launch (ST)	Deliverables: 3.1 Atawhai Matawhaiti (SE) 3.2 Finance Strategy (KF) 3.3 Doc 1 Finance section (KF)	Deliverables: 4.1 Process for Participation Prioritisation (KR) 4.2 Master Service List (KR) 4.3 Service Level Impact Assessment (SE) 4.4 Current State Care Continuum (JG) 4.5 Future State Care Continuum (JG) 4.6 Production/Capacity Modelling (SE) 4.7 Clinical / Non-clinical office space (GCS) 4.8 Workforce Modelling (JS)	Deliverables: 5.1 Definition of Key Terms (NJ) 5.2 Strategy Principles (PLG) 5.3 Treaty Responsible Guidelines (PLG) 5.4 Equity Framework (BTP)
	Delivery Leads: Hayley Turner Jos Buurmans Anna Kirk	Delivery Leads: Kate Rawstron, Bernard Te Paa Chris Ash Shari Tidswell	Delivery Leads: Stewart Eadie, Ken Foote	Delivery Leads: Kate Rawstron, Stewart Eadie, Jill Garrett, Jim Scott, Gavin Carey-Smith	Delivery Leads: Nick Jones, Patrick Le Geyt Bernard Te Paa
	Delivery Teams				
	Staff and community (workstreams to identify) Co-design, engage, participation				

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Hawke's Bay Health Strategy 2019–2029

WORKING DRAFT v2.2 29 April 2019

DRAFT



16.1



Mihi

[Placeholder]

Message from the CEO / Board

[Placeholder]

Introduction

Why a health strategy?

The health system is made up of a range of organisations contributing to the health of New Zealanders and local communities. As the New Zealand Health Strategy points out, to perform to a high standard the system needs more than a skilled workforce and resources. It needs a shared view of its overall purpose and the direction it is going, combined with effective ways of working.

'A strategy is a guide for achieving the sort of future that you want. It can help people, organisations or a whole system work together more effectively on the most important things. Without a strategy, small problems today can become big problems over time'.

New Zealand Health Strategy

Hawke's Bay District Health Board has a role to lead the Hawke's Bay health system and strengthen the links between its different parts. But we recognise that our partners will lead and support much of the transformation required in the sector. We also acknowledge that health and wellbeing are not solely influenced by the health sector and working with inter-sectoral partners is critical in people living and staying well.

Our Hawke's Bay health system

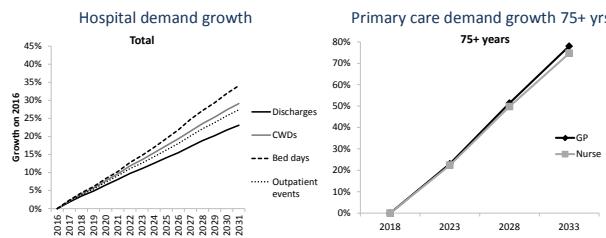
[Consider map of service network and/or key population figures]

Where are we at?

Over the last five years, we have shifted our perspective from DHB services to whole-system management and engagement with iwi and post-settlement governance entities, with our Transform and Sustain strategy. We set up our Consumer Council to work alongside our Clinical Council and Māori Relationship Board and have generally performed well over a number of years. Success in preventative services such as immunisation and screening show what can be achieved when we purposefully set out to understand the needs of our community and deliver our services in a way that meets the needs of whānau.

Despite the progress we have made many challenges still remain. Our 2018 Health Equity Report shows large inequities in health persist for Māori, Pasifika and those with the least social and economic resources. Demographic changes will increase pressure on our already stretched health services. If we continue to do things the way we do now the number of primary care consultations, hospital appointments and inpatient stays will outstrip population growth.

16.1



Māori and Pasifika, people with disabilities, people with experience of mental illness or addiction, and those living in socioeconomic deprivation continue to experience unacceptable inequities in health outcomes.

It is clear we need a new approach if we are to achieve equity amongst our population and meet future demand. We need to redesign our health system for the future and take bold decisions that will ensure we deliver the best and fairest outcomes for all people in Hawke's Bay.

A focus on people

At its heart, this strategy is about people: as members of whānau, hapū and iwi; and in their homes communities and workplaces. We exist because of them and we recognise that people and whānau are the experts in their own lives. We need to plan and deliver health services in the wider context of people's lives, and how we include cultural practices (eg, mirimiri and rongoā Māori). This strategy describes our goals to empower and partner with people and whānau,

and work across agencies to improve the conditions of life, so that everyone has fair opportunity to achieve good health and wellbeing.

We will turn to our people to find solutions. The district health board must act as a careful steward of health resources in the Hawke's Bay, which is a challenging task. We need our community to help us so that we invest in the areas that matter most to people and whānau. This strategy prioritises health improvement of populations with the poorest health and social outcomes.

Our commitment to the Treaty of Waitangi

The New Zealand Public Health and Disability Act holds us accountable for recognising and respecting the principles of the Treaty of Waitangi. Our Treaty of Waitangi Relationship is premised on our Memorandum of Understanding with Ngati Kahungunu, and is represented by the Māori Relationship Board which provides governance direction between the two entities. We are committed to improving health outcomes for Māori, increasing Māori representation in the health workforce, and ensuring a culturally appropriate and responsive health system.

Partnership – working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate services.

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Participation – involving Māori at all levels of the sector in decision making, planning, development and delivery of services.

Protection – working to ensure Māori have at least the same level of health as non-Māori and safeguarding Māori cultural concepts, values and practices.

16.1

How does the Strategy fit with other plans?

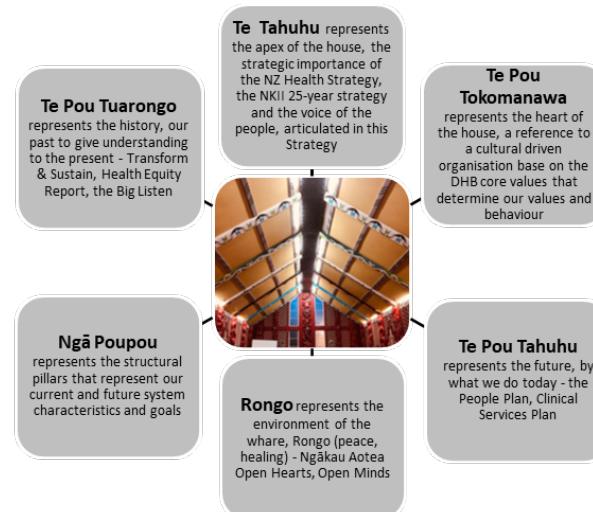
We have done a lot of listening, thinking and planning over the last two years. Our **Clinical Services Plan** sets out the challenges and opportunities the system faces and describes concepts for the future we want. Our **People Plan** describes the culture and values we want and how we will grow our people to deliver on those concepts. The evidence in our **Equity Report** gives weight to the call for a bolder approach to resolving previously intractable inequities. At the same time we are developing a **Digital Health Strategy** and **Finance Strategy** that will enable the implementation of our strategies and plans.

Each of the plans we have produced is an important part of the process and this Strategy is the conclusion of that phase. We have written the Strategy to ground the strategic themes that have emerged as common threads in our more detailed work.

This Strategy sets the compass to guide us for the next ten years. Each of the supporting documents is a key reference and guide that we will continuously refer to as we implement our strategy over the next five years...and the five years after that.

Rūia taitea kia tū ko taikaka ānake

(Discard the sapwood to uncover the hardwood)



Commented [KC1]: The values referenced below in Te pou tokomanawa are actually sector wide values not DHB values.... Plus should read "culture driven organisation based... not base"

Commented [HT2R1]: Accept Feedback . This will be updated in the next version

The wider context

The Government has undertaken or is in the process of important work that will shape the evolution of our health system. That work includes the refreshed New Zealand Health Strategy, the response to the Inquiry into Mental Health and Addiction, the Health and Disability System Review, and the Government's wellbeing budget approach. The kaupapa of this Strategy aligns with the principles and values articulated by central Government but the 'how' will have a distinctly Hawke's Bay flavour as we co-design responses with our local communities.

As a region the Matariki partnership provides a wider context and further enables us to achieve our vision.

Turning strategy into action

We are developing a five year implementation plan so we can 'get on and do it'. We need to be clear about what needs to happen and when, and who is responsible. This Strategy has a 10-year outlook but making it happen requires some shorter-term signposts. The implementation plan will prioritise and describe concrete actions with timeframes and budget requirements, identify key risks and dependencies, and define performance measures so we can monitor our progress. The Plan will be periodically updated throughout the lifetime of this 10-year strategy.

Commented [HT3]: Need to show link in document with health outcomes framework

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Vision

Taku wahine purotu, taku tane purotu

Everyone in Hawke's Bay is thriving

Mission

Working together to achieve equitable holistic health and wellbeing

[Insert Strategy Picture](#)

Our values



Commented [HT4]: Layout of this page to be finalised once Translations have come through

System goals

We have identified six system goals we need to achieve if we are to fulfil our mission and realise our vision by 2029. Goals are broad primary outcomes, that is, statements of what we hope to achieve in our system that give further definition to our vision. These goals have emerged as common system characteristics across our collective planning work and equity monitoring. That planning work involved extensive engagement with consumers and people working in the Hawke's Bay health system; and community consultation on the concepts put forward in our Clinical Services Plan. The six system goals are:



1. Community-led system



4. Fit-for-purpose workforce



2. Embed person and whānau-centred care



5. Digitally enabled health system



3. Equity for Māori as a priority; also equity for Pasifika and those with unmet need



6. High performance and sustainable System

[Consider diagram]

In the remainder of this document each system goal is described with our key objectives, strategic approaches and dependencies.

Our key objectives are a set of specific measurable results for each broad system goal. They will help us to determine if we have achieved our goals. Our strategic approaches describe our approaches or methods for achieving goals and resolving issues. They don't describe specific activities or projects—that level of detail will be described in our implementation plan(s). Understanding dependencies is important in a system with many

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activities happening at once. These activities make contribution and require resources, they interact with each other in planned (and unplanned) ways, and they share expectations and resources.

Headline objective

Halve the life expectancy gap between Māori and non-Māori by 2029

This objective is a high-level measure which will help us track achievement of our vision and mission. We know that there are many complex factors that contribute to life expectancy and we don't have control or influence over all of them. We want all groups in our community to enjoy the same life expectancy, but we know that our health strategy cannot achieve this alone. We do have a major part to play and our headline objective is to at least halve the gap between Māori and non-Māori. If we can do this at the same time as life expectancy continues to increase for non-Māori, it will suggest we are on track to realise our vision and mission.

Add assumptions re achieving this objective

Commented [HT5]: Include: Coronary heart, lung cancer, suicide and road crashes



Community-led system

Why is this important?

Effectively involving people, whānau and communities in the design and development of health services supports improvements in population health outcomes and consumer experiences. Our communities have local knowledge that can help us to provide cost-effective and sustainable services. Hawke's Bay has some small but relatively isolated rural communities. Our rural services must work together and we need to maximise opportunities such as virtual consultations and nurse-led services.

Wellness starts at home and in the community within environments such as schools and workplaces. We know that achieving equitable population health outcomes requires inter-sectoral collaborative action. Pooling expertise and resources across partners and aligning planning and action will help us to address long-standing social determinants of health in Hawke's Bay.

Key objectives

- At least 20% of all DHB resource is directly prioritised and deployed according to the commissioning goals of local communities
- 90% of our community reports they are happy with the level of co-design of services
- 100% of desired community or iwi prioritisation plans are in place
- 100% of social inclusion goals identified in the Matariki programme are achieved
- Population strategies achieve what the community wants

Commented [HT6]: This section need some re wording based on CA feedback. More emphasis on community owning solutions not us.....

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Our approaches

Support communities with tools and access to expert advice so they can drive 'ground-up' preventative strategies	Co-design services with the communities that will use them and develop 'grass-roots' responses where appropriate
Work actively with our inter-sectoral partners to ensure healthy environments for our communities	Base services in the community 'by default' and support primary health centres to function as people's 'health care home'
Contribute to community-level plans and place-based initiatives that promote and build healthy, safe and resilient whānau	Develop committed alliances with inter-sectoral agencies to improve social and economic conditions for people and whānau
Activate communities with the means, tools and support to take ownership of their local service network	Integrate rural health facilities with local communities and services

Dependencies

- Community trust and buy-in and effective engagement techniques
- DHB cultural competence to develop a fully engaged community
- Building a body of expertise about how to do this work (alliancing)
- Availability of resources for upstream investment
- Trust and acceptability of solutions by community, clinicians and organisations
- Ability to truly listen to consumer needs and design collaboratively
- Accountability and ability of agencies to break down inter-sectoral silos
- Digital enablement to allow care closer to home
- Alignment and integration of planning across the system



Embed person and whānau-centred care

Why is this important?

Our goal for the future is a health system that is person and whānau-centred. This means that our system will evolve with greater control of service design and provision resting with our people and whānau. We need to develop a new way of working alongside whānau to ensure that they feel ownership both in their own health journey and the system as a whole. Research shows that person and whānau-centred approaches improve health outcomes and consumer experience and the use of health resources. Creating a culture that is person and whānau-centred will require a fundamental shift in behaviours, systems, processes and services for people working across the Hawke's Bay health system.

Our key objectives

- 95% of consumers are positive about the service(s) they receive and would recommend Hawke's Bay Health as a great place to be treated
- 100% of enrolled consumers have a wellbeing plan that is developed with them and based in primary care by 2029
- XX% of consumers report they are able to find and access services when they are needed by 2029
- Whānau are involved 100% in adverse event reviews

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Commented [HT7]: Need new % as 100% too high (CA)

16.1

Our approaches

Ensure people have access to relevant information and enhanced preventative services when they need it, so they can make informed choices and take control of their own health and wellbeing	Plan the majority of care proactively and provide timely access to urgent care when people need it
Develop and reconfigure services so people are able to receive quality and timely services in the most convenient way, from the most appropriate provider, in the way they want it	Build wellbeing plans around what's important to people and whānau and everyone delivering care focuses on the person in everything they do
Design services with the input of the people who use them so that they are innovative and effective	Enhance supports so that older people are kept well at home and in their communities
Develop real-time feedback opportunities and act upon the feedback provided	Support people to return home safely from hospital as soon as possible

Dependencies

- Redesign of business models to change the way services are planned and accessed
- Individuals across the system will need to be culturally competent and responsive
- Workforce supply and accessibility to enable people to access the most appropriate provider
- Availability of resources for community investment
- Digital enablement to allow different ways of accessing services and everyone to view and update information
- Health and medical technology availability to support communities to take on full health needs
- Mindset change to allow increased consumer and whānau ownership and decision making



Equity for Māori as a priority; also Equity for Pasifika and those with unmet need

Why is this important?

Different groups in our community have differences in health that are not only avoidable but are unfair. Māori and Pasifika, people with disabilities or experience of mental illness; and those living in socioeconomic deprivation, continue to experience unacceptable inequities in health outcomes. Achieving equitable health outcomes underpins all of our priorities for the Hawke's Bay system.

We have an obligation to provide services that are high quality and do not add to the inequities between population groups, a significant factor enabler to achieve equity is therefore to work with our inter-sectoral partners to tackle the underlying causes of inequity. Differences in socioeconomic determinants of health are often long-term, inter-generational and as a result ingrained in individuals and families. We need to support community development, supporting whānau, hapū and iwi to achieve health and wellbeing of their people, thereby benefitting all.

We have control over the structural problems built into our health services and we can make immediate progress on this. An equitable

system recognises that different people with different levels of advantage require different approaches and resources to achieve the same outcome. Resources will be refocused in the areas that will make a real difference to eliminating unmet need and inequities. Whānau will be equal partners in planning and co-design of services that are mana-enhancing and focussed on what matters the most to them.

Our key objectives

- 95% of children and their whānau have completed a first 1000 days programme
- Double the funding of kaupapa Māori services
- Consumers can access traditional cultural practices where they are identified in their wellbeing plan

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- 95% of all People with a Disability are satisfied with the services they receive

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Our approaches

Refocus the regional Mataraki strategy on equity (under the title of Social Inclusion) to ensure economic progress is inclusive	Invest more in our children and young people with a focus on the first five years of life
Work with local iwi, hapū and post-Treaty settlement groups to address socioeconomic disadvantage for Māori	Shift resources into services that will meet the needs of those whānau with the poorest health and social outcomes
Invest more in kaupapa Māori and Pasifika wellbeing models that are co-designed with whānau and communities	Intensify our whānau ora approach for young whānau with the greatest unmet needs (including those with disabilities)
Learn from international best-practice and design and deliver services according to the priorities of our whānau and communities	Remove barriers to accessing high quality health care

Dependencies

- Equal commitment from inter-sectoral partners to collective action and pooled resourcing
- Trust-based relationships with hapū, iwi and communities where we are able to respond to their needs with new models and frameworks
- Commitment to equity as a principle for our investments and disinvestment in some services
- Resourcing to address cost and other barriers
- Digital enablement (including data sharing)
- Cultural shift to Hauora Māori philosophy to health and wellbeing
- Strong relationship-based mechanisms for linking with and co-designing with hard to reach populations

16.1



Fit-for-purpose workforce

Why is this important?

Our goal for the future is a system with a fit-for-purpose workforce. The people who work within the Hawke's Bay health system are our greatest asset, and a well-skilled, supported and engaged workforce supports high quality care. It is important that we have a workforce whose size and skills match our current and future needs. This will mean developing new or stronger skills for some and the emergence of new roles and competence and a more cohesive team approach. We also need to reduce barriers that stop people from using their skills flexibly and fully.

We are in the business of supporting people to be well and that applies to all our workforce. We need to attract high-quality people to work in Hawke's Bay, nurture talent, look after people's wellbeing, encourage improvement and celebrate success, and provide a satisfying professional life. Beyond the formal workforce it will become increasingly important to enable whānau and other individuals as supporters of people close to them. In order to deliver on this health strategy we will need transformational leadership. Skilled leadership

underpins engagement and growth in the capability and capacity of teams to support innovation and drive change.

Our key objectives

- Proportion of demographic groups in our workforce reflects the proportion in the local population
- 98% of local health sector positions are filled by appropriately competent workers
- Homegrown workforce / career pathways
- XX% increase in the voluntary workforce within the system
- XX% increase in behavioural health practitioners
- Safe workplace and meet the ISO standard for safe place to work
- XX% Staff health and wellbeing

Commented [HT8]: Further refinement of objectives required with sub EMT group

Our approaches

Recruit and develop staff to meet our current and future needs	Recruit and develop leaders that support and inspire, and engage with people to be their best
Ensure our workforce is culturally diverse and competent; reflecting, understanding and supporting our community's health needs	Make a wider range of disciplines, including non-traditional roles and specialist care, available in primary and community care
Value and provide support to develop our people's skills, leadership and initiative so they can make a difference now and in the future	Work as one team across the sector with more shared care arrangements and inter-professional practice
Help staff look after their own wellbeing and ensure a safe working environment with sufficient resourcing to provide quality care	Encourage, support and value the services provided by health related charitable organisations and volunteers within our communities
Continue to provide opportunities for everyone to get involved in designing our services and our workplace	

Dependencies

- 16.1
- Redefining scopes of practice and models of delivery within regulatory constraints
 - Attracting the right people to work in the health sector in Hawke's Bay
 - Recruitment and retention processes need to purposefully seek people who share our values
 - Digital enablement and up-skilling so that information can be viewed and updated by everyone necessary
 - Monitoring of resourcing and competencies to ensure we meet the system's needs
 - Evolution of roles requires continuous improvement, education and training so staff skills can be used in different ways
 - Strong leadership across the system (including our partners)

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- Robust and comprehensive health and safety framework



Digitally-enabled health system

Why is this important?

A digitally-enabled health system integrates people, information and processes to deliver better health outcomes. It has its focus firmly on people and outcomes, implementing smarter ‘ways of doing things’ that create the greatest value and enable us to achieve our strategic goals.

We must make information easy to access and share to implement new models of care. Trusted information needs to be available any time, any place and across different channels according to people’s preferences and situations.

We need to unlock the power of data and actionable insights. This supports our communities to take ownership of their local health environment. It also enables our workforce and consumers to make better and faster decisions.

We will develop a continuous service improvement culture to ensure we get best value from our system. This means streamlining workflow and developing more iterative and rapid ways of doing things. We

want to make it quicker and easier, and provide the solutions our people and communities need to improve health services and outcomes.

There are core technical capabilities that form the foundation of a digitally-enabled health system. This includes system and data architecture to enable access and integration. A widespread change to a ‘digital mindset’ will enable the transformation of our health system.

Our key objectives

- At least 85% of our community and clinical teams are happy with the level of co-design of our digital services by 2029
- At least 85% of our customers are happy with the digital services we provide (access to health services and information) by 2029
- All our workforce is able to comfortably use digital technologies to do their work by 2029

Commented [HT9]: This section needs to be checked for health literacy. A Health literacy review of final draft to be completed before print version

16.1

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- 70% reduction in the use of paper by 2029
- All appropriate (mission critical) digital services are available 24x7
- Critical systems are integrated to enable a consolidated information view and streamlined processes
- Adopt national and regional interoperability standards to support information flow
- ##% time spent by patients waiting in our system

Our approaches

Adopt an innovative and agile delivery approach underpinned by strategic partnerships and skilled local teams focused on delivering business value first, technology second	Use our data to better understand our health system and define new improved models of care
Adopt a holistic approach to improve the health system as a whole rather than focussing on individual parts	Support models of care that deliver the right care at the right time by the right team in the right place
Enable access to services and information at the right place and time by providing people with access options that support different preferences and care situations	Empower our workforce to confidently use digital technologies to deliver health services
Provide a consolidated, accurate, shared and comprehensive view of health, care and community information	Implement improvement methodologies and streamlined processes that make it easy for people to do the right thing and to try new things
Use the data we collect to make better informed decisions and improve our processes including predicting and responding to demand	Embed monitoring, evaluation and research within our system and share learning so best practice and innovation spreads

16.1

Dependencies

- Requires investment in digital technologies to keep pace with developments in healthcare and society
- Requires a change from clinical models of 'care' to a comprehensive understanding of holistic person centred health models of wellbeing
- Strong data governance to ensure person and whānau drive the appropriate use of information

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- Requires national and regional governance of interoperability standards (so systems 'talk to each other' across boundaries)



High performance and sustainability

Why is this important?

Our goal for the future is a high performing and sustainable health system. Our system performs well in many areas but we can and must do better. Increased pressure on the health dollar means that we must continually look for ways to live within our means. We have opportunities to do things differently and need to embrace every opportunity to enhance quality by providing better care within our available resources.

Through honest and respectful conversations with people and whānau we can stop doing things that are clinically ineffective or offer little value or are not what people want. If we cut out waste in the delivery of services we can then deliver different, better or more extensive services within our available resources. Technology offers us new ways of interacting with people and we need to modernise our business processes and change our traditional ways of doing things.

Our key objectives

- 25% increase in cost-effectiveness of funded services by 2029
- DHB is in top decile of Health Round Table performance
- No increase in the current number of hospital beds by 2029
- 90% of DHB owned and contracted services have agreed environmentally sustainable systems
- 50% reduction in the rate of adverse events

Commented [KC10]: Not called serious adverse events any more – just adverse events

16.1

Our approaches

Maintain strong local clinical governance and clinical networks to reduce variation in quality, safety and sustainability of services	Deliver services in the least resource intensive setting allowing good access to specialist interventions currently only available in hospital
Apply lean thinking to business models to deliver more proactive care and better use of the workforce	Have informed conversations with consumers, whānau and health professionals about interventions that add value to care
Develop alternatives to face-to-face contact so people can communicate with a wider range of health providers	Make responsible investment decisions that offer best value-for-money and we intervene at the most timely and cost effective time
Ensure facilities are fit-for-purpose and flexible so we can provide contemporary, high quality models of healthcare	Structure and locate our clinical support services appropriately to provide timely, effective and efficient diagnostics, interventions, treatment and monitoring services
Implement productivity programmes for 24/7 hospital services with timely decision making and minimal wasted time	Ensure our infrastructure is environmentally sustainable
Adopt a commissioning approach that considers whole-of-system resources and measures outcomes against what matters to people and whānau	

Dependencies

- Redesign of primary care business models enabled by strong relationships and change support that take into account other cultural ways of thinking
- Changes to hospital processes require clinicians to work in different ways, and at different times, than they traditionally have

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- Digital enablement to allow virtual and other interactions
- Upgrading current facilities requires capital injection within a constrained funding environment
- An understanding of the emerging risk factors of climate change and seismic risk which are factored in to planning
- Real-time monitoring of system performance
- Focus on lean process design and waste removal
- Robust prioritisation tool and evaluation data
- Learning system culture

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Investment principles

We have significant resources available to us which are fully deployed delivering services to the population of Hawke's Bay. However to achieve our system goals we will need to reshape the allocation of these resources. Our approach to this will be underpinned by the following principles:

Sustainable – through effective planning, we ensure decisions are sustainable over the long-term

Transparent – stakeholders have visibility of and input to, how resources are allocated

Value driven – prioritisation of investment and divestment underpinned by our values, the concepts of value for money and the triple aim

Commented [HT11]: Re word to include linkage to Equity investment

Outcomes-focussed – anticipated health outcomes and key success factors are known and monitored. Stakeholders are held to account for delivery

Holistic – considers the full impact of change, including equity impacts and inter-dependencies

Enabling – systems and controls appropriately balance stewardship and flexibility; empowered stakeholders have the right information to make sound decisions

Bold – we back ourselves to make change and move the resources to make it happen

	DRAFT Hawke's Bay District Health Board Annual Plan 2019/20, and Statement of Performance Expectations 2019/20	52
	For the attention of: HBDHB Board	
Document Owner	Chris Ash, Executive Director of Primary Care	
Document Author(s)	Kate Rawstron, Head of Planning & Strategic Projects Robyn Richardson, Principal Planner	
Month/Year	May, 2019	
Purpose	For review and noting	
Previous Consideration Discussions	Nil	
Summary	This draft of the Annual Plan is still in development as Ministry feedback on the first draft has not yet been received. We are presenting documents in the current state for review with final drafts being presented at the June meeting.	
Contribution to Goals and Strategic Implications	Improving quality, safety and experience of care; Improving Health and Equity for all populations; Improving Value from public health system resources are all essential to our Annual Plan.	
Impact on Reducing Inequities/Disparities	Note specific Equitable Outcomes Actions (EOA).	
Consumer Engagement	Consumer engagement activity is an essential part of activities within this plan.	
Other Consultation /Involvement	Planning & Commissioning, Health Hawke's Bay, Population Health, Māori and Pasifika Health and Health Services have been involved with the development of this plan.	
Financial/Budget Impact	Financials have been included in this plan, but will require further adaptation post MOH communication.	
Timing Issues	Submission of this final draft document to the Ministry of Health (MoH) is required by 21 June 2019 with final signatures required by 30 June 2019.	
Announcements/ Communications	Not applicable	
RECOMMENDATION:		
It is recommended that the HBHDB Board :		
<ol style="list-style-type: none"> 1. Review documents 2. Note offer for small group meetings to be arranged if a more detailed walk through of the draft plan(s) is required. 3. Note that a final version will be presented at the June Board for signoff ahead of submission to the Ministry 		

Subjectdate

**DRAFT Hawke's Bay District Health Board
Annual Plan 2019/20 and Statement of Intent
2019/22 and Statement of Performance
Expectations 2019/20**

Author:	Kate Rawstron, Robyn Richardson
Designation:	Head of Planning & Strategic Projects
Date:	20th May 2019

OVERVIEW

The first draft of the Hawke's Bay District Health Board (HBDHB) Annual Plan was submitted to the Ministry of Health (MoH), as requested, on 5th April.

This submission covered the following sections of the package as indicated below, and are included at attachments to this paper:

Section:	Submitted:
• Part A	Annual Plan <i>draft Annual Plan</i>
• Part B	Statement of Intent 2019/22 (SOI) Statement of Performance Expectations (SPE) <i>draft SPE</i>
• Appendix 1	System Level Measures (SLM) Improvement Plan
• Appendix 2	Population Health Annual Plan <i>draft PH AP</i>

Points to note:

- A SOI is required only three yearly, with the requirement for one this year, with our last being approved in 2016.
- It is important to note that we are still awaiting feedback on the submission as well as final guidance from the MoH regarding a number of areas hence further adaptations will be required before documents are due to the Ministry on 21st June. We expect that there will be changes to financials as well prior to the final.
- The Annual Plan strategic discussion with the MoH took place on May 14th.
- In order to meet legislative requirements our SOI and SPE require signatures prior to 30th June 2019.

Changes from 2018/19

In the Minister's letter of expectations, he identified that achieving equity within the New Zealand health system underpins all his priorities. He described the need for explicit focus on

Subject	date
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achieving equity for Māori across the life course and unmet need especially for Pacific and other population groups with poorer health outcomes. All of these areas have been addressed in the final draft Annual Plan.

Ministry driven changes:

- New format to outline activity for the year.
- Government planning priorities are clearly identified: Child Wellbeing; Mental Wellbeing; Strong and Equitable Health & Disability System; Environmental Sustainability and Drinking Water Safety and Primary Care and Prevention. Activities are grouped into 34 focus areas across these priority areas.
- Show line of sight to three of the Government's twelve priority outcomes:



Figure 1. Connection between the whole of government priorities and health system priorities

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- Performance Measures in the Statement of Performance expectations have had new nomenclature applied this year, in line with priority groupings. We have chosen to include the historical as well as the new nomenclature to help the transition with reporting.

Internal process changes

- Each focus area has had a DHB lead assigned to take responsibility for harnessing cross team input, agreeing actions, leads and timeframes and completing reporting during the year.
- A suggested working group from Planning and Commissioning, Health Hawke's Bay, Population Health, Māori and Pasifika Health and Health Services was provided to all DHB leads. This should lead to better ownership of reporting going forward.
- Our Comms Team is supporting a new look to the Annual Plan documents. A first cut is also attached. Formatting will be completed for presentation at the June meeting.

Reporting

Local indicators included in our SPE have been reviewed by Executive Directors Health Improvement and Equity and Primary Care.

System Level Measures

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The System Level Measure (SLM) Improvement Plan 2019/20 is required to go to Ministry along with the Annual Plan. With the establishment of the Te Pītau Alliance the responsibility for the SLM Improvement Plan moves under that group. The Te Pītau approved plan will be presented as an appendix to the Final draft Annual Plan in June.

Current status

Section	Plans	May Board Review	June Board Signoff
Part A	Draft Annual Plan	Draft Annual Plan; <i>A number of gaps - still awaiting Ministry feedback</i>	Final Draft AP (pending Ministry feedback)
Part B	SOI 2019/22	<i>SOI not presented - awaiting new strategy</i>	Final SOI 2019/22
	SPE	Draft SPE; <i>Still some gaps - awaiting Ministry</i>	Final SPE
Appendix 1	SLM Improvement Plan	<i>Not presented - Te Pītau scheduled to sign off (12/6)</i>	Final SLM Improvement Plan
Appendix 2	Population Health Annual Plan	Final post Ministry feedback	Final Pop Health AP

ATTACHMENTS

- | | |
|-----------------------|---|
| Part A | Draft HBDHB Annual Plan 2019/20 |
| Part B | SPE 2019/20 |
| Appendix 1
Concept | Population Health Annual Plan (Final)
Annual Plan layout |

Subject

date

RECOMMENDATION:

It is recommended that the Board

1. **Review** documents
2. **Note** offer for small group meetings to be arranged if a more detailed walk through of the draft plan(s) is required
3. **Note** that a final version will be presented at the June Board for signoff ahead of submission to the Ministry

COVER PAGE

HBDHB ANNUAL PLAN 2019-20

Version 2.4

17.1

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

TAUWHIRO

Delivering high quality care to patients and consumers

RĀRANGA TE TIRA

Working together in partnership across the community

HE KAUANUANU

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

ĀKINA

Continuously improving everything we do

Hawke's Bay District Health Board Annual Plan 2018/19

DHB Contact Information:

Planning

Hawke's Bay District Health Board

Private Bag 9014

HASTINGS

Ph: 06-878 8109

www.hawkesbay.health.nz

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17.1

PART A – Annual Plan

SECTION ONE: Overview of Strategic Priorities

1.1 Strategic Intentions/Priorities/Outcomes

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 Statement of Intent (SoI) 2019-22 outlines our strategic intentions and shows how local outputs impact on our population and contribute to local, regional and system-level outcomes.

As a sector we have a common vision: "TBC" and mission. We face challenges such as the growth in chronic illness, our aging population and vulnerability in a large sector of our community.

In 2018 we developed a clinical services plan to formulate our major responses to the challenges we face. It describes our vision for a very different health system that improves outcomes and experience for individuals and whānau living in Hawke's Bay. This plan is the natural evolution of our previous five year strategy, 'Transform and Sustain', and together with a number of related projects. This foundational document, together with other key organisational reports and plans, have informed the development of our new strategic plan "[HB Health Strategy]".

Over the last five years, we have shifted our perspective from DHB services to whole-system management and engagement with iwi and post-settlement governance entities, with our Transform and Sustain strategy. We set up our Consumer Council to work alongside our Clinical Council and Māori Relationship Board and have generally performed well over a number of years. Success in preventative services such as immunisation and screening show what can be achieved when we purposefully set out to understand the needs of our community and deliver our services in a way that meets the needs of whānau.

Despite the progress we have made many challenges still remain. Our 2018 Health Equity Report shows large inequities in health persist for Maori, Pacific and those with the least social and economic resources Demographic changes will increase pressure on our already stretched health services. If we continue to do things the way we do now the number of primary care consultations, hospital appointments and inpatient stays will outstrip population growth.

At its heart, our new strategy is about people: as members of whānau, hapū and iwi; and in their homes communities and workplaces. We exist because of them and we recognise that people and

whānau are the experts in their own lives. We need to plan and deliver health services in the wider context of people's lives, and how we include Māori and Pasifika practices. This strategy describes our goals to partner with people and whānau, and work across agencies to improve the conditions of life, so that everyone has fair opportunity to achieve good health and wellbeing

We will turn to our people to find solutions. The district health board must act as a careful steward of health resources in the Hawke's Bay, which is a challenging task. We need our community to help us so that we invest in the areas that matter most to people and whānau. This plan prioritizes health improvement of populations with the poorest health and social outcomes.

In 2019/20, the Hawke's Bay district population will grow to just under 168,000 people. Most of our population live in Napier or Hastings, two cities located within 20 kilometres of each other that together account for 81 % of the total numbers. About 8 % of the population live in or close to Wairoa or Waipukurau, which are relatively concentrated rural settlements, and the remaining 11 % 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 (26% vs 16%), more people aged over 65 years (19% vs 16%) and more people living in areas with relatively high material deprivation (28% 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 of people's opportunity to access and use the health system.

TBC – insert from strategy

1.2 Message from the Chair

TBC

1.3 Message from the Chief Executive

TBC

17.1

1.4 Signature Page

X_____

Dr Kevin Snee, Chief Executive
Hawke's Bay District Health Board

X_____

Kevin Atkinson, Board Chair
Hawke's Bay District Health Board

X_____

xxxx, Board Member
Hawke's Bay District Health Board

X_____

Hon. Dr David Clark
Minister of Health

SECTION TWO: Delivering on Priorities

2.1 Health Equity in DHB Annual Plans

In 2018 we updated the Health Equity in HB report, an analysis and report on health status in HB. The main focus of the report is 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 HB, 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. 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 and this is reflected in our plan.

The social conditions in which people live, powerfully influence their chances to be healthy. Indeed, factors such as poverty, food insecurity, social exclusion and discrimination, poor housing, unhealthy early childhood conditions and low occupational status are important determinants of most diseases, death, and health inequalities between and within countries.

Health therefore, is not just the outcome of genetic or biological processes, but is also influenced by the social and economic conditions in which we live. These influences have become known as the 'social determinants of health'. Inequalities in social conditions give rise to unequal and unjust health outcomes for Māori (and for different social groups). Ref: Kanupriya Chaturvedi Dr, S.K Chaturvedi Dr.

2.1.1 Health Equity Tools

HBDHB has developed very good health monitoring and measuring reporting systems. The 'dashboard reports' also measure health equity (by ethnicity) against national and localised health priorities and indicators within our Annual Plan, for example the Te Ara Whakawaiora (TAW) programme and the Pacific Health indicators, as included in the Ala Mo'ui Pathways to Pacific Health and Wellbeing 2014-2018.. The Te Ara Whakawaiora (TAW) programme is an exception based monitoring and improvement programme based on the non-performing indicators within the Annual Plan. TAW is led by 'TAW Champions', members of the Executive Management Team (EMT).

17.1

2.4 Government Planning Priorities

2.4.1 Child Wellbeing

Immunisation			This is an equitable outcomes action (EOA) focus area	
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
Work with Health Hawke's Bay to standardise new-born enrolment process within general practices	Q4	CW07	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Make New Zealand the best place in the world to be a child
Survey two local urgent care providers to investigate provision of opportunistic immunisation to children under five years of age	Q3		System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Make New Zealand the best place in the world to be a child
Check immunisation status of all children under five years of age on Health Hawke's Bay Whanau Wellness programme and if not up to date facilitate immunisation through general practice. EOA Māori and Pacific.	Q4	CW08 CW05	System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Make New Zealand the best place in the world to be a child
Explore the potential of a local Māori Health Provider to offer a weekly walk in immunisation clinic. Work with provider to implement. EOA Māori.	Q4		System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child

School-Based Health Services			This is an equitable outcomes action (EOA) focus area	
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families	

Midwifery Workforce – Hospital and LMC			This is an equitable outcomes action (EOA) focus area	
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families	
Develop a local midwifery workforce plan, in line with national planning, with a particular focus on matching workforce to community	Q1 plan		System outcome	Government priority outcome

• Building a culturally responsive workforce • Strengthening and supporting Māori midwifery undergraduate pipeline. EOA Māori and Pacific.	Q4 phase 1	100% completion rate of Turanga Kaupapa training % of midwifery workforce Māori and Pacific tbc	We have improved health equity (healthy populations)	Make New Zealand the best place in the world to be a child
Retention: In light of national midwifery shortages, review current workforce models (regulated and non-regulated roles) for maternity, with a view to ensuring safe staffing levels.	Q2		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Make New Zealand the best place in the world to be a child
Recruitment: Develop an attractive midwifery package for Hawke's Bay	Q1		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Make New Zealand the best place in the world to be a child

First 1000 Days (Conception to Around 2 Years of Age)			This is an equitable outcomes action (EOA) focus area	
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
Develop first 1000 days outcomes framework for Hawke's bay	Q4	SUDI rate CW06 SLM Healthy Start CW10	System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Make New Zealand the best place in the world to be a child
Analyse and report data collected as part of the māmā Māori interviews undertaken in 2018 Collate raw data and carry out Kaupapa Māori approach to analyse relevant SUDI, Smoking Cessation and Breastfeeding responses, complete a thematic analysis and compile into a brief summary report with recommendations for areas for improvement for whanau Māori. EOA Māori, see SUDI.	Q1 Q2		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Make New Zealand the best place in the world to be a child
Develop a plan for the development of appropriate messaging and support for whanau Māori. See SUDI. EOA Māori.	Q1		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Make New Zealand the best place in the world to be a child
Interview Pacific families who presented to ED for ASH 0-4 in 18/19 to gain insights into their experience. EOA Pacific	Q2		System outcome We have improved health equity (health populations)	Government priority outcome Make New Zealand the best place in the world to be a child
Develop a plan for the development of appropriate messaging, referrals and support for families engaged in action above. EOA Pacific	Q3		System outcome We have improved health equity (health populations)	Government priority outcome Make New Zealand the best place in the world to be a child
Continue to deliver the activities identified to support healthy weight in the Hawke's Bay Best Start Healthy Eating Plan.	Q4		System outcome We have improved health equity (health populations)	Government priority outcome Make New Zealand the best place in the world to be a child

Family Violence and Sexual Violence (FVSV)			This is an equitable outcomes action (EOA) focus area	
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
<p>Undertake a review of the utilisation of family violence and sexual violence services by Pacific families. (Low rates of Pacific community accessing services in HB – actual numbers unknown, but disproportionate rates in NZ Police statistics).</p> <ul style="list-style-type: none"> • Develop an understanding of family violence/sexual violence from a Pacific perspective. • Develop an understanding of utilisation and barriers of access to services. • Re-shape services to meet the needs identified through the review. • Improve awareness of services in the Pacific community. • Improve service delivery and community follow-up. <p>What are the rates of Pacific families accessing family and/or sexual violence services? What are the barriers to them accessing services for family and/or sexual violence? How do services need to be delivered to support Pacific community engagement? What are the long term pathways for engagement and feedback from the Pacific communities? EOA Pacific.</p>	Q3	CW11	System outcome We have improved health equity (health populations)	Government priority outcome Support healthier, safer and more connected communities
<p>Improve the responsiveness of family/sexual violence services for whanau Māori. (High prevalence of Māori in acute/crisis level family violence, sexual violence services).</p> <ul style="list-style-type: none"> • Understand the experience of Māori groups through engagement with stakeholders. • Gather whanau insights into their experiences and barriers to access to care to acute/crisis care and support. • Develop clear pathways for whanau Māori whether accessing family violence and sexual violence services. Consider the development of sustainable feedback processes and resources. <p>Make recommendations for family violence and sexual violence service delivery for Māori. EOA Māori.</p>	Q4		System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities
<p>Utilise community feedback to support the Sexual Assault Service's application of a therapeutic approach for clients accessing their team. Ensure a particular focus on responding to the needs of Pacific and Māori men accessing the service.</p>	Q4		System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities
<p>Inter-sectoral family harm responses – identify resources to support the on-going development of the Oranga Whānau – Government Agencies Group. Particularly address co-ordination and membership to ensure continued focus on a Family Harm response framework, from prevention through to crisis intervention/post-intervention. (High prevalence of Māori in regional statistics for family harm. Lack of joint up planning and response across Government Agencies).</p>	Q2		System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child

SUDI			This is an equitable outcomes action (EOA) focus area	
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families	
Review the Cot Bank for equity for Māori: Undertake a quality improvement activity to review responsiveness of eligibility criteria, programme referrals and uptake, allocation, ethnicity, deprivation data, and areas for improvement. EOA Māori.	Q2		System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities
<p>Analyse and report data collected as part of the māmā Māori interviews undertaken in 2018</p> <ul style="list-style-type: none"> • Collate raw data and carry out Kaupapa Māori approach to analyse relevant SUDI, Smoking Cessation, and Breastfeeding responses, complete a thematic analysis, and compile into a brief summary report with recommendations for areas for improvement for whanau Māori. EOA Māori. See First 1000 days. 	Q1	Rate SUDI CW06	System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
Gather the whānau story of whānau Māori that lost a pēpi to SUDI.	Q3		System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities
<ul style="list-style-type: none"> • Gather whanau stories about their experience losing pēpi to SUDI. EOA Māori. 	Q4			

Plan the development of appropriate messaging of SUDI for whānau Māori. Based on Actions 1, 2 and 3 above. Include a specific focus on smoking cessation, safe sleep and breastfeeding activities to enhance a SUDI response appropriate for Māori. EOA Māori. See First 1000 Days.	Q4		System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
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2.4.2 Mental Wellbeing

Inquiry into Mental Health and Addiction Please outline how your DHB will work to implement Government agreed actions following the Mental Health and Addiction inquiry Report and implement relevant Budget 2019 appropriations. (Further guidance will be provided following Government decisions).			This is an equitable outcomes action (EOA) focus area	
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
tbc				

Population Mental Health			This is an equitable outcomes action (EOA) focus area	
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
Work with Territorial Authorities, Safer Communities, HPA and other agencies to scope a community led initiative which aims to support community champions who assist community members and whanau in mental distress	Q4	MH06 CW12 MH04 CW12	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
Kaitakawaenga to conduct Aromatawai (cultural assessment) for inpatient Mental Health Services and liaise and follow-up on Māori patient progress with assigned mental health key workers once discharged	Q4		System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities
Increase the nurse credentalling for mental health in primary care	Q4		System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering
Phase 2 of a system wide MH & A re-design inclusive of co-design principles and an equity lens that aligns and integrates the recommendation and priorities from the National Mental Health Inquiry and HBDHB's Clinical Services Plan	Q4		System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Support healthier, safer and more connected communities

Mental Health and Addictions Improvement Activities			This is an equitable outcomes action (EOA) focus area	
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
Work with GPs to improve the quality of the information and appropriateness of the referrals from GPs to meet secondary care admission criteria as part of connecting care project of HQSC	Q4	MH02 HQSC MH01	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities

Scope mechanisms for the transfer of transition to GPs to increase the percentage target	Q4		System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
Identify where and when to triage in the model of care to de-escalate aggravation, agitation and threatening behaviour, in order to minimise seclusion	Q4		System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering

Addiction	This is an equitable outcomes action (EOA) focus area		
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.
Integrate Springhill AOD residential centre with identified NGO community addiction provider/s, potentially across region, to provide a seamless addiction response and reduce inequities for Māori, Pacific and criminal justice clients. The goal is to provide 'right care, right place, right time' and is in answer to gaps identified from the implementation of the central region AoD model of care.	Q2 tbc	MH03 MH04	System outcome We have improved quality of life (health maintenance and independence)
Implement the improvement plan for DHB Provider arm services to ensure that the target for young people referred for non-urgent addiction services within three weeks is met	Q1		System outcome We have improved quality of life (health maintenance and independence)

Maternal Mental Health Services	This is an equitable outcomes action (EOA) focus area		
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.
As a result of the stocktake of primary mental health service provision, undertake a scoping exercise toward building a more integrated model of care across the community, which addresses identified service gaps and barriers to access for Māori women. EOA Māori and Pacific.	Q4	CW12	System outcome We have improved health equity (healthy populations)

2.4.3 Strong and Equitable Health and Disability System

Engagement and Obligations as a Treaty Partner			This is an equitable outcomes action (EOA) focus area
DHB activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.

