BOARD MEETING

Date: Wednesday, 14 December 2016

Time **12.40pm** **Powhiri** for new Board members Te Wāhanga Hauora (Maori Health), followed by lunch at Corporate Office

Time **1.30pm** **Board Meeting Commences**

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

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

Apologies: -

In Attendance: Dr Kevin Snee, Chief Executive Officer
Members of Executive Management Team
Ana Apatu, Elected Boad Member (commencing December)
Members of the public and media

Board Administrator: Brenda Crene

Public Agenda

Item	Section 1 : Routine	Ref #	Time (pm)
1.	Karakia		1.30
2.	Apologies		
3.	Interests Register		
4.	Minutes of Previous Meeting		
5.	Matters Arising - Review of Actions		
6.	Board Workplan		
7.	Chair's Report - verbal	-	
8.	Chief Executive Officer's Report	143	

9.	Financial Performance Report - Resolution to terminate existing crown loan agreements	144	
10.	Board Health & Safety Champion's Update *(verbal)* - Helen Francis	-	
11.	Consumer Story - Kate Coley	-	
	Section 2: Reports from Committee Chairs		
12.	HB Clinical Council – Co-Chairs Chris McKenna & Dr Mark Peterson		2.20
13.	HB Health Consumer Council - Chair, Graeme Norton		2.30
14.	Pasifika Health Leadership Group - Chair, Caren Rangi - Pasifika Health Dashboard 2014-2018 (six monthly)	145	2.40
	Section 3: For Decision		
15.	Improving Endoscopy Services Construction Contract Approval - Sharon Mason	146	2.55
	Section 4: For Discussion and Information		
16.	Draft Palliative Care in Hawke's Bay 2016-2026 – Mary Wills	147	3.10
17.	Transform and Sustain Programme Refresh – Tracee TeHuia / Kate Rawstron	148	3.25
18.	Transform & Sustain Strategic Dashboard Q1 Jul-Sept 2016 - T TeHuia/ Kate Rawstron	149	3.40
19.	Te Ara Whakawaiora – Healthy Weight – Shari Tidswell	150	3.45
20.	Orthopaedic Review – Closure of Phase 1 – Andy Phillips	151	3.50
21.	Travel Plan Update Paper – Sharon Mason & Andrea Beattie	152	4.00
	Section 5: General Business - Te Matatini 2017 - presentation		4.05
22.	**Section 6: Recommendation to Exclude**		
	Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	Section 7: Agenda Items	Ref #	Time (pm)
23.	Minutes of Previous Meeting		4.15
24.	Matters Arising – Review of Actions		
25.	Board Approval of Actions exceeding limits delegated by CEO	153	
	Section 8: For Decision		
26.	Improving Endoscopy Services Construction Contract Approval (Financials)	154	4.25
	Section 9: For Information and Discussion		
27.	Annual Stocktake of HBDHB Owned and Leased Properties – Sharon Mason	155	4.40
28.	Air Ambulance Services – Ken Foote	156	4.50
29.	Cranford Hospice – Ken Foote	157	4.55
	Section 9: Reports from Committee Chair		
30.	Finance Risk & Audit Committee – Chair, Dan Druzianic	158	5.00
	Followed by Xmas Cheer		

Next Meeting: 1.00 pm, Wednesday 22 February 2017
Te Waiora (Boardroom), HBDHB Corporate Administration Building

Tauwhiro Rāranga te tira He kauanuanu Ākina

Board "Interest Register" - 5 December 2016

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. Unison leases 3 generators which are located at Hawke's Bay Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	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: (i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department. (ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department.	Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB.	The Chair	01.05.08
	Active	Brother of Waiariki Davis	Perceived Conflict of Interest. Non-Pecuniary interest. Waiariki Davis is employed by HBDHB and is the Health Records Manager.	Will not take part in any decisions in relation to Health Records management. All employment matters in relation to Waiariki Davis are the responsibility of the CEO.	The Chair	01.05.08
	Active	Uncle of Tiwai Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Tiwai Tomoana is employed by HBDHB and is a Kitchen Assistant in the Food and Nutrition Department at Hawke's Bay Hospital.	All employment matters in relation to Tiwai Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Uncle of Iralee Tomoana	Iralee Tomoana is employed by HBDHB and works in the Radiology Department as a clerical assistant.	All employment matters in relation to Iralee Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Brother of Numia Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Numia Tomoana is employed by Cranford Hospice and works as a palliative care assistant and, in this role, works with chaplains at Hawke's Bay Hospital.	Will not take part in any decisions in relation to the Chaplain service at Hawke's Bay Hospital.	The Chair	01.05.08
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
Helen Francis	Active	Alzheimer's Napier previously a Committee member 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 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. 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
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

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
	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	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.14
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
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 (aligned to Iron Maori Limited)	The Trust has contracts with HBDHB including the Green Prescription Contract	Will not take part in any discussions or decisions relating to the Contract with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15
	Active	Director of Kahungunu Asset Holding Company Ltd	The asset portfolio of the company in no way relates to health, therefore there is no perceived conflict of interest.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	26.10.16
Peter Dunkerley	Active	Trustee of Hawke's Bay Helicopter Rescue Trust	Actual conflict of interest. The Trust provides helicopter patient transfer services to HBDHB	Will not take part in any decision or discussion in relation to any contract or financial arrangement between HBHRT and HBDHB	The Chair	15.05.14
Ana Apatu	Active	CEO of U-Turn Trust (U Turn is a member of Takitimu Ora Whanau Collective)	Relationship and and may be contractural from time to time	No conflict	The Chair	5.12.16
	Active	Chair of Directions	Relationship and contractual	Potential Conflict as this group has a DHB Contract	The Chair	5.12.16
	Active	Chair, Health Promotion Forum	Relationship	No conflict	The Chair	5.12.16
Hine Flood TBC						5.12.16
						5.12.16
						5.12.16

MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 30 NOVEMBER 2016, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.02PM

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

In Attendance: Kevin Snee (Chief Executive Officer)
Members of the Executive Management Team
Chris McKenna and Mark Peterson (Co-Chairs, HB Clinical Council)
Graeme Norton (Chair, HB Health Consumer Council)
Ana Apatu (newly elected Board member from 5 December 2016)
Members of the public and media

Minutes Brenda Crene

KARAKIA

Ngahiwi Tomoana opened the meeting with a Karakia.

The Chair welcomed members and attendees to this the last meeting of this Board's term.

INTEREST REGISTER

No changes to the interests register was advised and no board member advised of any interest in the items on the Agenda.

CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on 30 November 2016, were confirmed as a correct record of the meeting.

Moved: Dan Druzianic
Seconded: Helen Francis
Carried

MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: **Fracture Clinic / Orthopaedic Dept. near ED** – ongoing, progress being made with the Board looking forward to ongoing updates.

Item 2: **Home Dialysis** - ongoing. A meeting had been arranged to discuss with the person who raised the matter. A renal review was being undertaken which would go to EMT in February 2017 and presentation to the Board in March. A letter to be drafted to Stuart Nash MP advising progress. Action to be removed.

Item 4: **"Laboratory Specimen Labelling"** – commentary had been included in the Clinical Council's Board Report (included with the papers). Action to be removed.

BOARD WORK PLAN

The Board Work Plan was noted.

CHAIR'S REPORT

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

Name	Role	Service	Years of Service	Retired
Kathleen Exley	Registered Nurse	Older Persons & Mental Health	21	24-Oct-16
Lillian Rangi	Kitchen Assistant	Facilities & Operational Support	22+	10-Nov-16
Susan Miles	Caseload Midwife	Oral Rural & Community	21	15-Nov-16
Eileen Mentzer	Registered Nurse	Surgical Directorate	32	29-Nov-16

- Health target reports received for PHO and DHB, relays a disappointing quarter for the DHB as in bottom 3 in half of the indicators. Bottom 6 for 5 of the indicators. Standout performance continues in increased immunisation and HB continue to have problems with low results for smoking in primary care target (in primary care).
- PSEC/Cranford: Advised the PSEC Board had appointed Royden Day as a community representative.
- The Chair had met with Napier Grey Power and will foster this relationship going forward.
- The National District Health Board financials (comparing DHBs) had been released. Whilst HB was a little behind budget we currently sit in the top six DHBs / 20, showing a surplus.

CHIEF EXECUTIVE OFFICER'S REPORT

The CEO provided an overview of his report with the targets taken as read.

In summary

- Performance indicators – finance (forecasting larger surplus than any DHB in the country and using that to invest in infrastructure.
- Concerning performance for the quarter : ED poor for quarter (a lot of work – now see that coming to fruition but ED is in a much better place than in the past – recent assessment on flow have largely sorted ED with downstream issues which are being worked on to sort). Trialling new shifts and senior presence at the front door.

  Expect to be at 95% by end of this quarter December and assume this will continue.
- Elective performance down partly due to Gastro and RMO strike. Expect to be at 100% which will get us to where we said we would be.
- Faster Cancer treatment remains a constant process. Others struggling around the country also. We will get there with a lot of focus.
- Raising healthy kids – doing very well in this area. Seen to be one of the best in the country despite current data issues.
- Comment on time spent with South Central Foundation and hearing about their journey. A lot of things they do, we do here but we don't drive them as hard. Take learning forward and connections made.
- Successful health awards run. Good to see a whole series of people being celebrated for their achievements and the quality of the work is improving.

- The re-launch of "vision and values" occurred at Transform and Sustain recently. The auditorium was full and people were engaged and enthusiastic for change.
- Smoking primary target – In broader sense Kevin advised DHB needs to be more deliberate in dealing with primary care – mediated through the PHO. Now need to have a more direct relationship with Primary care and the practices and that relationship needs to be one of support and of constructive challenge (which is lacking at present). From the time spent with South Central Foundation, they presented us with ways of doing things differently with primary care.
- CMO Primary Care advised that whilst smoking is an important target, the view from general practice (asking whether their patients are smokers) is unlikely to make a change in stopping people smoking. We are now well below the target. In June the target will become far more relevant and relate to those who are "smoke free".

  It was agreed that the PHO needs to do more to assist General Practice in the interim.
- Discussion needed with general practices on how can we drive service integration to a deeper level and develop agreement on how more effectively we can achieve and work closer together to achieve targets.

FINANCIAL PERFORMANCE REPORT

The Financial report for October 2016, showed an adverse variance of $251 thousand for the first four months of the financial year, with a $48k adverse for the month. It was noted this did not reflect a likely adverse variance in Inter District Flow. A brief overview of the report was provided to members.

- Need to focus on IDFs as we have not had issues for some time.
- MoH have indicated to replace debt with equity is imminent. This is a highly technical issue which will be brought back to FRAC in December for better understanding.

HEALTH & SAFETY BOARD CHAMPION'S UPDATE

Helen Francis provided a verbal report summarised as follows:

- Communication of H&S to the Board was being formulated.
- A Governance Guide would be presented shortly to the Board.
- Following contact with other DHBs around H&S reporting to their Boards, it was found Hawke's Bay are in a good position.

CONSUMER STORY

Kate Coley introduced "Health Award" winners for the engAGE Intermediate Care Beds team.

Project background was shared, as was a daughter's story of her elderly mother's referral to the engAGE intermediate care bed service and the wonderful outcome for her Mum and family.

In 9 months just over 100 had utilised the intermediate care bed service. Six individuals had been interviewed who have utilised this service and their stories would be used to encourage others.

Improvements suggested were being worked through and implemented progressively, including the potential to use key persons to be involved throughout the persons stay.

Referral methods to the service were discussed and relayed to board members.

This was a very positive story with congratulations conveyed by the Board on the Award received.

REPORT FROM COMMITTEE CHAIRS

Pasifika Health Leadership Group (PHLG)

A meeting had been held on 21st November and Chair of CPHAC (Barbara Arnott) who attends PHLG meetings provided a brief update.

Several members of the group had resigned and new appointments were being sought for a well-connected individual(s).

As Chair of CPHAC, Barbara Arnott had approved the appointment of Tivaini Fomai. Tivaini is studying towards a degree in sport and recreation and sees the importance of strategies around health. His goal is to work with older people and he would be a welcomed member.

The Board endorsed this appointment.

At the meeting PHLG members discussed investment funding provided (of $200k) and had two options to consider, however invited another option of the Nua Nua Health Group and would discuss this at a workshop the following Monday (5 December). It appeared practical to run the new navigators within a health team already working alongside them.

The other options with the PHO were good, but the barrier could be seen at the point of contact as being the person who makes the decision (ie, the receptionist). We need to get the model right first and then look at KPIs for the navigators around engagement.

The PHLG had been advised Berry Rangi (a Pacific Health Promoter) with the Population Screening team for the last 10 years was retiring. Berry has been instrumental in achieving breast and cervical screening health targets for Pacific. She has been a great support in encouraging women in the community to be screened and will be missed.

Pacific Health Dashboard: Members had reviewed and were pleased with the progress and approach towards achieving health targets. This Dashboard would be provided to the HBDHB Board in December.

Hawke's Bay Clinical Council & Consumer Council Report (combined meeting)

The respective Chairs jointly spoke to the report from the joint Council meeting held 9 November 2016 and included a Workshop on Palliative Care and Advanced Care Planning.

Detail provided in the report relayed what had been endorsed by Council and other papers that had been received for information.

Council received a Laboratory Specimens Labelling Improvement Initiative Update (*an action* from the October Board Meeting). This work remains an ongoing complex issue not only in HB but nationally, especially where multiple tests are requested by several professionals with all results back to their patients GP. Testing is generated from various sources and can be simultaneous ie., aged care facility, GP Practice and Hospital.

A question was asked about the scale of the problem ie, what percentage have issues. Total number of tests undertaken to be identified to provide context but noted that this is a complex issue. **Action**

Reappointment to HB Clinical Council

As the term of tenure for a Senior Nurse became vacant on Council, expressions of interest were sought and David was subsequently confirmed as the preferred candidate.

RECOMMENDATION

That the Board endorse the CEO's approval to reappoint David Warrington for a second term, expiring September 2019.

Carried

Māori Relationship Board (MRB)

Heather Skipworth (Deputy Chair), provided an overview of their meeting held on 9 November 2016 with the report taken as read. She commended Tracy TeHuia for bringing Nuka System of Care presenter to Hawke's Bay. *"South Central Foundation's Nuka System of Care is a name given to the whole health care system created, managed and owned by Alaska Native people to achieve physical, mental, emotional and spiritual wellness."* https://www.southcentralfoundation.com/nuka/

Detail provided in the MRB report included endorsements by MRB of topics/papers presented and others received for information. It was noted also that a presentation had been provided by the Clinical Director of Oral Health on the key facts around Fluoridation.

HBDHB Committee Structure and Meeting Schedule for 2017

RECOMMENDATION

That the Board

1. **Confirm** the current governance committee structures and processes
2. **Approve** the attached Meeting Schedule for 2017.

Carried

Other health governance meetings will now be incorporated into the schedule to provide a full overview.

The Chair noted that MRB will likely meet in its current form until the middle of June 2016 before any change may, or may not occur (following discussions with NKII).

- **Structure and Prioritisation matters:**

Heather Skipworth (MRBs Deputy Chair) felt funding proposals by-pass MRB with Council receiving such proposals.

It was advised that since inception of the Councils notable value had been received with both groups reporting directly to the CEO. The prioritisation (funding) review had been a conscious decision, for matters in clinical areas go through Clinical Council due to their wide technical knowledge across Hawke's Bay.

Funding proposals come from the ground up for EMT review, with the Board making the final decision. The processes for the Clinical Council and MRB review are continually evolving.

FOR DECISION

13-17 Year Old Primary Care Zero Fees Subsidy Project

This has been a targeted equity process (following consultation with GP practices) with a focus on deprivation areas 8, 9 and 10.

Cost is a barrier to accessing GPs in New Zealand with the government funding up to 12 years of age. Originally raised at a HB Health Sector Leadership Forum gathering several years ago, work has progressed for this first of a kind programme in NZ which is estimated to cost HBDHB approximately $583,235 per annum and will cover around 70 percent of the HBDHB 13-17 year old population from Wairoa to Central Hawke's Bay. This ongoing work has received much stakeholder consultation and was unanimously accepted by all Committees considering it on 9 November.

In discussion:

- The implementation plan is nearly ready.
- The outcomes framework will be provided in early 2017.

- Programme Commencement: there would be some training and quality improvements required which may take up to three months. The phase in / implementation period would likely occur in clusters.

Congratulation and thanks were conveyed for the wonderful work undertaken to bring this to the community of Hawke's Bay

RESOLUTION

That HBDHB Board:

1. **Approve** funding Eligible General Practices within the geographical area of Wairoa, Napier, Hastings and CHB to provide zero fees to their 13-17yr old population.
   - Eligible practices include those with high enrolled Māori (84.5%) and Pacific (89.6%) 13-17 year olds; and
   - cover 67.7% of all enrolled 13-17 year olds
   - costs $583,235 ($63,235 over budget)
3. **Approve** the requirement of general practices within programme to make 'youth friendly' changes to the model of primary care;
4. **Approve** the Programme Level Measures;
5. **Endorse** the content of this report and acknowledge that further work is required to develop an implementation plan, outcomes and evaluation framework to reach a go live date of 1 January 2017.

Moved **Heather Skipworth**
Seconded **Denise Eaglesome**
Carried

Position Statement on Reducing Alcohol-Related Harm

There had been unanimous support from the committees for the position statement put forward by Population Health around the reduction of alcohol related harm as a priority issue for our DHB. The position statement also set out the next steps for action. Based on evidence alcohol related harm is a key driver of inequity and harm in our community.

The board were assured that all the building blocks, operational and the governance structures would be in place, noting this work was not being done in isolation but in collaboration with other agencies (including Councils) within HB.

Following discussion the following action was noted prior to the Boards adopting the Recommendation.

Action: **That the Population Health team were to note that advocacy roles on health matters were taken to Councils on a regular basis, however Jacoby Poulain had noted these had dropped off over the past several years and should be reactivated.**

RECOMMENDATION

That the HBDHB Board:

1. Adopt the Position Statement on Reducing Alcohol-related Harm.
2. A progress report was requested in June 2017 with a full update in December 2017

Carried

MONITORING

HBDHB Non-Financial Exceptions Q1 (Jul-Sept 16)

GM PIF provided an overview of the report presented.

The Chair again noted Hawke's Bays MRI scanning performance fell well short, and the Board looked forward to the report from management in February 2017 on this matter. The COO advised this work is ongoing and the focus will be on an appropriate resource if demand cannot be met.

HBDHB Quarterly Performance Monitoring Dashboard Q4 (ex MoH)

- The report provided was noted.

HR KPIs Q1 (Jul-Sept 2016)

Acting GM Human Resources advised the report presented would be reviewed in 2017 as part of work being done nationally which will compare with other DHBs.

In summary:

- Annual leave, those with two years plus had improved and HB were now 2nd best in the country.
- A meeting around reinvigorating Maori representation (as a % staff numbers) had been held to further understand issues to reduce the gap. Need to do things differently to make it more appealing for Maori to apply for advertised positions. Could have a (DVD) trailer produced and include those employees (identifying as Maori) and their experiences in varied roles.
- Ngahiwi advised there was an active recruitment campaign across the sector with other agencies also which was encouraging.

Annual Maori Health Plan, Quarter 1 July – September Dashboard Report

An overview and discussion is summarised below:

- Reporting is being integrated and aligned for ease of understanding from a range of perspectives.
- Debating integrated planning across the central regions ("Trendly" provide for total ownership across the system vs Maori health championing where they could).
- Data issues and validation remains work in progress.
- Those areas highlighted as "red" on the A3 dashboard provided at the meeting was addressed and members were advised that most areas were trending in the right direction. Where there is good leadership, good results follow.
- There is a strong commitment to collaboration. Better collaboration in all areas was highlighted in the Nuka Training undertaken in November. Need to provide more opportunities for time together, however sometimes Maori feel they cannot talk openly without appearing to offend!
- Regarding Mental Health, Maori felt the NGOs lack connection. We need to get around the table and discuss this.
- Maori Workforce Indicator: A midway evaluation of the Turiki programme.(including workforce) had been undertaken and Dr George Gray (for the 20 DHBs). HB were found to be the best on how to recruit with work progressing to further improve.

Te Ara Whakawaiora / Smoke Free & the Regional Tobacco Strategy for HB 2015-2020 Update

The Director of Populaton Health reflected on the reports provided.

Most indicators in the early part are process indicators, and if we get them right we achieve the results. Strategy is more about the outcomes. Are the results improving and where do we need to focus.

- Smoke free pregnancy programme: we do not have the data as yet to see how we are progressing. Tobacco strategy data is obtained from the census and have seen the trend improving.
- Tobacco free retailers, we are not seeing the shift in the number of retailers going tobacco free, no doubt it is more lucrative for their businesses to sell tobacco.
- Unless this moves at a faster pace, achieving smoke free by 2025 will not occur as we need to be more aggressive in the earlier years.
- Tobacco Control Realignment – cessation providers are putting in bids, HBDHB put in for a regional services rather than a National service. Single focused cessation service.

  For the Government to achieve smoke-free in 2025 there needs to be more funding to ensure more focus, especially early on.

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:

24. Confirmation of Minutes of Board Meeting
    - Public Excluded

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

26. Board Approval of Actions exceeding limits delegated by CEO

Reports and Recommendations from Committee Chairs

27. Finance Risk and Audit Committee Report

28. HB Clinical Council Report

Moved: **Dan Druzianic**
Seconded: **Peter Dunkerley**
Carried

The public section of the Board Meeting closed 4.00pm

Signed: _____

Chair

Date: _____

BOARD MEETING - MATTERS ARISING
(Public)

Action No	Date Issue first Entered	Action to be Taken	By Whom	By When	Status
1	31/8/16	**Fracture Clinic / Orthopaedic Dept near ED:** Investigating options and oportunities Progressing with verbal updates to the Board in the interim.	Sharon Mason		Ongoing.
2	30/11/16	**Home Dialysis** presentation to the Board. Letter to Stuart Nash in December.	Sharon Mason	March 2017	Included on the workplan. Actioned.
3	30/11/16	**Positon Statement on Reducing Alcohol-Related Harm** 1. As requested at the meeting, the Board workplan has been updated to include a progress report in June 2017 and a full update in December 2017. 2. Population Health Team to note advocacy roles on health matters appear to have dropped off at Council meetings. Jacoby Poulain suggested these be re-activated.	Admin Caroline McElnay		Actioned
4.	30/11/16	**Specimen Labelling Improvements Initiative:** Identify the total number of transactions that puts the labelling errors into context.	Tim Evans / Ashton Kirk		

HAWKE'S BAY DISTRICT HEALTH BOARD
WORKPLAN

Mtg Date	Papers and Topics	Lead(s)
2017	Consumer Story	Kate Coley
22 Feb	Final Developing a Person Whanau Centred Culture	Kate Coley
	Orthopaedic Review – Phase 2 draft	Andy Phillips
	Review: Fracture Cliniic – Orthopaedic Dept near ED (board action)	Sharon Mason
	MRI Target Achievement (board action)	Sharon Mason / Mark
	Wairoa Strategy (integration)	Sharon Mason
	Palliative Care in HB 2016-2026 Final	Mary Wills
	Social Inclusions Strategy (referred to in REDS)	Kevin Snee
	Final External Audit Report (from Oct)	Tim Evans
	High level budget review presentation	Tim Evans
	Monitoring	
	HBDHB Non-Financial Exceptions Report Q2 Oct-Dec16 plus MoH dashboard	Tim Evans
	Annual Maori Health Plan Q2 Oct-Dec16	Tracee TeHuia
	Transform and Sustain Strategic Dashboard Q2 Oct-Dec 16	Tracee TeHuia
	Human Resource KPIs Q2	GM HR
	Te Ara Whakawaiora / Access (local indicator)	Mark Peterson
15 March	**Proposed HB Health Sector Leadership Forum (Venue TBA)**	
29 March	Consumer Story	Kate Coley
	Pasifika Health Leadership Group	Caroline McElnay
	HBDHB Workforce Plan – Final	GM HR
	Health and Social Care Networks (6 monthly update)	Tracee TeHuia
	Travel Plan Update	Sharon Mason
	Home Dialysis	Sharon Mason
	External Audit Engagement Arrangements	Tim Evans
	Te Ara Whakawaiora / Breastfeeding (national indicator)	TBC (previously Caroline)
	NKII MoU Relationship Review	Tracee TeHuia/Ken Foote
26 Apr	People and Culture Strategy (2016-2021)	GM HR
	Mental Health Consolidation / Benefits Realisation (final) from Oct16	Sharon Mason
	Board H&S responsibilities – agenda item (review 6 monthly)	Ken Foote
	Monitoring	
	Te Ara Whakawaiora / Cardiology (national indicator)	John Gommans

31 May	Best Start Healthy Eating Plan (yearly review)	Caroline McElnay
29 June	Orthopaedic Review closure phase 2 Orthopaedic Review closure phase 3 Draft Equity Update Final Youth Health Strategy Final Suicide Prevention Postevention update against 2016 Plan. Pasifika Health Leadership Group incl Dashboard (6mthly) ***Monitoring*** Te Ara Whakawaiora / Oral Health (national indicator)	Andy Phillips Andy Phillips TBC (previously Caroline) TBC TBC TBC Sharon Mason / Robin W

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** 143
	For the attention of: **HBDHB Board**
Document Owner:	Dr Kevin Snee, Chief Executive Officer
Reviewed by:	Not applicable
Month as at	7 December 2016
Consideration:	For Information

8

Recommendations

That the Board

1. Note the contents of this report.

INTRODUCTION

This month we welcome two new Board members; Ana Apatu, who is well known to us as a former member of staff and Hine Flood who is also a local councillor from Wairoa. Our board papers focus on a range of important issues including addressing healthy weight, orthopaedic services, palliative care, endoscopy services and travelling to and from our facilities. As we head into the Christmas period we can see that our services are in good shape. We can look forward to an exciting year as we commence the development of our clinical services plan and push forward the development of community services integrated with primary care.

PERFORMANCE

Measure / Indicator	Target	Month of November	Qtr to end November	Trend For Qtr
Shorter stays in ED	≥95%	94.8%	94.7%	▲
Improved access to Elective Surgery (2016/17YTD)	100%	-	96.7%	▲
Faster cancer treatment*	≥85%	57.1% (October 2016)	62.4% (6m to October 2016)	▼
Increased immunisation at 8 months (3 months to end of October)	≥95%	---	95.8%	▲
Better help for smokers to quit – Primary Care	≥90%	81.4% (As at October, 2016)	---	▲
Better help for smokers to quit – Maternity	≥90%	91.2% (Quarter 1, 2016/17)	---	▲

Waiting list	*Less than 3 months*	*3-4 months*	*4+ months*
First Specialist Assessments (ESPI-2)	2,800	406	7
Patients given commitment to treat, but not yet treated (ESPI-5)	973	115	28

Measure / Indicator	Target	Month of November	Qtr to end November	Trend For Qtr
Raising healthy kids (New)	≥95%	27% (Quarter 1 2016/17)	---	
Financial – month (in thousands of dollars)	$ (1,103)	$ (1,087)	---	---
Financial – year to date (in thousands of dollars)	$ 3,467	$ 3,232	---	---

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

Faster Cancer Treatment Expected Volumes v Actual	*Target*	*Month Actual / Expected*	*Rolling 6m Actual / Expected*
	100%	*21/19 = 111%*	*133/114 = 116.7%*

Note: The Ministry of Health expectation for the number of people expected to be identified as high suspicion has been increased from 11.4 to 19 a month.

Performance this month shows contiued improvement in the emergency department (ED) six hour target as we anticipated. Elective activity remains below what we would want but is on an improving trend.

Immunisation performance remains strong and our smoking cessation performance is good in relation to pregnant women and the target for PHO enrolled patients.

Work in the first quarter focused on clarifying the Raising Healthy Kids target and establishing systems to support the work towards meeting the target. It is expected the result will improve significantly in the next quarter.

The financial result for the month of November is is a favourable variance of $16 thousand making a year-to-date adverse variance of $235 thousand.

CONSUMER STORY
This month we will be releasing the results from the first quarter of the 2016/17 national impatient experience survey - including themes and quotes from consumers.

PASIFIKA HEALTH DASHBOARD
A six-monthly Pasifika dashboard was adopted by the Board earlier this year and a report on performance for the period January-June 2016 is on today's agenda.

The dashboard reflects that Pacific health performs well in certain areas but there are obvious areas that need improving, such as children's oral health. This information is being used to develop action plans across health services, as well as inform the priorities and performance indicators for the Pacific Health Navigators who will be contracted during 2017. These Navigators will work alongside a Pacific Health Promoter who will be working in five Pacific community groups. These groups are being supported to develop health committees and shape action plans towards better health and wellbeing. This Pasifika service model is currently being discussed and developed by the Pasifika Health Leadership Group ready for implementation in 2017.

IMPROVING ENDOSCOPY SERVICES CONSTRUCTION CONTRACT APPROVAL
The purpose of this paper is to gain approval from the Board to appoint a contractor for the construction of the Endoscopy Services Facility. Tenders have been received and evaluated and management now seeks approval from the Board for the letting of the construction contract to the nominated contractor, with completion scheduled for May 2018.

PALLIATIVE CARE IN HAWKE'S BAY
The draft palliative care plan has been developed with a combined clinical steering group involving primary and specialist palliative care. The plan is being circulated for feedback. Workshops are planned with key stakeholders and the community. We will hold community meetings in Central Hawke's Bay and Wairoa, meet with general practitioners with an interest in palliative care and the palliative care stakeholder group. The feedback will shape the resulting work programme and where action will be led from.

TRANSFORM AND SUSTAIN PROGRAMME REFRESH
The purpose of the Transform and Sustain Programme Refresh paper is to gain Board approval of the workplan for the second half of the Transform and Sustain Programme. A total of 19 new strategic projects have been identified and included in the workplan and are the result of an extension process of gap analysis, consultation and validation across a wide range of key stakeholders and forums. The 19 new projects have been grouped into six delivery work streams, each with a nominated Senior Responsible Owner and EMT Clinical Partner. The EMT Clinical Partner role is a new role which has been established to ensure there is strong clinical partnering within the work stream management structure.

TE ARA WHAKAWAIORA / HEALTHY WEIGHT
The Board has recognised the importance of childhood healthy weight and endorsed the Best Start: Health Eating and Activity Plan earlier this year. In July 2016 the Ministry of Health established a new Raising Healthy Kids target. This target is included in the Maori Health Annual Plan and Te Ara Whakawaiora reporting. This report defines the target and provides the nationally reported data. Over time the Board will be able to monitor decreases in numbers of children over the 98th weight percentile, indicating an increase in healthy weight children. Also, the number of children/whanau receiving nutrition, activity and lifestyle interventions will indicate the level of support provided. As with all new data, a clear picture will take time; the Ministry of Health expects this by quarter three.

ORTHOPAEDIC REVIEW – CLOSURE OF PHASE 1
The first phase of our work to review and fundamentally redesign our musculoskeletal and orthopaedic services to meet the needs of people in our community has been completed. The DHB had previously had many concerns expressed by people in our community living with pain and disability. Investigatory work demonstrated the lack of threshold setting for surgical candidature and inconsistencies with prioritisation between surgeons, and delays experienced by patients along the pathway from referral to surgery. These concerns were focussed on hip and knee conditions joints but public feedback, staff concerns and workforce planning also highlighted the back, spine and acute orthopaedic pathways as other areas for review and redesign.

The first phase, now complete, involved increasing surgical capacity and making conservative treatment options available. We have invested in providing non-surgical treatment options by increasing physiotherapy and other allied health resource, put in place a new pathway to successfully treat people with physiotherapy to reduce back pain and improve mobility, improved patient communication and collaborative services across the system, reduced wait times throughout the pathway, set equitable thresholds for surgery and invested in an additional orthopaedic surgeon. It is of note that the newly appointed Orthopaedic Senior Medical Officer identifies as Maori.

TRAVEL PLAN
Board members will receive an update on progress with the DHB's Travel Plan. This will outline the bus services, parking management controls, parking improvements and support for cycling that is now in place.

ANNUAL STOCKTAKE OF HBDHB OWNED AND LEASED PROPERTIES
An annual stocktake of properties has been requested. The purpose of this paper is to review the portfolio and identify recommendations and confirm decisions around retaining or disposing of HBDHB owned properties. It also provides an opportunity to review the leased property register. It has been recommended to continue with the disposal of the two former mental health recovery centres as there is no strategic value in holding these properties for the provision of health care services.

We have also received the Minister of Health's agreement to revoke the Ministerial approval to dispose of the property at 307 Omahu Road, Hastings (appendix 1).

CONCLUSION

Whilst we have achieved a lot in 2016 and there is an exciting year ahead, we cannot be complacent about our performance. We have performed below the high standards we have set in some areas in the first quarter, including our finances where we have performed below our expectation in the first half of this financial year. We are putting in place measures to ensure that we deliver our key targets in the remainder of the year.

