

BOARD MEETING

Date: Wednesday 28 November 2018

Time: 1:30pm

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

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

Apologies:

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

Mintute Taker: Brenda Crene

Public Agenda

Item	Section 1: Routine	Ref #	Time (pm)
1.	Welcome and Apologies		1:30
2.	Interests Register		
3.	Minutes of Previous Meeting		
4.	Matters Arising - Review of Actions		
5.	Board Workplan		
6.	Chair's Report (verbal)		
7.	Chief Executive Officer's Report – Kevin Snee	156	
8.	Financial Performance Report – Carriann Hall	157	
9.	Board Health & Safety Champion's Update – Board Safety Champion	158	
	Section 2: Governance / Committee Reports		
10.	Primary Care Development Partnership Governance Group Report – Helen Francis	159	2:00

11.	Pasifika Health Leadership Group	160	2:05
12.	Māori Relationship Board – Chair, Ngahiwi Tomoana	161	2:10
13.	HB Health Consumer Council – Deputy Chair, Malcolm Dixon	162	2:15
14.	HB Clinical Council – Co-Chairs, John Gommans and Jules Arthur	163	2:10
	Section 3: For Discussion / Decision		
15.	Wairoa Integrated Care Demonstrator Site – Chris Ash	164	2:15
16.	Radiology Facility Development Business Case – Colin Hutchison, Paula Jones, Janet Heinz	165	2:45
17.	Clinical Services Plan – Ken Foote 17.1 Transforming Our Health Services - Clinical Services Plan: the next ten years	166	3:00
18.	People and Quality Dashboard Q1 (July-Sept 2018) – Tracey Paterson for Kate Coley	167	3.15
	Section 4: For Information		
19.	Best Start Healthy Eating & Activity Plan update	168	-
20.	Te Ara Whakawaiaora - Access Rates 0-4 / 45-65 yrs (local indicator) Qtly	169	-
21.	Te Ara Whakawaiaora "Smokefree update" 6 mthly	170	-
22.	HBDHB Performance Framework Exceptions Report (Q1 Jul-Sept) 22.1 HBDHB Non-Financial Performance Framework Dashboard Q1	171	-
	Section 5: General Business		
23.	Section 6: Recommendation to Exclude the Public Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	Section 7: Routine	Ref #	Time (pm)
24.	Minutes of Previous Meeting (public excluded)		3:25
25.	Matters Arising – Review of Actions (nil)		-
26.	Board Approval of Actions exceeding limits delegated by CEO	172	
27.	Chair's Update (verbal)		
	Section 8: For Decision		
28.	Radiology Facility Development Business Case – Financials – Colin Hutchison, Paula Jones, Janet Heinz	165	3:40
29.	Draft Health Equity Report – Andy Phillips , Nick Jones and Jess O'Sullivan	173	4:00
	Section 9: For Information		
30.	Pasifika Health Leadership Group – Barbara Arnott	174	4:30
31.	Māori Relationship Board – Chair, Ngahiwi Tomoana	175	4:25
32.	HB Health Consumer Council – Deputy Chair, Malcolm Dixon	176	4:35
33.	HB Clinical Council – Co-Chairs, John Gommans & Jules Arthur	177	4:40
34.	Finance Risk and Audit Committee – Chair, Dan Druzianic	178	4:50
	Meeting concludes		5:00

The next HBDHB Board Meeting will be held at
1.30pm on Wednesday 19 December 2018

Board "Interest Register" - 10 November 2018

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Kevin Atkinson (Chair)	Active	Trustee of Te Matau a Maui Health Trust	The shares in Health Hawke's Bay (PHO) are owned by the Te Matau a Maui Health Trust, representing health and community stakeholders.	Will not take part in any decisions or discussion in relation to the Trust	The Chair of FRAC	Mar-11
	Active	Board Member of NZ Health Partnership Limited, effective from 20 March 2017	Lead, supported and owned by the 20 DHBs, NZ Health Partnerships creates efficiencies in the health sector that allow more to be spent on frontline services.	Will not take part in any decisions in relation to NZ Health Partnerships Limited where specific legal or fiduciary conflict identified.	The Chair of FRAC	22.02.17
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair of FRAC	26.10.17
Ngahiwi Tomoana (Deputy Chair)	Active	Chair, Ngati Kahungunu Iwi Incorporated (NKII)	Actual Conflict of Interest. Non-Pecuniary interest. Chair of NKII. NKII is titular head of 6 Taiwhenua. 2 NKII Taiwhenua have contracts for health services with HBDHB: (i) Te Taiwhenua Heretaunga is HBDHB's 5th largest health services contractor. The contracts are administered by HBDHB's Planning, Funding and Performance department. (ii) Ngati Kahungunu Ki Wanganui a Orutu has a contract with HBDHB to provide mental health services. This contract is administered by HBDHB's Planning, Funding and Performance department.	Will not take part in any decisions in relation to the service contracts between the NKII Taiwhenua and HBDHB.	The Chair	01.05.08
	Active	Uncle of Tiwai Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Tiwai Tomoana is employed by HBDHB and is a Kitchen Assistant in the Food and Nutrition Department at Hawke's Bay Hospital.	All employment matters in relation to Tiwai Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Uncle of Iralee Tomoana	Iralee Tomoana is employed by HBDHB and works in the Radiology Department as a clerical assistant.	All employment matters in relation to Iralee Tomoana are the responsibility of the CEO.	The Chair	01.05.08
	Active	Brother of Numia Tomoana	Perceived Conflict of Interest. Non-Pecuniary interest. Numia Tomoana is employed by Cranford Hospice and works as a palliative care assistant and, in this role, works with chaplains at Hawke's Bay Hospital.	Will not take part in any decisions in relation to the Chaplain service at Hawke's Bay Hospital.	The Chair	01.05.08
	Active	Involved with Waitangi Claim #2687 (involving Napier Hospital land) sold by the Government	Requested that this be noted on the Interest Register	Unlikely to be any conflict of Interest.	The Chair	28.03.18
	Active	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
Barbara Arnott	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	26.10.17
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.11
	Active	HB Medical Research Foundation	Trustee	Declare this interest prior to any discussion in relation to the Foundation, and an appropriate mitigation action is decided on.	The Chair	20.08.14
Dr Helen Francis	Active	Independent Consultant	To a variety of health organisations.	Will declare at the beginning of meeting(s) if there are any projects that have anything to do with items on the agenda and will not be involved in those discussions	The Chair	26.02.18

Board Meeting 28 November 2018 - Interests Register

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
	Active	Elected Board Member of the Federation of Primary Health Aotearoa New Zealand	Newly established sector wide multi-professional membership association, providing an inclusive platform for health and care integration with the people of New Zealand at the hear of the organisations objectives. No contracts held and have no financial interest in any of their work.	No conflict perceived	The Chair	10.11.18
Diana Kirton	Active	Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB.	Perceived Conflict of Interest. Non-Pecuniary interest.	Will not take part in any decisions in relation to surgical services provided by or contracted by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO	The Chair	18.02.09
	Active	Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014	Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers.	Declare this prior to any discussion in relation to EIT in the area of interest, and an appropriate mitigation action is decided on.	The Chair	16.01.14
	Active	Trustee of Hawke's Bay Power Consumers' Trust which holds all the shares in Unison Networks Limited.	Potential Conflict of Interest. Non-Pecuniary interest. Unison Networks Limited, trading as Unison, has a lease agreement with HBDHB for a generator which is located at Hawkes Bay Fallen Soldiers Memorial Hospital. HBDHB has an electricity supply contract with Meridian Energy Limited. Meridian Energy Ltd has a subcontract with Unison for the supply of power lines.	Will not take part in any decisions or discussions in relation to HBDHB electricity contracts. Will not take part in any decisions in relation to the generators at Hawke's Bay Hospital and electricity generation.	The Chair	03.10.14
	Active	Member, Hawke's Bay Law Society Standards Committee	Law Society	No conflict perceived	The Chair	20.06.17
	Active	RENEW Counselling Services	Counsellor	No conflict perceived	The Chair	17.07.17
Dan Druzianic	Active	Director of Markhams Hawke's Bay Limited	Potential Conflict of Interest. Some clients may from time to time be employed by or have contracts with HBDHB	Declare an interest at any time an issue arises concerning a client, and take no further part in any decision or discussion on this matter.	The Chair	7.12.10
Jacoby Poulain	Active	Board Member of Eastern Institute of Technology (EIT)	Perceived conflict - HBDHB has a Memorandum of Understanding (MOU) with EIT relating to training and development in health related occupations.	Will not take part in any decisions or discussions in relation to the MOU between HBDHB and EIT	The Chair	14.1.14
	Active	Councillor Hastings District Council	Potential conflict as potential advocate for Hastings District population whereas HBDHB covers whole of Hawke's Bay	Declare this interest prior to any discussion on the specific provision of services in Hastings and Chair decides on appropriate mitigation action.	The Chair	14.1.14
Heather Skipworth	Active	Daughter of Tanira Te Au	Kaumtua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust (aligned to Iron Maori Limited)	The Trust has contracts with HBDHB including the Green Prescription Contract; and the Mobility Action Plan (Muscular Skeletal)	Will not take part in any discussions or decisions relating to any actions or contracts with the Trust or aligned to Iron Maori Limited.	The Chair	04.02.14 25.03.15 29.03.17
	Active	Director of Kahungunu Asset Holding Company Ltd	The asset portfolio of the company in no way relates to health, therefore there is no perceived conflict of interest.	Unlikely to be any conflict of Interest. If in doubt will discuss with the HBDHB Chair.	The Chair	26.10.16
Peter Dunkerley	Active	Trustee of Hawke's Bay Helicopter Rescue Trust	Actual conflict of interest. The Trust provides helicopter patient transfer services to HBDHB	Will not take part in any decision or discussion in relation to any contract or financial arrangement between HBHRT and HBDHB	The Chair	15.05.14
	Active	Shareholder Need a Nerd	IT support for home or business	No conflict perceived	The Chair	13.12.17
	Active	Shareholder of NZ Technologies	Technology and innovative support for businesses to grow	No conflict perceived	The Chair	13.12.17
Ana Apatu	Active	CEO of Wharariki Trust (a member of Takitimu Ora Whanau Collective)	A relationship which may be contractual from time to time	Will advise of any perceived or real conflict prior to discussion	PCDP Chair	5.12.16
	Active	Whakariki Trust "HB Tamariki Health Housing fund"	Formed a relationship and MoU with HBDHB Child Health Team Community Women and Children's Directorate. The Trust created a "HB Tamariki Health Housing fund" to ensure warm dry homes for Hawke's Bay whanau.	Will advise at the outset of any discussions on this topic, and will not take part in any decisions / or financial discussions relating to this arrangement.	The Chair	8.08.18
Hine Flood	Active	Member, Health Hawkes Bay Priority Population Committee	Pecuniary interest - Oversight and advise on service delivery to HBH priority populations.	Will not take part in any conflict of interest that may arise or in relation to any contract or financial arrangement with the PPC and HBDHB	The Chair	14.02.17
	Active	Councillor for the Wairoa District Council	Perceived Conflict - advocate for the Wairoa District population and HBDHB covers the whole of the Hawkes Bay region.	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.02.17

**MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 31 OCTOBER 2018, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.36pm**

PUBLIC

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

Apology Ngahiwi Tomoana (Deputy Chair)

In Attendance: Kevin Snee (Chief Executive Officer)
Members of the Executive Management Team
Drs Gommans and Phillips (as co-Chairs, HB Clinical Council)
Rachel Ritchie (Chair, HB Health Consumer Council)
Members of the public and media
Brenda Crene

Members were welcomed to the meeting

An apology was advised for Ngahiwi Tomoana

3. INTEREST REGISTER

No changes to the interests register were advised

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

4. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on 29 September 2018, were confirmed as a correct record of the meeting following the removal of a paragraph relating to the tower block.

Moved: Ana Apatu
Seconded: Diana Kirton
Carried

5. MATTERS ARISING FROM PREVIOUS MINUTES

- Item 1: **HR KPIs – Diversity detail:** will be included with the Q1 report in November 2018, and quarterly thereafter.
- Item 2: **Addiction Services** – progress report to be provided. This will be provided to the November Board meeting.
- Item 3: **Equity and Cultural Competency:** raised in MRBs report to the Board in September – a process has been proposed and accepted.

Advised meetings will take place in February timelines to be determined. **Action**

Item 4: **After Hours Urgent Care** – action noted – item closed.

6. BOARD WORK PLAN

The Board Work Plan was noted.

7. CHAIR'S REPORT

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

Name	Role	Service	Years of Service	Retired
Mary MacLeod	Registered Nurse	Surgical Directorate	15	2-Nov-18

- A lovely acknowledgement card had been received from Elizabeth Morgan's family following the families' receipt of the retirement/bereavement letter.
- An update on the Helicopter Trust was provided by Peter Dunkerley advising the new service would transition seamlessly on the 1st November. Training started two weeks prior and would continue until all staff are fully conversant with the new helicopter. The new service is expected to deliver to the standards in the Contract.

8. CHIEF EXECUTIVE OFFICER'S REPORT

The CEO provided an overview of his report encompassing the following items:

Southcentral Foundation (SSF) - Nuka System of Care Conference was held on 23-24 October 2018 attended by many and acknowledgment was provided to those who made it all happen..

Anticipate early in the new year will have something that we can propose.

Hine Flood asked, could the Community and Iwi lead this 'new way' out in partnership?

In response we need to plan well and also need to get the culture right.

Rachel Ritchie found the Conference uplifting and was pleased to have spent concentrated time with SSF members. This is all very similar to what Consumer Council have talked about over the years ie, ensuring the consumer voice is at the front. It is not about us, without us!

The new Gastroenterology Unit opened on 9 October 2018 to screen 60-74 year olds. Hawke's Bay is the 7th DHB nationally to roll out bowel screening.

The Histology department built into the Education Centre (has improved laboratory). Three service development projects are now coming to fruition.

The 2017/18 financial year was challenging, this coupled with the demand on hospital services, three executive management team members left the organisation, each under different circumstances. Over the past nine years, on average, we have had one team member leave per annum which is to be expected in a team of 12 and around the average turnover rate for the organisation.

An update on Provider Services and Surgical Services was received.

Performance was noted: ED performance starting to improve; noted taking out maternity indicator for smoking (due to lack of confidence in the indicator); financially we are progressing however there are still challenges.

Cardiology services paper provided. Smoke Free critical measures including Manakai project.

Clinical Services Plan was well received by the Council's. This document will ultimately feed into the Five Year Strategic Plan.

9. FINANCIAL PERFORMANCE REPORT

Carriann Hall (ED of Financial Services) spoke to the Financial Report for September 2018 which reflected a favourable to plan result of \$59 thousand for the first four months of the financial year, with September showing as \$9 thousand favourable variance.

The forecasted deficit for the financial year ended 30 June 2019 remains at \$5m.

10. HEALTH & SAFETY BOARD CHAMPION'S UPDATE

Board Champion, Ana Apatu provided a review of the Emergency Department's physical space. It was mentioned that there can be 50 in the waiting room with staff advising it was hard at times to find the time to attend meetings and seminars. The area appeared have high health and safety awareness and staff were quick to comment on good processes and issues raised being actioned quickly. However there were still difficulties with patient flow.

The ED Provider Services advised they were looking at high risk areas (eg ED, Radiology and ICU), advising options were being considered to open up and provide more space at the entry.

Consumer responsiveness of staff was raised by Heather Skipworth with a recent experience conveyed. It was noted by Kate Coley that receptionist training had been provided some time ago and suggested this could be revisited. Suggested it may be better to provide “**kiwi host**” (customer service) courses, not only within ED but in other high traffic areas. NUKA provide 6 weeks of training for these roles. Kate Coley (HR) and primary care services should consider ongoing training of frontline staff. **Action**

REPORT FROM COMMITTEE CHAIRS

11. PRIMARY CARE DEVELOPMENT PARTNERSHIP GOVERNANCE GROUP REPORT

The report was provided for the Board's information from the meeting held 3 October 2018. Helen Francis provided an update on the report provided. A name change was not discussed however Kaumatua have come up with a phrase. Await clarification.

The next meeting is being held on 15 November 2018 with a report copied to the HBDHB Board at their November meeting.

12. MĀORI RELATIONSHIP BOARD

Chair Heather Skipworth provided a brief overview from the meeting held 10 October 2018 touching on the National Bowel Screening programme and the outcome of the equity discussion (which relayed cold hard facts about what the main causes of premature death in Maori were)– Hine Flood felt these should be well publicised within Maoridom. Equity and Cultural Competency, where MRB endorsed recommendations proposed around the process to address the issues raised. The TAW Cardiovascular report had been received; Maori workforce Project further discussion in November; Kaupapa Maori terminology – template provided at meeting excellent example to provide clarity around usage and was well accepted.

13. HAWKE'S BAY CLINICAL COUNCIL

Co-Chair John Gommans spoke to the report from the Council's meeting held on 10 October 2018.

Draft Quality Dashboard – principles were endorsed, now await feedback on indicators to be provided, it is about finding a balance.

Conception to five years, including the first 1,000 days, an approach to address a gap in the pre-school age group was a Council initiated report. We wanted to know more and the report was well received.

A brief overview around the make-up and operation of the four Committees of Council was provided. They work well with good engagement across the sector. Other Committee members include the CMO Primary Care, CMDO-Hospital, CNMO, CAHPO, ED People & Quality, Senior Advisor Cultural Competency and Consumer representative (or delegates).

A process for multi-disciplinary credentialing of departments was noted and suggested that external reviews may be the most appropriate means to achieve this.

14. HAWKE'S BAY HEALTH CONSUMER COUNCIL

Rachel Ritchie, Chair of Consumer Council advised the outcomes of their meeting held on 11 October 2018. In addition to the report provided, Rachel noted the Consumer Experience Group which had held their first meeting, with a focus on implementing Person & Whanau Centred Care.

Encouraged with IT initiatives being pursued and consumer input into aspects at governance level is being reactivated.

FOR APPROVAL

15. TERMS OF REFERENCE UPDATE – APPOINTMENTS AND REMUNERATION ADVISORY COMMITTEE

Background was provided and following discussion the recommendation was approved.

RECOMMENDATION

That the HBDHB Board approve an additional function within the Terms of Reference for the Appointments and Remuneration Advisory Committee:

- (c) Review (and endorse) any CEO proposed adjustments to the remuneration packages of the CEO's direct reports.

Adopted

In the main the ARAC Committee's focus is about setting KPIs of the CEO. All detail from these meetings are shared with all board members before they become absolute.

The Board Chair was asked to consider not only a gender balance on this committee but also ethnicity balance in line with Treaty responsibilities and change from two to three board members and include one Māori member.

This will be further discussed at the November Board meeting.

16. ALLIED LAUNDRY SERVICES ANNUAL GENERAL MEETING REPRESENTATION

Ken Foote, spoke to papers provided advising that Allied Laundry's Annual General Meeting was being held on 27 November. He noted an interest on capital dividend of \$0.06 per share to shareholders would be forthcoming for the 2017/18 financial year, as required by the Shareholders Agreement.

The board passed on their appreciation for Ken's good work and congratulated another successful year.

RECOMMENDATION**That the Board**

1. **Note** the Annual Report and Financial Statements for Allied Laundry Services Ltd (which have been reviewed but not yet signed off by the auditors) for the year ended 30 June 2018.
2. **Appoint** Ken Foote as the HBDHB Shareholder representative to attend the Allied Laundry Services Ltd Annual General Meeting to be held on Tuesday 27 November 2018, with Carriann Hall appointed as his Alternate.

Adopted**TAS ANNUAL GENERAL MEETING REPRESENTATION**

The reports were considered and the following resolution approved.

RESOLUTION**That the Board**

3. **Note** the Annual Report for TAS for the year ended 30 June 2018.
4. **Appoint** Kevin Atkinson as the HBDHB representative to attend the TAS Annual General Meeting being held on Wednesday 5 December 2018, with Kevin Snee appointed as his Alternate.

Moved: Ana Apatu
Seconded: Hine Flood
Carried

FOR DISCUSSION / INFORMATION**17. CLINICAL SERVICES PLAN UPDATE**

Feedback which included many overwhelming positive comments had been received. No feedback has indicated that we have 'got it wrong', nor appear to require any significant change to the commitments, concepts and themes contained within the CSP. The final draft (including tracked changes) will be issued together with a summary of changes/inclusions to MRB, PHLG, Clinical and Consumer Council in mid November for feedback prior to coming to the Board on 28 November. The final will essentially become an input/inform the 5 year Strategic Plan (likely to come through for approval in March 2019). We will not be 'publishing' the CSP, other than making it available on our website for the next 6 – 12 months.

A name change for the document was discussed but as it will not be "published" and informs the strategic plan - the name remains the same.

18. TE ARA WHAKAWAIORA CARDIOVASCULAR REPORT

Dr John Gommans spoke to the report provided.

There has been a challenge within the central region in meeting the access to angiography indicator for our total population and for Maori due to Capital and Coast DHB's limited ability to meet regional demand. It is doubtful that Hawke's Bay will meet these indicators without development of a local interventional cardiology service.

Every quarter HB's numbers are similar to Nelson which indicates we should be providing services locally, meeting the targets and avoiding transport costs. We are now looking at how to do this.

The average length of stay for those waiting needs to be factored into this equation. Our peaks often coincide with longer waiting times and risk. We could gradually staff up more over time and replace/recruit to meet demand when the service kicks in. Look also at outlying DHBs eg. Gisborne and offer services.

Rachel Ritchie noted the pressure on not only the patient but family members locally and having to travel to Wellington, can cause real hardship.

GENERAL BUSINESS

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

19. RECOMMENDATION TO EXCLUDE THE PUBLIC

RECOMMENDATION

That the Board

Exclude the public from the following items:

20. Confirmation of Minutes of Board Meeting
21. Matters Arising from the Minutes of Board Meeting
22. Board Approval of Actions exceeding limits delegated by CEO
23. Chair's Update
24. Annual Plan 2018/19 (final draft)
25. Hawke's Bay Clinical Council
26. Finance Risk and Audit Committee Report

Moved: Ana Apatu

Seconded: Peter Dunkerley

Carried

The public section of the Board Meeting closed 3.37pm

Signed:

Chair

Date:

BOARD MEETING - MATTERS ARISING (Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	30/5/18 26/9/18	Human Resource (HR) KPIs – Maori Workforce Kate Coley advised the HR KPI report soon to be provided will feature disparities within that report.	Kate Coley	Nov 18	On November Agenda, new report entitled “ People and Quality Dashboard Q1 ”
2	27/6/18 25/7/18 29/9/18	Addiction Services Raised by Diana Kirton in June advising this does not appear on the workplan currently. A number of teams in primary care are working up a scoping report. Diana Kirton received information and comfortable with progress. A report to be provided in near future and timing to be included on the workplan once ascertained	Chris Ash		Committees reviewed Scoping paper in November
3	29/9/18 10/10/18	The following process was agreed to move towards addressing the areas raised by MRB (in September’s Board Report) around Equity and Cultural Competency : Kevin Atkinson Board Chair suggested the following process which was accepted at the MRB meeting: a) That a Working Group come together to study and focus on next year’s planning. b) That a Workshop be set up in the New Year (including MRB members and other representatives as required), the result of which will be clear actions and targets we can aim for.	Kevin Snee	Timing Feb 19 TBC	
4	31/10/18	Kate Coley (HR) and primary care services should consider ongoing training of frontline staff (Consumer Service / kiwi host).	Kate Coley & Wayne Woolrich		Verbal update in November


Board Meeting 28 November 2018 - Board Workplan

BOARD Workplan as at 22 November 2018 (subject to change)	EMT Member	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	BOARD Meeting date
Health Equity Report Final for approval	Andy Phillips				19-Dec-18
People Plan Progress Presentation	Kate Coley	5-Dec-18	5-Dec-18	6-Dec-18	19-Dec-18
Mobility action plan implementation Presentation	Andy Phillips	5-Dec-18	5-Dec-18	6-Dec-18	19-Dec-18
Te Ara Whakawaiaora - Alcohol and other Drugs (National and Local Indicators)	Andy Phillips	5-Dec-18	5-Dec-18	6-Dec-18	19-Dec-18
Finance Report (Nov)	Carriann Hall				19-Dec-18
PCDP Report (monthly for info only)	Ken Foote				19-Dec-18
Alcohol Harm Reduction Strategy (6 monthly update) Feb -Aug-Feb-Aug	Andy Phillips	13-Feb-19	13-Feb-19	14-Feb-19	27-Feb-19
Consumer Engagement Strategy Implementation Plan and presentation. Effectiveness of the strategy via regular reporting to be confirmed to Board. (previously Nov 18 now Feb 19)	Kate Coley			14-Feb-19	27-Feb-19
Ngatahi Vulnerable Children's Workforce Development - annual progress Feb 19 (annual update)	Colin Hutchison	13-Feb-19	13-Feb-19	14-Feb-19	27-Feb-19
Te Ara Whakawaiaora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-Nov- Feb -May	Chris Ash	13-Feb-19	13-Feb-19	14-Feb-19	27-Feb-19
Te Ara Whakawaiaora - Improving First Specialist Appointment Access (previously did not attend) moved out from end of 2018	Colin Hutchison	13-Feb-19	13-Feb-19	14-Feb-19	27-Feb-19
Te Ara Whakawaiaora REVIEW	Patrick LeGeyt	13-Feb-19	13-Feb-19	14-Feb-19	27-Feb-19
HBDHB Performance Framework Exceptions Q2 Nov 18 Feb 19 /May/Aug 19 (jit)	Chris Ash	13-Feb-19			27-Feb-19
People and Quality Report for Q2 Oct-Dec 18 Incl Diversity (Nov- Feb -May-Aug)	Kate Coley				27-Feb-19
He Ngakau Aotearoa	Patrick LeGeyt				27-Feb-19
Finance Report (Jan)	Carriann Hall				27-Feb-19
HBDHB Non-Financial Performance Framework Dashboard Q2 - EMT/Board	Chris Ash				27-Feb-19
PCDP Report (monthly for info only)	Ken Foote				27-Feb-19
Matariki Regional Development Strategy and Social Inclusion Strategy update (6 mthly) Sept- Mar	Andy Phillips	13-Mar-19	13-Mar-19	14-Mar-19	27-Mar-19
Te Ara Whakawaiaora - Breastfeeding (National Indicator)	Chris McKenna	13-Mar-19	13-Mar-19	14-Mar-19	27-Mar-19
After Hours Urgent Care Service Update 6mthly (Sept-Mar-Sept)	Wayne Woolrich	13-Mar-19	13-Mar-19	13-Mar-19	27-Mar-19
Violence Intervention Programme Presentation Committees reviewed in July - EMT Nov - TBC for March 19	Colin Hutchison	13-Mar-19	13-Mar-19	14-Mar-19	27-Mar-19
Finance Report (Feb)	Carriann Hall				27-Mar-19
PCDP Report (monthly for info only)	Ken Foote				27-Mar-19
Finance Report (Mar)	Carriann Hall				24-Apr-19
Hawke's Bay Health Awards Event - review Alcohol at this event annually	Kevin Snee				24-Apr-19
PCDP Report (monthly for info only)	Ken Foote				24-Apr-19
Te Ara Whakawaiaora - Access Rates 0-4 / 45-65 yrs (local indicator) QUARTERLY Aug-Nov- Feb -May	Chris Ash	8-May-19	8-May-19	9-May-19	29-May-19
HBDHB Performance Framework Exceptions Q3 Feb19 / May /Aug/Nov (jit)	Chris Ash	8-May-19			29-May-19
Finance Report (Apr)	Carriann Hall				29-May-19
People and Quality Report for Q3 incl diversity (Nov- Feb -May-Aug)	Kate Coley				29-May-19
HBDHB Non-Financial Performance Framework Dashboard Q3 - EMT/Board	Chris Ash				29-May-19
PCDP Report (monthly for info only)	Ken Foote				29-May-19
People Plan Progress Update (6 monthly - Dec, Jun 19)	Kate Coley	12-Jun-19	12-Jun-19	13-Jun-19	26-Jun-19
Annual Plan 2019/20 SPEs to Board by end of June (include committees?)	Chris Ash	12-Jun-19	12-Jun-19	13-Jun-19	26-Jun-19
Finance Report (May)	Carriann Hall				26-Jun-19



CHAIR'S REPORT

Verbal

 HAWKE'S BAY District Health Board Whakawāteatia	Chief Executive Officer's Report	156
	For the attention of: HBDHB Board	
Document Owner:	Kevin Snee, Chief Executive Officer	
Reviewed by:	Not applicable	
Month as at	21 November 2018	
Consideration:	For Information	

RECOMMENDATION

That the Board

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

INTRODUCTION

On today's agenda there are four key strategic issues:

- Clinical Services Plan
- Health Equity Report
- Wairoa Integrated Care Demonstrator Site
- Radiology Business Case

The first two are key strategic documents that will guide our intent over the next five to ten years, the second two are key in helping us to deliver a high quality of service in primary and secondary care.

The Board will also receive a paper describing our broad approach to addictions, which is a critical health issue in our community. I have also acknowledged our award for Innovation and Leadership in Health and Safety.

PERFORMANCE

Measure / Indicator		Target	Month of October	Qtr to end October	Trend For Qtr
Shorter stays in ED		≥95%	87.6%	87.6%	▲
Improved access to Elective Surgery (2018/19YTD)		100%	97%	91.6%	▲
	Waiting list	Less than 3 months	3-4 months	4+ months	
	First Specialist Assessments (ESPI-2)	3,171	715	390	
	Patients given commitment to treat, but not yet treated (ESPI-5)	1,082	191	451	
Faster cancer treatment – 62 day indicator* <i>(Patients who breach the 62 day target due to Capacity Constraint are still counted against target however patients who breach the target due to Clinical Decision or Patient Choice are now excluded).</i>		≥90%	57% September	81% 6 months to September	▼
Faster cancer treatment - 31 day indicator		≥85%	86% September	85% 6 months to September	▼
Increased immunisation at 8 months		≥95%	---	91% 3 months to September	-
Better help for smokers to quit – Primary Care		≥90%	--	85% (15m to October)	-
Raising healthy kids (New)		≥95%	---	99% (6 m to October)	▼
Financial – month (in thousands of dollars)		-784	-1,568	---	---
Financial – year to date (in thousands of dollars)		-605	-1,331	---	---

*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%	7/19 = 37%	64/114 = 56%

Key performance issues remain:

- Emergency Department (ED): Whilst this is improving it remains at a level which is well below plan. We are currently in week two of the implementation of a new model of care and I expect to see significant improvement before Christmas.
- Elective performance: The figure for October overall has improved, although it remains behind plan, however it is of concern that those patients waiting longer than four months for surgery have increased from 375 to 451. I would expect to see this figure reduce as measures introduced have an impact, this will take a couple of months. The increases in outpatient waits for first specialist assessments represents a shift in emphasis to addressing highest priority clinical need in patients awaiting follow up appointments.

- Faster Cancer Treatment for the 62 day indicator has dropped in September partly as a consequence of the strikes that occurred, in October the figure was back up to 100 percent compliance.
- Financial performance is of concern with the figure for October being \$784k adverse. The key pressure is in the provider and additional steps are being taken to bring this under greater control.

WAIROA INTEGRATED CARE DEMONSTRATOR SITE

At this month's Board meeting we will conduct a workshop session on how the DHB engages with, and supports the development of, our rural communities. The briefing paper provides an explicit focus on Wairoa. It explores the key strategies we need to focus on to deliver high quality care (tauwhiro), establishing and maintaining strong relationships ((rāanga te tira), and considers how we make decisions with the community around seizing opportunities to improve health and wellbeing (he kauanuanu). Our approach seeks to learn from how these issues have been handled in the past (ākina), and to generate open and honest discussion around how to manage this in the future in a way that is consistent with our health system values.

RADIOLOGY FACILITY DEVELOPMENT BUSINESS CASE

The Radiology business case is focussed on urgent measures required to ensure IANZ accreditation is retained following the issuing of corrective actions (CARs) in 2017. This includes replacing the MRI and Fluoroscopy units and making floor plan changes to address patient privacy and safety issues. Additionally the detailed seismic report showed that strengthening work is required which will be done at the same time. These works create a cost effective opportunity to reconfigure the layout of the department in a way that will allow for additional changes in the future such as a dedicated cardiac catheter laboratory for interventional cardiology, without over capitalising or creating regretful spend. The total CAPEX budget 18.94 million.

Approval is subject to sourcing capital and is requested at this stage so that the detailed design can be completed. Capital sources include Ministry of Health, finance arrangements on the equipment and prioritisation of internally generated capital. The final solution could be a combination of all of these capital sources and will be presented to FRAC for approval later next year prior to entering into contractual arrangements.

CLINICAL SERVICES PLAN

After nearly 18 months of analysis, brainstorming, discussion, consultation and community engagement, today the Board is being presented with the final version of the Clinical Services Plan (CSP) for approval. A report is also attached, summarising the submissions and feedback received to the most recent period of sector and community engagement, noting the consequential changes made to the draft CSP in response to these submissions, and reflecting the endorsements from all four governance groups.

It needs to be noted that this CSP is particularly significant, in that it sets out and commits the DHB to transformational change in our health services over the next ten years.

BEST START HEALTHY EATING AND ACTIVITY UPDATE

The Best Start Plan's activity supports children and their families to achieve or maintain healthy weight. The plan is on track and we have maintained the slight reduction in four year old children with BMI in the 98th percentile. Recent Ministry of Health feedback has thanked us for sharing "*the broader areas of work especially on the new activities that are focussed on preventing obesity which will, hopefully, have a significant impact on reducing childhood obesity in the future*".

We have been delivering consistent and equitable screening in pregnancy, and at four years with follow-up support designed with pregnant women and families with young children. Early intervention and prevention continue to be the best strategies to increase our healthy weight population.

Over the last six months we have developed programmes to integrate more breast-feeding support, help schools become healthy weight environments, included a focus on water approaches linked with oral health and an eight-year-old measure to monitor the impact of the plan. The plan's activity has linked into the consultation and design led by Māori Health to provide a wellbeing focused programme for pregnant women and their whānau. In the next six months we will deliver these programmes.

TE ARA WHAKAWAIORA – ACCESS (AMBULATORY SENSITIVE HOSPITALISATION) RATES 0-4 AND 45-64 YEARS

While in line with a national deteriorating trend, the DHB is prioritising work to understand and tackle increasing Ambulatory Sensitive Hospitalisation (ASH) rates across both 0-4 and 45-64 age groups, which include slowed progress on closure of the equity gap for certain indicators. This month's Te Ara Whakawaiaora paper sets out our approach. For the younger age group, we are focussing on actions such as improving follow-up, dental public health awareness, and targeted work on seasonal health risks. For adults, we are concentrating on issues such as readmission amongst the most prevalent long term conditions, and targeting funding streams such as Co-ordinated Primary Options (CPO) to tackle inequitable outcomes.

TE ARA WHAKAWAIORA – SMOKEFREE

HBDHB continues to achieve the Ministry of Health (MoH) secondary care target. Feedback from the Ministry states HBDHB is one of the few DHB's who are exceeding this target. Clinicians and health professionals continue to ask, give brief advice, offer cessation support and complete documentation. HBDHB has also achieved the MoH maternity care target. In quarter one, 91.7 percent of pregnant women were given brief advice and/or support to stop smoking; a significant increase of 22.4 percent from the previous quarter with 95.0 percent of Māori pregnant women given brief advice and/or support to stop smoking. The carbon monoxide-free homes pilot in Wairoa is already seeing a greater number of referrals to the stop smoking service. Wairoa DHB midwives have embraced the use of the Maternal Carbon Monoxide monitor as a tool for Smokefree conversations and referrals to the Wahine Hapu, Increasing Smoking Pregnancy Programme. The pilot will be evaluated in December with the intention to roll out further to the rest of the Hawke's Bay LMCs in February 2019.

HBDHB PERFORMANCE FRAMEWORK EXCEPTIONS QUARER ONE

We continue to be above target for our Health Targets Raising Healthy Kids performance, percentage of the population enrolled in the PHO and Stroke patients being admitted to an organised stroke unit. However, we still have challenges meeting shorter stays in the emergency department, with 86 percent of patients admitted, transferred or discharged within six hours against a target of 95 percent. The number of publicly funded elective and arranged discharges for people living within the DHB region at 90 percent is below plan for this financial year. The rate of Section 29 Mental Health Compulsory Treatment Orders is unfavourable to target for Māori and non-Māori. Breastfeeding is also unfavourable at 52 percent against a target of 70 percent.

PEOPLE DASHBOARD

The gap to our Māori staff representation target for 2018/19 of 16.02 percent currently sits at 49 people. Comparisons to 20 DHBs, mid-sized DHBs and Central Region DHBs Māori representation figures continue to be favourable. Staff turnover is within the 10.0 percent annual target with 9.8 percent in the last 12 months. The flu vaccination programme for 2018 has significantly improved from 2017. Annual leave balances show no improvement so we are targeting a reduction in leave balances in 2018/19 by over 10 percent and the report makes clear how we will achieve this.

HEALTH EQUITY REPORT

This report acknowledges that in Te Matau a Māui, Hawke's Bay, our people have pervasive and enduring differences in health that are not only avoidable but unfair and unjust. Equity is defined as the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. To achieve health equity we must acknowledge that different people with different levels of advantage will require different approaches and resources to get the same outcome. The inter-generational traumatic impact of colonisation has had long term impacts on Māori health, wellbeing and culture. Socio-economic factors account for almost half of all health inequity. Health care is responsible for a further 10 percent.

To achieve our commitment to equal outcomes, we will all need to work across sectors to overcome the barriers to equity - poverty, discrimination, powerlessness, lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare. We know that many in our community face barriers to accessing high quality health care services. These barriers include difficulties in navigating our complex systems, limited cultural competence of providers, lack of transport, out-of-pocket costs and co-payments for GP services.

We know that to address health inequities across the life span we need to work across sectors and with communities to:

- give all tamariki the best start in life
- strengthen the role and impact of ill-health prevention
- ensure that all tamariki and rangatahi experience few adverse childhood events, many positive childhood experiences and have an education that enables them to maximise their capabilities and have control over their lives
- create fair employment and a healthy standard of living for all adults
- create and develop healthy and sustainable places and communities
- deliver excellent health services that produce the best outcomes for people with conditions such as cardiovascular disease, cancer, respiratory disease and diabetes
- deliver excellent mental health and addictions services
- improving Health and Equity for all populations

ADDICTIONS

The DHB's annual plan makes a commitment to review how we approach addiction-related harm in our communities. The Board requested that a scoping paper be developed looking specifically at the issue of methamphetamine use, and this was shared with the Māori Relationship Board (MRB) in November. It will now feed into a broad review of community mental health and addictions services, which will be delivered in full partnership with consumers, whanau and clinicians over the next 18 months. The process will be overseen by the Primary Care Development Partnership (Alliance). Engagement will be maintained with MRB, Clinical and Consumer Councils' throughout the duration of this work.

SAFE365 SAFEST PLACES TO WORK


Safe365 (DHBs health & safety assessment tool) held their national annual awards celebrating organisations who are working to create safe places to work and leading innovation around all health and safety matters. Our DHB, represented by Executive Director of People & Quality, was honoured to receive an award for Innovation and Leadership in Health and Safety, which was related to the assessment of all our high risk on site contractors using the Safe365 tool. The following summarises the citation from the awards dinner:

"The Health Sector by its very nature is a challenging environment with many moving parts and apart from a very clear focus on the care and safety of its patients and staff, there is also a critical need to ensure contractors in the supply chain are capable and effective in getting the job done safely. This DHB has asked the question "how do we meet our overlapping PCBU (person conducting a business or undertaking) requirements while ensuring something of value is given to the contractor in a manner that is business friendly. This is the first DHB to fundamentally seek to address this issue and target greater collaboration and offer supply chain leadership across their high-risk contractors. Taking a leadership role in lifting capability and culture in the supply chain for the benefit of the DHB itself, the contractor and the community, the Board and Executive Team have demonstrated courage and a willingness to take a different approach which has seen a further two DHBs subsequently follow their lead."

Further to our DHB winning this award it was great to see Falcon Electrical, Higgins Ltd, Te Tai Whenua o Heretaunga and Turefry all being recognised as finalists in the Safest Places to Work categories, following the pilot that we undertook with them last year. Turefry won their category (large enterprise) and were the evening's Supreme Winners. We will continue to prioritise our focus on health and safety within our DHB and celebrate this success within the organisation and the wider Hawke's Bay community.

CONCLUSION

Today is an important milestone in resetting our strategic direction with the adoption of the Clinical Services Plan – clearly the hard work will be in the delivery of this plan and we will regularly update the Board on our progress. We have also brought to the board confirmation that there is much more to do to address the injustice of health inequity in our community. This is not simply a matter for the DHB but for all people and all organisations in the Hawke's Bay community.

 HAWKE'S BAY District Health Board Whakawāteatia	Financial Performance Report October 2018	157
	For the attention of: HBDHB Board and the Finance Risk and Audit Committee	
Document Owner	Carriann Hall, Executive Director Financial Services	
Document Author	Phil Lomax, Financial and Systems Accountant	
Reviewed by	Executive Management Team	
Month/Year	November, 2018	
Purpose	For Information	

RECOMMENDATION:

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

- Note** the contents of this report

EXECUTIVE DIRECTOR FINANCIAL SERVICES COMMENTS**Financial Performance**

As shown in the table below, the result for the month of October is \$784k unfavourable to plan, taking the year-to-date (YTD) result to \$726k adverse. The forecast is to achieve plan. However, there are challenges in achieving this, which are explored further in this report.

\$'000	October				Year to Date				Year End Forecast	Refer Appendix
	Actual	Budget	Variance		Actual	Budget	Variance			
Income	46,847	47,988	(1,141)	-2.4%	191,882	191,544	338	0.2%	574,068	2
Less:										
Providing Health Services	25,794	25,252	(542)	-2.1%	96,524	94,729	(1,795)	-1.9%	287,108	3
Funding Other Providers	19,564	19,769	205	1.0%	81,801	80,139	(1,662)	-2.1%	242,044	4
Corporate Services	4,698	4,594	(104)	-2.3%	17,004	17,010	6	0.0%	48,908	5
Reserves	(1,640)	(844)	797	94.4%	(2,115)	272	2,387	878.6%	1,008	6
	(1,568)	(784)	(784)	-100.1%	(1,331)	(605)	(726)	-119.9%	(5,000)	

Key Drivers of Actual Position

There are a number of factors driving the unfavourable position including:

- Income (Appendix 2)
 - In month degradation of position due to review of funding expectations relating to In-Between-Travel, Health Hawke's Bay (PHO) performance, and Needs Assessment and Service Coordination (NASC) management, resulting in a reduction in revenue
 - Ongoing impact of reduced ACC revenue in elective surgery, due to capacity management actions
- Providing Health Services (Appendix 3)
 - Unachieved savings target \$1.5m YTD

- \$1.1m YTD overspend in clinical supplies, despite additional funding being provided from contingency. One contributor is a step change in pharmaceutical costs in 2018/19. This is being investigated in the context of changes to PHARMAC funding flows
- Inter-Hospital Transfers and associated costs linked to Inter-District Health Board Flow (IDF) activity
- Nursing personnel costs, driven by acuity, staff absence etc. The leave revaluation following salary settlement also impacted October results. Close monitoring of rostering and Clinical Nurse Manager (CNM) training underway
- Partially offset by external outsourcing slippage to plan, although actual expenditure is in line with 2017/18 levels and allied health personnel vacancies.
- Funding Other Providers (Appendix 4)
 - Impact of Pay Equity and acuity in external providers, particularly in Health of Older People and Mental Health.
 - Continued pressure on IDFs shown in Corporate Services . IDF inflow shortfall is expected to improve over summer months, due to impact of holidaymaker inflows. IDF outflow overspend is an ongoing pressure, management through local clinical management.
 - Partially offset by favourable variance on pharmaceutical rebates
- Reserves (Appendix 6)
 - Contingency and one-off benefits

Forecast

Looking forward there are a number of factors in our position that we expect to continue to have a favourable impact, including:

- Allied health vacancies through challenges recruiting staff;
- Additional Ministry of Health (MOH) income;
- Medical vacancies net of locum cover, again challenges recruiting staff; and
- Release of the remaining contingency and other reserves.

However, they are likely to be more than offset by ongoing factors such as:

- Undelivered savings;
- Management of IDFs, Inter-Hospital Transfers and impact of the National Ambulance Sector Office (NASO) national contract from 1st November;
- Pharmaceuticals and PHARMAC changes;
- Activity and acuity;
- Radiology activity;
- The cost of elective surgery and the associated loss of ACC revenue;
- Pay equity and the impact of pay settlements on other providers; and
- Actual cost of pay settlements vs funding received.

Ongoing management actions to mitigate downside risk include:

- Programme of work, led by Executive Director Provider Services, to get Provider Services on to a sustainable footing, including training for key managers and improved visibility and control around temporary resources;
- Maximising improved hospital status, with a focus on ensuring staff are flexed down and rested;
- Continued focus on savings plan and living within our means;

- Inter-Hospital Transfers, with actions underway to mitigate the cost increase, although these are unlikely to materially impact until the New Year.
- Housekeeping activities, including review of ACC revenue processes and a structured approach to reduce leave liability being implemented; and
- Progressing Atawhai Matāwhaiti prioritisation framework.

Resource Overview

	October				Year to Date				Year End Forecast	Refer Appendix
	Actual	Budget	Variance		Actual	Budget	Variance			
	\$'000	\$'000	\$'000	%	\$'000	\$'000	\$'000	%		
Net Result - surplus/(deficit)	(1,568)	(784)	(784) ▼	-100.1%	(1,331)	(605)	(726) ▼	-119.9%	(5,000)	1
Quality and financial improvement	723	1,179	(456)	-38.7%	1,441	4,717	(3,276)	-69.5%	14,152	9
Capital spend	1,213	1,319	(106)	-8.0%	6,389	8,286	(1,897)	-22.9%	17,933	13
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,410	2,509	99 ▼	3.9%	2,387	2,439	52 ▼	2.1%	2,452	3 & 5
	CWD	CWD	CWD	%	CWD	CWD	CWD	%	CWD	
Case weighted discharges	3,031	2,485	546 ▼	22.0%	9,752	10,191	(439) ▼	-4.3%	28,699	3

Savings Plans (Quality and Financial Improvement)

Achievement of the \$14.2m saving plan is a significant factor in the financial position. Savings plans have been identified for \$7.4m (52%) of the \$14.2m required. Of the identified savings \$3.8m has been removed from operational budgets (Appendix 9).

On a straight line basis YTD savings of \$4.7m should have been achieved by the end of October, and \$1.4m has been made. To adjust for timing, a further \$1m of the savings required has been accrued centrally. This is matched by \$479k budgeted contingency accrued to budget and a further \$533k relating to the new investments reserve accrued to budget. The remaining \$2.3m shortfall is in the year-to-date position.

Capital

Capital spend is behind budget reflecting plant and equipment needs and procurement lead times in the block allocations (Appendix 13). Ministry of Health has advised Hawke's Bay DHB has not been prioritised for capital investment in the next two financial years, although there will be opportunity for the Board to respond on this. A paper will be brought to FRAC next month on the impact and next steps.

Cash

October's low point was a \$6.2m overdraft with a forecast low of \$9m overdrawn by the end of the year. These are within our statutory limit of \$27m (Appendix 12 and 14).

Employees

Employee numbers are favourable reflecting investment in additional roles, challenges filling vacancies in medical and allied health positions, partly offset by additional nursing resources (Appendix 3 and 5).

Case Weighted Discharges (CWD)

Year-to-date CWD are lower than plan, which is at odds with the reports of high acuity and activity in Provider Services. There is a timing lag on this due to coding. Patient mix will also be a factor, but this will be investigated further (Appendix 3).

APPENDICES

1. FINANCIAL PERFORMANCE SUMMARY

\$'000	October				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Income	46,847	47,988	(1,141)	-2.4%	191,882	191,544	338	0.2%	574,068
Less:									
Providing Health Services	25,794	25,252	(542)	-2.1%	96,524	94,729	(1,795)	-1.9%	287,108
Funding Other Providers	19,564	19,769	205	1.0%	81,801	80,139	(1,662)	-2.1%	242,044
Corporate Services	4,698	4,594	(104)	-2.3%	17,004	17,010	6	0.0%	48,908
Reserves	(1,640)	(844)	797	94.4%	(2,115)	272	2,387	878.6%	1,008
	(1,568)	(784)	(784)	-100.1%	(1,331)	(605)	(726)	-119.9%	(5,000)

Income

Reduced expectation of Ministry of Health (MOH) income for In-Between-Travel (home care), PHO performance and NASC management. Lower ACC income as higher rehabilitation revenue only partly offset the reduction in ACC elective surgery.

Providing Health Services

Difficulty achieving evenly phased planned efficiencies, and nursing costs over the winter, partly offset by settlement timing differences between when they were incurred and provided for.

Funding Other Providers

Pay equity and In-Between-Travel offset in income, difficulty achieving efficiencies, sustainability of psychogeriatric beds, and IDF volumes, contribute to the unfavourable variance and are partly offset by PHARMAC rebates.

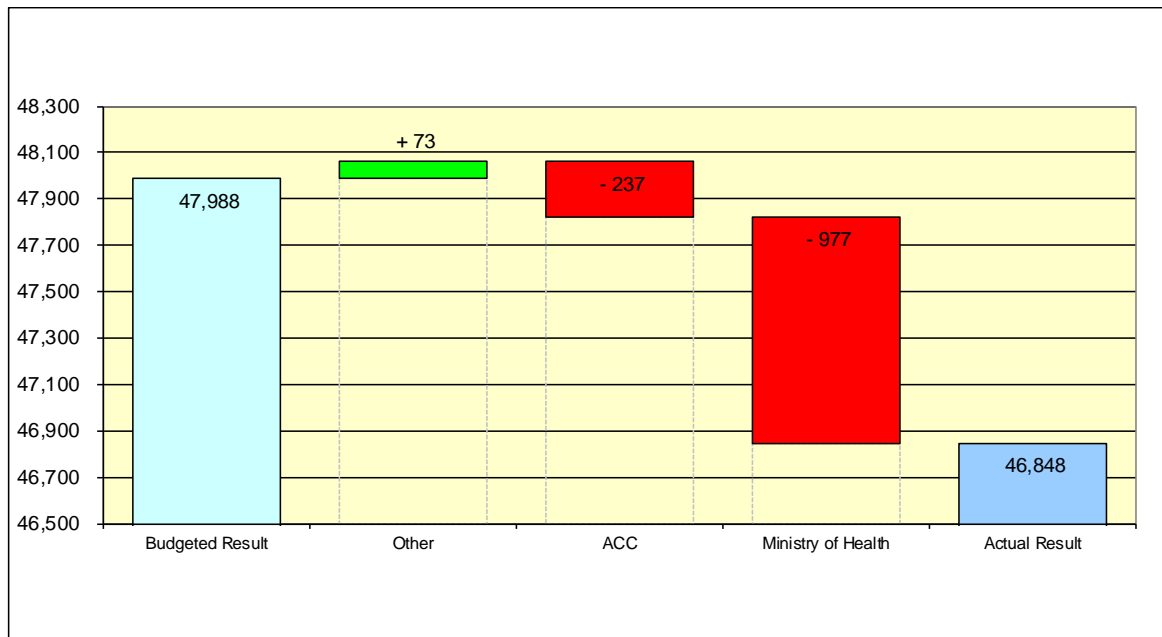
Reserves

The accrual for unachieved savings (recognising savings are more likely to increase incrementally rather than being achieved evenly over the year), is recognised in reserves, as are prior year adjustments (Appendix 6).

2. INCOME

	October				Year to Date				Year End
	Actual	Budget	Variance		Actual	Budget	Variance		Forecast
\$'000									
Ministry of Health	44,718	45,695	(977)	-2.1%	182,954	182,459	495	0.3%	546,934
Inter District Flows	819	762	57	7.4%	2,561	3,049	(488)	-16.0%	9,146
Other District Health Boards	362	354	8	2.2%	1,530	1,394	136	9.8%	4,229
Financing	28	55	(28)	-49.9%	147	221	(74)	-33.7%	663
ACC	186	423	(237)	-56.0%	1,601	1,776	(174)	-9.8%	5,370
Other Government	70	82	(12)	-14.6%	150	250	(99)	-39.8%	673
Patient and Consumer Sourced	80	79	0	0.5%	338	416	(79)	-18.9%	1,261
Other Income	585	538	47	8.8%	2,033	1,963	69	3.5%	5,774
Abnormals	-	-	-	0.0%	570	17	553	3250.2%	17
	46,847	47,988	(1,141)	-2.4%	191,882	191,544	338	0.2%	574,068

Month of October



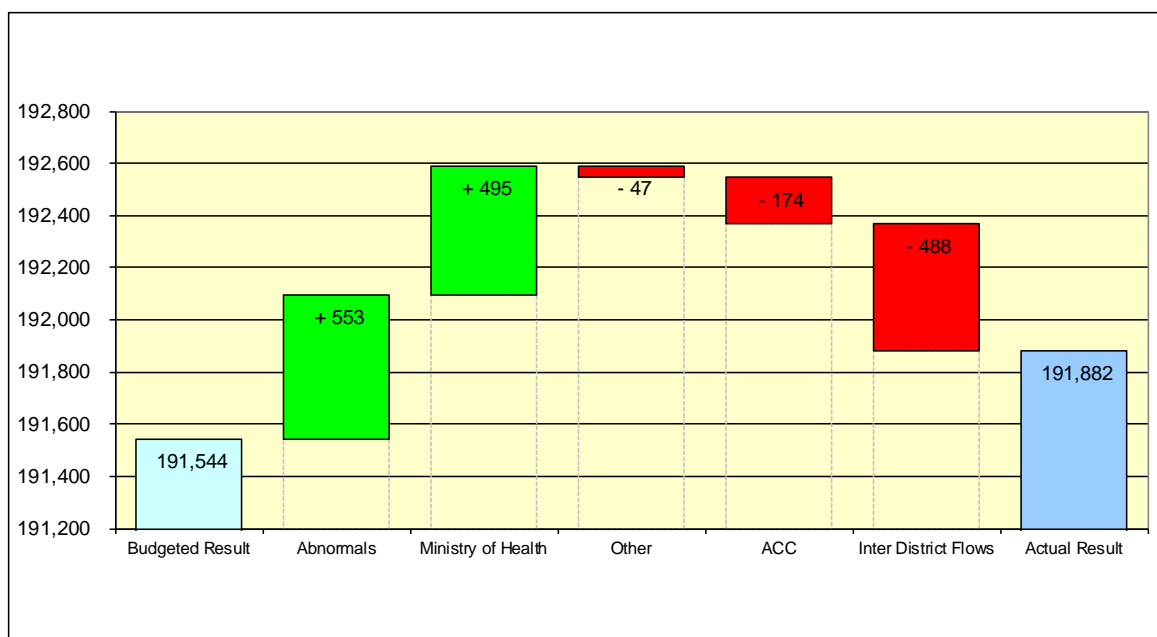
Note the scale does not begin at zero

ACC (unfavourable)

Lower elective surgery income reflecting capacity constraints.

Ministry of Health (unfavourable)

Review of likely funding income for In-Between Travel, PHO performance and NASC management, resulting in a reduction of income accrued.

Year to Date

Note the scale does not begin at zero

Abnormals (favourable)

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

Ministry of Health (favourable)

Pay equity and In-Between-Travel offset in related expenditure (Appendix 4). Also immediate relief and CCDM funding (nurses agreement).

ACC (unfavourable)

Reduced elective surgery income due to capacity constraints, partly offset by increased rehabilitation income.

Inter-District Flows (unfavourable)

Reduced income over the winter months, expected to increase going into summer.

3. PROVIDING HEALTH SERVICES

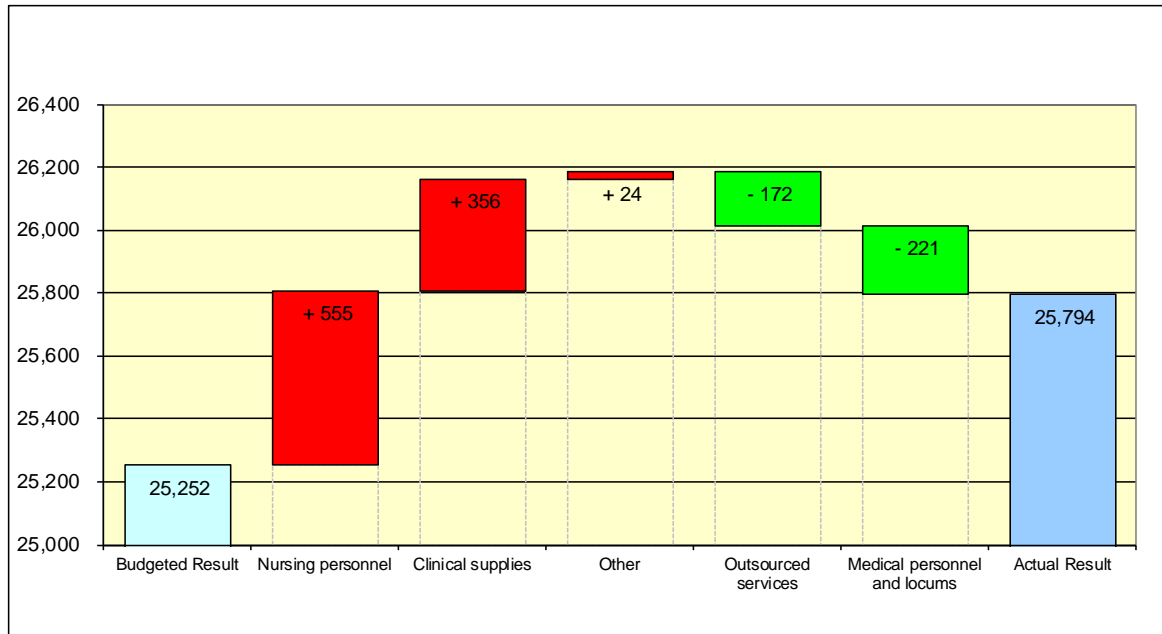
	October				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure by type \$'000									
Medical personnel and locums	5,266	5,487	221	4.0%	21,371	21,499	127	0.6%	67,602
Nursing personnel	8,215	7,659	(555)	-7.2%	28,670	27,931	(739)	-2.6%	84,656
Allied health personnel	3,139	3,301	162	4.9%	12,027	12,963	936	7.2%	38,523
Other personnel	2,138	2,117	(21)	-1.0%	8,356	8,278	(78)	-0.9%	24,660
Outsourced services	922	1,094	172	15.7%	3,253	4,077	824	20.2%	12,259
Clinical supplies	4,066	3,710	(356)	-9.6%	15,212	12,641	(2,571)	-20.3%	37,272
Infrastructure and non clinical	2,048	1,882	(165)	-8.8%	7,634	7,340	(295)	-4.0%	22,136
	25,794	25,252	(542)	-2.1%	96,524	94,729	(1,795)	-1.9%	287,108
Expenditure by directorate \$'000									
Medical	7,394	7,341	(54)	-0.7%	27,226	25,541	(1,686)	-6.6%	77,930
Surgical	5,460	5,558	98	1.8%	20,545	20,976	431	2.1%	64,054
Community, Women and Children	3,990	4,049	59	1.5%	15,318	15,047	(271)	-1.8%	45,650
Older Persons, Options HB, Mental Health	3,240	3,160	(80)	-2.5%	12,031	12,040	9	0.1%	36,272
Operations	3,870	3,688	(182)	-4.9%	13,985	13,622	(363)	-2.7%	40,730
Other	1,840	1,457	(383)	-26.3%	7,418	7,503	85	1.1%	22,473
	25,794	25,252	(542)	-2.1%	96,524	94,729	(1,795)	-1.9%	287,108
Full Time Equivalents									
Medical personnel	340.0	361.6	22	6.0%	344	361	17	4.8%	368.2
Nursing personnel	1,005.7	1,055.1	49	4.7%	989	981	(8)	-0.8%	988.2
Allied health personnel	464.8	487.0	22	4.6%	469	497	27	5.5%	496.6
Support personnel	142.9	137.5	(5)	-3.9%	140	138	(2)	-1.7%	138.9
Management and administration	276.9	276.5	(0)	-0.2%	272	278	5	1.9%	277.8
	2,230.3	2,317.7	87	3.8%	2,215	2,254	39	1.8%	2,269.6
Case Weighted Discharges									
Acute	2,144	1,718	425	24.7%	7,128	7,028	99	1.4%	19,417
Elective	566	579	(13)	-2.3%	1,860	2,340	(480)	-20.5%	6,850
Maternity	287	147	140	95.6%	699	671	28	4.2%	2,000
IDF Inflows	35	41	(6)	-14.6%	64	151	(86)	-57.3%	432
	3,031	2,485	546	22.0%	9,752	10,191	(439)	-4.3%	28,699

Directorates

- Medical (year-to-date) – challenges achieving planned efficiencies, nursing resource use, pharmaceutical costs (mainly biologics), medical staff vacancy cover, and radiology reads (radiologist vacancies).
- Other (October) – impact of the nursing settlement on annual leave balances.

Case Weighted Discharges

Acute and maternity discharges were significantly above plan for the month and marginally above budget year-to-date. This is likely to reflect a catch up in data collection rather than a high volume month. Electives and IDF inflows were marginally lower than plan in October, and remain well below plan year-to-date. Elective surgery is expected to catch up to plan later in the year, and IDF inflow is likely to pick up over the summer.

Month of October

Note the scale does not begin at zero

Nursing personnel (unfavourable)

Reflects differences in timing between when the nursing settlement costs were incurred and when they were provided for.

