HAWKE'S BAY District Health Board
Whakawāteatia

# BOARD MEETING

**Date:** Wednesday, 24 February 2016

**Time:** 1.00pm

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

**Members:**
Kevin Atkinson (Chair)
Ngahiwi Tomoana
Barbara Arnott
Peter Dunkerley
Helen Francis
Diana Kirton
Denise Eaglesome
Dan Druzianic
Jacoby Poulain
Heather Skipworth
Andrew Blair

**Apologies:** -

**In Attendance:** Dr Kevin Snee, Chief Executive Officer
Members of Executive Management Team

**Board Administrator:** Brenda Crene

**Public Agenda**

| Item | Section 1 : Agenda Items | Ref # | Time (pm) |
|---|---|---|---|
| 1. | Karakia | | 1.00 |
| 2. | Apologies | | |
| 3. | Interests Register | | |
| 4. | Minutes of Previous Meeting | | |
| 5. | Matters Arising - Review of Actions | | |
| 6. | HB District Health Board Workplan | | |
| 7. | Chair's Report (verbal) | | |
| 8. | Chief Executive Officer's Report | 01 | |
| 9. | Financial Performance Report, December 2015 and January 2016 | 02 | |
| 10. | Consumer Story (Kate Coley) | | |

| | | | |
|---|---|---|---|
| | **Section 2: Reports from Committee Chairs** | | |
| 11. | HB Clinical Council (Dr Mark Peterson and Chris McKenna) | 03 | 1.40 |
| 12. | HB Health Consumer Council (Graeme Norton) | 04 | |
| 13. | Māori Relationship Board (Ngahiwi Tomoana) | 05 | |
| | **Section 3: Discussion / Information** | | |
| 14. | Health and Social Care Networks (Kevin Snee and Liz Stockley) | 06 | 2.05 |
| | **Section 4: Monitoring Reports** | | |
| 15. | Human Resource KPIs Q2 Oct-Dec 2015 (John McKeefry) | 07 | 2.20 |
| 16. | Te Ara Whakawaiora / Access - local indicator (Mark Peterson) | 08 | |
| 17. | HBDHB Non-Financial Exceptions Report Q2 Oct-Dec 15 (Tim Evans)<br>HBDHB Q1 Performance Monitoring Dashboard ex MoH | 09 | |
| 18. | Transform and Sustain Strategic Dashboard Q2 Oct-Dec 15 (Tim Evans) | 10 | |
| | **Section 5: Recommendation to Exclude** | | |
| 19. | Under Clause 32, New Zealand Public Health & Disability Act 2000 | | |

**Public Excluded Agenda**

| **Item** | **Section 6: Agenda Items** | Ref # | **Time (pm)** |
|---|---|---|---|
| 20. | Minutes of Previous Meeting | | 2.50 |
| 21. | Matters Arising – Review of Actions | | |
| 22. | Board Approval of Actions exceeding limits delegated by CEO | 11 | |
| 23. | Chair's Report (verbal) | | |
| 24. | Allied Laundry Services Ltd Report to Shareholding DHBs (Kevin Snee) | 12 | 3.00 |
| 25. | Preliminary Budget - Presentation (Tim Evans / Peter Kennedy) | | 3.15 |
| | **Section 7: Reports from Committee Chair** | | |
| 26. | HB Clinical Council (Dr Mark Peterson and Chris McKenna) | 13 | 3.25 |
| 27. | Finance Risk & Audit Committee (Dan Druzianic) | 14 | |
| | **Section 8: General Business** | | |

**Next Meeting: 1.00pm, Wednesday 30 March 2016**
**Te Waiora (Boardroom), HBDHB Corporate Administration Building**

**Tauwhiro Rāranga te tira He kauanuanu Ākina**

## Board "Interest Register" - 17 December 2015

| 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 | Chair of 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.<br>Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation. | The Chair of FRAC | 18.02.09 |
| | Active | Director of Unison Fibre Limited | Non pecuniary interest. Unison is now a provider of high speed broadband to the District Health Board. | Will not take part in any decision or discussions in relation to the provision of high speed broadband to the District Health Board | The Chair of FRAC | 17.11.10 |
| | Active | Director of Hawke's Bay Rugby Football Union (HBRFU) | HBDHB has a sponsorship arrangement with HBRFU. | Will not take part in any decisions or discussion in relation to the sponsorship arrangement. | The Chair of FRAC | |
| | 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 |
| 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:<br>(i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department.<br>(ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department. | Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB. | The Chair | 01.05.08 |
| | Active | Brother of Waiariki Davis | Perceived Conflict of Interest. Non-Pecuniary interest. Waiariki Davis is employed by HBDHB and is the Health Records Manager. | Will not take part in any decisions in relation to Health Records management. All employment matters in relation to Waiariki Davis are the responsibility of the CEO. | The Chair | 01.05.08 |
| | Active | Uncle of Tiwai Tomoana | Perceived Conflict of Interest. Non-Pecuniary interest.<br>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.<br>Numia Tomoana is employed by Cranford Hospice and works as a palliative care assistant and, in this role, works with chaplains at Hawke's Bay Hospital. | Will not take part in any decisions in relation to the Chaplain service at Hawke's Bay Hospital. | The Chair | 01.05.08 |
| Barbara Arnott | Active | Trustee of the Hawke's Bay Air Ambulance Trust | HBDHB has a partnership contract with Skyline Aviation who together operate the HB Air Ambulance Service which is supported by the Trust. | Declare this interest prior to any discussion on the HB Air Ambulance Services and Chair decides on appropriate mitigation action | The Chair | 10.05.10 |
| | Active | Daughter is Commercial Manager Food for Health Benefits Limited | Health Benefits Limited transitioning to a new company being a DHB lead, supported and owned company to be the vehicle for DHBs to collectively maximise shared service opportunities for the national good. | Declare this interest prior to discussion/decisions around Health Benefits Limited and newly named company around the provision of food to DHBs nationally and locally. | The Chair | 27.05.15 |
| Helen Francis | Active | Alzheimer's Napier previously a Committee member<br><br>Patron and Lifetime Member | Alzheimer's Society holds a contract with the HBDHB to provide dementia specific daycare and community services. | Will not take part in any decisions or discussion in relation to HBDHB contract with Alzheimer's Society | The Chair | 08.06.10<br><br>21.06.14 |
| | Active | Employee of Hastings Health Centre | Actual Conflict of Interest. Pecuniary Interest. | Will not take part in any decisions or discussions in relation to Hastings Health Centre. | The Chair | 18.02.09 |
| | 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.<br>Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation. | The Chair | 03.10.11 |
| | Active | HB Medical Research Foundation | Trustee | Declare this interest prior to any discussion in relation to the Foundation, and an appropirate mitigation action is decided on. | The Chair | 20.08.14 |

# Board Meeting 24 February 2016 - 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 by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO | The Chair | 18.02.09 |
| | Active | Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014 | Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers. | Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on. | The Chair | 16.01.14 |
| | Active | Son, Chris Kirton, GP in Wairoa employed by HBDHB | Non-pecuniary interest: Will not take part in discussions around employment of GP's in Wairoa | All employment matters are the responsibility of the CEO. | The Chair | 26.02.14 |
| | Active | Daughter-in-law, Eve Fifield, Paediatric Registrar with HBDHB | Non-pecuniary interest: Will not take part in discussions regarding paediatric registrars | All employment matters are the responsibility of the CEO. | The Chair | 26.02.14 |
| | 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.<br>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 | Daughter-in-law, Eve Fifield, undertaking Community Paediatricts Training at Starship Hospital Auckland for a brief time. | Non-pecuniary interest: Will not take part in discussions regarding paediatric registrars | All employment matters are the responsibility of the CEO. | The Chair | 14.12.15 |
| 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 |
| | Active | Director of Hawke's Bay Rugby Football Union (HBRFU) | HBDHB has a sponsorship arrangement with HBRFU. | Will not take part in any decisions or discussion in relation to the sponsorship arrangement. | The Chair | 7.12.10 |
| Denise Eaglesome | Active | Deputy Mayor of Wairoa District Council | Advocate as Deputy Mayor for Wairoa District, whereas HBDHB covers whole of Hawke's Bay | Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action. | The Chair | 28.02.11 |
| | 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 discussions in relation to the Trust. | The Chair | 05.03.14 |
| | Active | Coordinator for Health Contract for Rugby Academy in Wairoa | Health Contract with Wairoa Rugby Academy | Will not take part in any decisions or discussions in relation to this contract. | The Chair | 25.05.15 |
| Andrew Blair | Active | Owner of Andrew Blair Consulting Limited | Engaged from time to time to provide consultancy and advisory services to healthcare and other organisations. | Will not take part in decision relating to organistions to which he provide consultancy and advisory services. | The Chair | 04.12.13 |
| | Active | Advisor to Trustees and Management of Chelsea Hospital Trust | Engaged to provide advisory services to the Trust who own and operate the private hospital in Gisborne. | Will not take part in decisions relating to services HBDHB may from time to time engage. | The Chair | 24.07.14 |
| | Active | Advisor to Hawke's Bay Orthopaedic Group Ltd | Engaged to provide advisory services to the Group | Will not provide advice in relation to contracting, employment or relationship matters between the HBOG and HBDHB. Will not participate in any decisions made by HBDHB regarding orthopaedic services. | The Chair | 19.09.15 |
| | Active | Chair of Southern Partnership Group | Southern Partnership is to progress the facilities redevelopment of Dunedin Hospital. | Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair. | The Chair | 19.09.15 |
| | Active | Director, Breastscreen Auckland Limited | Breast screening facility. | Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair. | The Chair | 17/12/2015 |
| | Active | Director, St Marks Womans Health (Remuera) Limited | Womans Health facility in Auckland | Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair. | The Chair | 17/12/2015 |
| Jacoby Poulain | Active | Board Member of Eastern Institute of Technology (EIT) | Perceived conflict - HBDHB has a Memorandum of Understanding (MOU) with EIT relating to training and development in health related occupations | Will not take part in any decisions or discussions in relation to the MOU between HBDHB and EIT | The Chair | 14.1.14 |
| | Active | Councillor Hastings District Council | Potential conflict as potential advocate for Hastings District population whereas HBDHB coveres whole of Hawke's Bay | Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action. | The Chair | 14.1.14 |
| Heather Skipworth | Active | Daughter of Tanira Te Au | Kaumatua - Kaupapa Maori HBDHB | All employment matters are the responsibility of the CEO | The Chair | 04.02.14 |
| | Active | Trustee of Te Timatanga Ararau Trust | The Trust has a lifestyle Contract with HBDHB signed 31 January 2015 Awarded a Green Prescription Contract with HBDHB 11 February 2015 | Will not take part in any discussions or decisions relating to the Contract. | The Chair | 04.02.14 |
| 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 |

**MINUTES OF THE BOARD MEETING**
**HELD ON WEDNESDAY 16 DECEMBER 2015, IN THE TE WAIORA ROOM,**
**DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS**
**AT 1.00PM**

| | |
|---|---|
| **Present**: | Kevin Atkinson (Chair)<br>Ngahiwi Tomoana (arrived at 1.40pm)<br>Peter Dunkerley<br>Andrew Blair<br>Diana Kirton (arrived at 2.00pm)<br>Barbara Arnott<br>Jacoby Poulain<br>Denise Eaglesome<br>Helen Francis<br>Dan Druzianic |
| **Apologies** | Heather Skipworth |
| **In Attendance**: | Kevin Snee (Chief Executive Officer)<br>Members of the Executive Management Team<br>Dr Mark Peterson (Chair, HB Clinical Council)<br>Graeme Norton (Chair, HB Health Consumer Council)<br>Members of the public and media |
| **Minutes** | Brenda Crene |

**KARAKIA**

Ngahiwi Tomoana opened the meeting with a Karakia.

**APOLOGIES**

Apology for lateness had been received from Diana Kirton

**INTEREST REGISTER**

A short term interest advised by email on 14 December by Diana Kirton had been included in the Interest Register presented in the board papers.

Subsequently two interests were included for Andrew Blair on 17 December 2015.

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

**CONFIRMATION OF PREVIOUS MINUTES**

The minutes of the Board meeting held on 25 November 2015, were confirmed as a correct record of the meeting.

**Moved: Barbara Arnott**
**Seconded: Peter Dunkerley**
**Carried**

**MATTERS ARISING FROM PREVIOUS MINUTES**

Item 1: The following will occur during 2016 therefore the actions will be removed for the following: Combined Clinical and Consumer Meeting (three meetings staggered throughout the year, as and when required); Obesity discussions were in hand; May consider including MRB consumer stories at the Board Meeting / and vice versa.

Item 2: Workplan updates – actioned.

Item 3: Mental Health Facility Tour – actioned.

## BOARD WORK PLAN

The Board Work Plan for January was noted. A planning workshop will be held in January and an updated detail workplan developed soon after for 2016.

## 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 | Area | Service | Years of Service |
|---|---|---|---|
| Julia MacKenzie | Registered Nurse | Acute & Medical | 35 |
| Carole Reese | Receptionist - Inpatient | Facilities & Operational Support | 29 |
| Liz Lack | Care Associate | Women Children & Youth | 27 |
| Maureen Fau | Uniform Co-ordinator | Facilities & Operational Support | 47 years overall |

  Maureen Fau had been working for the DHB for 47 years albeit with a break in service. An article in the Leader was provided at the board meeting for members to view.

- Allied Laundry Limited: Ministerial approval had been received for Allied Laundry to enter into a loan facility to purchase equipment, subject to shareholder approval.

  The Chair put forward the following recommendation for approval:

**RECOMMENDATION**

That HB District Health Board, as a shareholder in Allied Laundry, gives approval for Allied Laundry Services Limited to enter into a $2.550m (including overdraft) loan facility with the Bank of New Zealand for the purposes of purchasing plant and equipment.

**Moved Dan Druzianic**
**Seconded Barbara Arnott**

**Carried**

- A letter from the Ministry had been received around targets acknowledging the good work undertaken.
- HBDHB's financial result topped DHBs nationally for 2014/15 and the board acknowledged this result and the extraordinary amount of hard work by all concerned to achieve this.

## CHIEF EXECUTIVE OFFICER'S REPORT

The report was taken as read acknowledging:

- A drop in the target was noted for 'shorter stays in ED'. High ED attendances were being experienced around the country. A drop of 9.3% was experienced in the 'Improved access to Elective Surgery'. Results were encouraging for Faster Cancer treatment, immunisation and better help for smokers to quit.
- Financial performance was well placed, five months into the financial year.
- It was noted the Travel Plan business case presented was far broader than just about parking, we are looking for a long term sustainable solution.

## FINANCIAL PERFORMANCE REPORT

Matters highlighted by the CFO included:

- The pleasing financial result for November showed a favourable variance of $51 thousand, with the year to date result at $175 thousand favourable with no contingency used other than $1m transferred to surgical services and $90 thousand contributed to the corporate 3.0% savings plan.
- The debt write off of $22 thousand to November (authorised by GM PIF), had been itemised.

### Reorganisation of Non-Financial Reporting

A presentation was received on the Reorganisation of Non-Financial Reporting, to better reflect the strategic differences in the roles of the two committees; to connect appropriately to different audiences for non-financial performance; to monitor the impact of Transform and Sustain as well as the process of implementation.

The proposed changes would see:

- The Non-Financial Performance Framework Dashboard being replaced by the HBDHB Quarterly Monitoring Dashboard.
- The Transform and Sustain Programme Overview being replaced with the Transform and Sustain Strategic Dashboard.

The Board approved the proposed new reporting structure as follows:

| Report | Current Reporting | Proposed Reporting |
|---|---|---|
| HBDHB Non-Financial Performance Framework Dashboard | EMT, Board | EMT |
| HBDHB Non-Financial Exceptions Report | EMT, Board | EMT, Board |
| Transform & Sustain Project Overview and Detailed Project Report | EMT, Board | EMT, FRAC |
| Transform & Sustain Programme Overview Report | EMT, FRAC | EMT, FRAC |
| Hawke's Bay DHB Quarterly Performance Monitoring Dashboard | CHAIR, CEO | EMT, Board |
| Transform and Sustain Dashboard | Not Provided | EMT, Board |

## CONSUMER STORY

A patient story around difficulties experienced in ED was relayed. This highlighted the need for the changes already identified and occurring in ED or planned for implementation in the near future.

## REPORT FROM COMMITTEE CHAIRS

### Hawke's Bay Clinical Council

Bilingual Signage: Council supported the principles presented, advising the main decision makers in this process were Consumer Council and MRB.

Travel Plan: Council were happy to endorse the business case to implement the "Go Well" Travel Plan (option 3).

Urgent Care Year End Report and the additional expressions of interest, request for proposal timelines (phase one of the programme) was in progress with feedback being sought on the proposed options. Council endorsed the report and approved the options.

Collaborative Clinical Pathways: A query as to whether the development was progressing fast enough. In response, what had been experienced to date was in-line with others around the country

who were introducing Clinical Pathways. The focus now is to ensure implementation occurs with consumer input to ensure person centred care is aligned.

Other areas reviewed and supported were the Quality Accounts and Medicines Reconciliations, with acknowledgement of the monitoring reports provided.

## HB Health Consumer Council

An overview of Council discussions was summarised with the Chair advising his update had been provided to outline matters and issues occurring outside of normal Consumer Meetings.

Council strongly supported the Bilingual Signage principles with most vying for option B, however were happy to leave the final aspects to the process that follows to MRB and relevant staff.

The "Go Well" Travel Plan had been endorsed by Consumer Council.

The Quality Accounts had been reviewed and Council members were happy with this document, noting there were final tweaks being made up until submission to Health Quality and Safety Commission. The Urgent Care Year End Report was noted and endorsed.

## Māori Relationship Board (MRB)

The report was received for the Special Meeting of MRB held the week prior. It was noted MRB had endorsed the Bilingual Signage principles with several additions noted.

The Travel Plan business case received and feedback provided along with MRB endorsement, noting several areas for consideration.

Ngahiwi noted that the late inclusion of the PHLG report had created last minute technical issues for reporting presentation. He pointed out that that MRB and PHLG were quite separate Committees and there were no intentions to merge them.

## Pasifika Health Leadership Group (PHLG)

The Pasifika Group's meeting had been held the week of the Board meeting. Barbara Arnott (an attendee at all PHLG meetings as Chair of CPHAC), spoke to the report and advised she supported an increase in Pacific Navigators. Five were being sought and it was felt some of these may be provided from other intersector organisations eg, Ministry of Social Development. If there was an increased focus on Pasifika people's health (consisting of just over 5,000 people in HB), a very speedy improvement could be made.

It was noted PHLG felt an Intersector Project was required to address health and social issues for Pacific People in HB. They also alluded to changes in the TOR and meetings, with several taking place within the community.

The Board noted the issues raise in the Report.

**FOR DECISION**

## Quality Accounts 2014/15

Kate Coley (DQIPS) provided a presentation on the latest version of the Quality Accounts which had been reviewed by EMT, MRB and endorsed by Clinical and Consumer Counci,l noting there were still some minor tweaks to be made prior to issue.

The board were impressed with document which took on a different format to prior years (2013 and 2014).

**Action:** **If board members wished to provide feedback directly to kate.coley@hbdhb.govt.nz they were most welcome, noting this document would be issued to HQSC pre-Christmas.**

## Travel Plan Business Case

Sharon Mason (COO) introduced Andrea Beattie (DHB) and Louise Baker (Opus Consultants). Also in support was a representative from the HB Regional Council.

In 2013, the Board declined a 'Paid Parking' proposal because they were concerned it would impact negatively on patients and staff, and may be seen as a revenue generating exercise with 'profits' derived by a commercial operator going out of the district.

In 2014 the Facilities Management Team were tasked to revisit parking and transport in a more holistic way, taking into consideration the following objectives to:

- Improve access to facilities for low income families
- Promote exercise
- Reduce the carbon footprint and
- Increase the availability of car parks

As a result of this review the following options had been considered with preference for Option 3.

1. Do Nothing
2. Travel Plan, no charging - fewer sustainable options
3. *Travel Plan with 'gold-coin' charging to fund sustainable transport* ***FAVOURED***
4. Build More Parks.

Board members individually supported option 3. The HB Regional Council representative present, advised they were to review services in early 2016 to fully consider a viable transport service given the goals of the HBDHB for the HB community.

The capital cost and operational budget detail was explained to members

**RESOLUTION**

**That the Board** note the feedback from the respective Council's; and approve:

- The business case to implement the "Go Well" Travel Plan (Option 3) from 1 July 2016.
- The implementation of parking charges from 1 February 2017 to sustainably fund the Travel Plan.
- The 2016/17 capital and operational budgets as set out in the business case.

**Adopted**

**Action:** **a)** **The Board sought an update on progress prior to implementation (timing to be advised by COO in due course)**

**b)** **A request by a board member for regular reporting following implementation including a focus on monitoring for inequity.**

## Bilingual Signage - Presentation

Sharon Mason (COO) introduced Andrea Beattie who provided a presentation which took on board feedback from Council's and MRB during November. Sharon and Andrea's leadership was noted, given the tight timeframes.

As a result of feedback generally some **"basic principles"** were formulated for consideration**:**

- A commitment to incorporate bilingual signage around the HBDHB hospital and health facilities
- Te Reo Māori placed first, followed by English.
  - Rationale - preservation of language, reducing inequalities (improving Māori health is about making services and the environment more inviting for Māori so they'll actually feel ok about coming here to receive services)

  - Either Te Reo Māori above with English below, or both languages side-by-side (decision required – see examples appended)
- Font to be bold, upright roman style (no italics)
- Signage contents to simple, clear and consistent, using plain English terms
- Applies to new signage; transition of existing signage to new form will be phased through capital projects.

The Board agreed and approved the above principles and advised they would leave the final look and feel of signage to the experts. Over time, as signage is replaced it would be updated with the new signage. This sends a supportive message acknowledging Te Reo Māori and Kahungunu Reo strategy to the HB community.

**MONITORING**

## Urgent Care Year End Report and Update

The report provided noted progress made by the Urgent Care Alliance and the Urgent Care Stakeholder Group. The report summarised the progress to date of the Urgent Care Project that was established and is led by the Urgent Care Alliance Leadership Team. It sets out a series of options for key priorities and indicates the Urgent Care Alliances intentions over the coming year.

Note the additional document provided showed a high level work in progress timeline for an expression of interest and request for proposal process for the Urgent Care Project.

**Te Ara Whakawaiora Breast and Cervical Screening and the Annual Maori Health Plan Dashboard Q1 July-Sept 2015** were reviewed relative to their respective areas and progress/or otherwise noted.

**GENERAL BUSINESS**

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

**RESOLUTION TO EXCLUDE THE PUBLIC**

**RESOLUTION**

That the Board exclude the public from the following items:

22. Confirmation of Minutes of Board Meeting
    - Public Excluded

23. Matters Arising from the Minutes of Board Meeting
    - Public Excluded

24. Board Approval of Actions exceeding limits delegated by CEO

25. Chair's Report

Reports and Recommendations from Committee Chair

26. Finance Risk and Audit Committee
27. Hawke's Bay Clinical Council

**Moved:** **Diana Kirton**
**Seconded:** **Helen Francis**
**Carried**

The public section of the Board Meeting closed 3.07pm

**Signed:** _____

**Chair**

**Date:** _____

# BOARD MEETING - MATTERS ARISING
# (Public)

| Action No | Date Issue first Entered | Action to be Taken | By Whom | By When | Status |
|---|---|---|---|---|---|
| 1 | 16/12/15 | **Quality Accounts** Feedback to kate.coley@hbdhb.govt.nz if any. Noting the document will be issued to HQSC pre Christmas. | Board Members | asap | Actioned |
| 2 | 16/12/15 | **Travel Plan Business Case:**<br>a) Update on progress prior to implementation.<br>Timings for these updates to be confirmed once known, for the Board workplan.<br>b) Regular reporting following implementation including a focus on monitoring for "inequity". | COO<br>COO | | |

# HAWKE'S BAY DISTRICT HEALTH BOARD

## WORKPLAN



| Meeting Dates 2016 | Papers and Topics | Lead(s) |
|---|---|---|
| 30 Mar | Consumer Story<br>Davanti IS Review<br>Integrated Clinical Record<br>Draft Annual Plan and SOI<br>Draft Regional Services Plan<br>*Monitoring*<br>Annual Maori Health Plan Q2 Oct-Dec 2015<br>Te Ara Whakawaiora / Breastfeeding (National Indicator)<br>Occupational Health & Safety Q2 Oct-Dec 2015 | Kate Coley<br>Tim Evans<br>Tim Evans<br>Tim Evans<br>Tim Evans/Kevin Snee<br><br>Tracee TeHuia<br>Caroline McElnay<br>John McKeefry |
| 27 Apr | Consumer Story<br>"Refreshed" Transform and Sustain Draft<br>Strategic Relationships (6 monthly review)<br>*Monitoring*<br>Te Ara Whakawaiora / Cardiovascular<br>HBDHB Quarterly Performance Monitoring Dashboard Q2 Oct-Dec 15 – provided by MoH | Kate Coley<br>Tim Evans<br>Ken Foote<br><br>John Gommans |
| 25 May | Consumer Story<br>Obesity Strategic Plan (Final)<br>Suicide Prevention Plan Update<br>Heatlh Equity Update<br>"Refreshed" Transform and Sustain Final<br>Final Annual Plan and SOI<br>Final Regional Services Plan<br>*Monitoring*<br>HBDHB Non-Financial Exceptions Report Q3 Jan-Mar16<br>Transform and Sustain Strategic Dashboard Q3 Jan-Mar16<br>HR KPIs Q3<br>Annual Maori Health Plan Q3 TBC | Kate Coley<br>Caroline McElnay<br>Caroline McElnay<br>Caroline McElnay<br>Tim Evans<br>Tim Evans<br>Tim Evans / Kevin Snee<br><br>Tim Evans<br>Tim Evans<br>John McKeefry<br>Tracee TeHuia |

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Chief Executive Officer's Report** 01 |
| | For the attention of: **HBDHB Board** |
| Document Owner: | Dr Kevin Snee, Chief Executive Officer |
| Reviewed by: | Not applicable |
| Month: As at | 17 February 2016 |
| Consideration: | For Information |



**Recommendation**

**That the Board**
Note the contents of this report.
.

**INTRODUCTION**
In this month's Board report I will comment on our performance; the key problems in January were:

- patients waiting for longer than four months for first specialist appointments and elective surgery
- patients receiving smoking advice in primary care.

There will also be a detailed discussion on our quarter two performance and in Transform and Sustain reporting we will be bringing to the Board, for the first time, a Strategic Dashboard. In addition, we will be considering Ambulatory Sensitive Hospital admission rates (a measure at how effective our primary care services are at managing health problems in the community), the development of Health and Social Care Networks, and Human Resource KPIs.

It is also of significance that in January we completed and opened Ngā Rau Rākau, the Mental Health Inpatient facility, which is the largest single capital investment by the DHB for many years. This building was designed around the needs of patients and built in tandem with a redesign of the service to ensure that it is fit for purpose for many years to come.

**PERFORMANCE**
The number of people waiting for elective procedures and outpatient first specialist assessments has increased in January and will remain high in February before returning to more reasonable levels in March (below the 1% threshold). We will cover in more detail the steps we are taking to improve our position and keep below the four month waiting time in our March meeting.

| Measure / Indicator | Target | Month of January | Qtr to end January | Trend For Qtr |
|---|---|---|---|---|
| Shorter stays in ED | ≥95% | 93.0% | 93.0% | ▲ |
| Improved access to Elective Surgery (2015/16YTD) | 100% | 100.9% | - | ▲ |

| *Waiting list* | *Less than 3 months* | *3-4 months* | *4+ months* |
|---|---|---|---|
| *First Specialist Assessments (ESPI-2)* | *2,691* | *416* | *97* |
| *Patients given commitment to treat, but not yet treated (ESPI-5)* | *1,301* | *253* | *84* |

| Measure / Indicator | Target | Month of January | Qtr to end January | Trend For Qtr |
|---|---|---|---|---|
| Faster Cancer Treatment* | ≥85% | 67% (Dec 2015) | 77.6% (rolling 6m to Dec 2015) | ▲ |
| Increased immunisation at 8 months (3 months to January) | ≥90% | --- | 94.3% | ▲ |
| Better help for smokers to quit – Hospital | ≥95% | 100% | 99.1% | ▬ |
| Better help for smokers to quit – Primary Care<br>*there was a change in definition at the start of 2015/16 which has an impact on the results | ≥90% | 75% (Quarter 2, 2015/16) | --- | ▼ |
| More heart and diabetes checks | ≥90% | 90.3% (Quarter 2, 2015/16) | --- | ▬ |
| Financial – month (in thousands of dollars) | $2,250 thousand deficit | $2,122 thousand deficit | --- | ▲ |
| Financial – year to date (in thousands of dollars) | $6,662 thousand deficit | $6,581 thousand deficit | --- | ▲ |

***Based on the expected annual cancer registrations for the DHB supplied by the Ministry of Health, the DHB is expected to identify at least 76 people a year (11.4 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%* | *6/11 = 53%* | *58/68 = 84.8%* |

Since smoking cessation in primary care became a priority there has been a tendency to meet it by bringing in supernumerary staff, usually nursing, to deliver the target by contacting patients directly. What hasn't happened adequately is the development of practices to ensure that the smoking cessation work continued when the resource stopped and that we were fully focussed on how this would help us to deliver the ultimate goal of the reduction of smoking prevalence. In December 2015 Health Hawke's Bay (HHB) provided another 113 independent nursing hours and funded 1,043 Txt2Reminds to once again try and increase our coverage rates. HBDHB has employed a Smoke-free Community Systems Coordinator as part of the HBDHB Smoke-free team. This resource is currently working with six general practices identified as needing the most support and plans to meet with one more in 2016.

HHB and HBDHB Smoke-free team are working with these practices to achieve not only the 90% target, but also to ensure sustainability. Work is also being undertaken with reception staff to undertake the group based smoke-free training to provide a whole team approach to smoke-free activities within the practice; and two practices were incentivised to complete the e-Learning on-line training.

As we had hoped, the January finance figures rebalanced the dip we saw in December. Overall the month was $128 thousand favourable, to bring us back to a cumulative favourable performance of $81 thousand. Looking forward, the forecast for year end is still to hit our target surplus. However, we can expect a tough run in to year end, with the balance between anticipated pressures and expected gains firmly against us.

**CONSUMER STORY**

This month's story is a series of extracts from feedback and complaints received from consumers relating to their interactions with our reception staff and those individuals booking appointments for them. As you will see from the extracts, the level of service provided by our teams is well below our expectations and is not in line with the values of our organisation. A key piece of work is currently being undertaken under the Customer Focussed Booking programme of work to embed some real change in the behaviours and attitudes of our staff so that they are able to provide a much more consumer friendly service.

**TRANSFORM AND SUSTAIN PROJECTS OVERVIEW**

Our new Strategic Dashboard is being reported to the Board for the first time. This is aimed at dealing with the impact rather than the process of our Transform & Sustain strategy. Three 'vital sign' indicators for: service quality (what our consumers say about us); population health (the gap between Māori and European death rates under 50 years old), and; use of resources (PHO break even, DHB make target surplus) are each supported by seven representative indicators.

The Executive Management Team and Health Services Leadership team have been doing some structured work to agree those areas where we need to drive further projects to deliver our strategy as we move into the second half of our five year timeframe. This work will be brought through Board and its sub-committees to validate and enrich our planning of future projects.

There are only three amber projects in the Transform & Sustain programme at the moment. Videoconferencing (with delays in equipment delivery and a false start on clinical use); engAGE (excellent progress, but longer than planned roll out), and; RHIP - Regional Health Informatics Programme (moved from Red with the Rillstone review, but still not firmed up implementation dates and costs).

**TE ARA WHAKAWAIORA / AMBULATORY SENSITIVE HOSPITALISATION RATES**

The Te Ara Whakawaiora Ambulatory Sensitive Hospitalisation rate targets have shown some improvements, both in terms of Māori admission rates and also in terms of the comparative rates between Māori and the total population. This is particularly the case for the 0-4 age group where skin conditions and gastroenteritis have shown pleasing reductions in admissions. Rotavirus immunisation is likely to be a significant reason for this. Rates for the 45-65 age group continue to show significant disparity, though rates have improved.

**PERFORMANCE FRAMEWORK EXCEPTIONS QUARTER TWO**

Our overall performance on Elective Surgery is running just above 100%. This is because in-house Health Services are delivering well beyond planned levels of surgery to offset outsourced and IDF shortfalls. Heart and diabetes checks are at 90.3%, which is above target for the fourth successive quarter.

We are making progress on Faster Cancer Treatment, which has increased a further 2% from the previous quarter. A programme of work is underway to increase the number of patients identified with a high suspicion of cancer at referral. Shorter stays in ED shows a small improvement but continues to be below target at 92.7%. The result for Acute Coronary Syndrome Services (high risk patients receiving an angiogram within three days) was 68.7%, which is an 18% improvement on the previous quarter.

We need to focus on achieving: immunisations at eight months; better help for smokers to quit in Primary Care; improving wait time for diagnostic service; and cervical screening.

## HUMAN RESOURCE KPIS

Māori staff representation in the workforce has moved little in the last quarter and the gap to our 2015/16 target sits at 59 at 31 December 2015. To address this gap we have developed a comprehensive action plan deepening our focus in Nursing staff and extending our focus to include Allied Health staff. There are no concerns with Sick Leave, Staff Turnover or our Head Count, and positions with our Accrued FTE YTD are favourable to budget.

Annual Leave (2+ years) continues to be higher than last year and we have recently introduced some new measures which will hopefully address this unfavourable trend. While the numbers of 2+ years has increased in the last 12 months, the total liability is $0.3m favourable to the position at 30 June 2015 and our total leave actual $942k favourable to budget. Most of this favourable movement can be attributed to reduced hours in leave balances other than annual leave (for example Statutory Lieu leave) and reflects our broader focus on all leave balances, not just annual leave. We are the third best performing mid-sized DHB and the seventh best of the 20 DHBs for this measure.

The increase in staff related injury accidents reported, at 119, is well above the 90 target for the quarter. This is a concern and could be a result of increased awareness and the quarter being at year's end. This will be more fully reported to FRAC at the March meeting but we are taking every step to identify the cause of each accident and work to ensure those accidents aren't repeated.

## HEALTH AND SOCIAL CARE NETWORKS

The health system is increasingly under pressure as a significant growth in numbers of frail older people, and those living with complex long term conditions, increases the demand for services. In addition, we do not deliver equitable outcomes or access to services for Māori and Pacific populations and there are groups of people who struggle to access services because of their cost. There is a lack of co-ordination between a range of health and social care services that can be frustrating for individuals and lead to lack of engagement and wasted resources.

The Health and Social Care Networks paper introduces a proposed programme of work that seeks to address these challenges by developing a sector in which providers of health and social care services work in a more connected and collaborative way with each other, the community and patients. Our aim is to deliver a service where the right professional is delivering an appropriate service in the most sensible location supported by a network of providers who understand and respond to the needs of the patient and their whānau, who in turn are empowered to manage their own health and social wellness.

Following on from previous governance level discussions at the Health Sector Leadership forum and various committees, the purpose of this paper is to introduce the programme and establish its provenance as a key initiative focused on improving the health and wellness of our population. It will be a significant programme of activity and of associated change management, requiring support at all organisational levels. We are, therefore, seeking support from the DHB Board to begin this journey.

## ALLIED LAUNDRY SERVICES LIMITED REPORT TO SHAREHOLDING DHBS

The board of Allied Laundry Services Limited (Allied) has submitted a Report to Shareholding DHBs setting out the background, the process, and the agreements required for Capital and Coast DHB and Hutt Valley DHB to become both shareholders and customers of Allied. Due to the commercially sensitive nature of some of the information contained in the report and attached agreements, this matter will be considered in the 'public excluded' part of the meeting.

## SUMMARY

In summary, the local health system remains under pressure and we are struggling particularly in relation to waiting times and smoking cessation in primary care. Our programme of transformational change, however, continues to perform well and we are embarking on a major initiative to transform our services in the community.

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Financial Performance Report, December 2015** 02a |
| | For the attention of: **Finance Risk and Audit Committee and the Board** |
| Document Owner:<br>Document Author(s): | Tim Evans, GM Planning, Informatics & Finance<br>Finance Team |
| Reviewed by: | Executive Management Team |
| Month: | January 2016 |
| Consideration: | For Information |

**RECOMMENDATION**

**That the Board**
Note the contents of this report

# 1. GM Planning Informatics & Finance comments

## Financial performance

The result for December is an unfavourable variance of $223 thousand, making the year to date result $48 thousand unfavourable.

The result is inherently uncertain in December and January because of the effect of the holiday season on how staff take leave. Consequently one month's proportion of the remaining contingency has been released to mitigate factors in December that may reverse. The year to date part of the $1.0 million transferred to Surgical Services and the $90 thousand contributed to the corporate 3% savings plan, have also been released.

Elective surgery was 1.2% below plan in December, however volumes are 0.4% ahead of the health target year to date, with 82% provided in-house in comparison to the planned 76%.

## Forecast result

The forecast for the 30 June 2016 year remains at the $3.990 million budgeted surplus.

Cover for vacancies and sick leave, mainly medical personnel, is likely to offset the release of the remaining contingency by the end of the year. This makes realisation of planned efficiencies even more necessary to achieve the planned full year result.

Consequently the risk to the result is on the downside as savings get progressively harder to achieve (see section 11). MOH targets (case-weights and ESPIs) and the IDF wash-up also contribute some uncertainty to the forecast.

## 2. Resource Overview

| | December | | | | Year to Date | | | | Year End | Refer |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | Forecast | Section |
| | $'000 | $'000 | $'000 | % | $'000 | $'000 | $'000 | % | $'000 | |
| Net Result - surplus/(deficit) | (3,313) | (3,090) | **(223)** | **-7.2%** | (4,460) | (4,412) | (48) | -1.1% | 3,990 | 3 |
| Contingency utilised | 258 | 250 | (8) | -3.2% | 712 | 1,500 | **788** | **52.5%** | 3,000 | 8 |
| Quality and financial improvement | 128 | 736 | **(608)** | **-82.6%** | 3,640 | 4,494 | **(854)** | **-19.0%** | 10,200 | 11 |
| Capital spend | 1,024 | 1,605 | **(581)** | **-36.2%** | 10,808 | 8,396 | **2,412** | **28.7%** | 21,358 | 16 |
| | FTE | FTE | FTE | % | FTE | FTE | FTE | % | FTE | |
| Employees | 2,140 | 2,169 | 29 | 1.3% | 2,118 | 2,173 | 55 | 2.5% | 2,184 | 5 & 7 |
| | CWD | CWD | CWD | % | CWD | CWD | CWD | % | CWD | |
| Case weighted discharges | 2,481 | 2,113 | **367** | **17.4%** | 14,224 | 14,060 | 164 | 1.2% | 27,009 | 5 |

The result for December is an unfavourable variance of $223 thousand, with $712 thousand of the contingency utilised ($167 thousand to cover holiday period uncertainties, $500 thousand transferred to surgical, and $45 thousand contributed to the corporate 3% savings plan year to date).

Quality and Financial Improvement (QFI) programme savings are below plan reflecting the progressive realisation of savings. The implementation and monitoring of savings plans is ongoing. Realisation of IDF savings will not be known until the 2015/16 IDF wash-up process is complete.

Capital spend is well ahead of plan reflecting the catch-up of Mental Health Inpatient Unit project payments that were incurred more slowly than budgeted last year.

The FTE variance for December and year to date both reflect vacancies relating to new programmes or changes in the model of care.

Case weighted discharges were above plan in December, and are 1.2% ahead of plan year to date. High acute general surgery and gastroenterology volumes drive the year to date variance partly offset by lower than planned general internal medicine, acute neonates, and maternity volumes.

## 3. Financial Performance Summary

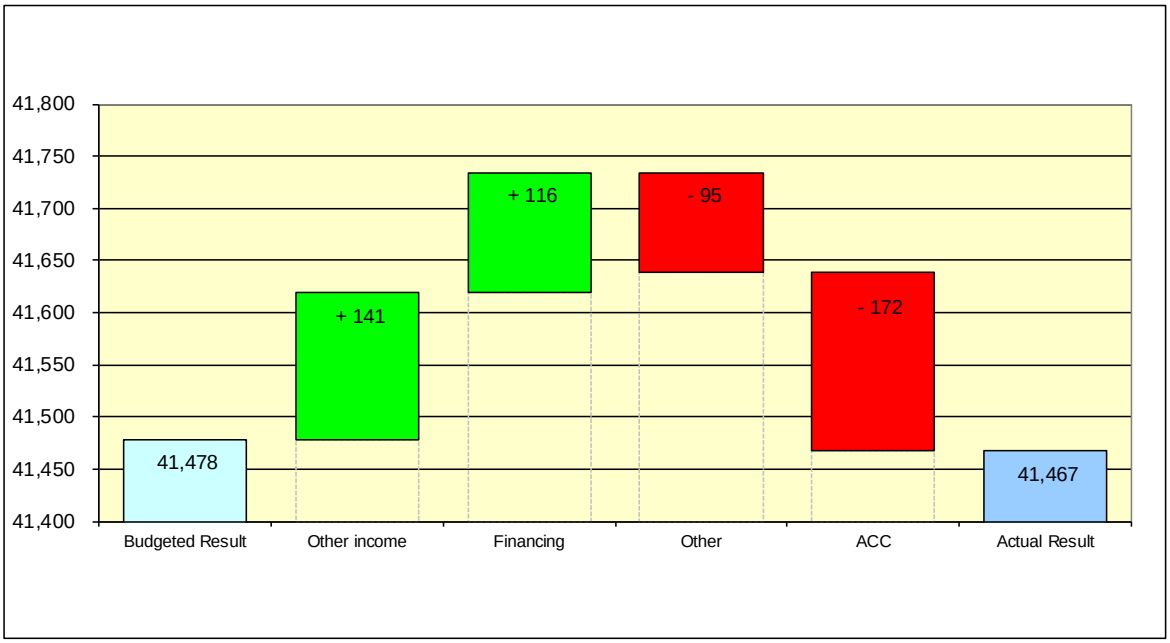
| | December | | | | Year to Date | | | | Year End | Refer |
|---|---|---|---|---|---|---|---|---|---|---|
| $'000 | Actual | Budget | Variance | | Actual | Budget | Variance | | Forecast | Section |
| Income | 41,467 | 41,478 | (11) | 0.0% | 249,728 | 249,575 | 153 | -0.1% | 512,681 | 4 |
| *Less:* | | | | | | | | | | |
| Providing Health Services | 20,263 | 19,720 | (542) | -2.8% | 117,654 | 116,908 | (747) | -0.6% | 238,617 | 5 |
| Funding Other Providers | 18,917 | 19,214 | 297 | 1.5% | 112,353 | 113,063 | 711 | 0.6% | 223,658 | 6 |
| Corporate Services | 5,382 | 5,322 | (61) | -1.1% | 22,257 | 22,104 | (153) | -0.7% | 44,314 | 7 |
| Reserves | 218 | 312 | **94** | **30.1%** | 1,923 | 1,912 | (12) | -0.6% | 2,102 | 8 |
| | **(3,313)** | **(3,090)** | (223) | 7.2% | **(4,460)** | **(4,412)** | (48) | 1.1% | **3,990** | |

Lower than budgeted leave taken ahead of the holiday season is the likely cause of the unfavourable variance in December, and will probably reverse in January. One month's proportion of the remaining contingency was released to partly offset this effect. The release of contingency partly offset by Transform expenditure on IT strategy is the driver of the favourable reserves variance in December.

# 4. Income

| $'000 | December | | | | Year to Date | | | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | |
| Ministry of Health | 39,331 | 39,416 | (86) | -0.2% | 237,218 | 237,199 | 19 | 0.0% | 488,039 |
| Inter District Flows | 624 | 624 | 0 | 0.0% | 3,745 | 3,741 | 3 | 0.1% | 7,486 |
| Other District Health Boards | 300 | 339 | (39) | -11.4% | 1,867 | 2,032 | (165) | -8.1% | 4,040 |
| Financing | 208 | 92 | 116 | 125.5% | 822 | 501 | 321 | 64.0% | 1,357 |
| ACC | 334 | 506 | (172) | -34.0% | 2,793 | 3,081 | (288) | -9.4% | 5,517 |
| Other Government | 49 | 35 | 14 | 40.9% | 198 | 207 | (9) | -4.2% | 405 |
| Patient and Consumer Sourced | 82 | 124 | (42) | -34.1% | 557 | 739 | (182) | -24.6% | 1,212 |
| Other Income | 483 | 343 | 141 | 41.0% | 2,503 | 2,074 | 429 | 20.7% | 4,597 |
| Abnormals | 58 | - | 58 | 0.0% | 26 | - | 26 | 0.0% | 26 |
| | **41,467** | **41,478** | (11) | 0.0% | **249,728** | **249,575** | 153 | 0.1% | **512,681** |

## December Income



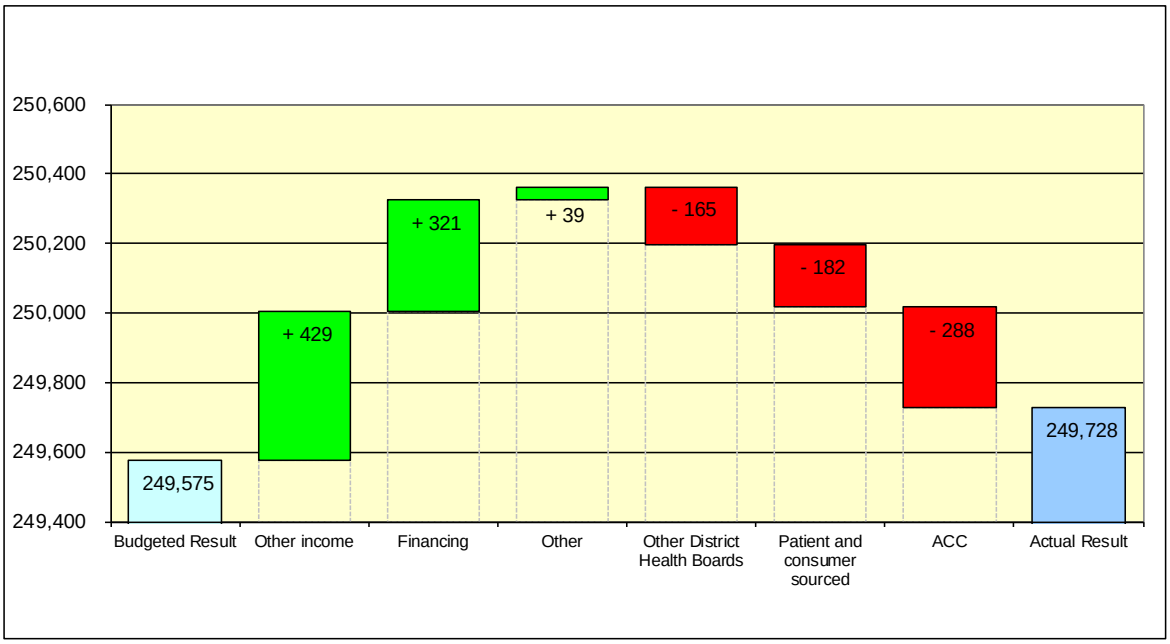

*Note the scale does not begin at zero*

**Other Income** (favourable)
Large donation from Countdown Kids.

**Financing** (favourable)
Interest on higher cash balances than projected. Interest on special funds and clinical trials is unbudgeted.

**ACC** (unfavourable**)**
Prioritisation of elective surgery over ACC volumes.

## Year to date Income




**Other income** (favourable)
Includes clinical trial income and donations (unbudgeted), and income from Hawke's Bay PHO.

**Financing** (favourable**)**
Higher cash balances than projected, and income on special fund and clinical trial balances unbudgeted.

**Other District Health Boards** (unfavourable**)**
Lower sales of cancer drugs to Tairawhiti DHB, partly offset by higher oncology clinic charges to Mid Central DHB. Both offset in expenditure.

**Patient and consumer sourced** (unfavourable**)**
Lower non-resident charges and patient co-payments, mainly since October.