Appendix 1

8.1

Office of Hon Dr Jonathan Coleman

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

07 DEC 2016

Dr Kevin Snee
Chief Executive Officer
Hawke's Bay District Health Board
Corporate Office
Private Bag 9014
HASTINGS

Dear Dr Snee

Application to Revoke Minister's consent to Dispose of Property at 307 Omahu Road, Hastings

On 21 September 2016 you wrote to the Ministry of Health seeking agreement from the Minister of Health to revoke the approval dated 19 June 2014 to dispose of the property situated at 307 Omahu Road, Hastings [legal description Lot 2 DP 26944 refers] as the DHB wishes to retain the property.

I agree to revoke the Ministerial approval to dispose of 307 Omahu Road, Hastings that had been provided pursuant to clause 43 of Schedule 3 of the New Zealand Public Health and Disability Act 2000 (the Act).

If in the future, the DHB subsequently decides this property is no longer required by the DHB, the DHB will be required to re-seek the necessary Ministerial approvals under the Act.

This letter must be tabled as soon as practicable at a Board meeting pursuant to clause 43(7) of Schedule 3 of the Act.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report, November 2016** 144
	For the attention of: **HBDHB Board and the Finance Risk and Audit Committee (FRAC)**
Document Owner: Document Author(s):	Tim Evans, GM Planning, Informatics & Finance Finance Team
Reviewed by:	Executive Management Team
Month:	December 2016
Consideration:	For Information

9

RECOMMENDATION

That the Board
Note the contents of this report

1. **Agree** to the termination of the loan agreement as outlined in the Minister's letter of 10 November 2016 (See discussion on the debt to equity swap below).

1. GM Planning Informatics & Finance comments

Financial performance

The result for the month of November is a favourable variance of $16 thousand making a year to date adverse variance of $235 thousand. Inter District Flows have been fully recognised and contingency to date has been fully utilised to mitigate and achieve this position.

2. Resource Overview

	November				Year to Date				Year End Forecast	Refer Section
	Actual	Budget	Variance		Actual	Budget	Variance			
	$'000	$'000	$'000	%	$'000	$'000	$'000	%	$'000	
Net Result - surplus/(deficit)	(1,087)	(1,103)	16	1.5%	3,232	3,467	(235)	-6.8%	5,000	3
Contingency utilised	1,250	250	(1,000)	-400.0%	1,250	1,250	-	0.0%	3,000	8
Quality and financial improvement	899	1,084	(185)	-17.1%	3,560	5,417	(1,857)	-34.3%	10,200	11
Capital spend	963	1,753	(790)	-45.0%	3,865	8,765	(4,899)	-55.9%	22,042	16
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,207	2,267	60	2.7%	2,192	2,196	4	0.2%	2,206	5 & 7
	CWD	CWD	CWD	%	CWD	CWD	CWD	%	CWD	
Case weighted discharges	2,754	2,447	307	12.5%	13,056	12,285	771	6.3%	27,609	5

The adverse Inter District Flow (IDF) signalled last month has been recognised making the unfavourable variance $1.4 million year to date. The contingency "earned" pro-rata to date of $1.25 million has been used to offset this high IDF pressure. Further work is being undertaken to understand and, where possible, mitigate the high IDF cost.

The $1.8 million increase, partly offset by reduced pharmaceutical and In-between-travel costs, requires the release of $1.25 million of the contingency. See Section 8 – Reserves for a reconciliation of the contingency and revenue banking.

Capital continues behind plan. A number of projects have not started at the estimated times projected in the capital plan, and the major radiology equipment purchases have been delayed into future years.

The FTE variance year to date reflects offsetting factors including high patient volume in some areas, efficiencies not yet achieved, unbudgeted leave cover including long term sick leave, and cover for employees undergoing training.

Case weighted discharges (CWD) reflect high acute volumes year to date, including gastroenterology, general medicine, and paediatrics. Elective CWDs are lower than plan especially in orthopaedics and vascular surgery.

Debt to Equity Swap

A review of the health capital funding system has concluded that access to Crown lending does not send the right signals to the sector, and does not address the recurring costs of major redevelopments.

Consequently from 15 February 2017 DHBs will no longer access Crown debt financing for funding of capital investment. Instead the Crown's contribution to DHB capital investment will be funded via Crown Equity injections. In addition to the change in funding mechanisms, on 15 February the existing Crown loans held by DHBs will be converted into equity.

The new regime will be cost neutral for at least the first two years, as each DHB will be funded for the difference between the additional capital charge cost, and the interest cost that otherwise would have been incurred. After two years the funding regime will be reviewed, and may possibly be incorporated into population based funding. If that is the case, the impact on HBDHB is more likely to be positive than negative until major redevelopment projects begin.

It is the Minister's expectation that HBDHB will agree to termination of the loan agreement by 16 December 2016.

3. Financial Performance Summary

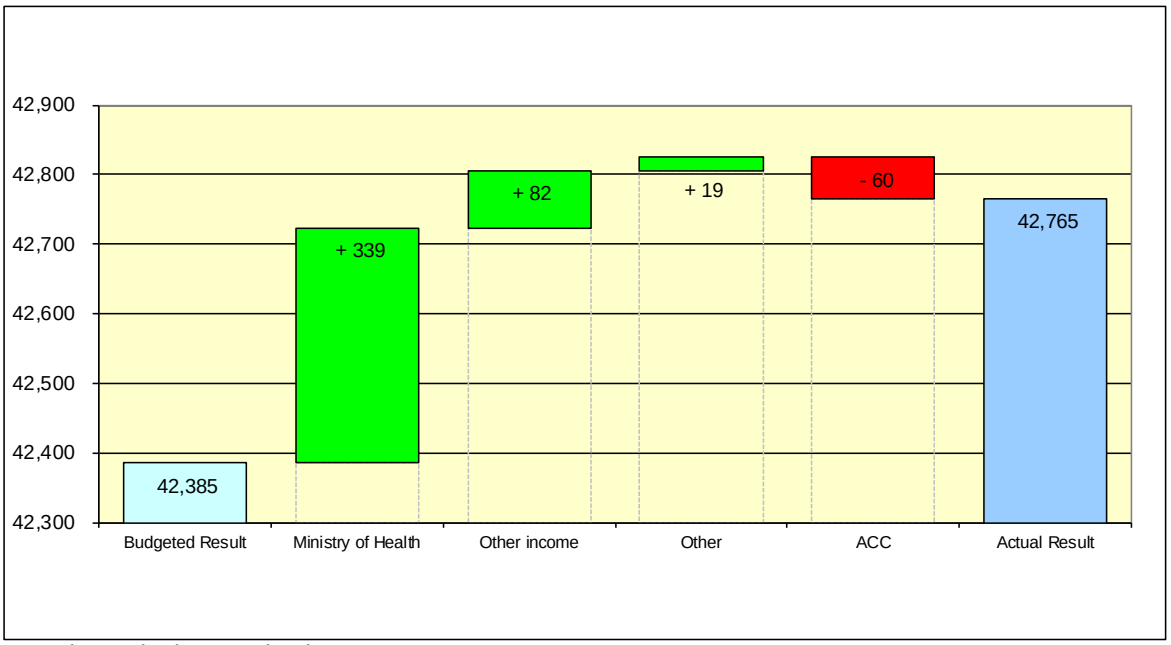
$'000	November				Year to Date				Year End Forecast	Refer Section
	Actual	Budget	Variance		Actual	Budget	Variance			
Income	42,765	42,385	380	0.9%	219,272	218,036	1,237	-0.6%	532,762	4
Less:										
Providing Health Services	21,584	21,113	(472)	-2.2%	103,004	100,740	(2,264)	-2.2%	246,134	5
Funding Other Providers	20,176	18,737	**(1,439)**	**-7.7%**	95,585	94,752	(833)	-0.9%	227,783	6
Corporate Services	3,251	3,504	**254**	**7.2%**	18,507	18,296	(211)	-1.2%	48,642	7
Reserves	(1,159)	134	**1,293**	**965.8%**	(1,056)	780	**1,836**	**235.4%**	5,203	8
	(1,087)	**(1,103)**	16	-1.5%	**3,232**	**3,467**	**(235)**	**-6.8%**	**5,000**	

November income includes high cost treatment and in-between-travel funding mostly offset in expenditure. Non achievement of efficiencies drives the Providing Health Services result. Adverse IDF provisioning in funding other providers is mostly offset by the release of contingency on the reserves line.

4. Income

$'000	November				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Ministry of Health	40,713	40,374	339	0.8%	209,300	207,812	1,488	0.7%	508,251
Inter District Flows	630	629	1	0.1%	3,311	3,144	167	5.3%	7,545
Other District Health Boards	358	334	24	7.3%	1,521	1,668	(147)	-8.8%	4,004
Financing	97	80	17	21.5%	351	374	(23)	-6.2%	885
ACC	433	493	(60)	-12.1%	2,288	2,496	(208)	-8.3%	5,980
Other Government	(9)	18	(27)	-152.4%	132	197	(65)	-33.1%	444
Patient and Consumer Sourced	125	121	4	3.0%	455	603	(148)	-24.5%	1,447
Other Income	419	337	82	24.3%	1,925	1,677	248	14.8%	4,140
Abnormals	-	0	(0)	-100.0%	(10)	66	(76)	-115.8%	67
	42,765	**42,385**	380	0.9%	**219,272**	**218,036**	1,237	0.6%	**532,762**

November Income



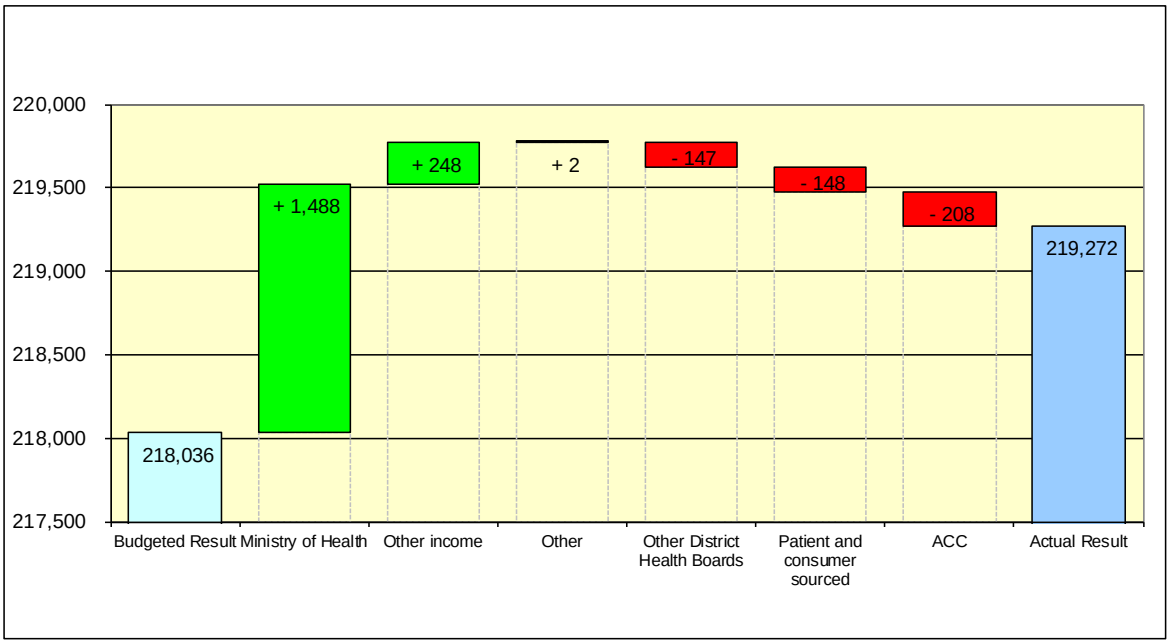
Note the scale does not begin at zero

Ministry of Health (favourable)
High cost treatment income and in-between-travel revenue.

Other Income (favourable)
Training courses and rent.

ACC (unfavourable)
Lower ACC rehabilitation volumes due to lower demand.

November YTD



Ministry Of Health (favourable)
High cost patient income, child development and in-between-travel funding.

Other income (favourable)
Unbudgeted donations and clinical trial income, and a wide variety of sundry income.

Other District Health Boards (unfavourable)
Lower than budgeted cancer drug sales to Tairawhiti DHB, marginally offset by patient transport recoveries from a number of DHBs.

Patient and Consumer Sourced (unfavourable)
Lower than budgeted non-resident, audiology and NASC recoveries.

ACC (unfavourable)
Lower ACC rehabilitation income due to lower demand. Lower ACC elective volumes due to capacity constraints.

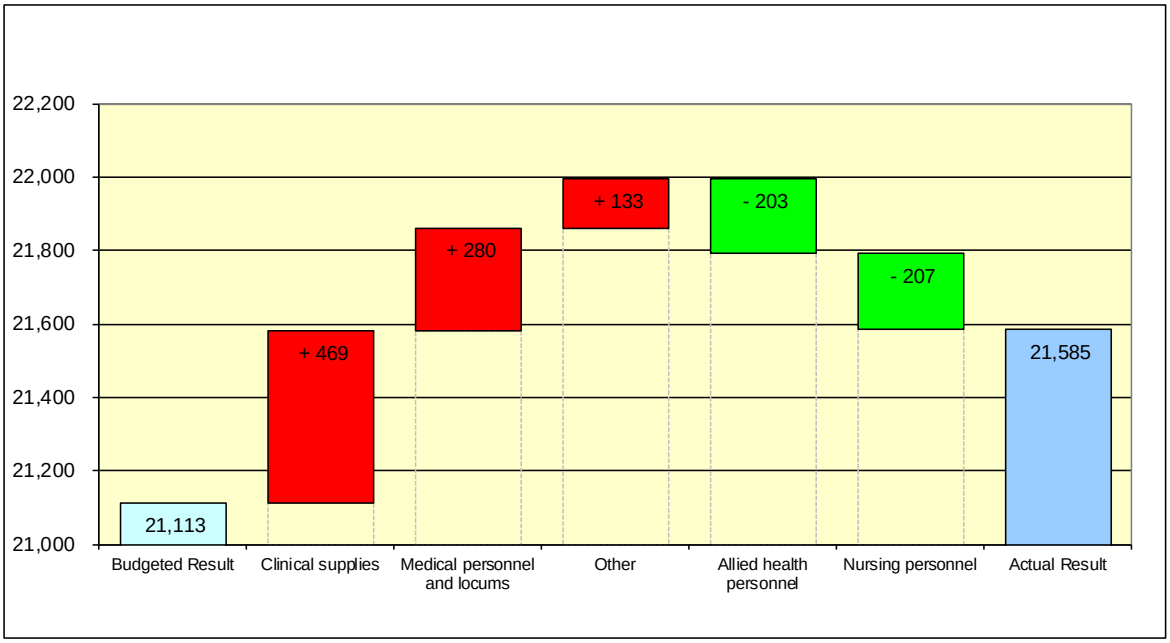
5. Providing Health Services

	November				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure by type $'000									
Medical personnel and locums	5,029	4,749	(280)	-5.9%	22,920	23,021	101	0.4%	58,566
Nursing personnel	6,430	6,637	207	3.1%	30,166	29,862	(303)	-1.0%	72,861
Allied health personnel	2,690	2,892	203	7.0%	13,297	13,871	574	4.1%	33,350
Other personnel	1,681	1,747	66	3.8%	8,927	8,666	(261)	-3.0%	20,830
Outsourced services	940	838	(101)	-12.1%	3,811	3,633	(177)	-4.9%	8,275
Clinical supplies	3,127	2,658	(469)	-17.6%	15,354	13,551	(1,803)	-13.3%	32,933
Infrastructure and non clinical	1,688	1,591	(97)	-6.1%	8,529	8,134	(395)	-4.9%	19,359
	21,584	**21,113**	(472)	-2.2%	**103,004**	**100,740**	(2,264)	-2.2%	**246,172**
Expenditure by directorate $'000									
Medical	5,750	5,650	(101)	-1.8%	27,503	26,374	(1,129)	-4.3%	65,121
Surgical	4,795	4,692	(103)	-2.2%	22,990	22,171	(819)	-3.7%	54,223
Community, Women and Children	3,818	3,851	33	0.8%	17,832	17,367	(465)	-2.7%	42,198
Older Persons, Options HB, Menta	2,923	2,847	(76)	-2.7%	13,791	13,600	(191)	-1.4%	33,269
Operations	2,887	2,997	110	3.7%	14,576	14,584	8	0.1%	35,123
Other	1,410	1,075	(335)	-31.2%	6,312	6,644	333	5.0%	16,239
	21,584	**21,113**	(472)	-2.2%	**103,004**	**100,740**	(2,264)	-2.2%	**246,172**
Full Time Equivalents									
Medical personnel	289.6	323.8	34	10.6%	302	308	6	2.0%	315.5
Nursing personnel	916.3	915.5	(1)	-0.1%	898	884	(14)	-1.6%	891.8
Allied health personnel	442.1	464.4	22	4.8%	435	453	18	4.0%	452.7
Support personnel	131.7	131.6	(0)	-0.1%	131	127	(4)	-3.1%	127.5
Management and administration	257.2	253.1	(4)	-1.6%	255	246	(9)	-3.5%	245.1
	2,036.9	**2,088.4**	52	2.5%	**2,022**	**2,020**	(3)	-0.1%	**2,032.6**
Case Weighted Discharges									
Acute	1,874	1,588	286	18.0%	9,202	8,378	824	9.8%	18,713
Elective	626	640	(15)	-2.3%	2,699	2,868	(170)	-5.9%	6,451
Maternity	191	180	10	5.8%	881	851	30	3.5%	2,000
IDF Inflows	63	38	25	66.4%	275	187	87	46.5%	445
	2,754	**2,447**	307	12.5%	**13,056**	**12,285**	771	6.3%	**27,609**

Directorates

- Medical includes vacancy and leave cover for medical staff, efficiencies not achieved, gastrointestinal pharmaceuticals and biologics, and ED nursing personnel.
- Surgical is efficiencies not achieved.
- Community, Women and Children is mostly efficiencies not achieved.

November Expenditure



Note the scale does not begin at zero

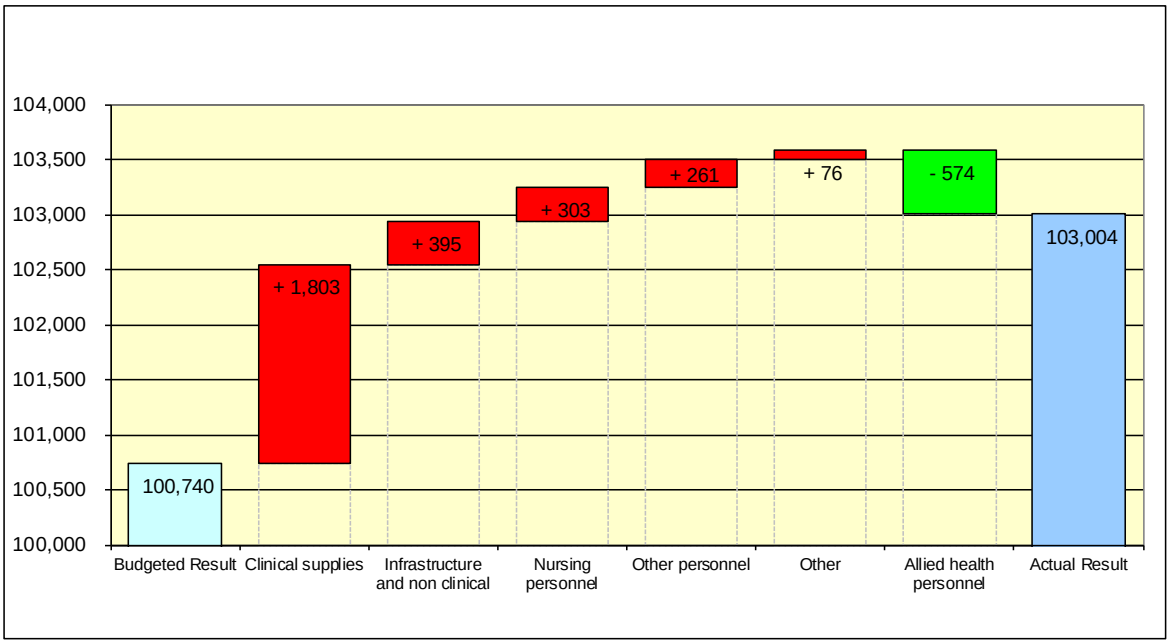
Clinical supplies (unfavourable)
Efficiencies not achieved and biologic drug costs.

Medical personnel and locums (unfavourable)
SMO locum costs for vacancy and leave cover. The associated medical personnel cost reductions are offset by unbudgeted positions.

Allied health personnel (favourable)
Vacancies.

Nursing personnel (favourable)
Lower leave provisioning offset unfavourable overtime, payments to retiring staff and higher duties allowances.

November YTD Expenditure



Clinical supplies (unfavourable)
Efficiencies not yet achieved.

Infrastructure and non-clinical (unfavourable)
Mental health efficiencies to be achieved elsewhere, hostel renovations in Wairoa, maintenance costs.

Nursing personnel (unfavourable)
Overtime, higher duties allowances and termination payments, and extra staffing (mainly in July).

Other personnel (unfavourable)
Payments to retiring staff, administration efficiencies not being achieved, and sick leave, long service leave and training costs.

Allied Health personnel (favourable)
Mental health vacancies including community staff, pharmacists, psychologists and community support.

Full time equivalents (FTE)

FTEs are 3 unfavourable year to date including:

Management and administration personnel (9 FTE 3.5% unfavourable)

- Minimal leave cover not coping with high workloads and long term sick leave. Hours related retirement payments.

Support personnel (4 FTE / 3.1% unfavourable)

- Leave cover, long term sick leave, and training, mainly impacting on orderlies and kitchen assistants.

Nursing personnel (14 FTE / 1.6% unfavourable)

- Higher than budgeted staffing in certain areas including: ED, rural and community services, A1 and B2 medical wards, and Ata Rangi, partly offset by the low use of the surgical overflow ward.

mostly offset by:

Allied Health Personnel (18 FTE / 4.0% favourable)

- Vacancies mainly in psychologists and social workers, community support, pharmacists and pharmacy technicians, and MRTs

Medical FTEs are 10.6% favourable for the month (34 FTEs) mainly comprising budget adjustments in November equivalent to 18 FTEs to remove distortions to RMO numbers. Otherwise RMOs were 8 FTEs favourable to budget mainly in ED, and SMOs are also 8 FTEs favourable mainly in anaesthetist vacancies that are offset by outsource costs.

MONTHLY ELECTIVE HEALTH TARGET REPORT
YTD To November 2016

Plan for 2016/17	On-Site	Outsourced	IDF Outflow	TOTAL
Non Surgical - Arranged	70		0	**70**
Non Surgical - Elective	187		0	**187**
Surgical - Arranged	390		307	**697**
Surgical - Elective	5,003	788	629	**6,420**
TOTAL	**5,650**	**788**	**936**	**7,374**

		YTD November 2016			
		Actual	Plan	Var.	%Var.
On-Site	Avastins	87	87	0	0.0%
	ENT	212	247	-35	-14.2%
	General Surgery	350	387	-37	-9.6%
	Gynaecology	244	218	26	11.9%
	Maxillo-Facial	73	79	-6	-7.6%
	Ophthalmology	398	461	-63	-13.7%
	Orthopaedics	342	383	-41	-10.7%
	Skin Lesions	78	78	0	0.0%
	Urology	210	187	23	12.3%
	Vascular	80	59	21	35.6%
	Surgical - Arranged	236	201	35	17.4%
	Non Surgical - Elective	29	82	-53	-64.6%
	Non Surgical - Arranged	9	28	-19	-67.9%
On-Site	**Total**	**2348**	**2497**	**-149**	**-6.0%**
Outsourced	Cardiothoracic	0	20	-20	-100.0%
	ENT	85	61	24	39.3%
	General Surgery	111	114	-3	-2.6%
	Gynaecology	10	15	-5	-33.3%
	Maxillo-Facial	13	30	-17	-56.7%
	Neurosurgery	0	8	-8	-100.0%
	Ophthalmology	76	17	59	347.1%
	Orthopaedics	30	42	-12	-28.6%
	Paediatric Surgery	0	2	-2	-100.0%
	Skin Lesions	1	0	0	0.0%
	Urology	41	34	7	20.6%
	Vascular	10	19	-9	-47.4%
	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**	**377**	**362**	**15**	**4.1%**
IDF Outflow	Cardiothoracic	32	32	0	0.0%
	ENT	12	19	-7	-36.8%
	General Surgery	15	20	-5	-25.0%
	Gynaecology	18	10	8	80.0%
	Maxillo-Facial	71	83	-12	-14.5%
	Neurosurgery	34	17	17	100.0%
	Ophthalmology	12	13	-1	-7.7%
	Orthopaedics	12	8	4	50.0%
	Paediatric Surgery	27	21	6	28.6%
	Skin Lesions	20	31	-11	-35.5%
	Urology	9	2	7	350.0%
	Vascular	6	6	0	0.0%
	Surgical - Arranged	75	124	-49	-39.5%
	Non Surgical - Elective	49	0	49	0.0%
	Non Surgical - Arranged	22	0	22	0.0%
IDF Outflow	**Total**	**414**	**386**	**28**	**7.3%**
TOTAL		**3139**	**3245**	**-106**	**-3.3%**

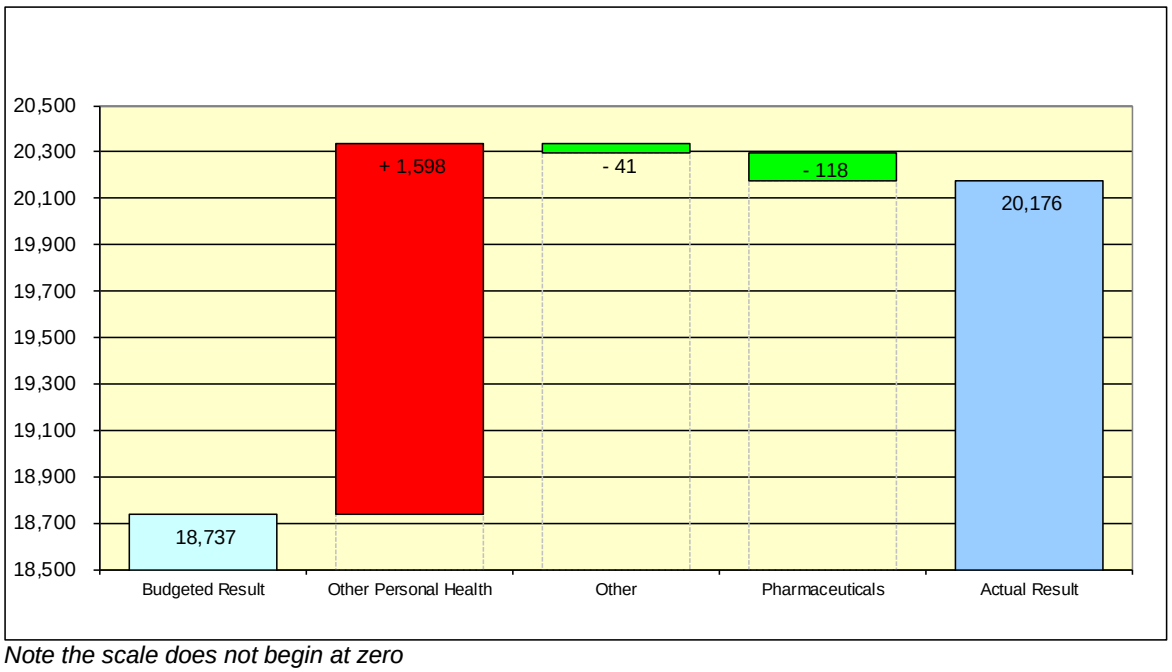
		Nov-16			
		Actual	Plan	Var.	%Var.
On-Site	Avastins	19	19	0	0.0%
	ENT	43	52	-9	-17.3%
	General Surgery	83	82	1	1.2%
	Gynaecology	33	46	-13	-28.3%
	Maxillo-Facial	13	16	-3	-18.8%
	Ophthalmology	110	99	11	11.1%
	Orthopaedics	71	80	-9	-11.3%
	Skin Lesions	18	18	0	0.0%
	Urology	49	40	9	22.5%
	Vascular	18	12	6	50.0%
	Surgical - Arranged	54	38	16	42.1%
	Non Surgical - Elective	2	18	-16	-88.9%
	Non Surgical - Arranged	0	5	-5	-100.0%
On-Site	**Total**	**513**	**525**	**-12**	**-2.3%**
Outsourced	Cardiothoracic	0	5	-5	-100.0%
	ENT	16	15	1	6.7%
	General Surgery	27	27	0	0.0%
	Gynaecology	0	5	-5	-100.0%
	Maxillo-Facial	3	9	-6	-66.7%
	Neurosurgery	0	2	-2	-100.0%
	Ophthalmology	32	5	27	540.0%
	Orthopaedics	15	12	3	25.0%
	Paediatric Surgery	0	0	0	0.0%
	Skin Lesions	1	0		
	Urology	7	8	-1	-12.5%
	Vascular	0	5	-5	-100.0%
	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**	**101**	**93**	**8**	**8.6%**
IDF Outflow	Cardiothoracic	8	7	1	14.3%
	ENT	0	4	-4	-100.0%
	General Surgery	2	4	-2	-50.0%
	Gynaecology	3	2	1	50.0%
	Maxillo-Facial	5	17	-12	-70.6%
	Neurosurgery	4	3	1	33.3%
	Ophthalmology	3	3	0	0.0%
	Orthopaedics	1	2	-1	-50.0%
	Paediatric Surgery	4	5	-1	-20.0%
	Skin Lesions	1	6	-5	-83.3%
	Urology	1	0	1	0.0%
	Vascular	2	1	1	100.0%
	Surgical - Arranged	8	25	-17	-68.0%
	Non Surgical - Elective	6	0	6	0.0%
	Non Surgical - Arranged	3	0	3	0.0%
IDF Outflow	**Total**	**51**	**79**	**-28**	**-35.4%**
TOTAL		**665**	**697**	**-32**	**-4.6%**

Please Note: This report was run on 6th December 2016. Skin Lesions and Avastins have been adjusted to plan. The data is subject to change.

6. Funding Other Providers

$'000	November Actual	November Budget	November Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Payments to Other Providers									
Pharmaceuticals	3,585	3,703	118	3.2%	18,328	18,582	254	1.4%	43,351
Primary Health Organisations	2,874	2,859	(15)	-0.5%	14,332	14,514	182	1.3%	35,401
Inter District Flows	3,784	3,776	(8)	-0.2%	19,098	18,882	(216)	-1.1%	45,317
Other Personal Health	3,316	1,717	**(1,598)**	**-93.1%**	11,390	9,021	**(2,369)**	**-26.3%**	22,636
Mental Health	1,173	1,148	(26)	-2.2%	5,487	5,722	235	4.1%	13,761
Health of Older People	5,062	5,159	97	1.9%	24,983	25,794	811	3.1%	61,928
Other Funding Payments	382	375	(7)	-2.0%	1,967	2,237	**270**	**12.1%**	5,389
	20,176	18,737	**(1,439)**	**-7.7%**	**95,585**	**94,752**	(833)	-0.9%	227,783
Payments by Portfolio									
Strategic Services									
Secondary Care	5,577	3,898	**(1,679)**	**-43.1%**	21,869	19,490	**(2,379)**	**-12.2%**	46,778
Primary Care	7,623	7,755	132	1.7%	39,146	39,382	236	0.6%	94,669
Mental Health	1,173	1,131	(43)	-3.8%	5,622	5,654	32	0.6%	13,574
Health of Older People	5,103	5,215	112	2.1%	25,281	26,056	775	3.0%	62,582
Other Health Funding	98	89	(10)	-10.8%	332	443	**111**	**25.0%**	1,063
Maori Health	460	458	(2)	-0.4%	2,333	2,588	**255**	**9.9%**	6,233
Population Health									
Women, Child and Youth	108	105	(3)	-3.1%	557	627	**69**	**11.1%**	1,669
Population Health	33	87	54	62.4%	445	513	68	13.3%	1,215
	20,176	18,737	**(1,439)**	**-7.7%**	**95,585**	**94,752**	(833)	-0.9%	227,783

November Expenditure

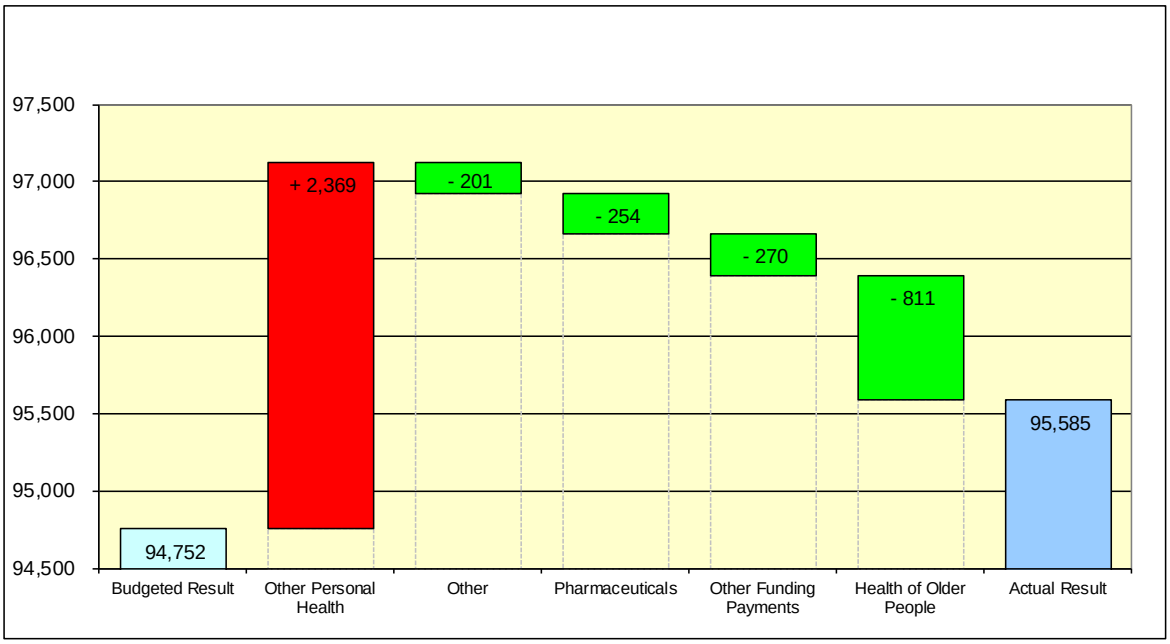


Note the scale does not begin at zero

Other Personal Health (unfavourable)
2016/17 IDF wash-up provisioning of $763 thousand, and high cost treatment costs.