Initiate scheduled meetings between HBDHB GM Māori Health and CEO Ngāti Kahungunu Iwi Inc. EOA Māori.	Q1	SS12	System outcome We have improved health equity (healthy populations)	Government priority Support healthier, safer and more connected communities
Review memorandum of understanding (MOU) between Ngāti Kahungunu Iwi Inc and HBDHB. EOA Māori.	Q2		System outcome We have improved health equity (healthy populations)	Government priority Support healthier, safer and more connected communities
Provide equity training to HBDHB staff. EOA Māori.	Q4		System outcome We have improved health equity (healthy populations)	Government priority Support healthier, safer and more connected communities
Provide Māori Cultural Competency Training to HBDHB staff. EOA Māori.	Q4		System outcome We have improved health equity (healthy populations)	Government priority Support healthier, safer and more connected communities

Cross-Sectoral Collaboration			This is an equitable outcomes action (EOA) focus area	
DHB activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
Develop an inter-sector framework to coordinate, prioritise, monitor and measure outcomes for HBDHB activity. EOA Māori and Pacific	Q1	n/a	System outcome We have improved health equity (healthy populations)	Government priority Support healthier, safer and more connected communities
Support the access to whānau voices (consumer feedback) collected by partner agencies. Enable its use in designing services, programmes and planning with whānau <ul style="list-style-type: none"> Investigate a clearinghouse approach to store and access recorded whanau voice, i.e. research, consumer feedback, meetings and workshop notes, to inform planning, develop and deliver services. 	Q4		System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities
Establish information sharing across Government agencies to ensure quality data is informing decisions and is available to monitor impact <ul style="list-style-type: none"> Through information sharing agreements with partner agencies By having regular meetings between information systems staff beginning with Police, MSD and HBDHB Through facilitating ways to share whānau voices. 	Q4		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
Support inter-sectoral projects by: <ul style="list-style-type: none"> Resourcing the work of the family violence interagency group Contributing to employment programmes including reducing barriers to employment, Rangatahi Ma Kia Eke and pathways to health roles Improving the quantity and quality of housing via leadership in the Housing Coalition projects Supporting frontline staff to link clients with mental health and addiction services. 	Q4		System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities

Strategic Health Measures			This is an equitable outcomes action (EOA) focus area	
<i>TBC following government decision</i>			(Equity focus and clear actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs)	
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
			System outcome	Government priority outcome

			We have improved quality of life (health maintenance and independence)	Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering

Disability			This is an equitable outcomes action (EOA) focus area	
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
Support Health and Wellbeing by establishing practises that ensure the rights of people with disabilities: <ul style="list-style-type: none"> Have whanau/support people when engaging with HBDHB services. Review and update policy. Investigate options to develop a system to record impairments on patient records to enable staff responsiveness and monitoring of health service delivery for people with disabilities. Develop a monitoring tool for the HBDHB Disability Plan. EOA Māori and Pacific	Q4	SI14	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
Improve Accessibility for people with disabilities by: <ul style="list-style-type: none"> Establishing feedback mechanisms which enable people with disabilities to provide feedback and receive responses Identify options of addressing barriers to accessing services EOA Māori and Pacific	Q2		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
Improve attitudes toward people with disabilities by: <ul style="list-style-type: none"> Developing training opportunities for HBDHB staff, in partnership with the disability community. EOA Māori and Pacific	Q4		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities

Planned Care			This is an equitable outcomes action (EOA) focus area (Equity focus and clear actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs)	
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	

Acute Demand	This is an equitable outcomes action (EOA) focus area	

DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
Acute Data Capturing. SNOMED coding implementation into ED for NNPAC in 2021. Actions: <ul style="list-style-type: none">• Install latest Patient Administration System (ECA) with applicable SNOMED capabilities and configure as required (existing platform, version upgrade only), testing• Super User acceptance testing, training of ED users• Reconfigure NNPAC data capture in Data Warehouse as required, adjust Extract requirements.	Q2 Q4	SS10 Inpatient length of stay	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
Patient Flow. Investigate digital solutions to managing emergency patient flows to improve health literacy and allow more informed decision regarding treatment options, thereby increasing the number of people appropriately utilising urgent care in primary care rather than ED. EOA Māori and Pacific	Q2		System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities
Patient Flow. Improving wait times for patients requiring mental health and addiction services who have presented to the ED by, in addition to referring to Consult Liaison (in hours) or Emergency Mental Health Service (after hours), referring to Māori Health Service if the person identified as Māori. EOA Māori	Q2		System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities
Patient Flow. Create hospital capacity to manage acute demand by improving acute hospital flow. <ul style="list-style-type: none">• Improved discharge processes by adoption of standardised Criteria Based Discharge (CBD) process across all adult in-patient wards• Reducing acute hospital re-admissions rates by identifying patients at risk of re-admission and focusing on support in the community EOA Māori			System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities

Rural Health	This is an equitable outcomes action (EOA) focus area		
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.
Wairoa Community Partnership Group (CPG); develop shared outcomes and processes (formal and informal) for whanau to input into CPG. EOA Māori .	Q4	Whānau feedback Written feedback Strategy completed	System outcome We have improved health equity (healthy populations)
A clinical governance group is developed and fully functioning for Wairoa health system. EOA Māori .	Q2		System outcome We have improved quality of life (health maintenance and independence)
Identify workforce gaps and skills required to implement the future model of care. Develop a strategy for sourcing and developing the Wairoa workforce. EOA Māori .	Q2		System outcome We have improved quality of life (health maintenance and independence)
Develop preventative and educational programmes for and with Wairoa community. EOA Māori .	Q3		System outcome We live longer in good health (prevention and early intervention)

Healthy Ageing	This is an equitable outcomes action (EOA) focus area		
DHB Activity	Milestone	Measure	Government Theme:

			Improving the well-being of New Zealanders and their families.	
Initiate, develop and monitor the effectiveness of 'Hoki te Kainga' an Early Support Discharge service, to improve patient outcomes and improve hospital flow. Linkages: <ul style="list-style-type: none">• Healthy Aging Strategy – enable high quality restorative care for effective rehabilitation, recovery and restoration after acute events• S&B – the rehabilitation service is linked to increasing strength and balance through focused functional rehabilitation goals• Evidence suggests a 25% reduction in six month post discharge all cause readmissions• Clinical Services Plan (CSP)– strong links; moving services from the hospital to the community/patients house	Q1-4	SS04	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
Investigate and develop a formal Health Equity Partnership to inform the ongoing development of health services to improve outcomes for older Māori. EOA Māori. Linkages: <ul style="list-style-type: none">• CSP – reducing inequalities by working with Māori with an outcome that they own their service delivery• CSP – inclusion in service design to ensure services meet the needs of Māori	Q2 Q4		System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities
To develop a system and processes for the effective management of frailty within the Medical and HOP Directorates. The objective is to create a hospital wide approach to frailty. The initial focus will be on: <ul style="list-style-type: none">• The development and implementation of processes to help prevent admissions for those living with frailty.• The development and implementation of processes to identify frailty on admission that better supports the patient's journey to achieve better outcomes. Linkages: <ul style="list-style-type: none">• HAS – "enabling high quality acute care" for elderly that meets their needs• HAS – "value and high performance" (reducing complications and LOS)• CSP – freeing up resources to improve community services	Q1-4		System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Support healthier, safer and more connected communities
Development and implementation of an "End of Life" Service Level Alliance (SLA) with a focus on delivering care closer to home and reducing acute bed days. Linkages: <ul style="list-style-type: none">• CSP – Keeping people well in their own homes in their own communities• HAS – Dying well, provide respectful end-of-life care that caters to physical, cultural and spiritual needs	Q4		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities

Improving Quality	This is an equitable outcomes action (EOA) focus area
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DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
Diabetes specialist services and renal services to work together toward earlier identification of high risk patients. CNS diabetes, as part of work with general practice to link renal patients to general practice thereby supporting renal patients being managed in primary care. EOA Māori and Pacific (Disproportional representation of Māori and Pacific in ASH rates 45-64)	Q2 Q4	SS13 SS05	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
Improve patient education on medicines through improved hospital pharmacy ward service; Work toward enabling more pharmacist-to-patient contact time throughout the patient stay and for discharge planning/education; continue current recruitment strategy that is focussed on seeking practitioners who are skilled or well-prepared to deliver culturally sensitive practice	Q1	N/A	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
Continue current recruitment strategy that is focussed on seeking practitioners who are skilled or well-prepared to deliver culturally sensitive practice.	Q1-4		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
Develop hospital wide antibiotic usage reports	Q4		System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Support healthier, safer and more connected communities

Cancer Services	This is an equitable outcomes action (EOA) focus area
<p>Cancer is the leading cause of morbidity in New Zealand, accounting for nearly one third of all deaths with 22,000 new cases diagnosed each year. Inequalities between Māori and non-Māori persist. Māori have a higher incidence of many cancers, are diagnosed with more advanced cancers, experience issues that impact on treatment options and are 1.7 times more likely to die from cancer than non-Māori New Zealanders.</p> <p>Key strategies and plans to help inform DHB Annual Plans are listed below:</p> <p>New Zealand Cancer Plan</p> <p>Cancer Health Information Strategy</p> <p>National Radiation Oncology Plan</p> <p>DHBs will describe and implement improvements in accordance with national strategies and be able to demonstrate initiatives that support key priority areas as outlined below. All initiatives will demonstrate clear strategies for addressing Māori health gain, equitable and timely access to services and the use of data to inform quality improvement across those initiatives.</p> <p>DHBs will describe actions to:</p> <ul style="list-style-type: none"> • ensure equity of access to timely diagnosis and treatment for all patients on the Faster Cancer Treatment (FCT) pathway (e.g. system/service improvements to minimise breaches of the 62 day FCT target for patient or clinical consideration reasons) <p>each DHB is expected to identify two priority areas for quality improvement identified in the Bowel Cancer Quality Improvement Report 2019 (the Report). DHBs received the draft Report in October 2018. Each DHB is expected to review their results and identify two areas for service improvement that are focused on improving outcomes for people with bowel cancer in their DHB area. DHBs are required to provide evidence</p>	17.1

that priorities have been identified and will be addressed. These activities could include service improvement initiatives undertaken at a regional or national level; particularly where the DHB relies on the wider region to undertake improvements in the areas it has identified.			
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.
<p>Cancer Screening Programmes – BreastScreen Aotearoa.</p> <ul style="list-style-type: none"> Continue to target Māori and Pacific unscreened women by conducting data matching between BreastScreen Coast to Coast and general practices patient databases, sending letters offering incentives for women who complete screening. EOA Māori and Pacific. Continue to follow-up Māori and Pacific women who have not responded (DNR) to BSA invitation letters for mobile breast screening unit, and explore extending DNR follow-up for TRG fixed sites at Royston and Greenmeadows. EOA Māori and Pacific. <p>National Cervical Screening Programme</p> <ul style="list-style-type: none"> Continue to improve general practice screening recall processes including encouraging recall to commence at 32 months to ensure on-time-three yearly screening. Work with general practices to review Karo reports, identify errors and how to resolve. Continue to target Māori and Pacific unscreened and under-screened women through targeted strategies and kanohi ki te kanohi approaches. EOA Māori and Pacific. 	Q1-4	SS07 SS08	<p>System outcome We have improved health equity (healthy populations)</p> <p>Government priority outcome Support healthier, safer and more connected communities</p>
Faster Cancer Treatment – Cancer health target. Comply with Cancer health targets:	Q1-4		<p>System outcome We have improved quality of life (health maintenance and independence)</p> <p>Government priority outcome Support healthier, safer and more connected communities</p>
<p>Cancer Survivorship Model of Care</p> <ul style="list-style-type: none"> Partner with the Cancer Society and Regional stakeholders to implement a model of care for cancer survivors. EOA. 	Q4	SS01 SS11	<p>System outcome We live longer in good health (prevention and early intervention)</p> <p>Government priority outcome Support healthier, safer and more connected communities</p>
tbc			
Continue to work with Central Cancer Network and tertiary providers to facilitate locally based cancer care for HBDHB population. (Radiation Oncology and Standards of Care. EOA).			<p>System outcome We have improved health equity (healthy populations)</p> <p>Government priority outcome Support healthier, safer and more connected communities</p>

Bowel Screening	This is an equitable outcomes action (EOA) focus area
New Zealand has one of the highest rates of bowel cancer in the world. Bowel cancer is the second most common cause of cancer death in New Zealand, after lung cancer, with the third highest bowel cancer death rate in the OECD for women and the sixth highest for men. The National Bowel Screening Programme aims to reduce the mortality rate from bowel cancer by diagnosing and treating cancers at an earlier more treatable stage. Early identification and removal of precancerous advanced bowel adenomas aims to reduce bowel cancer incidence over time.	

<p>Achieving equitable access is a key priority for the bowel screening programme because participation rates for Maori, Pacific and people living in our most deprived areas remain lower than other ethnic groups. A focus on equity is expected throughout the screening pathway.</p> <p>DHBs will describe and implement initiatives that support the National Bowel Screening Programme's priority areas outlined below (depending on their implementation stage). All initiatives will demonstrate clear strategies for increasing health gains for priority groups and improving equitable participation and timely access to services. Depending on implementation stage:</p> <p><u>ALL DHBs will describe actions to:</u></p> <ul style="list-style-type: none"> • Ensure colonoscopy wait time indicators are consistently met regardless of implementation stage; this requires active management of demand, capacity and capability. • Ensure equitable access throughout the screening pathway; this must be supported by visible leadership, effective community engagement, resources and clear accountability for equity at all levels. <p><u>All DHBs</u></p> <p>The National Bowel Screening Programme has adopted the 2018/19 Elective Funding and Performance Policy to monitor and manage the urgent, non-urgent and surveillance diagnostic colonoscopy wait time indicators. The Policy's escalation process has been adapted to:</p> <ul style="list-style-type: none"> • Include an Amber (tolerance period) and • Enable alignment with DHB non-financial quarterly reporting requirements <p><u>DHBS providing the bowel screening programme</u></p> <p>To ensure diagnostic colonoscopy wait times are not negatively impacted, the National Bowel Screening Programme indicator 306 will now be reported to measure screening colonoscopy performance in the context of managing total colonoscopy wait times (refer to DHB Non-financial Monitoring Framework and Performance Measures).</p>				
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
Implement Ministry of Health approved National Bowel Screening Programme HBDHB Annual Plan 2019/20, Equity Plan and Communications Plan. EOA Māori and Pacific.	Q1-4	SS15	System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities
Develop, implement and evaluate strategies to achieve at minimum the 62% target in participation for Māori, Pacific, decile 9 and 10, and total National Bowel Screening Programme eligible population through health promotion/health education activities and outreach follow up action. In addition we will set an internal target of 73% participation for Māori consistent with our intent to achieve equity of health outcomes for Māori across the life course. EOA Māori and Pacific.	Q1-4		System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities
Monitor and report on Colonoscopy Wait Time Indicators for urgent, non-urgent & surveillance, including for Māori and Pacific. EOA Māori and Pacific.	Q1-4		System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities
Monitor and report on the NBSP Interim Quality Standards, with specific analysis and relevant improvements for Māori and Pacific. EOA Māori and Pacific.	Q1-4		System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities

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Healthy Food and Drink			This is an equitable outcomes action (EOA) focus area	
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
Continue the implementation of the National Healthy Food and Drink Policy, committed to by HBDHB in August 2016.	ongoing	n/a	System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Support healthier, safer and more connected communities
Identify appropriate nutrition support for health providers from within our DHB.	Q1		We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
Develop online tools to support health contract providers e.g. policy templates, checklist etc.	Q1		We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities

Workforce			This is an equitable outcomes action (EOA) focus area	
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
Increase Māori and Pacific representation in the workforce via effective recruitment and retention strategies. Ensure alignment to endorsed Māori & Pacific Workforce Development Action plans. EOA Māori & Pacific.	Q4	% Māori and Pacific staff % staff trained	System outcome We have improved health equity (healthy populations)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring and volunteering
Increase HBDHB numbers completing Engaging Effectively with Māori. EOA Māori.	Q4		System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities
Workforce reporting: <ul style="list-style-type: none">• Continue to share Human Resource (HR) KPI report• Develop HR dashboards for Directorates• Develop Central Region HR benchmark KPI report.	Q4 Q2		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering
Education Framework: <ul style="list-style-type: none">• Prioritise focus on the development of an education framework to support all staff• Implement a Talent Mapping process (Tier 3&4 Managers) for leadership development• Maintain necessary standards for PGY1 and 2 aligned to Medical Council.• Maintain and develop relationships with EIT and tertiary institutions	Q2 Q1 Q1 Ongoing		We have improved health equity (healthy populations)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering
People and Whanau centred Care: <ul style="list-style-type: none">• Increase the number of staff completion rates of Relationship Centred Practice.			System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities

Data and Digital			This is an equitable outcomes action (EOA) focus area	
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
Regional Health Informatics Programme (RHIP) Clinical Portal. Continue programme to evolve new delivery method which is value driven and clinically led to allow clinicians to on-board whilst data migration runs parallel.	Ongoing	n/a	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering
Mobility Programme. Continue our mobility programme to enable access to people, services and information anytime and anywhere.	Ongoing		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
Unified Communications. Continue the rollout and enhancement of our Unified Communications solution to enable a mobile workforce and enhanced communication tools.	Q4		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering
Windows 10 Upgrade. Upgrade of HBDHB end user computing devices to Windows 10.	Q4		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering
M365. Plan and commence the implementation of the migration to the Microsoft 365 offering	Multi-year programme		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
Security programme. Continue to improve our security capabilities to improve connectivity while mitigating cyber risk to an acceptable level. In addition to enhancing our security-related incident and event management capabilities we aim to strengthen security controls at the edge of our organisation and increase security awareness of our workforce.	Ongoing		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
Primary Care Integration. Increase the adoption of Manage My Health and improve the referral process between primary and secondary care.	Multi-year programme		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities

17.1

TBA			This is an equitable outcomes action (EOA) focus area	
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	

			System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering
Delivery of Regional Service Plan (RSP) priorities and relevant national service plans			This is an equitable outcomes action (EOA) focus area (Equity focus and clear actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs)	
<ul style="list-style-type: none"> Identify any significant actions the DHB is undertaking to deliver on the Regional Service Plan. <p>Please provide actions for the following:</p> <p>Implementation of the New Zealand Framework for Dementia Care</p> <ul style="list-style-type: none"> tba <p>Hepatitis C</p> <ul style="list-style-type: none"> DHBs are asked to identify their role in supporting the delivery of the regional hepatitis C work and objectives. Action include for example how DHBs will: <ul style="list-style-type: none"> work in collaboration with other DHBs in the region to implement the hepatitis C clinical pathway work in an integrated way to increase access to care and promote primary care prescribing of the new pangenotypic hepatitis C treatments. 				
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
			System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child

			System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering
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2.4.3.1 Environmental Sustainability and Drinking Water Safety

Climate Change				
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
Annual carbon emissions footprint and certification process completed through Certified Emissions Management and Reduction Scheme (CEMARS).	Q4 (Ongoing)	n/a	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
Research/explore resources and investment required for HBDHB setting and achieving major emissions reduction target.	Q4		System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Support healthier, safer and more connected communities
Transition HBDHB toward 'dining consumable products' that are more environmentally sustainable	Ongoing		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
Sustainability working group to meet as needed to ensure HBDHB implements a strong response to climate change, in an equitable manner, in line with expectations from the Ministry of Health. Membership to include representation from Māori Health, Pacific Health, Population Health and other departments. EOA Māori and Pacific.	Ongoing		System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities
Waste Disposal				
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	

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Work with medical waste provider and community pharmacies to progress a comprehensive collection process.	Q4	n/a	System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Support healthier, safer and more connected communities
Begin measuring community pharmaceutical waste collected through community pharmacies.	Q4		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
Maintain annual waste reporting of landfill, recycling, green waste and medical waste as part of CEMARS certification process.	Q4 (Ongoing)		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
Apply a Ngāti Kahungunu environmental lens over key activities by partnering with Māori Health Services, Health Gains Advisor, utilising cultural knowledge to support the plan. EOA Māori .	Ongoing		System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities

Drinking Water			This is an equitable outcomes action (EOA) focus area	
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
Undertake the duties and functions of a Drinking Water Assessor and Designated Officer as required by section 69ZL-69ZN of the Health Act 1956. EOA Māori and Pacific ¹	Ongoing	See Population Health Plan	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
Continue to build and maintain relationships with relevant stakeholders including the Drinking Water Joint Working Group. Representatives of this group include Iwi, Territorial Authority (TA) Drinking Water suppliers, Regional Council and Medical Officer of Health and Drinking Water Assessors. EOA Māori .	Ongoing		System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities
Continue to provide technical support to supplies which received Capital Assistance Programme (CAP) and to networked supplies which have a population between 25-5000 people. In our area a number of Marae received CAP funding. As part of this programme will be the development of an equity partnership with the Maori Health Leadership team, Health Improvement and Equity Directorate. EOA Māori .	Ongoing		System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities

¹ The majority of the Pacific Island community in Hawkes Bay live in urban areas and are on a reticulated council drinking water supply.

Advocate for adoption of Source Protection Zones (SPZ) provisions with the TANK plan change and subsequent catchment management plans.	Ongoing		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
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2.4.4 Primary Care and Prevention

Primary Health Care Integration			This is an equitable outcomes action (EOA) focus area	
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
Te Pitāu (Primary Care – DHB Alliance); building the teams to become collective voice. • End of Life model of care development	Q4	# NPs ## RN prescribers # of contributors	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring and volunteering
Telemedicine in rural health settings to support the Rural Nurse Specialist model. EOA Māori.	Q3		System outcome We have improved health equity (healthy populations)	Government priority outcome Support healthier, safer and more connected communities
Nurse practitioner workforce development: develop and implement pathways for NP development – increase the NP workforce.	Q4		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering
Registered Nurse Prescribing workforce development: develop and implement pathways for RN prescribing – increase RN prescribing in primary and community care.	Q3		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering
Data sharing – use the development of a diabetes data repository to build data sharing protocols across the sector	Q3		System outcome We live longer in good health (prevention and early intervention).	Government priority outcome Support healthier, safer and more connected communities
Pharmacy			This is an equitable outcomes action (EOA) focus area	

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<ul style="list-style-type: none"> Continue to support the vision of the Pharmacy Action Plan and the Integrated Community Pharmacy Services Agreement (ICPSA) by working with pharmacists, the public, primary care and the wider health care team to commission integrated local services that prioritise local need and support equitable health outcomes. Support the work to enable the separation of dispensing into separate ICPSA schedules (medicine and supply and clinical advice) by June 2020. Commit to developing and reporting by quarter three local strategies that support pharmacy and other immunisation providers to work together to improve influenza vaccination rates in Māori, Pacific and Asian people over 65 years of age, for implementation from 1 April 2020 (start date for the annual influenza immunisation programme). Commit to reporting the outcomes of these local strategies to improve influenza vaccination rates in quarter two of the following financial year. <p>We recommend that you work with your district alliance System Level Measure (SLM) team(s) to investigate if influenza vaccination rates for those populations should be part of the SLM Improvement Plan. In particular those working groups developing actions for Acute hospital bed days and Patient experience of care SLMs. If the vaccination rates of these populations are seen to impact any of these SLMs, specific actions to improve influenza rates could be part of your SLM Improvement Plan.</p>			
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.
Introduce Rongoa Practitioners to Pharmacists in Primary Health Care with the aim of establishing community interventions which may include ensuring Māori and minority stakeholders fully understand their respective illnesses, are familiar with the medicines they are prescribed, may provide education on traditional Māori therapies/rongoa and could involve liaising with regard to the effectiveness and progress of medicines prescribed. EOA Māori. <ul style="list-style-type: none"> Specify the equity gap that the action is targeting: Māori ASH rates and amenable mortality. Identify the population group for whom the action will improve equity: Māori. Specify how success will be measured and monitored – see KPIs. 	Q4	n/a	System outcome We have improved quality of life (health maintenance and independence) Government priority outcome Support healthier, safer and more connected communities
Understand the training opportunities in the Pharmacy sector for Rongoa practitioners in order to take their interest in natural medicines and partner with Pharmacists clinical knowledge. EOA Māori. <ul style="list-style-type: none"> Specify the equity gap that the action is targeting: Māori ASH rates and amenable mortality. Identify the population group for whom the action will improve equity: Māori. Specify how success will be measured and monitored – see KPIs. 	Q4	n/a	System outcome We have improved health equity (healthy populations) Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering
Explore pharmacists providing influenza vaccinations in church settings. EOA Pacific. <ul style="list-style-type: none"> Specify the equity gap that the action is targeting: immunisation rate for 'flu vaccine in Pacific aged 65 and older population. Identify the population group for whom the action will improve equity: Pacific aged 65 and older population. Specify how success will be measured and monitored – see KPIs. 	Q3-4 (depending on flu vaccination availability)	n/a	System outcome We live longer in good health (prevention and early intervention) Government priority outcome Support healthier, safer and more connected communities
Educating Pacific community that pharmacy provides free 'flu injections to people over 65 years of age, via Pacific navigators when doing Bowel Screening home visits. EOA Pacific. <ul style="list-style-type: none"> Specify the equity gap that the action is targeting: immunisation rate for 'flu vaccine in Pacific aged 65 and older population. 	Q1-2		System outcome We live longer in good health Government priority outcome Support healthier, safer and more connected communities

• Identify the population group for whom the action will improve equity: Pacific aged 65 and older population. • Specify how success will be measured and monitored – see KPIs.			(prevention and early intervention)	
Explore the views of general practice and community pharmacy around development of a collaborative pathway which supports increased influenza vaccinations in community pharmacy.	Q4		System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Support healthier, safer and more connected communities

Smokefree 2025			This is an equitable outcomes action (EOA) focus area	
DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
HBDHB Smokefree Service will engage with the Wairoa Whanake Te Kura ante natal programme to encourage and support Wahine Hapu to stop smoking during and after pregnancy. Wahine Hapu will be referred and enrolled on the Wahine Hapu – Increasing Smokefree Pregnancy 8 week programme. EOA Māori and Pacific.	Q2 Q4	CW09	System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Make New Zealand the best place in the world to be a child
Investigate 'opt-off' option for all Wahine Hapu identified as 'smokers' at booking in HBDHB Maternity services. EOA Māori and Pacific.	Q1		System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Make New Zealand the best place in the world to be a child
Explore working with Health HB and General Practices to increase Wahine Hapu referrals to the Wahine Hapu – Increasing Smokefree Pregnancy 8 week programme at >12 weeks pregnancy confirmation. EOA Māori and Pacific.	Q1		System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Make New Zealand the best place in the world to be a child
Develop an education programme to build resilience in young Māori and Pacific women aged 15-19 years in schools, tertiary education, alternative education and teen parent units. EOA Māori and Pacific.	Q3 Q4		System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Support healthier, safer and more connected communities

Diabetes and Other Long-Term Conditions			This is an equitable outcomes action (EOA) focus area	
DHB Activity	Milestone	Measure	Government Theme:	

			Improving the well-being of New Zealanders and their families.
Implement and evaluate diabetes repository inclusive of retinal and podiatry services	Q4	SS13	System outcome We have improved quality of life (health maintenance and independence)
Creation of a Long Term Conditions flag within the hospital patient management system identifying those people who have multiple chronic conditions and frequent inpatient services. EOA Māori and Pacific.	Q4		System outcome We have improved health equity (healthy populations)
Implementation of the Long Term Conditions Self Review Matrix. EOA Māori and Pacific. Specialties: <ul style="list-style-type: none">• Diabetes• Renal• Respiratory• Cardiovascular• Palliative Care Team	Q4		System outcome We have improved quality of life (health maintenance and independence)
Support the delivery of action priorities within the following key plans acknowledging they contribute to the prevention and reduction in risk of long term conditions: <ul style="list-style-type: none">• Tobacco Strategy• Best Start Plan• Child Healthy Homes Plan	Q4		System outcome We live longer in good health (prevention and early intervention)

2.5 Financial performance summary

Projected Statement of Comprehensive Revenue and Expense

Projected Statement of Revenue and Expense						
<i>in thousands of New Zealand Dollars</i>	2018 Audited	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
For the year ended 30 June						
Ministry of Health - devolved funding	516,552	541,713	569,010	588,811	609,067	629,106
Ministry of Health - non devolved contracts	14,369	14,819	14,490	14,995	15,511	16,022
Other District Health Boards	12,710	13,197	12,399	12,841	13,293	13,741
Other Government and Crown Agency sourced	6,046	5,331	4,878	5,060	5,247	5,433
Patient and consumer sourced	1,117	1,158	1,244	1,291	1,339	1,386
Other	6,104	5,413	4,499	4,580	4,748	4,916
Operating revenue	556,898	581,630	606,521	627,578	649,205	670,604
Employee benefit costs	209,611	224,211	240,813	249,242	257,465	266,476
Outsourced services	19,294	20,467	16,305	16,872	17,453	18,026
Clinical supplies	49,696	54,787	37,129	37,620	38,379	36,780
Infrastructure and non clinical supplies	50,773	50,459	52,940	55,486	58,318	62,597
Payments to non-health board providers	236,100	240,344	259,332	265,358	274,590	283,725
Operating expenditure	565,474	590,269	606,521	624,578	646,205	667,604
Surplus/(Deficit) for the period	(8,576)	(8,638)	0	3,000	3,000	3,000
Revaluation of land and buildings	15,312	-	-	-	-	-
Other comprehensive revenue and expense	15,312	-	-	-	-	-
Total comprehensive revenue and expense	6,736	(8,638)	0	3,000	3,000	3,000

Table 1: Projected Statement of Comprehensive Revenue and Expense

17.1

Projected Summary of Revenue and Expenses by Output Class						
For the year ended 30 June <i>in millions of New Zealand Dollars</i>	2018 Actual	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Prevention Services						
Revenue	9.7	9.2	9.8	10.0	10.4	10.7
Expenditure	8.5	9.0	9.8	10.0	10.4	10.8
	1.2	0.2	-	(0.0)	(0.0)	(0.0)
Early Detection and Management						
Revenue	118.2	132.0	140.0	145.0	150.0	155.0
Expenditure	119.9	131.5	140.0	143.7	148.7	153.9
	(1.7)	0.5	-	1.4	1.4	1.0
Intensive Assessment and Treatment						
Revenue	345.3	349.4	357.7	369.1	381.8	394.4
Expenditure	353.4	359.0	357.7	369.8	382.5	394.7
	(8.1)	(9.6)	-	(0.7)	(0.8)	(0.4)
Rehabilitation and Support						
Revenue	83.6	91.1	98.9	103.4	107.0	110.5
Expenditure	83.6	90.8	98.9	101.1	104.6	108.2
	-	0.3	-	2.4	2.4	2.4
Net Result	(8.6)	(8.6)	-	3.0	3.0	3.0

Detailed plans for the new investment and efficiency programmes have yet to be defined, and the impact of the programmes on financial performance have been recognised under clinical supplies in the Intensive Assessment and Treatment output class. When the plans are determined, the efficiencies will be reclassified and could affect any line in any output class.

Table 2: Projected Summary of Revenue and Expenses by Output Class

SECTION THREE: Service Configuration

3.1 Service Coverage

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, 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.

3.2 Service Change

The table below is a high-level indication of some potential changes

Change	Description of Change	Benefits of Change	Change for Local, Regional or National Reasons
Urgent Care	Enhancement of Urgent Care Service provision for Hastings and Napier.	Improved access to afterhours care with resulting reduction in presentations and utilisation of ED as a primary care provider of care.	Local
Mental Health	A redesign of primary mental health services as part of the wider mental health redesign is underway and this will change current delivery.	Earlier access for mild and moderate mental health concerns targeting under-served populations. Better links between primary, community and secondary mental health services.	Local
	Repatriation of youth inpatient beds from the regional contract back to HBDHB.	Services closer to home.	Regional / local
Whole of sector mental health services	Commence redesign of mental health and addiction services across the sector.	Align with the government enquiry into mental health and addiction. Align with Clinical Services Plan. More accessible and integrated services.	Local
Adult Alcohol and Other Drugs (AoD)	New model for local providers of AoD residential services.	Practice integration of the of local AoD residential providers for best placements for clients.	Local
Community Pharmacy and Pharmacist services	Implement the National Integrated Community Pharmacy Services Agreement and develop local services. Assessment of Schedule 3B services for local review.	More integration across the primary care team. Improved access to pharmacist services by consumers. Consumer empowerment.	National

17.1

	Continue to implement the Community Based Pharmacy Services in Hawke's Bay Strategy 2016-2020. Medicine Use Review service review and implementation. Zero Fees U18 service review and implementation.	Safe supply of medicines to the consumer. Improved support for vulnerable populations. More use of pharmacists as a first point of contact within primary care. Increased geographical coverage.	Local
After hours U14 - Pharmacy	Rationalise and integrate general practice and pharmacy providers to deliver a single after hours under 14 service in both Napier and Hastings.	Single provider in both Napier and Hastings to aid consumer communication and access; with focus on integrated approach to urgent care including pharmacy support.	Local
Zero Fees U18 – Pharmacy	Removal of prescription co-payments for all youth aged 14 – 17 when prescription is written by a Hawke's Bay general practice prescriber.	Supporting parallel programme in general practice to increase access to primary care by youth, including associated prescriptions.	Local
Surgical Expansion Project	Project to expand HBDHB surgical in-house capacity to better meet elective health targets and HB population surgical needs. Aimed at calendar year of 2010.	HBDHB able to better meet elective health targets, manage acute demand and population surgical needs in-house and within budget.	Local
Under 18s	Reconfigure zero fees for Under 18s to align with government intention to provide greater access to services or those who hold community services cards.	Increased access for under 14 -17 year olds with Community Services Card.	Local
Coordinated Primary Options (CPO)	Provision of care within the primary care team that prevent hospital presentations and admissions.	Service review to inform redesign.	Local
Model of Care (primary)	"In line with the Clinical Services Plan, models of care changes will be based around: 1. Place-based planning 2. Evolving primary healthcare 3. Working with whānau to design the services they need 4. Relevant and holistic responses to support mental wellbeing. 5. Keeping older people well at home and in their communities 6. Specialist management of long term conditions based in the community " Models of care will be designed, developed and implemented to reflect whānau needs, and most importantly achieve equity within our rohe.	Models of care will be designed, developed and implemented to reflect whānau needs, and most importantly achieve equity within our rohe.	Local
Older Persons Services	Responding to the growing demands of acute and chronic care needs will necessitate providing services in different ways that have more of a rehabilitation and community focus.	Free up capacity and associated resources in order to deliver care more appropriately with the aim of minimising admission to hospital and ARRC settings.	Local

Health and Social Care Localities	Health and Social Care Localities development supported within Wairoa and CHB.	Achieving equity within our rural localities.	Local
Primary Care Development Partnership (PCDP)	Ongoing development and refinement of Te Pitāu (Primary Care – DHB Alliance) for the provision of coordinated services. Building teams to become a collective voice.	Enhancing provision and coordination of services.	Local
Faster Cancer Treatment	Redesigning of our oncology service model and Redesigning and refurbishing our buildings.	More streamlined services working toward meeting the FCT target.	Local/Regional
Bowel Screening	Implement Ministry of Health approved National Bowel Screening Programme HBDHB Annual Plan 2019/20, Equity Plan and Communications Plan.	Reduced mortality from bowel cancer.	Local/National

Service Integration

In line with our strategic documents and the National drive to shift services out of the specialised hospital setting and into the community, HBDHB are continually reviewing services and considering where these could be provided in the community and/or with better integration with primary care.

Procurement of Health & Disability Services

HBDHB periodically undertakes competitive processes (Registration of Interest, Request for Proposals etc.), in accordance with the Ministry of Business Innovation and Employment's Government Rules of Sourcing. Competitive processes may be undertaken for several reasons including, the time since the last competitive process and changes in service design. Competitive processes ensure cost effective services, increase innovation and can enhance efficient service provision. Competitive processes may result in a change of provider.

Note A: 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.

SECTION FOUR: Stewardship

TBC

4.1 Managing our Business

Organisational Performance Management

Given the scale and scope of our services, HBDHB has developed and implemented a comprehensive organisational performance management framework. This provides for the provision of relevant reports and performance management decision making at appropriate levels. Reports provided as part of this framework include:

Strategic

- MoH – DHB Performance Monitoring
- HBDHB Transform and Sustain Strategic Dashboard.

Operational

- Exceptions Report on Annual Plan performance
- Te Ara Whakawaiora – reporting on key Maori health indicators
- Pasifika Health Dashboard
- MoH Quarterly Health Target Report.
- Risk Management
- Monthly Strategic and High / Emerging Risk Report
- Occupational Health and Safety.

General

- Chief Executive Report
- Financial Performance
- Human Resources Key Performance Indicators
- Transform and Sustain Programme Overview.

Funding and Financial Management

HBDHB, as the lead Government agent for the Hawke's Bay public health budget, must always seek to live within its means, prioritise resources and manage in a fiscally responsible manner. In common with trends across the health sector, HBDHB has faced increasing difficulty in achieving financial balance, due to the cumulative effect of funding below the real cost

pressures over a number of years. Following many years of surplus, HBDHB has posted a financial deficit for the last two financial years, as shown in the table below.

Financial Year	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Surplus/(Deficit)	\$3.222m	\$3.054m	\$4.366m	\$3.567m	(\$8.576m)	(\$8.638m)

Due to the sustained pressure on our resources we planned a deficit of \$5m for 2018-19, with the intent to return to a balanced budget in 2019-20. HBDHB have set a balanced plan for 2019-20 but it should be noted that this requires delivery of \$14m to \$20m savings to achieve (X% to x%). This is a significant level of savings, particularly in this environment where many easily achieved efficiencies have already been delivered.

As the coming year will be a foundation year in our long-term strategy we will be relying on tactical savings to achieve breakeven in 2019-20 and deliver high quality services which are clinically appropriate, financially sustainable and support achievement of equity goals. This will require:

- prioritisation of resources to deliver the best health return from the funding available
- a focus on productivity, with effective management of cost drivers and robust planning of demand, capacity and capability, to improve performance whilst managing cost

Over the longer term, we anticipate that our work outlined in the strategy and delivery of the Clinical Services Plan (CSP), enabled by a financial strategy which walks alongside this, will support sustainable changes to how our services are resourced and delivered. The CSP will require a fundamental transformation of models care, with intervention occurring at the lowest cost opportunity. This is not about shifting resources from one provider to another, but changing the service model.

Investment and Asset Management

The MOH plans to establish a National Asset Management Plan (NAMP) by December 2019, to support them in their decision making and prioritisation of capital resources. HBDHB volunteered to be a NAMP pilot site and our critical building were assessed in 2018-19.

HBDHB also undertakes asset management planning at a local level and has a 10 year long term investment plan which outlines our planned asset expenditure. This will be updated once

the strategic implementation plan for delivery of the CSP is developed and reflected in the refresh of our facility master plan.

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.

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

HBDHB has a shareholding interest in, and receives shared services from:

- NZ Health Partnerships Ltd
- Central Region Technical Advisory Services Ltd
- Allied Laundry Services Ltd

Risk Registers are maintained throughout HBDHB with high and emerging risks and trends regularly reviewed at operational, senior management and governance levels.

4.2 Building Capability

Over the past five years we have shifted our perspective to integration and the wider health system with our strategy 'Transform and Sustain'. In preparation for our new strategy, we completed the development of a CSP and a People Strategy in 2018/19 and those input pieces informed the development of this plan. In addition, the national review of the health system and the national mental health inquiry will also inform our response to our challenges and delivery against our national, regional and local objectives. Broadly, we expect to be focusing on some key areas of capability development, including:

- Enhancing workforce capability and capacity to deliver new models of care (see 4.3)
- Information technology and communications systems to support a much more mobile workforce and a growing digital strategy (see 4.4)
- Capital and infrastructure development to focus on facilities off the hospital campus, and

17.1

SECTION FIVE: Performance Measures

5.1 2019/20 Performance Measure

The DHB monitoring framework aims to provide a view of performance using a range of performance markers. Four dimensions are identified reflecting DHB 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:

The health and disability system has been asked to focus on the following priorities:

- Child wellbeing
- Mental wellbeing
- Strong and equitable health and disability system
- Primary care and prevention.

Performance measure	Expectation	
CW01 Children caries free at 5 years of age	Year 1	
	Year 2	
CW02 Oral health: Mean DMFT score at school year 8	Year 1	
	Year 2	
CW03 Improving the number of children enrolled and accessing the Community Oral health service		

CW04	Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	Children (0-4) enrolled	Year 1	
		Children (0-12) examined according to planned recall	Year 2	
CW05	Immunisation coverage at 2 years of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	95% of two year olds fully immunised.		
		95% of four year olds fully immunised.		
CW06	Child Health (Breastfeeding)	75% of girls fully immunised – HPV vaccine.		
		75% of 65+ year olds immunised – flu vaccine.		
CW07	New-born enrolment with General Practice	70% of infants are exclusively or fully breastfed at three months.		
CW08	Increased immunisation (eight-month-olds)	55% of new-borns enrolled in General Practice by 6 weeks of age.		
		85% of new-borns enrolled in General Practice by 3 months of age.		
CW09	Better help for smokers to quit (maternity)	95% of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.		
CW10	Raising healthy kids	90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.		
CW11	Supporting child wellbeing	95% of obese children identified in the Before School Check (BASC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.		
CW12	Youth mental health initiatives	Provide report as per measure definition		
		Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement <i>Youth Health Care in Secondary Schools: A framework for continuous quality improvement</i> in each school (or group of schools) with SBHS.		
		Initiative 3: Youth Primary Mental Health.		
		Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team		

		(SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.
CW13	Reducing rheumatic fever	Reducing the Incidence of First Episode Rheumatic Fever to XX per 100,000
MH01	Improving the health status of people with severe mental illness through improved access	Age (0-19) Maori, other & total
		Age (20-64) Maori, other & total
		Age (65+) Maori, other & total
MH02	Improving mental health services using wellness and transition (discharge) planning	95% of clients discharged will have a quality transition or wellness plan.
		95% of audited files meet accepted good practice.
MH03	Shorter waits for non-urgent mental health and addiction services	Mental health provider arm
		80% of people seen within 3 weeks.
		95% of people seen within 8 weeks.
		Addictions (Provider Arm and NGO)
MH04	Rising to the Challenge: The Mental Health and Addiction Service Development Plan	80% of people seen within 3 weeks.
		95% of people seen within 8 weeks.
MH05	Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.
MH06	Output delivery against plan	Volume delivery for specialist Mental Health and Addiction services is within 5% variance (+/-) of planned volumes for services measured by FTE; 5% variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day; actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.
SS01		85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.

SS02		Provide reports as specified	
SS03		Provide reports as specified	
SS04		Provide reports as specified	
SS05			
SS06	Better help for smokers to quit in public hospitals (previous health target)	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.	Only applies to specified DHBs
SS07	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall.	
SS08	Improving cervical Screening coverage	80% coverage for all ethnic groups and overall.	
SS09	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 data within the NHI	Recording of non-specific ethnicity in new NHI registration >0.5% and < or equal to 2
			Update of specific ethnicity value in existing NHI record with a non-specific value >0.5% and < or equal to 2%
			Validated addresses excluding overseas, unknown and dot(.) in line 1 >76% and < or equal to 85%
	Invalid NHI data updates	Still to be confirmed	
	Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC and NMDS for FSA and planned inpatient procedures.	Greater than or equal to 90% and less than 95 %

			National Collections completeness	Greater than or equal to 94.5% and less than 97.5 %			90% of 'eligible Māori men in the PHO aged 35-44 years' will have had their CVD risk assessed in the past 5 years
			Assessment of data reported to the NMDS	Greater than or equal to 75%			Indicator 1: Door to cath - Door to cath within 3 days for >70% of ACS patients undergoing coronary angiogram.
			Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)	Provide reports as specified			Indicator 2a: Registry completion- >95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and Indicator 2b: ≥ 99% within 3 months.
SS10	Shorter stays in Emergency Departments		95% of patients will be admitted, discharged or transferred from an emergency department (ED) within six hours.				Indicator 3: ACS LVEF assessment- ≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF (ie have had an echocardiogram or LVgram).
SS11	Faster Cancer Treatment (62 days)		90% of patients 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.				Indicator 4: Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance >85% of ACS patients who undergo coronary angiogram should be prescribed, at discharge - - Aspirin*, a 2nd anti-platelet agent*, statin
SS12	Engagement and obligations as a Treaty partner		Reports provided and obligations met as specified				
SS13	Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	Focus Area 1: Long term conditions	Report on actions to: Support people with LTC to self-manage and build health literacy.				
		Focus Area 2: Diabetes services	Report on the progress made in self-assessing diabetes services against the <i>Quality Standards for Diabetes Care</i> .				
		Focus Area 3: Cardiovascular health	90% of the eligible population will have had their CVD risk assessed in the last 5 years.				

			and an ACEI/ARB (4 classes), and - LVEF<40% should also be on a beta-blocker (5-classes). <i>* An anticoagulant can be substituted for one (but not both) of the two anti-platelet agents.</i>
	Focus Area 5: Stroke services	Indicator 1 ASU: 80% of stroke patients admitted to a stroke unit or organised stroke service, with a demonstrated stroke pathway	
		Indicator 2 Thrombolysis: 10% of potentially eligible stroke patients thrombolysed 24/7	
		Indicator 3: In-patient rehabilitation: 80% patients admitted with acute stroke who are transferred to in-patient rehabilitation services are transferred within 7 days of acute admission	
		Indicator 4: Community rehabilitation: 60 % of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.	
SS14	Improving waiting times for diagnostic services	tbc	
SS15	Improving waiting times for Colonoscopy	90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure 14 calendar days or less 100% within 30 days or less.	
			70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure in 42 working days or less, 100% within 90 days or less.
			70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure in 84 calendar days or less of the planned date, 100% within 120 days or less.
			95% of participants who returned a positive FIT have a first offered diagnostic date that is within 45 working days of their FIT result being recorded in the NBSP IT system.
SS16	Delivery of collective improvement plan	tbc	
SSXX tbc	Delivery of Whānau ora	tbc	
SSXX tbc	Elective surgical discharges	tbc	
SSXX tbc	Elective Services Standardised Intervention Rates	tbc	
SSXX tbc	Inpatient length of stay	tbc	
SSXX tbc	Acute readmissions to hospital	tbc	
PH01	Delivery of actions to improve system integration and SLMs	Provide reports as specified	
PH02	Improving the quality of ethnicity data collection in PHO and NHI registers	Provide reports as specified	
PH03	Access to Care (PHO Enrolments)	Meet and/or maintain the national average enrolment rate of 90%.	
PH04	Primary health care :Better help for smokers to quit (primary care)	90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	
	Annual plan actions – status update reports	Provide reports as specified	

17.1

COVER PAGE

HBDHB Statement of Intent 2019-22

HBDHB Statement of Performance
Expectations

Version 2.4

17.2

PART B: Statement of Intent Incorporating the Statement of Performance Expectations including Financial Performance

Section 1: Strategic Direction (SOI)

TBC

1.1 Strategic Outcomes

TBC

Section 2: Managing our Business (SOI)

2.1 Managing our business

TBC – see 4.1

Section 3: Statement of Performance Expectations (SPE)

3.1 Statement of Performance Expectations (SPE)

This section includes information about the measures and standards against which HBDHB's 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
- Rehabilitation and Support Services.

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) and the 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 Sol, requires consideration of service performance. For each output class, we will assess performance in terms of the New Zealand Triple Aim (Figure xx in Sol xx). 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.

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 SPE for the 2019/20 year follows:

Board Member

Board Member

17.2

3.2 Output Classes

Output Class 1: Prevention

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

Prevention Services						
<i>For the year ended 30 June in millions of New Zealand Dollars</i>						
	2018 Actual	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Ministry of Health	9.3	8.7	9.4	9.7	10.1	10.4
Other sources	0.4	0.5	0.4	0.3	0.3	0.3
Income by Source	9.7	9.2	9.8	10.0	10.4	10.7
<i>Less:</i>						
Personnel	1.3	1.9	2.0	2.1	2.1	2.2
Clinical supplies	-	0.1	0.1	0.1	0.1	0.1
Infrastructure and non clinical supplies	0.3	0.5	0.5	0.5	0.6	0.6
Payments to other providers	6.9	6.5	7.2	7.3	7.6	7.8
Expenditure by type	8.5	9.0	9.8	10.0	10.4	10.8
Net Result	1.2	0.2	-	(0.0)	(0.0)	(0.0)

Detailed plans for the new investment and efficiency programmes have yet to be defined, and the impact of the programmes on financial performance have been recognised under clinical supplies in the Intensive Assessment and Treatment output class. When the plans are determined, the efficiencies will be reclassified and could affect any line in any output class.

Table 1 - Funding and Expenditure for Output Class 1: Prevention Service

Short Term Outcome	Indicator	New nomenclature	MoH Measure	Baseline					2019/20 Target
				Period	Māori	Pasifika	Other	Total	
Better help for smokers to quit	% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	SS05	PP31	Jan-Dec 2018	97%	96%	96%	96%	≥95%
	% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	PH04	HT	Jan-Dec 2018	82%	81%	89%	85%	≥90%
	% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking	CW09	HT	Jan-Dec 2018	88%	N/A	N/A	85%	≥90%
	SLM Number of babies who live in a smoke-free household at 6 weeks post-natal	PH01	SI13	Jan-Jun 2018	45%	45%	64%	45%	tbc
Increase Immunisation	% of 8 month olds will have their primary course of immunisation (6 weeks, 3 months and 5 month events) on time	CW08	HT	Jan-Dec 2018	92%	97%	92%	92%	≥95%
	% of 2 year olds fully immunised	CW05	PP21	Jan-Dec 2018	93%	97%	93%	93%	≥95%
	% of 4 year olds fully immunised	CW05	PP21	Jan-Dec 2018	90%	88%	92%	1%	≥95%
	% of boys & girls fully immunised – HPV vaccine	CW05	PP21	Jul 2017-Jun 2018	85%	88%	70%	76%	≥75%
	% of 65+ year olds immunised – flu vaccine	CW05	PP21	Mar-Sep 2018	53%	52%	59%	58%	≥75%
Reduced incidence of first episode Rheumatic Fever	Acute rheumatic fever initial hospitalisation rate per 100,000	CW13	PP28	Jul 2016 – Jun 2017	tbc	tbc	tbc	tbc	≤1.5 per 100,000
Improve breast screening rates	% of women aged 50-69 years receiving breast screening in the last 2 years	SS07	SI11	Two Years to Dec 2018	70%	67%	76%	74%	≥70%
Improve cervical screening coverage	% of women aged 25–69 years who have had a cervical screening event in the past 36 months	SS08	SI10	Three Years to Dec 2018	76%	72%	78%	76%	≥80%
Better rates of breastfeeding	% of infants that are exclusively or fully breastfed at 3 months	CW06	PP37	Six months to Dec 2018	43%	58%	N/A	57%	≥60%

17.2

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

Early Detection and Management						
For the year ended 30 June in millions of New Zealand Dollars	2018 Actual	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Ministry of Health	112.6	126.5	135.0	139.7	144.5	149.3
Other District Health Boards (IDF)	3.0	2.1	2.0	3.1	3.2	3.3
Other sources	2.6	3.4	3.0	2.2	2.3	2.4
Income by Source	118.2	132.0	140.0	145.0	150.0	155.0
<i>Less:</i>						
Personnel	18.7	30.8	33.1	34.3	35.4	36.6
Outsourced services	2.6	5.9	4.7	4.9	5.1	5.2
Clinical supplies	1.2	3.4	2.3	2.3	2.4	2.3
Infrastructure and non clinical supplies	3.3	9.0	9.4	9.9	10.4	11.1
Payments to other District Health Boards	2.7	2.8	2.8	2.9	3.0	3.1
Payments to other providers	91.4	79.6	87.7	89.4	92.5	95.6
Expenditure by type	119.9	131.5	140.0	143.7	148.7	153.9
Net Result	(1.7)	0.5	-	1.4	1.4	1.0

Detailed plans for the new investment and efficiency programmes have yet to be defined, and the impact of the programmes on financial performance have been recognised under clinical supplies in the Intensive Assessment and Treatment output class. When the plans are determined, the efficiencies will be reclassified and could affect any line in any output class.