**ACC** (unfavourable)
Prioritisation of elective surgery over ACC volumes.

# 5. Providing Health Services

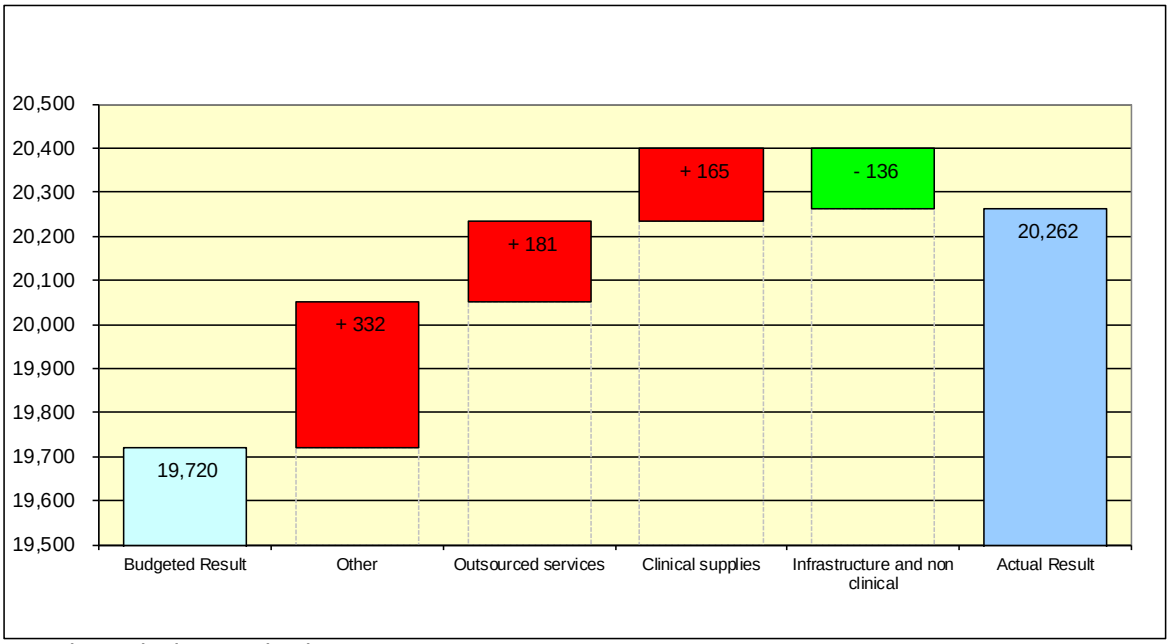
| | December | | | | Year to Date | | | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | |
| **Expenditure by type** $'000 | | | | | | | | | |
| Medical personnel and locums | 4,680 | 4,473 | (207) | -4.6% | 26,404 | 26,116 | (288) | -1.1% | 55,110 |
| Nursing personnel | 5,917 | 5,813 | (104) | -1.8% | 34,848 | 35,057 | 209 | 0.6% | 70,130 |
| Allied health personnel | 2,723 | 2,760 | 37 | 1.3% | 15,251 | 16,187 | **936** | **5.8%** | 31,534 |
| Other personnel | 1,772 | 1,714 | (58) | -3.4% | 10,168 | 10,172 | 4 | 0.0% | 20,242 |
| Outsourced services | 632 | 451 | **(181)** | **-40.2%** | 2,874 | 2,660 | **(214)** | **-8.0%** | 6,890 |
| Clinical supplies | 3,130 | 2,965 | **(165)** | **-5.6%** | 18,613 | 17,328 | **(1,285)** | **-7.4%** | 35,612 |
| Infrastructure and non clinical | 1,408 | 1,545 | **136** | **8.8%** | 9,497 | 9,389 | (108) | -1.1% | 19,100 |
| | **20,263** | **19,720** | (542) | -2.8% | **117,654** | **116,908** | (747) | -0.6% | **238,617** |
| **Expenditure by directorate** $'000 | | | | | | | | | |
| Acute and Medical | 5,563 | 5,231 | **(331)** | **-6.3%** | 31,380 | 30,358 | (1,022) | -3.4% | 62,998 |
| Surgical Services | 4,727 | 4,502 | (225) | -5.0% | 26,030 | 25,523 | (507) | -2.0% | 52,434 |
| Women Children and Youth | 1,665 | 1,626 | (38) | -2.4% | 9,563 | 9,493 | (70) | -0.7% | 19,674 |
| Older Persons & Mental Health | 2,940 | 2,900 | (40) | -1.4% | 16,118 | 16,475 | 357 | 2.2% | 32,758 |
| Rural, Oral and Communlty | 1,938 | 1,885 | (54) | -2.8% | 10,804 | 10,843 | 39 | 0.4% | 21,694 |
| Other | 3,430 | 3,575 | 146 | 4.1% | 23,759 | 24,214 | 455 | 1.9% | 49,059 |
| | **20,263** | **19,720** | (542) | -2.8% | **117,654** | **116,908** | (747) | -0.6% | **238,617** |
| **Full Time Equivalents** | | | | | | | | | |
| Medical personnel | 313.0 | 306.6 | (6) | -2.1% | 296 | 299 | 3 | 1.1% | 303.8 |
| Nursing personnel | 844.5 | 875.2 | 31 | 3.5% | 871 | 885 | 14 | 1.6% | 889.7 |
| Allied health personnel | 430.0 | 444.9 | 15 | 3.4% | 415 | 444 | **29** | **6.5%** | 445.5 |
| Support personnel | 133.0 | 127.6 | (5) | -4.3% | 129 | 129 | (1) | -0.5% | 129.4 |
| Management and administration | 256.2 | 247.2 | (9) | -3.7% | 249 | 248 | (2) | -0.6% | 247.7 |
| | **1,976.7** | **2,001.3** | 25 | 1.2% | **1,961** | **2,005** | 44 | 2.2% | **2,016.1** |
| **Case Weighted Discharges** | | | | | | | | | |
| Acute | 1,824 | 1,464 | **360** | **24.6%** | 9,978 | 9,714 | 264 | 2.7% | 18,426 |
| Elective | 438 | 443 | (5) | -1.1% | 3,113 | 3,122 | (9) | -0.3% | 6,195 |
| Maternity | 142 | 178 | (36) | -20.2% | 930 | 1,045 | **(114)** | **-11.0%** | 2,035 |
| IDF Inflows | 76 | 28 | 48 | 167.9% | 203 | 180 | 23 | 13.1% | 353 |
| | **2,481** | **2,113** | **367** | **17.4%** | **14,224** | **14,060** | 164 | 1.2% | **27,009** |

## Acute and Medical

The unfavourable result for December relates to:

- Savings not achieved
- Registrar cover for ED resignations
- Staffing up for the new FACEM position above AIM 24/7 budget
- Radiology after hours reads
- Pharmaceutical costs – increasing use of biologics
- Dermatologist vacancy cover

## December Expenditure



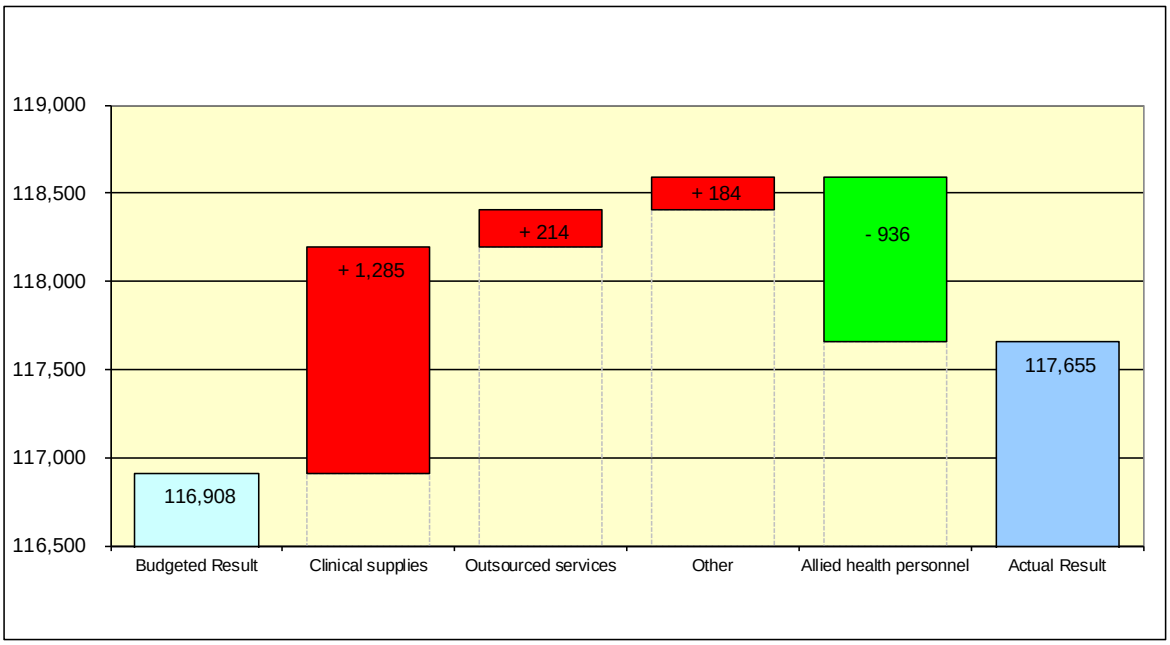

*Note the scale does not begin at zero*

**Outsourced services** (unfavourable)
Royston surgery and radiology spot purchases.

**Clinical supplies** (unfavourable)
Savings targets achieved elsewhere, partly offset by lower implant, prostheses and disposable instrument costs.

**Infrastructure and non-clinical** (favourable)
Low maintenance, staff travel, and laundry costs.

## Year to date Expenditure




**Clinical supplies** (unfavourable)
Savings targets achieved elsewhere, marginally offset by lower implant and prostheses costs.

**Outsourced services** (unfavourable)
Outsourced elective surgery.

**Allied health personnel** (favourable)
Vacancies mainly in mental health, pharmacy and health of older people.

## Full time equivalents (FTE)

FTEs are 44 favourable year to date, including:

**Allied health personnel** (29 FTE / 6.5% favourable)

- Vacancies. Recruitment to positions for new models of care, low supply of applicants, delays in staged recruitment of pharmacy facilitators, and difficulty recruiting laboratory vacancies.

**Nursing personnel** (14 FTE / 1.6% favourable)

- Management of low volumes in Ata Rangi, and vacancies in a number of services, including rurals and district nursing.

**Medical personnel** (3 FTE / 1.1% favourable)

- Vacancies in ED and mental health covered by locums.

# MONTHLY ELECTIVE HEALTH TARGET REPORT
# YTD To December 2015


| Plan for 2015/16 | On-Site | Outsourced | IDF Outflow | TOTAL |
|---|---|---|---|---|
| Non Surgical - Arranged | 70 | 0 | 0 | **70** |
| Non Surgical - Elective | 187 | 0 | 0 | **187** |
| Surgical - Arranged | 382 | 0 | 370 | **752** |
| Surgical - Elective | 4,682 | 768 | 650 | **6,100** |
| TOTAL | **5,321** | **768** | **1,020** | **7,109** |

| | | YTD December 2015 | | | |
|---|---|---|---|---|---|
| | | Actual | Plan | Var. | %Var. |
| On-Site | Avastins | 99 | 99 | 0 | 0.0% |
| | ENT | 275 | 213 | 62 | 29.1% |
| | General Surgery | 480 | 531 | -51 | -9.6% |
| | Gynaecology | 282 | 278 | 4 | 1.4% |
| | Maxillo-Facial | 72 | 62 | 10 | 16.1% |
| | Ophthalmology | 525 | 342 | 183 | 53.5% |
| | Orthopaedics | 469 | 472 | -3 | -0.6% |
| | Skin Lesions | 89 | 89 | 0 | 0.0% |
| | Urology | 214 | 228 | -14 | -6.1% |
| | Vascular | 69 | 57 | 12 | 21.1% |
| | Surgical - Arranged | 274 | 193 | 81 | 42.0% |
| | Non Surgical - Elective | 55 | 95 | -40 | -42.1% |
| | Non Surgical - Arranged | 22 | 35 | -13 | -37.1% |
| **On-Site** | **Total** | **2925** | **2694** | **231** | **8.6%** |
| Outsourced | Cardiothoracic | 0 | 0 | 0 | 0.0% |
| | ENT | 42 | 172 | -130 | -75.6% |
| | General Surgery | 83 | 85 | -2 | -2.4% |
| | Gynaecology | 0 | 28 | -28 | -100.0% |
| | Maxillo-Facial | 38 | 54 | -16 | -29.6% |
| | Neurosurgery | 0 | 0 | 0 | 0.0% |
| | Orthopaedics | 0 | 12 | -12 | -100.0% |
| | Paediatric Surgery | 0 | 0 | 0 | 0.0% |
| | Urology | 18 | 13 | 5 | 38.5% |
| | Vascular | 4 | 0 | 4 | 0.0% |
| | Surgical - Arranged | 0 | 0 | 0 | 0.0% |
| | Non Surgical - Elective | 0 | 0 | 0 | 0.0% |
| | Non Surgical - Arranged | 0 | 0 | 0 | 0.0% |
| **Outsourced** | **Total** | **185** | **364** | **-179** | **-49.2%** |
| IDF Outflow | Cardiothoracic | 37 | 43 | -6 | -14.0% |
| | ENT | 22 | 21 | 1 | 4.8% |
| | General Surgery | 23 | 27 | -4 | -14.8% |
| | Gynaecology | 18 | 18 | 0 | 0.0% |
| | Maxillo-Facial | 101 | 76 | 25 | 32.9% |
| | Neurosurgery | 25 | 21 | 4 | 19.0% |
| | Ophthalmology | 17 | 13 | 4 | 30.8% |
| | Orthopaedics | 7 | 16 | -9 | -56.3% |
| | Paediatric Surgery | 20 | 24 | -4 | -16.7% |
| | Skin Lesions | 31 | 32 | -1 | -3.1% |
| | Urology | 0 | 2 | -2 | -100.0% |
| | Vascular | 11 | 31 | -20 | -64.5% |
| | Surgical - Arranged | 78 | 183 | -105 | -57.4% |
| | Non Surgical - Elective | 67 | 0 | 67 | 0.0% |
| | Non Surgical - Arranged | 14 | 0 | 14 | 0.0% |
| **IDF Outflow** | **Total** | **471** | **507** | **-36** | **-7.1%** |
| **GRAND TOTAL** | | **3581** | **3565** | **16** | **0.4%** |

| | | December 2015 | | | |
|---|---|---|---|---|---|
| | | Actual | Plan | Var. | %Var. |
| On-Site | Avastins | 14 | 14 | 0 | 0.0% |
| | ENT | 40 | 31 | 9 | 29.0% |
| | General Surgery | 76 | 76 | 0 | 0.0% |
| | Gynaecology | 42 | 40 | 2 | 5.0% |
| | Maxillo-Facial | 6 | 9 | -3 | -33.3% |
| | Ophthalmology | 83 | 50 | 33 | 66.0% |
| | Orthopaedics | 70 | 68 | 2 | 2.9% |
| | Skin Lesions | 12 | 12 | 0 | 0.0% |
| | Urology | 30 | 33 | -3 | -9.1% |
| | Vascular | 15 | 8 | 7 | 87.5% |
| | Surgical - Arranged | 53 | 27 | 26 | 96.3% |
| | Non Surgical - Elective | 3 | 14 | -11 | -78.6% |
| | Non Surgical - Arranged | 1 | 5 | -4 | -80.0% |
| **On-Site** | **Total** | **445** | **387** | **58** | **15.0%** |
| Outsourced | Cardiothoracic | 0 | 0 | 0 | 0.0% |
| | ENT | 4 | 24 | -20 | -83.3% |
| | General Surgery | 15 | 12 | 3 | 25.0% |
| | Gynaecology | 0 | 4 | -4 | -100.0% |
| | Maxillo-Facial | 0 | 8 | -8 | -100.0% |
| | Neurosurgery | 0 | 0 | 0 | 0.0% |
| | Orthopaedics | 0 | 1 | -1 | -100.0% |
| | Paediatric Surgery | 0 | 0 | 0 | 0.0% |
| | Urology | 9 | 2 | 7 | 350.0% |
| | Vascular | 0 | 0 | 0 | 0.0% |
| | Surgical - Arranged | 0 | 0 | 0 | 0.0% |
| | Non Surgical - Elective | 0 | 0 | 0 | 0.0% |
| | Non Surgical - Arranged | 0 | 0 | 0 | 0.0% |
| **Outsourced** | **Total** | **28** | **51** | **-23** | **-45.1%** |
| IDF Outflow | Cardiothoracic | 1 | 7 | -6 | -85.7% |
| | ENT | 0 | 3 | -3 | -100.0% |
| | General Surgery | 2 | 4 | -2 | -50.0% |
| | Gynaecology | 2 | 3 | -1 | -33.3% |
| | Maxillo-Facial | 2 | 12 | -10 | -83.3% |
| | Neurosurgery | 0 | 3 | -3 | -100.0% |
| | Ophthalmology | 3 | 2 | 1 | 50.0% |
| | Orthopaedics | 1 | 3 | -2 | -66.7% |
| | Paediatric Surgery | 5 | 4 | 1 | 25.0% |
| | Skin Lesions | 1 | 5 | -4 | -80.0% |
| | Urology | 0 | 1 | -1 | -100.0% |
| | Vascular | 2 | 5 | -3 | -60.0% |
| | Surgical - Arranged | 13 | 28 | -15 | -53.6% |
| | Non Surgical - Elective | 5 | 0 | 5 | 0.0% |
| | Non Surgical - Arranged | 2 | 0 | 2 | 0.0% |
| **IDF Outflow** | **Total** | **39** | **80** | **-41** | **-51.3%** |
| **GRAND TOTAL** | | **512** | **518** | **-6** | **-1.2%** |

*Please Note: The data diaplayed is as at 11 January 2016. IDF events not yet captured in NMDS will not be reported above. Avastins and Skin Lesions have been manually adjusted to plan.*

# 6. Funding Other Providers

| $'000 | December Actual | December Budget | December Variance | | Year to Date Actual | Year to Date Budget | Year to Date Variance | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| **Payments to Other Providers** | | | | | | | | | |
| Pharmaceuticals | 3,922 | 3,900 | (21) | -0.5% | 21,775 | 21,859 | 85 | 0.4% | 42,159 |
| Primary Health Organisations | 2,979 | 3,024 | 45 | 1.5% | 17,068 | 17,060 | (8) | 0.0% | 34,628 |
| Inter District Flows | 3,903 | 3,899 | (4) | -0.1% | 23,447 | 23,392 | (55) | -0.2% | 46,839 |
| Other Personal Health | 1,803 | 1,889 | 86 | 4.5% | 11,920 | 11,787 | (133) | -1.1% | 22,709 |
| Mental Health | 1,167 | 1,116 | (51) | -4.6% | 6,734 | 6,694 | (40) | -0.6% | 13,432 |
| Health of Older People | 4,732 | 4,949 | 217 | 4.4% | 29,248 | 29,693 | 445 | 1.5% | 58,964 |
| Other Funding Payments | 413 | 438 | 25 | 5.7% | 2,161 | 2,578 | **417** | **16.2%** | 4,927 |
| | 18,917 | 19,214 | **297** | **1.5%** | **112,353** | **113,063** | **711** | **0.6%** | 223,658 |
| **Payments by Portfolio** | | | | | | | | | |
| Strategic Services | | | | | | | | | |
| Secondary Care | 4,190 | 4,161 | (29) | -0.7% | 25,059 | 24,944 | (115) | -0.5% | 48,238 |
| Primary Care | 7,718 | 7,796 | 79 | 1.0% | 44,460 | 44,759 | 299 | 0.7% | 88,746 |
| Chronic Disease Management | 295 | 345 | 50 | 14.4% | 1,896 | 2,058 | **163** | **7.9%** | 4,127 |
| Mental Health | 1,182 | 1,112 | **(70)** | **-6.3%** | 6,730 | 6,671 | (60) | -0.9% | 13,406 |
| Health of Older People | 4,832 | 5,035 | 203 | 4.0% | 29,954 | 30,208 | 253 | 0.8% | 60,185 |
| Other Health Funding | (31) | (17) | 14 | 85.4% | (46) | (100) | **(54)** | **-54.1%** | (146) |
| Maori Health | 496 | 526 | 30 | 5.7% | 3,024 | 3,158 | 134 | 4.2% | 6,235 |
| Population Health | 236 | 255 | 20 | 7.7% | 1,275 | 1,366 | **90** | **6.6%** | 2,866 |
| | 18,917 | 19,214 | **297** | **1.5%** | **112,353** | **113,063** | **711** | **0.6%** | 223,658 |

## December Expenditure

There are no highlighted issue areas in the table for December. Health of Older People reflects lower community and residential care costs. The Mental Health portfolio variance relates to service improvements.

## Year to date Expenditure

Other funding payments reflects later than planned implementation of new investments, and delay of the Whanau Manaaki programme to accommodate a service review. The portfolio variances mainly reflect delays in rolling out new investment partly offset by efficiencies not achieved.

# 7. Corporate Services

| $'000 | December Actual | December Budget | December Variance | | Year to Date Actual | Year to Date Budget | Year to Date Variance | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| **Operating Expenditure** | | | | | | | | | |
| Personnel | 1,391 | 1,276 | **(116)** | **-9.1%** | 7,518 | 7,475 | (43) | -0.6% | 14,878 |
| Outsourced services | 106 | 86 | (20) | -22.8% | 580 | 519 | **(61)** | **-11.7%** | 1,079 |
| Clinical supplies | 2 | 0 | (1) | -286.1% | 54 | 3 | **(51)** | **-1766.3%** | 56 |
| Infrastructure and non clinical | 623 | 616 | (7) | -1.2% | 4,589 | 4,434 | (155) | -3.5% | 8,574 |
| | 2,123 | 1,979 | **(144)** | **-7.3%** | 12,740 | 12,431 | (310) | -2.5% | 24,587 |
| **Capital servicing** | | | | | | | | | |
| Depreciation and amortisation | 1,107 | 1,106 | (1) | -0.1% | 6,549 | 6,618 | 70 | 1.1% | 13,802 |
| Financing | 165 | 166 | 1 | 0.3% | 981 | 984 | 3 | 0.3% | 1,954 |
| Capital charge | 1,987 | 2,071 | 84 | 4.1% | 1,987 | 2,071 | 84 | 4.1% | 3,971 |
| | 3,260 | 3,343 | 84 | 2.5% | 9,517 | 9,673 | 157 | 1.6% | 19,727 |
| | **5,382** | **5,322** | (61) | -1.1% | **22,257** | **22,104** | (153) | -0.7% | **44,314** |
| **Full Time Equivalents** | | | | | | | | | |
| Medical personnel | 1.1 | - | (1) | 0.0% | 1 | - | (1) | 0.0% | - |
| Nursing personnel | 11.2 | 16.4 | **5** | **32.1%** | 11 | 16 | **5** | **31.0%** | 16.5 |
| Allied health personnel | - | - | - | 0.0% | 0 | - | (0) | 0.0% | - |
| Support personnel | 10.2 | 9.4 | (1) | -8.1% | 10 | 9 | (0) | -1.6% | 9.4 |
| Management and administration | 141.1 | 142.3 | 1 | 0.8% | 136 | 143 | 7 | 4.9% | 142.5 |
| | **163.5** | **168.1** | **5** | **2.7%** | **157** | **169** | **11** | **6.7%** | **168.4** |

Personnel costs in December include low annual leave taken ahead of the holiday period that will reverse in January, and unbudgeted costs for clinical trials that are offset by unbudgeted income.

Outsourced services year to date include administration costs that were budgeted under personnel, and the DHB's contribution to the Hawkes's Bay intersectional advisor position.

Clinical supplies year to date includes efficiencies that have been achieved in infrastructure.

Regional Health Information Programme (RHIP) business as usual charges drive the infrastructure and non-clinical costs year to date unfavourable variance.

# 8. Reserves

| $'000 | December Actual | December Budget | December Variance | | Year to Date Actual | Year to Date Budget | Year to Date Variance | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| **Expenditure** | | | | | | | | | |
| Royston surgery contract | - | - | - | 0.0% | - | - | - | 0.0% | - |
| Contingency | (8) | 159 | **167** | **104.9%** | 788 | 955 | **167** | **17.5%** | (0) |
| Transform and Sustain resource | 101 | 43 | **(58)** | **-136.7%** | 239 | 233 | (6) | -2.7% | 993 |
| System improvement opportunities | - | - | - | 0.0% | - | - | - | 0.0% | - |
| Other | 125 | 110 | (15) | -13.4% | 896 | 724 | **(172)** | **-23.8%** | 1,109 |
| | **218** | **312** | **94** | **30.1%** | **1,923** | **1,912** | (12) | -0.6% | **2,102** |

One month of the remaining contingency has been released in December, reflecting uncertainty arising from the holiday period. Contingency budgets have previously been adjusted for the $1 million transfer to Surgical Services, and the 3% savings target.

Expenditure on IT strategy brings Transform up to budget.

Other includes loss on disposal of assets and TAS audits relating to 2014/15.

# 9. Financial Performance by MOH Classification

| $'000 | December Actual | December Annual Plan | December Variance | Year to Date Actual | Year to Date Annual Plan | Year to Date Variance | End of Year Forecast | End of Year Annual Plan | End of Year Variance |
|---|---|---|---|---|---|---|---|---|---|
| **Funding** | | | | | | | | | |
| Income | 39,741 | 39,783 | (42) U | 238,955 | 239,091 | (136) U | 491,652 | 491,789 | (137) U |
| *Less:* | | | | | | | | | |
| Payments to Internal Providers | 20,757 | 20,757 | (0) U | 133,559 | 133,558 | (0) U | 262,678 | 262,678 | (0) U |
| Payments to Other Providers | 18,917 | 19,214 | 297 F | 112,353 | 113,063 | 711 F | 223,658 | 224,462 | 804 F |
| Contribution | **67** | **(187)** | **254 F** | **(6,956)** | **(7,531)** | **575 F** | **5,316** | **4,649** | **666 F** |
| **Governance and Funding Admin.** | | | | | | | | | |
| Funding | 262 | 262 | - | 1,569 | 1,569 | - | 3,140 | 3,140 | - |
| Other Income | 10 | 3 | 8 F | 23 | 15 | 8 F | 38 | 30 | 8 F |
| *Less:* | | | | | | | | | |
| Expenditure | 230 | 257 | 27 F | 1,299 | 1,530 | 231 F | 2,745 | 3,049 | 304 F |
| Contribution | **42** | **7** | **35 F** | **293** | **54** | **238 F** | **433** | **121** | **311 F** |
| **Health Provision** | | | | | | | | | |
| Funding | 20,495 | 20,495 | 0 F | 131,989 | 131,989 | 0 F | 259,538 | 259,538 | 0 F |
| Other Income | 1,716 | 1,692 | 24 F | 10,750 | 10,469 | 281 F | 20,992 | 21,046 | (54) U |
| *Less:* | | | | | | | | | |
| Expenditure | 25,633 | 25,097 | (536) U | 140,536 | 139,393 | (1,142) U | 282,288 | 281,365 | (924) U |
| Contribution | **(3,421)** | **(2,909)** | **(512) U** | **2,204** | **3,065** | **(861) U** | **(1,759)** | **(781)** | **(978) U** |
| **Net Result** | **(3,313)** | **(3,090)** | **(223)** U | **(4,460)** | **(4,412)** | **(48)** U | **3,990** | **3,990** | **(0)** U |

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

# 10. Management Budget Movements

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

The major changes between revenue and expense lines are usually due to health provision savings programmes. As these numbers have firmed up some savings programmes are around growing revenue rather than reducing costs. In 2015/16 changes to the operation of the price volume schedule (payments by the funder to the provider arm) will also create movements between the annual plan and the management budget.

| $'000 | December Mgmt Budget | December Annual Plan | December Movement | Year to Date Mgmt Budget | Year to Date Annual Plan | Year to Date Movement | End of Year Mgmt Budget | End of Year Annual Plan | End of Year Movement |
|---|---|---|---|---|---|---|---|---|---|
| **Funding** | | | | | | | | | |
| Income | 39,783 | 39,586 | 197 F | 239,091 | 237,955 | 1,135 F | 491,789 | 489,518 | 2,271 F |
| *Less:* | | | | | | | | | |
| Payments to Internal Providers | 20,757 | 20,662 | (95) U | 133,558 | 134,318 | 760 F | 262,678 | 263,334 | 656 F |
| Payments to Other Providers | 19,214 | 19,017 | (196) U | 113,063 | 111,930 | (1,134) U | 224,462 | 222,194 | (2,268) U |
| Contribution | **(187)** | **(93)** | **(94) U** | **(7,531)** | **(8,293)** | **761 F** | **4,649** | **3,990** | **659 F** |
| **Governance and Funding Admin.** | | | | | | | | | |
| Funding | 262 | 262 | - | 1,569 | 1,569 | - | 3,140 | 3,140 | - |
| Other Income | 3 | 3 | - | 15 | 15 | - | 30 | 30 | - |
| *Less:* | | | | | | | | | |
| Expenditure | 257 | 268 | 11 F | 1,530 | 1,591 | 61 F | 3,049 | 3,170 | 121 F |
| Contribution | **7** | **(4)** | **11 F** | **54** | **(7)** | **61 F** | **121** | **(0)** | **121 F** |
| **Health Provision** | | | | | | | | | |
| Funding | 20,495 | 20,400 | 95 F | 131,989 | 132,749 | (760) U | 259,538 | 260,194 | (656) U |
| Other Income | 1,692 | 1,676 | 16 F | 10,469 | 10,386 | 83 F | 21,046 | 20,865 | 181 F |
| *Less:* | | | | | | | | | |
| Expenditure | 25,097 | 25,069 | (27) U | 139,393 | 139,248 | (146) U | 281,365 | 281,060 | (305) U |
| Contribution | **(2,909)** | **(2,993)** | **84 F** | **3,065** | **3,888** | **(823) U** | **(781)** | **0** | **(781) U** |
| **Net Result** | **(3,090)** | **(3,090)** | **(0)** U | **(4,412)** | **(4,412)** | **(0)** U | **3,990** | **3,990** | **(0)** U |

# 11. Quality and Financial Improvement Programme

| Row Labels | Sum of Planned Savings | Count of Planned Savings | Sum of ytd savings target | Sum of YTD actual Savings |
|---|---|---|---|---|
| **CORPORATE** | **1,360** | **14** | **680** | **678** |
| Green | 1,360 | 14 | 680 | 678 |
| **Health Services** | **7,000** | **77** | **3372** | **2533** |
| Amber | 2,703 | 12 | 1349 | 862 |
| Green | 3,415 | 57 | 1582 | 1652 |
| Red | 882 | 8 | 441 | 19 |
| **Maori Health** | **82** | **1** | **41** | **34** |
| Green | 82 | 1 | 41 | 34 |
| **POPULATION HEALTH** | **70** | **2** | **35** | **29** |
| Green | 70 | 2 | 35 | 29 |
| **STRATEGIC SERV** | **1,688** | **2** | **366** | **366** |
| Green | 1,688 | 2 | 366 | 366 |
| **Grand Total** | **10,200** | **96** | **4494** | **3640** |

We are $854 thousand behind in our savings plans year to date.

The eight red programmes are (full year planned savings in brackets, and no savings have been achieved unless stated otherwise):

- Radiology duplicate testing ($45 thousand);
- Reduction in harm from falls ($20 thousand);
- Reduction in pressure sores ($20 thousand);
- Surgical Services savings ($400 thousand) – theatre overtime and sick leave has contributed $19 thousand.
- Contribution to the $1 million additional savings requirement:
    - Acute and Medical ($131 thousand);
    - Chief Operating Officer ($48 thousand)
    - Laboratory ($83 thousand)
    - Surgical Services ($105 thousand)

### Corporate, Maori Health, Population Health and Strategic Services

All green

### Health Services

There are 12 Amber Programmes

Savings of $226 thousand have been realised in five of the projects in the Acute and Medical savings plan that has a full year planned savings target of $1.163 million.

Savings of $276 thousand have been made in two efficiency programmes being driven out of the COO's office that have a full year savings target of $726 thousand.

Savings of $287 thousand have been made in the Older Persons Health and Mental Health savings plan that has a full year target of $689 thousand.

Savings of $14 thousand have been achieved in three of the Rural, Oral and Community Services savings programmes that has a full year target of $114 thousand.

Savings of $59 thousand have been made in the Mental Health and Addiction services contribution to the $1 million additional savings. The full year target is $141 thousand.

# 12. Financial Position

| 30 June 2015 | $'000 | December Actual | December Budget | December Variance from budget | December Movement from 30 June 2015 | Annual Budget |
|---|---|---|---|---|---|---|
| | **Equity** | | | | | |
| 120,014 | Crown equity and reserves | 120,014 | 108,540 | (11,474) | - | 108,183 |
| (32,388) | Accumulated deficit | (36,847) | (24,822) | 12,025 | (4,460) | (16,420) |
| 87,626 | | 83,166 | 83,718 | 552 | (4,460) | 91,763 |
| | **Represented by:** | | | | | |
| | Current Assets | | | | | |
| 14,970 | Bank | 60,442 | 1,487 | (58,955) | 45,472 | 8,756 |
| 1,703 | Bank deposits > 90 days | 1,741 | 1,564 | (178) | 39 | 1,564 |
| 17,862 | Prepayments and receivables | 10,234 | 17,966 | 7,732 | (7,628) | 18,146 |
| 3,881 | Inventory | 4,151 | 3,787 | (364) | 270 | 3,845 |
| 1,220 | Non current assets held for sale | 1,220 | 1,275 | 55 | - | - |
| 39,635 | | 77,789 | 26,078 | (51,710) | 38,154 | 32,310 |
| | Non Current Assets | | | | | |
| 148,434 | Property, plant and equipment | 152,922 | 161,065 | 8,143 | 4,488 | 166,016 |
| 2,298 | Intangible assets | 1,939 | 1,440 | (499) | (358) | 2,217 |
| 7,301 | Investments | 8,142 | 8,668 | 526 | 840 | 9,351 |
| 158,033 | | 163,003 | 171,173 | 8,170 | 4,970 | 177,583 |
| **197,668** | **Total Assets** | **240,792** | **197,251** | **(43,540)** | **43,124** | **209,894** |
| | **Liabilities** | | | | | |
| | Current Liabilities | | | | | |
| - | Bank overdraft | - | - | - | - | - |
| 29,960 | Payables | 79,890 | 37,483 | (42,407) | 49,929 | 35,540 |
| 35,239 | Employee entitlements | 32,893 | 31,155 | (1,738) | (2,346) | 32,660 |
| 65,199 | | 112,783 | 68,638 | (44,145) | 47,584 | 68,200 |
| | Non Current Liabilities | | | | | |
| 2,342 | Employee entitlements | 2,342 | 2,395 | 53 | - | 2,431 |
| 42,500 | Term borrowing | 42,500 | 42,500 | - | - | 47,500 |
| 44,842 | | 44,842 | 44,895 | 53 | - | 49,931 |
| **110,042** | **Total Liabilities** | **157,625** | **113,534** | **(44,092)** | **47,584** | **118,131** |
| | | | | | | |
| **87,626** | **Net Assets** | **83,166** | **83,718** | **552** | **(4,460)** | **91,763** |

The variance from budget for:

- Crown equity and reserves relates to the budgeted transfer of the asset replacement reserve to accumulated deficit which will occur in January rather than December when the MHIU opens, and to a lower valuation of land and buildings than estimated at 30 June 2015;
- Bank includes the early payment of January funding from the MOH (due on the 4th of the month or the previous business day – 28 December)
- Prepayments and receivables reflect the receipt of wash-ups
- Property, plant and equipment relates to the revaluation and later payments for the MHIU over the project life;
- Payables relates to the early payment of January MOH funding treated as income in advance, and the catch up of residential care invoicing by providers;
- Employee entitlements – see below

# 13. Employee Entitlements

| *30 June* | | *December* | | | | *Annual* |
|---|---|---|---|---|---|---|
| *2015* | $'000 | *Actual* | *Budget* | *Variance from budget* | *Movement from 30 June 2015* | *Budget* |
| 7,916 | Salaries & wages accrued | 7,174 | 5,403 | (1,771) | (742) | 5,482 |
| 1,370 | ACC levy provisions | 1,359 | 822 | (537) | (11) | 1,176 |
| 4,951 | Continuing medical education | 3,696 | 3,485 | (211) | (1,255) | 4,860 |
| 19,383 | Accrued leave | 19,032 | 19,973 | 942 | (351) | 19,649 |
| 3,962 | Long service leave & retirement grat. | 3,975 | 3,867 | (108) | 13 | 3,925 |
| 37,582 | **Total Employee Entitlements** | 35,236 | 33,551 | (1,685) | (2,346) | 35,091 |

# 14. Treasury

**Liquidity management**

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

**Debt management**

The term debt facility with MOH is for $42.5 million, and is fully drawn. A further $5 million relating to the disposal of the Napier site, is available for the mental health build, and is likely to be drawn down in the first quarter of calendar 2016. The DHBs interest exposure is managed through a spread of maturity dates, rather than the use of derivative financial instruments, and the average cost of borrowing is currently 4.58%. No debt will become current until the 2017/18 financial year, and $25 million is for terms longer than five years.

The drawdown of $6.5 million in June 2012 increased the amount maturing in March 2019 to $11.5 million. This was done to take advantage of the low interest rate applying to that maturity, but it also puts the balance for that year above the $10 million limit set in the Treasury Management Policy.

**Foreign exchange risk management**

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

# 15. Capital Expenditure

| *2016 Annual Plan* | | *Actual $'000* | *Year to Date Budget $'000* | *Variance $'000* |
|---|---|---|---|---|
| | Source of Funds | | | |
| | **Operating Sources** | | | |
| 13,872 | Depreciation | 6,549 | 6,618 | 70 |
| 3,990 | Surplus/(Deficit) | (4,460) | (4,412) | 48 |
| (113) | Working Capital | 9,517 | 6,885 | (2,632) |
| 17,749 | | 11,606 | 9,092 | (2,514) |
| | **Other Sources** | | | |
| - | Special funds and clinical trials | 43 | - | (43) |
| 5,000 | Borrowings | - | - | - |
| 5,000 | | 43 | - | (43) |
| **22,749** | **Total funds sourced** | **11,649** | **9,092** | **(2,557)** |
| | Application of Funds: | | | |
| | **Block Allocations** | | | |
| 3,856 | Facilities | 1,310 | 1,863 | 553 |
| 3,000 | Information Services | 478 | 900 | 422 |
| 5,200 | Clinical Plant & Equipment | 1,482 | 1,698 | 216 |
| - | Minor Capital | - | 27 | 27 |
| 12,056 | | 3,270 | 4,488 | 1,217 |
| | **Local Strategic** | | | |
| 665 | Renal Centralised Development | 12 | 166 | 155 |
| 848 | New Stand-alone Endoscopy Unit | 93 | 23 | (70) |
| 5,654 | New Mental Health Inpatient Unit Development | 5,795 | 2,827 | (2,968) |
| 2,035 | Maternity Services | 1,525 | 830 | (695) |
| 100 | Upgrade old MHIU | - | 50 | 50 |
| 9,302 | | 7,425 | 3,896 | (3,529) |
| | **Other** | | | |
| - | Special funds and clinical trials | 43 | - | (43) |
| - | Transform and Sustain | 3 | - | (3) |
| - | Other | 68 | 12 | (55) |
| - | | 113 | 12 | (101) |
| ***21,358*** | ***Capital Spend*** | ***10,808*** | ***8,396*** | ***(2,412)*** |
| | **Regional Strategic** | | | |
| 1,391 | RHIP (formerly CRISP) | 840 | 696 | (145) |
| 1,391 | | 840 | 696 | (145) |
| **22,749** | **Total funds applied** | **11,649** | **9,092** | **(2,557)** |

*The year to date budget excludes any funding brought forward from last year, however the year to date actual column includes expenditure against that funding.*

# Monthly Project Board Report
## Dec 2015

HAWKE'S BAY District Health Board

## New Mental Health Unit Development

**Project Director: G Carey-Smith (Acting)**

| Overall Project Progress | Overall Status | Time Status | Financial Status |
|---|---|---|---|
| 81% | G | G | G |

**Phase: Service & Facility Implementation**

Formal approval of the Business Case was received in April 2013 from the Minister of Health for a replacement mental health facility. The project will provide four key deliverables:
1). Service redesign of acute mental health services to align with the HBDHB 2012 Mental Health Model of Care. Includes for investment in alternatives to inpatient care, with an increased focus on care provided in the community.
2). A replacement mental health inpatient unit on the Hawke's Bay Regional Hospital site.
3). A replacement mental health sub-acute facility, co-located with the inpatient unit.
4). A replacement of the Recovery Centres to move to a Day programme (co-located with the inpatient unit) and some services within the community.
The project programme spans over a 30 month period and occur in 2 phases. The first phase including service & transition planning, facility design & tendering was completed on time with the main construction contract approved at the 25 June 2014 Board Meeting. Phase 2 is now underway and includes the main build construction contract together with the implementation of transition management to the new service delivery model.

### Project Budget Status

| | | | |
|---|---|---|---|
| **Total Approved Project Budget** | **$ 19,800,000** | Total 15/16 Total Forecast Spend | $ 7,972,000 |
| Total Project Spend to Date | $ 16,115,269 | Total 15/16 Spend to Date | $ 5,795,000 |
| Percentage of Total Spend vs Budget | 81% | Percentage 15/16 Spend vs Forecast | 73% |

The building tender process was completed and approval received at the 25 June 2014 Board Meeting for the letting of a contract with the successful tenderer. A good tender price plus savings from the site development projects has provided an overall saving to budget of $2.2M resulting in the total project budget being reduced to $19.8M. The new figures are reflected in the graph below. The 2015/16 Total Forecast Spend against 15/16 Spend to Date is consistent with plan.

### Deliverable Dates

| | | | | | |
|---|---|---|---|---|---|
| Phase 2 Facilities: Design & Tendering Stage | Jul-14 | √ | Phase 2 / Stage 2 of Service Transition begins | Apr-15 | √ |
| Site Works | Sep-14 | √ | HBT, unplanned respite implemented & embedded | Jul-15 | √ |
| Main Construction | Oct-15 | √ | Design and IT decisions made re CMHT | Oct-15 | √ |
| Commissioning & Building Fit-out | Nov-15 | √ | Staff training commences | Nov-15 | √ |
| Decant Relocate Staff | Dec-15 | √ | Revised policies, process, performance indicators | Nov-15 | √ |
| Project Handed over for 'Go Live' | Jan-16 | √ | IT solutions, capacity management in place | Nov-15 | |
| Property Disposal | (Settlement Dependant) | | Acute Unit "Goes Live" | Jan-16 | √ |

### Key Achievements this period

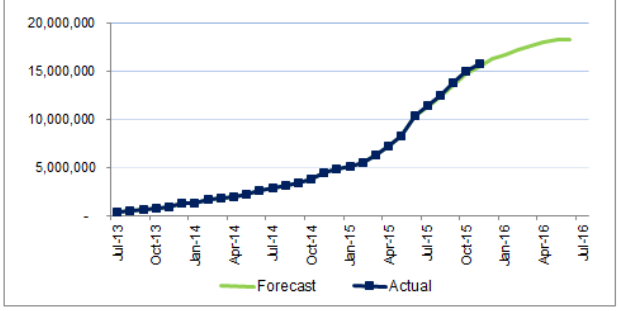
Very successful 'open days' with both staff and patients.
SPOE now in co-design phase with initial input group reconvened. Tasks established for sub-groups.
Continue to work with vendor to confirm the feasibility for IS developments needed to support the new model of care. IS systems necessary to support operations.
Community resilience programme ongoing.
Focus continues on integration across services and strengthening community mental health.
The main construction work is now complete and the building is certified for operation.

### Planned Activities next period

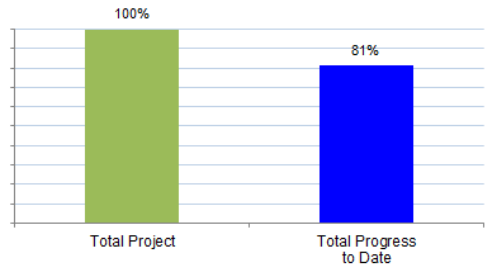
New Mental Health Unit to be fully occupied and operations functioning
IDP - Working group meeting weekly. Recruitment of lead priority, therefore developing position description, getting ready for advertising.
Case Load management – Working group to establish how data to be presented as a quick visual useful for management & staff to discuss implications.
Any building defects are managed as required over the next 12 months.
Final external landscaping, parking and other works are to be finalised.

| Risks & Issues of Note | Mitigation & Resolutions |
|---|---|
| Ensure project costs remain safely within budget parameters | Regular assessments and tight control of project costs and contingency spend |
| Service delivery model not fully "owned" by service providers | Onoging development and implementation of MoC. Staying true to MoC as founding document. |
| Timely alignment of any Community Contracts | Service Re-design & Transition Management completed in timely manner |
| Engagement with wider consumers | Partnership Advisory Group established. |
| Ability to secure adequate clinical resources in timely manner | Dependent on availability within current market but extending possible catchment area |
| Finalise IS requirements and possible funding requirements | Urgently complete work with dedicated Is resource and establish any funding requirements |
| Delay in HBT and Wai-o-Rua may impact on bed numbers in new facility | Work around pathways being developed to assist embedding new services yet retaining flexibility for a transition period re beds if needed |

### Forecast vs Actual Spend




### Total Project Progress



## 16. Rolling Cash Flow

| | December | | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Actual* | *Forecast* | *Variance* | *Forecast* | *Forecast* | *Forecast* | *Forecast* | *Forecast* | *Forecast* | *Budget* | *Budget* | *Budget* | *Budget* | *Budget* | *Budget* |
| **Cash flows from operating activities** | | | | | | | | | | | | | | | |
| Cash receipts from Crown agencies | 78,159 | 40,409 | 37,750 | 2,423 | 40,442 | 43,357 | 44,275 | 40,406 | 51,169 | 40,884 | 40,326 | 46,865 | 40,875 | 40,339 | 40,409 |
| Cash receipts from donations, bequests and clinical trials | 269 | - | 269 | - | - | - | - | - | - | - | - | - | - | - | - |
| Cash receipts from other sources | (395) | 451 | (846) | 467 | 428 | 433 | 453 | 447 | 428 | 451 | 467 | 450 | 451 | 449 | 451 |
| Cash paid to suppliers | (14,459) | (23,209) | 8,749 | (37,678) | (22,517) | (25,344) | (25,253) | (23,592) | (23,562) | (25,909) | (24,553) | (26,378) | (25,422) | (25,309) | (23,359) |
| Cash paid to employees | (17,467) | (17,759) | 292 | (15,213) | (14,019) | (18,418) | (15,191) | (14,869) | (17,112) | (16,516) | (13,472) | (18,454) | (14,355) | (14,976) | (16,609) |
| **Cash generated from operations** | **46,106** | **(108)** | **46,214** | **(50,001)** | **4,334** | **28** | **4,283** | **2,392** | **10,923** | **(1,090)** | **2,769** | **2,483** | **1,549** | **503** | **892** |
| Interest received | 208 | 92 | 116 | 92 | 86 | 91 | 88 | 90 | 88 | 87 | 79 | 79 | 85 | 78 | 92 |
| Interest paid | (339) | (199) | (140) | 0 | 0 | (98) | (419) | (261) | (190) | 0 | 0 | (99) | (420) | (264) | (199) |
| Capital charge paid | (3,485) | (3,910) | 425 | - | - | - | - | - | (3,910) | - | - | - | - | - | (4,142) |
| **Net cash inflow/(outflow) from operating activities** | **42,490** | **(4,125)** | **46,615** | **(49,908)** | **4,420** | **22** | **3,953** | **2,221** | **6,911** | **(1,002)** | **2,848** | **2,464** | **1,214** | **317** | **(3,357)** |
| **Cash flows from investing activities** | | | | | | | | | | | | | | | |
| Proceeds from sale of property, plant and equipment | - | - | - | - | - | - | - | - | 0 | - | - | - | - | - | - |
| Acquisition of property, plant and equipment | (1,018) | (2,248) | 1,231 | (1,724) | (1,682) | (1,659) | (1,423) | (1,113) | (2,786) | (2,724) | (2,724) | (2,724) | (1,505) | (1,505) | (1,505) |
| Acquisition of intangible assets | (7) | (257) | 250 | (79) | (129) | (104) | (119) | (45) | (50) | (76) | (76) | (76) | (126) | (126) | (100) |
| Acquisition of investments | - | (232) | 232 | (116) | (116) | (116) | (116) | (116) | (116) | (116) | (116) | (116) | (116) | (116) | (116) |
| **Net cash inflow/(outflow) from investing activities** | **(1,024)** | **(2,737)** | **1,713** | **(1,919)** | **(1,927)** | **(1,879)** | **(1,658)** | **(1,274)** | **(2,952)** | **(2,915)** | **(2,915)** | **(2,915)** | **(1,747)** | **(1,747)** | **(1,721)** |
| **Cash flows from financing activities** | | | | | | | | | | | | | | | |
| Proceeds from equity injection | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Proceeds from borrowings | - | - | - | - | - | 5,000 | - | - | - | - | - | - | - | - | - |
| Repayment of finance leases | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Equity repayment to the Crown | - | - | - | - | - | - | - | - | (357) | - | - | - | - | - | - |
| **Net cash inflow/(outflow) from financing activities** | **-** | **-** | **-** | **-** | **-** | **5,000** | **-** | **-** | **(357)** | **-** | **-** | **-** | **-** | **-** | **-** |
| Net increase/(decrease) in cash or cash equivalents | 41,466 | (6,862) | 48,328 | (51,828) | 2,493 | 3,143 | 2,295 | 947 | 3,601 | (3,917) | (67) | (452) | (533) | (1,430) | (5,078) |
| Add:Opening cash | 20,718 | 20,718 | - | 62,184 | 10,356 | 12,849 | 15,991 | 18,286 | 19,233 | 22,834 | 18,917 | 18,850 | 18,398 | 17,865 | 16,434 |
| **Cash and cash equivalents at end of year** | **62,184** | **13,856** | **48,328** | **10,356** | **12,849** | **15,991** | **18,286** | **19,233** | **22,834** | **18,917** | **18,850** | **18,398** | **17,865** | **16,434** | **11,356** |
| **Cash and cash equivalents** | | | | | | | | | | | | | | | |
| Cash | 7 | 7 | - | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 |
| Short term investments (excl. special funds/clinical trials) | 59,064 | 10,818 | 48,246 | 7,236 | 9,729 | 12,872 | 15,166 | 16,113 | 19,714 | 15,737 | 15,670 | 15,218 | 14,685 | 13,255 | 8,177 |
| Short term investments (special funds/clinical trials) | 3,112 | 3,029 | 82 | 3,112 | 3,112 | 3,112 | 3,112 | 3,112 | 3,112 | 3,172 | 3,172 | 3,172 | 3,172 | 3,172 | 3,172 |
| Bank overdraft | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | - | - | - | - | - | - |
| | **62,184** | **13,855** | **48,328** | **10,356** | **12,849** | **15,992** | **18,286** | **19,233** | **22,834** | **18,917** | **18,850** | **18,398** | **17,865** | **16,435** | **11,357** |

Draw-down of the revenue banking in 2015-16 is $0.8 million.