Clinical supplies (unfavourable)

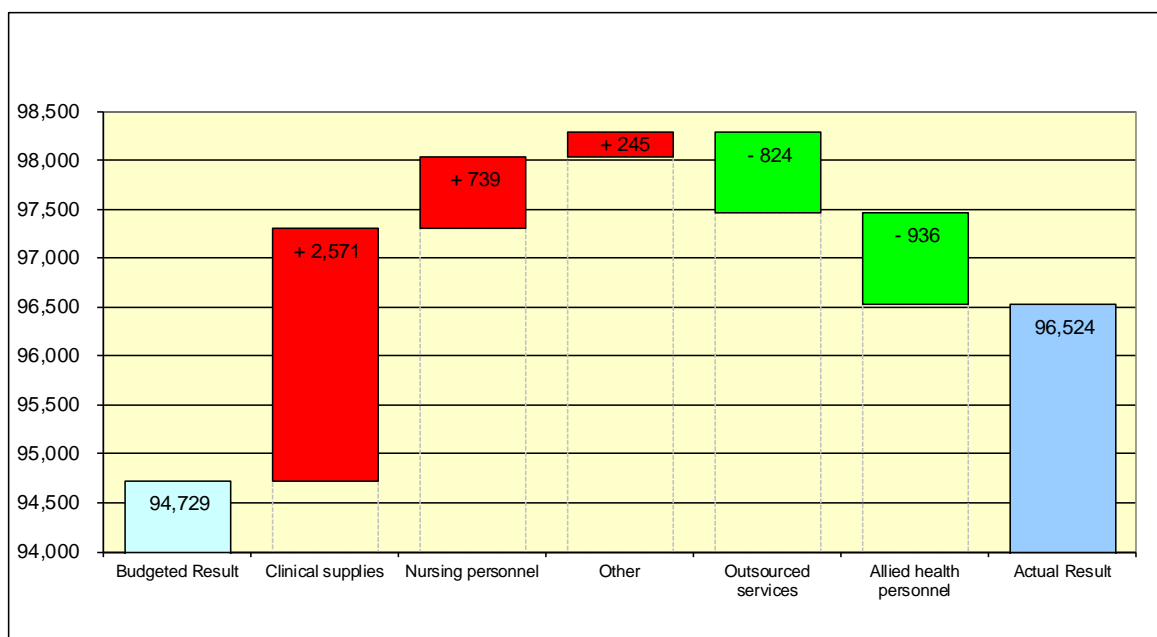
\$1.5m due to difficulty achieving efficiencies phased evenly over the year. Remaining variance due to pharmaceutical cost step change, Blood Intragam, and diagnostic supplies.

Outsourced services (favourable)

Outsourcing of elective surgery is expected to occur later in the year than budgeted, with the resulting favourable variance partly offset by after hours radiology reads caused by radiologist vacancies.

Medical personnel and locums (favourable)

Vacancies partly offset by locums.

Year to Date

Note the scale does not begin at zero

Clinical supplies (unfavourable)

Mainly challenges achieving evenly phased planned efficiencies. Pharmaceuticals including biologics continue to run higher than planned despite a transfer of budget from the contingency. Blood costs were high in October relating to the treatment of a specific patient.

Nursing personnel (favourable)

Nursing costs reflect high patient volumes over the winter months.

Outsourced services (favourable)

Outsourced elective surgery favourable variance is expected to reduce in future months as actions underway to manage elective surgery volumes start to impact.

Allied health personnel (favourable)

Challenges in recruitment/retention continue, and are a national issue.

Full Time Equivalents (FTE)

FTEs are 39 (1.8%) favourable year-to-date including:

Medical personnel (17 FTE / 4.8% favourable)

- Vacancies in radiology, Wairoa GPs, Emergency Department (ED), psychiatrists and anaesthetists.

Nursing personnel (-8 FTE / -0.8% unfavourable)

- Impact of high patient volumes in Intensive Care Unit, ED and the wards.

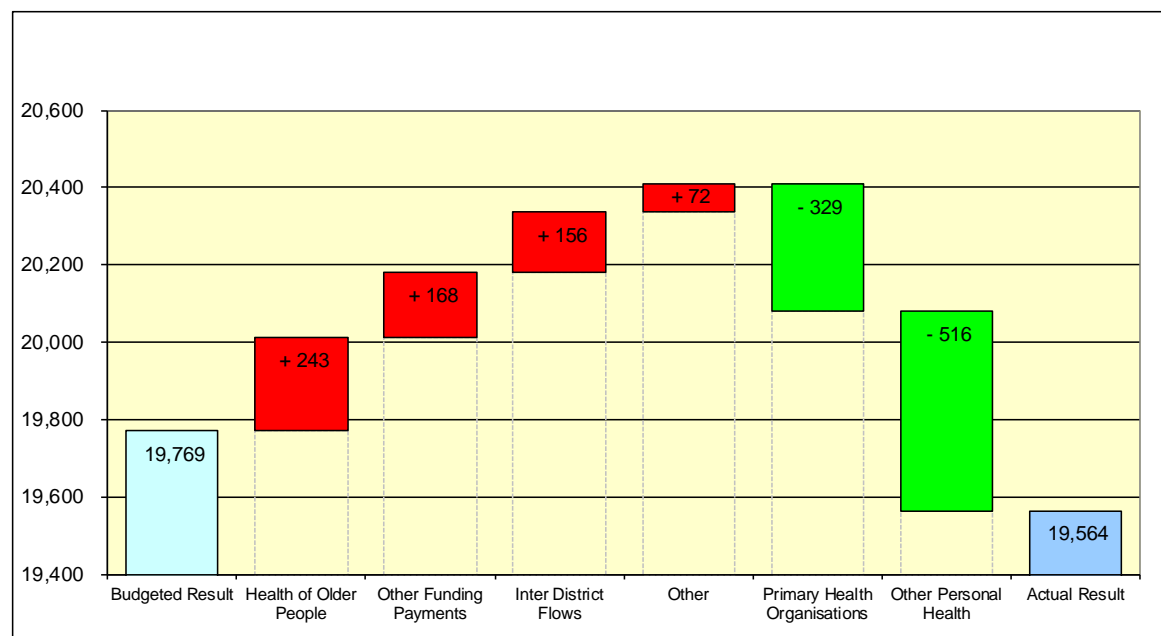
Allied health personnel (27 FTE / 5.5% favourable)

- Vacancies including medical radiation technologists (MRTs), technicians, occupational therapists, social workers, psychologists, and community support workers.

4. FUNDING OTHER PROVIDERS

\$'000	October				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Payments to Other Providers									
Pharmaceuticals	3,366	3,347	(19)	-0.6%	13,402	14,408	1,006	7.0%	43,284
Primary Health Organisations	2,636	2,965	329	11.1%	12,279	12,126	(153)	-1.3%	36,660
Inter District Flows	4,953	4,797	(156)	-3.2%	19,564	19,188	(376)	-2.0%	57,564
Other Personal Health	1,253	1,768	516	29.2%	7,439	6,758	(681)	-10.1%	21,503
Mental Health	1,111	1,058	(53)	-5.0%	4,329	4,231	(98)	-2.3%	12,699
Health of Older People	5,734	5,491	(243)	-4.4%	23,065	22,089	(976)	-4.4%	66,280
Other Funding Payments	510	342	(168)	-49.2%	1,723	1,339	(384)	-28.7%	4,053
	19,564	19,769	205	1.0%	81,801	80,139	(1,662)	-2.1%	242,044
Payments by Portfolio									
Strategic Services									
Secondary Care	4,557	4,244	(313)	-7.4%	17,787	16,977	(810)	-4.8%	50,928
Primary Care	6,802	7,656	854	11.2%	31,319	31,567	248	0.8%	96,316
Chronic Disease Management	-	-	-	0.0%	-	-	-	0.0%	-
Mental Health	1,363	1,298	(65)	-5.0%	5,286	5,192	(94)	-1.8%	15,581
Health of Older People	6,108	5,795	(313)	-5.4%	24,325	23,329	(996)	-4.3%	70,012
Other Health Funding	133	133	(0)	0.0%	533	533	(0)	0.0%	1,600
Maori Health	421	508	87	17.2%	1,974	2,033	59	2.9%	6,024
Population Health	179	134	(45)	-33.3%	576	507	(68)	-13.5%	1,582
	19,564	19,769	205	1.0%	81,801	80,139	(1,662)	-2.1%	242,044

Month of October



Note the scale does not begin at zero

Health of Older People (unfavourable)

Pay equity costs and In-Between-Travel offset in income.

Other Funding Payments (unfavourable)

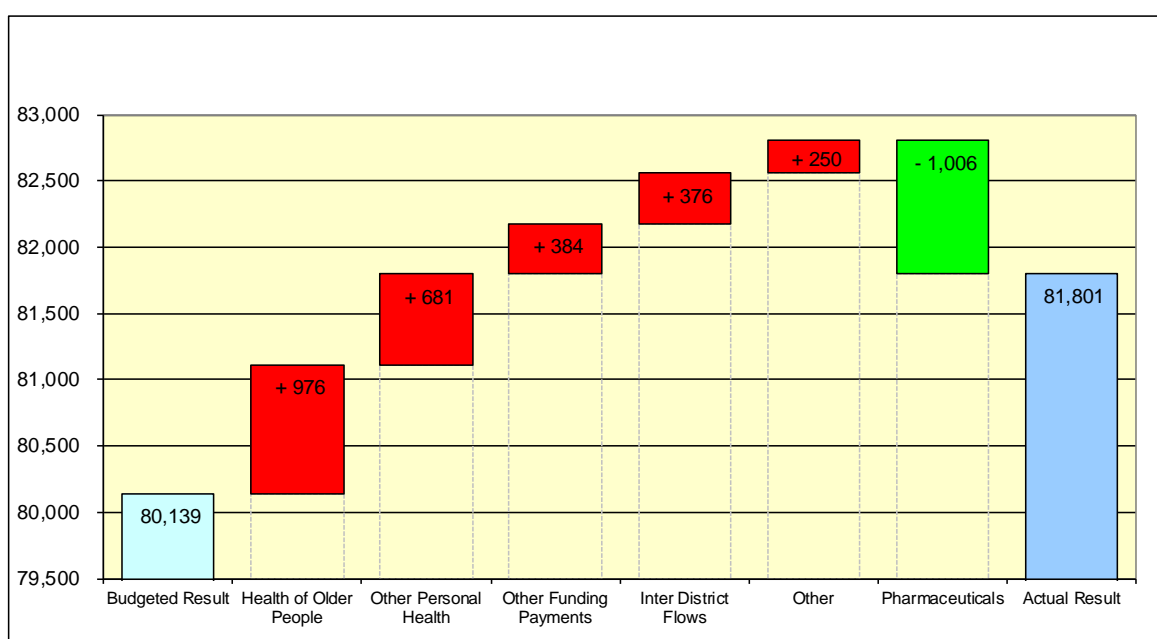
Mainly payments to secure bed capacity for psycho-geriatric patients.

Primary Health Organisations (favourable)

Adjustment to treat some of the payments made in September as prepayments.

Other Personal Health (favourable)

Contract savings expected.

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

Pay equity and In-Between-Travel offset in income.

Other Personal Health (unfavourable)

Includes the contract savings recognised in October, that partially meets the year-to-date savings target.

Other Funding Payments (unfavourable)

Bed capacity sustainability for psychogeriatric patients.

Inter District Flows (unfavourable)

Higher than planned volumes.

Pharmaceuticals (favourable)

Pharmaceutical rebates in line with PHARMAC forecasts.

5. CORPORATE SERVICES

\$'000	October			Year to Date			Year End Forecast
	Actual	Budget	Variance	Actual	Budget	Variance	
Operating Expenditure							
Personnel	1,671	1,712	40 2.4%	5,861	6,064	204 3.4%	17,600
Outsourced services	102	71	(31) -43.4%	289	290	1 0.2%	860
Clinical supplies	6	(25)	(30) -122.2%	66	(116)	(182) -156.8%	(371)
Infrastructure and non clinical	1,164	1,052	(112) -10.6%	3,872	3,842	(29) -0.8%	9,307
	2,943	2,810	(133) -4.7%	10,087	10,080	(7) -0.1%	27,395
Capital servicing							
Depreciation and amortisation	1,100	1,129	29 2.6%	4,296	4,309	13 0.3%	13,652
Financing	-	-	- 0.0%	-	-	- 0.0%	-
Capital charge	655	655	0 0.0%	2,620	2,620	(0) 0.0%	7,861
	1,755	1,784	29 1.6%	6,916	6,930	13 0.2%	21,513
	4,698	4,594	(104) -2.3%	17,004	17,010	6 0.0%	48,908
Full Time Equivalents							
Medical personnel	0.3	0.3	(0) -18.3%	0	0	(0) -3.4%	0.3
Nursing personnel	15.3	23.1	8 33.6%	14	16	2 12.5%	15.6
Allied health personnel	0.7	0.4	(0) -86.1%	0	0	0 11.8%	0.4
Support personnel	9.3	8.0	(1) -16.2%	10	8	(1) -16.5%	8.1
Management and administration	154.4	159.6	5 3.3%	149	160	11 7.1%	158.0
	180.1	191.4	11 5.9%	173	185	12 6.5%	182.5

The year-to-date clinical supplies variance is mainly planned efficiencies yet to be achieved. The infrastructure variance for October is mostly software charges.

6. RESERVES

\$'000	October			Year to Date			Year End Forecast
	Actual	Budget	Variance	Actual	Budget	Variance	
Expenditure							
Contingency	(413)	(422)	(10) -2.3%	389	379	(10) -2.5%	700
Efficiencies	131	-	(131) 0.0%	(1,027)	-	1,027 0.0%	0
Other	(1,359)	(422)	937 222.3%	(1,477)	(107)	1,370 1275.1%	308
	(1,640)	(844)	797 -94.4%	(2,115)	272	2,387 878.6%	1,008

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

Transfers out of the original \$4m contingency year-to-date include:

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

The accrual for unachieved savings (recognising savings are more likely to increase incrementally rather than being achieved evenly over the year), appears as a negative expense amount in the efficiency line. Similar accruals to budget have been made (CEO contingency \$379k, Executive Director Provider Services contingency \$100k and new investments reserve (\$533k) that offset the unachieved savings accrual.

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

7. FINANCIAL PERFORMANCE BY MOH CLASSIFICATION

\$'000	October			Year to Date			End of Year		
	Actual	Annual Plan	Variance	Actual	Annual Plan	Variance	Forecast	Annual Plan	Variance
Funding									
Income	44,457	45,089	(632)	180,696	180,587	109	541,947	541,947	-
Less:									
Payments to Internal Providers	25,216	25,181	(35)	106,476	106,476	-	309,784	309,784	-
Payments to Other Providers	18,683	19,148	464	78,553	77,652	(901)	234,581	234,581	-
Contribution	557	760	(203)	(4,332)	(3,540)	(792)	(2,419)	(2,419)	-
Governance and Funding Admin.									
Funding	301	288	12	1,170	1,170	-	3,424	3,424	-
Other Income	3	3	-	3	10	(7)	30	30	-
Less:									
Expenditure	373	268	(105)	1,016	1,210	194	3,489	3,489	-
Contribution	(69)	23	(93)	157	(30)	188	(36)	(36)	-
Health Provision									
Funding	24,915	24,905	10	105,306	105,306	-	306,361	306,361	-
Other Income	2,194	2,776	(582)	10,708	10,562	146	30,937	30,937	-
Less:									
Expenditure	29,165	29,249	83	113,170	112,904	(266)	339,843	339,843	-
Contribution	(2,056)	(1,567)	(488)	2,844	2,964	(120)	(2,546)	(2,546)	-
Net Result	(1,568)	(784)	(784)	(1,331)	(606)	(725)	(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.

8. MANAGEMENT BUDGET MOVEMENTS

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

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

	October			Year to Date			End of Year		
	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement
\$'000									
Funding									
Income	45,089	44,735	353	180,587	179,064	1,523	541,947	537,477	4,470
Less:									
Payments to Internal Providers	25,181	25,132	(49)	106,476	106,215	(260)	309,784	309,025	(759)
Payments to Other Providers	19,148	19,260	112	77,652	77,380	(272)	234,581	233,452	(1,130)
Contribution	760	343	416	(3,540)	(4,531)	990	(2,419)	(5,000)	2,581
Governance and Funding Admin.									
Funding	288	290	(2)	1,170	1,160	9	3,424	3,383	40
Other Income	3	3	-	10	10	-	30	30	-
Less:									
Expenditure	268	286	18	1,210	1,148	(62)	3,489	3,413	(76)
Contribution	23	7	16	(30)	23	(53)	(36)	-	(36)
Health Provision									
Funding	24,905	24,834	71	105,306	105,021	284	306,361	305,542	819
Other Income	2,776	2,782	(6)	10,562	10,423	139	30,937	30,594	342
Less:									
Expenditure	29,249	28,750	(498)	112,904	111,543	(1,361)	339,843	336,136	(3,707)
Contribution	(1,567)	(1,134)	(433)	2,964	3,902	(937)	(2,546)	-	(2,546)
Net Result	(784)	(784)	(0)	(606)	(606)	(0)	(5,000)	(5,000)	(0)

9. QUALITY AND FINANCIAL IMPROVEMENT PROGRAMME

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

The table below shows \$7.4m of savings targets have been identified. Of this amount, \$3.8m was removed from operational budgets at the time this report was prepared.

Savings targets have been budgeted evenly through the year at directorate level. However, the savings are more likely to grow incrementally as schemes are identified and implemented. The mismatch between budget and likely achievement obscures the underlying operational performance of the DHB, and savings are being accrued at a consolidated level to overcome this. The amount accrued year-to-date is \$1m. This is matched by reserves and contingency.

	Target	Current Year Identification					Savings Delivered / Forecast				Recurrency	
	2018/19 Savings Target \$'000	2018/19 Identified Saving \$'000		2018/19 Budget Adjusted	2018/19 Savings WIP	2018/19 Un- identified Savings	YTD Actual	YTD Plan		2018/19 Forecast	2019/20 Identified Saving \$'000	
Division			%						Var			%
Primary Care	4,673	1,884	40 %	715	1,169	2,789	102	1,558	(1,455)	1,509	1,784	38 %
Provider Services	6,544	2,875	44 %	1,939	936	3,669	938	2,181	(1,244)	3,071	3,230	49 %
HI&E	402	407	101 %	407	-	(5)	152	134	18	311	184	46 %
People & Quality	105	105	100 %	102	3	-	32	35	(3)	90	105	100 %
Information Services	254	254	100 %	-	254	-	-	85	(85)	254	254	100 %
Financial Services	1,430	1,238	87 %	12	1,226	192	6	477	(471)	653	1,150	80 %
Executive	112	-	- %	-	-	112	-	37	(37)	-	-	- %
Capital Servicing	632	632	100 %	632	-	-	211	211	-	632	632	100 %
Timing Adjustments	-	-	- %	-	-	-	-	(1,027)	1,027	-	-	- %
Totals	14,152	7,395	52 %	3,807	3,588	6,757	1,441	3,690	(2,250)	6,519	7,339	52 %

10. FINANCIAL POSITION

30 June 2018	\$'000	October				Annual Budget
		Actual	Budget	Variance from budget	Movement from 30 June 2018	
	Equity					
168,706	Crown equity and reserves	168,706	175,069	(6,363)	-	174,711
(15,982)	Accumulated deficit	(17,313)	(11,579)	(5,734)	(1,331)	(15,973)
152,723		151,392	163,489	(12,097)	(1,331)	158,738
	Represented by:					
	<u>Current Assets</u>					
7,444	Bank	822	8,905	(8,083)	(6,622)	2,313
1,885	Bank deposits > 90 days	1,862	1,901	(39)	(23)	1,901
25,474	Prepayments and receivables	28,541	24,756	3,784	3,067	25,045
3,907	Inventory	3,919	4,465	(546)	11	4,520
2,293	Investment in NZHP	2,638	-	2,638	345	-
-	Non current assets held for sale	-	625	(625)	-	625
41,003		37,781	40,653	(2,871)	(3,222)	34,404
	<u>Non Current Assets</u>					
179,460	Property, plant and equipment	181,469	180,576	893	2,009	185,018
1,479	Intangible assets	1,482	3,152	(1,670)	3	4,147
9,280	Investments	10,033	11,684	(1,651)	752	11,798
190,220		192,984	195,413	(2,428)	2,765	200,963
231,223	Total Assets	230,766	236,065	(5,300)	(457)	235,368
	Liabilities					
	<u>Current Liabilities</u>					
-	Bank overdraft	6,922	-	(6,922)	(6,922)	-
35,817	Payables	32,658	35,603	2,945	3,158	36,249
40,064	Employee entitlements	37,174	34,261	(2,913)	2,890	37,579
75,881		76,754	69,864	(6,890)	(874)	73,828
	<u>Non Current Liabilities</u>					
2,619	Employee entitlements	2,619	2,712	93	-	2,802
2,619		2,619	2,712	93	-	2,802
78,500	Total Liabilities	79,373	72,576	(6,797)	(874)	76,629
152,723	Net Assets	151,392	163,489	(12,097)	(1,331)	158,738

Crown equity and reserves includes changes in the 2017/18 result subsequent to the preparation of the 2018/19 budget. Bank and bank deposits > 90 days reflects special funds and clinical trials, and the bank overdraft reflects the operating cash position. Prepayments and receivables include significant amounts owing from Mid Central Health for oncology services, and from Health Workforce NZ for RMO training. The investment in NZHP relates to a classification change separating the investment from property, plant and equipment.

11. EMPLOYEE ENTITLEMENTS

30 June 2018	\$'000	October				Annual Budget
		Actual	Budget	Variance from budget	Movement from 30 June 2018	
10,004	Salaries & wages accrued	7,454	6,244	(1,210)	2,550	7,756
1,157	ACC levy provisions	1,329	476	(854)	(173)	532
5,945	Continuing medical education	4,651	5,053	402	1,294	6,456
21,348	Accrued leave	21,992	20,885	(1,107)	(644)	21,199
4,230	Long service leave & retirement grat.	4,367	4,315	(53)	(137)	4,438
42,683	Total Employee Entitlements	39,793	36,973	(2,820)	2,890	40,380

Salaries and wages accrued includes back pay provisions for collective agreements that were projected in the plan to have been settled by this point in the year. Accrued leave reflects the busy winter that reduced the opportunities for staff to take leave. Leave balances are expected to decline over the summer months and as management activities to reduce leave balances take effect.

12. TREASURY

Liquidity Management

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

The cash low point for each month is generally incurred immediately prior to receipt of MOH funding on the 4th of the month. October's low point was a \$6.2m overdraft, and next month's low point is likely to be the \$9.0m overdraft incurred on 2 November. The forecast low for the end of the financial year is \$9m overdraft, which is within our statutory limit of \$27m.

Debt Management

The DHB has no interest rate exposure relating to debt.

Foreign Exchange Risk Management

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

13. CAPITAL EXPENDITURE

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

See table on the next page.

2019 Plan Updated Sep-18		Year to Date		
		Actual \$'000	Budget \$'000	Variance \$'000
	Source of Funds			
	Operating Sources			
13,652	Depreciation	4,296	4,309	13
(5,000)	Surplus/(Deficit)	(1,331)	(606)	725
11,688	Working Capital	3,918	4,583	666
20,340		6,883	8,286	1,404
	Other Sources			
-	Special Funds and Clinical Trials	4	-	(4)
-		4	-	(4)
20,340	Total funds sourced	6,886	8,286	1,400
	Application of Funds:			
	Block Allocations			
3,430	Facilities	409	1,260	850
3,400	Information Services	481	1,144	662
3,225	Clinical Plant & Equipment	225	958	733
10,055		1,116	3,361	2,246
	Local Strategic			
100	Replacement Generators	-	-	-
26	Renal Centralised Development	24	-	(24)
2,872	Endoscopy Building	2,718	2,578	(140)
350	Travel Plan	47	117	69
1,180	Histology and Education Centre Upgrade	1,170	1,136	(34)
150	Radiology Extension	-	-	-
50	Fit out Corporate Building	-	-	-
500	High Voltage Electrical Supply	-	50	50
700	Seismic Upgrades	-	-	-
1,950	Surgical Expansion	1,166	1,044	(122)
7,878		5,126	4,925	(201)
	Other			
-	Special Funds and Clinical Trials	4	-	(4)
-	Other	144	-	(144)
-		148	-	(148)
17,933	Capital Spend	6,389	8,286	1,897
	Regional Strategic			
1,945	RHIP (formerly CRISP)	497	-	(497)
1,945		497	-	(497)
	National Strategic			
462	NOS (Class B shares in NZHPL)	-	-	-
462		-	-	-
20,340	Total funds applied	6,886	8,286	1,400

14. ROLLING CASH FLOW

	Actual	October Forecast	Variance	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast	Jun Forecast	Jul Forecast	Aug Forecast	Sep Forecast	Oct Forecast
Cash flows from operating activities															
Cash receipts from Crown agencies	48,253	53,331	(5,078)	47,042	46,722	46,840	46,587	46,841	46,918	46,585	46,939	46,875	46,174	53,627	46,947
Cash receipts from donations, bequests and clinical trials	25	-	25	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	206	3,096	(2,890)	5,138	489	492	498	492	492	498	492	495	501	502	529
Cash paid to suppliers	(29,456)	(27,268)	(2,188)	(27,688)	(35,325)	(19,203)	(26,265)	(27,602)	(27,566)	(25,270)	(28,338)	(28,728)	(25,345)	(28,626)	(27,144)
Cash paid to employees	(22,428)	(20,413)	(2,015)	(17,689)	(17,131)	(23,110)	(17,909)	(17,475)	(18,097)	(20,912)	(17,789)	(16,802)	(22,611)	(17,546)	(20,516)
Cash generated from operations	(3,400)	8,746	(12,146)	6,803	(5,244)	5,019	2,912	2,256	1,747	901	1,305	1,840	(1,281)	7,956	(185)
Interest received	28	49	(21)	25	20	15	10	5	0	0	0	(0)	(0)	0	0
Interest paid	-	-	-	-	-	-	-	-	-	5	10	15	20	25	30
Capital charge paid	(655)	61	(716)	(0)	(4,360)	(0)	(0)	(0)	(0)	(0)	(4,670)	(0)	(0)	0	(0)
Net cash inflow/(outflow) from operating activities	(4,027)	8,856	(12,884)	6,828	(9,584)	5,034	2,922	2,261	1,747	907	(3,355)	1,854	(1,261)	7,981	(154)
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	1	(0)	1	0	0	(0)	-	-	0	0	0	0	-	-	(0)
Acquisition of property, plant and equipment	(1,162)	(1,240)	79	(409)	(665)	(1,575)	(1,244)	(849)	(516)	(908)	(813)	(2,025)	(2,025)	(2,025)	(2,025)
Acquisition of intangible assets	(52)	(115)	63	(231)	(137)	(105)	(254)	(136)	(124)	(120)	(83)	(162)	(162)	(162)	(162)
Acquisition of investments	(390)	-	(390)	-	-	(129)	-	-	-	-	-	-	-	-	-
Net cash inflow/(outflow) from investing activities	(1,602)	(1,355)	(247)	(640)	(802)	(1,810)	(1,498)	(985)	(640)	(1,028)	(896)	(2,187)	(2,187)	(2,187)	(2,187)
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	(5,629)	7,501	(13,130)	6,188	(10,387)	3,224	1,424	1,275	1,107	(122)	(4,608)	(333)	(3,449)	5,794	(2,342)
Add: Opening cash	1,392	1,392	-	(4,238)	1,950	(8,437)	(5,212)	(3,789)	(2,513)	(1,407)	(1,528)	(6,136)	(6,470)	(9,918)	(4,124)
Cash and cash equivalents at end of period	(4,238)	8,893	(13,130)	1,950	(8,437)	(5,212)	(3,789)	(2,513)	(1,407)	(1,528)	(6,136)	(6,470)	(9,918)	(4,124)	(6,466)
Cash and cash equivalents															
Cash	4	4	-	4	4	4	4	4	4	4	4	4	4	4	4
Short term investments (excl. special funds/clinical trials)	(6,932)	6,012	(12,944)	(932)	(11,318)	(8,094)	(6,670)	(5,395)	(4,288)	(4,410)	(9,018)	(9,351)	(12,800)	(7,006)	(9,348)
Short term investments (special funds/clinical trials)	2,680	2,877	(197)	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877	2,877
Bank overdraft	10	-	10	-	-	-	-	-	-	-	-	-	-	-	-
	(4,238)	8,893	(13,131)	1,949	(8,437)	(5,213)	(3,789)	(2,514)	(1,407)	(1,529)	(6,137)	(6,470)	(9,919)	(4,125)	(6,467)

Cash flow was impacted by a number of factors in October, including a reduction in working capital due to the delay in collection of cancer clinic revenue from Mid Central Health, now expected in November. High cash outflows relating to personnel, clinical supplies, and non achievement of efficiencies were offset in the result by the release of accruals. However, they reduce available cash resources going forward. Also reducing cash going forward is an over estimate of the cash income from MOH including IDF inflows. Cash inflows from IDFs are likely to improve over the summer months. The forecast assumes achievement of the forecast result.



BOARD HEALTH & SAFETY CHAMPION'S UPDATE

Verbal

	Primary Care Development Partnership Governance Group 159
	For the attention of: HBDHB and Health Hawke's Bay Ltd Boards
Document Owner:	Bayden Barber, Chair
Author:	Ken Foote, HBDHB Company Secretary
Month:	November, 2018
Consideration:	For Information

RECOMMENDATION

That the Boards:

1. **Note** the contents of this report.
2. **Approve** the attached Draft Hawke's Bay Primary Care Development Partnership Agreement.

The Primary Care Development Partnership (PCDP) Governance Group met on Thursday 15 November 2018.

UPDATED DRAFT PCDP AGREEMENT

The Governance Group received, noted and approved a number of changes to the Draft:

- Arising from feedback at the previous meeting
- Minor technical issues raised by the HHB legal advisors
- Fully revised Schedule 1, to describe the initial scope of the Partnership and activities for 2018/19.

Further discussion resulted in agreement to change clause 8.3.6 to allow for the appointments of alternates should an appointed member of the Governance Group be unable to attend any meeting. Subject to all these agreed changes, the Governance Group then agreed that the Draft Agreement now be presented to the HBDHB and HHB Board's for approval.

Assuming both Boards approve the Drafts, the Boards would come together on 19 December 2018 to sign the PCDP Partnership Agreement.

SERVICE LEVEL AGREEMENTS (SLA)

The Governance Group were advised of the four initial SLA redesign areas, as outlined in the 2018/19 work programme:

- Community mental health and addiction
- End of life
- Integrated care teams
- Community pharmacy innovation

Each was briefly discussed.

COMMUNICATIONS PLAN

An initial communications brief and high-level contents of a potential communications plan were presented and discussed. A number of key messages, objectives and linkages were also raised. It was agreed that a small group of members will further discuss these issues and bring ideas to the next meeting.

NEW NAME

A suggestion had been made by HBDHB Kaumātua – “Te Pitau” – being the figurehead at the bow of the waka, representing the PCDP role in navigating the health system to new ground but also reflective of the young shoot of a fern and new beginnings.

It was agreed that this suggestion required further discussion before any decision/recommendations was made.

FUTURE GOVERNANCE GROUP MEETING DATES

It was agreed that future meetings would be held on the second Wednesday of each month from 1.00 to 2.30pm, commencing 12 December 2018

ATTACHMENT

Draft PCDP Agreement - for Approval

Hawke's Bay Primary Care Development Partnership Agreement

BETWEEN

HAWKE'S BAY DISTRICT HEALTH BOARD

AND

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

DRAFT – FOR APPROVAL

NOVEMBER 2018

Table of Contents

Parties	Error! Bookmark not defined.
Hawke's Bay District Health Board	5
Key Information	5
Our Agreement.....	5
PART A: OUR COMMITMENT	7
1. Scope of Our Partnership.....	7
2. Overview of Decision-making.....	8
3. Our Partnership Principles	9
PART B: HOW WE WILL SUCCEED	11
4. Commitments	11
5. Service Level Alliances & Working Groups.....	12
6. Services Planning	12
PART C: HOW WE WILL WORK TOGETHER.....	13
7. Leadership Structure	13
8. Partnership Governance Group Terms of Reference	13
9. Service Level Alliance Leadership Team	15
PART D: TERM OF THIS PARTNERSHIP	16
10. Term	16
11. Suspending Partnership Activities	16
12. Terminating Our Partnership.....	16
Schedule 1 - Scope of our Partnership	18

10.1

Our vision

HEALTHY
HAWKE'S BAY
TE HAUORA O
TE MATAU-Ā-MĀUI

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

Our values

Tauwhiro – delivering high quality care to patients and consumers

Rāranga te tira – working together in partnership across the community

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

Ākina – continuously improving everything we do

HAWKE'S BAY PRIMARY CARE DEVELOPMENT PARTNERSHIP AGREEMENT

(DATE) 2018

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

Hawke's Bay District Health Board (DHB)

Health Hawke's Bay Limited – Te Oranga Hawke's Bay (PHO).

1 KEY INFORMATION

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

2. **Partnership Governance Group Members**

Core members will be:

- Three Directors of Health Hawke's Bay Ltd
 - Bayden Barber - Chair
 - Jeremy Harker
 - Jason Ward
- Three Members of Hawke's Bay District Health Board
 - Ana Apatu
 - Hine Flood
 - Helen Francis - Deputy Chair
- HBDHB Maori Relationship Board NKII representative
 - Beverly Te Huia
- Hawke's Bay Clinical Council representative
 - David Rodgers
- Hawke's Bay Health Consumer Council representative
 - Rachel Ritchie.

As the Scope of our Partnership activities expands to cover them, representatives from other parts of the Hawke's Bay health sector may be added, e.g.

- Community Pharmacy
- Aged Care
- NGOs.

2 OUR AGREEMENT

In consideration of the mutual promises given and received by each of us in this Agreement, we agree that we will be bound by and perform this Partnership Agreement.

Our Agreement comprises the following parts:

Part A: Our Commitment - is a statement of our background, our commitment to a whole-of-system decision-making process, our purpose, principles and commitment to success. We agree that the remainder of this Agreement will be interpreted in accordance with the statements made in Part A

Part B: How We Will Succeed – is a statement of how we will work together, in particular, to achieve success by completing our partnership activities and meeting and exceeding our objectives

Part C: How We Will Work Together - details the processes that we have agreed to apply to how we will work together

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

Schedule 1 – includes the scope and annual activities of our Partnership.

PART A: OUR COMMITMENT

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

1. Scope of Our Partnership

- 1.1 **Who We Are:** We, the Parties to this Partnership, are the DHB and PHO for the Hawke's Bay district.
- 1.2 **Our Leaders:** We are led by our Partnership Governance Group, made up of those governance, management and clinical leaders and other key stakeholders, who can successfully lead our Partnership to complete our Partnership activities and achieve our objectives.
- 1.3 **Our Purpose:** We have formed our Partnership to improve health outcomes for our populations, through:
 - 1.3.1 transforming, developing, evolving and integrating primary and community healthcare services, consistent with commitments made within the 2018 Clinical Services Plan, i.e.
 - **achieve equity with a particular focus on those with unmet needs**
 - **create a culture that is person and whanau centred**
 - **co-design and prioritise services to meet the needs of populations with the poorest health and social outcomes**
 - **make health easy to understand.**
 - 1.3.2 eliminating inequities in primary care access and health care delivery
 - 1.3.3 making (and assisting the DHB to make) strategic health care decisions on a "whole-of-system" basis
 - 1.3.4 providing direction and building relationships within our primary and community health system
 - 1.3.5 assessing the primary and community health care needs of our populations
 - 1.3.6 planning health care delivery in our District that is amenable to primary and community settings, to make the best use of health resources
 - 1.3.7 balancing a focus on the highest priority needs areas in our communities, while ensuring appropriate care across all our populations
 - 1.3.8 determining models to be commissioned from delegated funding pools
 - 1.3.9 establishing Service Level Alliances to advise on the development, delivery and monitoring of primary and community health services within the scope of our Partnership
 - 1.3.10 monitoring the effectiveness and health outcomes of groups of services that fall within the scope of our Partnership; and
 - 1.3.11 informing our populations and other stakeholders of our performance in achieving our objectives.

10.1

1.4 **Our Partnership Activities:**

1.4.1 Our Partnership activities are defined in the scope of our Partnership. It is anticipated that this scope will be initially restricted to specific service areas, but will expand over time. Our Partnership, in carrying out its activities, may not be involved in all healthcare services in our District.

1.4.2 The scope and activities of our Partnership (including objectives) are set out in Schedule 1.

1.5 **Our Conduct:** We will conduct our activities and achieve our objectives, by acting consistently with our Partnership Principles.

1.6 **What We Are Not:**

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

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

1.6.3 We work collaboratively but are not collectively established as a legal entity.

2. **Overview of Decision-making**

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

2.2 **Clinician Input into Decision-making:** We recognise that clinical input is essential in all levels of decision-making. At the Partnership level, this will be achieved by ensuring all major Partnership activity decisions will involve input and support from the Hawke's Bay Clinical Council. At all other levels, this input will be provided through proactive involvement of appropriate clinicians.

2.3 **Maori Contribution to Decision-making:** We acknowledge our responsibilities under Te Tiriti o Waitangi and our desire to work with local Maori to enable them to contribute to our Partnership decision-making. Given the Memorandum of Understanding between HBDHB and Ngati Kahungunu Iwi Incorporated, this will be achieved through active engagement with HBDHB Maori Relationship Board (MRB) on all major Partnership decisions. At all other levels, we will ensure that a Maori perspective is present and/or represented in all decision-making processes.

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

2.5 **Other Input into Decision-making:** Where appropriate, we will work together with a wide range of different cultures, disadvantaged groups and communities to design the health services they need and engage them in our decision-making processes.

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

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

- 2.7.1 as a Party within our Partnership, and
- 2.7.2 as the Government's agent, as the funder of health services in the District.
- 2.8 Our Partnership is intended, in part, to assist the DHB to fulfil its statutory objectives and functions as a funder of health services. The DHB will work within our Partnership to fulfil those obligations where it is appropriate and practicable to do so.
- 2.9 However, we acknowledge that the DHB's statutory and other obligations will require it to make some decisions, which may affect our Partnership, outside of this Agreement. Without limiting its ability to make those decisions, the DHB undertakes to make those decisions, insofar as is reasonably practicable, in good faith and having regard to our Partnership's Principles. We agree that nothing in this Agreement limits the DHB's rights, powers, obligations or liabilities under any Law or other agreement.
- 2.10 **Decisions Made by the PHO:** Equally, we recognise that the PHO is subject to its own governance obligations. We also agree that nothing in this Agreement limits the PHO's rights or obligations, necessary to comply with its governance obligations under any Law or other agreement.

3. Our Partnership Principles

- 3.1 We will conduct ourselves and undertake our Partnership Activities in a manner consistent with the Hawke's Bay Health Sector Vision and Values, and our Partnership Principles and will take all reasonable steps to ensure that our employees, contractors and agents do likewise.
- 3.2 We agree that every part of this Agreement must be read in such a way as to be consistent with, and ensure the integrity of, our commitments to our Partnership Principles.
- 3.3 **Our Partnership Principles:** Our Partnership is founded on the following principles:
 - 3.3.1 we will adopt a person and whanau centred, integrated, whole-of-system approach, and make decisions on a 'Best for System' basis
 - 3.3.2 we will seek to make the best use of finite resources in planning and delivering health services to achieve improved health outcomes and equity for our populations
 - 3.3.3 we will apply the principles of Te Tiriti o Waitangi and incorporate kaupapa Maori practice and whanau ora approaches within our Partnership Activities
 - 3.3.4 we will conduct ourselves with honesty and integrity, and develop a high degree of trust
 - 3.3.5 we will support clinical leadership and, in particular, clinically informed service development
 - 3.3.6 we will promote an environment of high quality, performance and accountability, and low bureaucracy
 - 3.3.7 we will strive to resolve disagreements co-operatively and, wherever possible, achieve consensus
 - 3.3.8 we will adopt and foster an open and transparent approach to sharing information, subject only to statutory privacy principles
 - 3.3.9 we will monitor and report on our Partnership's achievements, including public reporting
 - 3.3.10 we will be collectively responsible for all decisions and outcomes of our Partnership
 - 3.3.11 we will operate as a unified team providing mutual support, appreciation and encouragement
 - 3.3.12 we will conduct ourselves in accordance with best practice

- 3.3.13 we will support professional behaviour and leadership
- 3.3.14 we will remain flexible and responsive to support an evolving health environment
- 3.3.15 we will develop, encourage and reward innovation and challenge our status quo
- 3.3.16 we will actively support and build on our successes; and
- 3.3.17 we commit to fully exploring the collective sharing and management of the risks and benefits arising from our Partnership Activities. Where we cannot manage risk collectively, our principle is to allocate responsibility for each risk to those of us who can best manage it
- 3.3.18 we will each accept our own costs of all participation in our Partnership Activities, and we agree that any third party costs directly incurred by our Partnership Activities, shall be shared equally.

PART B: HOW WE WILL SUCCEED

Part B of this Agreement is a statement of how we will work together, in particular, to achieve success by completing our Partnership activities and meeting and exceeding our objectives.

4. Commitments

4.1 Shared Decision-making:

4.1.1 Each of us is fully committed to our Partnership and carrying out our Partnership activities to achieve our Partnership objectives. We acknowledge that this commitment is fundamental to our Partnership's success

4.1.2 We will work as one team, in a transparent, innovative and collaborative manner, to produce outstanding results.

4.2 Shared Responsibility:

4.2.1 We both take responsibility for our Partnership's success and our failures

4.2.2 We both take responsibility for achieving consensus decisions within our Partnership

4.2.3 We both take responsibility for addressing all potential disputes within our Partnership

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

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

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

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

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

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

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

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

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

5. Service Level Alliances & Working Groups

- 5.1 **Service Development:** Where our Partnership identifies a service within the scope of our Partnership that requires transformational change, we may establish a Service Level Alliance (SLA) to:
- 5.1.1 Collaboratively co-design and recommend how the service should be delivered within the scope of our Partnership
 - 5.1.2 monitor and report on the performance of a service within the scope of our Partnership.
- 5.2 **Working Groups:** Clause 5.1 does not limit our Partnership's ability to establish any other Working Groups that it considers necessary to advise it on any aspect of our Partnership Activities.
- 5.3 **Scope and Conditions:** A SLA or other Working Group will operate according to any directions, conditions or restrictions established by us. This will include the lines of accountability to the appropriate body within our Partnership structures, and may include a direction to work collaboratively with others.

6. Services Planning

- 6.1 We will work together to decide how our Partnership will carry out service planning for those services within the scope of our Partnership, which may include delegating decision-making authority to our Partnership Governance Group.
- 6.2 Our Partnership Governance Group may, as a result of service model decisions or recommendations made by our Partnership, recommend to the DHB and/or PHO the method and form of contracting for the delivery of the service on a Best Practice basis.
- 6.3 The DHB and/or PHO will implement our Partnership Governance Group's decisions and recommendations, subject only to the provisions of clauses 2.9 and 2.10 respectively.
- 6.4 In implementing our Partnership Governance Group's decisions or recommendation, the DHB and/or PHO (as appropriate) may:
- 6.4.1 undertake a procurement process based on the specification for the activity, work or service recommended by our Partnership
 - 6.4.2 enter into agreements/contracts with relevant providers, which may include Parties and/or others; and/or
 - 6.4.3 select from the Parties and other service providers those capable of providing the activity, work or service in accordance with the specification for the activity, work or service recommended by our Partnership.

PART C: HOW WE WILL WORK TOGETHER

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

7. Leadership Structure

7.1 General Structure:

- 7.1.1 Our Partnership will be directed and lead by our Partnership Governance Group
- 7.1.2 The day-to-day affairs of our Partnership will be coordinated by our Partnership Support Team (made up of relevant members of the management and clinical leadership teams of the DHB and PHO) and supported by the Clinical and Consumer Councils, and the MRB
- 7.1.3 Our Partnership Support Team will be led by the HBDHB Executive Director Primary Care

- 7.2 **Service Developments:** Our SLAs will be led and directed by a Service Level Alliance Leadership Team, acting within a scope of authority, agreed by the Parties.

8. Partnership Governance Group Terms of Reference

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

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

- 8.2.1 promoting and supporting the vision, values and direction of our Partnership
- 8.2.2 facilitating development and implementation of commitments and service changes set out in the 2018 Clinical Services Plan, as they apply to primary and community care
- 8.2.3 role modelling our Partnership Principles and setting challenging objectives
- 8.2.4 facilitating, empowering and enabling the achievement of Partnership objectives/outcomes
- 8.2.5 maintaining a coherent set of policies and procedures as necessary to undertake its duties
- 8.2.6 agreeing with the DHB and PHO, in accordance with clause 6:
 - (a) our Partnership activities and objectives, including the systems and key performance indicators for assessing achievement of these
 - (b) the work, activity and services to be provided to meet our Partnership objectives
- 8.2.7 establishing and/or supporting Service Level Alliances and other Working Groups as necessary to oversee the development and delivery of services that fall within the scope of our Partnership
- 8.2.8 providing high level support and stakeholder interface
- 8.2.9 monitoring and encouraging inter-Party relationships and stakeholder engagement

- 8.2.10 agreeing and adopting transparent governance and accountability structures for our Partnership; and
- 8.2.11 mentoring and championing our Partnership and its Parties as reasonably required
- 8.2.12 approving the allocation of delegated/devolved funding pools
- 8.2.13 approving system and district level measures and related allocation of incentives, in conjunction with the Clinical Council.
- 8.3 **Membership of Our Partnership Governance Group:**
 - 8.3.1 At the date of this Agreement the appointed core members of our Partnership Governance Group are set out in the Key Information on page 5 of our Agreement
 - 8.3.2 Membership of our Partnership Governance Group shall be reviewed annually by an Appointments Panel made up of the Chairs and CEOs of the DHB and PHO, who shall consider the level of interest in membership, the benefits of some rotation balanced with retaining some experience, and the need to maintain a good mix of perspectives, skills and experience
 - 8.3.3 The Appointments Panel shall make recommendations to the DHB and PHO Boards
 - 8.3.4 The appointment of all core members requires the formal approval of both the DHB and PHO Boards
 - 8.3.5 Our Partnership Governance Group may, by agreement, add representatives from other parts of the Hawke's Bay health sector as members at any time, and may remove members as necessary
 - 8.3.6 We confirm that each Partnership Governance Group member may appoint an alternate to attend our Partnership Governance Group meetings, or may nominate another member to act by proxy in relation to any decision to be made by the Partnership Governance Group.
- 8.4 **Involvement:** We agree that the members' regular involvement in and attendance at our Partnership Governance Group meetings is critical to our Partnership's success.
- 8.5 **Chair:** The Chair of our Partnership Governance Group shall be the Chair of the PHO.
- 8.6 **Deputy Chair:** The DHB shall appoint one of the three DHB Board members to be the Deputy Chair.
- 8.7 **Decision-making:** When making a decision, determination or resolution, our Partnership Governance Group (together and individually) must:
 - 8.7.1 have regard to its duties, specified at clause 8.2 of this Agreement
 - 8.7.2 have regard to the intent of Agreement
 - 8.7.3 consider the matter before them in good faith and use their best endeavours to facilitate a consensus decision
 - 8.7.4 not prevent a consensus decision being made for trivial or frivolous reasons
 - 8.7.5 use all relevant information in a timely fashion
 - 8.7.6 actively seek and facilitate a consensus decision, determination or resolution; and
 - 8.7.7 where consensus cannot be reached, any decision, determination or resolution will require the support of at least 75% of those present and/or otherwise able to vote on the issue.

- 8.8 **Reporting:** Our Partnership Governance Group will provide a report to the Parties following each Partnership Governance Group meeting, and an Annual Report about its performance.
- 8.9 **Implementing Decisions:** We will implement all decisions and directions of our Partnership Governance Group concerning our Partnership and this Agreement.

9. **Service Level Alliance (SLA) Leadership Team**

- 9.1 **SLA Leadership Team:** We agree that our Partnership Support Team may appoint a leadership team (**SLA Leadership Team**), whose primary function will be to direct and lead a SLA and provide guidance and leadership to us with respect to those of our Partnership activities that are within the scope of that SLA
- 9.2 **Duties of a SLA Leadership Team:** The duties of a SLA Leadership Team may include:
 - 9.2.1 providing a vision, strategic leadership and direction
 - 9.2.2 providing operational/project leadership and relationship management
 - 9.2.3 recommending the model via which services should be delivered in the District; and
 - 9.2.4 monitoring and reporting on the performance of the service against its agreed outcomes.
- 9.3 **Consensus Decision-Making:** When making a decision, determination or resolution, a SLA Leadership Team (together and individually) must:
 - 9.3.1 actively seek and facilitate a consensus decision, determination or resolution; and
 - 9.3.2 where consensus cannot be reached, any decision, determination or resolution will require the support of at least 75% of those present and/or otherwise able to vote on the issue.

10.1

PART D: TERM OF THIS PARTNERSHIP

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

10. Term

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

10.1 30 June 2028

10.2 The Parties may agree to renew this Agreement from this date, after following an agreed process having been initiated at least twelve months before this date.

11. Suspending Partnership Activities

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

11.2 **Suspension by the DHB or PHO:** The DHB or PHO may suspend some or all of our Partnership activities, if it determines that it is necessary to do so to prevent a breach of a statutory, regulatory or contractual requirement (as acknowledged in clauses 2.9 and 2.10).

11.3 **Recommencement:** We will recommence the performance of Partnership activities only when directed to do so by our Partnership Governance Group.

12. Terminating Our Partnership

12.1 **Termination by the DHB or PHO:** We agree that the DHB or PHO may, in exceptional circumstances, terminate this Agreement if it determines that it is necessary to do so to prevent a breach of a statutory, regulatory or contractual requirement (as acknowledged in clauses 2.9 and 2.10).

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

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

Executed as an Agreement

Executed for Health Hawke’s Bay Limited by:

in the presence of

Director/Authorised Signatory

Director/Authorised Signatory

Witness signature

Full name

Occupation

Address

Executed for Hawke's Bay District Health Board by:

in the presence of

Director/Authorised Signatory

Director/Authorised Signatory

Witness signature

Full name

Occupation

Address

Schedule 1 - Scope of our Partnership

- 1 The ultimate scope of our Partnership may include any/all those publically funded primary and community healthcare services and activities, within the Hawke's Bay Health Sector that are amenable to delivery in a primary and community healthcare setting.
- 2 On an ongoing basis, the scope of our Partnership will generally be determined by agreement to establish specific Service Level Alliances or Working Groups. General issues may be included within the scope as agreed from time to time.
- 3 The initial scope of our Partnership and activities for 2018/19 shall include the following:


Area of Focus	SLA	Whole Model Redesign	Description	Delegation Notes	PCDP Involvement 2018/19
Community Mental Health & Addictions	Yes	Yes	Multi-stage redesign and re-procurement of community based mental health and addictions services ahead of July 2020 go-live	<ul style="list-style-type: none"> • Total indicative operating envelope <\$20m per annum (including DHB contracts and Primary Care directorate PVS transfers into provider arm) • PHO Mental Health packages of care (c\$1m) in-scope • Will be informed by national Mental Health & Addictions Inquiry 	<p>Receive regular SLA updates on progress of service design and provide governance oversight of the process in line with PCDP Principles.</p> <p>Approve the work of the SLA as design authority, in order to progress proposed model of care into the procurement phase.</p>

Area of Focus	SLA	Whole Model Redesign	Description	Delegation Notes	PCDP Involvement 2018/19
End of Life	Yes	Yes	Review of existing services supporting patients at the end of life, and redesign within existing resource envelope	<ul style="list-style-type: none"> Operating envelope to be confirmed, but will include DHB contracts (most notably hospice services) and PHO discretionary funding Likely to also include internal DHB provider PVS relating to hospital palliative care services 	<p>Receive regular SLA updates on progress of service design and provide governance oversight of the process in line with PCDP Principles.</p> <p>Approve the work of the SLA as design authority, in order to progress proposed model of care into the procurement phase.</p>
Community Pharmacy	Yes	No	Development, review and prioritisation of developmental schemes within Schedule 3b of the new Integrated Community Pharmacy agreement	N/A	Receive regular SLA updates for discussion and incorporation into the wider strategic approach
Integrated Care Teams (ICT)	Yes	No	Phased programme of work to test, refine and implement the model for extended integrated care teams operating seamlessly around the enrolled patient list	<ul style="list-style-type: none"> Year one activity likely to include District Nursing services (Primary Care directorate PVS transfers into provider arm) 	<p>Receive regular SLA updates on progress of service design pilots and provide governance oversight of the process in line with PCDP Principles.</p> <p>Review recommendations and guide the prioritisation of work to further iterate ICT design.</p>

Area of Focus	SLA	Whole Model Redesign	Description	Delegation Notes	PCDP Involvement 2018/19
Youth Services	TBC	Yes	Potential fast-follower SLA, reviewing design and effectiveness of primary health and wellbeing services targeted at young people	TBC	Receive proposal around potential scope and configuration of this work stream. Endorse establishment of SLA.
Urgent and On-Day Primary Care Access	TBC	Yes	Potential fast-follower SLA, reviewing design and effectiveness of primary care services meeting urgent and on-day healthcare needs	TBC	Receive proposal around potential scope and configuration of this work stream. Endorse establishment of SLA.
Health of Older People	TBC	Yes	Potential fast-follower SLA, reviewing design and effectiveness of services to keep older people well and independent. Will build on internal strategic programme within HBDHB.	TBC	Receive proposal around potential scope and configuration of this work stream. Endorse establishment of SLA.

Area of Focus	SLA	Whole Model Redesign	Description	Delegation Notes	PCDP Involvement 2018/19
Rural Localities Model	No	No	Develop a framework for the development of sustainable rural services	N/A	<p>Review intelligence relating to the development of rural services in line with the stated priorities of rural communities</p> <p>Commission focus work on underlying themes relating to sustainability (e.g. workforce, technology, clinical governance)</p> <p>Oversee development of a framework approach to the development of sustainable rural services</p>
Primary Care Innovation & Development	No	No	Develop the framework for the evolution of primary healthcare in line with the Hawke's Bay CSP	N/A	<p>Review intelligence relating to existing innovation and development of enrolment-based primary care, including structural considerations that impact the pace of change.</p> <p>Review recommendations and guide the prioritisation of work to further iterate primary care innovation and development</p>

Area of Focus	SLA	Whole Model Redesign	Description	Delegation Notes	PCDP Involvement 2018/19
System Level Measures	No	No	Ownership of the Hawke's Bay System Level Measures framework	N/A	<p>Review and critically evaluate progress against the System Level Measures for Hawke's Bay</p> <p>Provide commentary to the Boards of HBDHB and HHB concerning delivery against these priorities</p> <p>Review recommendations and prioritise the development of measures within future iterations of the framework</p>
Primary Healthcare KPI framework	No	No	Development and ownership of a set of key performance indicators by which to assess the quality of primary healthcare in Hawke's Bay	N/A	<p>Review recommendations and prioritise the selection of measures for the framework</p> <p>Critically evaluate reported progress and plans to mitigate adverse variances against the agreed KPIs</p>
Information Systems	TBC	No	Primary healthcare governance input to the development of the Information Systems strategy for Hawke's Bay	N/A	<p>Receive regular updates on progress against the IS Strategy.</p> <p>Review recommendations and prioritise the development of primary healthcare priorities within the Strategy</p>

 HAWKE'S BAY District Health Board Whakawāteatia	Pasifika Health Leadership Group	160
	For the attention of: HBDHB Board	
Document Owner:	Barbara Arnott, Chair of CPHAC	
Document Author(s):	Caren Rangi, Chair of PHLG	
Reviewed by:	n/a	
Month:	November 2018	
Consideration:	For Information	
RECOMMENDATION That the HBDHB Board 1. Note the contents of this report.		

The Pasifika Health Leadership Group (PHLG) met on 13 November 2018. An overview of the issues discussed and/or agreed at the meeting is provided below.

CLINICAL SERVICES PLAN

The Company Secretary spoke to the updated Clinical Services Plan seeking PHLG's feedback and approval on the listed changes. Due to the limited time available to review the CSP, the PHLG agreed to approval with the following conditions.

The Pasifika Health Leadership Group advised a **condition of approval** to the CSP is to include; confidence that current plans are supported, the community voice is heard, progress is to be shared back to this group as an ongoing action.

PASIFIKA HEALTH SERVICE

The Pacific Health Development Manager provided an insight and some challenges faced by the Pacific Health team's work from its inception in July 2017 and the progress to date.

Data capture is an important measure of the Navigators' work that provides a fundamental overview of the service. The current data is based on individuals and the next stage of development is to capture Kainga (family) data. Lenn French has been working with the Pasifika Health team to develop the next phase.

PHLG noted this is an exciting summary. The team were congratulated for the work achieved and for being realistic on the challenges faced in making the service sustainable.

The Pasifika Health Leadership Group **noted** the contents of the report and **endorsed** the resourcing of an appropriate solution for Kainga data that will reflect the depth and breadth of outputs and outcomes. **Moved and carried.**

PROJECT PLAN FOR A STUDY OF PACIFIC YOUTH HEALTH AND WELL-BEING IN HAWKE'S BAY (2018-2025)

This paper speaks to the Pacific Youth project foundation work commenced in Hawke's Bay secondary schools. The aim is to establish a working group with lead teachers, principals, and lead

students. A survey occurs every two years that provides an opportunity to shape services, e.g. Public Health Nurses in schools, with the survey informing on their needs.

The student survey will ask:

1. What are the perspectives of Hawke's Bay Pacific youth of their own health and well-being and access to services?
2. What are the aspects of Pacific youth health needs that will inform the provision of appropriate responsive youth health needs by HB DHB and PHO services?
3. What resilience factors and sources of support do Pacific youth access in ensuring their health and well-being needs are being met now and into the future?

The team were thanked for the work progressed to date and looked forward to the results from the survey and focus groups, and how this will shape health and education services for youth.


The Pasifika Health Leadership Group **noted** the contents of the report and;

- I. **Agreed** to act as a Governance Group for the Youth Project and ECE work; and
- II. **Endorsed** the Population Health Service, Health Hawke's Bay, Primary Care Directorate, Public Health and NGOs to work with the Pasifika Health Service to plan, implement and support the resourcing of targeted interventions for the Pasifika community engagement from the survey work. **Moved and carried.**

REPORTS FOR INFORMATION WERE NOTED.

- Workforce Development
- Pacific Health Report
- HBDHB Performance Framework Exceptions Report Qtr1 2018-19

The PHLG will meet in December to workshop the PHLG Work Plan activities for 2019.

 HAWKE'S BAY District Health Board Whakawāteatia	Māori Relationship Board	161
	For the attention of: HBDHB Board	
Document Owner:	Ngahiwi Tomoana, Chair	
Document Author:	Brenda Crene	
Month:	November, 2018	
Consideration:	For Information	

RECOMMENDATION

That the Board

Note the contents of this report; and that the Maori Relationship Board:

1. **Discussed and provided feedback** around the Scoping Report – Addictions
2. **Endorsed** the Clinical Services Plan and recommend that the Board approve the Final Draft.
3. **Received** the following reports for information:
 - Best Start Healthy Eating & Activity Plan
 - Te Ara Whakawaiaora “Smokefree update”
 - Te Ara Whakawaiaora – Access 0-4 / 45/64 years; and
 - HBDHB Performance Framework Exceptions Report for Quarter 1 (July-Sept 18)

The Māori Relationship Board met on 14 November 2018. An overview of issues discussed and/or agreed at the meeting is provided below.

SCOPING REPORT – ADDICTIONS

Drug use impacts are higher in high deprivation communities feedback was sought to help better understand. A summary of feedback:

- This work could benefit from a gender analysis (Fiona Cram to discuss with Chris Ash following the meeting)
- In Flaxmere, many whanau are cared for at home (this needs to be discussed with the community)
- The Police are doing a lot of harm reduction work, around sharing and working in the community. Whanau contribution is crucial in this regard.
- What is happening to the meth babies, neo-natal intensive care term these as “shaky babies”?
- Community research – governing, implementation, modi compass (distraction, harm, whanau voice driving factor) action plans to governance.
- This is within the Clinical Services Plan.

CLINICAL SERVICES PLAN

It was explained that the document provided would pave the way to future planning. An overwhelming number of people advised we have got this right. Following discussion MRB noted and endorsed the changes made and recommend that the Board approve the CSP.

BOWEL SCREENING

MRB had requested that the Board to lobby the MoH to lower the bowel screening age for Māori and Pasifika to 50 years (as did many nationally). A nationwide response had been received from the MoH advising that screening could do more harm than good. The report around Bowel Screening received in October noted DHBs are unlikely to get MoH approval to amend or change services that are delivered until there has been national review or evaluation of the programme. Under the system, screening occurs by birthdate and it will take several years to get onto the normal screening program.

Chris Ash advised that the most effective way to ensure equity would be to strongly monitor and performance manage against Māori participation/screening rates to achieve 73%.


Chris offered an off-line Wānanga with a few members of MRB and experts in this area, to discuss the current position regarding equity.

MĀORI WORKFORCE PROJECT

An update was received on work being undertaken by Māori Health Team members in this area.

NUKA CONFERENCE

A very positive response from those who attended and look forward to moving this work forward in HB.