Pharmaceuticals (unfavourable)
Volatile demand driven expenditure.

November YTD Expenditure



Other Personal Health (unfavourable)
High cost patient treatment, and IDF wash-up provisions for 2016/17.

Pharmaceuticals (favourable)
Volatile demand driven expenditure.

Other Funding Payments (favourable)
Lower costs in Māori primary health

Health of Older People (favourable)
Lower residential care costs partly offset by higher home support.

7. Corporate Services

$'000	November Actual	November Budget	November Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Operating Expenditure									
Personnel	1,299	1,384	85	6.2%	6,922	6,464	(459)	-7.1%	15,356
Outsourced services	54	94	40	42.3%	505	470	(35)	-7.4%	1,092
Clinical supplies	11	9	(1)	-15.4%	59	47	(12)	-24.8%	114
Infrastructure and non clinical	608	706	98	13.9%	4,516	4,790	274	5.7%	8,956
	1,972	2,193	221	10.1%	12,002	11,771	(231)	-2.0%	25,518
Capital servicing									
Depreciation and amortisation	1,121	1,144	24	2.1%	5,688	5,702	14	0.3%	13,887
Financing	158	167	8	5.1%	817	822	5	0.6%	2,052
Capital charge	-	-	-	0.0%	-	-	-	0.0%	7,186
	1,279	1,311	32	2.5%	6,505	6,525	20	0.3%	23,125
	3,251	**3,504**	254	7.2%	**18,507**	**18,296**	(211)	-1.2%	**48,642**
Full Time Equivalents									
Medical personnel	0.3	0.3	0	13.6%	0	0	(0)	-56.4%	0.3
Nursing personnel	12.3	15.7	3	21.8%	12	16	3	21.0%	14.9
Allied health personnel	0.5	3.5	3	86.4%	0	4	4	89.3%	3.2
Support personnel	9.6	9.6	(0)	-0.2%	10	9	(0)	-0.5%	9.4
Management and administration	147.8	150.0	2	1.5%	147	147	(0)	-0.1%	146.0
	170.4	**179.1**	9	4.8%	**170**	**177**	7	3.8%	**173.8**

Health Workforce NZ funded clinical training is behind budget and offsets the cost of strike cover for November. This favourable variance is offset in income where the revenue from HWNZ is treated as income in advance i.e. not earned until the expense is incurred.

8. Reserves

$'000	November Actual	November Budget	November Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Expenditure									
Contingency	(1,249)	1	1,250		(1,183)	67	1,250	1858.4%	3,863
Transform and Sustain resource	6	69	64	91.7%	58	321	263	81.9%	601
Other	85	64	(21)	-32.6%	68	391	323	82.6%	739
	(1,159)	**134**	1,293	965.8%	**(1,056)**	**780**	1,836	235.4%	**5,203**

Contingency budgets transferred to operational costs reconcile as follows:

	$'000
Original contingency budget	3,000
Plus:	
Revenue banking	4,200
Less:	
Additional surplus agreed with MOH	-500
Feasibility studies	-600
Elective surgery delivery costs	-1,942
Melanoma and oncology treatments	-295
Remaining contingency budget (per above table)	3,863

9. Financial Performance by MOH Classification

$'000	November Actual	November Annual Plan	November 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	41,352	40,819	534 F	211,002	209,289	1,714 F	512,094	512,094	-
Less:									
Payments to Internal Providers	24,115	24,061	(53) U	118,954	118,616	(338) U	279,328	279,328	-
Payments to Other Providers	20,176	18,737	(1,439) U	95,585	94,752	(833) U	227,783	227,783	-
Contribution	**(2,938)**	**(1,980)**	**(958) U**	**(3,537)**	**(4,079)**	**543 F**	**4,983**	**4,983**	**-**
Governance and Funding Admin.									
Funding	264	266	(2) U	1,331	1,331	-	3,197	3,197	-
Other Income	3	3	-	13	13	-	30	30	-
Less:									
Expenditure	212	276	64 F	1,234	1,351	117 F	3,243	3,243	-
Contribution	**55**	**(7)**	**62 F**	**110**	**(7)**	**117 F**	**(16)**	**(16)**	**-**
Health Provision									
Funding	23,850	23,795	55 F	117,622	117,284	338 F	276,131	276,131	-
Other Income	1,410	1,564	(154) U	8,258	8,734	(477) U	20,638	20,638	-
Less:									
Expenditure	23,464	24,475	1,011 F	119,221	118,465	(756) U	296,737	296,737	-
Contribution	**1,796**	**884**	**912 F**	**6,659**	**7,553**	**(894) U**	**33**	**33**	**-**
Net Result	**(1,087)**	**(1,103)**	**16 F**	**3,232**	**3,467**	**(235) U**	**5,000**	**5,000**	**-**

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 2016/17 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.

	November			*Year to Date*			*End of Year*		
$'000	***Mgmt Budget***	***Annual Plan***	***Movement***	***Mgmt Budget***	***Annual Plan***	***Movement***	***Mgmt Budget***	***Annual Plan***	***Movement***
Funding									
Income	40,819	40,806	13 F	209,289	209,545	(256) U	512,094	511,803	291 F
Less:									
Payments to Internal Providers	24,061	23,141	(920) U	118,616	116,600	(2,016) U	279,328	275,461	(3,867) U
Payments to Other Providers	18,737	19,110	373 F	94,752	96,252	1,499 F	227,783	231,341	3,559 F
Contribution	**(1,980)**	**(1,445)**	**(535) U**	**(4,079)**	**(3,307)**	**(773) U**	**4,983**	**5,000**	**(17) U**
Governance and Funding Admin.									
Funding	266	268	(2) U	1,331	1,341	(10) U	3,197	3,220	(23) U
Other Income	3	3	-	13	13	-	30	30	-
Less:									
Expenditure	276	271	(5) U	1,351	1,354	2 F	3,243	3,250	7 F
Contribution	**(7)**	**-**	**(7) U**	**(7)**	**-**	**(7) U**	**(16)**	**-**	**(16) U**
Health Provision									
Funding	23,795	22,873	922 F	117,284	115,259	2,025 F	276,131	272,241	3,890 F
Other Income	1,564	1,543	20 F	8,734	8,626	108 F	20,638	20,366	272 F
Less:									
Expenditure	24,475	24,074	(401) U	118,465	117,111	(1,354) U	296,737	292,608	(4,129) U
Contribution	**884**	**342**	**542 F**	**7,553**	**6,773**	**780 F**	**33**	**(0)**	**33 F**
Net Result	**(1,103)**	**(1,103)**	**0** F	**3,467**	**3,467**	**0** F	**5,000**	**5,000**	**0** F

11. Financial Position

30 June		*November*				*Annual*
2016	$'000	*Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2016*	*Budget*
	Equity					
102,608	Crown equity and reserves	102,608	105,733	3,125	-	105,376
(10,973)	Accumulated deficit	(7,741)	(12,802)	(5,061)	3,232	(11,268)
91,635		94,867	92,932	(1,936)	3,232	94,108
	Represented by:					
	Current Assets					
15,552	Bank	18,197	8,704	(9,493)	2,645	8,523
1,724	Bank deposits > 90 days	1,755	1,741	(14)	31	1,741
22,433	Prepayments and receivables	15,461	18,394	2,933	(6,972)	18,618
4,293	Inventory	4,273	3,996	(277)	(20)	4,044
1,220	Non current assets held for sale	625	1,220	595	(595)	-
45,222		40,311	34,055	(6,256)	(4,912)	32,927
	Non Current Assets					
151,944	Property, plant and equipment	150,894	161,058	10,164	(1,050)	166,159
2,037	Intangible assets	1,826	997	(829)	(211)	665
9,777	Investments	10,430	8,635	(1,795)	653	9,476
163,758		163,151	170,690	7,539	(607)	176,299
208,980	**Total Assets**	**203,461**	**204,745**	**1,283**	**(5,519)**	**209,226**
	Liabilities					
	Current Liabilities					
-	Bank overdraft	-	-	-	-	-
38,137	Payables	30,720	30,802	82	(7,417)	30,697
34,070	Employee entitlements	32,736	31,112	(1,625)	(1,334)	34,484
-	Current portion of borrowings	-	-	-	-	6,000
72,208		63,456	61,914	(1,543)	(8,751)	71,180
	Non Current Liabilities					
2,638	Employee entitlements	2,638	2,399	(238)	-	2,438
42,500	Term borrowing	42,500	47,500	5,000	-	41,500
45,138		45,138	49,899	4,762	-	43,938
117,345	**Total Liabilities**	**108,594**	**111,813**	**3,219**	**(8,751)**	**115,118**
91,635	**Net Assets**	**94,867**	**92,932**	**(1,936)**	**3,232**	**94,108**

The variance from budget for:

- Bank and property, plant and equipment mainly reflect the lower capital spend;
- Non-current assets held for sale has been adjusted for the reclassification of 307 Omahu Road to property, plant and equipment;
- Term borrowing has been delayed to February to coincide with the debt to equity swap.
- Employee entitlements – see below

13. Employee Entitlements

30 June		*November*				*Annual*
2016	$'000	*Actual*	*Budget*	*Variance from budget*	*Movement from 30 June 2016*	*Budget*
7,466	Salaries & wages accrued	7,268	5,216	(2,052)	(197)	6,559
482	ACC levy provisions	929	596	(333)	447	851
5,348	Continuing medical education	4,145	3,833	(312)	(1,203)	5,131
19,149	Accrued leave	18,865	19,801	935	(283)	20,249
4,263	Long service leave & retirement grat.	4,166	4,066	(101)	(97)	4,131
36,708	**Total Employee Entitlements**	35,374	33,511	(1,863)	(1,334)	36,922

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 as equity in February 2016 when the proposed swap of debt to equity is expected to occur. The DHB's 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 before the debt to equity swap is expected to occur.

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

2017 Annual Plan		*Actual $'000*	*Year to Date Budget $'000*	*Variance $'000*
	Source of Funds			
	Operating Sources			
14,440	Depreciation	5,688	5,702	14
5,000	Surplus/(Deficit)	3,120	3,467	347
(2,479)	Working Capital	(4,616)	(5,120)	9,496
16,961		4,192	4,050	9,858
	Other Sources			
-	Special funds and clinical trials	33	-	(33)
1,220	Sale of assets	-	-	-
5,000	Borrowings	-	5,000	(5,000)
6,220		33	5,000	(5,033)
23,181	**Total funds sourced**	**4,225**	**9,050**	**4,824**
	Application of Funds:			
	Block Allocations			
3,183	Facilities	785	1,326	541
3,125	Information Services	230	1,302	1,072
5,464	Clinical Plant & Equipment	1,359	2,276	917
11,772		2,374	4,904	2,530
	Local Strategic			
2,460	MRI	-	1,025	1,025
500	Renal Centralised Development	49	208	159
3,000	New Stand-alone Endoscopy Unit	436	1,250	814
710	New Mental Health Inpatient Unit Development	316	296	(20)
100	Maternity Services	129	42	(87)
400	Upgrade old MHIU	476	486	10
400	Travel Plan	18	167	149
400	Histology Upgrade	-	48	48
1,100	Fluoroscopy Unit	-	458	458
200	Education Centre Upgrade	-	(117)	(117)
9,270		1,423	3,861	2,438
	Other			
-	Special funds and clinical trials	33	-	(33)
1,000	New Technologies/Investments	-	-	-
-	Other	35	-	(35)
1,000		68	-	(68)
22,042	***Capital Spend***	***3,865***	***8,765***	***4,899***
	Regional Strategic			
1,139	RHIP (formerly CRISP)	360	285	(75)
1,139		360	285	(75)
23,181	**Total funds applied**	**4,225**	**9,050**	**4,824**

16. Rolling Cash Flow

	Actual	November Forecast	Variance	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast	Jul Budget	Aug Budget	Sep Budget	Oct Budget	Nov Budget
Cash flows from operating activities															
Cash receipts from Crown agencies	41,609	45,123	(3,514)	45,467	43,315	45,259	41,899	43,196	38,319	53,090	44,780	41,382	45,384	51,977	41,777
Cash receipts from revenue banking	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from donations, bequests and clinical trials	(10)	-	(10)	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	1,558	432	1,126	439	428	448	455	447	455	451	426	425	427	492	432
Cash paid to suppliers	(28,280)	(28,245)	(35)	(25,825)	(25,677)	(23,024)	(25,805)	(25,460)	(24,178)	(29,753)	(27,144)	(25,118)	(27,069)	(24,932)	(25,223)
Cash paid to employees	(18,371)	(17,754)	(617)	(14,458)	(16,713)	(14,490)	(19,556)	(15,283)	(17,919)	(15,614)	(13,909)	(19,483)	(15,098)	(15,100)	(17,792)
Cash generated from operations	**(3,494)**	**(444)**	**(3,050)**	**5,624**	**1,354**	**8,194**	**(3,007)**	**2,901**	**(3,323)**	**8,175**	**4,152**	**(2,793)**	**3,644**	**12,437**	**(806)**
Interest received	97	80	17	72	75	68	75	73	75	73	81	80	67	66	80
Interest paid	(263)	(69)	(194)	(160)	(359)	(325)	-	-	-	-	-	-	-	-	-
Capital charge paid	-	-	-	(3,636)	-	-	-	-	-	(5,476)	-	-	-	-	-
Net cash inflow/(outflow) from operating activities	**(3,661)**	**(433)**	**(3,227)**	**1,900**	**1,069**	**7,937**	**(2,932)**	**2,974**	**(3,247)**	**2,771**	**4,233**	**(2,713)**	**3,711**	**12,504**	**(726)**
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	0	0	-	625	0	0	0	0	0	0	0	0	0	0	0
Acquisition of property, plant and equipment	(963)	(1,648)	685	(1,694)	(1,617)	(1,972)	(2,180)	(2,025)	(1,905)	(2,143)	(2,511)	(2,511)	(2,511)	(2,511)	(2,511)
Acquisition of intangible assets	-	(286)	286	(200)	(315)	(345)	(340)	(265)	(115)	(70)	(85)	(85)	(85)	(85)	(85)
Acquisition of investments	-	(652)	652	(301)	(8)	-	(1,075)	-	-	(284)	-	-	(285)	-	-
Net cash inflow/(outflow) from investing activities	**(963)**	**(2,586)**	**1,623**	**(1,570)**	**(1,940)**	**(2,317)**	**(3,595)**	**(2,290)**	**(2,020)**	**(2,497)**	**(2,596)**	**(2,596)**	**(2,881)**	**(2,596)**	**(2,596)**
Cash flows from financing activities															
Proceeds from equity injection	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Proceeds from borrowings	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Repayment of finance leases	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Equity repayment to the Crown	-	-	-	-	-	-	-	-	-	(357)	-	-	-	-	-
Net cash inflow/(outflow) from financing activities	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**(357)**	**-**	**-**	**-**	**-**	**-**
Net increase/(decrease) in cash or cash equivalents	(4,624)	(3,019)	(1,604)	330	(871)	5,620	(6,527)	684	(5,268)	(83)	1,637	(5,309)	829	9,907	(3,322)
Add:Opening cash	24,575	24,575	-	19,951	20,281	19,410	25,030	18,503	19,187	13,919	13,836	15,473	10,163	10,993	20,900
Cash and cash equivalents at end of year	**19,951**	**21,555**	**(1,604)**	**20,281**	**19,410**	**25,030**	**18,503**	**19,187**	**13,919**	**13,836**	**15,473**	**10,163**	**10,993**	**20,900**	**17,578**
Cash and cash equivalents															
Cash	4	7	(3)	7	7	7	7	7	7	7	7	7	7	7	7
Short term investments (excl. special funds/clinical trials)	16,984	18,453	(1,469)	17,178	16,307	21,928	15,401	16,084	10,817	10,734	12,370	7,061	7,891	17,798	14,476
Short term investments (special funds/clinical trials)	2,951	3,095	(144)	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095	3,095
Bank overdraft	12	-	12	-	-	-	-	-	-	-	-	-	-	-	-
	19,952	**12,004**	**(1,604)**	**20,280**	**19,409**	**25,030**	**18,503**	**19,186**	**13,919**	**13,836**	**15,472**	**10,163**	**10,993**	**20,900**	**17,578**

Office of Hon Dr Jonathan Coleman
Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

10 NOV 2016

Chairperson
District Health Board

Dear Chair

Letter of Expectations for District Health Board - change in capital finance policy

This letter is to advise you that the Government has recently changed its policy on the capital financing of the District Health Board sector and that DHBs are expected to cooperate with implementing the change in government policy.

The change in policy

From the 15 February 2017 DHBs will no longer have access to Crown debt financing for funding of capital investment. Instead the Crown's contribution to DHB capital investment will now be solely funded via Crown equity injections. In addition to the change in funding mechanisms, on 15 February the existing Crown loans held by DHBs will also be converted into equity. The conversion of the loans to equity will change your DHB's financial position, increasing the Crown's equity balance.

Reason for the change

As you are aware the Ministry of Health and the Treasury have conducted a review of the health capital funding system. This review concluded that the anticipated benefits and behaviours of DHB access to Crown lending have not occurred. The current arrangement is unique to the DHBs and which makes it difficult to compare DHB investments with other Public Sector investments.

In addition, consultation with the DHB sector has identified that the principal problem identified with current capital financing arrangements was that the recurring costs of major redevelopments were unaffordable and led to DHB deficits. The current financing arrangements have not addressed this problem.

Implications of the change

It is not the intention of the policy change to increase the financial pressure to your DHB and therefore DHBs will receive an increase in revenue corresponding to the higher cost of capital. The Ministry has consulted with the DHB sector over the forecast impact of this change. This forecast has been used to calculate the additional revenue to the sector for the next two years. The Ministry and Technical Reference Group of DHB CFOs, will then review the allocation of the additional revenue going forwards and will report to Ministers with their recommendations.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

Implementing the change

At my request officials from the Ministry of Health will be communicating with your DHB about the implementation of this change in policy. In order to implement this change, in particular the conversion of existing loans to equity, I understand the existing loan agreements held by your DHB will need to be terminated.

It is my expectation that your DHB agrees to termination of the loan agreement by 16 December 2016 to ensure the implementation of government policy can begin on the 15 February 2017.

Future capital investment settings

As you are aware the change in capital financing policy is the first phase in the review of the health capital funding system. The Ministry is currently consulting with the DHB sector on a new system that would seek to address the issue of affordability of capital investments. This consultation has been with DHB CFOs and a representative group of DHB Chairs regarding this issue. I encourage you to take a strong interest in this work as it will establish how the sector is expected to affordably manage capital investment in the future.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

BOARD HEALTH & SAFETY CHAMPION'S UPDATE

Verbal

HAWKE'S BAY
District Health Board
Whakawāteatia

CONSUMER STORY

Verbal Presentation

12

HB CLINICAL COUNCIL

Verbal update

OURHEALTH HAWKE'S BAY Whakawateatia	**HB Health Consumer Council**
	For the attention of: **HBDHB Board**
Document Owner:	Graeme Norton, Chair
Reviewed by:	Not applicable
Month:	December, 2016
Consideration:	For Information

RECOMMENDATION

That the Board

Review the contents of this report; and

Note that Consumer Council:

- **Acknowledged and endorsed** the draft Long Term Conditions Framework along with feedback that should both widen and deepen the it to become "Our Hawke's Bay Wellness Framework"
- **Commenced work** with the Project Management Office to create high level guidance around how we build effective consumer engagement into start-up/ initiation of new projects, focussing first on the projects under Transform & Sustain.

Council met on 8 December 2016, an overview of issues discussed and/or agreed at the meeting are provided below.

The following papers/issues were considered:

- ***Consumer Engagement in Transform & Sustain Projects***

Members have had considerable experience in various projects since the formation of the Council in 2013. Project Management Office (PMO) workshopped with members to create high level guidance around how we build consumer engagement into start-up/ initiation of new projects. Transform and Sustain has been endorsed and there are a number of projects about to launch. PMO want to be clear from the start how consumers are involved with projects.

Members broke into groups to discuss the following:

1. What has worked well
2. What hasn't worked
3. What else should we consider
4. Anything else

Following discussion from the feedback provided to the questions above, PMO will draft principles for project managers to abide by and apply to consumer engagement.

- ***HBDHB Long Term Conditions Framework***

In general council members praised the work done to date and endorsed the framework. Much of the discussion was insights into how to widen and deepen the work

Members feel it is important to look at the whole of the person's life and wellbeing and not just their health. It is important to listen to the person, as a person and not as a condition or disability. Exposure to violence and abuse, mental health, environmental factors etc need to be taken into account also.

Members could see the changes in thought by the services, what now needs to happen is the consumers' change of thought and taking responsibility for their own health. The key to success in achieving that is through partnership, relationships and behaviours.

PASIFIKA HEALTH LEADERSHIP GROUP

Verbal update

HAWKE'S BAY District Health Board Whakawāteatia	**Pasifika Health Dashboard**
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Caroline McElnay, Director Population Health Talalelei Taufale, Pacific Health Development Manager
Reviewed by:	Executive Management Team
Month:	December 2016
Consideration:	For discussion / Information

RECOMMENDATION

That the HBDHB Board

- Notes the contents of this report.

Talofa lava and a warm Pacific greetings to you all.

OVERVIEW

The Pasifika Health Dashboard has been adopted by the Hawke's Bay District and is aligned to the outcomes and actions in the Ministry of Health's 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018.

Progress reports are six-monthly and this report is for June 2016. The December report will follow in 2017 as at the time of writing this document has not been released.

Progress to 30 June show that Hawke's Bay District Health Board, with a relatively small Pacific population, has been able to maintain a number of achieved targets.

Through the Pacific Health Dashboard we will gather best practice from health areas achieving targets and communicate and share with those health areas still moving towards achieving targets. The ultimate aim is to ensure we have a range of interventions specifically targeted for Pacifika that we know are effective.

Strategically, there are large prevention and management issues in child health as well as diabetes and CVD to be addressed. Having a system in place to sustain high performance against the health targets for Pacifika health will allow us to develop our specific Pacifika interventions for these areas. The Pacifika community settings work will be the framework that both the HBDHB, Health Hawke's Bay and primary care will use to address prevention and management issues.

Fortunately, through the funding bid we now have the beginnings of a Pasifika Health team who will work hard to support the drive to develop this focus in moving forward.

Faafetai lava mo le avanoa

PERFORMANCE HIGHLIGHTS

Achievements

1. Percentage of infants exclusively or fully breastfed at three months of age 63.5% (target is 60%).

2. Immunisation coverage (percent) at eight months of age (three months reporting) is 97.6%. The target is 95%. This is the first time the eight months immunisation coverage has been used to be in line with the health target. Previous 'Ala Mo'ui progress reports have used the six month immunisation coverage.

Areas of Progress

There is an increasing number of health areas that over a period of time fluctuate between achieving targets and falling within a realistic distance of achieving targets. There are also a number of areas that although, not achieving targets, have been improving steadily towards achieving the target over time.

- Percentage of newborn infants enrolled with a general practice by three months of age 85% (target is 98%).
- Percentage of 4 year olds who received a B4SC 88.9% (target is 90%).
- Percentage of children under five years old enrolled in a Community Oral Health Service 74.2% (target is 95%).
- Percentage of smokers offered brief advice and support to quit in primary health care 71.9% (target is 90%).
- Percentage of enrolled women aged 25-60 years who received a cervical smear in the past three years 70.4% (target is 80%).
- GP utilisation rate (average visits per person) 2.98 (target is 2.99).

Challenges

1. Percentage of children caries-free at age 5 38% (target is 65%).

2. Percentage of infants who received all WCTO core contacts in their first year of life 61% (target is 95%).

3. Mean rate of DMFT at school year eight 1.85 (target is 1.02).

4. Percentage of eligible adults who had cardiovascular risk assessed 86.3% (target is 90%).

5. Nurse utilisation rate 1.27 (target is 0.72).

6. Total GP and nurse utilisation rate (average visits per person) 4.25 (target is 3.71).

7. Estimated percentage of people with diabetes 8% (target is 6).

Pasifika Health Dashboard - HBDHB

Indicator No	Counties Manukau DHB			Auckland DHB			Waitemata DHB			Capital & Coast DHB			Canterbury DHB			Hutt Valley DHB			Waikato DHB			Hawke's Bay DHB		
	Jun-15	Dec-15	Jun-16	Jun-15	Dec-15	Jun-16	Jun-15	Dec-15	Jun-16	Jun-15	Dec-15	Jun-16	Jun-15	Dec-15	Jun-16	Jun-15	Dec-15	Jun-16	Jun-15	Dec-15	Jun-16	Jun-15	Dec-15	Jun-16
1																								
2																								
3																								
4																								
5																								
6																								
7																								
8																								
9																								
10																								
11																								
12																								
13																								
14																								
15																								
16																								
17																								
18																								
19																								
20																								

Indicator No.	Figure No.	Page No.	Indicator (timeline)	Health Target
1	1b	3	ASH rates per 100,000 in 0–4-year-olds, (2002–2015)	no target
1	1d	4	ASH rates per 100,000 in 45–64-year-olds, (2002–2015)	no target
2	3	9	Access rate to DHB specialist mental health services, (2005/2006–2014/2015)	no target
3	5	11	Access to DHB alcohol and drug services, (2012/2013–2014/2015)	no target
4	7	14	Percentage of newborn infants enrolled with a general practice by three months, (2013–2016)	98%
5	9	16	Percentage of infants who received all WCTO core contacts in their first year of life, (2013–2016)	95%
6	11	18	Percentage of four-year-olds who received a B4SC, (2013–2016)	90%
7	13	20	Percentage of infants exclusively or fully breastfed at three months, (2013–2016)	60%
8	15	22	Percentage of children with BMI >98th percentile referred to a GP or specialist services, (2013–2016)	95%
9	17	24	Percentage of children under five years old enrolled in DHB-funded dental services, (2007–2014)	95%
10	19	26	Percentage of children caries-free at age five, (2007–2014)	65%
11	21	27	Mean rate of DMFT at school year eight, (2007–2014)	no target
12	23	32	Percentage of smokers offered brief advice and support to quit in primary health care, (2013–2016)	90%
13	25	34	Percentage of eligible adults who had cardiovascular risk assessed, (2013–2016)	90%
14	27	37	Percentage of children who are obese, (2006–2015)	no target
15	29	40	Percentage of enrolled women aged 25–69 years who received a cervical smear in the past three years, (2013–2016)	80%
16	31	46	GP utilisation rate (average visits per person), (2008–2016)	no target
17	33	48	Nurse utilisation rate in average visits per person, (2008–2016)	no target
18	35	50	Total GP and nurse utilisation rate in average visits per person, (2008–2016)	no target
19	37	55	Estimated percentage of people with diabetes, (2010–2015)	no target
20	40	61	Percentage of immunisation coverage at six months of age for three-month reporting, (2013–2016)	95%

Legend	
	Target achieved at last measure (data point). When 'no target' is set, a gap score is calculated (percent) when compared with the total New Zealand population at the last measure (data point).
	<10 percent away from achieving the target or compared with the total New Zealand population (if 'no target' was set).
	10 and above but less than 20 percent away from the target or compared with the total New Zealand population (if 'no target' was set).
	20 or more percent away from the target or compared with the total New Zealand population (if 'no target' was set).
↗	An increasing trend usually means improvement except for Figure 1b, 1d, 21, 29 and 37 where an increasing trend means not improving.
↘	A decreasing trend usually means no improvement except for Figure 1b, 1d, 21, 29 and 37 where this is what one expects if this indicator was improving.
→	Flat-lining or plateauing.
	No data available (white box)

HAWKE'S BAY District Health Board Whakawāteatia	**Improving Endoscopy Services Construction Contract Approval** 146
	For the attention of: **Finance Risk and Audit Committee & HBDHB Board**
Document Owner: Document Author(s):	Sharon Mason, COO Trent Fairey, Project Manager Facilities
Reviewed by:	Executive Management Team
Month:	December, 2016
Consideration:	For Decision

15

RECOMMENDATION

That HBDHB Board:

1. **Approve.** A total capital project budget of **$11,792,685** subject to approval of the contract in the public excluded section.
2. **Note.** The implementation timeline as indicated in this paper with the 'Go-Live' date scheduled for August 2018.
3. **Note.** Due to the total project costs exceeding $10 million, this project is now subject to Ministry of Health & Finance approval.
4. **Note.** Potential risk with the final geotechnical design still exists, and the facilities project manager will report back to the EMT in March 2017 once the extent of these remedial works has been established.

PURPOSE

The purpose of this paper is to gain approval from the HBDHB Board of Directors to appoint a contractor for the construction of the Endoscopy Services Facility.
Tenders have been received and evaluated and management now seeks approval from the Board for the letting of the construction contract to the nominated contractor with completion scheduled for August 2018.

ENDORSEMENT and APPROVAL PROCESS

Steering Group Committee (via Email)	21st November 2016
HSLT & EMT	22nd November 2016
FRAC & Board	14th December 2016

BACKGROUND

Formal approval by the Board for the Improving Endoscopy Services Business Case was received on the 26th July 2015,

"That the Board:

1. *Approve as outlined in the paper presented to FRAC in December 2014:*
    a. *Confirming the original proposition signed off by the Board for the 2012 Business case.*
    b. ***A capital budget of $9,593 thousand (excl GST).***
    c. *An operating budget of $17,556 thousand unfunded over a ten year period (excl GST, interest and depreciation).*
2. *Approve additional operational budget over the paper presented to FRAC in December 2014 of $277 thousand in 2015/16, $300 thousand in 2016/17, $580 thousand in 2017/18 and $117 thousand per annum thereafter in order to build the Gastroenterology team capacity and capability and continue to meet demand and Ministry of Health waiting time targets making the total operational cost budget now $19,414 thousand (see Appendix Two).*
3. *Note the outcome for the site visit to Endoscopy Auckland on 3 July 2015.*
4. ***Note the final construction contract approval will come to the Board in late 2016."***

Since this date the project team, both Operational services and Facilities have continued developing the project into a complete construction contract. Regular reporting through to the following governing bodies has been undertaken,

Improving Endoscopy Services Steering Group	Quarterly
Progress reporting through to EMT & Frac	Monthly via the PMO office
EMT & FRAC Update	July 2016

The facility design process was based on the concept design included in the **2012** Business Case and involved three subsequent design stages: Preliminary, Developed and Detailed design. These stages were undertaken in close consultation with the nominated User Group to ensure alignment with the Model of Care and engaged a consumer group led by Graeme Norton. Three value engineering workshops and one health and safety workshop have been completed during this design process. The workshops have ensured the design of the building is fit for purpose, value engineered and safe to construct and manage. The final contract documentation was then put out for tender on the 12th of October with the Tenders closing on the 9th of November.

GEOTECHNICAL ISSUES

The original design for the Endoscopy building was based on geotechnical ultrasounds and typical details that had been successful in the mental health build. On completion of further boreholes and geotechnical reviews in July 2016 the original structural design required revised calculations and systems testing. In October 2016 the project team decided to test on site the proposed uplift anchor system. By testing these systems the project team would be assured the ground conditions and the technical response to the structure would be sufficient under various seismic loadings. The testing undertaken in October failed in all three locations, this then required the structural design team to modify the design and introduce significant changes to the uplift anchors and the structural system of the building. The changes to these systems have been completed in time for the tender with the main contractors, and the cost of these changes are included in the current tender recommendation. The new timeframe allows the project team to complete the testing of the new structural system before the main contractor begins the construction activity.