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Financial Performance Report, January 2016** 02b |
| | For the attention of: **Finance Risk and Audit Committee and the Board** |
| Document Owner:<br>Document Author(s): | Tim Evans, GM Planning, Informatics & Finance<br>Finance Team |
| Reviewed by: | Executive Management Team |
| Month: | February 2016 |
| Consideration: | For Information |

**RECOMMENDATION**

**That the Board**
Note the contents of this report

# 1. GM Planning Informatics & Finance comments

## Financial performance

The result for January is a favourable variance of $128 thousand following on from the $223 thousand unfavourable in December, making the year to date result $81 thousand favourable.

The one month's proportion of the remaining contingency released in December has been reversed. This related to the inherently uncertain results in December and January because of the effect of the holiday season on how staff take leave. The year to date part of the $1.0 million transferred to Surgical Services and the $90 thousand contributed to the corporate 3% savings plan, have been released.

Elective surgery was 0.6% above plan in January and 0.9% ahead of the health target year to date, with 92% provided in-house in comparison to the planned 75%.

## Forecast result

The forecast for the 30 June 2016 year remains at the $3.990 million budgeted surplus, however it is subject to high downside risk.

Cover for vacancies and sick leave and likely costs to avoid an ESPI breach, will more than offset the release of the remaining contingency. This makes realisation of planned efficiencies the most important factor in achieving the planned full year result.

However, the forecast prepared at the end of January has identified significant planned efficiencies as high risk (section 11 covers the year to date status of the savings plan). The IDF wash-up also contributes uncertainty to the forecast.

## 2. Resource Overview

| | January | | | | Year to Date | | | | Year End Forecast | Refer Section |
|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | | |
| | $'000 | $'000 | $'000 | % | $'000 | $'000 | $'000 | % | $'000 | |
| Net Result - surplus/(deficit) | (2,122) | (2,250) | 128 | 5.7% | (6,581) | (6,662) | 81 | 1.2% | 3,990 | 3 |
| Contingency utilised | 91 | 250 | 159 | 63.7% | 636 | 1,750 | 1,114 | 63.7% | 3,000 | 8 |
| Quality and financial improvement | 1,107 | 759 | 348 | 45.8% | 4,747 | 5,253 | (506) | -9.6% | 10,200 | 11 |
| Capital spend | 1,059 | 2,428 | (1,370) | -56.4% | 11,867 | 10,825 | 1,042 | 9.6% | 21,358 | 16 |
| | FTE | FTE | FTE | % | FTE | FTE | FTE | % | FTE | |
| Employees | 2,103 | 2,101 | (2) | -0.1% | 2,116 | 2,163 | 47 | 2.2% | 2,186 | 5 & 7 |
| | CWD | CWD | CWD | % | CWD | CWD | CWD | % | CWD | |
| Case weighted discharges | 2,216 | 1,894 | 322 | 17.0% | 16,440 | 15,954 | 486 | 3.0% | 27,009 | 5 |

The result for January is a favourable variance of $128 thousand, with $636 thousand of the contingency utilised ($583 thousand transferred to surgical, and $53 thousand contributed to the corporate 3% savings plan year to date).

Quality and Financial Improvement (QFI) programme savings are below plan reflecting the progressive realisation of savings, and the increasing difficulty achieving them. The implementation and monitoring of savings plans is ongoing. Realisation of IDF savings will not be known until the 2015/16 IDF wash-up process is complete.

Capital spend is well ahead of plan year to date reflecting the catch-up of Mental Health Inpatient Unit project payments that were incurred more slowly than budgeted last year.

The FTE variance year to date reflects vacancies relating to new programmes or changes in the model of care.

Case weighted discharges were above plan in January, and are 3.0% ahead of plan year to date. High acute general surgery, gastroenterology, and orthopaedic volumes drive the year to date variance partly offset by lower than planned maternity, general internal medicine, and acute neonates.

## 3. Financial Performance Summary

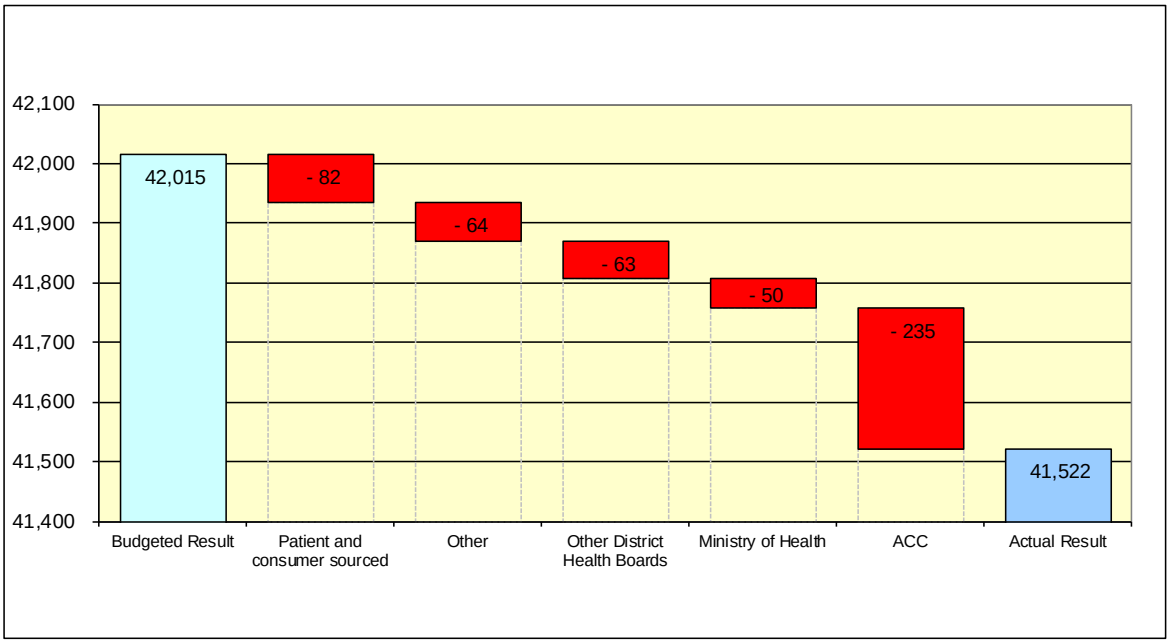
| | January | | | | Year to Date | | | | Year End Forecast | Refer Section |
|---|---|---|---|---|---|---|---|---|---|---|
| $'000 | Actual | Budget | Variance | | Actual | Budget | Variance | | | |
| Income | 41,523 | 42,015 | (493) | -1.2% | 291,251 | 291,590 | (339) | 0.1% | 512,517 | 4 |
| *Less:* | | | | | | | | | | |
| Providing Health Services | 21,894 | 22,176 | 282 | 1.3% | 139,549 | 139,084 | (465) | -0.3% | 238,334 | 5 |
| Funding Other Providers | 18,367 | 18,600 | 233 | 1.3% | 130,720 | 131,664 | 944 | 0.7% | 223,798 | 6 |
| Corporate Services | 2,941 | 3,179 | 238 | 7.5% | 25,198 | 25,283 | 85 | 0.3% | 43,991 | 7 |
| Reserves | 442 | 309 | (133) | -42.9% | 2,365 | 2,221 | (144) | -6.5% | 2,405 | 8 |
| | **(2,122)** | **(2,250)** | 128 | -5.7% | **(6,581)** | **(6,662)** | 81 | -1.2% | **3,990** | |

The lower than budgeted leave taken ahead of the holiday season that was the driver of the December result, reversed in January. The contingency released to partly offset the effect in December, was re-provided for in January. Leave taken in January instead of December and later than budgeted depreciation on Nga Rau Rakau explain the corporate variance. The re-provision of contingency is the driver of the favourable reserves variance in January.

# 4. Income

| $'000 | January | | | | Year to Date | | | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | |
| Ministry of Health | 39,775 | 39,825 | (50) | -0.1% | 276,993 | 277,024 | (31) | 0.0% | 488,064 |
| Inter District Flows | 624 | 624 | 0 | 0.0% | 4,368 | 4,365 | 4 | 0.1% | 7,486 |
| Other District Health Boards | 307 | 370 | **(63)** | **-17.0%** | 2,174 | 2,402 | **(228)** | **-9.5%** | 4,112 |
| Financing | 94 | 87 | 7 | 8.5% | 916 | 588 | **328** | **55.8%** | 1,360 |
| ACC | 314 | 550 | **(235)** | **-42.8%** | 3,107 | 3,631 | **(524)** | **-14.4%** | 5,321 |
| Other Government | 18 | 35 | (16) | -47.7% | 216 | 242 | (25) | -10.4% | 389 |
| Patient and Consumer Sourced | 83 | 165 | **(82)** | **-49.5%** | 640 | 904 | **(264)** | **-29.2%** | 1,211 |
| Other Income | 322 | 361 | (39) | -10.8% | 2,825 | 2,435 | **390** | **16.0%** | 4,564 |
| Abnormals | (15) | - | (15) | 0.0% | 10 | - | 10 | 0.0% | 10 |
| | **41,523** | **42,015** | (493) | -1.2% | **291,251** | **291,590** | (339) | -0.1% | **512,517** |

## January Income




*Note the scale does not begin at zero*

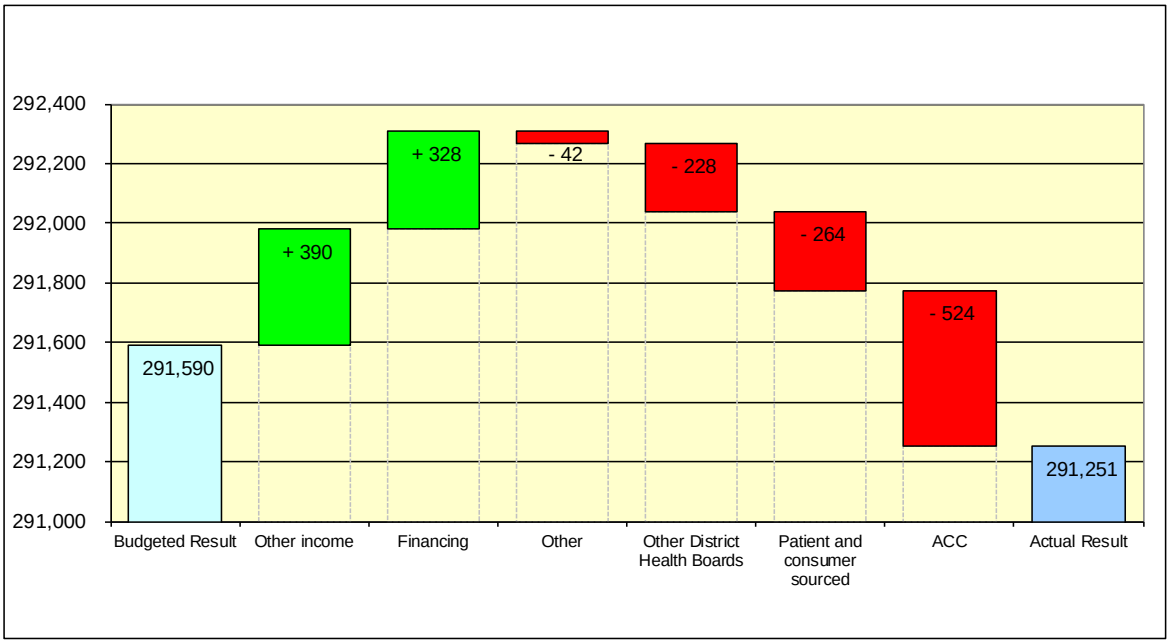
**Patient and consumer sourced** (unfavourable)
Non-residents and patient co-payments down on last year.

**Other District Health Boards** (unfavourable)
Lower sales of cancer drugs to Tairawhiti DHB, mostly offset by lower expenditure. Partly offset by higher oncology income from Mid Central DHB.

**Ministry of Health** (unfavourable**)**
Reduced clinical training income, offset by reduced costs.

**ACC** (unfavourable**)**
Prioritisation of elective surgery over ACC volumes.

## Year to date Income




**Other income** (favourable)
Includes clinical trial income and donations (unbudgeted), and income from Hawke's Bay PHO.

**Financing** (favourable**)**
Higher cash balances than projected, and income on special fund and clinical trial balances unbudgeted.

**Other District Health Boards** (unfavourable**)**
Lower sales of cancer drugs to Tairawhiti DHB, partly offset by higher oncology clinic charges to Mid Central DHB. Both offset in expenditure.

**Patient and consumer sourced** (unfavourable**)**
Lower non-resident charges and patient co-payments.

**ACC** (unfavourable)
Prioritisation of elective surgery over ACC volumes.

# 5. Providing Health Services

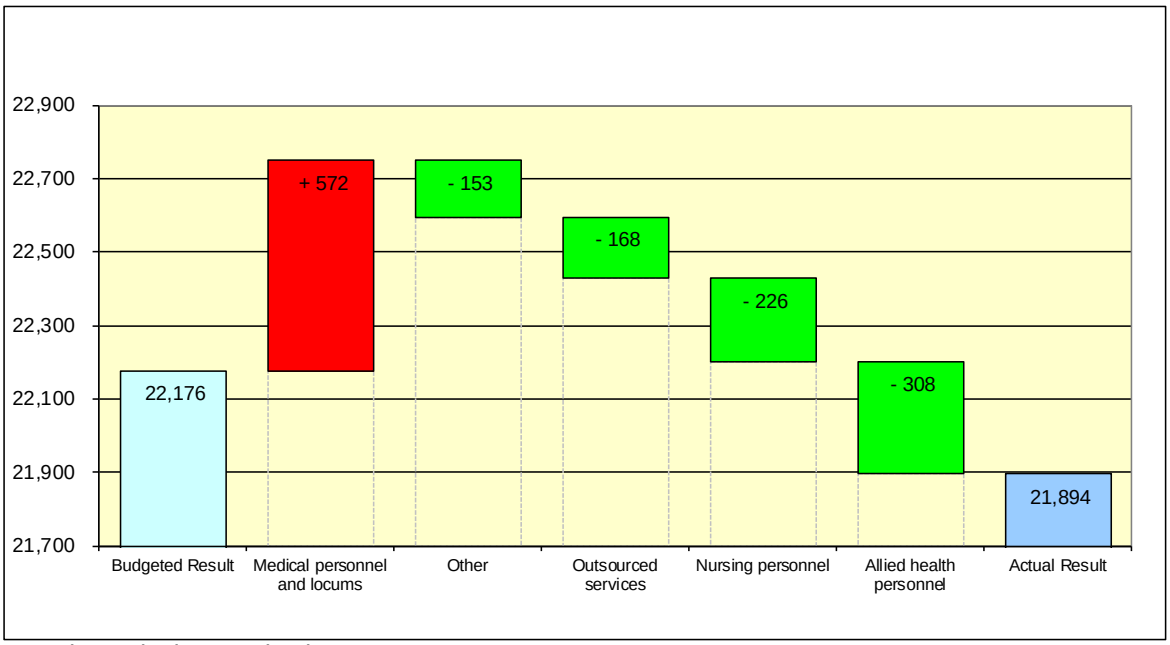
| | January | | | | Year to Date | | | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| | Actual | Budget | Variance | | Actual | Budget | Variance | | |
| **Expenditure by type** $'000 | | | | | | | | | |
| Medical personnel and locums | 7,548 | 6,976 | (572) | -8.2% | 33,952 | 33,092 | (860) | -2.6% | 57,073 |
| Nursing personnel | 5,909 | 6,135 | 226 | 3.7% | 40,757 | 41,192 | 435 | 1.1% | 70,116 |
| Allied health personnel | 2,230 | 2,538 | 308 | 12.1% | 17,481 | 18,725 | 1,243 | 6.6% | 31,097 |
| Other personnel | 1,630 | 1,693 | 64 | 3.8% | 11,798 | 11,865 | 67 | 0.6% | 20,312 |
| Outsourced services | 309 | 477 | 168 | 35.1% | 3,183 | 3,137 | (46) | -1.5% | 5,553 |
| Clinical supplies | 2,893 | 2,905 | 12 | 0.4% | 21,506 | 20,233 | (1,272) | -6.3% | 35,224 |
| Infrastructure and non clinical | 1,374 | 1,452 | 77 | 5.3% | 10,871 | 10,841 | (31) | -0.3% | 18,958 |
| | **21,894** | **22,176** | 282 | 1.3% | **139,549** | **139,084** | (465) | -0.3% | **238,334** |
| **Expenditure by directorate** $'000 | | | | | | | | | |
| Acute and Medical | 6,529 | 6,294 | (234) | -3.7% | 37,908 | 36,652 | (1,256) | -3.4% | 63,334 |
| Surgical Services | 5,121 | 4,835 | (285) | -5.9% | 31,151 | 30,359 | (792) | -2.6% | 52,545 |
| Women Children and Youth | 1,889 | 1,976 | 88 | 4.4% | 11,452 | 11,470 | 18 | 0.2% | 19,655 |
| Older Persons & Mental Health | 2,920 | 3,179 | 259 | 8.2% | 19,038 | 19,654 | 617 | 3.1% | 32,680 |
| Rural, Oral and Communlty | 1,785 | 1,966 | 182 | 9.2% | 12,589 | 12,809 | 221 | 1.7% | 21,660 |
| Other | 3,652 | 3,925 | 273 | 7.0% | 27,411 | 28,140 | 728 | 2.6% | 48,461 |
| | **21,894** | **22,176** | 282 | 1.3% | **139,549** | **139,084** | (465) | -0.3% | **238,334** |
| **Full Time Equivalents** | | | | | | | | | |
| Medical personnel | 374.1 | 334.8 | (39) | -11.7% | 307 | 304 | (3) | -0.9% | 303.8 |
| Nursing personnel | 869.7 | 840.1 | (30) | -3.5% | 871 | 879 | 8 | 0.9% | 891.7 |
| Allied health personnel | 370.1 | 416.0 | 46 | 11.0% | 409 | 440 | 31 | 7.1% | 445.5 |
| Support personnel | 138.6 | 123.4 | (15) | -12.3% | 131 | 128 | (3) | -2.0% | 129.4 |
| Management and administration | 223.7 | 229.8 | 6 | 2.6% | 246 | 245 | (1) | -0.2% | 247.7 |
| | **1,976.2** | **1,944.2** | (32) | -1.6% | **1,963** | **1,996** | 33 | 1.7% | **2,018.1** |
| **Case Weighted Discharges** | | | | | | | | | |
| Acute | 1,634 | 1,264 | 370 | 29.3% | 11,612 | 10,978 | 634 | 5.8% | 18,426 |
| Elective | 505 | 429 | 76 | 17.6% | 3,617 | 3,551 | 67 | 1.9% | 6,195 |
| Maternity | 59 | 174 | (115) | -65.9% | 990 | 1,219 | (229) | -18.8% | 2,035 |
| IDF Inflows | 18 | 26 | (8) | -31.2% | 221 | 206 | 15 | 7.4% | 353 |
| | **2,216** | **1,894** | 322 | 17.0% | **16,440** | **15,954** | 486 | 3.0% | **27,009** |

## Directorates

The favourable result for January relates to:

- Surgical Services – RMO changeover and efficiencies not achieved
- Older Persons and Mental Health – CME forfeits and vacancies
- Rural, Oral and Community – dental therapist and district nurse leave over the school holiday period, and CME forfeits.
- Other – oncology pharmaceuticals, blood products, vehicle fleet costs and utilities

## January Expenditure




*Note the scale does not begin at zero*

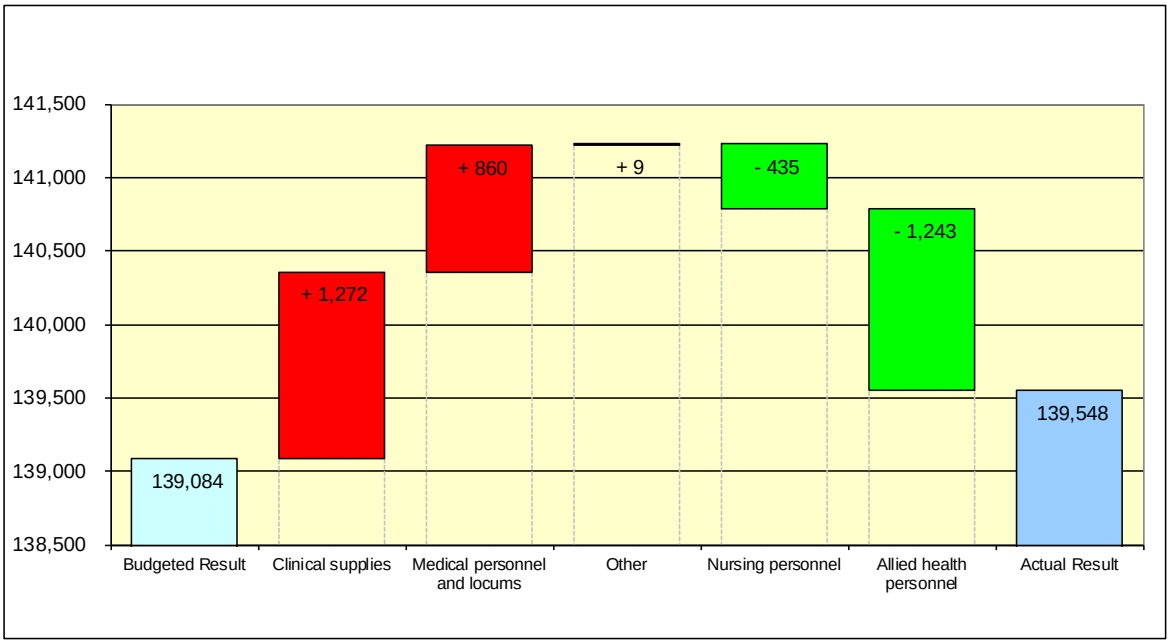
**Medical personnel and locums** (unfavourable)
RMO change-over, partly offset by CME forfeits. Vacancy and sick leave cover.

**Outsourced services** (favourable)
Royston surgery and radiology spot purchases reduced over the holiday period.

**Nursing personnel** (favourable)
Additional hours worked in January in comparison to budget and the resulting reduced annual leave hours usually increases costs. However the rate per hour budgeted for the valuation of annual leave is higher than the actual valuation, and more than offsets the increased costs.

**Allied health personnel** (favourable)
Vacancies mainly in therapies, laboratory technicians, and community support workers.

## Year to date Expenditure




**Clinical supplies** (unfavourable)
Savings targets of $1.9 million not achieved (offset elsewhere), marginally offset by lower clinical supply costs including implant/prostheses, pharmaceuticals and patient appliances.

**Medical personnel and locums** (unfavourable)
Vacancy and annual leave cover mainly in psychiatry, emergency medicine and Wairoa GPs.

**Nursing personnel** (favourable)
Annual leave taken by district nurses over the summer school holiday period, and the effect of annual leave valuations in January. Both of these variances will reverse over the remainder of the financial year.

**Allied health personnel** (favourable)
Vacancies mainly in mental health, pharmacy, and health of older people. Annual leave taken by dental therapists over the school holidays.

## Full time equivalents (FTE)

FTEs are 33 favourable year to date, including:

**Allied health personnel** (31 FTE / 7.1% favourable)
- Vacancies. Recruitment to positions for new models of care, low supply of applicants, delays in staged recruitment of pharmacy facilitators, and difficulty recruiting laboratory vacancies.

**Nursing personnel** (8 FTE / 0.9% favourable)
- Management of low volumes in Ata Rangi, and vacancies in rural services.

**Medical personnel** (3 FTE / 0.9% unfavourable)
- Medical FTEs have turned unfavourable as registrar and house officer worked hours were above budget in January.

# MONTHLY ELECTIVE HEALTH TARGET REPORT
# YTD To January 2016




| Plan for 2015/16 | On-Site | Outsourced | IDF Outflow | TOTAL |
|---|---|---|---|---|
| Non Surgical - Arranged | 70 | 0 | 0 | **70** |
| Non Surgical - Elective | 187 | 0 | 0 | **187** |
| Surgical - Arranged | 382 | 0 | 370 | **752** |
| Surgical - Elective | 4,682 | 768 | 650 | **6,100** |
| TOTAL | **5,321** | **768** | **1,020** | **7,109** |

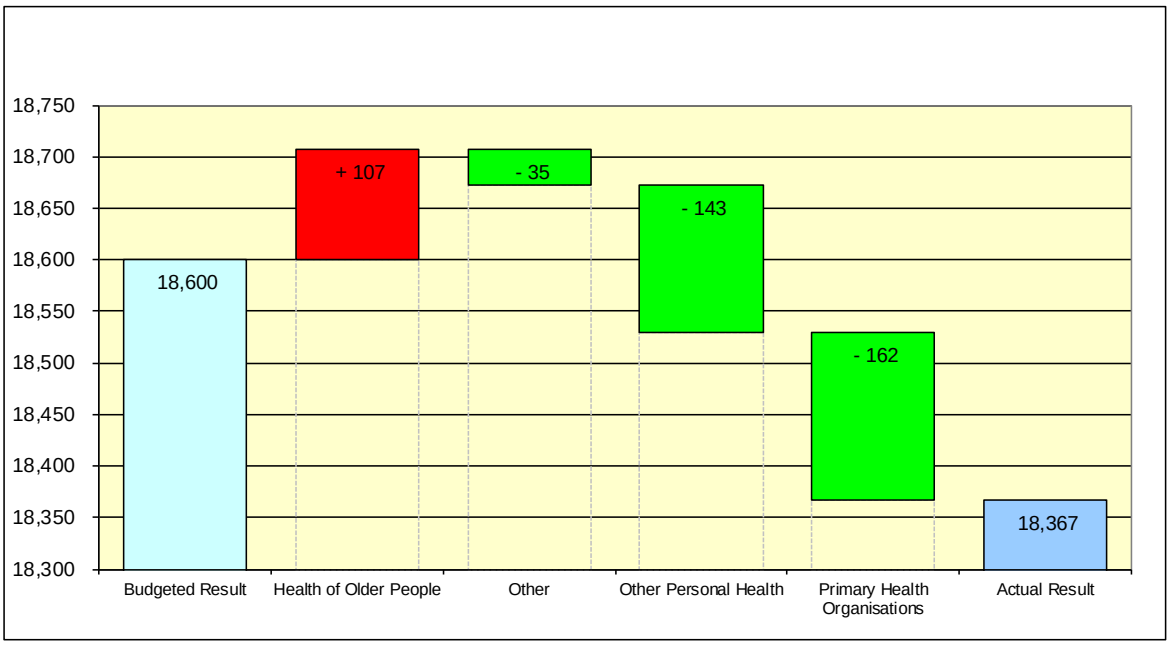
| | | YTD January 2016 | | | |
|---|---|---|---|---|---|
| | | Actual | Plan | Var. | %Var. |
| On-Site | Avastins | 113 | 113 | 0 | 0.0% |
| | ENT | 292 | 243 | 49 | 20.2% |
| | General Surgery | 560 | 608 | -48 | -7.9% |
| | Gynaecology | 351 | 319 | 32 | 10.0% |
| | Maxillo-Facial | 89 | 71 | 18 | 25.4% |
| | Ophthalmology | 621 | 391 | 230 | 58.8% |
| | Orthopaedics | 531 | 540 | -9 | -1.7% |
| | Skin Lesions | 102 | 102 | 0 | 0.0% |
| | Urology | 223 | 261 | -38 | -14.6% |
| | Vascular | 83 | 65 | 18 | 27.7% |
| | Surgical - Arranged | 337 | 221 | 116 | 52.5% |
| | Non Surgical - Elective | 57 | 108 | -51 | -47.2% |
| | Non Surgical - Arranged | 23 | 41 | -18 | -43.9% |
| **On-Site** | **Total** | **3382** | **3083** | **299** | **9.7%** |
| Outsourced | Cardiothoracic | 0 | 0 | 0 | 0.0% |
| | ENT | 46 | 190 | -144 | -75.8% |
| | General Surgery | 91 | 94 | -3 | -3.2% |
| | Gynaecology | 0 | 31 | -31 | -100.0% |
| | Maxillo-Facial | 38 | 59 | -21 | -35.6% |
| | Neurosurgery | 0 | 0 | 0 | 0.0% |
| | Orthopaedics | 0 | 13 | -13 | -100.0% |
| | Paediatric Surgery | 0 | 0 | 0 | 0.0% |
| | Urology | 18 | 14 | 4 | 28.6% |
| | Vascular | 4 | 0 | 4 | 0.0% |
| | Surgical - Arranged | 0 | 0 | 0 | 0.0% |
| | Non Surgical - Elective | 0 | 0 | 0 | 0.0% |
| | Non Surgical - Arranged | 0 | 0 | 0 | 0.0% |
| **Outsourced** | **Total** | **197** | **401** | **-204** | **-50.9%** |
| IDF Outflow | Cardiothoracic | 39 | 51 | -12 | -23.5% |
| | ENT | 26 | 25 | 1 | 4.0% |
| | General Surgery | 26 | 32 | -6 | -18.8% |
| | Gynaecology | 20 | 21 | -1 | -4.8% |
| | Maxillo-Facial | 112 | 91 | 21 | 23.1% |
| | Neurosurgery | 28 | 25 | 3 | 12.0% |
| | Ophthalmology | 19 | 15 | 4 | 26.7% |
| | Orthopaedics | 7 | 19 | -12 | -63.2% |
| | Paediatric Surgery | 23 | 28 | -5 | -17.9% |
| | Skin Lesions | 40 | 38 | 2 | 5.3% |
| | Urology | 1 | 2 | -1 | -50.0% |
| | Vascular | 11 | 36 | -25 | -69.4% |
| | Surgical - Arranged | 93 | 215 | -122 | -56.7% |
| | Non Surgical - Elective | 73 | 0 | 73 | 0.0% |
| | Non Surgical - Arranged | 22 | 0 | 22 | 0.0% |
| **IDF Outflow** | **Total** | **540** | **598** | **-58** | **-9.7%** |
| | | **4119** | **4082** | **37** | **0.9%** |

| | | January 2016 | | | |
|---|---|---|---|---|---|
| | | Actual | Plan | Var. | %Var. |
| On-Site | Avastins | 14 | 14 | 0 | 0.0% |
| | ENT | 19 | 30 | -11 | -36.7% |
| | General Surgery | 81 | 77 | 4 | 5.2% |
| | Gynaecology | 72 | 41 | 31 | 75.6% |
| | Maxillo-Facial | 17 | 9 | 8 | 88.9% |
| | Ophthalmology | 97 | 49 | 48 | 98.0% |
| | Orthopaedics | 63 | 68 | -5 | -7.4% |
| | Skin Lesions | 13 | 13 | 0 | 0.0% |
| | Urology | 12 | 33 | -21 | -63.6% |
| | Vascular | 14 | 8 | 6 | 75.0% |
| | Surgical - Arranged | 75 | 28 | 47 | 167.9% |
| | Non Surgical - Elective | 1 | 13 | -12 | -92.3% |
| | Non Surgical - Arranged | 0 | 6 | -6 | -100.0% |
| **On-Site** | **Total** | **478** | **389** | **89** | **22.9%** |
| Outsourced | Cardiothoracic | 0 | 0 | 0 | 0.0% |
| | ENT | 4 | 18 | -14 | -77.8% |
| | General Surgery | 8 | 9 | -1 | -11.1% |
| | Gynaecology | 0 | 3 | -3 | -100.0% |
| | Maxillo-Facial | 0 | 5 | -5 | -100.0% |
| | Neurosurgery | 0 | 0 | 0 | 0.0% |
| | Orthopaedics | 0 | 1 | -1 | -100.0% |
| | Paediatric Surgery | 0 | 0 | 0 | 0.0% |
| | Urology | 0 | 1 | -1 | -100.0% |
| | Vascular | 0 | 0 | 0 | 0.0% |
| | Surgical - Arranged | 0 | 0 | 0 | 0.0% |
| | Non Surgical - Elective | 0 | 0 | 0 | 0.0% |
| | Non Surgical - Arranged | 0 | 0 | 0 | 0.0% |
| **Outsourced** | **Total** | **12** | **37** | **-25** | **-67.6%** |
| IDF Outflow | Cardiothoracic | 1 | 8 | -7 | -87.5% |
| | ENT | 0 | 4 | -4 | -100.0% |
| | General Surgery | 2 | 5 | -3 | -60.0% |
| | Gynaecology | 1 | 3 | -2 | -66.7% |
| | Maxillo-Facial | 0 | 15 | -15 | -100.0% |
| | Neurosurgery | 3 | 4 | -1 | -25.0% |
| | Ophthalmology | 1 | 2 | -1 | -50.0% |
| | Orthopaedics | 0 | 3 | -3 | -100.0% |
| | Paediatric Surgery | 3 | 4 | -1 | -25.0% |
| | Skin Lesions | 2 | 6 | -4 | -66.7% |
| | Urology | 1 | 0 | 1 | 0.0% |
| | Vascular | 0 | 5 | -5 | -100.0% |
| | Surgical - Arranged | 8 | 32 | -24 | -75.0% |
| | Non Surgical - Elective | 3 | 0 | 3 | 0.0% |
| | Non Surgical - Arranged | 5 | 0 | 5 | 0.0% |
| **IDF Outflow** | **Total** | **30** | **91** | **-61** | **-67.0%** |
| | | **520** | **517** | **3** | **0.6%** |

# 6. Funding Other Providers

| $'000 | January Actual | January Budget | January Variance | | Year to Date Actual | Year to Date Budget | Year to Date Variance | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| **Payments to Other Providers** | | | | | | | | | |
| Pharmaceuticals | 3,398 | 3,454 | 56 | 1.6% | 25,173 | 25,313 | 140 | 0.6% | 42,103 |
| Primary Health Organisations | 2,693 | 2,855 | 162 | 5.7% | 19,760 | 19,915 | 155 | 0.8% | 34,562 |
| Inter District Flows | 3,903 | 3,899 | (4) | -0.1% | 27,349 | 27,291 | (59) | -0.2% | 46,843 |
| Other Personal Health | 1,731 | 1,874 | 143 | 7.6% | 13,651 | 13,661 | 10 | 0.1% | 22,818 |
| Mental Health | 1,162 | 1,116 | (46) | -4.2% | 7,896 | 7,809 | (87) | -1.1% | 13,479 |
| Health of Older People | 5,056 | 4,949 | (107) | -2.2% | 34,304 | 34,642 | 338 | 1.0% | 59,071 |
| Other Funding Payments | 425 | 454 | 29 | 6.5% | 2,586 | 3,032 | 446 | 14.7% | 4,922 |
| | 18,367 | 18,600 | 233 | 1.3% | **130,720** | **131,664** | 944 | 0.7% | 223,798 |
| **Payments by Portfolio** | | | | | | | | | |
| Strategic Services | | | | | | | | | |
| Secondary Care | 4,004 | 4,161 | 157 | 3.8% | 29,063 | 29,106 | 42 | 0.1% | 48,198 |
| Primary Care | 6,912 | 7,190 | 278 | 3.9% | 51,371 | 51,948 | 577 | 1.1% | 88,680 |
| Chronic Disease Management | 353 | 345 | (9) | -2.5% | 2,249 | 2,403 | 154 | 6.4% | 4,173 |
| Mental Health | 1,162 | 1,112 | (50) | -4.5% | 7,893 | 7,783 | (110) | -1.4% | 13,456 |
| Health of Older People | 5,191 | 5,035 | (156) | -3.1% | 35,145 | 35,242 | 97 | 0.3% | 60,341 |
| Other Health Funding | - | (17) | (17) | -100.0% | (46) | (117) | (71) | -60.7% | (146) |
| Maori Health | 506 | 526 | 21 | 3.9% | 3,530 | 3,684 | 154 | 4.2% | 6,214 |
| Population Health | 239 | 249 | 9 | 3.8% | 1,515 | 1,614 | 100 | 6.2% | 2,882 |
| | 18,367 | 18,600 | 233 | 1.3% | **130,720** | **131,664** | 944 | 0.7% | 223,798 |

## January Expenditure

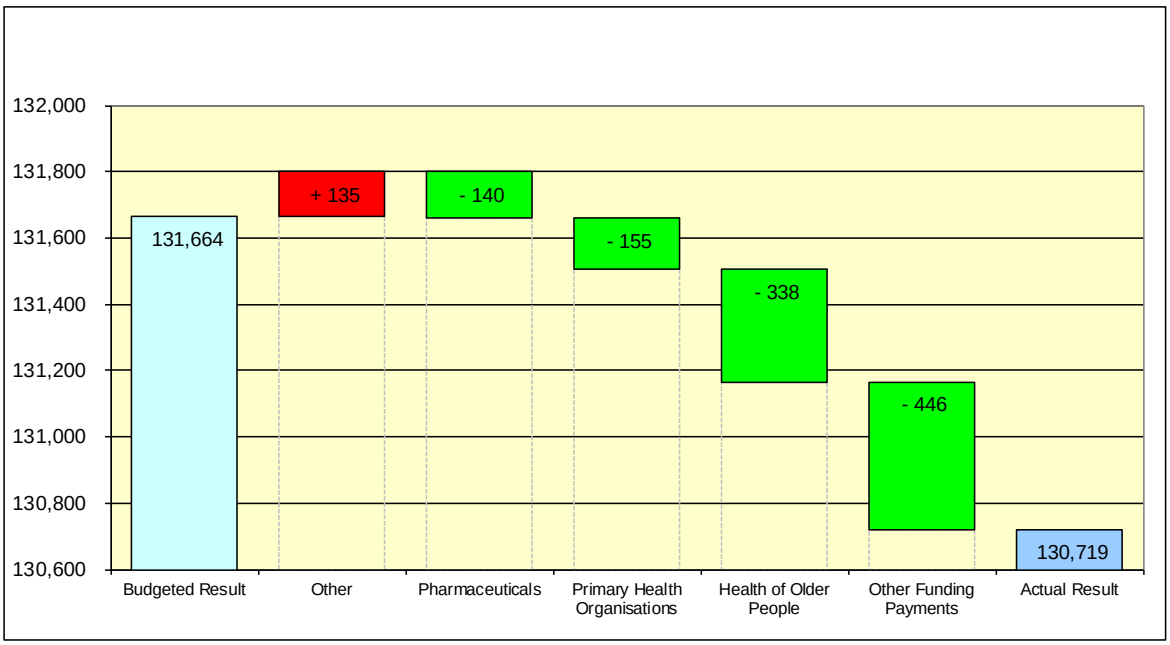



**Health of Older People** (unfavourable)
Higher community and residential care costs, partly offset by lower community support costs.

**Other Personal Health** (favourable)
Release of part of the exceptional circumstances provision.

**Primary Health Organisations** (favourable)
Lower access payments.

## Year to date Expenditure




**Primary Health Organisations** (favourable)
Lower access payments.

**Health of Older People** (unfavourable)
Lower community and residential care costs.

**Other Funding Payments** (favourable)
Other funding payments reflects later than planned implementation of new investments, and delay of the Whanau Manaaki programme to accommodate a service review.

# 7. Corporate Services

| $'000 | January Actual | January Budget | January Variance | | Year to Date Actual | Year to Date Budget | Year to Date Variance | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| **Operating Expenditure** | | | | | | | | | |
| Personnel | 993 | 1,105 | 112 | 10.1% | 8,511 | 8,580 | 69 | 0.8% | 14,687 |
| Outsourced services | 120 | 86 | (33) | -38.5% | 699 | 605 | (94) | -15.6% | 1,115 |
| Clinical supplies | 6 | 0 | (6) | -1196.5% | 60 | 3 | (56) | -1684.9% | 62 |
| Infrastructure and non clinical | 554 | 603 | 49 | 8.1% | 5,143 | 5,037 | (106) | -2.1% | 8,516 |
| | 1,673 | 1,795 | 122 | 6.8% | 14,413 | 14,225 | (188) | -1.3% | 24,380 |
| **Capital servicing** | | | | | | | | | |
| Depreciation and amortisation | 1,103 | 1,219 | 116 | 9.5% | 7,652 | 7,837 | 186 | 2.4% | 13,686 |
| Financing | 165 | 166 | 1 | 0.3% | 1,146 | 1,149 | 3 | 0.3% | 1,953 |
| Capital charge | - | - | - | 0.0% | 1,987 | 2,071 | 84 | 4.1% | 3,971 |
| | 1,268 | 1,385 | 116 | 8.4% | 10,785 | 11,058 | 273 | 2.5% | 19,610 |
| | **2,941** | **3,179** | 238 | 7.5% | **25,198** | **25,283** | 85 | 0.3% | **43,991** |
| **Full Time Equivalents** | | | | | | | | | |
| Medical personnel | 0.2 | - | (0) | 0.0% | 1 | - | (1) | 0.0% | - |
| Nursing personnel | 10.6 | 15.7 | 5 | 32.3% | 11 | 16 | 5 | 31.1% | 16.5 |
| Allied health personnel | - | - | - | 0.0% | 0 | - | (0) | 0.0% | - |
| Support personnel | 8.0 | 8.8 | 1 | 8.2% | 9 | 9 | (0) | -0.3% | 9.4 |
| Management and administration | 108.3 | 132.3 | 24 | 18.1% | 132 | 141 | 9 | 6.6% | 142.5 |
| | **127.2** | **156.8** | 30 | 18.9% | **153** | **167** | 14 | 8.3% | **168.4** |

Personnel costs reflect annual leave taken in January that was budgeted to be taken in December, and unbudgeted costs for clinical trials that are offset by unbudgeted income.

Depreciation and amortisation costs reflects the later than budgeted opening of the new mental health inpatient unit.

Outsourced services year to date include the OSH medical locum, administrative support for the doctor's office and secondment of staff from Health Hawke's Bay.

Clinical supplies year to date includes efficiencies that have been achieved in infrastructure and non-clinical costs.

# 8. Reserves

| $'000 | January Actual | January Budget | January Variance | | Year to Date Actual | Year to Date Budget | Year to Date Variance | | Year End Forecast |
|---|---|---|---|---|---|---|---|---|---|
| **Expenditure** | | | | | | | | | |
| Royston surgery contract | - | - | - | 0.0% | - | - | - | 0.0% | - |
| Contingency | 326 | 159 | (167) | -104.9% | 1,114 | 1,114 | (0) | 0.0% | 326 |
| Transform and Sustain resource | 40 | 38 | (2) | -6.3% | 279 | 270 | (9) | -3.2% | 916 |
| System improvement opportunities | - | - | - | 0.0% | - | - | - | 0.0% | - |
| Other | 76 | 112 | 37 | 32.7% | 972 | 836 | (136) | -16.2% | 1,163 |
| | **442** | **309** | (133) | -42.9% | **2,365** | **2,221** | (144) | -6.5% | **2,405** |

The contingency released in December, reflecting uncertainty arising from the holiday period, has been re-provided for in January. Contingency budgets have previously been adjusted for the $1 million transfer to Surgical Services, and the 3% savings target.

The Other category includes loss on disposal of assets and TAS audits relating to 2014/15.

# 9. Financial Performance by MOH Classification

| $'000 | January Actual | January Annual Plan | January Variance | Year to Date Actual | Year to Date Annual Plan | Year to Date Variance | End of Year Forecast | End of Year Annual Plan | End of Year Variance |
|---|---|---|---|---|---|---|---|---|---|
| **Funding** | | | | | | | | | |
| Income | 39,972 | 39,962 | 9 F | 278,927 | 279,053 | (126) U | 491,662 | 491,789 | (127) U |
| *Less:* | | | | | | | | | |
| Payments to Internal Providers | 20,299 | 20,299 | (0) U | 153,858 | 153,858 | (0) U | 262,678 | 262,678 | (0) U |
| Payments to Other Providers | 18,367 | 18,600 | 233 F | 130,720 | 131,664 | 944 F | 223,798 | 224,462 | 664 F |
| Contribution | **1,305** | **1,063** | **243 F** | **(5,651)** | **(6,468)** | **817 F** | **5,186** | **4,649** | **537 F** |
| **Governance and Funding Admin.** | | | | | | | | | |
| Funding | 262 | 262 | - | 1,831 | 1,831 | - | 3,140 | 3,140 | - |
| Other Income | 4 | 3 | 1 F | 26 | 18 | 9 F | 39 | 30 | 9 F |
| *Less:* | | | | | | | | | |
| Expenditure | 197 | 245 | 49 F | 1,496 | 1,775 | 279 F | 2,701 | 3,049 | 347 F |
| Contribution | **69** | **19** | **50 F** | **361** | **73** | **288 F** | **477** | **121** | **356 F** |
| **Health Provision** | | | | | | | | | |
| Funding | 20,038 | 20,038 | 0 F | 152,027 | 152,027 | 0 F | 259,538 | 259,538 | 0 F |
| Other Income | 1,547 | 2,051 | (503) U | 12,298 | 12,520 | (222) U | 20,816 | 21,340 | (524) U |
| *Less:* | | | | | | | | | |
| Expenditure | 25,080 | 25,419 | 339 F | 165,616 | 164,813 | (803) U | 282,028 | 281,659 | (369) U |
| Contribution | **(3,495)** | **(3,331)** | **(164) U** | **(1,291)** | **(266)** | **(1,025) U** | **(1,674)** | **(781)** | **(893) U** |
| **Net Result** | **(2,122)** | **(2,250)** | **128 F** | **(6,581)** | **(6,662)** | **81 F** | **3,990** | **3,990** | **(0) U** |

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

# 10. Management Budget Movements

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

The major changes between revenue and expense lines are usually due to health provision savings programmes. As these numbers have firmed up some savings programmes are around growing revenue rather than reducing costs. In 2015/16 changes to the operation of the price volume schedule (payments by the funder to the provider arm) will also create movements between the annual plan and the management budget.

| $'000 | January Mgmt Budget | January Annual Plan | January Movement | Year to Date Mgmt Budget | Year to Date Annual Plan | Year to Date Movement | End of Year Mgmt Budget | End of Year Annual Plan | End of Year Movement |
|---|---|---|---|---|---|---|---|---|---|
| **Funding** | | | | | | | | | |
| Income | 39,962 | 39,788 | 174 F | 279,053 | 277,743 | 1,310 F | 491,789 | 489,518 | 2,271 F |
| *Less:* | | | | | | | | | |
| Payments to Internal Providers | 20,299 | 20,001 | (298) U | 153,858 | 154,319 | 462 F | 262,678 | 263,334 | 656 F |
| Payments to Other Providers | 18,600 | 18,426 | (174) U | 131,664 | 130,356 | (1,308) U | 224,462 | 222,194 | (2,268) U |
| Contribution | **1,063** | **1,361** | **(298) U** | **(6,468)** | **(6,932)** | **464 F** | **4,649** | **3,990** | **659 F** |
| **Governance and Funding Admin.** | | | | | | | | | |
| Funding | 262 | 262 | - | 1,831 | 1,831 | - | 3,140 | 3,140 | - |
| Other Income | 3 | 3 | - | 18 | 18 | - | 30 | 30 | - |
| *Less:* | | | | | | | | | |
| Expenditure | 245 | 255 | 9 F | 1,775 | 1,846 | 71 F | 3,049 | 3,170 | 121 F |
| Contribution | **19** | **9** | **9 F** | **73** | **2** | **71 F** | **121** | **(0)** | **121 F** |
| **Health Provision** | | | | | | | | | |
| Funding | 20,038 | 19,740 | 298 F | 152,027 | 152,488 | (462) U | 259,538 | 260,194 | (656) U |
| Other Income | 2,051 | 1,960 | 91 F | 12,520 | 12,346 | 173 F | 21,340 | 20,865 | 475 F |
| *Less:* | | | | | | | | | |
| Expenditure | 25,419 | 25,319 | (100) U | 164,813 | 164,567 | (246) U | 281,659 | 281,060 | (600) U |
| Contribution | **(3,331)** | **(3,620)** | **289 F** | **(266)** | **268** | **(534) U** | **(781)** | **0** | **(781) U** |
| **Net Result** | **(2,250)** | **(2,250)** | **-** | **(6,662)** | **(6,662)** | **(0) U** | **3,990** | **3,990** | **(0) U** |

# 11. Quality and Financial Improvement Programme

| Row Labels | Sum of Planned Savings | Count of Planned Savings | Sum of ytd savings target | Sum of YTD actual Savings |
|---|---|---|---|---|
| **CORPORATE** | **1,360** | **14** | **793** | **783** |
| Green | 1,360 | 14 | 793 | 783 |
| **Health Services** | **7,000** | **77** | **3943** | **3509** |
| Amber | 2,703 | 12 | 1574 | 1257 |
| Green | 3,415 | 57 | 1856 | 1988 |
| Red | 882 | 8 | 514 | 264 |
| **Maori Health** | **82** | **1** | **48** | **48** |
| Green | 82 | 1 | 48 | 48 |
| **POPULATION HEALTH** | **70** | **2** | **41** | **41** |
| Green | 70 | 2 | 41 | 41 |
| **STRATEGIC SERV** | **1,688** | **2** | **427** | **366** |
| Green | 1,688 | 2 | 427 | 366 |
| **Grand Total** | **10,200** | **96** | **5253** | **4747** |

We are $506 thousand behind in our savings plans year to date.