	Hawke's Bay Health Consumer Council 162
	For the attention of: HBDHB Board
Document Owner:	Rachel Ritchie (Chair)
Month:	November 2018
Consideration:	For Information

RECOMMENDATION

That the Board

Note the contents of this report; and that the HB Health Consumer Council:

1. **Endorsed** the Clinical Services Plan and recommend that the Board approve the Final Draft.
2. **Received** feedback from members who attended the Nuka Conference in Napier on 23 and 24 October
3. **Received** the following reports for information:
 - Scoping Report - Addictions
 - Best Start Healthy Eating & Activity Plan Update
 - Te Ara Whakawaiaora "Smokefree update"
 - Te Ara Whakawaiaora – Access 0-4 / 45/64 years; and
 - Consumer Council Meeting dates for 2019

Council met on 15 November 2018. An overview of matters discussed is provided below:

CLINICAL SERVICES PLAN

Council noted all the feedback received from the final engagement process, and the changes made to the Final Draft, in response to the submissions. It was noted that this was a well researched document that puts consumers at the centre, and that this will impact on everything going forward. The key however will be in the actions to come.

Council endorsed the Final Draft for approval by the Board.

NUKA CONFERENCE REPORT BACK FROM ATTENDEES

Eight Consumer Council members had attended the recent NUKA Conference. Each of them shared their reflections and "take outs" from the two days. Members were generally excited by with the "customer driven" of the NUKA model (which we see as Person & Whanau Centred Care) and could see some real benefits of something similar being developed in Hawke's Bay. They see the level of change required and the challenge this brings as significant, but something the DHB needs to aspire to.


OVERVIEW OF OTHER ITEMS DISCUSSED

Council received and discussed updates from

- the Chair
- Youth Consumer Council
- Consumer Experience Facilitators
- Representatives on the Disability Strategy Group; and
- Consumer Experience Committee

REPORTS RECEIVED FOR INFORMATION INCLUDED

- Scoping Report - Addictions
- Best Start Healthy Eating & Activity Plan Update
- Te Ara Whakawaiaora "Smokefree update"
- Te Ara Whakawaiaora – Access 0-4 / 45/64 years; and
- Consumer Council Meeting dates for 2019

	Hawke's Bay Clinical Council	163
	For the attention of: HBDHB Board	
Document Owner:	Dr John Gommans (Chair) & Jules Arthur (Co-Chair)	
Month:	November 2018	
Consideration:	For Information	

RECOMMENDATION

That the Board

Note the contents of this report; and that the HB Clinical Council:

1. **Endorsed** the Clinical Services Plan and recommend that the Board approve the Final Draft.
2. **Endorsed** the local direction for Collaborative Pathways.
3. **Discussed** Advance Care Planning, with further discussions to be held.
4. **Received** reports from the Clinical Governance Committees
5. **Received** the following reports for information:
 - Scoping Report - Addictions
 - Best Start Healthy Eating & Activity Plan Update
 - Clinical Portal Project Update
 - Te Ara Whakawaiaora "Smokefree update"
 - Te Ara Whakawaiaora – Access 0-4 / 45/64 years; and
 - Clinical Council Meeting dates for 2019

Council met on 14 November 2018. An overview of matters discussed is provided below:

CLINICAL SERVICES PLAN

Council received a summary of the feedback received from the recent community engagement process on the Draft, and noted the changes made in response to the submissions. Apart from a couple of minor additional 'technical' changes, members believed that incorporating the changes from the submissions had added 'value' to the document. In discussion Council acknowledged the challenge in the next steps re implementation; in particular the preparedness of the health sector to enable and support the change required. Council agreed that the Final Draft be endorsed and recommended to the Board for approval.

COLLABORATIVE PATHWAYS

Council received an update on collaborative pathways following the withdrawal of Map of Medicine. Although alternative tools are available these do not integrate well into primary care, therefore it was recommended that we wait for the technology to improve further. After discussion it was agreed that we should 'park' the electronic tool, continue to develop pathways and continue to look at better aligning the pathways and eReferrals.

ADVANCE CARE PLANNING (ACP)

The DHB has had an informal ACP Group for some time. The Group was now seeking guidance on how they could be better linked into governance. Options discussed included the ACP Group becoming an Advisory Group to one of Council's four Clinical Governance Committees the Consumer Experience Committee being preferred as it is made up of representatives of both Consumer and Clinical Council and this was likely to be an important issue for Consumer Council. Further discussions were deemed necessary before a decision was made.


COMMITTEE REPORTS TO COUNCIL

Reports were received from the following Committees, with no issues discussed.

- Patient Safety & Risk Management Committee and
- Consumer Experience Committee

REPORTS RECEIVED FOR INFORMATION INCLUDED

- Scoping Report - Addictions
- Best Start Healthy Eating & Activity Plan Update
- Clinical Portal Project Update
- Te Ara Whakawaiaora "Smokefree update"
- Te Ara Whakawaiaora – Access 0-4 / 45/64 years; and
- Clinical Council Meeting dates for 2019

 <p>HAWKE'S BAY District Health Board Whakawāteatia</p>	Wairoa Integrated Care Demonstrator Site 163
	For the attention of: HBDHB Board
Document Owner	Chris Ash, Executive Director of Primary Care
Document Author	Emma Foster, Deputy Executive Director of Primary Care
Reviewed by	Chris Ash, Executive Director of Primary Care; Wietske Cloo, Acting Service Director (Communities, Women & Children); Wayne Woolrich, CEO Health Hawke's Bay; and circulated to the Executive Management team
Month/Year	November, 2018
Purpose	Decision and Input/Discussion
Previous Consideration Discussions	Discussions have occurred over a sustained period of time relating to the development and integration of health services to meet population need in the Wairoa locality. The most recent paper came in February 2018, detailing activity in Wairoa as part of a paper that described attempts to establish Health and Social Care localities in Hawke's Bay.
Summary	<p>The Wairoa District community has the opportunity to transform how services are designed, commissioned, delivered, and monitored. After many years of plans being developed, opportunities being missed and health outcomes ultimately not improving, now is the time to actively focus and move forward with the community in Wairoa.</p> <p>We need to agree as a DHB that the future state for Wairoa must encompass:</p> <ul style="list-style-type: none"> ▪ Strong, valued and authentic community ownership and governance, ▪ One health system for all of Wairoa (regardless of the ownership structure) ▪ Services that operate through strong outreach into the community ▪ Consistent, high quality care
Contribution to Goals and Strategic Implications	<p>Our Strategic goals, outlined in Transform and Sustain (2013) that relate to this paper are:</p> <ol style="list-style-type: none"> 1. Transforming our engagement with Māori 2. Transforming patient involvement 3. Transforming health promotion and health literacy 4. Transforming multi-agency working 5. Transforming clinical quality through clinical governance 6. Transforming patient experience through better clinical pathways 7. Transforming through integration of rural services 8. Transforming primary health care 9. Transforming business models

Impact on Reducing Inequities/Disparities	<p>Intersectoral action and governance is vital to secure health equity. Approached in the wrong way, however, it can also slow and frustrate attempts to address inequity.</p> <p>The quality of governance shapes the decision-making and policy processes of institutions, which in turn influence the social determinants of health. Governance must be:</p> <ol style="list-style-type: none"> 1. Strong, participatory and locally inclusive 2. Structured to ensure that the voices of the most vulnerable and marginalised groups are heard in decision making 3. Supported and trusted with detailed, relevant information 4. Transparent, accountable and fair <p>4) Transparency and accountability should be promoted in the decision-making processes and mechanisms within, as well as outside the health-sector.</p>
Consumer Engagement	<p>The Wairoa Community Partnership Group is led, owned and delivered in Wairoa, for Wairoa, by Wairoa. The purpose of this group is:</p> <ul style="list-style-type: none"> • <i>United leadership for a joined-up, community led and Government partnered approach to community design, investment and decision making</i> • <i>Ensuring that 'all whānau across the Wairoa district are thriving'</i>
Other Consultation /Involvement	<p>This paper is a meta-analysis of multiple plans and strategies that have been developed over the year to meet the needs and desires of Wairoa today. Each one of these plans and strategies have had some level of engagement.</p> <p>The purpose of this paper is to ensure that the HBDHB Board are on track to support and enable the proposed direction, so that we can walk alongside the Wairoa community to support implementation.</p>
Financial/Budget Impact	<p>Approximately \$24 million of MOH funding is invested in the Wairoa population, this investment includes primary, secondary and tertiary healthcare services.</p>
Timing Issues	<p>A draft plan has been developed by management to understand the period of time it would be to support the Wairoa community to achieve future state desire. It is expected that this would take 24-36 months of intensive activity, support and leadership. There will always be a need for strong local leadership within Wairoa to support local design, decision making, commissioning, delivery and monitoring.</p>
Announcements/ Communications	<p>No formal announcement or communication is required, but ongoing engagement through locally led actions and decisions.</p>

RECOMMENDATION:

It is recommended that the Board:

1. **Note** the work completed to date in analysis and planning, in relation to integrated models of service and care for Wairoa District.
2. **Note** that work is underway to strengthen Clinical Governance in Wairoa to support improved communication, risk assessment and clinical processes improvement.
3. **Note** the significant investment, both financially and in human resources, required to maintain facilities in Wairoa to a standard that meets the needs of the community.
4. **Note** that this method of community relationships, value based decision making and strong local voice is in line with our organisational values.
5. **Discuss** whether we use this community led process as a model for engagement and negotiation with our most vulnerable populations.
6. **Agree** that increased focus needs to be included in future state delivery on customer/whānau relationships, open and proactive communication in response to clinical events.
7. **Approve** that the CPG and whānau voice is the vehicle for future model of engagement with the community and how we negotiate with this vulnerable community in relation to service allocation, design and delivery.
8. **Approve** that management can walk alongside the Wairoa community to progress the identified future state without compromise.
9. **Approve** that management continue to work with the primary and secondary care sector in Wairoa to progress towards one health system with shared leadership (clinical and management), pathways, processes and staff.



Wairoa Integrated Care Demonstrator Site

Author:	Emma Foster
Designation:	Deputy Executive Director, Primary Care
Date:	1 November 2018

SUMMARY

Wairoa District community has the opportunity to transform how services are designed, commissioned, delivered and monitored. This comes after many years of plans being developed, opportunities being missed and health outcomes not ultimately improving.

We need to agree as a DHB that the future state for Wairoa must encompass:

1. Strong, valued and authentic community ownership and governance
2. One health system for all of Wairoa (regardless of the ownership structure)
3. Services that operate through strong outreach into the community
4. Consistent, high quality care

This means that we need to do work in the following areas:

1. Support the Community Partnership Group (CPG) to provide effective governance, advocacy and promotion of biculturalism within the system, to promote and raise the profile of the successes and the gaps.
2. One health system – we work with our primary care partners to develop one system that is seamlessly linked with the secondary health system. This will necessitate hiring and developing high quality staff now and in the future, effective systems and processes, and appropriate facilities.
3. Together we develop and evaluate services to improve health and wellbeing of the Wairoa community through preventative and educational programmes.

BACKGROUND

What do we know about Wairoa population from a health perspective?

In 2015 HBDHB completed a Health Status Review in Wairoa, which informed the Wairoa Health Needs Assessment (HNA) 2016. Together with other data such as primary care utilisation and enrolment data, hospitalisation data, cancer pathway information and Ambulatory Sensitive Hospitalisation (ASH) rates, we know a lot about the health needs of the Wairoa District.

Wairoa is the smallest populated district in Hawke's Bay. Nearly 60% of the population is Māori. In the future its population is expected to be smaller, with fewer people aged under 65 (HNA, 2016). The same report states the 65 years+ population will increase to 48% in the next 15 years. Wairoa has already seen significant demographic change over the past 10 years, with fewer children, fewer adults aged 30-49 years, and more older people.

Wairoa has a particularly high proportion of its population living in very high deprivation areas. 64% live in NZ deprivation 9 and 10 areas, compared to a NZ average of 20%.

We know:

- Wairoa District has lower life expectancy than all other TLAs in Hawke's Bay.
- The rates of chronic disease hospitalisations are higher than the rest of Hawke's Bay:
 - Ischaemic heart disease (20% higher)
 - Stroke (50% higher)
 - Diabetes (70% higher)
 - Chronic Obstructive Pulmonary Disease (COPD) (20% higher)
- Smoking prevalence rates in Wairoa remain higher than the overall Hawke's Bay rates.
- ASH are higher than overall Hawke's Bay rates for 0-4 year olds, and 50% higher for 0-74 year olds. Higher ASH rates are symptoms of poor access to quality healthcare services, poor health service coordination and a lack of health service continuity.
- Whānau with limited income and/or no access to transport face considerable barriers.
- Tamariki Māori are disproportionately over-represented in having dental procedures under general anaesthetic, with Wairoa having a higher rate than Hawke's Bay as a whole.

Health Hawke's Bay data shows us that enrolment with a general practice in Wairoa is high, with 99% of the population being enrolled. The NZ average is 93%. We also know that Wairoa has the highest rate of capitated consultations in the Hawke's Bay region. However, 24% of the enrolled population have no consultations in a given year, similar to other areas in Hawke's Bay.

We have been provided with a number of cases, identified by the community, which we have been asked to review. The high-level thematic analysis would suggest that there continues to be inequities in access to services due to ethnicity, rural isolation, deprivation and limited financial resource. This is causing concern for the community and the DHB, and would suggest that we need to:

- Review how we communicate with whānau and the community regarding health services
- Establish a more integrated view across the health sector when responding to community/whānau concerns
- Proactively manage the relationship with whānau when care concerns arise or when something goes wrong in our care

What has been discussed before?

Over the past 15 years there have been a number of discussion papers, business cases and planning documents developed that link in with what the future state of Wairoa should or could be.

In 2005 a sustainability planning framework was developed that identified the following priorities:

- Providing services in an integrated manner so that services are delivered across the care continuums and include both hospital-based services and services provided in the community by other health care providers in the service continuum.
- A need to develop "centres" that provide consumers with a "one stop shop" to access different aspects of their care in one place.
- Focus on care coordination to improve management of consumers with chronic diseases and disabilities.
- Implementing innovative information technology solutions to make clinical information easily available and accessible.
- Delivery of more services in the community and increased alignment of service provision between secondary and primary care.
- Facility planning to ensure that capacity can be developed to cater for projected increase in activity.
- Focus on developing the health workforce and focus on accommodating and widening roles of health practitioners.

2009 saw the development of a Strategic Business Case which highlighted issues that needed to be addressed and key elements of the future pathway to sustainability. Key areas of focus that came out of this plan were:

- Capacity to deliver – changing nature of relationships within the primary care workforce.
- Volume and complexity of demand – coordination of care crucial.
- Integrated Models of Care - governance models, contracting models and health information.

2010/11 District Annual Plan again referred to Integrated Models of Care and specifically to develop/implement an integrated solution in Wairoa. The planning that came out of this Annual plan led to the project being initiated that focussed on:

- Integrated model between primary and secondary as well as within provider groups
- That it was financially sustainable and cost effective
- Addresses workforce issues and realities
- Coordinated to minimise waste and duplication
- Able to deliver health outcomes that improves the health status of Wairoa population.

Two key milestones that were achieved were:

- Agreement to co-locate general practice on the Wairoa Health Centre site.
- Investment into extension and refurbishment of existing facility.

There was significant activity over this time in Wairoa, and consequentially information flow through the Executive Management Team and Board.

In 2013, Transform and Sustain was established as the key strategy to transform the Hawke's Bay health system and meet the growing needs of the local population. One of the work streams that resulted from this strategy was the Health and Social Care Localities programme. The vision of this programme was "consumers accessing a wide range of coordinated services closer to home". Wairoa was identified as one of the locality areas and much effort was put into this piece of work. A steering group was developed to act as central governance group for all government and local authority activities in their community.

What is happening now?

Community Partnership Group

There is a strong Community Partnership Group ("CPG") in Wairoa with good intersectoral commitment. Through clarified terms of reference that embed the concept of community leadership in partnership with government, the CPG is now establishing a stronger voice. This provides a good avenue for whānau voice at all levels of decision making for Wairoa.

The CPG has a clear reason for being:

United leadership for a joined-up community-led and
government-partnered approach to community design,
investment and decision-making that will ensure '*all whānau
across Wairoa district are thriving*'.

We now have the opportunity to transform the health system in Wairoa by building on the community engagement that the CPG is making possible.

Health services

The Wairoa health system has pockets of good leadership, coordination and community relationships but this is not consistent across the system. Due to the lack of coordinated funding, service provision and coverage is duplicated or fragmented.

The primary and secondary health services are starting to work more effectively together, although this remains uncoordinated and patchy on too many occasions. Over the past 2-5 years we have seen 4 general practices move to 3, two of which are based on the Wairoa Health Centre site. The third community primary care provider is a strong, values-based practice that provides a multifaceted, innovative service to the community. This is evidenced by utilisation data.

Financial overview

MOH Investment in Wairoa Population 24mil	
Wairoa Based Healthcare Services 9mil	O v e r h e a d 2 mil
Services Provided by Visiting Clinicians + Emergency Flights 1mil	
Healthcare Services Provided Outside Area (Secondary & Tertiary) 12mil	
<u>Notes:</u> All amounts shown in millions of dollars; Figures are estimates based on prior year data, amounts will vary each year.	

Approximately \$24 million of MOH funding is invested in the Wairoa population:

- \$9 million investment on services provided in Wairoa facilities by Wairoa based staff;
- \$1 million investment on visiting specialist to Wairoa, plus emergency flights;
- \$12 million investment on services provided outside of the Wairoa area, this includes secondary and tertiary care;
- \$2 million on overhead which includes, but is not limited to, corporate, capital and depreciation.

Integrated information

There are opportunities for further work on integrating data to provide a more joined up picture to enable us to target health care appropriately in all areas. This will support Wairoa CPG and health service providers in their prioritisation and decision making.

Facilities requirements

Wairoa has a number of activities underway in relation to facilities.

- We have invested in facility leadership in Wairoa locally, which will allow improved local decision making and responsiveness.
- Renal House – the community have told us that they want to move the community renal service from the standalone facility on Marine Parade to a base on the Wairoa Health Centre campus. We will need some additional investment in this area due to clinical infrastructure requirements.
- Mortuary – we are process of completing the tidy up of the existing mortuary for the short term. We will be looking at the viability of a new build within the Wairoa Health Centre campus so that we are compliant with IANZ, and to meet community need and expectations.
- HBDHB owns a property in Lucknow Street, there is no activity in this property and will need additional work should we sell it. Further investigation needs to occur in this area.
- Wairoa Health Centre ‘feel’ – the community have spoken in various forum that there needs to be more a Wairoa ‘feel’ to the facility. They want their own tikanga and stories to frame the building through art work, whakatauki and in ways that capture birthing and other health traditions that are important for Wairoa community.
- Clinical Equipment replacement –This covers x-ray equipment, manual handling equipment etc. Wairoa has historically being last on the list for replacement (and programmes) and often resources get reprioritised before implementation.

Workforce requirements

The HNA states that access to health care services is a major challenge facing the health system in Wairoa. It indicates that the health workforce development needs are increased peer review, professional development including cultural competency training and Nuka 'core concepts' (specifically, the need to institute customer service training for all front line staff).

The primary and secondary care workforce is vulnerable to both recruitment and retention complications due to rurality, isolation and clinical risk factors. We also know that future specialist services are becoming more scarce across the wider health sector, so we need to utilise different methods of assessment, care and delivery planning, and managing complexity.

Recent thematic analysis in Wairoa health incidents have shown that continuity of care be impacted by over-reliance on the medical profession, and that more community upstreaming programmes need to be delivered to address health need. This means our workforce requirements will also change. We need to proactively engage with our whānau, community and health workforce in Wairoa to establish how we ensure the future of Wairoa's healthcare delivery is sustainable.

EngAGE

The next six months will build on the work already done by the local community and DHB staff, to define the programme of work to achieve a locally-owned and sustainable model of care for older people.

- Review data related to local health needs, identifying gaps to ensure there is a clear understanding of requirements
- Ensure all health expenditure (service providers etc.) in the region are mapped, to define overlaps and opportunities
- With the community and key stakeholders redefine the MOC
- Re-scope health services to align to the Model

What have been some of the barriers to change?

- Flexibility from base - resources and programmes get reprioritised away from Wairoa – *"all the oxygen goes to the heart and lungs and the limbs lose out"*.
- Community/whānau trust
- DHB operating in silos

What are our risks?

Community perception is that HBDHB is not doing enough for Wairoa, that clinical services aren't listening to the community/whānau, and that decisions are made by Hastings for Wairoa. The narrative continues to be present in the Wairoa community, specifically around individual cases, and this could be a reflection of a lack of trust by the community in the services that are provided.

Lack of community ownership of the service and how it is delivered has an impact on the way whānau/community feel about facilities. Community voice is strong in the narrative that the facilities need to have a Wairoa 'feel' to it. Due to financial and in some cases resource constraints we are finding it difficult to move quickly enough so that the community feel heard/listened too.

What do we need to do?

Community Partnership Group

Continue to build relationship and trust with the Wairoa community, whānau and leaders. Over the past 10-12 weeks the HBDHB and HHB have been working hard with to build and in some cases rebuild relationships with the community, leadership and clinical teams within Wairoa. It is critical that these relationships locally are supported by a commitment from HBDHB and HHB governance to ensure we don't compromise these relationships.

We need to value the community/whānau voice, alongside working together to achieve sustainable health services and as a result improved, and equitable health outcomes for Wairoa. The community are saying they are ready for a high trust relationship and we, as HBDHB, need to respond in kind.

We need to develop a process, information and development to support the CPG to become a fully functioning whānau/community led group that designs, prioritises and leads decision making for Wairoa. We also need to support the CPG to develop community owned outcomes and monitoring systems to support local governance. This will need to include outcome monitoring against the stated health expenditure priorities that Wairoa determines. This provides the potential to drive equity for the Wairoa community on many levels.

Health services

We want one health system that has shared leadership (clinical and management) which includes shared pathways, processes and staff, and one patient list. One single site for coordination, but strong outreach into the community such as community facilities, marae etc, telemedicine and mobile outpatient services, and aged residential care facilities connected to the one site. We need Māori Health providers and social services strongly integrated in to the health system with shared vision, agenda, activities and outcomes.

We have agreement from the key primary care providers to work in a different way, which will support our proposed vision of one health system that has shared leadership (clinical and management) which includes shared pathways, processes and staff and one patient list. It is expected that we will have an agreed process whereby we integrate primary services initially. This will lead us to improved system relationships, clinical governance and quality programmes.

We also need to be considering how we build a shared consumer engagement resource for Wairoa to proactively work with whānau/community on building communication, trust and open conversations around specific clinical events.

Up-streaming of services – We need to transition resources and have the capacity to promote wellbeing at a community level. We need to ensure supportive environments that will empower the Wairoa whānau and community to make healthy lifestyle decisions.

Integrated information

There are opportunities for further work on integrating data to provide a more joined up picture to enable us to target health care appropriately in all areas. This will support Wairoa CPG and health service providers in their prioritisation and decision making.

Telehealth

Activity is underway to improve business processes that will enable us to improve access to specialist services and advice in the area of ED and outpatients through telehealth strategies. We are also working on enabling staff to be more productive through unified communications tools.


Finally, there is a lot of activity and action in Wairoa, and it is acknowledged that Wairoa has been a focus for many years to support improved health outcomes. We finally have the opportunity to change the narrative and action that goes with this through improved relationships, a strong and vibrant community voice and a willingness by all to work collaboratively for Wairoa. Wairoa community are giving us their trust to make the system better for their people, we need to reciprocate by giving them our trust and listening to their voices.

RECOMMENDATION:

It is recommended that the Board:

1. **Note** the work completed to date in relation to analysis and planning in relation to integrated models of service and care for Wairoa District
2. **Note** that work is underway to strengthen Clinical Governance in Wairoa to support improved communication, risk assessment and clinical processes improvement.
3. **Note** the significant investment both financially and human resources, required to maintain facilities in Wairoa to a standard that meets the needs of the community.
4. **Note** that this method of community relationships, value based decision making and strong local voice is in line with our organisational values.
5. **Discuss** whether we use this community led process as a model for engagement and negotiation with our most vulnerable populations.
6. **Agree** that increased focus needs to be included in future state delivery on customer/whānau relationships, open and proactive communication in response to clinical events.
7. **Approve** that the CPG and whānau voice is the vehicle for future model of engagement with the community and how we negotiate with this vulnerable community in relation to service allocation, design and delivery.
8. **Approve** that management can walk alongside the Wairoa community to progress the identified future state without compromise.
9. **Approve** that management continue to work with the primary and secondary care sector in Wairoa to progress towards one health system with shared leadership (clinical and management), pathways, processes and staff.

Governance Report Overview

 <p>HAWKE'S BAY District Health Board Whakawāteatia</p>	Radiology Facilities Redevelopment Single Stage Business Case 165
	For the attention of: Hawke's Bay District Health Board
Document Owner	Colin Hutchison ED Provider Services
Document Author(s)	Project Working Group
Reviewed by	Health Services Leadership Team (HSLT), Executive Management Team (EMT) and HB Clinical Council
Month/Year	November, 2018
Purpose	For Approval
Previous Consideration Discussions	Has this been previously considered by any governance group? This business case was presented to HSLT and EMT in May 2018. Since then it has been updated to the better business case format and then represented to HSLT and EMT in October and HB Clinical Council in November 2018.
Summary	Key Issues/Actions Approval to invest \$18.942 million, subject to sourcing capital funding (discussed in Financial/Budget Impact section) to replace the MRI & Fluoroscopy units in radiology and make floor plan changes. This includes relocation of the MRI and Fluoroscopy equipment, adds additional space to the first floor, seismic strengthening works and relocating ultrasound outside of the current departmental footprint. These changes will address corrective action requests (CARS) issued by International Accreditation New Zealand (IANZ) regarding patient safety, accommodation, environment and equipment replacement. Failure to address IANZ CARS will result in loss of IANZ accreditation. Losing accreditation means: <ul style="list-style-type: none"> • Damage to the reputation of HBDHB and its commitment to quality care • Loss of community, clinician and industry confidence in the HBDHB radiology department • Breaching the ACC high tech contract losing \$570,000 revenue per annum • Increased vacancies within the department with no ability to attract and retain highly sought after staff • Breach of the National Bowel Screening Programme requirements. The existing MRI & Fluoroscopy units are beyond end of life and are at risk of failing. These units are heavily relied upon to support acute and elective demand from both primary and secondary care.

	The preferred option provides physical capacity within the Radiology footprint for future developments such as Percutaneous Coronary Intervention (PCI) and Pacemaker services.
Contribution to Goals and Strategic Implications	<p>Providing Radiology services to support clinical requirements for the community of Hawke's Bay across primary, secondary and tertiary care in alignment with:</p> <ul style="list-style-type: none"> • Clinical Services Plan • Establishment of a cardiac catheter laboratory in Hawke's Bay (PCI/Pacemaker services)
Impact on Reducing Inequities/Disparities	<p>What impact will this have on reducing inequities and has a HEAT Tool been applied?</p> <p>Where tapu wahi has been applied rather than the HEAT tool to two consumer stories (appendix eight). Radiology covers an array of fundamental diagnostic tools used in the identification and treatment of all the major conditions affecting Māori and Pacific in Hawke's Bay. Therefore, investment in radiology helps support all major health equity programmes.</p>
Consumer Engagement	<p>What level of consumer engagement has been undertaken?</p> <p>None at this stage. Co-design workshops and consultation will be held during the development of the design for the floor plan changes during the execution stage of this project.</p>
Other Consultation /Involvement	<p>Who else was consulted / involved?</p> <p>Stakeholder engagement completed, clinicians, staff, Maori Health, Clinical Advisory Group, HSLT, EMT, HB Clinical Council, Radiology Services Committee (which includes primary care) and other key stakeholders.</p>
Financial/Budget Impact	<p>The proposed cost of the project is \$18.942 million +/- 15% for capital and \$18.217 million operating costs over the ten year time horizon including depreciation and interest.</p> <p>Approval is subject to sourcing capital and is requested at this stage so that the detailed design can be commenced. Capital sources include Ministry of Health, finance arrangements on the equipment and prioritisation of internally generated capital. The final solution could be a combination of all of these capital sources and will be presented to the FRAC and Board for approval prior to entering into contractual arrangements.</p>
Timing Issues	<p>Critical dates: Priority to replace end of life equipment that carries significant risk.</p>
Announcements/ Communications	Once the business case is approved and funding secured a media release will be issued

RECOMMENDATION:

That the HBDHB Board

Approve the business case for the replacement of the MRI and Fluoroscopy equipment and make floor plan changes to address correction actions in a way that allows for future changes.

Subject to:

1. Approval of the capital budget of \$18,942 million
2. Approval of \$18.217 million operating costs over the ten year time horizon including depreciation and interest.
3. Sourcing the required capital funding.

Note that:

- The project cannot progress beyond detailed design without a further submission to FRAC and Board on funding options.
- Tenders for equipment purchases and construction will come back to the Board for approval in due course.

Attachment: Radiology Facilities Redevelopment Single Stage Business Case

Radiology Facilities Redevelopment Single Stage Business Case

16.1

Prepared by:	Project Working Group
Prepared for:	HBDHB Board
Date:	19 November 2018
Version:	4
Status:	FINAL

Radiology Facilities Redevelopment Single Stage Business Case

Document Control

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0.7	15 Jan 2018	Project team review
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1.0	23 Feb 2018	Health Services Leadership Team update
1.3	28 Mar 18	Post Executive Management Team
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1.8-2.1	27 July 2018	Project team reviews
2.2	1 Aug 2018	For Steering Group
3	12 Oct 2018	Realigned to Better Business Case template, submitted to HSLT
3.1	26 Oct 2018	Updated with changes from HSLT, Submitted to EMT
3.2	08 Nov 2018	Updated with changes from EMT, Submitted to MRB, Clinical & Consumer Councils
4	19 Nov 2018	Finalised and submitted to HBDHB Board

Document Review

Role	Name	Review Status
<i>Project Sponsor</i>	Paula Jones	Feedback received
<i>Project Assurance</i>	Kate Rawstron	Feedback received
<i>Quality of business case</i>	Health Services Leadership Team	Feedback received
<i>Quality of business case</i>	Executive Management Team	Feedback received
<i>Quality of business case</i>	Clinical Council	Feedback received

Document Sign-off

Role	Name	Sign-off Date
<i>Project Manager</i>	Janet Heinz	19 Nov 2018
<i>Project Sponsor</i>	Paula Jones	
<i>Senior Responsible Owner/ Project Executive</i>	Colin Hutchison	
<i>Project Assurance</i>	Kate Rawstron	

16.1

Contents

Executive Summary	6
Strategic Case	6
Economic Case	10
Commercial Case	11
Financial Case	12
Management Case	13
1. The Strategic Case – Making the Case for Change	17
Strategic Context	17
Organisational overview	17
Demand forecasting	19
Outsourcing	19
Alignment to existing strategies	20
Investment Objectives, Existing Arrangements and Business Needs	23
Existing Arrangements and Business Needs	24
Potential Business Scope and Key Service Requirements	33
Main Benefits	34
Main Risks	35
Key Constraints and Dependencies	36
2 The Economic Case – Exploring the Preferred Way Forward	38
Critical Success Factors	38
Long-List Options and Initial Options Assessment	38
Build options	41
The Short-listed Options	53
Economic Assessment of the Short-Listed Options	53
Non-monetary Benefits and Costs	55
Risk and Uncertainty	56
Testing the Preferred Option and Sensitivity Analysis	57
3 Commercial Case - Preparing for the Potential Deal	59
The Procurement Strategy	59
The Procurement Plan	60
Specify Requirements	62
Payment Risk Allocation	63
4 Financial Case - Affordability and Funding Requirements	64
The Financial Costing Model	64
5 Management Case: Planning for Successful Delivery	66
Project Management Planning	66
Change Management Planning	73
Benefits Management Planning	73
Risk Management Planning	74
Risk register	74
Post-Project Evaluation Planning	75
Next Steps	75

6	Appendix	76
	Appendix One: Commissioner's Letter	76
	Appendix Two: IANZ Corrective Action Requests	77
	Appendix Three: Summary Presentation of the Long-list Options Assessment	78
	Appendix Four: Floor plans	79
	Appendix Five: Radiology Capital Equipment replacement programme	Error! Bookmark not defined.
	Appendix Six: Glossary of Terms	81
	Appendix Seven: Consumer stories	83
	Appendix Eight: Project Risks	84

Executive Summary

This Single Stage Business Case seeks formal approval of \$18.942 million capital investment and \$18.217 million operating costs over a ten year time horizon including depreciation and interest to execute the preferred option put forward in this business case.

As a 2017 radiology business case focused on urgent workforce needs, the focus of this business case is:

- The urgent replacement of critical equipment (work horses of the department) which have reached end of life
- Retaining International Accreditation New Zealand (IANZ) accreditation
- Seismic strengthening work

This executive summary business case follows the Treasury Better Business Cases guidance for a single stage business case and is organised around the five case model. Both the executive summary and main body of the business case will step through each of the five cases.

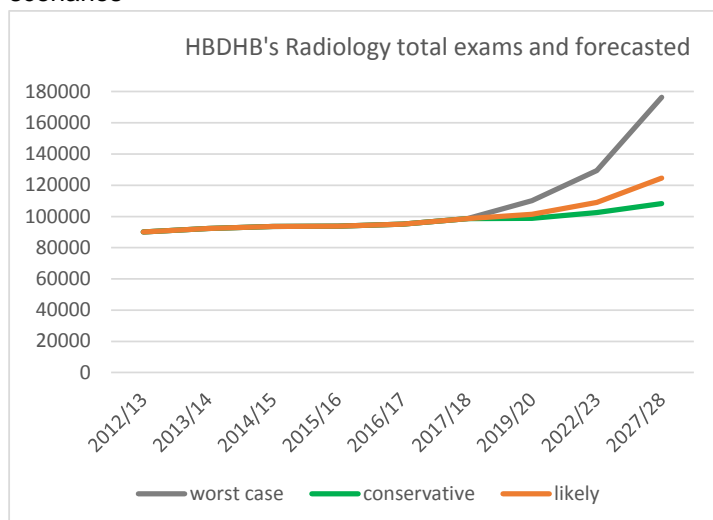
- Strategic Case – the case for change
- Economic Case – options analysis and identification of the preferred way forward
- Commercial Case – procurement of the preferred option
- Financial Case – financial analysis of the preferred option
- Management Case – project management plan for the execution of the preferred option

Strategic Case

The strategic case outlines the strategic context for the investment proposal and makes a robust and compelling case for change.

The strategic context

Radiology is a capital intensive service made up of a wide range of imaging modalities each with a limited life based on maintenance and technology capability. Globally radiology services have become heavily relied upon by clinicians from primary through to tertiary care and across all specialties in order to eliminate possibilities, confirm diagnosis and monitor progress of injuries and disease. This has resulted in large volume increases for radiology in both acute and elective services which is expected to continue for some time yet due to patient demographics and care pathways. Against this backdrop, radiology imaging technology is advancing and changing rapidly and skilled staff are becoming harder to attract for core radiology roles such as radiologists, MRI technicians and sonographers as global demand for their skills increases exponentially to meet the growing demand for diagnostic services.

Graph 1: HBDHB's radiology total forecasted growth for the next 10 years based on three scenarios

Nationally and regionally the focus is on how to support radiology services and make them more resilient in the face of growing demand and staffing shortages.

In order to support local strategies such as the Clinical Services Plan (CSP) first and foremost Hawke's Bay District Health Board (HBDHB) needs a fully functioning radiology department to support acute and elective services as a platform that can be built upon in the future to meet the changing diagnostic needs of clinicians and patients.

Additionally health inequities exist in Hawke's Bay particularly in our Maori and Pacifica populations, being able to provide quality radiology diagnostics and procedures is key for better management of conditions prevalent in these communities such as ischaemic heart disease, diabetes and cancers.

The case for change

IANZ accreditation

HBDHB's radiology department is in jeopardy of losing its status as an accredited radiology provider from IANZ. In 2012 IANZ first noted concerns and issued strong recommendations to do with:

Staffing levels, patient privacy and safety concerning the floor plan layout, the need to continue to support ongoing equipment capital replacement in a planned approach this specifically mentioned the MRI, Fluoroscopy, Angiography units at Hawke's Bay Hospital and the plain film x-ray unit at Wairoa.

In the 2017 accreditation visit these progressed to corrective actions and included replacing equipment that had reached end of life including MRI, Fluoroscopy and the Angiography units, with a note that this business case was being developed to address most of these. The same outstanding CARs relating to equipment replacement, patient privacy and safety were noted again in the 2018 surveillance visit. The next step by IANZ if HBDHB does not move forward with addressing these is withdrawal of accreditation. Losing accreditation means:

- Damage to the reputation of HBDHB and its commitment to quality care
- Loss of community, clinician and industry confidence in the HBDHB radiology department
- Breaching the ACC high tech contract losing revenue per annum
- Breach of the National Bowel Screening Programme

- Increased vacancies within the department with no ability to attract or retain highly sought after staff

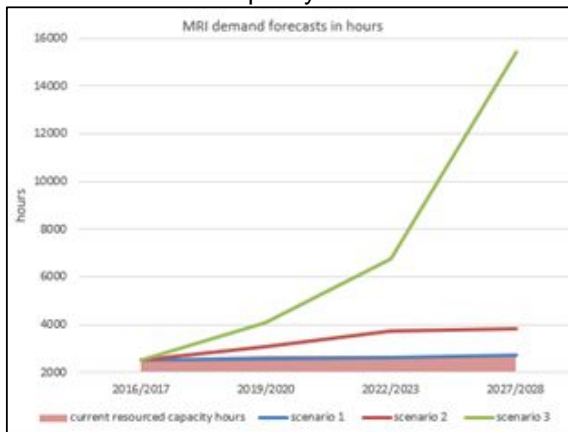
Urgent replacement of critical equipment

The MRI and Fluoroscopy units are passed end of life and need replacing and are subject to CARs issued by IANZ. These units are heavily relied upon as some of the diagnostic work horses of the radiology department that support both acute and elective demand.

Demand for MRI

In financial year 2017/18 3,900 scans were performed, an increase of 17.6% on 2016/17. Looking back five years to 2012/13 there has been a 37% increase in scans performed on the same equipment.

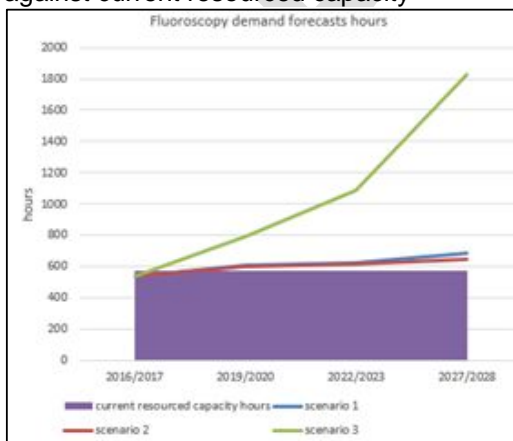
Graph 2: MRI forecasted hours for the next 10 years based on the three scenarios against current resourced capacity



Demand for Fluoroscopy

Demand has grown at an average of 2.1% per year over the last 5 years. In financial year 2017/18, 791 examinations were performed an increase of 5.7% (67 exams) compared to the previous year suggesting factors influencing demand are accumulating.

Graph 3: Fluoroscopy forecasted hours for the next 10 years based on the three scenarios against current resourced capacity



Seismic Strengthening work

The building is rated as an Importance Level 4 building (IL4) under the New Zealand building code “Buildings that are essential to post-disaster recovery or associated with hazardous facilities” and therefore needs to be able to withstand a 1 in 2,500 year seismic event. Following the establishment of this project a detailed seismic assessment was commissioned which found there was significant structural strengthening work required to bring the radiology building up to code. The outcome of the detailed report has been notified to Hastings Council as per legislative requirements, HBDHB now has 7.5 years from notification in which to complete these works, regardless of whether this project proceeds.

Key stakeholders identified three investment objectives for this investment proposal.

Table 1: The case for change is summarised for each of the three investment objectives.

Investment Objective One	Mitigate significant risk of end of life equipment failure in order to retain service continuity of high quality diagnostics and interventional procedures that meet the needs of clinicians and patients for effective diagnosis and treatment
Existing Arrangements	Radiology equipment has a limited useful life, the MRI and Fluoroscopy units are beyond theirs which has led to a decline in image quality and a steady increase in maintenance down time. As radiology diagnostics are heavily relied upon by all facets of the health care sector the ramifications of equipment down time is widely felt.
Business Needs	Acute services are heavily reliant upon immediate access to diagnostic imaging as is the wider health sector who are driving demand for diagnostic imaging at a rapid rate.
Potential Scope	<ul style="list-style-type: none"> • Replacement of existing Fluoroscopy and MRI units • 1.5T wide bore MRI scanner • Medium spec fluoroscopy
Potential Benefits	<ul style="list-style-type: none"> • Equipment fit for purpose and located in the most appropriate setting • Acute demand and MoH targets are met • Avoid an increase in the social costs associated with delayed care and travelling for tests • Ability to perform diagnostics on disease types that are prevalent in Māori and Pacifica
Potential Risks	<ul style="list-style-type: none"> • The project's replacement of equipment is delayed and maintenance down time increases or equipment fatally breaks down causing clinical risks from delays in diagnosis, increased wait times and high outsourcing costs • Interruptions to business as usual (BAU) due to difficulties in the build-ability of floor plan layout changes and replacing equipment resulting in current volume through put dropping off and wait times increasing
Constraints and Dependencies	HBDHB's current financial position has meant that available capital is tight and some projects have had to be deferred
Investment Objective Two	Avoid reputational damage and retain community, clinician and industry regulators confidence in HBDHB's radiology department by maintaining IANZ accreditation. Meet legal, statutory and industry requirements for radiology services relating to, professional practicing certificates as well as college, board and council standards and the Health & Disability Commission's (HDC) consumer rights.
Existing Arrangements	IANZ noted in 2012 issues with patient safety and privacy relating to the built environment of the radiology department. In 2017 these were upgraded to corrective actions requests (CARs). If HBDHB does not to resolve these the next progression by IANZ is withdrawal of accreditation. A detailed seismic assessment of the radiology department noted that significant structural strengthening work is required which must be completed within 7.5 years
Business Needs	IANZ accreditation is required contractually for ACC high tech contract (annual revenue), national bowel screening program and a must in order to retain and attract skilled staff who are in short supply. The radiology department needs to be able to continue to occupy the building after a major seismic event in order to support acute services.
Potential Scope	Comply with statutory and IANZ accreditation requirements by addressing all floor plan layout CARs, replacement of MRI and Fluoroscopy units and seismic structural work

16.1

Potential Benefits	<ul style="list-style-type: none"> • Radiology is performed in a professional and technically reliable way in accordance with accreditation standards • Enhanced working environment for staff • Ability to continue business as usual and support acute services following a major seismic event
Potential Risks	If this project is delayed this would impact on the urgent replacement of end of life equipment and retention of IANZ accreditation. Additionally if this project is postponed or cancelled the seismic strengthening work is still required to be completed.
Constraints and Dependencies	IANZ accreditation is a requirement of: <ul style="list-style-type: none"> • the national Bowel Screening Program • ACC high tech contract
Investment Objective Three	Operate a service that meets existing demand and creates a platform on which future capacity may be built up in the most cost effective way
Existing Arrangements	The allocation of volumes via in-house, IDF or outsourcing is based on the most cost effective and timely options, except where specific skills gap/shortfall requires outsourcing.
Business Needs	Continue to allocate volumes based on the most cost effective and timely options in order to meet clinical need and MoH targets through keeping wait times at a minimum.
Potential Scope	Replace equipment and do associated footprint changes to meet CARs in a way that has flexibility to increase capacity in the future
Potential Benefits	Radiology department is financially sustainable
Potential Risks	If the project's scope is kept to an absolute minimum and the longer term picture is not understood then this could cause problems in the near future when the capacity this project creates is maximised which could require a large amount of additional work in order to expand capacity.
Constraints and Dependencies	HBDHB's current financial position has meant that available capital is tight and some projects have had to be deferred

Economic Case

A wide range of options were identified and short-listed by stakeholders from them the following short-listed options were selected for more detailed economic analysis in this business case:

- Option one: (Status quo)
Replace existing MRI and Fluoroscopy units and MRI safety shielding. No footprint changes. IANZ CARs not addressed.
- Option three: (the preferred way forward)
Replacement of existing Fluoroscopy and MRI equipment and plan for replacement of other existing equipment. Footprint increase for existing and planned services. All CARs issued by IANZ addressed. Seismic strengthening works completed.

This part of the economic case has undertaken more detailed options analysis to determine the preferred option likely to optimise the relative value for money.

Option 1 present value of costs includes ACC high tech revenue forgone due to loss of IANZ accreditation and excludes seismic strengthening and project management costs.

The preferred option

Option three is the preferred option because it is the only cost effective way of replacing the MRI and Fluoroscopy units, retaining IANZ accreditation by addressing all of the CARS, enable changes to the department in the future and address the seismic strengthening works without regrettable spend.

Although status quo would enable HBDHB to replace the MRI and Fluoroscopy units in the shortest possible time, it would very likely result in the withdrawal of IANZ accreditation. This will cause the loss of significant revenue associated with the ACC high tech contract and make it even more difficult to hire in to existing radiology workforce vacancies as well as hold on to experienced staff. Additionally, in order to address all the CARs in the future, further funds would need to be spent as the opportunity to relocate the MRI would have been lost. Also the seismic strengthening work would still need to be completed at a later date within the required timeframe.

In the preferred option the position of both the MRI and fluoroscopy units in the radiology department change. This means the construction works can be phased so the existing equipment continues in service until the new units are commissioned allowing normal MRI volumes to continue throughout the build program. Doing so improves the department layout addresses the CARs around patient safety, privacy and accommodation and allows for further changes to the department at a later date. These works will enable the radiology department to continue to support acute and elective services at Hawke's Bay Hospital in the medium term (2-3 years from completion of project) and support future development of the department in alignment with nine themes of the CSP.

16.1

Commercial Case

The procurement strategy for the preferred option is to take a separate market approach for the two procurement areas:

Construction works, managed by Facilities:

The proposed approach to market, evaluation of offers and identification of the preferred supplier are as follows:

1. Having met all of the preconditions, interested parties will be invited to participate in a closed negotiated tender and will be notified at this time of any conditions and dates the tender is subject to.
2. Upon receipt of tender responses the evaluation team will gather to review responses. Based on the review by the evaluation team, negotiations with tenderers will be completed after which the evaluation team will select a preferred supplier to enter in to final negotiations with.
3. Once final negotiations are completed including allocation of risk, the evaluation team will put forward a recommendation to HBDHB's board to award the contract to the preferred supplier.

Equipment replacement, managed by Procurement:

The proposed approach to procure the equipment is a closed secondary market Request for Proposal (RFP), seeking submissions from interested suppliers as per the specifications required for each piece of equipment. A secondary contestable process will be undertaken including but not limited to shortlisting, site visits and trialling that will be evaluated by an

evaluation panel. This panel will include members from key stakeholder groups across the DHB.

The procurement strategy for each of these will follow the procedures detailed in HBDHB's Procurement Policy and Procedures (HBDHB/OPM/081). For the equipment purchase and maintenance agreements HBDHB's own standard contract template will be used.

For the construction works the form of contract will be NZS 3910:2013 Conditions of Contract and payment for the capital works will be made through a series of Progress Payments in accordance with the Construction Contracts Act. Variations to the contract works will be in writing and agreed by both parties. Variations involving an increase in price must only be made within the limit of the financial delegated authority. Progress Payments will provide for a percentage of the amount certified as due to the contractor to be deducted from the amount due and retained by the client. The purpose of the retention is to ensure that the contractor properly completes the activities required of them under the contract. The risk allocation has not been agreed at this stage, and would be negotiated with the successful supplier as part of the appointment process at the conclusion of the tender.

Financial Case

The preferred option replaces the equipment on site, addresses the corrective action requests and provides a build option that ensures continuity of service. This is done by phasing the works over several stages to accommodate footprint expansion and to allow the radiology service to operate business as usual, (BAU) providing acute and elective services to primary and secondary care during the project.

As per the table below the total capital investment is \$18.942 million phased over a 5 year period (see appendix 6.4 for details).

The operating costs over the ten year time horizon of \$18.217 million (including interest and depreciation) is to be funded by crown funding.

- Total costs have an accuracy of +/- 15%.
- The equipment costs may be higher, due to exchange rate fluctuations or other cost factors unforeseen at the time pricing was estimated.
- The build programme is based on need for the MRI and Fluoroscopy scanners to be replaced by the end of 2020.

The following cost, benefit assumptions and risks have been used for the financial modelling in this business case:

- The interest rate (capital charge) rate used is 6.0%;
- Modelling time horizon is 2018-28;
- Baseline costs are held constant over time i.e. no inherent growth assumed;
- No inflation modelled; this includes equipment and build cost Depreciation has been calculated using the straight line method. The rates applied are as follows; Build Costs

5.28%, Equipment 12%; Due to the expansion of the footprint additional support staff are required such as orderlies

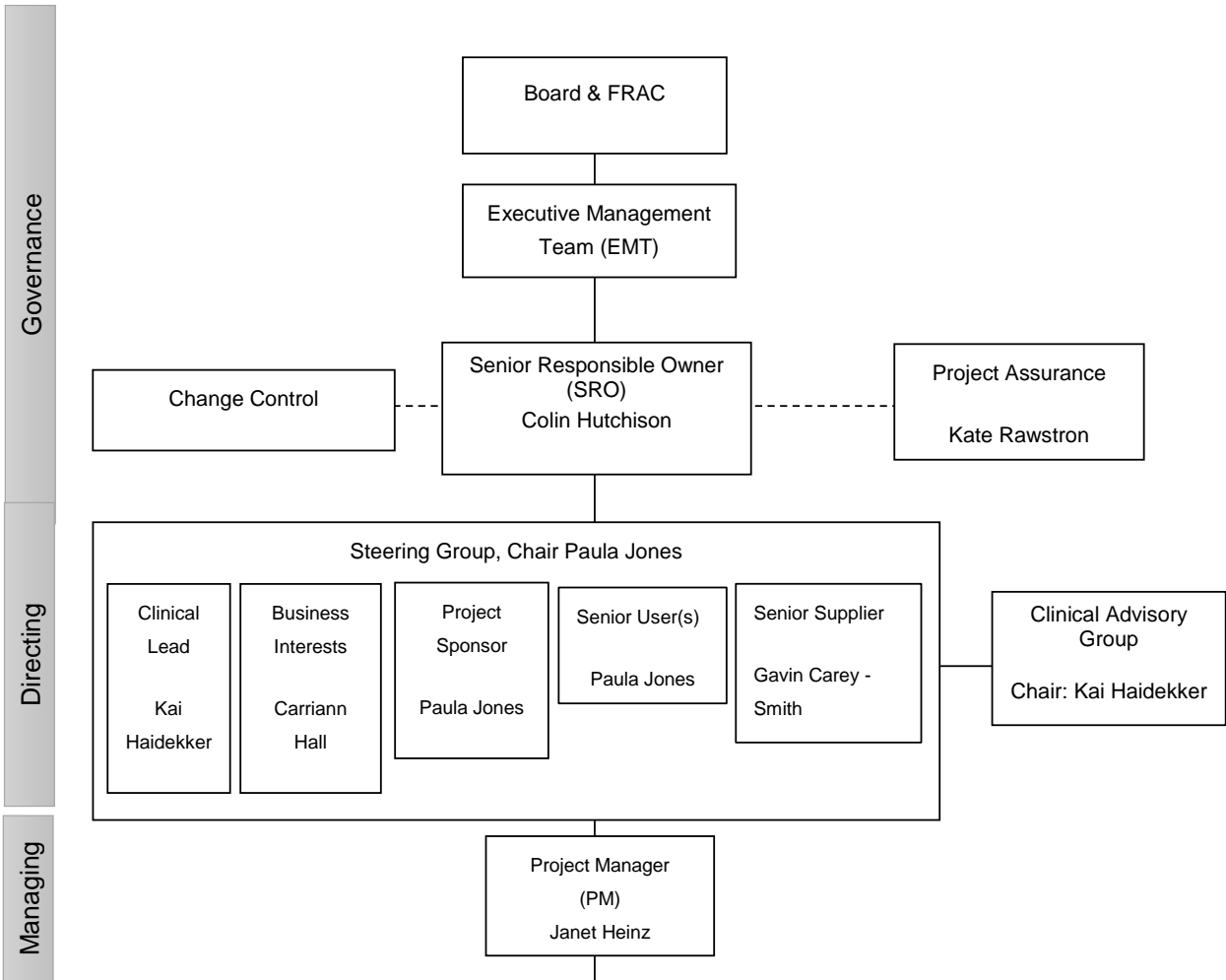
- Facility whole of life costs have been accounted for;
- Feasibility costs have been accounted for;
- Financials have been modelled on the demand assumptions in the strategic case (reference). There is a risk that demand growth more closely models the worst case scenario. Exchange rates for equipment purchase remain static from quote to purchase.

Management Case

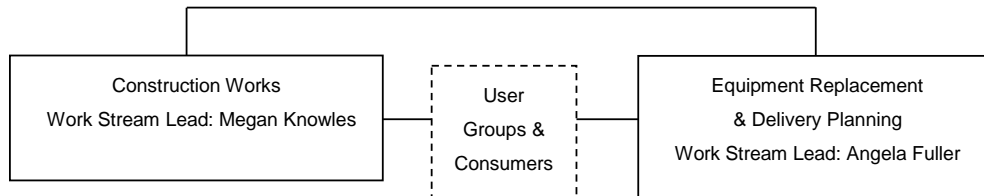
In the event that this investment proposal receives formal approved, a project will be established to deliver the required services and will be managed using the Hawke’s Bay Project Method framework based on PRINCE2 project management methodology.

The relevant project management and governance arrangements are proposed to be as follows:

Figure 1: The project organisation chart



16.1



The strategy, framework and plan for dealing with change and associated contract management is as follows:

- Where appropriate internal staff will be given leading project roles in identifying and communicating changes so as to both develop their skills as change champions and harness existing professional relationships.
- Floor plan changes will be co-designed with staff user groups and consumers to ensure the new floor plan layout is fit for purpose and considers what future development might be possible at a later date.
- Consumer workshops will be programmed at regular intervals throughout the design process. This will ensure proposed changes are developed with the consumers' needs at the heart of the plan.
- A media plan will be developed for notifying clinicians, health professionals and patients about the works and how it may affect them. This will include information about the specifications of the replacement MRI and Fluoroscopy units, rationale behind the floor plan changes (retention of IANZ accreditation, space for a cardiac catheterisation lab) and how business as usual services will be accommodated during the building works.

The strategy, framework and plan for dealing with the management and delivery of benefits are as follows:

The project's Benefits Realisation Plan will outline how the benefits will be managed and the accountabilities that will be applied. This will include the mechanisms to assign accountability, track progress, achievement of milestones and ongoing monitoring post Go Live against the KPIs. These will be used to measure the outcomes of the project in the benefits realisation review which will be carried out as part of the post project evaluation.

The strategy, framework and plan for dealing with the management of risk follows the Hawke's Bay Project Method framework for managing risk which aligns with HBDHB's risk management policy OPM040.

The strategy, framework and plan for managing benefits are as follows:

The project's Benefits Realisation Plan will outline how the benefits will be managed and the accountabilities that will be applied. This will include the mechanisms to assign accountability, track progress, achievement of milestones and ongoing monitoring post Go Live against the KPIs. These will be used to measure the outcomes of the project in the benefits realisation review which will be carried out as part of the post project evaluation. A post implementation review is planned for one year post project closure to analysing the success of the project against the anticipated improvements and benefits. Benefit realisation reviews to determine if the project is delivering its anticipated improvements and benefits, will be undertaken on a quarterly basis leading up to the completion of the Post implementation review.

Next Steps

This Single Stage business case seeks formal approval from HBDHB to approach the market for services and progress the implementation of the preferred option. Firstly the project manager will plan for the execution stage of the project by preparing the project initiation documentation and stage plan for the first execution stage. Architects will be hired and staff user groups formed to co-design the floor plan changes. The equipment specifications for the MRI and fluoroscopy units will be finalised and the procurement plan completed in preparation for tendering.

Introduction

Critical MRI and Fluoroscopy equipment located at the hospital site is past end of life expectancy and needs replacing. Outsourcing these services is more costly than replacement and has constrained availability locally. Alongside this the radiology department layout has significant issues regarding patient safety, accommodation and environment highlighted by IANZ Corrective Actions issued in 2017.

This Single Stage Business Case seeks formal approval of \$18.942 million capital to execute the preferred option put forward in this business case.

The business case process is organised around a five case structure designed to systematically ascertain that the investment proposal:

- is supported by a compelling case for change - the 'strategic case'
- optimises value for money - the 'economic case'
- is commercially viable - the 'commercial case'
- is financially affordable - the 'financial case', and
- is achievable - the 'management case'.

The purpose of this Single Stage Business Case is to:

- confirm the strategic context of the organisation and how the proposed investment fits within that strategic context
- confirm the need to invest and the case for change
- identify a wide range of potential options
- determine the preferred option which optimises value for money, by undertaking a detailed analysis of the costs, benefits and risks of the short-listed options
- prepare the proposal for procurement
- plan the necessary funding and management arrangements for the successful delivery of the project
- inform a proposal for the procurement of equipment and construction works to seek agreement to approach the market to procure these and finalise the arrangements for the implementation of the project.

1. The Strategic Case – Making the Case for Change

Strategic Context

Medical diagnostics such as radiology are an integral part of the effective operation of the New Zealand health system as a whole. They form a critical component in the effective and timely diagnosis, intervention, and treatment for elective and acute clinical services in both the hospital and community settings and are influenced by developments in all aspects of medical practice. At the same time, advancing radiology imaging technology is creating increasing opportunities for radiology services to become more deeply incorporated in to clinical management and best practice pathways leading to more informed choices, earlier treatment and better patient experiences and outcomes.

Health inequities exist in Hawke's Bay particularly in our Maori and Pacific population, and being able to provide access to quality radiology services assists in better management of conditions prevalent in these communities such as ischaemic heart disease, diabetes and cancers.

As each facet of the health system asks more of radiology, the effect on the service multiplies, even though their client departments' service level may change in a relatively small and measured way. By the time these small increments in demand are added up all the way through from primary to tertiary care, the combined demand growth on the service has been up to 17 percent per year for some imaging modalities. Therefore as radiology services become further ingrained as an intermediate input, the service is under increasing pressure to manage growth in demand at a rate faster than planned increases in funding, workforce and assets has been able to keep abreast with.

Organisational overview

Hawke's Bay District Health Board (HBDHB) is a crown entity employing 2,984 staff to fulfil both provider and funder roles for the provision of health services for the population of Hawke's Bay. For financial year 2018/19 The Ministry of Health (MoH) funded \$528 million to improve, protect and promote the health of the estimated 161,300 people that live in the district. The funding is apportioned via HBDHB's commissioning managers who allocate this to internal and external providers who deliver the services. Internal providers are funded via the price volume schedule (PVS) whereas private providers are funded through commercial contracts and other District Health Boards (DHBs) are funded via either inter district flow (IDF) or commercial contracts, based on case weight pricing.

In addition to the radiology department's MoH funding it also generates revenue through a contract with the Accident Compensation Corporation (ACC) for low tech and high tech imaging worth approximately \$570,000 in revenue per annum.

The core function of HBDHB's Radiology Department is to aid diagnosis and treatment throughout the life cycle of health conditions from early stage diagnostics through to follow up using diagnostic imaging, procedures and interventions that require imaging guidance. It is one

16.1

of five radiology imaging providers in Hawke's Bay and services the wider health sector from primary through to tertiary.

The department, which sits within the Medical Directorate, has an annual cost base of \$14.3 million dollars and employs 75 staff comprising of an interdisciplinary team made up of radiologists, medical imaging technologists, nurses and support personnel. Services are predominately delivered at Hawke's Bay Fallen Soldiers Memorial Hospital in Hastings as well as satellite facilities at Napier Health Centre, Wairoa Health Centre and Central Hawke's Bay Health Centre in Waipukurau. This matches the geographical makeup of the bay where approximately 49% of the population live in the vicinity of Hastings, 38% in Napier, 8% in Central Hawke's Bay and 5% in Wairoa. Modalities provided by the service include:

Diagnostic Imaging

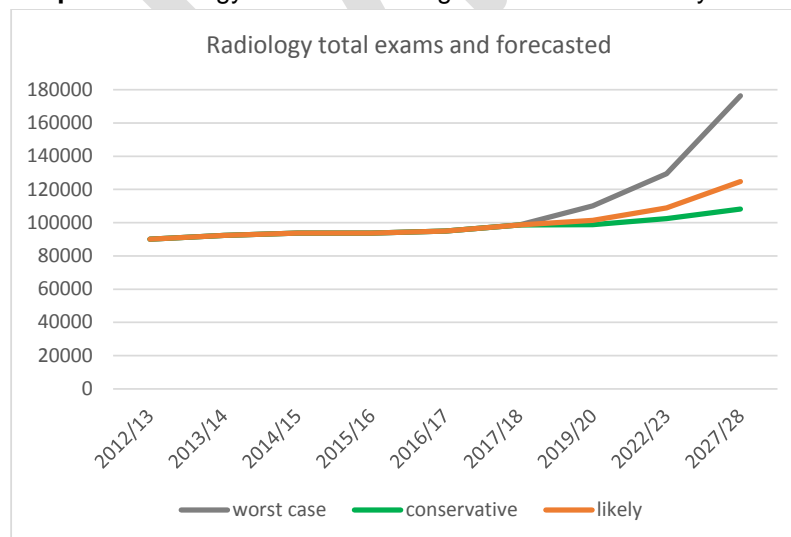
- Plain film x-ray (Computed Radiology (CR) or Digital Radiology (DR))
- Ultrasound (US)
- Nuclear Medicine (NM), also known as Scintigraphy
- Magnetic Resonance Imaging (MRI)
- Computed Tomography (CT)
- Digital Subtraction Angiography (DSA)
- Fluoroscopy
- Intra operative fluoroscopy Imaging intensifier (II)

Interventional Procedures

- Ultrasound guided biopsies, drainages, steroid injections, PICC line insertions and fine needle aspirations (FNA's)
- CT guided biopsies, drainages and steroid injections
- Interventional fluoroscopy and angiography procedures e.g. vascular stent insertions, angioplasties, tunnel line insertions, percutaneous nephrostomies and biliary stenting.