Table 2 –Funding and Expenditure for Output Class 2: Early Detection and Management Service

Short Term Outcome	Indicator	New nomenclature	MoH Measure	Baseline					2019/20 Target
				Period	Māori	Pasifika	Other	Total	
Improved access primary care	% of the population enrolled in the PHO	PH03	PP33	Jan 2018	99%	92%	97%	98%	≥90%
Reduce the difference between Māori and other rate for ASH Zero-Four - SLM	Ambulatory Sensitive Hospitalisation (ASH) rate per 100,000 zero - 4 years	PH01	SI1 / SI5 / PP22(SLM)	12 months to Dec-17	8,750	18,028	5,891	7,969	Māori tbc
Reduce ASH 45-64	Ambulatory sensitive hospitalisation rate per 100,000 45-64 years	PH01	SI1		9,328	8,404	3,437	4,613	Māori tbc
More pregnant women under the care of a Lead Maternity Carer (LMC)	% of women booked with an LMC by week 12 of their pregnancy			Jul to Sep 2018	53%	36%	76%	65%	80%
Improving new-born enrolment in General Practice	% of new-borns enrolled in General Practice by 6 weeks of age	CW07	SI18						≥55%
	% of new-borns enrolled in General Practice by 3 months of age	CW07		Jun to Aug 2018	86%	76%	86%	80%	≥85%
Better oral health	% of eligible pre-school enrolments in DHB-funded oral health services	CW04	PP13	12 months to Dec-18	tbc	tbc	tbc	tbc	≤10% Yr1 tbc Yr2
	% of children who are caries free at 5 years of age	CW02	PP11 / SI5		tbc	tbc	tbc	tbc	≥59% Yr1 tbc Yr1
	% of enrolled preschool and primary school children not examined according to planned recall	CW04	PP13		10%	13%	10%	10%	10%
	% of adolescents(School Year 9 up to and including age 17 years) using DHB-funded dental services	CW03	PP12	12 months to Dec-16	tbc	tbc	tbc	tbc	tbc
	Mean 'DMFT' score at Year 8	CW01	PP10	12 months to Dec-18	0.94	1.16	0.62	0.76	≤0.75 Yr1 tbc Yr2
Improved management of long-term conditions(CVD, Acute heart health, Diabetes, and Stroke)	Proportion of people with diabetes who have good or acceptable glycaemic control (HbA1C indicator)	SS13	PP20	12m to Dec-18	tbc	tbc	tbc	tbc	tbc
	% of the eligible population will have had a CVD risk assessment in the last five years	SS13	PP20	Five years to Dec-18	84%	80%	87%	86%	≥90%

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Short Term Outcome	Indicator	New nomenclature	MoH Measure	Baseline					2019/20 Target
				Period	Māori	Pasifika	Other	Total	
Less waiting for diagnostic services	% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks)	SS14	PP29	Dec-18	NA	NA	NA	92%	≥95%
	% of accepted referrals for MRI scans who receive their scans within 42 days (6 weeks)	SS14	PP29	Dec-18	NA	NA	NA	90%	≥90%
Increase referrals of obese children to clinical assessment and family based nutrition, activity and lifestyle interventions	% of obese children identified in the B4SC programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	CW10	HT / SI5	6 months to Nov-18	98%	93%	94%	96%	≥95%
Improved youth access to health services - SLM	Total self-harm hospitalisations and short stay ED presentations for <24 year olds per 10,000	PH01	SI12	12 months to Sep -18	63.9	39.8	48.7	54.3	tbc
	% of ED presentations for 10-24 year olds which are alcohol related	PH01		12 months to Sep -18	4%	1%	3%	3%	tbc
Amenable Mortality - SLM	Relative Rate between Māori and Non-Maori Non-Pasifika (NMNP)	PH01	SI9	2015	2.45 relative rate				tbc

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, 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.

Intensive Assessment and Treatment						
For the year ended 30 June in millions of New Zealand Dollars	2018 Actual	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Ministry of Health	328.5	332.8	342.4	354.4	366.6	378.6
Other District Health Boards (IDF)	2.2	4.4	4.1	6.3	6.6	6.8
Other sources	14.6	12.2	11.2	8.4	8.6	9.0
Income by Source	345.3	349.4	357.7	369.1	381.8	394.4
<i>Less:</i>						
Personnel	182.0	183.5	197.0	203.9	210.7	218.0
Outsourced services	16.7	14.5	11.5	12.0	12.4	12.8
Clinical supplies	47.6	50.2	34.1	34.6	35.3	33.8
Infrastructure and non clinical supplies	46.8	38.9	40.8	42.8	45.0	48.3
Payments to other District Health Boards	50.3	51.7	52.0	53.8	55.7	57.5
Payments to other providers	10.0	20.2	22.3	22.7	23.5	24.3
Expenditure by type	353.4	359.0	357.7	369.8	382.5	394.7
Net Result	(8.1)	(9.6)	-	(0.7)	(0.8)	(0.4)

Detailed plans for the new investment and efficiency programmes have yet to be defined, and the impact of the programmes on financial performance have been recognised under clinical supplies in the Intensive Assessment and Treatment output class. When the plans are determined, the efficiencies will be reclassified and could affect any line in any output class.

Table 3 –Funding and Expenditure for Output Class 3: Intensive Assessment and Treatment Service

Short Term Outcome	Indicator	New nomenclature	MoH Measure	Baseline					2019/20 Target
				Period	Māori	Pasifika	Other	Total	
Less waiting for ED treatment	% of patients admitted, discharged or transferred from an ED within 6 hours	SS10	HT	Jan to Dec 2018	91%	92%	87%	88%	≥95%
Faster Cancer Treatment (FCT)	% 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 2 weeks	SS01	HT	6 months to Dec-18	92%	100%	98%	95%	≥90%
	% of patients who receive their first cancer treatment (or other management) within 31 days from date of decision to treat	SS01	PP30	6 months to Dec-18	NA	NA	NA	85%	≥85%
Patients with ACS receive seamless, coordinated care across the clinical pathway	% of ACS patients undergoing coronary angiogram, door to cath, within 3 days	SS13	PP20	Jan to Dec-18	57%	50%	64%	61%	>70%
	% of ACS patients who undergo coronary angiogram have pre-discharge assessments of LVEF	SS13	PP20	Jan to Dec-18	64%	75%	66%	66%	≥85%
	Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance all ACS patients who undergo coronary angiogram should be prescribed, at discharge, aspirin, a second anti-platelet agent, statin and an ACE/ARB (four classes) and those with LVEF<40% should also be on a beta blocker (five classes)	SS13	PP20	Jan to Dec-18	67%	80%	51%	55%	>85%
	% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within a) 30 days of discharge and b) within 3 months	SS13	PP20	Sep to Nov 2018	93% 100%	100% 100%	98% 100%	97% 100%	a) >95% b) >99%
Equitable access to care for stroke patients	% of potentially eligible stroke patients who are thrombolysed 24/7	SS13	PP20	Jan to Dec-18	15%	N/A	N/A	9%	10%
	% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	SS13	PP20	Jan to Dec-18	82%	88%	80%	80%	80%
	% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	SS13	PP20	Jan to Dec 18	93%	NA	68%	73%	≥80%

Short Term Outcome	Indicator	New nomenclature	MoH Measure	Baseline					2019/20 Target
				Period	Māori	Pasifika	Other	Total	
	% of stroke patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.	SS13	PP20	N/A	tbc	tbc	tbc	tbc	≥60%
Equitable access to surgery - Standardised intervention rates for surgery per 10,000 population for:	Major joint replacement	SS	SI4	12 months to Sep-18	N/A	N/A	N/A	19.6	tbc
	Cataract procedures	SS			N/A	N/A	N/A	46.5	tbc
	Cardiac surgery	SS			N/A	N/A	N/A	5.3	tbc
	Percutaneous revascularisation	SS			N/A	N/A	N/A	13.2	tbc
	Coronary angiography services	SS			N/A	N/A	N/A	39.6	tbc
Shorter stays in hospital	LoS Elective (days)	SS	OS3	12 months to Sep-18	N/A	N/A	N/A	1.59	tbc
	LoS Acute (days)	SS			N/A	N/A	N/A	2.37	tbc
Fewer readmissions	Acute readmissions to hospital	SS	OS8	12 months to Sep-18	11.3%	11.7%	12.6%	12.2%	tbc
Quicker access to diagnostics	% accepted referrals for elective coronary angiography completed within 90 days	SS14			NA	NA	NA	100%	tbc
	% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive),	SS15	PP29	Dec-18	100%	NA	94%	95%	tbc
	% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 days)	SS15			67%	NA	69%	69%	tbc
	% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date	SS15	PP29	Dec-18	NA	NA	NA	55%	tbc
Fewer missed outpatient appointments	Did Not Attend (DNA) rate across first specialist assessments			Jan to Dec 18	11.3%	13.3%	3.9%	5.9%	≤5% total ≤9% Māori and Pacific
Better mental health services Improving access	Child & youth (zero -19)	MH01	PP6		4.3%	2.0%	3.8%	5.3%	
	Adult (20-64)	MH01	PP6	12 months to Sep-18	9.8%	3.9%	3.9%	5.3%	tbc

Short Term Outcome	Indicator	New nomenclature	MoH Measure	Baseline					2019/20 Target				
				Period	Māori	Pasifika	Other	Total					
Better access to MH&A services	Proportion of the) population seen by MH&A services	Older adult (65+)	MH01	PP6		1.47%	0.86%	1.01%	1.05%	tbc			
Reducing waiting times Shorter waits for non-urgent mental health and addiction services for Zero-19 year olds	% of zero-19 year olds seen within 3 weeks of referral	Mental Health Provider Arm	MH03	PP8	12 months to Dec-18	80%	94%	71%	75%	≥ 80%			
		Addictions (Provider Arm and NGO)	MH03	PP8		69%	100%	60%	67%	≥ 80%			
	% of zero-19 year olds seen within 8 weeks of referral	Mental Health Provider Arm	MH03	PP8		93%	100%	91%	92%	≥ 95%			
		Addictions (Provider Arm and NGO)	MH03	PP8		93%	100%	93%	89%	≥ 95%			
Improving mental health services using discharge planning	Community Services Transition (Discharge) Plans			MH02	PP7	Jan-Dec 2017							
	% of clients discharged from community MH&A will have a transition (discharge) plan						N/A	N/A	N/A	78.5% ≥95%			
	% of audited files have a transition (discharge) plan of acceptable standard						N/A	N/A	N/A	97.0% ≥95%			
	Wellness Plans						N/A	N/A	N/A	99.3% ≥95%			
	% of clients with an open referral to MH&A services of greater than 12 months have a wellness plan.						N/A	N/A	N/A	89.0% ≥95%			
	% of audited files meet accepted good practice – Wellness plans						N/A	N/A	N/A	- ≥95%			
	Inpatient Services Transition (Discharge) Plans						N/A	N/A	N/A	64.3% ≥95%			
	% of clients discharged from adult inpatient MH&A services have a transition (discharge) plan						N/A	N/A	N/A	- ≥95%			
	% of audited files have a transition (discharge) plan of acceptable standard						N/A	N/A	N/A	- ≥95%			
Increasing consumer focus More equitable use of Mental Health Act: Section 29 community treatment orders	Rate of s29 orders per 100,000 population	MH05	PP36 / SI5	12 months to Sep-18	392	120	126		Maori ≤10% reduction				
Better patient experience - SLM	Response rate for Patient Experience Surveys - inpatient and general practice	PH01	SI8	tbc	tbc	tbc	tbc	tbc	tbc				

Short Term Outcome	Indicator	New nomenclature	MoH Measure	Baseline					2019/20 Target
				Period	Māori	Pasifika	Other	Total	
Better aligned services - SLM	Total acute hospital bed days per capita (per 1,000 population)	PH01	SI7	Jan-Dec 2018	636	511	354	410	tbc
More appropriate elective surgery	Number of publicly funded, casemix included, elective and arranged discharges for people living within the DHB region	SS	PP45	12 months to Jun-18	NA	NA	NA	7,467	tbc

17.2

Output Class 4: Rehabilitation and Support Services

This output class includes: 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 via our Provider Arm. 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.

Rehabilitation and Support						
<i>For the year ended 30 June in millions of New Zealand Dollars</i>	2018 Actual	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Ministry of Health	80.5	88.5	96.6	100.0	103.4	106.8
Other District Health Boards (IDF)	3.0	2.3	2.2	3.4	3.5	3.6
Other sources	0.1	0.3	0.1	0.1	0.1	0.1
Income by Source	83.6	91.1	98.9	103.4	107.0	110.5
<i>Less:</i>						
Personnel	6.2	8.1	8.7	9.0	9.3	9.6
Clinical supplies	0.8	0.9	0.6	0.6	0.6	0.6
Infrastructure and non clinical supplies	1.8	2.1	2.2	2.3	2.4	2.6
Payments to other District Health Boards	4.2	4.4	4.4	4.6	4.7	4.9
Payments to other providers	70.6	75.3	83.0	84.6	87.5	90.5
Expenditure by type	83.6	90.8	98.9	101.1	104.6	108.2
Net Result	-	0.3	-	2.4	2.4	2.4

Detailed plans for the new investment and efficiency programmes have yet to be defined, and the impact of the programmes on financial performance have been recognised under clinical supplies in the Intensive Assessment and Treatment output class. When the plans are determined, the efficiencies will be reclassified and could affect any line in any output class.

Table 4 –Funding and Expenditure for Output Class 4: Rehabilitation and Support Service

Short Term Outcome	Indicator	New nomenclature	MoH Measure	Baseline					2019/20 Target
				Period	Māori	Pasifik a	Other	Total	
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		12 months to Dec-18	202.2	83.3	124.7	127.5	≤130
		80-84 years			129.2	250	174.8	169.1	≤170
		85+ years			278.6	166.7	228.8	227.5	≤225
Better community support for older people	Acute readmission rate: 75 years +		SSxx	OS8	12 months to Sep-18	11.8%	10.7%	12.7%	12.6% ≤11%
	Rate of carer stress :Informal helper expresses feelings of distress = YES, expressed as a % of all Home Care assessments		SS04	PP23	Oct-Dec 2017	tbc	tbc	tbc	tbc ≤26%
	% of people having homecare assessments who have indicated loneliness				Oct-Dec 2017	tbc	tbc	tbc	tbc ≤23%
Increased capacity and efficiency in needs assessment and service coordination services	Conversion rate of Contact Assessment (CA) to Home Care Assessment where CA scores are four-six for assessment urgency					tbc	tbc	tbc	tbc
	Clients with a Change in Health, End-stage Disease, Signs and Symptoms) (CHESS) score of four or five at first assessment				Oct-Dec 2017	tbc	tbc	tbc	tbc 11%
More older patients receive falls risk assessment and care plan	% of older patients given a falls risk assessment			12 months to Dec-18	N/A	N/A	N/A	93% 90%	≥90% ≥90%
	% of older patients assessed as at risk of falling receive an individualised care plan								

baseline to be established as the target for this measure

17.2

Section 4: Financial Performance (for SOI and SPE)

In accordance with the Crown Entities Act 2004, this section contains projected financial statements prepared in accordance with generally accepted accounting practice, and for each reportable class of outputs identifies the expected revenue and proposed expenses. The section also includes all significant assumptions underlying the projected financial statements, and additional information and explanations to fairly reflect the projected financial performance and financial position of the DHB. Summary financial performance statements for funding services, providing services, and governance and funding administration are also included in this section.

Performance against the 2019/20 financial year projections will be reported in the 2019/20 Annual Report.

4.1 Projected Financial Statements

Introduction

Hawke's Bay DHB is planning to deliver a break-even result for 2019/20, recognising the increased demands placed on DHBs, by increased acuity and patient volumes arising from demographic trends and technological advances. The results from 2020/21 are expected to see a return to the \$3 million surpluses used to help fund capital replacement.

There is a high level of risk to achieving break-even and based on the indicative funding envelope, the DHB will have to deliver cost efficiencies between \$14 million and \$20 million. This is significantly higher than have been delivered in prior years.

Effort will continue to be focussed on tactical solutions to close the financial gap, whilst the strategy and five-year implementation plan are developed. These include prioritisation of resources and increasing productivity through management of cost drivers.

Reporting entity

The financial statements of the Hawke's Bay DHB comprise the DHB and its 16.7% interests in Allied Laundry Services Limited and Central Region's Technical Advisory Services Limited. Hawke's Bay 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 **5 April 2019**.

Accounting Policies

The projected financial statements in this plan have been prepared in accordance with the Crown Entities Act 2004, which includes the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP). The projected financial statements have been prepared in accordance with tier 1 Public Benefit Entity (PBE) accounting standards.

The accounting policies applied in the projected financial statements are consistent with those used in the 2017/18 Annual Report. That report is available on the DHB's website at:

<http://ourhealthhb.nz/assets/Publications/Annual-Reports/2018-HBDHB-Annual-Report-website-version.pdf>

Projected Statement of Revenue and Expense						
<i>in thousands of New Zealand Dollars</i> For the year ended 30 June	2018 Audited	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Ministry of Health - devolved funding	516,552	541,713	569,010	588,811	609,067	629,106
Ministry of Health - non devolved contracts	14,369	14,819	14,490	14,995	15,511	16,022
Other District Health Boards	12,710	13,197	12,399	12,841	13,293	13,741
Other Government and Crown Agency sourced	6,046	5,331	4,878	5,060	5,247	5,433
Patient and consumer sourced	1,117	1,158	1,244	1,291	1,339	1,386
Other	6,104	5,413	4,499	4,580	4,748	4,916
Operating revenue	556,898	581,630	606,521	627,578	649,205	670,604
Employee benefit costs	209,611	224,211	240,813	249,242	257,465	266,476
Outsourced services	19,294	20,467	16,305	16,872	17,453	18,026
Clinical supplies	49,696	54,787	37,129	37,620	38,379	36,780
Infrastructure and non clinical supplies	50,773	50,459	52,940	55,486	58,318	62,597
Payments to non-health board providers	236,100	240,344	259,332	265,358	274,590	283,725
Operating expenditure	565,474	590,269	606,521	624,578	646,205	667,604
Surplus/(Deficit) for the period	(8,576)	(8,638)	0	3,000	3,000	3,000
Revaluation of land and buildings	15,312	-	-	-	-	-
Other comprehensive revenue and expense	15,312	-	-	-	-	-
Total comprehensive revenue and expense	6,736	(8,638)	0	3,000	3,000	3,000

Table 5 – Projected Statement of Comprehensive Revenue and Expense

17.2

Projected Statement of Movements in Equity						
<i>in thousands of New Zealand Dollars</i> For the year ended 30 June	2018 Audited	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Equity as at 1 July	142,345	148,724	139,728	149,362	173,960	205,790
Total comprehensive revenue and expense:						
Funding of health and disability services	3,101	(539)	-	3,000	3,000	3,000
Governance and funding administration	568	165	-	-	-	-
Provision of health services	(12,245)	(8,264)	-	-	-	-
	6,736	(8,638)	-	3,000	3,000	3,000
Contributions from the Crown (equity injections)	-	-	9,991	21,956	29,187	22,142
Repayments to the Crown (equity repayments)	(357)	(357)	(357)	(357)	(357)	(357)
Equity as at 30 June	148,723	139,728	149,362	173,960	205,790	230,575

Table 6 - Projected Statement of Movements in Equity

Projected Statement of Financial Position						
<i>in thousands of New Zealand Dollars</i> As at 30 June	2018 Audited	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Equity						
Paid in equity	82,002	81,645	91,278	112,877	141,707	163,492
Asset revaluation reserve	82,704	82,704	82,704	82,704	82,704	82,704
Accumulated deficit	(15,982)	(24,621)	(24,621)	(21,621)	(18,621)	(15,621)
	148,723	139,728	149,362	173,960	205,790	230,575
Current assets						
Cash	6,488	4	4	4	4	4
Short term investments (special funds/clinical trials)	2,841	2,690	2,690	2,690	2,690	2,690
Receivables and prepayments	25,463	26,059	26,488	27,410	28,353	29,286
Loans (Hawke's Bay Helicopter Rescue Trust)	11	12	-	-	-	-
Inventories	3,907	3,856	3,933	4,070	4,210	4,349
	38,711	32,621	33,116	34,175	35,258	36,330
Non current assets						
Property, plant and equipment	174,500	178,619	187,714	211,578	241,083	266,322
Intangible assets	1,479	2,101	3,412	6,158	7,185	7,597
Investment property	960	610	610	610	610	610
Investment in NZ Health Partnerships Limited	2,293	2,293	2,638	2,638	2,638	2,638
Investment in associates	9,266	9,725	9,002	9,002	9,002	9,002
Loans (Hawke's Bay Helicopter Rescue Trust)	15	-	-	-	-	-
	188,512	193,348	203,375	229,985	260,517	286,168
Total assets	227,223	225,968	236,491	264,160	295,775	322,498

17.2

Continued ...

Projected Statement of Financial Position						
<i>in thousands of New Zealand Dollars</i> As at 30 June	2018 Audited	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Less:						
Current liabilities						
Bank overdraft	-	11,353	12,535	13,003	10,186	9,414
Payables and accruals	35,817	32,451	37,122	38,414	39,736	41,043
Employee entitlements	40,065	39,727	34,682	35,895	37,080	38,378
	75,881	83,531	84,339	87,312	87,002	88,835
Non current liabilities						
Employee entitlements	2,619	2,709	2,790	2,888	2,983	3,088
	2,619	2,709	2,790	2,888	2,983	3,088
Total liabilities	78,500	86,240	87,129	90,200	89,985	91,923
Net assets	148,723	139,728	149,362	173,960	205,790	230,575

Table 7 - Projected Statements of Financial Position

Projected Statement of Cash Flows						
<i>in thousands of New Zealand Dollars</i> For the year ended 30 June	2018 Audited	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Cash flow from operating activities						
Cash receipts from MOH, Crown agencies & patients	554,785	579,423	605,891	627,011	648,616	669,993
Cash paid to suppliers and service providers	(329,707)	(342,896)	(344,256)	(352,667)	(361,257)	(373,502)
Cash paid to employees	(204,561)	(225,410)	(238,881)	(247,242)	(255,401)	(264,340)
Cash generated from operations	20,517	11,117	22,754	27,102	31,958	32,151
Interest received	876	292	84	-	-	-
Interest paid	(235)	-	(164)	-	-	-
Capital charge paid	(8,378)	(8,320)	(8,623)	(8,818)	(10,294)	(12,203)
	12,780	3,089	14,050	18,284	21,664	19,948
Cash flow from investing activities						
Proceeds from sale of property, plant and equipment	661	9	(9)	-	-	-
Acquisition of property, plant and equipment	(20,193)	(18,409)	(22,793)	(39,008)	(46,334)	(39,618)
Acquisition of intangible assets	(920)	(2,290)	(2,078)	(1,700)	(1,700)	(1,700)
Acquisition of investments	(1,068)	-	15	-	-	-
	(21,519)	(20,690)	(24,865)	(40,708)	(48,034)	(41,318)
Cash flow from financing activities						
Proceeds from equity injections	-	-	9,991	22,313	29,544	22,499
Equity repayment to the Crown	(357)	(357)	(357)	(357)	(357)	(357)
	(357)	(357)	9,634	21,956	29,187	22,142

17.2

Continued ...

Projected Statement of Cash Flows						
<i>in thousands of New Zealand Dollars</i> For the year ended 30 June	2018 Audited	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Net increase/(decrease) in cash and cash equivalents	(9,097)	(17,958)	(1,181)	(468)	2,817	772
Cash and cash equivalents at beginning of year	16,541	7,444	(10,514)	(11,695)	(12,163)	(9,346)
Cash and cash equivalents at end of year	7,444	(10,514)	(11,695)	(12,163)	(9,346)	(8,574)
<u>Represented by:</u>						
Cash	6,488	(11,349)	(12,531)	(12,999)	(10,182)	(9,410)
Short term investments	956	835	835	835	835	835
	7,444	(10,514)	(11,695)	(12,163)	(9,346)	(8,574)

Table 8 - Projected Statement of Cash Flows

Projected Funder Arm Operating Results						
<i>in thousands of New Zealand Dollars</i> For the year ended 30 June	2018 Audited	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Revenue						
Ministry of Health - devolved funding	516,552	541,713	569,010	588,811	609,067	629,106
Inter district patient inflows	8,237	8,827	8,344	8,634	8,931	9,225
Other revenue	148	191	164	170	176	182
	524,937	550,731	577,517	597,615	618,174	638,513
Expenditure						
Governance and funding administration	3,416	3,424	3,614	3,740	3,869	3,996
Own DHB provided services						
Personal health	247,301	272,510	280,465	290,225	300,210	310,087
Mental health	24,435	23,522	23,522	24,342	25,179	26,007
Disability support	9,325	9,370	9,370	9,695	10,028	10,358
Public health	641	1,480	594	615	636	656
Maori health	619	619	619	640	662	684
	282,320	307,502	314,570	325,517	336,715	347,792
Other DHB provided services (Inter district outflows)						
Personal health	51,547	54,579	53,928	55,805	57,725	59,624
Mental health	2,375	1,739	2,137	2,212	2,288	2,363
Disability support	3,305	3,129	3,147	3,256	3,368	3,479
	57,228	59,447	59,213	61,273	63,381	65,466

17.2

Continued ...

Projected Funder Arm Operating Results <i>in thousands of New Zealand Dollars</i> For the year ended 30 June						
	2018 Audited	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Other provider services						
Personal health	96,287	92,963	102,543	103,112	106,760	110,371
Mental health	11,725	12,573	13,761	14,238	14,728	15,214
Disability support	66,878	71,015	78,794	81,537	84,343	87,119
Public health	1,237	1,382	2,247	2,325	2,406	2,485
Maori health	2,745	2,965	2,776	2,873	2,972	3,070
	178,873	180,897	200,120	204,085	211,209	218,259
Total Expenditure	521,836	551,269	577,517	594,615	615,174	635,513
Net Result	3,101	(539)	-	3,000	3,000	3,000

Table 9 - Projected Funder Arm Operating Results

Projected Governance and Funding Administration Operating Results						
<i>in thousands of New Zealand Dollars</i> For the year ended 30 June	2018 Audited	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Revenue						
Funding	3,416	3,424	3,614	3,740	3,869	3,996
Other government and Crown agency sourced	7	-	-	-	-	-
Other revenue	67	30	30	31	32	33
	3,490	3,454	3,644	3,771	3,901	4,029
Expenditure						
Employee benefit costs	617	1,182	1,199	1,242	1,283	1,328
Outsourced services	508	512	552	571	590	609
Clinical supplies	-	4	1	1	1	1
Infrastructure and non clinical supplies	852	642	946	978	1,014	1,045
	1,976	2,339	2,699	2,792	2,888	2,983
Plus: allocated from Provider Arm	946	950	946	979	1,013	1,046
Net Result	568	165	-	-	-	-

Table 10 - Projected Governance and Funding Administration Operating Results

17.2

Projected Provider Arm Operating Results						
<i>in thousands of New Zealand Dollars</i> For the year ended 30 June	2018 Audited	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Revenue						
Funding	282,320	307,391	314,500	325,444	336,639	347,714
Ministry of Health - non devolved contracts	14,369	14,819	14,490	14,995	15,511	16,022
Other District Health Boards	4,473	4,370	4,056	4,207	4,362	4,516
Accident insurance	5,423	4,775	4,205	4,362	4,523	4,683
Other Government and Crown Agency sourced	617	557	673	698	724	750
Patient and consumer sourced	1,117	1,158	1,244	1,291	1,339	1,386
Other revenue	5,888	5,193	4,305	4,379	4,540	4,701
	314,207	338,261	343,473	355,376	367,638	379,772
Expenditure						
Employee benefit costs	208,994	223,029	239,614	248,000	256,182	265,148
Outsourced services	18,787	19,844	15,683	16,228	16,787	17,339
Clinical supplies	49,696	54,783	37,128	37,619	38,378	36,779
Infrastructure and non clinical supplies	49,921	49,818	51,994	54,508	57,304	61,552
	327,397	347,475	344,419	356,355	368,651	380,818
Less: allocated to Governance & Funding Admin.	946	950	946	979	1,013	1,046
Surplus/(Deficit) for the period	(12,245)	(8,264)	-	-	-	-
Revaluation of land and buildings	(15,312)	-	-	-	-	-
Net Result	3,067	(8,264)	-	-	-	-

Table 11 – Projected Provider Arm Operating Results

SIGNIFICANT ASSUMPTIONS

General

- Revenue and expenditure have been budgeted on current Government policy settings and known health service initiatives. Where information is not available, assumptions have been made and are included below.
- No allowance has been made for any new regulatory or legislative changes that 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 MOH.
- No allowance has been made for the recalculation of payments that were not compliant with the Holidays Act, as the amount is not currently measurable.
- Allowance has been made for expected costs arising from RHIP.
- Detailed plans for new investment and efficiency programmes have yet to be finalised. The impact of the two programmes on financial performance have been recognised in clinical supplies.
- Unless otherwise stated, increases in revenue and expenditure due to changes in price levels have been allowed for at 2.0% per annum over the time horizon of the plan, based on Treasury forecasts for CPI inflation in the Half Year Economic and Fiscal Update 2018 published (13 December 2018).

Revenue

- Crown funding under the national population based funding formula is as determined by MOH. Funding including adjustments has been allowed at \$522.1 million for 2019/20. Funding for the years 2020/21, 2021/22 and 2022/23 is based on the standard DHB funding allocation methodology that projects demographic increases of 1.73%, 1.69% and 1.54% respectively, to which a 2% contribution to cost pressures less 0.25% for efficiencies has been added for each year.

- Crown funding for non-devolved services of \$14.5 million is based on agreements already in place with the appropriate MOH directorates, and assumes receipt of the DHB's full entitlement to elective services funding.
- Inter district flows revenues is in accordance with MoH advice.
- Other income has been budgeted at the DHB's best estimates of likely income.

Personnel Costs and Outsourced Services

- Workforce costs for 2019/20 have been budgeted at actual known costs, including step increases where appropriate. Increases to employment agreements have been budgeted in accordance with settlements, or where no settlement has occurred, at the DHB's best estimate of the likely increase. Personnel cost increases have been allowed for at 3.5%, 3.3% and 3.5% for 2020/21, 2021/22 and 2022/23 respectively based on Treasury forecasts for wage inflation in the Half Year Economic and Fiscal Update 2018 (published 13 December 2018).

Supplies and Infrastructural Costs

- The cost of goods and services has been budgeted at 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.

Services Provided by Other DHB's

- Inter district flows expenditure is in accordance with MOH advice.

Other Provider Payments

- Other provider payments have been budgeted at the DHB's best estimate of likely costs.

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. No amortisation has been allowed for the investment in NZHPL as it is a right to use a system, and is considered to have an indefinite life.

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- DHBs do not have authority to borrow long term. The DHB expects to draw on the DHB banking collective's overdraft facility arranged by New Zealand Health Partnerships (NZHP) for working capital requirements, and borrowing costs at 3% per annum have been recognised in the plan.
- The DHB expects to finance a number of capital expenditure projects using equity injections provided by the Crown. The capital charge rate has been allowed for at 6% per annum.

Investment

Investment	2020 Projected \$'000	2021 Projected \$'000	2022 Projected \$'000	2023 Projected \$'000
Buildings and Plant	17,693	31,908	34,808	34,518
Clinical Equipment	3,400	3,400	9,826	3,400
Information Technology	3,778	5,400	3,400	3,400
Capital Investment	24,871	40,708	48,034	41,318

- The purchase of class B shares in New Zealand Health Partnerships Limited (NZHPL), 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 further impairment of the asset, other than the \$0.2 million recognised in 2017/18.
- The DHB's share of the assets in RHIP will be amortised over their useful lives. The cost of amortisation is included in infrastructural costs. No allowance has been made for any impairment of the asset.
- No collaborative regional or sub-regional initiatives have been included other than RHIP.

- 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 :

Capital Investment Funding

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

Investment Funding	2020 Projected \$'000	2021 Projected \$'000	2022 Projected \$'000	2023 Projected \$'000
Capital Investment	24,871	40,708	48,034	41,318
<i>Funded by:</i>				
Depreciation and amortisation	14,465	15,752	15,847	17,321
Operating surplus/(deficit)	-	3,000	3,000	3,000
Equity injection	9,991	21,956	29,187	22,142
Cash holdings/overdraft	415	-	-	(1,145)
Capital Investment Funding	24,871	40,708	48,034	41,318

- Equity injections are to fund Hawke's Bay DHB's strategic capital needs, as defined in the DHB's Capital Plan, and are subject to Ministry of Health approval.

Property, Plant and Equipment

- Hawke's Bay DHB 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 was completed as at 30 June 2018 and is included in the financial statements. The next revaluation is likely to be at 30 June 2021 and the effect is unknown, and no adjustment has been made to asset values as a consequence.

Debt and Equity

- Borrowings from MOH to all DHBs converted to equity on 15 February 2017. No borrowings have been recognised for Hawke's Bay DHB after 2016/17.
- Equity movements will be in accordance with the table below

Equity	2019/20 \$'000	2020/21 \$'000	2021/22 \$'000	2022/23 \$'000
Opening equity	139,728	149,362	173,960	205,790
Surplus/(deficit)	-	3,000	3,000	3,000
Equity injections (capital)	9,991	21,956	29,187	22,142
Equity repayments (FRS3)	(357)	(358)	(357)	(357)
Closing equity	149,362	173,960	205,790	230,575

Additional Information and Explanations:

Disposal of Land

- Disposal of land is subject to current legislative requirement and protection mechanisms. Hawke's Bay District Health Board 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.
- Disposal of land is subject to current legislative requirement and protection mechanisms. Hawke's Bay District Health Board 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.

17.2

2019-20

Hawke's Bay District Health Board Population Health Annual Plan



HAWKE'S BAY
District Health Board
Whakawateatia

17.3

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17.3

1. The Hawke's Bay Population

The population of Hawke's Bay district has some distinct characteristics compared to the rest of New Zealand. Differences in health status, as well as socio-economic and demographic profiles provide us with specific challenges. The district has a higher proportion of Māori (26% vs 16%), more people aged over 65 years (19% vs 15%)¹ and more people living in rural communities and areas with relatively high material deprivation (28% vs 20%). Hawke's Bay will see significant changes in age groups; over 65 year olds will increase by 47% and over 85 year olds will increase by 45.5%. Growth in the population is expected to come from births in the Māori and Pasifika populations, increased life expectancy across the whole population, and migration.

2. Improving Health and Equity

Improving health and equity remains the overarching focus for the Population Health Service. This has been reinforced by the establishment of the Health Improvement and Equity Directorate which includes the Population Health Service, Pacific Health Service and Māori Health Service.

Social and economic forces in combination with biological and environmental factors shape the health of a population over the life course.

Population health approaches and services are essential components to address the determinants of health and to achieve better health status and equity. Health starts in our homes, schools, workplaces and communities. To be healthy, people need:

- Protection from environmental factors leading to health issues and risk
- Adequate housing
- A liveable income
- Employment
- Educational opportunities
- A sense of belonging and feeling valued
- A sense of control over life circumstances
- Culturally responsive approaches and services

¹ Summary of Resident Total Population Projections 2018-2043; 2013 base. Statistics New Zealand.

Cross sector working is crucial in addressing these determinants of health, by working in partnership with central government agencies, local government, Iwi, non-government organisations, business and the community sector we are improving determinants of health. Hawke's Bay DHB is a partner in the Hawke's Bay Matariki Strategy - its actions include addressing barriers to employment, developing a social responsible employment sector, establishing groups to enable community voice and developing a new sustainable operating system for social services. These innovative steps all support the outcome of greater equity, enabling all whānau in Hawke's Bay to benefit.

In addition to the broader population health focus, the Population Health Service delivers public health services with the aim to improve, promote and protect public health. These services focus on communities and the environment, rather than at a personal level. Public health services cover a broad range of diseases and risk factors, and include services provided at a population level (e.g. investigation of disease outbreaks, environmental and border health control) as well as services at an individual level (e.g. smoking cessation, immunisation, breast, cervical screening and bowel screening).

The Population Health Service has a multi-disciplinary workforce with expertise to work across the whole health spectrum, utilising the five core public health functions of health assessment and surveillance, public health capacity development, health promotion, health protection, and preventive intervention services. The effectiveness of these activities aimed at reducing the burden of disease has a downstream impact on reducing costs for the whole health system.

The Ministry of Health defines equity as:

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

Challenges we face include financial constraints, insufficient capacity, prioritisation of work, reactive work e.g. responding to communicable disease outbreaks and regulatory functions, long term versus short term outcomes (it takes time to see the results of our work), and selling the reason why a population should adopt a healthier lifestyle in the face of behavioural, environmental and other social factors.

17.3

Whānau Voice Informing Our Approach

In the delivery of this Plan we will establish approaches to engage the whānau voice across planning, design and deliver. This will be based on a clear understanding of 'equity' and how we will address inequity, including applying equity assessment tools. Also all staff being culturally competent in our approaches and practice. Engaging whānau voice will utilise a wide range of approaches, ensure engagement is reciprocal and is visible in all planning, design and delivery.

3. Key Priorities for 2019-2020 – National and Local

National

The Government's priorities are:

1. Improving Māori health
2. Achieving equity in health and wellness
3. Child and youth wellbeing
4. Mental health
5. Primary health care

The Ministry of Health's priorities (relating to population health and public health) are:

1. Drinking water regulation
2. Bowel screening
3. Smokefree 2025
4. Long term conditions (alcohol and other drugs, tobacco, nutrition, physical activity, healthy weight)

Local

The Clinical Services Plan sets out the Hawke's Bay DHB's direction for the next ten years in response to challenges faced in the coming years. It describes the DHB's vision for a very different health system that improves outcomes and experience for individuals and whānau living in Hawke's Bay. The plan takes a view of the health system as a whole, encompassing primary care, community and hospital level care; and acknowledging the important influence of socioeconomic determinants.

The Health Improvement and Equity directorate led the development of the Health Equity Report 2018. The report highlights significant improvement in the rate of teenage pregnancy, ASH 0-4, and breast and cervical screening, such that the equity gap is almost closed. Equity continues to be maintained in immunisation coverage for Māori and Pacific populations in Hawke's Bay. Whilst ASH 0-4 rates have improved for Pacific there is considerable inequity for Pacific compared to other ethnic groups concerning upper, lower and ENT respiratory infections, asthma, and cellulitis. The equity gap in amenable mortality was improving up until 2012 but has stalled along with avoidable deaths, ASH 45-64 year olds and sexually transmissible infections. Areas showing no improvement or getting worse are mental health and hazardous alcohol use, acute respiratory (bronchiolitis) admissions, obesity amongst children over 4 years of age and adults, oral health of five year olds, tobacco use in pregnancy and violent crime. Sexual health, mental health, alcohol harm reduction, childhood obesity, oral health and tobacco use in pregnancy are areas of focus in this 2019/20 plan. Key findings of the Health Equity Report are summarised in figure 1 below.

What is happening in health equity?



Figure one: Summary of Findings Health Equity Report 2018

The next step in implementing the clinical services plan and responding to the Health Equity Report is the establishment of a new 10 year strategy for health in Hawke's Bay along with a 5 year implementation plan. The Health Improvement and Equity directorate will be responsible for establishing an equity framework that embeds equity in all decision making processes as the plan is rolled out. This will include an equity assessment of intersectoral actions carried out under the Matariki strategy.

Population Health Strategy

The Population Health Strategy for Hawke's Bay, *Supporting Healthy Communities*, was developed by the Population Health Service in partnership with the Primary Health Organisation, Health Hawke's Bay some years ago but its objectives are still relevant today.

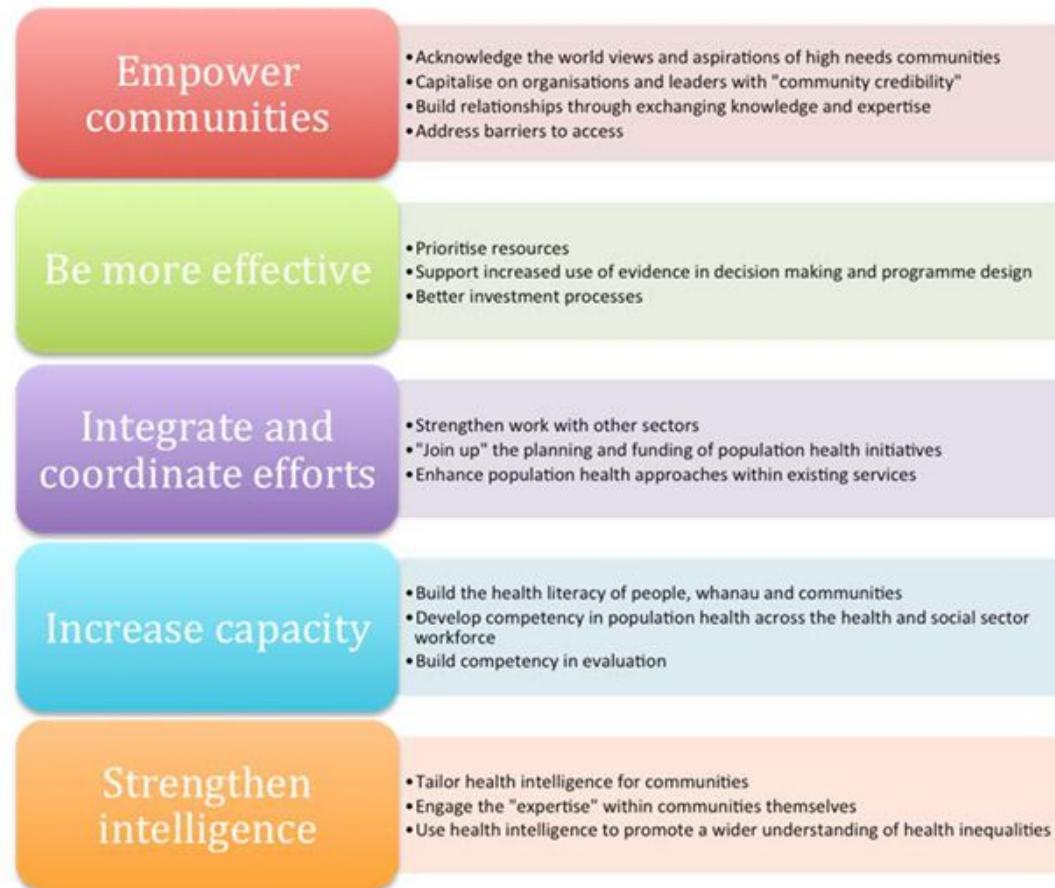


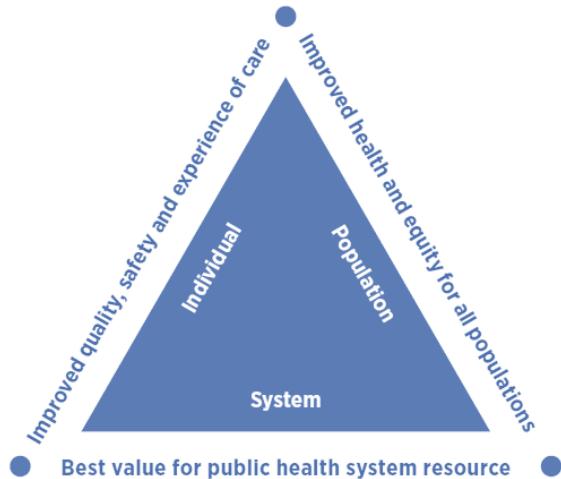
Figure 2: Supporting Healthy Communities objectives

4. Alignment with Other Plans

This Population Health Annual Plan is aligned to and contributes to the Government and Ministry of Health priorities and health targets, Hawke's Bay DHB's annual plan, Clinical Services Plan, and Health Equity Report. The table below shows how the Population Health Annual Plan is aligned to these areas.

Population Health Annual Plan	Government Priorities	Ministry of Health Priorities	Ministry of Health Targets	Clinical Services Plan	Hawke's Bay Health Equity Report	HBDHB Annual Plan
Environmental & border health	✓	✓		✓		✓
Alcohol & other drugs harm reduction	✓	✓		✓	✓	✓
Tobacco	✓	✓	✓	✓	✓	✓
Communicable disease						
Healthy housing	✓			✓		✓
Immunisation	✓		✓	✓		✓
Child & youth wellbeing	✓		✓	✓	✓	✓
Nutrition, physical activity, healthy weight		✓	✓	✓	✓	✓
Social environments, cross sector development	✓			✓		
Mental health	✓			✓	✓	✓
Migrant health	✓			✓		
Sexual health					✓	
Health education	✓			✓		
Public health workforce				✓		
Population screening	✓	✓	✓	✓		✓
Oral health	✓			✓	✓	

5. NZ Triple Aim Quality Framework



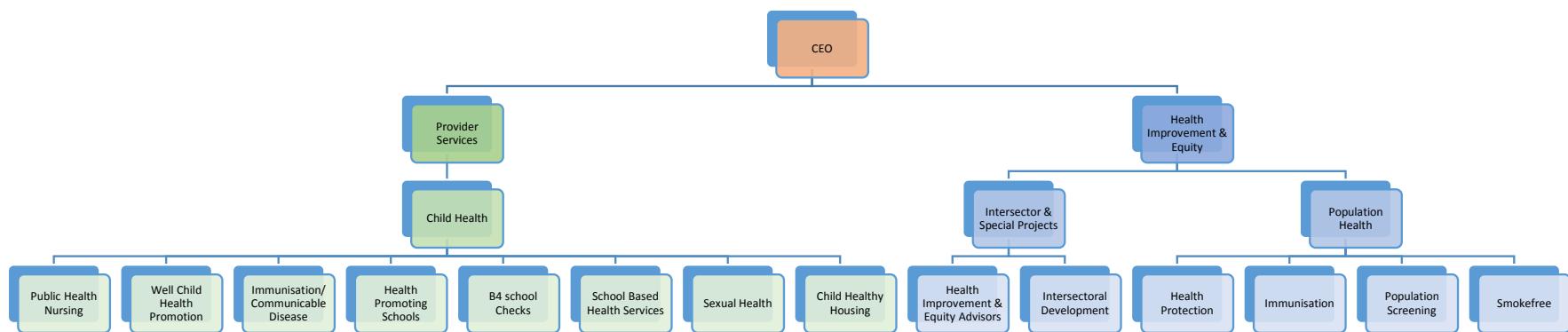
The New Zealand Health Quality and Safety Commission uses the New Zealand Triple Aim goals for quality improvement.

The Population Health Service utilises a quality framework to ensure services are delivered efficiently, effectively, safely and of a high quality standard in line with the Triple Aim goals (as shown in table).

Triple Aim	Quality Improvement Actions
Individual: Improved quality, safety and experience of care	<ul style="list-style-type: none"> • Client-centred services • Competent, skilled workforce • Ongoing professional development • Scope of practice • Policies & procedures • Performance monitoring & review • Event reporting • Clinical leadership
Population: Improved health and equity for all populations	<ul style="list-style-type: none"> • Equity focus • Evidence based • Best practice • Evaluation & review • Surveillance
System: Best value for public health system resource	<ul style="list-style-type: none"> • Stakeholder collaboration • Efficient & effective service delivery • Quality data systems • Quality & risk management

6. Structure of the Population Health Service

Population health and public health services are delivered within two Hawke's Bay District Health Board Directorates - Health Improvement and Equity Directorate and Provider Services. The Population Health Service, along with Māori Health now forms part of the Health Improvement and Equity Directorate and the Child Health Team forms part of the Provider Services Directorate. This structure is shown below.