ESCALATION IN PROJECT COST

Escalation of the total project costs has occurred from the following areas,

Geotechnical issues and the Design response.
As indicated in the previous section, due to the failing of the original uplift anchor design the design team has had to change the design significantly. The design has increased quantities of structural steel, excavation services, compacted infill, and the new screw pile anchors systems.

Total increase from the original cost estimate in the 2015 Board approval due to geotechnical issues is approximately 11.5%

These costs can be broken down into the following categories,

- Increase in quantities Concrete, Steel, Reinforcing, and Anchor Piles/Excavation. 6.5%
- Increase in contingency fund to remove risk around geotechnical issues. 3.5%
- Increase in consultancy fees for alternative designs & peer reviews. 1.5%

Escalation in the construction industry.
The construction market costs have increased significantly from the original cost estimates established from 2012 through to 2015. Comment from Rider levett Bucknell the Quantity surveyors for this project is as follows,

"It is clear from the trade values tendered, that the overall construction market has shifted considerably since our early estimates between 2012-2015. This has been particularly noticeable since April 2016, as prior to this date the New Zealand construction market had been in a depressed state since 2008, with yearly movement between -1% to 1% being the norm.

The catalyst for the sudden boom in construction, which has had an impact in the majority of regions, is most likely due to the mix of low inflation, lower debt interest rates, buoyant local economy, favourable FX rates and general market confidence. These factors have contributed to a stellar increase in the volume of work put to the market in a short space of time. Up until the start of 2016, we were only seeing this level of growth in a Christchurch and Auckland, but this has now spread quickly throughout the remainder of the country.

This boom is slightly unusual from previous trend statistics, in that the market is being purely driven higher by the volume of work being put to the market rather than actual price inflation or worsening FX rates. This type of boom has found the country wanting in terms of construction labour resource and reducing competitiveness between subtrades and main contractors".

Total increase from the original cost estimate in the 2015 Board approval due to construction industry escalation issues is approximately 8%

These costs can be broken down into the following categories,

- Increase in construction costs across all trades 4.5%
- Increase in P&G from 4% up to 9% 2.5%
- Increase in offsite overheads and profit. 1%

MINISTERS OF HEALTH & FINANCE APPROVAL

Capital investment regulations require the District Health Boards to gain approval from the Capital Investment Committee (CIC) for capital project that exceed 10 million total project costs. The CIC is a section 11 committee which provides advice to the Ministers of Health and Finance on the prioritisation and allocation of funding for capital investment and health infrastructure.

The CIC process applies to capital investment proposals in the public health sector that meet any one of the following criteria:

i. all investment in fixed assets that require Crown equity

ii. investment in projects or programmes where one or more of the following applies:

a) capital expenditure of $10M

b) capital expenditure of $10M calculated as the capitalized value of future revenues if financed from those revenues (such as a finance lease)

c) Twenty percent of total assets on the DHB balance sheet.

iii. strategic investments by DHBs that may substantially affect DHB performance

iv. Investments identified as high risk in DHB annual plans (using the State Services Gateway Risk Profile Assessment).

All proposals falling under criteria 1-4 require the agreement of the Ministers of Health and Finance [Cabinet Minute (00) M 20/4, refers].

Under these regulations the project meets the criteria ii (a) and will require the agreement of Ministers of Health and Finance.

Currently the HBDHB management team are in communication with the CIC seeking approval to proceed and therefore progress on this project will be subject to this approval.

PROCUREMENT

In accordance with the NZ Government Rules of Sourcing and procurement best practice, the opportunity was advertised on the Government Electronic Tendering (GETS) website and incorporated a two-step open competitive tender process. The first step called for Registrations of Interest (ROI) from interested contractors to respond to specific non price criteria, identified in the Project Procurement Plan, as being critical to the success of the project. Respondents were scored using an anchored marking scale and the four highest ranked suppliers were invited to submit a tender (RFT) for the building construction works. 3 complying tenders were received and evaluated on both **non-priced** and **price attributes**.

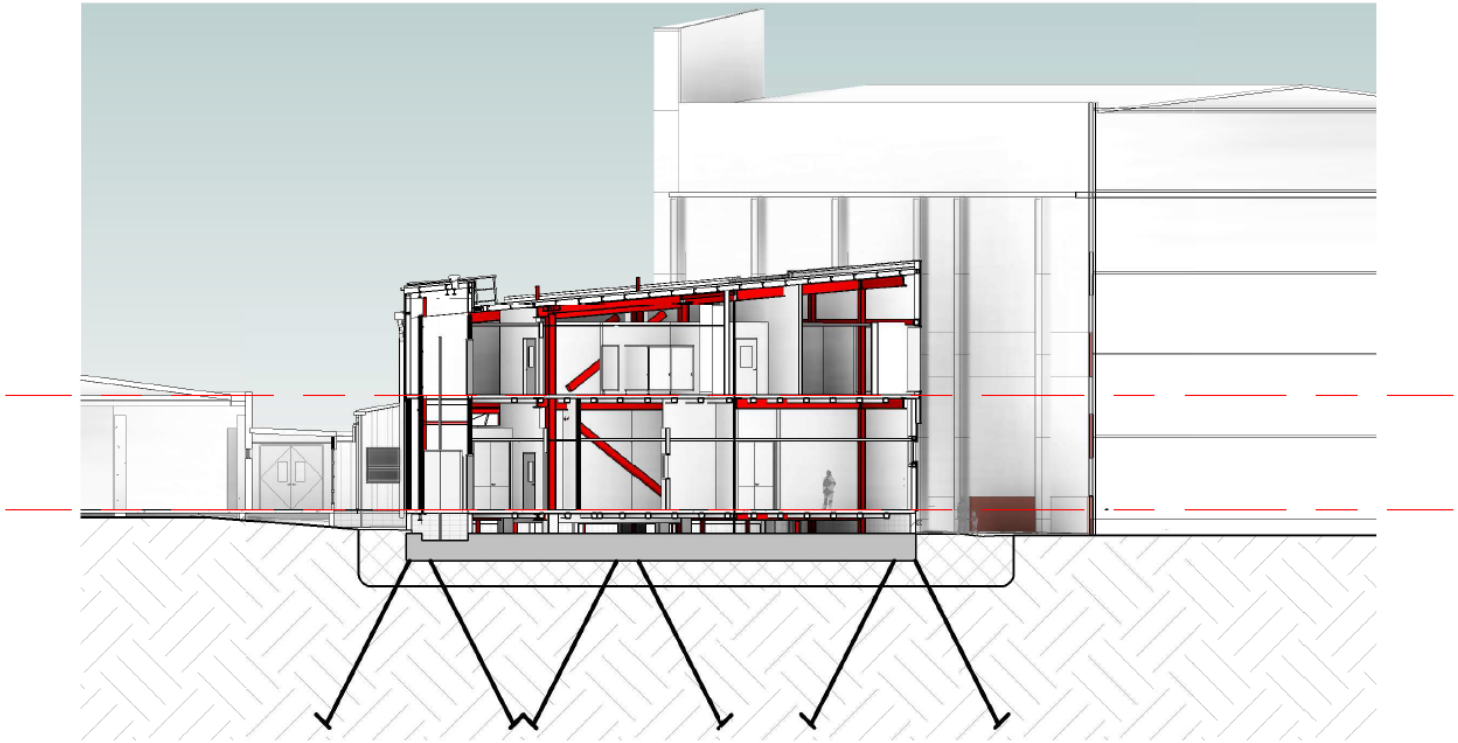
All price tender evaluations have been completed independently by Rider Levett Bucknell registered quantity surveyors.

TIMEFRAME

Board Approval	14th December 2016
Contract finalised and signed	23rd December 2016
Uplift Anchor & Pre-Works	January 2017 – February 2018
Construction Phase	March 2017 – March 2018
Commissioning/Fit out/Training	April 2018 – May 2018
Staff Handover/Relocations	June 2018 – July 2018
Go Live	August 2018

APPENDIX 1. Geotechnical Scenarios

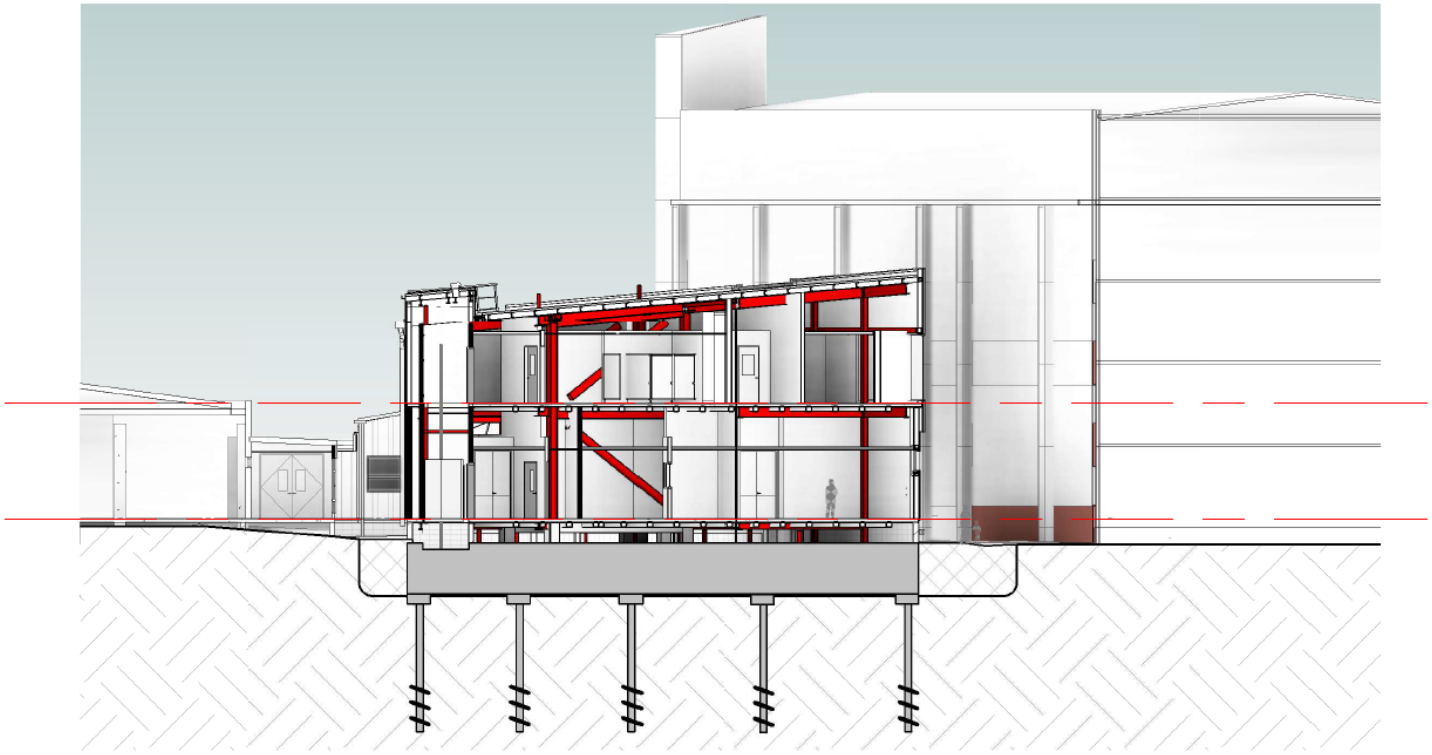
APPENDIX 1 – Geotechnical Design- Initial Estimate was based on Scenario 1



SCENARIO 1 - CROSS SECTION

Scenario 1
As per the Original RLB estimate
1M of Foundation raft in layers with sting ray anchors at 7M deep

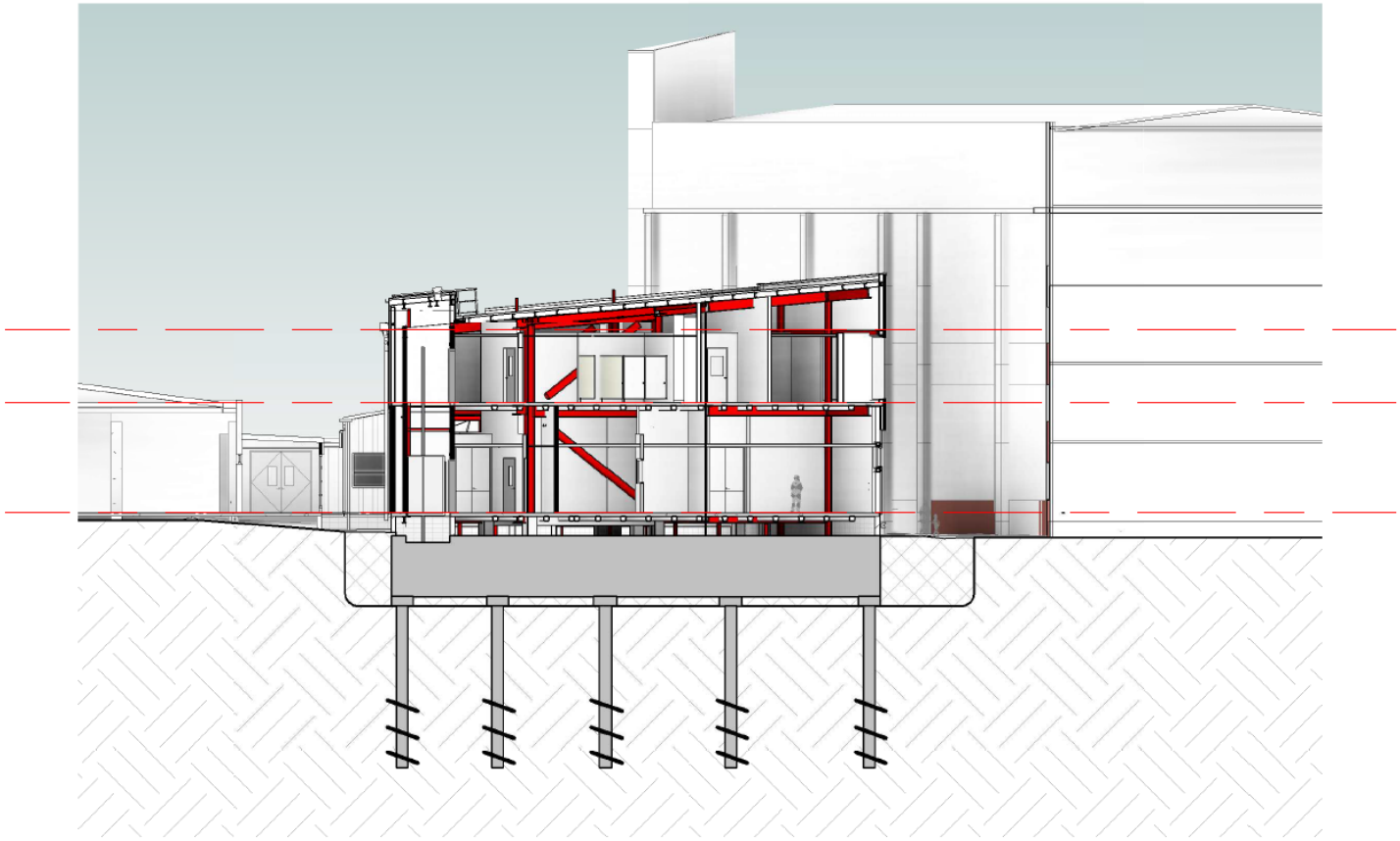
Geotechnical Design – Contract is currently based on Scenario 2



SCENARIO 2 - CROSS SECTION

Scenario 2
As per the design
2M of Foundation raft in layers with screw piles acting for uplift

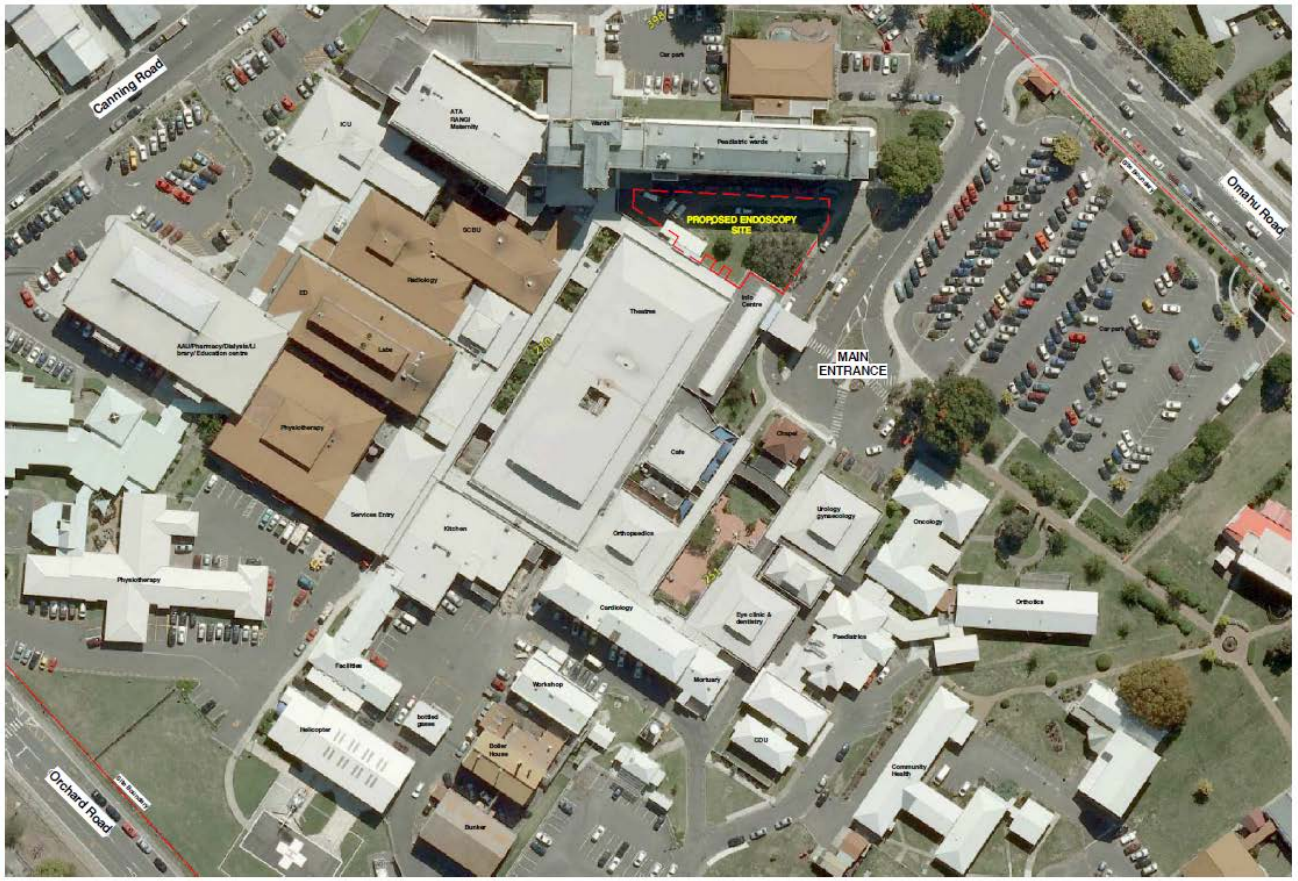
Geotechnical Design – Potential Design if Scenario 2 ground conditions are not suitable.



SCENARIO 3 - CROSS SECTION

Scenario 3
Possible conclusion if S2 fails
2.5M of Foundation raft in layers, thickened foundations beams and larger deeper screw piles

APPENDIX 2 Design Overview



Klein

HAWKE'S BAY District Health Board

Site Address: Hawkes Bay Regional Hospital
210 Omahu Road
Hastings 4120

Total Site Area: 12.3116 Hectare

Legal Description: LOT 8 PTS LOTS 3 DP 2395
LOTS 2-3 PT 1 DP 2443
PT LOTS 8-10 DP 1911
LOTS 10 13 DP 4841 -
HOSPITAL

REV.	DATE	BY	REASON
D	12.10.2016	KLN	TENDER ISSUE
C	02.09.2016	KLN	BUILDING CONSENT ISSUE
B	19.08.2016	KLN	COORDINATION ISSUE
A	17.06.2016	KLN	DEVELOPED DESIGN ISSUE

Klein Limited
27 College Hill Freemans Bay
Phone: 09 377 7665
Web: www.klein.co.nz
PO Box 47 034 Auckland
Fax: 09 377 7066
Email: klein@klein.co.nz

Consultants:

Quantity Surveyor:	Rider Levett Bucknall	T: 04 384 9180
Structural:	Holmes Consulting	T: 07 839 4849
Fire:	Aurecon	T: 04 220 6019
Mechanical:	Aurecon	T: 04 220 6019
Electrical:	Aurecon	T: 04 220 6019
Hydraulic:	Aurecon	T: 04 220 6019

Project:
NEW ENDOSCOPY SUITE

HAWKES BAY HOSPITAL, OMAHU RD
For: HAWKES BAY DISTRICT HEALTH BOARD

Drawing Title:
AERIAL PHOTO & LOCATION PLAN

Drawn	Author	Checked	Checker
Date:	20.04.2016		

Scale: 1 : 800 @ A1 (half scale @ A3)

Job No.	Drawing No.	Revision
3.0993	A-0010	D

15

HBDHB ENDOSCOPY

Job No. 3.0903 | Scale N.A | Page No. 2
Date SEPT 2016 | Cadfile No.

HAWKES BAY ENDOSCOPY INTERIOR FINISHES
SCHEME 1 - WAITING AREA

Klein

HBDHB ENDOSCOPY

Job No. 5.0903 | Scale N.A | Page No. 4
Date SEPT 2016 | Cadfile No.

HAWKES BAY ENDOSCOPY INTERIOR FINISHES
SCHEME 1 - RECOVERY 1 BED BAYS 2

Klein

15

Klein

HAWKE'S BAY District Health Board

REV	DATE	BY	REASON
D	12.10.2016	KLN	TENDER ISSUE
C	03.06.2016	KLN	BUILDING CONSENT ISSUE
B	19.05.2016	KLN	COORDINATION ISSUE
A	17.05.2016	KLN	DEVELOPED DESIGN ISSUE

Klein Limited

27 Colleys Hill Freemans Bay
Phone: 09 377 7002
Web: www.klein.co.nz

PO Box 47 556 Auckland
Fax: 09 377 7006
Email: klein@klein.co.nz

Consultants:

Quantity Surveyor:	Rider Levett Bucknall	T: 04 384 9166
Structural:	Holmes Consulting	T: 07 928 4849
Fire:	Aurecon	T: 09 526 6019
Mechanical:	Aurecon	T: 09 526 6019
Electrical:	Aurecon	T: 09 526 6019
Hydraulic:	Aurecon	T: 09 526 6019

Project:
NEW ENDOSCOPY SUITE

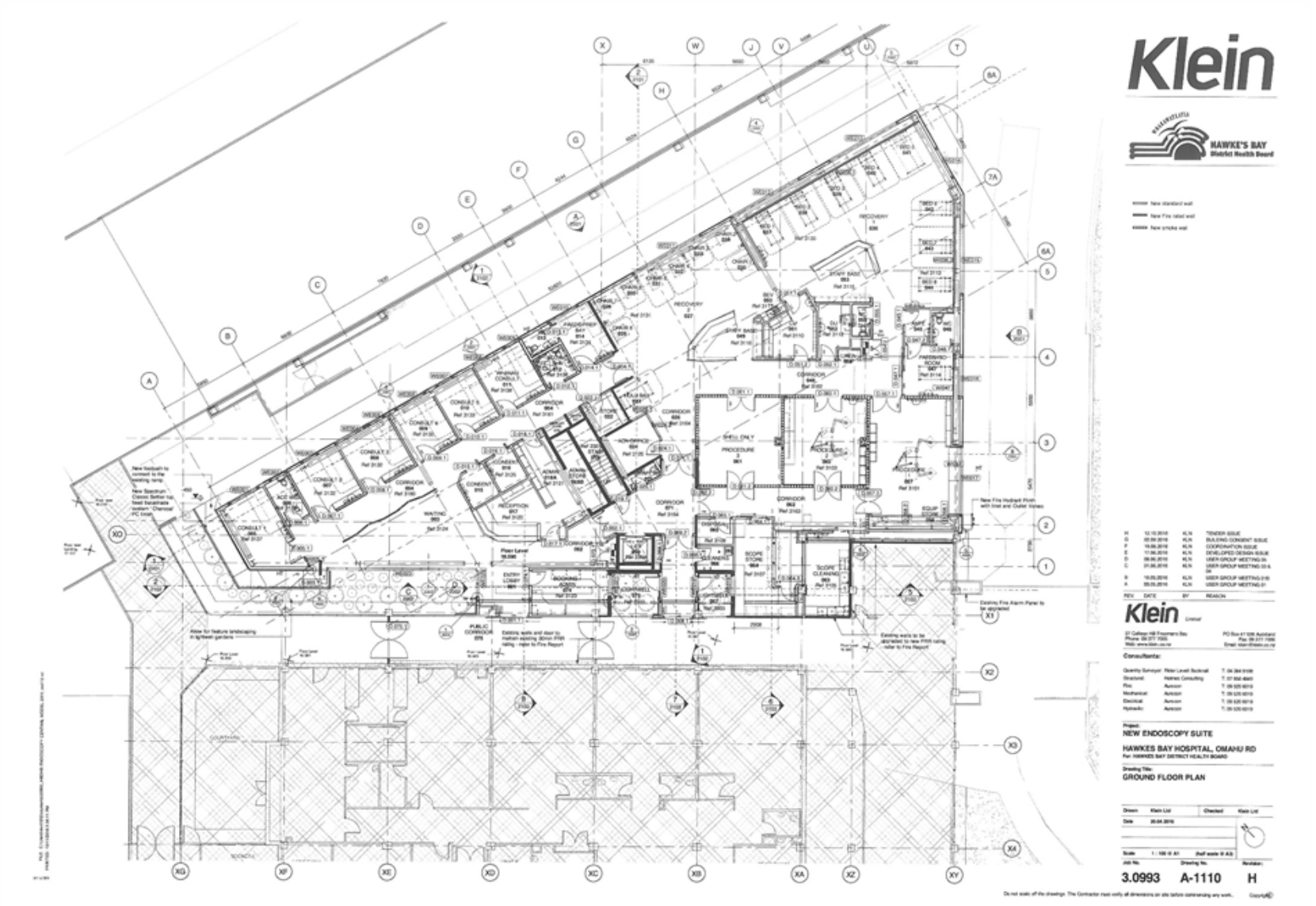
HAWKES BAY HOSPITAL, OMAHU RD
For: HAWKES BAY DISTRICT HEALTH BOARD

Drawing Title:
3D VIEW - EXTERIOR PERSPECTIVE

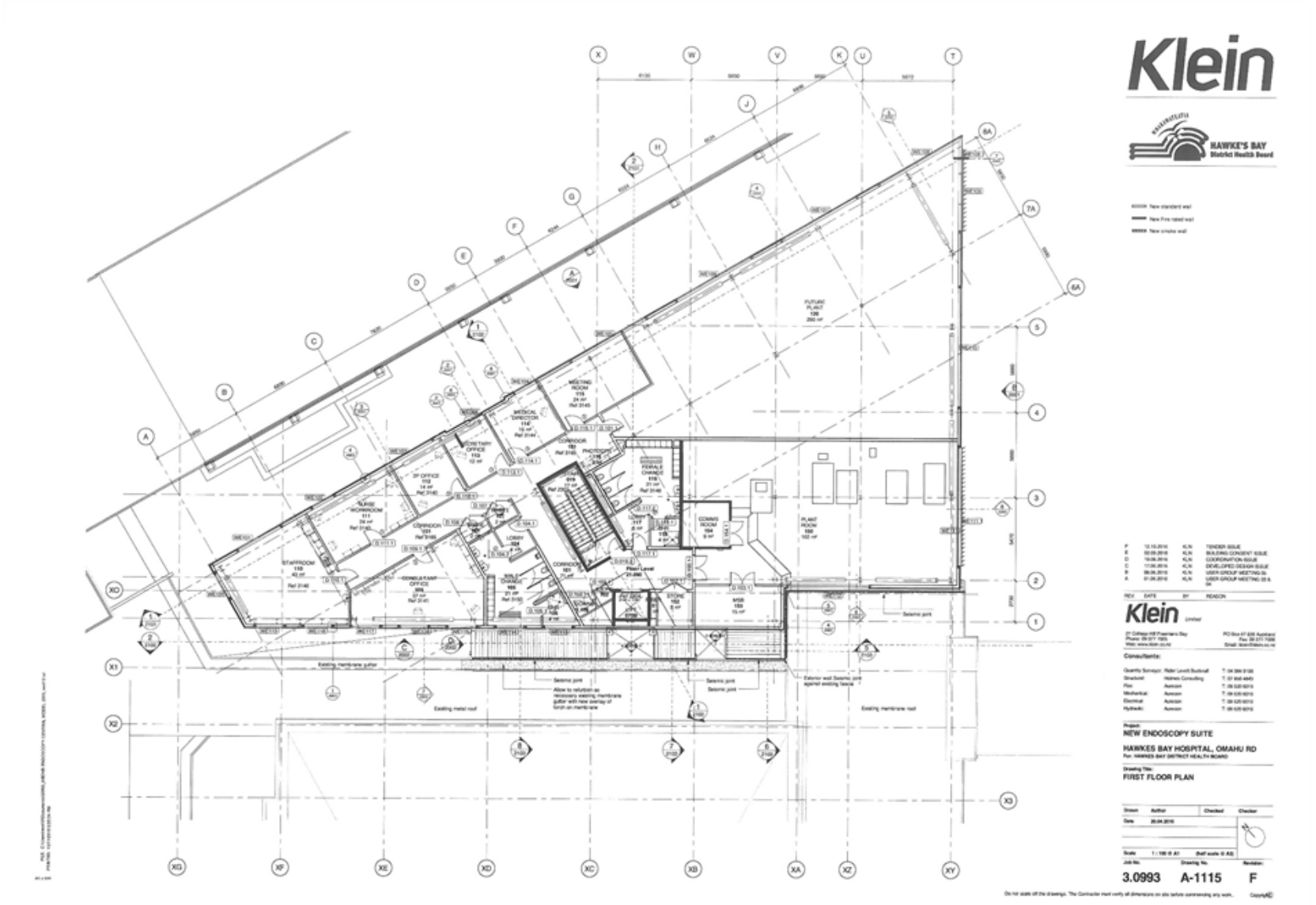
Drawn	Author	Checked	Checker
Date	20.04.2016		

Scale @ A1 (half scale @ A3)

Job No.	Drawing No.	Revision:
3.0993	A-2000	D


Klein
HAWKE'S BAY
District Health Board
Klein
Consultants:
NEW ENDOSCOPY SUITE
HAWKES BAY HOSPITAL, OMAHU RD
GROUND FLOOR PLAN
3.0993
A-1110
H

15


Klein
HAWKE'S BAY
District Health Board
NEW ENDOSCOPY SUITE
HAWKES BAY HOSPITAL, OMAHU RD
FIRST FLOOR PLAN
3.0993
A-1115
F

HAWKE'S BAY District Health Board Whakawāteatia	**Palliative Care in Hawke's Bay (Draft)** 147
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Chris McKenna Director of Nursing Mary Wills Head of Strategic Services
Reviewed by:	Executive Management Team; Māori Relationship Board, HB Clinical and HB Health Consumer Council (Nov)
Month:	December 2016
Consideration:	For feedback

RECOMMENDATION

That the HBDHB Board:

1. Provide feedback on the draft plan
2. Note that further consultation with the community is underway.

16

OVERVIEW

The draft palliative care plan has been developed with a combined clinical steering group involving primary and specialist palliative care. The initial draft plan was shared with Consumer Council to check the content is on the right track before broader engagement and feedback. The Maori Relationship Board meeting and Clinical Council Workshop in November discussed the paper and the broader issues of end of life and advance care planning.

Feedback so far is that the plan is on the right track but also needs to:

- More clearly show how we will improve equity
- Develop services for Pasifica and Maori to reflect changes in the Hawke's Bay population
- Make sure care responds to individual needs
- Show how end of life care can be provided more consistently
- Consider how we talk to patients and family members when a person is dying. How do we make sure "conversations that count" happen earlier so that everyone understands what is happening
- Reflect the needs of rural communities in Central Hawke's Bay and Wairoa
- Strengthen primary care
- Consider what fit for purpose palliative care facilities are to meet the needs of the Hawke's Bay population. Most services are provided in the community.

The plan is being circulated for feedback. Further consultation workshops are planned with key stakeholders and the community. We will hold community meetings in Central Hawke's Bay and Wairoa, meet with general practitioners with an interest in palliative care and the palliative care stakeholder group. The feedback will shape the resulting work programme and where these will be led from.