In the 2017/18 financial year the department performed approximately 98,650 diagnostic imaging and interventional procedures. This is expected to grow in the next 10 years to just under 125,000 based on the "most likely" demand modelling as shown in graph one below.

Graph 1: Radiology total forecasted growth for the next 10 years based on the three scenarios



Demand forecasting

Five and ten year demand projections have been modelled for the service based on three scenarios.

- **Conservative:** current volumes extrapolated by population growth and demographic changes.
- **Most likely:** current volumes extrapolated by the average annual increases and decreases for the different modalities of the past five years
- **Worst case:** current volumes extrapolated by the highest annual increase of the past five years

Outsourcing

Outsourcing is largely used to provide assistance with in-house reporting capacity. Outsourcing volumes for imaging mainly sit within community plain film x-ray contracts with Hastings Health Centre, the Doctors Hastings, the Doctors Napier and TRG. Within this context outsourcing is used for:

- X-ray reporting
- Reporting of Nuclear medicine (NM) exams
- Ultra sound (US) reporting only
- MRI
- Tele-radiology services for reporting acute CT after hours
- Tele-radiology services for reporting routine examinations in order to maintain report turnaround times

For modalities that HBDHB does not itself have outsourcing and IDF are relied on:

- Mammography
- Bone densitometry (DEXA)
- Cardiac and breast MRI
- Positron Emission Tomography (PET) scans
- Specialised NM reporting e.g. cardiac studies
- Cone Beam CT
- Some specialised Interventional radiology e.g. cardiology

Of the four private providers in Hawke's Bay TRG are the only ones who offer a wide range of services including MRI, however fluoroscopy is not available after they chose not to replace their unit when it reached end of life. The contract with TRG has contingency provisions for assistance with MRI volumes and a reciprocal agreement for when either party's MRI equipment breaks down.

There is an intention to extend this contract to include Cardiac and Breast MRI imaging when TRG replace their existing 1.5T MRI scanner with a 3T MRI unit, planned for mid-2019. This will be a positive for patients who currently have to travel out of the district for these exams.

16.1

Table 1: Radiology providers in Hawke's Bay and the modalities they offer

Services Provider	X-ray	CT	MRI	US	Fluoroscopy/ Angiography	Nuclear Medicine	Mammography	DEXA
HBDHB	√	√	√	√	√	√	x	x
TRG	√	√	√	√	x	x	√	√
Onsite	x	x	x	√	x	x	x	X
Unity	x	x	x	√	x	x	x	x
Hastings Health Centre	√	x	x	x	x	x	x	x
The Doctors Napier/hasting	√	x	x	x	x	x	x	x

Alignment to existing strategies

This investment proposal aligns to the following national, regional and local strategic activities:

- National workforce planning
- National Radiology Service Improvement Initiative (NRSII)
- 2017/18 Central Regional Services Plan
- HBDHB Clinical Services Plan
- HBDHB Radiology Department, Medical Directorate Service Plan 2018/19
- External review of HBDHB's radiology service

Globally the biggest focus in radiology is filling the shortfall of skilled staff capable of working with the ever increasing advancements in diagnostic technologies.

Nationally it is recognised that DHBs are finding it difficult to fill vacancies due to the globally competitive market for skilled roles. As such the two most recent national strategies supported by the MoH have focussed on work force development. These are:

National workforce planning

A hui was held in early 2017 sponsored by the 20 DHBs Workforce Strategy Group in conjunction with the Medical Imaging Workforce Action Group and the DHB Directors of Allied Health. Also present at the hui were key stakeholders involved in the medical imaging workforce within New Zealand including radiation therapists, medical radiation technologists (MRTs), sonographers, echocardiographers, mammographers, nuclear medicine technologists, and MRI technologists. Following on from this the 2018/19 work plan for the 20 DHBs Workforce Strategy Group includes supporting the Medical Imaging Workforce Action Group create a service approach to workforce development and continued sector engagement.

HBDHB has several vacancies within the department that are proving hard to fill. Should IANZ accreditation be lost filling these vacancies will become much more difficult and may cause the department to loose existing staff. Replacing the MRI and Fluoroscopy units and addressing the CARs will ensure the equipment and diagnostic services are of sufficient quality to recruit and retain this vulnerable workforce.

National Radiology Service Improvement Initiative (NRSII)

To alleviate the pressures DHB's were facing from growing demand for diagnostic services the NRSII focussed on increasing competency nationally through knowledge sharing in order to improve workforce and production planning for Computed Tomography (CT), and Magnetic Resonance Imaging (MRI) services. NRSII was established with funding of \$3.5 million dollars from 2014 – 2016. The initiative's goal was to support DHBs achieve the MoH's 42 day wait time indicators for CT and MRI routine patients through the principals outlined in the 'Ministry of Health and National Radiology Advisory Group Service Improvement Workbook 2014'. and had six objectives:

- Improved utilisation of resources
- Better alignment between demand and capacity
- Better consistency in the quality of radiology protocols for better patient care
- Responsive delivery to support both acute and elective flows
- Effective and supportive collaborative approach to improvement
- Value for money

The additional capacity that was created at HBDHB's radiology department by this initiative had an immediate effect of reducing CT and MRI wait times. However this was quickly absorbed by increased acute and faster cancer treatment (FCT) demand across primary and secondary care leading again to wait times extending out. Like other DHBs, HBDHB Radiology department has since maximised the additional capacity created through the NRSII initiative.

Central Region Service Plan

The 2017/18 Central Regional Services Plan has two areas of focus for radiology which are largely focused on workforce to assist with alleviating capacity constraints:

- Implementation of the regional Radiology Information System (RIS) to enable radiology imaging to be viewed within the region and encourage the sharing of expertise.
- Workforce recruitment and retention, in particular radiologists, sonographers, MRI and nuclear medicine MITs

Based on full participation by all the DHB's within the region these focus areas are aimed at ensuring the quality of diagnostic imaging services across the region meets the expectations of regional partners and tertiary providers and thereby assist with the recruitment and retention of core radiology staff.

HBDHB's participation in and contribution to these regional focus areas is based on the assumption that with upcoming equipment replacements and addressing the CARs issued by IANZ are proceeding as planned.

HAWKE'S BAY DISTRICT HEALTH BOARD

HBDHB Clinical Services Plan

The draft CSP, due for completion in late 2018, will guide the strategic direction of the organisation for the next 10 years. It establishes a firm commitment to prioritising and designing services to meet the needs of populations with the poorest health and social outcomes.

All indicators from this point toward continued growth in the requirement for medical imaging diagnostics and interventions across the whole of health sector for both acute and elective services in order to support the aims of the CSP. Retaining the current breadth of radiology modalities and having a department flexible enough to manage short and long term changes

in service delivery will form a vital role in enabling the expected benefits of the CSP to be realised. The nine themes of the CSP are:

1. Place-based planning
2. Evolving primary health care
3. Working with whānau to design the services they need
4. Relevant and holistic responses to support mental wellbeing
5. Keeping older people well at home and in their communities
6. Specialist management of long term conditions based in the community
7. Well supported transitions from hospital
8. The hospital takes a narrower focus in the future
9. Surgical services continue to be refined

Although increased capacity will be required for most radiology modalities in coming years to support the CSP's aim of closing equity gaps, this business case is not seeking to create that capacity. Instead the scope of this project has been kept to addressing urgent changes required to meet pressing needs whilst the CSP is finalised so that the long term direction of the department can be planned in alignment with that. The project has however been tasked with considering how these issues can be addressed in a way that can later be built upon in the future when increased capacity is required.

Medical Directorate Service Plan 2018/19

Over and above the known growth in demand across the health sector for radiology diagnostics, the current years' service plan for the directorate includes the following large scale initiatives that will further add to the demand for radiology services to some degree:

- National bowel screening program
- Repatriation of Oncology services from MidCentral
- Establishment of a local cardiac percutaneous coronary intervention (PCI) and pacemaker service

External review of HBDHB's radiology service

In October 2016 a peer review was performed by Canterbury DHB's radiology department. The key finding of the review was that demand is growing based on similar trends seen nationally and that additional resourced capacity was required to service this.

Following on from this review, work done for NRSII and a December 2016 roster review HBDHB approved a business case in January 2017. That business case focussed on increasing funding for additional staff and extending the diagnostic imaging capacity after hours and across the weekend.

Recruitment to fill the radiologist vacancies continues, hampered by the global shortage of skilled staff. Replacing equipment to ensure HB can provide modern imaging and diagnostic services will play an important role in attracting and retaining the radiologist workforce.

HBDHB Radiology Department Service Plan 2018/19

The current service plan for the Radiology department includes several activities aimed at achieving the correct staff resourcing levels required by the service, alongside planned equipment replacements and the approval of this business case. These align to the Medical

Directorates Service Plan for the same year and are based on an external peer review of HBDHB's radiology service completed in 2016.

Despite ongoing initiatives, vacancies for key roles such as radiologists and sonographers are still proving hard to fill. Like other DHB's the thinking locally has therefore now turned to how technological and clinical advancements within each of the modalities can assist with capacity planning to keep pace with growing demand and minimise the impact of prolonged staff vacancies. As part of this project, the selection of the replacement MRI and Fluoroscopy units will carefully consider the specifications of the new units in order to maximise capability and capacity opportunities in production planning across all modalities.

Summary of alignment to existing strategies

Demand for radiology services in Hawke's Bay is growing as the health system as a whole becomes more reliant on diagnostics based on the expectation by clinicians that they can rely on radiological investigations to actively exclude possibilities and track treatment progress rather than just confirming diagnosis.

This comes against a backdrop of a global skills shortage for core radiology roles. Additionally radiology is a capital intensive service made up of a wide range of imaging equipment each with a limited useful life based on maintenance and technology capability.

Nationally and regionally there is a focus on how to support radiology services and make them more resilient in the face of growing demand for imaging and interventional procedures and global skills shortages.

In order to support local strategies such as the CSP first and foremost HBDHB needs a fully functioning radiology department to support acute and elective services as a platform that can be built upon in the future to meet the future diagnostic needs of clinicians and patients.

As a 2017 radiology business case focused on workforce capacity, the focus of this business case is urgently replacing critical equipment that has reached end of life and addressing corrective actions requests relating to patient safety, environment and equipment issued against the radiology department by IANZ. This will enable the radiology department to continue to support acute and elective services at Hawke's Bay Hospital in the medium term (2-3 years from completion of project) and support future development of the department in alignment with the CSP.

16.1

Investment Objectives, Existing Arrangements and Business Needs

1.1.1 Investment Objectives

The following key investment objectives have been identified:

- **Investment objective one:** Mitigate significant risk of end of life equipment failure in order to retain service continuity of high quality diagnostics and interventional procedures that meet the needs of clinicians and patients for effective diagnosis and treatment
- **Investment objective two:** Avoid reputational damage and retain community, clinician and industry regulators confidence in HBDHB's radiology department by maintaining IANZ accreditation. Meet legal, statutory and industry requirements for radiology

services relating to, professional practicing certificates as well as college, board and council standards and the Health & Disability Commission's (HDC) consumer rights

- **Investment objective three:** Operate a service that meets existing demand and creates a platform on which future demand may be built up in the most cost effective way

Existing Arrangements and Business Needs

Investment objective one: **Mitigate significant risk of end of life equipment failure in order to retain service continuity of high quality diagnostics and interventional procedures that meet the needs of clinicians and patients for effective diagnosis and treatment**

CURRENT STATE

Radiology equipment lifecycle

Radiology equipment has a definite lifespan. As equipment ages, there is a gradual deterioration in image quality coupled with increases in maintenance down time. This results in patients' care being impacted because delays in diagnosis and treatment. Likewise to close equity gaps every aspect of a patient's journey through the health system has to work, therefore when diagnostics or interventional procedures are delayed due to equipment downtime or ineffective image quality the patient's quality of care is eroded. For some patients these delays could have substantial impacts on their care, treatment and health outcomes.

Equipment rating system

New Zealand does not have its own rating system for radiology equipment instead the Canadian Association of Radiologists rating system is relied upon by IANZ as the preferred model because Canada most closely aligns to the New Zealand health system. The Canadian rating system endorses general rules regarding the life cycle of equipment based on the equipment's age and utilisation rates per year as shown in the table below.

Table 2: Canadian Radiology Association rating system of equipment's useful life

Equipment	Equipment age based on utilisation Low – Medium – High	Utilisation in 8 hr. shifts/year Low – Medium – High	HBDHB equipment age
Fluoroscopy	12-10-8	250 - 500 - 750	14 years old Low Utilisation
MRI scanner	12-10-8	250 - 500 - 750	16 years old Medium utilisation

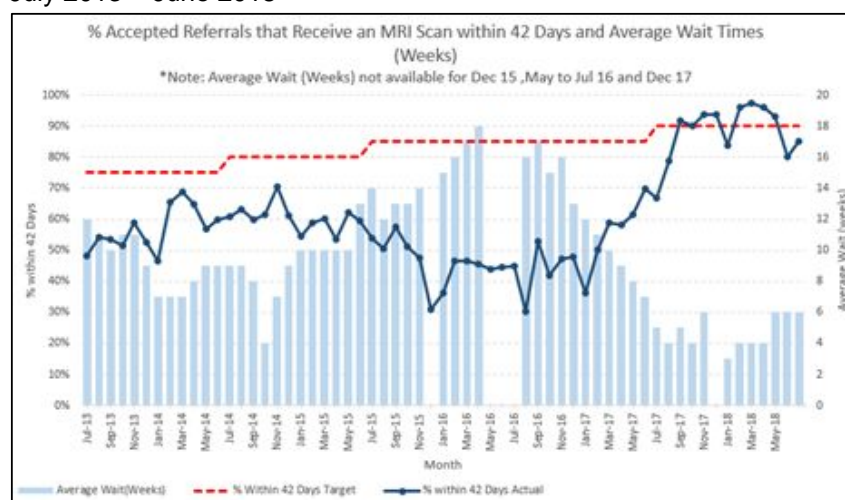
Alternately the European Society of Radiology (ESR) promotes the use of up-to-date equipment especially in the context of their Euro Safe Imaging Campaign focused on both equipment safety and quality diagnostic imaging. ESR rates equipment as:

Table 3: The European rating system of Radiology equipment's useful life

Equipment age	ERS rating
0 – 5 years	state of the art equipment
6-10 years	Properly maintained equipment still suitable for use, however a replacement strategy needs to be developed.
10 years +	High risk of failure and breakdown, replacement is essential especially if no spare parts are available.

HBDHB MRI equipment

HBDHB owns one 16 year old MRI scanner located at Hawke's Bay hospital to support essential acute and specialist services as well as inpatient, outpatient and community demand. The unit is at the end of its extended life following a 2010 investment in hardware and software upgrades which brought the equipment up to date, extended its lifespan and allowed for additional scanning options. There have been no significant upgrades since and there is now a notable disparity in image quality compared to newer units within New Zealand. In 2017 resourced capacity was expanded to provide MRI services seven days per week. By doing this the average wait time for a routine scan reduced from 18 weeks (126 days) in April 2016 to 4 weeks (28 days) in March 2018, well below the MoH wait time indicator for MRI. The MoH wait time has consistently been achieved since September 2017, excluding January 2018. However with demand for MRI increasing by 17.6% in 2017/18 the waiting time has again increased, currently the wait time is sitting at six weeks (42 days) and will likely increase well beyond this in the very near future if growth continues to grow at an exponential rate.

16.1**Graph 2:** performance against the 42 day wait time target and average wait time for MRI scans, July 2013 – June 2018**HBDHB Fluoroscopy equipment**

Fluoroscopy is a core technology of radiology for all DHBs that provide secondary level care. It is the only radiology modality capable of imaging body systems in real time. This gives the advantage of immediate visualisation of structures and their physiology, providing faster diagnosis at the time of care. The current Fluoroscopy machine is at end of life being 14 years old. It is used across the whole population from new born babies through to the elderly. 50% of all examinations are performed on the over 65 year age group and 22% of patients are Māori and Pacific Islander. In financial year 2016/17 year 724 examinations were performed in general fluoroscopy with 390 of these in-patients. For this acute work fluoroscopy provides a fast and immediate evaluation of post-operative abdominal conditions, interventional

placement of long term IV access, and insertion of drains and catheters. It is also used in the investigation of swallowing and gastrological problems, including cancer diagnosis and follow up to surgical procedures. It plays an important role evaluating feeding and nutrition in patients post stroke and head injury, and also in diagnosing children with feeding, intestinal, and urological disorders.

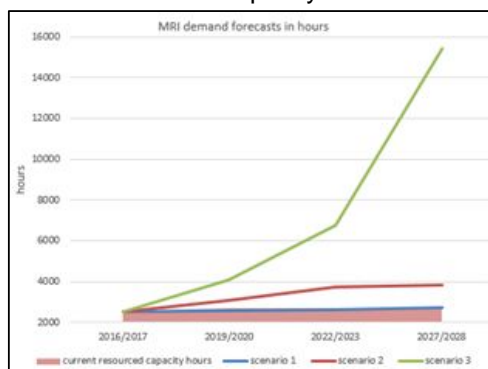
Fluoroscopy is intentionally located at the hospital in order to support essential acute and specialist services as well as inpatient, outpatient and community demand. If the general fluoroscopy service was unavailable on site, there is no private provider locally. The closest outsourcing option would be IDF to Mid Central DHB. There would be a cost associated with the outsourcing and would include procedural cost and patient transportation costs

Demand for MRI

In financial year 2017/18 3,900 scans were performed, an increase of 17.6% on 2016/17. Looking back five years to 2012/13 there has been a 37% increase in scans performed on the same equipment. This growth in demand is due to many factors including:

- Changing clinical practice such as medical pathways for diagnosis and treatment whereby modern practice relies more heavily on medical imaging
- Tertiary provider services: relocation of patient scans closer-to-home as imaging demands increase e.g. Starship Hospital liver specialists require imaging to be done locally before referral. Repatriation of MRI scans for patients with specified metal and cardiac implants
- Elective surgery targets and demand: increase in surgery volume increases demand for knee, spine, shoulder, hip MRI imaging pre surgery
- Population growth and demographics
- Prostate cancer surveillance: MRI is now accepted as the most accurate diagnostic test for prostate disease progress
- Paediatric imaging where MRI preferred over CT and plain film as has no radiation risk for paediatric patients
- Pharmaceutical Management Agency (PHARMAC) funding of multiple sclerosis, brain cancer, neuroendocrine tumour and melanoma drugs that rely on MRI for measuring disease progress e.g. Keytruda for melanoma and potentially in the near future for lung cancer also
- Colorectal cancer screening programme: an increase in cancers detected will increase demand for MRI imaging for rectal cancer staging and liver staging for secondary colorectal cancer and progression of disease

Graph 3: MRI forecasted hours for the next 10 years based on the three scenarios against current resourced capacity



Demand for Fluoroscopy

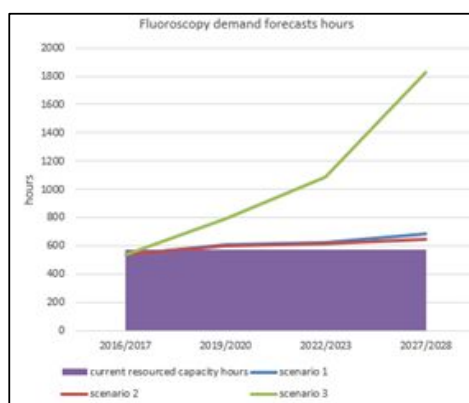
Demand has grown at an average of 2.1% per year over the last 5 years. In financial year 2017/18, 791 examinations were performed an increase of 5.7% (67 exams) compared to the previous year suggesting factors influencing demand are accumulating.

These include:

- Population growth and demographic shift to an aging population, as stroke patients often require fluoroscopy to assist with issues with swallowing.
- Increasing demand for inpatient PICC line service to provide long term IV access. Currently there is limited capacity for this to be done in the Fluoroscopy and Angiography rooms rather than in an operating theatre.
- There is no fluoroscopy unit installed in the Endoscopy unit for Endoscopic Retrograde Cholangio Pancreatography (ERCP) procedures and expected demand has been incorporated into this fluoroscopy replacement business case.
- An increase in demand for fluoroscopic procedures for gastroscopy services with the implementation of the new endoscopy unit, such as stent insertions and ERCPs.
- An increase in the demand for renal services and dialysis is contributing toward increased demand for procedures in Radiology such as tunnel line insertion, and fistula interventions for renal patients. This work is currently performed in the Angiography suite that has multiple services utilising this capacity, but some of these procedures could be performed in an appropriately specified general fluoroscopy room.
- Increase in demand for video fluoroscopy swallow studies for inpatients and community referrals. For people recovering from stroke to ensure they can safely swallow food and fluids without causing aspiration pneumonia requiring readmission and treatment. This service requires fluoroscopy equipment with the appropriate specifications to perform these studies
- Increase in demand for surgical inpatients having post-operative bowel imaging performed for bowel leaks and stomas that can be visualised in real time. Introduction of bowel screening will impact demand with more cancer diagnoses leading to more imaging demand.
- An increase in demand for fluoroscopic rectal studies such as defecating proctograms for colorectal cancer and surgery follow up
- Joint imaging (arthrograms) and steroid injection under fluoroscopy guidance which is expected to increase with the aging population.

16.1

Graph 4: Fluoroscopy forecasted hours for the next 10 years based on the three scenarios against current resourced capacity



BUSINESS NEED

Current resourced capacity in HBDHB's radiology department is fully utilised which is causing wait times to increase. Nationally radiology services expect to see a continuation of a steep rise in demand based on the dependence on diagnostic services superimposed on the background of upward trends relating to complexity of patients. The 5 and 10 year forecasts show that demand will continue to grow well beyond current resourced capacity based on the *most likely* scenario modelling.

Increasingly there is a cohort of patient who are unable to access MRI services in Hawke's Bay due to body size and are sent out of the district to a wide bore scanner. The 2014 Health Inequity in Hawke's Bay key findings notes:

- One in three adults in Hawke's Bay are obese
- One in two Māori adults
- Two in three Pacifica adults are obese.

This is a significant issue for access to MRI well as a contributing factor to health inequity. The service requirements for the replacement MRI are for a wide bore unit that is more suited to the increased average patient size and body habitus.

Investment objective two: Avoid reputational damage and retain community, clinician and industry regulators confidence in HBDHB's radiology department by maintaining IANZ accreditation. Meet legal, statutory and industry requirements for radiology services relating to, professional practicing certificates as well as college, board and council standards and the Health & Disability Commission's (HDC) consumer rights.

CURRENT STATE

Accreditation, legal and statutory requirements guide many radiology practices these include legislation governing radiation safety, national radiation guidelines, best practise guidelines, multi-employer collective agreements (MECA's) and International Accreditation New Zealand (IANZ) which includes professional competency, facility standards and the patients code of rights.

IANZ accreditation

IANZ accreditation clearly defines the standard that radiology departments should follow for equipment, accommodation and personnel to ensure diagnostics are of an appropriate standard and that patient and staff safety is protected. Having accreditation gives assurance to industry regulators and external parties such as MoH and ACC that radiology exams and procedures are performed in a professional and technically reliable way in accordance with international standards.

IANZ regularly report to the MoH on accreditation audit findings and common issues DHB's are facing with regards to meeting the New Zealand code of radiology management practice (NZCRMP) requirements for accommodation, equipment and personnel. Having accreditation means:

- Formal recognition
- Standardisation of best practice
- Governed by international trends
- Safe practice

- Equality, fairness and safety for staff working environments
- Competitive security
- External validation of quality standards
- Enhances credibility
- Reassurance for clinicians and patients

HBDHB's accreditation status

In October 2016 EMT endorsed HBDHB's strategic intention to retain IANZ accreditation for the radiology department.

- It is a requirement of the ACC high tech imaging contract worth \$570 thousand in annual revenue, note this work is done regardless of whether revenue is received.
- A requirement of National Bowel Screening program (BSP) for providing CT virtual colonoscopy (CTVC) imaging
- Losing accreditation would cause reputational damage to the DHB
- Is essential for the Radiology department to recruit and maintain staff in an already constrained and competitive global employment market, evidenced by current vacancies within the department
- The Hawke's Bay community have the assurance that radiology services are of an appropriate standard as is their consumer right under the Health and Disability Services Commission code of rights (right four)

16.1

Corrective Action Requests (CARs) issued against HBDHB Radiology

During a 2012 accreditation visit IANZ first identified several issues including the floor plan layout of the radiology department relating to patient safety, environment and equipment replacement for which strong recommendations to rectify were issued. Following no action they progressed to corrective action requests (CARs) following the 2017 accreditation visit (appendix 1). Three of the CARs issued were of such a serious nature that IANZ requested bi-monthly updates on progress towards rectifying them. These were for:

1. Personnel (subject of separate business case)
2. Accommodation & environment (Hawke's Bay hospital)
3. Equipment replacement (Hawke's Bay Hospital)

CAR (2) - Accommodation & environment Hawke's Bay hospital

Patient safety issues identified by IANZ include:

- Nuclear Medicine patients sharing waiting space with ultrasound patients which may present a radiation contamination risk to pregnant patients and infants.
- Only one 'hot' toilet available to Nuclear Medicine patients adjacent to ultrasound patient waiting areas which could present a potential patient radiation contamination risk and compromise patient safety.
- Area used for performing biopsies too small for more than one assisting staff member if a patient event were to occur.

Patient privacy issues identified by IANZ include:

- Lack of patient privacy at radiology reception
- Patient change cubicles visible off main radiology thoroughfare
- CT and MRI waiting area behind temporary screen in main corridor
- Patients in beds parked in the main corridor sometimes 2-3 abreast whilst awaiting tests/ procedures

- Area used for performing biopsies behind a curtain off a public corridor
- Patient consent for procedures performed in public corridor outside examination room

CAR (3) - Equipment replacement Hawke's Bay Hospital

Equipment issues identified by IANZ include:

- Fluoroscopy, Angiography, general x-ray units and MRI scanner all past expected life with evidence of multiple failures and resultant downtime within the previous year with no tangible evidence that replacing this equipment was being prioritised.

Current status of CARs

During the 2018 IANZ surveillance visit the same CARs (2 and 3) were recorded with a note that this business case was being developed and the requirement of bimonthly reporting on progress extended to quarterly updates. If however HBDHB does not make progress or decides not to resolve the CARs, then the next progression by IANZ is withdrawal of accreditation.

Consumer code of rights

Right one and two of the Health and Disability Commission's consumer's code of rights relates to respectful treatment, dignity and respect are not currently being met as evidenced by the patient privacy issues identified by IANZ. Right four states that patients have a right to services of an appropriate standard, the age of the fluoroscopy and MRI equipment resulting in diminishing imaging quality and increased maintenance down time is eroding HBDHB's ability to comply with this right. As is the increased clinical risks and social costs associated with outsourcing used as a reactive response to equipment outages.

Seismic strengthening works

The buildings the radiology department is housed in are rated as an Importance Level 4 building (IL4) under the New Zealand building design standard NZS1170.0 *"Buildings that are essential to post-disaster recovery or associated with hazardous facilities"*. IL4 buildings need to be able to withstand a 1 in 2,500 year seismic event. Radiology sits within the two story clinical services building (south block) and a single story building (north block) with two extensions one for radiology and the other for the laboratory.

- radiology building: built in 1980
- radiology extension: built in 1997
- laboratory extension: built in 1997

Following the establishment of this project a detailed seismic assessment (DSA) was commissioned which found there was significant structural strengthening work required to bring the radiology building up to code. The outcome of the detailed report has been notified to Hastings Council as per legislative requirements, HBDHB now has 7.5 years from notification in which to complete these works, regardless of whether this project proceeds.

The south block was rated at 65% New Building Standard (NBS) of IL4 and is therefore classified as low risk under the New Zealand Earthquake Engineering (NZEE) classification scheme. However as the second story has only one means of escape via a single stairway, the DSA recommends improving the structural connections to maintain structural integrity and accommodate inter-story drift (swaying).

The north block assessed seismic rating is:

- radiology building: 35%NBS (IL4)
- radiology extension: 20%NBS (IL4)
- laboratory extension: 70%NBS (IL4)

Additionally north block was identified as having critical structural weaknesses (CSWs) which include the potential premature failure of:

- the roof trusses at the 1997 radiology extension
- concrete columns of the 1980 radiology building

Based on the above the north block has been categorised as an Earthquake Risk Building, it also meets the criteria that could categorise it as an Earthquake Prone Building which would require it to be strengthened above 34%NBS (IL4) before the year 2025.

BUSINESS NEED

Retaining IANZ accreditation for the radiology department is a requirement for both the ACC High Tec Imaging contract (\$570 thousand in annual revenue) and the National Bowel Screening program. In order to retain it, actions need to be taken to rectify safety and privacy issues with the floor plan layout of the radiology department at Hawke's Bay hospital and replace end of life equipment.

The radiology department's capital equipment replacement program is phased over multiple years however previous delays in this program has led to increasing and lengthy maintenance down time of equipment that should have been replaced. As radiology diagnostics are heavily relied upon by all facets of the health care sector for both acute and elective services the ramifications of not replacing aged equipment, addressing compliance issues and loosing accreditation will widely impact on both service delivery and income.

Outside of this project is the ongoing business as usual capital replacement program that is an essential part of the running of the department to ensure equipment is replaced as it reaches end of life.

Investment objective three: Operate a service that meets existing demand and creates a platform on which future capacity may be built up in the most cost effective way

CURRENT STATE

Achievement of MoH targets

Radiology has MoH wait time targets for MRI and CT directly contribute to the achievement of MoH targets for Emergency Department six hour wait time (ED6) and indirectly contributes to Length of Stay (LoS), Faster Cancer Treatment (FCT) and the Elective Services Patient Flow Indicators (ESPI) such as ESPI 2 and ESPI 5. Due to the age of the MRI and Fluoroscopy equipment maintenance down time is becoming regular and for longer periods as parts become harder to source. As a result outsourcing of scans is being considered for in the future as a mechanism to meet MoH wait time indicators and minimise clinical risk from delays in diagnosis and treatment. However due to the excessive costs associated with outsourcing and patient transport it is not a financially sustainable model to pursue in the long run except where specific skills gap/shortfall requires it. As well as the high social costs for the patient and their whānau associated with travel and delays in care.

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Vendor support for maintenance and repair is only guaranteed until 2019/20 for the current MRI and Fluoroscopy units, after this time maintenance and repair will be on a best endeavours basis only. In addition to this the quality of the images these units are producing is progressively diminishing requiring additional imaging examinations which again cause unnecessary delays for patients.

The general fluoroscopy unit at Hawke's Bay hospital is the only machine of this type in Hawke's Bay making out sourcing difficult. If the unit is not replaced patients would have to travel out of the region which is both costly and comes with limitations such as:

- Increased clinical risk relating to transporting critically ill in-patients having to travel four hours for a 20 minute test/ procedure.
- Increased clinical risk when imaging identifies the need for immediate (acute) surgery.
- Risk to patients from delayed diagnosis and treatment due to increased waiting from having to travel out of region travel for tests/ procedures.
- High social costs for the patient and their whānau associated with travel and delays in care.
- Impact on community patients having to travel for 4 hours for a 20 minute procedure (especially for the elderly and children).
- Nutritionally compromised patients waiting longer for fluoroscopic imaging e.g. stroke and head injury patients, leading to longer stays in hospital.
- Limitations in capacity of the identified out source provider.

BUSINESS NEED

The ACC high tech imaging contract states the supplier will hold IANZ accreditation for each modality and site where high tech imaging is provided. If the radiology department lost accreditation and was therefore unable to meet contractual obligations this could result in a loss of \$570,000 income per year whilst still undertaking the same work. Additionally Radiology itself is a technology based service completely reliant on equipment which ages therefore the department is dependent on ongoing capital investment to replace end of life equipment and keep abreast of new services and clinical best practice.

Reliance on outsourcing is difficult due to its high cost, the clinical risks associated with the transportation of acute in-patients and the associated high social costs which reduces access to care and diminishes the health equity of the Hawkes Bay community. Therefore HBDHB's radiology department needs to be fully functional with sufficient capabilities to support clinical needs and improve equity outcomes.

Table 4: Summary of the existing arrangements and business needs

Investment Objective One	Mitigate significant risk of end of life equipment failure in order to retain service continuity of high quality diagnostics and interventional procedures that meet the needs of clinicians and patients for effective diagnosis and treatment
Existing Arrangements	The MRI and Fluoroscopy units are past their useful life which has led to a decline in image quality and a steady increase in maintenance down time. As radiology diagnostics are heavily relied upon by all facets of the health care sector the ramifications of equipment down time is widely felt.
Business Needs	Acute services are heavily reliant upon immediate access to diagnostic imaging as is the wider health sector who are driving demand at a rapid rate.
Investment Objective Two	Avoid reputational damage and retain community, clinician and industry regulators confidence in HBDHB's radiology department by maintaining IANZ accreditation. Meet legal and industry requirements for radiology services relating to, professional practicing certificates as well as college, board and council standards and the Health & Disability Commission's (HDC) consumer rights.

Existing Arrangements	IANZ accreditation is in jeopardy, CARs have been issued for patient safety and privacy relating to the built environment of the radiology department. If HBDHB does not resolve these the next step by IANZ is withdrawal of accreditation.
Business Needs	IANZ accreditation is required contractually for ACC high tech contract (\$570k annual revenue), national bowel screening program and a must in order to retain and attract skilled staff who are in short supply.
Investment Objective Three	Operate a service that meets existing demand and creates a platform on which future capacity may be built up in the most cost effective way
Existing Arrangements	The allocation of volumes via in-house, IDF or outsourcing is based on the most cost effective and timely options, except where specific skills gap/shortfall requires outsourcing.
Business Needs	Continue to allocate volumes based on the most cost effective and timely options in order to meet clinical need and MoH targets through keeping wait times at a minimum.

Potential Business Scope and Key Service Requirements

The potential business scope and key service requirements were identified and assessed by stakeholders. As urgent staff resourcing needs were covered off in an earlier business case this project is focussed on the equipment and floor plan layout requirements of the department.

16.1

Table 5: Potential business scope and key service requirements

Service Requirements (in decreasing order of relevance compared to the investment objectives)	Scope Assessment			
	Minimum Scope	Intermediate Scope	Maximum Scope	Out of Scope
Equipment specifications	Replacement of existing Fluoroscopy and MRI units <ul style="list-style-type: none"> 1.5T wide bore MRI scanner Medium spec fluoroscopy 	Replacement of existing Fluoroscopy and MRI equipment, and plan for replacement of other existing equipment <ul style="list-style-type: none"> 1.5T wide bore MRI scanner Medium spec fluoroscopy General x-ray room Angiography suite Procedure room with US facilities 	Replacement of existing Fluoroscopy and MRI equipment, and plan for replacement of other existing equipment Create footprint for expanding services <ul style="list-style-type: none"> 1.5T wide bore MRI scanner Medium spec fluoroscopy General x-ray room x 3 Angiography suite Cone beam CT Procedure room with US facilities PCI 	Additional equipment or services to address long term capacity needs e.g. additional MRI, Ultra sound, X-ray and CT units. Install new PCI <ul style="list-style-type: none"> Additional CT scanner 2nd MRI (3T) Additional US facilities Additional Plain Film X-ray facilities Additional mobile x-ray and image intensifiers Mammography DEXA scanning PETCT
Facilities specifications	Compliance with statutory and IANZ	Compliance with statutory and IANZ	Compliance with statutory and IANZ	CARs relating to staffing

	accreditation requirements Address CARs - Footprint changes and replace Equipment Replace equipment and do associated footprint changes to meet current demand and plan to increase capacity	accreditation requirements Address CARs - Footprint changes and replace Equipment Replace equipment and do associated footprint changes to meet current demand with flexibility to increase capacity	accreditation requirements Address Car's - Footprint changes and replace Equipment Replace equipment and do associated footprint changes to meet current demand and create space to increase capacity Location of secondary equipment married to demand	full relocation service review of radiology department
Capacity specifications	minimal disruption to existing services during replacement Approximately 12-16 weeks Retain current service levels for all modalities post replacement Increase in capacity possible with extended working for each area	Maintain current services during build and replacement Retain current service levels for all modalities post build and replacement. Increase in capacity possible with extended working for each area	Maintain current services during build and replacement Retain current service levels for all modalities post build and replacement. Flexibility to increase capacity by extending the working day and/or adding or changing equipment with increased footprint	Maintain current services during build and replacement Flexibility to increase capacity by extending the working day and/or adding or changing equipment with increased footprint All services provided at DHB by Repatriation of outsourced work and IDF. Flexibility to add new modalities

Main Benefits

Stakeholders identified the following benefits:

Table 6: Analysis of potential benefits that can be expressed in monetary terms

Main Benefits	Who directly benefits?	Who indirectly benefits?	Description
Maintain service Radiology is performed in a professional and technically reliable way in accordance with accreditation standards	Wider health sector, patients, HBDHB,	MoH	Radiology diagnostics keeps abreast with the growing reliance on its services by the health system as a whole. Measure: accreditation reports
Timely service Acute demand and MoH targets are met	MoH, HBDHB, patients	Wider health sector	Enabling shorter, safer, patient journeys Measure: utilisation rates, wait times

Financially viable service Radiology department is financially sustainable	HBDHB and patients	MoH, Wider health sector	Outcomes of this project enable the service to continue within financially viable parameters Measure: Quarterly and year end results
Reliable service Equipment fit for purpose and located in the most appropriate setting	HBDHB, patients and wider health sector	MoH	High quality diagnostic imaging, procedures and interventions that aid in the diagnosis and treatment of health conditions. i.e. equipment meets clinical and ergonomic needs of patients/ compatible with emerging technologies/ safe for patients and staff e.g. fluoroscopy equipment low radiation dose Measure: equipment down time. Imaging error rates

Table 7: Analysis of potential benefits that cannot be expressed in monetary terms

Main Benefits	Who Benefits?	Direct or Indirect?	Quantitative or Qualitative?	Description and Possible Measures
Equitable Service Social costs associated with delayed care and travelling for tests reduced	HBDHB, the Hawke's Bay community and health sector	Direct	Qualitative	Wait times and Out sourcing rates
Enhanced working environment for staff	Radiology professionals	Direct	Qualitative	Accreditation reports

16.1

Main Risks

Risks result from uncertain events that either improve or undermine the achievement of benefits. The main risks that might create, enhance, prevent, degrade, accelerate or delay the achievement of the investment objectives are identified and analysed below.

Table 8: Initial risk analysis

Main Risks	Consequence (H/M/L)	Likelihood (H/M/L)	Comments and Risk Management Strategies
If the project's scope is kept to an absolute minimum and the longer term picture is not understood then this could cause problems in the near future when the capacity this project creates is maximised which could require a large amount of additional work in order to expand capacity.	H	H	In parallel to proceeding with the execution of this project an external service review will be undertaken as a part of this project to understand what modalities, technologies and service locations the Radiology department will focus on in the future.
1. If this project is delayed this would impact on the urgent replacement of end of life equipment. This could cause imaging quality to reduce to levels that introduces clinical risks associated with delays in diagnosis, increased wait times and high outsourcing costs	H	H	Peer reviews of images would need to increase in step with the decrease in image quality. Where quality is excessive outsourcing would need to be put in place.
2. Replacing equipment is delayed and maintenance down time increases or equipment fatally breaks down causing clinical risks from delays in diagnosis, increased wait times and high outsourcing costs	H	H	Out sourcing contract with TRG has a contingency clause in it which enables some volumes to be directed to them when equipment is down. However as they no longer have a fluoroscopy unit acute volumes would have to be managed via IDF and non-urgent would need to be postponed.
3. Interruptions to business as usual (BAU) due to difficulties in the build-ability of floor plan layout changes and replacing equipment resulting in current	H	H	Building works will be phased in such a way as to minimise the impact on BAU. Any extension in the building program to allow for BAU would need to

volume through put dropping off and wait times increasing			be measured against the risk of delaying equipment replacement. Where the impact on BAU is excessive outsourcing would need to be put in place.
4. If the project is not sufficiently resourced throughout then this could cause crucial delays in the progress of this project. Any delays further add risk to the end of life equipment fatally breaking down before this project replaces them	H	L	Ensure approved project resource budget for the execution of the project includes all costs associated with fully resourcing the project through to completion. Ensure all project team members are across all of the aspects of the project so that if we were to lose a team member for any period of time the rest of the team can cover and knowledge loss is minimised

A risk register has been developed and will be progressively updated as more detailed analysis is undertaken throughout the project.

Optimism bias

Based on the nature of the investment proposal, the expected net benefits should be reduced by 20% to reflect the effects of optimism bias. This loading will be progressively reduced as the accuracy of the estimates for proposal costs and benefits improves.

Key Constraints and Dependencies

The proposal is subject to the following constraints and dependencies, these will be carefully monitored during the project to ensure any risks are flagged early and acted upon before they become issues.

Table 9: Key constraints and dependencies

Constraints	Notes
Existing floor plan limitations	Radiology is land locked on all sides by critical care units such as emergency department (ED), Special Care Baby unit (SCBU), Intensive Care Unit/ High Dependency Unit (ICU/ HDU), hospital street corridor, Records Management and Physiotherapy. There is limited ability to utilise the space above radiology due to the seismic assessment of the strength of the building.
Capital investment	HBDHB's current financial position has meant that available capital is tight
Dependencies	Notes and Management Strategies
Bowel Screening Program (BSP)	IANZ accreditation is a requirement of the BSP
MoH targets	ED6, FCT, ESPI's
Hospital acute services	Requires immediate access to on site diagnostic imaging in order to support essential life preserving services

Summary

Critical MRI and Fluoroscopy equipment is past end of life and needs replacing urgently for the radiology department to maintain the ability to provide fast and accurate diagnosis heavily relied upon from primary through to tertiary care for both elective and acute services. This is a

capital intensive medical speciality that sits at the heart of medicine. As ongoing technology advancements offer new and previously non-existent options for diagnostics and treatment guidance resulting in improved health outcomes and quality of life for patients the health sector becomes more and more reliant. This has been evidenced by rapid growth in volumes over the last few financial years with modelling suggesting this growth is likely to continue for some time yet. In order to continue to deliver timely, safe and expert radiology services to the community of Hawke's Bay and achieve the equity aims of the CSP, large ongoing investment is required in the service. Additionally HBDHB's status as an accredited radiology provider by IANZ is in jeopardy due to outstanding CARs and a detailed seismic assessment of the radiology department has revealed significant structural work is required to seismically strengthen the structures.

16.1

2 The Economic Case – Exploring the Preferred Way Forward

Critical Success Factors

The following critical success factors were identified by stakeholders.

Table 10: Critical Success Factors

Generic Critical Success Factors	Broad Description	Proposal-Specific Critical Success Factors
Strategic fit and business needs	How well the option meets the agreed investment objectives, related business needs and service requirements, and integrates with other strategies, programmes and projects.	Replace equipment on hospital campus to maintain essential acute services. Clinicians and patients in primary and secondary care are supported by the radiology department for diagnostics to deliver high quality health care in a way that helps close the equity gap. IANZ accreditation retained.
Potential value for money	How well the option optimises value for money (i.e., the optimal mix of potential benefits, costs and risks).	Achieves lowest cost option for an optimal mix that delivers capacity that meets demand “most likely scenario” Achieve minimal out sourcing during build. Minimises re-work spend for future capital investment to increase capacity
Supplier capacity and capability	How well the option matches the ability of potential suppliers to deliver the required services, and is likely to result in a sustainable arrangement that optimises value for money.	MRI & Fluoroscopy units replaced with new units that meet clinical specifications and have capacity to be upgraded for future service needs. MRI & Fluoroscopy units replaced with models that best fit the clinical and ergonomic needs of the community. Layout design meets needs of the services/patients/whānau. Construction enables BAU to continue through out
Potential affordability	How well the option can be met from likely available funding, and matches other funding constraints.	Minimise regretful spend by relocating the MRI to a location that can accommodate future changes.
Potential achievability	How well the option is likely to be delivered given the organisations ability to respond to the changes required, and matches the level of available skills required for successful delivery.	Project completed before equipment fatally breaks down Project approved before IANZ accreditation withdrawn.

Long-List Options and Initial Options Assessment

A wide range of options was generated by stakeholders over a period of two months in early 2018. Separate to working through the options for addressing the floor plan, the options relating to the replacement of the MRI and Fluoroscopy units was also reviewed.

2.1.1 Options identification

Equipment Options

Table 11: Options analysis for the new MRI unit

MRI capabilities	1.5T Upgrade existing magnet	1.5T Wide bore	3.0T
Safety			
Immediate fringe field strength risk as current	√	√	
5 Gauss line as current	√	√	
Ability to scan all implants as current	√	√	
Gradient noise levels lower		√	
Heating potential within current safety levels	√	√	
Decreased risk of skin irritation/burn from coils and cables	√	√	
Technical			
Signal to noise ratio improved – image quality			√
Spatial and temporal resolution improved			√
Acceptable artefact/noise from implants	√	√	
Able to use full variety of coils for imaging	√	√	
Scanner			
Magnet weight same as current (current floor specs OK)	√	√	
Increased Bore diameter >60cm from current		√	
Increased bariatric capability (>150kg)		√	
Clinical			
Patient tolerance (less risk of claustrophobia/sedation)		√	
Improved patient throughput/efficiency		√	
Improved imaging for general abdominal work		√	
Improved imaging for small parts e.g. Fingers, toes, prostate			√
Improved imaging for spinal neurology work		√	
Improved imaging for Brain neurology work		√	√
Improved imaging for breast work		√	√
Improved imaging for paediatric work			√
Improved imaging for cardiac work			√
Improved imaging for MSK work below knee/elbow			√
Improved imaging for MSK above knee/elbow		√	
Improved imaging for implants		√	
Economy			
Cheapest option – dollar value	√		
Value for money (versatility and utilisation)		√	
RECOMMENDED OPTION		√	

Table 12: Options analysis for the new Fluoroscopy unit

Fluoroscopy options High spec unit vs medium spec unit	High spec Fluoroscopy	Medium spec Fluoroscopy
Safety		
Decrease radiation dose to patients –intelligent dose optimization	√	√
Decrease scatter dose to staff	√	√
Unit/Table capability		
Able to stand upright (90° to floor)	√	√
C-arm with rotational movement (all angles)	√	
Bariatric table capability (>150kg)	√	√
Highest generator output for bariatric patients	√	
Footprint same or less than current unit	√	√
Clinical		
Highest resolution detector	√	√
Digital radiography capable	√	√
Upper and lower GI work capable	√	√
SLT video capable	√	√
High frame rate Vascular capable	√	partial
High quality interventional work capable -high frame rate	√	partial
Able to perform current Angiography suite work	√	partial
Capable of proctogram examinations	√	√
Height adjustable table	√	√
Patient access from back of table	√	√
Multiple tube angles for biopsy/injection	√	
3D imaging capable (purchasable upgrade)	√	√
Economy		
Cheapest option ----dollars		√
Value for money (versatility)		√
Value for money – utilisation		√
RECOMMENDED OPTION		√

Equipment capacity requirements

In order to maintain timely, high quality services that meets this anticipated growth radiology should be able to increase capacity of the units by extending working hours with additional resources until such time as demand requires additional devices. As TRG intend to install a 3T MRI scanner, the population of Hawke's Bay will have access to both 1.5T and 3T imaging as HBDHB intends to enter into an extension of the current MRI contingency contract with that Provider. This will ensure we can provide 3T scanning for those patients that require it and also backup support for 1.5T when needed. Once maximum capacity is reached with both these options a review will be undertaken to assess viability for additional devices with the potential of them being located at others sites across the DHB.

Build options

The radiology department is currently surrounded by the Perioperative Unit, Special Care Baby Unit (SCBU), Intensive Care, Physiotherapy/Support Services and the Emergency Department (ED). The Perioperative Unit and SCBU, Intensive Care are relatively landlocked, however there is some limited capacity for expansion towards Canning Road/ED. There is also potential scope for reviewing the location of non-acute services such as Physiotherapy and Support Services. The existing Radiology footprint is 1,285 square metres with an additional 370 square metres required in order to accommodate the existing and new equipment, to address the CARs and allow space for future development such as a dedicated cardiac cath lab. The options for expanding the footprint have been identified as “Push out” or “Build up”.

Push Out Options

Relocate Physiotherapy/Support Services

Initial concept planning investigated the potential for increasing the Radiology footprint by moving the southern corridor to align with the kitchen corridor (Health Village Street). While this would maintain an integrated Radiology department it would not provide sufficient additional space. The extra strip of floor area would also present configuration difficulties without relocating other major items of equipment such as the SPECT/CT hybrid scanner in Nuclear Medicine.

Relocate Emergency Department (ED)

This option has the potential to provide a better overall result in Radiology however it faces the same issues with building new space and refurbishing existing space with the added difficulty of maintaining a functional ED and ambulance bay with access to other acute services during construction. The space available for extension is limited by Canning Rd and access for car parking.

Note: Either of the above two scenarios would require new facilities to be built elsewhere to accommodate the displaced services before changes to the Radiology department could commence, thereby adding additional time and cost to the project. In some instances this could create a chain reaction of ongoing refurbishments and relocations to ensure core services remain within the vicinity.

Relocate ultra sound

In order to provide space for future development, such as a dedicated Cardiac suite, it is proposed to permanently re-house Ultrasound outside of the department in a nearby location. Ideally this would be completed as a pre-work package to create decanting space within radiology to assist with the building program.

Build Up Options

Given the limited options for extending the ground floor, investigations were undertaken to determine the options for building another floor above the Radiology Department.

Large upstairs addition

Advice from the structural engineer confirmed that the existing structure would need to be re-built from the ground floor up in order to provide sufficient support for a second floor level over the whole area. Much of Radiology would need to be vacated for a significant length of time to achieve this, which was not considered to be viable.

Small upstairs addition

However, there is already a second floor over a portion of Radiology (X-ray, Nuclear Med and Reception) in which Laboratory is currently located. The concrete floor slab that supports this structure extends through and provides an external roof over Ultrasound. This slab could be built on as an extension to the laboratory building and provide a significant amount of the additional space required for Radiology. It is proposed to locate non-clinical staff functions to

the second floor which would provide ground floor space for the additional waiting areas, treatment spaces and toilet facilities to resolve the CARs.

Build options assessment

The assessment criteria for the build options are:

1. Build ability and ongoing accessibility to major equipment
2. Timeframe regarding end of life of existing equipment
3. Minimal disruption to radiology departments business as usual
4. Minimal disruption to other departments and acute services
5. Ability to create sufficient additional space for Radiology

Table 13: Options analysis of the build options

Assessment Criteria for build options	Build Options Assessment Scores				
	push out Relocate Physiotherapy/ Support Services	push out Relocate ED	build-up Large upstairs addition	build-up Small upstairs addition	build-up & push out Small upstairs addition & relocate ultra sound
1. Build-ability and ongoing accessibility to major equipment	x	x	x	y	y
2. Timeframe regarding end of life of existing equipment	x	y	x	y	y
3. Minimal disruption to radiology department's business as usual	x	y	x	y	y
4. Minimal disruption to other departments and acute services	x	x	y	y	y
5. Ability to create sufficient additional space for Radiology	x	y	y	x	y
Overall Assessment	Discounted	Discounted	Discounted	Discounted	Carry forward

2.1.2 Long-list options assessment

Under the five dimensions, stakeholders have identified a comprehensive long list of in-scope options as follows.

Table 14: Possible long-list options classified by the five dimensions of choice

Dimension	Description	Options within each Dimension
Scale, scope and location	In relation to the proposal, what levels of coverage are possible?	<ul style="list-style-type: none"> • Replace MRI and Fluoroscopy Equipment. No Footprint changes. IANZ CARS not addressed. • Replacement of existing Fluoroscopy and MRI equipment, and plan for replacement of other existing equipment. Minor footprint changes. Some IANZ CARS addressed • Replacement of existing Fluoroscopy and MRI equipment, and plan for replacement of other existing equipment. Footprint increase for existing and expanding services. All IANZ CARS addressed. • Maximum scope and scale. Location given equal consideration to all other dimensions. New radiology department built with existing equipment plus additional equipment or services to address long term capacity needs e.g. additional MRI, Ultra sound, X-ray and CT units. Install new PCI • Outsource/PPP ALL radiology services to private providers and IDF's. Existing HBDHB services assimilated by out source provider.
Service solution	How can services be provided?	<ul style="list-style-type: none"> • Existing Model - Retain existing mix of in house/outsource capacity based on Modality. Graduate resource capacity to meet demand • In house – extend modalities offered in house and extend associated resourcing. • Outsource/PPP ALL radiology services to private providers and IDF's. Existing HBDHB services assimilated by out source provider
Service delivery	Who can deliver the services?	<ul style="list-style-type: none"> • Retain status quo – In house capacity remains as is, with in house and outsource reporting • Align Capacity with demand - Service provision reviewed. Full review of service, location and resources required. Mix of in-house/outsource capacity to meet demand • Outsource/PPP ALL radiology services to private providers and IDF's. Existing HBDHB services assimilated by out source provider
Implementation	When can services be delivered?	<ul style="list-style-type: none"> • Replace - Equipment taken out and replaced. No or limited service during this time. Will require out-sourcing during build • Replace and move. - Equipment taken out and replaced. Facility changes made and equipment moved. No or limited service during build. Out sourcing will be required. • Phased Replacement – Phased building and equipment replacement. Allows for service continuity • Outsource/PPP ALL radiology services to private providers and IDF's. Complex transition from in house to out sourced model
Funding	How can it be funded?	<ul style="list-style-type: none"> • Existing HBDHB capital utilised • National capital committee funding • PPP/Sponsorship/ philanthropic donation

The potential long-list options in each of the five dimensions were assessed against the investment objectives and critical success factors using the following assessment methodology:

- Does the option meet the investment objectives
- Does the option meet the critical success factors
- Does the option meet the minimum or maximum service requirements
- Does the option support the longer term needs of the department
- How long will the option take to implement

The summary assessment of the long-list options is included below. A more detailed analysis is included in the appendices.

2.1.3 The status quo or do nothing option (option 1)

Description

Replace existing MRI and Fluoroscopy units and MRI safety shielding. No footprint changes, IANZ CARs not addressed.

Advantages

The main advantages are:

- Less capital investment
- Speed up the equipment replacement process for these end of life units
- Less probability of MRI and Fluoroscopy units fatally breaking down before project completed, decreasing associated clinical risk

Disadvantages

The main disadvantages are:

- No MRI services on site during equipment replacement (approximately 16 weeks)
- Outsourcing all MRI during this time inclusive of patient transport costs
- No fluoroscopy services during equipment replacement (4-6 weeks) with no local outsourcing option
- Loss of IANZ accreditation and associated ACC high tech imaging revenue as not addressing CARs relating to patient safety and privacy
- Regretful spend - Any future radiology development will require significant rework
- Lose opportunity to reconfigure floor plan layout of radiology department, once new MRI is in place the next opportunity to reconfigure the floor plan layout of the department will be in 12-15 years during the next MRI replacement.
- Does not address the seismic structural works which will need to be done at a future date

Conclusion

Although this option is the cheapest and fastest solution to replace equipment only in the short term it would result in the loss of IANZ accreditation and the seismic work would still need to be undertaken in the near future.

2.1.4 Long list – option 2

Description Replacement of existing Fluoroscopy and MRI equipment and plan for replacement of other existing equipment. Minor footprint changes, and some IANZ CARs addressed however the seismic strengthening works will not be addressed.

This option will create a new suite for MRI and a new Fluoroscopy room and address the CARs associated with these areas. In order to maintain an operational Radiology Department it is proposed to complete the project in multiple stages.

Stage 1 – Create space for new MRI Suite

- Relocate Medical Records (or alternative service) and refurbish area for Ultrasound
- Move Ultrasound out of Radiology
- Vacate existing X-ray 5 and relocate OPG unit
- Build on second floor and relocate non-clinical functions off ground floor
- Refurbish old Ultrasound, office and staff areas for new MRI suite
- Install and commission new MRI scanner
- Remove old MRI scanner

Stage 1a – Reception & waiting area (in conjunction with Stage 1)

- Refurbish existing reception, admin area and offices to accommodate waiting area, toilets, reception, office and bed bay
- Alterations to Nuclear Med waiting area, toilet and cannulation room

Stage 2 – Create space for new Fluoroscopy

- Refurbish old conference/meeting room and MRI area for new Fluoroscopy suite
- Build shell for future dedicated cardiac angiography suite
- Install and commission new Fluoroscopy suite
- Remove old Fluoroscopy suite

The impact of progressing to stage 2 only will be the loss of one general x-ray room. This will reduce the capacity for plain film imaging and affect patient flow for all areas. For example the 3 existing general rooms provide cover for community patients, inpatients, various outpatient clinics such as fracture and respiratory clinics as well as emergency patients. If this capacity is reduced it will lead to delays in patient care and treatment for each of these areas, with forecasted increased demand across the region, plain film radiology will become a bottle neck for patient flow. Additionally there will be very limited cover for maintenance and breakdowns, potentially there will be only one x-ray room available for all plain film imaging during these times. The two existing rooms were installed in 2009, with an expected lifespan of 8-10 years, they are due for replacement in 2019/20. Due to their increasing age and heavy utilisation an increase in breakdown is expected up to replacement. This represents a significant risk to the DHB.

By not completing the full reconfiguration of the radiology department in conjunction with equipment replacement, the department will not optimise patient flow. There will continue to be a lack of bed bays, private waiting areas for patients and whanau, corridors will continue to be used as waiting rooms impeding patient flow into and out of radiology. Additionally the lack of dedicated and private patient preparation, treatment and after care areas will continue to compromise the safe transition of patients through imaging and interventional procedures.

Although this option is costly not all the CARs will be cleared which could result in loss of accreditation with associated income and impacts as noted previously. Nor does it give any provision for future expansion of the department or address the required seismic strengthening work.

Advantages

The main advantages are:

- MRI and Fluoroscopy units are replaced
- Service continuity mostly retained during replacement and build except for Fluoroscopy
- Potential to maintain IANZ accreditation, the ACC high tech imaging contract and associated revenue. Able to support National Bowel Screening program on site
- Allows flexibility for planned capital replacement and service changes or development
- Lower capital spend than options 3-5

Disadvantages

The main disadvantages are:

- Does not address the patient safety and privacy CARs
- Potential to lose IANZ accreditation and revenue associated with loss of the ACC high tech imaging contract and revenue and ability to support the National Bowel Screening Program on site.
- An unaccredited Radiology service may make retention and attraction of skilled Radiology staff difficult in an already vulnerable workforce
- Some outsourcing required during build at cost
- Regretful spend - no consideration given to the optimal floor plan layout for the unit which would mean that in the near future significant rework would be needed requiring additional capital to address the remaining CARs
- Footprint changes may create new CARs or change location of CARs. For example, patients will be still required to wait in corridors
- Does not address the seismic structural works which will need to be done at a future date

Conclusion

This option is not cost effective in the long run as a lot of additional work would have to be done at a later date in order to facilitate planned radiology capital replacements, address the remaining CARs, change workflow to support service delivery to meet “most likely” demand and complete the seismic strengthening work.

2.1.5 Long list – option 3

Description

Replacement of existing Fluoroscopy and MRI equipment and plan for replacement of other existing equipment. Footprint increase for existing and planned services. All IANZ CARs addressed. In order to maintain an operational Radiology Department it is proposed to complete the building works in multiple stages.

Stage 1 – Create space for new MRI Suite

- Relocate Medical Records (or alternative service) and refurbish area for Ultrasound
- Move Ultrasound out of Radiology
- Vacate existing X-ray 5 and relocate OPG unit
- Build on second floor and relocate non-clinical functions off ground floor
- Refurbish old Ultrasound, office and staff areas for new MRI suite
- Install and commission new MRI scanner
- Remove old MRI scanner

Stage 1a – Reception & waiting area (in conjunction with Stage 1)

- Refurbish existing reception, admin area and offices to accommodate waiting area, toilets, reception, office and bed bay
- Alterations to Nuclear Med waiting area, toilet and cannulation room

Stage 2 – Create space for new Fluoroscopy

- Refurbish old conference/meeting room and MRI area for new Fluoroscopy suite
- Build shell for future 2nd Angiography suite
- Install and commission new Fluoroscopy suite
- Remove old Fluoroscopy suite

16.1

Stage 3 – Back of house X-Ray, Nurse station/bed bay, utility rooms and bariatric toilet

- Demolish old MRI, X-ray reporting and Radiologist offices
- Build new block at back of existing X-ray
- Demolish 3x old bed bays

Stage 4 – X-ray 3, treatment room, CT change/waiting/bed bay, staff WC/lockers and storeroom

- Demolish old Fluoroscopy block
- Build new X-ray, treatment room, CT change/waiting/bed bay, staff WC/lockers and storeroom
- Demolish old utility area and build shell for future 2nd CT

Advantages

- MRI and Fluoroscopy units are replaced
- Service continuity retained during replacement and build
- Addresses patient safety and privacy CARs within the footprint changes
- IANZ accreditation maintained and the ACC high tech imaging contract and associated revenue. Able to support National Bowel Screening program on site
- Phased building and capital costs.
- Allows flexibility for planned capital replacement and service changes or development that is better equipped to meet “most likely scenario” demand
- Allows flexibility for service changes such as addition of cardiac interventional suite, cone beam CT, or additional imaging units.
- Seismic structural strengthening works are completed

Disadvantages

- The construction program is much longer than options 1 and 2 due to the amount and sequence of works in order to be less disruptive to business as usual.
- Clinical risk of MRI and/or Fluoroscopy units failing before the project is completed
- Cost to the DHB

Conclusion

This is the only options meets all of the investment objectives . It addresses IANZ CARs replaces equipment and addresses seismic strengthening. It provides a long term cost effective solution that ensures IANZ accreditation, its associated revenue and reputational standing will be retained.