17.3

PART A: PUBLIC HEALTH CORE CONTRACT

1. Environmental and Border Health

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
1.1	Health Protection	<p>Drinking Water</p> <p>Maintain accreditation of Drinking-Water Assessors and Drinking Water Assessment Unit.</p> <p>Identify and investigate incidents, complaints and notifications of adverse drinking water quality (or adequacy) of networked, tankered and temporary drinking water supplies.</p> <p>Undertake all duties and functions required by the Health Act 1956, including:</p> <ul style="list-style-type: none"> • Register drinking-water suppliers and water carriers as required. • Routinely go through the drinking water register each year and verify or update details of network supplies. • Promote compliance with the drinking-water requirements of the Health Act 1956 and achievement of the <i>Drinking-Water Standards for New Zealand</i> to drinking-water suppliers and water carriers, and undertake compliance and enforcement action as required. • Conduct the annual review of drinking-water supplies serving more than 100 people and report to water suppliers as required by Scope 1. 	# Drinking Water Assessor FTEs. # investigations related to incidents, complaints and notifications. # water supplies surveyed in the annual review. # of water safety plans assessed.	% Drinking-Water Assessors that maintain accreditation. Numerator: # Drinking-Water Assessors that maintain accreditation; Denominator: # Drinking-Water Assessors. % drinking water register entries (network supplies) verified or updated at least annually. Numerator: # of network registered water supplies verified or updated; Denominator: # of network registered water supplies. % networked water supplies (by class of water supply) receiving at least one compliance inspection per annum with findings confirmed in writing. Numerator: # networked supplies (by class) receiving written findings of visit per annum.	#/% networked water supplies (broken down by class i.e. large, medium, minor, small and rural agricultural) compliant with sections 69V and 69Z of the Health Act 1956 (BC, O). Numerator: # networked water supplies (broken down by class i.e. large, medium, minor, small and rural agricultural) compliant with sections 69V and 69Z of the Health Act 1956; Denominator: # networked water supplies (broken down by class i.e. large, medium, minor, small and rural agricultural). Note: The above measure should be informed by the

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		<ul style="list-style-type: none"> • Assess water suppliers' water safety plans as required and provide a report to the water supplier within 20 working days. Ensure water safety plans include critical control points and promote the use of process control summaries by water supply staff. This will include a visit to the water supplier if the assessor is not familiar with the water supply, treatment plant and water supply staff. • Assess and process applications as required for the use of temporary drinking water supplies. • Ensure water-suppliers have plans and PHU responds in a timely manner to transgressions, water supply contamination or interruptions to the supply, including taking appropriate measures to protect and advise the community. <p>Certify the implementation of water safety plans. At least annually check the water safety plan is being maintained (i.e. is a living document and the water supplier does not wait for the five year review period to update the plan). Authorise organisations for the purposes of ensuring compliance with the Act, drinking water standards, and water safety plans. Report serious drinking water incidents to the Ministry of Health within 24 hours. Report suspected or confirmed waterborne disease outbreaks to the Ministry of Health within 2 hours. Undertake enforcement activities in consultation with, and at the direction of, the Ministry of Health.</p>	# temporary drinking water supplies assessed and approved. # authorisations.	Denominator: # networked supplies (by class). % water suppliers' water safety plans assessed and reported on within 20 working days. Numerator: # water safety plans assessed and reported on within 20 working days; Denominator: # water safety plans assessed within the reporting period. % networked water supplies (by class of water supply) where timely response was provided by PHU to transgressions, contamination or interruption in accordance with drinking water legislation and standards. Numerator: # networked water supplies (by class) where timely response provided; Denominator: # networked water supplies (by class) which reported transgressions, contamination or interruptions to the PHU.	previous year's Annual Survey % of Hawke's Bay population served by a supplier implementing an approved WSP

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No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		<p>Refer issues and concerns with self-supplies to territorial authorities as required.</p> <p>Implement the requirements of the Drinking-Water Standards for New Zealand as required (e.g. P2 assignments, catchment risk assessments, and secure ground water assessments).</p> <p>Ensure activities are integrated with the drinking water technical advice services for networked supplies serving up to 5000 people.</p> <p>Provide technical advice and information on public health aspects of drinking water supplies, including the implications of the Health Act 1956 and the <i>Drinking Water Standards for New Zealand</i>, to water suppliers, councils, the public and organisations on issues of public health significance in respect to drinking water supplies.</p> <p>Ensure that the public health effects of drinking water supplies are considered and managed by making timely submissions on:</p> <ul style="list-style-type: none"> • regional and district plans and policies, including giving effect to the National Environmental Standard for drinking water catchments • territorial authority assessments of drinking water supplies • resource consent applications. <p>Provide advice on the benefits of water fluoridation when the issue becomes a significant issue in the community by:</p>	<p># assessments related to requirements of the Drinking-Water Standards</p> <p>The TANK collaboration is moving through the plan change process during 2019 and 2020. The plan includes many provisions drafted by the JWG to protect drinking water sources for NCC and HDC. Further submissions and hearing appearances will be required</p>	<p>Note: PHU to assess risk accordingly and determine response within 24 hours on becoming aware of a P1 or P2 transgression, contamination or interruption.</p> <p>% networked water suppliers serving more than 100 people with approved water safety plans. Numerator: # of networked supplies serving more than 100 people with an approved water safety plan; Denominator: # of networked supplies serving more than 100 people.</p> <p>% of network drinking water supplies with an approved WSP that have had an implementation completed in the last 3 years (expected 100%). Numerator: # of network water that have had an implementation completed in the last 3 years; Denominator: # of networked supplies with current approved WSP.</p>	

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		<ul style="list-style-type: none"> • supporting health professionals who are promoting the extension or maintenance of fluoridated water supplies • ensuring appropriate education material is available to institutions, health professionals, territorial authorities, community groups and the public • ensuring that messages on fluoridation and oral health are consistent and current, and keep all health providers well informed • making timely submissions on water fluoridation when appropriate. <p>Form collaborative arrangements with water suppliers, district councils and regional councils to share information about potential risks to drinking-water catchments, drinking-water supplies and other relevant issues.</p> <p>Carry out public health grading of drinking-water supplies at the request of drinking-water suppliers.</p>	<p>As noted above the HB drinking water JWG is acting as an advisory group to the TANK plan change. The JWG is providing oversight of the source water protection zone modelling work. An information sharing protocol is under development</p>	<p>Narrative report: Why it isn't 100% (if it isn't).</p> <p>% of network drinking water supplies with an approved WSP that has been updated and is being actively implemented. Numerator: # of network drinking water supplies with an approved WSP that has been updated and is being actively implemented; Denominator: # of network drinking water supplies with an approved WSP.</p>	<p>#/% networked water supplies serving 1000 or more people that are fluoridated (CC, O). Numerator: # networked water supplies serving 1000 or more people that are fluoridated; Denominator: # networked water supplies serving 1000 or more people.</p>
1.2	Health Protection	Hazardous Substances	# public health HSNO enforcement officers.		Narrative reporting:

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No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		<p>Use the priority criteria in the Hazardous Substances Action Plan, and injury surveillance data, to develop hazardous substances programme plans.</p> <p>Report all notifications of hazardous substances injuries, including agrichemical spray-drift complaints, lead poisoning and poisoning arising from chemical contamination of the environment, to the science provider in the format required, including General Practitioner (GP) notifications.</p> <p>Promote hazardous substances injury notifications by GPs.</p> <p>Participate in the Hazardous Substances Injury Surveillance System and other notifiable condition surveillance systems, including GP notifications via the HSDIRT system and according to Ministry of Health guidelines and direction.</p> <p>Investigate notifications of lead poisoning, poisoning from chemical contamination of the environment, and hazardous substances injuries as required.</p> <p>Process applications for Vertebrate Toxic Agent (VTA) operations that require public health permissions.</p> <p>Ensure that the conditions imposed by the public health HSNO enforcement officer granting permits for the use of controlled vertebrate toxic agents are complied with. Field or desktop audits of all permissions are required to ensure compliance, as appropriate.</p> <p>Audit compliance with, investigate breaches of, and where appropriate, enforce the relevant Acts and Regulations, including:</p>	<p># cases of hazardous substances injuries that are notified by GPs, hospitals and others.</p> <p># applications for Vertebrate Toxic Agent (VTA) permission received</p> <p># applications for VTA permission issued.</p> <p># desktop audits of 1080 operations.</p> <p># field audits of 1080 operations.</p>	<p>% routine applications for VTA permissions processed within 20 working days. Numerator: # routine applications processed within 20 working days; Denominator: # routine applications.</p> <p>% of 1080 operations with permissions audited, either by desktop or field audit, for compliance with permission conditions (expected 100%).</p>	<p>Outcomes of promotion of the HSDIRT reporting process to GPs, hospitals and others.</p> <p>#/% audited Vertebrate Toxic Agent (VTA) operations compliant with permit approval conditions (BC, O). Numerator: # audited VTA operations compliant with permit approval conditions; Denominator: # audited VTA permissions.</p>

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		<ul style="list-style-type: none"> • attending hazardous substances incidents as requested by Fire and Emergency NZ. • surveillance of hazardous substances injuries and reporting via the HSDIRT system. <p>Work with other HSNO enforcement agencies to support their regulatory roles and manage potential public health risk, for example, through assisting with recalls and public warnings as required.</p> <p>Receive annual reports on methyl bromide fumigations.</p> <p>Maintain effective risk management strategies and response plans for hazmat incidents and emergencies, including deliberate chemical contamination and chemical fires, and including at designated points of entry. Responses are required to be consistent with the Ministry's advice and guidelines as noted in the service delivery expectations.</p> <p>Represent public health interests at meetings of the Area Hazmat Coordination Committee.</p> <p>Promote public knowledge on the risks of environmental and non-occupational exposures to hazardous substances and products, including asbestos in the non-occupational environment by:</p> <ul style="list-style-type: none"> • providing public health advice and information on hazardous substances and products to the public, health professionals and organisations • advising on the safe management of hazardous substances and products, including their removal and disposal from contaminated areas 	# desktop or field audits of non 1080 operations. # VTA complaint investigations received and investigated. # VTA complaints referred to another agency. # hazmat incidents or emergencies attended. # hazmat exercises attended. # response plans reviewed and revised, if necessary, following responses and exercises. # area hazmat coordination committee meetings attended. # investigations/activities undertaken, by	Numerator: # 1080 operations with permissions audited; Denominator: # 1080 operations with permissions. % debriefs/audits that show responses have been consistent with the Ministry's advice and guidelines, including the <i>National Hazmat Response Plan, Major Response to Fires; guidelines for public health units (Revised 2014), Investigation and Surveillance of Agrichemical Spray drift Incidents</i> :	Narrative reporting: Outcomes of hazmat meetings and exercises.

17.3

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		<ul style="list-style-type: none"> • advising on the safe management of asbestos in the non-occupational environment according to the Ministry of Health's guidelines and direction. • advising on the safe management of products containing lead, including lead-based paint and mercury (including its removal and disposal). <p>Advise, encourage and/or assist territorial authorities and Regional Councils to:</p> <ul style="list-style-type: none"> • identify potentially contaminated sites in the region and identify contaminants • implement health impact assessment systems to ensure contaminated land is remedied, where appropriate, and to minimise adverse effects on human health • determine appropriate land use controls for contaminated sites to minimise the risk to the public • ensure appropriate advice is provided to manage any public health risk from sites and during any remediation processes. 	<p>type (e.g., crayons, face paint, chemical spills).</p>	<p><i>guidelines for public health units.</i> Numerator: # debriefs/audits that show that response was consistent with Plans, Ministry Guidelines, etc.; Denominator: # of responses.</p> <p>Narrative reporting: Outcomes related to whether Local Authorities have been responding appropriately to public health risks from contaminated land.</p>	
1.3	Health Protection	<p>Mosquito surveillance</p> <p>Undertake surveillance of mosquitoes at appropriate frequency (weekly over summer and warmer part of spring/autumn and fortnightly over winter and colder part of autumn/spring at international sea and airports or monthly audit of surveillance undertaken by the air or sea port company).</p> <p>Provide mosquito interception response situation reports to the Environmental and Border Health Team using the</p>	<p># interceptions. # incursions. # responses to other organisms.</p>	<p>% responses initiated within 30 minutes of notification. Numerator: # responses initiated within 30 minutes; Denominator: # responses.</p> <p>Narrative reporting: On mosquito surveillance and whether it is occurring at appropriate frequency (will</p>	<p>#/% exotic mosquitoes that have crossed the border and established in your region (CC, O). Numerator: # incursions; Denominator: # interceptions.</p>

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		<p>template in the border health section of the Environmental Health Protection Manual.</p> <p>Respond promptly to interceptions of pests with a human health significance (e.g., rats, ticks, poisonous spiders and cases of imported disease).</p> <p>Border health</p> <p>Ensure designated points of entry achieve and maintain core capacities as required by the International Health Regulations 2005; audit core capacities annually as required by the Ministry of Health. Ensure all other ports of first arrival achieve and maintain as many core capacities as feasible for their situation.</p> <p>Identify and monitor border health protection risks from biological (including pests and diseases), chemical and physical (including ionising radiation) hazards.</p> <p>Develop/maintain contingency plans to deal with border health risks, including surveillance, ill traveler protocols, and border emergency response plans; work with border stakeholders to support the inclusion of public health response plans within sea and airport emergency response plans.</p> <p>Respond promptly to requests for pratique, inspections and certification (e.g., ship sanitation).</p> <p>Attend border and other intersectoral meetings with relevant agencies and organisations on matters relating to border health protection.</p>	<p># authorised or accredited persons under the Biosecurity Act 1993.</p> <p># intersectoral meetings (#airports, # seaports).</p> <p># responses to border public health incidents.</p> <p># maritime pratiques issued.</p> <p># maritime pratiques issued on arrival.</p> <p># aircraft met on arrival.</p> <p># ship sanitation exemption, extension and control certificates issued.</p>	<p>depend on weather and indicators, such as biomass).</p> <p>Narrative reporting: On requirements of a competent authority met by PHU (report against the appendix).</p> <p>% current staff members involved in ship sanitation inspections who have completed the WHO on-line ship sanitation course (expected 100%).</p>	<p>#/% international points of entry that meet requirements of annual verification assessment under International Health Regulations 2005 (BC, O). Numerator: # international points of entry that meet requirements of annual verification assessment under International Health Regulations 2005; Denominator: # international points of entry located in PHU area of coverage.</p> <p>#% international points of entry that have contingency plans to deal with ill travelers and other border health responses that are interoperable with</p>

17.3

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		<p>Provide sound technical and professional advice on public health issues that are related to border health protection objectives in relation to imported risk goods, disease vector surveillance and control, preparation of contingency plans for emergency response, preparation of submissions as appropriate on proposed pest management strategies.</p> <p>Provide public health training to air and sea port staff, as required, on border health protection risks and their management.</p> <p>Contribute to or lead (when required) the preparation of health impact assessments in relation to border health protection threats and eradication and control activities.</p> <p>Maintain on-call roster to ensure appropriately trained staff are available at all times for any border responses.</p>	# public health training (e.g. advice, update, event) to air and sea port staff.	<p>Numerator: # current staff members involved in ship sanitation inspections who have completed the WHO on-line ship sanitation course;</p> <p>Denominator: # current staff members involved in ship sanitation inspections.</p>	<p>public health response plans (CC, O).</p> <p>Numerator: # international points of entry that have contingency plans to deal with ill travelers and other border health responses that are interoperable with public health response plans;</p> <p>Denominator: # international points of entry located in PHU area of coverage.</p>
1.4		<p>Emergency Planning and Response</p> <p>Carry out all emergency management planning, preparedness and responses in collaboration with other relevant agencies and according to Ministry of Health guidelines, plans and advice.</p> <p>Maintain and review Emergency Response Plan(s). There must be plans covering the following minimum areas:</p> <ul style="list-style-type: none"> - Border Health Response - Communicable Disease – Outbreak/Pandemic 	# responses.	<p>% public health unit plans include reduction/readiness/response/recovery/resilience, and identify resources needed to support and carry out public health action (expected 100%).</p> <p>Numerator: # public health unit plans include the four 'Rs';</p> <p>Denominator: # public health unit plans.</p>	<p>#/% PHU Emergency Planning and Response Plans interoperable with stakeholder plans (i.e. TLAs, DHBs, airport, seaport (CC, O).</p> <p>Numerator: # PHU Emergency Planning and Response Plans interoperable with stakeholder plans (i.e. TLAs, DHBs, airport, seaport;</p>

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		<ul style="list-style-type: none"> - Hazardous Substances (including radiation, hazmat responses, and Chemical and Biological Counter Terrorism Response) - Civil Defence/National Disaster. <p>Take appropriate emergency actions, as the need arises. This includes liaison with and taking directions from other agencies involved, including providing services for, be directed by, and report to civil defence authorities.</p> <p>Maintain, exercise and regularly review plans for responding effectively to a range of public health emergencies, including national, regional and local meetings, exercise and training opportunities.</p> <p>Maintain civil defence and public health emergency planning and response capacity, and ensure there are appropriate numbers of staff trained in emergency management/CIMS.</p> <p>Ensure key health messages are available in educational and promotional materials through collaboration with other agencies/organisations involved in emergency planning and response.</p>	# exercises. Contribution to HBCDEM group plan review in 2019/2020. This will include review of capacity and a new risk assessment. Heat health and climate change related hazards to be included Attendance at CEG meetings	% plans and Standard Operating Procedures updated each year (required 100%). Numerator: # plans and Standard Operating Procedures updated; Denominator: plans and Standard Operating Procedures. Note: As a minimum the annual update should include a check to ensure that relevant contact phone numbers are still correct. % plans tested, including emergency communications (required 100%). Numerator: # plans tested; Denominator: # plans. Note: checking that all emergency phone numbers are still correct as a minimum. % exercises and responses that are followed by a debrief (required 100%) Numerator: # exercises and responses followed by a debrief;	Denominator: # stakeholder plans. Please report in narrative, if plans are not interoperable, on how you are working towards making plans interoperable. Definition of interoperable: <i>The two Plans operate together seamlessly, are aligned and there is no discontinuity (e.g., if the airport EOC incident controller role is undertaken by the Police, then that is documented in the PHU Plan).</i> Narrative reporting: Outcomes of exercises. #/% Health Protection Officers and Medical Officers of Health completed CIMS 4 or CIMS (Health) training

17.3

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
			<p>Denominator: # exercises and responses. Note: If the exercise is held by another agency and there is no debrief, the PHU should hold its own debrief.</p> <p>% debrief recommendations that are incorporated into plans and SOPs. Numerator: # debrief recommendations that are incorporated into plans and SOPs; Denominator: # debrief recommendations.</p>	<p>within the last four years (SK, O). Numerator: # Health Protection Officers and Medical Officers of Health completed CIMS 4 or CIMS (Health) training within the last four years and currently employed; Denominator: # Health Protection Officers and Medical Officers of Health employed by the PHU.</p> <p>Narrative reporting: If not 100%, please report on when they would be completing this training. Note: target should be 100% over a four-year period.</p>	
1.5	Health Protection	<p>Stakeholder Planning, Submissions and Resource Management</p> <p>Encourage and assist Councils to develop and implement policies through processes, such as the review of district plans, including variations or plan changes or Council Long Term Plans that address the wider determinants of health.</p>	<p># applications/plans/statements/standards assessed for public health issues.</p> <p># submissions made.</p>	<p>% submissions completed that include a public health risk assessment to ensure submission is (expected 100%):</p> <ul style="list-style-type: none"> • evidence based 	<p>Narrative reporting: Public Health impact (or expected impact) of submissions and/or proactive/upstream work with stakeholders (i.e., key public health gains).</p>

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		<p>Make timely and professional submissions on national (including national policy statements, national environmental standards and or guidelines) and regional plans and policy statements, district long term and annual plans and, where appropriate, resource consent applications to ensure that the public health effects are considered and managed of:</p> <ul style="list-style-type: none"> • adverse air quality • the disposal of the dead • environmental noise • ionising radiation (in consultation with the Office of Radiation Safety) • non-ionising fields • recreational waters • gaseous, liquid and solid waste • urban design/form • sewage collection, treatment and disposal • drinking water (cross reference with the separate drinking water section) • other environmental health issues. <p>Monitor decisions made under the Resource Management Act 1991 to ensure that the health impacts of environmental hazards have been considered. Follow up with regional councils and territorial authorities where this has not occurred.</p> <p>Make timely and professional submissions on local government assessments of sanitary works to ensure that the public health aspects are considered.</p> <p>Comment, as appropriate, on territorial authority plans for sanitary works infrastructure planning.</p>	<p># hearings where evidence presented.</p> <p>Narrative reporting: Brief description of proactive/upstream work with stakeholders (who and what).</p>	<ul style="list-style-type: none"> • proportionate to the public health risk • peer reviewed. <p>Numerator: # submissions completed that include a public health risk assessment;</p> <p>Denominator: # submissions completed.</p> <p>Note: PHU should keep brief documentation to show that above criteria has been considered and implemented.</p>	17.3

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		<p>Liaise and, where appropriate, undertake joint projects with consent authorities and affected communities to ensure that public health aspects of planning and resource management are considered.</p> <p>Provide technical advice and information to regional councils and territorial authorities.</p> <p>Inform other agencies and the public on the public health aspects of matters relating to sustainable resource management.</p>			
1.6	Health Protection	<p>Other Regulatory Issues</p> <p>For the following public health issues:</p> <ul style="list-style-type: none"> • air quality • the disposal of the dead • environmental noise • ionising radiation • non-ionising fields • recreational waters • gaseous, liquid and solid waste • other environmental health issues <p>undertake the following:</p> <ul style="list-style-type: none"> • Provide information and advice to other agencies, organisations and the public on their adverse effects • Take appropriate action to minimise risks and to protect the public health from environmental exposures to these issues 	# ionising radiation source transports overseen. # requests for advice or information responded to.	% activities and advice related to ionising radiation undertaken in consultation and with approval of the Ministry's Office of Radiation Safety (expected 100%).	

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		<ul style="list-style-type: none"> • Monitor territorial authorities' actions on these issues to ensure health impacts are minimized • Respond to public enquiries and investigate and/or redirect public complaints and queries on these issues. • Support local government implementation of national policy statements and national environmental standards. <p>Ensure applications for approvals are complete, and include the health protection officer's covering report and recommendations before they are forwarded to the Ministry of Health for action, including:</p> <ul style="list-style-type: none"> • disinterments • burials in special places • medical referee appointments • other burial and cremation approvals. <p>Supervise disinterments as required.</p> <p>Advise and assist applicants to export cadavers, as required, to ensure public health concerns are addressed. (Note that costs may be recovered for this activity.)</p> <p>Conduct six-monthly visits to commercial solaria to encourage compliance with best practice guidelines.</p> <p>Conduct and report on pre-licensing inspections of early childhood centres, including compliance by the licensee of the premises with the Education (Early Childhood Centres) Regulations 1998.</p> <p>Investigate/inspect and report on early childhood centres in response to complaints.</p>	# complaints referred to the appropriate agency for action (where it is outside PHU's responsibility). # complaints investigated (where it is within PHU's responsibility). # sanitary surveys conducted by PHU (if it is within the PHU's responsibility).	Numerator: # activities and advice related to ionising radiation undertaken in consultation with the Ministry's Office of Radiation Safety; Denominator: # activities and advice related to ionising radiation undertaken.	#/% of known commercial solaria operators who report

17.3

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		<p>Survey the availability of high-power laser pointers at retail outlets, provide advice on compliance and take compliance action as required by the Ministry of Health.</p> <p>Encourage local authorities to clearly identify, and publically notify, existing or potential recreational waters, which do not meet minimum microbiological water quality guidelines in the Ministry of Health/Ministry for the Environment Microbiological Water Quality Guidelines for Marine and Freshwater Recreational Areas.</p> <p>Encourage the grading of bathing beaches, as outlined in the Microbiological Water Quality Guidelines for Marine and Fresh Water Recreational Areas.</p> <p>Provide input into regional and local activities associated with recreational water quality. Provide public and stakeholders with appropriate advice relating to recreational waters (e.g., public health fact sheets, media releases, and updated website information).</p> <p>In 2019/2020 the results of a coliminder pilot will be reviewed with a view to establishing a new warning regime for Pandora Pond.</p> <p>Encourage territorial authorities and pool managers (including school pools) to implement the requirements of NZS5826: 2010 Pool Water Quality to avoid or reduce public health risks.</p> <p>Conduct routine evaluation of the performance of controlling authority management of public health aspects of sewage collection and disposal with</p>	<p># pre-licensing inspections of early childhood centres.</p> <p># of early childhood centre inspections undertaken as a result of complaints.</p> <p>Narrative reporting: Nature of any significant work not reported elsewhere e.g. Beauty/appearance industry work such as nail bars.</p>	<p>Numerator: # visits to commercial solaria; Denominator: # known commercial solaria.</p>	<p>they are aware of the under-18 age ban (SK, S). Numerator: # of known commercial solaria operators who report they are aware of the under-18 age ban; Denominator: # of known commercial solaria operators located in PHU area of coverage.</p>

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		<p>reference to statute, guidelines, standards, resource consent conditions and accepted public health practice.</p> <p>Investigate and assess the public health need for sewerage systems in areas not adequately serviced.</p> <p>Undertake sanitary and waste surveys as required. Provide a system for monitoring of significant public health risks in waste management. Undertake surveys of representative waste management facilities in the region as resources allow.</p> <p>Liaise with councils to verify that sewage overflows that pose a significant public health risk are adequately responded to, engage with sewage collection and disposal providers to ensure overflows are appropriately managed and reduce overflows to high risk areas.</p> <p>Promote improvements in public sewage collection and disposal systems where this is considered necessary.</p> <p>Consider becoming a signatory to the NZ Urban Design Protocol (2005).</p> <p>Where appropriate, advocate the use of health impact assessment.</p> <p>Where appropriate, promote the Healthy Cities/communities concept.</p> <p>Individually and collectively make efforts to reduce carbon emissions and, where appropriate, promote the adoption of CEMARS (or other carbon neutral scheme) by the public health unit, DHB and potentially by other healthcare providers.</p>			17.3

2. Alcohol and Other Drugs Harm Prevention

No.	Core Functions	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = # % (quantity and quality of effect)
2.1	Health Protection	Inquire into all on-, off-, club and, where appropriate, special licence applications, and provide Medical Officer of Health (MOsH) reports to District Licensing Committee, either where there are matters in opposition or recommendations (on the basis of application of the relevant risk assessment tool in the Public Health Alcohol Regulatory Officer Toolkit, May 2013).	# applications and renewals received for each licence type (on, off, club, special). # applications and renewals that were inquired into for each licence type (on, off, club, special). # applications and renewals inquired into that had reports in opposition subsequently withdrawn because applicant's made amendments to the application, for each licence type (on, off, club, special).	% reports (for premises where matters in opposition were identified) provided to the District Licensing Committee (DLC) submitted within 15 days as per Sale and Supply of Alcohol Act 2012 for each licence type (on, off, club, special). Numerator: # reports (for premises where matters in opposition were identified) provided to the DLC submitted within 15 days for each licence type (on, off, club, special); Denominator: # reports where matters in opposition were identified for each licence type (on, off, club, special).	#/% reports (for premises where the PHU had matters in opposition) discussed with applicants that resulted in applicants either withdrawing or amending their application accordingly ² for each licence type (on, off, club, special). (CC, O). Numerator: # reports (for premises where the PHU had matters in opposition) discussed with applicants that resulted in applicants either withdrawing or amending their application to include conditions that the DLC could then attach to the licence for each licence type (on, off, club, special); Denominator: # reports in opposition that were

² There are several scenarios that may be applicable, two examples are as follows:

1. a PHU may have opposed external advertising of alcohol that appeals to young people (RTDs) which the applicant agrees to, and this is subsequently written as a condition of the licence.
2. an applicant may agree to reduce the hours of operation and changes the application accordingly which then doesn't attract an opposition.

No.	Core Functions	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = # % (quantity and quality of effect)
					<p>discussed with applicants for each licence type (on, off, club, special).</p> <p>#/% reports (for premises where matters in opposition were made by the PHU) submitted to the DLC, which resulted in conditions being attached to the licence or a refusal to grant/renew licence, for each licence type³ (on, off, club, special) (CC, O). Numerator: # reports (for premises where matters in opposition were made by the PHU) submitted to the DLC, which resulted in conditions being attached to the licence or a refusal to grant/renew licence, for each licence type (on, off, club, special); Denominator: # reports (for premises where matters in opposition were made by the PHU) for</p>

³ Please report the outcome in your report that covers the six monthly period in which the DLC decision was made as given the inevitable time lag from submitting opposition to the release of a DLC decision, the outcome may not always be able to be reported within the 6 month period in which the opposition was submitted.

17.3

No.	Core Functions	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = # % (quantity and quality of effect)
					each licence type (on, off, club, special).
2.2					Summarise the outcomes of matters in opposition made by the PHU to DLC. Summarise the outcomes of matters in opposition made by the PHU to the Alcohol Regulatory and Licensing Authority.
2.3		Work in conjunction with staff from the other two reporting agencies (Police and Territorial Authority Liquor Licensing Inspectors) to ensure that there is an effective mechanism to enable all retailers, clubs and entities applying for new licences, re-licences and special licences and their employees and volunteers, to receive education about their responsibilities under the Sale and Supply of Alcohol Act 2012.	Provide a summary of your role and contribution to establishing and maintaining an effective mechanism for educating retailers, including their employees and volunteers.		Provide a summary on whether there is an effective mechanism in place to ensure that all applicants for licences and their employees and volunteers are systematically provided with education.
2.4		Collaborate in police-led Controlled Purchase Operations (CPOs), if any conducted, to reduce sale of alcohol to minors. (Note: One CPO equals one total organised operation that targets a number of premises).	# CPO operations conducted ⁴ . # premises visited during the CPO operations.	% high risk premises visited during CPO operations. Note: General criteria for high risk premises are as defined in the Public Health Alcohol Regulatory Officer Toolkit May 2013.	#/% premises that are compliant, at the time of CPO, with the Sale and Supply of Alcohol Act 2012 (i.e., no alcohol sale to the minor) (BC, O).

⁴ If no CPOs have been conducted, state the reason why.

No.	Core Functions	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = # % (quantity and quality of effect)
				Numerator: # high risk premises visited during CPO operations; Denominator: # premises visited during CPO operations.	Numerator: # premises that are compliant at the time of CPO; Denominator: # premises visited during CPO operations.
2.5		To work with our stakeholders to develop a strategic document which outlines the respective roles, responsibilities, and guides the way we work together to achieve alcohol harm reduction from a regulatory perspective (as per s 295 SASoAA ‘Agencies duty to collaborate’).	Joint liaison /MOU protocol developed (Y/N/Progress)	Joint Liaison Protocol/MOU – evidence of it being applied (Narrative report)	Examples of increased alignment between agencies for example during oppositions to be more effective (Narrative report)
2.6		Work with relevant agencies to undertake monitoring visits of high risk premises and special licence events (to ensure they comply with their licence conditions/host responsibility obligations) as per PHU risk rating tool and/or based on local data, complaints or other intelligence, including requests from police or licensing inspectors (together with Police and/or Licensing Inspector, as appropriate).	# high risk premises and special licence events with monitoring visits conducted.		#/% high risk premises and special licence events visited that complied with their licence conditions/host responsibility obligations (CC, O). Numerator: # high risk premises and special licence events visited that complied with their licence conditions/host responsibility obligations; Denominator: # high risk premises and special licence events with monitoring visits conducted.

17.3

No.	Core Functions	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = # % (quantity and quality of effect)
2.7					Summarise the remedial actions that are/will be undertaken by the PHU for high risk premises and special licence events identified as not fulfilling their licence conditions/ host responsibility obligations.
2.8		To work with our stakeholders to develop a strategic document which outlines the respective roles, responsibilities, and guides the way we work together to achieve alcohol harm reduction from a regulatory perspective (as per s 295 SASoAA ‘Agencies duty to collaborate’).	Joint liaison /MOU protocol developed (Y/N/Progress)	Joint Liaison Protocol/MOU – evidence of it being applied (Narrative report)	Examples of increased alignment between agencies for example during oppositions to be more effective (Narrative report)
2.9	Health Promotion	<p>Make submissions as needed on national and local policy that supports the outcomes of the HBDHB Alcohol Harm Reduction Strategy.</p> <p>Make submissions to, and proactively support/influence Territorial Authorities (TA's) to develop and implement policies that will reduce alcohol-related harm, including:</p> <ul style="list-style-type: none"> • Supporting TAs to develop and maintain their local alcohol policy • Actively participating in LAP reviews. 	# of alcohol harm reduction submissions # and names of TAs supported	% submissions are evidence- based & peer reviewed by Medical Officers of Health	%% submissions implement healthy public policy recommendations
2.10		Implement the HBDHB Alcohol Harm Reduction Strategy.	# steering group meetings # reporting to HBDHB Committees and Board	% activities completed	Narrative report

No.	Core Functions	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = # % (quantity and quality of effect)
2.11		Work with Napier City and Hastings District Council (and other partners) to implement the Joint Alcohol Strategy Action Plan with a focus on young people and prevention of FASD.	# group meetings	% activities completed	Narrative report Youth Service Level Alliance
2.12		Brand design and promotion of alcohol free areas and events in Hawkes Bay. One for One promotion at large music and sporting events.	# of attendees at events # new and existing events that have an alcohol free zone # large events promoting one for one		Narrative community & stakeholder feedback Evaluation report
2.13		Design community advocacy toolkit for HBDHB staff that will assist community oppositions to licence applications			
2.14		Implement Māori Wardens project – a partnership project with Māori wardens to increase knowledge of the legal requirements of the Smokefree Environments Act and Sale and Supply of Alcohol Act and provide a mechanism for community identified issues.	# training sessions # participants # health promotion campaigns at events are supported by Māori wardens	#% licensing decisions are supported with intelligence from Māori wardens	Narrative: feedback from community
2.15		Support the implementation of Alcohol Social Supply Wairoa project.	#activities completed		Narrative report.
2.16		Continue to produce alcohol networks e-newsletter and increase readership.	# newsletters produced		
2.17		Schools are supported to be alcohol free and develop alcohol policies.	# schools with alcohol policy		

17.3

No.	Core Functions	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = # % (quantity and quality of effect)
2.18		<p>Deliver alcohol & pregnancy communications plan</p> <p>Identify workforce development opportunities to raise profile of alcohol harm reduction with a focus on hapu mama and young women (prevention of FASD).</p>	# actions completed		
2.19		Continue to work with Health Hawke's Bay (PHO) to advocate for improving the quality and quantity of alcohol screening & brief intervention in General Practice.	# quality improvement initiatives implemented		
2.20		Investigate integrated approaches to screening and brief intervention in identified settings e.g. ED.			Narrative report.
2.21		Collate literature on the relationship between alcohol and family violence and broader social harms	# evidence review with a focus on inequity of harms		
2.22		<p>Work with ED staff and business intelligence to review and improve the quality of ED alcohol data collection.</p> <p>Share data with key stakeholders as a means for advocacy to reduce alcohol related harm</p> <p>Design infographics to communicate and raise profile of alcohol harm reduction</p>	# system of data capture in ED # data and infographics shared with key stakeholders		Improved data collected and reported

3. Tobacco

No.	Core Functions	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
3.1	Health Protection	Maintain an up-to-date database of tobacco sellers.	# tobacco free retailers	100% of known tobacco sellers are entered into Healthscape.	
3.2		Implement plan for undertaking compliance/ education visits (including controlled purchase operations) of retailers. Note the plan will ensure all known tobacco retailers will have a compliance/education visit and at least 5% of identified tobacco sellers within each Territorial Local Authority Area (TLA) will be included in a controlled purchase operation. A focus of education visits will be promoting the Smokefree Retailer Kit.	# tobacco retailer education visits (one visit = one visit to one tobacco retailer) # controlled purchase operations (one CPO = one total organised operation that targets a number of premises). # tobacco retailers visited during CPOs. # number of sales from CPO operations	100% of infringements notices are sent to the Ministry of Health for processing within 5 working days or less. % tobacco retailers visited during CPOs that are located in low socio-economic communities (i.e., deprivation index 7-10). Numerator: # tobacco retailers visited during CPOs that are located in low socio-economic communities (i.e., deprivation index 7-10); Denominator: # tobacco retailers visited during CPOs.	#% tobacco retailers that are compliant at CPOs with the provision of the Smoke-free Environments Act 1990 that prohibits tobacco sales to persons aged under 18 years (BC, O). Numerator: # tobacco retailers compliant at time of CPOs; Denominator: total # tobacco retailers undertaken in CPOs.
3.3		Maintain an appropriate and efficient system for receiving, considering and responding to complaints from the public.		100% of complaints received are considered and responded to.	

17.3

No.	Core Functions	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
3.4		Participate in Central Region Smokefree Officers network meetings/ teleconferences.	# of meetings attended		Narrative on the outcomes of the network.

4. Communicable Disease

No.	Core function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
4.1	Health Assessment and Surveillance	Collaborate with clinical practitioners and laboratories to obtain high quality information on notifiable and other communicable diseases of significance enabled by regular Public Health Lab Liaison meetings		Maintain or improve ranking for data quality items in the ESR Annual EpiSurv Data Quality Report (e.g. first in country for data completeness). Note: report lags one year behind.	Narrative report on how Public Health Lab Liaison meetings are progressing
4.2	Public Health Capacity Development	Quarterly workforce development sessions to maintain knowledge and skills related to communicable disease control.			Communicable disease workforce maintains skills and knowledge related to communicable disease control.
4.3		Participate in the Public Health Clinical Network working group looking at business requirements for a national case and contact information system.			Narrative
4.4	Health Protection	Investigate and manage all notified cases as per national guidelines and MoH CD Manual, and in accordance with HBDHB Population Health Services policies. Audit all vaccine preventable cases including Meningococcal and Hepatitis.	HBDHB communicable disease policies reviewed at least every 3 years in order to keep updated, or as required when national policies/guidelines change.	% policies due for review have reviews completed. In-house data quality reports on the number of investigated cases/ outbreaks meet standard timeframes (target > 90%).	Narrative report on audit results for vaccine preventable diseases

17.3

No.	Core function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
4.5		Needle exchange (Onekawa, Napier) is supported by the Medical Officer of Health to maintain their authorisation under the Health (Needle and Syringes) Regulations 1998.	Annual review of Needle Exchange will be undertaken by Medical Officer of Health.		Needle Exchange maintains its authorisation
4.6		<p>Provision of surveillance and communicable disease control advice to cases, health care professionals, local authorities and NGOs, rest-homes, Māori providers and the public.</p> <p>Two publications of 'Public Health Advice' per annum</p> <p>Kotahi Whānau develops a pathway for integrated working 'initiative' involving Māori and Pacific Health Services.</p>	Report any additional specific publications/ communications that target relevant groups, such as GPs.	Narrative report on initiatives taken targeted at primary care. Established pathway developed by Kotahi Whānau. •	Timely reporting by GPs of suspected notifiable diseases is likely to lead to better health outcomes for individuals and communities.
4.7		<p>Support delivery of rheumatic fever prevention programmes and initiatives.</p> <p>Plan for Rheumatic Fever Governance Group to oversee programme/ initiatives to ensure alignment with evidence-based practice.</p>	# of Rheumatic Fever Governance Groups attended. # of clinical and expert advice provided.	As per MoH reporting: <ul style="list-style-type: none"> • HHI (Child Healthy Homes Programme) • Say Ahh (sore throat management) • Rapid Response Root cause analysis	Narrative

5. Healthy Housing

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
5.1	Health Assessment and Surveillance	Monitor the impact of housing-related illness as part of the health equity monitoring framework and will be developed further for ongoing Health Equity Reports.	One health equity monitoring framework	External appraisal of effectiveness	Description of impact on housing supply and quality responses within Hawke's Bay
5.2	Health Promotion	Support the Housing Coalition by: <ul style="list-style-type: none"> • Providing health leadership • Providing secretariat and chairmanship • Support projects 	# Coalition meetings		Narrative report of outcomes of meetings
5.3		Support intersectoral housing initiatives including Matariki actions in the Social Inclusion Strategy, Housing First programme and other new developments.			Impact of housing work on key areas i.e. housing supply and housing quality as reported through the Housing Coalition and Matariki Framework
5.4		Complete the assessment of the minor repairs pilot.			Narrative report
5.5	Health Protection	Respond to reported incidences of mouldy or insanitary housing. Implement the insanitary housing toolkit. This work is being completed in collaboration with an external provider (see Habitat for Humanity assessment and minor repairs programme in Part B of this plan).			Description of work including the outcome of the pilot assessment and repair programme

17.3

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/%(quantity and quality of effect)

6. Immunisation

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
6.1	Preventative intervention	Infants born to Hepatitis B positive mothers are protected from the disease	# infants per year		All infants born to HepB +Ve mothers receive HBIG and Hep B immunisation post-delivery.
6.2		<p>Promote and support existing networks providing immunisation information, education, support and advice for all vaccinators, non-vaccinators and the general public.</p> <p>Maintain effective collaborative working relationships with all service providers that have an interest in immunisation activity with emphasis on equity and those providers servicing our hard to reach population.</p> <p>Engage with TTOH Whanake Te Kura ante natal programme, designed to engage the HB Population of largely Māori and Pacific births, to increase inclusion of immunisation education within the programme.</p> <p>Meet with Choices, Māori Health Provider, to explore opportunities to increase capacity and capability for immunisation by implementing a weekly walk in immunisation clinic – if contract made available.</p>	# immuwise newsletters created and distributed # of training workshops # of education sessions provided 1 meeting held	% workshop participants report they are satisfied or very satisfied with workshops provided	% of children receiving on-time national schedule immunisation with equity maintained. Evaluation of education sessions by Whanake Te Kura ante natal programme coordinator.

17.3

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		<p>Work with Health HB PHO to standardise newborn enrolment process with general practices.</p> <p>Facilitate the Immunisation Steering group which provides the forum for a collaborative approach to improving immunisation coverage.</p>	<p>% of newborns electronically enrolled on the B code within the PHO by 4 weeks of age</p> <p>4 meetings (quarterly)</p>		<p>% of children receiving on-time national schedule immunisation with equity maintained.</p> <p>Annual evaluation of Steering Group by group members shows that this forum is beneficial for its members and the organisations / communities they serve.</p>
6.3		Survey two local urgent care providers to investigate provision of opportunistic immunisation to children under five years of age.	2 surveys undertaken		

7. Child & Youth Wellbeing

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
7.1	Health Promotion	<p>Well Child Tāmariki Ora Facilitate and chair bimonthly Well Child Interagency Group (CING) meetings.</p> <p>Lead the annual review of the Terms of Reference and agenda's for CING.</p> <p>Lead coordination, planning, implementation & review of Well Child Week celebrations, Positive Parenting programmes, Safekids activities and other relevant promotional activities.</p> <p>Support and integrate distribution of the Hawke's Bay Well Child Interagency Group's quarterly newsletter.</p> <p>Well Child Interagency Network, including Early Childhood Education Centres will promote, plan & deliver Safe Sleep activities in collaboration with HBDHB Safe Sleep Coordinator and Hāpai Te Hauora Regional SUDI Coordinator.</p>	Six CING meetings held annually Annual audit/evaluation feedback Four newsletters produced and distributed widely to all well child stakeholders	% of CING stakeholders who report that they are satisfied or highly satisfied with the leadership & coordination of CING activities. Quality improvement recommendations from review of all promotional activities will be implemented	# of Early Childhood Education sector CING stakeholders who report that participation in CING activities has led to adoptions or improvements of well child policy in their Early Childhood Education Centres
7.2		<p>First 1,000 days Support the cross-DHB/intersector development of first 1,000 days outcomes framework for HB</p> <p>Investigate potential missing information/data sources</p> <p>Highlight rates by ethnicity over time localised where possible</p>	Framework developed Localised equity measures identified Baseline set		

17.3

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
7.3		In collaboration with Pacific Health team support the ASH 0-4 Pacific engagement project to determine quality improvement activities and opportunities for integrated supports/program	# of families interviewed	% of referrals from whānau engaged with plans i.e. healthy homes referrals	ASH 0-4 Pacific admission rates
7.4		<p>Provide population health expertise and support to key settings involved in 0-5 year's programs i.e. SUDI, breastfeeding, ASH 0-4 respiratory project/ASH 0-4 years Pacific Project, Wellchild Tamariki Ora quality improvement initiatives</p> <p>Link with national Child wellbeing strategy development</p> <p>Participate in the Wellchild/Tamariki Ora review process (<i>guidance to come from MoH</i>)</p> <p>Coordinate policy and advocacy initiatives to improve equity for child and youth wellbeing outcomes</p>	# of meetings attended # of submissions	Narrative of activities % of submissions that result in policy/advocacy changes/acceptance	Evidence of integration/consistent messaging between 0-5 years programs/providers Evidence of local participation/engagement
7.5		<p>Safe Sleep Hawke's Bay Child & Youth Mortality Review Coordinator is an active member of the Safe Sleep Action Group and will support implementation of recommendations for systems change regionally from mortality review findings.</p> <p>In collaboration with the Māori Health Service, review the Cot Bank for equity for Māori</p>	% of relevant HB Child & Youth Mortality Review SUDI prevention recommendations implemented by the HB Safe Sleep Action Group All actions agreed at meetings are documented in minutes and outcomes reviewed at following meetings.	Undertake quality improvement activity to check responsiveness of eligibility criteria, uptake, ethnicity, quintile, and areas for improvement, Complete analysis and use findings to inform improvements and to develop a plan for the development of	Reduction of SUDI rate in HB Significant majority of whānau using the Cot Bank will be Māori or Pacific whānau

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		In collaboration with the Māori Health Service, analysis and reporting of data collected as part of the māmā Māori interviews undertaken in 2018		appropriate messaging and support for whānau Māori	
7.6		<p>Breastfeeding Facilitate Hawke's Bay Breastfeeding interagency forum to promote the benefits of breastfeeding for both mother and baby.</p> <p>Deliver community breastfeeding promotion by implementing a local communication plan that provides consistent breastfeeding messaging, promotes breastfeeding support services and initiatives including:</p> <ul style="list-style-type: none"> ▪ WHO Breastfeeding week ▪ Mama Aroha resource for mothers ▪ Supporting HBDHB breastfeeding policy ▪ Promotion of local support services <p>Support the Baby Friendly Hospital and Community Initiatives</p> <p>Report any issues concerning compliance of the WHO Code of Marketing of Breastmilk Substitutes.</p>	<p>% of HB Breastfeeding Group stakeholders who report that they are highly satisfied with the leadership & coordination of HB breastfeeding promotion activities.</p> <p># of meetings% of breaches of the Code followed up and rectified</p>	<p>Narrative summary of engagement with breastfeeding promotions:</p>	<p>100% compliance of the WHO Code of Marketing of Breastmilk Substitutes in HB</p> <p>HB BFHI & accreditation status is maintained</p>
7.7		<p>Healthy conversation tool distributed to all early childhood education settings in Hawkes Bay*</p> <p>Provide training and education to workforce engaged with whānau in early year's settings including healthy conversations, safe sleep.</p>	<p># of tools distributed to ECE settings</p> <p># of training/education supports provided</p> <p># of participants</p>	<p>% of tools in use in ECE settings</p>	<p>% of ECE settings setting that report they have integrated tool in practice</p> <p>% of participants who report that training/education has</p>

17.3

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		<p>Facilitate annual ECEC/TKR Hauora hui – a collaborative, multiagency hui between health and social service providers and ECEC/KR workforce</p> <p>*Refer to nutrition, physical activity & healthy weight section</p>	Annual hui		<p>increased their knowledge/ ability to support whānau</p> <p>ECEC/TKR workforce will feel better equipped to support families with health and wellbeing needs.</p>

8. Nutrition, Physical Activity & Healthy Weight

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
8.1	Health Promotion	Contribute population health evidence and data to inform transport and sustainability initiatives within the HBDHB and other relevant forums with a focus on improving equity in active transport users.	# meetings attended # feedback provided		
8.2		Support the development of a HBDHB sustainability communication plan and education plan to raise staff awareness and initiate further behavior change.	# communication plan # activities delivered	% actions are informed by evidence	
8.3		<p>Deliver actions from Best Start: Healthy Eating and Activity Plan to increase healthy weight environments:</p> <ul style="list-style-type: none"> • implementing healthy conversation tool – in ECEs* • monitor schools programme* • monitor the National Food and Drink Policy within the HBDHB • Identify nutrition tools to assist HBDHB contract providers with Food & Drink Policy guidance. • Coordinate the delivery of the Maternal and Child nutrition and physical activity program* • Promote breastfeeding* <p>(*Refer to Child and Youth Wellbeing section)</p>	# ECEs engaged # schools engaged # agreed activities completed # tools and resources # of programs delivered	% Kohanga, Nests & High Dep ECEs % High deprivation % compliant HBDHB sites % web page content reviews	#/% Children increased fruit and veg #/% of contracted providers with policies
8.4		<p>Deliver actions from to Best Start: Healthy Eating and Activity Plan by providing leadership:</p> <ul style="list-style-type: none"> • Advocating water only (<i>links to Oral Health</i>) • Engaging key partners TLAs, Sport HB, Business organisations 	# Events/location promoting water only # partners engaged		

17.3

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		<ul style="list-style-type: none"> • Linking to regional planning including Matariki, Transport Plan, and TLA Plans. 			
8.5		Support the implementation of the National Healthy Food and Drink Policy to which HBDHB committed to in August 2016.			Narrative
8.6		Identify appropriate nutrition support for health providers from within our DHB.			Narrative
8.7		Develop online tools to support health contract providers e.g. policy templates, checklist etc.			Narrative

9. Social Environments, Cross Sector Development

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
9.1	Health Promotion	Support the sharing of data across agencies to support planning, response and measuring outcomes.	# agencies sharing data	% used in planning	
9.2		Utilise cross sector relationships to build capacity and influence key determinants and outcomes of health- <ul style="list-style-type: none"> • Water • Healthy weight • Tobacco • Drugs • Housing 	# of cross sector working groups		See also Healthy Housing section
9.3		Engage with key plans and strategic documents to influence the impact of equity in health outcomes and determinants of health including: <ul style="list-style-type: none"> • Regional Transport Plan • Regional Economic Development Plan • Regional Social Inclusion Plan • TLA annual and long term plans • Water 	# submission made	% of plan with DHB engagement	
9.4		Establish approaches for Population Health to engage the whānau voice across planning, design and deliver.	# approaches	% Māori and Pasifika whānau	#/% whānau voices heard
9.5		Review current cross sector engagement to support: <ul style="list-style-type: none"> • Effective engagement, people with right information, authority and skill at each engagement • Develop a tool to provide oversight of cross sector engagement and share information 	# service manager reviews # tool established		% of tool users

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No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
9.6		Continue working with Safer Communities across HB to implement the Pan Pacific Safe Communities model and identified goals for each rohe.	# DHB supported activities # Health Equity Report data shared	% identified priorities align with health equity report	Narrative: evidence of contribution and support implementation of an equity framework / tool
9.7		Contribute to Street by Street initiative (Hastings District Council) planning, community engagement and messaging.	# street by street events		Narrative: HDC and whānau engagement and feedback
9.8		Coordinate and participate in key whānau/community events e.g. Ngati Kahungunu Iwi Inc Waitangi Day	# hauora providers supporting event/s # consistent and coordinated key messages	% providers engage effectively with whānau	Narrative report: feedback from Hauora providers and Iwi
9.9		Submit and participate in national and local policy and strategy that positively influence the determinants of health and inequity	# of submissions made # regional planning documents and strategies that includes a population health & equity lens	% of submissions that are focused on reducing inequity	Narrative: early discussions and planning meetings with Territorial Authorities regarding District and Long Term Plans #% submissions implement healthy public policy recommendations
9.10		Project to improve the Population Health OurHealth website content working with the HBDHB Communications Team. Ensure the website is regularly maintained and accessible for community and key stakeholders.	# website page views #average time spent on website page	% page content reviews	Narrative: revisions, peer review of content

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
9.11	Public Health Capacity Development	Develop and implement submission management module within Healthscape to support submission work			

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10. Mental Health

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
10.1	Health Promotion	<p>Provide leadership and continue to identify the needs of Hawke's Bay workplaces.</p> <p>Provide up to date evidence, support and information to workplaces on workplace wellbeing. Including promotion of the Health Promotion Agency Good4work programme.</p> <p>Deliver the Mental Health Foundation's 'Working Well' train the trainer programme to workplaces.</p>	# of workplaces engaged in the network. # trained workplace managers provided with new tools and resources # of workplaces engaged in the network	% workplaces training staff % of workplaces with high Māori or Pasifika workforce	Narrative: survey feedback from workplaces #% workplaces that report increased skills, knowledge and planned activities as a result of training
10.2		<p>Support the implementation of the HB Suicide Prevention Plan 2018-2021, Goal 1 and 4.</p> <p>Work with Territorial Authorities, Safer Communities, HPA and other agencies to scope a community lead initiative which aims to support community champions who assist community members and whānau in mental distress.</p>	# meetings with partner organisations # community lead initiatives	% activities completed	Narrative report from participants and key partners.
10.3		Promote consistent suicide prevention / mental wellbeing messaging throughout the community.	# events supported with 1737 messaging		
10.4		Provide support to the HBDHB to implement the relevant public health promotion aspects of the Government agreed actions following the Mental Health and Addiction Inquiry Report.			Awaiting further guidance.