Questions for the Board to Consider:

- Given the way our population will change in the next ten years – what are the opportunities and challenges for the way care is provided?
- Is it ambitious enough for the next 10 years?
- Should we focus on a few key projects?
- What would you see as the most important issues for Hawke's Bay?
- What is missing?

All people who are dying and their family/whānau who could benefit from palliative care have timely access to quality palliative care services that are culturally appropriate and are provided in a coordinated way

(NZ Palliative Care Strategy 2001)

Palliative Care in Hawke's Bay

Our vision and priorities for the future 2016 – 2026

Executive Summary

"You matter because you are you, and you matter to the last moment of your life. We will do all we can, not only to help you die peacefully, but also to live until you die"
Dame Cicely Saunders

Dying is a normal part of the human experience and affects people regardless of age. Whenever a person dies in Hawke's Bay, there are impacts for their family/whānau, friends, work colleagues and the community in which they live. Many people would prefer to die in their own home, cared for and surrounded by their loved ones. [24] Others will die in hospice, hospital or aged residential care, by choice or by necessity.

The experience of dying, and of caring for loved ones at the end of life, can have a deep and lasting impact on those involved. Poorly supported dying, with inadequate symptom control and failure to meet the needs of those who are dying as well as those who care for them, may lead to a complicated bereavement process for those left behind. In contrast, high quality and well-co-ordinated care at the end of life provides a setting for a healthy experience of death for both family/whānau and surrounding community.

The quality of care provided in the Hawke's Bay region to those at the end of life is everyone's responsibility. Death is not a subject that should be avoided or concealed. It is one of the great certainties of life, and involvement in caring for those people who are dying can, not only strengthen family relationships, encourage compassion and resilience, and promote positive connections in the community, enhance respect for health and life, and reduce community fears about death and dying.

We will extend the ways we receive patient feedback and hear what is important to patients and family/whānau. As the numbers of people needing palliative care grows rapidly over the next 10 years, we will need to be culturally responsive in our practice. This will be supported by shared leadership, working as one team and with agreed priorities for the next 10 years.

We will recruit and train staff in palliative care. This includes sustainable medical staff and replacement of our retiring nursing workforce. Allied health and family support team members will work with primary care to provide a multidisciplinary response for patients with dementia and who are frail. Our focus on education and training will develop the next generation of palliative care practitioners in primary and specialist palliative care.

We will agree how services provide access 24 hours a day 7 days a week. As the national strategies for Health of Older people and Palliative Care are implemented in Hawke's Bay, we will invest in sustainable specialist palliative care services and education and training. This will be supported by technology, shared information across services and using information to inform service improvement.

Our six priorities for the future will improve care for people and their family/whānau. To achieve this requires us to work together as one team to strengthen the foundations on which our vision is built.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

Our six priorities:

1. **Each person and their family/whānau will have their individual needs as the centre of care**
2. **Each person gets fair access to high quality individualised care**
3. **Comfort and wellbeing maximised**
4. **Care is seamless**
5. **The community is involved**
6. **People are prepared to care**

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

Introduction

In today's society, people are increasingly expressing the importance of choice and independence as major components of dignity in advancing illness and old age. Most of us expect to make decisions, not only on how we live our last years, months, weeks and days of life but also on how and where we die. With advances in chronic disease management, single disease approaches for planning end of life will make less sense as functional decline towards end of life could be very hard to predict. This will have wide reaching implications for the co-ordination of care, health and social needs, predictions of future outcomes, referrals and patient, family/whānau experience and choice.

Increasing numbers of people with neurodegenerative conditions like dementia suggests an increasing need for early participation in planning for, and conversation about dying if we are going to be able to provide quality care to those at end of life.

Palliative care is recognised as a speciality that focuses on patient centred care, but as future demands for services increase, more than ever we will need to ensure we continue to place the patient and their family/whānau needs and goals at the centre. Our response to needs will have to be tailored so that we are providing just the right amount of support to empower and enable individuals to achieve their goals and to live their lives until they die. Services will need to ensure that they are providing a culture of enablement alongside our care. This will enable people greater choice, independence and dignity in advancing illness and/or old age.

For Hawke's Bay the level of need for palliative care is hard to predict. There is literature stating that for most people their palliative care needs can be met through good primary palliative care provided by general practitioners, hospitals, aged residential care, district nurses and Māori health providers without the need for direct care provision of specialist palliative care. [18;20.] Providing palliative care needs to be a core part of everyone's practice.

What is palliative care?

Palliative care is the care of people who are dying from active, progressive diseases or other conditions that are not responsive to curative treatment. Palliative care embraces the physical, social, emotional and spiritual elements of wellbeing–tinana, whānau, hinengaro and wairua – and enhances a person's quality of life while they are dying. Palliative care also supports the bereaved family/whānau. [13.]

The principles of palliative care are that it:

- provides relief from pain and other distressing symptoms
- affirms life and regards dying as a normal process
- intends neither to hasten or postpone death
- integrates the psychological and spiritual aspects of patient care
- offers a support system to help patients live as actively as possible until death
- offers a support system to help the family cope during the patient's illness and in their own bereavement
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- will enhance quality of life, and may also positively influence the course of illness
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Palliative care is provided according to an individual's need, and may be suitable whether death is days, weeks, months or occasionally even years away. It may also be suitable sometimes when treatments are being given aimed at extending quality of life.

It should be available wherever the person may be located. It should be provided by all health care professionals, supported where necessary, by specialist palliative care services.

Palliative care should be provided in such a way as to meet the unique needs of people from particular communities or groups. This includes but is not limited to: Māori, children and young people, immigrants, those with intellectual disability, refugees, prisoners, the homeless, those in isolated communities and lesbian, gay, transgender and intersex people. [16.]

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

Palliative care will be delivered by both primary palliative care and specialist palliative care providers working together as one team.

Primary palliative care (PPC) refers to care provided by general practices, Māori health providers, allied health teams, district nurses, aged residential care staff, general hospital ward staff as well as disease specific teams e.g. oncology, respiratory, renal and cardiac teams. The care provided is an integral part of usual clinical practice. Primary palliative care providers assess and refer people to specialist palliative care services when the needs of the person exceed the capability of the primary palliative care provider. [7.]

Specialist palliative care (SPC) is palliative care provided by those who have undergone specific training or accreditation in palliative care/medicine, working in the context of a multidisciplinary team of palliative care health professionals.

Specialist palliative care may be provided by hospice or hospital based palliative care services where people have access to at least medical and nursing palliative care specialists.

Specialist palliative care is delivered in two key ways:

- Directly – direct management and support of the person and family/ whānau where more complex palliative care needs exceed the physical, spiritual or social resources of the primary provider. SPC involvement with any person and the family/ whānau can be continuous or episodic depending on the changing need.
- Indirectly – to provide advice, support, education and training for other health professionals and volunteers to support the primary provision of palliative care.

Future need

Like all of New Zealand, and the World, the increasing numbers of people dying and the changing patterns of illness means the number of people who could benefit from a palliative approach to care is increasing. We will need to manage resources and ensure that we have the right people equipped to care and support the needs of those with a life limiting condition.

Evidence is showing us that in the next 20 years we will have more people dying. They will be living with and dying from not only malignant conditions such as cancer, but chronic conditions and multiple comorbidities, including dementia. Their longevity will be frequently compromised by fragility and disability.[10.]

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

For New Zealand the estimates are:

- Projected deaths will increase by almost 50 percent (from 30,000 to 45,000 per annum in 2038).
- Deaths will reach 55,500 per annum by 2068. This is the result of people living longer than before, coupled with an absolute increase in numbers due to the "baby boom" generation (born between 1946 – 1965) entering their older years.
- There will be rapid ageing of those deaths. In 20 years over half of the deaths will be in the age group 85 years and older. Deaths at the oldest ages will be predominantly women.
- Over the last decade deaths from circulatory system conditions have been declining and deaths from other conditions, including respiratory conditions, dementia and frailty, have been proportionally increasing.

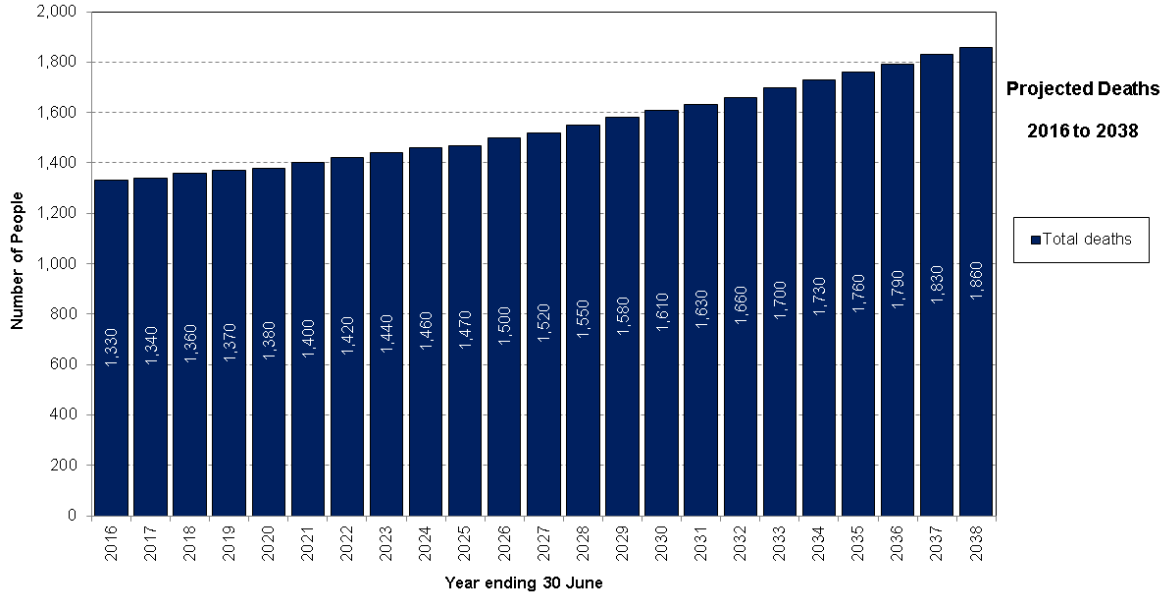
For Hawke's Bay our data is showing us:

- The number of deaths per year will increase by over 500 people. From 1,330 predicted for 2016 to 1,860 by 2038. See graph 1.
- People in the 84-94 age group will more than double from 420 in 2016 to 870 by 2038. See graph 2.
- We will also see an increase in the 95 years and over age group with increases from 100 in 2016 to 200 by 2038.
- The number of Māori and Pasifika people dying will increase and whilst the numbers are relatively small per annum, the increased incidence of poverty plus barriers to access caused by cultural differences and lack of resources means that they are likely to require more support to achieve equitable outcomes.
- The estimated number of people dying who are likely to benefit from palliative care services is 822 in 2015 rising to 927 in 2025.
- The Hospice NZ Palliative Care Demand Model suggests that Cranford Hospice could possibly have been involved with 822 deaths in 2015 based on population data. They were actually involved in 663 deaths. There may be an unmet need of approximately 160 patients currently per annum.

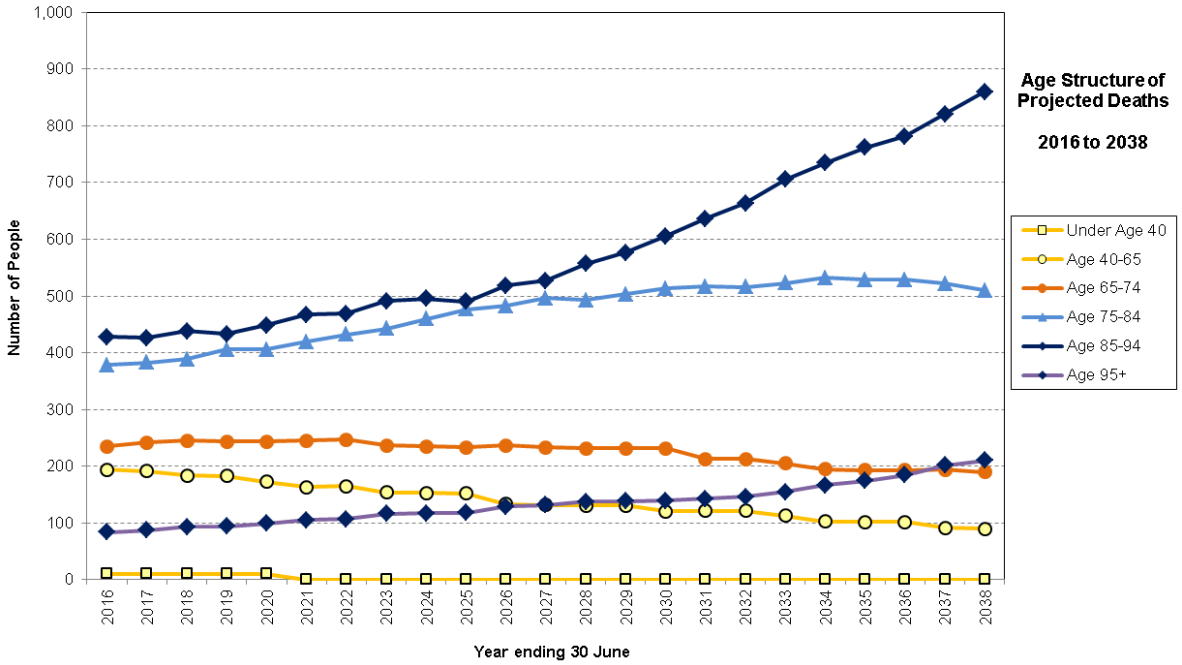
Uptake of specialist and primary palliative care services by Māori (15.8%) and Pasifika (1.1%) was in line with their younger population profiles in 2014. However, it is not known whether the experiences of those groups is equitable, or whether they receive similar number of contacts per person as other non-Maori, non-Pasifika people.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

Graph 1 : Number of projected deaths in Hawke's Bay 2016 to 2038



Graph 2 : Estimated change in age of death in Hawke's Bay from 2016 to 2038

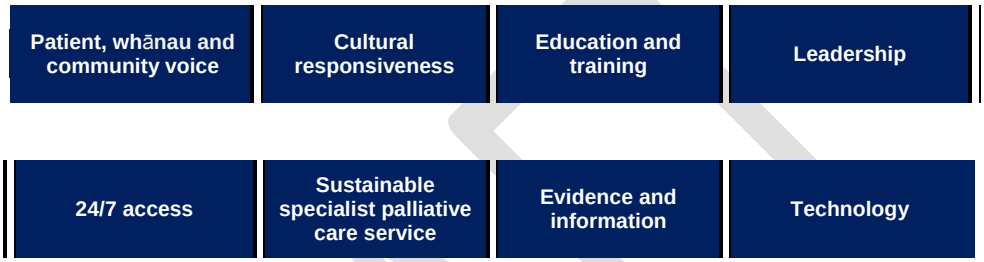


Acknowledgement: This document was developed using the National Palliative and End of Life Care Partnership. Ambitions for Palliative and End of Life Care; A national framework for local action 2015-2020. www.endoflifeambitions.org.uk.

Foundations on which our vision is built

"All people who are dying and their family/whanau who could benefit from palliative care have timely access to quality palliative care services that are culturally appropriate and are provided in a coordinated way" [13].

To realise our vision we have identified eight foundations that need to be in place to meet our commitments to palliative care in Hawke's Bay. They are necessary for each and underpin the whole. These foundations are prerequisites for success in providing quality palliative care to our community now and into the future.



1. Patient, Whānau and Community Voice

Systems for palliative care are best designed in collaboration with people who have had personal experience of death, dying and bereavement. We need to ensure that we are listening to the voices of patients, family/whānau, carers and communities in all that we do.[3] We need to engage communities in their own care design and how health services are delivered. Patients and whānau have told us they need better information so they are aware of support and can access it when they need it.[21]

2. Cultural responsiveness

We will provide culturally responsive care that is mindful of the beliefs and values of patients, family/whanau. This will include considering how to provide palliative care for the growing numbers of Māori and Pasifika who will need these services. Whānaungatanga, kanohi ki te kanohi, wairuatanga, and the availability of Māori kaitakawaenga are all important for effective communication with Māori patients and their family/whānau. [11]

3. Education and Training

To have palliative care as everybody's business there is a large education programme that needs to be implemented. We will need to educate patients, family/whānau, carers and primary palliative care providers in palliative care. With increasing demands on time we will need to look at a range of methods to teach appropriate knowledge and skills in end of life care. They include face-to-face, e-learning, simulation, reflective learning, health promotion, telemedicine, case studies, death reviews, mentoring and supervised clinical practice. We also need to look at ways to educate and train our informal workforce, unpaid volunteers and carers so they too are well equipped to provide hands on care and support. We will need to understand death and dying and advance care planning.

For PPC providers core elements will include:

- Identifying patients who need palliative care
- Breaking bad news
- Conversations with patients and their family/ whānau around advance care planning
- Providing care according to patient and family/whanau needs
- Basic symptom management
- Psychosocial support
- Knowledge of when to refer to specialist palliative care

These should be routine aspects of care delivered by any PPC health practitioner.

With a greater focus on primary palliative care, we will need a sustainable and sufficient specialist workforce to provide advice, support and education to PPC providers. They will also be educated, trained and equipped to manage and care for those who will need complex palliative care management including those with dementia and frailty.

There needs to be a focus on increasing opportunities for introducing and training students in all disciplines in palliative care.

4. Leadership

Shared leadership with clear responsibilities will deliver our vision and priorities. A business case will describe the priorities for investment so that services are planned to meet Hawke's Bay population needs.

Clinical leadership must be at the heart of this strategic vision to ensure that each person and their family/whānau receives the care they need, at the right time, by the right people. They must be committed to the priorities and are key in ensuring outcomes are met. As the Ministry of Health finalises the Palliative Care Strategy and Health of Older People Strategy, we will link new national priorities to our agreed local priorities.

5. Access 24 hours, 7 days a week

Every person at the end of life should have access to services 24 hours, 7 days per week (24/7). In times of distress, uncontrolled pain and other symptoms cannot wait for office hours. People need to know who to contact, no matter what the time. PPC providers, especially GPs, are providing the majority of care. They need to be resourced to meet the demands, with access to 24/7 advice and support from SPC. For those who experience complex symptoms, the SPC nursing and medical team needs to be able to provide advice, care and support to those in need.

In Hawke's Bay we have a PPC programme that is intended to support patients who have a life limiting condition. The funding allocated to this programme is focussed on providing patients with dedicated care led by their primary health care team that works to moderate symptoms, pain, physical stress and the mental stressors associated with serious illness. The goal of this programme is to support planned care to improve the quality of life for both patients and their families.

A patient is offered access to this programme when they meet criteria and when there is a sense of need to provide palliative care therapies when no cure can be expected and when there is an expected length of life of six months or less. We will plan for sustainable funding past 30 June 2017.

6. Sustainable Specialist Palliative Care Service

Specialist palliative care is a vital foundation if we are to realise our vision and our priorities. Our specialist service needs to be equipped and resourced to meet the needs of complex patients, family/whānau, increased education needs, support of primary palliative care providers, advice and support 24/7.

There is a national shortage of palliative medicine specialists, an ageing nursing workforce and the low use of allied health teams.[24] Allied health professionals are commonly part of the palliative care multidisciplinary team in other countries (e.g. United Kingdom) but are not always in New Zealand.

SPC has been working hard since 2011 to build its workforce for the future needs with the introduction of advanced trainee positions, the introduction and expansion of clinical nurse specialists in hospice and hospital and the development of a nurse practitioner role. There is still work to do to ensure that we have a sustainable workforce that is well educated and equipped to meet needs.

In 2016 Cranford Hospice was successful in its submission for Ministry of Health innovation funding. The following roles have been established, based on feedback from General Practice and Aged Residential Care.

The existing Aged Residential Care Palliative Care Resource Nurse position increased from 0.6 to 1.2 full time equivalent. The Aged Residential Care liaison nurse will support and teach skills in palliative care.

A new 0.9FTE Palliative Care Nurse Practitioner supports primary care and rural services. This role works within General Practice with an emphasis in the first instance on rural populations in Central Hawke's Bay and Wairoa. The focus of this role will be to develop the skills, capacity and systems/processes required in primary care to deliver high quality primary palliative care. The Nurse Practitioner will support a primary care training programme and establish a process for regular case review with practices.

A new Caregiver Support Coordinator provides support to family/whanau caring for palliative patients by mobilising existing support services and volunteer networks.

Alongside new innovation and new roles the core clinical team positions need development to meet current and future demands.

Our specialist medical workforce is an urgent priority. We do not have a sustainable medical workforce to meet required needs. With increasing complexity of patient and family/whānau needs and population growth we need to plan to increase resources.

This is not unique to Hawke's Bay. In 2014 the national Palliative Medicine and Training Coordination Committee surveyed District Health Boards and reviewed work force projections for Senior Medical Officer positions. They found 12 Senior Medical Officer positions were vacant and over the next five years to 2019, vacancies due to retirement would increase this to 30.[10.]

The current medical, nursing, allied health, family support workforce is summarised in Appendix 1. Proposed roles and FTEs are described for 2026, to be able to cope with an increased demand for clinical care provision, advice, mentorship, supervision, rural support and education.

Over 50% of our SPC nursing workforce are eligible for retirement in the next 2 to 5 years. In the last few years we have been successful in recruiting for positions, as more nurses are considering palliative care as a speciality. These nurses will need time (2 to 3 years) to specialise and train. As half of our experienced workforce retires in the next 5 years providing support, mentorship and training will be challenging.

We have proposed increases in the nursing workforce to meet the increased need for complex care provision, an increase in inpatient beds at Hospice from 8 to10, increased education and mentorship of primary care providers and training new specialist nursing staff. Staff, services and facilities will respond to the growing numbers of people with dementia and frailty.

To provide a holistic approach to care, SPC has also been growing its family support team and allied health team. This team will almost double to be able to meet demands in the community, especially with increased frailty, the need for a rehabilitative approach and patients living for longer with multiple comorbidities. As interdisciplinary teams develop further with primary care we will improve our communication and systems so we coordinate with new services such as engAGE services for frail older people.

To respond to the needs of the Hawke's Bay population, we will integrate Cranford Hospice and the Hospital Specialist Palliative Care team (HPCT) to form one specialist palliative care service for Hawke's Bay. This integrated service will provide quality clinical care at Cranford Hospice, within the community, and an in-reach consultation liaison service to the Hawke's Bay Fallen Soldiers Memorial Hospital. The service will use the same management support, human resources and clinical guidelines across all care settings. There will be one single point of entry to SPC, and care will be more seamless no matter what bed you are in or which setting that bed is placed in. SPC will be delivered equitably, with greater care coordination and with opportunities for workforce development. There will be rotation of staff across hospice, community and hospital areas.

7. Technology

Care planning conversations need to be effectively recorded and appropriately shared through electronic systems. Electronic systems will need to support wider access to information, extended information context and new functions, such as write access by multiple sources. Access to Advanced Care Plans, pre-emptive charting and crisis plans must be maximised. [19].

8. Evidence and Information

We need to ensure that data and evidence, including people's accounts of their experience of care are used effectively to inform learning, improvement. We will improve the collection, analysis, interpretation and dissemination of data related to palliative and end of life care. This will include evidence relating to needs, provision, activity, indicators and outcomes.[19].

1 Each person and their family/whanau will have their individual needs as the centre of care

"On one occasion the hospice nurse arrived after he was discharged from hospital and worked through the discharge summary to make sure we understood the plan"
Wife of patient

What we already know

- People are unique, they want to be listened to, respected and involved in their care.
- People and their family/whānau require care. The needs of all individual members need to be identified and addressed.
- Leaders and care professionals need to be innovative in how they ask, record and work to support choices, particularly with limited resources.
- People, family/ whānau want to be involved in their care. They should be given all the information, advice and support they need to make decisions about it.
- Advance care planning gives everyone a chance to say what is important to them, ahead of time. It helps people understand what the future might hold and to say what treatment they would and would not want. It helps people, their families and healthcare teams plan for the future and end of life care [14].
- Having conversations about death, dying and end of life requires compassion, knowledge, experience, sensitivity and skill on the part of the health professional involved. A series of conversations may be needed to determine the goals, values and wishes of the person and their family/ whānau in order to reach decisions about the appropriate plan of care.

The building blocks we need in place

Enablers for person centred care

Care must be delivered by systems that are carefully and consciously designed to ensure people retain control and are active participants in their care. Whenever possible care must be respectful of the person's values and preferences **16**.

Access to social support

There is a mix of health, personal and social need at the end of life and afterwards which requires skilled assessment and available resources, delivered in an appropriate environment.

Meaningful conversations

People should have the opportunity to say what's important to them and be well informed about dying, death and bereavement by the right people in the right way at the right time **.14.**

Clear expectations

People and their family/whānau should know what they are entitled to expect as they reach the end of their lives.**15.**

Integrating the philosophy

The philosophy of person centred care is promoted and integrated into models of care across the health and social sectors.

Good end of life care includes bereavement

Caring for the individual includes understanding the need to support the unique set of relationships between family, friends, carers, other loved ones and their community, and includes preparations for loss, grief and bereavement.

2 Each person gets fair access to high quality care

"The hospital palliative care team explained what 'hospice' meant, communication was great. Once this had been explained they were happy to accept a referral"
Consumer feedback

What we already know

- The number of Māori and Pasifika people dying will increase and whilst the numbers are relatively small per annum, the increased incidence of poverty in this population and the barriers to access caused by cultural difference and lack of resources means that they are likely to require more support to achieve equitable outcomes .11.
- We cannot identify and predict when every person will die. The population is ageing and chronic conditions and co-morbidities will increase, making this even more difficult.
- Adults living in Wairoa and Central Hawke's Bay had fewer face to face contacts with SPC than in urban areas. They did not receive a corresponding increase in GP contacts, suggesting an inequity between urban and rural service delivery. 22.
- There is substantial data available regarding the palliative population. This needs to be standardised and used appropriately to identify the needs of the Hawke's Bay population and inform decision making. 23.
- Access to good and early palliative care can improve outcomes, not only with regards to quality of life, but also life expectancy 15; 18
- The way messages relating to the likely outcomes of medical conditions are communicated to people, affect their transition from curative to palliative care and willingness to accept referral to specialist palliative care.
- A public health approach recognises and plans to accommodate those disadvantaged by the economy, including rural and remote populations, tangata whenua, the homeless, lesbian, gay, bisexual, transgender and intersex communities.
- "Until recently, almost all assessments of the quality of palliative care focused on care structures and processes rather than on outcomes. Outcome measures are widely used in palliative care research to describe patient populations or to assess the effectiveness of interventions, but they are not, as yet, always incorporated into routine clinical practice". 2.

The building blocks we need in place

Person centred outcome measurement

With a consistent data set, improvement can be tracked and action taken to ensure all providers are accountable for enabling fair access to quality care.

Using data

"Well-organised data collection can help us to target different population groups and track their progress towards better outcomes, access and wider goals shared with other agencies. Information we collect can improve our understanding of the cause and effect relationships between health and other social services, the effectiveness of different ways of working, and the value for money offered by different interventions" **13**

Unwavering commitment

To achieve equity and access, provision and responsiveness requires unwavering commitment to local contracts and sustainable funding.

Referral criteria

A clear referral process is designed to ensure limited resources are appropriately allocated to serve those most in need. Other barriers to access are proactively evaluated and reduced to ensure an equitable service.

Community partnerships

Local plans should include partnerships between different faith groups and cultural communities, as well as the diverse organisations that support children and young adults, people living with different life shortening illness, and those managing the difficulties of older age.

Population based needs

Palliative care needs for the Hawke's Bay population should inform service design and resource allocation.

3 Comfort and wellbeing maximised

"The hospice doctor was the first to look at my whole picture, she asked "what sort of person are you? Do you want to know anything? She was the first to work with my interest in other therapies"
Patient feedback

What we already know

- What matters most to people at the end of life is good control of pain and other symptoms and being accompanied by but not a burden to their family/whānau. 10.
- People want to be considered as a whole. We need to care for physical, spiritual, family and mental health needs.
- Many people approaching death are fearful of being in pain or distress. Dying and death can be a powerful source of emotional turmoil, social isolation and spiritual or existential distress. 15
- The experience of dying, and of caring for loved ones at the end of life, can have a deep and lasting impact on those involved. Poor support and inadequate symptom control may mean we fail to meet the needs of those who are dying, as well as those who care for them. This may lead to a complicated bereavement process for those left behind.
- A rehabilitation approach to palliative care is central to the person-centred ethos of hospice care, and promotes a culture that helps patients to thrive, not just survive, when faced with uncertainty and serious illness. 8.
- "The benefits of this rehabilitative approach are huge, not only for patients and their families but for hospices too, as they seek to respond to the challenges of supporting more people living longer with chronic conditions". 8.
- Members of the interdisciplinary team offer a diverse range of skills in the provision of emotional, social, psychosocial, cultural, religious and spiritual support, and it is recognised that all team members play a vital role.

The building blocks we need in place

Recognising distress whatever the cause

"Promptly recognising, acknowledging and working with the person to assess the extent and cause of the distress, and considering together what might be done to address this is important. This must be available in every setting." **15**

Skilled assessment and symptom management

Attending to physical comfort and pain and symptom management is the primary obligation of health professionals at this time of a person's life. Their skills to do so must be assured and kept up to date. **15**

Addressing all forms of distress

The experience of suffering associated with physical symptoms may be caused or made worse by emotional or psychological anguish or social or spiritual distress. Addressing this requires professionals to recognise, understand and work to alleviate the causes.

Priorities for care of the dying person

The delivery of care is respectful, individualised and tailored to the person who is in their last days of life. This includes acknowledgement of physical, spiritual, social, mental and cultural factors important to each individual and their family/whanau. Mechanisms to incorporate these factors into the delivery of care are prioritised as decided by the person, wherever they may be dying.

Specialist palliative care

Specialist palliative care is available to those people whose assessed needs exceed the capability of the primary palliative care provider. Specialist palliative care is responsible for supporting primary palliative care to achieve improved outcomes for patients and their family/whānau.

Rehabilitative palliative care

Rehabilitation aims to improve quality of life by enabling people to be as active and productive as possible, with minimum dependence on others, regardless of life expectancy **8.**

Fit for purpose facility

A suitable, well located facility will ensure that everyone has access to expertise and care. It also provides a hub for community engagement.

4 Care is seamless

"It feels like the nurses are all up with the play, we don't have to repeat the story each time, it quickly felt like they really know us"

Patient feedback

What we already know

- People report not having a clear understanding of the role of the multiple health services involved in their care.
- Feedback indicates that lack of coordinated care and services increases the stress experienced by the patient, their carer/s, family and whānau. The alleviation of this would add significantly to their quality of life.
- People feel supported and safe with 24 hour advice available. The quality of the advice directly influences the level of trust people have with a service as a whole.
- Poor communication and failure to share information about the person who is dying is a recurrent theme when care is not good enough. **15**.
- Primary palliative care professionals, including aged residential care staff report the increased confidence and increased ability to provide quality of care when access to specialist advice is available.
- High quality and well-co-ordinated care at the end of life provides a setting for a healthy experience of death for both family/whānau and the surrounding community. **19.**
- People at the end of life with high levels of health, support and palliative needs require flexible packages of quality home nursing and support services to enable them to die at home, and to support their family and whanau at this time.

The building blocks we need in place

Systems for shared records

Health records for all people living with a life-limiting condition must include documentation of their assessed needs, as well as their preferences for end of life care. The person must have given their informed consent and the records should be shared electronically with all those involved in their care.

Clear roles and responsibilities

People living with life limiting conditions may have different services involved in their care. It is essential that people and their families know who and where to turn to for advice in times of change or crisis.

A system-wide response

Coordinated services need to be responsive to need in the community. These systems must include enabling dying people and their family/whānau access to 24/7 advice and support.

Continuity in partnership

Communication between service providers and consistent knowledge across settings, facilitates the smooth and timely delivery of quality care.

5 The community is involved

What we already know

- Talking about death, dying and bereavement is avoided in most community groups.
- Many members of the community do not understand what palliative care is.
- People who are dying and bereaved people often feel disconnected or isolated from their communities and networks of support. 15
- Globally there is much known about helping to nourish compassionate and resilient communities, and how to build capacity to provide practical support. 15
- Death, dying and loss affect everybody.
- The majority of people living and eventually dying from life-limiting conditions spend the greater part of their time at home being cared for and supported by family members, friends and neighbours.
- Many people feel unprepared when faced with the experiences of life-limiting conditions, death and bereavement and are uncertain about how to offer support and assistance.
- The experience of death, dying and bereavement can bring additional personal, health and social costs to those left behind. Much of this is preventable and/or relievable if the right supports are available in the right place at the right time. 9.
- The use of volunteers maximises community engagement and promotes partnerships between agencies and the community. Volunteers add value to the patient and family experience and complement the work of paid staff.

Palliative Care in Hawke's Bay: Our vision and priorities for the future.