The eight red programmes are (full year planned savings in brackets, and no savings have been achieved unless stated otherwise):

- Radiology duplicate testing ($45 thousand);
- Reduction in harm from falls ($50 thousand);
- Reduction in pressure sores ($20 thousand);
- Surgical Services savings ($400 thousand) – theatre overtime and clinical supplies has contributed $216 thousand.
- Contributions to the $1 million additional savings requirement:
    - Rural, Oral and Community ($90 thousand);
    - Mental Health ($82 thousand);
    - Women, Child and Youth ($61 thousand);
    - Older Persons Health and Allied Health ($52 thousand);
    - Laboratory ($48 thousand)
    - Other ($37 thousand)

**Corporate, Maori Health, Population Health and Strategic Services**

All green

**Health Services**

There are 12 Amber Programmes

Acute and Medical (5 projects): Savings of $481 thousand against a $1.033 million full year plan.

COO (2 projects): Savings of $276 thousand against a $726 thousand full year plan.

Older Persons Health and Allied Health (1 project): Savings of $402 thousand against $689 thousand full year plan.

Rural, Oral and Community (3 projects): Savings of $16 thousand against a full year target of $114 thousand.

Mental Health and Addiction (1 project): Savings of $82 thousand against a full year target of $141 thousand.

# 12. Financial Position

| 30 June 2015 | $'000 | January Actual | January Budget | Variance from budget | Movement from 30 June 2015 | Annual Budget |
|---|---|---|---|---|---|---|
| | **Equity** | | | | | |
| 120,014 | Crown equity and reserves | 102,965 | 108,540 | 5,574 | (17,048) | 108,183 |
| (32,388) | Accumulated deficit | (21,921) | (27,072) | (5,151) | 10,467 | (16,420) |
| 87,626 | | 81,045 | 81,468 | 423 | (6,581) | 91,763 |
| | **Represented by:** | | | | | |
| | Current Assets | | | | | |
| 14,970 | Bank | 14,192 | (3,247) | (17,439) | (778) | 8,756 |
| 1,703 | Bank deposits > 90 days | 1,741 | 1,564 | (178) | 39 | 1,564 |
| 17,862 | Prepayments and receivables | 10,806 | 17,996 | 7,190 | (7,056) | 18,146 |
| 3,881 | Inventory | 3,970 | 3,790 | (180) | 89 | 3,845 |
| 1,220 | Non current assets held for sale | 1,220 | 1,275 | 55 | - | - |
| 39,635 | | 31,929 | 21,377 | (10,552) | (7,706) | 32,310 |
| | Non Current Assets | | | | | |
| 148,434 | Property, plant and equipment | 152,943 | 162,139 | 9,196 | 4,509 | 166,016 |
| 2,298 | Intangible assets | 1,873 | 1,579 | (294) | (424) | 2,217 |
| 7,301 | Investments | 8,190 | 8,784 | 593 | 889 | 9,351 |
| 158,033 | | 163,007 | 172,502 | 9,495 | 4,974 | 177,583 |
| **197,668** | **Total Assets** | **194,936** | **193,879** | **(1,057)** | **(2,732)** | **209,894** |
| | **Liabilities** | | | | | |
| | Current Liabilities | | | | | |
| - | Bank overdraft | - | - | - | - | - |
| 29,960 | Payables | 33,027 | 35,409 | 2,381 | 3,067 | 35,540 |
| 35,239 | Employee entitlements | 36,022 | 32,101 | (3,921) | 782 | 32,660 |
| 65,199 | | 69,049 | 67,510 | (1,539) | 3,850 | 68,200 |
| | Non Current Liabilities | | | | | |
| 2,342 | Employee entitlements | 2,342 | 2,401 | 59 | - | 2,431 |
| 42,500 | Term borrowing | 42,500 | 42,500 | - | - | 47,500 |
| 44,842 | | 44,842 | 44,901 | 59 | - | 49,931 |
| **110,042** | **Total Liabilities** | **113,891** | **112,411** | **(1,480)** | **3,850** | **118,131** |
| | | | | | | |
| **87,626** | **Net Assets** | **81,045** | **81,468** | **423** | **(6,581)** | **91,763** |

The variance from budget for:

- Crown equity and reserves relates to the reversal of revaluation reserves for assets disposed of prior to 30 June 2015, to comply with Audit NZ's recommendations, and to a lower valuation of land and buildings than estimated at 30 June 2015;
- Bank reflects lower capital spend and the receipt of wash-ups
- Prepayments and receivables reflect the receipt of wash-ups. This amount will grow towards $18 million at 30 June 2016.
- Property, plant and equipment relates to the revaluation and later payments for the MHIU over the project life;
- Payables reflect lower purchasing over the holiday period;
- Employee entitlements – see below

# 13. Employee Entitlements

| *30 June* | | *January* | | | | *Annual* |
|---|---|---|---|---|---|---|
| *2015* | $'000 | *Actual* | *Budget* | *Variance from budget* | *Movement from 30 June 2015* | *Budget* |
| 7,916 | Salaries & wages accrued | 7,804 | 6,076 | (1,728) | (112) | 5,482 |
| 1,370 | ACC levy provisions | 1,468 | 873 | (595) | 98 | 1,176 |
| 4,951 | Continuing medical education | 6,295 | 5,826 | (469) | 1,344 | 4,860 |
| 19,383 | Accrued leave | 18,775 | 17,850 | (925) | (608) | 19,649 |
| 3,962 | Long service leave & retirement grat. | 4,022 | 3,877 | (145) | 60 | 3,925 |
| 37,582 | **Total Employee Entitlements** | 38,364 | 34,502 | (3,862) | 782 | 35,091 |

# 14. Treasury

**Liquidity management**

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

**Debt management**

The term debt facility with MOH is for $42.5 million, and is fully drawn. A further $5 million relating to the disposal of the Napier site, is available for the mental health build, and is likely to be drawn down in the first quarter of calendar 2016. The DHBs interest exposure is managed through a spread of maturity dates, rather than the use of derivative financial instruments, and the average cost of borrowing is currently 4.58%. No debt will become current until the 2017/18 financial year, and $25 million is for terms longer than five years.

The drawdown of $6.5 million in June 2012 increased the amount maturing in March 2019 to $11.5 million. This was done to take advantage of the low interest rate applying to that maturity, but it also puts the balance for that year above the $10 million limit set in the Treasury Management Policy.

**Foreign exchange risk management**

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

# 15. Capital Expenditure

| *2016 Annual Plan* | | *Actual $'000* | *Year to Date Budget $'000* | *Variance $'000* |
|---|---|---|---|---|
| | Source of Funds | | | |
| | **Operating Sources** | | | |
| 13,872 | Depreciation | 7,652 | 7,837 | 186 |
| 3,990 | Surplus/(Deficit) | (6,581) | (6,662) | (81) |
| (113) | Working Capital | 11,632 | 10,461 | (1,171) |
| 17,749 | | 12,702 | 11,636 | (1,066) |
| | **Other Sources** | | | |
| - | Special funds and clinical trials | 54 | - | (54) |
| 5,000 | Borrowings | - | - | - |
| 5,000 | | 54 | - | (54) |
| **22,749** | **Total funds sourced** | **12,756** | **11,636** | **(1,120)** |
| | Application of Funds: | | | |
| | **Block Allocations** | | | |
| 3,856 | Facilities | 1,528 | 2,184 | 656 |
| 3,000 | Information Services | 587 | 1,300 | 713 |
| 5,200 | Clinical Plant & Equipment | 1,668 | 2,441 | 774 |
| - | Minor Capital | - | 27 | 27 |
| 12,056 | | 3,783 | 5,952 | 2,170 |
| | **Local Strategic** | | | |
| 665 | Renal Centralised Development | 18 | 277 | 259 |
| 848 | New Stand-alone Endoscopy Unit | 132 | 165 | 32 |
| 5,654 | New Mental Health Inpatient Unit Development | 6,163 | 3,298 | (2,865) |
| 2,035 | Maternity Services | 1,636 | 1,062 | (575) |
| 100 | Upgrade old MHIU | - | 58 | 58 |
| 9,302 | | 7,949 | 4,860 | (3,090) |
| | **Other** | | | |
| - | Special funds and clinical trials | 54 | - | (54) |
| - | Transform and Sustain | 3 | - | (3) |
| - | Other | 78 | 12 | (66) |
| - | | 135 | 12 | (123) |
| ***21,358*** | ***Capital Spend*** | ***11,867*** | ***10,825*** | ***(1,042)*** |
| | **Regional Strategic** | | | |
| 1,391 | RHIP (formerly CRISP) | 889 | 811 | (78) |
| 1,391 | | 889 | 811 | (78) |
| **22,749** | **Total funds applied** | **12,756** | **11,636** | **(1,120)** |

*The year to date budget excludes any funding brought forward from last year, however the year to date actual column includes expenditure against that funding.*

# Monthly Project Board Report
## Jan 2016

HAWKE'S BAY District Health Board

## New Mental Health Unit Development

**Project Director: G Carey-Smith (Acting)**

| Overall Project Progress | Overall Status | Time Status | Financial Status |
|---|---|---|---|
| 83% | G | G | G |

**Phase: Service & Facility Implementation**

Formal approval of the Business Case was received in April 2013 from the Minister of Health for a replacement mental health facility. The project will provide four key deliverables:
1). Service redesign of acute mental health services to align with the HBDHB 2012 Mental Health Model of Care. Includes for investment in alternatives to inpatient care, with an increased focus on care provided in the community.
2). A replacement mental health inpatient unit on the Hawke's Bay Regional Hospital site.
3). A replacement mental health sub-acute facility, co-located with the inpatient unit.
4). A replacement of the Recovery Centres to move to a Day programme (co-located with the inpatient unit) and some services within the community.
The project programme spans over a 30 month period and occur in 2 phases. The first phase including service & transition planning, facility design & tendering was completed on time with the main construction contract approved at the 25 June 2014 Board Meeting. Phase 2 is now underway and includes the main build construction contract together with the implementation of transition management to the new service delivery model.

### Project Budget Status

| | | | |
|---|---|---|---|
| **Total Approved Project Budget** | **$ 19,800,000** | Total 15/16 Total Forecast Spend | $ 7,972,000 |
| Total Project Spend to Date | $ 16,483,269 | Total 15/16 Spend to Date | $ 6,163,000 |
| Percentage of Total Spend vs Budget | 83% | Percentage 15/16 Spend vs Forecast | 77% |

The building tender process was completed and approval received at the 25 June 2014 Board Meeting for the letting of a contract with the successful tenderer. A good tender price plus savings from the site development projects has provided an overall saving to budget of $2.2M resulting in the total project budget being reduced to $19.8M. The new figures are reflected in the graph below. The 2015/16 Total Forecast Spend against 15/16 Spend to Date is consistent with plan.

### Deliverable Dates

| | | | | | |
|---|---|---|---|---|---|
| Phase 2 Facilities: Design & Tendering Stage | Jul-14 | √ | Phase 2 / Stage 2 of Service Transition begins | Apr-15 | √ |
| Site Works | Sep-14 | √ | HBT, unplanned respite implemented & embedded | Jul-15 | √ |
| Main Construction | Oct-15 | √ | Design and IT decisions made re CMHT | Oct-15 | √ |
| Commissioning & Building Fit-out | Nov-15 | √ | Revised policies, process, performance indicators | Nov-15 | √ |
| Decant Relocate Staff | Dec-15 | √ | Acute Unit "Goes Live" | Jan-16 | √ |
| Project Handed over for 'Go Live' | Jan-16 | √ | IT solutions, capacity management in place | Mar-16 | |
| Property Disposal | (Settlement Dependant) | | TOR Phase 3 commences | Mar-16 | |

### Key Achievements this period

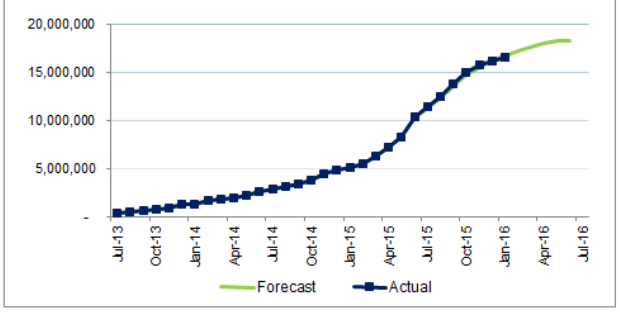
New Mental Health Unit fully occupied and fully operational.
SPOE continues in co-design phase with initial input group reconvened. Established sub-groups working well to task.
Continue to work with vendor to confirm the feasibility for IS developments needed to support the new model of care. IS systems necessary to support operations.
Community resilience programme ongoing.
Focus continues on integration across services and strengthening community mental health.
Blessing/Closing of old unit - well attended with positve feedback.

### Planned Activities next period

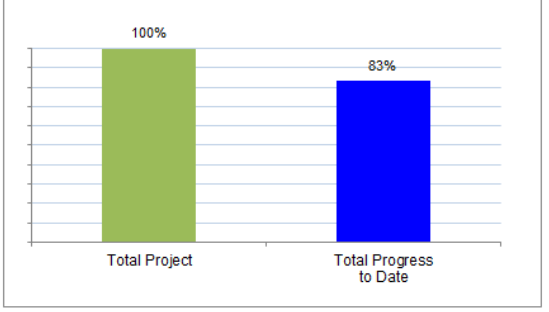
SPoE - progressing towards implementation
IDP - Working group meeting weekly. Recruitment of lead priority, position description developed, getting ready for advertising.
Case Load management – Working group to establish how data to be presented as a quick visual useful for management & staff to discuss implications.
Any building defects are managed as required over the next 12 months.
Final external landscaping, parking and other works are to be finalised. Review of Transition completed.

| Risks & Issues of Note | Mitigation & Resolutions |
|---|---|
| Ensure project costs remain safely within budget parameters | Regular assessments and tight control of project costs and contingency spend |
| Service delivery model not fully "owned" by service providers | Onoging development and implementation of MoC. Staying true to MoC as founding document. |
| Timely alignment of any Community Contracts | Service Re-design & Transition Management completed in timely manner |
| Engagement with wider consumers | Partnership Advisory Group established. |
| Ability to secure adequate clinical resources in timely manner | Dependent on availability within current market but extending possible catchment area |
| Finalise IS requirements and possible funding requirements | Ongoing engagement with IS resource and potential provider to establish timeline & any funding requirements |

### Forecast vs Actual Spend




### Total Project Progress



## 16. Rolling Cash Flow

| | Actual | January Forecast | Variance | Feb Forecast | Mar Forecast | Apr Forecast | May Forecast | Jun Forecast | Jul Budget | Aug Budget | Sep Budget | Oct Budget | Nov Budget | Dec Budget | Jan Budget |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Cash flows from operating activities** | | | | | | | | | | | | | | | |
| Cash receipts from Crown agencies | 3,035 | 2,423 | 612 | 40,942 | 43,857 | 44,775 | 40,906 | 41,919 | 41,384 | 40,826 | 49,815 | 41,375 | 40,839 | 40,909 | 41,392 |
| Cash receipts from revenue banking | - | - | - | - | - | - | - | 800 | - | - | - | - | - | - | - |
| Cash receipts from donations, bequests and clinical trials | (66) | - | (66) | - | - | - | - | - | - | - | - | - | - | - | - |
| Cash receipts from other sources | (5) | 467 | (472) | 428 | 433 | 453 | 447 | 428 | 451 | 467 | 450 | 451 | 449 | 451 | 510 |
| Cash paid to suppliers | (33,452) | (37,678) | 4,226 | (25,162) | (25,344) | (26,608) | (23,592) | (23,562) | (25,909) | (24,553) | (26,378) | (25,422) | (25,309) | (23,359) | (19,207) |
| Cash paid to employees | (14,753) | (15,213) | 459 | (14,019) | (18,418) | (15,191) | (14,869) | (17,112) | (16,516) | (13,472) | (18,454) | (14,355) | (14,976) | (16,609) | (17,263) |
| **Cash generated from operations** | **(45,242)** | **(50,001)** | **4,759** | **2,189** | **528** | **3,428** | **2,892** | **2,473** | **(590)** | **3,269** | **5,433** | **2,049** | **1,003** | **1,392** | **5,432** |
| Interest received | 94 | 92 | 2 | 86 | 91 | 88 | 90 | 88 | 87 | 79 | 79 | 85 | 78 | 92 | 87 |
| Interest paid | 5 | 0 | 5 | 0 | (98) | (419) | (261) | (190) | 0 | 0 | (99) | (420) | (264) | (199) | 0 |
| Capital charge paid | - | - | - | - | - | - | - | (3,910) | - | - | - | - | - | (4,142) | - |
| **Net cash inflow/(outflow) from operating activities** | **(45,143)** | **(49,908)** | **4,766** | **2,275** | **522** | **3,098** | **2,721** | **(1,539)** | **(502)** | **3,348** | **5,414** | **1,714** | **817** | **(2,857)** | **5,520** |
| **Cash flows from investing activities** | | | | | | | | | | | | | | | |
| Proceeds from sale of property, plant and equipment | - | - | - | - | - | - | - | 0 | - | - | - | - | - | - | - |
| Acquisition of property, plant and equipment | (997) | (1,724) | 728 | (1,378) | (1,665) | (1,544) | (1,390) | (3,328) | (2,469) | (2,469) | (2,469) | (2,830) | (1,505) | (1,505) | (2,228) |
| Acquisition of intangible assets | (62) | (79) | 17 | (121) | (65) | (50) | (20) | (20) | (425) | (425) | (425) | (476) | (100) | (100) | (200) |
| Acquisition of investments | (49) | (116) | 67 | (116) | (116) | (116) | (116) | (116) | (116) | (116) | (116) | (116) | (116) | (116) | (116) |
| **Net cash inflow/(outflow) from investing activities** | **(1,108)** | **(1,919)** | **812** | **(1,615)** | **(1,846)** | **(1,710)** | **(1,526)** | **(3,464)** | **(3,009)** | **(3,009)** | **(3,009)** | **(3,422)** | **(1,721)** | **(1,721)** | **(2,544)** |
| **Cash flows from financing activities** | | | | | | | | | | | | | | | |
| Proceeds from equity injection | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Proceeds from borrowings | - | - | - | - | - | - | - | 5,000 | - | - | - | - | - | - | - |
| Repayment of finance leases | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Equity repayment to the Crown | - | - | - | - | - | - | - | (357) | - | - | - | - | - | - | - |
| **Net cash inflow/(outflow) from financing activities** | **-** | **-** | **-** | **-** | **-** | **-** | **-** | **4,643** | **-** | **-** | **-** | **-** | **-** | **-** | **-** |
| Net increase/(decrease) in cash or cash equivalents | (46,250) | (51,828) | 5,578 | 660 | (1,324) | 1,388 | 1,195 | (361) | (3,511) | 339 | 2,404 | (1,708) | (904) | (4,578) | 2,975 |
| Add:Opening cash | 62,184 | 62,184 | - | 15,933 | 16,593 | 15,269 | 16,657 | 17,851 | 17,491 | 13,979 | 14,318 | 16,722 | 15,014 | 14,110 | 9,532 |
| **Cash and cash equivalents at end of year** | **15,933** | **10,356** | **5,578** | **16,593** | **15,269** | **16,657** | **17,851** | **17,491** | **13,979** | **14,318** | **16,722** | **15,014** | **14,110** | **9,532** | **12,507** |
| **Cash and cash equivalents** | | | | | | | | | | | | | | | |
| Cash | 7 | 7 | - | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 | 7 |
| Short term investments (excl. special funds/clinical trials) | 12,828 | 7,236 | 5,592 | 13,474 | 12,150 | 13,538 | 14,733 | 14,372 | 10,800 | 11,139 | 13,543 | 11,835 | 10,930 | 6,352 | 9,327 |
| Short term investments (special funds/clinical trials) | 3,095 | 3,112 | (16) | 3,112 | 3,112 | 3,112 | 3,112 | 3,112 | 3,172 | 3,172 | 3,172 | 3,172 | 3,172 | 3,172 | 3,172 |
| Bank overdraft | 3 | 1 | 2 | - | - | - | - | - | - | - | - | - | - | - | - |
| | **15,933** | **10,356** | **5,578** | **16,593** | **15,269** | **16,657** | **17,852** | **17,491** | **13,980** | **14,319** | **16,723** | **15,015** | **14,110** | **9,532** | **12,507** |

Draw-down of the revenue banking in 2015-16 is $0.8 million.

| | |
|---|---|
| OURHEALTH HAWKE'S BAY Whakawateatia | **Hawke's Bay Clinical Council** 03 |
| | For the attention of: **HBDHB Board** |
| Document Owner: | Chris McKenna and Dr Mark Peterson as Co-Chairs |
| Reviewed by: | Not applicable |
| Month: | February, 2016 |
| Consideration: | For Information |



**RECOMMENDATION**

**That the HBDHB Board**

Note the contents of this report

Council met on 10 February 2016, an overview of issues discussed/agreed in the Public Section of the meeting.

**Health Literacy Strategic Review**

Clinical Council reviewed and provided feedback to Quigley and Watts in regards to the review of Health Literacy across the HB health sector.

Four key questions were posed to Council:

1. Where do you think the Hawke's Bay health sector is currently at in terms of health literacy?
2. How can the DHB support clinical services to respond to the health literacy needs of communities?
3. What do you think are the biggest challenges to be addressed in creating and implementing a sector-wide framework for health literacy?
4. What are some solutions to the challenges you just mentioned?

General discussion held and Clinical Council members provided their feedback. Overall feeling is that we needed to do better for our consumers and that there is inconsistency across the sector. We needed to focus on reducing the amount of jargon and clinical terms used when engaging with patients and spend more time making sure the information we provide (written or verbal) was well understood. Technology would be a key driver in developing our health literacy.

**Clinical Governance Structures – Consultation Document**

Clinical Council received a discussion document in regards to aligning our clinical committees structure to meet the challenges from a quality and patient safety perspective across the sector.

General feedback was provided and it was felt that whilst the direction of travel was correct we perhaps needed to be more ambitious and develop clinical committees that were integrated across

the sector. Further work will be completed and a document would be presente to Clinical Council in April/May.

**Clinical Council – Portfolio's of Interest**

Clinical Council members identified that the present system of identifying a champion for specific conditions etc was not effective and it was agreed that some thought would be given to identifying areas of interest by members, and also key priority areas within Transform and Sustain. This would be discussed further at the meeting in March.

**Health & Social Care Networks**

Clinical Council reviewed the report presented at the meeting and supported the overarching principles of the paper and the long term strategic direction. There was much discussion about how these would integrate with other service providers outside of health, as this concept would only be effective if WINZ, MSD etc were involved. Community and consumer engagement would be key if we were to get this right and ultimately improve the health outcomes for our community.

**Respiratory Pilot**

Clinical Council received a presentation from the team that had been running a pilot to support those consumers with respiratory conditions. The pilot had been very successful in reducing the average length of stay of patients reducing the number of referrals to secondary care from 600 to 100 during the period and there was very positive feedback from consumers who were now fully engaged with the team. The team were congratulated on their success and Clinical Council looked forward to receiving their investment bid in the coming round.

**Monitoring Reports**

The Te Ara Whakawaiora ASH Rates was presented and noted by Clinical Council.

| | |
|---|---|
| OURHEALTH HAWKE'S BAY Whakawateatia | **Hawke's Bay Health Consumer Council** 04 |
| | For the attention of: **HBDHB Board** |
| Document Owner: | Graeme Norton, Chair |
| Reviewed by: | Not applicable |
| Month: | February, 2016 |
| Consideration: | For Information |

12

**Recommendation**

**That the Board**

Note the contents of this report

Council met on 11 February 2016, an overview of issues discussed/agreed at the meeting is provided below.

**Health Literacy Strategic Review**

Members provided feedback to the consultants from Quigley & Watts

Key points follow:

- Health professionals need to make sure they use language and terminology that consumers can understand
- Need to spend more time with their patients
- Consumers need to have the confidence to ask questions and be listened to
- Need to get the balance of information right – too much or too little
- Pacific population needs must be met when it comes to health literacy
- Need to factor in literacy across our communities
- Factor in our rural communities
- Partnerships are key between the clinicians and the patient
- Some clinicians are starting to make changes in the way they interact with patients e.g. Pharmacists
- Need to look at building skill set of new clinicians about cultural competence alongside health literacy skills
- Question perhaps needs to be turned around – how consumer literate is the health sector? Definition of health literacy is about what knowledge consumers should have, this needs to be turned on its head and needs to come from what is the capacity to communicate so that consumers can use information and health services to make effective decisions.

### Alcohol Strategy Update

Population Health and Consumer Council have agreed to collaborate on the development of the Alcohol Strategy. The work will begin in earnest following the co-design training in early March. This sessions was a chance to meet the strategy lead, Rachel Eyre, and hear where the background work had got up to, prepariung for the work ahead.

### Health and Social Care Networks

There was general consensus that this was the right way to go and that we needed to start this development as soon as we could. It was suggested that perhaps from a steering group perspective we might need a couple of consumer representatives. Obviously consumer engagement was essential when it came to the development of specific health social care networks.

### Consumer Stories

Now that the habit of sharing stories within governance had become embedded it is time for Consumer Council to move on and look at how well these are being used to enable change or reinforce/support what is going well within services. We will work with QIPS on that.

### Consumer Engagement – Key Principles

QIPS is developing, with our support and input, a plan to enable a person and whanau centred culture within the health sector. We are almost at the stage of sharing this with other governance groups with finalisation expected April/May.

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Māori Relationship Board (MRB)** 05 |
| | For the attention of: **HBDHB Board** |
| Document Owner: | Ngahiwi Tomoana (Chair) |
| Reviewed by: | Not applicable |
| Month: | February 2016 |
| Consideration: | For Information |

13

**RECOMMENDATION**

**That the Board**

Note the content of this report.

The MRB meeting was held on 10 February 2016. Here are the highlights of the meeting below.

**WHĀNAU ORA**

There will be a workshop in either March or April for MRB to develop a Whānau Ora statement and vision for the organisation. This is very important because it will provide clarity therefore reduce confusion about what Whānau Ora is, its purpose and the intention of Whānau Ora. Furthermore, a statement will enhance business throughout the District Health Board (DHB) and sector by providing a clear pathway around Whānau Ora, particularly in a Kahungunu context ensuring everyone has direction and understanding of the requirements for achieving the outcomes and expectations of Whānau Ora.

**LIVING WAGE IN HAWKE'S BAY**

Reducing inequalities and decreasing drivers for the rohe of Kahungunu is a key principle of MRB. For the DHB to adopt and support all DHB staff being on the living wage would send a powerful and positive statement as well as cause significant movement across other DHBs. Those below the living wage is only 12% of the workforce (approximately 280) and is highly achievable. MRB are in full support of such an important change that would decrease poverty and improve equity. This was a water shed moment and a momentous demonstration of the DHB truly buying in to our statement. To influence change MRB has been advised to address this issue at a national level so will be seeking support from the Board Chairs to drive their views and recommendations at a national then regional level.

**WĀNANGA MRB WORKPLAN 2016-17**

Inadequate timeframes to discuss agenda items, measure recommendations and the forensics has at times impacted on MRBs ability to add value and make an informed decision. The purpose of the wānanga is to provide an opportunity to prioritise MRBs workplan, set agendas to ensure full discussion of agenda items and how MRB want things to flow for the next 12-months. The following feedback was received about how MRB would like future agendas to be structured:

- Increase from eight meetings to 10 per year not including the Hawke's Bay Health Leadership Forums. The reason being currently two of the 10 meetings are reserved for Hawke's Bay Health Leadership forums and with MRBs busy schedule we cannot afford to lose two meetings
- Reduce agenda items to no more than six items
- Remove the Monthly Consumer Story as an agenda item

- Prioritise agenda items with topics pertaining to Māori health requiring in-depth discussion to be placed first on the agenda to allow sufficient time for discussion
- Increase discussion times per item to allow sufficient time for good input and avoid rushing through topics impertinent to Māori health
- Use time efficiently and remain within the allocated timeframe
- A reasonable sized workplan that is not too big
- Have a set amount of key strategies with a plan of how these will be addressed
- Restrict the number of goals
- Email feedback about papers to provoke thinking and discussion prior to the meeting
- Look at the possibility of presentations being presented to all of the committees at the one time
- Develop a feedback tool for presentations so that there is an outcome
- Consider doing something for the organisation in terms of determining a Whānau Ora statement that is more of a vision statement for policies to drop off.

There also was a discussion about MRB priorities. Below are the top priorities as articulated by MRB which will also be the focus of the MRB Work Plan for 2016-2017:

1. Smoking
2. Obesity
3. Alcohol and Other Drugs (AOD)
4. Young mothers and children.

**MĀORI BACHELOR OF NURSING STUDENTS**

There has been a significant amount of work undergone to resolve the issues around the Bachelor of Nursing Māori students. As a result, the DHB is punching way above its weight in comparison to other much larger DHBs and responding to the needs of our community. The quality of the Nursing Entry to Practice (NEtP) programme and employment security following graduation remains a concern for MRB. It is still unclear if the funding for students that do not complete the nursing course is returned to the Tertiary Commission or retained by EIT and Chris McKeena (Chief Nursing Officer) will be discussing MRBs concerns with EIT.

**MRB REPRESENTATION ON CLINICAL COUNCIL**

From a health professional perspective clinical competencies or skills are given more consideration in comparison to cultural competencies even though the two competencies have an equal part in the entire picture of health, especially reducing disparities for Māori. With this in mind, having a MRB representative on Clinical Council to provide a Māori lens and inform Clinical Council will only add more value. Kevin Snee (CEO HBDHB), Peter Kennedy (Head of Finance), Tim Evans (General Manager Planning, Informatics and Finance), Chris McKenna (Chief Nursing Officer) and the Chairs of each committee; Kevin Atkinson (Chair HBDHB Board), Graeme Norton (Chair Consumer Council) and myself will discuss MRBs representation on Clinical Council for every meeting and the level of representation that everyone will be comfortable with and that works. The outcome of the discussion will be presented to MRB in March 2016.

**HEALTH LITERACY STRATEGY REVIEW**

There seemed to be a general view that the state of health literacy in Hawke's Bay was unsatisfactory and this was evident in the reports presented to MRB today where there was some misinterpretation. Key points about health literacy were highlighted by MRB as follows:

- Simplicity may not mean the same for different individuals
- Māori do not know what 'literacy' is so will assume literacy does not apply to them therefore we need to look at the branding of health literacy
- The language we use becomes so familiar that it's not until we step outside the sector that we see the communication we are using is ineffective
- Health literacy causes risks such misunderstanding, error and potentially death

- To take in to consideration that emotions and fears are usually elevated so whānau are probably already feeling anxious, stressed, ill, 'whakamā' (shy, embarrased) therefore it is Important to put whānau at ease to allow for effective engagement
- Creating comfortable relationships between patient, health professional and whānau support
- There is a lot of valuable material about health literacy that needs to be socialised more effectively throughout the community
- When socialising health literacy information we must be aware the public may be computer illiterate so may not know how to access the information
- Whānau want to drive their own health literacy so the system should be designed to enable whānau to take ownership to drive their own health literacy and provide the ability to articulate their needs
- We want to empower whānau who can self-manage, are knowledgeable and can navigate their way through health systems from primary, secondary and tertiary, that understand their condition, medication and treatment and be informed
- A mass training may be required for all staff on how to provide the information in a way that relates to the people in a meaningful and effective way. For Māori, using a whānau approach
- Good health literacy is Whānau Ora from a system level that ensures the system is whānau centred and easily transfers information that is easily understood.
- Think about what our ideal system would look like and the outcomes evidencing our system is working effectively. This could be that our whānau are fully armed with enough information that enables them to take responsibility for their own health. And that our people will become hypochondriacs and present to the hospital to report their own worries
- Māori perspectives should not be reflected in the strategy. Māori principles, Tikanga and Kawa should be the driver for an integrated strategy. Kanohi ki te kanohi is the only proven strategy that has been effective for Māori. The strategy requires Māori drivers to be a success for Māori
- There is lack of understanding by health professionals about the benefits of Rongoā Māori (traditional Māori medicine) as an alternative therefore Rongoā should be included into the strategy
- Allowing patients and their whānau to drive the strategy.



**HEALTH AND SOCIAL CARE NETWORKS**

**RECOMMENDATION**

**MRB did not:**

1. Endorse the content of this Programme Brief, **but have**
2. Provide feedback and input on its content and strategic direction.

MRB provided the following feedback regarding the Health and Social Care Networks Programme Brief:

- The programme is in line with what MRB have been talking about for the last 10 years. Finally we have a design and from a Chairs perspective it's about time
- Be mindful of the smaller geographical areas and look at how we can meet the needs of these smaller populations. Perhaps merging smaller populations for example Camberley and Flaxmere.
- Look at harnessing volunteers to ensure sustainability to look after our population therefore include how we manage volunteers, non-for profit charitable agencies and organisations into the programme
- The proposal has a lack of Māori concepts. It is difficult to see Pae Ora, Whānau Ora or tikanga based approaches to medicine. There needs to be more push for our Māori values and concepts in the design phase. For the Māori of the HBDHB patient population, it is critical for these Māori ideals to come through the programme. Liz Stockley (CEO Health Hawke's Bay PHO/ / General Manager Primary Care) advised the Māori ideals will come through the

design of the model of care that will be co-designed with the communities allowing each of those communities to support a design that suits them.

- Articulating how the model will reduce inequity and improve health profiles is not clearly described in the document and should be added as a guide or principle. There were issues with the language used within the report and perhaps it could have been a little more descriptive. It was suggested that perhaps it is worthwhile having a template for the front page of each paper that asks how the paper addresses inequality, efficiency and quality
- Being bold enough to disinvesting in programmes that aren't effective. We may not have the evidence base but it feels right to disinvest and re-invest.
- Use of the Health Equity Assessment Tool (HEAT) and the Whānau Ora Health Impact Assessment (WOHIA) tool throughout the entire process including funding bids, what will be the impact of the decisions and how we are going to engage the community
- Look at how we manage the inconsistencies and untended consequences. Are we creating poverty zones and if so what incentives are in place to prevent this
- Exploring other opportunities like the 'Pop Up' type models of approaches where you have a group of expertise in one place for a day or two instead of 24-hour services
- The major premise of this programme is the devolution out to communities which is fantastic. But the difficulty is communities are defined by size so already there is potential disadvantage for Māori communities who don't have a population of 30,000. So smaller populations are merged further disempowering communities. There are a number of small Māori communities that are going to be affected. A view had been formed that the criteria be primarily geographically however this needs to be re-looked at.
- This programme will be hugely beneficial to the community because of the efficiencies and quality of service delivery as a result of those services being more focused. If this programme is put in place, it is up to us as MRB members to ensure it happens to the advantage of our people so they have equity.
- The principle is good but the detail that needs a 'Māoriness' strand interwoven throughout from the start to finish. Therefore we need to get the first principle right so this is carried throughout. While it is important to have a statement it is more important for people to understand the meaning of the statement and how it can be achieved
- The wording of the report has the potential to be misinterpreted. Although it was written for governance, maybe we need to look at how reports are being written to accommodate the community if we are to improve health literacy.

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Health and Social Care Networks Programme Brief** 06 |
| | For the attention of: **HBDHB Board** |
| Document Owner:<br>Document Author(s): | Steering Group – Health and Social Care Networks<br>Kevin Snee |
| Reviewed by: | Executive Management Team; Clinical and Consumer Council and Māori Relationship Board |
| Month: | February 2016 |
| Consideration: | For Discussion |

14

**RECOMMENDATION**

**That the HBDHB Board:**

1. Endorse the content of this Programme Brief
2. Provide feedback and input on its content and strategic direction

## INTRODUCTION

Under the auspices of Transform & Sustain, we are proposing a new programme of work that will significantly change the structure of the Hawke's Bay health sector. This work is transformational in nature, requiring new ways of operating and strong relationships across all stakeholders.

The programme will take a staged approach, with an initial project that will establish the DHB's processes and standard requirements for network development, plus develop standardised documentation and templates. These resources will be available for use in later projects, by stakeholder groups (including patients and community leaders) that wish to establish geographically-based provider networks ("Health and Social Care Networks") that will work collaboratively to better address the needs of their combined enrolled population. One such group is already considering network development (Wairoa), and two others are in the early stages of considering the potential to work together (Central Hawke's Bay and central-Hastings); these groups will be supported and encouraged within the overall programme.

This paper introduces the programme (the Programme Brief) and provides further information on the development of standard tools and processes (Appendix 1), an intial stakeholder analysis (Appendix 2) and a terms of reference for the Steering Group that will oversee all programme work, ensuring alignment and synthesis across all projects (Appendix 3).

## BACKGROUND

The health system in Hawke's Bay, as with the rest of New Zealand, will experience significant challenges in meeting the future needs of our population, particularly in terms of the aging cohort and a rise in conditions requiring long term and complex care. To better prepare our sector for these challenges, an alternative service delivery model that integrates primary, secondary and social services has been proposed; this model seeks to increase effectiveness and efficiency of health care delivery closer to where people live, whilst recognising and addressing the key role of socio-economic factors in determining health outcomes.

Recent discussions have centred upon how this integration could be effected, focussing on the establishment of clusters of health and social service providers working closely together with the patients that they have in common; these clusters have been termed *Health and Social Care Networks.*

Initially networks will focus on delivering current services most appropriately in a manner which is responsive to each community and engages community based resources and facilities effectively. This vision will grow over time to support devolved decision making over service design and investment in resources and facilities to clinicians and community leaders. The time frame to achieve this expanded vision may be different for different communities.

Stakeholder engagement and input will be essential to the success of the Health and Social Care Networks Programme. In Phase One, outlined in Appendix 1, this engagement will focus on DHB and PHO stakeholders. This is because the work focuses on determining these organisations' approach to networks, including a proposal on how networks could be structured, the level of decision-making that could be devolved to communities and developing supporting resources to assist communities on this journey. Where possible, Phase One deliverables will be over-arching, rather than prescriptive, as each Network will result from a co-design process and will be as individual as the community it serves. In later projects, in which communities establish networks that meet their needs and aspiations, co-design will be the key process by which a much wider range of stakeholders will be involved in a partnership to design and implement their network. Such projects will be the subject of separate Terms of Reference.

**ATTACHMENTS** – Programme Brief, Appendix 1, 2 and 3

**Programme Brief**

**Establishing Health and Social Care Networks**

January 2016

**Purpose of this document**

The purpose of this document is to outline the scope and activities required to enable Health and Social Care Networks to be established in Hawke's Bay.

This document is for:

- The Health and Social Care Networks Steering Group – to describe a way forward for sector redesign, providing a clear statement of intent, leadership and responsibility
- EMT – to gain managerial approval and support for this initiative and approach



**Background**

The health system in Hawke's Bay, as the rest of New Zealand will experience a significant growth in the population of frail older people and a further growth in the numbers of people living with complex long term conditions. The health system is currently not designed to deliver equitable outcomes or access to services for Māori and Pacific populations and there are groups of people who are unable to afford, access or navigate the health sector. This problem is not unique to health. There is a lack of co-ordination between health and social care services that can be frustrating for individuals and lead to lack of engagement and wasted resources across the board.

Transform and Sustain has established a strategic framework and an environment under which significant change can be achieved, and is already underway in some areas. There is a need for primary care to be better positioned to address acknowledged challenges, to be more connected and collaborative, and to deliver services that are accessible and appropriate for the Hawke's Bay population. Other providers of health and social services in the community need to be more connected and services need to be joined up. The concept of Health and Social Care Networks, as a vehicle for addressing these challenges has been discussed in several forums.

This journey will lead to a health service in which the right clinician is delivering an appropriate service in the most sensible location supported by a network of providers who understand and respond to the needs of the patient and their whānau, who in turn are empowered to manage their own health and social wellness.

The establishment of Health and Social Care Networks requires a significant programme of activity and of change management. We propose to begin this journey by delivering current services differently, to respond to the community more effectively and to encourage and motivate collaboration. This journey will be challenging because of the number and breadth of stakeholders, because it requires changes to the status quo and because the day to day operations of a complex health sector need to continue whilst this vision is realised. It is also an opportunity to revitalise our sector and increase sustainability in terms of service affordability, infrastructure and workforce.

**Proposal**

We propose to establish a number of networks of collaborative services that are clustered around geographical communities that work closely together to care for patients that they have in common.

Initially networks, with community input, will focus on delivering current services most appropriately in a manner which is responsive to each community and engages community based resources and facilities effectively. This will be the focus of Phase One.

This vision will grow over time to support devolved decision making over service design and investment in resources and facilities to clinicians, professionals and community leaders. The time frame to achieve this expanded vision may be different for different communities - this is a long term vision.

**Phase One**

We will cluster existing services around geographical communities and use the design of these services as a lever to engage providers, other public services, Iwi, NGO's and voluntary organisations in the concept of community networks. We will begin with health services and invite community partners to also review their services through an aligned approach.

In Napier and Hastings the clustering of services will be based on populations of around 30,000 people, in an aligned geographical area. The 30,000 figure represents a likely lower limit at which a network would be viable; an upper limit, although not specified, would be a figure at which a sense of community is lost. In Wairoa and Central Hawke's Bay remoteness rather than population size determines each to be a sensible geographical network and, therefore, smaller network populations are envisaged for these areas.

In order to reshape services so that they are appropriate for the community the HDBHB and HHB teams will work with local general practice teams and other local clinicians, consumers and community partners to:

- Ensure services are appropriate to prevent ill health, enable people to keep themselves well and independent for as long as possible
- Support the development of quality services that are provided in the community
- Ensure services provided by a wide range of health and social care professionals in the community are better co-ordinated and respond to local need
- Improve communication and information sharing between different health, social care and voluntary sector professionals
- Facilitate closer working between community based and hospital services, ensuring that patients receive a smooth and safe transition from hospital services to community based services and vice versa.

To achieve this first phase the programme of work detailed below proposes:

1. Background work - understanding ourselves (services, processes and models) and the potential benefits to be gained from networks, developing expertise through a central repository of knowledge, tools and resources that will support sector change. Key activities include:
    - ensuring various projects, existing and new initiatives, are aligned
    - reviewing our services and considering the most appropriate delivery models
    - analysing our systems and processes to reflect the collaborative working environment
    - developing a standard pathway, tools and templates to guide establishment of networks throughout Hawke's Bay
    - reviewing examples of good practice from other places to avoid reinventing the wheel
2. Establishing a network in Wairoa
3. Motivating collaboration in Central Hawke's Bay
4. Supporting collaborative general practice initiatives in Hastings (e.g. Totara health and Hastings Health Centre)

5. Supporting the identification of sensible network groupings in Napier and Hastings
6. Initiating the development of the technology platform in primary care.

Each of the associated individual pieces of work will be subject to appropriate project management rigour and business case processes. Some of these initiatives will be concurrent and will inform each other.

**Progress to date:**

A proposed scope, deliverables and high-level milestones for item 1 above is provided in Appendix 1. Progress to date in this space has included the health services directorates considering services that could be provided in the community and the consideration of some models from elsewhere (e.g. Nuka). Work has also been done to review what the community wants from services – what have we already been told, and to engage consumers in consideration of the general practice model of care.

On the back of the development of the new facility in Wairoa there have been positive discussions between community providers about working together in a smarter way. This will be nurtured and furthered through joined-up activity. Establishing a network in Wairoa is being developed under separate Terms of Reference document.



An initial meeting was held at the end of 2015 in Central Hawke's Bay which was attended by representatives of the key providers. A further meeting will be held in February to identify what the local priorities for service development are.

Whilst the Totara Health and Hastings Health Centre programme has stalled temporarily the opportunity for collaboration between general practices in Hastings remains. The PHO and DHB will continue to motivate collaboration and initiatives such as urgent care will support a collaborative approach.

The EngAGE, District Nursing and Pharmacy Facilitator projects are essentially trialing geographical groupings of services in Napier and Hastings. Lessons will be learned from these.

The DHB and PHO are currently considering what the next steps with the development of primary care infrastructure should be. A single shared care record will be a priority and some research has been undertaken as to solutions in this space.

**Interdependencies**

A range of other existing projects will also inform and support the network programme:

| **Project Name** | **Interdependency description** |
|---|---|
| Patient Experience | Will inform this project by providing patient insight to service requirements and information on patient profiling by geographic practice area |
| EngAGE; DN GP Alignment; Clinical Pharmacy Facilitators roll out | Information on existing models of service delivery and potential geographical networks |
| Urgent Care | Some of these services, co-designed with primary care stakeholders, may become part of one or more networks. This may motivate collaboration |
| Customer Focused Booking | Influenced by, and influences, models of care that could be adopted by practices within a network |
| Health Literacy | Health literacy will be a key component of models of care implemented by general practices within networks |
| Model of Care support in primary | PHO project to develop a centre of knowledge regarding |

| Project Name | Interdependency description |
|---|---|
| Care | general practice models of care. Will inform and assist general practices |

**What success will look like**

Success in the short term will mean we are delivering more health services in the community and we are supporting services to work collaboratively with other organisations (across the health and social care spectrum) in specific geographical communities to deliver better care for individuals and whānau.

For phase one networks will have a standard set of services but these may be delivered against different models of care depending on the needs and resources (such as clinical skill, capacity and facilities) of the community.

During the implementation of phase one, we will analyse information and engage with consumers and providers within communities to better understand the needs and cultural requirements of the community. We will understand what approach will support successful outcomes for each network. This will set up a solid foundation for progressing networks beyond mechanisms for service delivery to meet our longer term vision.

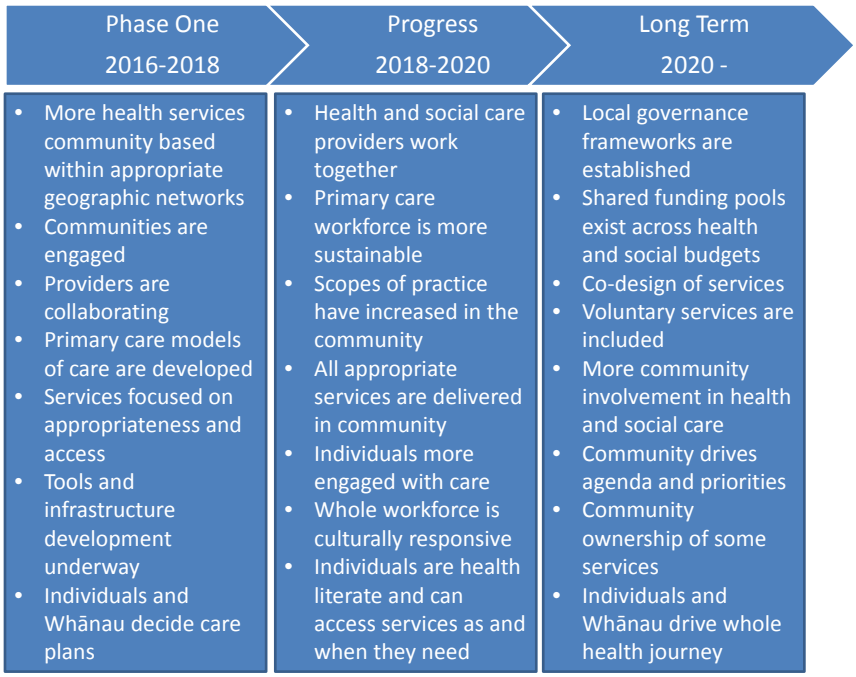
Successful implementation of Phase One means:

- People find it easy to identify and access the help and services they need because they are health-literate, the services have been designed to be easily understood, and there is additional navigation and kaiawhina assistance if required.
- Existing services will be configured in ways that improve the patient experience and respond better to communities.
- Community resources and facilities are increasingly evolving to provide a broad range of services.
- Multi-disciplinary, multi-provider case-management is the established approach for working with people and/or whanau with complex health and social needs.
- There is reduced need for hospital visits because many services are conveniently accessed in a community setting. This has led to reduced waiting times for necessary hospital-based treatment.
- General practice clinicians have the time to work with patients who need it.
- Primary care clinicians have opportunities to increase scopes of practice and develop additional expertise
- General practice business models are motivated to support sector activity
- Patients at risk are proactively identified and supported
- Technology and information is used effectively for joined up service delivery and for to support self-management
- Health outcomes, codified in a set of performance indicators covering central and local expectations, have improved.
- Continuous improvement and innovation is a central tenet of the system,

- Networks are supported by nimble, responsive management, using existing resources where possible. Organisations are working collaboratively to get the best value from all publicly funded resources.