11. Migrant Health

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
11.1	Health Assessment and Surveillance	Ongoing involvement with MBIEs current RSE research regarding health screening stock take, and the impact RSE employee's health on Hawke's Bay health services.			Hawkes Bay perspective reflected in the MBIE report. Less outbreaks of communicable disease in RSE workers.
11.2	Health Promotion	PHU focus is on migrant health and improving health for RSE workers. Through participation on the Hawke's Bay Settlement Network Group forum, the PHU is able to advocate that key stakeholders ensure that the Group's objectives, targets and indicators are aligned with the New Zealand Migrant Settlement and Integration Strategy.		100% attendance at bi-monthly Settlement Network Group meetings	
11.3	Preventive Interventions	Work with MBIE to review communicable disease outbreaks, involving RSE workers and explore preventative strategies.	Potential for quality initiative work to support MBIE's current health stock take.		Less outbreaks of communicable disease in RSE workers.

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12. Sexual Health

No.	Core Functions	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
12.1	Health Promotion	<p>Re-establish Family Planning input into the Hawke's Bay region.</p> <p>Ensure regular training is provided by Family Planning Health Promotion team (as per their contract)</p>	# of training sessions provided (teacher training etc.)	# of teachers attending training % teachers reporting improved confidence in teaching sexuality education	
12.2		<p>Syphilis outbreak management/Sexual health communications.</p> <p>Action activity outlined in <i>Syphilis Communications Plan</i>.</p> <p>Improve the communication channels from clinical to public health when issues arise (e.g.: PReP, syphilis)</p>	# actions completed # of coordinated updates from SH clinical services # of updates to public/stakeholders		Narrative: Stakeholders report feeling more informed of Ministry/DHB activity in sexual health #% priority groups collaborated with (maternity, primary care, sexual health NGOs, Māori and Pacific providers) Rates of testing and treatment of syphilis in Hawke's Bay increase
12.3		<p>Promote awareness of the <i>Just the Facts</i> website in primary care and schools in Hawke's Bay</p> <p>Refresh content relating to Hawke's Bay services</p>	# of promotions online (Facebook)	Increase in traffic to website from Hawke's Bay	Narrative: Young people report knowledge of the website and how to find information/seek services

No.	Core Functions	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		Promote services in Hawke's Bay - particularly to priority groups	Content regularly refreshed		
12.4		Support the role-out of funding for free/very low cost long-acting reversible contraception (LARCs)	# of targeted communications and engagement plan drafted/number of actions completed	# of low-cost and Māori and Pacific health providers informed of LARC funding # of women report receiving LARC who could previously not afford it	Women holding community services cards, living on a welfare benefit and/or in a Quintile 5 area have the choice of a LARC for contraception removing cost as a barrier
12.5		Support the development of a <i>Sexual and Reproductive Health Plan</i> for Hawke's Bay	# of plans developed	% of priority groups and priority services engaged with during the engagement phase	# new health promotion initiatives developed in collaboration with stakeholders Narrative: including evaluation of health promotion initiatives are positive
12.6		Participate in the Sexual Health Clinical Governance Group	# of meetings attended	# of SH health promotion updates provided	Narrative: SH clinical team report having a good understanding of health promotion activity in Hawke's Bay Health promotion/communication to the public is considered alongside all SH issues,

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No.	Core Functions	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
					projects and developments (e.g.: PrEP)
12.7		<p>Contribute to the establishment of the Youth Service Level Alliance including identifying external stakeholder groups involved with youth wellbeing and development.</p> <p>Lead the sexual health promotion component of the Youth SLA.</p>	# of identified activities across the alliance		

13. Health Education

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
13.1	Health Promotion	<p>Continue to perform the 'Authorised Provider' role and promote health literacy by facilitating access to health education resources and other information on HealthEd.</p> <p>Provide up to date information about new health resources availability e.g. interactive e-newsletter and calendar of events.</p> <p>Maintain and develop databases and networks that support distribution of health education resources.</p>	# requests received for health information resources # e- newsletters # calendar of events	% requests for health information resources are responded to within five working days % service users satisfied or very satisfied with the service	Narrative report: top five resources ordered per month compared with new emergent issues. Which groups are predominantly accessing the top five resources, who is missing out and the reasons why.
13.2		<p>Respond and manage the online booking system for resources and equipment</p> <p>Manage resources and equipment that supports large events e.g. One for One, alcohol free events, water only.</p>	# of bookings # large events promoting health messages	% requests are responded to within five working days % large events using service	
13.3		Provide booking coordination for breastfeeding classes.	# bookings	% booking and requests responded to within five working days.	

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14. Public Health Workforce

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
14.1	Public Health Capacity Development	Maintain the MoH target for public health qualifications.		80% of staff hold public health qualifications	#% of staff with public health qualifications
14.2		Managers and Team Leaders support staff to develop and complete their agreed performance development plan.		90% of staff have a current PD plan	#% completing planned training
14.3		Staff are supported to maintain professional competencies. <ul style="list-style-type: none"> • Professional competencies are articulated to each staff member. • Activities to support professional competency are included in each staff member's development plan. • Competencies are monitored / reviewed with each staff member. 		100% of staff with professional competencies are monitored	
14.4		The Population Health Service provides opportunities to share knowledge and skill within and across teams.	# events		#% of staff engaged
14.5		Demonstrate leadership and support workforce development across public health & health promotion.	# forums for sharing projects & work # workforce development opportunities	#of partner organisations # of participants at workforce development	Narrative: workforce development evaluations

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
14.6		<p>Provide training on equity to Population Health staff.</p> <p>Develop and trial an equity framework for Population Health.</p>	# training in place # equity framework	% participants received training	Narrative reporting Knowledge improved
14.7		<p>Support alcohol staff to attend training and workforce development opportunities appropriate to their roles, including workshops offered by the National Public Health Alcohol Working Group, NZ Liquor Licensing Institute, and the South Island alcohol health promotion meeting.</p> <p>Note: PHU staff are encouraged to attend alcohol and other drug-related fora with relevant stakeholders and partners, such as Health Promotion Agency, as appropriate.</p>	Data will be reported by the National Public Health Alcohol Working Group to the Ministry of Health.	% Alcohol staff completed appropriate training. Numerator: # Alcohol staff completed appropriate training; Denominator: # Alcohol staff in PHU.	#/% Alcohol staff who have undergone appropriate training are competently undertaking their roles (BC, S ⁵). Numerator: # Alcohol staff that are competently undertaking their role; Denominator: # Alcohol staff who have undergone appropriate training in the reporting period.

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⁵ This competency assessment is subjective and will be carried out by each staff member's line manager and in accordance with each PHU's staff competency requirements.

PART B: OTHER CONTRACTS

15. Healthy Housing

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
15.1	Health Promotion	Develop and monitor housing interventions funded as part of the DHB Rheumatic Fever Plan			Narrative report
15.2		Fund and monitor the delivery of the Ready to Rent programme.			Narrative report

16. Immunisation – NIR Administration, Coordination, Outreach

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
16.1	Preventive Interventions	Facilitate the Immunisation Steering group which provides the forum for a collaborative approach to improving immunisation coverage.	4 meetings (quarterly)		Annual evaluation of Steering Group by group members shows that this forum is beneficial for its members and the organisations / communities they serve.
16.2		Maintain competent immunisation service providers, with a focus on Māori health providers, working across the health sector basing their work ethics on the Immunisation Standards and recommendations from the Ministry of Health	# of training sessions delivered annually # of authorized vaccinators # of current service delivery plans	% of training participants report that they are satisfied or very satisfied with the training provided	Number of authorised vaccinators remains unchanged or increases.
16.3		NIR is well coordinated. NIR is used to its maximum potential and assists HBDHB to reach and maintain its immunisation targets. All live births are recorded and monitored. Support primary care providers providing past/due reports, updating individual records, answering status queries, supporting electronic enrolment of newborns. Support outreach service.	Monthly datamart reports Fortnightly Monthly # referrals to outreach	100% of live births are recorded on NIR. 100% of past/due reports returned to NIR % outcomes of outreach referrals.	Datamart coverage reports indicating consistent achievement of immunisation targets with equity maintained Quarterly report presented to Immunisation Steering Group of services

17.3

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		<p>Track and trace children to ensure immunisation targets are maintained, cleaning and sorting data, doing reconciliations.</p> <p>Maintain working relationships with primary care providers, Wellchild/Tamariki Ora providers, HHB PHO, B4SC coordinator, Family Start providers, PHNs, parents.</p> <p>Liaise with other NIR coordinators.</p>		<p>No complaints by consumers through the DHB quality service.</p>	<p>provided by outreach service.</p> <p>Narrative of outcomes</p> <p>Narrative of outcomes</p>
16.4		Maintain vaccine potency by ensuring good cold chain procedures are in place.	# of Immunisation providers that have current cold chain accreditation # of fridge audits completed	85% of Immunisation providers have current cold chain accreditation	No reports of revaccination of individuals due to cold chain failure.
16.5		Ensure all major milestones on the HPV immunisation communication plan are achieved to ensure a systematic process and avoid gaps in service delivery.	# of year 8 children vaccinated	Increasing % of coverage	Equity of coverage with Māori and Pasifika
16.6		<p>Increase the % of Māori ≥ 65 years having annual influenza vaccination by collaborating with Māori providers and Health HB to improve uptake.</p> <p>Promote influenza immunisation through Health Hawke's Bay PHO's Whānau Wellness education session 'Preparing for Winter' in Q4.</p> <p>HBDHB contracts with three NGOs to provide 175 influenza vaccinations to the eligible population.</p>	# Māori providers engaged with # of education sessions delivered		Increased % of Māori ≥65 immunised as recorded on NIR

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
			# of individuals vaccinated through this programme HBDHB contracts with NGOs		
16.7		Align eligible 65 year and over influenza immunisation with Bowel Screening outreach work for Pacific aged 65 years and over.	# Influenza immunisations given to eligible Pacific aged 65 years and over at Pharmacy/Dr/ community settings		Increased % of Pacific ≥65 immunised as recorded on NIR

17. Population Screening

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
17.1	Preventive Interventions	BreastScreen Aotearoa Continue to target Māori and Pacific unscreened women by conducting data matching between BreastScreen Coast to Coast and general practices patient databases, sending letters offering incentives for women who complete screening.	# Māori and Pacific women who attends screening as a result of incentivisation letter	% Māori and Pacific women who attends screening as a result of incentivisation letter	% coverage rate by Māori, Pacific, and total population
17.2		Continue to follow-up Māori and Pacific women who have not responded (DNR) to BSA invitation letters for mobile breast screening unit, and explore extending DNR follow-up for TRG fixed sites at Royston and Greenmeadows.	# Māori and Pacific women who originally DNRd who then completed screening after being followed-up	% Māori and Pacific women who originally DNRd who then completed screening after being followed-up	
17.3		Priority women who do not confirm their appointment when booked to have a mammogram on the BSA Mobile unit will be referred to an Independent Service Provider for support to services.	# of women contacted via list # of women contacted via list who have had breast screen		% increase in coverage for Māori and Pasifika
17.4		Population Screening Kaiawhina and Pasifika Community Support worker working with general practice to increase breast screening rates for priority women.	# priority women Identified attend a breast screen	Feedback from women	
17.5		Invite letter and a \$20 grocery koha to Māori and Pacific women 45-69 unscreened on the BSA.	# priority women identified and invited to enrol and have a mammogram	% of women who enrolled and had a mammogram	

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
17.6		National Cervical Screening Programme Continue to improve general practice screening recall processes including encouraging recall to commence at 32 months working towards improving on-time three yearly screening. Work with general practices to review Karo reports, identify errors and how to resolve.	# general practices	% general practices	% coverage rate by Māori, Pacific, Asian and total population
17.7		Continue to target Māori and Pacific unscreened and under-screened women through targeted strategies and kanohi ki te kanohi approaches.	# Māori and Pacific women able to be identified as attending screening as a result of these strategies		
17.8		Coordination of screening services <ul style="list-style-type: none"> • Promote and support existing networks providing cervical screening, education, support and advice for all smear takers, GP's and Practice Nurses and the general public • Deliver lectures at EIT smear taker training • Facilitate the Population Screening Steering group which provides the forum for a collaborative approach to improving screening coverage. • Provide annual training NCSP and BSA information to ISPs. 	# of health professionals attending the update 3 meetings One training event per annum	% participants attending the update are satisfied or very satisfied with the update % of stakeholders attending meetings # of stakeholders attending	Evaluation to ensure ongoing benefits for future updates Feedback from the nurses attending training. Annual evaluation of Steering Group by group members shows that this forum is beneficial for its members and the organisations / communities
17.9		Improve ethnicity data quality: <ul style="list-style-type: none"> ○ Remind smear takers to enter correct ethnicity on laboratory forms. 	# of practice who have updated their 99 & 54 ethnicity codes to the correct code	% of practices identified and amended their PMS	

17.3

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		<ul style="list-style-type: none"> ○ Identify and follow up Practices on the PHO Cx report using 99 and 54 ethnicity codes ○ General Practice will continue to update the NHI/Ethnicity data as per the National Enrolment Service (NES) workflow 			
17.10		Target geographical areas with large pockets of unscreened and under-screened Māori, Pasifika and Asian women using the PHO Cx monthly report and offer the women a smear.	# of Priority women identified and screened	% of Priority women coverage has increased	Equity of cervical screening coverage between different ethnicities.
17.11		<p>Explore the role of GPs in influencing women's cervical screening behaviours</p> <ul style="list-style-type: none"> ○ GP's encourage positively with women to have a smear when visiting for other health reason ○ All GP letters for a specific period of time are signed by a GP 	# of General Practices trial cervical screening letters signed by a GP		% coverage per general practice involved has improved
17.12		<p>Support Primary Care to focus on systems and process within general practice. This quality improvement initiative involves improving participation in NCSP, equity for Māori, improving access, service quality, and data quality.</p> <ul style="list-style-type: none"> ○ Accurate patient records – ethnicity, contact details, screening status and history ○ Use of patient management systems e.g. clearing inboxes, recalls and checking dashboards ○ Invitation and recall strategies targeting wāhine Māori e.g. personal approach instead of written communication 	# General practices supported to and comply with best practice guidelines	# of practices approached participate	Pre and post intervention audits show an increase in Māori and Pasifika coverage rates per practice

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		<ul style="list-style-type: none"> o Responsive / available smear taking services and holistic and opportunistic consultations o Consumer feedback on the cervical screening experience for women o Compliance with NCSP Policies and Standards and HPV 			
17.13		Population Screening Kaiawhina and Pasifika Community Support worker working with general practice to increase cervical screening rates for priority women. This includes provision of home screening.	# priority women change in coverage at practices involved.	Feedback from the women screened.	% of Priority women coverage has increased.
17.14		Establish a referral process for general practice to refer all Māori, Pasifika and Asian women who are ≥ 5 years overdue for cervical screening, to an Independent Service Provider.	# of priority women referred and screened via new process		% of the women referred are contacted and screened.
17.15		Encourage nurses to attend smear-taker training and mentor them to pass their assessments, with specific focus on Māori and Pasifika nurses and cultural competency.	Increased number of Māori and Pasifika nurses completing smear taker training and passing their assessments.	%increase of Māori and Pasifika nurses completing smear taker training and passing assessments.	Smear taker workforce reflects demographic of population.
17.16		Continue to monitor and work towards reducing DNAs for FSA and follow-up appointments, particularly for Māori women with high grade cytology results.	# of Māori & Pacific women referred with a high grade smear who DNA FSA and follow-up appointments for Colposcopy.	90% of eligible Māori women with a high grade cytology result attend colposcopy FSA and follow-up appointments.	HBDHB meet timeliness to treatment guidelines, and cost effective treatments are provided.

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No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
17.17		Explore and discuss working in collaboration with local Kapa Haka groups to encourage wāhine to participate in screening.	# of local kaikapa are engaged with discussions.	% of self-determined kapa haka groups supported as appropriate.	Report on outcome.
17.18		National Bowel Screening Programme Implement Ministry of Health approved National Bowel Screening Programme HBDHB Annual Plan 2019/20, Equity Plan and Communications Plan.		Plans approved by the Ministry of Health	
17.19		Develop, implement and evaluate strategies to achieve at minimum the 62% target in participation for Māori, Pacific, decile 9 and 10, and total National Bowel Screening Programme eligible population through health promotion/ health education activities and outreach follow up action. In addition we will set an internal target of 73% participation for Māori consistent with our intent to achieve equity of health outcomes for Māori across the life course.	# Māori and Pacific participating in NBSP. Target: Māori \geq 1,091, Pacific \geq 134 # of health promotion/education events held targeting Māori and Pacific eligible populations # of Māori, Pacific and decile 9 & 10 invitees referred for outreach follow up	% spoilt kits by Māori, Pacific, and total population % Māori, Pacific and decile 9 & 10 referrals followed up by outreach services	% participation by Māori, Pacific, decile 9 & 10, and total population. Target: \geq 62%

18. Oral Health

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
18.1	Health Promotion	Project manage the Oral Health Under 5 Equity Project.	# completed project activities		#% progress reporting to PMO
18.2		Increase community membership onto Te Roopu Matua to assist with co-design activities.	# community champions from Napier and Wairoa	% activities with proof of community input	Narrative report.
18.3		Implement teeth brief (5 months) and lift the lip (15 months) pilot into high deprivation general practices.	# GP's providing oral health education and lift the lip		Narrative report.
18.4		Develop handout which replicates the Healthy Teeth and Eating Flipchart for ECEs. Investigate translation into Pacific and Te Reo Māori.	# revised resource		Narrative report.
18.5		Community water fluoridation – monitor and respond to Drinking Water Amendment Bill.	# submission	% stakeholders input into submission	
18.6		Adopt the Water 4 Mums Campaign initiatives for rollout across Maternity Services.	# staff trained	% resources have consistent messaging	Narrative report.
18.7		Test social media as the platform to promote screening vans for high dep areas and improve accessibility.	# communications plan # social media reach		Narrative report. Survey clients are registration.

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19. Tobacco

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
19.1	Health Promotion	HBDHB Smokefree Service will engage with the Wairoa Whanake Te Kura ante natal programme to encourage and support Wāhine Hapu to stop smoking during and after pregnancy. Wāhine Hapu will be referred and enrolled on the Wāhine Hapu – Increasing Smokefree Pregnancy 8 week programme.	# sessions # referrals # enrolments	Programme completion survey	HT5
19.2		Work with Health HB and General Practice to explore the possibility of identifying newborn babies residing in a house with known smokers to offer cessation support and referral to the Wāhine Hapu – 8 week programme.	# Newborn # referrals # enrolments	Practicability study with Health HB	HT5
19.3		Develop an education programme to build resilience in young Māori and Pacific women aged (15 years – 19 years) in schools, tertiary education, alternative education and teen parent units.	# education settings	Project Plan completed Programme survey	HT5 Regional Tobacco Control Strategy
19.4		Work in collaboration with the Hawke's Bay Smokefree Coalition and Health Protection team to implement the Tobacco-free Retailers Tool kit with all alcohol on-licensed premises in Hawke's Bay.	# Alcohol on-licensed premises visited	#Tobacco-free retailers	

20. Drinking Water Technical Advice Services

	Core Function	Components of service	Service Description	Performance Measures
20.1	Health Protection	Support for drinking-water supplies which are receiving a drinking-water subsidy.	Appropriate and adequate resources assigned to support drinking-water suppliers receiving subsidies to ensure their works are delivered on time and within budget.	All subsidy projects followed up. Timely assistance provided when requested. Report provided on all active projects to drinkingwatersubsidy@moh.govt.nz by 15th of each month.
20.2			Seek additional technical advice and support from within the public health unit if required, or from other Ministry contracted providers within the Environmental & Border Health Team if necessary through the National Drinking-Water Coordination Service.	Inform the Ministry of Health Drinking-water team within five working days of any significant issues arising with any project.
20.3			Monitor subsidy contract milestones and ensure providers submit invoices as works progress and milestones are achieved.	Invoice documentation is complete and accurate. Submitted within one working month to drinkingwatersubsidy@moh.govt.nz All queries followed up within five working days.
20.4			Contract Variations: support water suppliers to request contract variations, if required, to ensure no milestones are missed and no contracts expire while works are underway.	Contract variations submitted at least eight weeks prior to contract expiry. All milestones are achieved on time.
20.5			Completion reports: when works are completed, review each water supplier's completion report and provide us with a final report on each completed subsidy project using the updated 2018	Completion report forwarded within one month on correct template with all required documentation included. Ministry of Health informed of any issues or delays.

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Core Function	Components of service	Service Description	Performance Measures
		template available from drinkingwatersubsidy@moh.govt.nz	
20.6		Completed projects: Maintain a record of all subsidised projects in your region and provide assistance to optimise and support the water supplier maintain a sustainable and safe water supply. This includes providing support and training for new water operators.	The Ministry of Health is informed within five working days of any water supply that may not be sustainable or may not providing a safe and adequate water supply.
20.7	Support for networked drinking-water supplies serving 25 to 5000 people	Appropriate and adequate resources assigned to support supplies serving 25-5000 people. Review the <i>Register of Drinking-water Supplies in New Zealand</i> to identify all networked drinking-water supplies serving 25 to 5000 people in your region and develop a work programme that will assist these water suppliers to optimise their water supplies. The work plan should prioritise water supplies based on public health risk (quality of drinking-water, adequacy of supply, population receiving the water, etc.).	Work plan developed and identifies all water supplies serving 25 to 5000 people. Water supplies are prioritised according to their public health risk. Activities are integrated into the wider drinking-water programme. New work plan attached.
20.8		Assist water suppliers with the preparation or review of their water safety plans and with optimising the operation and sustainability of their water supplies. Ensure the WSP includes Critical Control Points (CCPs).	Water suppliers identified in the work plan assisted with optimising their supplies. Water suppliers identified in the work plan have approved and implemented water safety plans (status of each supplier's WSP).
20.9		Provide technical assistance, advice and information to water suppliers when requested. Where necessary, arrange and organise technical	Appropriate and timely requests for technical assistance and advice provided.

Core Function	Components of service	Service Description	Performance Measures
		consultants/engineers and work alongside all parties to complete the request. Technical assistance & advice may be provided through your PHU or requested via the National Drinking-Water Advisory & Co-ordination Service or requested through other contracted providers as outlined in the current edition of the <i>Environmental Health Analysis and Advice Services: Guide for Public Health Units</i> . Support also includes providing advice and training for water suppliers and other health education materials.	Requests for technical consultants/engineers confirmed as appropriate and support requested. Operators have appropriate training and/or qualifications to operate their water supplies and training provided where needed.
20.10		Assist water suppliers with the interpretation of the drinking-water provisions of the Health Act 1956, the <i>Drinking-water Standards for New Zealand</i> , the <i>Drinking-Water Guidelines</i> and with Government policy and guidance on drinking-water supplies.	Appropriate and timely advice is provided. Suppliers identified in the work plan assisted to meet compliance with the Act and DWSNZ. Advice provided is consistent with the Ministry's policy, standards and guidelines.
20.11		Support any water supplier not on the Register of Drinking-water Supplies in New Zealand to submit their application for registration.	Water suppliers assisted with applying for registration, are registered.
20.12		Formal systems in place for receiving, considering and responding to notifications of suspected and confirmed cases of water borne disease outbreaks, transgressions and complaints of drinking-water quality (or adequacy) of supplies on your work plan.	Serious drinking-water incidents including waterborne disease outbreaks reported to the Ministry of Health within 24 hours. Suspected or confirmed cases reported within 2 hours. Significant issues with any water supply reported within five working day.

17.3

Core Function	Components of service	Service Description	Performance Measures
			Timely investigation of transgressions and complaints.
20.13	Support for drinking-water carriers	Work programme includes assistance to drinking-water carriers to deliver safe drinking-water. Work plan should prioritise carriers based on public health risk (source/abstraction point).	Water carriers are prioritised according to their public health risk. Activities are integrated with the wider drinking-water programme.
20.14		Assist drinking-water carriers with the preparation of water safety plans and ensure the WSP includes Critical Control Points (CCPs).	Appropriate and timely assistance provided to prepare WSP.
20.15		Assist drinking-water carriers with the interpretation of their obligations under the Act and the <i>Drinking-water Standards for New Zealand</i> .	Advice provided is accurate and consistent with the Ministry's policy, standards and guidelines.
20.16		Assist drinking-water carriers to submit their application for registration. At least annually, review the information on the Register and assist these water suppliers with re-registration.	Drinking-water carriers identified on the work plan are registered.
20.17	Service Linkages	Ensure linkages are developed and maintained with Ministry of Health, other public health units, owners and operators of water supplies, local/regional councils and community organisations identified as partners in the Services to collaborate on supplying safe drinking-water.	Collaborative arrangements include participating in discussions/workshops/meeting with suppliers serving 25 to 5000 people to share information, best practice solutions, to resolve potential risks/drinking-water issues.



HBDHB PERFORMANCE FRAMEWORK RESULTS – QTR 3, 2018/19

Health Targets:	Target	Baseline	Total	Maori	Pacific	Other
Shorter Stays in ED	≥ 95%	94%	87%	89%	92%	85%
Faster Cancer Treatment	≥ 90%	95%	87%	-	-	-
Increased Immunisation	≥ 95%	95%	90%	88%	93%	91%
Better Help for Smoker to Quit (Primary Care)	≥ 90%	87%	Awaiting Data			
Better Help for Smoker to Quit (Pregnant Women)	≥ 90%	89%				
Raising Health Kids	≥ 95%	40%	97% *	97%	100% *	97% *
Output Class 1: Prevention Services	Target	Baseline	Total	Maori	Pacific	Other
Better Help for Smoker to Quit (Hospital)	≥ 95%	96%	96% *	97% *	100% *	95%
SLM Number of babies who live in a smoke-free household at six weeks post natal	≥ 95%	66%	45%	21%	45%	64%
% of 2 year olds fully immunised	≥ 95%	95%	94%	93%	97%	94% *
% of 4 year olds fully immunised	≥ 95%	94%	90%	88%	92% *	91%
% of women aged 50-69 years receiving breast screening in the last 2 years	≥ 70%	74%	74% *	70% *	67% *	76% *
% of women aged 25-69 years who have had a cervical screening event in the past 36 months	≥ 80%	77%	76%	76%	72%	78%
% of infants that are exclusively or fully breastfed at 3 months	≥ 60%	51%	57% *	43% *	58% *	-
Output Class 2: Early Detection and Management Services	Target	Baseline	Total	Maori	Pacific	Other
% of the population enrolled in the PHO	≥ 90%	98%	98% *	99% *	92% *	97% *
Ambulatory sensitive hospitalisation rate per 100,000 0-4 years			7969	8750	18028	5891
Ambulatory sensitive hospitalisation rate per 100,000 45-64 years			4613	9328	8404	3437 *
% of women booked with an LMC by week 12 of their pregnancy	≥ 80%	66%	64%	55% *	44% *	72%
% of new-borns enrolled in General Practice by six weeks of age	≥ 85%	85%	90%	93%	91%	88%
% of eligible pre-school enrolments in DHB-funded oral health services	≥ 95%	89%	96% *	78% *	77% *	115% *
% of children who are carries free at 5 years of age	≥ 64%	59%	62% *	43% *	28%	75%
% of enrolled preschool and primary school children not examined according to planned recall	≤ 10%	8%	10%	10%	13%	10%
Mean 'decayed, missing or filled teeth (DMFT)' score at Year 9	≤ 0.96	0.72	0.76	0.94 *	1.16	0.62
% of the eligible population will have had a CVD risk assessment in the last 5 years	≥ 90%	88%	Awaiting Data			
% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks)	≥ 95%	93%	99% *	No Ethnicity Data		
% of accepted referrals for MRI scans who receive their scans within 42 days (6 weeks)	≥ 90%	48%	96% *			
SLM Total self-harm hospitalisations and short stay ED presentations for <24 year olds per 10,000	≤ 45.8	46	65.6	79.8	39.6 *	58
SLM % of ED presentations for 10-24 year olds which are alcohol related	≤ 10.5%	1.3	9%	11% *	8%	9%
Key:						
Within 0.5% or Greater than Target						
Within 5% of Target						
Greater than 5% from Target						
* Favourable Trend from Previous Quarter						

OUTPUT CLASS 3: Intensive Assessment and Treatment Services	Target	Baseline	Total	Maori	Pacific	Other	
% of high-risk patients will receiving an angiogram within 3 days of admission.	≥ 70%	74%	62%	59%	100%	62%	
ACS Left Ventricular Dysfunction (LVEF) assessments >85% of ACS patients who undergo coronary angiogram have pre-discharge assessments of LVEF.	≥ 85%	51%	79% *	73%	100%	77% *	
Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance all ACS patients who undergo coronary angiogram should be prescribed, at discharge, aspirin, a second anti-platelet agent, statin and an ACE/ARB (four classes) and those with LVEF<40% should also be on a beta blocker (five classes)	≥ 85%	66%	58%	67% *	100%	52%	
% of potentially eligible stroke patients who are thrombolysed 24/8	≥ 10%	6%	7%	16%	-	-	
% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	≥ 80%	88%	83% *	89% *	-	76% *	
Major joint replacement	≥ 21	22.4	19.66 *	No Ethnicity Data			
Cataract procedures	≥ 27	46.6	45.97				
Cardiac surgery	≥ 6.5	4.8	4.92				
Percutaneous revascularisation	≥ 12.5	11.9	12.94				
Coronary angiography services	≥ 34.7	36.4	39.99 *				
Length of stay Elective (days)	≥ 1.45	1.52	1.59	No Ethnicity Data			
Length of stay Acute (days)	≥ 2.3	2.39	2.31				
Acute readmissions to hospital	NA	NA	12% *	12%	12%	12% *	
% accepted referrals for elective coronary angiography completed within 90 days	≥ 95%	88%	100%	No Ethnicity Data			
% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive).							
% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)							
% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date							
Did not attend (DNA) rate across first specialist assessments	≤ 7.5%	5.3%	7%	13%	17%	4%	
% of 0-19 year olds seen within 3 weeks of referral: Mental Health Provider Arm	≥ 80%	73%	75% *	80%	88%	71% *	
% of 0-19 year olds seen within 3 weeks of referral: Addictions (Provider Arm and NGO)	≥ 80%	72%	66%	63%	-	73% *	
% of 0-19 year olds seen within 8 weeks of referral: Mental Health Provider Arm	≥ 95%	91%	91%	93%	94%	90%	
% of 0-19 year olds seen within 8 weeks of referral: Addictions (Provider Arm and NGO)	≥ 95%	96%	89%	93%	-	100% *	
% of clients discharged will have a quality transition or wellness plan	≥ 95%	93%	99%	No Ethnicity Data			
Rate of s29 orders per 100,000 population	≤ 375		119 *	395	109 *	-	
Number of publicly funded, casemix included, elective and arranged discharges for people living within the DHB region	100%	NA	90%	No Ethnicity Data			

OUTPUT CLASS 4: Rehabilitation and Support Services							Not Reported in Q3
	Target	Baseline	Total	Maori	Pacific	Other	
Time from referral receipt to initial Cranford Hospice contact within 48 hours	≥ 80%	98%	100% *	No Ethnicity Data			% of girls fully immunised – HPV vaccine
% of older patients given a falls risk assessment	≥ 90%	98%	90%				% of 65+ year olds immunised – flu vaccine
% of older patients assessed as at risk of falling receive an individualised care plan	≥ 90%	96%	91% *				Acute rheumatic fever initial hospitalisation rate per 100,000
							% of new-borns enrolled in General Practice by three months of age
							% of adolescents(School Year 9 up to and including age 17 years) using DHB-funded dental services
							Proportion of people with diabetes who have good or acceptable glycaemic control (HbA1C indicator)
							% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission
							% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.
							Proportion of the population seen by mental health and addiction services: Child & Youth (0-19)
							Proportion of the population seen by mental health and addiction services: Adult (20-64)
							Proportion of the population seen by mental health and addiction services: Older Adult (65+)
							Response rate for Patient Experience Surveys - inpatient and general practice
							Total acute hospital bed days per capita (per 1,000 population)
							Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 75-79 years
							Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 80-84 years
							Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) 85+ years
							Acute readmission rate: 75 years +
							Rate of carer stress :Informal helper expresses feelings of distress = YES, expressed as a % of all Home Care assessments
							% of people having homecare assessments who have indicated loneliness
							Conversion rate of Contact Assessment(CA) to Home Care Assessment where CA scores are four-six for assessment urgency
							Clients with a Change in Health, End-stage Disease, Signs and Symptoms) (CHESS) score of four or five at first assessment
							Number of day services
							SLM Amenable Mortality Relative Rate between Māori and NMNP

No Update This Quarter

 <p>HAWKE'S BAY District Health Board <i>Whakawāteatia</i></p>	HBDHB Performance Framework Exceptions Report Quarter 3 2018/19	
	54	
	For the attention of: HBDHB Board	
Document Owner	Chris Ash, Executive Director of Primary Care Directorate	
Document Author(s)	Peter Mackenzie, Business Intelligence Analyst	
Reviewed by	Executive Management Team	
Month/Year	May, 2019	
Purpose	Monitoring	
Previous Consideration Discussions	N/A	
Summary	Areas of Success: Population Enrolled in PHO, Length of Stay-Acute Areas of Progress: Breastfeeding at 3 months, Areas of Focus: Health Target – ED, Mental Health Waiting Times, Immunisation at 8 months	
Contribution to Goals and Strategic Implications	Ensuring the DHB meets/improves performance for our Ministry of Health key performance indicators and local measures outlined in the DHB Annual plan.	
Impact on Reducing Inequities/Disparities	This report highlights areas of inequity, comments are provided in relation to programs of work that are underway/planned in order to positively affect equity gaps.	
Consumer Engagement	N/A	
Other Consultation /Involvement	Comments are supplied from various staff members throughout the DHB including service directors or their delegate, program Leaders and the PHO	
Financial/Budget Impact	NA	
Timing Issues	NA	
Announcements/ Communications	NA	
RECOMMENDATION: It is recommended that the HBDHB Board: <ol style="list-style-type: none"> 1. Note the contents of this report 		



HBDHB PERFORMANCE FRAMEWORK Quarter 3 2018/19

Author:	Peter Mackenzie
Designation:	Business Intelligence Analyst
Date:	May 2019

OVERVIEW

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

As this report ends 31th March 2019, the results in some instances may vary to those presented in other reports.

BACKGROUND

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

ANNUAL PLAN (AP) 2018/2019

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

STATEMENT OF PERFORMANCE EXPECTATIONS (SPE) 2018/19

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

HAWKE'S BAY DISTRICT HEALTH BOARD (HBDHB) PERFORMANCE FRAMEWORK

The four dimensions of the non-financial monitoring framework, which was developed by the Ministry as a mandatory framework, will reflect DHB's functions as owners, funders and providers of health and disability services.

The 4 dimensions of DHB performance are:

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

MINISTRY OF HEALTH ASSESSMENT CRITERION

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

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

KEY FOR DETAILED REPORT

Baseline	Latest available data for planning purpose
Target 2018/19	Target 2018/19
Actual to date	Actual to date
F (Favourable)	Actual to date is favourable to target
U (Unfavourable)	Actual to date is unfavourable to target
Trend direction ▲	Performance is improving against the previous reporting period or baseline
Trend direction ▼	Performance is declining
Trend direction -	Performance is unchanged

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PERFORMANCE HIGHLIGHTS – TOTAL POPULATION

Achievements

- Health Targets – The DHB has remained favourable for the Raising Healthy Kids measure with a Total Rate of 97%, Māori at 97% and Pacific at 100% against a target of 95%.
- PHO Enrolment - The DHB has remained favourable for all ethnicities this quarter, achieving 98% overall compared to the target of 90%

Areas of Progress

- Breastfeeding at 3 months – The overall rate has increased to 57.4% compared to 52% in the previous quarter, Māori has increase to 43.1% compared to 36% previously and Pacific has increased to 57.7% from 35% previously. All of the current results are still short of the 70% target (page 13)

Areas of Focus

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

- Health Target – ED 6 Hour result is 87% against a target of 95%. Māori Is 89% and Pacific is 85% (page 7)
- DNA – Overall we have seen DNA rates increase from 5.5% to 6.5%. Both Māori (12.7 %) and Pacific (17.3%) have increased over the previous quarter and sit significantly above the target of 7.5%. (page 25)
- Health Target – Immunisation at 8 months – The overall rate for the DHB (90%) and Māori (88%) are below the target of 95% (page 8)

PERFORMANCE HIGHLIGHTS – EQUITY

Achievements

- PHO Enrolment – The Māori rate is currently 99% and the Pacific rate is 92%, both are favourable to the target rate of 90%.

Areas of Progress

- Breastfeeding at 3 months – Māori results have improved by 7% and current sit at 43.1%, this is short of the 70% target (page 13)

Areas of Focus

- Rate of Section 29 orders per 100,000 population – Māori Rates are currently 395 per 100,000 against the target of <81.5 and are 3 times higher than the non-Māori Rate (page 28)
- DNA – Both the Māori and Pacific rates of DNA have increased over the Q3 period which is disappointing to see. The Māori increased by 1.8% in Q4 and now sits at 12.7%, the Pacific rate has increased by 5.3% and now sit at 17.3%. Other Ethnicity is 4% for the period against a target of 7.5% (page 25)

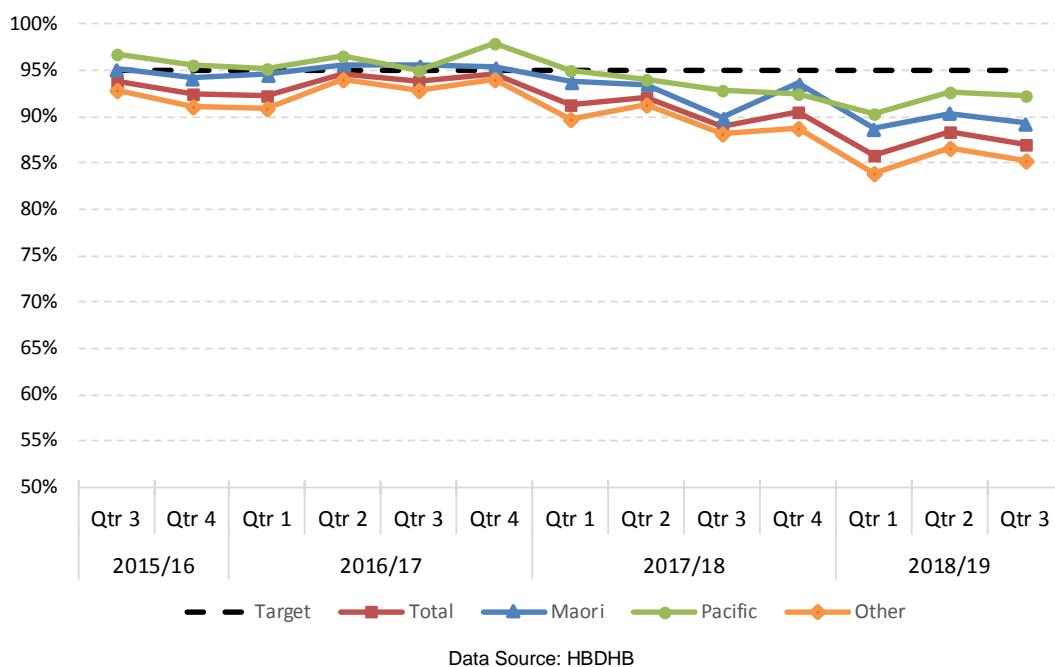
HEALTH TARGETS

Health Target: Shorter stays in emergency departments

95% of all people attending the Emergency Department will be admitted, transferred or discharged within six hours

Ethnicity	Baseline ¹	Previous result ²	Actual to Date ³	Target 2018/19	Trend Direction
Total	93.9%	88.3% (U)	87% (U)	≥95%	▼
Māori	95.3%	90.4% (U)	89.3% (U)	≥95%	▼
Pacific	96.2%	92.7% (U)	92.3% (U)	≥95%	▼
Other	93.0%	86.7% (U)	85.2% (U)	≥95%	▼

Shorter Stays in the Emergency Department



Data Source: HBDHB

19

Comments:

This quarter the DHB has made a change to the Triage process in ED front of house, expanding nursing utilisation and practice change in triage. This includes streamlining and standardising triage processes, early identification of triage 2 patients, and early implementation of treatment/pathways. Work continues due to limitations of resources, hospital acuity, capacity and demand. There is also a stronger organisational focus on specialty response to ED and discharge processes including the provision of senior nursing resource into the discharge lounge and re-establishment of the long-stay patient rounds. High patient volumes still pose a challenge to the physical and resource capacity of ED. High levels of hospital bed occupancy (including ICU/HDU) constraining acute patient flow and increasing ED length of stay. Many streams of work being undertaken under executive level sponsorship including 'stranded' patient initiative (identifying/addressing barriers for people with excessive LOS), implementation of Criteria-based discharge processes across acute ward areas and continued evolution of Integrated Operations Centre activity.

¹ October to December 2017

² July to September 2018

³ January to March 2019

Health Target: Increased immunisation					
% of 8 month olds fully immunised					
Ethnicity	Baseline ⁴	Previous result ⁵	Actual to Date ⁶	Target 2018/19	Trend direction
Total	95%	93.3% (U)	89.8% (U)	≥95%	▼
Māori	93%	90.2% (U)	88.4% (U)	≥95%	▼
Pacific	97%	96.4% (F)	93.3% (U)	≥95%	▼
Other	86%	95.6% (F)	90.6% (U)	≥95%	▼

Immunisation Coverage at 8 Months of Age

3 months to:

— — Target
 ■ — Total
 ▲ — Maori
 ● — Pacific
 ◆ — Other

Data Source: National Immunisation Register

Comments:

We had 53 children not complete this quarter including 21 declines (some or all immunisation); a number transferred in from other regions without the possibility of us being able to get them on time due to them not being up to date when they transferred to our area (nearly 6% in these groups). Of the other infants there were hesitations or delays (some of the parents were anxious re the deaths in Samoa); difficulty engaging (outreach had at some time been in contact with but not home when home visited, then not responding to phone, text, home visits). Due to more whanau being hesitant, more input is required to encourage immunisation which is stretching our already stretched resources. We will continue to provide information to hesitant families and revisit declining parents at the 12 month and 18 month milestone ages (if appropriate). We are working with the PHO to ensure new-born enrolment and general enrolment is the best it can be. The immunisation coordinator has met with general practice managers to encourage timely new-born enrolment, good pre-call systems, and the ability to opportunistically immunise and for them to know which children are outstanding in regards to being up to date with immunisations. We have also provided education to Plunket nurses this quarter to encourage consistent information out to families.

⁴ October to December 2017. Source: National Immunisation Register, MOH

⁵ October to December 2018. Source: National Immunisation Register, MOH

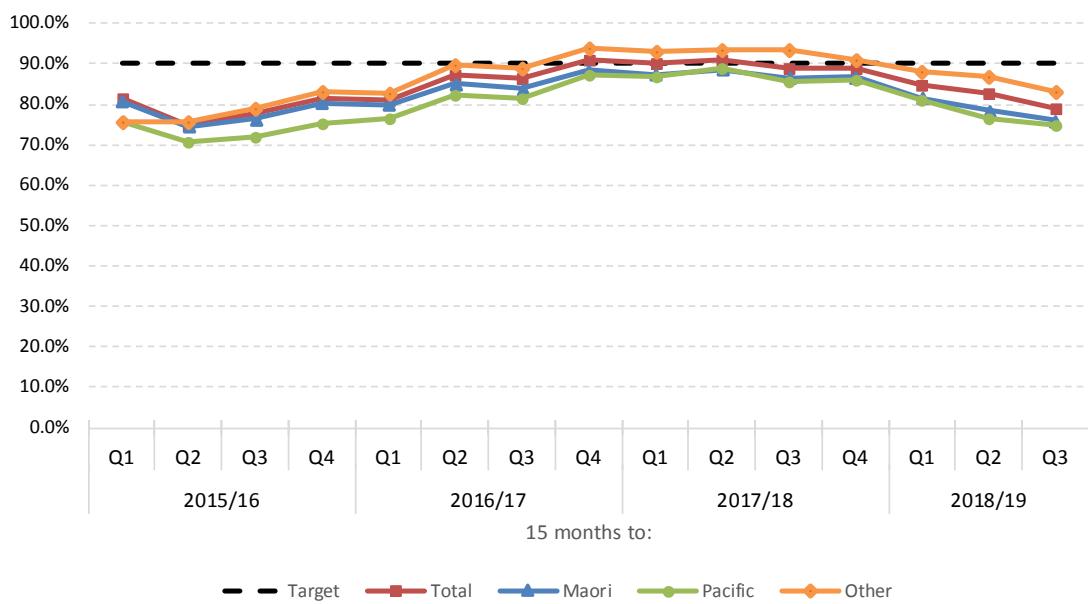
⁶ January to March 2019. Source: National Immunisation Register, MOH

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

PHO Enrolled Patients Who Smoke have been Offered Brief Advice & Support to Quit Smoking

Ethnicity	Baseline ⁷	Previous result ⁸	Actual to Date ⁹	Target 2018/19	Trend direction
Total	90%	83% (U)	79% (U)	≥90%	▼
Māori	89%	79% (U)	76% (U)	≥90%	▼
Pacific	89%	77% (U)	75% (U)	≥90%	▼
Other	94%	87% (U)	83% (U)	≥90%	▼

% of PHO Enrolled Patients Who Smoke have been Offered Brief Advice & Support to Quit Smoking



Data Source:

Comments:

Practice champions continue to be supported to encourage colleagues to provide SBA (smoking brief advice). There is a constant agenda item to ensure it is forefront of practice managers, nurse leaders and clinicians minds. Two additional independent nurses will be contracted to support SBA in general practice, Maori and Pacific smokers are prioritised on the lists they will use to guide them. Those smokers yet to be offered SBA are often elusive, requiring multiple attempts at contact, for many out of hours and weekend calling is the best way to reach them. This requires a dedicated resource outside of standard clinical hours.

⁷ 15 months to December 2017. Source: Health Hawkes Bay Karo

⁸ 15 months to December 2018. Source: Health Hawkes Bay Karo

⁹ 15 months to March 2019. Source: Health Hawkes Bay Karo

Health Target: Better help for smokers to quit - Maternity					
Pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking					
Ethnicity	Baseline ¹⁰	Previous result ¹¹	Actual to Date ¹²	Target 2018/19	Trend direction
Total	86.7%	88.9% (U)	84.6% (U)	≥90%	▼
Māori	84.0%	88% (U)	80% (U)	≥90%	▼
Pacific	-	-	-	≥90%	—
Other	-	-	-	≥90%	—

% of Pregnant Patients who Smoke Have Been Offered Brief Advice & Support to Quit Smoking

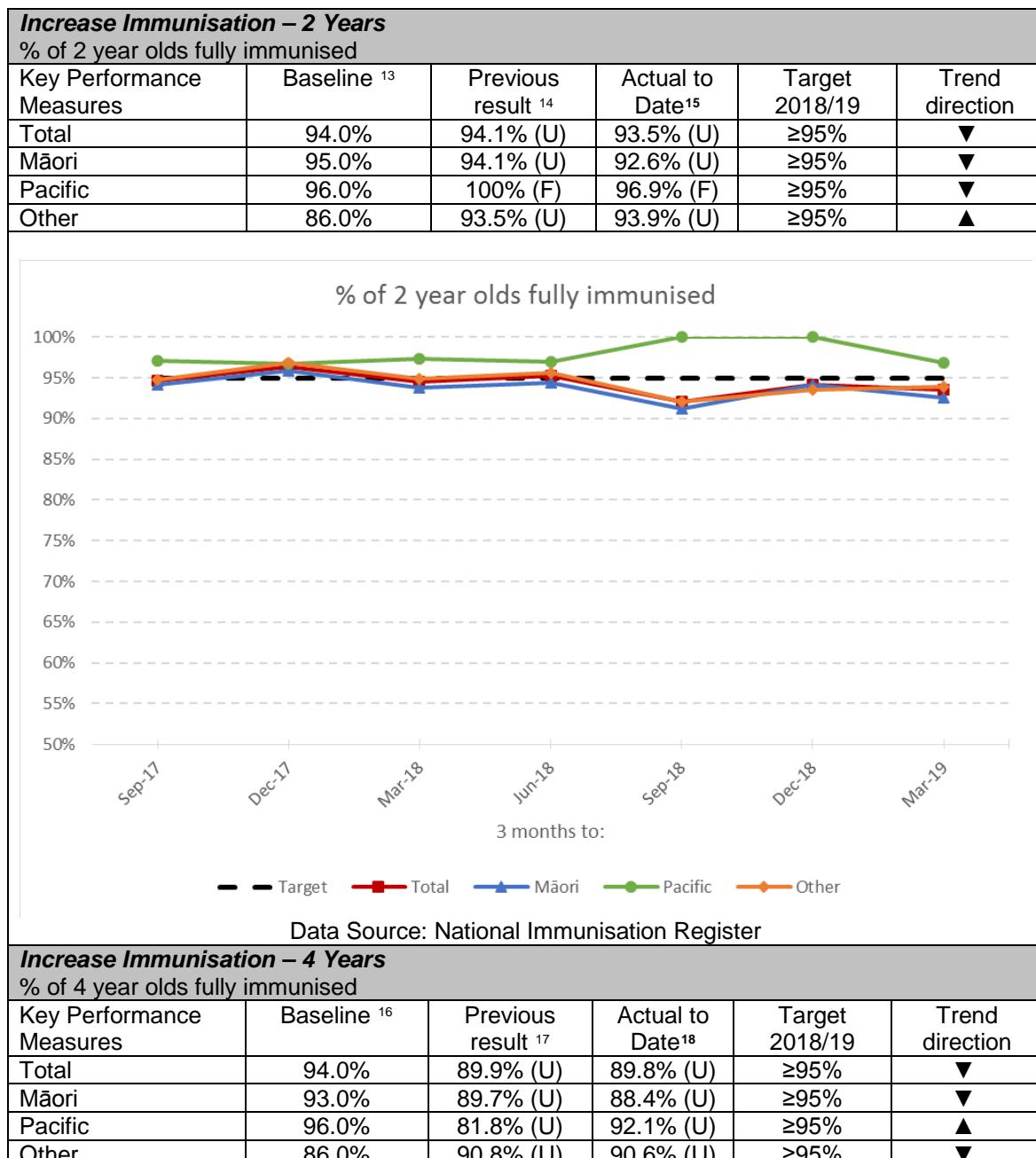
Quarter	Total (%)	Maori (%)	Target (%)
Q1 2015/16	90	88	90
Q2 2015/16	95	95	90
Q3 2015/16	88	85	90
Q4 2015/16	88	82	90
Q1 2016/17	90	88	90
Q2 2016/17	88	80	90
Q3 2016/17	92	95	90
Q4 2016/17	85	82	90
Q1 2017/18	82	55	90
Q2 2017/18	75	72	90
Q3 2017/18	75	72	90
Q4 2017/18	68	70	90
Q1 2018/19	92	95	90
Q2 2018/19	88	88	90
Q3 2018/19	85	80	90

Data Source:

Comments:
Smokefree training is continuing with the DHB Midwives, there is also increase education for staff via the bulletin and one on one education with a variety of staff, NZCOM meeting.