2.1.6 Long list – option 4

Description

Maximum scope and scale. Location given equal consideration to all other dimensions.

New radiology department built with existing equipment plus additional equipment or services to address long term capacity needs e.g. additional MRI, Ultrasound, X-ray and CT units. Scope includes a full service review of the radiology department and implements the recommendations including what modalities are offered and at which locations in order to best meet population need and the nine themes of the CSP.

Advantages

The main advantages are that the project would set the long term direction for the radiology service in alignment with the strategic direction of the organisation. There would be no need to re-examine the needs of the department again for many years as long as the equipment replacement program was adhered to.

Disadvantages

The main disadvantage is that it would take a very long time to complete, risks IANZ accreditation being revoked in the interim and would very likely result in the MRI and fluoroscopy units fatally breaking down before they are replaced. There would be significant costs associated with a full review and rebuild of radiology.

Conclusion

Having clarity around the long term needs would be advantageous however the risk of losing essential clinical services, accreditation and the MRI and fluoroscopy units fatally breaking down before they are replaced are very high. Additionally the seismic work would still need to be undertaken in the near future.

2.1.7 Long list – option 5

Description

Outsource all radiology work to private and IDF providers, existing HBDHB services assimilated by outsource provider.

Advantages

The main advantages are that equipment replacement and compliance with IANZ accreditation

would become the responsibility of the private provider. Secondly service level agreements (SLA's) would ensure that wait times were maintained at an agreed level. Thirdly HBDHB capital would be freed up for other priorities.

Disadvantages

The main disadvantages are that

- There is no private provider currently operating in Hawke's Bay that is capable of readily taking on an outsourcing contract of this scale
- It is highly unlikely that outsourcing would be less expensive than providing the same services in house in the medium to long term
- Does not address the seismic structural works which will need to be done at a future date

Conclusion

Would require an extensive tender process as none of the private providers currently established in Hawke's Bay would be capable of taking on such a contract. To hasten the process the private provider would likely need to take over the existing radiology department which knowing the issues that exist would not hasten their resolution. Additionally the seismic work would still need to be undertaken in the near future.

16.1

Table 15: Format for the stakeholder assessment of scale, scope and location choices. This process is repeated for each of the five dimensions of choice.

Assessment Criteria for Choices within the Scale, Scope and Location Dimension	Assessment Scores for Choices within the Scale, Scope and Location Dimension				
	SCO1 Do Nothing Option 1	SCO2 Minimum Option2	SCO3 Intermediate Option 3	SCO4 Maximum Option 4	SCO5 Outsource/PPP Option 5
Investment objectives:					
• Provision of high quality diagnostics and interventional procedures that meet the needs of clinicians and patients for effective diagnosis and treatment.	Y	Y	Y	Y	Y
• Retain IANZ accreditation, meet legal and statutory requirements for Radiology services relating to Patient code of rights, professional practicing certificates. College, board and council standards.	N	N	Y	Y	Y
• Operate a service that meets "most likely" demand in the most cost effective way.	N	Possible	Y	Y	No
Critical Success Factors:					
• Strategic fit and business needs	N	Partial	Y	Y	N
• Potential value for money	No	No	Y	X	X

• Supplier capacity and capability	Y	Y	Y	Y	X
• Potential affordability	Y	Y	Y	X	X
• Potential achievability	Y	Y	Y	X	X
Advantages and Disadvantages	As noted above	As noted above	As noted above	As noted above	As noted above
Overall Assessment	Carry forward to short-list to manage clinical risk	Discounted	Carry forward to short-list	Discounted	Discounted
Assessment Criteria for Choices within the Service solution Options Dimension		Assessment Scores for Choices within the Service solution Options Dimension			
		SOL1 In-house outsource	+	SOL2 In-house	SOL3 Outsource/PPP
Investment objectives:					
Provision of high quality diagnostics and interventional procedures that meet the needs of clinicians and patients for effective diagnosis and treatment.		Y		Y	Y
Retain IANZ accreditation, meet legal and statutory requirements for Radiology services relating to Patient code of rights, professional practicing certificates. College, board and council standards.		Y		Y	Y
Operate a service that meets "most likely scenario" demand in the most cost effective way.		Y		N	N
Critical Success Factors:					
• Strategic fit and business needs		Y		N	N
• Potential value for money		Y		N	N
• Supplier capacity and capability		Y		Y	Possible
• Potential affordability		Y		N	Possible
• Potential achievability(timely)		Y		N	N
Advantages and Disadvantages:		Achievable		Reduce cost of out-source and IDF – unlikely to achieve due to resourcing	Cost Medium to Long term Supplier Capacity unknown
Overall Assessment		Carry forward to short-list		Discounted	Discounted
Assessment Criteria for Choices within the Service Delivery Options Dimension		Assessment Scores for Choices within the Service Delivery Options Dimension			
		SD1 Current Capacity maintained	SD2	SD3 Outsource/PPP	

		Align capacity with demand		
Investment objectives:				
Provision of high quality diagnostics and interventional procedures that meet the needs of clinicians and patients for effective diagnosis and treatment.	Y	Y	Y	
Retain IANZ accreditation, meet legal and statutory requirements for Radiology services relating to Patient code of rights, professional practicing certificates. College, board and council standards.	Y	Y	Y	
Operate a service that meets “most likely scenario” demand in the most cost effective way.	N	Y	N	
Critical Success Factors				
• Strategic fit and business needs	N	Y	N	
• Potential value for money	N	Y	N	
• Supplier capacity and capability	Y	Y	Possible	
• Potential affordability	Y	Y	Possible	
• Potential achievability(timely)	Y	Y	N	
Advantages and Disadvantages:	Capacity will not meet most likely demand	Capacity matched with demand	Costly in the Medium to Long term Supplier Capacity unknown	
Overall Assessment	Discounted	Carried forward to shortlist	Discounted	
Assessment Criteria for Choices within the Implementation Options Dimension	Assessment Scores for Choices within the Implementation options			
	IMP1 Replace	IMP2 Replace move and	IMP3 Phased replacement	IMP4 Outsource/PPP
Investment objectives:				
Provision of high quality diagnostics and interventional procedures that meet the needs of clinicians and patients for effective diagnosis and treatment	N	N	Y	Y
Retain IANZ accreditation, meet legal and statutory requirements for Radiology services relating to Patient code of rights, professional practicing certificates. College, board and council standards	N	Possible	Y	Y
Operate a service that meets “most likely scenario” demand in the most cost effective way.	N	Y	Y	N
Critical Success Factors:				

16.1

• Strategic fit and business needs	N	N	Y	Y
• Potential value for money	N	N	Y	N
• Supplier capacity and capability	N	N	Y	Possible
• Potential affordability	Y	Y	Y	Possible
• Potential achievability(timely)	Y	Y	Y	N
Advantages and Disadvantages:	Achievable and quick. Lose accreditation, revenue and redesign opportunities	Achievable and quick. Possible loss of accreditation and revenue. Rework required	Maintain accreditation with no rework. Costs phased. Service continuity. However Equipment may fail before completion	Costly Medium to Long term
Overall Assessment	Discounted	Discounted	Carry forward to short-list	Discounted
Assessment Scores for Choices within the Funding options				
Assessment Scores for Choices within the Funding Options Dimension Assessment criteria	FUND1 HBDHB capital	FUND2 National capital committee	FUND3 PPP	
Investment objectives:				
Provision of high quality diagnostics and interventional procedures that meet the needs of clinicians and patients for effective diagnosis and treatment.	Y	Y	Y	
Retain IANZ accreditation, meet legal and statutory requirements for Radiology services relating to Patient code of rights, professional practicing certificates. College, board and council standards.	Y	Y	Y	
Operate a service that meets "most likely scenario" demand in the most cost effective way.	Y	Y	Possible	
Critical Success Factors:				
• Strategic fit and business needs	Y	Y	Y	
• Potential value for money	Y	Y	Possible	
• Supplier capacity and capability	Y	Possible	Possible	
• Potential affordability	Y	Possible	Possible	
• Potential achievability(timely)	Y	N	N	
Advantages and Disadvantages:	Achievable and quick.			

		Achievable, but not guaranteed. Lengthy process	Achievable, but not guaranteed. Lengthy process High Cost Medium to Long term
Overall Assessment	Carry forward to short-list	Possible	Discounted

2.1.8 The status quo or do nothing option

As the MRI and Fluoroscopy units require urgent replacement regardless of whether the CARs are addressed in order to support acute and elective services at Hawke's Bay Hospital, the replacement of these units has been included in the do nothing option.

The Short-listed Options

On the basis of this analysis, the recommended short-list for further assessment is as follows:

Option 1: Status quo option- Replacement of existing (retained to manage clinical risk of existing equipment fatal breakdown). Note: Seismic strengthening works would still need to be completed at a future date.

Option 3: Replacement of existing Fluoroscopy and MRI equipment and plan for replacement of other existing equipment. Footprint increase for existing and planned capital replacement to meet all CARs. Seismic strengthening works completed.

16.1

Economic Assessment of the Short-Listed Options

2.1.9 Assumptions

For the purposes of the cost benefit analysis the following assumptions have been made....

Assumptions are defined as "a belief that something is true or will happen, although there is no proof." The following key assumptions have been made for this project:

Table 16: Assumptions for the purposes of the cost benefit analysis

Assumptions	Implications if the Assumptions are incorrect
Radiology can operate Business As Usual during build and replacement	Increase in wait times and and/or outsourcing costs
Hawke's Bay hospital remains the only acute centre in Hawke's Bay	The facility will have excess capacity
Technological advances will continue to utilise modalities invested in by HBDHB	New technologies and modalities will supersede equipment investments
Clinical pathways continue to rely on imaging for diagnosis and monitoring of conditions e.g. primary care pathways and treatment criteria	The facility will have excess capacity

Demand, population growth and ageing trends continue as projected.	The imaging capacity will not meet demand requirements
The government continues to require DHBs to meet health targets for access and intervention rates.	No ministerial requirement to meet existing health targets or indicators
When this project is completed, catch up activity will be undertaken if required, to meet or exceed the maximum waiting times/exceed targets.	Catch up activity may not be required if demand has been managed through outsourced activity.
Current equipment will remain operational until replacement	Equipment fails and is not repairable –Fluoroscopy requires expedited purchase and temporary install, and then will be relocated. MRI failure will require outsourcing until build and replacement completed
Relocation of Ultrasound across the corridor out of the department, will not have a large cost implication due to displacement of other services	Project cost estimates could be higher
Capacity for MRI and fluoroscopy will be maintained as replacement for existing equipment only. No change in operating resource	Opportunity to increase resourced capacity is not part of this project

2.1.10 Assessment period

The start date for valuation purposes is yet to be confirmed.

The economic life of the proposed assets is assumed to be 10 years and this is the period over which costs and benefits are assessed.

2.1.11 Discount and inflation assumptions

The Public Sector Discount Rate specified by the Treasury for projects of this type is 6% per annum. As this is a real discount rate, all costs and benefits are expressed in today's dollar terms.

2.1.12 Estimated costs

Depreciation, capital charges, interest and other financing costs are excluded from the NPV analysis.

2.1.13 Taxation

All dollar figures are expressed in GST exclusive terms.

2.1.14 Estimating monetary benefits

Stakeholders identified the following benefits as per the table below.

Table 17: Estimated monetary benefits from

Monetary Benefits	Estimates and Timing	Description
ACC Revenue	570,000 pa	High tech imaging is undertaken regardless of funding
In sourcing		Provide radiology support to Lakes DHB Tairāwhiti DHB Mid Central DHB

Self-reliance resilience	financial		Lower maintenance costs whilst new equipment is under warranty, less out sourcing due to lower equipment down time rates, less extra sessions/overtime to make up for down time
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Non-monetary Benefits and Costs

Some benefits could not be reliably quantified in monetary terms and are described below

Table 18: Non-monetary benefits from the investment proposal

Non-monetary Benefits	Description
Equitable Service (20% weight)	Social costs associated with delayed care and travelling for tests reduced. Wait times and Out sourcing rates, increased rates of participation with health system
Attraction and retention of Radiology workforce (20% weight)	Enhanced working environment for staff, especially as Radiology workforce is venerable in NZ across Radiologists, MRI technicians, and sonographers.by operating an accredited radiology service with up to date equipment.
Confidence in service provided (40% weight)	Clinicians, patients, and contract partners have confidence in the ability of the department to deliver services of an appropriate standard. Complies with Patient Code of Rights
Patient safety and privacy (20% weight)	Complies with accreditation requirements

The non-monetary benefits for each short-listed option were assessed using multi-criteria analysis by stakeholders who were asked to:

- agree on a set of mutually exclusive benefit criteria
- agree and assign percentage weights to each of the criteria

16.1

Risk and Uncertainty

2.1.15 Risk identification and measurement

The key risks have been revisited and assessed for each of the short-listed options.

2.1.16 Risk assessment

Stakeholders identified and evaluated the key risks that might create, enhance, prevent, degrade, accelerate or delay the achievement of the investment objectives. The results of this assessment are detailed below. This risk analysis was also used to inform the development of the risk register, attached to this business case.

Table 19: Risk assessment and risk management strategies for Option 1 (status Quo)

Risk	Consequence (H/M/L)	Likelihood (H/M/L)	Comments and Risk Management Strategies
Loss of IANZ accreditation including loss of ACC revenue	H	H	Unable to meet contractual requirements for ACC high tech imaging contract, with loss of associated revenue. But the work would still be completed by DHB as part of acute services. Reputational risk to organisation losing IANZ, recruitment and retention of staff may be impacted
Breach of BSP	H	H	Loss of accreditation would mean CT Colon referrals would not be able to be done at DHB site as part of the BSP. Requiring contract with Private Provider to manage CTCs if accreditation lost.
End of life equipment fatally breaks down before it is replaced limiting the range of acute diagnostics	H	L	This option can be achieved in short time frame as the equipment could be replaced within 4 months of approval. Minimising the risk for this option
Patient and staff safety issues not resolved	H	H	CARs not resolved, potential clinical safety risk to patients leading to loss of accreditation/revenue
Patient privacy issues not resolved	M	H	CARs around this not met and potential loss of accreditation. Potential to extend timeframes for resolution with IANZ
Maintaining BAU during works	H	H	No MRI or Fluoroscopy service available onsite during replacement. Requiring outsourcing and waitlist catch up time after work completed

Table 20: Risk assessment and risk management strategies for Option 3 (preferred option)

Risk	Consequence (H/M/L)	Likelihood (H/M/L)	Comments and Risk Management Strategies
Loss of IANZ accreditation including loss of ACC revenue	H	L	Risk to accreditation only due to timeframe for completion of work. DHB to negotiate with IANZ to manage expectations on timeliness of CAR resolution
Breach of BSP	H	L	Loss of accreditation would mean CT Colon referrals would not be able to be done at DHB site as part of the BSP. Requiring contract with Private Provider to manage CTCs if accreditation lost.

End of life equipment fatally breaks down before it is replaced limiting the range of acute diagnostics	H	M	Time to complete replacement and build is longer. Continue to work with vendors re maintenance contracts to repair equipment until replaced
Patient and staff safety issues not resolved	M	L	Build work resolves CARs. CARs resolution timeframe to be managed with negotiation with IANZ
Patient privacy issues not resolved	M	L	Build work resolves CARs. CARs resolution timeframe to be managed with negotiation with IANZ
Maintaining BAU during works	H	L	Due to MRI relocation this service will be available onsite during replacement. Fluoroscopy waitlist will grow during outage, but acute work managed in house via other means. Little requirement for outsourcing, but some waitlist catch up time after work completed

2.1.17 Quantitative risk analysis

The approach used to quantify and model risks was based on the HBDHB risk register methodology.

16.1

Testing the Preferred Option and Sensitivity Analysis

2.1.18 Identifying the preferred option

The results of the cost benefit analysis used the following core assumptions

- Technological advances will continue to utilise modalities invested in by HBDHB
- Clinical pathways continue to rely on imaging for diagnosis and monitoring of conditions e.g. primary care pathways and treatment criteria
- Demand, population growth and ageing trends continue as projected.

This analysis excludes seismic strengthening and project management costs.

Option 1 present value of costs included \$570,000 of ACC high tech revenue forgone due to loss of IANZ accreditation.

2.1.19 Testing the robustness of the options analysis

In order to test the robustness the NPV calculation +/- 15% has been added to the cost of capital. Equipment costs may be higher, due to exchange rate fluctuations or other cost factors unforeseen at the time pricing was estimated.

Option 1 present value of costs includes \$570,000 of ACC high tech revenue forgone due to loss of IANZ accreditation.

2.1.20 The preferred option

The preferred option is three because it is the only cost effective way of replacing the MRI and Fluoroscopy units and retaining IANZ accreditation, Enable future development and complete seismic strengthening work.

Although status quo would enable HBDHB to replace the MRI and Fluoroscopy units in the shortest possible time, it would very likely result in the withdrawal of IANZ accreditation. This will cause the loss of significant revenue associated with the ACC high tech contract and make it even more difficult to hire in to existing radiology workforce vacancies as well as hold on to experienced staff. Additionally, in order to address all the CARs in the future and complete the seismic strengthening work additional funds would need to be spent as the opportunity to relocate the MRI would have been lost and therefore alternate solutions to address floor plan layout issues would need to be found. Whereas in the preferred option the position of the MRI and fluoroscopy units in will change to enable better utilisation of the department. These changes will be phased so the existing MRI and fluoroscopy service can continue until the new units are commissioned retaining business as usual through the build program.

3 Commercial Case - Preparing for the Potential Deal

The Procurement Strategy

The procurement strategy is to take a separate market approach for the two procurement areas:

- Construction works: managed by Facilities
- Equipment replacement: managed by Procurement

The procurement strategy for each of these will follow the procedures detailed in HBDHB's Procurement Policy and Procedures (HBDHB/OPM/081). The policy references the February 2015 directive from Ministers of State Services that stipulates the DHBs must follow the Principles of Government Procurement Rules of Sourcing. There are five key principles to follow:

1. Plan and manage for great results
2. Be fair to all suppliers
3. Get the right supplier
4. Get the best deal for everyone
5. Play by the rules

16.1

According to the HBDHB procurement policy, the strategy for purchasing goods and services is determined by the monetary threshold. As this project has a whole of life cost of greater than \$100,000 it will therefore use the guidelines for this spend bracket.

The Government's Electronic Tender Service (GETS) will be used to provide Requests for Tender (RFT) and Requests for Proposals (RFP) as required for individual purchases or bulk contract situations.

This approach to market fits with HBDHB's procurement policy HBDHB/OPM/081, the Government Rules of Sourcing¹ and the Government Principles of Procurement².

3.1.1 Commitment to Environmental Sustainability

HBDHB values the important role environmental sustainability plays in enabling us to operate in a way that meets our present needs without compromising the fabric of the social community, economy or the natural environment, so that future generations continue to benefit.

In all activities, HBDHB will seek to support environmental sustainability and improve our environmental performance in all capital projects. Key principles to be considered for this project include minimising harm, maximising efficiency, applying a whole-of-life view, implementing sustainable design, trialling new technologies and leading by example.

¹ Government Rules of Sourcing (October 2013), *Mastering Procurement: A Structured Approach to Strategic Procurement* (March 2011) <http://www.business.govt.nz/procurement>

² Supply Positioning model outlined in *Mastering Procurement – A Structured Approach to Strategic Procurement* <http://www.business.govt.nz/procurement>

The target areas where we can see the most significant financial, social and environmental impacts are:

- Energy and Carbon Management.
- Sustainable Waste Management.
- Sustainable Water Management.
- Sustainable and Efficient Buildings and Site Design.
- Sustainable Transportation and Travel Management.

As the preferred option (option three) enables future development with the least amount of rework it is the most environmentally sustainable option. As demolition is sent to landfill the options that involve larger amounts of demolition in the future would be less environmentally sustainable in the long term.

3.1.2 Contractual Relationship with our Outsource Partners

The Hawke's Bay DHB has a long standing relationship with the major private Radiology provider in the Hawke's Bay, TRG group. We already outsource work to them of a specialist nature (breast work) and this will continue. It is likely that with the purchase of a 1.5T MRI that we will outsource some work that is best suited to a 3T MRI. Currently some of this work is sent out of district, however when TRG replace their current 1.5T MRI to a 3T MRI we plan to outsource this work to the local provider instead. This practice will continue until such a time volumes dictate we should purchase our own 3T machine (second MRI).

The Procurement Plan

Equipment Procurement

The proposed approach for equipment procurement will be a closed secondary market Request for Proposal (RFP) seeking submissions from interested suppliers as per the specifications required for each piece of equipment.

A secondary contestable process will be undertaken including but not limited to shortlisting, site visits and trialling that will be evaluated by an evaluation panel. This panel will include members from key stakeholder groups across the DHB.

Table 21: The following cross-functional team will be involved in the evaluation panel.

Role	Membership	Name	Department
Chair of evaluation panel	Non-voting	Bela Jones	Procurement
Financial analyst	Non-voting	Malenya Taylor	Management accounting
Contracts advisor	Non-voting	Aaron Howes	Procurement
Business group / owner	Voting	Paula Jones	Acute & Medical
User group / beneficiary	Voting	Angela Fuller	Radiology
Clinical lead / beneficiary	Voting	Kai Haidekker	Radiology
Subject matter expert	Voting	Megan Knowles	HBDHB Facilities PM
Subject matter expert	Voting	Steyn Van Der Spuy	Clinical Engineering Manager
Subject matter expert	Voting	Racquel McDonald	Infection Prevention & Control
Subject matter expert	Voting	Paula Dean	Clinical Product Coordinator
Subject matter expert	Voting	Euan Cooper	Information Services

The proposed timeline for the procurement of equipment is as follows:

Table 22: Indicative timeline –equipment procurement

Procurement Milestones	Indicative Date
Pre-procurement	
Procurement Plan approved	December 2018
Proposal	
Proposal advertised on GETS	February 2019
Proposal closing date	March 2019
Evaluation	
Recommendation accepted / denied	August 2019
Post-evaluation	
Contract start date	September 2019

The evaluation model that will be used is weighted attributes. Having met the preconditions, responses will be evaluated on their merits using the evaluation criteria and weightings that will be developed as part of the detailed Procurement Plan, to be prepared following approval of this Business Case.

16.1

Construction Procurement

The Hawkes Bay construction market has experienced significant growth over recent years and is forecast to maintain a trend of moderate and sustained growth over the next 5-6 years (MBIE National Pipeline Report 2018). Despite this growth the local construction industry remains relatively small and due to the geographical isolation of the region there is little competition from out of town contractors.

Contractors are generally categorised as Tier 1, 2 or 3 (large/medium/small) companies, reflecting the scale and complexity of the work they specialise in. There are currently only 2 Tier 1 companies in HB that consistently prove their capabilities in delivering large scale complex projects. Market analysis will require engagement with these contractors to determine their availability and identify any barriers to the tender process.

Competitive lump sum tendering is the traditional method to procure building projects, however in the current marketplace it is common for contracts to be secured by negotiation - particularly when contractors are working with regular clients. This method presents the least risk to the contractor and is therefore preferred over the uncertainty and cost of the tendering process in a buoyant market.

The proposed approach to market, evaluation of offers and identification of the preferred supplier are as follows:

4. Having met all of the preconditions, interested parties will be invited to participate in a closed negotiated tender and will be notified at this time of any conditions and dates the tender is subject to.
5. Upon receipt of tender responses the evaluation team will gather to review responses. Based on the review by the evaluation team, negotiations with tenderers will be completed after which the evaluation team will select a preferred supplier to enter in to final negotiations with.

6. Once final negotiations are completed including allocation of risk, the evaluation team will put forward a recommendation to HBDHB's board to award the contract to the preferred supplier.

Table 23: The following cross-functional team will be involved in the evaluation of bids and recommending the preferred supplier.

Role	Membership	Name	Department
Chair of evaluation panel	Non-voting	Ashton Kirk	Contracts and Procurement
Financial analyst	Non-voting	Malenya Taylor	Management accounting
Contracts advisor	Non-voting	Ashton Kirk	Contracts and Procurement
Business group / owner	Voting	Gavin Carey-Smith	Facilities
User group / beneficiary	Voting	Angela Fuller	Radiology
Clinical lead / beneficiary	Voting	Kai Haidekker	Radiology
Subject matter expert	Voting	Megan Knowles	HBDHB Facilities PM
Subject matter expert	Voting	Aaron Howes	Procurement
Subject matter expert	Voting	RLB	Quantity Surveyor

The proposed timeline for the procurement of the construction works is as follows:

Table 24: Indicative timeline – construction procurement

Construction Procurement Milestones	Indicative Date
Pre-procurement	
Procurement Plan approved	December 2018
Pre-procurement market engagement	December 2018
Advance notice published on GETS	February 2019
Tender	
Tender advertised on GETS	March 2019
Tender closing date	May 2019
Evaluation	
Recommendation accepted / denied	June 2019
Post-evaluation	
Contract start date	July 2019

The evaluation model that will be used is weighted attributes. Having met the preconditions, qualifying bids will be evaluated on their merits using the evaluation criteria and weightings that will be developed as part of the detailed Procurement Plan, to be prepared following approval of this Business Case.

Specify Requirements

The required goods and services included in the equipment procurement are:

- One 1.5T wide bore MRI unit and associated maintenance agreement
- One medium spec Fluoroscopy unit and associated maintenance agreement

The equipment will be selected using evaluation criteria that ensures we purchase the most suitable solution at the most cost effective whole of life price.

The required goods and services included in the construction procurement are:

- Building a specific space for the MRI unit
- Building a specific space for the Fluoroscopy unit
- Building as required to address the patient privacy and safety issues raised in the corrective action requests.

Construction works will be in accordance with the drawings and specifications that will be developed and signed off during the design phase.

The procurement of the capital building works and equipment will follow a conventional design and construct approach. The design specification and requirements will be agreed with key stakeholders. Consultants and contractors will then be selected on the basis of a competitive tender process to complete the detailed design and construction of the required works. The final awarding of tenders to the successful tenderers will be the subject of a separate request for approval to the Board.

Payment Risk Allocation

For the equipment purchase and maintenance agreements HBDHB's own standard contract template will be used.

For the construction works the form of contract will be NZS 3910:2013 Conditions of Contract and payment for the capital works will be made through a series of Progress Payments in accordance with the Construction Contracts Act.

Variations to the contract works will be in writing and agreed by both parties. Variations involving an increase in price must only be made within the limit of the financial delegated authority.

Progress Payments will provide for a percentage of the amount certified as due to the contractor to be deducted from the amount due and retained by the client. The purpose of the retention is to ensure that the contractor properly completes the activities required of them under the contract.

The risk allocation has not been agreed at this stage, and would be negotiated with the successful supplier as part of the appointment process at the conclusion of the tender.

16.1

4 Financial Case - Affordability and Funding Requirements

The Financial Costing Model

4.1.1 Financial costing approach

The preferred option replaces the equipment on site, addresses the corrective action requests and provides a build option that ensures continuity of service. These works are phased over several stages to accommodate footprint expansion and to allow the radiology service to operate BAU, providing and acute and elective services to primary and secondary care during the project.

The total capital investment is \$18,942k phased over a 5 year period. The project will require capital funding. Capital sources include Ministry of Health, finance arrangements on the equipment and prioritisation of internally generated capital. The final solution could be a combination of all of these capital sources.

The following cost and benefit assumptions have been used for the financial modelling in this business case:

- The capital budget for this project has an accuracy of +/- 15%.
- The equipment costs may be higher, due to exchange rate fluctuations or other cost factors unforeseen at the time pricing was estimated.
- The build programme is based on need for the MRI and Fluoroscopy scanners to be replaced by the end of 2020.
- The interest rate (capital charge) rate used is 6.0%;
- Modelling time horizon is 2018-28;
- Baseline costs are held constant over time i.e. no inherent growth assumed;
- No inflation modelled; this includes equipment and build cost;
- Depreciation has been calculated using the straight line method. The rates applied are as follows; Build Costs 5.28%, Equipment 12%; Due to expansion of the footprint additional support staff are required;
- Facility whole of life costs have been accounted for;
- Feasibility costs have been accounted for;
- Financials have been modelled on the demand modelling in the strategic case (reference). With the “most likely” modelling taken forward as the base assumption;
- There is a risk that growth more closely models the worst case scenario;
- Exchange rates for equipment purchase remain within budget from quote to purchase;
- The project manager is to be funded within existing resources.

4.1.2 Overall affordability

The proposed cost of the project is \$18.942 million +/- 15% for capital and \$18.217 million operating costs over the ten year time horizon including depreciation and interest.

The project will require capital funding. Capital sources include Ministry of Health, finance arrangements on the equipment and prioritisation of internally generated capital. The final solution could be a combination of all of these capital sources.

Operating costs will be funded within our crown funding.

5 Management Case: Planning for Successful Delivery

The management case confirms that the proposal is achievable and details the arrangements needed to both ensure successful delivery and to manage project risks.

Project Management Planning

5.1.1 Project management arrangements

In the event that this investment proposal receives formal approval, a project will be established to deliver the required services.

The project will be managed using the Hawke's Bay Project Method framework which aligns with PRINCE2 project management methodology and HBDHB's project management policy OPM048.

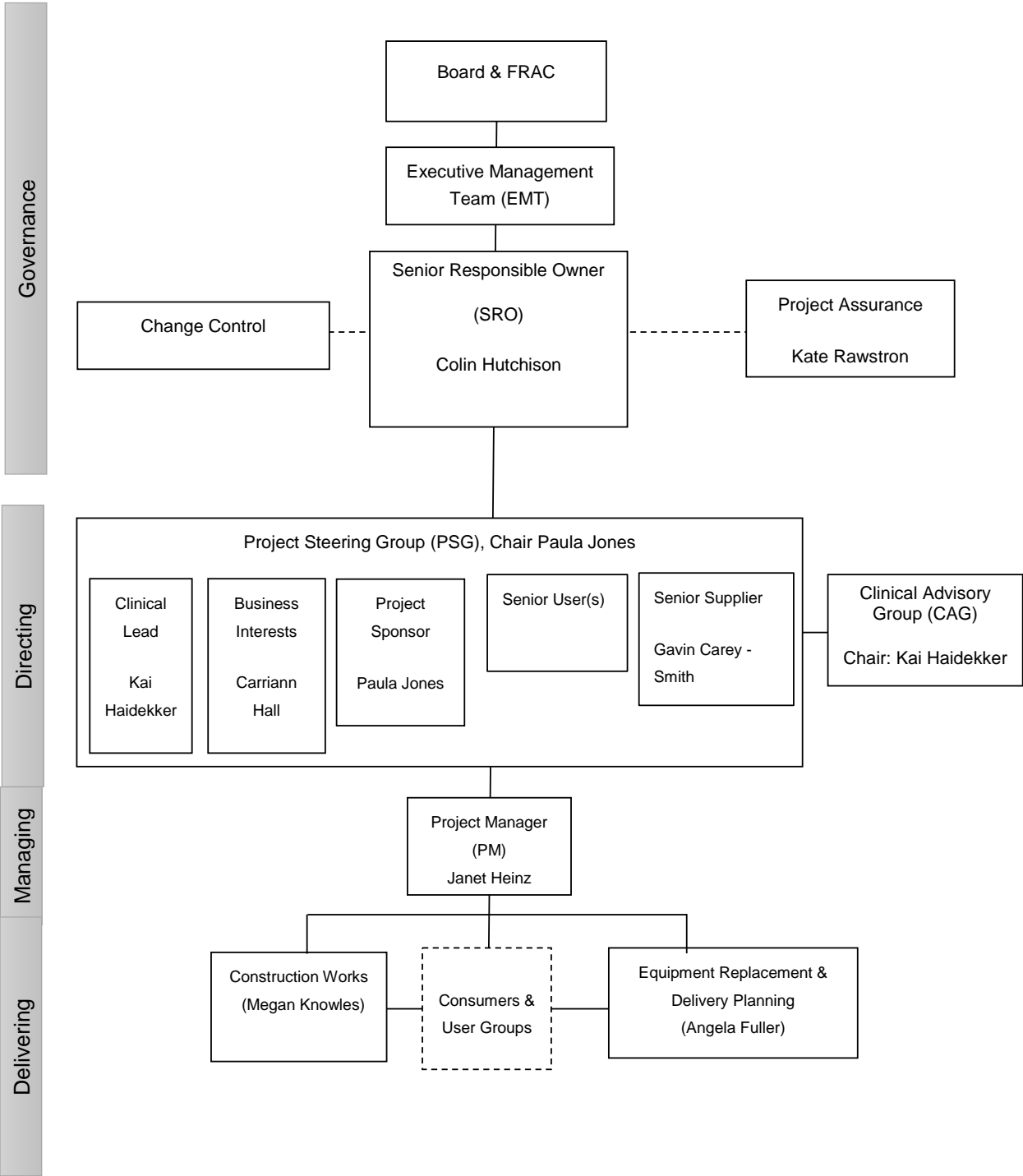
The relevant project management arrangements are proposed to be as follows:

- The project manager will complete project initiation documentation and stage plan that outlines the way in which the execution stage of the project will be managed on behalf of the project's sponsor and steering group. This will include frameworks for the following:
 - quality management strategy
 - configuration management strategy
 - risk management strategy
 - communication management strategy
 - Project plan
 - Project controls
 - Benefits review plan
 - Tailoring of PRINCE2
- Work streams will be established reporting directly to the project manager to develop the products/deliverables of the project
- The project steering group and clinical advisory groups will be reformed to best support the project through the execution stage

5.1.2 Proposed governance arrangements

The proposed governance structure and reporting arrangements for the project are as follows:

Figure 1: The project organisation chart



16.1

5.1.3 Project roles and responsibilities

5.1.4 Project Sponsor

The Project Sponsor is responsible for the delivery of the project, ensuring that the project is focused throughout its life on achieving its objectives and delivering products that will achieve the forecasted benefits. The sponsor may delegate to members of the PSG but still retains overall accountability. In addition to the PSG's collective responsibilities, the sponsor's responsibilities include:

- Designing and appointing the project management team or requesting PM resource via the programme steering group or EMT
- Monitoring and controlling the progress of the project (main driving force behind the project)
- Key decision maker ensuring the project gives value for money by balancing the demands of the business, user, and supplier
- Escalates issues or risks to corporate or programme management if project tolerance is forecast to be exceeded - no surprises
- Responsibility for the business case throughout the project and ensures that risks associated with the business case are identified, assessed and controlled
- Makes decisions on escalated issues with particular focus on continued business justification
- Organises and chairs PSG
- Ensures overall business assurance of the project
- Designs and appoints a Change Manager, where required

5.1.5 Senior User (Service Director, Consumers, Clinicians)

In addition to the PSG's collective responsibilities, they are responsible for:

- Providing the customers quality expectations and defining acceptance criteria for the project
- Ensuring that the desired outcome of the project is specified
- Ensuring that the project produces products that will deliver the desired outcomes and meet user requirements
- Ensuring that the expected benefits (derived from the project's outcomes) are realised
- Provide a statement of actual versus forecast benefits at the benefits review
- Resolve user requirements and priority conflicts
- Ensure that any user resources required for the project are made available
- Make decision on escalated issues with particular focus on safeguarding the expected benefits
- Briefing and advising user management on all matters concerning the project
- Maintaining business performance stability during transition from the project to business as usual
- Providing the user view on follow on recommendations
- Undertaking project assurance from the user perspective
- Please also see R&R's under 'Project Assurance'

5.1.6 Senior Supplier (Facilities, Information Services, external vendor)

In addition to the PSG's collective responsibilities, the Senior Supplier's responsibilities include:

- Assessing and confirming the viability of the project approach
- Ensuring that the proposals for designing and developing the products are realistic
- Advising on the selection of design, development and acceptance methods
- Making supplier resources available as required
- Making decisions on escalated issues, with particular focus on safeguarding the integrity of the complete solution
- Resolving supplier requirements and priority conflict
- Briefing non-technical management on supplier aspects of the project
- Ensuring quality procedures are used correctly so that products adhere to requirements
- Representing the interests of those designing, developing, facilitating, procuring and implementing the project's products
- Accountability for the quality of products delivered by the supplier(s) and responsible for the technical integrity of the project. If necessary, more than one person may be required to represent the suppliers
- Depending on the particular customer/supplier environment, the customer may also wish to appoint an independent person or group to carry out assurance on the supplier's products (for example, if the relationship between the customer and supplier is a commercial one).
- Please also see R&R's under 'Project Assurance'

16.1

5.1.7 Clinical Lead

The Clinical Lead represents the clinical perspectives of interest within the project and provides a key point of contact in decisions related to clinical matters. They work with the clinical stakeholder community to resolve issues within the project which need the agreement of clinical stakeholders to ensure progress. Ensuring realisation of benefits by supporting clinical change to achieve project goals. Participates as a member of the PSG and Clinical Advisory Group.

5.1.8 Project Manager (PM)

The PM has the authority to run the project on a day to day basis on behalf of the PSG within the constraints laid out by the PSG (delegated authority), including the planning, delegating, monitoring and controlling of all aspects of the project. The PM is responsible for ensuring that the project produces the required products or services to the necessary standard of quality and within the specified constraints and tolerances. The PM is also responsible for the project producing a result capable of achieving the benefits defined in the business case.

Specific responsibilities include:

- Working with the Project Sponsor to plan the management stages of the project (where relevant)
- Organise / set-up the PSG and the terms of reference in consultation with the Project Sponsor
- Preparation of required management products in conjunction with any project assurance roles and agreed with the PSG
- Managing the project to successful completion within agreed tolerances of time, cost, quality, scope, risk and benefits
- Managing exceptions to the agreed tolerances
- Overseeing the recording, impact assessment, approval and implementation of change requests

- Identifying, tracking and reporting on issues and corrective actions as appropriate
- Managing risks and dependencies
- Leading, managing and motivating the project management team
- Monitoring, managing and reporting on project progress
- Planning, managing and monitoring of consultation engagement required with all stakeholders
- Ensuring effective communication is maintained between all stakeholders both internal to HBDHB and external with respect to the project
- Develop and maintain work packages and their user acceptance criteria
- Manage any Work Stream Managers and project support staff and monitor their progress and performance
- Contract manage the vendor's delivery and work in partnership with the vendor's Project Manager
- Configuration management of both management products and deliverables
- Please refer to the P2 manual for a full description of the PM roles and responsibilities

5.1.9 Work Stream Lead

The Work Stream Lead's (WL) prime responsibility is to ensure production of those products defined by the PM to an appropriate quality, in a set timescale and at a cost acceptable to the PSG.

The WL role reports to, and takes direction from the PM. Responsibilities include:

- Preparing the work stream plan and agreeing it with the PM
- Planning, monitoring and managing the work stream work
- Progress of the work and use of the resources, including corrective actions where necessary within the constraints and tolerances agreed with the PM
- Production of progress reports as agreed with the PM
- Identification of any issues and risks associated with a work package including reporting them to the PM. Assisting the PM in the examination and management of these including advising the PM of any deviation from the plan, recommended corrective actions and help to update any plans as required
- Pass back to the PM products that have been completed and approved in line with the agreed work package requirements
- Liaising with any project assurance and project support roles
- Ensuring that quality activities relating to the teams work are planned and performed correctly and are within agreed tolerances
- Manage specific issues and risks as directed by the PM

5.1.10 Project Assurance

Project Assurance covers the primary stakeholder interests (business, user and supplier). Project Assurance has to be independent of the PM, therefore the PSG cannot delegate any of its assurance activities to the PM. Responsibilities for all people involved in project assurance include ensuring that:

- Liaison is maintained between the business, user and supplier throughout the project
- Risks are controlled
- The right people are involved in writing product descriptions and in quality inspections at the corrective points in the products development

- Staff are familiar with the Quality Plan, quality methods are being correctly followed and follow up actions are dealt with correctly
- An acceptable solution is developed
- The scope of the project is not changing unless through the agreed process
- Internal and external stakeholder communications are working
- Applicable standards are being used
- Any special needs / interest are being observed

Project assurance from the business perspective will be provided by the PMO Manager and may include the following additional responsibilities:

- Assisting the PM to develop the business case and benefits review plan where appropriate
- Advising on the selection of the project management team members
- Advising on the risk management strategy
- Reviewing the business case for compliance with corporate or programme standards
- Verifying the business case against external events and project progress
- Checking that the business case is being adhered to throughout the project
- Checking that the project remains aligned to corporate and programme strategies
- Reviewing overall project finance in conjunction with other departments for e.g. Facilities who may be managing the capital expenditure element of the budget
- Verifying that the solution continues to provide value for money
- Periodically check that the project remains viable
- Check that the aggregated risk exposure remains within project tolerance
- Check that the HBDHB financial policies around supplier and contractor payments are being adhered to in conjunction with other departments where relevant for e.g. Facilities
- Review issues and risks by assessing their impact on the business case
- Constraining user and supplier excesses
- Informing the project management team of any changes caused by the overall programme
- Monitoring stage and project progress against the agreed tolerances

Project assurance from the Senior User perspective will also include the following responsibilities:

- Advise on stakeholder engagement
- Advise on the communication management strategy
- Ensuring that the specification for the users' needs is accurate, complete and unambiguous
- Assess whether the solution will meet the users' needs and is progressing towards that target
- Advise on the impact of potential changes from the user's point of view
- Monitor risks to the user
- Ensure that the quality activities relating to products have appropriate user representation at all stages
- Ensure that quality control procedures are used correctly to ensure that products meet user requirements
- Ensure that user liaison is functioning correctly

16.1

Project assurance from the Senior Supplier perspective will also include the following responsibilities:

- Reviewing product descriptions
- Advising on the quality management strategy and configuration management strategy
- Advising on the selection of the development strategy, design and methods
- Ensuring that any supplier and operating standards defined for the project are met and used to good effect
- Advise on potential changes and their impact on the correctness, completeness and integrity of products against their product description from a supplier perspective
- Monitor any risks in the production aspects of the project
- Assess whether quality control procedures are used correctly, so that products adhere to requirements

5.1.11 Change Authority (CA)

The PSG may delegate authority for approving requests for change or off-specifications to a separate individual or group, called a Change Authority. The Project Manager could be assigned as the Change Authority for some aspects of the project (e.g. changing baseline work packages if it does not affect stage tolerances). The CA will vary depending on the level of change against the agreed tolerances and will be either:

- Project Manager
- Programme Manager
- Project Steering Group
- SRO
- EMT

The responsibilities of the CA, at any of the levels described above, include:

- Review and approve or reject all requests for change and off-specifications within the delegated limits of authority and change budget
- Refer to the next higher CA if any delegated limits of authority or allocated change budget are forecasted to be exceeded

5.1.12 Project Support (PS)

PS is the responsibility of the PM. If required the PM can delegate some of this work to a project support role.

5.1.13 Project plan and milestones

The project's execution stage will run over three stages (design, tender and construction) which is estimated to take approximately two and a half years from approval of the business case by HBDHB's board.

Table 25: Project plan timetable

Key Project Milestone	Approximate Date
Approval of Business Case by HBDHB Board	Nov 2018
Approval of Business Case by Ministers of Health and Finance	April 2019
Design Phase	Dec 2018 – Dec 2019
Procurement Phase	Jan 2020 – Mar 2020
Construction Phase	Apr 2020 – Jan 2022

Change Management Planning

The strategy, framework and plan for dealing with change and associated contract management is as follows:

- Where appropriate internal staff will be given leading project roles in identifying and communicating changes so as to both develop their skills as change champions within existing and new professional relationships.
- Floor plan changes will be co-designed with staff user groups and consumers to ensure the new floor plan layout is fit for purpose and considers what future development might be possible at a later date.
- Consumer workshops will be programmed at regular intervals throughout the design process. This will ensure proposed changes are developed with the consumers' needs at the heart of the plan.
- A media plan will be developed for notifying clinicians, health professionals and patients about the works and how it may affect them. This will include information about the specifications of the replacement MRI and Fluoroscopy units, rationale behind the floor plan changes (retention of IANZ accreditation, space for a cardiac cath lab) and how business as usual services will be accommodated during the building works.

16.1

Benefits Management Planning

Key Performance Indicators (KPIs) and measures of benefit realisation will be identified and agreed at the commencement of the execution stage as part of Benefits Realisation Plan.

As projects progress and more becomes known about the challenges of achieving the outcomes, benefits can become diluted or fade away over time. Therefore a structured approach will be taken to ensure the anticipated benefits are realised. To guide this the project's Benefits Realisation Plan will outline how the benefits will be managed and the accountabilities that will be applied. This will include the mechanisms to assign accountability, track progress, achievement of milestones and ongoing monitoring post Go Live against the KPIs. These will be used to measure the outcomes of the project in the benefits realisation review which will be carried out as part of the post project evaluation.

The key principles of these planning activities are:

- Ensuring benefits are clearly defined and understood at the outset, are robust and based on accurate modelling.
- Planning the points or milestones in the implementation phase where benefits should be realised, so that activities can be driven towards the right outcome.

- Tracking progress during the project and beyond, as benefits realisation may occur during or after the closure of the project.
- Assigning ownership of each benefit area to ensure focus is maintained.
- Key Performance Indicators (KPIs) and measures for assessing benefit realisation.

Risk Management Planning

The strategy, framework and plan for dealing with the management of risk follows the Hawke's Bay Project Method framework for managing risk which aligns with HBDHB's risk management policy OPM040.

Risk register

Identifying, evaluating, planning and resourcing responses/mitigations and monitoring risks will all be undertaken and logged in the project's risk register on a regular basis throughout the project. The register lists all the identified risks and the results of their analysis and evaluation. Information on the status of the risk is also included. The risk register is intended to be continuously updated and reviewed throughout the course of a project with risks rated high or above appearing in the monthly project status report that is submitted to the projects steering group.

Table 26: Risk register

Key Risks						
Ref No	Title & Cause	Description	Implication	Owner	Current Rating	Treatment Plan
R_05	Project resourcing if the project is not sufficiently resourced	then this could cause crucial delays in the progress of this project	any delays further add risk to the end of life equipment fatally breaking down before this project replaces them	Janet Heinz	Extreme	Ensure approved project resource budget for the execution of the project includes all costs associated with fully resourcing this project through to completion
R_04	Equipment breakdown if the end of life MRI and Fluoroscopy equipment fatally break down before they are replaced	then both acute and elective exams would not be able to be performed in house	Could cause elective wait times to grow extensively whilst we wait for this project to complete. Acute cases would need to be transported for assessment either to TRG at Royston or out of region	Janet Heinz	Extreme	Business case is being expedited to completion ready for approval. Project schedule is being updated in preparation for the execution stage of this project
R_03	loss of IANZ accreditation if the project does not rectify the CAR's issued for environment and safety	then IANZ could revoke accreditation	Radiology department will be in breach of the ACC high tech contract, National Bowel Screening programme and struggle to retain and attract skilled staff	Janet Heinz	High	Radiology will continue to update IANZ on progress via their quarterly reporting

The following process will be followed for change requests:

1. Potential changes will be recorded as risks
2. Formal change requests will be raised and documented in the projects change register outlining the change and its consequences
3. If a decision cannot be made about the change at the steering group level it will be raised to the change authority for a final decision

Post-Project Evaluation Planning

A post implementation review is planned for one year post project closure to analysing the success of the project against the anticipated improvements and benefits. Benefit realisation reviews to determine if the project is delivering its anticipated improvements and benefits, will be undertaken on a quarterly basis leading up to the completion of the Post implementation review.

Next Steps

This Single Stage business case seeks formal approval from Hawke's Bay District Health Board to approach the market for services and progress the implementation of the preferred option. Firstly the project manager will plan for the execution stage of the project by preparing the project initiation documentation and stage plan for the design stage. Architects will be hired and staff user groups formed to co-design the floor plan changes. The equipment specifications for the MRI and fluoroscopy units will be finalised and the procurement plan completed in preparation for tendering.

16.1

6 Appendix

Appendix One: Commissioner's Letter

[date]

[To whom it may concern]

Radiology Facilities Redevelopment Single Stage Business Case

This Single Stage Business case is a significant deliverable of a strategic project by the Radiology Department at Hawke's Bay DHB to investigate value for money options to meet its future requirements at Hawke's Bay Hospital.

I confirm that:

- I have been actively involved in the development of the attached investment proposal through its various stages
- I accept the strategic aims and investment objectives of the investment proposal, its functional content, size and services
- the indicative cost and benefit estimates of the proposal are sound and based on best available information
- the financial costs of the proposal can be contained within the agreed and available budget
- the organisation has the ability to pay for the services at the specified price level, and
- suitable contingency arrangements are in place to address any current or unforeseen affordability pressures.

This letter fulfils the requirements of the current Better Business Cases guidance. Should either these requirements or the key assumptions on which this case is based change significantly, revalidation of this letter of support should be sought.

Yours sincerely

Appendix Two: IANZ Corrective Action Requests

Table 27: CARs issued against HBDHB radiology department by IANZ

no.	CARs	Action required to clear the CARs	Final Clearance date	Current status
1	Personnel	<ul style="list-style-type: none"> Evidence of completion of recruitment initiatives for radiologist and MRT FTE and timelines for actual start dates. Evidence of forward planning and consideration to the examination/service matrix along with potential additional FTE (MRT, Nursing, Admin/support). Evidence of review of capacity/demand ratios and associated FTE requirements anticipated to meet demand. Evidence of confirmed outsourcing provision in the interim to meet demand and reporting within KPI expectations. Two monthly reports are required indicating evidence of progression with the first due 1 June 2017. 	3 April 2018	Resolution agreed in 2017 business case focussed on additional staffing
2	Accommodation & environment (Hastings Hospital)	<ul style="list-style-type: none"> Evidence of discussion and subsequent approval for a redesign plan, incorporating corrective actions to address the above listed issues. An implementation plan including expected timeframes for completion. Two monthly reports are required, including floor plans supporting the redevelopment, with the first due 1 June 2017. 	3 April 2018	Subject of this business case
3	Equipment replacement (Hastings Hospital)	<ul style="list-style-type: none"> Evidence of an approved Project Plan including detailed timelines for completion and risk management. Evidence of documented contingency plans for all areas in the event of failure. Two monthly reports are required indicating evidence of progression with the first due 1 June 2017. 	3 April 2018	Subject of this business case
4	Radiology equipment Wairoa hospital (X-ray)	<p>Provide evidence to IANZ of corrective action taken, along with indication of the expected timeframe for replacement of this unit.</p> <p>Note: Proactive resolution occurred during the course of the assessment with improvement to the recording of instances and replacement planning discussion initiated.</p>	5 July 2017	Subject of separate business case, outside of the scope of this project
5	Reporting of examinations	Document and communicate all policies, processes and procedures. The reporting policy must comply with IANZ and RANZCR requirements.	5 July 2017	
6	Document control	Review all quality management system documentation and associated templates and to apply appropriate document control parameters where required. Examples of the above listed documents are to be provided to IANZ.	5 July 2017	
7	Accommodation & environment - MRI	<ol style="list-style-type: none"> A self-closing mechanism installed on the sliding door from the corridor into Zone III. Facilitated access to the existing camera feed, or provision of an alternative, to ensure oversight of patients is maintained at all times. <p>Furthermore, when undergoing site redevelopment planning, consideration of Zoning compliance and functionality within the suite is expected.</p>	5 July 2017	Subject of this business case

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Appendix Three: Summary Presentation of the Long-list Options Assessment

Table 28: Options analysis of the long list of options

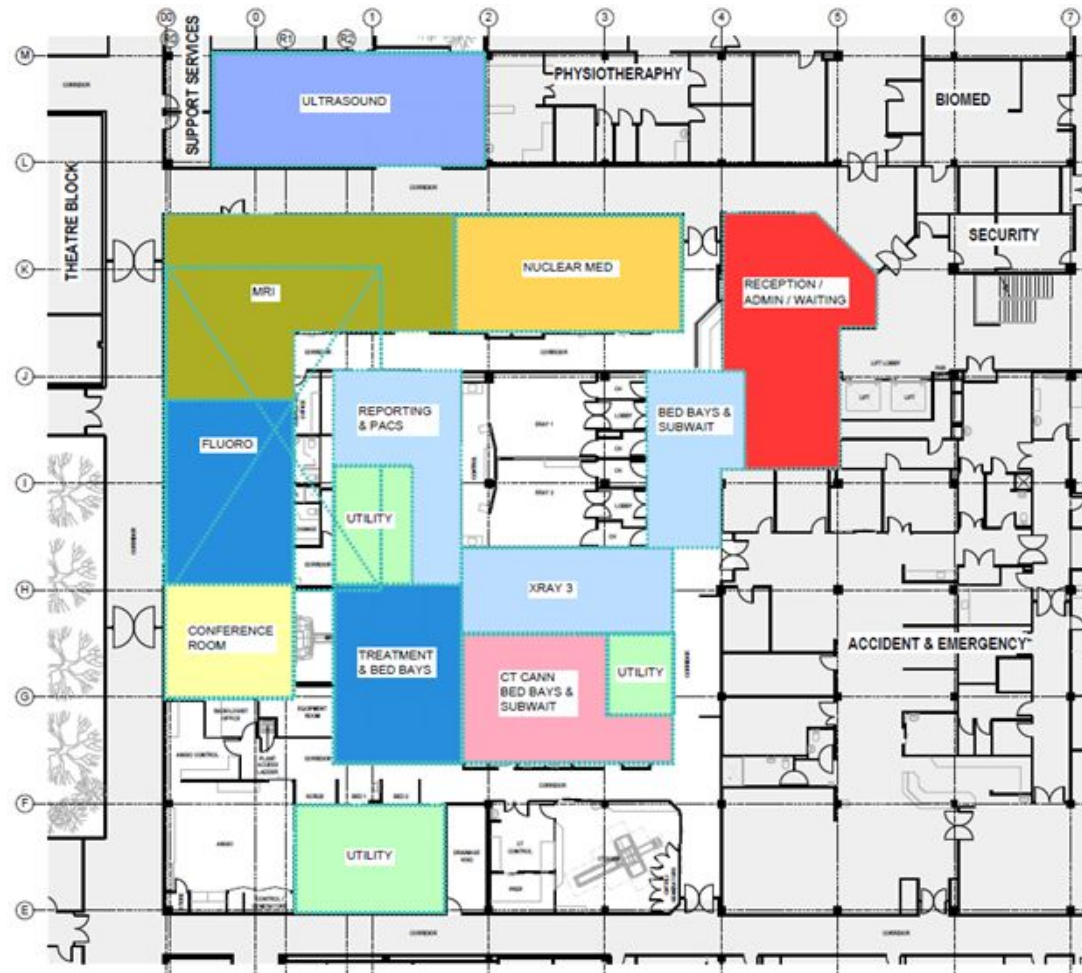
Reference	Scoping Options					Service Solution Options			Service Delivery Options			Implementation Options				Funding		
	SC01	SC02	SC03	SC04	SC05	SOL1	SOL2	SOL3	SD1	SD2	SD3	IMP1	IMP2	IMP3	IMP4	FUND1	FUND2	FUND3
Description of Option:	Do nothing	Minimum	Intermediate	Maximum	Outsource /PPP	In-house + outsource	In house	Outsource/ PPP	Status Quo	Align Capacity with demand	Outsource /PPP	Replace	Replace and Move	Phased replacement and build	Outsource /PPP	HBDHB capital	National capital committee funding	PPP
Investment Objectives:																		
Investment Objective 1	yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes
Investment Objective 2	No	Possible	Yes	Yes	Yes - contract requirement	Yes	Yes	Yes - contract requirement	Yes	Yes	Yes - Contract Requirement	No	Possible	Yes	Yes - Contract Requirement	Yes	Yes	Yes
Investment Objective 3	No	Possible	Yes	Yes	No	Yes	No	No	No	Yes	No	No	Yes	Yes	No	Yes	Yes	Possible
Critical Success Factors (CSF):																		
CSF 1	No	Partial	Yes	Yes	No	Yes	No	No	No	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes
CSF 2	No	No	Yes	Possible	No	Yes	No	No	No	Yes	No	No	No	Yes	No	Yes	Yes	Possible
CSF 3	Yes	Yes	Yes	Yes	Possible	Yes	Yes	Possible	Yes	Yes	Possible	No	No	Yes	Possible	Yes	Possible	Possible
CSF 4	Yes	Yes	Yes	Possible	Possible	Yes	No	Possible	Yes	Yes	Possible	Yes	Yes	Yes	Possible	Yes	Possible	Possible
CSF 5	Yes	Yes	Yes	No	No	Yes	No	No	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	No
Summary : Options progressed to the shortlist	Yes - continued to manage clinical risk ↓	Discounted	Preferred	Discounted	Discounted	Preferred	Discounted	Discounted	Discounted	Preferred	Discounted	Discounted	Discounted	Preferred	Discounted	Preferred	Possible	Discounted
Overall Assessment:				Yes														
Option 1	SC01 - replacement continued due to clinical risk					SOL1 - In house plus outsource				SD2 - align with services			IMP1 - Replace			FUND1 - HBDHB Capital		
Option 2	SC02 - Minimum					SOL1 - In house plus outsource				SD2 - align with services			IMP2 - Replace and Move			FUND1 - HBDHB Capital		
Option 3	SC03 - Intermediate					SOL1 - In house plus outsource				SD2 - align with services			IMP3 - Phased			FUND1 - HBDHB Capital		
Option 4	SC04 - Maximum					SOL1 - In house plus outsource				SD2 - align with services			IMP3 - Phased			FUND2 - Capital Committee		
Option 5	SC05 - Outsource					SOL3 - Outsource				SD3 - Outsource or SD 4 PPP			IMP3 - Release of funding as work done			FUND 3 - PPP		

Appendix Four: Floor plans
Existing layout



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Floor plan of layout of the proffered option (option 3)



Appendix Five: Glossary of Terms

Table 29: Glossary of terms used in this business case

Term	Definition
Computed Tomography (CT)	A CT scanner combines a series of x-ray data from multiple angles and processes these to form sets of cross sectional imaging. CT is the preferred method of imaging for many major conditions and is crucial in the management of patients due to its accuracy and speed. It has key applications for trauma patients, the management of acute symptoms such as chest or abdominal pain, management of spinal conditions, vascular anomalies, neurological defects, and cancer treatment. CT is also used in interventional work such as guided biopsy.
Digital Subtraction Angiography (DSA)	DSA is an imaging technique that uses x-rays and special dyes (contrast media) to show blood vessels in the body and with image processing can eliminate any anatomical structures that overlay the vessels.
Tesla (T)	Tesla (T) is the unit of measurement quantifying the strength of a magnetic field in an MRI machine. Prior to the 3 Tesla Machine, the high-field standard was 1.5 Tesla.
1.5T imaging	
3T imaging	3T MRI has a stronger magnet and makes better images of organs and soft tissue than other types of MRI. It is used to make images of the brain, the spine, the soft tissue of joints, and the inside of bones and blood vessels. Also called 3 Tesla magnetic resonance imaging and 3 Tesla MRI
Endoscopic retrograde cholangio-pancreatography (ERCP)	A diagnostic procedure used to examine diseases of the liver, bile ducts, and pancreas. ERCP is usually performed under intravenous sedation rather than general anaesthesia.
Fluoroscopy	An imaging technique to obtain real-time moving images of the internal structures of a patient using radiation. Examinations often involve the administration of a contrast agent (e.g. barium) to show particular features in greater detail.
Image intensifiers (II)	II's are used in x-ray imaging systems (e.g. fluoroscopes) and are often used in surgery.
Interventional radiology	Interventional radiology is a medical sub-specialty of radiology, which utilises minimally invasive image-guided procedures to diagnose and treat diseases in nearly every organ system. The concept behind interventional radiology is to diagnose and treat patients using the least invasive techniques currently available in order to minimise risk to the patient and improve health outcomes. The rise of interventional radiology means that interventional radiologists can now treat many conditions that once required surgery non-surgically.
Magnetic Resonance Imaging (MRI)	MRI uses radio waves and a strong magnetic field rather than radiation to provide clear and detailed pictures of internal organs and tissues.
Mammography	low-energy x-rays to examine the breast for diagnosis and screening. It aids in the early detection and diagnosis of breast diseases in women.
Medical Radiation Technologists (MRTs)	MRTs prepare patients and equipment for imaging studies, and produce and check the quality of diagnostic images. They provide information to patients about what will happen during their imaging study and undertake administrative or managerial tasks.
Multi-Disciplinary Teams (MDTs)	MDT's have become an established part of the process for planning and monitoring the care of patients. Radiologist input is a key component of this process.
Nuclear medicine	Nuclear medicine imaging scans are performed to: <ul style="list-style-type: none"> • evaluate bones for fracture, infection, joint diseases, tumours and other conditions not evident on X-rays or MRI • detect disorders of coronary artery blood flow and cardiac function with Rest/Stress myocardial perfusion scans • measure cardiac function (mostly an urgent scan performed for chemotherapy patients)

	<ul style="list-style-type: none"> • evaluate thyroid structure and function • lung scans, mainly for blood clot detection, especially in younger patients in whom the radiation dose from CT angiography may be an issue, patients with iodine allergy, or in patients with renal problems for whom contrast CT studies are contra-indicated • identify problems of the biliary tract and gallbladder • detect some uncommon cancers by way of specific tumour-seeking agents, and • identify the source and nature of bleeding into the bowel where other investigations have not succeeded.
Positron Emission Tomography (PET)	PET scans use radioactive isotopes to diagnose, locate and assess a disease process, especially cancers.
PICC line	A peripherally inserted central catheter or "PICC" is a thin, soft, flexible tube — an intravenous (IV) line. Treatments, such as IV medications, can be given through a PICC. Blood for laboratory tests can also be withdrawn from a PICC.
Radiologists	Radiologists are the medical doctors who specialise in diagnosing and treating diseases and injuries using medical imaging techniques. The Royal Australian and New Zealand College of Radiologists (RANZCR) radiology training programmes (for radiation oncology or clinical radiology) last for five years. Once RANZCR training is completed, doctors are awarded the Fellowship of the RANZCR. Once qualified, radiologists can subspecialise. Some examples of radiology subspecialties are paediatric, interventional, musculoskeletal, breast imaging, and neuro-radiology.
Ultrasound (US)	Ultrasound uses high frequency sound waves to examine soft tissue. It does not use radiation. The average length of time taken to perform an ultrasound is around half an hour. Ultrasound is used regularly for interventional work.