**High-level time line**

The following diagram highlights the journey networks will take. The dates are indicative only, setting the direction of travel that we intend to take. Some networks may progress more quickly, particularly where geographic locality is clear and there is a group of existing engaged stakeholders. The detail highlights the key anticipated achievements of each phase.






**Appendices**

The appendices to this document provide additional information on the following:

- Appendix 1 – High level plan for Phase 1 (timelines, financials, deliverables, risks and communication)
- Appendix 2 – Stakeholder Analysis
- Appendix 3 – Terms of Reference for the Steering Group

## APPENDIX 1: Phase One – timelines, financials, deliverables, risks

Phase One (Core Network Expertise project) is proposed to run for 7 months (February – August 2016). It will establish minimum/standard requirements of networks and support network establishment in localities.

### Deliverables and high-level milestones

| Objectives | Deliverables/ high level milestones |
|---|---|
| 1. Set the scene | 1. Agreed set of over-arching principles for Network design, operations and benefits realisation<br>• Get approval for progress from EMT<br>• Determine the governance and approvals processes required by HBDHB<br>• Get input/feedback from a wide range of stakeholders (this will get their input and also socialise the ideas) to finalise the principles<br>2. Review of other current projects (engAGE, Pharmacy and DN) to ensure alignment across these and the Networks programme and identify lessons learned so far<br>3. Establish an appropriate project management framework, appropriate roles and responsibilities and resources. This will include a communications framework. |
| 2. Geographic groups / communities | 1. Localities proposal: proposed geographic regions ('localities') for networks<br>• Analyse HB data (health, economic, other) to characterise the population, identify areas of shared needs or opportunities etc<br>• Propose localities, using principles and interests (populations they serve) to guide boundaries; Wairoa and Central HB are geographically distinct, so work will focus on defining Napier and Hastings groupings<br>• Map current capacity, capability, service provision and facilities in each proposed locality |
| 3. Services and service delivery | 2. Standardise a list of services that could be delivered in the community in an integrated way<br>• Map those services for which we have some control over (i.e. DHB and PHO-funded), bring in others as we socialise the networks.<br>• Identify how these services fit with each locality (appropriateness, resources, capability, priorities, local motivations etc.)<br>• With network input identify how individual service lines might work differently to deliver more effective, efficient services in the community that are better of the patient and support a collaborative approach.<br>3. Service delivery models – options document<br>• Research existing models of integrated services to inform the options (e.g. Nuka, Kaiser Permanente, NHS CCGs, Counties Manukau)<br>• Determine appropriate delivery models (these will be tailored during implementation in each locality)<br>• Create a centre of Knowledge and information around models of integration and primary and community models of care |
| 4. Network development processes and guidelines | 1. Document a standard set of requirements and standards that each network will work within. Some of these will be relevant from day one, others will be prepared for when they are needed. These will include:<br>• Governance mechanism<br>• KPIs/targets (minimum standards) and accountability mechanisms<br>• Contracting mechanisms (between funder and provider, between network partners, etc)<br>• Levels of delegated authority and mechanisms to increase autonomy over time<br>• Budget tools and financial accountability requirements |

| Objectives | Deliverables/ high level milestones |
|---|---|
| | • Asset mapping tool<br>• Network stakeholder analysis<br>• Communications templates<br><br>2. Analyse existing DHB and PHO systems and processes and review/redraft these to reflect the collaborative working environment; develop new systems and processes where required. Examples include funding and contracting arrangements – to enable and support different ways of working.<br>3. Once we are ready for some decision making to be devolved to networks there will need to be a standard mechanism/pathway for 'applications' from locality groups wishing to establish a network (by submission of an outline business case or similar process). It is prudent to begin drafting what this may look like.<br>4. Tools and templates as required by locality groups who wish to form a network. Examples could be:<br>• High-level 'how to' plan providing a suggested pathway/series of steps for network establishment (include alternatives/not prescriptive but indicates the minimum requirements)<br>• 'Business Case' application template (for point 3 above)<br>• Terms of Reference template to support establishment project scoping and planning<br>• Terms of Reference for project Steering Groups, Partnership Advisory Groups, etc<br>• Risk identification and management plan<br>• Infrastructure/resource map and plan<br>• budget template<br>• Guide to co-design<br>• Community asset mapping tool (beyond health and social service providers) |

## Risk Analysis and Management

### Preliminary Risk Analysis:

| Risk | Likelihood Hi/Med/Lo | Impact Hi/Med/Lo | Planned Response |
|---|---|---|---|
| Lack of primary care engagement | M | H | Early and clear communication to sell benefits, address concerns; gain their involvement in co-design through workshops, feedback opportunities. |
| Lack of engagement with secondary care | M | H | Senior clinicians to act as champions for the initiative; keep them fully informed of/involved in the project's work programme. Regular communications and opportunities to contribute in the co-design process. |
| Project doesn't adequately address consumer priorities | L | H | Consumer input based on a co-design approach will be integral to the establishment and operation of networks. |
| Project, programme and change fatigue | M | M | Communicate the vision and engage stakeholders at an early stage so that they own the solutions.<br>Communicate regularly. |

| Risk | Likelihood Hi/Med/Lo | Impact Hi/Med/Lo | Planned Response |
|---|---|---|---|
| | | | Promote and celebrate success |
| Scale of what we're trying to achieve | M | L | Low impact for this current project stage, but recognised as considerably higher likelihood and impact for network implementation. Stage implementation projects, concentrating on those groups most able to move forward as early adopters, so that we can learn from mistakes. Recognise the need to learn from experience. |
| Too busy keeping the current state afloat | H | H | Adequately resource the project (staff time, resourcing and financials) to ensure that there is enough 'space' to effect change. |
| New ways of working/new relationships (as equal partners) that parties are not used to (working in partnership with consumers | M | H | Conduct activities to address gaps in knowledge/skills/experience. Be clear that this is change behaviour and all parties need to take responsibility for engagement and the resulting outputs.<br>Support relationship building opportunities. |
| Governance of networks; how do we account for them? | M | M | Build robust processes based on best practice. |
| Duplication of efforts across other T&S projects (e.g. patient experience, urgent care, AIM 24/7, etc) | H | M | Project Manager to get a good understanding of results from other projects, and synthesise the lessons. |



**Financial Profile**

This budget covers the Phase One 'Core Network Expertise' project, and is expected to be conducted during February-August 2016 inclusive (7 months). The project manager role is in addition to this budget. Further budgets will need to be supported by business cases to support implementation of health and social care networks.

As the timing of this project spans two financial years, the indicative spend in each year is as follows:

- 2015/16: $71,400
- 2016/17: $28,600

| Item | Itemised Description | Cost$ | Budget Source and Status (approved / approval in process etc.) |
|---|---|---|---|
| Project resources and operating expenses | o DHB staff (existing resources)<br>o Incidental travel<br>o Catering at meetings<br>o Printing<br>o Room hire<br>o Patient engagement costs | Time<br>$50,000 (combined items)<br><br><br><br>$20,000 (combined items) | Existing staff budget<br><br>New<br><br><br>New |

| | | | |
|---|---|---|---|
| | o Research costs | | |
| External advice | o Specialist advice (e.g. legal and governance); DHB expertise<br>o Graphic design<br>o Qualitative Engagement software and support (Cognise) | Time<br><br>$30,000 (combined items) | Existing staff budget<br><br>New |
| | **Total cash investment:** | **$100,000** | **New** |

## APPENDIX 2: Stakeholder Analysis

| Stakeholder group | What they may like | What they may not like | Risks |
|---|---|---|---|
| Consumers | Opportunity to fix the problems they experience re choice, access, etc<br>Potential to be involved in the changes/have a voice<br>More responsive to consumer needs and wants | Shared patient records – perceived confidentiality breaches<br>Change<br>Additional expectations for self management | Perception that this is yet another sector restructure (waste of time/money)<br>Rumours / media stories (negative perception or incorrect info) |
| General practices | General practices are key partners in this initiative – seen as progressive<br>More influence over what services are commissioned<br>Meritocratic increase in authority as networks prove themselves<br>Opportunity to expand general practice scope/ potential for job enrichment<br>May offer opportunities for succession planning<br>Opportunities for efficiencies<br>Opportunities to be seen to do more for patients<br>Opportunities to improve sustainability of business and workforce | Likely to disrupt current business models<br>Uncertainty of funding in the short-term<br>Collaborating with competitors, particularly if there is ill will<br>Shareholders may have other priorities for their business<br>Business needs may be at odds with required network outcomes<br>Out of their depth (planning etc) | Lack of practice leadership may mean that staff don't engage/ get the wrong story<br>Staff uncertainty re jobs, scope of their role<br>Competitive behaviour leads to perverse outcomes<br>May not share data/info<br>Shared geography may not mean aligned aims/objectives/philosophy<br>Poor use of data for strategic planning – can't see the SWOT |
| General practitioners | Potential to decrease time pressures<br>Ability to specialise in an area of interest<br>Better able to refer patients with non-medical issues to other network providers<br>Sustainability | May be expected to network with practices or people they don't like or respect<br>May feel forced by the DHB<br>Feel out of control | Stall progress by continually bringing up issues and/or avoiding engagement<br>Curmudgeons promulgate negative stories/perceptions<br>Keeping the current state going uses up all their time/energy |
| Community-based nurses | Work at top of scope in a new model of care; less admin/low level tasks<br>Introduces new roles and development opportunities | Potential for loading a lot more responsibility on them | Nursing workforce in primary care may not want to change |
| Health Hawke's Bay | Decrease complexity and variability across practice offerings | Changes potentially conflict with nationally-determined priorities | Inability to get cross-practice information sharing and shared IT |

| Stakeholder group | What they may like | What they may not like | Risks |
|---|---|---|---|
| | More responsive primary care sector<br>Joined up system, improve access, address inequity<br>Doing better for patients<br>More engagement across the sector<br>Efficiency<br>More services in the community<br>Sustainable workforce | Out of our depth?<br>Resource requirements and effort to achieve this change | platform<br>Lose support of practices<br>Communities/providers not wanting to engage |
| DHB | Keep the hospital the same size despite increased demand for services<br>Local responsibility for infrastructure and resourcing (??)<br>Address equity gap | Devolving control to communities due to lack of certainty/ track record of delivery<br>Has invested in the current state<br>Resource requirement to make this happen<br>If things don't move at the right pace | Could lead to more complexity of 6-8 'different' systems (networks) to interact with<br>Too prescriptive, meaning that communities don't feel that they own the network |
| Hospital services | Sustainable workloads<br>Efficient service collaboration with primary care | Keeping the current going doesn't allow time for change<br>Scared about jobs/instability?<br>Might have to travel to work remotely?<br>Worry about community capability<br>Effort in addition to day job | Risk adverse, so will 'dig in their heels'?<br>Perverse behaviour re network vs private patients?<br>Services fail / community-based services don't work |
| MSD (funder) | Collective impact is greater than working in silos<br>Keep people well; keep people in work<br>Fit with national agenda | Potential lack of clarity re budgets (split between H&SC)<br>Conflict between network outcomes and MSD policy directions?<br>Never been done before<br>Control issues? | Change seen as too difficult, too soon, or only benefitting the health sector<br>Targets / national picture gets in the way of local decision making |
| MSD-funded services | Better access to the health resources available in the health sector, ability to cross-refer patients/clients<br>Clarity of service provision | Likely to disrupt current business models / have other priorities<br>Uncertainty of funding in the short-term<br>Skills to engage in doing things differently | Service failure<br>Don't meet targets |
| Maori providers | Better access to the health resources available in the health sector; ability to cross-refer patients/clients<br>Focus on Maori – close gaps, decrease inequities<br>More holistic approach fits with Maori | Likely to disrupt current business models / have other priorities<br>Uncertainty of funding in the short-term<br>How does this fit with current initiatives?<br>Mistrust of HBDHB gets in the way of progress | Fear of losing autonomy |

| Stakeholder group | What they may like | What they may not like | Risks |
|---|---|---|---|
| | way of approaching things (e.g. whanau ora)<br>Opportunities for collaboration<br>Opportunities to think strategically | A lot going on with post settlement groups – this is 'another thing' | |
| NGOs | Better access to the health resources available in the health sector; ability to cross-refer patients/clients<br>Potential to re-direct their services/service delivery to become an integral part of the network<br>Better integration / collaboration with voluntary organisations | Likely to disrupt current business models / have other priorities<br>Uncertainty of funding in the short-term<br>Potential for more referrals; will need to see $$ coming their way | Overloading them<br>No resources to engage<br>Don't have sustainable funding streams |

APPENDIX 3

HAWKE'S BAY District Health Board

**TERMS OF REFERENCE**

**Health and Social Care Networks Programme Steering Group**

HEALTH HAWKE'S BAY Te Oranga Hawke's Bay

| | |
|---|---|
| **Purpose** | The purpose of the Steering Group is to ensure sound decision making in the Health and social care network programme, to ensure the programme brief is adhered to and to communicate messages as appropriate. |
| **Functions** | At a programme level, the steering group is responsible for achieving the high level strategic vision of the Networks programme. This includes the following responsibilities:<br>• Oversees all deliverables in Phase One - Health and Social Care Networks Programme to ensure strategic fit.<br>• Actively champions the Networks Programme and provides leadership for change<br>• Understands the desired outcomes, and tracks progress towards these, taking corrective action where necessary.<br>• Monitors the management of major programme issues and risks and provides advice on the best approach to resolving these.<br>• Owns the process and the deliverables of the programme.<br>• Maintains a high-level view of project work being conducted across the health sector so that potential synergies with, or impacts on, the Networks Programme can be identified and addressed appropriately.<br>• Reports to HBDHB Executive Management group on a monthly basis.<br>• Holds and allocates the programme budget.<br>• Ensures programme benefits KPIs are tracking positively.<br>• Ensures sound decision making processes are followed<br>• Establishes the brief or terms of reference for subsequent phases<br>• Support and endorse Terms of Reference documents for network establishment projects in each geographic locality. |
| **Decision Making** | A consensus is required for any decision. Where meeting attendance is not possible a member will endorse/reject a deicision electronically either before a meeting or upon receipt of the minutes.l |
| **Membership** | The Core Membership of the steering group is:<br>GM Primary Care/CEO HHB<br>COO HBDHB<br>GM PIF HBDHB<br>DAH<br>GM Māori Health HBDHB<br>Head of Innovation and development HHB |

14.4

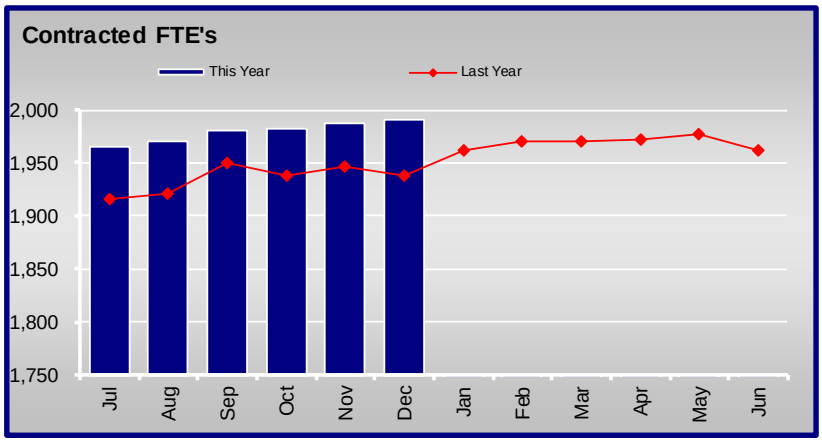
| | |
|---|---|
| | CMO (Primary)<br>Chief Nursing Officer<br>Medical Advisor Sector Development HHB (GP to be appointed)<br>Manager, Wairoa Health Centre<br>Service Director, Rural, Oral and Community Health Services<br>Medical Director HBDHB<br>Consumer representative<br>Ministry of Social Development representative<br>Other individuals will be invited to provide expertise as and when appropriate. These will include:<br>HHB leadership team members<br>Health Service Directors<br>Specific service or facility managers |
| **Chairperson** | The Chair will be the GM Primary Care |
| **Administration** | The Project Manager - Network Development will:<br>• administer the steering group<br>• maintain an accurate and up to date record of decisions and activities<br>• Set up meetings of the group<br>• Draft Reports on behalf of the group<br>• Monitor progress against programme plans |
| **Meetings** | Meetings will be held on at least a monthly basis, although additional meetings may be set up as required.<br>Meeting attendance will be restricted to the Group members only (and appropriate support staff) with other persons attending only by specific invitation.<br>Matters may be dealt with between meetings through email exchange with a record being maintained by the project manager. |
| **Reporting** | The steering group will report to the CEO HBDHB and to the executive management team on a monthly basis. |
| **Minutes** | Notes and action points will be circulated to all members of the Group and a summary of discussion from each meeting will be provided to EMT and the HHB Leadership team for information by email. |

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Human Resource KPIs (Q2 Oct-Dec 2015)** 07 |
| | For the attention of: **HBDHB Board** |
| Document Owner:<br>Document Author: | John McKeefry, GM Human Resources<br>Jim Scott, Workforce Analyst |
| Reviewed by: | Executive Management Team |
| Month: | February 2016 |
| Consideration: | For Information |

15

## Headcount and positions

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




Contracted FTEs
1991.2 at 31 Dec 2015
1937.9 at 31Dec 2014
= 2.7% increase

Overall increases/ (decreases)

| | FTE | |
|---|---|---|
| Medical | 12.5 | 5.4% |
| Nursing | 12.7 | 1.6% |
| Allied Health | 17.1 | 4.2% |
| Support | 6.3 | 5.4% |
| Mge. & Admin | 4.7 | 1.2% |
| **Total** | **53.3** | **2.7%** |

Accrued FTE:

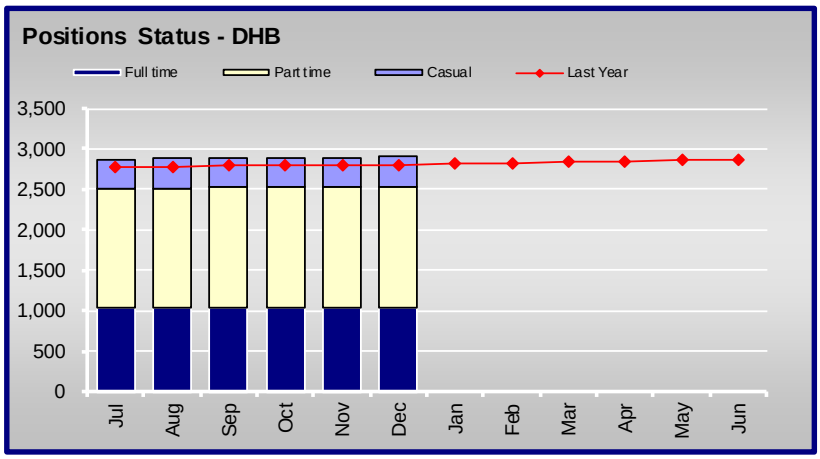
| | **Budget** | **Actual** | **Variance** | **% Variance** |
|---|---|---|---|---|
| Month of December 2015 | 2173 | 2149 | 24 | 1.1% |
| Year to date to December 2015 | 2177 | 2129 | 48 | 2.2% |

Accrued FTE has a year to date favourable variance to December of 48 or 2.2%. Details are in the Finance Report and include:

| | FTE | Comments |
|---|---|---|
| Medical | 3 | Vacancies in ED and Mental Health (covered by locums) |
| Nursing | 14 | Management of low volumes in Ata Rangi, and vacancies in a number of Services including rurals and district nursing |
| Allied Health | 29 | Vacancies. Recruitment to positions for new models of care, low supply of applicants, delay in staged recruitment of pharmacy facilitators and difficulty recruiting to laboratory vacancies. |

New Position Requests to Recruit approved by EMT in October to December 2015 quarter:

| **Position** | **FTE** |
|---|---|
| Graduate Dental Therapist | 1.00 |
| Health Care Assistant | 0.60 |
| Registered Nurse – Pulmonary Rehabilitation | 0.90 |
| Physiotherapist – Pulmonary Rehabilitation | 1.00 |
| Administration Co-ordinator | 0.60 |
| Clinical Nurse Co-ordinator - Community Nursing | 1.00 |
| District Nurse | 2.00 |
| Clinical Nurse Educator – Community Nursing | 1.00 |
| Newborn Safe Sleep Co-ordinator – Community | 0.50 |
| Orderly | 0.75 |
| Laboratory Scientist | 1.00 |
| Physiotherapist | 2.52 |
| Scientist - Histology | 1.00 |
| Laboratory Technician - Histology | 1.00 |
| Charge Preanalytical Services | 1.00 |
| Laboratory Technician - Specimen Services | 1.00 |




Positions filled:
2911 at 31 Dec 2015
2805 at 31 Dec 2014
= 3.8% increase (106 positions)

Of the 2892 positions (last year in brackets):
36% are full-time (37%)
51% are part-time (51%)
13% are casual (12%)

15

**Overall increases/ (decreases) – breakdown of 3.8% increase**

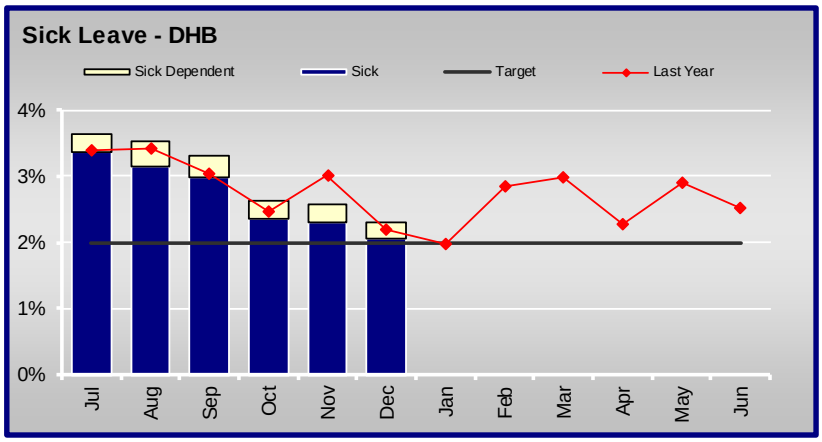
| | Full time | Part time | Casual | Total | % change |
|---|---|---|---|---|---|
| Medical | 5 | 10 | 2 | 17 | 6.4% |
| Nursing | (10) | 36 | 38 | 64 | 4.6% |
| Allied Health | 16 | 0 | (11) | 5 | 0.9% |
| Support | 4 | 4 | 4 | 12 | 6.8% |
| Management & Admin | 0 | 4 | 4 | 8 | 1.8% |
| **Totals** | **15** | **54** | **37** | **106** | **3.8%** |

## Sick Leave

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

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

Target is 2.00%




Dec 2015 = 2.30%
Dec 2014 = 2.20%

YTD Dec '15 = 2.99%
YTD Dec '14 = 2.90%

Sick leave slightly higher than last year although overall no concerns for December quarter or year to date to report.

HBDHB is the lowest of the mid-sized DHBs.

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

31 Dec. 2015 – 3rd lowest out of 19 DHBs (12 months ended Dec. 2015 ranked 3rd lowest)

31 Dec. 2015 – the lowest out of 6 mid-sized DHBs (12 months ended Dec. 2015 ranked the lowest)

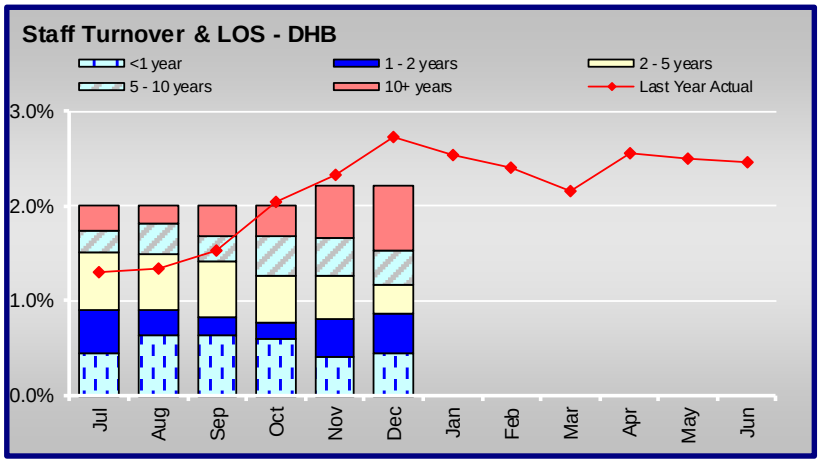
## Staff Turnover

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

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

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

Target is 2.50% per quarter.




3 months ended Dec '15 = 2.21% which is below the target of 2.50%

12 months to Dec '15 = 8.93% which is below the 10% annual target.

Allied Health, Support and Management & Administration turnover are slightly higher than the 10% annual target but present no concerns.

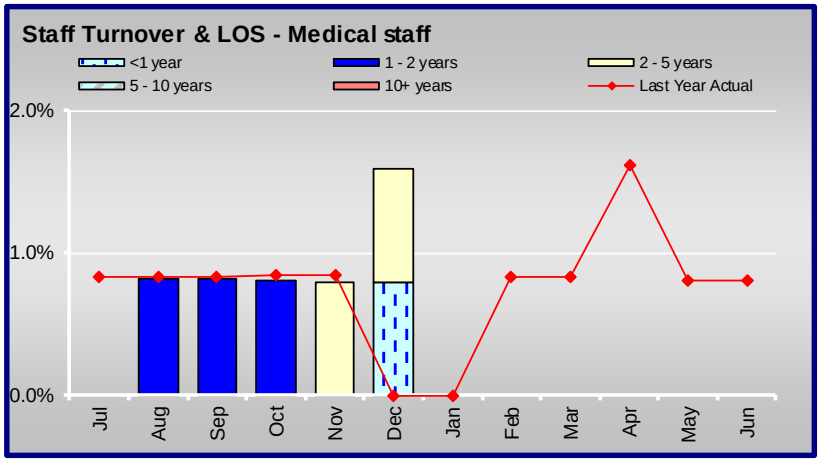
| | |
|---|---|
| 2216 | Staff at 1 Oct '15 |
| 47 | New Staff |
| (49) | Staff resignations |
| 12 | Change of status – mostly fixed term to permanent |
| 2226 | Staff at 31 Dec '15 |

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

31 Dec. 2015 – 8th lowest out of 20 DHBs (12 months ended Dec. 2015 ranked 7th lowest)

31 Dec. 2015 – 4th lowest out of 6 mid-sized DHBs (12 months ended Dec. 2015 ranked 3rd lowest)

## Staff Turnover – Medical Staff




3 months ended Dec '15 = 1.59% which is below the 2.50% target.

12 months to Dec '15 = 4.17% which is below the 10% annual target.

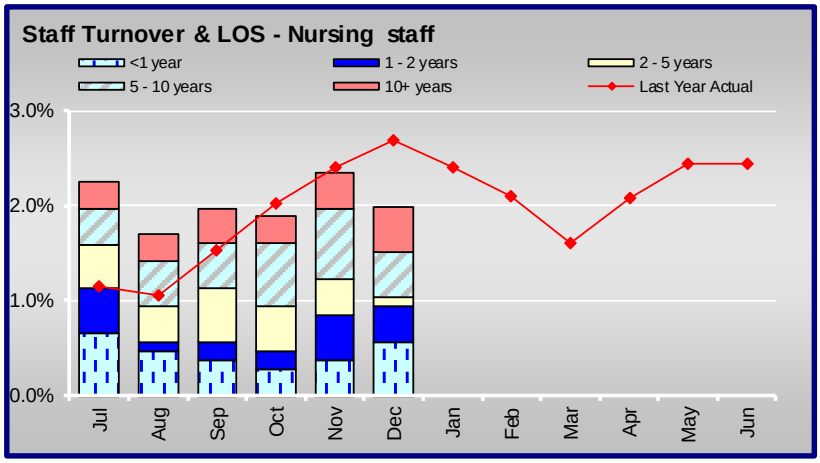
| | |
|---|---|
| 126 | Staff at 1 Oct '15 |
| 1 | New Staff |
| (1) | Staff resignations |
| 2 | Change of status –fixed term to permanent |
| 128 | Staff at 31 Dec '15 |

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

31 Dec. 2015 – 12th lowest out of 20 DHBs (12 months ended Dec. 2015 ranked 6th lowest)

31 Dec. 2015 – 4th lowest out of 6 mid-sized DHBs (12 months ended Dec. 2015 ranked 3rd lowest)

## Staff Turnover – Nursing Staff




3 months ended Dec '15 = 1.98% which is below the target of 2.50%

12 months to Dec '15 = 8.06% which is below the 10% annual target.

No significant trends.

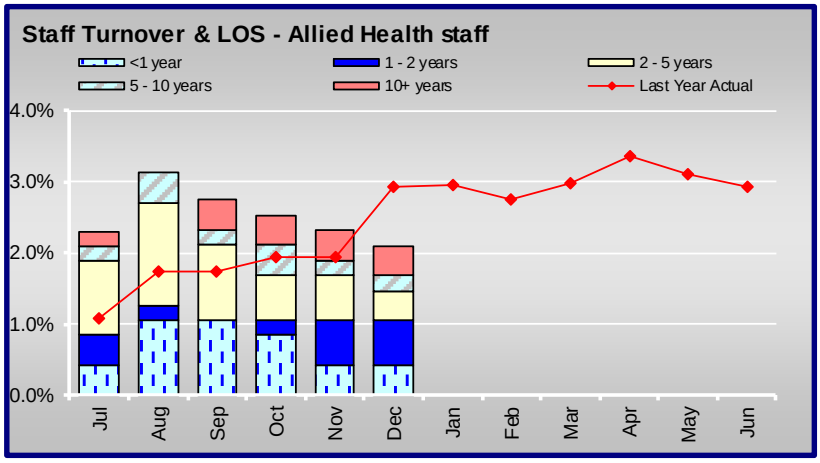
| | |
|---|---|
| 1062 | Staff at 1 Oct '15 |
| 22 | New Staff |
| (21) | Staff resignations |
| 13 | Change of status – mostly fixed term to permanent |
| 1 | Trf other staff group |
| 1077 | Staff at 31 Dec '15 |

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

31 Dec. 2015 – 7th lowest out of 20 DHBs (12 months ended Dec. 2015 ranked 7th lowest)

31 Dec. 2015 – 3rd lowest out of 6 mid-sized DHBs (12 months ended Dec. 2015 ranked 3rd lowest)

## Staff Turnover – Allied Health Staff




3 months ended Dec '15 = 2.09% which is below the 2.50% target.

12 months to Dec '15 = 10.81% which is above the 10% annual target.

This 10.81% represents 51 resignations in the year:

- 23 moved to position outside HBDHB.
- 7 relocating outside HB.
- 5 retired
- 4 family reasons
- 12 other reasons.

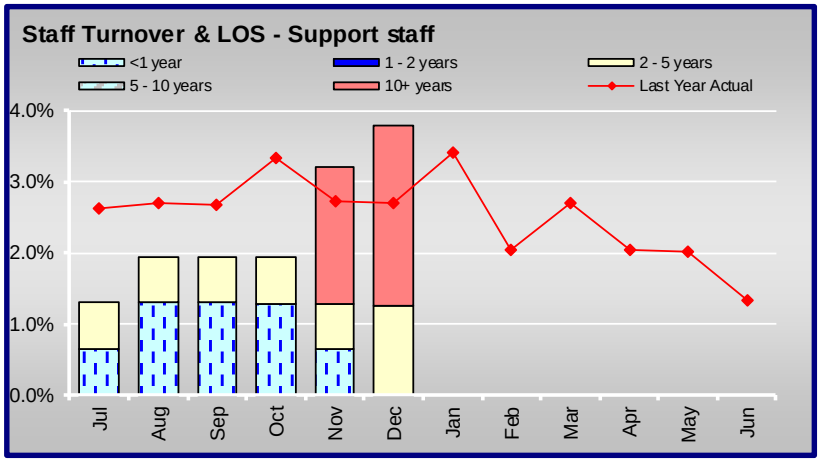
| | |
|---|---|
| 478 | Staff at 1 Oct '15 |
| 14 | New Staff |
| (11) | Staff resignations |
| 0 | Change of status – fixed term or casual to permanent |
| 2 | Trf other staff group |
| 483 | Staff at 31 Dec '15 |

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

31 Dec. 2015 – 4th lowest out of 20 DHBs (12 months ended Dec. 2015 ranked 7th lowest)

31 Dec. 2015 – 2nd lowest out of 6 mid-sized DHBs (12 months ended Dec. 2015 ranked 4th lowest)

## Staff Turnover – Support Staff




3 months ended Dec '15 = 3.80% which is above the 2.50% target.

This 3.80% represents 6 resignations in the quarter:

- 3 retired
- 1 relocating outside HB
- 1 moved to position outside HBDHB.
- 1 unknown reason

12 months to Dec '15 = 10.14% which is above the 10% annual target.

This 10.14% represents 15 resignations in the quarter:

- 4 moved to positions outside HBDHB.
- 3 relocated outside HB.
- 3 retired
- 1 further education
- 4 other reasons

| | |
|---|---|
| 158 | Staff at 1 Oct '15 |
| 3 | New Staff |
| (6) | Staff resignations |
| 0 | Change of status – casual to permanent |
| 0 | Trf. other staff group |
| 155 | Staff at 31 Dec '15 |

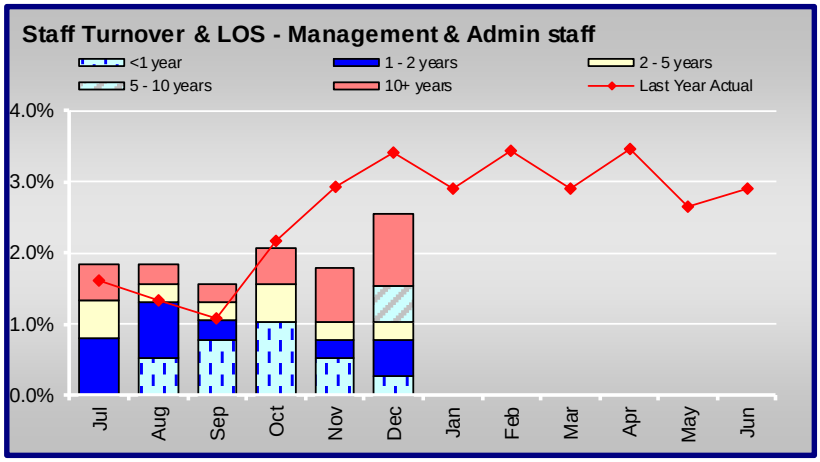
Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

31 Dec. 2015 – 13th lowest out of 20 DHBs (12 months ended Dec. 2015 ranked 11th lowest)

31 Dec. 2015 – 3rd lowest out of 6 mid-sized DHBs (12 months ended Dec. 2015 ranked 4th lowest)

Note a number of other DHBs outsource much of their Support staff which can impact on their Turnover rate.

## Staff Turnover – Management & Administration Staff




3 months ended Dec '15 = 2.55%
This is above the 2.50% target.

This 2.55% represents 10 resignations in the quarter:

- 4 retired
- 2 family reasons
- 1 relocated outside HB
- 1 moved to position outside HBDHB.
- 2 other reasons

12 months to Dec '15 = 10.03% which is slightly above the 10% annual target.

This 10.03% represents 38 resignations for the year:

- 12 moving to positions outside HBDHB.
- 11 retired
- 3 relocating outside HB
- 2 further education
- 4 family reasons
- 6 other reasons

| | |
|---|---|
| 392 | Staff at 1 Oct '15 |
| 7 | New Staff |
| (10) | Staff resignations |
| (3) | Change of status – mostly permanent. To fixed term |
| (3) | Trf from staff groups |
| 383 | Staff at 31 Dec '15 |

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

31 Dec. 2015 – 12th lowest out of 20 DHBs (12 months ended Dec. 2015 ranked 13th lowest)

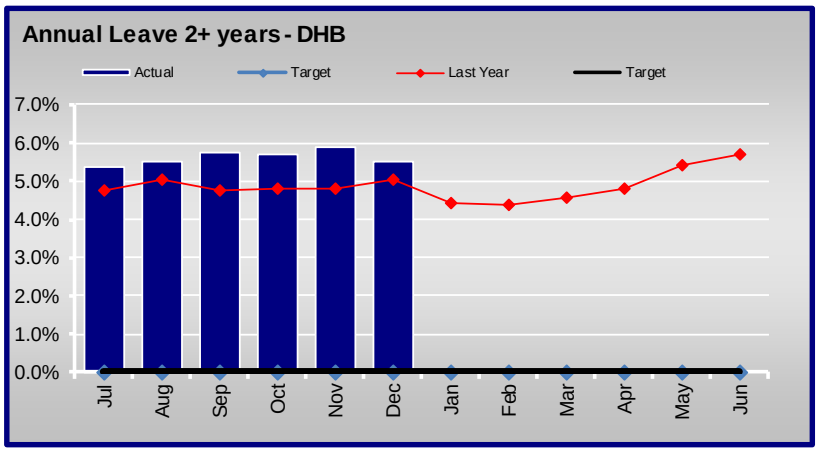
31 Dec. 2015 – 4th lowest out of 6 mid-sized DHBs (12 months ended Dec. 2015 ranked 4th lowest)

15

## Accrued Annual Leave (2+ years)

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

Target is 0%.




Jun '15 = 5.69% (143 staff)
Dec '15 = 5.51% (140 staff)
Reduced by 3

Dec '15 = 5.51% (140 staff)
Dec '14 = 5.05% (125 staff)
Increased by 15
The number of staff with more than 2 years accumulated annual leave has increased from this time last year.

We are the third best performed mid-sized DHB for this KPI and the 7th best overall.

The percentage of staff with 2+ year's accumulated annual leave has decreased from 5.69% to 5.51% since 30 June 2015.

The total liability at 31 December 2015 was $18.8m compares to $19.1m at 30 June 2015. This $0.3m improvement is made up of:

1. $0.6m favourable driven by a decrease in the hours owing.
2. $0.3m unfavourable driven by an increase in the average rates.

The total accrued leave actual to budget at 31 December 2015 was $942k favourable reflecting on our focus to reduce all accrued leave balances and staff able to take leave over the Christmas period. In addition our Managers and Team Leaders, particularly in Health Services are working very hard to optimise leave being taken including the taking of short notice leave.

Note that the average AL balance has reduced slightly over the last 5 years despite staff with 5 weeks (or more) annual entitlements increasing from 51.3% in December 2010 to 65.5% in December 2015.

| | Average AL balance (hours) | % staff with an annual entitlement of 5 or more weeks Annual Leave |
|---|---|---|
| Dec. 2015 | 125.08 | 65.5% |
| Dec. 2010 | 126.09 | 51.3% |

We have renewed our focus on managing Annual Leave balances. These actions and the status of each are below:

| Action | Progress |
|---|---|
| HR Services in partnership with Health Services leadership working to reduce annual leave and other leave balances whilst developing and implementing the processes necessary to support this. | Identified 7 major contributors to excessive annual leave balances and developing leave management plan for each. Potential saving of up to a maximum of $433k. Short notice leave opportunities being maximised. At 31 December the overdue balances for these employees totalled $450k. We are following up with managers to ensure leave plans are in place to manage these balances appropriately.<br><br>SMO engagement on this is high. |
| Improved reporting:<br>1. Additional KPIs to the online report<br>2. Online report to show total excessive/ overdue balance and drill down to detail.<br>3. Top 50 excessive/ overdue balances to be reported to EMT and Health Services leadership group and all 2+ employees to Service Directors and Nurse Directors.<br>4. Report on dollar balances of leave owing not just hours.<br>5. Finance to develop a new report to assist managers to plan leave and stay within their budget.<br>6. Develop trend reports with drill down capability. | 1. Completed<br>2. Completed<br>3. Completed and ongoing.<br>4. Under development with a view to be released early 2016.<br>5. Under development<br>6. Under development with a view to be released early 2016. |
| Encourage staff to take more responsibility for their leave balances:<br>1. Employees with excessive/ overdue leave balances to get a letter showing the excessive/ overdue balances and outlining the need for them to discuss with their manager and agree on a leave plan which will ensure these balances are managed appropriately.<br>2. Managers to receive a list of employees with excessive/ overdue leave balances in preparation of their meeting with their employees.<br>3. The ability to request leave (and for it to be approved/ declined) electronically is being rolled out across the organisation.<br>4. Test a new leave planner tool from our HRIS supplier. This will allow employees to enter their own leave plan. | 1. Completed and ongoing review of leave taken and need for follow up.<br>2. Completed and ongoing.<br>3. Ongoing over the coming year.<br>4. Ongoing. We have gone back to supplier with some queries and suggested improvements. |
| Highlighting good practice within HBDHB and encourage the sharing of ideas | Ongoing |
| Working across Central region to identify and share good practice. | Discussed at Central region GM HR November 2015 meeting with recommendations going to the CEOs at their March meeting. |
| Work with managers to identify further improvements, enhancements or assistance they require. | Ongoing |
| Review the current Leave Policy and provide more guidance and direction to managers and employees. | Comparative information sought from other DHBs and HBDHB leave policy updated and ready to go out for consultation with staff and unions. |

Compared to other DHBs, HBDHB has ranked as follows in the latest quarter.

31 Dec. 2015 – 7th lowest out of 20 DHBs (Dec. 2014 – 5th)

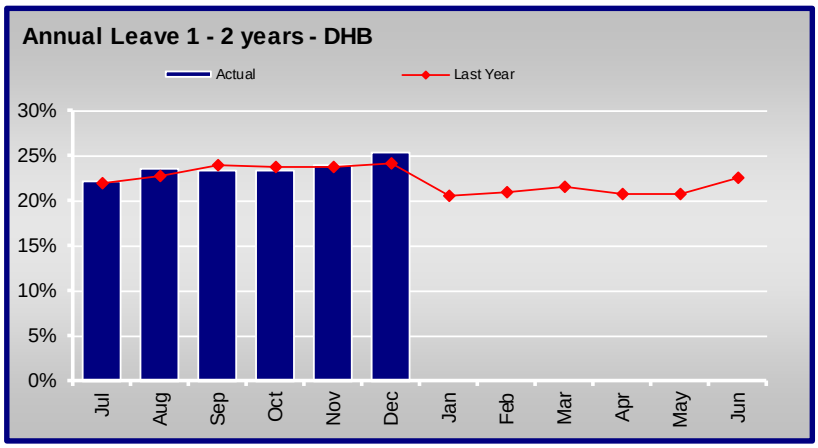
31 Dec. 2015 – 3rd lowest out of 6 mid-sized DHBs (Dec. 2014 – the lowest)

31 Dec. 2015 – 3rd lowest of the central Region DHBs (Dec. 2014 – 3rd lowest)

## Accrued Annual Leave (1 – 2 years)

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

Target is 15%.




Jun '15 = 22.43% (564 staff)
Sep '15 = 23.27% (591 staff)
Dec '15 = 25.25% (641 staff)

The percentage of staff with 1 to 2 years accumulated leave has increased slightly since this time last year.
Dec '15 = 25.25% (641 staff)
Dec '14 = 24.09% (596 staff)

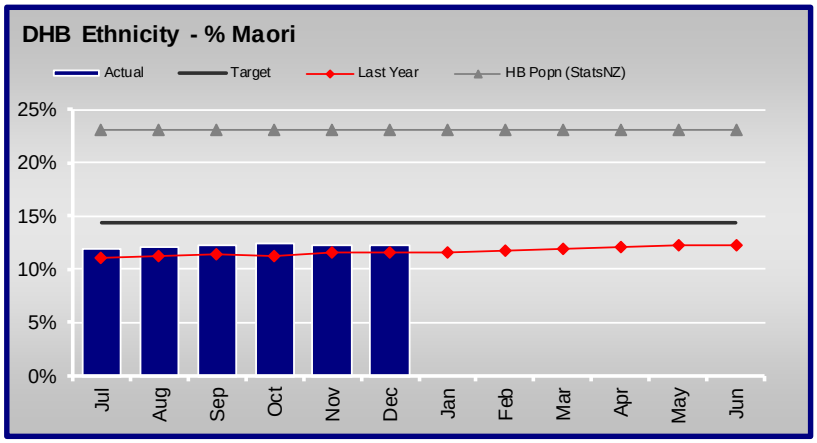
15

## Staff Ethnicity

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

Target is set at 10% improvement on previous year. 2015/16 target = 14.3%. The Māori population for HB is 23.1%

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




Note – at 31 Dec. 2010 the percentage of Māori staff was 8.7% compared to 12.3% at 31 Dec. 2015.

Māori staff representation in the Workforce:

| | People | Positions |
|---|---|---|
| Dec '15 | 12.61% | 12.26% |
| Dec '14 | 11.90% | 11.62% |

Dec 2015 breakdown:

| | Positions filled | % of Total |
|---|---|---|
| NZ & European | 2196 | 75.44% |
| Maori | 357 | 12.26% |
| Pacific Islands | 38 | 1.31% |
| Other | 238 | 8.18% |
| Not known | 82 | 2.81% |
| **Total** | **2911** | |

Support staff (28.19%) and Management & Admin staff (16.52%) exceed the DHB target.

Allied Health (12.55%) Medical (2.85%) and Nursing staff (10.64%) are below the target. Nursing has been the primary focus for recruitment and has increased from 10.1% to 10.6% in the last year.

The gap to our target sits at 59 at 31 December 2015.

| | |
|---|---|
| 355 | Maori Staff - 1 Oct 2015 |
| 18 | New Staff |
| (16) | Staff resignations |
| | Changes to ethnicity |
| 357 | Maori Staff – 31 Dec 15 |

With the target increasing from 12.97% to 14.3% at 30 June 2016 it was recognized that we needed to deepen our focus in Nursing and broaden our focus to Allied Health as our second largest workforce.

To increase Maori staff representation in Nursing and Allied Health from current levels is a significant challenge and requires an approach where the competency Engaging Effectively with Maori is more highly valued by the organisation. To do this the competency of Engaging Effectively with Maori will be including in ALL position profiles and a question to establish competence for effectively engaging with Maori included in the interview question template and given double weighting. In addition the need to recruit more Maori is being re-promoted to all hiring managers and team leaders.