The building blocks we need in place

Compassionate and resilient communities

In a compassionate community, people are motivated by compassion to take responsibility for and care for each other with collective benefit.
http://www.charterforcompassion.org/index.php/shareable-community-ideas/what-is-a-compassionate-community

Public awareness

A community will be in the best position to care when they are comfortable with death and dying, can understand the difficulties people face, and know what help is available.

Practical support

Practical support, information and training are needed to enable families, neighbours and community organisations to help.

Volunteers

To meet our commitment, more should be done locally to recruit, train, value and connect volunteers into a more integrated effort to help support people, their family/whanau and communities. **15.**

6 People prepared to care

"People didn't focus on physical symptoms – hospice staff were able to see the whole picture"

Consumer feedback

What we already know

- The recruitment and retention of palliative care medicine specialists in urban and provincial areas is a major issue. 12. This is also an issue for Hawke's Bay. 12.
- We have an ageing specialist palliative care nursing workforce.
- The demand for palliative care services, and thus workforce, will increase slowly over the next ten years but thereafter will increase more rapidly in line with the ageing population. 12.
- There is a growing need for a workforce that is culturally competent to accommodate diverse personal, cultural and spiritual customs and values. 10.
- Feedback suggests that the relationship people have with their GP and practice nurse is extremely important.
- The ageing population and emphasis on integrated care means that home and personal caregiver roles are becoming an increasingly critical part of the palliative care multidisciplinary team.
- Much of palliative care is provided by family members as informal carers. Reliance on informal carers and the volunteer workforce will only increase and we will need to support them to undertake potentially more complex roles. 10.
- A primary palliative care workforce works best when it is well-informed, educated and supported by specialist palliative care in caring for those with life-limiting conditions.
- Specialist palliative care services will need the capability and capacity to be able to provide care, support and educate others to meet projected demands and complexities of care.
- In order to meet identified needs of patients and their family/whanau we need a diverse range of skill and expertise within the interdisciplinary team.
- Staff can only compassionately care when they are cared for themselves. They must be supported to sustain their compassion so that they can remain resilient. This allows them to use their empathy and apply their professional values every time. 15.

The building blocks we need in place

Knowledge base

Only well-trained competent and confident staff can bring professionalism, compassion and skill to the most difficult, and intensely delicate, physical and psychological caring. **15**

Support and resilience

Dealing with death and dying can be challenging. The potential impact of providing end of life care should not be minimised by clinicians, the team or the health service. **1.**

Sustainable workforce

A sufficient formal and informal workforce is needed to provide the necessary hands-on support, advice and education, now and into the future.

Using technology

Professionals have to adapt to new ways of learning and interacting with the people that they are supporting and they need help and guidance to do so. Technology can also play a significant role in enhancing professional's self-directed learning and development. **15**.

Clinical governance

Specialist and primary palliative care services will lead and co-ordinate a single system of care.

HOW WE PLAN TO STRENGTHEN OUR FOUNDATIONS AND MEET OUR PRIORITIES

OUR PRIORITIES

Each person and their family/whānau will have their individual needs as the centre of care

- Enablers for person centred care
- Access to social support
- Meaningful conversations
- Clear expectations
- Integrating the philosophy
- Bereavement Support

Each person gets fair access to high quality care

- Using data
- Unwavering commitment
- Person centred outcome measurement
- Population based needs
- Referral criteria
- Community partnerships

Comfort and wellbeing is maximised

- Recognising distress
- Skilled assessment & symptom management
- Priorities for care of the dying person
- Addressing all forms of distress
- Specialist palliative care
- Rehabilitative palliative care
- Fit for Purpose Facility

Care is seamless

- Systems for shared records
- Clear roles and responsibilities
- System-wide response
- Continuity in partnership

The community is involved

- Compassionate communities
- Public awareness
- Practical support
- Volunteers

All staff are prepared to care

- Knowledge base
- Support and resilience
- Using technology
- Sustainable workforce
- Clinical governance

ACTIONS REQUIRED

- Patients and family members know where to go for palliative care and are connected to services
- Information, education and visibility in the community on innovative ways to increase awareness and community culture around death and dying.
- Health and support workforce is skilled and informed to be able to support conversations around death and dying.
- Integration of Cranford Hospice and Hospital Palliative Care Team to form one specialist palliative care service.
- Specialist medical workforce developed to meet minimum recommended requirements.
- Training and supervision systems in place to support the development of SPC workforce.
- Confirm sustainable and responsive after hours primary palliative care arrangements
- Specialist palliative care provide education and support the efforts of primary palliative care providers in delivering patient care.
- Develop and expand nurse-led initiatives and expert roles such as the Nurse Practitioner.
- Last Days of Life (Te Ara Whakapiri) Pathway is developed and implemented across the region.
- Increase the role and size of the allied health and family support services.
- Research and evaluation outcomes are used to inform best practice.
- New purpose built facility for specialist palliative care. Increase from 8 to 10 inpatient beds as per recommendations (MOH 2013).
- Information technology systems accessible across primary and specialist settings. Palcare or other system.
- Look for opportunities to expand volunteer and informal support services in the community.
- Continued involvement in national data work – to develop measurable patient outcomes.
- Implementation of a rehabilitative approach to palliative care.

OUTCOME MEASUREMENTS

1. Increase in satisfaction with care by family members surveyed after death using a standard questionnaire relating to comfort and wellbeing. Measure baseline then increase by x to y by 2026.
2. National palliative care outcome measures are implemented and used for data collection and evaluation by 31 December 2017.
3. 95% of referrals to specialist palliative are accepted, reflecting appropriateness.
4. 70% of GP practice have access to the electronic patient management system Palcare by 1 July, 2018 and 70% of hospital by 1 July 2021.
5. Monitor access to SPC compared to our population profile & then adapt services to respond:
   - - Death by ethnicity in HB.
   - - Access by area reflects deaths in each area.
   - - Access by condition reflects deaths by condition.
6. The proportion of people dying in their preferred setting will be 90% by 31 December, 2018.
   - The proportion of people dying in hospital will decrease by one third from 34% to 21% by 31 December 2018
7. 100% of aged residential care facilities and hospital wards have implemented the Last Days of Life Care (Te Ara Whakapiri) Plan supported by Specialist Palliative Care services.
8. People with palliative care needs living in aged residential care facilities have care plans reflecting individual needs and best practice via documentation peer review.
9. New SPC facility built by 31 December 2019.
10. One specialist palliative care team for Hawkes Bay providing hospice, community and hospital in-reach consultation-liaison services by 1 July 2018
11. 20% nursing staff under the age of 50 by 2021.
12. Increase the proportion of Maori nurses to reflect the population in Hawke's Bay from 8% to 24 by 2026.
13. SPC FTE medical staff increased from 3.2 to 6.4 by 31 December 2018

FOUNDATIONS

- Patient, whānau and community voice
- Cultural responsiveness
- Education and training
- Leadership
- 24/7 access
- Sustainable specialist palliative care service
- Evidence and information
- Technology

Appendix 1

Table 1: Current & Proposed Medical Workforce

Role 2016	Full Time Equivalent (FTE)	Proposed Roles 2026	Full Time Equivalent (FTE)
Palliative medicine specialist (Hospital 0.5; Hospice 0.5)	1.0	Palliative medicine specialist	2.0
Medical officer special scale Advanced trainee (currently in Hospital)	1.8 0.4	Medical officer special scale or GP with special interest, or advanced trainee or registrar physician training. (Covering community, hospice inpatient unit and hospital services)	3.0
		House officer trainee Hospital & Hospice	1.0
Medical Director	0.4	Medical Director	0.4
TOTAL	**3.6**		**6.4**

This FTE does not include 30% non-clinical time as per contracts or leave requirements.

Table 2: Current & Proposed Nursing Workforce

Roles 2016	Full Time Equivalent (FTE)	Proposed Roles 2026	Full Time Equivalent (FTE)
Nurse Practitioner Candidate	0.9	Nurse Practitioner	0.9
Clinical Nurse Specialists Hospital 2.0; Hospice 2.8	4.8	Clinical Nurse Specialists Hospital 2.0; Hospice 3.0	5.0
Aged Care Liaison Nurses	1.2	Aged Care Clinical Nurse Specialist	2.0
Registered Nurses inpatient unit and community nurses	18.2	Registered Nurses inpatient unit and community nurses, new graduate position	21.8
Education	0.5	Education	2.0
	0.8	Enrolled Nurse	0.8
		Health care assistants	3.0
TOTAL	**26.4**		**35.5**

Table 3: Current & Proposed Allied Health & Family Support Workforce

Roles 2016	Full Time Equivalent (FTE)	Proposed Roles 2026	Full Time Equivalent (FTE)
Counsellor	1.0	Counsellor	2.0
Social Worker	1.0	Social Worker	2.0
Pastoral Care	0.8	Pastoral Care	1.0
Carer Support Coordinator	1.0	Carer Support Coordinator	1.6
Music Therapist	0.4	Music Therapist	0.6
Kaitakawaenga	0.8	Kaitakawaenga	1.0
Cultural Advisor	0.2	Cultural Advisor	0.2
Pharmacist	0.5	Pharmacist	0.8
Occupational Therapist	0.6	Occupational Therapist	1.0
		Physiotherapist	1.0
TOTAL	**6.3**		**11.2**

References

1. Australian Commission on Safety and Quality in Health Care. (2015). National Consensus Statement: essential elements for safe and high-quality end-of-life care. Sydney: ACSQHC
2. Bausewein et al. (2016). EAPC White Paper on outcome measurement in palliative care: Improving practice, attaining outcomes and delivering quality services. Palliat Med. 2016 Jan;30(1):6-22. doi: 10.1177/0269216315589898. Epub 2015 Jun 11.
3. Boon, A. (2012). Excellence through Patient and Family Centred Care; Literature Review. Wellington: Health Quality and Safety Commission
4. BPAC. (2016). Providing palliative care to Maori. As retrieved from: http://www.bpac.org.nz/resources/campaign/palliative/palliative_maori.asp
5. Canadian hospice Palliative care Association. (2013). Innovative Models of Integrated Hospice Palliative Care, the Way Forward Initiative: An Integrated Palliative Approach to care.
6. Heatley, R. (2008). Carers' services guide. London: Help the Hospices
7. Hospice New Zealand. (2011). Hospice New Zealand standards for the care of people approaching the end of life. Wellington: MoH
8. Hospice UK. (2015). Rehabilitative palliative care: enabling people to live fully until they die – A challenge for the 21st century.
9. Kellehear, A. (1999). Health Promoting Palliative Care. Melbourne: OUP
10. Ministry of Health (2016). Review of Adult Palliative Care Services, DRAFT June 2016
11. Ministry of Health. (2014). Palliative Care and Māori from a Health Literacy Perspective. Wellington: Ministry of Health.
12. Ministry of Health. (2011). Palliative Care Workforce Service Review; Health Workforce New Zealand. Wellington: Ministry of Health
13. Ministry of Health. (2001). New Zealand Palliative Care Strategy. Wellington. MoH
14. Northern Regional Alliance. (2016). Advance Care Planning asks "What matters to you?" as retrieved from: http://www.advancecareplanning.org.nz/
15. National Palliative and End of Life Care Partnership. Ambitions for Palliative and End of Life Care; A national framework for local action 2015-2020. www.endoflifeambitions.org.uk.
16. Palliative Care Subcommittee, NZ Cancer Treatment Working Party (2007) New Zealand Palliative Care: A Working Definition. [Online]. Available from: http://www.moh.govt.nz/moh.nsf/pagesmh/2951/$File/nz-palliative-care-definitionoct07.pdf.
17. Palliative Care Council of New Zealand. (2012). New Zealand Palliative Care Glossary. Wellington: Ministry of Health
18. Temel, J.S, Greer, J.A, Muzikansky, M.A, Gallagher, E.R, Admane, M.B, et al (2010). Early Palliative Care for Patients with Metastatic Non-Small-Cell Lung Cancer. N Engl J Med 2010; 363:733-42
19. The Scottish Government. (2015). Strategic Framework for Action on Palliative and End of Life Care 2016-2021. Edinburgh: The Scottish Government.
20. Quill, T.E., & Abernethy, A.P. (2013). Generalist plus Specialist Palliative Care — Creating a More Sustainable Model. N Engl J Med; 368:1173-1175March 28, 2013DOI: 10.1056/NEJMp1215620
21. Layden, Connelly, Sandeman, Hekerem, Alexander, McLoughlin & Tyrrell. (2014). Understanding palliative and end of life care through stakeholder and community engagement. BMJ Support Palliat Care 2014;4:117-118 doi:10.1136/bmjspcare-2014-000653.39
22. Palliative Care Council. (2013). Needs Assessment for Palliative Care: Summary Phase 2 Report: Palliative Care Capacity and Capability in New Zealand June 2013
23. McLeod, H. (2016). Hospice New Zealand Data Project Plan
24. Gomes, Calanzan, Gysels, Hall, Higginson Heterogeneity and changes in preferences for dying at home: a systemic review 12:7 BMC Palliative Care 2013 12:7

Consumer feedback 2015 – 2016

This information is from written and verbal feedback. Quotes are adapted to maintain confidentiality

PRIMARY PALLIATIVE CARE

Almost all mentioned their GP – always expressed strongly, whether good or bad This is a very important relationship. Majority spoke positively about their GP, the sense of support, advocacy and availability. Practice nurses mentioned occasionally, positive addition to sense of support.
Criticisms related to communication:
- of prognosis and introduction of the idea of referral to Hospice
- availability, the need to be able to access as needed and not to have to see other GPs who don't know them
- concentration on physical / medical needs of the patient

SECONDARY PALLIATIVE CARE

Some people reported satisfaction with the service they were provided if/when admitted. Of those that met with the HPCT, all but one was positive and the communication provided relief and more confidence and understanding of hospice.
Several negative experiences expressed of communication from specialists / doctors regarding diagnosis and prognosis. These were all expressed with quite a bit of emotion. Mostly related to 'abruptness' or suddenness of the message. Some felt that this was even "rude" and left them with negative feelings including an inability to ask questions. Many left not knowing what 'palliative care' was and afraid to accept the referral.
Many felt the doctors at the hospital were only interested in one aspect of them and this was a barrier to quality care.

16.2

I can tell my GP anything, she is a great advocate

The Hospital Palliative Care Team explained what 'hospice' meant, communication was great. Once this had been explained they were happy to accept referral

It is hard to get the same GP so we have to "start again" each time - this stopped us talking about Long Term Care like we wanted to. GP is there for/focuses on "medical matters"

When they decide they can't do anything medically for you, you are off on your own, they don't want to know you….

SPECIALIST PALLIATIVE CARE

The majority of those visited described having strong beliefs about Hospice as a 'place to die' and were unhappy about the referral, some saying that this meant they refused referral initially and later regretted this once they learned what it is really about.
All felt that Cranford Hospice staff were great and there were no complaints or criticism about this. Often people felt supported and safe with the 24 hour advice available.
People didn't focus on physical symptoms – most were more interested in talking about the general feeling of psychosocial support and several mentioned that the Hospice staff were able to see the 'whole picture'.
Actually coming into the Hospice building for an appointment was universally a positive experience and reduced fears / barriers to accepting admission if needed.
People talked about the need to keep 'living' and things like vague appointment times were interruptions to that.

My out-patient appointment made all the difference, they linked everything together

Cranford people are non-intrusive; responsive and great for advice

When we ask for a visit – the response is always "yip, no problem"

The doctor was the first to look at the "whole picture"

HAWKE'S BAY District Health Board Whakawāteatia	**Transform & Sustain Programme Refresh** 148
	For the attention of: **HBDHB Board**
Document Owner:	Tracee Te Huia, GM Maori Health
Document Author(s):	Tracee Te Huia & Kate Rawstron, Project Management Office Manager
Reviewed by:	Transform & Sustain Steering Group, Executive Management Team, Māori Relationship Board, HB Clinical and HB Health Consumer Council (November)
Month:	December, 2016
Consideration:	For Discussion

17

RECOMMENDATION

That the HBDHB:

1. **Note** the contents of this report.
2. **Endorse** the proposed new projects.

OVERVIEW

The Transform & Sustain Programme was initiated back in 2013 and is now more than half-way through its five year horizon. Whilst the overarching Transform & Sustain Strategy will not require refreshing until the second of 2017, a mid-point refresh of the programme of projects (that underpin of the strategy) is critical to ensure that we remain on track to delivery against all of our key intentions as planned.

The paper includes:

- The refreshed Transform & Sustain programme workplan
- High-level outline for each of the new proposed projects
- Programme success criteria
- Key next steps

BACKGROUND

The refresh of the Transform and Sustain programme workplan was kicked off with an evaluation of the outcomes achieved at the 'half-way point'. This review highlighted five priority areas where outcomes had not yet been achieved as intended.
These priority areas, plus a sixth that was added subsequently, were identified, validated and endorsed by a wide range of stakeholders as summarised below:

- Project Management Office identified 24 outcome statements from Transform & Sustain document

- EMT members scored each statement as doing well/ making some progress/ not yet making change - scores are aggregated
- Health Services Leadership Team identifies the 8 outcomes with 'least progress' - these are mapped against the EMT scores
- There is a strong degree of consensus and 'five areas' emerge to which EMT add 'organisation development' as a sixth area
- These six priority areas are validated with front line project leaders and change managers
- 'World Café' exercise held at Waipatu Marae with wider health sector leadership forum to confirm priority areas and to gather input to inform future project plans
- List of 21 proposed new projects, across the six priority areas, is generated
- EMT members assigned to a priority area to work with the Project Management Office to establish full programme of work

(Refer Transform & Sustain Refresh 2016 – July 2016).

DEVELOPMENT OF THE REFRESHED PROGRAMME WORKPLAN

Taking the information gathered during the 'World Café' exercise and the list of proposed projects, a benefits mapping exercise was undertaken for each priority area. The purpose of this exercise was to ensure a clear relationship exists between the identified problem statements, business outcomes and objectives, and to ensure the proposed projects aligned to this and would deliver the desired set of business outcomes and benefits. Each session included three nominated EMT members and was facilitated, and outputs documented, by the PMO Manager.

Overall these sessions were very productive, generating a lot of good robust challenge and discussion, and for the majority of priority areas this resulted in a number of refinements to the list of proposed projects.

In addition to the project changes, this exercise also highlighted the high degree of working dependencies between projects within a single priority area but also across priority areas. In recognition of this, and programme lessons learned thus far, it was agreed that a single EMT member should be assigned as SRO to all projects under one priority area, and that a priority area would be managed as a workstream under the programme.

It is important to note that further lessons, learned during the first half of Transform & Sustain, have also been applied at a project level and will continue to be applied as new projects are initiated and stood-up as part of the refresh activity.

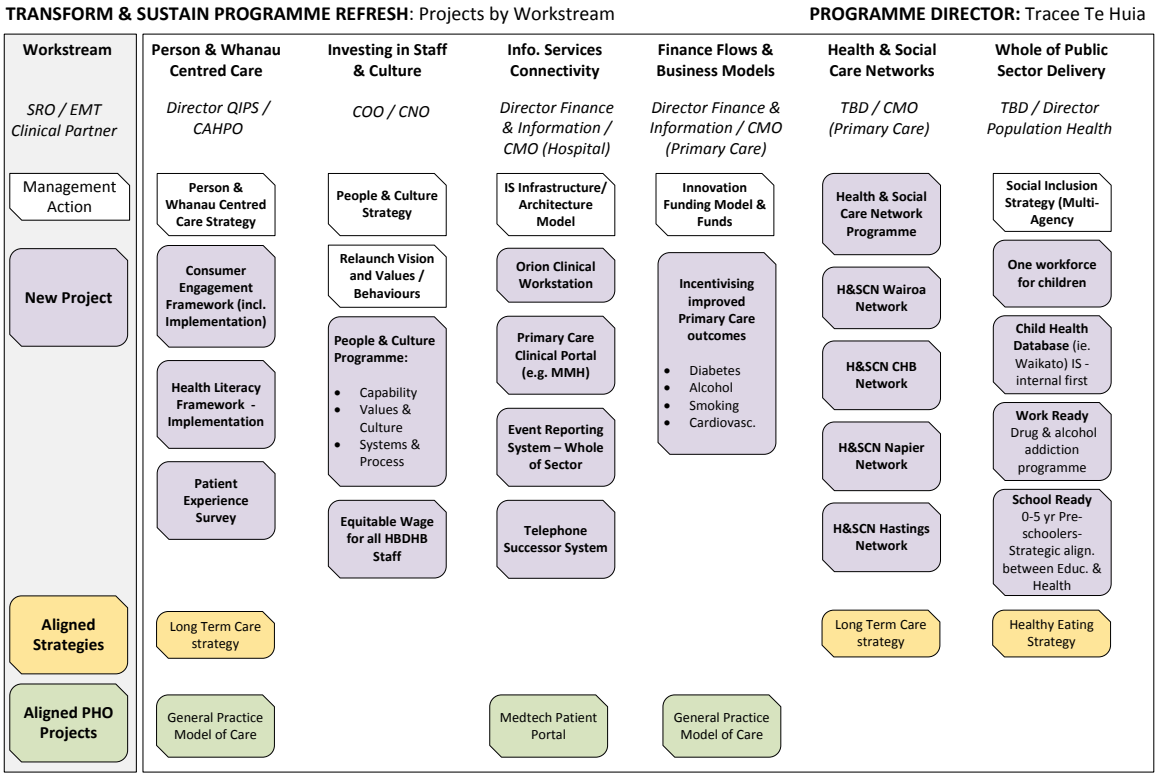
Following the documentation of outputs from the benefit's mapping sessions, one further review, by workstream, of the proposed projects was undertaken with the nominated workstream SRO before final review by the Transform & Sustain Programme Director and Transform & Sustain Steering Group.

CLINICAL LEADERSHIP

By moving to a workstream management structure (with a single SRO per workstream) this enables increased management and alignment to operational functions however, it does not enable the desired level of clinical partnering. As such a 'EMT Clinical Parter' role will be established at the workstream level to partner with the workstream SRO. Clearly defined roles and responsibilities for this role, and that of the workstream SRO, are currently being developed.

In addition to this new role, the programme will also ensure clinical leadership is maximised at a project level (e.g. within project roles such as Project Sponsor, Steering Group membership etc.), ensure clinical leadership is distributed across the team and development opportunities for future leaders identitied.

The final list of 19 proposed projects, by workstream, is shown on the next page.



***QIPS** = Quality Improvement & Patient Safety / **CAHPO** = Chief Allied Health Professions Officer / **COO** = Chief Operating Officer / **CNO** = Chief Nursing Officer / **CMO** = Chief Medical Officer*

Further detail on each of the projects can be found in the following tables.

It is important to note, however, that this information should be viewed as indicative only at this time. Once the programme workplan has been approved each project will undergo full scoping, as per the prescribed HBDHB project methodology, with any significant new investment approved via the normal prioritisation and funding processes.

WORKSTREAM: Person & Whanau Centred Care – Director QIPS / CAHPO

Key Intention	**Project**	Short Description	Dashboard KPI
2	**Patient Experience Survey**	To develop and implement a local patient experience survey, and set of processes to utilise results alongside the National Patient survey, to support continuous improvement.	Patient Experience
2	**Consumer Engagement Framework (CEF)**	Design and implementation of a CEF to ensure the voice of the consumer is utilised in the right way on a consistent basis across the health sector, through the application of a co-design model.	Patient Experience
3	**Health Literacy Framework (HLF) - Implementation**	Implementation of the HLF (Action Plan & detailed Implementation Plan), this project includes: - Stanford Programme; empowering self-management - Relationship centred practice; clinical engagement tool - Health Passport - Review of all info provided to consumers/patients	Patient Experience

WORKSTREAM: Investing in Staff and Changing Culture – GM HR / CNO & COO

Key Intention	Project	Short Description	Dashboard KPI
Enabler	**People & Culture Programme**	A 2-5 year programme of work to change the culture of health sector focusing initially on the 'hospital'; the programme will be planned and implemented on a rolling 12-mth basis and is made up of the 3 strands: **Capability** - Workforce development (CI) - leadership (including Maori leadership development) - Talent Mapping and succession planning - Training Hub **Values & Culture** - Behaviours - creation of a Healthy at Work Programme (incl. nurse-led assessment clinics) - Resilience / kindfulness / mindfulness - Employee Brand - Staff Engagement Survey **Systems & Process** - BAU - Better, Smarter, Faster - Staff discounts / confidential budgeting services	KPI - Better staff engagement KPI - Culturally competent workforce KPI - Better staff retention KPI- Improved hospital workforce productivity
Enabler	**Equitable Wage for All HBDHB Staff**	To establish a training route for DHB staff, paid below the living wage, to attain the living wage, this project will include: - framework and processes i.e. appraisals - training programme tailoring for each staff group	KPI - Improved hospital workforce productivity KPI - Better staff engagement KPI - Better staff retention KPI - Reduced infant mortality KPI - Fewer premature deaths KPI - Fewer women smoking in pregnancy KPI - Reducing Rheumatic fever

WORKSTREAM: Financial Flows and Business Models – Director Finance & Information / CMO (Primary Care)

Key Intention	Project	Short Description	Dashboard KPI
11	**Incentivising improved Primary Care outcomes**	Establishment of new funding flows to target evidence based interventions within Primary Care, initial focus will be on reducing ASH rates in particular those issues relating to: - Diabetes - Alcohol - Smoking - Cardiovascular	KPI - Care close to home KPI - More treatments out of hospital

WORKSTREAM: Information Services Connectivity – Director Finance & Information / CMO (Hospital)

Key Intention	**Project**	Short Description	Dashboard KPI
Enabler	**Orion Clinical Portal**	Implement an enhanced version of the regional standard clinical workstation, standardise and document associated business processes.	KPI - A safer hospital KPI - Improved hospital workforce productivity
Enabler	**Primary Care Clinical Portal**	Implementation of a system which allows clinical access to a single Primary Care Record, is centred on the patient and facilitates multi-disciplinary recording & patient management.	KPI - Care close to home KPI - Fewer premature deaths
Enabler	**Event Reporting System**	Upgrade of the current system (RL6 solution) and subsequent roll out to the community.	KPI - Patient Safety
Enabler	**Telephone Successor System**	Design and implementation of a replacement system for the current switchboard and Wi-Fi telephone system that enables both current and enhanced functionality e.g. mobile devices.	KPI – More efficient building

WORKSTREAM: Health & Social Care Networks – SRO TBD / CMO (Primary Care)

Key Intention	**Project**	Short Description	Dashboard KPI
8	**Health Social Care Network - Overarching Programme**	Establish a framework that supports community-led redesign of health and wellness services, based on the needs and aspirations of the local population. There is a focus on collaborative working practice across health and social service providers.	KPI - Reduced Readmissions KPI - Emergency Department Waits KPI - Fewer premature deaths KPI - Care closer to home KPI - More treatments out of hospital KPI - Better staff engagement
7	**HSCN - Wairoa**	Design and implement a network with locality based planning and delivery of services - includes: - Health Needs Assessment - Asset Mapping - MSD profiling	
7	**HSCN - CHB**		
8	**HSCN - Napier**		
8	**HSCN - Hastings**		

WORKSTREAM: Whole of Public Sector Delivery – SRO TBD / Director Population Health

Key Intention	Project	Short Description	Dashboard KPI
4	One Workforce for Children	Identify and address the gaps in knowledge and skills of the vulnerable children's workforce in Hawke's Bay in order to work effectively with families and improve outcomes (particularly for tamariki and rangatahi Māori and their Whānau) including: - benchmark skills against the Children's Action Plan Core Competency Framework and relevant registration bodies - aggregate the results up to each service, each sector and as a region - design, deliver and evaluate a training programme to address the skills gaps identified, and assess the impact on outcomes for children and families	Living healthier and longer lives KPI - Reduced infant mortality KPI - Healthier weight KPI - Reduced rheumatic fever KPI - Reduced readmissions
4	School Ready	Through the strategic alignment between Education and Health sectors, developing an integrated view of services provided/ aimed at Pre-schoolers (0-5yrs) to ready children for the best possible start to schooling.	Living healthier and longer lives KPI - Reduced infant mortality KPI - Healthier weight KPI - Reduced rheumatic fever KPI - Reduced readmissions
4	Work Ready	A drug & alcohol addiction programme providing a health service response to current addiction issues within our population who would otherwise be available to work.	Living healthier and longer lives
4	Child Health Database	To evaluate, recommend and implement the preferred solution to combine the various child health databases into a single repository (i.e. Waikato model)	Living healthier and longer lives KPI - Reduced infant mortality KPI - Healthier weight KPI - Reduced rheumatic fever KPI - Reduced readmissions

Currently there are 23 projects in-flight; of which 14 are planned to be in closure or closed by the end of the year. A further 4 projects ('next phase' or from the capital master plan) are either in the process of starting up or are planned to start in early 2017. Combined with the 19 new proposed projects this brings the total number of projects to 32:

23	-	14	+	4	+	19	=	**32**
In- flight Projects		Closing		Other Projects		Refresh Projects		**Total Projects**

A draft Transform & Sustain Programme workplan, based on the planned and estimated projects timeframes, can be found in **Appendix 1**.

KEY ASSUMPTIONS / KEY RISKS

- Resource availability e.g. Project Manager resource, IS support, funding
- Necessary Clinical engagement and availability of subject matter experts
- Feasibility of the planned programme of change and ability for the health system to absorb this schedule of change
- The number of new projects to be scoped and stood-up in the next 3-6 months
- Alignment with PHO and Primary Care programme of change

TRANSFORM & SUSTAIN PROGRAMME SUCCESS CRITERIA

As we move into the second half of the Transform & Sustain Programme it is critical that we continue to remain focused on delivering transformational change that meets the original objectives as outlined in the 11 key intentions and delivers sustainably business outcomes and benefits.

Whilst it is important that appropriate structures and discipline are applied at an individual project level, it is the collective change to the way we 'do business' across the sector that will ultimately determine the success (or otherwise) of the programme.