Appendix Six: Consumer stories

The two consumer complaints below are examples of some of the privacy issues that will be addressed when the CARS issued by IANZ are rectified.

Example 1

Compliant: January 2014

Details: staff member (named) yelling at elderly woman in wheelchair and not respecting her privacy.

Table 30: Whare tapa wha tool applied to Example 1 patient experience

Whare Tapa Wha	
How were the patient's physical needs not met	This elderly woman would be feeling physically vulnerable as evidenced by her being in a wheelchair and hard of hearing. She would have felt demoralised and embarrassed at being yelled at particularly as this was done in front of other people.
How were the patient's emotional needs not met	She is in radiology for an exam for which she is probably worried about. She may have felt lonely and depressed at being sat in a wheelchair, she might also have been feeling stressed and disorientated by the health system and therefore had trouble focussing on what was going on.
How were the patient's spiritual needs not met	She doesn't appear to have been treated with kindness or understanding.
How were the patient's whānau needs not met	She doesn't appear to have had any whānau support or carer with her to advocate on her behalf.

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Example 2

Compliant: August 2014

Details: Door was not shut – felt so embarrassed and invaded with somebody watching


Table 31: Whare tapa wha tool applied to Example 2 patient experience

Whare Tapa Wha	
How were the patient's physical needs not met	The examination this lady was having was not done in private even though she could see the means to do so were there.
How were the patient's emotional needs not met	She has felt embarrassed and invaded by the door being open and people seeing. Additionally she hadn't felt able to speak up to say she didn't feel safe and ask for the exam to stop or for her privacy to be protected.
How were the patient's spiritual needs not met	She doesn't appear to have been asked if she was comfortable or felt that it was safe and okay for her to voice her concerns or that the staff would respond kindly and rearrange things to make her more comfortable if she spoke up.
How were the patient's whānau needs not met	She doesn't appear to have had any whānau support with her to advocate on her behalf.

Appendix Seven: Project Risks

Table 32: Risk register for project

Drop-down button	Type in text	Drop-down button	Drop-down button	Automatic	Automatic	Type in text	Type in	Drop-down button	Type in text
Risk Category	Risk Description	Likelihood	Impact	Combine	Severity	Mitigating Actions / Status Update	Risk Owner	Status	Status Update
Project Management	If Stakeholders are missed / not included in engagement plan then this could result in delays and/or additional rework which could delay the planned completion date and add cost to the project.	L	H-	LH-	-6	1. Complete Stakeholder analysis and engagement planning 2. Establish meetings/ensure membership covers all stakeholders or groups. 3. Staff notices as an update tool. 4. comms plan	Project Manager	Open	7/8 - Stakeholder analysis drafted
services	disruption of services through breakdown of fluoroscopy unit	L	H-	LH-	-6	keep maintenance upto date, ensure replacement parts are available	Angela Fuller	Open	07/07 - Meeting scheduled for 21 July between HBDHB & Mid Central reps
services	disruption of services through breakdown of MRI	L	M-	LM-	-3	keep maintenance upto date, ensure replacement parts are available	Angela Fuller	Open	07/07 - Risk accepted, watching brief with continued comms between parties
Communication	poor communication can lead to confusion and incorrect understanding of the project and what the outcomes will mean	M	M-	MM-	-5	ensure managers are keeping their teams up to date. Use of any comms resources, facebook, website Internal comms plan - support from ?	Project Manager	Open	commence discussion with comms team
Communication	managing stakeholder engagement and expectations of outcomes	M	H-	MH-	-7	clear regular communication - as per the comms plan,	Project Manager	Open	07/07 - waiting on completion of comms plan
Communication	poor engagement with affected staff may create delays to progress and outcomes	M	H-	MH-	-7	employing business services champions Provide outputs from meetings	Angela Fuller	Open	7/8 first presentation to radiology staff
Project Management	Any time line slippage will have an impact on when the business case can go for approval which in turn will have a knock on impact to implementation	H	M-	HM-	-8	readdress time line Identify approval pathway and map out timeline readdress financials, including costs of project and cost on DHB for delayed results	Project Manager	Open	07/08 - updated the project timeline,
Project Management	scope creep on project and on model of care	H	H-	HH-	-9	clinical group set up to address decisions around model of care and provide clarity as project boundaries require.	Project Manager	Open	07/08 - Agenda item to agree scope items
Project Management	project not sufficiently resourced throughout then this could cause crucial delays in the progress of this project. Any delays further add risk to end of life equipment fatally breaking down before this project replaces them	L	H-	LH-	-6	Ensure approved project resource budget for the execution of the project includes all costs associated with fully resourcing the project through to completion. Ensure all project team members are across all of the aspects of the	Paula Jones	Open	
Financial	If funding for this project is not secured before the project reaches the end of design it could cause the project to be put on hold until this is resolved which could make it difficult for the project to meet its timeline	M	H-	MH-	-7	the business interests of the project are working on securing funding	Paula Jones	Open	In progress

	CLINICAL SERVICES PLAN (CSP) – Final Draft Clinical Services Plan Engagement Feedback Summary	166
	For the attention of: HBDHB Board	
Document Owner:	Kevin Snee, CEO	
Document Authors:	Ken Foote (Clinical Services Plan Project Sponsor & Company Secretary) and Hayley Turner (Clinical Services Plan Project Manager, Planning and Strategic Projects).	
Reviewed by:	Executive Management Team, Māori Relationship Board, Pasifika Health Leadership Group, HB Clinical Council; and HB Health Consumer Council	
Month:	November 2018	
Consideration:	For Review and Endorsement	

RECOMMENDATION:**That the HBDHB Board:**

1. **Review** the summary of the engagement feedback
2. **Note** the endorsement and recommendations from EMT and all four governance groups
3. **Approve** the final version of the Clinical Services Plan

PURPOSE OF THIS PAPER

The purpose of this paper is to provide a summary of the process collating all feedback at close of the CSP engagement activity, key themes of feedback received and a summary of changes to be included in the final CSP document and recommend approval of the final version of the CSP

A tracked change version of the final CSP is attached, showing all the changes / additions made in response to submissions received.

A full schedule of all submissions received is available if required. This will be placed on the Our Health Website in due course, in the interests of full disclosure and transparency

CONTEXT

The Engagement Activity concluded on the 31st October, and overall the feedback received was positive and accepted the CSP direction.

Feedback Received:

- Total feedback received =55
 - Phone=0

- Email (including letters)= 33
- Pamphlet= 22
- Sources of feedback came from:
 - Community (general public, community groups)
 - Health sector (DHB staff, PHO, community providers)
 - Intersectoral partners (At Matariki and formal feedback received from Hastings District Council and Napier City Council)
- Additionally the project team received a lot of general feedback and valued discussions from various meetings/individuals throughout the engagement process.

Feedback Responses:

Not all feedback received was relevant to complete the final version of the CSP. Response to this type of feedback was “noted” and a summary of this type is listed below:

- Support/affirmation of the CSP with no highlighted gaps or feedback.
- Next phase: Requests for more detailed planning to be carried through to the next phase as part of the strategic planning process.
 - Phasing - this was indicative only at this stage.
 - Information around the how all the plans will be integrated and where services feature.
 - Detail around the elements/options in terms of priority and decision making for investment.

Accepted changes to be incorporated into the final CSP:

Feedback received that has been included in the updated version included the following

- Language changes
 - Incorrect/ lack of use of the Te Reo Māori. An example includes the description of using Māori health model, Te Whare Tapa wha but thereafter only using English to describe the four dimensions and not Te Reo. This has now been incorporated into the plan.
 - Terminology or spelling corrections
 - Definitions: including extra definitions such as “Equity and inequity”
 - Clarification
 - Enhanced elements/options
- Additional paragraphs/section to the CSP
 - Environmental sustainability – Not originally covered, but have now included reference this as part of determinants of health and impact on inequity and long term conditions.
 - Dying well – Not originally covered, but have now included under person and whanau centred care and wraparound services.
 - Preventative care/population health/public health – covered within the “plan in a nutshell” but was not sufficiently covered within the plan. This has now been carried through and developed within the plan, examples include the three pillars of health (diet, exercise and sleep).
 - Behavioural economics – Linked to the above as part of understanding the consumer and their needs.
 - Early intervention to dementia – has been added.
 - Tamariki (Children) and Rangatahi (youth) - as a key focus of the plan, this was deemed too general and required further development within the plan.
 - Support services – previously community pharmacy, radiology, laboratory and dietitians were not sufficiently covered. It is recognised that these services may need to change to support the new models of care and therefore have now been included through relevant sections of the CSP.

- Place based planning – Whilst important to recognise community needs by geography, it was also highlighted that the plan did not include “communities of interest” being cohorts of consumers with similar health needs and not necessarily within a geographic area. Applying the same approach and principles used within place based planning would fulfil this requirement.

Governance Reviews:

A similar summary and tracked change version of this final CSP have been considered by: Executive Management Team, Pasifika Health Leadership Group, Māori Relationship, HB Clinical Council and HB Health Consumer Council.

With some very minor additions each of these groups have resolved to:

- Endorse the listed changes for the final version of the CSP
- Recommend that the Board approve this final CSP

In their own way, all the above governance groups expressed very strong desires to see the commitments, concepts and themes in the CSP translated into meaningful actions and impact ‘on the ground’, as soon as possible.



Transforming Our Health Services

Clinical Services Plan: the next ten years

17.1

~~Draft August~~ Final November 2018

Karakia

Rurukutia rurukutia

Rurukutia te poutiriao o mahara

Paiheretia i a Ranginui atea ki a Papa-tua-nuku

Pihi ake te whakaaro pai

Hauhake tonu iho

Kia Ukaipo

Haumie Hui e Taiiki E

Prepared by
Sapere Research Group Limited
For Hawke's Bay District Health Board
July-November 2018





Mihi

‘He mangawai koia e kore e whitikia’

‘A river never to be crossed’¹.

Rerehua a wairua i te kāpehu o Urutengangana,²

Ka rangona e te whare o Rongo.

‘Beautiful is the soul that soars through the compass of Urutengangana,

And it embraced in the home of Peace’.

Kei aku nui, kei aku rahi, tēnā koutou katoa kua emi mai ki tēnei rautaki whakaaro, kua eke mai ki tenei waka hauora. He oranga wairua, he oranga tinana, he oranga tangata.

Ka hoki te pae o mahara ki ō tātou tini mano kua karapinepine atu ki Te Kāpunipunitanga O Wairua³. E māringiringi mātuturu tonu ana ngā roimata, he maimai aroha ki a rātou. Okioki mai.

Nei rā ngā whetū e tiaho mai nei i te maramatanga hei atawhai, hei arataki i te iwi e anga whakamua ai tātou, e mahea noatia ai ngā taimahatanga.

Heoi anō, ka wani kē te waihangatanga o te hōtaka nei, hao ai i ngā tukanga poipoi whānau o mōhoa nei.

Mātuarautia te whānau, te iwi - kia pihi ake a kounga, hauhake tonu iho.

Mā reira a kāpehu mātāpono⁴ - a Āwhina, a Atawhai, a Manaaki, a Mirimiri.

Mātika maranga e tū, huakina e Tāne.

¹ A comment from Kahungunu on his journey south of Kaitiaki.

Essentially, you cannot cross a river by looking at the waters and wishing it will happen. You have to jump into the waka, and paddle for your life! Be prepared, be strong of heart, and draw on all the strength of those around you. The future will not wait for those that ponder.

² Urutengana the eldest child of Rangi and Papa was given the task of looking after the stars the planets. They know not of jealousy but live together in celestial harmony. It is a korowai woven from the universe joining the physical and spiritual elements of life.

³ The place where the spirits gather

⁴ Principle guiding points



Foreword

If you live in Hawke's Bay, you will want to know that the right health care services are there for you and your whānau when you need them.

Over the period June 2017 to July 2018, Hawke's Bay health professionals, who live and breathe the way we deliver services and care throughout the region, governance groups, as well as a wide range of people who use our health care services, brainstormed ideas and provided their thoughts and feedback to draft a future-thinking health care services concept plan, called the Clinical Services Plan. Thousands of people were engaged in either this process or the wider public consultation so we could establish if we were on the right track.

This draft plan set out the themes and range of options that we believe will best meet future health service needs in Hawke's Bay—what services will be delivered, how they will be delivered and where they should be delivered—looking out for the next 10 years.

During September and October 2018, we asked the wider Hawke's Bay population—have we got this right? The consistent answer to this question was YES.

The general feedback received was positive and affirming, with a number of recommended refinements being included in this final version of the plan.

The Board has now approved this final concept plan, so we will now begin working on prioritising, designing and implementing those services, as well as identifying what future workforce and infrastructure we will need to meet the future health needs of our community.

Meeting the goals identified in the Clinical Services Plan will be challenging, and will require collaboration and commitment from both our health sector partners and the community.

It is, however, both necessary and achievable and provides us with a road map to follow.

If you live in Hawke's Bay, you will want to know that the right health care services are there for you and your whānau when you need them.

Over the past 12 months, Hawke's Bay health professionals, who live and breathe the way we deliver services and care throughout the region, governance groups, as well as a wide range of people who use our health care services, have been brainstorming and providing their thoughts and feedback to draft a future-thinking health care services concept plan, called the Clinical Services Plan.

We think we have come up with the right themes and range of options that will best meet future health service needs in Hawke's Bay—what services will be delivered, how they will be delivered and where they should be delivered—looking out for the next 10 years.

Now we are asking the wider Hawke's Bay population—have we got this right?

Once we collect all your feedback, we will finalise this concept plan and begin working on prioritising, designing and implementing those services, as well as identifying what future workforce and infrastructure we are going to need to meet the future health needs of our community.



This is an once in a lifetime opportunity to be part of helping to shape Hawke's Bay's future health services.

We want to hear from you, and welcome your feedback to the draft Clinical Services Plan.

KEVIN SNEE
Chief Executive Officer
Hawke's Bay District Health Board

KEVIN ATKINSON
Chair
Hawke's Bay District Health Board

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Table of contents

Foreword	ii
The plan in a nutshell.....	v
INTRODUCTION.....	1
1. This plan sets our direction for the next ten years.....	2
2. We face a major challenge	5
Inequities persist for some groups in our population.....	5
We cannot continue with the status quo	6
We need a new approach to achieve equity and meet future demand.....	9
We have pockets of service excellence already and will build on these in our new system.....	10
3. Our commitment to achieving equity underpins this plan.....	11
A new approach to commissioning is required to ensure equitable access and outcomes	
12121211	
We will support people to make good choices by making health easy to understand	13
We will provide appropriate services responses for different groups	14
THE PLAN	16161615
4. We have a range of options for responding to the challenge	17171716
Place-based planning	18181817
Evolving primary health care	22222120
Working with whānau to design the services they need	27272625
Relevant and holistic responses to support mental wellbeing.....	32322928
Keeping older people well at home and in their communities.....	36363231
Specialist management of long term conditions based in the community	41413735
Well supported transitions from hospital	45454038
The hospital takes a narrower focus in future	49494341
Surgical services continue to be refined	55544846
5. We will put the right support structure in place to achieve our vision for the future	58575149
Growing our workforce is critical to the delivery of a new model of care	58575149
Better information and communication technology will enable us to work smarter	59585250
Assets and infrastructure	62615451



Governance and leadership	<u>62615452</u>
Health and business intelligence.....	<u>63625552</u>
Creating a learning and innovation culture	<u>63625552</u>
6. We aim to make a significant impact on the system.....	<u>64635754</u>
We have a bold goal to achieve equity	<u>64635754</u>
A significant impact means the hospital footprint will not be increased	<u>64635754</u>
So what happens next?	<u>64635754</u>
7. List of acronyms and te reo Māori terms	<u>66655956</u>
8. References	<u>67666057</u>
Appendix 1: Hospital bed projections scenario analysis.....	<u>70696360</u>
Appendix 2: Hawke's Bay population profile.....	<u>73726663</u>
Appendix 3: CSP engagement process	<u>77767067</u>



The plan in a nutshell

Our purpose

We have developed this clinical services plan to formulate our major responses to the challenges we face. It describes our vision for a very different health system that improves outcomes and experience for individuals and whānau living in Hawke's Bay. This plan is the natural evolution of our previous five year strategy, 'Transform and Sustain', and together with a number of related projects will inform our next strategic plan.

We cannot continue with the status quo

Māori and Pasifika, people with disabilities or experience of mental illness; and those living in socioeconomic deprivation, continue to experience unacceptable inequities in health outcomes. Our system is increasingly seeing the effects of poverty, inadequate or delayed access to services, and significant unmet need.

Demographic changes will increase pressure on our already stretched health services. Māori and Pasifika are more likely to live in deprived areas and their higher growth rate is reflective of the increasing social complexity associated with future health service activity.

If current models continue over the next 15 years, the number of primary care consultations will increase at a rate that is higher than the overall population growth. This is driven by the rapid increase for older people, which almost doubles, bringing with it an increase in complexity and time required to manage multiple co-morbidities and frailty. Similarly, under current models demand for hospital admissions will increase by around one-quarter. Increasing complexity and length of stay driven by an older consumer profile means demand for beds will be even greater. Demand for Māori will increase more rapidly than for other groups.

It is clear we need a new approach if we are to achieve equity amongst our population and meet future demand. We cannot sustain services into the future if we continue to provide them in the same way we do now.

What impact do we want to make?

This plan establishes a firm commitment to prioritising and designing services to meet the needs of populations with the poorest health and social outcomes. We have a bold goal to achieve equity and will monitor this through our system level measures and related performance indicators.

Person and whānau centred care will become the 'way we do things around here'. This means that we will work *with* consumers and whānau rather than doing *to*, or *for*, them. Research shows that person and whānau centred care improves health outcomes and consumer experience, and the use of health resources.

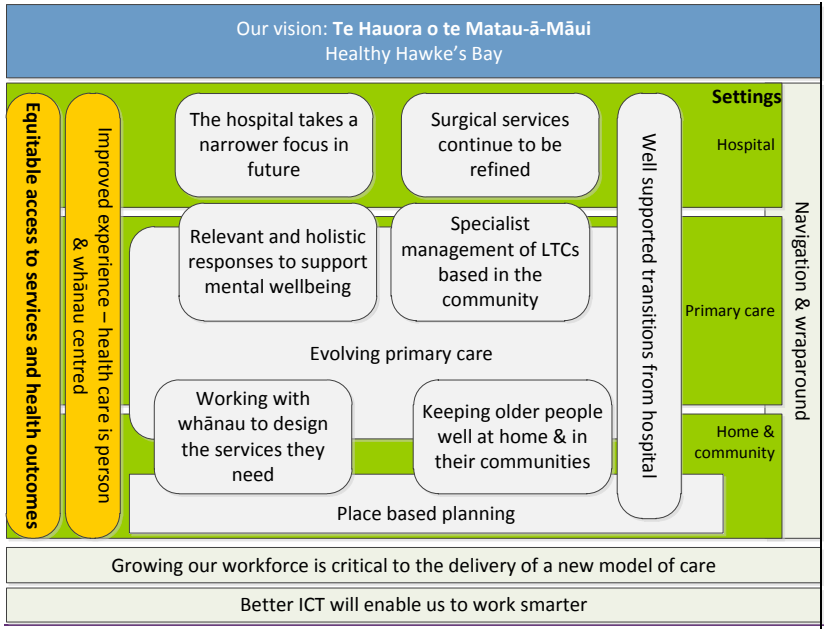
We aim to fundamentally shift our system and invest more in preventative ~~care strategies~~ and primary health services, to improve consumer experience and outcomes, and avoid the need for more costly hospital treatment wherever possible. We will support people to stay well in their own homes and communities.



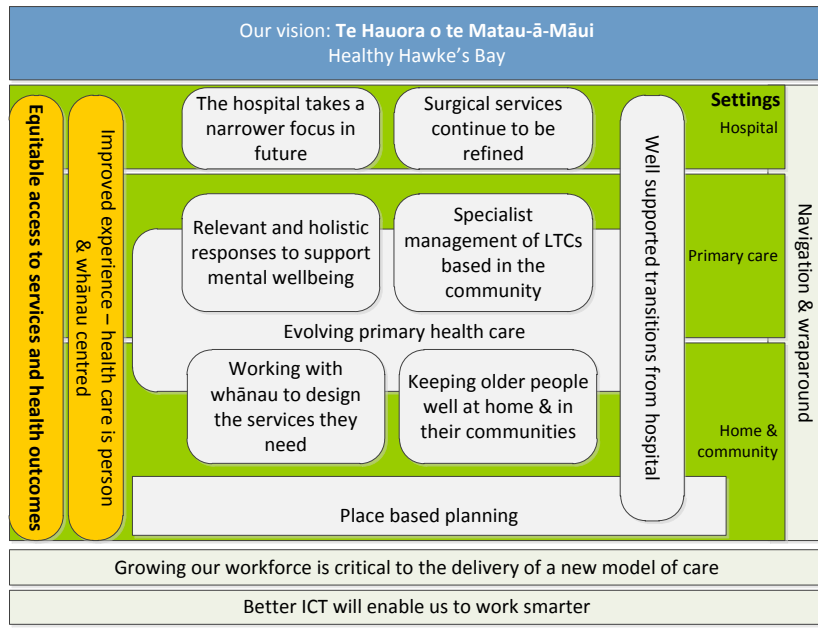
We will change the way we commission services. This means that needs assessment will be data driven but will also take a broad approach to community resources. People and whānau will be equal partners in the planning and co-design of services. We will refocus resources in the areas that will make a real difference to eliminating unmet need and inequities, and align incentives so providers are encouraged to innovate.

Our future health system

We have formulated a range of options for responding to the challenges we face, organised around key themes developed with stakeholders in the Hawke's Bay health system. The diagram sets out the key areas for change (in grey), highlights the overarching outcomes we want across all parts of the system (yellow), and sets out the critical enablers to a new system of care.



17.1



Place-based planning will provide us with a strong platform to work collaboratively with communities to build on natural assets and co-design services, including primary [health](#) care.

Evolving primary [health](#) care is the lynchpin of our plan, with expanded teams offering a wider range of culturally relevant services. In Hawke's Bay, we will develop our own local model that embeds kaupapa Māori practice and builds on the strength of our iwi-led services. Consumers and whānau will be able to interact with their care teams in different ways than they do currently, including virtual and web-based options and same day access.

There are two priority population groups we need to respond to: whānau with children and young people, and older people. Meaningful collaboration with **whānau to design the services they need** is crucial if we are to eliminate inequities and ensure children have the best start in life. There is good evidence around the impact that adverse childhood experiences have on future outcomes. This means we need to support the whole whānau, to achieve its goals and aspirations.

At the same time, we recognise our population is ageing and we will step up our response to **keep older people well at home and in their communities**. We will identify frailty, developing person and whānau led plans that enable proactive and preventative [intervention strategies](#), and ensuring we provide the best and most appropriate care when health events occur.

We expect the prevalence of long term conditions to increase as the population ages, and we will base the **management of long term conditions firmly in primary care**. The emphasis will be on prevention and proactive self-management, and the majority of specialist clinicians will operate as



‘wraparound’ specialists integrated with primary care instead of ‘destination’ specialists requiring consumers to attend hospital.

Care for mental health and addictions is a priority for our health system. We will develop ground up, **relevant and holistic responses to support mental wellbeing**. Primary and community care will facilitate direct access to self-management, wellness and resilience programmes for people with emerging mental health and addiction issues. Good support in primary and community services will include early recognition and referral for specialist services so that those with the most severe and complex needs receive rapid attention by the right level of expertise.

There will always be a need for inpatient hospital care. When it happens, we will engage consumers, their whānau and other support people, and community providers in planning for **well supported transitions from hospital**, from day one. Intensive rehabilitation will be available in the home so people don’t spend longer than necessary in hospital.

Many of these themes are inter-related, and all of them are building blocks to achieve our goal that **the hospital takes a narrower focus in future**. If we can achieve our ambition in other areas, in future the hospital will be a place providing specialist assessment and decision making for patients with critical illnesses or injuries, followed by intensive therapies for the first 24-48 hours of inpatient care before discharge or transfer to community settings; or delivering services that require specialist teams or equipment that isn’t feasible or cost effective to replicate in multiple settings. Better community based support for mental health and addictions issues will ensure that specialist mental health services at the hospital are focused on those with the highest complexity and need.

We will focus on prevention and non-operative management, but the requirement for surgery will inevitably increase as the population ages and **surgical services will continue to be refined**. In future we will deliver some procedures in different settings, develop a more comprehensive ambulatory surgery model, and organise ourselves in networks with other DHBs for more complex specialties.

All of this relies on us **growing our workforce**, creating new roles and expanding scopes of practice, embedding cultural competency and person and whānau centred care; and the implementation of modern **ICT** to enable sharing of information and new ways of delivering services.

So what happens next?

A number of things in this plan we need to just ‘get on and do’. Other elements will be incorporated into upcoming annual planning cycles as they require investment or more detailed development. But to achieve the more profound change we are seeking, some core parts of this plan are strategic decisions that will be taken through to our five year strategy.

17.1



17.1

INTRODUCTION

Page | 1



1. This plan sets our direction for the next ten years

The clinical services plan is the evolution of our strategic planning

We have developed this clinical services plan (CSP) to formulate our major responses to the challenges we face in the coming years. It describes our vision for a very different health system that improves outcomes and experience for individuals and whānau living in Hawke's Bay.

The CSP informs the priorities for future investment in the Hawke's Bay health system. It sets out the potential demand for services in the future and a range of service and model of care options for how the District Health Board (DHB) and its health and social system partners will respond to that demand. The plan takes a view of the health system as a whole, encompassing primary [health](#), community, and hospital level care; and acknowledging the important influence of socioeconomic determinants. The planning horizon is long term and considers options for the Hawke's Bay health system over a ten year time frame.

Over the past five years, we have shifted our perspective from DHB services to whole system management and engagement with iwi and post-settlement governance entities, with our strategy 'Transform and Sustain'. We set up our Consumer Council to work alongside our Clinical Council and Māori Relationship Board, and have generally performed well over a number of years. Now, we need to step up our focus on achievement of equity, the development of primary [health](#) care, changing our culture, working with local public and business partners, reviewing services across the whole system and considering our infrastructure requirements. Transform and Sustain set us up well for this challenge, and this CSP is the natural evolution of our planning.

The CSP will inform our next five year strategic plan. It is just one input to the strategic plan—we have undertaken and are in the process of other important, and related, pieces of planning work. These related projects will be considered together with the CSP, to determine the investment priorities for our future health system.



Our vision and values guide our approach



OUR VALUES



OUR VISION

*Tā mātu whakarehu
Te hauora o te matau-ā-m āui
Healthy Hawke's Bay*

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

17.1



The plan relates to national and regional priorities

This CSP sits within the context of the New Zealand Health Strategy, and other plans or strategies in the Central Region and at the national level. A number of other national strategies set the scene for this CSP, including the NZ Disability Strategy, He Korowai Oranga and Ala Mo'ui.

The Government has established a review into the health and disability sector to identify change that could improve the performance, structure and fairness of the sector. The Review seeks to address the 'pervasive inequities that exist across our health system' and achieve a sustainable public health service in the face of demographic and inflationary pressures. Mental health and addictions and primary care have been identified as areas to be strengthened.

We are also part of the Central Region and rely on our regional DHB partners for provision of some tertiary level clinical care. Regional service arrangements will remain part of the landscape over the life of this CSP and we are committed to the Central Region Services Plan. The current plan focuses on three priority areas, which align to our own local priorities: a health system that is digitally enabled, clinically and financially sustainable, with an enabled and capable workforce. The Plan also provides for the development of specialised care networks across the Central Region, for example cardiac and cancer services.

It has been developed after engagement across the system

Creating the CSP for the Hawke's Bay Health System involved four main stages:

- 1. Understanding the current state of service provision and challenges for the future**
Stage one brought together clinicians and managers in individual service groupings to identify the main issues and challenges of current provision, as well as highlight the good things already happening, and consider the implications of future service demand projections.
- 2. Mapping healthcare journeys through patient journey workshops**
Patient journey workshops provided an opportunity for health professionals, consumers and other stakeholders to identify areas for improvement in the care chain, from a consumer perspective, rather than an organisational perspective. Eleven journeys were mapped over eight workshops.
- 3. Exploring options for service and model of care development in broad areas**
We held workshops around four broad topics: primary [health](#) care, unmet health and social needs, caring for frailty, the hospital. Participants included consumer representatives, health professionals and managers.
- 4. Expanding those possibilities and bringing it all together**
To build on stage three, we held a final workshop to expand and integrate the CSP options, and identify a sense of priority. Participants included all those involved stage three, along with senior leadership and a number of key individuals supporting the next phase of strategic planning in Hawke's Bay.



2. We face a major challenge

Inequities persist for some groups in our population

Looking across the Hawke's Bay health system, inequities and unmet needs persist. Māori and Pasifika, people with disabilities or experience of mental illness; and those living in socioeconomic deprivation, continue to experience unacceptable inequities in health outcomes. Growth in inequities is also fuelling health need. The system is increasingly seeing the effects of poverty, inadequate or delayed access to services, and significant unmet need. [Housing is a well-recognised driver of poor health and inequity in Hawke's Bay.](#)

Alongside this, disability now accounts for over half of the total health loss experienced by the New Zealand population (Ministry of Health, 2016). While increasing resources are required to support older people with both volume and complexity of services increasing, we are not meeting the needs of many in our communities, particularly young Māori and Pasifika families.

Our DHB health equity updates give us a chance to see how we are progressing in some of the key measurable areas of health inequity.

Key findings from our updated health equity monitoring include:

- Immunisation rates are high with no difference between Māori and Pasifika, and children of other ethnicity.
- Cervical screening rates for Māori and Pasifika women are only slightly lower than for women of 'other' ethnicity, however the rate for Asian women is low in comparison.
- There has been a trend towards a decrease in the prevalence of amphetamine use in Hawke's Bay, meaning equity compared to the rest of New Zealand is improving.
- Avoidable hospital admissions for children under five are low compared to ~~national~~, ~~national~~; however the reductions for Māori and particularly for Pasifika children have not been sustained.

There remain many areas of inequity amongst our population:

- Progress in reducing the gap in avoidable deaths between Māori and non-Māori has stalled since 2012.
- The prevalence of psychological distress among adults is higher in Hawke's Bay than any other DHB in the country and there has been no sign of improvement over time.
- Admissions to mental health inpatient services have increased significantly and Māori continue to be admitted at over twice the rate of non-Māori.
- Hazardous drinking is significantly higher amongst Māori compared to non-Māori.
- There has been no improvement in bronchiolitis admissions for 0-4 year olds since 2011, and no reduction of the gap between Māori and Pasifika, and other children since 2013.
- Despite a small improvement since 2015 in the proportion of Māori 5 year olds with no dental decay, a large inequity persists, and there has been no improvement for Pasifika children.



- Māori and Pasifika in Hawke's Bay are less likely to have adequate diabetes control than European or Asian.
- Breastfeeding rates are lower than the national average and lower for Māori and Pasifika.
- Prevalence of obesity has increased across all ethnic groups in Hawke's Bay and our rate is higher than national. Pasifika and Māori, and those living in deprived areas, have higher prevalence.
- Tobacco smoking has decreased but is higher amongst Māori compared to non-Māori. Māori women are still nearly three times more likely to smoke than non-Māori women, and the proportion of Māori mothers smoking during pregnancy increased in the latest year.

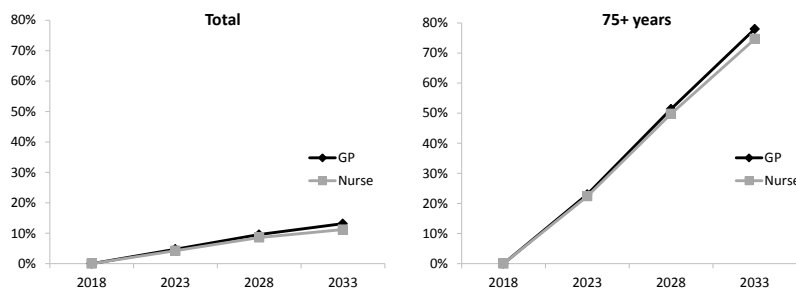
We cannot continue with the status quo

The Hawke's Bay population is not projected to grow significantly over the next 10–15 years, but the profile of our population will change. Like the rest of New Zealand, we will experience substantial ageing with a much greater proportion of older people in the community. Our Māori, Pasifika, and Asian populations will grow, representing a greater proportion of our total population in future. These demographic changes will increase pressure on our already stretched health services. Māori and Pasifika are more likely to live in deprived areas and their higher growth rate is reflective of the increasing social complexity associated with future health service activity. This complexity is likely to change the nature of many interactions between consumers and health professionals, and interactions may take longer.

The increasing prevalence of long term conditions such as diabetes, heart disease and arthritis will place additional strain on our health services and we need to find better ways of working with people and communities to prevent and manage their impact. [The liveability of our communities and the environments that shape our behaviour are also important influences on the development of long term conditions.](#)

If current models of general practice continue over the next 15 years, the number of consultations will increase at a rate that is higher than the overall population growth ([Figure 1](#)~~Figure 1~~[Figure 1](#)). This is driven by the rapid increase for older people, which almost doubles, bringing with it an increase in complexity and time required to manage multiple co-morbidities and frailty.

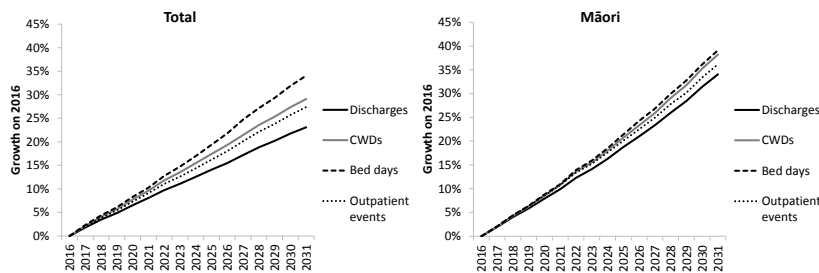
Figure 1 Percentage growth in primary care consultation volumes on 2018 base





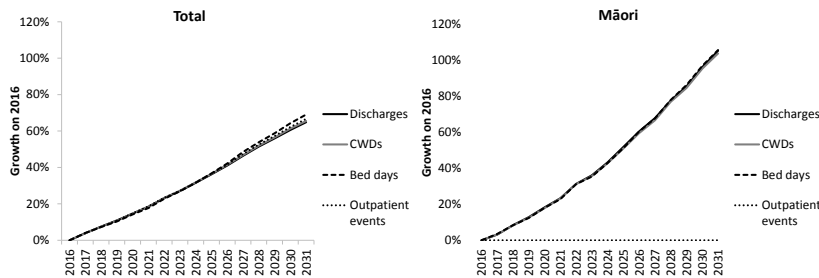
Similarly, under current models demand for hospital admissions will increase by around one-quarter. Increasing complexity and length of stay driven by an older consumer profile means demand for beds will be even greater (Figure 2 Figure 2 Figure 2). Demand for Māori will increase more rapidly than for other groups. Although our population appears to be reasonably well serviced for elective surgery compared to the national average, we have significantly lower rates of orthopaedic and plastic surgery.

Figure 2 Percentage growth in hospital volumes on 2016 base



Within this overall growth picture, hospital demand for older people will increase substantially, by around two-thirds (Figure 3 Figure 3 Figure 3). We will need to respond appropriately to the increasing care requirements of kaumātua—hospital demand will double for older Māori. Under the status quo, we would see increases in admissions in the order of 40–60 percent for key areas of older persons' activity such as general medicine, ophthalmology, rehabilitation and community nursing.

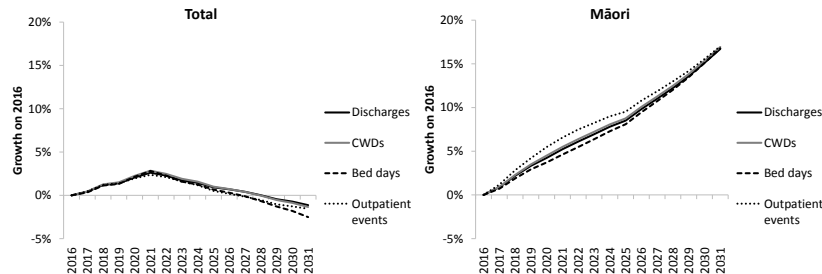
Figure 3 Percentage growth in volumes on 2016 base, 65+ years



We don't expect significant change in the overall number of hospital events for children, but within that there will be a steady growth for Māori children, driven by the higher birth rate (Figure 4 Figure 4 Figure 4). This change in the child population being seen by our health services is one that is likely to bring with it an increase in need and social complexity.



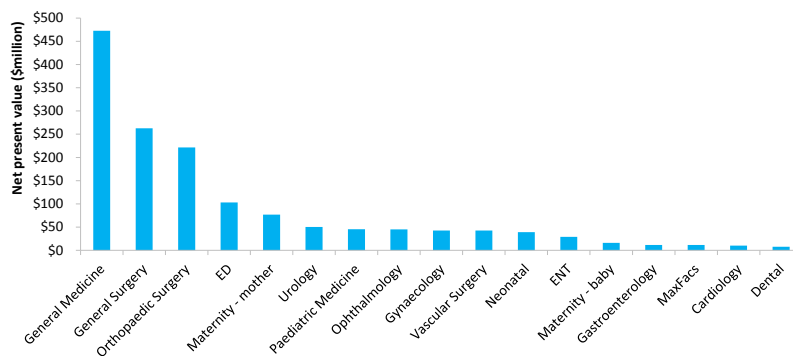
Figure 4 Percentage growth in volumes on 2016 base, 0-14 years



If we don't change the hospital will consume more and more resources as a 'provider of last resort'

A central aim of modern health systems is to shift activity from the hospital and closer to the consumer and their home. This is quite a challenge—more than most people realise. To demonstrate the extent of this challenge, the following chart shows the potential cost of hospital inpatient services within a 15 year horizon, if nothing changes. It is a 'net present value', that is, the value in today's dollars of inpatient medical and surgical care over all the years from now until 2031. The total present value of these services is \$1,488 million.

Figure 5 Net present value of medical and surgical inpatient services, 2018 to 2031



These demand pressures are coupled with evidence that we don't use our health systems as effectively as we could. Research from the United Kingdom suggests that when services do not respond appropriately, needs remain unmet or increase, creating artificial demand and spiralling cost (Locality and Seddon, 2014).



We need a new approach to achieve equity and meet future demand

It is clear we need a new approach if we are to achieve equity amongst our population and meet future demand. We cannot sustain services into the future if we continue to provide them in the same way we do now. Health equity must remain at the heart of all we do and those people with an unfair burden of illness deserve the greatest investment from health services. However without shifting the drivers of health at a population level many inequities will persist despite additional targeting of services. A balance of the two approaches is vital to achieve equity and ensure sustainability of the health system.

Holding people at the centre of planning has been challenging as technology, funding, government accountability and business systems have been focused on organisations and how they perform, rather than what works for people. The Government focus on investing for social wellbeing and significant changes in medical and information technology open up new opportunities. They have the potential to change health care investment decisions, and the way care is organised and delivered.

Listed below are some key problems identified with the current state, through service engagement and patient journey workshops. Alongside this we re-define the future we want for our health system.

Problem with the current state	What a person and whānau centred system looks like in future
Services are not accessible or appropriate to the needs and wants of all groups.	Services are designed with communities, whānau and consumers to reflect their needs and wants, and are delivered as close to home as possible. Nobody misses out on the care they deserve because of affordability, transport, or other social issues.
<u>A shortage of safe, warm and dry homes means children experience an unnecessary burden of childhood illness.</u>	<u>Issues of housing supply and affordability are addressed so that all children, including those in rental and social housing grown up in a safe, warm and dry home.</u>
Lack of clear communication tailored to people and their whānau.	Health workers are friendly and welcoming and take time to develop relationships with people. Communication is clear and health information is easy for all people to understand.
Cultural competency is variable across services and workforce.	People and whānau have their cultural needs met no matter which health service they engage with.
Care is organised around the service rather than the people it serves and it tends to be focussed on a single issue and not holistic.	People have a broad range of services in the community, designed with them, to help them achieve their objectives and keep them well. Longer consultations are available when necessary and specialist services support primary care to manage people closer to home.
Care is not coordinated well, with too many referrals, delays, and discontinuity. There are multiple points where people can be lost in the system.	Everyone has a care plan that is developed with them and based in primary care. The consumer and whānau, and all health workers involved in their care can view and update the plan. Referrals are minimised by having a wider range of services available in primary care. Navigators support people and whānau with complex needs through the system.

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Problem with the current state	What a person and whānau centred system looks like in future
Physical spaces are not well designed, lack privacy and can be inappropriate for children, older people, and whānau.	Assessments and interventions are delivered in appropriate spaces, both in primary care and the hospital. Health facilities are whānau friendly—consumers have whānau and support people on site, with specific areas for group conversations and meetings.
Workforce and services are stretched too thinly across both primary and secondary care. Hospital and theatres are full.	The hospital has a narrower scope in the future. People and whānau are empowered to self-care at home and can access services virtually when appropriate. Primary care consultations are targeted to those who need them most, and services are delivered by a range of different professionals working to the top of scope. Proactive care reduces the occurrence of acute events.
Discharge from hospital is not well planned and some people have poor experiences.	If people are admitted to hospital, their transfer back home is well supported and planned from day one, and involves the consumer, their whānau or support people, and other professionals involved in their care. People are able to return home as soon as they are medically fit, with appropriate care and support in place at home.
Expenditure is focussed at the hospital end of care.	The system is designed to deliver care when and where it will make best use of health system resources, meeting people's needs at the earliest and lowest cost opportunity and reducing the onset of complex health need.
Lack of IT development hinders service productivity.	Consumers, whānau and health professionals have access to modern IT infrastructure (hardware and applications) that supports self-care, access to services, and appropriate sharing of information. Tele-health supports equal access to specialist services for people living in remote or rural locations.

We have pockets of service excellence already and will build on these in our new system

We are not starting from scratch—there are clear examples of service excellence within our system already. Just a few examples are: strong and innovative service provision amongst kaupapa Māori providers and some primary [health-care](#) centres, emerging workforce models such as nurse practitioners, close connections with inter-sectoral agencies by child development services, and the engAGE model of multi-disciplinary care for older people. Diabetes and respiratory nurses are working with primary care. [We have a clinical support workforce that has much more to offer as an intrinsic part of health service delivery.](#) Some of our services are held up nationally as best practice.

Now we need to redesign our health system for the future; retaining and growing the good things we're doing and taking bold and courageous decisions to ensure we deliver the best and fairest outcomes for all people in Hawke's Bay.



3. Our commitment to achieving equity underpins this plan

Health *inequities* are differences in health outcomes that are avoidable or preventable—and therefore unfair. ~~The health system can make a difference with a determined and focused effort that works to address underlying causes and provides better, closer to home health services. It also means working across the whole community to make sure living conditions that support health are distributed fairly.~~ Social determinants of health, including environment, housing, income and education explain a large part of inequitable outcomes. The health system can make a difference with a determined and focused effort that works to address underlying causes and provides better, closer to home health services. It also means working across the whole community to make sure living conditions that support health are distributed fairly.

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We know that many in our community face barriers to access and high quality care, including difficult structures within our services and confusing information, limited cultural competence of providers and lack of transport. Out-of-pocket costs are significant barriers to accessing care—general practice and other fees are unaffordable to some. Our vision of a healthy Hawke's Bay is necessarily an equity vision and requires a particular focus on those with unmet needs.

When we achieve equity, there are no avoidable or remediable differences in health outcomes between groups of people. Our vision of a healthy Hawke's Bay is necessarily an equity vision and requires a particular focus on those with unmet needs.

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The CSP establishes a firm commitment to equity by prioritising and designing services to meet the needs of populations with the poorest health and social outcomes. This means:

- Up-skilling of health professionals, with particular regard to cultural competence, mental health and addictions, wellness focus, ~~family violence~~ family harm and poverty. The workforce reflects the population it serves
- Commissioning for equitable outcomes
- Multi-disciplinary and team-based approaches which more holistically consider and address health and social needs and aspirations for whānau
- Re-framing our approach to focus on wellness, preserving mana and building on existing strengths of whānau, communities, and population groups
- Whānau wellness models in addition to an expectation that core services will meet the needs of those with poorer outcomes
- A rights-based approach to health meeting our responsibilities under Te Tiriti o Waitangi
- Incorporating the guiding principles and our learning from⁵ the Nuka System of Care⁵ whilst giving primacy to Māori indigenous thinking, values and solutions.

⁵ <https://www.southcentralfoundation.com/nuka-system-of-care/>



- [Holding ourselves accountable through monitoring and evaluation and supporting with adequate resources](#)

A new approach to commissioning is required to ensure equitable access and outcomes

Commissioning is defined as

The process of continuously developing services and committing resources to achieve the best health outcomes for individuals and the population, and ensure equity and enhance experience within the resources available.

We want to shift our system so that it targets and works with people and whānau experiencing the poorest outcomes, and supports them to thrive and enjoy good health and wellbeing.

Our commitment to achieving equity will include implementing a data-driven quality improvement process with root cause analysis that addresses the specific needs of people and whānau in context, and forming partnerships with whānau, hapu and iwi.

The national commissioning framework for mental health and addiction (Ministry of Health, 2016) provides a useful guide when commissioning services to improve equity; acknowledging the social determinants of health by taking a much broader approach to health and wellbeing.

Figure 6 The commissioning framework for mental health and addiction



Note: KPIs = key performance indicators

Source: Ministry of Health, 2016

Commissioning for equity means that:

- Needs assessment will take a broad approach to community resources, considering disconnects or gaps between health, social, community, government and non-government funded services. It will



capture the voices of communities, consumers and whānau, as well as clinical leaders and health social services

- Resources (including but not limited to money) will be refocused in the areas that will make a real difference to eliminating unmet need and inequities. This might mean disinvesting in some things in order to prioritise others
- Whānau are equal partners in planning and co-design of services. We will ask people what services they need and how they want to access them, and act on this so whānau continue to engage and have a sense of ownership of their own health and health system
- Aligning incentives and supporting providers to innovate, with robust monitoring and evaluation to ensure equity of access and assess their contribution to achievement of equity. Where possible we will scale up and spread services that are achieving good outcomes, and stop or change those that are not achieving outcomes.

Person and whānau centred care is a core principle of commissioning

A person and whānau centred approach has its primary focus on people, their whānau, friends and carers; understanding their needs and aspirations and what matters to them (not, 'what is the matter with them'). Research⁶ shows that person and whānau centred care improves health outcomes and consumer experience, and the use of health resources. Creating a culture that is person and whānau centred requires a fundamental shift in behaviours, systems, processes and services for all people working across the Hawke's Bay Health system. Person and whānau centred care is a core plank of our DHB People Plan.

Co-design is the process of working collaboratively with other key stakeholders to develop a response to an identified need or opportunity. If we are to 'transform our model of care towards an integrated primary and community based response that leverages our hard won but limited capacity in specialist care' (Health Workforce New Zealand, 2011), then services need to be designed in quite a different way. Fundamentally, we need to work with people and whānau whose needs are not met, to 'design out' the inequities that are built into our current system.

We will support people to make good choices by making health easy to understand and navigate

Making health easy to understand and navigate is critical to ensure people stay well at home and in their communities, and know when and how to access services. Often this concept is described as 'health literacy'. We need to improve the way we organise health information and services and the competencies and behaviours of the health workforce. When we make health easy to understand people are able to make better informed and more appropriate health decisions, and better manage their own health. People also want to have control over the determinants of health and we, as a health sector, have a role to play to influence these determinants and support communities to advocate on their own behalf.

-Unfortunately, the health system does not make its information easy for everyone to access and we often don't spend enough time ensuring consumers and their whānau are able to process it. In addition, many of the choices made by the most disadvantaged groups in our communities are

⁶ Del Canale et al, 2012; Dahlin et al, 2010; Pereira et al, 2016; Bertakis and Azari, 2011; Stewart et al, 2000



influenced by factors outside their control. We need to dig deeper into what those influences are so we can help people make the best decisions they can, in their circumstances at different points in time. We need to understand what is important, inspirational and motivational for Māori communities and whānau if we are to support behaviour change.

We will **make health easier to understand and navigate** by:

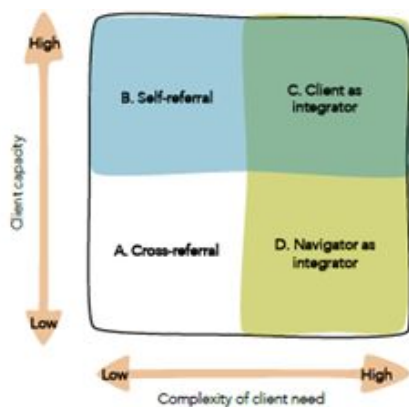
- Ensuring whānau have information about the role of different services, including when, how and where to access services for urgent needs
- Developing the health literacy and cultural competencies of the workforce and embedding person and whānau centred practice as the way we do things
- Investing in the workforce that supports people in their healthcare journeys, for example kaitakawaenga, kaiawhina, navigators, social workers, and informal supports
- Making it easier for consumers and whānau to participate in their health and wellbeing by making their health information available to them electronically
- Developing health coaching, peer support and behavioural services in community settings.

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We will provide appropriate services responses for different groups

The New Zealand Productivity Commission has found it useful to segment four different social service consumer types, shown in the diagram below.

Figure 7 Characteristics of clients of the social services system



Source: New Zealand Productivity Commission, 2015

To maximise effectiveness, services should be arranged differently to match the needs of people in different quadrants. The Commission notes that there is the most potential for improvement in services and outcomes for people in quadrant D, with high and complex needs but lower capacity to navigate the system. 'Capacity' does not refer to a deficit of the person or whānau. It means that for



a variety of reasons, which are often complex and outside people's direct control, they are less able to get what they need from health and social systems.

Many people are low users of the health system, and only need episodic clinical interventions to meet specific, short-term health needs. Often these people are able to access the service they need on their own, or cross-referral between providers or health professionals works well for them. We want to simplify care for those with high capacity, with standardisation of pathways and a range of virtual and electronic options to access services. This will unlock resources and allow us to provide more intensive services to those people with more complex or unmet needs.

We need specific responses for those people and whānau with unmet health and social needs. For whānau with lower capacity, we will wrap a range of services around them and use navigators to support them through the system. Whānau with limited capacity, unmet need and risk factors for mental illness and addictions are particularly vulnerable, and wraparound support that recognises these critical factors will be delivered. Whānau empowerment is our aim—we will partner with whānau to identify the mix of services that will support them to achieve their goals and aspirations.

Along with targeted initiatives, we also need *all* services and those working within them, to be culturally responsive, and demonstrate values and behaviours that are characterised as welcoming, inclusive, caring and non-judgemental.

17.1



THE PLAN



4. We have a range of options for responding to the challenge

The plan that follows sets out a range of options for service and model of care development, organised around key themes developed with stakeholders in the Hawke's Bay health system. It does not explicitly address every area of the health system. In the future, we will keep doing many of the things we do currently, and continue to develop new models of care we have already started. As well as that we will change our system in the areas described here. There is significant overlap between many of the themes and some are dependent on others to achieve the model we want for the future. The themes in this plan are:

1. Place-based planning
2. Evolving primary health care
3. Working with whānau to design the services they need
4. Relevant and holistic responses to support mental wellbeing
5. Keeping older people well at home and in their communities
6. Specialist management of long term conditions based in the community
7. Well supported transitions from hospital
8. The hospital takes a narrower focus in future
9. Surgical services continue to be refined

Each theme includes a high-level description of what the model of care could look like in the future and our headline goal or goals. A range of more specific elements of service and model of care development follows in table format, with the possible phasing of each.

Prioritisation will take a variety of information into account

We need to determine the priority of each theme, its place in our new five year strategic plan and the elements that will be adopted and developed collaboratively with stakeholders. Prioritisation will take into account the outcomes of other key pieces of planning work occurring in the DHB.

A sense of priority was identified through the CSP workshops. Participants valued models that specifically target a reduction in unmet needs and achievement of equity the most highly. This includes services to meet the needs of under-served whānau, practising person and whānau centred care in all parts of the system, and a de-medicalised model of care for mental wellbeing that is based in the community. Workforce and IT enablers were ranked a top priority to facilitate different ways of working and consumer ownership of their health.

Once we have considered all the options and determined our course of action, we will need an implementation plan to make it happen.

We will monitor our progress over time

The headline goals describe what success looks like. We have seen the demand growth path we are on if we don't change what we're currently doing; in the appendices to this CSP we show what it will take to contain that demand. We will monitor our progress in key areas by using a suite of performance indicators—we have many useful measures already and will develop new ones to ensure we have a comprehensive picture of how we're tracking.



Place-based planning

Community partnerships and development

The population health and equity focus of the CSP and the multi-factorial nature of many health needs in Hawke's Bay requires inter-sectoral collaborative action to address. Pooling expertise and resources across inter-sectoral partners and aligning planning and action should provide greater leverage to address longstanding social determinants of health in Hawke's Bay.

Effectively involving communities in the design and development of health services can support improvements in population health outcomes and consumer experience. Communities have local knowledge that can help us to provide cost-effective and sustainable services. It can also empower communities to take ownership for addressing previously intractable issues, producing more sustainable outcomes.

In this CSP we define the concept of place-based planning as

[Stakeholders engaging collaboratively in a process to address issues they are experiencing within a geographical space, be it, a neighbourhood or region.](#)

Collaborative place-based approaches rather than person-based approaches are most effective when the problems are complex and the solutions either uncertain or require multiple forms of intervention. Not all places or communities will need the same type of place-based approach. This approach might only be needed or justified in communities with entrenched social problems while other communities may benefit from other forms of place-based or integrated services.

Place-based initiatives focus resources and efforts in selected communities over a period of time. They share a commitment to community level systematic change through inter-connected approaches, including: community decision making, collaborative partnerships, integrated programmes and data and results-driven programmes. Depending on the needs identified the emphasis of the initiatives can vary (e.g. health, education, other factors).

Place-based planning will provide us a strong platform to work closely and collaboratively with communities to prioritise and co-design place-based initiatives that will meet the needs of our communities and populations with the poorest health and social outcomes and thereby working towards a goal of achieving equity.

[-We acknowledge that a lot of work is already happening including collaboration with councils and a number of existing community plans or networks. Public health nurses work with all schools and early childhood education centres, but with a focus on those in high deprivation areas. Future development of place-based approaches will recognise and respect existing providers and community structures and work in partnership with communities, whilst adopting community development principles and bringing evidence to the table.](#)

Important components in the place-based planning process will be:

- needs assessments to identify communities with greatest need
- integration of health and social services around the needs of the communities they serve (e.g. health connects with social services, justice and education)
- effective co-ordination of local assets
- integration of population health information with local service provision



- consideration of social commissioning
- monitoring outcomes (e.g. have all young mothers been identified and linked with an appropriate maternity service?)

Healthy environments

Population health strategies and core public health services are a key part of place-based or locality planning and action. Wellness starts at home, and in the community within environments such as schools and workplaces.

Our preventative strategies will focus on places that people congregate in groups so they are efficient—reaching wider than households—and help to reduce stigma. These initiatives are more likely to be ‘ground-up’, driven by the community and supported by health organisations.

We will work to influence decisions on the built infrastructure within communities, including safer street design, the density of alcohol and fast food outlets, active as well as age-friendly transport, and healthy affordable housing. Place-based planning also builds on community assets such as libraries, marae, churches, sports clubs, playgrounds and swimming pools. We will work with our inter-sectoral partners to ensure communities have safe drinking water, sewerage and housing as requirements for good health.

Headline goals

- Establish community level plans are supported that promote and build healthy, safe and resilient whānau
- Establish place-based initiatives operate in self-identified and high need communities, bringing local leaders together to address health and social issues and improve outcomes for individuals and whānau
- Communities are activated with the tools and support to take ownership of their local service network

Elements of service and model of care development

Element	Phasing
Focus	Broad determinants of health including social services (e.g. housing), wellbeing, prevention, early intervention.
	Work with the community (at a population level rather than individual level) to build safe, resilient whānau through the elimination of family harm (i.e. by a collective group including police, health, etc.).
	Work closely with communities to implement the suicide prevention plan, designed to empower and enable communities to promote wellbeing, build resilience and stay connected.
Needs assessment	Consult and work with the community/stakeholders to map out their needs.
	Complete community level needs analysis to identify needs and gaps.
	Provide stakeholders with robust data to give them information so they can see what the issues are and decide what they need (dialogue).

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Element	Phasing
Use the Integrated Data Infrastructure to bring together data from multiple sectors and identify 'hot spots' of need in the community.	

Element	Phasing
Planning and co-ordination	Support local communities' involvement throughout the planning process from information sharing, need assessment to planning services.
	Develop a central registry of community-based health and social service providers by geographical location and a plan to raise community awareness.
	In Wairoa <u>and Central Hawke's Bay</u> provide enabling resources that will improve the co-ordination of current services.
	Facilitate rural service integration and identify what is required in and around the rural facilities (e.g. rural nurse capacity).
	Fully implement existing technology, such as tele-health and videoconferencing, and explore new technology, to support delivery of rural health services.
	Work with councils, Ministry of Social Development (MDS) and local business to grow socially responsible employment and enterprise.
	Support the development of frameworks and pathways to prepare and support people into employment.
Commissioning and funding	Investigate options for co-funding and contracting.
	Explore a commitment to social commissioning with combined funding from inter-sectoral agencies.
	Investigate separating roles and responsibilities at a governance level while maintaining responsibility for own areas.
Partnerships, co-location and links to other services	Review and improve services: <ul style="list-style-type: none"> • how they link or should link • where are they or should they be located to provide (e.g. consider co-location with other social services) • enhance and/or expand and invest in services that work well (e.g. taiwhenua provider) • build on prior experience when developing new options (e.g. the community partnership group) • identify any services that are not working well.
Community hubs as settings for wellness	Take the services to the people and be more responsive locally with the co-design of services.
	Build on services already available in primary <u>health care</u> (e.g. <u>dieticians</u> , dental, district nurses, public health nurses in schools and early childhood education, child development service).
	Set up and resource location-based hubs, community-based clusters (not based in the DHB but in community).
	Use existing structures/systems that are in place and build around them to enhance current hub-like facilities, consider the use of: <ul style="list-style-type: none"> • schools (education/health in partnership) • community cultural centres • MSD community hubs • council facilities.
	Implement mobile services (e.g. a mobile wellbeing centre to get around to bringing services to Māori and Pasifika communities or to remote towns).

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Evolving primary health care

A fundamentally different primary [health](#) care system is the lynchpin of this CSP. There are large expectations for a primary care response to burgeoning health need, and the model of general practice will continue to evolve to respond to this demand. There is a groundswell of readiness for a new approach and we already have examples of practices doing things differently. Some are implementing telephone triage to better manage appointments, holding daily team 'huddles', and there is good uptake in places of the patient portal. Strong relationships between primary care and the DHB need to be developed and nurtured to amplify the scale of this change.

Our health system needs to work with communities and people who need services to improve access, remove barriers and deliver proactive [care](#) and preventative ~~care~~[strategies](#). This is particularly important for under-served populations with long term physical and mental health conditions, with an expectation of an integrated service. [We know that cost can be a barrier to accessing primary care; some people delay or do not seek care when they need it, or access hospital services instead. As we expand and evolve primary care, embedding a wider range of services and specialism within it, we will develop equitable funding models that ensure costs are not shifted to consumers.](#) Primary health centres will operate within community networks that are planned and developed as part of place-based planning.

Primary care teams will be expanded with new roles and capabilities

Traditional primary care is based on a medical model, focused on the role of general practitioner and practice nurse. This workforce is ageing, under significant workload pressure, and is unable to address all the health and related social needs of consumers. In future, the primary ~~care~~[care](#) team will be expanded with new roles including (for example): specialist long term conditions therapists or nurses, midwives, district nurses, care navigators or key workers, [health promoters](#), social workers, ~~behaviourists~~[behavioural practitioners](#), [dietitians](#), mental health workers, clinical pharmacy facilitators as well as community pharmacists, ~~allied health~~[therapists](#) and home support carers. [For example, community pharmacist skills will be harnessed to provide public health interventions and triage services and we will work to increase the number of non-medical pharmacist prescribers.](#) Behavioural practitioners will work with other team members such as dietitians and pharmacists. ~~These~~[The full range of](#) practitioners will not necessarily be employed by practices but will be a core part of a multi-disciplinary team around them, enabled by shared IT and providing holistic and culturally appropriate stepped care. [Changes will be required to business models and/or funding models to ensure new and team-based workforce models can be developed.](#)

The Health Care Home model has many of the features we want in our primary care services

The Health Care Home (HCH) model of care, as it develops, is being implemented throughout New Zealand and represents an opportunity for a fundamental and sustainable change in the primary care model to improve the quality of care delivered in, and around, general practices. It works to improve the management of people in community settings and increase equity of access to primary care, and enables greater integration with health and social services across the system as a whole.