**Maori Staffing Recruitment Plan 2015 / 2016** ***updated Jan 2016***

**Initial focus to increase Māori staff representation. *Nursing Recruitment Plan*:** Has been in place for 2 years and managed in conjunction with Maori Health Services / Turuki Workforce Development

| Action | Status |
|---|---|
| Keep Hiring Managers informed of need to increase Māori staff representation and advise KPI performance to date | Reports sent to CNO, Nurse Directors monthly<br><br>To provide report to DAH – Dec15 |
| Recruitment Tool Kit updated to provide information and guidance on interviewing Maori candidates | Tool Kit is currently up to date with a focus on Maori staff recruitment and is updated on a regular basis |
| Recruitment videos featuring Maori staff | Developed early 2014 and appear on HBDHB website, Work For Us |
| NEtP Recruitment – targeted to increase Maori staff representation | Ongoing since 2013<br><br>NEtP recruitment for Jan16 intake completed – 8 Maori Grads hired |
| Provide support to EIT Nursing students | Nursing Director Maori Health works with EIT to support students at all levels. |
| Tuakana / Teina Programme implemented to support Maori Nurses and included in Orientation checklist for new staff | Programme in place since 2014.<br>Support provided to assist with application process for NEtP and HBDHB Recruitment process |
| HBDHB vacancies provided to Kahungunu for distribution on their Panui network | Vacancy list provided weekly since 2014 |
| Workforce Development Pipeline defined showing pathway from interview to employment at HBDHB, emphasising need to be engaging and providing support and initiative for Maori at all stages | Initiatives for each stage defined re Intermediate, Secondary and Tertiary work placement |
| Work with Kia Ora Hauora to identify Maori candidates who are keen to work in the Hawke's Bay and develop ongoing relationships | Initial contact made with candidates and now following up with responses |
| Briefing of CNMs and NDs re need to increase Maori staff representation | Briefing given to CNMs |

**Update of Recruitment plan**- August 2015; **to include focus on Allied Health and introduce additional initiatives for Nursing and other areas of the DHB** to increase Maori staff representation

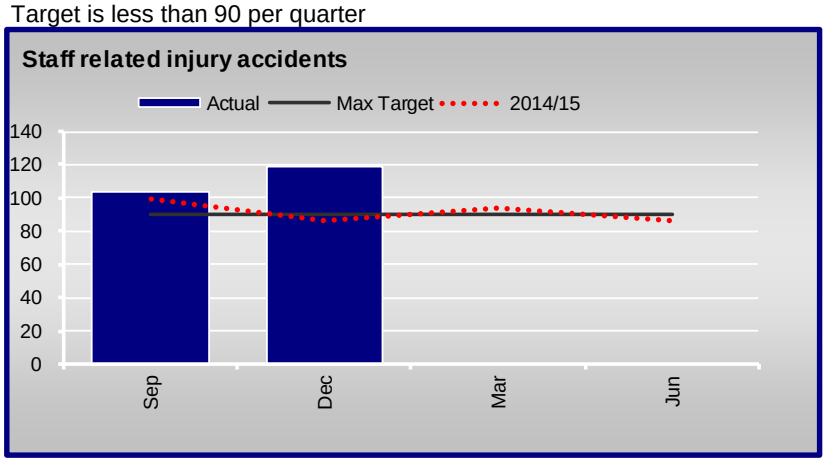
| Action | Status |
|---|---|
| Include our values in Te Reo in all our advertising | In place |
| Develop Values Pre-Screening tool to ensure applicants aligned with DHB values and that they engage effectively with Maori<br><br>Stage 1 will involve including a pre-screening question for all Team Leader / Manager roles – "please research the HBDHB values and provide examples of how you have delivered on these in a previous role or situation" | Investigating available online tools available but in the interim using a pre-screening question.<br><br>To update Taleo – due November – *waiting on Taleo updates*<br><br>Piloted for Snr HR Advisor recruitment in Dec 15 and will continue in 2016 for all senior, team leader and management roles |
| Ensure all HBDHB Hiring Managers complete Engaging Effectively with Maori course | In progress – by June 2016 |
| Ensure all members of an interview panel have completed Engaging Effectively with Maori, and for this eventually to be a mandatory requirement before they can be involved in selection and assessment | In progress – by Oct 2016 |
| Position profiles to be updated (key competencies and essential criteria) to include Engaging Effectively with Maori. | Draft completed - for review and to implement Feb 2016 |
| Update interview question template to ensure Engaging Effectively with Maori is Q2 or Q3 and also it is weighted 2 or higher for assessment | Hiring Managers currently advised as and when required – Dec 2015<br><br>Interview question templates to be updated – Feb 2016<br><br>Include in Recruitment training |
| Include a consumer representative on interview panel | In place for Senior Management and SMO Roles. Consumers invited to be on the interview panel and presentation panel<br><br>Trialled for Nurse Director Maori Health – completed & worked well – to update Recruitment Tool Kit to advise of this option particularly for consumer facing roles |
| Develop "Day in the Life" success stories promoting current Maori staff | 15 people identified by Maori Health Services – Patrick and Dianne to confirm individuals who will participate – Nov 2015<br><br>Develop stories and use in promotional activity online from Feb 2016 |

| Action | Status |
|---|---|
| Enhance training to Hiring Managers on selection techniques, the support available from MHS and ensure their candidate selection focuses on the relationships the role needs and those who can best engage with Maori. | Deliver as part of next HR Foundations Course, Recruitment module, - *completed in session on 19 November to be included in future sessions*<br><br>Include MHS in setting the EEM questions for interviews. |
| Develop seminar to provide CV and interview training and support to candidates | Presentation recently to Year 12/13 students completed<br><br>Work with E & D and MHS to develop additional seminars – Feb 2016, and one on ones as required |
| Audit recent appointments where Maori have been unsuccessful to understand why | Review sample of unsuccessful candidate CVs and discuss with Hiring Managers – March 2016 |
| Identify unsuccessful Maori applicants and refer to other Hiring Managers and MHS for other potential opportunities | To progress – March 2016 |
| Meeting with Allied Health Managers to confirm focus on recruiting Maori staff and define specific initiatives to improve Maori staff representation in their areas | Underway – have met with Team Leaders of Physio, Social Work and Occupational Therapy<br><br>To develop additional initiatives – Feb 2016 |
| Investigate Maori Champions in area where an increase in Maori staff is a high priority e.g.;<br>Surgical Nursing<br>District Nursing<br>Orderly<br>Security | To discuss with Service Directors – Dec 2015 |
| Set up a work station in MHS to enable those Maori candidates without online access to apply for roles | To implement - March 2016<br>Link to CV templates and Interview tips |

## Occupational Health & Safety KPIs

### Staff related injury accidents reported

*Workplace injuries reported.*
Target is less than 90 per quarter




Total for the quarter = 119
October = 45
November = 35
December = 39

Percentage of total staff by quarter:

| | |
|---|---|
| Dec '15 | 4.1% |
| Compared to:<br>Dec '14 | 3.1% |

Unfortunately our percentage of total staff injured at 4.1% is higher than the December 2014 levels and well above the target of 90. The actions reported to the Board at the September Board meeting will start to impact going forward.

The DHB is putting additional emphasis with the Worksafe Representatives in working with their teams in the identification of hazards and providing education to those teams. The DHB also initiated an online training tool to support greater awareness of health and safety in the organisation. The increase in reporting could be partly due to the greater awareness by staff of the need to report.

Of the 119 for the June quarter:

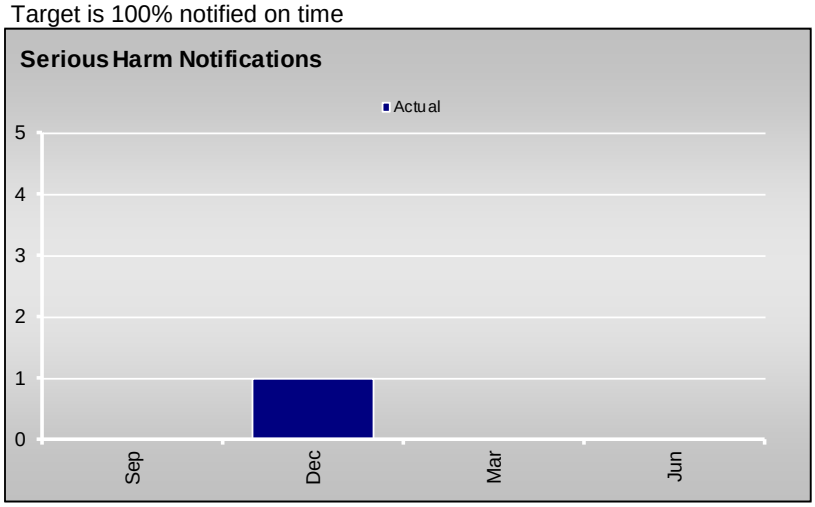
- 48 back injuries/ sprain/ strain
- 26 cuts/ bruises/ lacerations/ burns
- 14 needlestick injuries and exposure to blood and body fluids
- 31 remaining included fracture/ possible fracture, gradual onset discomfort, graze, abrasion.

One of the above was notified to Work Safe NZ as serious harm injury.

## Serious Harm Injuries

*Accidents notified to the Ministry of Business Innovation and Employment (MoBIE) as soon as possible'. Measured against next working day.*

Target is 100% notified on time




One serious harm was reported for the quarter.

15

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **Te Ara Whakawaiora: Access (ASH Rates 0-4 & 45-64 years)** 08 |
| | For the attention of: **HBDHB Board** |
| Document Owner:<br>Document Author(s): | Dr Mark Peterson<br>Mary Wills |
| Reviewed by: | Executive Management Team; Clinical and Consumer Council; and Māori Relationship Board |
| Month: | February 2016 |
| Consideration: | Performance Monitoring |

**RECOMMENDATION**

**That HBDHB Board**

Note the contents of this report.

16

## OVERVIEW

The national GMs Māori (Tumu Whakarae) raised concerns about the slow pace of progress on some of the Māori health indicators in 2013. As a result, individual EMT members agreed to providing a championship role for the Māori Health Plan areas of key concern. Part of that role is to provide the Board with a report each month from one of the champions. This report is from Dr Mark Peterson, Champion for the Access Indicators.

## UPCOMING REPORTS

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

| Priority | Indicator | Measure | Champion | Responsible Manager | Reporting Month |
|---|---|---|---|---|---|
| **Access**<br>*Local Indicator* | Reducing acute admissions of Ambulatory Sensitive Hospitalisations (ASH):<br>0-4 year olds - dental decay, skin conditions, respiratory and ear, nose and throat infections.<br>45-64 year olds - heart disease, skin infections, respiratory infections and diabetes | TBC<br>TBC<br>TBC | Mark Peterson | Mary Wills | Feb 2016 |
| **Breastfeeding**<br>*National Indicator* | Improve breastfeeding rate for children at:<br>6 weeks,<br>3 months;<br>6 months of age | <br>>75%<br>>60%<br>>65% | Caroline McElnay | Nicky Skerman | Mar 2016 |

| | | | | | |
|---|---|---|---|---|---|
| **Cardiovascular** *National Indicator* | Total number (%) of all ACS patients where door to cath time is between -2 to 3 days of admission.<br>Total number (%) with complete data on ACS forms | 70% of high risk<br>>95% of ACS patients | John Gommans | Paula Jones | Apr 2016 |
| **Oral Health** *National Indicator* | The total number (%) of children are caries free at first examination after the child has turned five years, but before their sixth birthday | >66% | Sharon Mason | Patrick LeGeyt | Jun 2016 |

## OVERVIEW

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

Ambulatory Sensitive Hospitalisations (ASH) reflects hospital admissions for conditions which could potentially be prevented by early access to treatment in care. In many countries ASH is used as a means to assess the performance of primary care and to identify potential barriers to access. However, while ensuring early access to effective primary care is still likely to be of considerable value in reducing ASH, in countries such as New Zealand, where large socioeconomic and ethnic disparities in child health exist, a greater emphasis may need to be placed on addressing those factors, often outside of the health sector, which drive the underlying burden of disease (e.g. household income, housing, nutrition, exposure to second hand cigarette smoke). This is because, even with optimal access, the ability of a general practitioner to prevent a paediatric pneumonia admission after the first crucial hours may be limited, but the opportunities available for a DHB to prevent paediatric respiratory infections via e.g. healthy housing projects and parental smoking cessation programmes may be considerable.

The HBDHB is committed to non-differential targets and significant inequality is seen in this indicator. Our work programmes focus on targeting vulnerable populations to reduce hospitalisation, improving the home environment and improving consistency of practice and early access to primary care programmes and reducing inequities.

The Ministry of Health ASH definition and methodology has been revised for ASH reporting from quarter one of the 15/16 year. A group of Ministry and health sector subject matter experts made several consensus recommendations for changes to the ASH definition. Implementation of these recommended changes to the Ministry ASH definition have taken effect for all Ministry ASH reporting from Quarter 2 of the current (15/16) year. There was no expectation of ASH target-setting for the current (15/16) year in light of the review process that was underway at the time of DHB Annual Planning.

However there is an expectation that baseline ASH data (with the revised methodology) be reviewed by DHBs in order to better understand present performance, and in particular variation in DHB performance for different population groups. This will inform the 16/17 planning and appropriately targeted activities for each district. This paper highlights findings from this review.

At the end of June 2014 the results for Hawke's Bay children aged 0-4 were 38% above the national rate of 100%. Analysis of data in 2014/15 concluded that we should focus on the two most preventable ASH conditions (skin infections and dental) which show the highest inequities. The healthy population team has therefore re-established DHB services to Kohanga reo and e introduced new-born oral health enrolment with the aim to reduce hospitalisations for these conditions. We can see from the results outlined in this paper that Maori rates in these conditions have improved.

The highest ASH rates for 45-64 year olds are cardiac conditions and respiratory (including COPD) and cellulitis. Our focus is on development of Clinical Care Pathways.

## MĀORI PLAN INDICATOR

***Target 0-4 year age group***

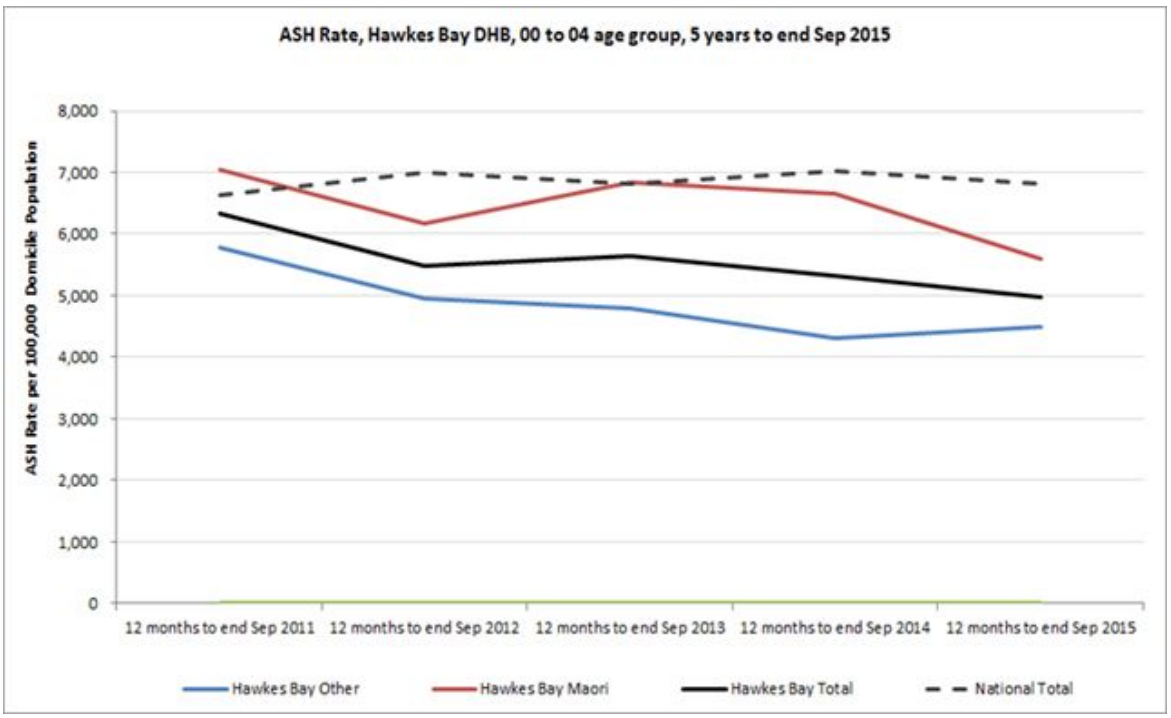
There is no expectation of ASH target-setting for the current (15/16) year in light of the review process that was underway at the time of DHB Annual Planning. DHBs have received 2015/16 baseline ASH performance results using the new ASH definitions and the expectation is that DHBs review the present performance of ASH and in particular variation in performance between Maori and Non Maori results. These results gives us an opportunity to examine performance over a 5 year period.

At the end of June 2014 the ASH results for Hawke's Bay children aged 0-4 were 38% above the national rate of 100%. Analysis of data in 2014/15 concluded that we should focus on the two most preventable ASH conditions (skin infections and dental) which show the highest inequities. The healthy population team has therefore re-established DHB services to Kohanga Reo and the introduced of new-born oral health enrolment with the aim to reduce hospitalisations for these conditions.

**Hawke's Bay Distribution and Trends**

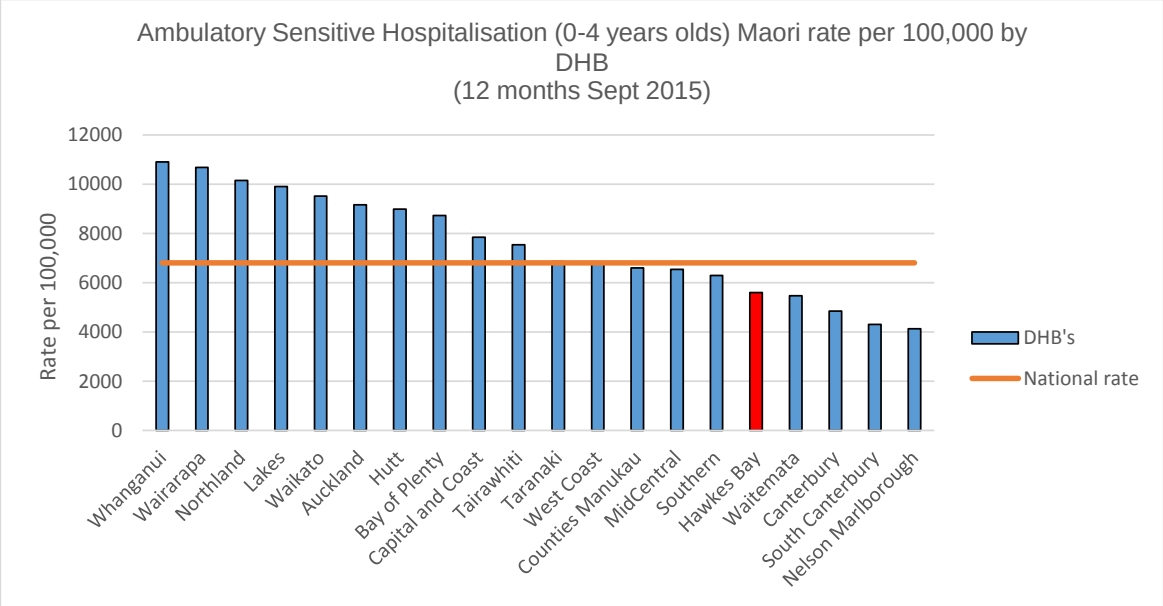
*Hawke's Bay Māori ASH rates 0-4 year age group– 12 months to end Sept 2011-2015*






Hawkes Bay tamariki have lower rates of ASH compare to national rates for both Maori and Non Maori. There has been a reduction in the gap between the Maori ASH rate and the National rates particularly in the 12 months to Sept 2015. By 2015 the Top 5 ASH conditions for Maori in the 0-4 year age group are Asthma, Dental conditions, Respiratory Infections- Upper and ENT,Respiratory Infections – Lower, Gastroenteritis/Dehydration and Cellulitis (5$^{th}$ equal).

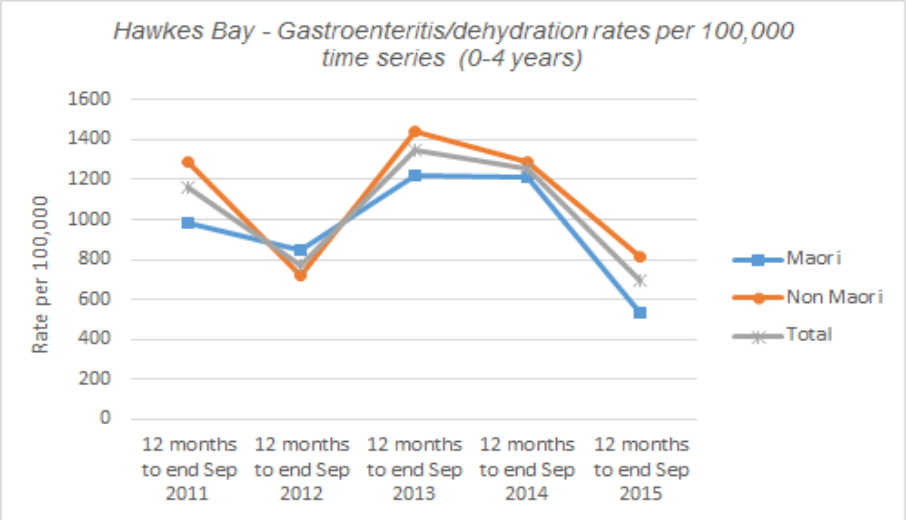
*Māori ASH rates 0-4 year age group by DHB's – 12 months to end Sept 2015*



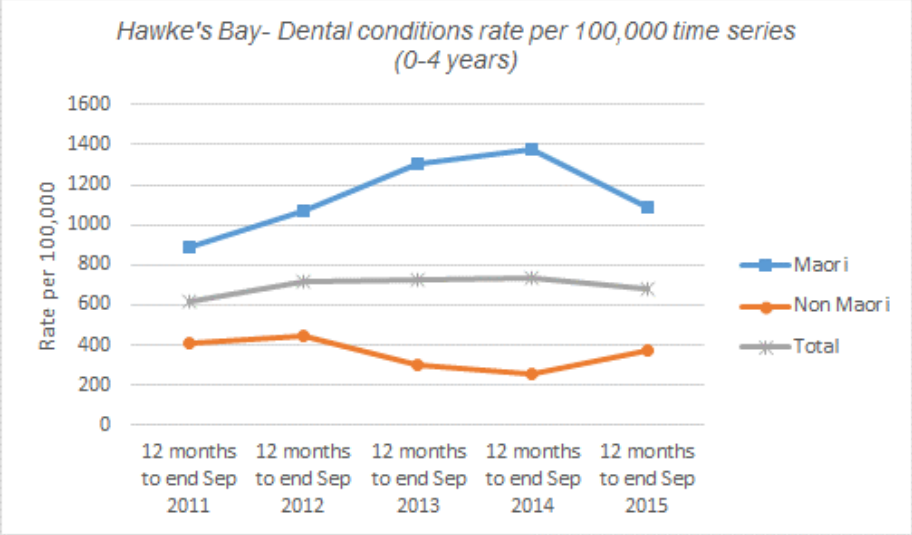

In the 12 months to Sept 2015 the Hawkes Bay Maori rate was 82 % of the national rate and Hawkes Bay DHB was the 5 th best performer of all DHB's with Maori rates substantially lower than national rates in this age group.

In 2015 the largest differences between Hawkes Bay Maori rates and national rates in the 0-4 year age group are in the conditions Asthma and Respiratory infections- lower.

***ASH conditions where Maori rates are improving***

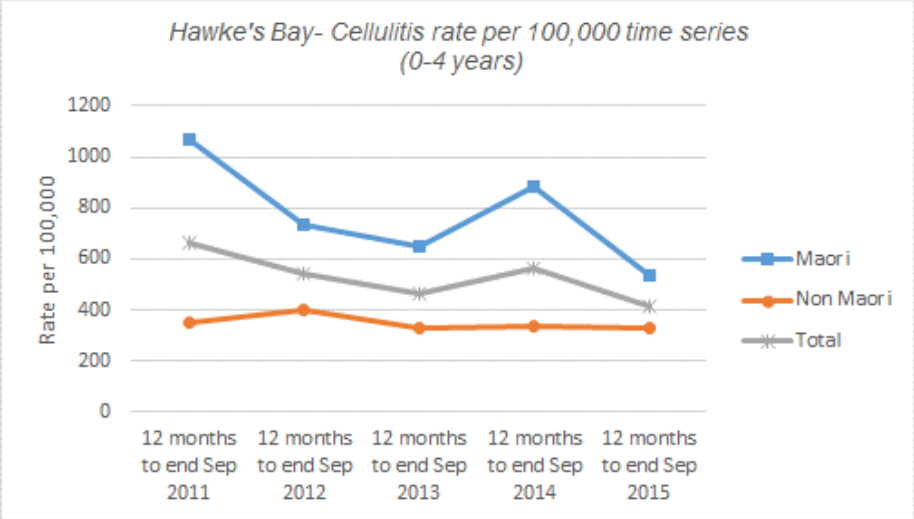



Gastroenteritis/dehydration rates in the 0-4 years have declined in the last 2 years. The Hawke's Bay Maori 0-4 year rate is half the national rate.

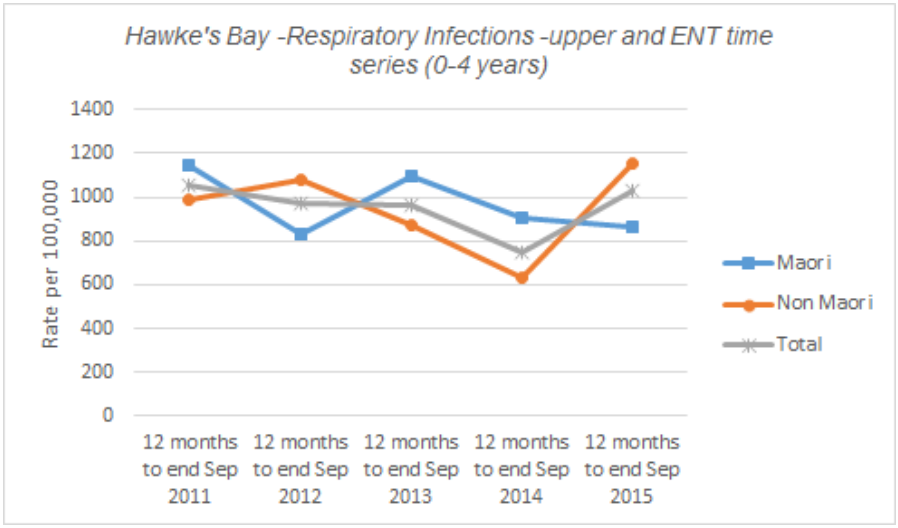



Dental is the 2nd ranked Maori ASH condition in the 0-4 year olds. Rates have dropped in the last 12 months to Sept 2015 and the gap has narrowed between Maori and non Maori. In the 12 months to Sept 2015 Hawke's Bay Maori rates are 2.9 times the Hawke's Bay Non Maori rate and 1.1 times the national rate.

16

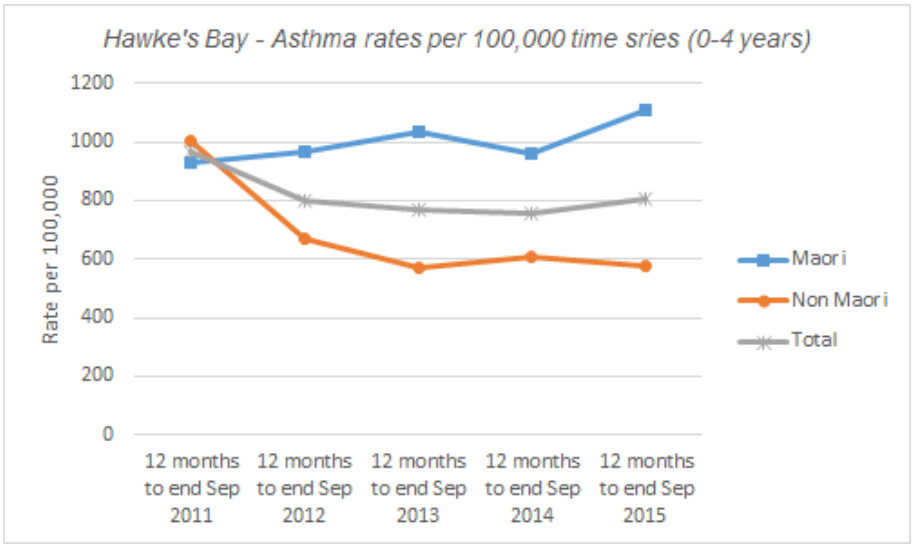



Cellulitis rates for both Maori and Non Maori have improved Maori rates are 1.6 times the Non Maori rates in the 12 months Sept 2015 and 1.2 times the national rate .

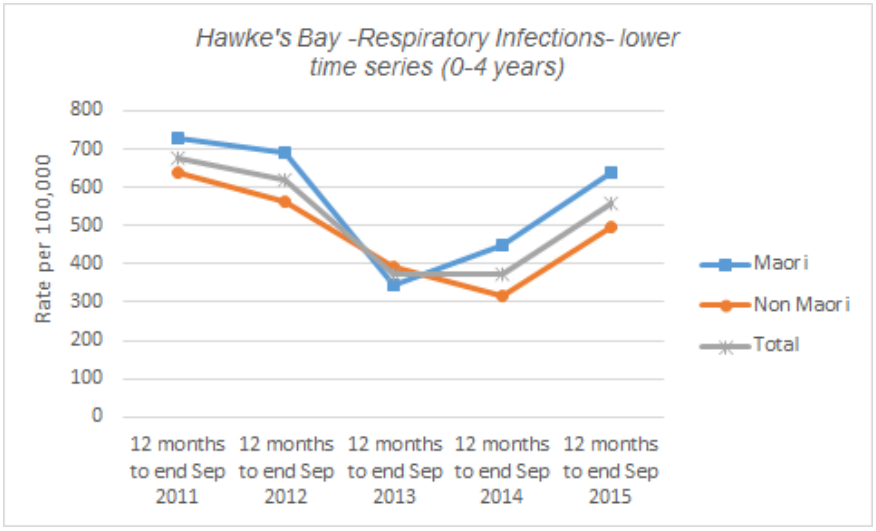



Respiratory Infections – upper and ENT are the 3rd highest ASH conditon for Maori 0-4 year old children. Maori rates have dropped particularly in the last 2 periods. Maori rates are lower than Non Maori rates and national rates in the 12 months to end of Sept.

***ASH conditions where rates are not improving***




Asthma is the top ASH condition for Maori 0-4 years and rates have been increasing over time and the gap between Maori and Non Maori have widened. By 12 month to end of September 2015 Maori rates were 90 % higher than Non Maori rates.



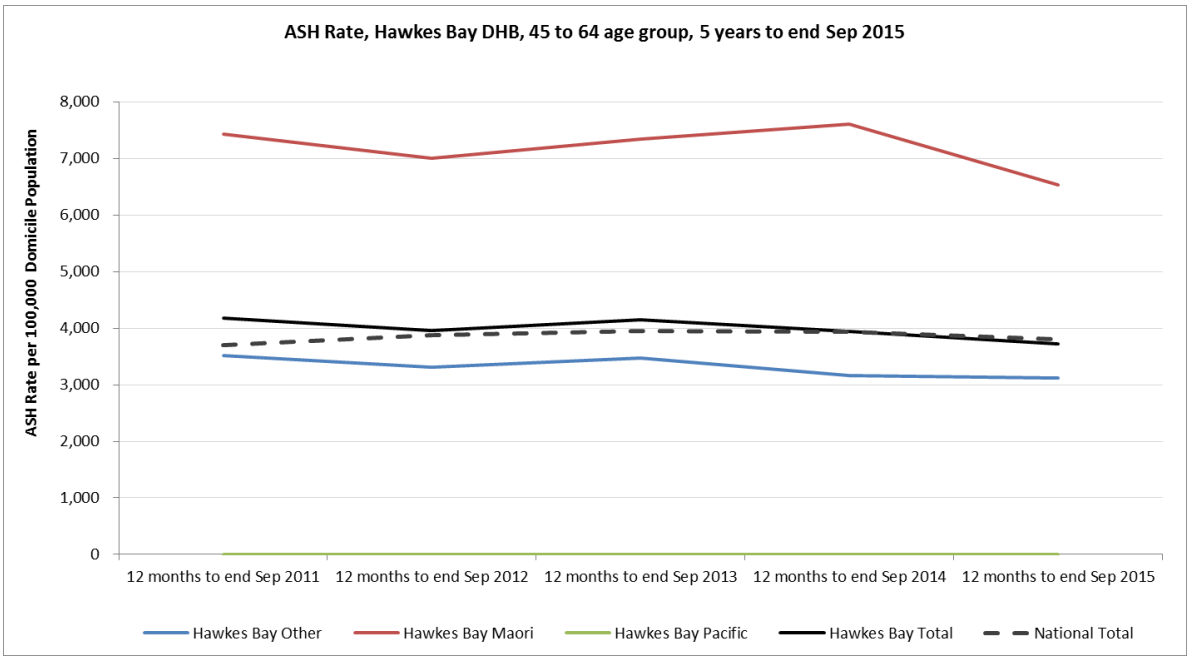

Respiratory infections – lower are the 4th ranked ASH condition in Maori children and rates have increased in the last 2 years.

***Target 45-64 age group***

There is no expectation of ASH target-setting for the current (15/16) year in light of the review process that was underway at the time of DHB Annual Planning. DHB's have received 2015/16 baseline ASH performance results using the new ASH definitions and the expectation is that DHBs review the present performance of ASH and in particular variation in performance between Maori and Non Maori results. This has also given us an opportunity to examine performance over a 5 year period.

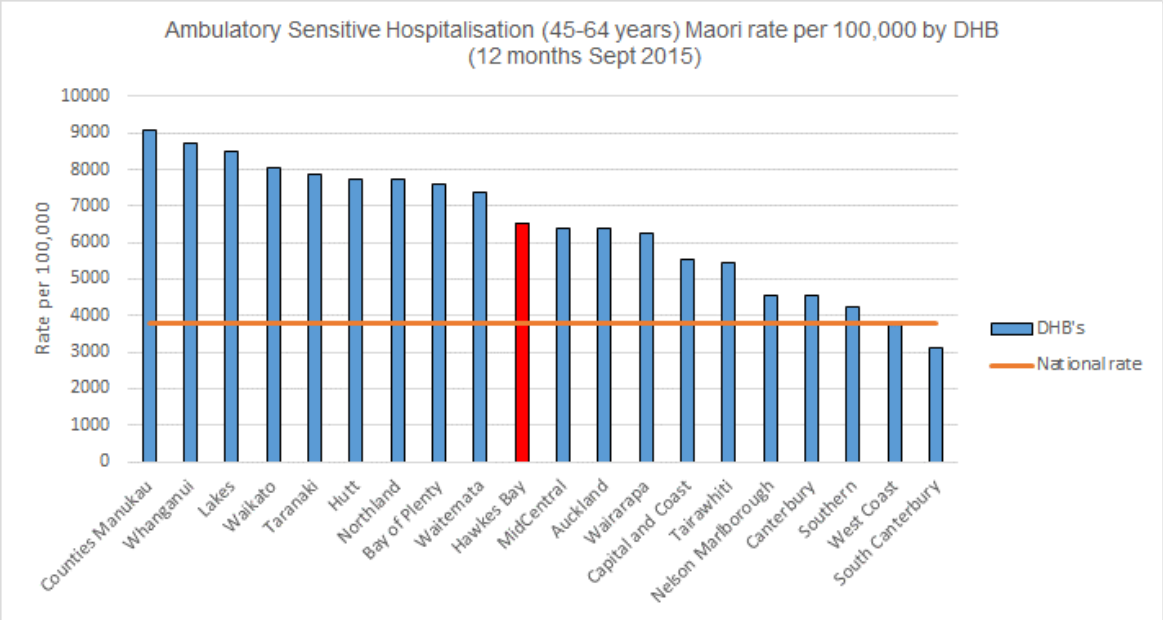
**Hawke's Bay Distribution and Trends**

Hawke's Bay Māori ASH rates 45-64 age group 2010/11 – 12 months Sept 2015



There has been improvement in Hawke's Bay ASH rates in the 45-64 year age group in both Maori and Non Maori. The gap between the Hawke's Bay Maori rate and the Hawke's Bay Non Maori rate has narrowed between 2011 and 2015 as has the gap between the Hawke's Bay Maori rate and the national rate. In the 12 months to Sept 2015 the Hawkes Bay Maori rate was 2.1 times the Hawke's Bay Non Maori rate and 1.7 times the national rate. The top 5 ASH conditions for Maori in this age group are Angina and Chest pain, Congestive Heart Failure, Respiratory Infections- COPD, Cellulitis and Myocardial Infarction.

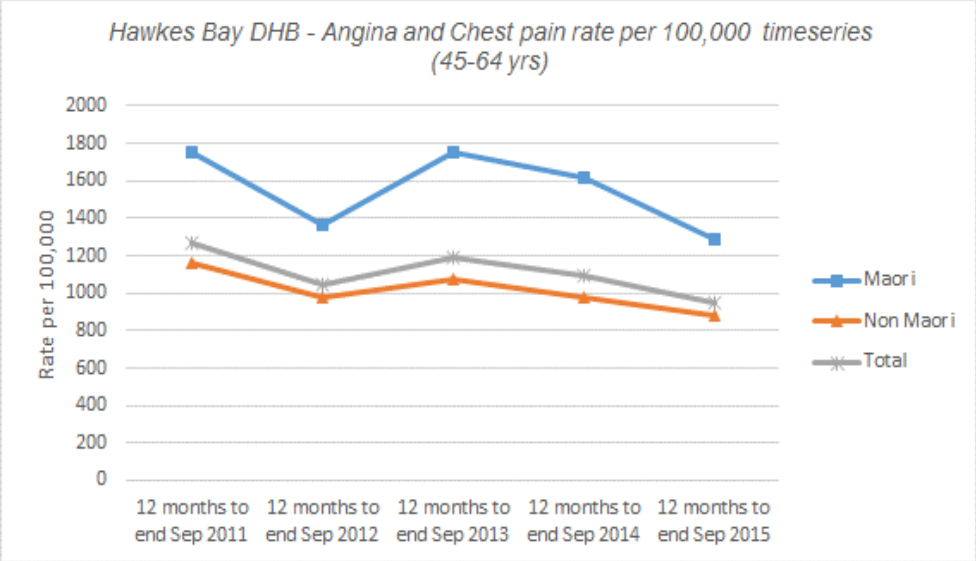
*Māori ASH rates 45-64 year age group by DHB's – 12 months to end Sept 2015*




In the 12 months to Sept 2015 the Hawke's Bay Maori rate was 72 % higher than the national rate and Hawkes Bay DHB is ranked 11 th out of 20 DHBs. Maori rates are substantially higher than national rates in this age group across the majority of DHB's.

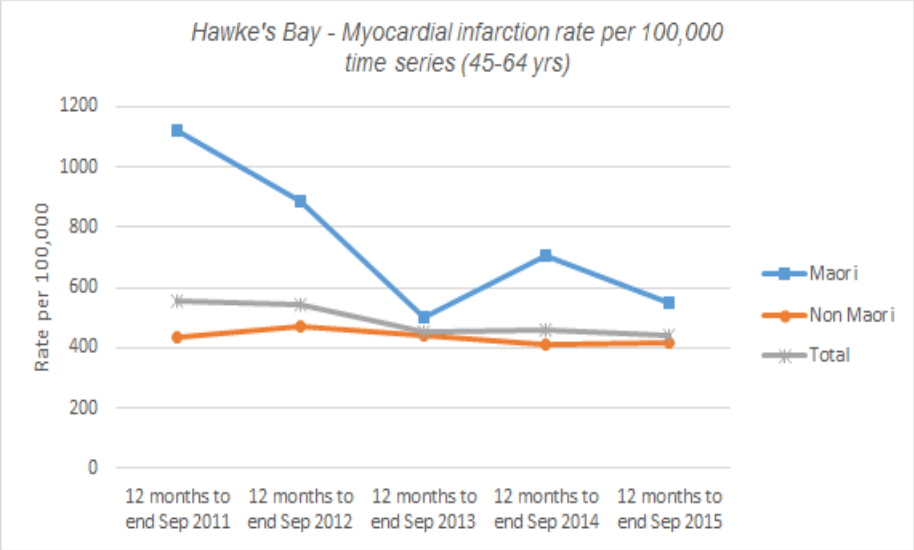
The largest differences in Maori rates and national rates by ASH condition in this age group are Congestive Heart Failure and Respiratory infections-COPD.

***ASH conditions where Maori rates are improving***

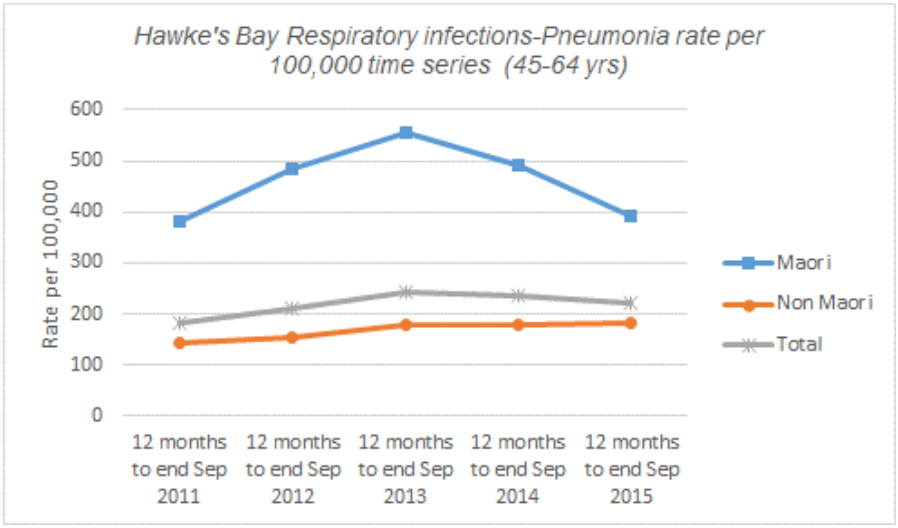



Angina and Chest Pain is the top ASH condiiton for Maori in the age group contributing 20 % of all Ambulatory Sensitive Hospitalisations in Maori in the 45-64 year age group. We have seen Maori rates decline and the gap between Maori and Non Maori narrow. In the 12 months to Sept 2015 Maori rates were 50 % higher than Non Maori rates.

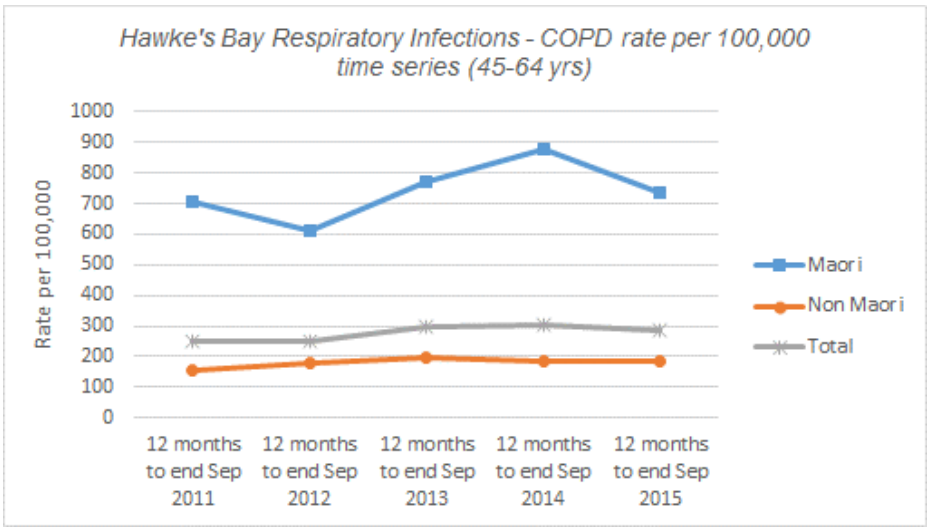





Maori rates in the ASH condition Myocardial Infarction have also improved and by 12 months to end Sept 2015 Maori rates were 30%  higher than Non Maori rates.

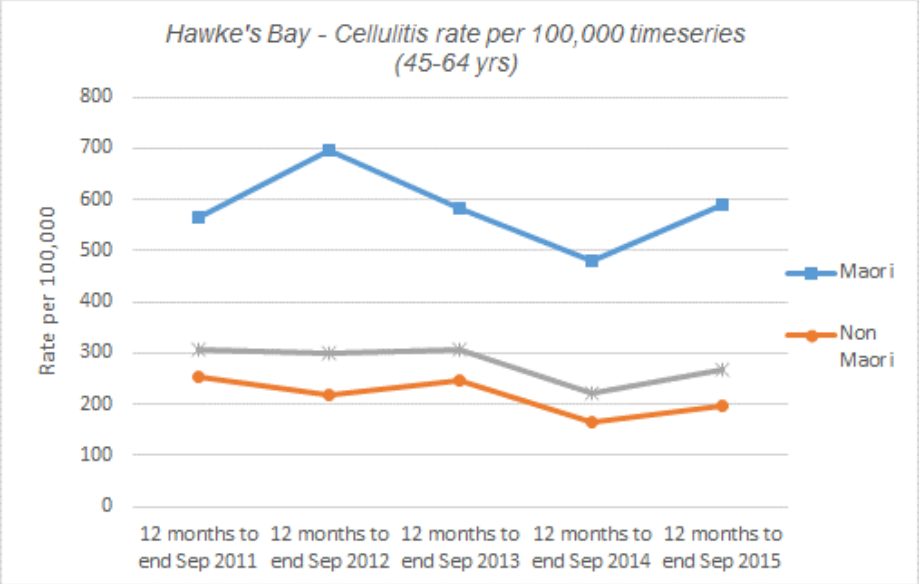



Maori rates in the ASH condition Respiratory Infections – Pneumonia have also improved in the last 2 years.

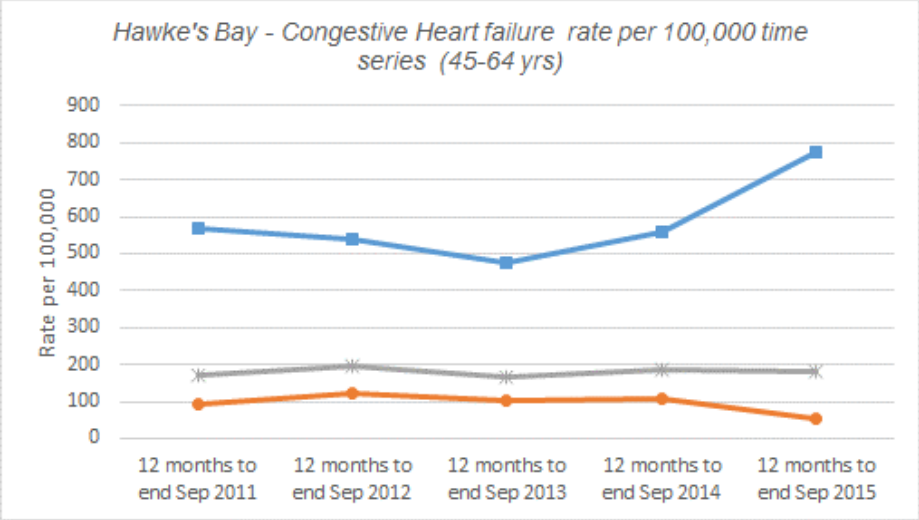



Respiratory Infections – COPD is the 3rd ranked ASH condition in terms of volume of hospitalisations for Hawke's Bay Maori in the 45-64 years age group. There has been some improvement in rates in the last reported period. In the 2015 period Maori rates are 3.9 times the Non Maori rates and 2.9 times the national rates for this condition and age group.

***ASH conditions where rates are not improving***




Cellulitis contribute 10 % of total Maori ASH hospitalisations in the 45 -64 year age group and is the 4th ranked ASH conditon for Hawke's Bay Maori in the age group. Maori rates have deteriorated in the last 12 month reporting period. Maori rates are 3 times the Non Maori rates and 2.9 times the national rates.




Congestive heart failure is the 2nd ranked ASH condition for Hawke's Bay Maori in the age group 45-64 years. Maori rates have deteriorated in the last 2 years and the gap between Maori and Non Maori rates has widened.

## ACTIVITY TO SUPPORT THIS INDICATOR
## 0-4 YEAR OLDS

***New Born Enrolment Programme***

All children are linked to general practice as part of the new born enrolled programme with nearly 98% of children linked by 8 weeks. Quadruple enrolment with General Practitioner; Well Child/Tamariki ora; National Immunisation Register and Oral Health is now standard practice.

***Kohanga Reo***

Public Health Nurse Visits and Vision/Hearing screening for Kohanga continues. Public health nurse's offer education and advice to whānau, tamariki and Kohanga staff around key ASH conditions including gastroenteritis/dehydration and skin conditions.

The recent re-establishment of DHB service provision within HB Kohanga reo enable's the provision of education and advice to whānau, tamariki and Kohanga around the management and treatment of skin conditions. 2015/2016 will see the development of

A skin resource has been translated to be used in local Kohanga. This supports parents and Kaiako around best practice in recognition and management of skin issues. This aims to lead to earlier recognition and treatment of skin infections, avoiding the need for admission.

***Co-Ordination of Child Health Data Systems***

Excellent communication is maintained between different child health programmes databases in Hawke's Bay due to the goodwill of the NIR/immunisation team, however this is relationship based rather than a reflection of good systems. It is clear that what is required is a national child health database developed at the Ministry of Health level.

***Hawkes Bay Child Interagency Network Group***

This group is co-ordinated by the HBDHB child health team and meets bi-monthly with a wide range of key stakeholders include representatives from early childhood centres, kindergartens and home-based care for pre-school children. Each meeting a different topic is covered to ensure information provided around the prevention of conditions and promotion of initiatives and services is consistent.