This means that by December 2018:

- Our staff are happier; they feel valued and supported, and are more resilient
- Consumers have a voice; they are engaged consistently across the health sector, co-design is just how we do things and consumers own their own health plans
- Our primary and secondary clinicians, and patients, have access to the same patient information, interventions are faster, and paper has been removed from our processes
- Patients are happier, safer and receiving more treatment in the community
- Communities have increased ownership of the services delivered in their locality
- The HBDHB is leading the way on building intersectoral relationships with a multi-agency programme of work in-place and visible

KEY NEXT STEPS

09/11/16 Workplan reviewed and endorsed by:

- Clinical Council
- Consumer Council
- MRB

16/11/16 Refresh update at Bi-partite meeting

30/11/16 Review and endorsement of workplan by FRAC

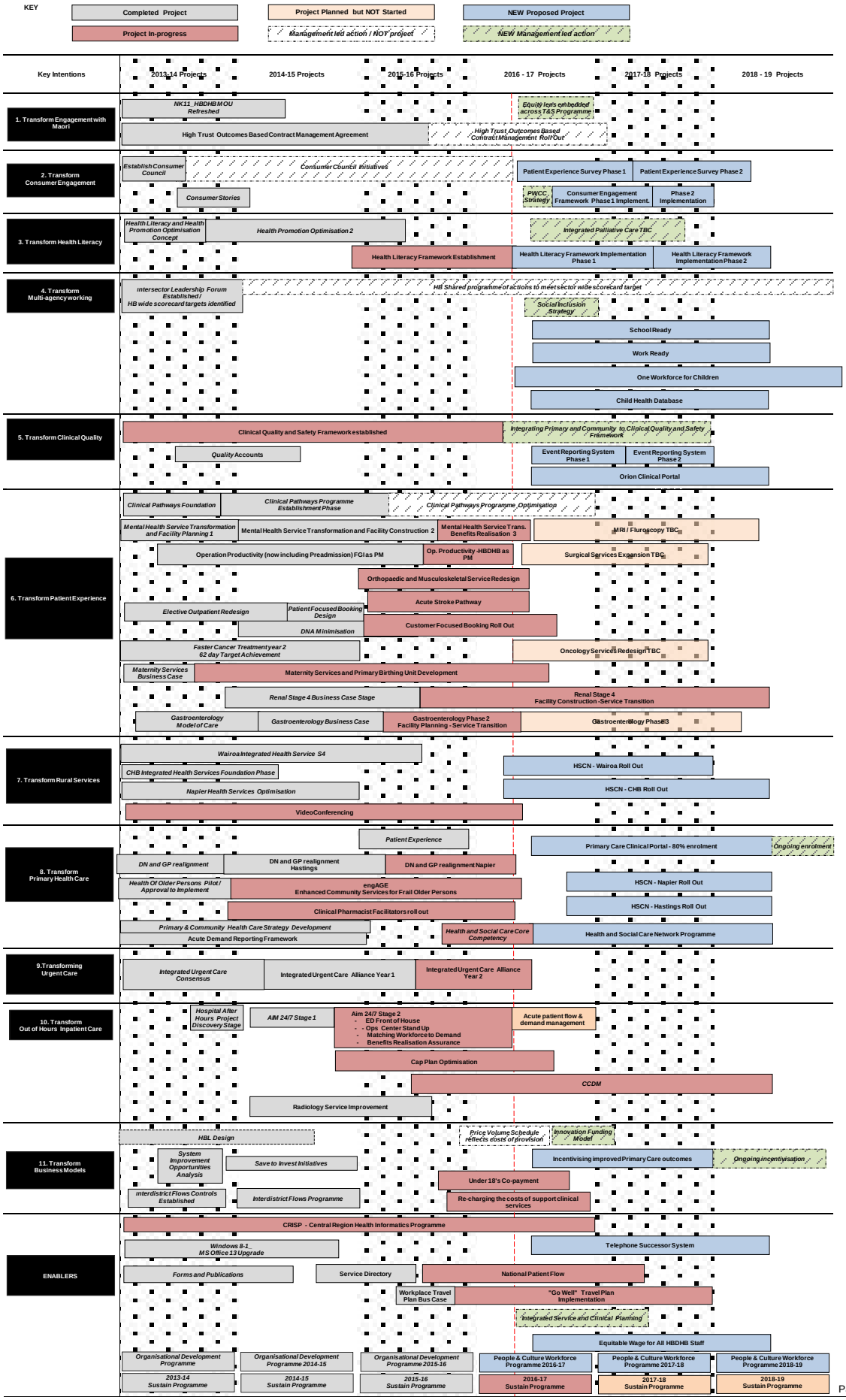
30/11/16 BOARD approval of workplan – *alternative date December Board meeting*

Post approval:

Dec 2016 Syndication with PHO/ HSLT / Service Directorate / Unions

Feb 2017 T&S Refresh launched – *exact date TBC*

APPENDIX 1: TRANSFORM & SUSTAIN PROGRAMME WORKPLAN DRAFT



APPENDIX 2: Strategic Dashboard Q4 2014/2015

Transform and Sustain Strategic Dashboard – Q4

HEALTHY HAWKE'S BAY

NZ TRIPLE AIM

TRANSFORM & SUSTAIN

OURHEALTH HAWKE'S BAY Whakawateetia

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

VITAL SIGNS

SUPPORTING DIMENSIONS

		Baseline	Previous	Current	Target
Patient experience	Patient Experience Survey Score	8.5	8.7	8.7	≥ 8.5
	*Communication				
Better access to specialist outpatients	Did not attend (DNA) rate across first specialist assessments	6.10%	7.80%	7.40%	≤ 7.50%
A safer hospital	Standardised Hospital Mortality Rate	101	108	103	≤ 100
More Very High Quality General Practices	General Practices with Cornerstone Accreditation	50.0%	86.0%	86.0%	≥ 80.0%
All General Practices are Demonstrably Good	General Practices that meet Foundation Standards	0.0%	64.0%	71.0%	≥ 100.0%
Reduced readmissions	Hospital Standardised Readmission Rate	7.5%	7.7%	7.7%	≤ 7.4%
A culturally responsive workforce	Percentage of DHB Staff Ethnicity who are Māori	11.6%	12.4%	12.5%	≥ 13.9%
Emergency Department Waits	Patients waiting less than 6 hours in ED	91.5%	93.9%	92.5%	≥ 95.0%

		Baseline	Previous	Current	Target
Resource sustainability	Financial Surplus DHB $'000		(-188)	$376	≥ $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	3.158	3.12	≥ 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%	2.7%	≤ 2.41%
Better staff retention	Staff Turn-over	8.10%	9.11%	9.3%	Between 9.5% and 10.5%
Care close to home	Strategic Spending Shift	-0.3%	0.1%	0.4%	≥ 0.2%
More Treatments Out of Hospital	Ambulatory-sensitive Hospital Admissions	76.0%	73.0%	70.0%	≤ TBC

		Baseline	Previous	Current	Target
Live healthier and longer lives	Difference in Maori Death rates (Below 50 years of age)	17%	17%	9%	≤ 14%
Reduced infant mortality	Infant Mortality Rate	4.41	4.41	2.79	≤ 5
Fewer premature deaths	Maori All Cause Mortality Rate (less than 75 years and per 100,000 population)	469	469	-	≤ 310
Healthier weight	Maori Children Obesity Rate	7.9%	9.3%	10.5%	≤ 8%
More heart and diabetes Checks	Diabetes and Cardiovascular Services Checks	88%	90%	89%	≥ 90%
Faster cancer treatment	Faster Cancer Treatment (FRAC: July 16)	62%	63%	63%	≥ 85%
Fewer women smoking in pregnancy	Maori Women Smoking During Pregnancy	44%	44%	44%	≤ 22%
Reducing Rheumatic Fever	Rheumatic Fever Hospitalisation Rates	0.6	0.6	1.88	≤ 2

APPENDIX 3: Benefit Mapping Session Attendees

PRIORITY AREA	ATTENDEES			
Investing in Staff and Changing Culture	Tracee Te Huia	Kate Coley	Chris McKenna	
Person & Whanau Centred Care	Tracee Te Huia	Kate Coley	Andy Phillips	
IS Connectivity	Tim Evans	John Gommans	Chris McKenna (apologies)	
Financial Flows & Business Models	Tim Evans	Tracee Te Huia	Ken Foote	Allison Stevenson
Health & Social Care Networks	Tracee Te Huia	Liz Stockley	Mark Petersen (apologies)	Belinda Sleight
Whole of Public Sector Delivery	Kevin Snee	Tracee Te Huia	Caroline McElnay	

APPENDIX 4: Transform & Sustain Key Intentions

1. Transform Engagement with Maori
2. Transform Consumer Engagement
3. Transform Health Literacy
4. Transform Multi-agency working
5. Transform Clinical Quality
6. Transform Patient Experience
7. Transform Rural Services
8. Transform Primary Health Care
9. Transforming Urgent Care
10. Transform Out of Hours Inpatient Care
11. Transform Business Models

HAWKE'S BAY District Health Board Whakawāteatia	**HBDHB Transform & Sustain Strategic Dashboard Q1 Jul-Sep 2016** 149
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Tracee Te Huia, GM Maori Health Peter Mackenzie, Business Intelligence Analyst
Reviewed by:	Executive Management Team
Month:	December, 2016
Consideration:	For Monitoring

BACKGROUND

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

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.

ONGOING REVIEW OF REPORTING

A review of the Transform and Sustain Strategic Dashboard in relation to programs of work and other relevant quarterly reporting is currently underway in order to better align with the organisations performance. The main outcomes of the review are focusing on:

- Better aligning the dashboard with the efforts of the Transform and Sustain Strategy.
- Making the reporting clearer for the less technically competent.
- Moving to exceptions reporting.
- Considering our current reporting against the planning advice changes from the ministry for 2017/18 financial year.

EXCEPTIONS AND AREAS OF FOCUS

General Practices that meet Foundation Standards:
There are currently 2 more practices that have been audited and awaiting accreditation, that will leave 4 more practices to assess this financial year.

Financial Surplus:
Update of IDF wash-up provisions adversely affected the September result, and were partly offset by lower than budgeted elective volumes and allied health vacancies.

Maori Children Obesity Rate:
Additional funding for under 5's has only been rolled out for 2 years via the Maternal nutrition programme, any benefit from the very early intervention (i.e. GDM (gestational diabetes management), maternal GRx (green prescriptions) and Healthy Frist Food – under 2) will only start showing in 2017 data, we expect that change to be small as they will have only interacted with a developing programme. We know the GDM is happening 2 week earlier than before the maternal nutrition programme started.
Creating lifestyle change for whanau takes time and engagement (as Heather Skipworth has pointed out) to influence the weight of 4 year olds we need to change attitude to "no SSBs" (sugar sweetened beverages), increase breastfeeding and reduce portion sizing (this mean both at home and take-away providers).
We have reoriented funding to increase Active Families volume this financial year so that should also support change but will not be evident until 2018 data. We are moving to work with early childhood education provider to support them to be a healthy eating environment – work beginning in 2017. Also we are supporting school in order to continue the work being done for under 5's.

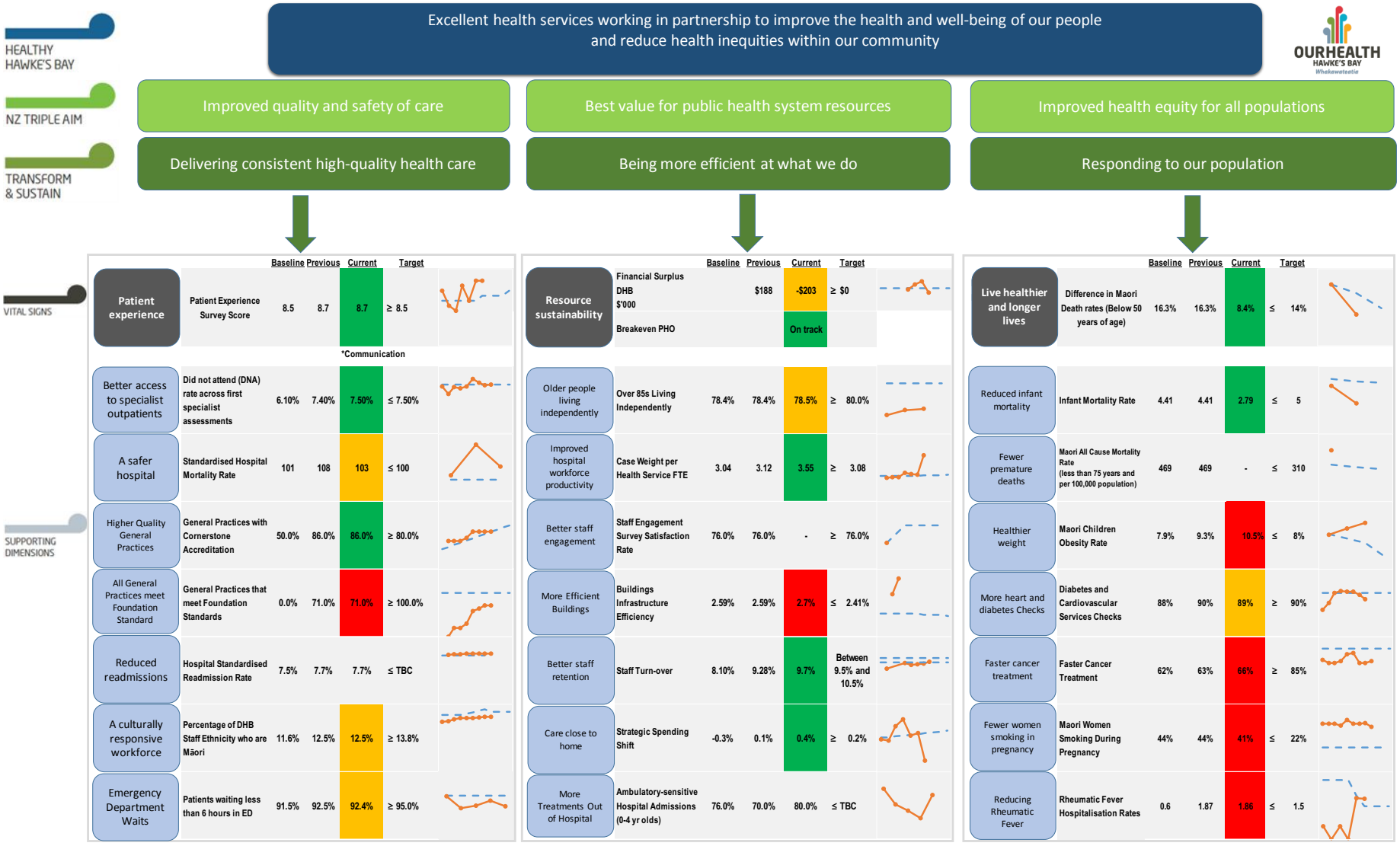
Faster Cancer Treatment:
There have been multiple discussion with FCT (faster cancer treatment) Governance group and clinical teams for implementation of internal standards, such as referral to MDM (multi disciplinary meeting) < 28 days, and referral for urgent CT (computer tomography) within 10 days.

The IT team have developed a module in the PMS (patient management system), that will support the capture of patient information in an electronic format. The value of this development ensures all the data for the patients, identified for the 62 day target and the 31 day indicator to be held in an electronic database.

Maori women smoking during pregnancy:
There are a number of activities run by the smokefree team and Ata Rangi Maternity to address the high smoking rate in Maori and Pacific birthing women.

- Close work with Information technology team to make sure we pull out the correct data.
- Incentivized cessation provided not only to pregnant and postnatal women but to their whanau too since July 2016.
- Early Engagement Project being launched in November 2016 within all GP practices and primary health care providers to increase early referral to smoking cessation services. This project involves the maternity smokefree coordinator directly engaging with each GP practice in the area to inform them of the incentivized cessation options and to distribute free merchandise to all practices for women, whanau and medical staff.
- The smokefree team has sourced more funding for baby carbon monoxide monitors to be purchased for use within the DHB but also in the Napier Midwifery Resource Centre, as well as a couple of monitors for the community based cessation providers.
- All three cessation providers in the area are Maori providers with a high ratio of Maori to non-Maori staff. This should strongly support the cultural needs of our non smokefree women and their whanau.

Rheumatic Fever Hospitalisation Rates:
Within the last quarter a small baseline survey within the Flaxmere school communities undertaken, this shows good understanding of throat swabbing for sore throats but not the link to rheumatic fever. The Action plan from survey and anecdotal evidence is multifaceted and includes engaging with throat swabbing schools and close-by ECEC Facebook pages, local performers, national health promotion materials, etc. Kaiawhina's find children more likely to report incomplete adherence than caregivers and a 5 day reminder useful.


HEALTHY HAWKE'S BAY
NZ TRIPLE AIM
TRANSFORM & SUSTAIN
VITAL SIGNS
SUPPORTING DIMENSIONS
Excellent health services working in partnership to improve the health and well-being of our people and reduce health inequities within our community
OURHEALTH HAWKE'S BAY Whakawateatia
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
Patient experience
Patient Experience Survey Score 8.5 8.7 8.7 ≥ 8.5
*Communication
Better access to specialist outpatients
Did not attend (DNA) rate across first specialist assessments 6.10% 7.40% 7.50% ≤ 7.50%
A safer hospital
Standardised Hospital Mortality Rate 101 108 103 ≤ 100
Higher Quality General Practices
General Practices with Cornerstone Accreditation 50.0% 86.0% 86.0% ≥ 80.0%
All General Practices meet Foundation Standard
General Practices that meet Foundation Standards 0.0% 71.0% 71.0% ≥ 100.0%
Reduced readmissions
Hospital Standardised Readmission Rate 7.5% 7.7% 7.7% ≤ TBC
A culturally responsive workforce
Percentage of DHB Staff Ethnicity who are Māori 11.6% 12.5% 12.5% ≥ 13.8%
Emergency Department Waits
Patients waiting less than 6 hours in ED 91.5% 92.5% 92.4% ≥ 95.0%
Resource sustainability
Financial Surplus DHB $'000 $188 -$203 ≥ $0
Breakeven PHO On track
Older people living independently
Over 85s Living Independently 78.4% 78.4% 78.5% ≥ 80.0%
Improved hospital workforce productivity
Case Weight per Health Service FTE 3.04 3.12 3.55 ≥ 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% 2.7% ≤ 2.41%
Better staff retention
Staff Turn-over 8.10% 9.28% 9.7% Between 9.5% and 10.5%
Care close to home
Strategic Spending Shift -0.3% 0.1% 0.4% ≥ 0.2%
More Treatments Out of Hospital
Ambulatory-sensitive Hospital Admissions (0-4 yr olds) 76.0% 70.0% 80.0% ≤ TBC
Live healthier and longer lives
Difference in Maori Death rates (Below 50 years of age) 16.3% 16.3% 8.4% ≤ 14%
Reduced infant mortality
Infant Mortality Rate 4.41 4.41 2.79 ≤ 5
Fewer premature deaths
Maori All Cause Mortality Rate (less than 75 years and per 100,000 population) 469 469 - ≤ 310
Healthier weight
Maori Children Obesity Rate 7.9% 9.3% 10.5% ≤ 8%
More heart and diabetes Checks
Diabetes and Cardiovascular Services Checks 88% 90% 89% ≥ 90%
Faster cancer treatment
Faster Cancer Treatment 62% 63% 66% ≥ 85%
Fewer women smoking in pregnancy
Maori Women Smoking During Pregnancy 44% 44% 41% ≤ 22%
Reducing Rheumatic Fever
Rheumatic Fever Hospitalisation Rates 0.6 1.87 1.86 ≤ 1.5

	Indicator Origin	Measure	Definition	Frequency
Patient Experience	National	Communication	Patient Experience Survey - Dashboard only displays Domain with the lowest score each quarter. Target ≥ 8.4	Quarterly
		Partnership	Patient Experience Survey - Dashboard only displays Domain with the lowest score each quarter. Target ≥ 8.4	Quarterly
		Co-Ordination	Patient Experience Survey - Dashboard only displays Domain with the lowest score each quarter. Target ≥ 8.4	Quarterly
		Physical and Emotional Needs	Patient Experience Survey - Dashboard only displays Domain with the lowest score each quarter. Target ≥ 8.4	Quarterly
Better Access to Specialist Outpatients	Local	Did not attend (DNA) rate across first specialist assessments	Patients who do not show up to an outpatient appointment without any prior notice	Quarterly
A Safer Hospital	Local	Standardised Hospital Mortality Rate	Ratio of actual to expected hospital deaths	Annually
More Very Higher Quality General Practices	Local	General Practises with Cornerstone Accreditation (Practices with Population >3,142)	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.	Quarterly
All General Practices are Demonstrably Good	Local	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	Quarterly
Reduced Readmissions	National	Hospital Standardised Readmission Rate	Patients re-admitting to the hospital within 28 days of being discharged. MOH target.	Quarterly
A Culturally Responsive Workforce.	Local	Percentage of DHB Staff Ethnicity who are Maori	The % of staff employed at the DHB that identify their ethnicity as Maori	Quarterly
Emergency Department Waits	National	Patients waiting less than 6h in ED	Health Target. Patients waiting less than 6 hours in the ED department	Quarterly

Resource Sustainability	Local	Financial Surplus DHB	$0 or + variance to budget	Quarterly
	Local	Breakeven PHO	Financial result = $breakeven	Quarterly
Older People Living Independently	Local	Over 85s Living Independently	The proportion of 85years who are not living in Age Residential Care	Annually
Improved Hospital Workforce Productivity	Local	Case Weight per Health Service FTE	Numerator: Total caseweights. Denominator: Total Doctor and Nursing FTE. Improve productivity by either increasing case weights or decreasing	Quarterly
Better Staff Engagement	Local	Staff Engagement Survey Satisfaction Rate	% engaged employees at HBDHB based on the Engagement questions in the staff engagement survey	Annually or longer
More Efficient Buildings	Local	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	Quarterly
Better Staff Retention	Local	Staff Turn-over	Turn-Over of HBDHB employees	Quarterly
Care Closer to Home	Local	Strategic Spending Shift	To shift resources from hospital and IDFs to Primary and Community by 0.5% p.a.	Annually
More Treatment Out of Hospital	National	Ambulatory-sensitive hospitalisations	HBDHB ASH rate 0-4 year olds relative to the national Rate as a percentage. (the Ministry of health have recently updated the indicator and are currently collecting baseline data. A target will be set as part of the 2016/17 planning process).	Six Monthly

Live Healthier and Longer Lives	Local	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.	Annaully or longer
Reduced Infant Mortality	Local	Infant Mortality Rate	HB Children who die from any cause under the age of 1 / total number of live births in the year	Annually
Fewer Premature Deaths	Local	Maori All Cause Mortality < 75	The age standardised rate of death for Maori people under the age of 75. per 100,000	Annually or longer
Healthier Weight	Local	Obesity Rate	Prevalence of Maori children having a B4shcool check who are obese according to the international obesity task force.	Annually
More Heart and Diabetes Checks	National	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.	Quarterly
Faster Cancer Treatment	National	Faster Cancer Treatment	62 Day FCT Health Target	Quarterly
Fewer women smoking in pregnancy	Local	Maori Woman Smoking During Pregnancy	% All Maori Women who are recorded as smoking at the birth of their baby.	Quarterly
Reducing Rheumatic Fever	National	Rheumatic Fever Hospitalisation Rates	Rate per 100,000 TBC	Quarterly

HAWKE'S BAY District Health Board Whakawāteatia	**Te Ara Whakawaiora- Healthy Weight Strategy** 150
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Caroline McElnay, Director Population Health Shari Tidswell, Team Leader/Population Health Advisor
Reviewed by:	Executive Management Team
Month:	December 2016
Consideration:	For Information and receive recommendations

RECOMMENDATION:

That the HBDHB Board:

Note the contents of this report and receive the recommendations as noted below.

1. As the reporting against this target improves it will be important to ensure equity of referrals and to capture outcome data resulting from the referrals.
2. Interventions available need to be effective and appropriate, whether they are delivered by clinicians, or through whānau or other group based programmes. These programmes need to have ongoing review to ensure this is so.
3. Further work is required to identify the need for a nutrition advice resource for key organisations engaging with whānau including; kohanga, punanga and other early childhood education providers, marae, community groups, primary care and hauora. This will reinforce messages provided in Before School Checks and support lifestyle changes whānau are making to reduce weight prior to their child's four year check and reduce the number of children in the 98th percentile and over (i.e. target denominator).
4. There needs to be a coordinated and integrated approach to supporting healthy messages about nutrition and activity from conception to school age. This is outlined in the Healthy Weight Strategy and needs to be implemented.

OVERVIEW

Te Ara Whakawaiora (TAW) is an exception based report, drawn from Annual Māori Plan (AMP) quarterly reporting, and led by TAW Champions. Specific non-performing indicators are identified by the Māori Health Service which are then scheduled for reporting on progress from committees through to Board. The intention of the programme is to gain traction on performance and for the Board to get visibility on what is being done to accelerate the performance against Māori health targets. Part of that TAW programme is to provide the Board with a report each month from one of the champions. This report is from Director Population Health, Champion for the Healthy Weight Indicator.

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
Obesity *National Indicator*	% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	≥95%	Caroline McElnay	Shari Tidswell	**SEPT 2016**

MĀORI HEALTH PLAN INDICATOR:

At the end of 2015 the Board endorsed the Hawke's Bay Healthy Weight Strategy and requested a plan to outline activity to support childhood healthy weight. The resulting Best Start: Healthy Eating and Activity Plan was endorsed in May 2016. This Plan reflected the evidence that demonstrated early intervention has the greatest lifetime impact. Part of the Plan focuses on the work tacking place in primary care and is linked to the Before School Check (Check) screening. Before School Checks are a national Ministry of Health programme supporting all 4-year olds in their transition to school.

The Check includes an assessment of healthy weight. If a child's weight is greater than the 98th percentile, (for the purposes of this Raising Healthy Kids and Te Ara Whakawaiora target, this is a BMI over 18.3), whānau are offered further support for lifestyle changes which can increase healthy weight. In Hawke's Bay from 1 July 2016 whānau are provided with family based nutrition, activity and lifestyle intervention (including plans, information and education) and have the opportunity of a dual referral:

- Clinical assessment by a health professional with the expertise to complete such an assessment.
- Whānau based programme delivered in the community.

Parents choose to accept or decline either of these referrals. Referrals are recorded as separately in the Before School Check data.

The Ministry of Health have set a new (implemented for 1 July 2016) Raising Healthy Kids target for the Before School Check programme (see Appendix One for Raising Healthy Kids target definition):

> *"The health target is that 'By December 2017, 95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions."*

This is measured in the quarterly Before School Check reporting to Ministry of Health and is taken from the Before Schools Check database. The target is calculated as the percentage of children completing a Check who have weight in the 98th percentile and over, who have a received a referral to a health professional for a clinical assessment and this referral has been acknowledged by the provider within 30 days.

There is a significant transition process to accommodate the change in the target, including a staged transition for the reported data. The first reporting period to include Quarter One reporting has been completed as part of the B4SCs six-month period from 1 March to 31 August, where the referral to a registered health professional was acknowledged within 60 days (or 30 days for checks completed from 1 July 2016). The first reporting quarter where the new 30 day and health professional criteria expectation will be fully reported on is Quarter Three of 2016/17.

Data is extracted from the Before School Check database and occurs one month after the period the B4SC is completed to allow appropriate time for acknowledgment to occur. For example for Quarter One, the data extract will occur in October covering completed B4SC checks processed in the six month period 1 March to 31 August 2016.

The Māori Health Plan indicator is the same as the new Raising Healthy Children and as such the data used in this report is effected by the transition and changes to the Before School Check reporting and we will not have a full baseline until the Quarter Three reporting. To manage this, the report draws on data provided by Health Hawke's Bay as the provider of Before School Checks.

The Māori Health Plan indicator will provide a measure to monitor both reductions in the total number of children in the 98th percentile and over for weight and the level of support offered to these children and their whānau to achieve healthy weights, both clinically and via a whānau based programme.

WHY IS THIS INDICATOR IMPORTANT?

This indicator focuses on increasing the proportion of 4-year olds who have a healthy weight (not overweight, obese or underweight; children between 2nd percentile and 98th percentile). We are not yet seeing improvements in the proportion of 4-year olds who have a healthy weight and there is significant inequity with 69% "Other" children having healthy weight and 61% of Māori and 43% for Pasifika children (see Appendix Two).

Evidence shows that children with healthy weight will be more likely to have a healthy weight in later life. This is due to the combination of physiological and behavioural patterns laid down in early life. Maintaining a healthy weight and intervening early in life to achieve healthy weight provides resilience against a wide range of health issues including; heart disease, cancers, diabetes and muscular skeletal problems.

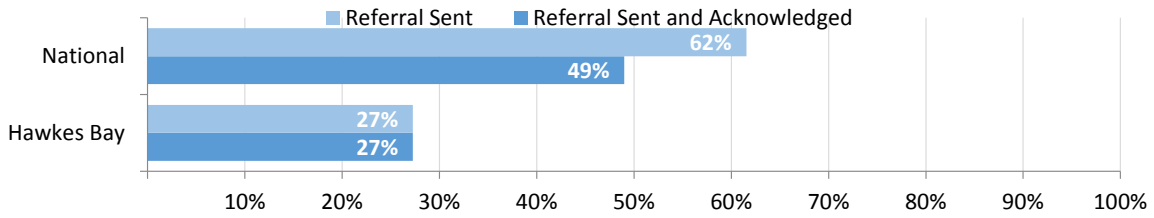
The Before School Check is a screening tool, with 97% (2016 reported data) of children in Hawke's Bay engaged. Data from the Check provides population data to monitor the impact of activities prior to 4-years and the effectiveness of any subsequent interventions.

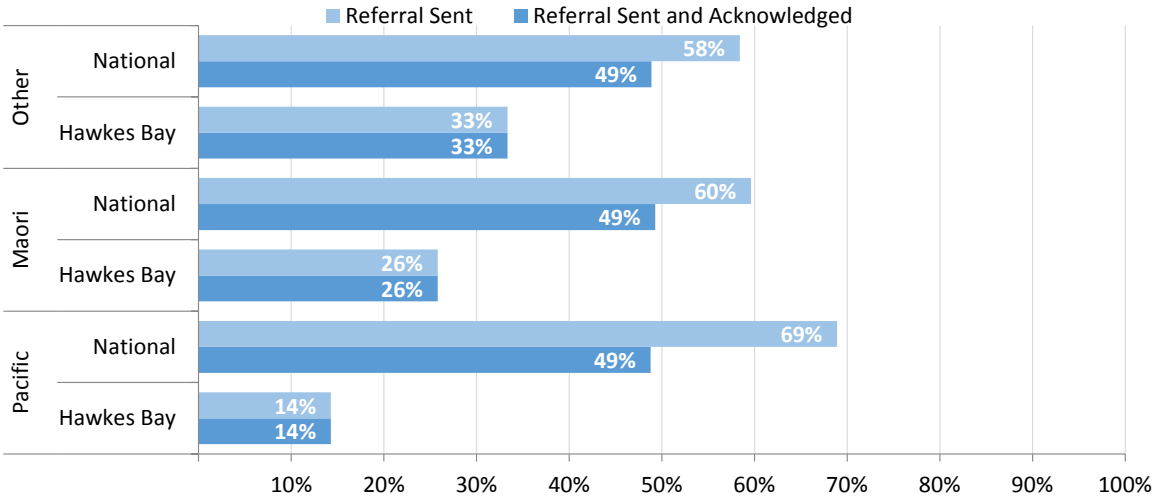
> *"If you are going to screen, age 4-5 is a good time, as it allows for adiposity rebound (regaining the long-term health benefits associated with healthy weight)"*
>
> (Phil Moore, HBDHB Paediatrician)

Te Ara Whakawaiora target is the Ministry of Health's "Raising Healthy Kids target" (see Appendix Two for a detailed explanation of the target).

WHAT DATA DID THE INDICATOR REPORT QUARTER ONE?

Data from Ministry of Health first quarter reporting for Before School Check six months to end of August 2016





Appendix Two provides a comparison across DHBs and shows Hawke's Bay to be mid-range in the percentage of healthy weight children. This provides another baseline for future comparison.

The data above reflects the percentage of referrals (total of all referral types), for children in the 98th percentile and over for Hawke's Bay and the national average. There are a mixture of referral processes and target expectations involved due to the reporting spanning a period covering both the pre-1 July and post-July targets.

For Hawke's Bay, referral processes have been well managed with all referrals acknowledged within the timeframe.

The gaps between the national average and Hawke's Bay and, "Other" and Māori and Pasifika will need to be monitored to ensure changes being made are reducing these gaps.

Data for children who completed a Before School Check between 1 July and 30 September 2016 (data provided by Health Hawke's Bay)

Before School Check support	Total	Māori	Pasifika	Other
# of child completing a Before School Check	589	238	28	323
# of children with BMI great than 98th percentile	68 (11.5%)	44 (18.4%)	5 (17.8%)	19 (5.8%)
# that declined referrals to a clinical assessment	4	3	0	1
# that agreed to a referral to a clinical assessment	59	36	5	18
# and % referred to clinical assessment	63 (92.6%)	39 (88.6%)	5 (100%)	19 (100%)
# and % that received nutrition, activity and lifestyle interventions	100%	100%	100%	100%
# that declined a referral to whānau based programme (Active Families)	9	5	1	3
# that accepted referral to a whānau based programme (Active Families)	14	12	0	2
# and % referred to whānau based programme	23 (33.8%)	17 (38.6%)	1 (20%)	5 (26.3%)

We know the transition data (above) is not providing a clear picture of whānau experiences during a Check when we compare the Ministry of Health data with the data provided by Health Hawke's Bay (table above). The table shows Pasifika and Other with referrals (acknowledged and unacknowledged) at 100%; and for Māori at 88.6%, indicating system and data issues, which should be remedied by the activity undertaken this quarter.

From the table above, all whānau with a child in the 98th percentile and over were provided with nutrition, activity and lifestyle intervention, demonstrating that in Hawke's Bay from 1 July to 30 September the second part of the Raising Health Kids target was met for everyone. The following examples illustrate the type of work being done with whānau:

> *"Discussed this with Mum and grandmother and they are happy to help A reduce her weight. Stop fizzy drinks and reduce sweets to a minimum. Stop all day snacking and focus on meals and morning and afternoon snacks. Has started going to gymnastics which she is enjoying. Mum would be interested in talking to Active Families but cannot be tied to weekend attendance"*

> *"Given Healthy Eating for Children' resource. Given goal sheet. Good discussion with father around further referrals for high BMI, parent declined this."*

For the additional support provided for Hawke's Bay whānau, Māori have higher referral rates to a whānau based programme than all other groups. Reasons provided by whānau for declining are varied and included; being happy with the plan developed with the nurse, confident they can implement change on their own and/or "happy" with their child's weight.

In summary, this first quarter data provides the beginning of a baseline which will be added to in the next two quarters. When we have this baseline, we will be able to monitor improvement including reductions in the number and percentage of children 98th percentile and over, and maintain the level of nutrition, activity and lifestyle interventions provided to whānau.

CHAMPION'S REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THIS INDICATOR?

This indicator, whilst new, is part of wider messages, activities and programmes that are coordinated under the Best Start: Healthy Eating and Activity Plan. The Best Start Plan is integrated into service contracts and has been shared with key partners. As a result, the support whānau receive is not just from health service providers or about health information but comes from across the whole community in order to support access to healthier food choices and activity for our tamariki. Activities being delivered this quarter include:

- Screening programme for pregnant women – referrals come from LMCs and GPs, which picks up all women with gestational diabetes, providing education and support and referral to Maternal GRx
- Supporting breastfeeding, via Breastfeeding Café, resource delivered by Kahungunu Executive and Te Taiwhenua o Heretaunga, lactation support, breastfeeding and key stakeholder training i.e. Mama Aroha. Providing parent resources with a healthy lifestyle approach
- Healthy First Foods, supports Well Child/Tamariki Ora providers to education/increase skill for parent around first foods
- Supporting early childhood education providers to provide healthy eating environments, through policy support and training on healthy food options and portion sizes
- Supporting primary care with training and resources to deliver education and healthy conversations with whānau including during Before School Checks. Funding Active Families under 5 programme. This programme has been picked up by two DHBs due to the programme's success and Hutt Valley DHB are now delivering their equivalent to Active Families under 5.