The HCH model has six core attributes:

- **Person & whānau centred:** supports people to manage and organise their own care based on their preferences, and ensures that consumers, whānau, and caregivers are fully included in the development of their care plans and ultimately the design of primary care services.



- **Comprehensive:** a team of professionals providing care for a person's physical and mental health needs, including prevention and wellness, acute care, and chronic care.
- **Coordinated:** ensures that care is organised across all elements of the health care system, including specialty care, hospitals, and community services and supports.
- **Accessible:** delivers accessible services with shorter waiting times, enhanced in person hours by prioritising consumer–clinician contacts for those who need it most, extended hours, electronic or telephone access, and alternative methods of communication through IT innovations.
- **Continuous:** recognises the value of continuity of care, and enables this by creating capacity within practices.
- **Accountable and committed to quality:** demonstrates commitment to quality improvement through the use of data and other tools to guide people and whānau to make informed decisions about their health and to monitor progress at a practice population level.

We will develop our own local system based on our learning from indigenous models

In Hawke's Bay, we will develop our own local model that embeds kaupapa Māori practice and builds on the strength of our iwi-led services. Our model will be based on a real understanding within the primary care team of who consumers and whānau are, and how to respond to their wellbeing needs. This includes easy access to advice around any social problems (e.g. social welfare, housing) and specific access equity components such as co-payment reduction or removal for priority groups.

We have learnt a lot from the Nuka System of Care at the Southcentral Foundation in Alaska. We will take the lessons from Nuka but create a local system that is co-designed by our own communities and whānau, and is completely in tune with our Hawke's Bay culture.

The Nuka System of Care incorporates key elements of the Health Care Home model, with multi-disciplinary teams providing integrated health and care services in primary ~~care~~ health centres and the community, co-ordinating with a range of other services. This is combined with a broader approach to improving family and community wellbeing that extends well beyond the co-ordination of care services—for example, through initiatives like Nuka's Family Wellness Warriors programme, which aims to tackle ~~domestic violence~~ family harm, abuse and neglect across the population through education, training and community engagement. Traditional healing is offered alongside other services, and all services build on indigenous culture (The King's Fund, n.d.).

Primary care will be at the heart of rural health service provision in Hawke's bay, with the development of outreach models to reach those in remote locations (for example, nurse-led care and mobile clinics).

Scale and consistency of operating model and care philosophy is critical to allow more specialisms to be provided in and around the healthcare home. There may be cross-referral to other practices with special interests, where sufficient size allows this to develop.

Active involvement of consumers in the on-going development of primary health care

One of the key successes of Nuka, that we will adopt in Hawke's Bay, is actively involving consumers in its management in a number of ways. These include community participation in place-based planning groups, the active involvement of consumers in management and governance structures, and the use of surveys, focus groups and telephone hotlines to ensure that people can give feedback that is heard and acted on.



Stakeholder and community engagement will be undertaken in a far more responsive way than in the past. We will keep listening to what the community is saying, go away to find ways of meeting their needs, then report back on our progress. We will not be able to achieve everything that people want and we need to be transparent and realistic about the limitations we work within. ~~But the~~The Nuka experience suggests that by listening, feeding back and being honest with our community, people can understand they are partners in the transformation and delivery of care, and walk with us through challenging decisions.

Broader population health approach with preventative strategies

Overall primary health care includes both services delivered to individuals and population-level, public health type functions. Population health approaches take account of all influences on health (the determinants of health) and how they can be tackled to reduce inequities and improve the overall health of the population. At the same time as we evolve, transform, and target the services we fund and provide, we will step up our population health strategies. We will continue our work with councils and other partners to ensure healthy environments for people to live, work, learn and play. This includes a focus on the physical environment to ensure healthy choices are the easy choices (such as access to healthy food and drink, smoke-free strategies, access to alcohol, etc.).

We will continue to participate in the Hawke's Bay Regional Social Inclusion Strategy, and work with our inter-sectoral partners on employment and housing. Our Population Health Directorate will work closely with a range of other providers to implement preventative strategies, including a focus on mental health and addiction. Much of this work fits within our place-based planning approach, but we must ensure that as we co-design and develop our model of primary care services, they are well connected to our population health approach.

IT is critical to support this approach

The model requires IT enablement to work. This means a single electronic record and shared care plan, that is accessible to all those involved in a person's care and to the consumer (through a patient portal). Ideally, consumers will be able to add their own information to their record. As well as email and telephone contacts, consumers will be able to use patient portals and video-chat to interact with members of their primary care team. Clinicians will be able to refer electronically for specialist appointments and diagnostics.

Headline goal

- Consumers and whānau have choice to meet their needs and wants, with services easily accessed when they want them

Components of service and model of care development

Element	Phasing
Business processes	
Change management support for practices and support for process improvement methodologies.	
Structured co-design process for progressing the primary <u>health</u> care model and wraparound services.	
Primary care clinician triage and call management to ensure face-to-face consultations are targeted to those that need them most—clinicians triage calls each morning to see whether people can be managed by phone, on another day, etc.	



Element		Phasing		
Accessible and acceptable services	Same day acute appointments—practices block out time slots to accommodate acute appointments from clinician triage or walk ins.			
	A greater number of practices with extended opening hours e.g. until 7pm or Saturdays.			
	Electronic booking of appointments via the patient portal.			
	Appropriate appointment lengths are booked based on people's needs, longer appointments are available for those with more complex health and social needs.			
	Practices proactively identify people and whānau with affordability issues and put in place a planned approach to facilitate access. Consider reduction or removal of co-payments for target groups.			
	Web based or virtual consultation options – alternatives to face-to-face consultations via the secure patient portal.			
	Practices have a commitment and plan to provide care appropriate to cultural needs.			
Proactive care and alternatives for acute care	Proactive assessment, care planning, and care coordination processes are put in place to support people and whānau with complex needs, facilitating integrated health and social care.			
	Population stratification is used to identify levels of clinical risk and those with complex health or social needs.			
	Implementation of an electronic shared care plan tool & development of shared care plans for those with the most complex care needs initially and extending to all.			
	People identified as having high and complex needs have a named care coordinator.			
	Practices proactively work to involve whānau support practitioners/advocates/navigators in care planning and coordination for the most under-served people.			
	Members of the primary care team have greater decision rights to arrange care support to keep people well at home.			
	Implementation of a full range of primary options for acute care, including rapid response at home (above), and using ambulance services where appropriate (e.g. Chronic Obstructive Pulmonary Disease (COPD) management).			
Expanding the primary care team	Extension of the clinical pharmacy facilitator programme to cover all practices, <u>Community pharmacists supported to provide monitoring, screening, brief interventions and triage services, along with a focus to increase pharmacist prescribers, in line with the national Pharmacy Action Plan.</u>			
	Extension of the general practice team to include mental health professionals, health coaches, behaviourists <u>behavioural practitioners</u> , etc. as well as development of the unregulated and lay workforce.			
	Practices participate and lead multi-disciplinary team (MDT) meetings in the community and support integration with specialist and community services.			
	Close collaboration with other health and social providers, and government agencies in localities.			
	Expansion of engAGE as necessary so community nurses and allied health form community based teams or clusters, and are full members of MDTs.			
	Key specialist services (geriatrics, general medicine, midwifery and paediatrics, mental health, and other specialist services in the area of diabetes, respiratory and cardiac etc.) provide support for primary care through expert advice, case collaboration and supporting the management of more complex people in the community.			
	Referrals to secondary care are prioritised based on severity of condition, not capacity, and urgent referrals can be seen on the same day if necessary.			

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Case study: Health Care Home model of care, New Zealand

The overarching aim of the Health Care Home (HCH) model is the creation of an improved and sustainable primary care service for New Zealand. It puts patients at the centre, enhancing and simplifying their experience, and it gives practitioners the tools they need for better management of their time and resources. The first HCH practices were established in New Zealand around 2011 and there are now 128 practices using some, or all, of the Health Care Home model of care. A new requirements guide sets out the service elements and characteristics of a HCH practice over and above the traditional model.

The most recent roll-out has been in Capital & Coast and Hutt Valley DHBs. Early indications in Capital & Coast were positive, suggesting a reduction in ED attendances and acute hospital admissions for HCH practices (Compass Health, 2017). High need practices are less stressed and more proactive. The practice may phone a person and ask them to attend whereas, in the past, the person may not have been contacted, and may not have prioritised their own health. HCH teams have time for proactive management with consumers, and in cooperation with other providers.

An evaluation of the HCH model in Pinnacle practices (EY, 2018) compared service utilisation rates by patients at HCH practices with patients at comparable practices with a traditional general practice model, over a six month period April to September 2017. A multiple logistic regression analysis found the HCH model was associated with significantly lower rates of ambulatory sensitive hospitalisations (odds ratio of 0.80 favouring HCH). Additionally, patients attending HCH practices had a significantly lower rate of ED presentations (odds ratio of 0.86). Two important contributions to this effect were a large difference in Māori ED presentation rates and a large difference in ED presentations for older people aged 65+ years.

Shared Medical Appointments are proving popular with both HCH clinicians and consumers. A group of people, perhaps six to 10, with similar conditions or needs, receives both individual attention and the benefits of sharing and learning at a group session organised by their practice. These might last for around 90 minutes and attendees might include the chief clinician as well as members of the extended care team.

In Taupo, a peer support worker in the extended HCH team, runs an 'Off Highways' group consultation for truckers, which meets every fortnight. GPs, dietitians, nurse practitioners and clinical pharmacists are invited into group meetings as required for 'light touch' health education and individual assessment.

A GP gives another example of a COPD shared medical appointment in Taupo, where a kuia involved herself in a discussion with a young woman about her smoking, 'I saw a dramatic change in the younger woman from hearing the message from an older woman that she respected, who could describe her own journey'.

Hora Te Pai Health Service in Paraparaumu has also formed a COPD group. As one attendee says, 'Being Maori, it's easier to share your conditions with a group of other people. If you're hurting, sometimes the tendency is to shut up, "she'll be right", you know? But when you're all in there with the same problem, it's easier to share.' The longer appointment also led to an increase in consumers' general understanding of their condition—especially what to do when they had an acute exacerbation of their COPD. 'By the end of the 90 minutes, everyone walked out with a back-pocket script and a new inhaler script, if necessary.'



Working with whānau to design the services they need

The New Zealand Health Survey (Ministry of Health, 2018) shows that Māori and Pasifika in Hawke's Bay experience persistent unmet need for health care. Through consumer experience surveys and consumer engagement forums, whānau have spoken of services that are not designed to meet their needs. They articulated feelings of not being listened to, lack of cultural competence, unclear communication and explanation from health professionals, and not being treated with respect.

~~Rangatahi have told us they want integrated health and social services that are close to where they live, with virtual as well as drop in options for accessing care, and a diverse workforce that includes young people as well as different ethnicities and cultures.~~

As well as ensuring our workforce is culturally competent, we need two key things to be happening: better design of all services and resourcing that is geared towards meeting the needs of underserved people, plus targeted services that are wrapped around whānau with complex needs, supporting them to achieve their goals and aspirations and independently manage their own health and wellbeing.

Equal partnerships with whānau in service design

In section 3 of this plan, we stated our commitment to achieving equity and set out our principles for prioritising service design for those with unmet needs. Addressing the social determinants of health goes hand-in-hand with health service provision. Our response to working with whānau to design the services they need will also include:

- Better understanding of the health needs and aspirations of young, low income whānau in Hawke's Bay, and in particular Māori and Pasifika families. To do this we will undertake more regular health needs assessment with an explicit health equity focus. Services will be designed to prioritise addressing the needs of those with the poorest outcomes.
- Analysis and identification of complex health and social need will become more sophisticated in future. We will use tools such as the Integrated Data Infrastructure and Index of Multiple Deprivation to quantify this complex population group and plan the size and location of our responses.
- Taking a life course approach, recognising the need to shift resources to services focussed on the best possible start to life and achieving better outcomes for future generations, and addressing adverse childhood experiences.
- [Supporting and working with collectives of people and whānau with similar needs, including cohorts within the disability community and people with complex conditions.](#)
- Meaningfully including the voices of individuals and whānau with unmet need at every step.

We will trial and adopt new ways of doing this to ensure the voices of under-served whānau are heard—not just through surveys but using alternative tools such as smart devices. Young people have told us they want to interact with supports in an environment that is tailored to their age-group and that includes their own peers in delivering that support. Rangatahi with lived experience will be encouraged and supported to assist in co-design and to form peer support groups. Co-design and feedback will extend beyond primary and community services, to ensure these whānau are able to access specialist and hospital based services (including those provided outside of Hawke's Bay) when they need them. We will address barriers such as cost, transport and child care.



New services will be defined with consumers and whānau, but examples might include an increase in free drop-in and one-stop-shop clinics, which may be mobile or located near to where people live in marae, schools or early childhood education, churches; or home visiting services. Fundamentally, the primary health care model will be designed within cultural frameworks, such as Te Whare Tapa Wha and Fono Fale, to support all aspects of wellbeing: physical (taha tinana (physical)), mental (taha hinengaro (mental)), family (taha whānau (family)) and spiritual (taha wairua (spiritual)).

Getting it right for children and young people

The first 1000 days is the time from conception to a child's second birthday. There is a growing body of evidence that proves experiences during the first 1000 days provide the foundations for lifelong health and wellbeing. It is important that we also focus on young people—our rangatahi—supporting them to fulfil their potential and transition into healthy adulthood and parenthood.

We need to harness the efforts of many, to improve the experience of growing up for our children and young people in Hawke's Bay. This means improving both the environments and services available to children and young people via early childhood education, schools and other youth-friendly services delivered in a culturally appropriate way, and to those most in need. We will build on the strength of our public health nursing service. Rangatahi have told us they want integrated health and social services that are close to where they live, with virtual as well as drop-in options for accessing care, and a diverse workforce that includes young people as well as different ethnicities and cultures.

We will develop workforce strategies to ensure sustainable maternity services across Hawke's Bay, particularly in our rural areas. We also need to ensure that the full range of child health services are integrated and children do not 'fall through the gaps', including maternity and Well Child Tamariki Ora services, general practice and immunisation services, oral health services, school health services, community-facing paediatric services and child development services. Our Child Development Service is recognised nationally and has implemented successful initiatives such as its community educational modules focused on Fetal Alcohol Spectrum Disorder. We will support the service to introduce similar initiatives.

Ensuring children are safe and healthy is everyone's responsibility and our commitment to whānau centred care means being child-centred. Being child-centred means thinking about how decisions and actions will affect children and having an understanding of child development, allowing for the capacities of children at different ages and recognising differences in ability or development. Considering children in decision-making is an important way to uphold children's rights.

As well as our population health strategies, place-based planning and inter-sectoral work; we will expand the provision of wraparound services, taking a whānau ora approach to provide intensive support to those whānau whose needs are not currently being met.

Rangatahi have told us they want integrated health and social services that are close to where they live, with virtual as well as drop-in options for accessing care, and a diverse workforce that includes young people as well as different ethnicities and cultures.

Whānau wraparound

With our inter-sectoral partners we will increasingly identify the whānau most in need of support and work in equal partnerships to manage their health care alongside other aspects of their lives. Our

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focus will be to work with Oranga Tamariki to invest in and provide intensive wraparound services for whānau, especially tamariki during the first 1000 days of life and rangatahi during the adolescent years. We will work with whānau and agencies to ensure people have security of affordable housing, and a warm and dry, healthy home.

-We already have some services that are meeting broader needs by taking a whānau ora approach but we need to expand and coordinate them. This will mean resourcing existing providers to do more and commissioning additional providers. Key workers, or kaimahi whānau (family workers), will be assigned to individual whānau and work with them to develop a whānau plan centred on their goals. Wraparound services will include, but are not limited to:

- Ensuring whānau members receive screening and preventative health interventions
- Education and coaching around healthy behaviours and self-management of physical and mental health conditions and addictions
- Provision of accessible, positive pregnancy and parenting programmes, home visiting services, mental wellbeing services, addiction services, and other intensive services the whānau needs
- Advocacy and support for interactions with health and other social services, for example housing, work and income support and budgeting, education, justice, etc. Key workers will act as navigators and walk with consumers across community and hospital services.

Coordination, referral, budgets

Expanding provision of wraparound services may require a coordination service, or whānau service centre, as a single point of entry. Referrals will come from multiple places including general practices or other community providers, hospital, schools or early childhood education, social service providers, police and corrections, or self-referrals. Risk assessment tools will be used that incorporate known social determinants and the relationship of health and wellbeing with adverse childhood experiences. Some referrals may be straightforward and can be directed to an appropriate service. Others requiring wraparound and navigation will be assessed and assigned to a key worker. Budgets for wraparound services will follow people. The key worker will partner with the whānau so they have greater choice and control over the services they access.

Headline goals

- People and whānau are equal partners in design of health services and decisions about their care
- Within 10 years there is no difference between population groups in self-reported health status
- All children have a safe, warm and dry house and inequities in avoidable illnesses are eliminated
- Rangatahi feel that services for them are appropriate and accessible
- All population groups have equal access to health services and equitable outcomes

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Elements of service and model of care development

Element	Phasing
Needs analysis and service design	Work with expert providers (kaupapa Māori, Pacific navigators, etc.), Māori Relationship Board, Consumer Council and Youth Council to establish mechanisms for engaging the voices of under-served people and particularly young Māori and Pasifika in service design.
	Develop DHB commissioning framework that explicitly delivers equity and resources services designed to meet the needs of under-served consumers and whānau.
	Investment in prevention of type 2 diabetes and heart disease in Māori and Pasifika.
	New primary <u>health</u> care model is developed through a co-design process that uses mechanisms identified to engage with the most under-served whānau.
	Ensure the primary <u>health</u> care model is designed <u>to meet physical, mental, whānau, spiritual needs within the Te Whare Tapa Wha model within a kaupapa Māori framework (e.g. Te Whare Tapa Wha).</u>
	Rongoā Māori, mirimiri and traditional healing practices are valued and integrated with care plans.
	Work with consumers and whānau to establish real time service feedback tools.
	Investigate and where appropriate establish with consumer input, mobile, drop-in, one-stop shop, home visiting services.
	Implement specific service access equity projects that address cost, cultural competency, transport, and other barriers.
	On-going design of hospital services involves consumers and whānau so that they are accessible and culturally appropriate.
	Utilise the Integrated Data Infrastructure for complex needs analysis, including bespoke analysis for Hawke's Bay DHB and tools such as the Index of Multiple Deprivation.
Expand wraparound/whānau ora	Introduce risk assessment and stratification tools for referrers and promote them to the health and social service workforces.
	Resource additional capacity within existing kaupapa Māori and whānau ora providers and/or expand services to other appropriate providers.
	Develop expanded wraparound services as required to <u>seek ensure whānau members receive</u> screening and health interventions, provide education and support for self-management, provide access to a range of intensive health and social services, provide advocacy support and navigation.
Establish coordination and budget model	Establish a care coordination/whānau service centre as a single point of entry for whānau health and social support services.
	Develop a referral pathway for care coordination and needs assessment.
	Determine a devolved funding model for whānau wraparound services, with budgets that follow people.
	Establish reporting requirements and budget management processes for care coordination/whānau service centre, and wraparound services.
Child & youth focus	<u>Work with rangatahi to co-design youth-friendly services, and different ways for rangatahi to access information and/or appointments.</u>
	<u>Whānau wraparound services have a focus on the first 1000 days of life and supporting rangatahi to transition into adulthood.</u>
	<u>Work to ensure all child health services are connected and integrated and transitions are seamless.</u>
	<u>Workforce strategies to ensure sustainable maternity services in all localities of Hawke's Bay.</u>
	<u>Support the Child Development Service to implement educational initiatives.</u>

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Relevant and holistic responses to support mental wellbeing

Social deprivation is closely linked to poorer mental health and addiction outcomes and, with the socio-economic profile across Hawke's Bay, it is not surprising that there is excess demand for intensive mental health services that are in fact directly related to social issues.

We have some good examples of mental health services in Hawke's Bay, that deliver peer support, day centres and recovery programmes, advocacy and housing services and return to work programmes; and nurse-led primary mental health clinics. We need more and we need to intervene earlier, so we focus on wellness and prevention, as well as recovery. Strengthening mental wellbeing and resilience is critically important if we are to achieve equity for those people with the poorest health and social outcomes.

Access to a wider range of services and workforces in the community

Our primary mental health packages of care are limited in scope and not able to be offered to everyone that would benefit. Referrals to our specialist mental health services have increased dramatically in the last decade, especially for young people, and we are not able to see everyone in a timely fashion. There is a growing burden of mental ill health in our rangatahi with high levels of drug addiction and suicide.

In future, primary and community care will facilitate direct access to self-management, wellness and resilience programmes for people with emerging mental health and addiction issues. We will need to work much more closely with other agencies to develop more holistic community responses and we will develop ground up approaches to this including, for example, peer led services and culturally specific services. Access to assistance for mild and moderate mental health and addiction issues will be expanded in three key ways. Firstly, new roles will be recognised to ensure responsiveness to a wider range of people who need varying support in different settings. The services of the future will have to rely on a broader range of skills than those currently only offered by registered health professionals. Secondly, mental health and addiction workers will become an integral part of the primary care team. We will develop better support for new families, maternal wellbeing and inclusive support for youth. And thirdly, close liaison with, and access to, specialist mental health services will enable members of the primary care team to manage better care in the community. Good support in primary and community services will include early recognition and referral for mental health and addiction services so that those with the most severe and complex needs will receive rapid attention by the right level of expertise.

We will use alternative therapies

We will explore and implement alternative therapies, which could include e-therapies, narrative based approaches, learning circles or group work. Group work provides opportunities for people to connect and build relationships through a variety of wellness activities. They bring small groups of people with similar needs together to talk, share stories and learn from each other. Group-based therapies could focus on topics such as healthy relationships, pregnancy and parenting, nutrition and fitness, addictions and recovery, and general life skills.

Emergence of behavioural services in of the primary care-behaviourist

There is growing advocacy for integration of 'behaviourists'-behavioural services within primary care. By extending or up-skilling primary care teams to include behaviourists-behavioural practitioners we can provide a better first line mental wellbeing service, providing early intervention as part of holistic



primary care services and, ultimately, reducing referrals to specialist services. It is an opportunity to increase equity, providing direct support for the most vulnerable people.

Behavioural services deal with psychological, emotional, relationship and cultural issues, offering alternative therapies that are culturally relevant to consumers. They help people to cope with their health and social issues as well as with life in general, and have a positive impact on health literacy.

Behaviourists-Behavioural practitioners will collaborate with consumers and whānau, and members of the wider general practice team to develop shared care plans, monitor progress and flexibly provide care to meet people's changing needs. It may become the norm for people to see a GP and behaviourist-behavioural practitioner together.

There are alternative workforce models for behavioural services—all will require significant training. Behaviourists-Behavioural practitioners may be psychologists, primary care clinicians with advanced training and certification in the diagnosis and treatment of mental and behavioural problems, or behavioural health consultants such as those embedded within the Nuka System of Care. Behaviourists-Behavioural practitioners are trained in processes they can perform in the practice, such as motivational interviewing and brief interventions

Behavioural services may include assessment, case management, individual and group therapies, and medication management; as well as unplanned interactions and crisis intervention. If additional care is needed, the behaviourist-behavioural practitioner can coordinate care and facilitate engagement with specialist mental health and addiction services. Behavioural services will also support those caring for people with mental illness or substance dependency.

Headline goals

- Access to mental health and addictions support is expanded to cover mild and moderate issues
- Primary and community services ordinarily provide a range of support and treatment options for mental health and addictions
- Support is provided for all rangatahi with mental health and addiction problems
- The primary and community workforce will expand to recognise a wider array of skills that support mental wellbeing
- A stepped-care approach to service access is integrated across the district
- Behavioural services are more widely available to primary and community services
- There are no suicides of young people in our community

Elements of service and model of care development

Element	Phasing
Expanded mental wellbeing services in community	Investigate expansion of existing mental health services in the community, such as those provided by Whatever it Takes Trust and taiwhenua health services.
	<u>Work closely with communities to implement the suicide prevention plan.</u>
	Develop primary mental wellbeing services in primary care for people with emerging mental health and addiction issues, including peer led and culturally specific services.
	Provide support services for new families and whānau, with training for primary care team members in the recognition of post-natal depression.
	Mental health workers are embedded as part of the primary care team.



Element	Phasing
Alternative therapies are available in the community such as e-therapies, narrative based approaches, learning circles/group work.	
<u>Community programmes that build social connection and social inclusion, and celebrate community diversity.</u>	
Primary care behaviourists <u>behavioural services</u>	
Investigate alternative workforce models for primary care behaviourists <u>behavioural services</u> and provide the required education and training.	
Behavioural services are embedded within all primary health centres.	
Primary care behaviourists <u>behavioural services</u> offer a range of services, including case management, assessment, individual and group therapies and coaching, help with medication and life skills.	
Behaviourists <u>Behavioural practitioners</u> and other mental health workers in primary care are available for unplanned, same day consultations and crisis management.	
Shared care plans are developed between consumers and whānau, behaviourists <u>behavioural practitioner</u> and members of the wider primary care team, with input from specialist services if required. Shared care plans are viewable by all parties.	
Specialist integration with primary care	
Specialist mental health services are closely integrated with primary care, providing case collaboration and consultation.	
Increase capacity and access to maternal and child mental health services.	
Behaviourists <u>Behavioural practitioners</u> and other members of the primary care team coordinate and facilitate engagement with service coordination and specialist mental health services.	
Specialist mental health and addiction service consumers have a behaviourist <u>behavioural practitioner</u> assigned to them to support them in the community and act as an integrator of holistic care.	

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Case study: Mahi a Atua, Tairāwhiti

Te Kūwatawata, a primary mental health service in Tairāwhiti, is using a Māori approach to primary mental health care called *Mahi a Atua* (tracing the ancestral footsteps of the Gods). Anecdotal evidence suggests that the programme has reduced referrals and use of secondary mental health services however a study into the programme's outcomes is being undertaken.

Mahi a Atua is an engagement, an assessment and an intervention based on pūrākau (Māori creation and custom narratives). Stories are recited and shared by the consumer, their whānau and the therapeutic team. The story telling is guided by Mataora who may be mental health, social, education workers, or artists, and who are trained as 'change makers'.

The whānau are introduced to a particular Atua (God) within the pūrākau, for example Uru-te-ngārara, the oldest brother who became reclusive (and depressed) after he couldn't cope with the bullying challenges of his younger brother. Consumers and whānau are able to contextualise the pūrākau and its characteristics to their own situation and are able to reflect on feelings (in this case of depression) in a manner that can create a shift in awareness.

Advocates point to the rapid development of therapeutic relationships, identification of the 'problem' within a Māori lens, the injection of meaning into the pathway ahead, and the sharing of a common set of understood values, beliefs and practices. The process appears to facilitate consumers to be 'on board' rather than in opposition, therapies that are agreed on rather than enforced, a likely increase in 'talk therapy' and decrease in medication, involvement of whānau members, and an appreciation of the complex nexus of relationships that make up real life for the person. It frameworks the 'road to wellness from a difficult place', rather than a 'road to recovery from illness'.

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Mahi a Atua is now part of the front door to mental health services—Te Kūwatawata is a single point of entry for those who are struggling with mental distress and who don't meet the criteria for specialist services.
_ (Rangihuna et al, 2018)

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Keeping older people well at home and in their communities

Community connections to keep people well

We need to renew our focus on keeping people well at home, and preventing loneliness and depression, by connecting older people with opportunities to contribute to, and participate in their community. Wellness clinics in the community can provide an opportunity for socialisation, exercise classes, screening and health promotion, connection to health and social services, as well as philanthropic services. Many older people still have much to offer their community, and a wellness clinic or 'hub' is a place to find volunteering opportunities or work that will keep them active. Clinics may be run by a variety of people and in a variety of places, dependent on the neighbourhood they serve. They will be well connected to primary health centres in their locality and to transport services.

There are many volunteers in the older person's sector, but often little coordination. We need to centralise coordination of such services, and this could be organised through the council, as it is in some overseas examples. There is also benefit in bringing young people together with older people to share knowledge and skills, and reduce social isolation. An example is the young person teaching and helping the older person to use technology.

In future we will work with our partners to develop elder-age-friendly and dementia friendly communities. Age-friendly environments foster health and wellbeing and the participation of people as they age. They are accessible, equitable, inclusive, safe and secure, and supportive. Age-friendly communities promote health and prevent or delay the onset of disease and functional decline. They provide people-centred services and support to enable recovery or to compensate for the loss of function so that people can continue to do the things that are important to them. A dementia friendly community is a place where people living with dementia and their care partners feel understood, respected and supported, and confident that they can contribute to community life. In a dementia friendly community people are aware of and understand dementia, and people with dementia feel included and involved, and have choice and control over their day-to-day lives. The community is made up of dementia friendly individuals, businesses, organisations, services and faith communities that support the needs of people with dementia.

We will build on the aspects of older person's care we do well

Our engAGE service was designed as a 'whole-of-health system' approach with the older person in the centre, linking care across the primary, community, and secondary services continuum, providing earlier and more responsive input, and making more effective use of all available health professional expertise. It includes community multi-disciplinary teams (MDTs), intermediate care beds, and the ORBIT rapid response team in ED. engAGE works closely with other DHB services for older people as well as with general practice, home based support providers and aged residential care. We will embed and expand this approach as the primary care model evolves, and extend its reach to the rural areas of Hawke's Bay.

Proactive care that gives people choice

We will provide increasing support for carers in future, including greater access to respite care as well as education and training for whānau carers. Respite care might be in an aged residential care facility, or it might be an in-home option during the day or overnight. We know that Māori and Pasifika populations are ageing rapidly and are likely to want to care for their older people at home.



We will work with whānau to ensure they can do this according to their cultural customs, and with access to appropriate support and services.

Intensive, restorative home based support services will be targeted to those who will benefit the most. We will provide a coordinated approach to training and support so our home support workforce are up-skilled to do more. Home support workers may be the person in most regular contact with an older person. With training and supervision, there is much more they could be doing, such as ensuring safe home environments (to prevent falls etc.), providing support with diet and nutrition.

Aged residential care providers have identified they need more support. This means greater access to GPs, specialist or advanced nurses and geriatricians in future (and particularly out-of-hours). Practice teams will also be better supported to manage their growing register of older and frail consumers, with specialist nursing and geriatrician support for the primary health centre.

‘Health care home’ models wrap allied health, community nursing and others around the person, working towards the goals of a shared care plan that has been developed with the person and their whānau and carers. Although it can be very complex, we will introduce standardisation of frailty pathways, with agreed definitions and screening tools. Screening and assessment will happen in the home as much as possible, and we will be using a wider range of validated tools (such as additional interRAI modules). We will consider alternative options for community support and residential care for younger people with disability or early onset dementia.

IT is critical to support this way of working, particularly shared tools, clinical records and care plans, and easy communication between health professionals. It will facilitate access to specialist medical and allied health support from a distance (tele-health). On-going training of the workforce is also required to manage challenging behaviours and dementia, the impacts of trauma and poverty, and respectful conversations around advanced care plans (ACPs). We also need to attract and retain younger staff to a new model of home support provision.

Early intervention and support for people to live well with dementia

General practitioners need to be up-skilled to make dementia diagnoses and people with dementia need to have input into the services provided. We will include cognitive assessment and hearing checks in a free annual health check for people aged 65 and over to improve detection and diagnosis of dementia. Following diagnosis, we will provide a year of support to give people with dementia, their whānau and carers the tools, connections, resources and plans they need to live as well as possible. On-going, we will provide services such as navigation services, high quality information about dementia and the care and support available, and provide flexible respite so carers can have a break when they need it.

Appropriate responses to acute need

When there is an acute need, the primary care team will be able to organise rapid response, short term care in the home, or hospital in the home services, to avoid the need for hospitalisation. This could be multiple daily visits from a home support worker or nurse.

Advanced care plans will become commonplace. When someone with an ACP presents to hospital, it is immediately alerted to and can be viewed by those involved in their hospital care. Discharge planning starts on day one, and rehabilitation services pull older people through the hospital system to avoid deconditioning and accidental harm.

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People at the end of life that will benefit from palliative care services (which are not just required by older people), will have a personalised plan. Their primary care team will be educated and supported to be the integrator of care.

Headline goals

- People remain well at home with whānau support, for as long as that remains their choice

Elements of service and model of care development

Element	Phasing
Community connections to keep people well	Wellbeing clinics based in the community that may be run by a variety of people such as advanced practice nurses, rehabilitation or care assistants, social workers, health promoters, volunteer organisations, etc. Wellness clinics will be able to connect older people to medical services, or social and volunteering services (to either receive or provide).
	Social work support in the primary health centre particularly for those on the lowest incomes. Social workers can connect people to budget advice and a range of other services and supports.
	Establish steering group(s) and process to develop one or more elder/dementia-friendly communities. Resources include the WHO Global Age-friendly Cities guide and local examples include work in Rotorua, drawing on research outcomes from the Netherlands and Scotland.
	Central (one-stop-shop) volunteer coordination function that may be organised out of councils or other agencies.
	Initiatives that bring young people to support older people to stay well (e.g. through exercises or activities), navigate electronic tools, etc.
	Connect people to free transport to attend wellbeing clinics, general practice with chronic care nurses overseeing plans of care, pharmacy support and regular medicines reconciliation, and hospital appointments if necessary.
	Increase access to funded respite care, including in-home options during the day and overnight if possible. Maintain strong connections with specialists and primary care.
	Education and training available for whānau carers, possibly run by home-based support providers.
	Culturally specific approaches to this education and training, including training existing whānau carers to provide peer support and education to other whānau.
Proactive and accessible care in the community	Expand engAGE and embed within primary health centres to cover the rural localities.
	Sufficient gerontology nurses and geriatricians linked with aged residential care facilities and general practices to provide specialist advice and training for practitioners (e.g. dementia diagnosis) and case collaboration, either physically or virtually.
	Aged residential care facilities have evening and weekend access to specialist nurse or GP, and pharmacist advice and support.
	Support aged residential care with workforce development for regulated and non-regulated workers.
	Up-skill the home-based support workforce to deliver other services, e.g. simple exercises to increase strength and balance, nutrition support, etc.
	Screen for frailty in general practice using an agreed tool. Develop frailty pathways.

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Element	Phasing
Multi-disciplinary team wrapped around primary health centre uses a shared care planning tool. Everyone can see interRAI assessments and update care plans.	
Specialist services (medical or nursing) are provided in the primary health centre either physically or virtually. GPs can consult with geriatricians and other specialists virtually while the person is in front of them.	
Complex people have a named case manager in their 'health care home'. HCHs have close relationships with aged-residential care and home-based support providers.	
Appropriate responses when things go wrong	
Navigators, case managers or liaison workers are available to support people and facilitate other services when they attend hospital.	
Advanced care plans are put in place that may be developed by a range of professionals, are viewable by all health providers, and are alerted to when people attend hospital.	
Rapid response or 'hospital in the home' to avoid hospital admission or facilitate discharge. This may include intensive visiting from home-based support providers, or nursing support in the home (e.g. IV antibiotics).	
Implement a return to home/transfer of care service – Hoki te Whare Kainga.	
interRAI assessments are completed in the home, not in the hospital.	

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Case study: engAGE community teams, Hawke's Bay

engAGE is part of Hawke's Bay DHB's Older Persons Health Service. engAGE community teams are locality-based multidisciplinary teams who meet weekly, at general practices, and bring together professionals from primary care, hospital older person's services, and a range of community agencies. Team members work inter-professionally—the clinician visiting the person carries out a person-centred, holistic assessment, and shares this information with the rest of the team, avoiding the need for multiple visits.

Working together, teams develop a better picture of the older person's needs and develop creative solutions to maximise independence. Home care staff and district nurses working in people's homes identify problems early and bring crucial information about the home situation which the GP may not have been aware of. Home care staff follow-up and feed back to the team about how the person is going, so changes can be made and crises averted. Faxed paper referrals to distant departments have been replaced by phone calls and emails between colleagues who support each other to provide the best care possible.

While the numbers of older people in Hawke's Bay grew between 2015 and 2016, ED presentations for people aged over 85 years decreased and there was a reduction in acute hospital bed days utilised by this group.

ED presentations	2015	2016	Change	Population change
65+ years	10,495	10,625	+1.2%	+3.7%
85+ years	2345	2283	-2.6%	+3.3%
Acute bed days	2015	2016	Change	Population change
65+ years	32,082	31,463	-1.9%	+3.7%
85+ years	8941	8766	-2.0%	+3.3%

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For those who have presented to the emergency department a thorough assessment and discharge support plan, from the engAGE ORBIT team, and follow-up by engAGE community teams, has increased the likelihood of an early and successful return to home rather than an inpatient admission.

engAGE also provides an Intermediate Care Beds (ICB) service, that involves MDT input in partnership with primary care for up to six weeks in an aged residential care facility for people not well enough to be home but not requiring hospital care.

(Shanahan S et al, 2017)

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Specialist management of long term conditions based in the community

A new model for accessing specialist support

Specialist clinicians will be deeply integrated with primary and community care teams, providing advice, episodic care for people with more complex needs virtually or in clinic-based settings, and contributing to the development and implementation of health pathways. The majority of specialist clinicians will operate as 'wraparound' specialists integrated with primary care instead of 'destination' specialists requiring consumers to attend hospital.

Growing specialisms such as sleep medicine, driven largely by an increasing burden of obstructive sleep apnoea, will be delivered primarily in the community and closely linked to population health strategies.

The current system of referral and appointments will evolve, to provide a much more responsive service, with minimal waiting time, that ultimately supports self-management of long term conditions. The primary care team will have rapid access to specialist advice and, if required, will be able to refer people for same day consultation with a secondary care specialist.

Specialist services will be delivered in a much wider range of settings, in different ways and in unstructured formats as well as organised meetings. Unstructured conversations will be as much the norm as 15 or 30 minute appointments. To do this, specialists will have to stop some of what they are currently doing. First specialist assessments (FSAs) and follow-ups will be reduced or organised differently and nurses will take over much more specialist work.

Working in this way will be supported by availability of secure messaging and email options as well as videoconferencing and video-chat.

Identifying people early will ensure proactive and preventative care

There are a number of specialist services working in the community already such as diabetes and respiratory services, and engAGE community teams. These are good examples of meeting needs by working inter-professionally and in an increasingly flexible way. However, even in these good examples we see people, particularly Māori and Pasifika, accessing services at a later stage of illness.

Prevention and wellness will be a core focus of our future health system and we will see even greater connection between population health and other parts of the system, to ensure the success of preventative strategies. ~~and we~~ We will also proactively identify at risk people through screening tools and risk stratification. Care plans will be developed with consumers and their whānau, with shared care between a range of health professionals to support self-management and ensure all needs are met. Specialists will participate in the development of shared care plans and multi-disciplinary team meetings in primary health centres.

Up-skilling primary care clinicians to deliver more complex care in the community

Primary care may need to be up-skilled in some areas of work such as gynaecology. Specialists will be attached to large practices within a clustered network of need. General practice will, over time, continue to develop specialism to manage the particular needs of their community by supporting development of GPs with special interests. Scale of operation will need to change to enable this to occur. Fragmented small businesses are unable to maintain specialist services and practices will need



to network together to allow the transfer of some services from secondary to primary care settings. Practices may cross-refer to each other for some things, as well as to specialists.

Clinical pathways will be one lever to make change happen

Clinical pathways need to be simplified and re-ordered both to allow clinicians to address issues as they turn up (for example, resolving an issue with a brief phone call rather than a referral) or by bypassing the GP (for example, if there is a breast lump). GPs will be able to seek that advice and support in an unstructured way.

Dying well

Dying is a normal part of the human experience and affects people regardless of age. The support a person and their whānau receive can significantly change their experience during this period of their life, and can help to avoid complicated bereavement for the whānau. Both chronic disease and cancer can be a protracted experience for a person who is dying and their whānau, and it is important to manage and support this period of living proactively from the start of this final stage of life. High quality and well-coordinated planning and care provides a setting for a healthy experience of death for whānau and their communities.

The Hawke's Bay population will be living with and dying from, not only conditions such as cancer, but long term conditions, with multiple co-morbidities, including dementia. Their longevity will be frequently compromised by frailty and disability. Advance care planning and palliative care have an important role in helping to provide support to family members and their carer network (including volunteers). Reliance on formal carers and the volunteer workforce will only increase, and we will need to support them to undertake potentially more complex roles.

Headline goals

- Reduce booked appointments for secondary care management of long term conditions by at least 30%
- Establish unstructured consultation and liaison with primary care as standard practice
- Individuals and their whānau are proactively supported in the last years of life so they die well, with on-going support for their whānau in bereavement

Elements of service and model of care development

Element	Phasing
Remove barriers to access	
Reduce FSA and follow-up workload and release time to unstructured consultations.	
Build relationships with primary health centres to support GPs and nurses to manage complex people.	
Allow brief phone calls so GPs can get brief advice rather than generate a referral.	
Provide specialist access at a time GPs are able to call (typically after hours).	
Establish a platform for secure virtual consultations.	
Establish case management (extensivist) for people needing multiple specialisms.	
Allow direct referral to specialists without a referral from General Practice (e.g. assessment of breast lumps).	
Progressively review pathways to remove barriers and reduce workload and enhance speed of diagnosis and treatment.	



Element		Phasing		
Change care settings	Develop primary care–specialist relationships through shared training (in evenings so primary care can train).			
	Undertake most specialist work in a primary or community care setting.			
	Identify specialist character of large primary health centres and build additional specialist services into them.			
	Actively follow-up Do Not Attends as per the Wairoa model; register them as a quality of service failure.			
	Actively track quality service failures to identify and address common patterns in geography or demographics.			
	Provide diagnostics (e.g. spirometry) in primary care.			
	Provide drop in clinics with diagnosis and treatment where possible.			
	Establish a common clinical portal.			
Change the workforce and facilities	Train primary care practice nurses in clinical nurse specialties focussed on metabolic disease.			
	Undertake increasing specialist work with <u>Clinical-clinical Nurse-nurse Specialists</u> .			
	<u>Inter-disciplinary clinical nurse specialists / allied health professionals for long term conditions take a holistic, rather than disease-specific, focus.</u>			
	Remove administration load from specialists by active time management and administrative streamlining.			
	Redesign ambulatory care so it is person focussed not the current specialty focussed villas.			
	Provide specialist consultation to primary care and case management services so whānau are empowered to manage long term conditions.			
	Provide online booking integrated across primary and secondary care and different settings.			
	Provide business intelligence to identify who is not being seen but should be.			
End of life	<u>People requiring palliative care have an individualised plan, supported by specialist services but based in community and primary care. Primary care providers receive education and training in core palliative care competencies.</u>			
	<u>People at the end of life have access to 24/7 services.</u>			

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Case study: Reducing specialist referrals, Southcentral Foundation in Anchorage, Alaska

Southcentral Foundation is a not-for-profit health system, owned and run by Alaska Native people for Alaska Native people, located in Anchorage, Alaska. It delivers a broad spectrum of services and also co-owns and co-manages a 150-bed hospital, the Alaska Native Medical Center, providing inpatient, specialist and tertiary services. It delivers services to a population of 65,000 Alaska Native people in Anchorage, Alaska and across the Southcentral region, covering a landmass twice the size of England.

Alongside improvements to access and quality of primary care, Southcentral Foundation has built effective working relationships between primary care teams and hospital specialists, as a strategy for retaining people in primary care where possible and reducing pressure on hospital services. For example, the primary care teams have built strong relationships with the cardiologists and respiratory physicians in the hospital. The hospital doctors also tend to know most of the people with fragile cardiology and fragile respiratory cases on the primary care teams' books. When they see service users with complex conditions, the primary care doctors and nurses are able to phone the



specialists for rapid consultations. The specialists spend a greater proportion of their time supporting and educating the primary care teams instead of treating people themselves. The primary care doctors are, in turn, able to spend more time with people with complex needs, and to take on more demanding roles, because they are themselves pushing more routine work down to the nurses and other staff in their teams.

For their part, the specialists understand that it is in their interests to respond quickly to the primary care teams when they ask for support. If they can respond in five minutes, they can help the general practitioners to manage the person's condition in primary care. If they can't, they will receive a referral for which, there is often no financial reimbursement.

These strategies have contributed to huge reductions in referrals to hospital specialists, with referrals per person falling by more than 60 per cent between 2000 and 2009. The specialists in many of the hospital's clinics have in turn been able to reduce the waiting times for outpatient appointments, in some cases moving from long waits to same-day appointments. The changes have also helped to reduce the costs of the hospital system. The numbers of hospital specialists in some disciplines and the number of hospital beds have been held roughly constant over the past 17 years, despite an approximate tripling of Southcentral's regional Alaskan Native population.

(Collins B. The King's Fund, 2015)



Well supported transitions from hospital

We recognise that many patients could avoid admission or be discharged earlier if better home support services or options for convalescent care were provided, and that for older people a prolonged stay can lead to deconditioning and harm. When people do require hospital care, the transition needs be organised better than it is currently. Within that transfer, whānau, friends and support people are as important as the health professional but are not always included in planning. People do better at home and we currently both disempower and decondition them in hospitals.

We know we could do better. Our own review of what we do suggests poor discharge planning leads to extended length of stay. We currently have limited whānau or cultural engagement resulting in poor ownership by consumers of their journey. Delirium and dementia are not well-recognised and we need to better manage people with these conditions. Some people are accepted for rehabilitation with little potential for improvement, which is not a good use of limited resources.

We will develop better transitions for people with complex mental health needs who may require intensive wraparound services or tailored treatment and care packages. Growing complexity of mental health issues may result in some of our current community services being unable to cope. In order to prevent an automatic return to intensive hospital services, we will need to ensure the supply of community services continues to be developed and supported to match the need that we are seeing.

We need to anticipate admissions

Development of proactive person-centred planning with primary care teams is an opportunity to anticipate and plan for hospital admissions. A well-developed stepped care model of mental health and addictions services will also contribute to more appropriate use of intensive services.

A new way of doing things for older people

The development of our new model of care for discharge of older people is built around the following principles:

- Consumer and whānau ownership of their health journey
- Streamlined processes, focused throughout to achieve the discharge date set on admission
- All activity with the consumer is rehabilitation focused and delivered by one cohesive team (inter-professional practice)
- Early supported discharge and other alternatives to inpatient care to improve hospital flow and consumer satisfaction, improving outcomes and six month readmission rates
- On-going consumer involvement with robust quality assurance/improvement processes.

We will establish Hoki te WhareKainga, a home-based rehabilitation service. The service will be staffed mostly by rehabilitation assistants and overseen by a registered health practitioner. After returning home from hospital, rehabilitation will continue at home with up to four visits a day, for up to six weeks.

We expect these changes will have material, positive impacts on people. We expect increased consumer and whānau engagement in their own care, and improved satisfaction as a result. We expect reduced complications associated with hospitalisation (deconditioning). As a result, functional well-being of our consumers will improve.



Inter-professional practice ensures the whole team is activated

We need to consistently apply functional rehabilitation principles to preserve independence. Implementing inter-professional practice will ensure the whole team is involved in active functional rehabilitation of each person, with their whānau.

Core mental health and addiction skills will be evident in community and primary care while specialised treatment skills will need to be retained in the intensive/acute hospital teams to support greater accessibility to the right level of care. People with mild to moderate mental health and addiction needs will be much better served outside of the hospital, with strong support to those services, while people with moderate to severe conditions and greater risk will also have quick access to the right level of support via a range of options.

Appropriate responses to social issues

For whānau with unmet social needs, we need to bring community partners in from the start of the hospital stay. We sometimes keep children in hospital while sorting through social issues and the hospital is not the place to do that, but at the moment may be the only alternative. We need to find a different place for children until safe arrangements are in place that is not characterised by a medical model of practice. Increasing interagency work, such as social housing, will also add strong support to transitions for people with mental health and addictions issues that are further complicated by social complexity. We will ensure people can leave hospital appropriately and safely, using navigators to draw all the services together if required.

Reducing co-ordination issues

Co-ordination is the key as we currently work in silos and do not pass on the baton. IT is a key enabler of this co-ordination and will ensure full inclusion of the health workforce in the community, primary and hospital care. That enablement will ensure the team working with people and whānau on transitions have the right information, at the right place, and at the right time. We need to step our Needs Assessment and Care Co-ordination processes up to this new challenge.

Headline goals

- People return home after an acute medical stay in hospital as soon as they are medically stable and have regained an adequate level of function
- Average length of stay for older people is reduced substantially
- Re-admission rates are reduced substantially
- Stepped care model for mental health and addictions is in place

Elements of service and model of care development

Element	Phasing
Re-define attitudes to hospital	
Ensure there are appropriate destinations after discharge for vulnerable children.	
Ensure consumers and whānau are aware of <u>and up-skilled to prevent</u> risks of hospitalisation including pressure injuries and deconditioning.	
Use mental health and general practice approaches to identify generic situations and build information packs around triggers and responses other than hospital.	
Establish navigator roles in primary care that pull <u>consumers out of hospital support</u> <u>people to stay well at home and ensure they return quickly following hospitalisations.</u>	



Element	Phasing
Honest conversations with consumers and whānau about goals of care and recovery paths.	
Provide support/education to whānau likely to be supporting consumers through surgery and recovery.	
Build local MDT teams that link closely with geography and practices and localised resources.	
Focus NASC as a client relationship management team.	
Provide supporting IT and shared care records to the wider health team.	
Electronically share discharge plans.	
Build discharge plans prior to hospitalisation.	
Better enable volunteering.	
Better utilise home care support workers to provide early warning and support on discharge.	
Work with local social agencies including Housing NZ to provide alternative accommodation solutions.	

Case study: Community Rehabilitation Enablement and Support Team (CREST), Canterbury
Early supported discharge in Waikato and Canterbury

Waikato DHB launched an early supported discharge team, the START (Supported Transfer & Accelerated Rehabilitation Team) service in 2010. START consists of health care assistants (HCAs), registered nurses and allied health. Geriatricians provide input through case conferencing. HCAs provide up to 4 visits a day, 7 days a week and use functional rehabilitation principles to maximise recovery through incorporating exercises within activities of daily living tasks.

A study (Parsons et al, 2018) funded by the Health Research Council from 2011-2014 sought to identify the relative impact of the START service for DHB clients. The randomised controlled trial recruited 183 older people who were randomised to either usual care or START. All participants were followed up over 6 months and their service utilisation was recorded.

Participants randomised to the START team spent less time in hospital during their first admission in comparison to usual care (mean difference 5.9 days, 95% confidence interval 0.6, 11.3, p=0.03) and spent less time in hospital in the 6 months following discharge home.

Canterbury DHB launched the Community Rehabilitation Enablement and Support Team (CREST) in April 2011 to ease pressure on capacity stretched hospitals after the earthquake. CREST began as a community-based supported discharge team facilitating earlier discharge from hospital to appropriate home-based rehabilitation services. It has since been quickly extended to accept referrals directly from general practice, providing older people referred this way with care and support to be rehabilitated in their own homes to avoid hospital admission altogether.

CREST provides goal oriented, interdisciplinary support for up to six weeks which may involve: nursing services; occupational therapy and physiotherapy; daily support until the person can manage on their own or with assistance from their usual service provider; home-based rehabilitation; continuing clinical assessment to recognise any deterioration; development of agreed individualised care plans for long-term use in the person's home; improved education and information for consumers, their carers and families; and liaison with general practice.

The University of Otago is evaluating the CREST service, using a retrospective cohort (looking backwards), a prospective cohort (looking forwards) and qualitative interviews.

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Between 2010 and 2014:

- Overall hospital admissions reduced—the admission rate for people aged 75+ decreased from 197 per 1000 to 187 per 1000, a 5 percent decrease
- Length of stay reduced from 9.2 to 7.8 days ($p < 0.001$)
- Inpatient older person's health use reduced.

For those receiving CREST in 2014 (605 people)

- Reduction in aged residential care use after older person's health admission—5.6 percent compared to 8.1 percent for those that didn't receive CREST support
- Increased time to ARC—65 days compared to 48.9 days for those entering ARC having not received CREST prior.

(Heppenstall C, 2017)

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The hospital takes a narrower focus in future

The hospital will have a narrower focus in future. Achieving this would free up resources that will be redirected for investment in preventative and primary health care services and addressing the needs of people with the poorest outcomes. In future, the hospital will be a place providing specialist assessment and decision making for patients with critical illnesses or injuries, followed by intensive therapies for the first 24-48 hours of inpatient care before discharge or transfer to community settings; or delivering services that require specialist teams or equipment that isn't feasible or cost effective to replicate in multiple settings. Better community based support for mental health and addictions issues will ensure that specialist mental health services at the hospital are focused on those with the highest complexity and need.

We will always need hospital services and they are the right place for some specialist assessment and care. We have a number of challenges within our current hospital—our facilities and workforce are stretched and wards are often full. All of the previous sections in this CSP are the building blocks for the hospital we want in the future, and we need to achieve our ambition across all of them if we are to use hospitals in a different way. We need providers across the whole system to step up to the challenge, and we need to support and resource them to do that.

At the Emergency Department

Only people requiring resuscitation or specialist medical assessment and care that an only ED can provide, should be managed in an ED. Currently, our ED receives a large number of people that would be more appropriately managed, and could have a better overall experience, by accessing primary care.

We need good alternatives in the community that are easy for people to access, especially those for who access is inequitable at present. A primary driver of our acute model of care will be to improve access to urgent primary care for those with unmet needs in order to improve longer term outcomes. For mental health crises, a 24 hour response is essential but the ED is not the right place for this either. Future pathways will result in fast access to emergency mental health services including ease of access after-hours along with greater input from social and cultural resources. In addition, primary care clinicians will require rapid access to specialist advice via telephone or other means, and access to the necessary diagnostics.

People who do not require specialist medical assessment or resuscitation, but do require hospital admission for further care, should not be admitted via the ED. This means community providers have the ability to refer directly into various acute assessment units. In addition, streaming will move people rapidly from ED to the right service in the hospital, or support people to attend primary care where more appropriate.

A range of disciplines and professionals will be present in the ED to ensure journeys start off right, that all people's health, social and wellbeing needs are attended to, and transition back to home is facilitated.

Improving flow through the inpatient journey

Early senior assessment will support better decision making and planning, and the future hospital will enable this over extended hours, seven days per week. Discharge planning will begin on day one of a person's hospital stay, and daily MDT reviews on the wards will ensure continued progress and that any issues are addressed quickly. In future, a large majority of hospital inpatients will be older people



with increasing prevalence of comorbidities and frailty, and their care will be led by physicians and geriatricians, with allied health input and appropriate specialist nursing care. For others with enduring and complex needs we will need to keep innovating in terms of step down facilities, wraparound services, navigation support and tailored treatment and care packages in the community.

An 'Intensive Care Unit (ICU) without walls' approach will enhance the care of many seriously ill or potentially unstable patients on general medical and surgical wards, reducing demand on the ICU.

Maximising touch points and looking after all needs

Avoiding unnecessary admissions to hospital is the priority, but when it does happen we will maximise each touch point. Bringing navigators, kaitiaki and social workers to the front door is a good start. We also need to ensure our hospital is whānau friendly, allowing whānau members and support people to accompany consumers at a vulnerable time. Providing whānau and meeting rooms enables shared care with all players and provides space for respectful conversations in hospital, as well as ones around wellness at home.

The discharge lounge will be expanded to facilitate better transitions back to the community, including the ability to enrol and book people directly with primary care. It is important to consider the particular challenges for each consumer and their whānau, for example transport for people to attend general practice.

Rehabilitation focus across the whole hospital

An increasing proportion of inpatients will be frail, older people requiring a whole of hospital rehabilitation focus. Geriatricians and allied health input will be required at the front door of the hospital and throughout the hospital stay, with additional social support.

The rehabilitation model for older people will change and pull people through the system to reduce deconditioning and harms from hospitalisation. It will take a broad view, with close person and whānau engagement to address all aspects of rehabilitation.

Headline goals

- A substantial reduction in wasted consumer time while in hospital i.e. time waiting to see the right person, waiting for diagnostics or treatment is minimised
- The hospital is focussed on specialist assessment and intensive therapies for the first 48 hours of acute medical care

Elements of service and model of care development

Element	Phasing
Multiple entry points and streaming	
Direct referral from general practice, aged residential care facilities, ambulance service to acute assessment units within the hospital, following triage by GPs, senior nurses, paramedics, etc.	
Triaging from ED to primary care where appropriate with vouchers to subsidise co-payments targeted to those most in need.	
Extend hours of the Paediatric Acute Assessment Unit.	
Establish women's health acute assessment unit, staffed by senior midwives, gynaecology nurses and senior doctors, with direct access for pregnant women.	



Element		Phasing		
	Develop and implement a public communication plan on the role of the hospital and good community alternatives for urgent care as they develop.			
	Establish surgical assessment unit that can deal with minor acute presentations, e.g. abscesses.			
	Create separate area within the ED that is more appropriate for older people, e.g. to manage delirium more appropriately.			
	Attendances at ED trigger a follow-up with primary care.			
Right start to the hospital journey	Re-design the workforce model so people in ED receive early senior medical assessment and decision making.			
	Psychiatric liaison nurse in ED to ensure mental health consumers are directed to the safest and most appropriate place as soon as possible.			
	Kaitakawaenga and social workers in ED to address unmet health and social needs from the start of the inpatient journey, as well as community navigators being able to follow the person from community to hospital and out again.			
	Consider a range of other disciplines in ED such as specialist nurses, physiotherapists, etc.			
	Create a whānau friendly hospital with facilities such as meeting rooms to support whānau centred practice and consumer support and advocacy during a vulnerable period.			
	Establish shared care early on with whānau and all practitioners involved in a person's care.			
	Expand ORBIT model to include additional disciplines as required.			
Better, more streamlined inpatient stays	Estimated date of discharge planning starts on day one in conjunction with the person and whānau, and connecting with community providers involved in care.			
	Daily multi-disciplinary huddles and regular assessment on the wards to ensure continued progress and attend to issues efficiently.			
	Essential services will run 7 days a week (e.g. allied health and radiology).			
	Higher dependency and ICU outreach services provided for general medical and surgical wards.			
	Surgical cases will be managed by physicians and geriatricians on the wards as much as possible with shared care arrangements where necessary.			
	Expand the discharge lounge to transition a greater number of people with the ability to enrol people in general practice and book appointments.			
Rehabilitation focus	Fast track admission from ED or acute assessment unit for frail older people requiring non-surgical management after a fall.			
	Fast track people to rehabilitation 48 hours post-fractured neck of femur surgery.			
	Implement proposed rehabilitation model of care with the longer term aim of predominantly community-based rehabilitation.			
	Implement inter-professional practice to reduce duplication and overlap, using the Calderdale framework to extend inter-professional scope of practice.			
	Care assistants are used as key workers for designated people.			
	Functional rehabilitation focus and early mobilisation to limit deconditioning in hospital.			
	Develop delirium/dementia pathways to manage length of stay and improve outcomes.			



Summary of evidence: care closer to home and reducing hospital length of stay

Bed audits across a large number of acute hospitals in the United Kingdom found that up to half of bed days could theoretically take place in other settings, but pointed out that there are some constraints on this in practice (Monitor, 2015a).

Monitor (2015b) developed an approach to modelling the impact of telehealth, enhanced step-up, rapid response and early supported discharge, and reablement services. The schemes reviewed show it is possible to treat people with quite severe clinical needs in community-based settings. A literature review of the clinical impacts (Monitor, 2015a) indicates that although there are risks, well-designed schemes are likely to have clinical outcomes that are equal to hospital care and sometimes better (particularly the case for older people). Financial analysis (Monitor, 2015c) suggests that in the long run, well-designed schemes could be used to create capacity for managing expected increases in demand, reducing the rate of expenditure growth by substituting for, or at least delaying, the need for investment in new acute hospital facilities.

A review by Imison et al (2017) found the most positive evidence of impact for the following initiatives: improved GP access to specialist expertise, ambulance/paramedic triage to the community, condition specific rehabilitation, remote monitoring of people with certain long-term conditions and support for self-care, additional clinical support to aged residential care and improved end-of-life care.

Reducing length of stay in hospital

We have been working hard to improve flow within our hospital but we know we can do better. The Health Roundtable (2018) shows we have improved our length of stay (LOS) and we do well at discharging people from hospital before noon; but we still have a relative stay index near the upper quartile of our peer group and high readmission rates.

Figure 8 Acute relative stay index

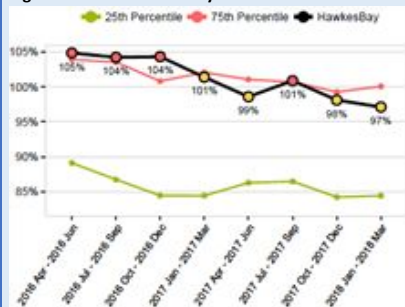
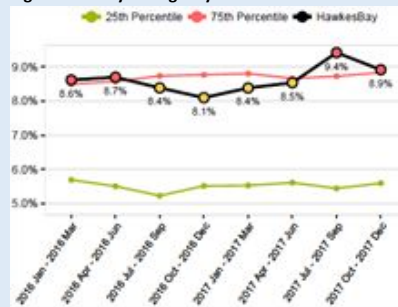


Figure 9 28 day emergency readmission rate



Nuffield Trust (2015) undertook a high-level review of the literature relating to hospital flow and length of stay. They collected case study material (including from interviews) from hospitals that had made significant improvements in length of stay over the last five years. The following approaches were highlighted as having a positive impact on improving flow and LOS:

- **Early senior input** – A UK study of senior review in the ED reported that senior review of 556 patients reduced inpatient admissions by 11.9 percent and reduced admissions to the acute medical unit by 21.2 percent (White et al, 2010).
- **Designated short-stay units** – Short stay observation and assessment units can reduce LOS and prevent a full admission. Some units are successful in discharging upwards of 65 percent of patients before the third night in hospital (Emergency Care Intensive Support Team, 2010).