***Healthy Homes Programme***

HBDHB and HHB continue to fund a programme providing insulation and a range of safety measures for households living in low socioeconomic areas who have significant health need. The greatest percentage of referrals into the Healthy Homes programme are for Maori and Pacific whānau.

## ACTIVITY TO SUPPORT THIS INDICATOR
## 45-64 YEAR OLDS

***Collaborative Clinical Pathways***

Health Hawke's Bay and Hawke's Bay DHB are developing clinical care pathways across a range of services to increase consistency of practice in Hawke's Bay. In 2015/16 there will be another 24 pathways. Our focus is on promoting the use of the pathways in primary care, ensuring easy access for GPs and developing more pathways for high priority conditions.

Atrial fibrillation and chest pain pathways have been developed and were published in December. Asthma Pathways through Map of Medicine have been completed for children and adults and are currently being published. The next phase is to socialise the pathways into general practice. Key outcomes are evidence based practice, standardisation across Hawke's Bay, care planning continuity of care and reduced hospitalisations. Currently co-ordinating a multi-disciplinary group to work on community acquired pneumonia.

***Nurse-Led Respiratory Pilot***

Nurse led respiratory (including asthma and Chronic Obstructive Pulmonary Disease-COPD) clinics located in General Practices from 1 September 2014 to 30 June 2015. The project has been jointly implemented by Health Hawke's Bay, Hawke's Bay District Health Board and Asthma Hawke's Bay. Key goals of the project are to reduce unnecessary hospital admissions, emphasis on co-ordination and streamlining of client healthcare, with a strong Primary Health Care ethos focusing on early detection and timely management of chronic conditions at the primary care level. Evaluation of this Project has been undertaken by EIT and results are to be presented to EMT January 2016. In summary:

- nurse-led clinics are effective in co-ordination and self-management.
- the majority of clients enrolled in the pilot were identified as being in Quintiles 4 and 5 (45% Maori accessing from quintile 5, and 65% Pacific) reflecting improved access to healthcare for high-needs clients
- higher representation of women compared with men;
- nurses working in the pilot felt empowered and autonomous in their respiratory practice highlighting a high level of professional development in the management of chronic respiratory conditions.

The pilot has proven that costs and spirometry charges have been a barrier to access. It is clear that for the pilot to continue with success is to have security of ongoing funding (business case will be presented at next bid rounds).

***Sharing Primary Care Practice Information***

Business Intelligence has produced reports for several general practices on their admission rates to hospital and emergency department attendances. This is now available as a regular report. We are working with Health Hawke's Bay to extend this to all practices, with appropriate oversight.



## RECOMMENDATIONS FROM TARGET CHAMPION

The data provided shows quite a bit of variability in the change in rates of ASH in both age groups in the different diagnostic criteria. With the 0-5 age group there is a pleasing drop in the overall Maori ASH rates and a significant narrowing of the disparity gap. It is also notable that HB rates are among the lowest in the country.

Most notable is the change in gastroenteritis admissions in the last two years, and that HB rates are about half the national average. This will need to be correlated with the uptake of the Rotavirus immunisation. HB's high immunisation rate, especially among Maori children may be part of the answer to this (pleasing) improvement.

The ASH rates for the 45-65 age group show higher levels of disparity between Maori and the total population than for the 0-5 group. While rates have come down the disparity gap remains very similar.

Most concerning is the very large difference and climbing rates of admission for congestive heart failure. While the myocardial infarction rate has improved this is not reflected in CHF, which is often a longer term complication of IHD.

A clinical pathway for CHF should be developed and introduced as soon as possible.

## CONCLUSION

Kohanga Reo targeted initiatives focussing on specific conditions have seen a decline in cellulitis ASH rates for 0-4 year olds. In addition whanau will have increased awareness of the need for early intervention with skin issues for all family members which includes the 0-4 year age group. The focus of public health nurses on early intervention with skin issues in low decile schools and Kohanga Reo is likely to have contributed to improvements in rates.

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **HBDHB Performance Framework Exceptions Quarter 2 2015/16**<br><br>**HBDHB Quarterly Performance Monitoring Dashboard Quarter 1 2015/16 (ex MOH)** 09 |
| | For the attention of:<br>**HBDHB Board** |
| Document Owner:<br>Document Author(s): | Tim Evans, GM Planning Informatics and Finance<br>Peter Mackenzie, Operational Performance Analyst |
| Reviewed by: | EMT |
| Month: | February 2016 |
| Consideration: | For Monitoring |

**RECOMMENDATION**

**That the Board:**

Note the contents of this report.

17

## 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). A quick reference summary dashboard will be supplied prior to the meeting and shows our position as at the end of this quarter for all indicators. The dashboard uses traffic light methodology (as described on page 4) to represent this. Detailed information is included for all indictors where the variance to target was greater than 0.5% (indicated on the dashboard as a red cell with a 'U' symbol).

As this report ends 31 December 2015, 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) 2015/2016

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) 2015/16

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

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

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

The 4 dimensions of DHB performance are:

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

KEY FOR DETAILED REPORT AND DASHBOARD

| | |
|---|---|
| **Baseline** | Latest available data for planning purpose |
| **Target 2015/16** | Target 2015/16 |
| **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 |

## CONTENTS

## PERFORMANCE HIGHLIGHTS

### *Achievements*

- More Heart and Diabetes checks. The provisional result provided by the Ministry is 90.3% which is above target for the fourth successive quarter (page9)
- (Provisional) Improved Access to Elective Surgery. At the end of the quarter the result is 100.4%.

### *Areas of Progress*

- Shorter Stays in ED. Patients waiting less than 6 hours in ED has increased slightly from 92.1% to 92.7% however this is still below the target of 95% (page 5)
- Faster Cancer Treatment. Results have increased a further 2% from the previous quarter. A program of work is underway to increase the number of patients identified with a high suspicion of cancer at referral. This will enable us to identify more patients with cancer and manage timeframes more effectively (page 6).
- Acute Coronary Syndrome Services – High risk patients seen receive an angiogram within 3 days. This quarter the result was 68.7% and although this is below the target of 70% the result is an 18% increase on the previous quarter (page 14).

### *Areas of Focus*

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

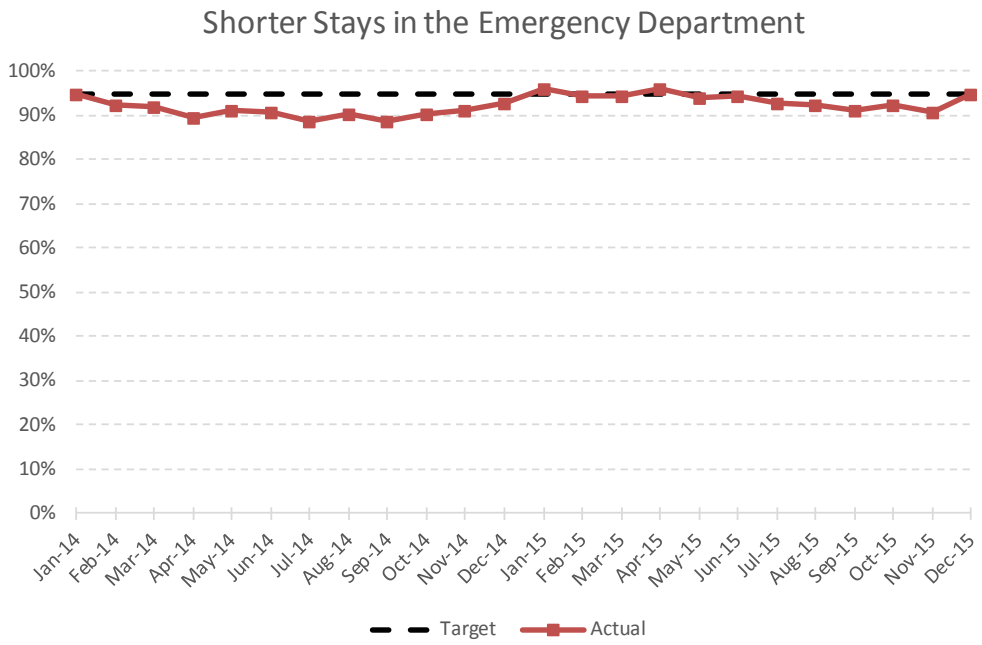
- Immunisation at 8 months. The result for the quarter was has dropped from 95% to 93.3% and is now below the target of 95% (page 7).
- Better Help for Smokers to Quit in Primary Care. The result for this quarter was 75.0% which is below the target of 90% and a drop from the previous quarter. Programs are already in place to improve this rate over the next quarter (page 8).
- Improving Wait Time for Diagnostic Service – CT and MRI. The percentage of accepted referrals that receive a CT or MRI scan within 42 days is below target at 88.7% for CT and 31% for MRI (page 16).
- Cervical Screening. Results have dropped slightly this quarter from 76.2% to 75.8% which is below the target of 80% (page 17)

## DIMENSION 1 – ACHIEVING GOVERNMENT PRIORITIES AND 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

| Baseline [1] | Previous result [2] | Actual to Date [3] | Target 2015/16 | Trend direction |
|---|---|---|---|---|
| 91.5% | 92.1% (U) | 92.7% (U) | ≥95% | ▲ |

Please note: Data presented in the graph are monthly results, whilst the data in the result section above ('Previous result' and 'Actual to date') are for a 3 month period.



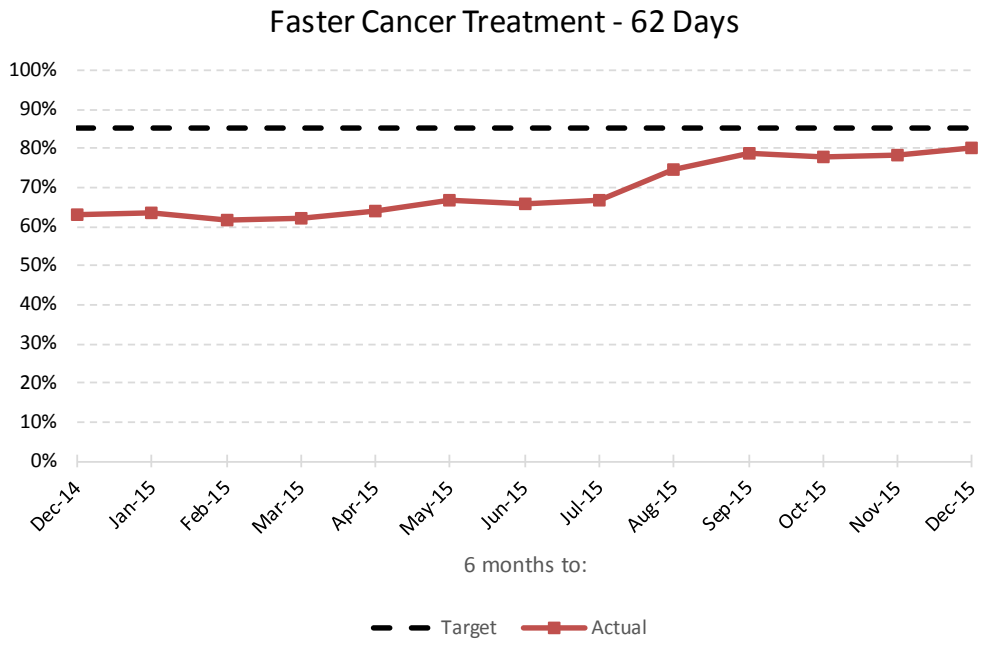

*Comments:*
There have been daily reviews of breaches from the previous day to identify trends and actions required. There has also been a review of staffing levels within ED to ensure patient flow can be maintained, along with improved medical registrar rostering to provide cover in ED and AAU for acutely presenting or referred medical patients. A senior Change Manager role to support acute patient flow has been implemented, including day to day operational activity across the hospital.

Going forward there is a proposal to get together a small working group to assess the reports and information we currently use to monitor and track ED target. The purpose is to review current reports and potentially pull into one single report that clearly meets the need for all relevant teams, including how this data is monitoring and reviewed.

1 *October to December 2014*
2 *July to September 2015*
3 *October to December 2015*

**Health Target: Faster Cancer Treatment**
Patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer

| Key Performance Measures | Baseline[4] | Previous result [5] | Actual to Date [6] | Target 2015/16 | Trend direction |
|---|---|---|---|---|---|
| | 61.5% | 75.9% (U) | 77.6% (U) | ≥85% | ▲ |




*Comments:*
The volumes remain lower than the predicted MoH assumptions and the issues have been discussed at the HBDHB Faster Cancer Treatment governance group. The HSCan definitions have been circulated to the specialists as it is important there is a national based interpretation of the definitions and criteria for the target. Access to timely diagnostics and reports (particularly if the diagnostic is in a tertiary centre is a delay factor).

The Ministry also provide expected annual cancer registration numbers and set a target for the DHB to identify at least 15% of expected registrations as High Suspicion.
Our results for 6m to December 2015 is 12.7%

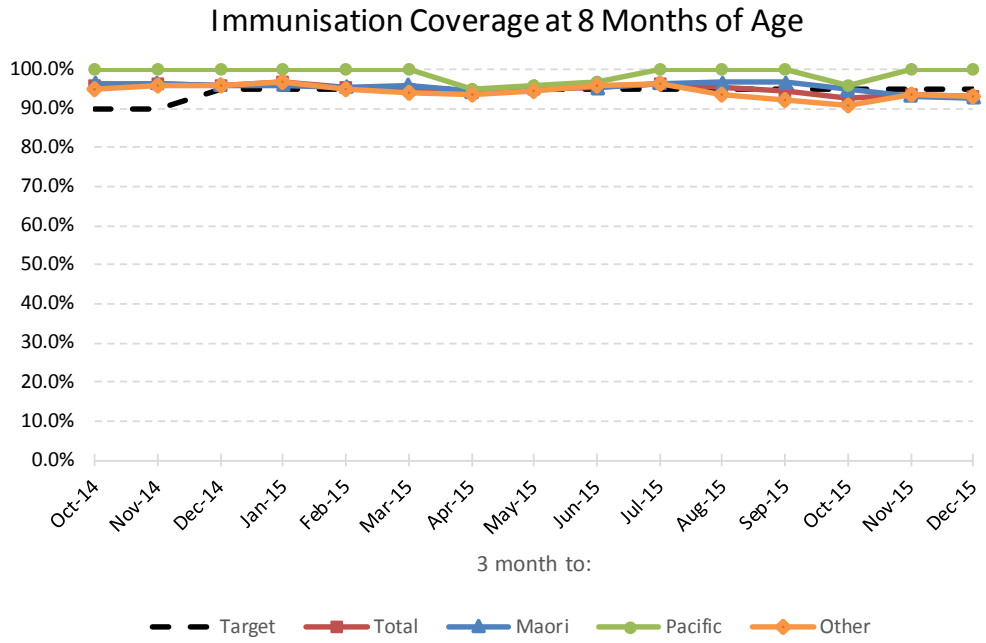
4

*5 March to September 2015*

*6 June to December 2015*

**Health Target: Increased immunisation**
95% of 8 month olds will have had their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2015

| Ethnicity | Baseline [7] | Previous result [8] | Actual to Date [9] | Target 2015/16 | Trend direction |
|---|---|---|---|---|---|
| *Total* | 96.0% | 94.5% (F) | 93.3% (U) | ≥95% | ▼ |
| *Māori* | 95.9% | 96.7% (F) | 92.6% (U) | ≥95% | ▼ |
| *Pacific* | 100.0% | 100% (F) | 100% (F) | ≥95% | ▬ |
| *Other* | 95.7% | 92.3% (U) | 93.3% (U) | ≥95% | ▲ |




Source: National Immunisation Register, Ministry of Health

*Comments:*
There were 35 infants in this cohort who were not up to date to 8 months in this quarter, effort has been put into all of these infants by general practice, the DHB Immunisation team and the outreach team. The decline rate was 5.4% so we were unable to achieve the target. We know some of the infants have been partially vaccinated and we are currently trying to engage via outreach and GP's to get immunisations done.

17

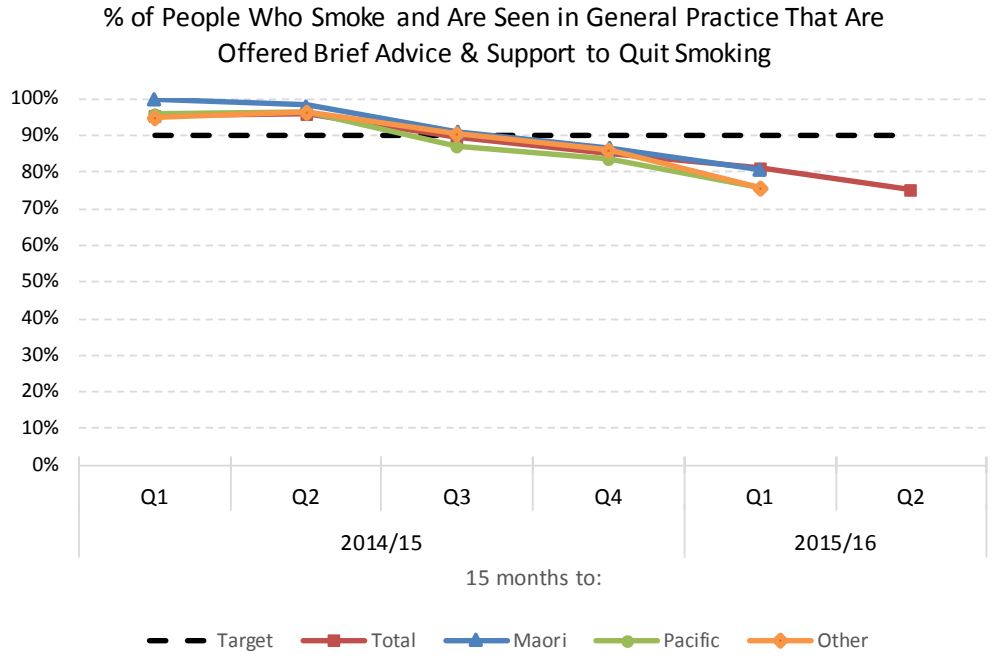
7 *October to December 2014. Source: National Immunisation Register, MOH*

8 *July to September 2015. Source: National Immunisation Register, MOH*

9 *October to December 2015. Source: National Immunisation Register, MOH*

**Health Target: Better help for smokers to quit – Primary Care**
90% of patients who smoke are seen by a health practitioner in primary care are offered brief advice and support to quit smoking

| Key Performance Measures | Baseline [10] | Previous result [11] | Actual to Date [12] | Target 2015/16 | Trend direction |
|---|---|---|---|---|---|
| *Total* | 96.1% | 81.2% (U) | 75% (U) | ≥90% | ▼ |
| *Māori* | 98.3% | 80.8% (U) | | ≥90% | |
| *Pacific* | 96.3% | 75.7% (U) | | ≥90% | |
| *Other* | 96.3% | 75.7% (U) | | ≥90% | |




Source: Ministry of Health

*Please note: At the start of the 2015/16 financial year the definition for this indictor was changed by the Ministry of Health. The denominator has changed from*

- *"the number of current smokers (within the last 15 months) **estimated** to have received consultation from their GP's within the last 12 month" to*
- *"PHO **enrolled** patients who smoke who have been offered help to quit smoking by a health practitioner in the last 15 months.*

*This has increased the denominator and affected the results for quarter 1 and 2.*

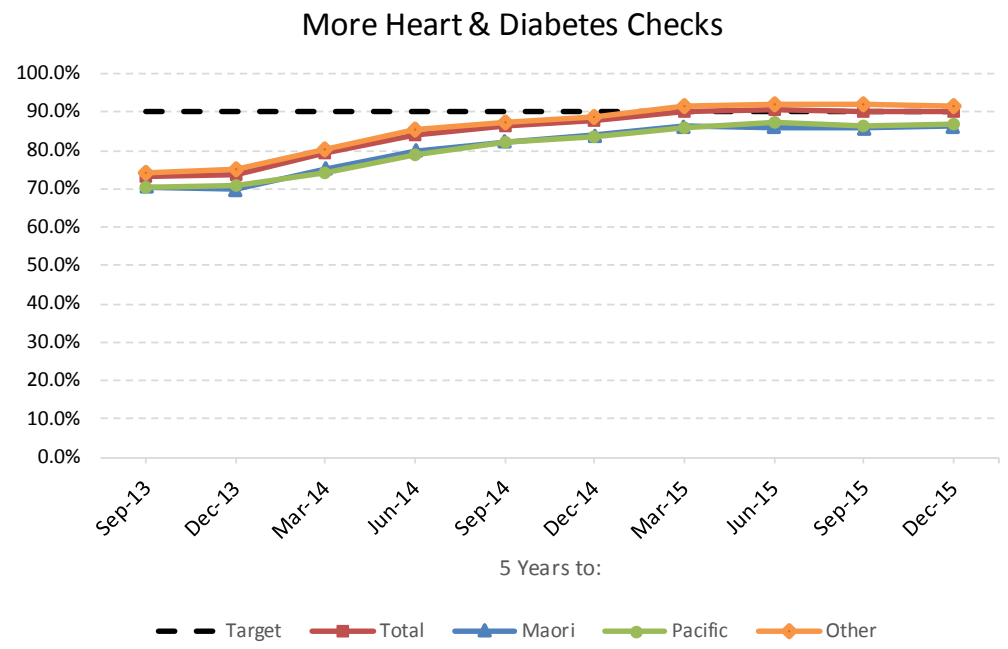
*Comments:*
In June 2014 Independent nurses were funded to support GP Practices to increase their brief advice rates by calling patients directly. In 2015 all those patients became due for another intervention and due to being unable to create sustainability collectively across all 28 Practices, in the last six months we have seen a gradual reduction in the Primary Care Target. The Hawkes Bay DHB and PHO plan is to work with 6 Practices intensively, developing high level commitment by meeting with Leadership/Director teams, reviewing processes and systems, support Smokefree education, working closely with nursing teams and importantly building strong relationships with Practices. We will then take the successes and learnings from this and work with the next group of Practices. The PHO will continue to utilise independent nurses, clinical facilitators and work closely with HBDHB to ensure the best use of each other's resources.

10 October to December 2013. Source: DHB Shared Services

11 July to September 2015. Source: DHB Shared Services

12 October to December 2015. Source: DHB Shared Services

| **Health Target: Better diabetes and cardiovascular service – More heart and diabetes checks**<br>90% of the eligible population will have had their cardiovascular disease risk assessed in the last 5 years | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline** [13] | **Previous result** [14] | **Actual to Date** [15] | **Target 2015/16** | **Trend direction** |
| *Total* | 87.7% | 90.3% (F) | 90.3% (F) | ≥90% | ▬ |
| *Māori* | 83.9% | 85.8% (U) | 86.3% (U) | ≥90% | ▲ |
| *Pacific* | 83.7% | 86.5% (U) | 87% (U) | ≥90% | ▲ |
| *Other* | 87.0% | 91.8% (F) | 91.7% (F) | ≥90% | ▼ |




Source: Ministry of Health

*Comments:*
As from the 1 July 2015 Health Hawke's Bay have been focusing on our eligible enrolled patients 35-55 years who do not have a cardiovascular risk recorded in their practice management system. In November and December 2015 Health Hawkes Bay funded six practices a bulk mail out, sending an invitation letter offering a free Cardiovascular Risk Assessment to a total of 1154 patients.

17

*13 October to December 2013. Source: Ministry of Health*

*14 July to September 2015. Source: Ministry of Health*

*15 October to December 2015. Source: Ministry of Health*

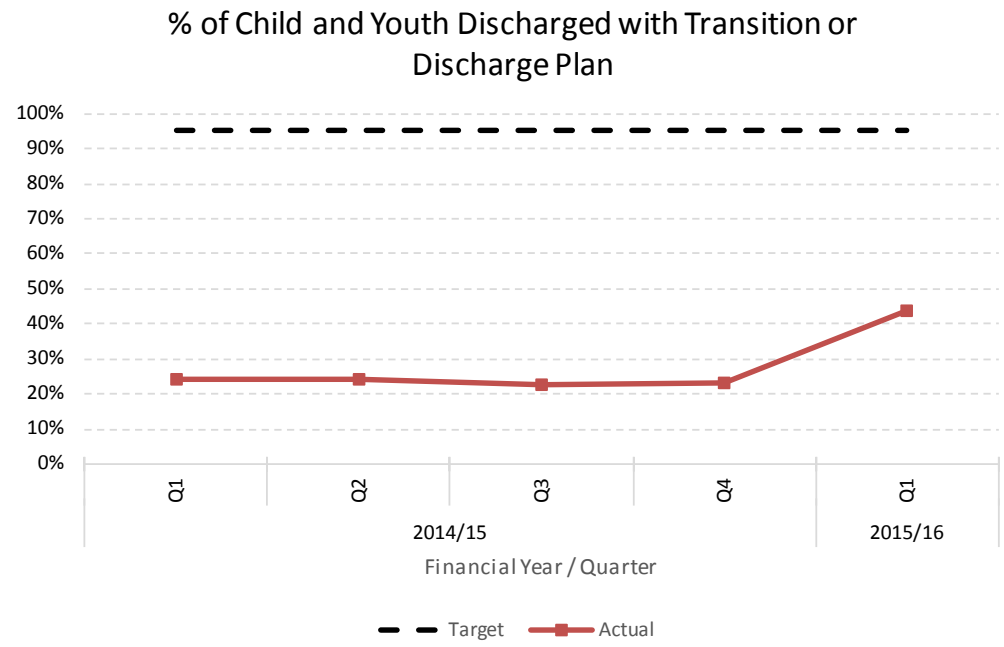
| Improving the health status of people with severe mental illness through improved access (PP6) | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline** [16] | **Previous result** [17] | **Actual to Date** [18] | **Target 2015/16** | **Trend direction** |
| 0-19 years – Child and Youth | | | | | |
| Total | 4.1% | 3.89% (F) | 4.5% (F) | ≥3.5% | ▲ |
| Māori | 4.8% | 4.5% (F) | 4.62% (F) | ≥3.5% | ▲ |
| Pacific | 2.4% | 2.67% (U) | 2.95% (U) | ≥3.5% | ▲ |
| Other | 3.6% | 3.49% (F) | 3.7% (F) | ≥3.5% | ▲ |
| 20-64 years (Adults) | | | | | |
| Total | 5.1% | 5.06% (F) | 4.94% (F) | ≥4.5% | ▼ |
| Māori | 8.8% | 8.95% (F) | 8.75% (F) | ≥4.5% | ▼ |
| Pacific | 4.6% | 2.67% (U) | 2.95% (U) | ≥4.5% | ▲ |
| Other | 4.0% | 3.91% (U) | 3.79% (U) | ≥4.5% | ▼ |
| 65+ | | | | | |
| Total | 1.2% | 1.03% (F) | 1.04% (F) | ≥1.15% | ▲ |
| Māori | 1.2% | 1% (F) | 0.96% (F) | ≥1.15% | ▼ |
| Pacific | 1.2% | 0.34% (U) | 0.97% (F) | ≥1.15% | ▲ |
| Other | 1.2% | 1.03% (F) | 1.05% (F) | ≥1.15% | ▲ |
| *Comments:*<br>We are currently exceeding targets for 0-19 Maori but Pacific remains low due to low Pacific numbers in the community reaching out for help/assistance. Communication to Pacific is a piece of work that will be happening through our Primary Health Organisation for all ages. 65+ are not reaching target due to a number of issues including social issues. | | | | | |

*16 12 months to September 2014*

*17 12 months to March 2015*

*18 12 months to September 2015*

| Improving mental health services using transition (discharge) planning (PP7) | | | | |
|---|---|---|---|---|
| **Key Performance Measures** | **Previous result** [19] | **Actual to Date** [20] | **Target 2015/16** | **Trend direction** |
| *Total* | 23.0% (U) | 43.7% (U) | ≥95% | ▲ |



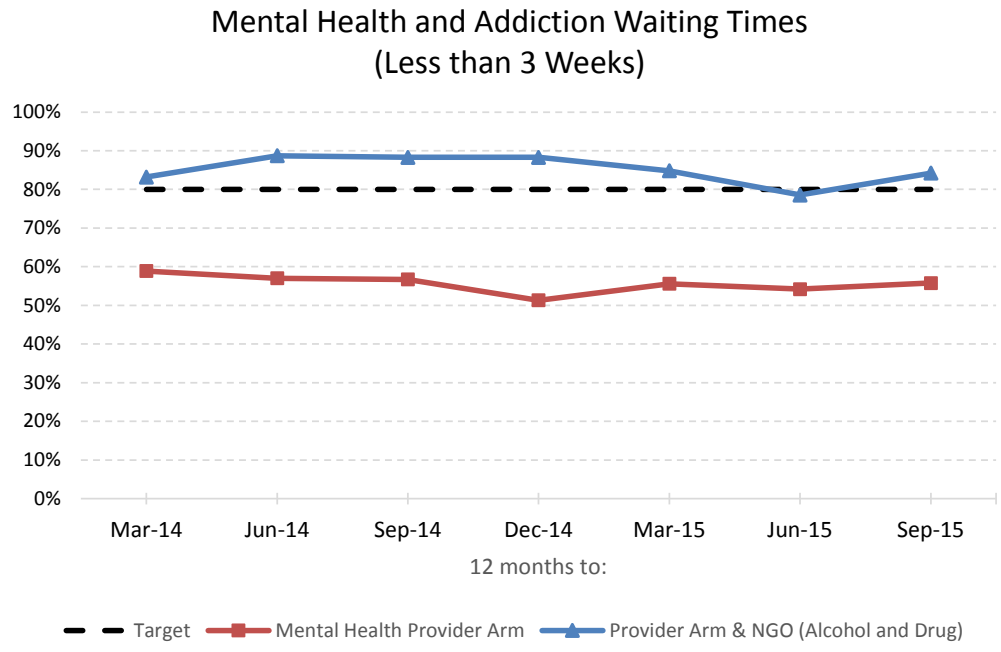

*Comments:*
Prior to the introduction of the KPI in 2014 It has not been common practise within the CAFS (Child, Adolescent and Family Services) teams to discharge patients to Primary Care with a "Transition Plan". We have seen a significant increase this quarter over previous quarters and it is also expected to see an increase in compliance over time as this new practice becomes 'business as usual'.

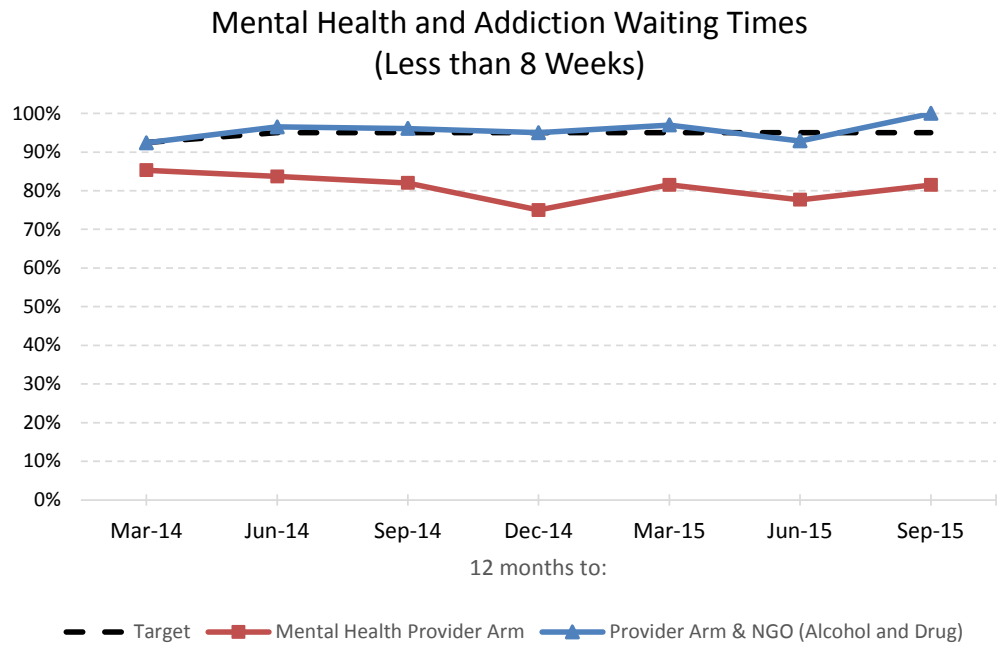
17

*19 January to March 2015.*

*20 July to September 2015.*

| Shorter waits for non-urgent mental health and addiction services (PP8): Mental Health Provider Arm | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline** | **Previous result** [21] | **Actual to Date** [22] | **Target 2015/16** | **Trend direction** |
| **Mental Health Provider Arm: Age 0-19** | | | | | |
| <3 weeks | 56.7% | 54.2% (U) | 55.8% (U) | ≥80% | ▲ |
| <8 weeks | 88.3% | 77.6% (U) | 81.5% (U) | ≥95% | ▲ |
| **Addictions (Provider Arm & NGO): Age 0-19** | | | | | |
| <3 weeks | 82.0% | 78.6% (U) | 84.2% (F) | ≥80% | ▲ |
| <8 weeks | 96.1% | 92.9% (U) | 100% (F) | ≥95% | ▲ |




*21 12 months to March 2015*

*22 12 months to September 2015*

Source: Ministry of Health

*Comments:*

High DNA rates for initial appointments are resulting in a re-scheduled (later) appointment. We now have a text reminder prior to appointments to see if this reduces DNA rates. There is daily triaging of referrals and appropriate follow-ups with referrals deemed urgent are seen that same day and non-urgent referrals are booked into a choice appointment.

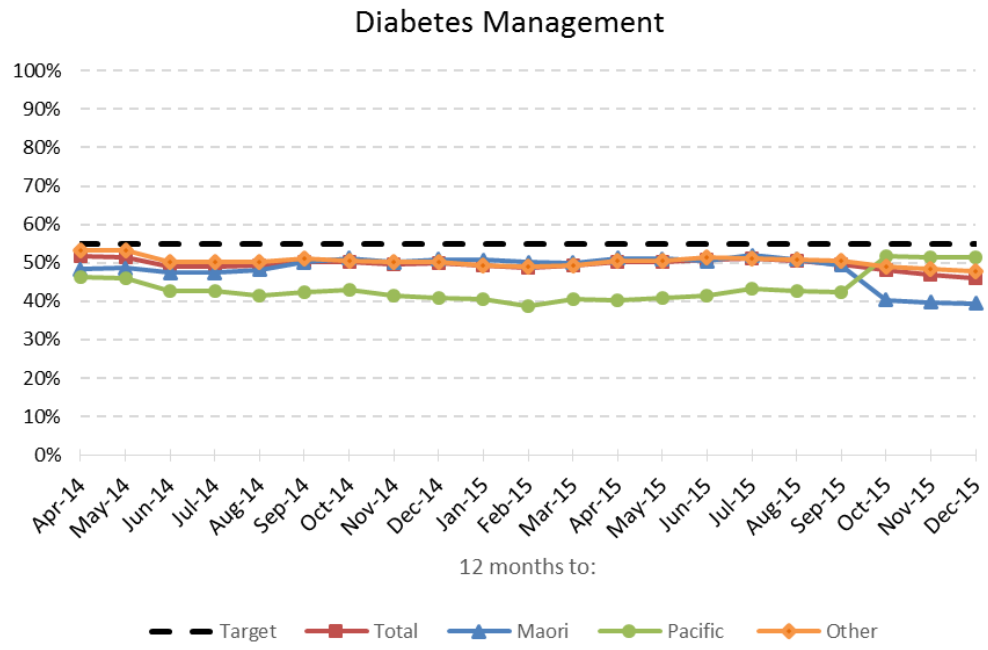
To help improve the rates we have introduced "Acute appointments" (short notice). Responses to DNA's improved with phone calls and letters to patients within 48 hours with those being booked into choice get a text reminder. CAFS (Child Adolescent and Family Services) will now contact all accepted referrals via telephone to book into choice appointment and also closer monitoring of appointments versus demand – create more appointments as required.

**Improved management for long-term conditions (CVD, Diabetes and Stroke) (PP20) – Diabetes Management**

People aged 15-74 with a HbA1c equal to or less than 64mmols

| Key Performance Measures | Baseline [23] | Previous result [24] | Actual to Date [25] | Target 2015/16 | Trend direction |
|---|---|---|---|---|---|
| *Total* | 49.2% | 47.9% (U) | 42.9% (U) | ≥55% | ▼ |
| *Māori* | 50.0% | 45.9% (U) | 41.4% (U) | ≥55% | ▼ |
| *Pacific* | 40.5% | 39.5% (U) | 37.8% (U) | ≥55% | ▼ |
| *Other* | 49.5% | 51.3% (U) | 45.5% (U) | ≥55% | ▼ |

Please note: Data presented in the graph are monthly results, whilst the data in the result section above ('Previous result' and 'Actual to date') are for a financial year to date period.




*Comments:*

To improve future rates there is currently an emphasis on management of population health – using risk stratification of individual practice populations, routine use of clinical audits. Planning and commitment to increase availability of Patient Education Sessions provided to patients diagnosed with diabetes but also to have a focus on patients with pre-diabetes. Further develop the resources available for patients with diabetes and pre-diabetes

*23 January to December 2013*

*24 October 2014 to September 2015*

*25 January 2015 to December 2015*

to increase their knowledge and understanding of their role in improving their lifestyle factors to improve their health and lead more active lives. Workforce development – historically over the last two years HHB (Health Hawkes Bay) have advocated Mentor On Line – developed by the New Zealand Society for the Study of Diabetes, but we have had a very low uptake by nurses in primary care which is to be reviewed. We are to going to further develop the diabetes Clinical Nurse Specialist resource in primary care to mentor, increase building capacity and capability, improve skills and knowledge as well as develop and introduce new ways of working and insulin initiation.

**Acute Coronary Syndrome Services:**
**Improvement management for long term conditions (PP20) Cardiovascular Disease: 70% of high-risk patients will receive an angiogram within 3 days of admission**

| Key Performance Measures | Baseline [26] | Previous result [27] | Actual to Date [28] | Target 2015/16 | Trend direction |
|---|---|---|---|---|---|
| Total | 62.3% | 50.7% (U) | 68.7% (U) | ≥70% | ▲ |
| Māori | 66.7% | 38.5% (U) | 60% (U) | ≥70% | ▲ |
| Pacific | 50.0% | 50% (U) | 100% (F) | ≥70% | ▲ |

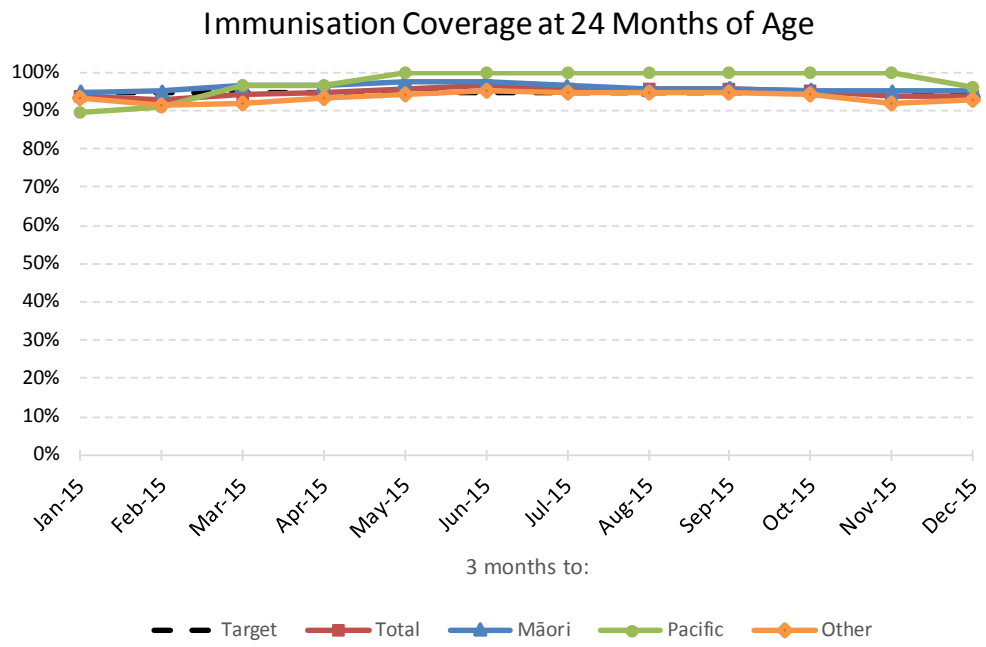
**Improvement management for long term conditions (PP20) Cardiovascular Disease: Over 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days**

| Key Performance Measures | Baseline [29] | Previous result [30] | Actual to Date [31] | Target 2015/16 | Trend direction |
|---|---|---|---|---|---|
| Total | 27.8% | 85.1% (U) | 84.1% (U) | ≥95% | ▼ |
| Māori | 12.5% | 91.7% (U) | 71.4% (U) | ≥95% | ▼ |
| Pacific | - | 50% (U) | - | ≥95% | * |

*Comments*:
The introduction of Friday cardiac angiography session along with the existing Tuesday and Thursday morning session, has helped to increase compliance and these sessions are continuing when necessary. There is a 0.5 FTE Clinical Nurse Specialist Heart Failure vacancy that will be recruited to in the near future which should also contribute to increasing compliance. A 2015/16 new investment for a Heart Failure Nurse Practitioner was prioritised by the HBDHB Clinical Council and Executive Management Team and a business case and associated position profile is currently under development and it is anticipated this role will be introduced mid-2016.

26 *January to March 2015*
27 *July to September 2015*
28 *October to December 2015*
29 *January to March 2015*
30 *July to September 2015*
31 *October to December 2015*

| Key Performance Measures | Baseline [32] | Previous result [33] | Actual to Date[34] | Target 2015/16 | Trend direction |
|---|---|---|---|---|---|
| **Immunisation coverage (PP21) – 95% of 2 year olds are fully immunised** | | | | | |
| Total | 94.4% | 95.7% (F) | 93.9% (U) | ≥95% | ▼ |
| Māori | 95.0% | 95.9% (F) | 95.1% (F) | ≥95% | ▼ |
| Pacific | 95.0% | 100% (F) | 96.2% (F) | ≥95% | ▼ |
| Other | 91.8% | 95% (F) | 92.9% (U) | ≥95% | ▼ |




Source: National Immunisation Register

*Comments:*
This was a frustrating quarter for Hawke's Bay not to reach the 2 year 95% target. With a decline rate of 4.2% and 0.5% opted off we had a difficult task to reach 95%. Work has gone into ensuring all these families have had access to discussion about immunisation. Of the 36 children not up to date with immunisations. We have a number of partial completions with declined or delayed preventing the achievement of fully immunised. There is also a small number of overseas children which could not be caught up prior to turning 2 years. We are pleased for the 4 year coverage to be in the 90% region and this is taking time and resource as it is the hardest group of children to track and trace.

17

32 October to December 2014. Source: National Immunisation Register, MOH

33 July to September 2015. Source: National Immunisation Register, MOH

34 October to December 2015. Source: National Immunisation Register, MOH

| Key Performance Measures | Baseline [35] | Previous result [36] | Actual to Date[37] | Target 2015/16 | Trend direction |
|---|---|---|---|---|---|
| **Improving waiting time for diagnostic services (PP29)** | | | | | |
| Coronary Angiography | 89.8% | 95.8% (F) | - | ≥95% | * |
| Computed Tomography (CT) | 92.6% | 96.4% (F) | 88.7% (U) | ≥90% | ▼ |
| Magnetic Resonance Imaging (MRI) | 61.3% | 57.5% (U) | 43.4% (U) | ≥80% | ▼ |
| Diagnostic Colonoscopy: Urgent | 92.6% | 90% (F) | 82.4% (F) | ≥75% | ▼ |
| Diagnostic Colonoscopy: Non-Urgent | 39.7% | 84.1% (F) | 87.1% (F) | ≥60% | ▲ |
| Surveillance Colonoscopy | 50.7% | 88.5% (F) | 79.3% (F) | ≥60% | ▼ |
| *Comments:*<br>We have been working hard as part of the MoH NRSII to help us achieve wait time indicators in CT and MRI. Although we have increased the numbers of patients scanned, the demand has increased across the urgent IP, urgent OP and planned patient groups. This is supporting ED, FCT and elective targets across the DHB whilst reducing Radiology's ability to met the diagnostic indicators for routine patients. We have identified a capacity and demand mismatch in CT and MRI and are working to mitigate within available resource. | | | | | |

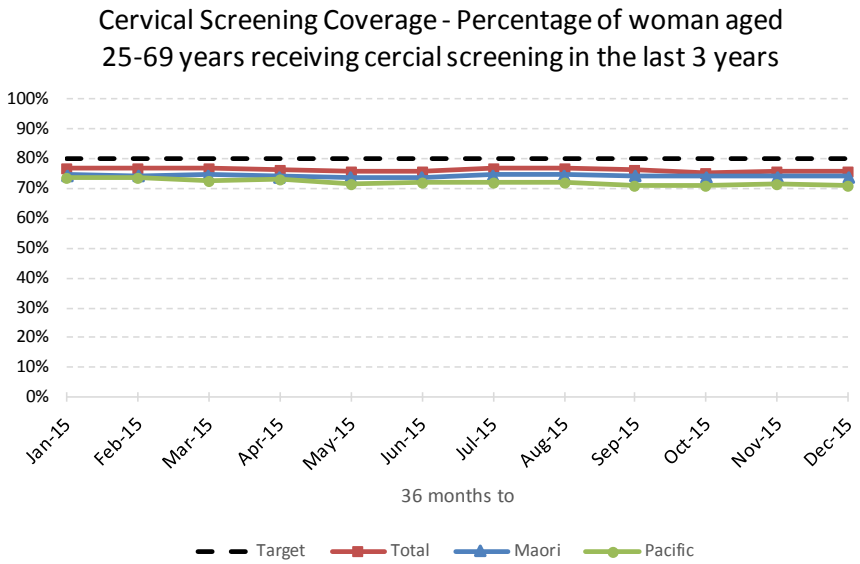
35 October to December 2014.

36 September 2015.

37 December 2015

## DIMENSION 2 – SYSTEM INTEGRATION

| Percentage of women aged 25-69 years receiving cervical screening in the last 3 years | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline** [38] | **Previous result** [39] | **Actual to Date** [40] | **Target 2015/16** | **Trend direction** |
| Total | 76.9% | 76.2% (U) | 75.8% (U) | ≥80% | ▼ |
| Māori | 73.8% | 74.4% (U) | 74.1% (U) | ≥80% | ▼ |
| Pacific | 72.8% | 71.2% (U) | 71.2% (U) | ≥80% | — |
| Other | 78.0% | 76.9% (U) | 76.5% (U) | ≥80% | ▼ |




Source: National Screening Unit

Please note: Rates of cervical screening coverage will now be reported for women aged 25-69 years, not 20-69 years as was previously reported. This change aligns with international best practice.[41]

Comments:
While HBDHB's cervical screening coverage does not look favourable, HBDHB remains the best performing DHB for Māori screening coverage and has the lowest disparity gap between Māori women and European women. There are only 520 additional Maori women and 102 Pacific women who need to be screened to achieve the cervical screening national target.