¹⁰ 15 months to December 2017. Source: Maternity¹¹ 15 months to December 2018. Source: Maternity¹² 15 months to March 2019. Source: Maternity

OUTPUT CLASS 1: PREVENTION SERVICES



13 October to December 2017 . Source: National Immunisation Register, MOH

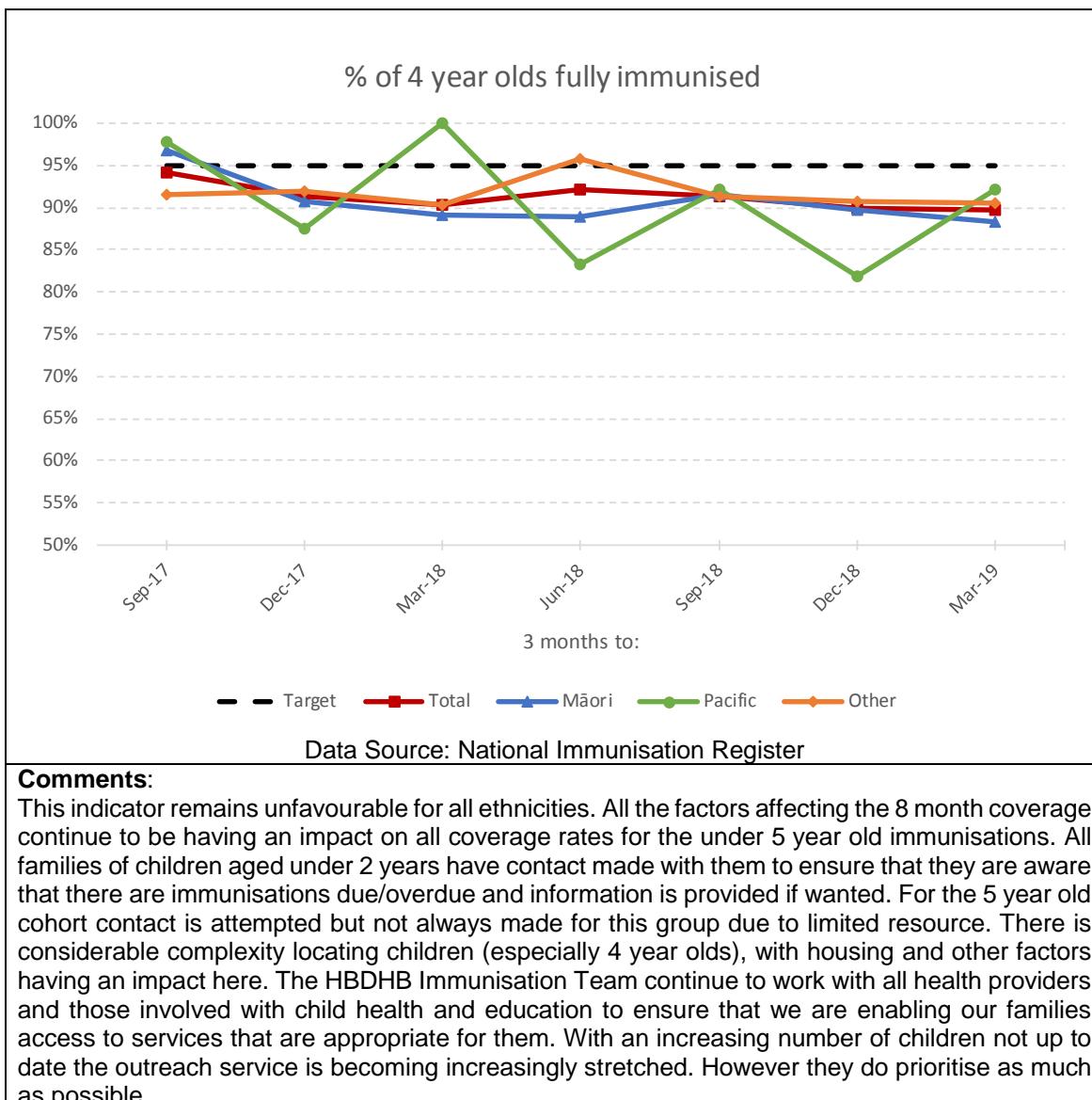
14 October to December 2018 . Source: National Immunisation Register, MOH

15 January to March 2019 . Source: National Immunisation Register, MOH

16 October to December 2017 . Source: National Immunisation Register, MOH

17 October to December 2018 . Source: National Immunisation Register, MOH

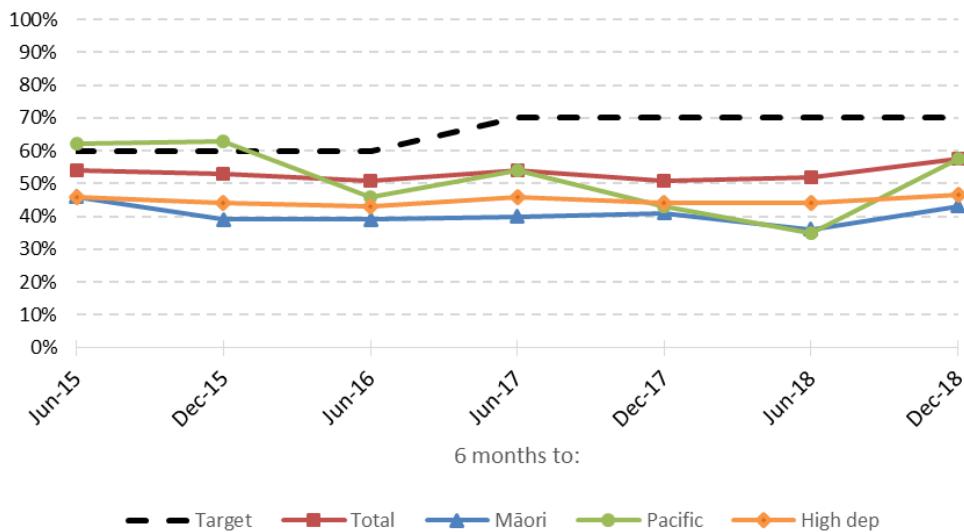
18 January to March 2019 . Source: National Immunisation Register, MOH



Better rates of breastfeeding – 3 months

% of infants that are exclusively or fully breastfed at 3 months

Key Performance Measures	Baseline ¹⁹	Previous result ²⁰	Actual to Date ²¹	Target 2018/19	Trend direction
Total	51.0%	52% (U)	57.4% (U)	≥70%	▲
Māori	41.0%	36% (U)	43.1% (U)	≥70%	▲
Pacific	43.0%	35% (U)	57.7% (U)	≥70%	▲
Other	-	0% (U)	0% (U)	≥70%	—

Newborns who are Exclusively or Fully Breastfed at 3 Months old**Comments:**

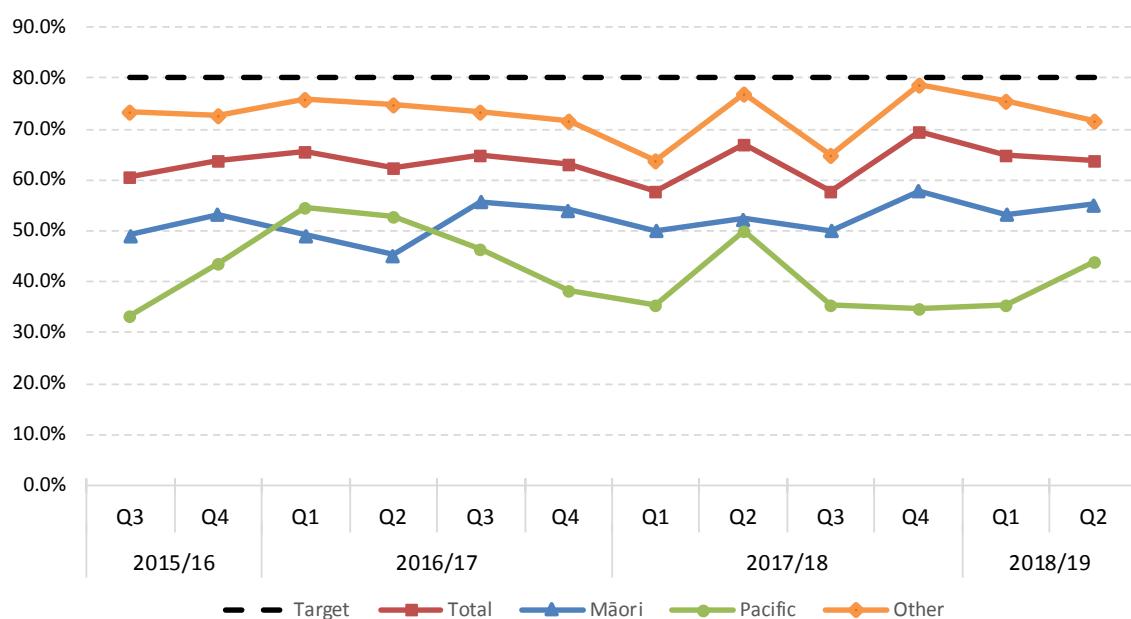
We are pleased to see the slight improvement in the breastfeeding rates but acknowledge the persistent equity gap still evident for Māori. The HBDHB has prioritized investment into all three WellChild Tamariki Ora services to increase their capacity to provide lactation consultant and/or peer support outreach approach to breastfeeding. This service provides added support targeted specifically to whānau Māori to help establish and maintain breastfeeding through those first few months. Data is not yet available but the providers have already made progress establishing community based pēpi clinics and close alignment with other māmā and pēpi services such as antenatal education, and maternity services. The implementation of these services identified a lack of lactation consultants available in Hawke's Bay and a lack of appropriately trained lactation consultants that can competently work with whānau Māori. This has meant two of the three providers have recruited Māori nurses that are undertaking the LC training, while the other requires strong cultural guidance and support.

¹⁹ 6 months to December 2017²⁰ 6 months to June 2018²¹ 6 months to December 2018.

OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT SERVICES

More pregnant women under the care of a Lead Maternity Carer (LMC)					
% of women booked with an LMC by week 12 of their pregnancy					
Key Performance Measures	Baseline ²²	Previous result ²³	Actual to Date ²⁴	Target 2018/19	Trend direction
Total	67.1%	64.8% (U)	64.0% (U)	≥80%	▼
Māori	52.4%	53.3% (U)	55.2% (U)	≥80%	▲
Pacific	50.0%	35.5% (U)	43.9% (U)	≥80%	▲
Other	76.9%	75.5% (U)	71.7% (U)	≥80%	▼

Percentage of women registered with an LMC by week 12 of their pregnancy



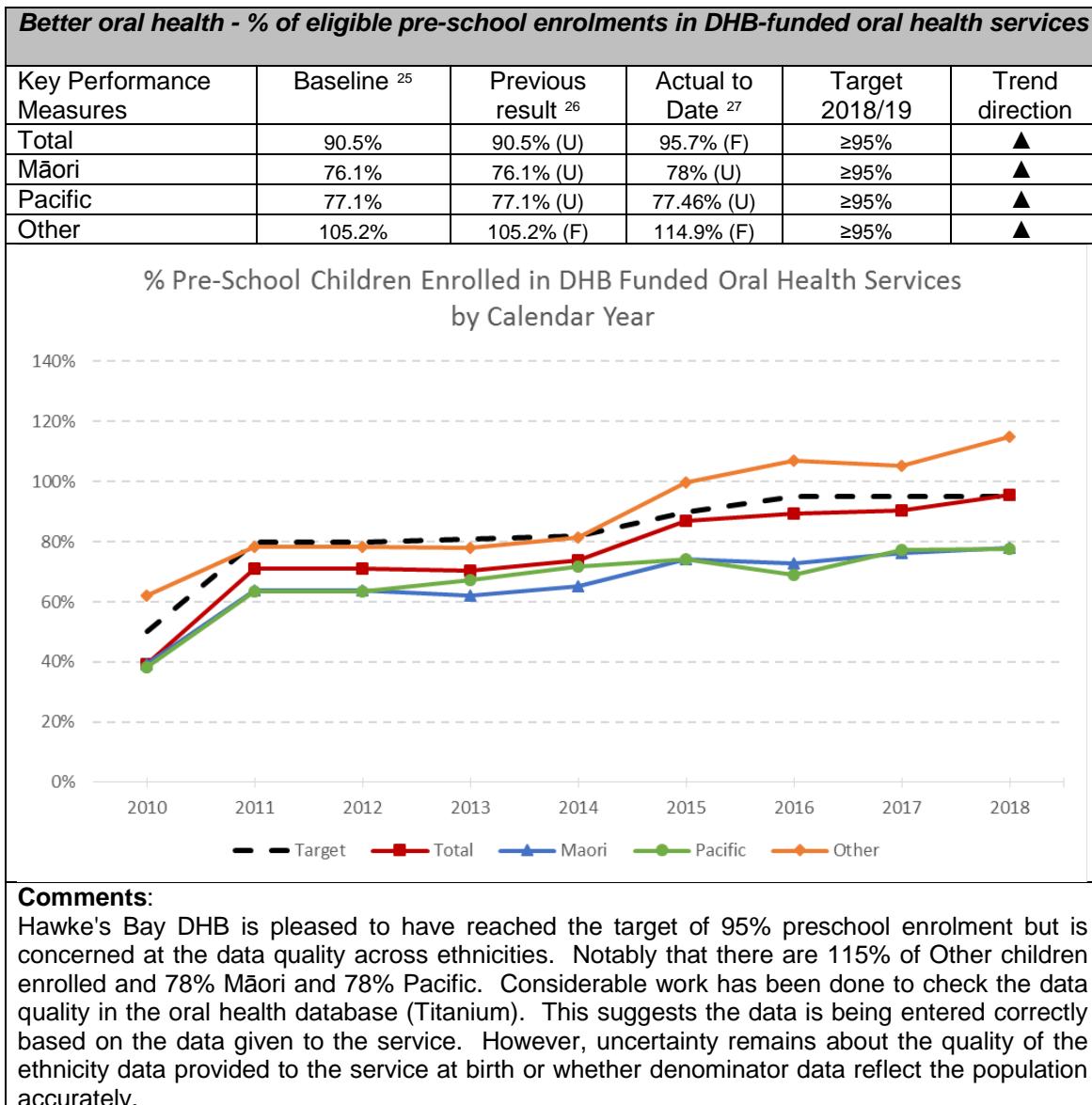
Comments:

Historical data shows that rates for māmā Māori tend to consistently stay around this level, and the inequity with Other māmā persists. There is an explicit commitment by HBDHB to achieve equitable health outcomes for Māori in Hawke's Bay. There are a number of activities that are underway that will have a direct and positive impact on this indicator. Two Māori health providers are currently in the process of developing Kaupapa Māori Maternal Health Programmes. The programmes have a specific emphasis on early engagement to support māmā Māori to engage a lead maternity carer in the first trimester, and to identify any unmet health needs. One of the providers is due to start the programme by 1 July 2019, the other will likely be in 2020. Whanake te Kura is the HBDHB funded ante-natal education programme. Delivered by a local Māori health provider, the kaupapa of the programme is to encourage and engage māmā early, and more than once during their pregnancy. The programme is only a year old, but looks to empower māmā with information about on how to navigate the maternal health pathway. We anticipate these gains will be fully realised through subsequent pregnancies and whānau sharing knowledge. An area of improvement is the number of referrals from local LMCs and strengthening the relationship with this sector. He Korowai Manaaki is a HRC funded study being undertaken by the Women's Health Research Centre, University of Victoria. The study is being carried out in Hawke's Bay. The study involves a Randomised Trial to test the maternal health pathway. Early engagement with māmā in the primary care setting is a key feature of this study, and will provide key learnings for how we can continue to improve early engagement along the maternal health pathway.

²² October to December 2017.

²³ July to September 2018.

²⁴ October to December 2018

²⁵ October to December 2017.²⁶ January to December 2017.²⁷ January to December 2018.

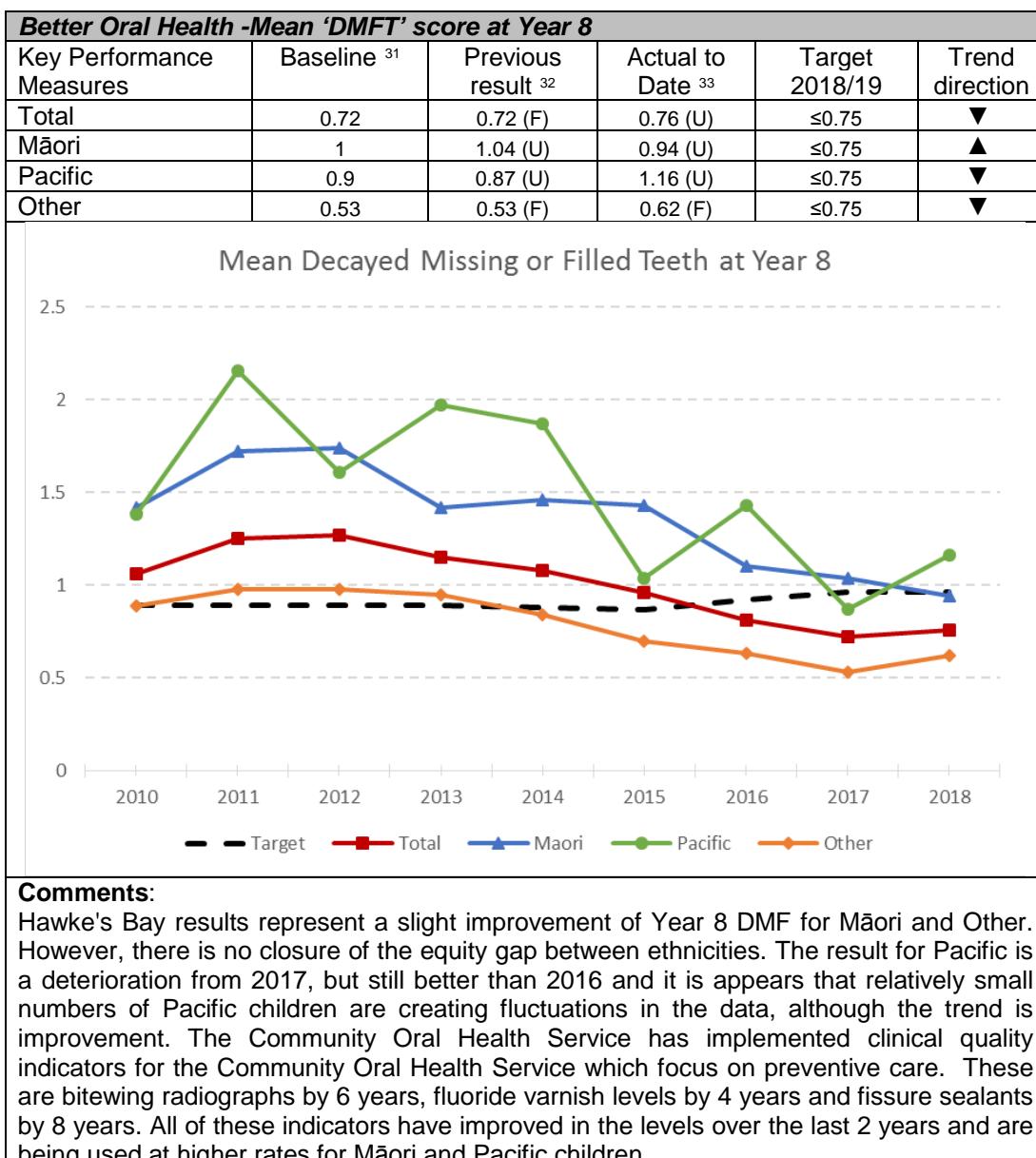
Better oral health - % of children who are caries free at 5 years of age					
Key Performance Measures	Baseline ²⁸	Previous result ²⁹	Actual to Date ³⁰	Target 2018/19	Trend direction
Total	59.5%	59.5% (F)	62% (F)	≥59.1%	▲
Māori	42.6%	42.6% (U)	43% (U)	≥59.1%	▲
Pacific	31.3%	31.3% (U)	28% (U)	≥59.1%	▼
Other	75.0%	75% (F)	75% (F)	≥59.1%	—

Children Caries Free at 5 Years of Age

Year	Total	Māori	Pacific	Other	Target
2010	58%	38%	35%	72%	65%
2011	53%	35%	40%	68%	65%
2012	53%	37%	39%	65%	65%
2013	53%	37%	32%	66%	65%
2014	56%	39%	38%	71%	65%
2015	53%	36%	30%	70%	65%
2016	59%	43%	30%	73%	68%
2017	59%	42%	31%	74%	65%
2018	61%	42%	28%	74%	65%

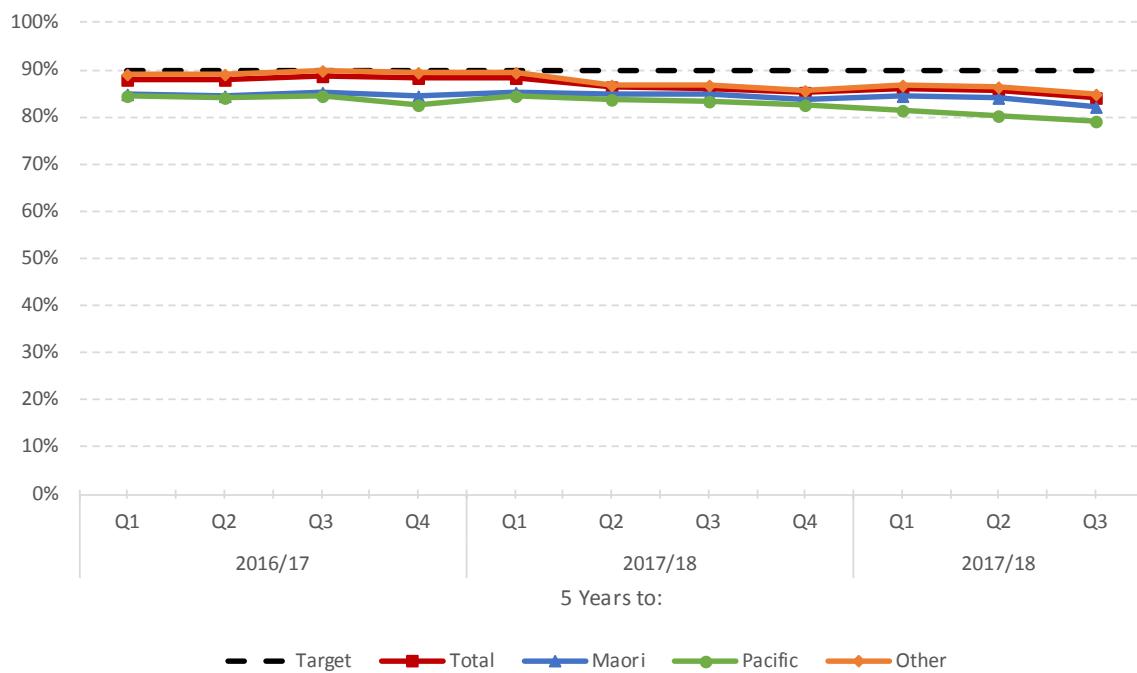
Comments:
Caries free 5 year old levels have remained static for Māori and Other children and declined to 28% for Pacific children. The inequity between Māori and Other is static and the inequity between Other and Pacific has increased. The DHB has implemented a specific project focussed on "Under 5 year caries free". This project has multiple initiatives to improve the levels of enrolments and engagement, increase use of fluoride varnish including a kaiawhina working under standing orders in kohanga reo to apply fluoride varnish, and initiatives to increase the environment supporting the removal of dental caries - such as sugar free drink Paediatric Ward. Community water fluoridation was lost in Hastings at the end of 2016 and has remained out of the Central Hawke's Bay supply since 2012. This means that in 2017 and 2018 all of Hawke's Bay DHB had no community water fluoridation. Area data within the DHB suggest this has contributed to the difficulty with improving outcomes and reducing equity. Hastings DC have indicated that a gradual return of community water fluoridation can be expected over the next 2-3 years as supply points are upgraded.

²⁸ January to December 2017.²⁹ January to December 2017.³⁰ January to December 2018.

³¹ January to December 2017.³² January to December 2017.³³ January to December 2018.

Improved management for cardiovascular health					
Key Performance Measures	Baseline ³⁴	Previous result ³⁵	Actual to Date ³⁶	Target 2018/19	Trend direction
Total	86.3%	85.7% (U)	84.1% (U)	≥90%	▼
Māori	85.0%	84% (U)	82.2% (U)	≥90%	▼
Pacific	83.6%	80.2% (U)	79.2% (U)	≥90%	▼
Other	86.7%	86.5% (U)	85% (U)	≥90%	▼

More Heart & Diabetes Checks



Comments:

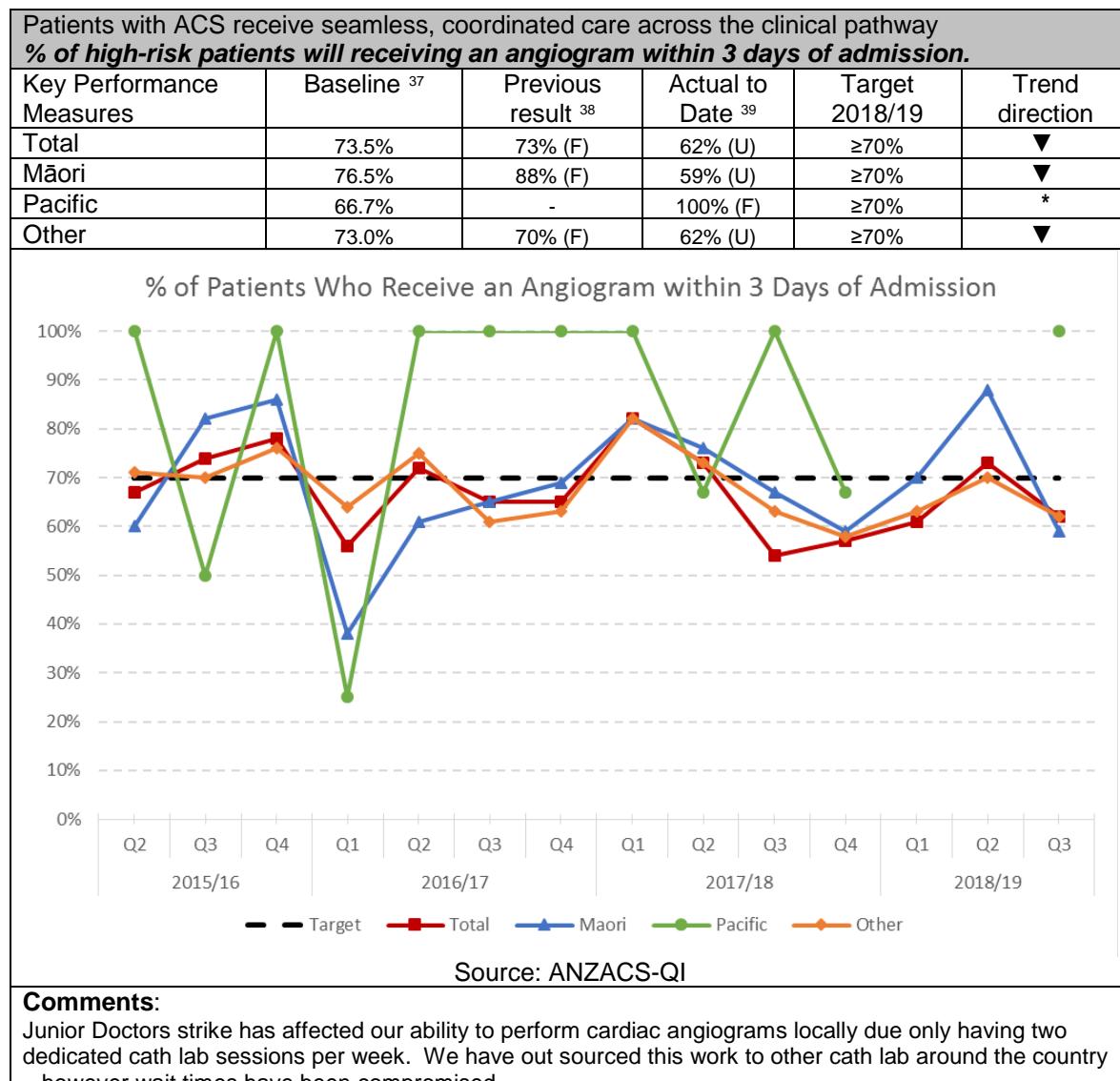
The target population of Maori males 35 – 44yrs are traditionally not high users of health care, they do not routinely engage with general practice as are often out working, health is not routinely prioritised unless issues arise, therefore a 90% target for this cohort is difficult to achieve. Remuneration payments to practices for High Needs CVRA, for Maori & Pacific males 33 – 45 yrs. and females 43 – 45 yrs. commenced this quarter. The payment is in recognition of the effort required to engage with and successfully assess this younger cohort. We are merging CVRA and Smoking Brief Advice [SBA] lists so the clinician phoning can offer a CVRA when providing SBA. Also there is ongoing use of the Independent Practitioner (IP) resource to outreach into local businesses, local sports clubs, gyms etc to offer CVRA to employees and club members.

³⁴ 5 years to December 2017.

³⁵ 5 Years to December 2018.

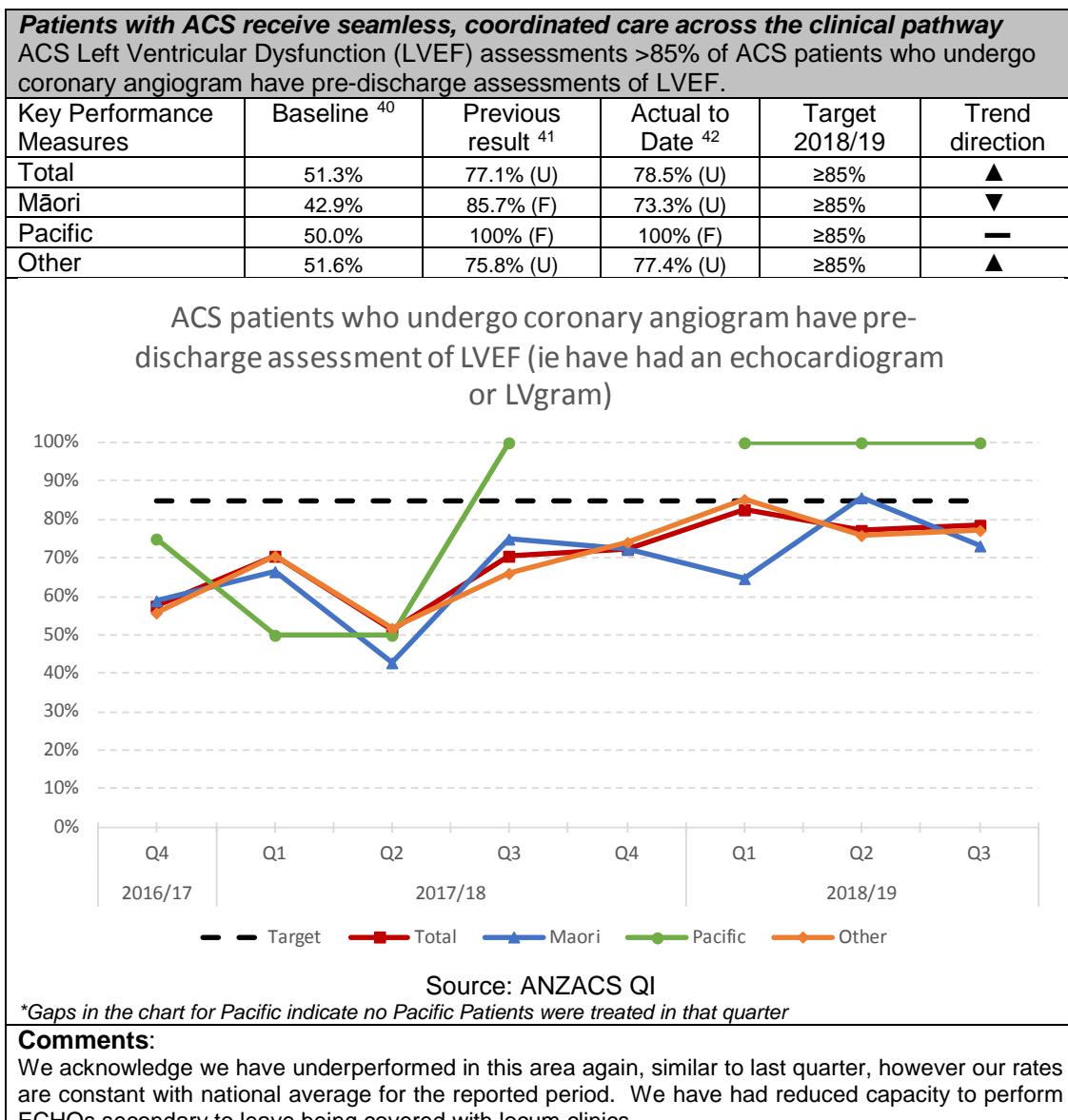
³⁶ 5 Years to March 2019

OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT SERVICES



19

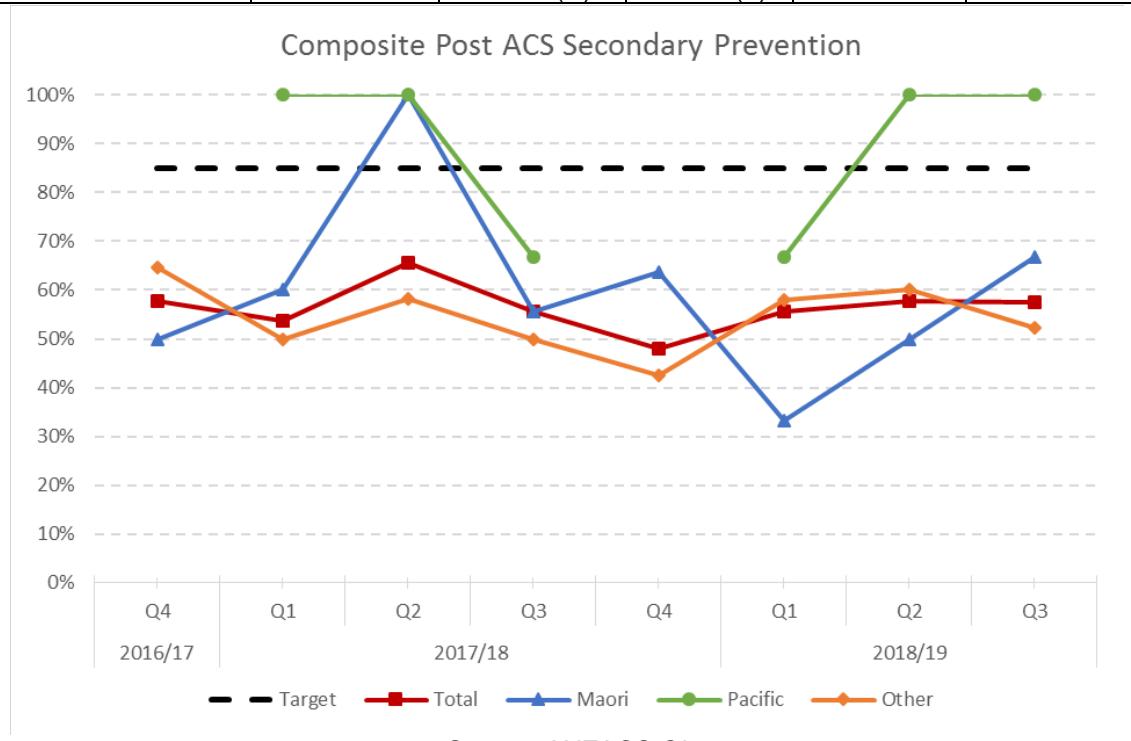
³⁷ October to December 2017. Source: Ministry of Health³⁸ July to September 2018. Source: Ministry of Health³⁹ January to March 2019 . Source: Ministry of Health

⁴⁰ September to November 2017. Source: Ministry of Health⁴¹ September to November 2018 . Source: Ministry of Health⁴² December to February 2018 Source: Ministry of Health

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

Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance all ACS patients who undergo coronary angiogram should be prescribed, at discharge, aspirin, a second anti-platelet agent, statin and an ACE/ARB (four classes) and those with LVEF<40% should also be on a beta blocker (five classes)

Key Performance Measures	Baseline ⁴³	Previous result ⁴⁴	Actual to Date ⁴⁵	Target 2018/19	Trend direction
Total	55.6%	58.8% (U)	57.6% (U)	85%	▼
Māori	33.3%	50.0% (U)	66.7% (U)	85%	▲
Pacific	66.7%	100% (F)	100% (F)	85%	▬
Other	58.0%	60.0% (U)	52.2% (F)	85%	▼



Source: ANZACS QI

Comments:

Variance to practice in this area is around the use of ACEi/ARB meds. These are prescribed in accordance with guidelines on a case by case basis (per clinical lead cardiologist and TAS meetings)

43 September to November 2017. Source: Ministry of Health

44 September to November 2018 . Source: Ministry of Health

45 December to February 2018 Source: Ministry of Health

Equitable access to surgery -Standardised intervention rates for surgery per 10,000 population					
Key Performance Measures	Baseline ⁴⁶	Previous result ⁴⁷	Actual to Date ⁴⁸	Target 2018/19	Trend direction
Major joint replacement	22.4	19.59 (U)	19.66 (U)	≥21	▲
Cataract procedures	46.6	46.45 (F)	45.97 (F)	≥27	▼
Cardiac procedures	4.8	5.27 (U)	4.92 (U)	≥6.5	▼
Percutaneous revascularization	11.9	13.2 (F)	12.94 (F)	≥12.5	▼
Coronary angiography services	36.4	39.55 (F)	39.99 (F)	≥34.7	▲

Cataract Procedures

Period	Actual (rate per 10,000 pop)	Target
Dec-14	52	27
Mar-15	53	27
Jun-15	50	27
Sep-15	51	27
Dec-15	47	27
Mar-16	49	27
Jun-16	54	27
Sep-16	58	27
Dec-16	57	27
Mar-17	53	27
Jun-17	47	27
Sep-17	50	27
Dec-17	47	27
Mar-18	48	27
Jun-18	47	27
Sep-18	47	27
Dec-18	46	27

— Target ● Actual

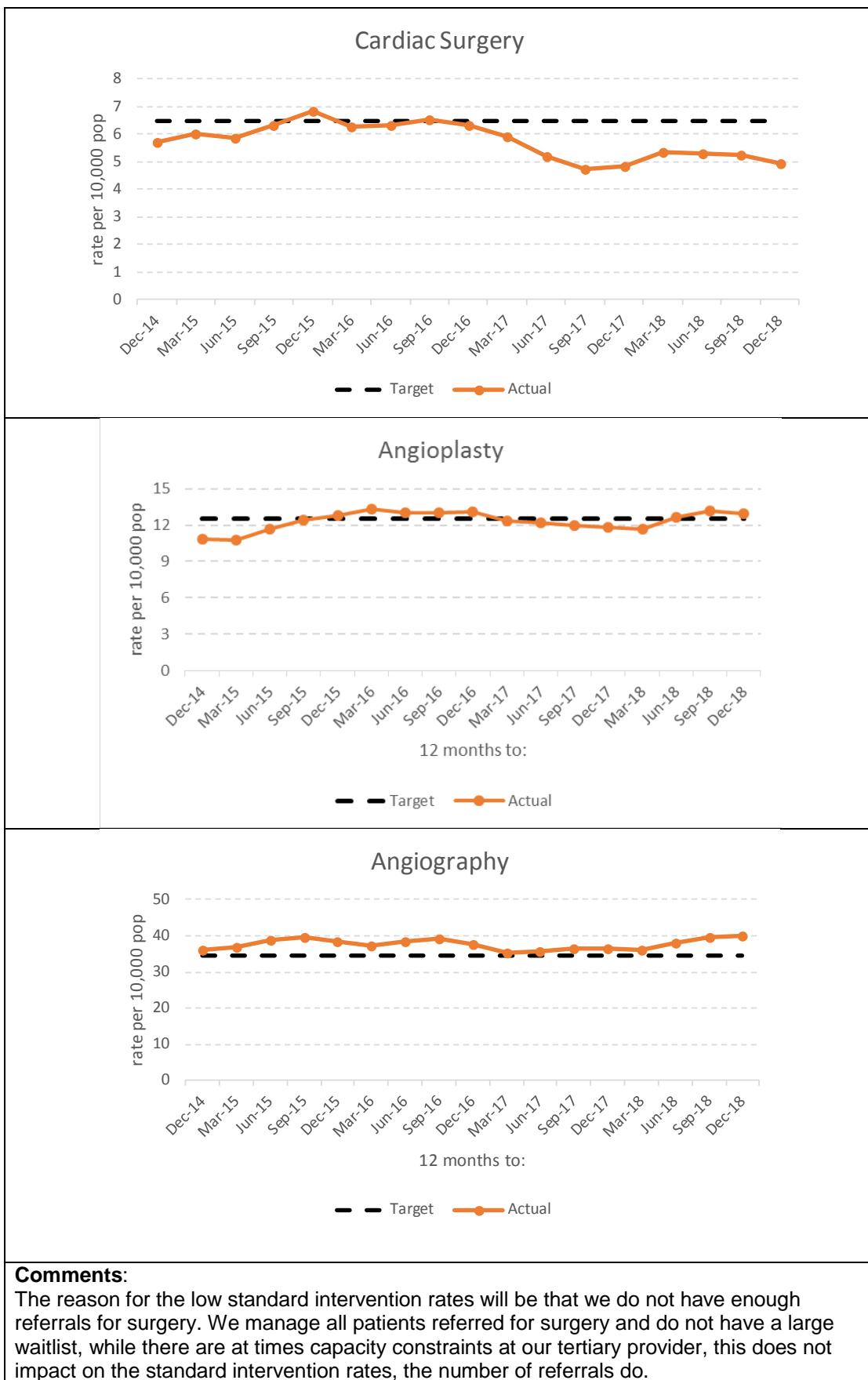
Source: Ministry of Health

Major Joint Replacements

Period	Actual (rate per 10,000 pop)	Target
Dec-14	21	20
Mar-15	22	20
Jun-15	16	20
Sep-15	17	20
Dec-15	19	20
Mar-16	19	20
Jun-16	20	20
Sep-16	22	20
Dec-16	20	20
Mar-17	21	20
Jun-17	22	20
Sep-17	23	20
Dec-17	22	20
Mar-18	21	20
Jun-18	19	20
Sep-18	19	20
Dec-18	19	20

— Target ● Actual

⁴⁶ 12 months ending December 2017. Source MoH⁴⁷ 12 months ending September 2018. Source MoH⁴⁸ 12 months ending December 2018. Source MoH



Shorter stays in hospital					
Length of stay (days)					
Key Performance Measures	Baseline ⁴⁹	Previous result ⁵⁰	Actual to Date ⁵¹	Target 2018/19	Trend direction
Acute	2.39	2.37 (U)	2.31 (F)	≤2.32	▲
Elective	1.52	1.59 (U)	1.59 (U)	≤1.48	—

Average Length of Stay (Acute)

Date	Target (Days)	Actual (Days)
Jun-15	2.70	2.60
Sep-15	2.60	2.55
Dec-15	2.65	2.50
Mar-16	2.60	2.45
Jun-16	2.55	2.45
Sep-16	2.50	2.45
Dec-16	2.45	2.40
Mar-17	2.50	2.50
Jun-17	2.45	2.45
Sep-17	2.40	2.40
Dec-17	2.35	2.35
Mar-18	2.35	2.35
Jun-18	2.35	2.35
Sep-18	2.35	2.35
Dec-18	2.30	2.30

Source: Ministry of Health

Average Length of Stay (Elective)

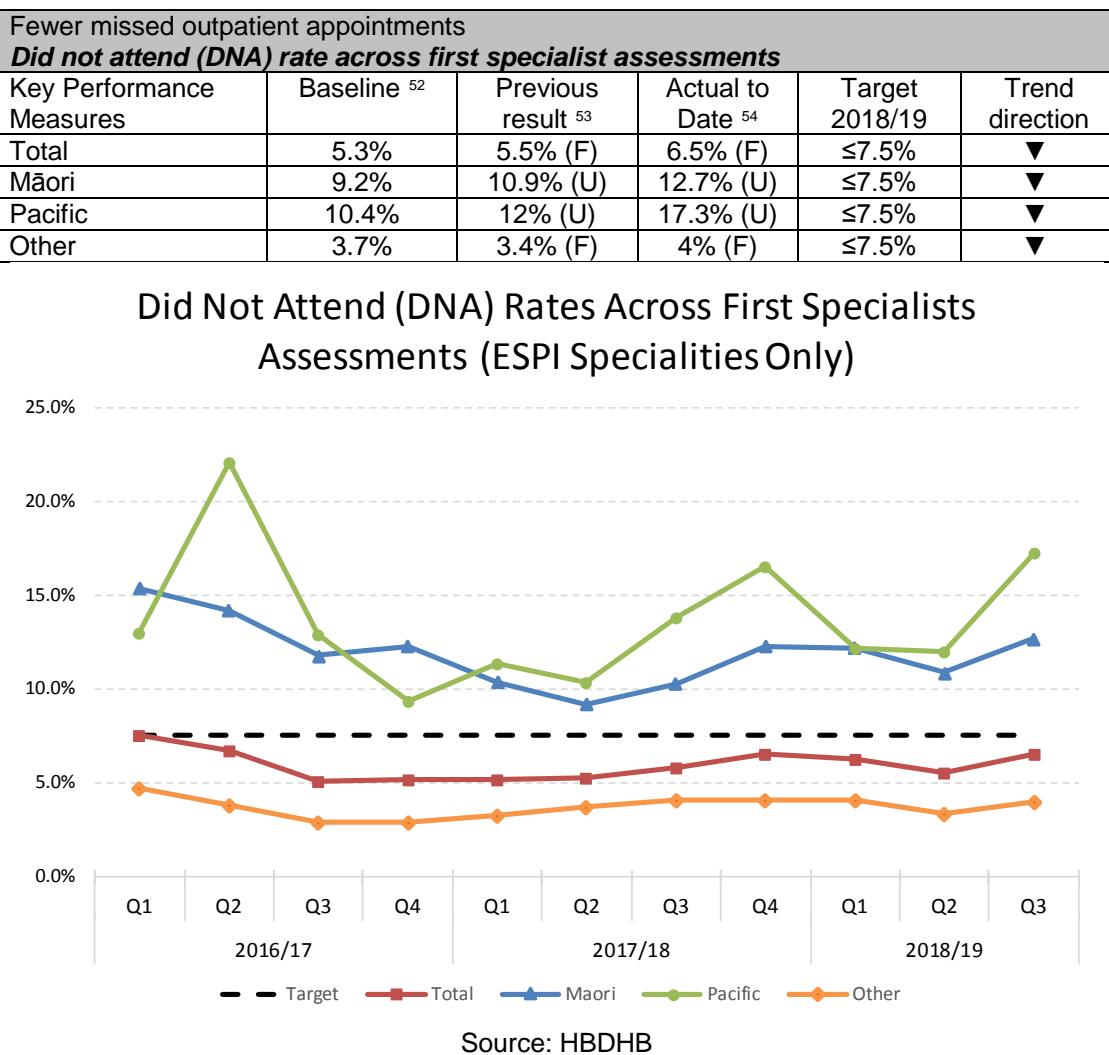
Date	Target (Days)	Actual (Days)
Jun-15	1.70	1.70
Sep-15	1.65	1.65
Dec-15	1.70	1.70
Mar-16	1.65	1.60
Jun-16	1.60	1.55
Sep-16	1.55	1.55
Dec-16	1.60	1.55
Mar-17	1.65	1.65
Jun-17	1.60	1.60
Sep-17	1.55	1.55
Dec-17	1.50	1.50
Mar-18	1.55	1.55
Jun-18	1.60	1.60
Sep-18	1.65	1.65
Dec-18	1.55	1.60

Source: Ministry of Health

Comments:

⁴⁹ 12 months to September 2017. Source: Ministry of Health⁵⁰ 12 months to September 2018. Source: Ministry of Health⁵¹ 12 months to December 2018. Source: Ministry of Health

Length of stay has the same as the previous period, we are experiencing an increase in complexity which is hampering our ability to reduce the ALOS. There is no specific program of work specifically designed to help reduce the average length of stay however analysis is done on the cases that have the longer length of stays to ensure they are clinically appropriate.