Appendix Three provides an overview of activity delivered under the Plan which supports the achievement of childhood healthy weight and this report provides information and data specifically associated with the indicator.

Specifically for Before School Checks, referrals to Active Families whānau have identified a number of positive changes including; no fizzy and raro, less sugar, more biking and eat more vegetables (see Appendix Four for more feedback). This indicates the value in providing the additional referral to a whānau based community programme as an option for whānau in the Hawke's Bay.

CHAMPION'S REPORT - ACTIVITY THAT WILL OCCUR TO INCREASE PERFORMANCE OF THIS INDICATOR

The Te Ara Whakawaiora target is affected by the transition and changes to the Raising Healthy Kids target rolled out 1 July 2016. The first quarter data is combined with data prior to 1 July 2016 and can only provide a very limited picture. However, there has been work to support the achievement of the new target and address systems and data issues (implementation began 1 July 2016) which include:

- Communication with primary care and other key stakeholders re; target, pathway, referrals, assessments and supporting resources
- Assessment and documentation to support the target
- Developing resources to support effective messages for whānau – these are being developed with practitioners and whānau input
- Extending contract volumes for whānau based lifestyle programmes, to support a greater volume of referrals (providers are Sport HB and Iron Māori)
- Training planned to support B4 School Check providers to deliver consistent and effective messages and referrals

The data provided by Health Hawke's Bay indicates that this work has had a positive impact. These activities are expected to continue to support healthy weight messages at during Checks, and increase the number of whānau referred for a clinical assessment.

The Best Start: Healthy Eating and Activity Plan will continue to provide activity supporting children and their whānau to maintain or achieve healthy weights. Implementing this Plan is supporting; lifestyle change, effective interventions and healthy weight environment – all of which are needed to sustain healthy lifestyles. (Delivery is detailed in Appendix Three for the first quarter)

We will monitor the feedback and data (including this indicator) to assess the impact of the work done this quarter to support increased clinical assessment referrals and, to identify changes needed to reduce the inequity for Māori and Pasifika children and work to implement these changes.

CONCLUSION

Work this quarter has focused on clarifying the new Raising Healthy Kids target and establishing systems to support the work toward the target. This indicator will, over time, provide data to track increases in the number of healthy weight children at 4-years and the level of support provided to children over the 98th percentile in weight and their whānau.

The Best Start: Healthy Eating and Activity Plan is delivering a wide range of activity to support an increase in healthy weight children. This includes supporting messages and referrals for Before School Checks.

Appendix One: Raising Healthy Kids Target Definition

What is the Raising Healthy Kids target?

The health target is that 'By December 2017, 95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.'

What is the purpose of the target?

At the core of the target is a desire to:

- build momentum to ensure that referrals of obese children are acted on to manage any clinical risk associated with obesity (rule out any underlying health risk);
- encourage the parents to take some action; and
- regularly monitor the child's growth towards supporting the child to achieve a healthy weight.

Which healthcare professionals can children be referred to?

From 1 July 2016, the Ministry accepts the following registered health professionals as valid referrals for the purposes of the health target

- general practitioner
- practice nurse
- community dietician
- public health nurse
- multi-disciplinary team that includes a registered primary health care professional in attendance

These practitioners need to have the requisite skills to conduct a clinical assessment and be able to ensure the child's growth is routinely monitored.

A child may simultaneously be referred to a family based nutrition, activity and lifestyle intervention. However this alone would not count as referred for the purposes of the health target.

Why do referrals need to be acknowledged to count towards the target?

The rationale for acknowledgement of referrals is to recognise the shared responsibility for referrals in ensuring the 'handover' is complete and that these children and their families are followed up in a timely way by their primary or community health care team for clinical assessment, and routine monitoring.

Several Healthy and Disability Commission cases have highlighted the importance of primary and community health care providers following up on referrals they have made. This includes ensuring the child's caregiver is adequately informed about the referral process and steps to take if they have not heard from the service referred to within a certain timeframe.

There are a number of ways providers can follow up on referrals made, for example fax, phone call, a secure form of system generated messaging – there could be other ways. The key issue however is that there must be a mechanism in place that notifies the referrer (plus or minus the family) that the referral about a specific child was received.

Those receiving the referrals must be aware of their own responsibilities in ensuring children are not being inadvertently overlooked or delayed by responding to and following up on referrals.

Processes need to be auditable.

How are the data extracted for the target?

Each quarter, data is pulled from the Before School Check (B4SC) database for DHBs to report on the target.

The reporting period for the Raising Healthy Kids health target for quarter one will be all completed B4SCs processed in the six-month period from 1 March to 31 August, where the referral to a registered health professional was acknowledged within 60 days (or 30-days for checks completed from 1 July 2016).

The change to the expectation of a 30-day acknowledgement of referrals applied from 1 July 2016. The first reporting quarter where this 30 day expectation will cover all B4SCs captured in the data reported is quarter three of 2016/17.

Quarter two will include a mix of completed checks with the 60 days acknowledgement period (for checks completed prior to 1 July 2016) and 30 days acknowledgement period (for checks completed from 1 July 2016).

The data extract occurs one month after the period the B4SC is completed to allow appropriate time for acknowledgment to occur. For example for quarter one the data extract will occur in October covering completed B4SC checks processed in the six month period 1 March to 31 August 2016.

How is the target result calculated?

As an example, for quarter 1 of 2016/17

- the **denominator** is the number of children identified as obese (BMI>98th percentile) from all completed checks[1] processed in the six month period from 1 March to 31 August 2016
- the **numerator** is a subset of the group of children identified in the denominator. The numerator is the number of children where their referral was acknowledged within 60 days (30 days applies from 1 July 2016)[2] ***or*** who are already under care ***or*** the referral was declined by the parent/caregiver

[1] Only completed B4SC checks are included as part of the denominator where all the components of the B4SC have been completed and all necessary referrals made and entered into the B4SC system

[2] The 30 (or 60 days) includes weekends and holidays. The date used is the date referral sent (field in the B4SC database), and when date of acknowledgement entered; the acknowledgement period is counted from the referral sent date

Appendix Two: Well Child Tamariki Ora Indicator 15 – Children are a healthy weight at four year by DHB

	Total Population			Māori			Pacific			High Deprivation		
DHB of Service	**# Children at Health Weight**	**# Children**	**% Children at Healthy Weight**	**# Children at Health Weight**	**# Children**	**% Children at Healthy Weight**	**# Children at Health Weight**	**# Children**	**% Children at Healthy Weight**	**# Children at Health Weight**	**# Children**	**% Children at Healthy Weight**
Auckland	2,199	2,973	74%	184	286	64%	306	600	51%	414	682	61%
Bay of Plenty	1,018	1,492	68%	364	591	62%	27	58	47%	288	457	63%
Canterbury	2,091	2,878	73%	221	355	62%	66	123	54%	234	354	66%
Capital and Coast	1,102	1,520	73%	126	216	58%	81	173	47%	157	279	56%
Counties Manukau	3,244	4,687	69%	646	944	68%	758	1,384	55%	1,193	1,924	62%
Hawke's Bay	792	1,149	69%	283	461	61%	28	65	43%	216	373	58%
Hutt Valley	638	919	69%	138	228	61%	42	97	43%	147	232	63%
Lakes	564	786	72%	255	378	67%	18	25	72%	208	295	71%
MidCentral	683	1,055	65%	180	326	55%	28	73	38%	142	265	54%
Nelson Marlborough	664	909	73%	121	175	69%	19	34	56%	57	81	70%
Northland	718	1,126	64%	346	552	63%	12	24	50%	299	477	63%
South Canterbury	229	344	67%	28	47	60%	5	9	56%	19	26	73%
Southern	1,272	1,857	68%	179	308	58%	37	63	59%	122	201	61%
Tairawhiti	228	378	60%	129	238	54%	8	19	42%	112	202	55%
Taranaki	584	798	73%	125	198	63%	4	7	57%	85	133	64%
Waikato	1,807	2,644	68%	446	755	59%	42	80	53%	346	582	59%
Wairarapa	177	262	68%	41	69	59%	6	10	60%	21	34	62%
Waitemata	2,795	3,786	74%	370	544	68%	253	458	55%	265	415	64%
West Coast	79	113	70%	12	19	63%		1	0%	9	13	69%
Whanganui	293	443	66%	115	186	62%	9	20	45%	111	186	60%
Total	**21,177**	**30,119**	**70%**	**4,309**	**6,876**	**63%**	**1,749**	**3,323**	**53%**	**4,445**	**7,211**	**62%**

Appendix Three: Health Weight Strategy, Best Start: healthy eating and activity Plan

At the end of 2015 the Board endorsed the Hawke's Bay Healthy Weight Strategy and request a plan to outline activity to support childhood health weight. The resulting Best Start: healthy eating and activity plan was endorsed May 2016. This plan reflected the evidence which show early intervention has the greatest lifetime impact – with activity focusing on

Indicator	Date	Planned Goal	Progress Update
Healthy Weight Strategy 1) Implement the Best Start- healthy eating and activity Plan	September 2016	The Best Start: Healthy Eating and Activity plan has been approved and endorsed all the Board and DHB councils. The plan has key objectives: The plan was developed using the evidence base and community input – both supporting early intervention by focusing on childhood healthy weight beginning with healthy weight during pregnancy. This Plan has been shared with other DHB's and the sector in HB. Goals: • Increasing healthy eating environments, by increasing healthy eating choices and physical activity opportunities. • Developing and delivering prevention programmes which include food literacy, maternal nutrition, implementing policy and physical activity. • Interventions which support children to have healthy weight. • Providing leadership in Hawke's Bay for health eating.	Currently delivered activities include: • Gestational diabetes screening and support, all women identified are screened and supported • Maternal GRx programme 160 referrals (July 2015 – June 2016) 50% Maori and Pasifika • Breastfeeding support/resources via KE and TToH. 174 women accessing supporting via Kahungunu Executive and Te Taiwhenua O Heretaunga (Last financial year) • Promoting World Breastfeeding Week- Facebook brelfies, breastfeeding friendly cafes were the focus. Well Child Interagency Group led this work. • Active Families under 5years – 57 whanau engaged 67% Maori. 72% are more active and 63% note improved healthy food choices. • Healthy First Foods 0-2 years, deliver via Plunket and Well Child Tamariki Ora providers. 100 families engaged 69% Maori. Launching Healthy Foods 2-5 years with B4 School Check Nurses • HBDHB Healthy Eating Policy adopted including educative traffic light model, supporting breastfeeding for staff/visitors/patients • School and environment survey for HB conducted with Informus • Funding secured to support the school based programme development and implementation. • Promoting "Water Only Schools" message and supporting 6 schools to extend their water only policy.

Appendix Four - Case-studies and feedback from Whānau engaged in Active Families

Example 1:
"Mum says Jamie is a lot more confident, has more energy and has improved his balance recently (this was something he had a lot of difficulty with). He has reduced his bread intake and packaged foods, also there are less takeaways in the household. He is attending cooking sessions and has been learning about portion sizes. So from this we set June's goal as 3 x a week he dishes up the portion size he should eat of each food group. Mum has also lost 10kgs in 6 weeks as she improved her diet considerably and started going to the gym and aqua aerobic several times a week. The older sisters are now more on board as well.

EXAMPLE 2:
"William has been in the programme for 12mths now and has made several dietary changes along with other members of his family. William is now playing ripper, is starting basketball next term and is now choosing to do physical activities instead of indoor more sedentary activities. He is also asking family members to take him places to play. He walks to school regularly. Also the family is trying new foods like couscous and he now chooses an apple over a biscuit for a snack. Mum and dad are now on Green Prescription Adults, Dad is having difficulty cutting down on carbs which was his most recent goal but now goes to the gym 3x a week. Mum is doing really well has lost several kilos, goes to the gym each day after walking kids to school. She has cut a lot of carbs and sugars out of her diet, has more energy to do things and is really motivated to keep going".

Some other comments received about changes made:

- "No fizzy or raro/chips/potato chips and sweets in our home"
- "Now more empowered not to eat sugar foods e.g., lollies and replaced with other food".
- Homemade everything
- Less sugar
- More biking
- Watching portions
- Learning how to say no when full or not hungry
- More confident at activities
- Having smaller meals
- Quit fizzy and takeaways
- Eats more vegetables

HAWKE'S BAY District Health Board Whakawāteatia	**Orthopaedic Review – Closure of Phase 1** 151
	For the attention of: **HBDHB Board**
Document Owner: Document Author(s):	Andy Phillips and Sharon Mason Carina Burgess and Andy Phillips
Reviewed by:	Executive Management Team; Māori Relationship Board, HB Clinical Council and HB Health Consumer Council (November)
Month:	December 2016
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board:

Note the progress to date in the Orthopaedic Review and the Closure of the First Phase.

PURPOSE

This paper gives a brief overview of the work that has been carried out to redesign Musculoskeletal and Orthopaedic Services and notes the closure of the first phase.

20

OVERVIEW

It is evident that there are a large number of people in the community living with pain and disability caused by musculoskeletal conditions. This number is expected to rise as the population of Hawke's Bay ages and the incidence of osteoarthritis increases.

This paper describes the first phase of work to review and fundamentally redesign musculoskeletal and orthopaedic services to meet the needs of people in our community.

Initial work demonstrated the lack of threshold setting for surgical candidature and inconsistencies with prioritisation between surgeons, and delays experienced by patients along the pathway from referral to surgery. These concerns were focussed on hip and knee conditions joints but public feedback, staff concerns and workforce planning also highlighted the back, spine and acute orthopaedic pathways as other areas for review and redesign.

The redesign of Musculoskeletal and Orthopaedic services was set out in three phases. The first phase, now complete involved increasing surgical capacity and making conservative treatment options available. The second phase will involve the co-design of a long term plan to effectively manage demand and align capacity over two to five years. The third phase will address 'third horizon' issues over ten years that will require innovative approaches.

In 2015 a project was initiated to review Orthopaedic Services. The objective of the project was to reduce pain and disability to patients in our community from musculoskeletal conditions by reviewing and co-designing musculoskeletal services. A paper outlining the programme and actions for Phase One was presented to Clinical Council and the Board resulting in funding being approved for additional surgical capacity and a non-surgical intervention programme.

The initiatives completed in the first phase included:

- Implementing non-surgical treatment options by increasing physiotherapy and other allied health resource.
- Implementing a new pathway for back pain patients offering an alternative non-surgical treatment option.
- Improved patient communication and collaborative services within the DHB.
- Reducing wait times throughout the pathway.
- Setting thresholds for surgery based on data for orthopaedic scoring and Oxford score.
- Increasing surgical capacity to deliver on the major joint replacement target.

Non-surgical Treatment Programme

Non-surgical assessment and treatment is now being provided by physiotherapists for those being referred to the orthopaedic department for hip, knee or back pain. Following assessment, patients who do not meet the threshold for surgery and/or those who are assessed as being likely to benefit from non-surgical interventions are offered physiotherapy or other allied health treatment and management.

1. Spine Clinic

The spine clinic delivered by Advanced Practitioner Physiotherapists was launched on 15th February 2016. Since then, there have been 333 referrals, 171 directly to the clinic and 162 were originally referred to Orthopaedic FSA by their GP and were redirected to the Physio Spine Clinic. All of these patients had complex worsening symptoms lasting between six months and forty years with average duration of eighteen months. Many had previous spinal surgery. A proportion of these are still undergoing treatment but discharge data has been collected for 50% of the referrals.

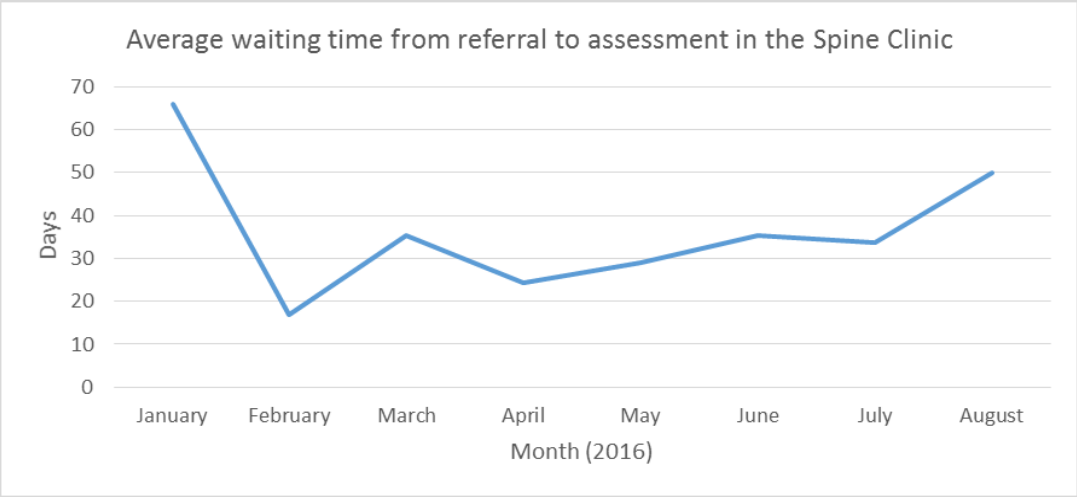
Total Referrals all sources	Discharge Data collected		Discharge Outcomes			
		Fully resolved or minimal signs and symptoms	Managing symptoms successfully	Did not access of did not complete	Inappropriate referral – discharge or referred on	Referred to FSA
333	165 (50%)	43%	18%	23%	3%	14%

Of the 162 patients originally referred to Orthopaedic FSA by their GP and redirected to the Physio Spine Clinic for assessment and treatment, only 14% were referred back to Orthopaedic clinics.

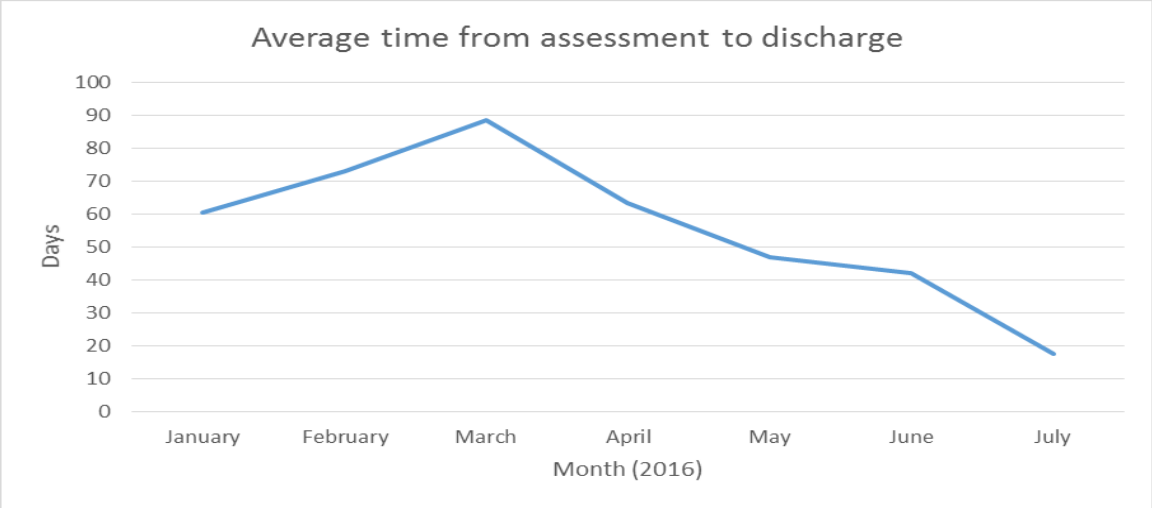
Intercepted FSA referrals	Discharge Data collected	Discharge Outcomes		% of patients 'Highly Satisfied' with the service
		Managed within the spine clinic	Referred back to FSA	
162	97	86%	14%	93%

Of the patients seen in Spine clinic, 76% had improvement in symptoms, 20% had no change whilst one patient had worsening of symptoms and was referred for Orthopaedic treatment.

Access and Timeliness:



The waiting time from referral to assessment had increased as the number of referrals to the clinic is increasing. GPs are now referring directly to the clinic.



With two advanced practice therapists now in post, patients are being followed up and discharged more promptly. One therapist is averaging three treatments per referral and the other four treatments per referral.

The clinic is primarily based in Hastings, and 94% of assessments have been carried out in Hastings, 4% in Napier and 1% in Waipukarau.

20

Patient Outcomes:

New outcome measuring tools were researched, trialled and developed over the six month period. New reports generated in August 2016 include percentage change data and client satisfaction recording. The data from these reports below show an improvement across all outcome areas – reduced pain, and increased function and self-management. The results also show a reduction in the STarT back score which is a measure of the risk factors for back pain disability. Of the 33 discharged patients using the new outcomes tool, 73% scored 10/10 on the patient satisfaction score.

Patient based average outcome scores (discharged patients)			
Average Reduction in Pain % change	**Average Improvement in Function % change**	**Average Improvement in self-management Ability % change**	**Average Improvement in STarT back score % change**
23.6%	12.5%	30.0%	14.8%

Patient Satisfaction score	**Frequency %**
1-5 Low	0
6	3
7	3
8	15
9	6
10 High	73

Communication and Education:

The spinal clinic has been promoted through letters to GPs and information pamphlets. GPs are now referring directly to the spine clinic rather than to FSA. Attendance is improving as patients are now better informed of the clinic and assessment process and are therefore willing to engage.

A number of resources have been made available such as back facts booklets, education packs for all referrers and an education tool which is widely available in GP practices and the community.

2. Hip and Knee Pathway

In March 2016 funding was made available to:

1. Expand the hip/knee scoring clinic to allow 6 and 12 month rescore by physiotherapist.
2. Establish multi-disciplinary education and exercise programme (MEEP) team to provide treatment to patients who had not met criteria for FSA and therefore had been declined hip/knee joint replacement surgery.

The aims were to provide treatment to:

- Improve patient satisfaction around arthritis surgical process.
- Increase self-management through greater patient knowledge of arthritis and utilisation of medications.
- Slow clinical decline of joints through better muscle strength/ posture.
- Support patients with activities of daily living through access to equipment.

FTE was provided primarily for physiotherapy to lead the programme of multi-disciplinary education and exercise [MEEP] and be the major speaker. Occupational Therapy, Social Work and Pharmacy disciplines each gained 0.3 FTE to provide educational segments of sessions.

Following early piloting of group programmes that was not successful, a change was made to individualised treatment and education provided by the physiotherapist alone, who had the ability to refer to other discipline as required.

The physiotherapist works with patients individually covering education topics of all the disciplines along with specific training in posture, gait, and muscle strengthening. Strengthening was provided as home programme along with access to supervised gym and/ or gym sessions.

Outcomes:

- Patients now have 6-12 month re-scoring to ensure they can access orthopaedic specialist appointment if required, rather than being referred back to Primary Care.
- The wait time for physiotherapy assessment has reduced to ten days from the previous 4-12 weeks.
- Patients report significant satisfaction in having access to gym and pool session in a safe environment which fits their level of activity, and where they gain individualised physiotherapist guidance.
- Arthritis New Zealand now use the pool after hours and this provides a community link to which patients can transition.

Individualised treatment and education format 17 June to 30 September 2016:

- 105 patients attended 188 individual sessions.

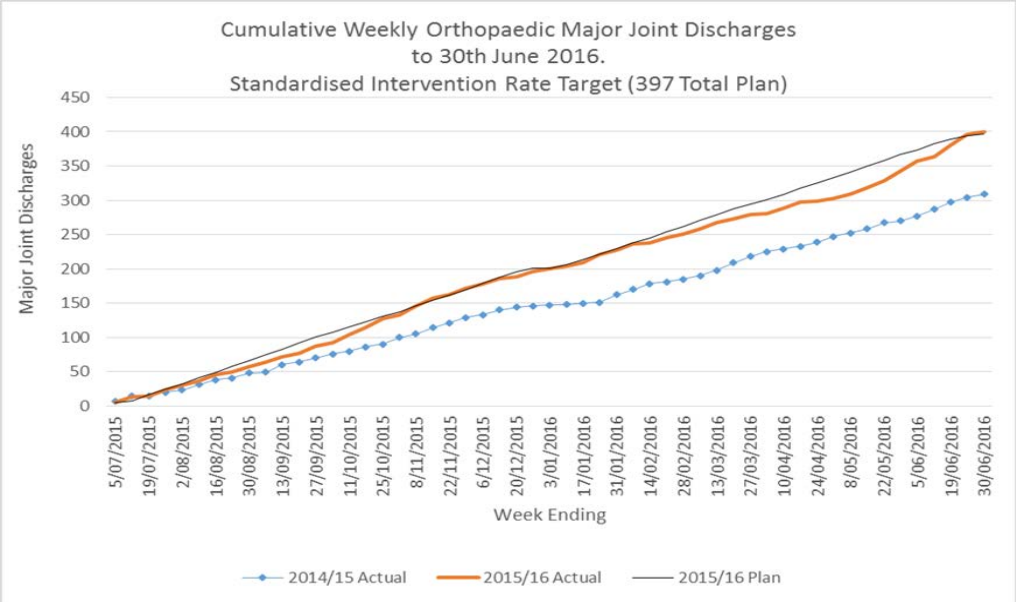
Areas for development:

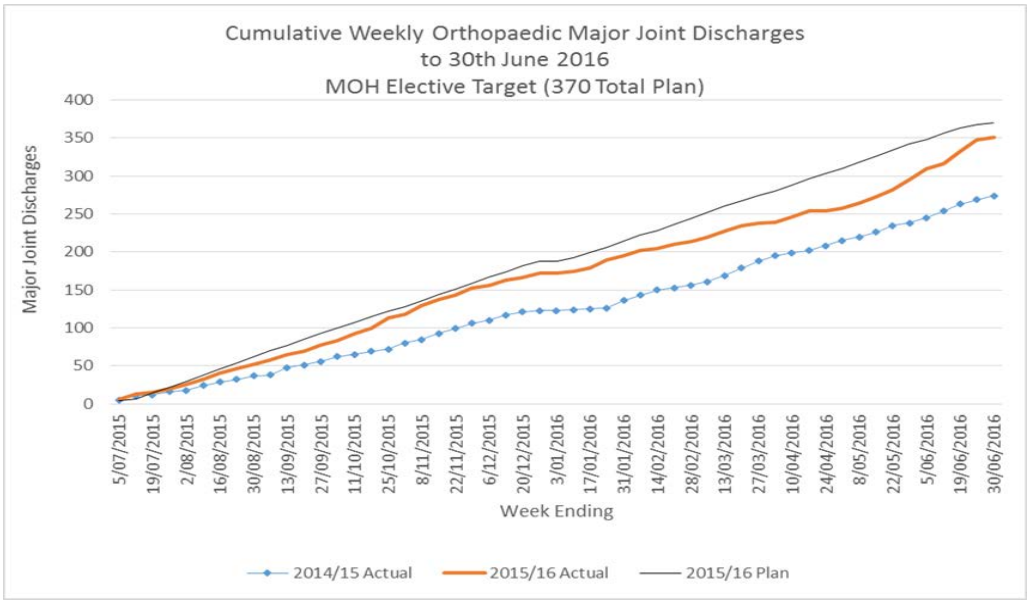
- There will be a focus on making clinics more accessible across Hawke's Bay, especially in Wairoa and Waipukarau.
- A triage tool and referral pathway has been developed using the StarT Back Tool, Keele University. This will be rolled out within the DHB and in the community to educate on when to refer to limit unnecessary referrals. Examples of when this will most useful are:
  - Use in ED to limit hospital admissions.
  - Use by HBDHB staff in ENGAGE, ORBIT, and prior to internal referrals.
  - Triage by general practitioners.
- Professional development of at least one new staff member to up skill over the next year to work within the clinic.
- Provide opportunities for current advanced practitioners to share data and success stories to support HBDHB initiatives nationally and internationally.

- Investigation of potential for physiotherapists to treat patients currently treated by radiologists with image guided injection of joints.
- Implementation of shoulder pathway.

Surgical Capacity

In 2015/16 there were 91 additional Orthopaedic Major Joint Replacement discharges than in 2014/15. The standardised intervention target of 397 was met as we delivered 400 discharges in the year. The elective target however was not met as only 351 of the 400 were elective surgeries (target 370) and the remaining were acute. We ended the year at 94.9%.





Outsourcing was required throughout the year. Fifty surgeries were outsourced to Royston and the majority of these occurred in the last three months. Going forward, outsourcing will be more planned.

Following an External Review of Orthopaedics the business case for an 8th orthopaedic surgeon has been approved and is being recruited to.

Additional orthopaedic surgical acute lists on a Sunday commenced on 23 October 2016 and have been evaluated as a success.

System Changes – Referral to Discharge

During the initial stages of the project it was determined that there were many delays in the process from referral to discharge. Many of these have been resolved and others are being addressed through the National Patient Flow (NPF) project which is targeted at orthopaedics and other surgical specialties. We have worked with the NPF project team to develop a referral pathway for effective data capture.

Patient Experience

Patient letters have been rewritten so that they are more informative and better explain the process. These have been developed in conjunction with the Consumer Engagement Manager. In the hip and knee pathway, following scoring, there is a set threshold for FSA. If the threshold is not met the decline is immediate rather than waiting three weeks which is what was happening previously.

Mobility Action Programme

The Ministry of Health is investing $6million over three years to improve diagnosis and treatment for people with musculoskeletal health conditions. The focus is on early intervention, community based, multidisciplinary community services.

HBDHB, with Health Hawke's Bay and Iron Māori, were successful in securing $380,000 of this funding to deliver the Mobility Action Programme. The proposal was based on a Whānau Ora, community model to improve access to services for people in high deprivation areas. The service offers walk in clinics located in targeted communities for early intervention to reduce pain and disability and support people to remain in work and live independently. Iron Māori will act as the hub of the Mobility Action Programme coordinating services from Community Physiotherapists, Mananui lifestyle collective and Long Term Conditions Programme (Stanford Model).

Co-designed Clinical Pathways

A Hip and Knee osteoarthritis clinical pathway was developed in early stages of the clinical pathways work. This pathway was published but not socialised. In the second phase of the programme a new pathway will be co-designed by consumer groups, NGOs and staff from November 2016.

Outstanding Issues for Resolution from the First Phase

Whereas additional funding of $60,000 was agreed for Coordinated Primary Options work, this has not eventuated. This funding was granted to support a GP with Special Interest in muscular skeletal treatment to provide additional management and treatment including joint injections for patients who had completed physiotherapy treatment and been referred for Orthopaedic FSA but declined for surgery due to not meeting the threshold. This service will be implemented once the GPSI is in post.

HAWKE'S BAY District Health Board Whakawāteatia	**Travel Plan Update**	152
	For the attention of: **HBDHB Board**	
Document Owner: Document Author(s):	Sharon Mason (Chief Operating Officer) Andrea Beattie (Property and Service Contracts Manager)	
Reviewed by:	Executive Management Team; Māori Relationship Board, Clinical and Consumer Council (Nov)	
Month:	December, 2016	
Consideration:	For Information	

RECOMMENDATION

That the HBDHB Board:

Note the contents of the report

OVERVIEW

The purpose of this report is to provide an update on progress since the previous update in August 2016.

21

UPDATE

In early September the first of the Go Well personnel started with HBDHB. This means there is now a dedicated and focussed resource to drive the implementation of the travel plan.

Engagement with the working groups and other staff stakeholders has continued with regular meetings taking place. A representative of Sport Hawke's Bay has now joined the working group.

A Go Well update was presented to staff including a few external stakeholders at the monthly Transform and Sustain seminar in October.

Bus Services

On 26 September, new and improved bus services commenced. Our partnership with Hawke's Bay Regional Council means our communications teams are working closely around developing messaging and promoting these services.

A proposal is currently in development around extending free bus transport for patients, and will be presented to the travel plan steering group in November.

Parking Management Controls

The request for proposals process to identify appropriate and suitable parking management control equipment closed in late September. After completing evaluations and vendor interviews a preferred vendor has been selected. The parking controls team has elected to implement the parking controls in a phased manner, commencing with pay and display equipment, with considering being given to adding barrier arms to some parking areas in future.

Parking Improvements

A new car park with approx. 40 parks in currently being constructed beside the Diabetes Service off McLeod Street.

The proposed car park remarking and signage updates are currently being finalised and we expect work to start on this shortly.

Cycling

A number of new cycle stands are now in place, and planning has commenced around the construction of a second secure bike store on the Hospital site.

Discussions are also underway with our landlord about providing a secure bike store for our corporate office staff.

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:

23. Confirmation of Minutes of Board Meeting
- Public Excluded

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

25. Board Approval of Actions exceeding limits delegated by CEO

26. Improving Endoscopy Services Construction Contract Approval

27. Annual Stocktake of HBDHB Owned and Leased Properties

28. Air Ambulance Services

29. Cranford Hospice

30. Finance Risk and Audit Committee Report

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).