17

*38 36 months to 31 December 2013. Source: National Screening Unit*

*39 36 months to 30 September 2015. Source: National Screening Unit*

*40 36 months to 31 December 2015. Source: National Screening Unit*

*41 Cervical screening coverage: An update on calculation methods. National Screening Unit. http://www.nsu.govt.nz/health-professionals/4949.aspx*

| **Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections System (OS10)**<br>**Focus area 1: Improving the quality of identity data within the NHI** | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline** | **Previous result** [42] | **Actual to Date** [43] | **Target 2015/16** | **Trend direction** |
| New NHI registration in error (causing duplication) | 1.6% | 6.29% (U) | 1.9% (F) | ≤3% | ▲ |
| Recording of non-specific ethnicity in new NHI registration | 2.2% | 2.64% (U) | 3.5% (U) | ≤2% | ▼ |
| Update of specific ethnicity value in existing NHI record with a non-specific value | - | 0.31% (F) | 0.3% (F) | ≤2% | ▲ |
| Validation of NHI addresses where validation should have been possible | 78.2% | - | - | ≥76% | * |
| Invalid NHI data updates causing potential identity confusion (overlays) | - | - | - | - | * |
| Source: Ministry of Health | | | | | |
| *Comments:*<br>To help improve future rates we are currently submitting our training plan for 2016 to commence in February. MOH data requirements is a priority for the Administration Service with regular training sessions on PMS (Patient Management System). | | | | | |

| **Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections System (OS10)**<br>**Focus area 2: Improving the quality of identity data Submitted to National Collections** | | | | | | |
|---|---|---|---|---|---|---|
| **Key Performance Measures** | | **Baseline** | **Previous result** [44] | **Actual to Date** [45] | **Target 2015/16** | **Trend direction** |
| NBRS collection has accurate dates and links to NNPAC and NMDS | | 99.0% | 93.8% (U) | 97.8% (F) | ≥97% | ▲ |
| National Collections file load success | NBRS | 92.9% | 94.6% (U) | 92.5% (U) | ≥98% | ▼ |
| | NMDS | 92.3% | 94.6% (U) | 92.8% (U) | ≥98% | ▼ |
| | NNPAC | 99.5% | 78.7% (U) | 99.7% (F) | ≥98% | ▲ |
| | PRIMHD | 98.0% | 98.7% (F) | 99% (F) | ≥98% | ▲ |
| Standard versus edited diagnosis code descriptors in the National Minimum Data Set (NMDS) | | 70.0% | - | 77.3% (F) | ≥75% | * |
| Timeliness of National Non-admitted Patient (NNPAC) data | | 32.4% | - | 99.4% (F) | ≥95% | * |
| Source: Ministry of Health | | | | | | |
| *Comments:*<br>HBDHB has had significant delays in coding (and data corrections) due to staff vacancies. This has impacted on NMDS file load success. | | | | | | |

42 *July to September 2015*

43 *October to December 2015*

44 *July to September 2015*

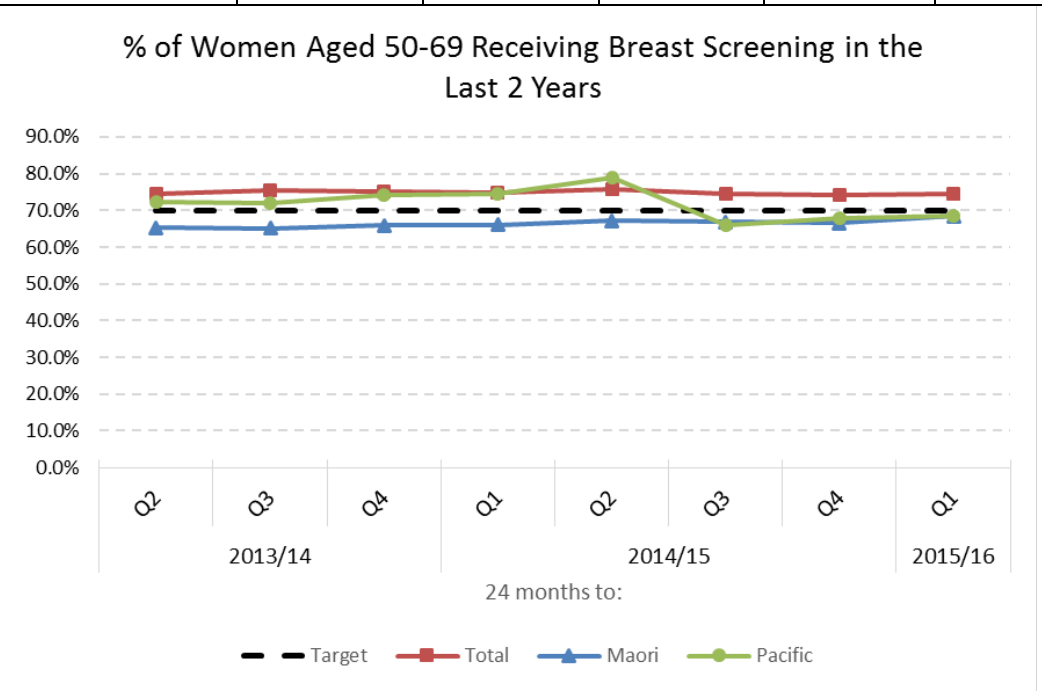
45 *October to December 2015*

## DIMENSION 4 – SERVICE PERFORMANCE

### PREVENTION SERVICES – POPULATION BASED SCREENING SERVICES

**Percentage of women aged 50-69 years receiving breast screening in the last 2 years**

| Key Performance Measures | Baseline [46] | Previous result [47] | Actual to Date [48] | Target 2015/16 | Trend direction |
|---|---|---|---|---|---|
| Total | 75.8% | 74.1% (F) | 74.6% (F) | ≥70% | ▲ |
| Māori | 67.2% | 66.6% (U) | 68.4% (U) | ≥70% | ▲ |
| Pacific | 79.0% | 67.8% (U) | 68.5% (U) | ≥70% | ▲ |
| Other | 77.2% | 75.5% (F) | 75.8% (F) | ≥70% | ▲ |




Source: Breast Screen Coast to Coast

*Comments:*
It is pleasing to see Breast our screening coverage continues to improve. Only 56 additional Maori women and 5 Pacific women need to be screened to achieve the national target for breast screening.

**% of youth accessing a Coordinated Primary Options sexual health service who are Māori**

| Key Performance Measures | Baseline [49] | Previous result [50] | Actual to Date [51] | Target 2015/16 | Trend direction |
|---|---|---|---|---|---|
| Māori | New | 40.6% (U) | 41.0% (U) | ≥50% | ▲ |

*Comments:*
We see the result for the last quarter as positive as the programme has not been targeted and 41% Maori accessing the sexual health services through Primary care is a good result. There are other services providing free sexual health services for young people in the Hawkes Bay community such as the Youth One Stop Shop and the school based health services. Of concern is the low number of males accessing sexual health services.

*46 24 months to December 2014. Source: Breast Screen Coast to Coast*

*47 24 months to June 2015. Source: Breast Screen Coast to Coast*

*48 24 months to September 2015 . Source: Breast Screen Coast to Coast*

*49 -.*

*50 July to September 2015.*

*51 October to December 2015.*

| Proportion of the population enrolled in the PHO | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline** [52] | **Previous result** [53] | **Actual to Date** [54] | **Target 2015/16** | **Trend direction** |
| Total | 97.3% | 95.6% (U) | 96.4% (U) | ≥97% | ▲ |
| Māori | 94.7% | 95.9% (U) | 97.2% (F) | ≥97% | ▲ |
| Pacific | 99.3% | 87.8% (U) | 88.7% (U) | ≥97% | ▲ |
| Other | 98.2% | 95.9% (U) | 96.5% (F) | ≥97% | ▲ |
| Source: Ministry of Health | | | | | |
| *Comments:*<br>Census population data has been updated this quarter and is used as the denominator to calculate the percentage of population enrolled. Proportionally there has been a higher increase in the number of Pacific peoples in Hawke's Bay. Population figures for Pacific peoples has increased by 740 (14.3%) resulting in a drop in the percentage of Pacific people enrolled. This information has been supplied to Hawke's Bay PHO to consider. | | | | | |

| Rate of high intensive users of hospital ED as a proportion of total ED visits | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline** [55] | **Previous result** [56] | **Actual to Date** [57] | **Target 2015/16** | **Trend direction** |
| Total | 5.5% | 5.44% (F) | 5.57% (F) | ≤5.4% | ▼ |
| Māori | 5.5% | 6.27% (U) | 6.13% (U) | ≤5.4% | ▲ |
| Pacific | 5.5% | 7.13% (U) | 6.89% (U) | ≤5.4% | ▲ |
| Other | 5.5% | 4.91% (F) | 5.27% (F) | ≤5.4% | ▼ |
| *Comments:*<br>We have acknowledged for some time that there is a problem with our Maori and Pacific population accessing GP services and utilising ED instead. Electronic discharge summaries are generated for patients discharged from ED and advice at the end of the summary advises to return to ED if there is a problem, or go to the GP. As part of the ED Front of House project, work has been ongoing with HBDHB communications team to develop a pamphlet to support enrolling with GPs, this is yet to be finalised. A Pacific Navigator role has been developed (January) and is currently being introduced to the department through awareness of the role, developing relationships, and education as to what the role can deliver, this role is already in place for Women and Child Health. This role will provide support for Pacific patients presenting to ED and support them with follow up after discharge. | | | | | |

| Percentage of women registered with an LMC by week 12 of their pregnancy | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline** [58] | **Previous result** [59] | **Actual to Date** [60] | **Target 2015/16** | **Trend direction** |
| Total | 51.4% | 55.8% (U) | 54.5% (U) | ≥80% | ▼ |
| Māori | 44.1% | 43.9% (U) | 50.7% (U) | ≥80% | ▲ |
| Pacific | 47.8% | 35% (U) | 40.6% (U) | ≥80% | ▲ |
| Other | 56.6% | 64.8% (U) | 58.5% (U) | ≥80% | ▼ |
| *Comments:*<br>Whilst the result remains unfavourable it is pleasing to note a significant increase in early engagement with a midwife for Maori and Pacifica women for the last quarter. This is beginning to reflect the collaborative work between LMCs and GP practices in relation to early referral and follow up of women with positive pregnancy confirmation. It is concerning that a drop of 6.3% is noted for the Other ethnicities. The report for the proof of concept early engagement with an LMC work has identified positive feedback from women who felt supported to find a midwife more easily. The recommendations from this report are being presented through PHO education meetings, LMC/DHB meetings and costing's of roll out of the key recommendations have been identified. Support has been given, via senior midwifery colleagues, to our admin/clerical team with the identification of the booking date with the midwife to improve the accuracy of the data collected. This is troublesome as the booking information is received from 3 different LMC software programmes. | | | | | |

*52 October to December 2014.*

*53 July to September 2015.*

*54 October to December 2015.*

*55 January to December 2014.*

*56 October* 2014 *to September 2015.*

*57 January* 2015 *to December 2015.*

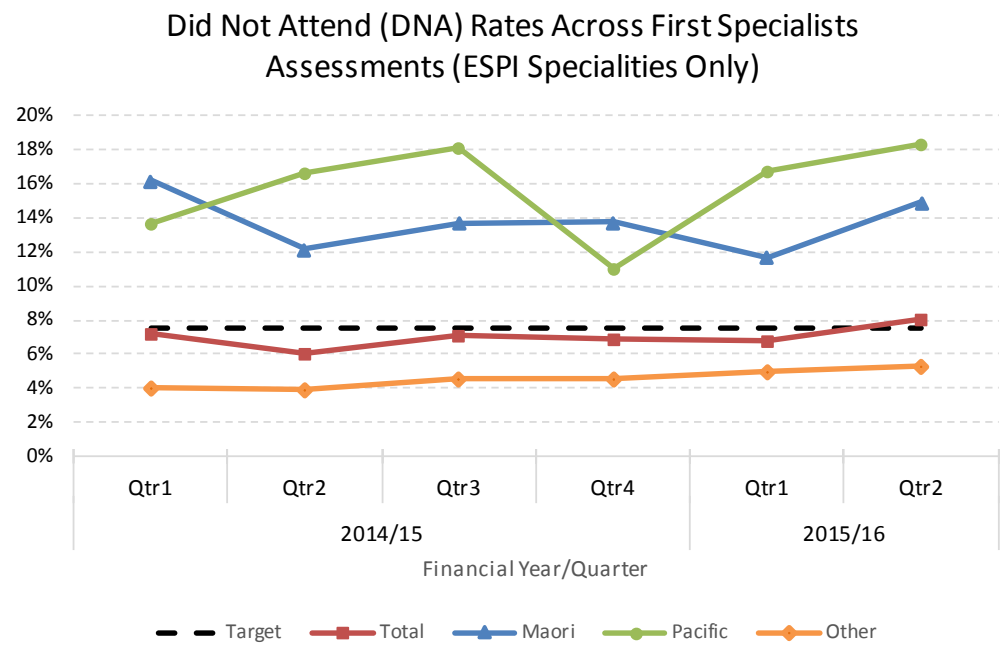
*58 October to December 2014.*

*59 January to March 2014.*

*60 July to September 2015.*

| |
|---|
| A pilot is about to commence of triaging the booking forms received, by a small group of DHB midwives, ensuring information is accurate and sending back to the referrer in a timely fashion to improve data accuracy, improve referral information received and increase timeliness in booking entry to healthware. The next quarter of consumer feedback has just been received from our survey monkey and is currently being reviewed. |

| Did not attend (DNA) rate across first specialist assessments[61] | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline** [62] | **Previous result** [63] | **Actual to Date** [64] | **Target 2015/16** | **Trend direction** |
| Total | 7.2% | 6.8% (F) | 8.1% (U) | ≤7.5% | ▼ |
| Māori | 16.2% | 11.6% (U) | 14.9% (U) | ≤7.5% | ▼ |
| Pacific | 13.6% | 16.8% (U) | 18.3% (U) | ≤7.5% | ▼ |
| Other | 4.0% | 4.9% (F) | 5.3% (F) | ≤7.5% | ▼ |




*Comments:*
At the end of the DNA project, and subsequent merge with the 'Customer Focused Booking Project', the focus of the two DNA Kaitakawaenga changed slightly, maintaining the pre-emptive Patient phone calls, and a new focus on DNA tracking (post DNA) to re-engage Whânau with the outpatient Villas. We expect some variation in the results as the Customer Focused Booking implementation phase develops, the systems issues identified by the DNA project have yet to be remedied and this may be seen in the sharp rise in the DNA rates.

The DNA Kaitakawaenga will continue their effort to reduce the DNA rate, reducing and sustaining the DNA rate below the desired threshold of 7.5% will be linked successful re-furbishment of customer (focus) booking.

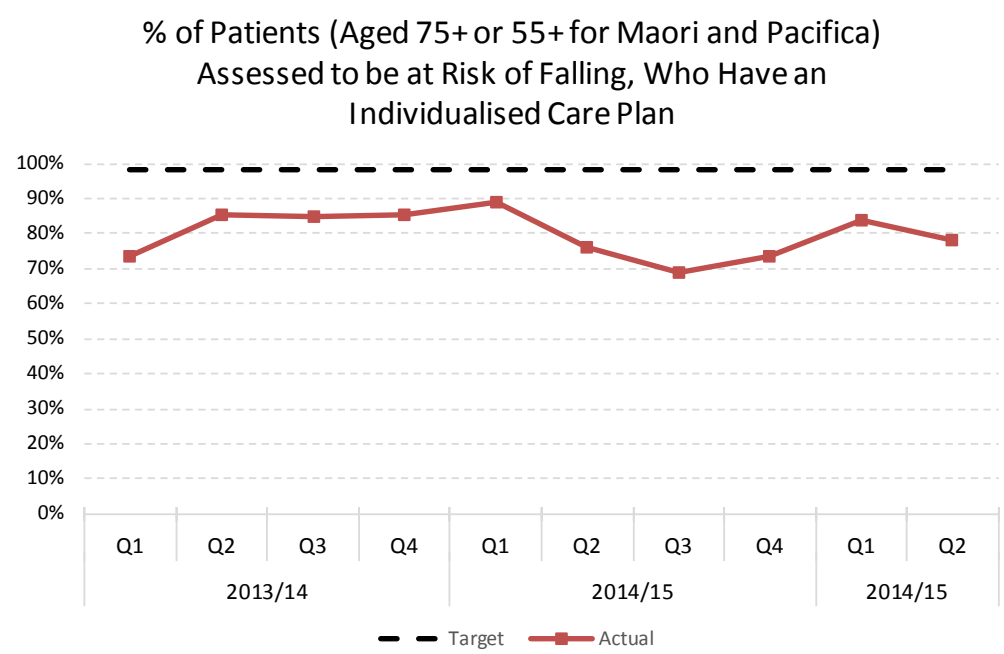
*61 ESPI specialities only*

*62 3months to Dec 2014*

*63 July to September 2015*

*64 October to December 2015*

| Percentage of older patients assessed as risk of falling who received individualised care plan that addressed these risks | | | | | |
|---|---|---|---|---|---|
| **Key Performance Measures** | **Baseline** [65] | **Previous result** [66] | **Actual to Date** [67] | **Target 2015/16** | **Trend direction** |
| | 76.0% | 83.8% (U) | 78.4% (U) | ≥98% | ▼ |




Comments:
Compliance is disappointing despite a focus on this target. Clinical units will be increasing audit activity and utilising quality initiative learnings to improve on performance.

17

*65 October to December 2014. Source: Cranford Hospice.*

*66 July to September 2015.*

*67 October to December 2015.*

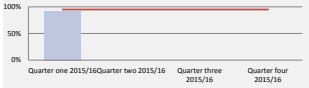
# Hawke's Bay DHB performance monitoring report quarter one 2015/16

**Monitoring Status** Standard Monitoring

## HEALTH TARGETS

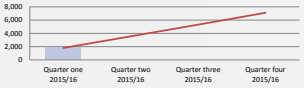
Shorter Stays in Emergency Departments

PERFORMANCE 92% TARGET 95% CHANGE -2.7%




Improved Access to Elective Surgery

PERFORMANCE 1823 TARGET 1807 VARIANCE 16

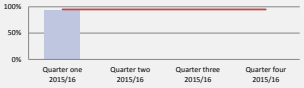



Faster Cancer Treatment

PERFORMANCE 79% TARGET 85% CHANGE 11.9%


Increased Immunisation

PERFORMANCE 95% TARGET 95% CHANGE -1.0%

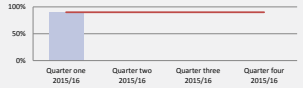



Better Help for Smokers to Quit

PERFORMANCE Primary Care 81% TARGET 90% CHANGE NA NA


More Heart and Diabetes Checks

PERFORMANCE 90% TARGET 90% CHANGE -0.1%

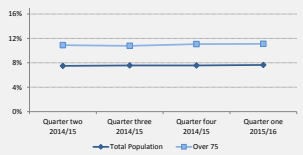



## SERVICE RECONFIGURATION - SHIFTING SERVICES (IMPROVING SYSTEM INTEGRATION)

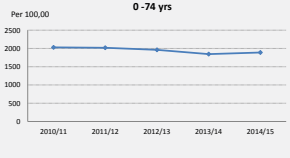
While the DHBs provided some information about progress against their Annual Plan integration commitments, they did not provide the requested information, they did not respond at all in round two to the Ministry's questions. Further information was requested about progress against their $1.01M spend commitment for geriatrician services this quarter, milestones for clinical pathway development, nurse practitioner implementation and improving discharge co-ordination.

## OVERALL INDICATORS ACROSS DHBs

### ACUTE READMISSIONS RATES (standardised)




### AMBULATORY SENSITIVE HOSPITALISATION RATES (standardised)



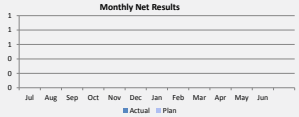

## FINANCIAL MANAGEMENT

**Financial Performance Rating: Needs Watching**

NET RESULT

| $'000 | YTD-Sep 2015 Actual | Plan | Variance |
|---|---|---|---|
| YTD Net Result: | (1,056) | (766) | (289) |

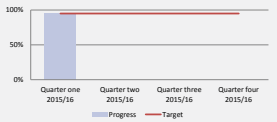
Monthly Net Results




MAIN FINANCIAL CATEGORIES

| $'000 | YTD-Sep 2015 Actual | Plan | Variance |
|---|---|---|---|
| Personnel Costs | (45,273) | (46,368) | 1,095 |
| Outsourced Services | (2,744) | (2,598) | (145) |
| Clinical Supplies | (10,975) | (10,826) | (150) |
| Infrastructure/Other Supplies | (10,150) | (9,513) | (637) |

## 2-year-old immunisation coverage




## PROGRESS AGAINST LOCAL ACTIONS AS DEFINED IN THE DHB ANNUAL PLAN

**IMPROVED MANAGEMENT FOR LONG TERM CONDITIONS** (CVD, DIABETES AND STROKE)

**IMPROVING WRAP AROUND SERVICES – HEALTH OF OLDER PEOPLE**

## REGIONAL SERVICE DELIVERY

Quarter one 2015/16

**Overall Performance**

| National Priorities | |
|---|---|
| Cancer Services | |
| Cardiac Services | |
| Health of Older People | |
| Elective Services | |
| Stroke Services | |
| Mental Health and Addictions | |
| Major Trauma | |
| Hepatitis C | |

| Information Technology Critical Priorities | |
|---|---|
| eMedicines Reconciliation | |
| Clinical Workstation (CWS) and Clinical Data Repository (CDR) | |
| Replacement of legacy Patient Administration Systems (PAS) | |
| National Infrastructure Platform (NIP) | |
| Patient Portal | |
| National Patient Flow | |

**Health Workforce** Regional Actions against Workforce Plan

### Regional Performance Highlights

- Central region has improved slightly since the previous quarter and most of the national priorities are making stable progress. Six out of the ten national priorities received an 'Achieved' rating.
- Good work is being done in Central region's Cancer Services to review and identify opportunities to improve Health Target performance in the region.
- In Mental Health and Addiction Services, all work programmes continue to be on track.
- A project manager is now in place for Hepatitis C services in the Central region and contact has been made with the Hepatitis Foundation and other regions.

### Regional Performance Issues

- For Cardiac Services (Acute Coronary Syndrome), the Central region has achieved the two ACS indicators for the first time. However, there are still inconsistencies in achievement across DHBs in the region, and the Ministry has asked to see further strategies in place at a regional level to support achievement.
- For Cardiac Secondary Services, there was one week in Q1 where the Central region was above the maximum number of patients expected. The region also had patients waiting beyond maximum waiting time expectation and YTD delivery was behind plan.
- The partially achieved rating for Elective Services is due to their waiting times performance in July and August.
- For Stroke Services, the Ministry has been working with the Central region to provide a telestroke pilot to look at ultimately providing a more sustainable acute stroke service for all DHBs.
- The IT RHIP programme is tracking to the agreed timeframes but is still at significant risk due to lack of agreement on the delivery model for the region. Agreement over the next steps is expected in the next quarter for the region to progress.

## WAITING TIMES

### Diagnostic waiting times

| | Goal | Performance |
|---|---|---|
| **Coronary angiography** (<90 days) | 95% | 95.8% |
| **Radiology** | | |
| CT Scan (<42 days) | 95% | 96.4% |
| MRI Scan (<42 days) | 85% | 57.5% |

| | Goal | Performance |
|---|---|---|
| **Colonoscopy** | | |
| Urgent colonoscopy (<14 days) | 75% | 90.0% |
| Non-urgent colonoscopy (<42 days) | 65% | 84.1% |
| Surveillance colonoscopy (<84 days) | 65% | 88.5% |

### Patients Waiting For FSA and Treatment

PATIENTS WAITING FOR FSA

| | Jul | Aug | Sep | last mnth | 3 mnths |
|---|---|---|---|---|---|
| ESPI 2 | 8 | 4 | 2 | -2 | -6 |
| ESPI 2 % | 0.3% | 0.1% | 0.1% | -0.1% | -0.2% |

PATIENTS WAITING FOR TREATMENT

| | Jul | Aug | Sep | last mnth | 3 mnths |
|---|---|---|---|---|---|
| ESPI 5 | 7 | 5 | 8 | 3 | 1 |
| ESPI 5 % | 0.7% | 0.5% | 0.7% | 0.3% | 0.0% |

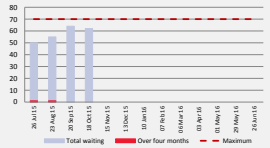
### Regional Provision Cardiac Surgery Delivery

REGIONAL DELIVERY - CAPITAL & COAST DHB OF SERVICE

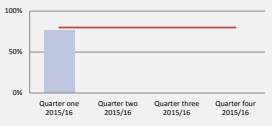
PERFORMANCE AGAINST PLAN 103% VARIANCE 7


WAITING LIST - CAPITAL & COAST DHB OF SERVICE

| | |
|---|---|
| TOTAL REGIONAL WAITING LIST | 62 |
| % OF NATIONAL WAITING LIST | 33% |

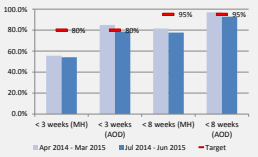



### Cervical Screening Coverage




### Mental Health

Mental health and addictions waiting times: Child and Youth aged 0-19 years




### SERVICE COVERAGE DELIVERY NA

Not reported in quarter one.

## CROSS-AGENCY PRIORITIES

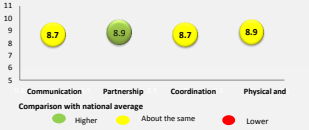
| Prime Minister's youth mental health project | Reducing Rheumatic fever | Delivery of the children's action plan |
|---|---|---|
| On track | On track | On track |

### Quality and Safety Markers

| | Goal | Performance |
|---|---|---|
| Falls risk assessment (Apr-Jun15) | 90% | 90% |
| Hand hygiene (Apr-Jun15) | 80% | 85% |
| Perioperative harm (Apr-Jun15) | 90% | 99% |

| | Goal | Performance |
|---|---|---|
| Surgical site infections (Jan-Mar 2015): | | |
| Patients receive cefazolin or cefuroxime | 95% | 93% |
| Appropriate skin preparation | 100% | 100% |

### Patient Experience**




## PERFORMANCE HIGHLIGHTS

Good financial performance.

The DHBB has made another strong improvement in the Faster Cancer Treatment health target this quarter with the DHB making good progress towards the 85% target.

## PERFORMANCE ISSUES

Shorter Stays in ED health target: Hawke's Bay DHB's performance dropped by 2.7 percent in quarter one due to a sharp increase in ED presentations. The DHB did achieve the 95 percent target in quarters three and four of 2014/15. The Ministry will arrange a teleconference with the DHB in the New Year to see how it is progressing and what its plans are for winter 2016.

Service Reconfiguration: Please refer to the 'Service Reconfiguration' text box in the dashboard.

## How to read this dashboard

This dashboard shows a summary of most aspects of DHB performance. It combines indicators of DHB performance, as agreed in the 2015/16 Annual Plan, as well as complementary information such as financial net results, hospital indicators and other priorities. The structure has been designed to display DHB information using an 'at-a-glance' approach. It is not to be used for general publication. It groups information according to the following areas:

| | |
|---|---|
| **Health targets** | Shows the progress made by the DHB against the health targets. The top bar chart show relative performance to target for each measure, while the time series charts absolute performance throughout the year. |
| **Service Reconfiguration** | This area displays information related to the progress DHBs are achieving in the implementation of the System Integration Programme. |
| **Waiting Times** | This area summarises an array of indicators that show DHB progress towards reducing waiting times. |
| **Other Priorities** | Emerging priorities such as the Prime Minister's youth mental health initiative. |
| **Service coverage** | Self-reported confirmation & exception report. DHBs must ensure service coverage expectations are met, or demonstrate resolution of service coverage gaps by providing an appropriate resolution plan, and adequate progress is being made against the resolution plan. |
| **Financial Management** | Overview of the financial performance of the DHB based on data provided by the DHBs in monthly financial templates. |
| **Highlights and Lowlights** | High level description of particular issues in which a DHB exceeded agreed performance expectations or has not met agreed performance expectation and does not have an appropriate resolution plan in place, or needs to progress further. |

Each area includes one or more indicators. Definitions for those are as follow: (Definitions for health target indicators are shown in the health target summary table and therefore are not repeated here.)

| | |
|---|---|
| **Acute readmissions rates *** | Acute readmission rates are defined as the number of unplanned acute readmissions to hospital within 28 days of a previous inpatient discharge that occurred within the 12 months to the end of the quarter, as a proportion of inpatient discharges in the 12 months to the end of the quarter. The rates are standardised by patient population characteristics, deprivation, rurality, patient health conditions, comorbidity and surgery, using national patient population as a 'standard'. Indirect standardisation using logistic regression method is applied to derive the rates. |
| **Ambulatory sensitive hospitalisations (ASH) *** | Ambulatory Sensitive Hospitalisations (ASH) result from diseases and conditions sensitive to prophylactic or therapeutic interventions deliverable through primary care and are, therefore, avoidable. The ASH rates are derived by the total number of 12-month ASH for DHB patients aged 0-74 as the numerator and the same age population of the DHB as the denominator. The rates are standardised by age group using WHO population as a standard. Direct standardisation is applied. |
| **Local Integration DHB indicators** | DHBs are expected to report on delivery of the actions and milestones to improve integration identified in 2015/16 Annual Plans, for system integration, long term conditions (LTC), and diabetes care improvement packages (DCIP). The Indicators shown for the System Integration area are only a small subset of the measures agreed in APs. |
| **2-year-old immunisation coverage** | The percentage of children who have completed their age-appropriate immunisations (six weeks, three, five and fifteen months immunisation events) by the age of 24 months. |
| **Cervical screening coverage** | The number of eligible women (aged 25-69 years) screened in the three years to end of quarter being reported as a proportion of the hysterectomy adjusted female population. |
| **Regional delivery - cardiac** | Regional cardiac provider delivery against plan. DHBs submit four-weekly reports. |
| **Waiting list - cardiac** | Regional cardiac provider total waiting list against the waiting list target including those waiting over four months. Proportion of regional to national waiting list. DHBs submit four-weekly reports. |
| **Patients waiting for FSA (ESPI 2)** | The total number on the waiting list waiting longer than four months for an FSA for the last three months, and the number waiting as a % of the total list. |
| **Patients waiting for treatment (ESPI 5)** | The total number on the waiting list waiting longer than four months for treatment for the last three months, and the number waiting as a % of the total list. |
| **Alcohol and drugs waiting times: * Child and Youth aged 0-19 years** | Waiting times are measured from the time of referral for treatment to the first date the client is admitted to treatment, following assessment in any service whether it be NGO or provider arm. |
| **Prime Minister youth mental health initiative** | Progress report on implementation of Youth Service Level Alliance Team (SLAT), and progress against local youth SLAT plan to implement named actions to improve primary care responsiveness to youth. |
| **Reducing rheumatic fever *** | A progress report against the DHB's rheumatic fever prevention plan (the regional plan for the South Island), plus hospitalisation rates per 100,000 DHB total population for acute rheumatic fever are 40% reduction from baseline (2009/10-2011/12). |
| **Delivery of the children's action plan** | Progress on delivery of the actions and milestones identified in DHB Annual Plans support the implementation of the Children's Action Plan and reduce child assaults. |
| **Regional service delivery** | A qualitative assessment of a progress report on behalf of the region agreed by all DHBs within that region. The report focuses on the actions agreed by each region as detailed in its RSP implementation plan. |
| **Quality and Safety Markers** | Progress toward the markers set by the Health Quality and Safety Commission. These include older patients receiving a falls assessment, compliance with good hand hygiene practice, use of all three parts of the surgical safety checklist, and two surgical site infection measures: hip and knee replacement patients receiving 2g or more of cephazolin and hip and knee replacement patients that have appropriate skin preparation. |
| **Patient Experience** | Average rating out of 10 for inpatient experience across the four domains of communication, partnership, coordination of their care, and having physical and emotional needs met, based on results from the national patient experience survey. |
| **Diagnostic waiting times** | Performance against the waiting time indicators for Coronary Angiography, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), and Colonoscopy. |
| **Performance highlights** | Brief analysis of areas where a DHB is performing above expectations by achieving/exceeding a performance expectation, making significant progress from their base position, or implementing/leading an innovation process that will lead to performance improvement. |
| **Performance issues** | Brief analysis of areas where a DHB is performing below expectations, and actions being taken to resolve the issue(s) |

*** Data for these measures covers a period prior to the current quarter to ensure complete coding of data.**

**# The target definition of Better help for smokers to quit - primary care has change from quarter one 2015/16. There is no comparison to previous quarter.**

**** Patient experience survey result is not shown for Tairawhiti due to a small number of survey respondents.**

Some indicators are for information only. Some, on the other hand, are accompanied by a traffic light colour.
This colour represents the perceived risk to a DHB achieving their target for the year.

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

The Quality and Safety markers use a different traffic light scheme, to mimic that used by the Health Quality and Safety Commission.

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

17.1

| | |
|---|---|
| HAWKE'S BAY District Health Board Whakawāteatia | **HBDHB Transform & Sustain Strategic Dashboard Q2 Oct-Dec 2015** 10 |
| | For the attention of: **HBDHB Board** |
| Document Owner:<br>Document Author(s): | Tim Evans, GM Planning Informatics and Finance<br>Peter Mackenzie, Operational Performance Analyst |
| Reviewed by: | Executive Management Team |
| Month: | February 2016 |
| Consideration: | For Monitoring |

## Introduction

The Transform and Sustain Strategic dashboard has been developed to measure our Vision and Values and progress towards long term Transform and Sustain strategic objectives. In December FRAC and the Board endorsed the reorganisation of strategic non-financial reporting to better reflect the strategic roles between the two committees. It was agreed that the Transform and Sustain Dashboard would be presented to the Board quarterly.

18

This is the first time the dashboard has been presented to the Board and covers quarter 2 performance monitoring. Based the Triple Aim Framework it falls under 3 headings of 'Improved quality and safety of work', 'Best Value for public health system resources' and 'Improved health equity for all populations'. Each heading is accompanied by a vital sign and 7 supporting dimensions.

Current results are colour coded to Red if significantly below target, Amber if below target but close to achieving target and Green if achieving target. There is also a trend line against each vital sign and dimension, this shows the trend over time and how each indicator is tracking to target. As this is the first issue of the dashboard not all indicators have a clear trend line but in future issues the trend line will start to become clearer and help to predict future trajectories.

Provided on the back of the dashboard are definitions of each measure.

# Transform and Sustain Strategic Dashboard - Q2

HEALTHY HAWKE'S BAY

NZ TRIPLE AIM

TRANSFORM & SUSTAIN

VITAL SIGNS

SUPPORTING DIMENSIONS

OURHEALTH HAWKE'S BAY Whakawhanaungatia

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

| Improved quality and safety of care | Best value for public health system resources | Improved health equity for all populations |
|---|---|---|
| Delivering consistent high-quality health care | Being more efficient at what we do | Responding to our population |

## Delivering consistent high-quality health care

| | | Baseline | Previous | Current | Target |
|---|---|---|---|---|---|
| Patient experience | Patient Experience Survey Score | 8.5 | 8.4 | 8.7 | ≥ 8.4 |
| | *Communication | | | | |
| Better access to specialist outpatients | Did not attend (DNA) rate across first specialist assessments | 6.10% | 6.80% | 8.10% | ≤ 7.50% |
| A safer hospital | Standardised Hospital Mortality Rate | 101 | 0 | 101 | ≤ 100 |
| More Very High Quality General Practices | General Practices with Cornerstone Accreditation | 50.0% | 64.0% | 71.0% | ≥ 65.0% |
| All General Practices are Demonstrably Good | General Practices that meet Foundation Standards | 70.0% | 78.0% | 85.0% | ≥ 100.0% |
| Reduced readmissions | Hospital Standardised Readmission Rate | 7.5% | 7.6% | 7.7% | ≤ 7.4% |
| A culturally responsive workforce | Percentage of DHB Staff Ethnicity who are Māori | 11.6% | 12.3% | 12.3% | ≥ 13.0% |
| Emergency Department Waits | Patients waiting less than 6 hours in ED | 91.5% | 92.1% | 92.7% | ≥ 95.0% |

## Being more efficient at what we do

| | | Baseline | Previous | Current | Target |
|---|---|---|---|---|---|
| Resource sustainability | Financial Surplus DHB | | | $48,000 | ≥ $0 |
| | Breakeven PHO | | | On track | |
| Older people living independently | Over 85s Living Independently | 78.4% | 78.1% | 78.4% | ≥ 80.0% |
| Improved hospital workforce productivity | Case Weight per Health Service FTE | 3.04 | 3.06 | 3.158 | ≥ 3.08 |
| Better staff engagement | Staff Engagement Survey Satisfaction Rate | 76.0% | - | 76.0% | ≥ 76.0% |
| More Efficient Buildings | Buildings Infrastructure Efficiency | 2.59% | 2.59% | 2.73% | ≤ 2.41% |
| Better staff retention | Staff Turn-over | 8.10% | 8.10% | 9.39% | Between 9.5% and 10.5% |
| Care close to home | Strategic Spending Shift | -0.3% | -1.0% | 0.8% | ≥ 0.1% |
| More Treatments Out of Hospital | Ambulatory-sensitive Hospital Admissions | 76.0% | 76.0% | 73.0% | ≤ TBC |

## Responding to our population

| | | Baseline | Previous | Current | Target |
|---|---|---|---|---|---|
| Live healthier and longer lives | Difference in Maori Death rates (Below 50 years of age) | 17% | - | 17% | ≤ 17% |
| Reduced infant mortality | Infant Mortality Rate | 4.41 | 0 | 4.41 | ≤ 5 |
| Fewer premature deaths | Maori All Cause Mortality Rate (Below 75 years of age) | 469 | 0 | 469 | ≤ 310 |
| Healthier weight | Obesity Rate | 7.9% | 7.9% | 9.3% | ≤ 8% |
| More heart and diabetes Checks | Diabetes and Cardiovascular Services Checks | 88% | 90% | 90% | ≥ 90% |
| Faster cancer treatment | Faster Cancer Treatment | 62% | 76% | 78% | ≥ 85% |
| Fewer women smoking in pregnancy | Maori Women Smoking During Pregnancy | 44% | 43% | 44% | ≤ 22% |
| Reducing Rheumatic Fever | Rheumatic Fever Hospitalisation Rates | 0.6 | 0 | 0.6 | ≤ 2.7 |

| | Measure | Definition |
|---|---|---|
| Patient Experience | Communication | Patient Experience Survey - Dashboard only displays Domain with the lowest score each quarter. Target ≥ 8.4 |
| | Partnership | Patient Experience Survey - Dashboard only displays Domain with the lowest score each quarter. Target ≥ 8.4 |
| | Co-Ordination | Patient Experience Survey - Dashboard only displays Domain with the lowest score each quarter. Target ≥ 8.4 |
| | Physical and Emotional Needs | Patient Experience Survey - Dashboard only displays Domain with the lowest score each quarter. Target ≥ 8.4 |
| Better Access to Specialist Outpatients | Did not attend (DNA) rate across first specialist asse | Patients who do not show up to an outpatient appointment without any prior notice |
| A Safer Hospital | Standardised Hospital Mortality Rate | Ratio of actual to expected hospital deaths |
| More Very Higher Quality General Practices | General Practises with Cornerstone Accreditation (P | GP's with Cornerstone accreditation (CORNERSTONE is an accreditation programme specifically designed by the Royal New Zealand College of General Practitioners for general practices in New Zealand) it allows GP's to measure themselves against a defined set of standards. |
| All General Practices are Demonstrably Good | General Practices that meet Foundation Standards ( | The Foundation Standard represents what is considered to be the minimum legal, professional, and regulatory requirements for general practice |
| Reduced Readmissions | Hospital Standardised Readmission Rate | Patients re-admitting to the hospital within 28 days of being discharged. MOH target. |
| A Culturally Responsive Workforce. | Percentage of DHB Staff Ethnicity who are Maori | The % of staff employed at the DHB that identify their ethnicity as Maori |
| Emergency Department Waits | Patients waiting less than 6h in ED | Health Target. Patients waiting less than 6 hours in the ED department |

| | | |
|---|---|---|
| Resource Sustainability | Financial Surplus DHB | $0 or + variance to budget |
| | Breakeven PHO | Financial result = $breakeven |
| Older People Living Independently | Over 85s Living Independently | The proportion of 85years who are not living in ARC |
| Improved Hospital Workforce Productivity | Case Weight per Health Service FTE | Numerator: Total caseweights. Denominator: Total Doctor and Nursing FTE. Improve productivity by either increasing case weights or decreasing |
| Better Staff Engagement | Staff Engagement Survey Satisfaction Rate | % engaged employees at HBDHB based on the Engagement questions in the staff engagement survey |
| More Efficient Buildings | Buildings Infrastructure Efficiency | Numerator : Total Infrastructure costs (everything to do with buildings & facility costs e.g. buildings, lease, maintenance, depreciation, rates . Denominator: Infrastructure costs weighted output e.g. service weights which is everything we do e.g. caseweights, contacts, face to face, tests, appointments |
| Better Staff Retention | Staff Turn-over | Turn-Over of HBDHB employees |
| Care Closer to Home | Strategic Spending Shift | To shift resources from hospital and IDFs to Primary and Community by 0.5% p.a. |
| More Treatment Out of Hospital | Ambulatory-sensitive hospitalisations | HBDHB ASH rate relative to the national Rate as a percentage. |

| | | |
|---|---|---|
| Live Healthier and Longer Lives | Premature deaths under 50 years | The number of deaths under the age of 50 as a percentage of all deaths. Gap between Maori and Non-Maori. |
| Reduced Infant Mortality | Infant Mortality Rate | HB Children who die from any cause under the age of 1 / total number of live births in the year |
| Fewer Premature Deaths | Maori All Cause Mortality < 75 | The age standardised rate of death for Maori people under the age of 75. per 100,000 |
| Healthier Weight | Obesity Rate | Prevalence of Maori children having a B4shcool check who are obese according to the international obesity task force. |
| More Heart and Diabetes Checks | Better diabetes and cardiovascular services | Health Target. Enrolled people in the PHO who are eligible for a CVD risk assessment who have had a CVD risk recorded within the last 5 years. |
| Faster Cancer Treatment | Faster Cancer Treatment | 62 Day FCT Health Target |
| Fewer women smoking in pregnancy | Maori Woman Smoking During Pregnancy | % All Maori Women who are recorded as smoking at the birth of their baby. |
| Reducing Rheumatic Fever | Rheumatic Fever Hospitalisation Rates | Rate per 100,000 TBC |

HAWKE'S BAY
District Health Board
Whakawāteatia

# Recommendation to Exclude the Public

## *Clause 32, New Zealand Public Health and Disability Act 2000*

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

**20. Confirmation of Minutes of Board Meeting**
**- Public Excluded**

**21. Matters Arising from the Minutes of Board Meeting**
**- Public Excluded**

**22. Board Approval of Actions exceeding limits delegated by CEO**

**23. Chair's Report**

**24. Allied Laundry Services Ltd Report to Shareholding DHBs**

**25. Preliminary Budget - Presentation**

**Reports and Recommendations from Committee Chairs**
**26. HB Clinical Council**
**27. 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).

# GLOSSARY OF COMMONLY USED ACRONYMS

| | |
|---|---|
| **A&D** | Alcohol and Drug |
| **AAU** | Acute Assessment Unit |
| **AIM** | Acute Inpatient Management |
| **ACC** | Accident Compensation Corporation |
| **ACP** | Advanced Care Planning |
| **ALOS** | Average Length of Stay |
| **ALT** | Alliance Leadership Team |
| **ACP** | Advanced Care Planning |
| **AP** | Annual Plan |
| **ASH** | Ambulatory Sensitive Hospitalisation |
| **AT & R** | Assessment, Treatment & Rehabilitation |
| **B4SC** | Before School Check |
| **BSI** | Blood Stream Infection |
| **CBF** | Capitation Based Funding |
| **CCDHB** | Capital & Coast District Health Board |
| **CCN** | Clinical Charge Nurse |
| **CCP** | Contribution to cost pressure |
| **CCU** | Coronary Care Unit |
| **CEO** | Chief Executive Officer |
| **CFO** | Chief Financial Officer |
| **CHB** | Central Hawke's Bay |
| **CHS** | Community Health Services |
| **CMA** | Chief Medical Advisor |
| **CME / CNE** | Continuing Medical / Nursing Education |
| **CMO** | Chief Medical Officer |
| **CMS** | Contract Management System |
| **CNO** | Chief Nursing Officer |
| **COO** | Chief Operating Officer |
| **CPHAC** | Community & Public Health Advisory Committee |
| **CPI** | Consumer Price Index |
| **CPO** | Co-ordinated Primary Options |
| **CQAC** | Clinical and Quality Audit Committee (PHO) |
| **CRISP** | Central Region Information System Plan |
| **CSSD** | Central Sterile Supply Department |
| **CTA** | Clinical Training Agency |
| **CWDs** | Case Weighted Discharges |
| **CVD** | Cardiovascular Disease |
| **DHB** | District Health Board |
| **DHBSS** | District Health Boards Shared Services |
| **DNA** | Did Not Attend |
| **DRG** | Diagnostic Related Group |
| **DSAC** | Disability Support Advisory Committee |
| **DSS** | Disability Support Services |
| **DSU** | Day Surgery Unit |
| **ED** | Emergency Department |
| **ECA** | Electronic Clinical Application |

| | |
|---|---|
| **ECG** | Electrocardiograph |
| **EDS** | Electronic Discharge Summary |
| **EMT** | Executive Management Team |
| **EoIs** | Expressions of Interest |
| **ER** | Employment Relations |
| **ESU** | Enrolled Service User |
| **ESPIs** | Elective Service Patient Flow Indicator |
| **FACEM** | Fellow of Australasian College of Emergency Medicine |
| **FAR** | Finance, Audit and Risk Committee (PHO) |
| **FRAC** | Finance, Risk and Audit Committee (HBDHB) |
| **FMIS** | Financial Management Information System |
| **FSA** | First Specialist Assessment |
| **FTE** | Full Time Equivalent |
| **GIS** | Geographical Information System |
| **GL** | General Ledger |
| **GM** | General Manager |
| **GMS** | General Medicine Subsidy |
| **GP** | General Practitioner |
| **GP** | General Practice Leadership Forum (PHO) |
| **GPSI** | General Practitioners with Special Interests |
| **GPSS** | General Practice Support Services |
| **HAC** | Hospital Advisory Committee |
| **H&DC** | Health and Disability Commissioner |
| **HBDHB** | Hawke's Bay District Health Board |
| **HBL** | Health Benefits Limited |
| **HHB** | Health Hawke's Bay |
| **HQSC** | Health Quality & Safety Commission |
| **HOPSI** | Health Older Persons Service Improvement |
| **HP** | Health Promotion |
| **HR** | Human Resources |
| **HS** | Health Services |
| **HWNZ** | Health Workforce New Zealand |
| **IANZ** | International Accreditation New Zealand |
| **ICS** | Integrated Care Services |
| **IDFs** | Inter District Flows |
| **IR** | Industrial Relations |
| **IS** | Information Systems |
| **IT** | Information Technology |
| **IUC** | Integrated Urgent Care |
| **K10** | Kessler 10 questionnaire (MHI assessment tool) |
| **KHW** | Kahungunu Hikoi Whenua |
| **KPI** | Key Performance Indicator |
| **LMC** | Lead Maternity Carer |
| **LTC** | Long Term Conditions |
| **MDO** | Maori Development Organisation |
| **MECA** | Multi Employment Collective Agreement |
| **MHI** | Mental Health Initiative (PHO) |
| **MHS** | Maori Health Service |
| **MOPS** | Maintenance of Professional Standards |
| **MOH** | Ministry of Health |
| **MOSS** | Medical Officer Special Scale |
| **MOU** | Memorandum of Understanding |

| | |
|---|---|
| **MRI** | Magnetic Resonance Imaging |
| **MRB** | Māori Relationship Board |
| **MSD** | Ministry of Social Development |
| **NASC** | Needs Assessment Service Coordination |
| **NCSP** | National Cervical Screening Programme |
| **NGO** | Non Government Organisation |
| **NHB** | National Health Board |
| **NHC** | Napier Health Centre |
| **NHI** | National Health Index |
| **NKII** | Ngati Kahungunu Iwi Inc |
| **NMDS** | National Minimum Dataset |
| **NRT** | Nicotine Replacement Therapy |
| **NZHIS** | NZ Health Information Services |
| **NZNO** | NZ Nurses Organisation |
| **NZPHD** | NZ Public Health and Disability Act 2000 |
| **OPF** | Operational Policy Framework |
| **OPTIONS** | Options Hawke's Bay |
| **ORBS** | Operating Results By Service |
| **ORL** | Otorhinolaryngology (Ear, Nose and Throat) |
| **OSH** | Occupational Safety and Health |
| **PAS** | Performance Appraisal System |
| **PBFF** | Population Based Funding Formula |
| **PCI** | Palliative Care Initiative (PCI) |
| **PDR** | Performance Development Review |
| **PHLG** | Pacific Health Leadership Group |
| **PHO** | Primary Health Organisation |
| **PIB** | Proposal for Inclusion in Budget |
| **P&P** | Planning and Performance |
| **PMS** | Patient Management System |
| **POAC** | Primary Options to Acute Care |
| **POC** | Package of Care |
| **PPC** | Priority Population Committee (PHO) |
| **PPP** | PHO Performance Programme |
| **PSA** | Public Service Association |
| **PSAAP** | PHO Service Agreement Amendment Protocol Group |
| **QHNZ** | Quality Health NZ |
| **QRT** | Quality Review Team |
| **Q&R** | Quality and Risk |
| **RFP** | Request for Proposal |
| **RIS/PACS** | Radiology Information System<br>Picture Archiving and Communication System |
| **RMO** | Resident Medical Officer |
| **RSP** | Regional Service Plan |
| **RTS** | Regional Tertiary Services |
| **SCBU** | Special Care Baby Unit |
| **SLAT** | Service Level Alliance Team |
| **SFIP** | Service and Financial Improvement Programme |
| **SIA** | Services to Improve Access |
| **SMO** | Senior Medical Officer |
| **SNA** | Special Needs Assessment |
| **SSP** | Statement of Service Performance |
| **SOI** | Statement of Intent |

| | |
|---|---|
| **SUR** | Service Utilisation Report |
| **TAS** | Technical Advisory Service |
| **TOR** | Terms of Reference |
| **UCA** | Urgent Care Alliance |
| **WBS** | Work Breakdown Structure |
| **YTD** | Year to Date |