Comments:

The 3rd Quarter saw a spike in DNA rates, up to 7.6% for January, above the target 7.5%, which is the first time since June 2018 the total rate has risen above target. School holidays and lack of Kaitakawaenga resourcing were the main contributing factors, which highlights the impact Kaitakawaenga have on maintaining DNA rates below the target line. Dental, General Surgery, Orthopaedics and Paediatrics continue to present difficulties for our Māori and Pacific population when it comes to FSA access. For our Māori population, over 35% of those that were unable to access FSA's over the last year in Hawkes Bay, were under 10 yrs old and nearly 14% of those patients that did not access their FSA over the last year, were not enrolled with a primary health provider. The next steps for Administration Services and Kaitakawaenga over the next Quarter is to develop an action plan to better target these two vulnerable groups of patients

52 October to December 2017. Source: Ministry of Health

53 October to December 2018. Source: Ministry of Health

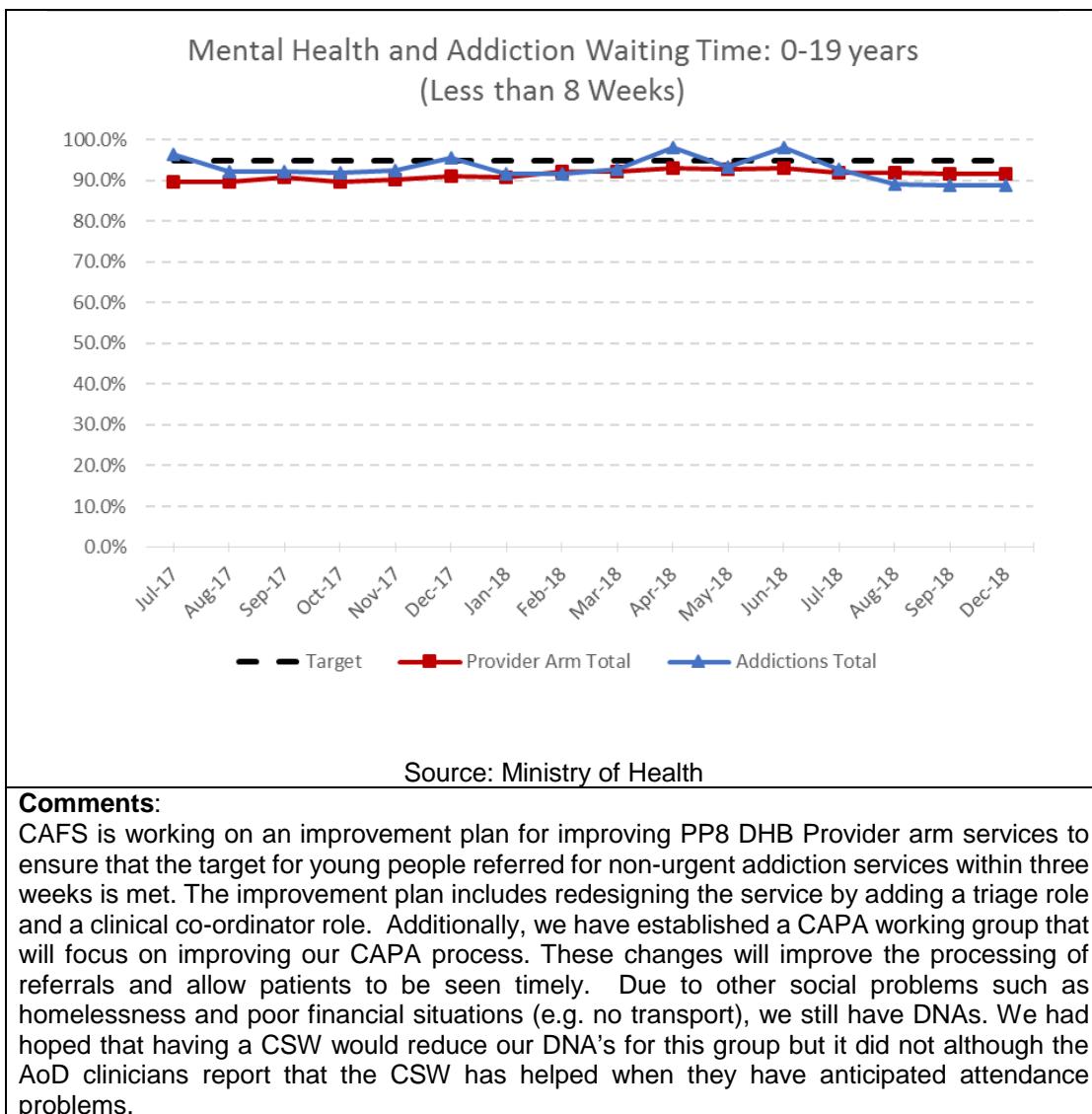
54 January to March 2019. Source: Ministry of Health

Reducing waiting times Shorter waits for non-urgent mental health and addiction services for 0-19 year olds																																																								
Key Performance Measures	Baseline ⁵⁵	Previous result ⁵⁶	Actual to Date ⁵⁷	Target 2018/19	Trend direction																																																			
Mental Health Provider Arm: Age 0-19																																																								
<3 weeks																																																								
Total	72.5%	74.9% (U)	75% (U)	≥80%	▲																																																			
Māori	76.4%	79.8% (F)	79.8% (F)	≥80%	▬																																																			
Pacific	82.6%	94.4% (F)	88.2% (F)	≥80%	▼																																																			
Other	70.2%	70.5% (U)	70.9% (U)	≥80%	▲																																																			
<8 weeks																																																								
Total	91.2%	91.6% (U)	91.2% (U)	≥95%	▼																																																			
Māori	94.1%	92.6% (U)	92.6% (U)	≥95%	▬																																																			
Pacific	91.3%	100% (F)	94.1% (U)	≥95%	▼																																																			
Other	88.7%	90.5% (U)	90.1% (U)	≥95%	▼																																																			
Addictions (Provider Arm & NGO): Age 0-19																																																								
<3 weeks																																																								
Total	72.1%	66.7% (U)	65.7% (U)	≥80%	▼																																																			
Māori	61.1%	69% (U)	62.5% (U)	≥80%	▼																																																			
Pacific	100.0%	100% (F)	0% (U)	≥80%	▼																																																			
Other	85.7%	60% (U)	72.7% (U)	≥80%	▲																																																			
<8 weeks																																																								
Total	95.6%	88.9% (U)	88.6% (U)	≥95%	▼																																																			
Māori	94.1%	92.6% (U)	92.6% (U)	≥95%	▬																																																			
Pacific	100.0%	100% (F)	0% (U)	≥95%	▼																																																			
Other	100.0%	93.3% (U)	100% (F)	≥95%	▲																																																			
Mental Health and Addiction Waiting Time: 0-19 years (Less than 3 Weeks)																																																								
<table border="1"> <caption>Data for Mental Health and Addiction Waiting Time: 0-19 years (Less than 3 Weeks)</caption> <thead> <tr> <th>Month</th> <th>Provider Arm Total (%)</th> <th>Addictions Total (%)</th> </tr> </thead> <tbody> <tr><td>Jul-17</td><td>70</td><td>75</td></tr> <tr><td>Aug-17</td><td>71</td><td>74</td></tr> <tr><td>Sep-17</td><td>72</td><td>73</td></tr> <tr><td>Oct-17</td><td>72</td><td>72</td></tr> <tr><td>Nov-17</td><td>73</td><td>71</td></tr> <tr><td>Dec-17</td><td>72</td><td>71</td></tr> <tr><td>Jan-18</td><td>74</td><td>73</td></tr> <tr><td>Feb-18</td><td>74</td><td>73</td></tr> <tr><td>Mar-18</td><td>72</td><td>71</td></tr> <tr><td>Apr-18</td><td>74</td><td>73</td></tr> <tr><td>May-18</td><td>73</td><td>73</td></tr> <tr><td>Jun-18</td><td>74</td><td>73</td></tr> <tr><td>Jul-18</td><td>74</td><td>70</td></tr> <tr><td>Aug-18</td><td>74</td><td>65</td></tr> <tr><td>Sep-18</td><td>74</td><td>66</td></tr> <tr><td>Dec-18</td><td>74</td><td>70</td></tr> </tbody> </table>						Month	Provider Arm Total (%)	Addictions Total (%)	Jul-17	70	75	Aug-17	71	74	Sep-17	72	73	Oct-17	72	72	Nov-17	73	71	Dec-17	72	71	Jan-18	74	73	Feb-18	74	73	Mar-18	72	71	Apr-18	74	73	May-18	73	73	Jun-18	74	73	Jul-18	74	70	Aug-18	74	65	Sep-18	74	66	Dec-18	74	70
Month	Provider Arm Total (%)	Addictions Total (%)																																																						
Jul-17	70	75																																																						
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55 12 months to December 2017

56 12 months to September 2018

57 12 months to December 2018



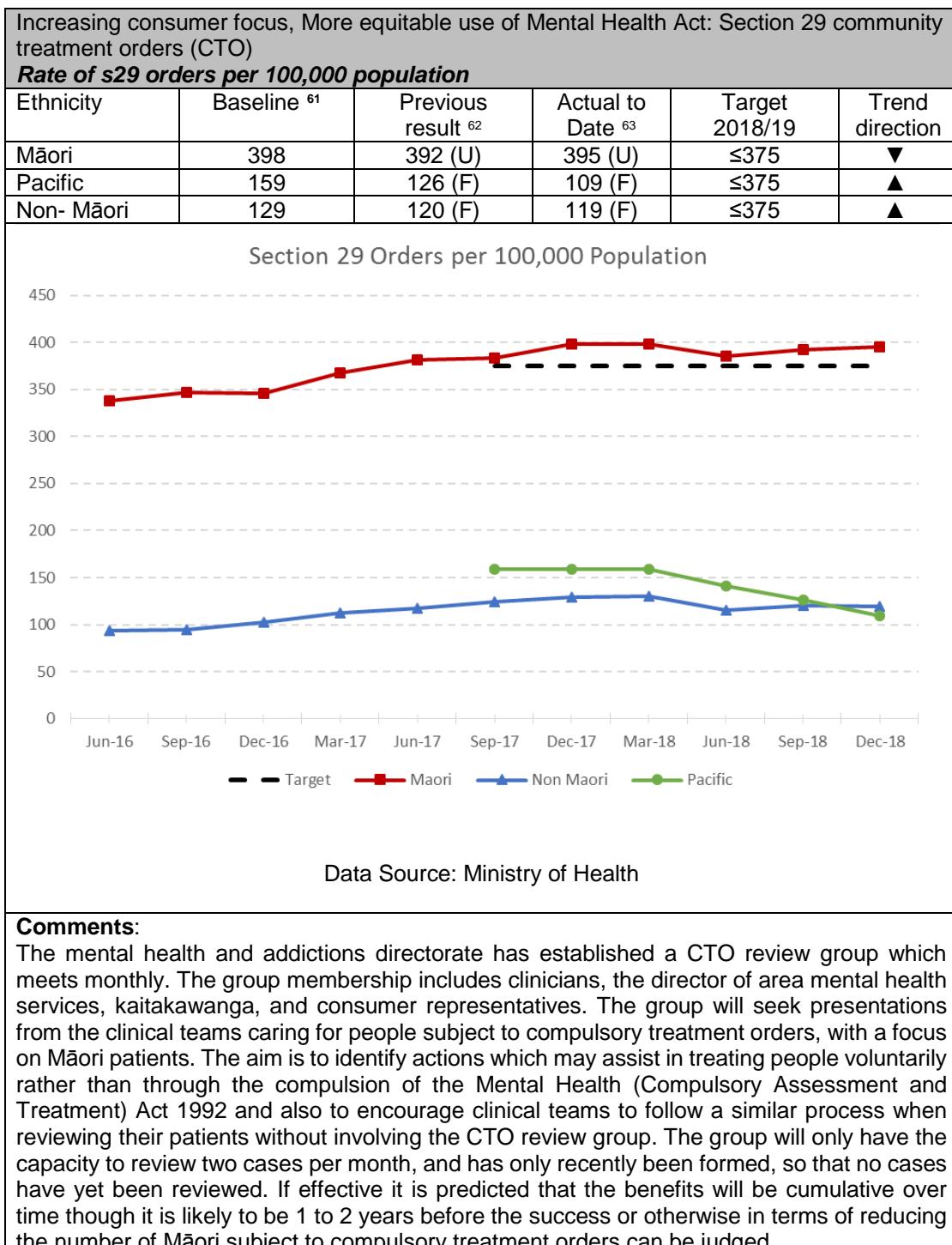
Improving mental health services using discharge planning					
% of clients discharged will have a quality transition or wellness plan					
Ethnicity	Baseline ⁵⁸	Previous result ⁵⁹	Actual to Date ⁶⁰	Target 2018/19	Trend direction
Transition Plan	-	79.8% (U)	78.5% (U)	≥95%	▼
Wellness Plan	-	99.3% (F)	99.3% (F)	≥95%	—
Inpatient Transition Plan	-	56.1% (U)	64.3% (U)	≥95%	▲

Comments:
The number of files audited for quality measures will increase in the next quarter and will include quality of inpatient plan data now being gathered. Please also note that our quality audit programme runs from February to November each year. In each quarter we expect to review between 180 and 270 for the quality measures.

58 October to December 2017

59 12 months to September 2018

60 12 months to December 2018

**RECOMMENDATION:**

It is recommended that the HBDHB Board:

1. Note the contents of this report

61 12 months to December 2017

62 12 months to September 2018

63 12 months to December 2018

 <p>HAWKE'S BAY District Health Board <i>Whakawāteatia</i></p>	Te Ara Whakawaiora – Child Health	56
	For the attention of: HBDHB Board	
Document Owner	Patrick Le Geyt, Director Māori Health	
Champions	ASH 0-4 years – Chris Ash Child Oral Health – Robin Whyman Breastfeeding – Chris McKenna Child Healthy Weight – Bernard Te Paa	
Document Author(s)	Shari Tidswell, Intersectoral Manager, Te Puni Matawhanui Tracy Ashworth, Health Equity Advisor, Te Puni Matawhanui Jeanette Frechling, Acting Deputy Director, Communities, Women, and Children's Directorate Marie Beattie, Planning and Commissioning Manager, Primary Care Directorate Charrissa Keenan, Programme Manager, Te Puni Matawhanui	
Reviewed by	Māori Relationship Board, Consumer Council, Clinical Council and Executive Management Team	
Month/Year	May 2019	
Purpose	<p>The purpose of this report is to present information about the status of Child Health and equity targets for:</p> <ul style="list-style-type: none"> • ASH 0 – 4years • Breastfeeding • Oral Health • Healthy Weight. <p>The report presents relevant data, progress to date, and advice about intended actions over the next 12 months to achieve respective equity targets.</p>	20
Previous Consideration Discussions	Previously each child health indicator was reported separately and annually; it is now presented as one report annually.	
Summary	<p>This is the first collective report on key Child Health indicators. Progress across all indicators has been mixed. Data shows:</p> <ul style="list-style-type: none"> • Increases in inequities in ASH 0 – 4 year olds, particularly for asthma, lower-respiratory infections, and cellulitis among Māori and Pacific children. • Child oral health shows some improvement in the number of caries free children at age five across all ethnic groups but no equity gain, and an increase in ASH GA dental rates. • There has been a slight improvement in breastfeeding rates across Māori, Pacific, and high deprivation groups. • HBDHB is meeting the target for Child Healthy Weight. <p>Over the past year, concerted and considered efforts have been applied to develop and implement whanau-centred, equity focused actions, but it's too early to know how effective or what difference these efforts are</p>	

	<p>having on equitable health outcomes for tamariki Māori, Pacific, and Other children of low socioeconomic backgrounds. The oral health prevention initiative and the Māori breastfeeding service are examples of these efforts and while showing positive signs of responsiveness to whānau Māori, will be monitored for their equity impact over the coming quarters.</p> <p>In addition to the actions and activities outlined in this report, a new programme is proposed to establish a Child Health kaupapa to lead, influence, monitor and track how we develop, deliver, fund child health across HBDHB. This will bring a more cohesive and collaborative approach to organising child health activities across the organisation, and will ensure health areas are working unitedly toward equitable health outcomes for tamariki.</p>
Contribution to Goals and Strategic Implications	Health Equity report 2018 – Actions to create a responsive and equitable health system and services; Clinical Services Plan - Whanau centred, kaupapa Māori approaches; HBDHB expectation - Equitable health outcomes for Māori.
Impact on Reducing Inequities/Disparities	Tamariki Māori, Pacific, and children from low socioeconomic background are prioritised in planning, development, and service implementation. The implication is improved health outcomes for the poor and under-served tamariki and their whānau.
Consumer Engagement	Included where appropriate in respective planning and development activities within each child health indicator.
Other Consultation /Involvement	Not applicable
Financial/Budget Impact	Not applicable
Timing Issues	Not applicable
Announcements/ Communications	Not applicable
RECOMMENDATION:	
It is recommended that the HBDHB Board:	
<ol style="list-style-type: none"> 1. Note the contents of the report. 2. Note the planned improvements and activities over the next 12 months to achieve equitable health outcomes for tamariki. 3. Support the intention to establish a Child Health kaupapa to bring a more cohesive and collaborative approach to track progress and improve effectiveness in child health activities across the organisation. 	



CHILD HEALTH – TE ARA WHAKAWAIORA REPORT

Author/s:	Shari Tidswell, Intersectoral Manager Tracy Ashworth, Health Equity Advisor Jeanette Frechling, Acting Deputy Director, Communities, Women, and Children Marie Beattie, Planning and Commissioning Manager Charrissa Keenan, Programme Manager, Māori Health
Designation:	As above
Date:	May 2019

PURPOSE

This report presents the inaugural Child Health – Te Ara Whakawaiora report (report). The report provides information about the status of Child Health in Hawke's Bay with a description of relevant indicators, equity targets, and current and planned activities to achieve equitable health outcomes for tamariki Māori and other disadvantaged tamariki.

CONTEXT

Te Ara Whakawaiora (TAW) was first introduced in 2014 as an equity improvement programme where significant inequities in health outcomes exist between Māori and non-Māori. Following a review in 2018, changes were made to the Te Ara Whakawaiora programme to improve the way child and other health priorities are being actioned, tracked and reported across the organisation. For the first time, Child Health indicators are being collectively reported under a new Child Health TAW report that includes:

- ASH 0 – 4 years
- Breastfeeding
- Oral Health
- Child Healthy Weight

The above indicators were part of the previous TAW reporting, and were included because of their national and local significance. For the purposes of this report they have been retained however, recommendations are made in this report to ensure future indicators remain relevant and applicable to areas disproportionately affecting the health and well-being of tamariki Māori in Hawke's Bay.

WHY IS THIS INDICATOR IMPORTANT?

The HBDHB has committed to equitable health outcomes for Māori. Early childhood is recognised as critical to health equity, as children in families with limited economic resources often face multiple physical and psychosocial hardships in early childhood that can impact their health, and can result in lifelong consequences. To advance our commitment to equity it is imperative HBDHB health services and programs reflect whānau-centred approaches to grow and nurture pepi and tāmariki in a supported way with their whānau.

Evidence supports a number of health and intersectoral initiatives which, when designed well with communities improve maternal and child outcomes. Healthy nutrition including breastfeeding, on time immunisations, raising awareness of family harm, reducing harm from alcohol, tobacco and other drugs, supporting parenting and attachment programs and addressing mental health all reflect protective factors for early childhood. Aligned intersectorial initiatives to raise incomes, improve

housing conditions and provide high quality early childhood education also interact with the health sector to support healthy childhoods. Environments and practices which are responsive and culturally competent enhance health when intertwined with Te Ao Māori principles of health and wellbeing.

IMPLICATIONS

Child health kaupapa

In addition to the actions and activities outlined in this report, a new programme is proposed to establish a Child Health kaupapa with a Child Health Governance group to lead, influence, monitor and track how we develop, deliver, fund, and track child health across our region. This kaupapa will bring a more cohesive and collaborative approach to organising child health activities across the organisation, and will ensure health areas are working unitedly toward equitable health outcomes for tamariki.

It is proposed that the first tranche include: aligning Safe Sleep, Breastfeeding, and Smoking Cessation programmes. There are common risk factors across all three areas impacting on child health outcomes that would benefit from more joined up planning. This first tranche will test out this new approach and identify information needed to track progress and improve the effectiveness of child health services.

Governance and integration of child health indicators to maximise opportunities and leverage potential for targeted and sustainable programs of work is essential. Alongside the Child Health kaupapa we propose a fuller set of indicators reflective of the first 5 years of age be included in the next TAW annual report of Child Health, essentially a child focused Health Equity report to be published annually.

The new Child Health kaupapa is a partnership approach between Primary Care Service, Primary Health Organisation, Māori Health, Population Health, Maternity Services, Children Womens and Communities Services, and will also include community and whanau participation.

Annual Planning

The 2019/20 HBDHB Annual Plan includes measures of Child Wellbeing and intersectorial action of which this annual Child Health TAW report will measure progress of measures of health equity for our tamariki. By looking at the indicators we gain an understanding of the environments tamariki are experiencing which impact on their health. A number of these indicators reflect modifiable risk factors and inequities which often have underlying causal links, such as, smoking and unhealthy housing and yet are often looked at in isolation in terms of systems, strategies and monitoring.

Inclusion and exclusion of new child health areas

During the preparation of this report, it has been recommended that the following health areas be considered for inclusion in future Child Health – TAW reports. These areas are requested because of the significant immediate and long-term health and social impacts on tamariki health and well-being:

- Family Violence
- Smokefree
- Immunisation

It is also recommended that Child Healthy Weight be excluded from future reports because equity targets are being met.

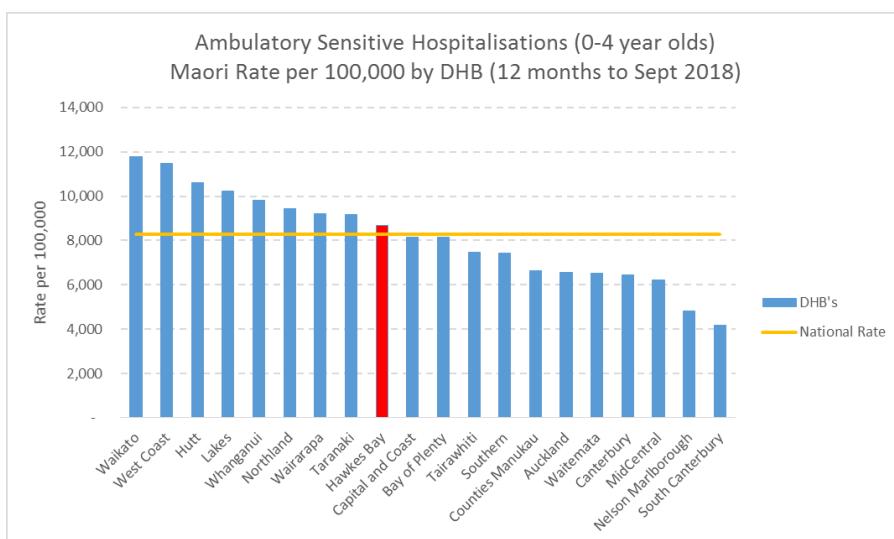
CHILD HEALTH PRIORITY INDICATORS

The table below provides a description of each priority health area, including: the indicator, measure, and the respective Equity Champion.

Priority	Indicator	Measure	Champion	Responsible Manager
Access <i>Local Indicator</i>	Reducing acute admissions of Ambulatory Sensitive Hospitalisations (ASH):		Chris Ash	Emma Foster Marie Beattie
	1. 0-4 year olds - dental decay, skin conditions, respiratory and ear, nose and throat infections.	$\leq 82\%$		
Breastfeeding <i>National Indicator</i>	Improve breastfeeding rates for children at 6 weeks, 3 months and 6 months:		Chris McKenna	Shari Tidswell Jules Arthur Charrissa Keenan
	1. % of infants that are exclusively or fully breastfed at 6 weeks of age;	$\geq 75\%$		
	2. % of infants that are exclusively or fully breastfed at 3 months of age;	$\geq 60\%$		
	3. % of infants that are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)	$\geq 65\%$		
Child Oral Health <i>National Indicator</i>	1. % of eligible pre-school enrolments in DHB-funded oral health services. 2. % of children who are carries free at 5 years of age	$\geq 95\%$ $\geq 67\%$	Robin Whyman	Liz Read Charrissa Keenan
Child Healthy Weight <i>National Indicator</i>	% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	$\geq 95\%$	Bernard Te Paa	Shari Tidswell

CHILD HEALTH PRIORITY: AMBULATORY SENSITIVE HOSPITALISATIONS (ASH) CHAMPION'S REVIEW

When compared to national rates, HBDHB ASH rates for tamariki Māori aged 0 – 4 years have worsened over the previous 12 months to September 2018. HBDHB is now ranked 12th compared to 8th in 2017¹.

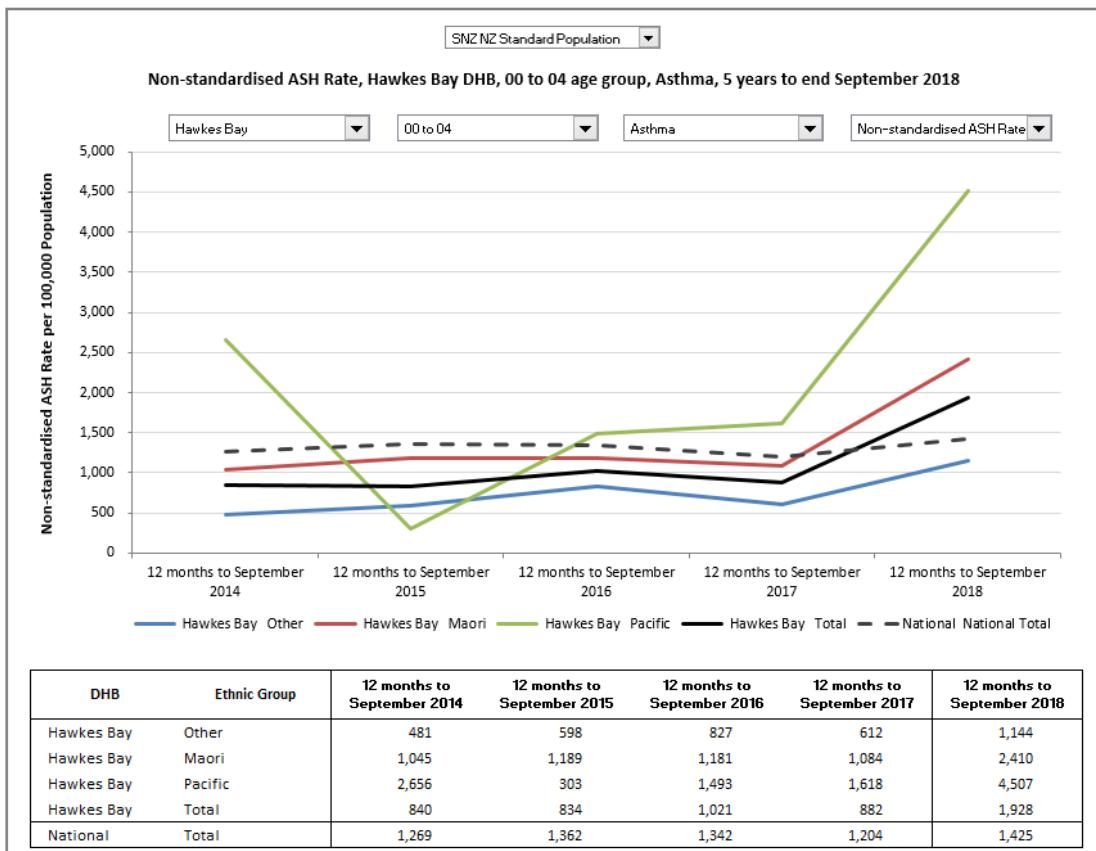


Graph 4. Hawke's Bay Māori ASH rates 0-4 age group 12 months to September 2018 – Benchmark against DHBs

Asthma

The ASH rate for Asthma 0-4 year olds has increased in the 12 month period from September 2017 (882) to September 2018 (1,982). This increase represents an additional 116 children admitted to hospital for asthma. Of these admissions, 67% were tamariki Māori, 28% Pacific children. The Pacific rate is particularly concerning; when compared with 2017 the rate increased by 190%.

¹ Note: Data is reported in the non-standardised format for this age band. It is important therefore to examine the number of events over a 12 month period and comparisons to previous periods to get a picture of progress or decline against specific ASH conditions.

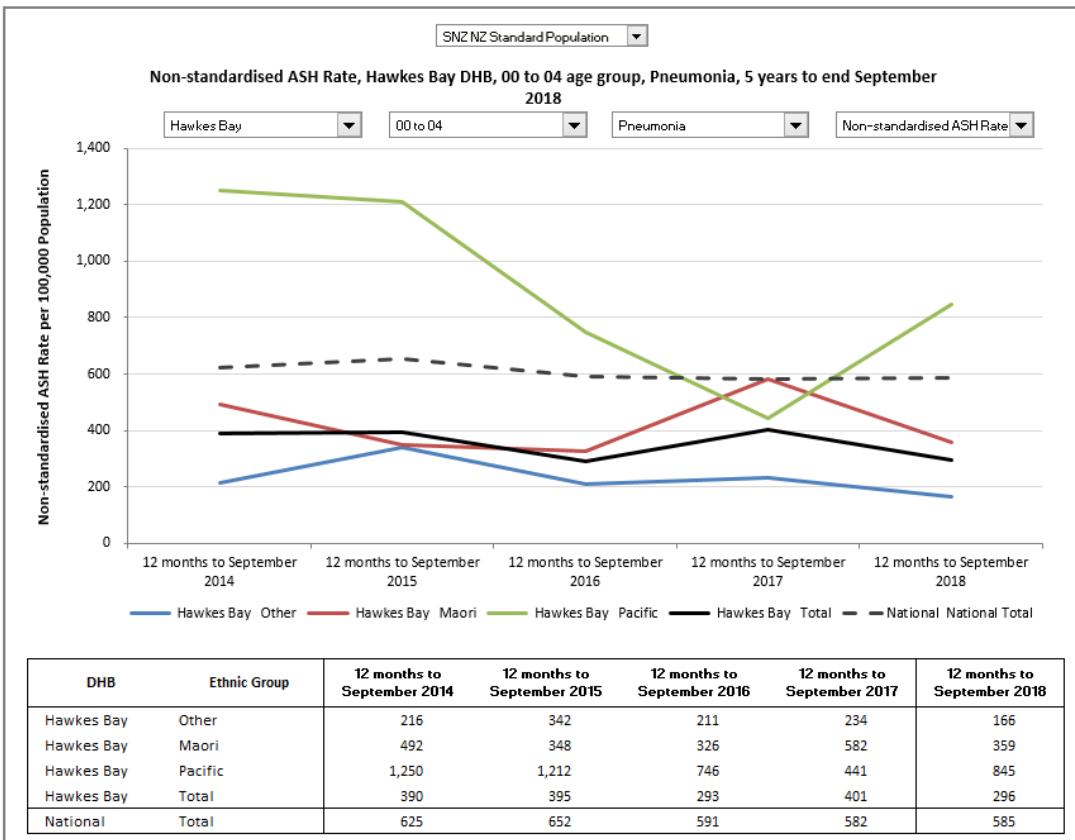


Asthma Events

DHB	Ethnic Group	12 months to September 2014	12 months to September 2015	12 months to September 2016	12 months to September 2017	12 months to September 2018
Hawkes Bay	Other	481	598	827	612	1,144
Hawkes Bay	Maori	1,045	1,189	1,181	1,084	2,410
Hawkes Bay	Pacific	2,656	303	1,493	1,618	4,507
Hawkes Bay	Total	840	834	1,021	882	1,928
National	Total	1,269	1,362	1,342	1,204	1,425

Pneumonia

The ASH rate for Pneumonia 0-4 year olds has decreased in the 12 month period from September 2017 (401) to September 2018 (296), this was due to a decrease of 12 events. Despite the overall rate decreasing, Pacific actually had an increase in its ASH rate, this was due to numbers going from 3 (12 months to Sep 2017) to 6 (12 months to Sep 2018). Māori events decreased by 9, from 29 (12 months to Sep 2017) to 18 (12 months to Sep 2018).



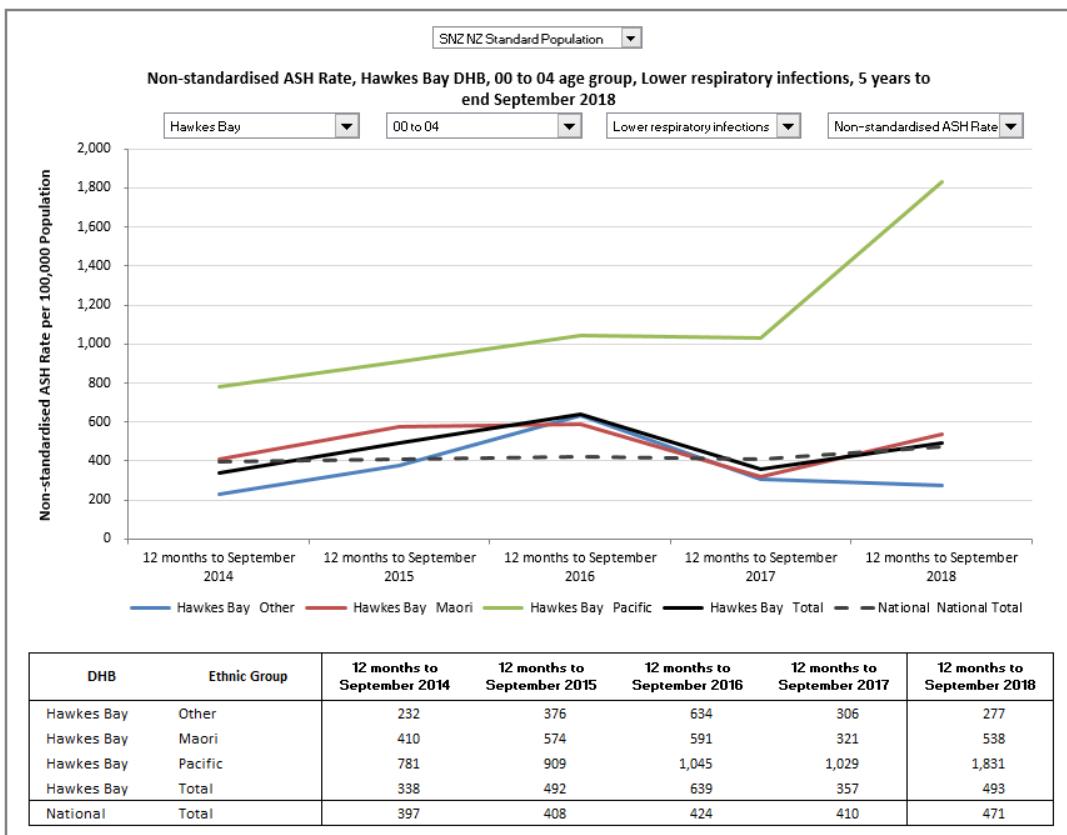
Events

DHB	Ethnic Group	12 months to September 2014	12 months to September 2015	12 months to September 2016	12 months to September 2017	12 months to September 2018
Hawkes Bay	Other	13	20	12	13	9
Hawkes Bay	Maori	24	17	16	29	18
Hawkes Bay	Pacific	8	8	5	3	6
Hawkes Bay	Total	45	45	33	45	33
National	Total	-	-	-	-	-

20

Lower respiratory infections

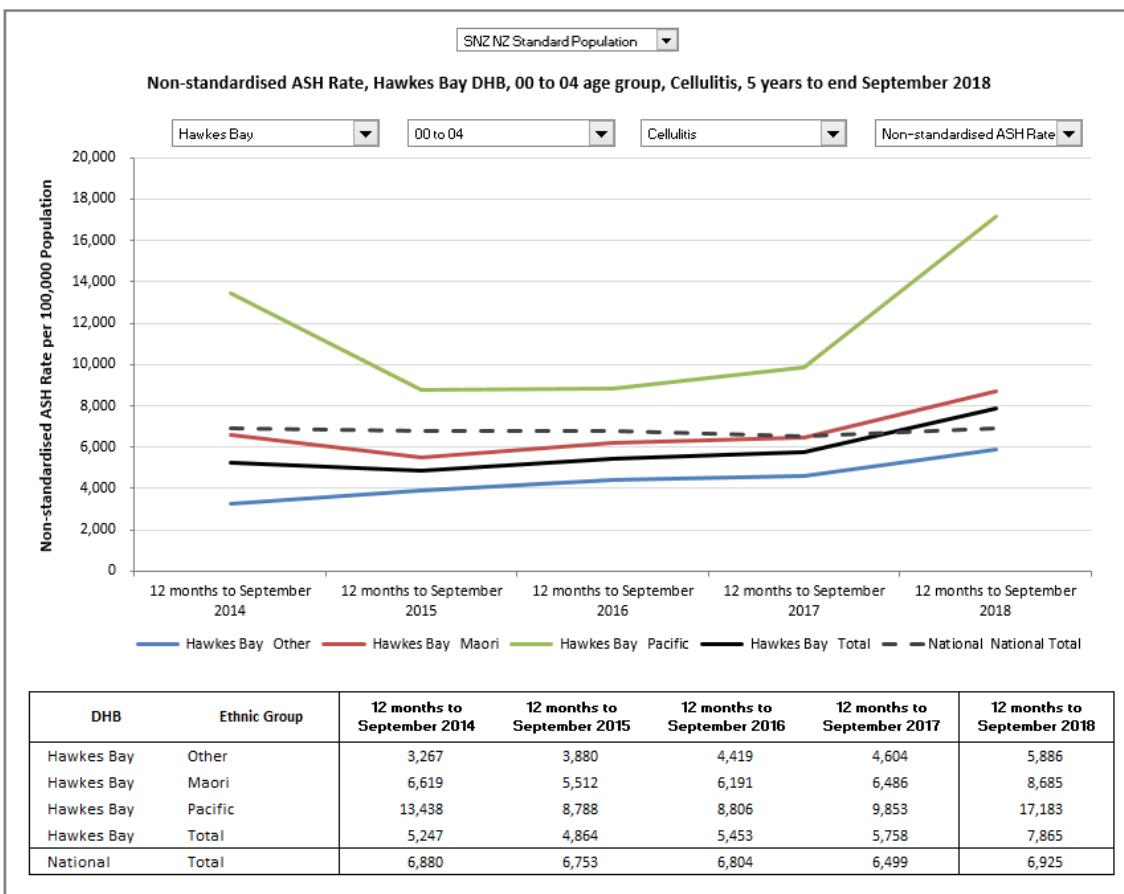
The ASH rate for Lower Respiratory Infections 0-4 year olds has increased in the 12 month period from September 2017 (357) to September 2018 (493), this was due to an increase of 15 events. Tamariki Māori saw the largest increase in actual events (11) and Pacific saw the largest increase in rate, this was due to events increasing from 7 (12 months to Sep 2017) to 13 (12 months to Sep 2018).



Events

DHB	Ethnic Group	12 months to September 2014	12 months to September 2015	12 months to September 2016	12 months to September 2017	12 months to September 2018
Hawkes Bay	Other	14	22	36	17	15
Hawkes Bay	Maori	20	28	29	16	27
Hawkes Bay	Pacific	5	6	7	7	13
Hawkes Bay	Total	39	56	72	40	55
National	Total	-	-	-	-	-

Cellulitis



Events

DHB	Ethnic Group	12 months to September 2014	12 months to September 2015	12 months to September 2016	12 months to September 2017	12 months to September 2018
Hawkes Bay	Other	3,267	3,880	4,419	4,604	5,886
Hawkes Bay	Maori	6,619	5,512	6,191	6,486	8,685
Hawkes Bay	Pacific	13,438	8,788	8,806	9,853	17,183
Hawkes Bay	Total	5,247	4,864	5,453	5,758	7,865
National	Total	6,880	6,753	6,804	6,499	6,925

The ASH rate for Cellulitis 0-4 year olds has increased in the 12 month period from September 2017 (5,758) to September 2018 (7,865), this was due to an increase of 231 events. Tamariki Māori saw the largest increase in actual events (113) and Pacific saw the largest increase in rate, this was due to events going from 67 (12 months to Sep 2017) to 122 (12 months to Sep 2018) a 82% increase.

CHAMPION'S REPORT OF ACTIVITY TO INCREASE PERFORMANCE OF THIS INDICATOR ANALYSIS AND ADVICE: ASH 0 – 4 YEARS

Respiratory support for tamariki and their whanau

Following a 2017 review of the ASH 0 – 4 respiratory care pathway an action plan was developed to provide better, responsive, and appropriate support for tamariki and their whānau with a respiratory illness. Overseen by an ASH 0 – 4 Respiratory Working Group, actions implemented in the previous 12 months include:

- Improvements to the respiratory referral pathway
- Process to ensure every child admitted to hospital receives a referral to the Child Healthy Housing Programme
- Paediatric respiratory training for primary care respiratory nurse champions to improve confidence working with young children

- Improvement to the primary care respiratory care pathway for following up whanau in the community after a hospital admission
- Winter respiratory support pilot programme.

A main finding of the review identified HBDHB do not fund a child respiratory support service. Without any resources or dedicated funding, the Working Group has not been able to implement any actions that have resource implications. To mitigate this lack of prioritisation, Māori health using Well Child Tamariki Ora quality improvement funding, invested in a pilot winter respiratory support service for the 2018 winter months. Whilst the program was positive in regards to the upskilling of staff and kaiawhina in respiratory care for tamariki, the service did not have the intended impact at the whanau level.

Current activity: A main barrier to the winter pilot was the timely access to information from secondary to primary care services to enable immediate support and follow up in the home when the child was sick. Learnings from the pilot have been considered by the ASH 0 – 4 Respiratory Working Group, and plans are underway to deliver a sustainable long term whanau-centred child respiratory support service. The service will be implemented in two phases over the coming 12 months:

- Phase 1) establishment of a Respiratory Resource Nurse Māori to directly support tamariki and their whanau who present to hospital for a respiratory related illness. The service will have a hospital presence but will be the link between secondary care services, whanau in the home, and their primary care provider.
- Phase 2) establishment of a Community based Respiratory Resource Nurse Māori based in primary care but interfacing with whanau and secondary care services.

Tamariki Māori living in Flaxmere disproportionately carry the burden of respiratory illness in Hawke's Bay with higher rates of presentations and admissions than any other group or location. Therefore, in the first instance, the service will support tamariki Māori living in the Flaxmere community.

The ASH 0 – 4 Respiratory Action Plan will also be reviewed and updated.

Child Healthy Housing program

The Child Healthy Housing Programme (CHHP) provides access to housing resources for whānau at risk of, or who have, a respiratory illness. Cold, crowded, damp housing leads to child illnesses such as respiratory infections. Key results of the CHHP show:

- 68.5% of all eligible referrals identify as whānau Māori, and 17.5% Pacific. There has been good progress to identify, refer, and assess whānau Māori and Pacific referrals compared to previous years.

In July 2018/19 whānau feedback was sought to gather information about the responsiveness and effectiveness of the CHHP. Feedback from whānau showed:

- 89% felt their home was warmer and drier; and their children less sick.
- 97% felt they had increased knowledge regarding maintaining a warm dry home
- 16% of tamariki had been admitted to hospital with ASH symptoms since receiving the intervention
- 2 whānau were re-referred to the CHHP as their circumstances had changed.

As housing is such an important determinant of health, the CHHP actively seeks opportunities to engage in other health and non-health areas to collectively work together to improve child health and well-being. These activities, which have a specific goal to improve equitable health outcomes for tamariki Māori include:

- HB Cot Bank – a programme for older pēpi to minimise barriers to access for whānau with limited or no means to provide a safe sleep environment for their babies once they have outgrown the wahakura/pēpi pod.
- 1000's of pairs of Jammies for June were distributed.
- HBDHB Government submissions to property legislation and housing standards have been enhanced with 'reality stories' and advocacy through the programme.
- A collaborative pilot with Habitat for Humanity homes are receiving minor repairs to maintain a thermal envelope and reduce dampness.
- Collaboration with companies/organisations such as Tumu Timbers and Red Cross to attain resources for warm dry homes at very low or no cost to whanau.
- Pathways and relationships with NGO's and Government Organisations, such as MSD, HNZC improves access to services and supports.

Current activity: A comparison of healthy homes program data between 2017/18 and 2018/19 has revealed a 40% increase in eligible referrals that were unable to be contacted/ or disengaged with the CHHP (17 to 42 whānau). An investigation to find out what is happening, and how we can improve this, is planned.

Supporting tamariki and their whānau with skin infections

The HBDHB Skin program aims to reduce admissions to hospital for skin infections and infestations. The programme promotes healthy skin, providing appropriate resources to support whānau with preventative measures, and facilitating access to early treatment.

After feedback from the Early Childhood Education Centres (ECE's) including Kohanga Reo, flip charts and talk cards have been produced in Te Reo Māori, Samoan and English. Resources have been distributed in each language to all education settings via Public Health Nurses who are trained to work with kaimahi. The resources are also available through outreach immunizations, B4 School Checks, Māori health providers, and have also been requested and shared with other regions. The program has also established links with Kidscan to support a head lice prevention pilot in seven ECEs that include Kōhangā Reo and Pacific Language Nests. The pilot involves education for staff regarding the treatment and prevention of head lice.

Tamariki aged 0 – 4 years can now access treatment for impetigo, boils, cellulitis, head lice and scabies when their older siblings are identified with skin infections at school. PHN with standing orders are able to provide treatment directly to whanau on the day. The Schools involved in the programme are targeted to low decile schools that have 1 – 2 visits per week by a PHN. Tracking ethnicity data for tamariki accessing this service is being investigated.

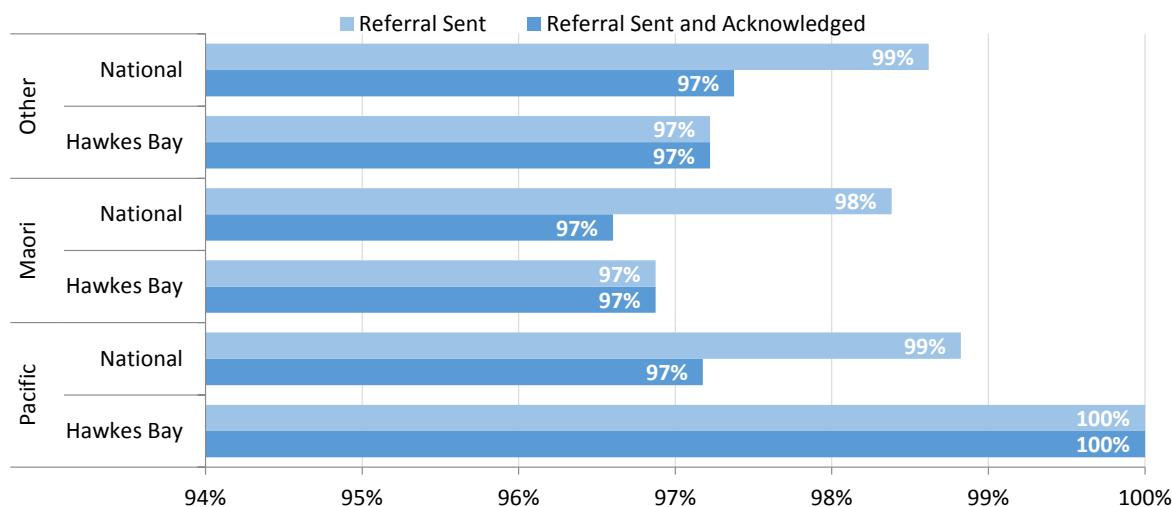
Current activity: An audit is underway for an in depth analysis of ASH rates for children admitted to hospital with preventable and/or recurrent skin infections and infestations. This will identify equity gaps for tamariki Māori.

Equitable immunisation rates

Childhood immunisation significantly reduces pneumonia and lower respiratory infections in children. Hawke's Bay continues to maintain equitable immunisation rates for tamariki Māori. However , one area of being monitored is the declining immunisation rates in infants aged under 8 months. 89.8% of infants were up to date with their immunisations at 8 months in the quarter ending 31 March 2019, down 3.5% from the previous quarter. Immunisation coverage is influenced by a complex mix of social, behavioural, demographic and structural factors. Immunisation data should be included in the proposed wider set of indicators for Child Health - TAW.

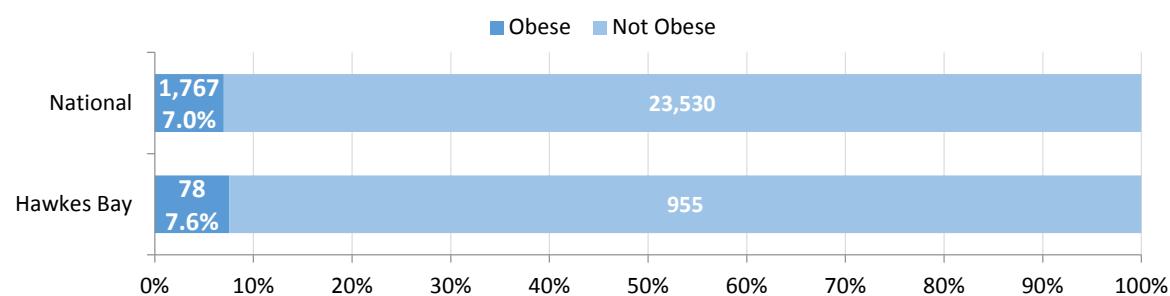
CHILD HEALTH PRIORITY: CHILD HEALTHY WEIGHT CHAMPION'S REVIEW

The national target for child healthy weight is - 95% of all children identified as obese are referred to a health professional for follow up support. The graph below shows that of the eligible tamariki Māori, 97% were referred for follow up support, and that referral was received. There is no equity gap for this target and the target has been consistently achieved for over a year.



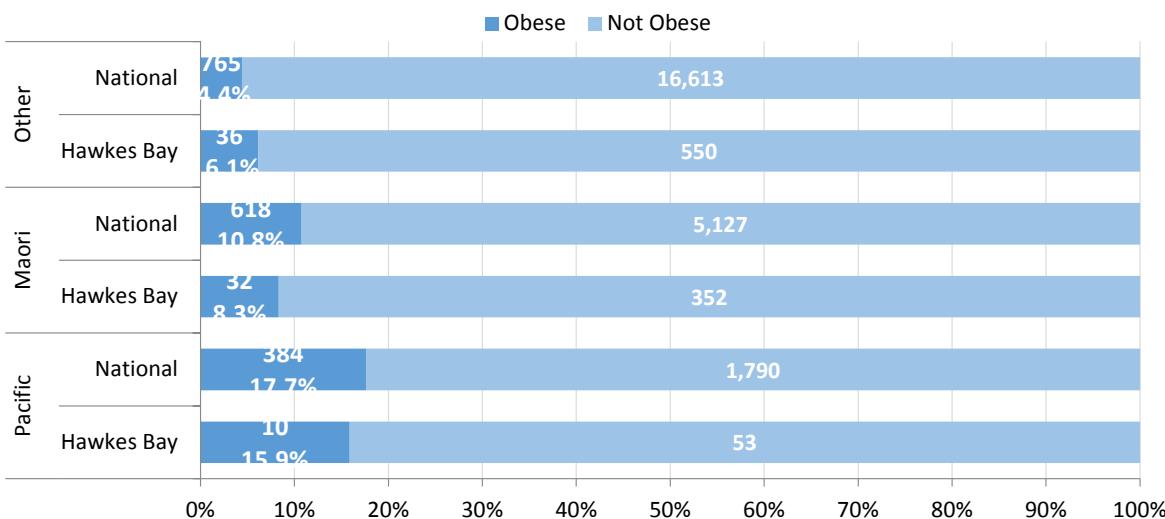
Graph 1: Child Healthy Weight Referrals sent.

Data collected at the Before School Check at age 4 years shows a continued decline in obesity rates in this age group at 7.6% for this quarter, and Hawke's Bay is moving closer toward the national average of 7%.



Graph 2: B4 school check percentage of tamariki Obese national versus HB comparison.

Graph 3 below shows tamariki Māori (8.3%) and Pasifika (15.9%) rates for obesity are lower than the national average (Māori 10.8% and Pasifika 17.7%). However, the small numbers for Hawke's Bay will require ongoing monitoring of this trend, but it is positive to see HBDHB moving toward a child health vision where **every** tamariki Māori gets a healthy start in the first four years of life.



Graph 3: B4 School check percentage of Obese tamariki in Hawke's Bay data by ethnicity.

CHAMPION'S REPORT OF ACTIVITY TO INCREASE PERFORMANCE OF THIS INDICATOR: ANALYSIS AND ADVICE: CHILD HEALTHY WEIGHT

Since 2016, HBDHB has continued to implement the HBDHB Best Start: healthy nutrition and activity Plan. The Plan delivers actions to support equitable healthy weight in four areas:

Increase healthy eating and activity environments: School programmes to support healthy environments in and around education settings. Early Childhood providers are using a healthy conversation tool to use with whānau to support healthy eating in early childhood. The tool was codesigned with Māori parents and Pacific parents. The next step is to work with Kohanga Reo to develop a reo/tikanga based tool.

Develop and deliver prevention programmes: supporting ante-natal programmes to support māmā to have a healthy pregnancy, including access to the Maternal GRx programme. Active Families programmes via Sport HB and Iron Māori are also funded for whānau. All programmes have achieved their Māori engagement targets. Active Families under 5 years has 82% Māori referral rates and for Maternal GRx 42% of hapū māmā referrals are Māori.

Intervention to support children to have healthy weight in the last 12 months an evaluation of Before School Check referrals has been completed to inform equity based improvements. A number of changes have been subsequently implemented including the referral pathway to ensure informed whanau decision making, and a new referral pathway for school aged children identified as needing supporting to achieve healthy weight. The evaluation targeted whānau Māori input and their feedback has been incorporated accordingly.

Provide leadership in healthy eating: a water only policy has been implemented in the Paediatric Ward. Besides the fact that fizzy drinks have no nutritional value, and are a major cause of tooth decay and a contributor to dental hospitalisations under GA, it was agreed it would not be appropriate to have fizzy drinks on the children's ward. Overall, whanau and staff have been receptive and supportive of the policy. HBDHB is considering extending the policy to other areas. HBDHB is supporting contracted providers to develop healthy weight policies.

CHILD HEALTH PRIORITY: BREASTFEEDING CHAMPIONS REVIEW

	Target	Total	Māori	Pacific	High dep	National
Jun-18	70%	52%	36%	35%	44%	59%
Dec-18	70%	57%	43%	58%	46%	58%

December 2018 data shows an increase in the breastfeeding rate at 3 months old across all ethnicities and high deprivation groups. However, there is a persistent equity gap still evident across all these groups, and still well below the national rate, and national target of 70%.

CHAMPION'S REPORT OF ACTIVITY TO INCREASE PERFORMANCE OF THIS INDICATOR ANALYSIS AND ADVICE: BREASTFEEDING

HBDHB is undertaking a program of work that reflects our commitment to achieving equitable breastfeeding outcomes for Māori and also alignment of Child Health indicators. To inform our decision making and to improve our response to māmā Māori and their whānau, interviews with fifty māmā Māori from a 2017/18 birth cohort were conducted in September 2018. Breastfeeding issues and a lack of breastfeeding support was one of the main challenges māmā identified after the birth of their baby. Māmā expressed feelings of confusion and isolation during this difficult time but also desperately wanting to do their best for pēpi.

Maternity Service, Population Health, Primary Care, and Māori Health are working closely to better design and deliver breastfeeding support for māmā Māori. A main piece of work ahead is the proposed establishment of a Child Health kaupapa; breastfeeding will be included under this umbrella of work. Activities to date are outlined below.

Māori Breastfeeding Support Service

Māori Health has invested in a whanau-centred breastfeeding support service for māmā Māori delivered by all three Well Child Tamariki Ora services. The service is delivered by lactation consultant and/or peer support outreach to whanau in the home and community settings. The service provides added support targeted specifically to whānau Māori to help establish and maintain breastfeeding through those first few months. The services have only been in place since October/November 2018 but are already reporting positive activities and feedback from whanau, including:

- Visits in the home are good with a māmā sharing, '*Thank you for your help today...it means a lot that you came over*'. Visits in the home also enables other whanau to be present and involved. Whanau are willing and eager to gain knowledge and how to support māmā and pēpi
- Māmā are using texting to communicate with the LC to share how their breastfeeding is going, which also allows the LC to adapt support for māmā as needed
- Māmā are expressing that the ongoing support phone calls are appreciated as they feel valued and supported during times of vulnerability and uncertainty.

Current activities: growing the service to reach māmā that need breastfeeding support, establishing and embedding referrals pathways, collaboration with the other WCTO breastfeeding support services. Actions are also underway to improve mental health support for māmā.

Hospital to Home – Breastfeeding support

An aligned investment from population health into the community midwifery team was to support transition from hospital to home with increased visits available for breastfeeding to determine if more time spent post natal with women in the home improved rates. Due to staff pressures in midwifery this position has not been realized.

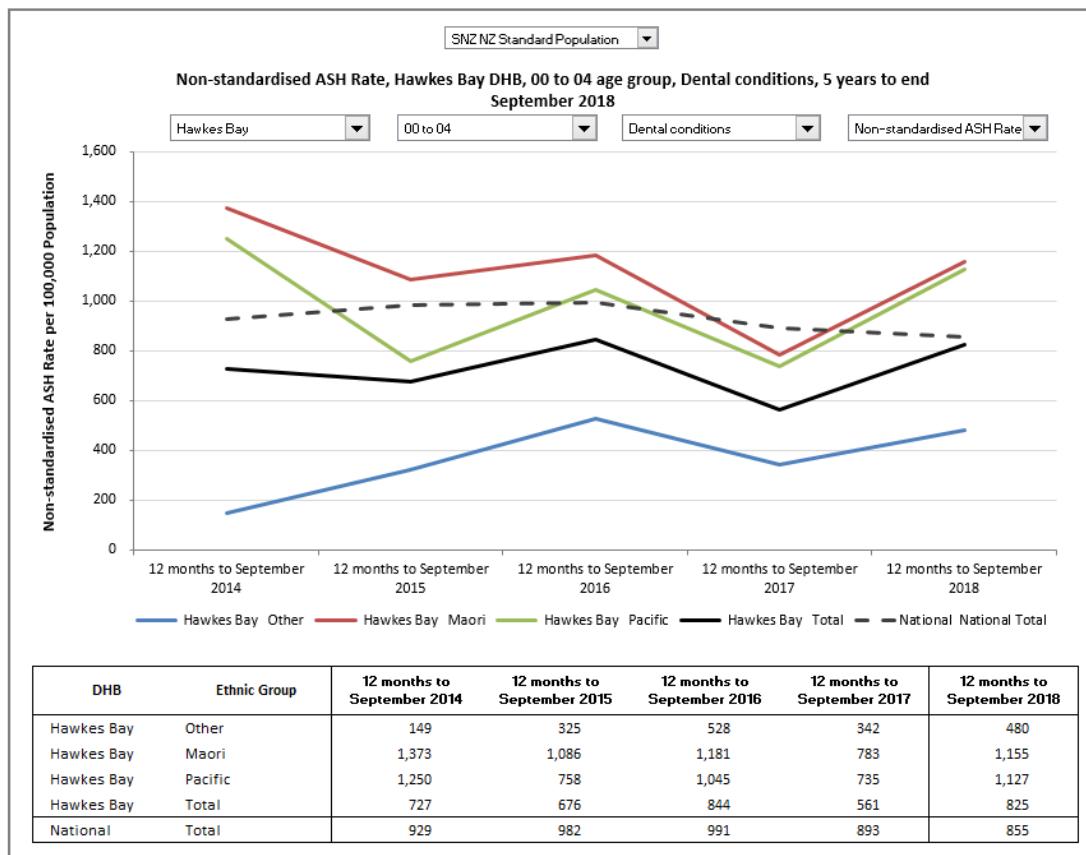
Current activity: Previous investment recommendations for a Kaiawhina role to actively engage with māmā and provide a defined early post-natal resource dedicated to breastfeeding and an engagement point between LMCs, Maternity Services and the community based support services are being re-scoped.

Kaupapa Māori Health Programmes

Two Māori health providers are currently in the process of developing Kaupapa Māori Maternal Health Programmes. The programmes will have a specific emphasis on breastfeeding support for māmā Māori, and to work with whānau to identify any unmet needs. One of the providers is due to start the programme by 1 July 2019, the other will likely be in 2020.

Whanake te Kura is the HBDHB funded ante-natal education programme. Delivered by a local Māori health provider, the programme includes information to support establishing and maintaining breastfeeding, and where to go for breastfeeding support. The programme is receiving very positive feedback from whānau.

CHILD HEALTH PRIORITY: DENTAL CHAMPION'S REVIEW

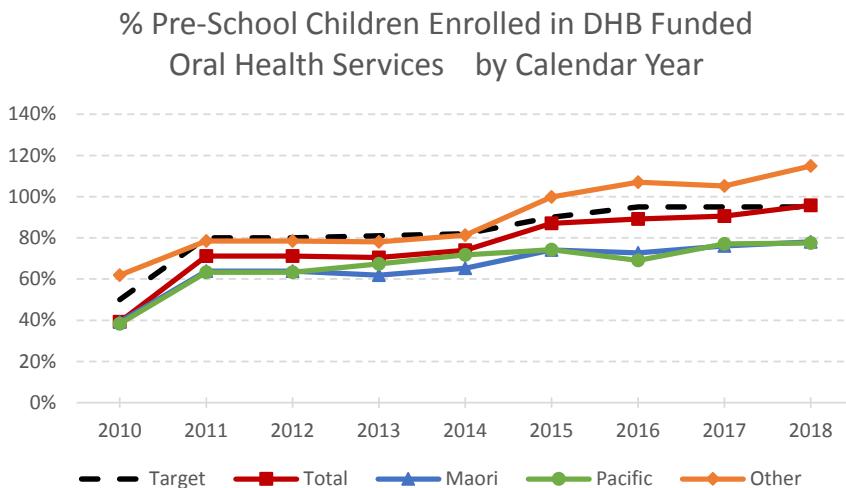


Events

DHB	Ethnic Group	12 months to September 2014	12 months to September 2015	12 months to September 2016	12 months to September 2017	12 months to September 2018
Hawkes Bay	Other	9	19	30	19	26
Hawkes Bay	Maori	67	53	58	39	58
Hawkes Bay	Pacific	8	5	7	5	8
Hawkes Bay	Total	84	77	95	63	92
National	Total	-	-	-	-	-

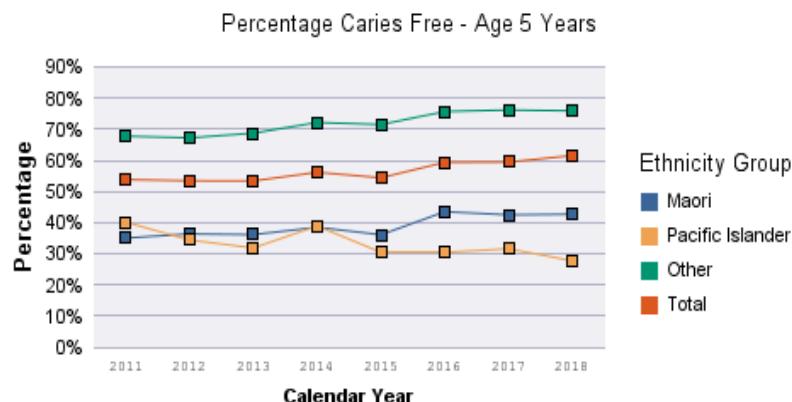
The ASH rate for Dental 0-4 year olds has increased in the 12 month period from September 2017 (561) to September 2018 (825), this was due to an increase of 29 events or an additional 29 tamariki admitted to hospital for dental under a general anaesthetic. Māori saw the largest increase in actual

events at 65% (19) and Pacific saw the largest increase in rate, this was due to events increasing from 5 (12 months to Sep 2017) to 8 (12 months to Sep 2018).



	Target	Total	Māori	Pacific	Other
2010	50%	39%	39%	38%	62%
2011	80%	71%	64%	63%	78%
2012	80%	71%	64%	63%	78%
2013	81%	70%	62%	67%	78%
2014	82%	74%	65%	72%	81%
2015	90%	87%	74%	74%	100%
2016	95%	89%	73%	69%	107%
2017	95%	91%	76%	77%	105%
2018	95%	96%	78%	77%	115%

It is pleasing to note the target of 95% enrolment has been met, although with caution due to data challenge. The data challenges are evident from the recording of 115% of tamariki identified as Other. This is being actively addressed within both the Oral Health Service and Information Services. Previous work in 2017 checked that the Oral Health database is capturing the correct ethnicity as provided to Oral health. The concern remains accuracy of the denominator used to calculate the indicator which is externally provided from Ministry of Health data, or the accuracy of initial ethnicity capture at time of birth and used for quadruple enrolment of children at birth in HB health services.



% Caries Free	2011	2012	2013	2014	2015	2016	2017	2018
Māori	35.1%	36.4%	36.2%	38.5%	36.1%	43.5%	42.5%	42.7%
Pacific Islander	40.2%	34.4%	31.9%	38.9%	30.5%	30.5%	31.6%	27.8%
Other	67.3%	65.5%	66.9%	70.8%	70.1%	74.2%	75.1%	75.2%

Total:	53.8%	53.5%	53.4%	56.2%	54.4%	59.4%	59.5%	61.6%
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The target of 67% caries free has not yet been achieved for Māori or Pacific children, and results for both groups remain particularly concerning. A small closure of the inequity of Māori to Other in the 2016 period has been maintained but not improved. The inequity for Pacific children may have increased in 2018, although very small numbers in this group do cause greater year to year data movements.

The percentage of children caries free (decay free) at 5 years measures the proportion of children that are 5 years of age, and commencing school education without dental decay severe enough to have caused cavitation (holes) to develop in the primary teeth. Caries free at 5 years is an important indicator as longitudinal studies indicate that children with good early childhood oral health have improved Year 8, adolescent and adult oral health. Children that are free of dental decay in the preschool and early primary school years are also less disrupted with education, eating and sleeping and have better general health.

CHAMPION'S REPORT OF ACTIVITY TO INCREASE PERFORMANCE OF THIS INDICATOR ANALYSIS AND ADVICE: ORAL HEALTH

There is a stronger focus on equity within the Oral Health Service with concerted effort to deliver an whanau responsive, interdisciplinary, community engaged approach to the design and continuous improvement of oral health delivery.

A preventive clinical practice and a service focus on equity also exists in the context of the complex interplay of societal factors that affect oral health. The importance of ongoing DHB influences on improving these for tamariki cannot be underestimated when considering the oral health outcomes at 5 years. Environmental influences are also important. The caries free outcomes have been achieved in an environment of loss of access to community water fluoridation in Hastings during 2017 and 2018, and therefore no community water fluoridation across the whole DHB in that time. Specific assessment of the Hastings results for caries free Māori 5-year-olds indicates that the proportion of children caries free plateaued during that time following several years of sustained small improvements. In Central Hawke's Bay it appears the losses in the proportion of caries free Māori 5-year-old children sustained in the 2013-2016 period have continued through 2017 and 2018.

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Enrolment

There remains a potentially significant opportunity to progress enrolments for tamariki Māori, which do trend positively, but an apparent inequity between Māori and Other remains, contingent upon the data quality. Several workstreams within the Communities Women and Children Directorate's Oral Health Equity Under 5 years five project specifically target enrolment and we would expect to observe improvements, provided data quality can be assured.

Activity planned to support these indicators has been progressed since that outlined within the 2017 report. Many of the activities are now business as usual with an ongoing continuous improvement focus to ensure they are meeting expected outcomes. These include:

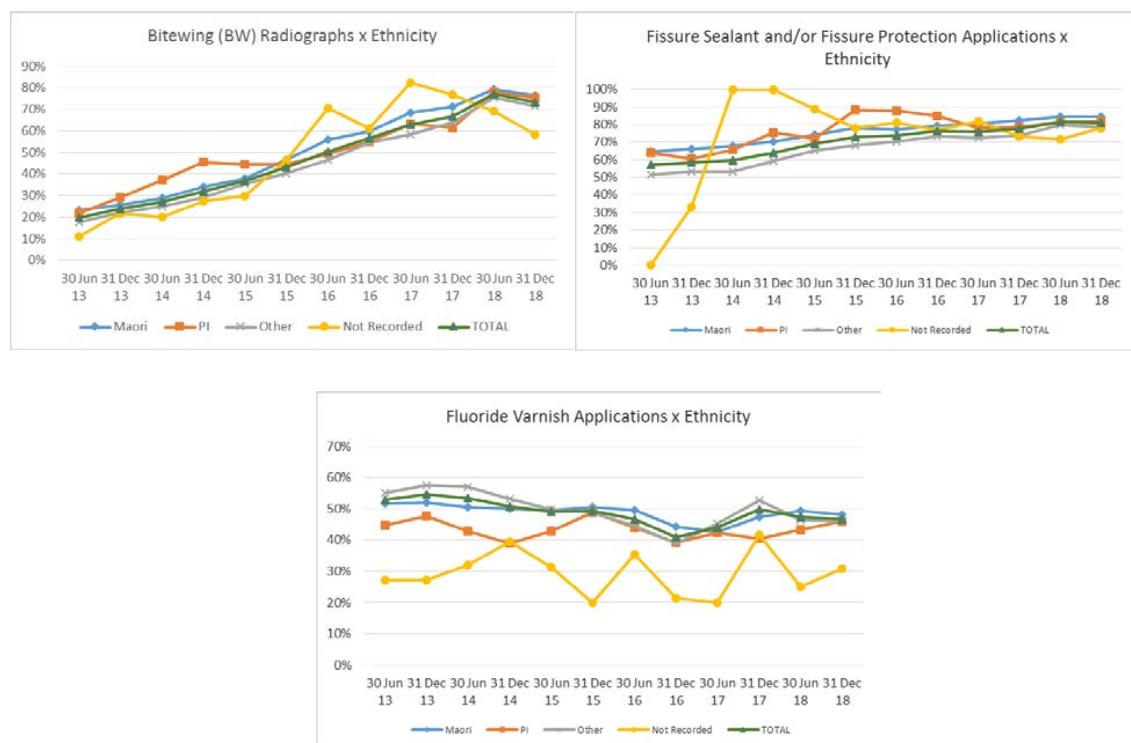
- Quadruple enrolment in the oral health service from birth, alongside enrolment for primary care, Well Child/Tamariki Oral and immunisation services.
- Population health strategies, including the delivery of oral health key messaging at other health touchpoints – including the Before School Check

Oral health prevention

In 2018, the focus was on ensuring preventive practice continued to strengthen across the Community Oral Health Service. The use of preventive clinical care measures including fluoride varnish, fissure sealants, and radiographs are monitored on an individual therapist level, with positive trends noted across the service. The aim of this activity is to ensure individual clinicians focus their clinical activity

on preventive oral health care, and not just interventional treatments. It also aims to ensure clinicians consider equity at a clinical level in their day to day work.

This ongoing work commenced in 2015-16 with a focus on three key quality indicators led by the Clinical Director. Progress is reflected in these graphs. Pleasingly these demonstrate that the highest rates of preventive interventions are provided for Māori and Pacific tamariki and that particularly for use of fluoride varnish in 4-year-old children the use for Māori and Pacific children has increased to levels consistent with appropriate consideration of clinical risk of dental caries and equity.



We are anticipating a further increase in the use of Fluoride Varnish now that the Kaiawhina is actively working under Standing Orders to provide Fluoride Varnish applications within community settings. Noting in the first six months of 2018 no fluoride applications were undertaken by the Kaiawhina, with 90 in the latter half of 2018, and 80 within the first three months of 2019. The clinical impact of these applications is unlikely to be clearly seen within the 'Caries free' indicator for 2-3 years as it is measured at 5 years of age. The number of tamariki Māori seen within this programme is also increasing as more Kohanga Reo engage, which will also be evident within the enrolled children indicator in time.

The focus of the Kaiawhina has been adjusted to meet the needs of the Community. While remaining focused on improving service utilisation for tamariki Māori (pre-schoolers in particular), most of the work is now through engagement with Te Kohanga Reo, facilitating engagement with the local hubs / mobiles and delivering a preventative package – including fluoride varnish and brushing programmes. The oral health team are seeing the benefits of this work as the oral health of tamariki visiting the clinics has already visibly improved.

The kaiawhinia also accepts referrals from the Outreach Immunisation team, who refer 15 month to 4 year old children who are not engaged with the dental service – these may be children who are new to Hawke's Bay or have changed address, phone numbers etc so have not been able to engage with the dental service easily. In the 12 months ending March 2019 44, children were referred .

Equity under 5 years project

The Under 5 years equity project is the key driver of activities to address the persistent inequities within Community Oral Health Services, although this is supported by additional changes within the service. Key achievements include:

- Ensuring workforce cultural responsiveness – 78.4% have now completed Engaging Effectively with Māori, and 92% Treaty of Waitangi training
- Changes within staffing allocation – to improve ratios of Therapist / tamariki in areas of high need; to provide cover across more work days for example two part-time Therapists now have a Hub open five days / week.
- Community Oral Health Service Model of Care review and decisions
- Te Roopu Mātua – Māori Oral Health Advisory Group
- Water-Only Policy in the Paediatric Services

Planned activities

Over the next 12 months a number of activities are planned to ensure we are consistent and persistent in our commitment to improve equitable oral health outcomes for Māori. There is a willingness and recognition across the workforce that 'doing the same thing will produce the same results'. Planned activities include:

- Initial presentation of an Oral Health Business case focused on increasing capacity of the workforce needs to be progressed with additional information
- Continue quality control of the ethnicity coding and patient status accuracy within the oral health patient management system (Titanium)
- Extend capacity of those providing fluoride varnish, exploring opportunities to train others in the application of fluoride varnish. Noting the standing order has provision for dental assistants to undertake this.
- Heath HB to trial the "lift the lip" at 5 month immunisation with 2 high needs practices (2019 - 2021)
- Agree recommendations from preschool child GA audit and develop action plan
- Continue to transition clinical service delivery towards a preventive care focus using clinical quality indicators to monitor service performance

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RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the contents of the report.
2. **Note** the planned improvements and activities over the next 12 months to achieve equitable health outcomes for tamariki.
3. **Support** the intention to establish a Child Health kaupapa to bring a more cohesive and collaborative approach to organising child health activities across the organisation.

 <p>HAWKE'S BAY District Health Board <i>Whakawāteatia</i></p>	<p>Tō Waha - A Whānau-Centred Collaborative Approach</p>	57
	<p>For the attention of: HBDHB Board</p>	
Document Owner	Bernard Te Paa, Executive Director, Te Puni Matawhānui	
Document Author(s)	Charrissa Keenan, Programme Manager, Māori Health	
Reviewed by	Māori Relationship Board & Executive Management Team	
Month/Year	May 2019	
Purpose	The purpose of this report is to provide information about the 'Tō Waha' – New Zealand Defence Force oral health initiative, what made it so successful, gaps and unrealised opportunities, and the planned next steps.	
Previous Consideration Discussions	A verbal summary was provided to the HBDHB Board on 3 rd April 2019. The Board subsequently requested more information about how HBDHB might implement future initiatives.	
Summary	<p>The Tō Waha initiative demonstrates what can be achieved when activities are established on whānau-centred, kaupapa Māori principles and practices, and the HBDHB core values. When this happens, a model is created where whānau are empowered, staff are working as one team, and equitable health gains are made.</p> <p>Key successes:</p> <ul style="list-style-type: none"> • Sector Collaboration: The Tō Waha team, which comprised a number of different community-facing organisations, was able to use networks to affect positive change among whānau that went beyond the individual and their immediate oral health need. • Person and Whanau Centred Care: Tō Waha was purposeful in it's the focus on whanau and ensuring every whanau member benefitted. • Community Led – 'Knowing Your Role': Communities were empowered when clinicians were able to focus solely on the technical skills they are trained to do, and communities and community-facing organisations determined the way the service was delivered. • Outcome Focus: When everyone committed to the kaupapa ('no empty dental chairs'), opportunities to respond to whānau need (not service needs) were maximized. • Community Branding: Tō Waha is now a trusted brand among whānau Māori and the wider community. • Community Participation: When the above were done well, whānau were willing and eager to be informed and involved in decisions to have control of their oral health. <p>Gaps and unrealised opportunities:</p> <ul style="list-style-type: none"> • A lack of primary care prevention involvement undermined opportunities to fully realise whānau health and well-being. 	21

	<ul style="list-style-type: none"> • Whānau miss out on important health messages and necessary support when we don't prioritise and normalise integrated approaches. • Given the high oral health needs across the community, there are still a lot of people living with poor oral health and in high dental pain.
Contribution to Goals and Strategic Implications	Health Equity Report 2018 – Actions to create a responsive and equitable health system and services; Clinical Services Plan - Whānau centred, kaupapa Māori approaches; HBDHB expectation - Equitable health outcomes for Māori
Impact on Reducing Inequities/Disparities	Prioritisation of those disproportionately affected and who do not enjoy the same level of oral health as Other New Zealanders. The implication is improved oral health outcomes for these under-served groups.
Consumer Engagement	Te Roopu Matua – HBDHB Māori Oral Health Advisory Group, and Whānau interviews and feedback at the Tō Waha event.
Other Consultation /Involvement	Tō Waha team (20+ attendees) held on 3 rd April 2019 to discuss learnings and successes. Informal local dental community feedback.
Financial/Budget Impact	The total cost of the Tō Waha kaupapa - \$27,307.00 GST Inclusive. The total sponsorship received - \$23,633.00 GST Inclusive. HBDHB Māori Health will cover the remaining \$3,674.00.
Timing Issues	HBDHB is carrying out a redesign and RFP process for a Whānau Ora oral health service that is due to be implemented in early 2020.
Announcements/ Communications	An article on the HBDHB and NZDF Tō Waha experience will be submitted to a peer reviewed journal. Whānau feedback gathered from Tō Waha will be used to inform local service design and changes as well as the development of a national Māori Oral Health Symposium to be held later this year.
RECOMMENDATION:	
It is recommended that the HBDHB Board:	
<ol style="list-style-type: none"> 1. Note the key learnings, successes, and unrealised opportunities of the Tō Waha kaupapa 2. Support the intention to: <ol style="list-style-type: none"> I. Set up a Charitable Tō Waha clinic for essential dental care for whānau with unmet need. II. Develop a long term sustainable Whānau Ora oral health service for adults, with strong links to primary health care and prevention. 	



Tō Waha – A Whānau-Centred Collaborative Approach

Author:	Charrissa Keenan
Designation:	Programme Manager, Māori Health
Date:	April 2019

OVERVIEW

In March 2019, New Zealand Defence Force (NZDF), Hawke's Bay District Health Board (HBDHB), local Hawke's Bay dentists, and the oral and general health community worked collaboratively to deliver oral health care to high need whānau living in Hawke's Bay. The initiative was part of the NZDFs deployment training, and in preparation for these possible situations, provide access to dental care to communities in Aotearoa New Zealand.

From the 11th to 22nd March, the Tō Waha initiative was held at the Cook Island Community Centre in Flaxmere. Over the 10 days, the NZDF ran six dental chairs (4 dentists and 2 hygienists), and HBDHB ran a two-chair dental clinic using a mobile dental unit (the Waka) which was kindly donated by the local Māori health provider, Te Taiwhenua o Heretaunga. The waka was run by the local HB dental community who kindly donated their time to the event.

Key results:

- 702 dental appointments (531 NZDF and 171 Waka)
- 1297 dental treatments (259 hygiene appointments, 391 fillings, and 647 extractions)
- 92% of whānau accessing dental care identified as Māori (70%) and Pacific (22%)
- 65% of patients were female, 35% male
- 42% of patients were aged between 30 – 49 years
- 33% of patients were aged between 18 – 30 years
- 183 stop smoking referrals

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SUCCESSES

Key successes of the Tō Waha initiative include:

- Sector collaboration
- Whānau focused
- 'No empty chairs' approach
- Community-led

Sector collaboration – Rāranga te Tira

The Tō Waha initiative was not led solely by, or for, HBDHB. A key point of difference early ongoing involvement of a range of community, health and wider-non-health sector stakeholders - that is typically not the norm when it comes to delivering dental care. This Rāranga te Tira relationships-based approach was integral to the planning, preparation, and delivery of Tō Waha. In total, about 60 volunteers participated, ranging from population health advisors, smoking cessation, and primary health care workers to Māori development advisors, Māori wardens, and Pacific navigators. Many local dentists gave up time to support the initiative. One local dental practice closed their practice on

World Oral Health Day and bought their dental team to participate. Local dentists, in total, provided an additional 171 treatments to whānau. (A list of volunteers is appended).

The event also attracted sponsorship from around the community. Te Puni Kōkiri covered venue costs, Royston Health Trust funded all dental supplies, GRS Generators supplied the generator for powering the Waka, Bostocks provided apples for the event, and One Pure donated bottled water throughout the event.

Community Led - Knowing Your Role – Rāranga te Tira, Tauwhiro, He Kauanuanu, Ākina

Tō Waha is an example of a model of care that is community centric with a whānau ora approach, where health services support whānau ways of knowing and doing health. While the NZDF provided the catalyst for the initiative, their approach was to have HBDHB take ownership over how the event would run. It enabled clinicians to focus solely on the technical skills they are trained to do and communities and community-facing organisations designing with community the way the service was delivered. This meant that health provider agendas were put aside, and community stakeholders were able to determine how to best work for whānau.

Because of how the kaupapa was developed, and the visibility and success of the event in the community, Tō Waha is now a trusted brand among whānau Māori. Given its name by the HBDHB Kaumatua Hawira Hape, Tō Waha not only signifies the importance of our mouths in every aspect of our lives in terms of how we speak, eat, smile, and generally, how we feel about ourselves, but it also represents the connection of Tō Waha, Tō Tīnana, Tō Whānau, Tō Ora. The link between our mouths, to our bodies, to our families, to our lives – an inseparable continuum that embraces Māori well-being.

Outcome Focus: 'No empty chairs' approach - Ākina

The To Waha team agreed the key principle underpinning the event would be 'No empty chairs'. The team realised that although demand would outweigh supply, the potential failure point would be Did Not Attend (DNA). Throughout the event a 7% DNA rate was experienced, which is still lower than other dental DNA rates.

The collaborative approach between the sectors involved, and the relationships with their respective communities was a key factor in keeping DNA rates low. They were key to locating and finding whānau to ensure that there were always whānau ready to be treated.

Person and Whanau Centred Care: Tō Waha, Tō Whānau – Tauwhiro, He Kauanuanu

Tō Waha was purposeful in its focus on whānau. In this sense, Tō Waha was consistent with HBDHBs intention to develop 'whānau centred approaches', and supports the aim of the government Oral Health Strategy, 'Good Oral Health, For All, For Life'. The initiative sought to lift the oral health status of whānau by targeting and providing essential dental care to everyone in the home aged over 18 years. It also provided ongoing plans to whānau to help them stay orally fit. Fundamentally, this approach is consistent with kaupapa Māori principles and practices that acknowledge the whānau-unit as central to relationships, decision making, and overall health and well-being.

Within this context, every person received:

- One on one motivational support to stay on a path of good oral health in the home
- Oral health resources for the whole whānau including age appropriate toothbrushes and toothpaste
- Motivational messaging to establish a change in behaviour and follow the key five oral health messages to support good oral health for the whole whānau
- Practical advice about how and where to find a dentist for them and their tamariki who will support their oral health aspirations.

GAPS AND UNREALISED OPPORTUNITIES

Gaps and unrealized opportunities of the Tō Waha initiative include:

- Unmet need
- Primary care prevention opportunities

Unmet need – Ākina, Tauwhiro

By the end of the event, there was a waitlist of more than 420 people that registered for the To Waha kaupapa and did not receive a dental appointment. Given the high oral health needs across the community, we suspect this waitlist is only a fraction of the people and is limited to people who 1) knew about the initiative, and 2) completed a registration form. A māmā who heard about Tō Waha afterward, who had been living in dental pain for months and faced the weekly dilemma of buying food for her family or spending money on her teeth, cried with disappointment, ‘*If only I’d known, I would’ve come*’.

Primary Care Prevention – Ākina, He Kauanuanu, Rāranga te Tira

“The way to be culturally competent and to narrow health disparities is to put services into culture rather than culture into services. This means to integrate services, functions and advice into individuals’ lives on their terms in personal partnership over time.”

Dr Katherine Gottlieb, CEO South Central Foundation

Primary care participation at the event was disappointing. Many were invited but chose not to participate. This was a missed opportunity for primary care providers to integrate health care services around priority populations on their terms; to engage, screen, educate, and link whānau with needed health care and support. Opportunities to check a patient’s blood pressure, plasma glucose, and cholesterol for indications of heart disease and diabetes mellitus would’ve added immense value to Tō Waha and to the overall efforts to help reduce the incidence and minimise the adverse impact of chronic conditions on the quality of life of people already living with, or at risk of, such illnesses. It also reflects a lack of integrated model where oral health is often an undervalued and overlooked area of health and well-being. A lack of integration can in fact prevent good health outcomes because failure to provide necessary primary care can undermine dental treatment outcomes and vice versa.

The participation of the HBDHB Smoking Cessation team throughout the whole event, however, was a very good example of integration with a primary care prevention approach with a leading health concern – tobacco consumption. As well as being a major preventable cause of premature death, tobacco is also a risk factor for oral cancers, periodontal diseases, and can also suppress the immune system’s response to oral infection, compromises healing following oral surgery, and promotes periodontal degeneration in diabetes and adversely affects the cardiovascular system (WHO¹, 2012). During Tō Waha the Smoking Cessation team completed 183 stop smoking referrals, and provided 107 packets of NRT. Of the referrals, 84% identified as Māori, 10% Pacific, and 5% Other.

Furthermore, an opportunistic visit by the cervical screening kaiwhakarite over two days resulted in 45 women who required follow up, 4 women who received breast screening, and additional support for women referred to other services, had no GP, or requiring further support.

¹ World Health Organisation. (2012). *Oral Health Priority Action Areas* [online]. Available from: http://www.who.int/oral_health/action/risks/en/index2/.html.

NEXT STEPS

To maintain the momentum of the Tō Waha kaupapa, the following activities are planned:

- To set up a bi-annual charitable Tō Waha oral health clinic to deliver essential dental care for whānau with unmet need
- To develop a long term sustainable oral health service with strong links with primary health care and prevention services, and greater regional coverage.

Tō Waha – Charitable kaupapa

There is a need to hold another Tō Waha event. Many people on the waitlist indicated high levels of dental pain and poor oral health. Untreated dental disease, while often not visible, can have a profound affect on a person's well-being, and like many of those who accessed the Tō Waha event, will at some point inevitably present to hospital for emergency care.

There is a lot of goodwill among the oral health community in Hawke's Bay. Many of the local dentists, hygienists, and dental assistants that participated in Tō Waha or who would've liked to, but weren't available at the time, have indicated they would be willing to be part of a future initiative. The Tō Waha team have also expressed they would assist in a future.

Forty-two percent of whānau that accessed Tō Waha were aged between 30 – 49 years. We noticed dental deterioration and unmet need among this group, and will therefore target the initiative to this group, but still maintain an inclusive whānau approach. Primary health care involvement will be a necessity, and whānau needing dental treatment will receive a whānau plan to ensure theirs and their whānau screening, immunisations, and other health checks are completed.

There are also opportunities to hold the kaupapa at minimal cost, including:

- Holding the event at the HBDHB Flaxmere Dental Hub – a two chair dental clinic which is currently vacant for around 80% of the year
- Seek charitable funding from the Royston Health Trust to fund dental supplies
- Seek local dental clinician support i.e. donate 2 days per year
- Seek HBDHB Community Oral Health Service agreement to use their treatment mobiles when not in use
- Seek wider sector buy-in and participation to fund and support the event

Tō Waha - Long term sustainable service

HBDHB Māori Health is currently redesigning a whānau centred oral health service. The service will be fully funded by HBDHB and will look to provide full dental treatment in an integrated way with primary health care interventions. Based on the learnings from Tō Waha the service must:

- Be underpinned by Kaupapa Māori principles and practices ensuring a responsive and appropriate service to whānau Māori
- While not exclusive, target 18 to 30 year old young people
- Include the primary health care components to maximize prevention and population health opportunities to advance whānau health and well-being
- Be delivered across the region from Wairoa to CHB
- Target high need groups including Māori, Pacific, and Other people from low socioeconomic backgrounds.

Māori Health are currently undertaking an RFP process and the service is due to be in place in 2020.

Listening to whānau – He Kauanuanu

When it comes to oral health service planning, investment, and delivery the focus is often monopolised by service centric designs and clinician-led motives. Whānau realities and aspirations for oral health

are often overlooked or their participation is not appropriately valued and included in a meaningful way. Tō Waha involved whānau who have been let down by the oral health system, and listening to their story, their oral health aspirations, and what is needed to make a difference for them was an important part of the Tō Waha Kaupapa Māori approach that seeks to empower those involved.

With support from the Māori Oral Health Quality Improvement Group, interviews with whānau were held at Tō Waha. The information will be used to:

1. Better respond to the oral health needs and aspirations of whānau Māori.
2. Inform and shape future Tō Waha initiatives.
3. Guide the development of a national Māori Oral Health Equity Symposium to provide a platform for national change.

A paper will also be submitted to a peer reviewed journal and presentations at relevant hui. Te Roopu Matua – the HBDHB Māori Oral Health Advisory Group will continue to play a key role in the development of oral health equity projects and Tō Waha initiatives.

FINANCIAL INFORMATION

The total cost² to hold the Tō Waha kaupapa was \$27,307.00 GST Inclusive. The total sponsorship received was \$23,633.00 GST Inclusive. Māori health will cover the remaining \$3,674.00.

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the key learnings, successes, and unrealised opportunities of the Tō Waha kaupapa
2. **Support** the intention to:
 - I. Set up a Charitable Tō Waha clinic for essential dental care for whānau with unmet need.
 - II. Develop a long-term, targeted, sustainable Whānau Ora oral health service for adults.

² All costs included in total budget, but outstanding invoices still to be received [as of 17 April 2019].

Appendix 1: List of HB dental volunteers

Dentist	Contact	Organisation
Laura Lee	laura.yunjeong.lee@gmail.com Dentist@parkside 514 Kennedy Rd, Napier	Dentist at Parkside
Natalie Stent	natalie.stent@xtra.co.nz	Peak Dental
Sarah Cruickman	cruicky21@hotmail.com>	Bishops Dental Surgery
Jo Jackson	joannadallimore@hotmail.com	
Isha Woodham	isha.akula@gmail.com	Golden Apple Dental
Donna Holder	donna.richard@xtra.co.nz	
Jocelin McIntosh	jocelinmcintosh@gmail.com	
Stephen Jenkinson	jenkinsons@xtra.co.nz	Jenkinson Dental Surgery
Jay Jesani	jaydip.jesani@gmail.com	David Marriot Dental
Helen Cho + dental assistants	Office_hchodental@xtra.co.nz	Helen Cho Dental
Nic Cutfield David Tyman + x2 DA	nic.cutfield@gmail.com	Bay Dental
Desmond Cheong	dhwcheong@yahoo.com	
Wynton Perrot + Hannah	hello@smilehaus.nz	Smile Haus
Dental Hygienist/Therapist		
Catherine Schillinger	Crs20002@hotmail.com 06 8760032	
Madeline Beserra	maddiebeserra@gmail.com	
Krissia De Rosario	Krizzia.DelRosario@hawkesbaydhb.govt.nz	
Deirdre Nieuwland	Deirdre.nieuwland@hawkesbaydhb.govt.nz	
Adele Cochrane	Adele.cochrane@hawkesbaydhb.govt.nz	
Dental Assistants		
Jan	napiermckinleys@yahoo.co.nz 844 0175	
Wendy Yates (hospital DA)	Wendy.Yates@hawkesbaydhb.govt.nz	
Sue Holloway	Sue.holloway@hawkesbaydhb.govt.nz	
Lerlene Wright	Lerlene.wright@hawkesbaydhb.govt.nz	
Andrea Pinto	Andrea.pinto@hawkesbaydhb.govt.nz	
Jasmine McDonald	Jasmine.macdonald@hawkesbaydhb.govt.nz <u>Z</u>	
Rachel Pere + Hope and Candice	Rachel.pere@ttoh.iwi.nz	

List of Volunteers

Name	Email	Organisation
Charrissa Keenan	Charrissa.Keenan@hawkesbaydhb.govt.nz	HBDHB
Rawinia Edwards	Rawinia.Edwards@hawkesbaydhb.govt.nz	HBDHB
Laurie Te Nahu	Laurie.TeNahu@hawkesbaydhb.govt.nz	HBDHB
Lisa Pohatu	Lisa.Pohatu@hawkesbaydhb.govt.nz	Te Puni Kokiri
Coralee Thompson	Coralee.Thompson@hawkesbaydhb.govt.nz	HBDHB
Rebecca Adams	Rebecca.Adams@hawkesbaydhb.govt.nz	HBDHB
Justin Nguma	Justin.Nguma@hawkesbaydhb.govt.nz	HBDHB
Cassie Aranui	aranc@tpk.govt.nz	Te Puni Kokiri
Farley Keenan	keenf@tpk.govt.nz	Te Puni Kokiri
Kelly Richards	Kelly.Richards@hawkesbaydhb.govt.nz	HBDHB
Tracy Ashworth	Tracy.Ashworth@hawkesbaydhb.govt.nz	HBDHB
Roya Ebrahimi	Roya.Ebrahimi@hawkesbaydhb.govt.nz	HBDHB
Rachel Pere	Rachel.Pere@ttoh.iwi.nz	TTOH
Julia Ebbett	Julia.Ebbett@ttoh.iwi.nz	TTOH
Johanna Wilson + team	Johanna.Wilson@hawkesbaydhb.govt.nz	HBDHB
Paul Faleono	Paul.Faleono@hawkesbaydhb.govt.nz	HBDHB
Rebecca Peterson	Rebecca.Peterson@hawkesbaydhb.govt.nz	HBDHB
Amataga Iuli	Amataga.Iuli@hawkesbaydhb.govt.nz	HBDHB
Simeona Sau	simeona.sau@totarahealth.co.nz	Totara Health
Ina Graham	ina@healthhb.co.nz	Health HB
Shari Tidswell	Shari.Tidswell@hawkesbaydhb.govt.nz	HBDHB
Phillipa Keenan	027 233 3138	Community
Wayne Ormsby	ormsw@tpk.govt.nz	Te Puni Kokiri
Silia Momoisea	Silia.Momoisea@hawkesbaydhb.govt.nz	HBDHB

Sponsors

Name	Email	Organisation
Janine Thompson	janinet@bostocks.nz	Bostocks
Kayran Hatherell	kayren@pkryouthservices.co.nz	Purena Koa Rehua Youth Services o Heretauga
Paul Kim	paul.kim@onepure.co.nz	One Pure
Noel Houston	GRS Generators	noel@grsnz.co.nz
Royston Health Trust	jessosullivan@icloud.com>	Royston Health Trust Board

 HAWKE'S BAY District Health Board Whakawāteatia	PRIMARY CARE AFTER HOURS SERVICE REVIEW	58
	For the attention of: HBDHB Board	
Document Owner	Chris Ash, Executive Director of Primary Care Wayne Woolwich, CEO, Health Hawke's Bay	
Document Author(s)	Peter Satterthwaite, GM Health Services & Innovation, Health Hawke's Bay Jill Garrett, Senior Commissioning Manager	
Reviewed by	Executive Management Team, MRB, Clinical Council & Consumer Council	
Month/Year	May 2019	
Purpose	Information only	
Previous Consideration Discussions	Te Pitau Health Alliance Support Group (17/04/19); Te Pitau Health Alliance Governance Group (scheduled for 08/05/19) Māori Relationship Board / Clinical Council / Consumer Council (8/05/19)	
Summary	Review of current After Hours primary care model	
Contribution to Goals and Strategic Implications	Strengthening Primary Health Care / Community based care delivery	
Impact on Reducing Inequities/Disparities	Achieving equitable access for priority populations	
Consumer Engagement	Consumer consultation (existing and new) will form part of the data resource to inform decision making	
Other Consultation /Involvement	Primary care sector engagement	
Financial/Budget Impact	N/A at this stage	
Timing Issues	N/A at this stage	
Announcements/Communications	N/A at this stage	

RECOMMENDATION

That the HBDHB Board:

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

OVERVIEW

A process has commenced to strategically review the current Primary Care After Hours service model alongside a review of the City Medical service contract. Key stakeholders have been engaged and a strategic approach to the review has been presented and endorsed at the After Hours Steering Group.

BACKGROUND

- A new Primary Care After Hours service model was implemented in December 2017 after a long process of review. A review drafted by Dr David Rodgers in August 2018 identified deficiencies and concerns with the model. For example, some parts of the service model are expensive and have low utilisation.
- Since the commencement of this model, City Medical has not been delivering the overnight GP availability aspect of their contract. In lieu of this, 12 months' notice on their current contract was issued in December 2018. Negotiations are well underway reviewing and negotiating a replacement contract. There are opportunities for City Medical to provide an expanded range of services which are being explored in separate discussions.
- The DHB continues to fund and support the overnight nursing service operated from City Medical and staffed by DHB employees.
- The current service model also has direct funding by the PHO sourced through a levy on capitation of practices.
- The overnight provision of services is the service being reviewed.

KEY ISSUES

- Overall the Napier based overnight service is considered to be relatively efficient and cost effective.
- There is no overnight service in Hastings apart from the HB Hospital Emergency Department (ED). Use of the ED is high with a low percentage of patients admitted. Indications are that there is a high Primary Care component to ED presentation. ED attendance by residents of suburbs surrounding HB Hospital is very high.
- A comprehensive 2018 ED attendance dataset has been obtained. Analysis of attendance patterns by domicile and decile by hour of day is underway to inform a future service model.
- A strategic framework for developing a new service model has been proposed and is currently being socialised.
- The current After Hours Governance Group have endorsed the intentions of the framework. Active discussions continue with City Medical and the wider Napier network as required.
- A Hastings Practice Working Group is being established to develop an evening and overnight service model.



Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

26. Confirmation of Minutes of Board Meeting 24 April - Public Excluded
27. Matters Arising from the Minutes of Board Meeting - Public Excluded
28. Board Approval of Actions exceeding limits delegated by CEO
29. Chair's Update
30. Finance Risk and Audit Committee

The general subject of the matter to be considered while the public is excluded, the reason for passing this resolution in relation to the matter and the specific grounds under Clause 32(a) of the New Zealand Public Health and Disability Act 2000 for the passing of this resolution are as follows:

- Official Information Act 1982 9(2)(ba) to protect information which is subject to an obligation of confidence.
- Official Information Act 1982 9(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions between the organisation, board and officers of the Minister of the Crown.
- NZPHD Act 2000, schedule 3, clause 32(a), that the public conduct of the whole or relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982).