- **Frailty units and services** – A study in the United States found that a service for the elderly located in the ED reduced admissions by 3 percent (Keys et al, 2014). Specialist frailty units are associated with shorter LOS (Barnes et al, 2012), less functional decline and lower readmission rates (Traissac et al, 2011). Specialist frailty services that provide in-reach services to outliers can also reduce LOS (Foundation Trust Network, 2012).
- **Tracking patient progress through the hospital** – There have been few large-scale studies on systems that track patient progress through hospitals however individual hospital case studies and interviewees highlighted the value of constant visibility of patient progress when supported by proactive MDT patient management.
- **Proactive multi-disciplinary management through rounds** – The number of unnecessary days in hospital can be reduced through twice-daily MDT rounds and decision-making (Singh et al, 2012; Emergency Care Intensive Support Team Urgent, 2010). Some successful hospitals have an early morning round that provides an action list for the ward coordinator and a mid-afternoon round to review new admissions and check on the progress of patients.
- **Seven-day rounds and supporting services** – In Hawke's Bay, the LOS for a general medical patient admitted over the weekend is on average more than a day longer than someone admitted on a Wednesday (Health Roundtable, 2018). Increasing senior review and seven day working does usually require investment in numbers of staff however a case study hospital managed to stretch occupational therapy services to seven day working with only minimal additional investment (Nuffield Trust, 2014). Therapy services available seven days a week can reduce LOS and support increased weekend discharges. An Australian study found that increasing physiotherapy input over the weekend led to a 3.2 day reduction in LOS (Brusco et al, 2007).
- **Discharge planning** – Effective discharge planning and timely transfers of care can reduce the length of hospital stays and reduce readmissions (Shepperd et al, 2003; Kahnna et al, 2012). Case study hospitals have found that early identification and active case management of people at risk of complex discharge on admission can reduce LOS. These people are given a comprehensive geriatric assessment and tracked through the hospital, while district nursing and other community services are lined up in parallel for transfer home. Case study hospitals that implemented nurse-led discharge found that equipping senior nursing staff to facilitate discharge, once defined medical criteria have been reached, can enable more timely transfers.
- **Standardised enhanced recovery programmes and clinical pathways** – Standardisation of enhanced recovery programmes (ERPs) and clinical pathways has been found to reduce LOS and costs across a range of conditions. For example, in a heart failure ERP, managed patients had a significantly lower length of stay (3.9±2.2 days) compared to unmanaged patients (6.1±2.8 days) (Discher et al, 2003). In Hawke's Bay heart failure accounts for the largest number of general medical bed days (ranked by diagnosis) and our relative stay index is in the upper quartile of our peer group (Health Roundtable, 2018).
- **Therapy interventions to improve flow and support transfer to alternative settings** – Therapy interventions can enable recovery at home, reducing overall LOS in hospital. Systematic reviews have consistently found that physiotherapy can reduce LOS by one day (Peiris et al, 2011; de Morton et al, 2007). Evidence suggests there is a reduction in LOS when home-based multidisciplinary early supported discharge is used instead of usual care. A review of evidence found that early mobilisation and therapy interventions post joint replacement surgery can result in a reduced LOS of about 1.8 days (Guerra et al, 2014; College of Occupational Therapists, 2012).
- **Working with partners to transfer complex people out of hospital** – The literature and case studies highlighted the need for effective communication and close working between health and social partners, consumers and carers at the point of transfer out of the hospital. Case study sites that were successful in



improving discharge planning moved away from 'discharge' to 'care transfer'—where community, social care and acute teams share core links and decision making points.



Surgical services continue to be refined

Surgical services will continue to be provided in Hawke's Bay in a manner that both meets the needs of our geographically isolated population and is sustainable for a hospital of our size. This means we will continue to provide general surgery, orthopaedic surgery and other key elements of surgery relevant to our consumers including appropriate diagnostic and support services; and will have good relationships with tertiary providers for those services that cannot be provided locally.

All of these services will come under increasing pressure as our population ages; operations related to cancer will increase particularly in the short term following introduction of bowel screening. We know we have lower than average rates of orthopaedic and plastic surgery currently. We have made improvements in our surgical productivity over time and we will continue to refine our surgical services into the future, making sure we offer timely surgical intervention to those who will benefit.

Prevention first and foremost

Currently we talk about surgical outcomes and need to emphasise wellness outcomes. Surgery is a response to a symptom that has an underlying cause rather than an intervention that will fix all health issues. People may have expectations that surgery will give them the full level of functionality they once had and that is not always the case. We need to focus more on understanding and preventing, and finding alternatives to surgery rather than continuing to build capacity in the way we have. This means looking closely at pathways for a number of conditions to understand how we can intervene earlier and provide alternative interventions before surgery is needed. Allied health professionals will support a wellness model with earlier intervention using non-operative management. For example, physiotherapy interventions can delay the need for joint replacement, and improve recovery from eventual surgery. We will need to re-set expectations of consumers in primary care, using health pathways as a tool to help us do that.

New settings for surgical interventions

Some minor procedures will be shifted to less resource intensive settings. Examples are removal of skin lesions and some eye procedures that could be done in primary care if clinicians were up-skilled. Some of the work we do in operating theatres could be moved to procedure rooms. By shifting procedures to different settings we can create capacity in our operating theatres for more rapid access to urgent theatre, and to meet increasing demand for some surgeries.

We will develop our day surgery model further, establishing the need for an ambulatory theatre facility and considering where that would be most appropriately located.

Continuing to improve surgical productivity

We are planning for additional theatre capacity and need to ensure we use our theatre capacity as efficiently as we can. This may mean extended theatre lists in future so that, for example, an additional operation is performed in each elective theatre each day, or additional cases are done on a weekend day. This will reduce the need to outsource surgery to private providers.

We have already changed our model to protect acute operating time and will continue to refine our acute surgical efficiency. Part of this is having more senior assessment of people at the front door of the hospital so people are not admitted unnecessarily. We will also improve access to acute theatre, balancing the need for additional acute operating theatres (including obstetric) with increasing efficiency of those theatres.



In future, a large majority of surgical inpatients will be older people with increasing prevalence of medical comorbidities and frailty. Therefore, over time, we are likely to distinguish less between medical and surgical patients and wards with physicians having a substantial role in the care of those needing surgery, to address issues of medication, perioperative disease management and rehabilitation before and after surgery. Increasingly enhanced recovery after surgery programmes will mean that the needs of those arriving in the surgical ward will be anticipated in care planning, and reactions to their arrival and recovery from surgery will be faster. Perioperative activities will be undertaken by a wider team.

Networks to provide more complex surgery closer to home when possible

We will work in service networks supported by tertiary providers to provide some more complex surgery closer to home where possible. Examples of this will include plastic surgery, minor paediatric surgery, and vascular surgery.

Headline goals

- Referrals for surgery are appropriate and decline rates are low. Non-operative management options are offered where people will benefit
- Elective surgeries are planned after a discussion with the consumer has clarified their wellness goals
- An increase in the proportion of day case surgeries

Elements of service and model of care development

Element		Phasing		
Refine demand for surgery	Undertake discussion of surgical options in a wellness discussion based on alternatives and quality of life.			
	Ensure the workforce has the health literacy skills that consumers understand what surgery is going to offer them.			
	Ensure there are practical alternatives (such as physiotherapy-led programmes) to invasive surgery in key areas of demand.			
	Ensure advanced care plans are in place for all people considering elective surgery and, over time, all people likely to need acute surgery.			
	Re-examine health pathways for conditions that may require surgery.			
	Revamp pain management services to provide better support pre and post-surgery.			
	Increase prevention activities aimed as weight loss and reduction in smoking and alcohol consumption.			
	Ensure proactive care planning for Māori and Pasifika to ensure they receive an increased level of surgical intervention where appropriate.			
Shorter surgical stays	Provide geriatrician and allied health support on all surgical wards.			
	Focus available surgeon time on surgery.			
	Support pre and post-surgical.			
	Develop an ambulatory surgery model of care within a dedicated space. Determine whether this facility is best place on or off the hospital site.			
	Clinical assessments are performed by a multi-disciplinary team.			
	Develop day stay practices aggressively.			
	Ensure acute theatre capacity is available in the weekend and use that capacity for catch-up operations.			



Element	Phasing
Build a sustainable surgical model	Ensure all surgical patients in hospital are there for surgery and go for surgery.
	Embed and/or maintain enhanced recovery after surgery programmes.
	Only offer surgical specialties where there are two surgeons at a minimum, and sufficient supporting service capacity including beds.
	Provide weekend and evening lists for elective catch-ups, and possibly extend regular lists (e.g. one more procedure a day).
	Develop long-term capacity and capability contracts with the private sector.
	Networked (hub and spoke) models being supportive of local surgeons. Priority services include vascular surgery, plastics, minor paediatric surgery.



5. We will put the right support structure in place to achieve our vision for the future

Growing our workforce is critical to the delivery of a new model of care

A key enabler for achieving our vision and for delivering this CSP is to create a culture shift—from being system-centric to person and whānau centred. By that we mean working with our community and whānau to build our services around the people it serves and creating a safe environment for staff and consumers. Our first step was to embark on the development of a People Plan: *Grow Our People by Living Our Value*, based on stakeholder feedback, models and theories around improving engagement, and our desire to demonstrate our values in everything we do. The Plan is a people focussed strategy that will also inform the next 5 year strategic plan and along with ICT is critical to delivering this CSP.

The People Plan is a commitment to our staff to make this a great place to work and bring our workforce together as a cohesive health system and one team. Living our values will require immediate changes in behaviour, particularly from leaders at all levels of the health system. Through delivery of the Plan we will ensure that our workforce is well supported, capable, appropriately resourced, engaged and motivated to provide the best possible service to our community. In relation to this CSP it means aligning our workforce capacity and capability with the future models of care described here, as well as the introduction of new roles and up-skilling the workforce both professionally and culturally. There are three key themes:

1. Cultural competency and person and whānau centred care

One of our intentions is that our workforce reflects, understands and supports the health needs of the population it serves. We will work proactively with schools, training institutions, and the Ministry of Social Development to facilitate employment of Māori and Pasifika in particular. As part of the Māori and Pacific Workforce Action Plan, we will provide culturally appropriate vocational pathways so we can 'grow our own' and improve the ethnic diversity of our workforce. Cultural competency will be a core competency for all our staff and organisation. We will set our expectations high and provide regular and active education and training in tikanga Māori, Pacific custom and practice, and disability responsiveness.

Person and whānau centred care is firstly about enabling the workforce to develop partnerships with people, whānau, carers, communities and colleagues. This requires working in a different way and not simply developing new skills and knowledge. Behaviour change is not easy—it requires the combination of workforce capability together with the opportunity and motivation to change.

2. Working to top of scope and new scopes of practice

All workforces will come under increasing pressure to managing increasing levels of need and complexity. All roles involved in health care will be working to the top of their scope of practice and will perform tasks that have traditionally been done by more senior roles. Senior nurses and allied health professionals will [be supported with advancing practice models and this will](#) play an increasingly important role in the planning and delivery of health care—and in turn we will use care assistants and therapies assistants more effectively. Volunteer workforces will be called upon more



frequently, so we must recognise and value their contribution to ensure their continued participation in our system. Workforces such as paramedics and home support carers will play an increasingly important role, as they do more in the community and people's homes. [Clinical support service clinicians will help resolve equity, workforce and patient experience challenges outlined at the beginning of this plan.](#)

3. Team based practice

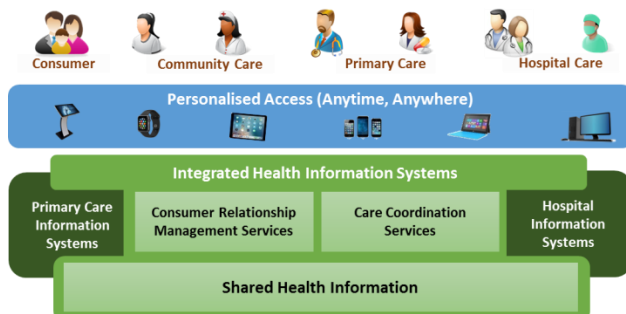
We are increasingly working alongside each other in an inter-professional manner rather than working within our professional silos. We need to keep on doing this, to be able to work with and include whānau and consumers as carers as well as the range of skills in the health care team. This inter-professional practice requires a multi-disciplinary team focussed on collaborating and sharing skills to meet consumers' needs.

The Calderdale Framework (Smith and Duffy, 2010) provides a clear and systematic method of reviewing skill mix and roles within a service to ensure quality and safety for consumers. It is transferable to any health or social care setting, and enables consumer focused development of new roles and new ways of working, leading to improved efficiency in utilisation of roles (Nancarrow et al, 2014).

Better information and communication technology will enable us to work smarter

Our Information and Communication Technology (ICT) environment has not kept pace with developments in healthcare and other parts of society. The health system we have described for the future relies on closer alignment between ICT and health objectives—without it we cannot achieve our plan. We have put in place best practice ICT foundations with business led governance and operating frameworks within our organisation. In addition we are actively working on continuously improving our ICT capabilities by investing in our people and strategic partnerships. This positions us strongly to enable the transformation of our health eco-system through digital services.

Figure 10 Accessible and integrated health information systems



Our new models of care require the availability of trusted health information for consumers and providers, at the right place and time. This relies on us working in partnership providing innovative



and agile solutions. Our new models of care require the integration of our information systems to provide a single and accessible view of the patient's health record, care plan, and interactions.

The team-centric approach in our new primary care model emphasises the need for care coordination and communication. We will enable and facilitate this through modern unified communications and collaboration services as well as a range of coordination services supporting collaborative pathways, workflow, referral, and case management. Additionally, consumer relationship management services will enable consumer and whānau information, contact details and preferences, relationships, interactions, and tasks to be recorded and shared.

Modern technology solutions enable new methods for consumers and providers to access information and health services, personalised to support different preferences and work situations. For example, the use of smart devices, such as smart phones and tablets, will enable a mobile workforce and gain measurable productivity improvements. Consumer technologies provide opportunities to enhance access to health information and our services; enabling consumers to view and add their own information, make appointments, receive reminders, interact with their health care providers through a self-care facility such as kiosks, web portals or mobile applications. Emerging technologies that support self-management, such as home based monitoring systems, wearable digital devices, and near patient testing, will be adopted with real time data feeds into systems that people can access easily. Remote medical care through tele-health technologies, for example, will improve access to specialist services, particularly for those living at distance to health facilities.

Underpinning these enablers will be a portfolio of secure and resilient infrastructure and systems management services to ensure 'always on' access to our information.

We will deliver these health enablers by working collegially and adopting an agile implementation strategy underpinned by a skilled ICT team that delivers real business value. We will design and develop our services following a 'business value first, technology second' principle to ensure we focus on delivering measurable benefits to people and the health eco-system.

Clinical support services are at the core of health service delivery

The role of imaging (radiology), laboratory tests and pharmacy services are key components to an effective health system within primary and secondary care. Radiology, and laboratory and pharmacy services facilitate diagnosis, intervention, treatment and monitoring of patients. Timely access to effective diagnostics, in both the hospital and community can reduce specialist appointments, ED attendance, medical and surgical admissions, and the length of hospital stay.

Currently, clinical support services provided within the hospital are stretched from both a facilities and workforce viewpoint. As each part of the health system asks more of clinical support services—particularly radiology—the effect on the service multiplies. We will emphasise 'choosing wisely' so only necessary tests and examinations are undertaken (where there is benefit to the individual). At the same time we need to determine our facility, equipment and workforce requirements for the future to ensure people have access to timely diagnostics and new technologies.

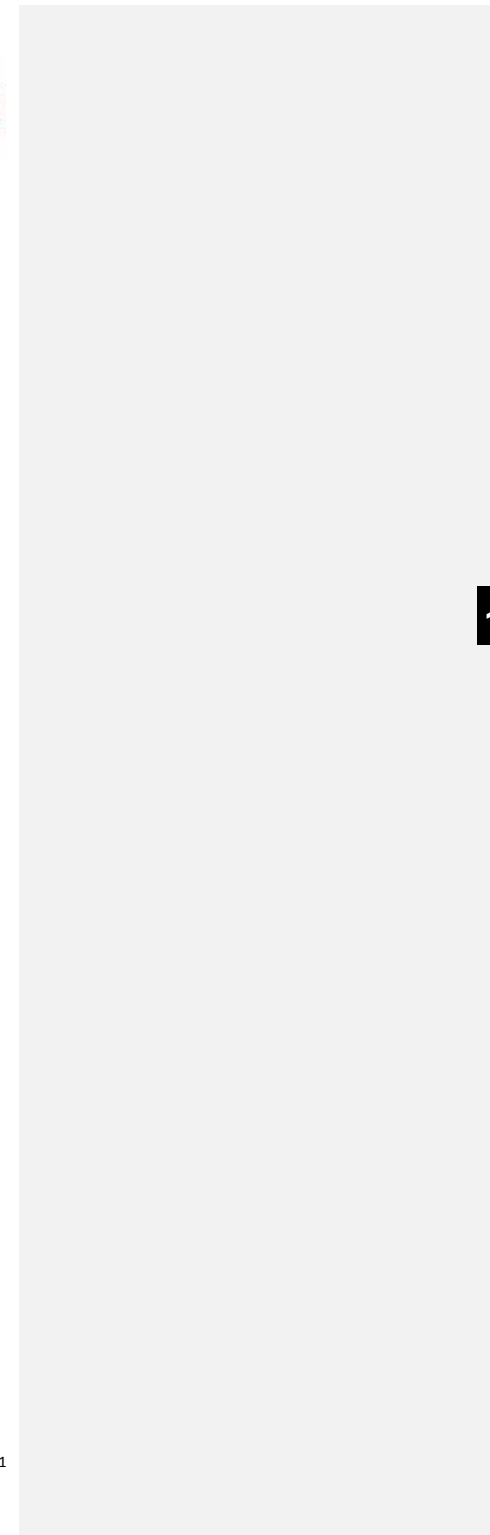
With on-going integration and the narrower hospital focus, engagement of all clinical support service providers will be essential to ensure understanding of each service's function and the value they can add as our population and services change.

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Sustainable and fit-for-purpose Assets and infrastructure

The capacity of some of our facilities is stretched. The way our hospital has been built over a number of years has left us with a 'mismatch' of buildings and add-ons, which hamper patient flow. Our ED was not designed to receive the number of patients that attend currently, and triage and waiting areas are not well laid out. The Intensive Care Unit has outgrown its footprint and there is considerable pressure on our operating theatres. In many cases primary health centres lack the physical space to be able to deliver new services in the community. This constrains our ability to deliver contemporary models of care, of the highest quality and in the most efficient manner.

Our view of assets needs to extend across community and primary care and not just be focussed on the hospital. We need fit for purpose primary care facilities and we need fit for purpose hospital facilities. We will make best use of all existing spaces and look for opportunities in new models of care that make use of non-specific assets.

This CSP recognises that we cannot, and do not wish to, build bigger and bigger hospitals; however we need to address our immediate term pressures while we focus on improving service delivery outside and around the hospital. We are already preparing for an additional operating theatre, and we will extend this planning to include all our facilities through a master site planning exercise over the next 18 months.

Environmental sustainability

The climate and the environment are determinants of health, just like social and economic determinants. The Government has signalled an expectation that DHBs implement a strong response to climate change. We have already taken steps to play our part. We have adopted a DHB Sustainability Policy and have created a sustainability plan focused on energy and carbon management, waste, water, buildings and site design, transportation and travel management.

This work will become even more important in the future and as we plan our facilities. The DHB will form a sustainability committee, to ensure it implements a strong response to climate change, in an equitable way, and in line with Government expectations. The Committee will develop and prioritise a Hawke's Bay DHB environmental sustainability and climate change strategy to mitigate and adapt to the changing climate across our operations.

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Governance-We need strong governance and leadership

We are fortunate in having built a committed and functional consumer and clinical council which, over the years, has assisted the Board and the health system more generally with sound advice and comment. We will continue with this effort to integrate consumer views in particular and seek to extend our governance strategies further.

We see that a key role of the DHB is to align people with the skills and insights to lead change is a complex sector, around a common vision, and with a greater degree of inter-dependence. We need to trust those system leaders with the tools and problem solving capabilities, to work with communities and people who need services, to transform care and increase health equity.

Many parts of New Zealand's health sector operate in alliances but rarely do those alliances extend beyond health services. Bringing together local community, primary health care and DHB resourcing,



together with social services agencies (Education, Justice, Police, Social Development, Oranga Tamariki and our councils) will be needed for us to achieve our health goals. We will ally ourselves with social agencies at the health system level.

Regional cooperation and collaboration

We are part of the Central Region of six lower North Island DHBs. We collaborate with our regional partners to develop and implement the Central Regional Services Plan (RSP), and we rely on other DHBs to provide some tertiary services for our population. In addition to the clinical care arrangements articulated in current and future RSPs, there are opportunities with our close neighbours; with shared challenges around rural service provision and the Ngāti Kahungunu rohe stretching beyond our district boundary. We will work with partners that have shared characteristics, where there is benefit for our populations, services and staff.

Health and business intelligence drives better decisions

Health and business intelligence plays a vital role in supporting evidence-based planning, funding and care delivery. This includes supporting the rapid evaluation of initiatives and provision of feedback for performance improvement. Health and business intelligence will be strengthened at strategic and operational levels, through an expanded health and business intelligence function working closely across primary and secondary care, and accessing regional capability where appropriate. Integration of data across primary and secondary care providers enables a deeper understanding of health journeys and health outcomes.

A system that learns needs timely person-centred data and analytics to be available to decision makers at all points in the system. Cost-effectively collecting, sharing and analysing data across the health (and social) system will greatly increase our capacity to design and commission effective services, and to target resources to where they have the strongest effect on improving outcomes (New Zealand Productivity Commission, 2015).

Creating We will create a learning and innovation culture

Increasing the effectiveness of our services will require a system that learns over time about what works, then spreads the successful approaches and changes or winds down those that don't achieve results. An effective learning system results in innovation. Innovation runs in starts and stops in our health system and we need to commit to an innovation pipeline that pilots, assess and then implements fully.

The Productivity Commission (2015) describes learning systems as having clear goals, incentives and flexibility to try new ways of doing things, on-going feedback about what is working, a willingness to tolerate trials that fail (while dealing with failure quickly), the ability to structure trials in a way that can be scaled up if successful, and the flexibility to take up and spread successful innovations.

More devolved approaches to commissioning tend to result in more bottom up experimentation however information on what works must be shared and success rewarded so innovation spreads.

In Hawke's Bay, we will trial new initiatives and measure outcomes, before expanding, to ensure they are effective, accepted and increase equity.



6. We aim to make a significant impact on the system

We have a bold goal to achieve equity

We know that life expectancy is significantly less for Māori compared to non-Māori and it is taking too long to close the gap. Difference in life expectancy is related to broader factors than just health alone; however we have a key role to play as an influencer and ensuring we eliminate the inequity in preventable deaths. We also need to eliminate inequities in a number of other areas listed below. The Ministry of Health System Level Measures⁷, along with a number of other indicators, help us to quantify our performance in these areas, and our goal is to achieve equity between population groups across all measures.

Domain	System level measure
Healthy and safe home environments	Babies living in smoke-free homes
Access to high quality and timely health services	Youth access and utilisation of youth appropriate health services Ambulatory sensitive hospitalisations
Experience of care	Patient experience of care (primary and hospital care surveys)
Health outcomes	Acute hospital bed days per capita Amenable (avoidable) mortality rates

A significant impact means the hospital footprint will not be increased

In the introduction to this CSP, we highlighted the demand pressures on hospital services if we don't change the way we do things. We aim to fundamentally shift our system and invest more in preventative [care strategies](#) and primary health services, to improve consumer experience and avoid the need for more costly hospital treatment wherever possible. To do this we must contain the costs of hospital care.

To demonstrate the size of the impact we would need to target, we present a scenario analysis in Appendix 1 that show how changes in hospital admission rates and length of stay would change the potential requirement for hospital beds. This sort of analysis helps us to think about the level of our ambition and where we want to aim.

So what happens next?

At the start of this plan, we described the journey that has led to the development of the CSP, from understanding our current state of service provision and what challenges we face in the future, through a series of patient journeys and workshops to design our future options, pulling it all together to form the plan you have just read.

This process is the first part of the overall journey to develop the next five year strategy, which will build on and replace Transform and Sustain. The CSP is a key input to the new strategy along with other strategic initiatives such the People Plan and Health Equity Report 2018.

⁷ <https://www.health.govt.nz/new-zealand-health-system/system-level-measures-framework>



A number of things in this plan we need to just 'get on and do'. Other elements will be incorporated into upcoming annual planning cycles as they require investment or more detailed development. But to achieve the more profound change we are seeking, some core parts of this plan are strategic decisions that will be taken through to our five year strategy.

Our new strategic plan will set the direction and pace of implementation for the next five years. Out of this will fall a series of implementation plans or road maps, including long term investment, facilities and workforce plans.

We have a lot of hard work ahead and we know it will take considerable time and effort. This CSP calls for changes in workforce and funding models; development of strong relationships, based on common purpose and trust, to take collective action; and behaviour and practice changes throughout the system. We are up for the challenge.

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7. List of acronyms and te reo Māori terms

Acronyms

ACP	Advanced Care Plan
CSP	Clinical Services Plan
COPD	Chronic Obstructive Pulmonary Disease
DHB	District Health Board
ED	Emergency Department
FSA	First Specialist Assessment
GP	General Practitioner
HCH	Health Care Home
ICT	Information and Communication Technology
InterRAI	International Resident Assessment Instrument, a suite of comprehensive clinical assessment tools for older people
MDT	Multi-Disciplinary Team
NASC	Needs Assessment & Service Coordination
WHO	World Health Organisation

Te reo Māori terms

Atua	God
Iwi	Tribe—often refers to a large group of people descended from a common ancestor and associated with a distinct territory
Kaimahi whānau	Family support worker
Kaitakawaenga	Liaison worker
Kaumātua	Elder
Kaupapa	Topic, purpose
Kuia	Elderly woman, grandmother, female elder
Mana	Authority, influence, status, spiritual power
Mirimiri	Massage
Pūrākau	Myth, ancient legend, story
Rangatahi	Youth
Rohe	Boundary, district, region, territory, area, border (of land)
Rongoā Māori	Traditional Māori healing
Tamariki	Children
Whānau	Extended family, family group, a familiar term of address to a number of people. Sometimes used to include friends who may not have kinship ties to other members.



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Appendix 1: Hospital bed projections scenario analysis

The scenario analysis presented here shows how changes in hospital admission rates and length of stay would change the potential requirement for hospital beds. This sort of sensitivity analysis helps us to think about the level of our ambition and where we want to aim.

The lines represent the projected number of beds, assuming they are occupied at a planning benchmark percentage (to ensure there is still reasonable flow of people through the hospital during busy periods):

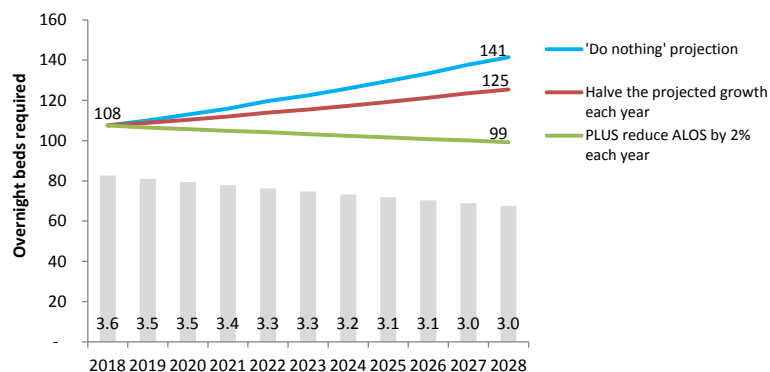
- The blue line is the beds required under a basic demographic projection, that is, the 'do nothing' projection.
- The red line is the beds required if the projected yearly growth in admissions can be constrained (but average length of stay may still increase with the ageing population).
- The green line is the beds required if admission growth is constrained AND the average length of stay is reduced year on year.

This analysis does not determine or recommend the future number of beds we will need in Hawke's Bay Hospital. It shows us a range of possibilities, including an ambitious bed scenario, and what it might take to land within it.

General medicine

Here is the picture for general medicine, comparing against beds required under the 'do nothing' projection, firstly if we halve the expected growth each year, and if we also reduce the average length of stay by 2 percent year on year. The bed number assumes benchmark occupancy of 85 percent.

Figure 11 Change in general medicine beds under the base projection and modified scenarios



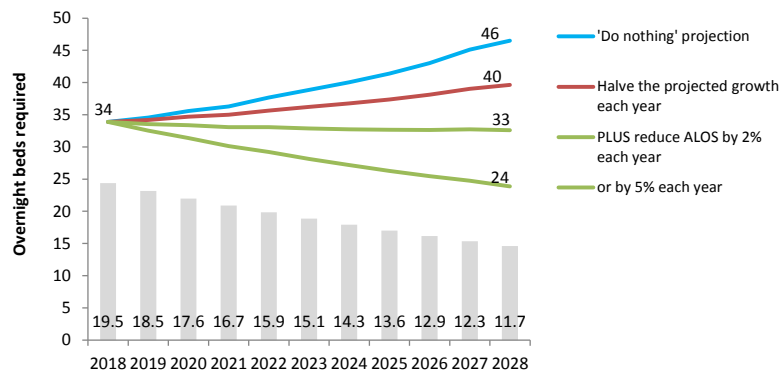


The grey bars represent the average length of stay in days if it were to be reduced in this way. It does not look unreasonable and we have a goal to focus hospital care on the first 48 hours, followed by out of hospital options. It does get harder to reduce length of stay as people in hospital are older and more complex, and as we prevent admissions that were likely to be short stay cases, but if we can achieve this, we could hold or even reduce the number of general medical hospital beds we need.

Rehabilitation

Here is the same picture for rehabilitation, comparing against beds required under the 'do nothing' projection, firstly if we halve the expected growth each year, and if we also reduce the average length of stay by 2–5 percent year on year.

Figure 12 Change in rehabilitation beds under the base projection and modified scenarios



The grey bars represent the average length of stay if it were to be reduced by 5 percent each year. The reduction in length of stay is challenging, however we know from Australasian benchmarking⁸ we have a high rehabilitation length of stay compared to other hospitals, and this CSP aims to provide rehabilitation in the community and at home as much as possible.

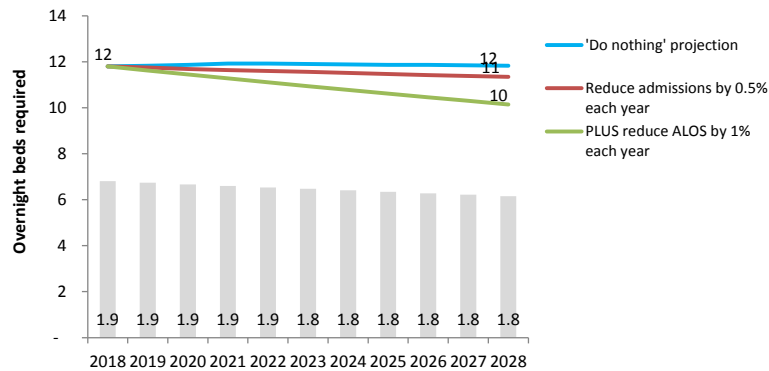
Paediatric medicine

In paediatric medicine, we are not expecting growth in bed demand over the next decade. Here is the picture under the 'do nothing' projection, then if we reduce admissions by 0.5 percent each year, and if we also reduce the average length of stay by 1 percent each year.

⁸ <https://ahsri.uow.edu.au/aroc/index.html>



Figure 13 Change in paediatric medicine beds under the base projection and modified scenarios

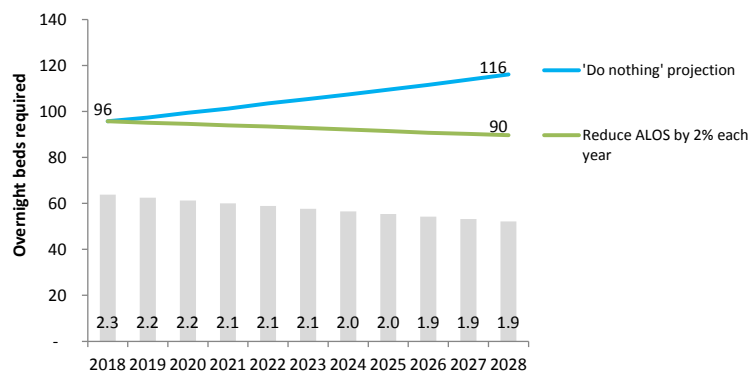


The grey bars show the average length of stay is already low. The changes in future bed requirements are probably marginal even when we reduce admissions. Note that this chart only shows paediatric medical cases. There are also children that require a bed for an overnight, or multiple night stay after having surgery.

Surgery

Here is the picture for surgery, showing the beds required under the 'do nothing' projection, and if we reduce the average length of stay by 2 percent year on year. Surgical admissions are less amenable to change than medical admissions—we want fewer acute operations but more elective operations for those who will benefit. Future Government policy directions will play a part. Advances in surgical techniques will be balanced by conversations around anticipated benefit and quality of life impact.

Figure 14 Change in surgical beds under the base projection and modified scenarios





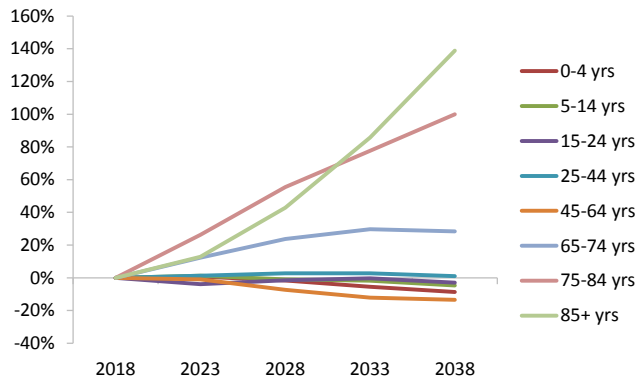
Appendix 2: Hawke's Bay population profile

Demographic changes

The Statistics New Zealand medium population projection is used as the basis for demographic service demand projection. It is important to understand the population projections in order to understand their impact on future demand for clinical services. The Hawke's Bay projection has the following features over a 15-year horizon:

- A small increase in total population from 163,580 to 173,800.
- A significant increase in the older population (51 per cent increase in the overall population aged 65 years plus, and within that an 80 per cent increase in the population aged 75 years plus).

Figure 15 Hawke's Bay population growth on 2018

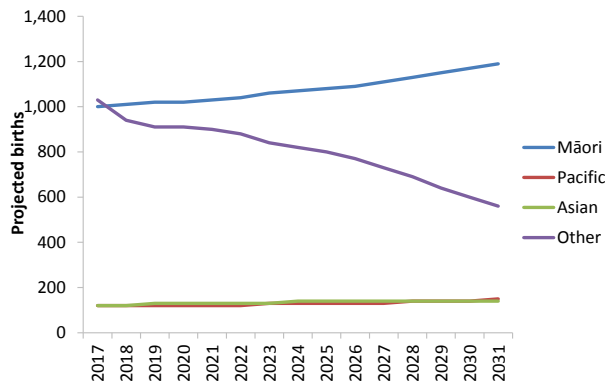


Source: Statistics New Zealand

- A slight decrease in the number of children and young people, and working aged adults (around 5000 decline).
- A significant decline in the number of births in the 'other' ethnic group (from about 1000 to fewer than 600 per year), and increasing births for Māori (from about 1000 to nearly 1200).



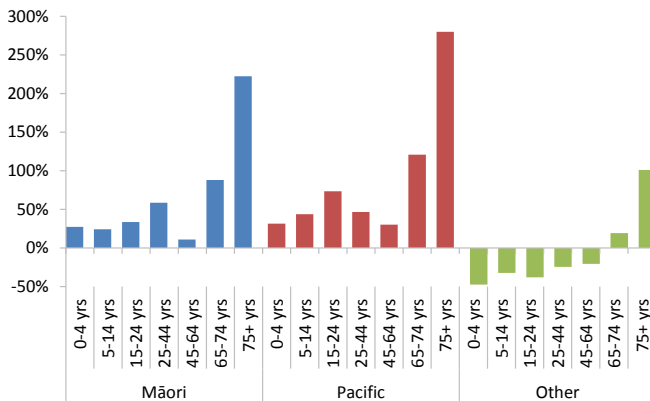
Figure 16 Hawke's Bay births projections



Source: Statistics New Zealand

- An increase in the proportion of population identifying as Māori (from around one-quarter to nearly one-third of the population) or Pasifika (from around four to five per cent). Māori and Pasifika populations increase in all age groups.

Figure 17 Growth by ethnicity & age, 2018 to 2038



Source: Statistics New Zealand

- A decline in the population living in the Wairoa District.

The major trends are the significant increase in the older population and the increasing proportion of Māori within the total population. There is a higher prevalence of disease seen within each of these groups. Māori have a tendency to exhibit the disease of age at a younger stage, showing earlier onset of symptoms of chronic conditions associated with ageing.

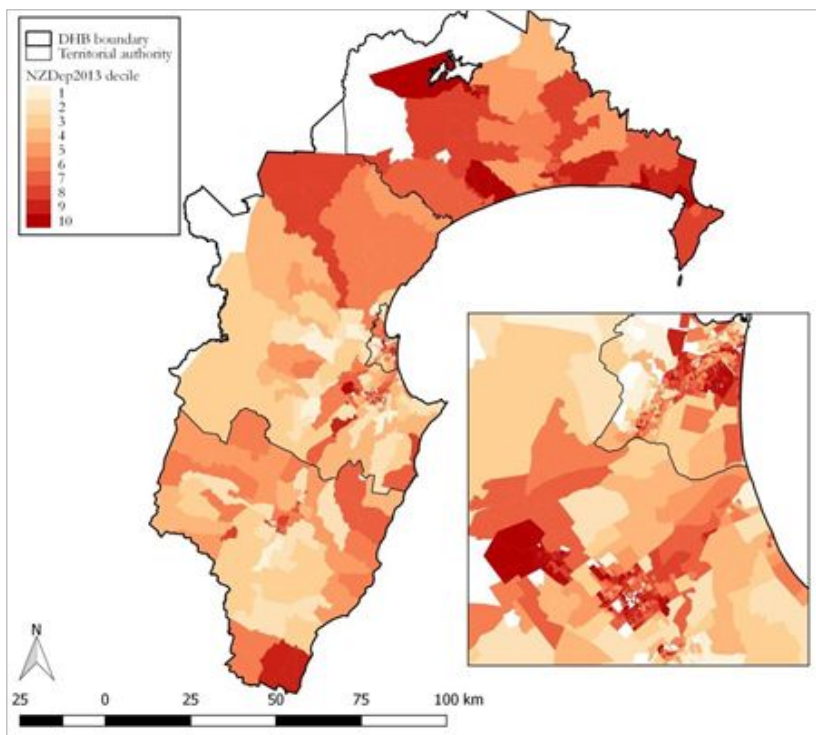


In absolute terms, the increase in the population for Māori aged 65 years plus is about 2,700 people and smaller than the absolute increase for the 'other' population, which is approximately 12,370. However, in proportionate terms, the increase in the older Māori population is much greater. The impact of changes associated with ageing is therefore likely to have a disproportionate impact upon services for Māori.

Determinants of health

The New Zealand Index of Deprivation or NZDep2013 (Atkinson et al, 2014) combines census data relating to income, home ownership, employment, qualifications, family structure, housing, access to transport and communications. It provides a deprivation decile for each small area in New Zealand, where 1 represents the areas with the least deprived scores and 10 the areas with the most deprived scores.

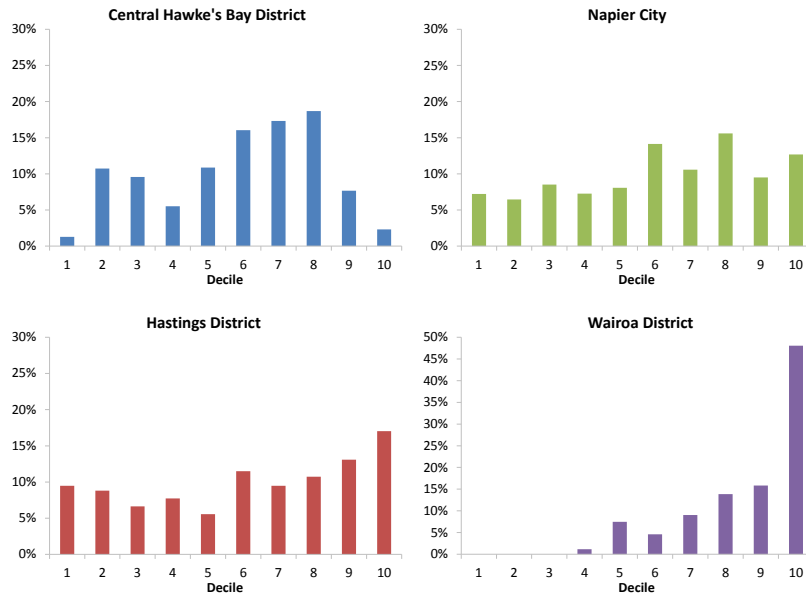
Figure 18 Map of Hawke's Bay meshblocks by NZDep2013 decile



Source: University of Otago, Sapere map



Figure 19 Population distribution by deprivation decile



Source: University of Otago, Sapere chart

- Twenty-seven per cent of the DHB's total population live in decile 9 or 10 areas; however, the profile differs between the four local authorities:
- Nearly half of the Wairoa population lives in a decile 10 area (48 per cent) with a further 16 per cent in decile 9. There are no decile 1-3 areas in the Wairoa District.
- The Napier and Hastings populations are slightly overrepresented in decile 6-10 areas. Thirty per cent of the Hastings population lives in the most deprived areas (decile 9-10).
- The Central Hawke's Bay population has a very small proportion of population at either extreme (decile 1 or decile 10) and has a higher than average proportion of population living in deciles 6-8.



Appendix 3: CSP engagement process

Creating the CSP for the Hawke's Bay Health System involved four main stages with the following analysis and engagement:

Understanding the current state of service provision and challenges for the future	
Desktop review of relevant documents	Review of national strategies and documents, as well as: Transform & Sustain, Annual Plans/Statement of Intent, Annual Report and Quality Account, Regional Services Plan, Matariki, Hastings District Council locality plans, various strategies, DHB Equity Update, locality planning documents, Regional Services Plan. A number of additional documents were provided by DHB services.
Technology horizon scanning	A brief scan of emerging models and health technologies.
Data analysis and projections	Review of New Zealand and Australasian benchmarking reports; summary of population projections, primary care utilisation, hospital utilisation and intervention rates. Primary care and hospital demographic demand projections.
Meetings with primary care	During May – July 2017
Meetings with hospital services	July to September 2017
Mapping healthcare journeys through patient journey workshops	
Patient journey workshops	Stroke & congestive heart failure – 11 September 2017 Youth alcohol & drug – 12 September 2017 Youth pregnancy, fractured neck of femur & inflammatory arthritis – 13 September 2017 Tertiary oncology, paediatric asthma (Pacific) – 20 September 2017 Diabetes/kidney disease & ear disease (Wairoa) – 21 September 2017 Mild dementia (Central Hawke's Bay) – 22 September 2017
Themed workshops	
Four thematic workshops	Looking After Frailty – 9 April 2018 What is the Character of our Hospital in Ten Years' Time – 10 April 2018 Designing Services for Whānau with Unmet Health & Social Needs – 2 May 2018 Reorganising Primary Care for the Challenge – 3 May 2018
Integrated workshop	
Integrated workshop	31 May 2018 with participants from across all the thematic workshops and other key stakeholders.
Approval process	
Consumer and Clinical Councils, Māori Relationship Board	11-12 July 2018 and 10-11 <u>14 November-October</u> 2018
District Health Board	25 July 2018
Sharing and feedback on draft <u>Consultation</u>	August to October <u>September to October</u> 2018
Board approval	<u>28</u> November 2018

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People & Quality Dashboard

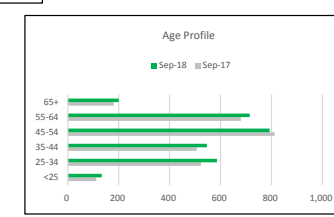
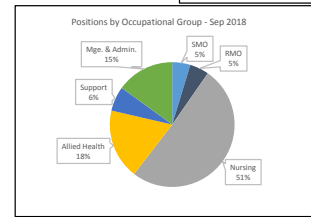
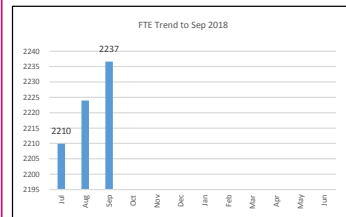
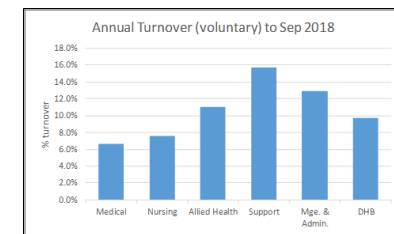
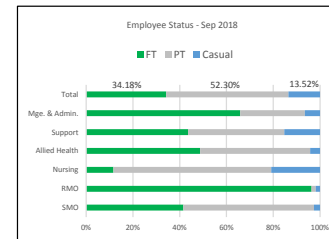
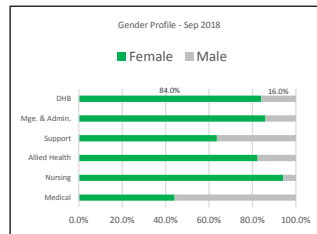
Key Highlights

Contracted FTE shows a 6.0% increase since September 2017 (Medical up 10.3% and Nursing up 7.5%)

Employee status shows slight increase in part-time and reduction in casual since Sept. 2017.

Annual turnover at 9.8% - this is lower than the average across central regions.

Our People



Key Highlights

Average recruitment costs slightly below 2017/18

Vacancies at Sept. 2018

SMO 25.10

RMO 56.00

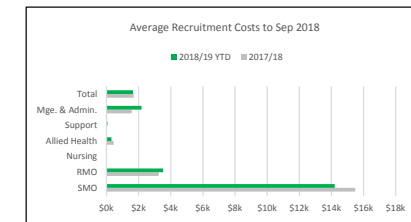
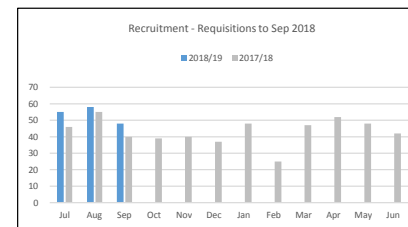
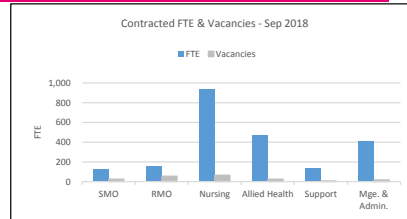
Nursing 65.80

Allied Health 25.60

Support 6.70

Management & Admin 17.00

Our People Recruitment



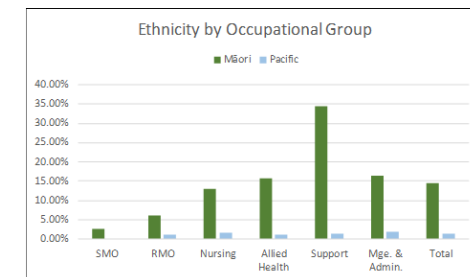
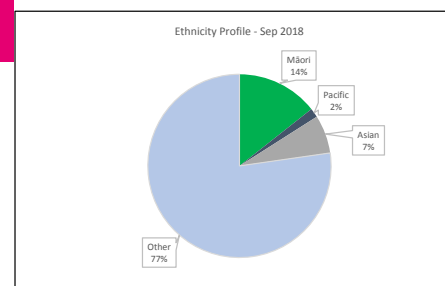
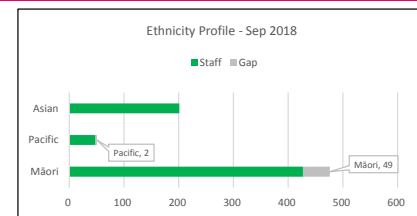
SMO costs due to advertising nationally and international, agency costs and costs associated with interviews and travel.

Key Highlights

Still 49 Māori (and 2 Pacific) employees off meeting our targets for 2018/19

HBDHB compares favourably against mid-sized DHBs (1st), Central Region (1st) and 20 DHBs (4th) when looking at Māori representation (Māori staff as % of Māori population)

Our People's Diversity



Key Highlights

YTD sick leave as at September 2018 is 3.6% compared to 3.8% for the same period last year.

Annual Leave 2+ years = 162 (5.7%) compared to 153 (5.7%) this time last year.

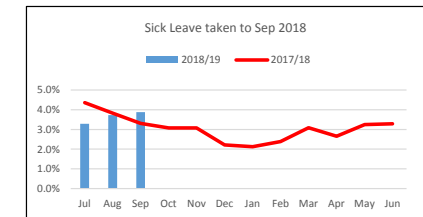
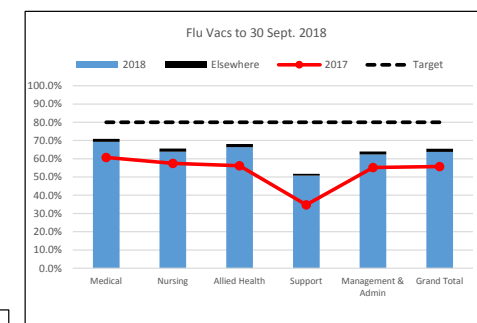
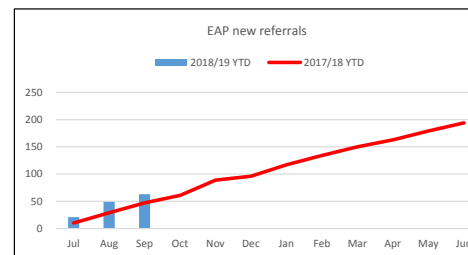
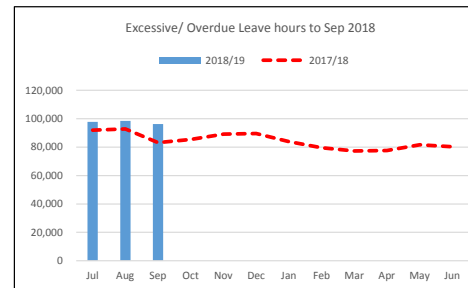
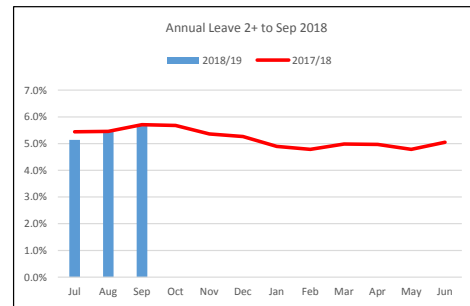
Excessive/ overdue leave hours 96,145 at average of 74.5 per employee. Compared to 83,093 at average of 71.6 per employee last year.

Employees to be encouraged to take more leave to rest and recharge over the coming summer months. Targets being set and to be monitored.

EAP referrals = 63 YTD compared to 47 for same period last year.

Final flu vaccination figures for 2018 64% (65.4% including those vaccinated elsewhere) compared to 56% for 2017.

Our People's Wellbeing

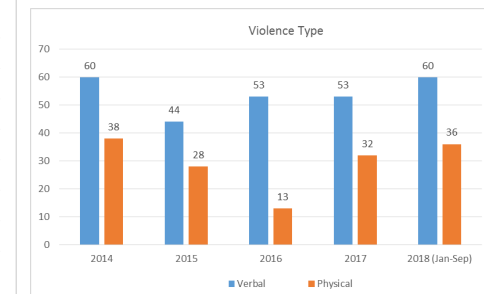
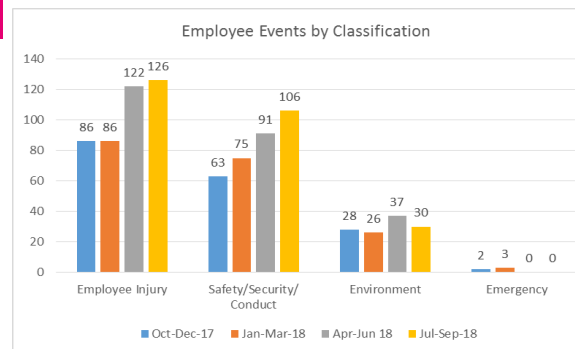
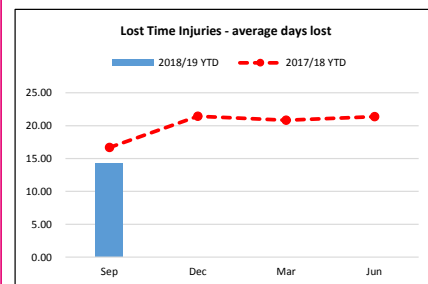



Key Highlights

YTD = 14.3 days (9 injuries) compared to:
YTD 2017/18 (to September) = 16.7 days (12 injuries)

There has been a steady increase in the number of employee related events, specifically in Abuse/assaults and bruising (connected with assaults increase). Significant work is being undertaken in 'hot spots' to support staff and provide them with the necessary skills to de-escalate these situations.

Our People's Safety



 <p>HAWKE'S BAY District Health Board Whakawāteatia</p>	Best Start: Healthy Eating and Activity Plan - Healthy Weight Strategy 168
	For the attention of: HBDHB Board
Document Owner	Andy Phillips, Executive Director Health Improvement and Equity
Document Author	Shari Tidswell, Equity and Intersector Development Manager
Reviewed by	Phil Moore (Clinical Lead); Executive Management Team; Māori Relationship Board; HB Clinical Council and HB Health Consumer Council
Month/Year	November 2018
Purpose	The Board requested six monthly progress reports. This report provides an overview of the progress and changes impacting the Best Start Plan's delivery.
Previous Consideration Discussions	Reported six monthly.
Summary	<i>Work delivered is part of the Best Start Plan that includes; supporting healthy eating environments, delivers prevention programmes, provides intervention pathways and supports health leadership in healthy weight. In the last six months we have worked with early childhood services, developed a pre-pilot for the 8 year old measure, worked with schools to support healthy weight environments and set priority areas for Plan delivery in the next 12 months.</i>
Contribution to Goals and Strategic Implications	Health equity – Healthy weight is the second highest contributor to wellbeing for people in Hawke's Bay. Transform and Sustain – increasing focus on prevention. Improving health outcomes for Māori and Pasifika peoples.
Impact on Reducing Inequities/Disparities	Directly aligned to addressing inequity for Māori and Pasifika.
Consumer Engagement	Delivered by the Best Start: Healthy Eating and Activity Plan Development and Delivery, consumer/stakeholder/community engagement are noted in all programme development and delivery.
Other Consultation /Involvement	Ongoing - as part of all delivery and programme development.
Financial/Budget Impact	Not applicable
Timing Issues	Not applicable
Announcements/ Communications	Not applicable
RECOMMENDATION: It is recommended that HBDHB Board: 1. Note the content of the report. 2. Endorse the next step recommendations.	



Best Start: Healthy Eating and Activity Plan - Healthy Weight Strategy

Author(s):	Shari Tidswell
Designations:	Intersector Development Manager
Date:	November 2018

OVERVIEW

In 2015 the Healthy Weight Strategy and in 2016 the Best Start: Healthy Eating and Activity Plan were endorsed by the HBDHB Board. These documents responded to the areas identified as most impacting wellbeing in the Health Equity Report (2015). These documents guide the HBDHB's work in increasing the number of healthy weight people, with a focus on children. Work is delivered across HBDHB and other sectors including primary care, councils, education, workplaces and Ngati Kahungunu Iwi Inc.

Childhood healthy weight is also being reported to the HBDHB Board via Te Ara Whakawaiaora performance programme and nationally through the Raising Healthy Kids target. These reports share information and the Best Start Plan provides the direction and overview for work.

REPORTING ON PROGRESS

Below is a summary of the highlights for each of the Plan's four objectives. Appendix one provides further detail of the progress on the Plan's activities to date.

1) *Increasing healthy eating and activity environments*

Resource in development for early childhood settings to support healthy conversation, identifying additional resources to support education opportunities and engage whānau. Schools programme support role is being established so that school's healthy weight plans can be facilitate and monitored.

2) *Develop and deliver prevention programmes*

Programmes are now at the embedding stage with key messages going to wāhine and whānau during pregnancy; via Mama Aroha – messaging is consistently provided to new parents/whānau; Healthy First Foods programme is part of Well Child Tamariki Ora and Plunket services; Healthy Conversation and BESMARTER Tools are used by health professionals engaging with 2-4 year olds and "Water is the Best Drink" messaging is consistently being used from 2 to 10 years.

An evaluation is underway to identify improvements in how we communicate about healthy weight with whānau. This is to engage with whānau to complete their child's Before School Check. These findings will be used to improve working with whānau.

The 8-year old measure is being pre-piloted this term, with a pilot to be delivered in Term One 2019. Kimiora, Marewa, Irongate and Henry Hill Schools are participating in the pre-pilot. The aim is to measure 90% of 8-year olds in decile 1-4 schools annually; providing information for schools about their school population's healthy weight, impact of their healthy weight activities and ability to feedback to their whānau. A pathway will also be provided to support the child and their whānau if they are identified as obese. We can also now monitor change over three measurement points; 4-year olds (B4SC), 8-year olds (decile 1-4 schools) and 13-year olds (completing HEADDSS assessments in decile 1-4 secondary schools)

To increase the rate of breastfeeding for Māori pēpē we are trialling increased midwife visits for whānau engaged with community midwives. This is to provide extra support with breastfeeding in the first 6-weeks. Data will be collected to assess the impact on breastfeeding rates. There has also been a review of services from 6-weeks to 6-months to improve support whānau are receiving.

3) *Intervention to support children to have healthy weight*

HBDHB continues to meet the Raising Healthy Kids target six months earlier than the target date and has now achieved 100% of children identified at a B4 School Check in the 98th percentile weight being referred to a primary care assessment. Further supportive pathways and tools have been developed to support whānau to make lifestyle changes which support healthy weight. This includes; Active Families under Five and the BESMARTER goal setting tool.

A programme is being established that will provide support for schools through Public Health Nurses accessing referral pathways to Active Families programmes. This is also linked to the 8-year old measure.

4) *Provide leadership in healthy eating*

The HBDHB continues to provide leadership across sectors to provide advice and support to implement healthy weight programmes, activities and sharing of information. The DHB have provided feedback on the Child Poverty measures and are contributing feedback on the draft Child and Youth Wellbeing Strategy.

WIDER CONTEXT FOR CHILD HEALTHY WEIGHT

Obesity is the second leading risk to population health outcomes in Hawke's Bay. Medium and long-term costs of not addressing obesity are very high, as obesity leads to a range of diseases with high health sector costs. A third of our adult population are obese; 48% and 68% for Māori and Pacific adult populations respectively. Childhood weight is a significant influence for adult weight and changing behaviours to increase healthy weight are more effective during childhood years.

The national target (Raising Healthy Kids) has been in place for 18 months and Hawke's Bay performs well in our consistent achievement of this target. There is wider work being undertaken nationally including the Child and Youth Wellbeing Strategy and Child Poverty Reduction work programme. Both of these will impact on childhood healthy weight and the DHB are engaging with the development, including providing submissions and feedback on the strategy.

HB Community Fitness Trust held a key stakeholder workshop, which the DHB participated in. Meeting have also occurred with key research staff from Auckland University engaging with the Trust.

NEXT STEPS

1. Trial the conversation tool in early childhood settings and collect feedback from whānau and educators.
2. Complete a process review of the pre-pilot and apply findings to the pilot design. Deliver the pilot in term one 2019.
3. Monitoring the impact of the increased visits and breastfeeding support for whānau.
4. Engage 10 primary schools over the next 12 months to implement a healthy weight environment. Establish a baseline with current practice and monitor implementation of change.
5. Identify and develop leadership opportunities promote healthy weight messaging, increase healthy weight environments and support national changes which influence healthy weight.

RECOMMENDATIONS

Key Recommendation	Description	Responsible	Timeframe
Develop a pilot programme for in-home support for breastfeeding	Completed a review of the trial and make recommendations for future programme delivery.	Jules Arthur/ Shari Tidswell	July 2018
Develop a pilot for monitoring and measuring children at 8-years	Engage decile 1-4 schools to participate in the pilot, develop tool and supporting clinical pathways for the pilot. Evaluate the pilot.	Child Health Team/ Shari Tidswell	April 2019
Identify and implement leadership opportunities	Engage with nationally led developments to support Hawke's Bay healthy weight gains. Supporting healthy weight messages.	Best Start Advisory Group	July 2019

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the content of the report.
2. **Endorse** the next step recommendations.

Appendix One

Objective 1: Increase healthy eating and activity environments

Indicator 1a: Increase the number of schools with healthy eating policies

Indicator 1b: Increase the number of settings including workplaces, churches and marae with healthy eating policy

What the data shows

The data we have is improving, there will be a survey completed by June 2018 for all primary schools and data for the school environments has been collected with Auckland University (Informas) and reported.

Activity to deliver objective one				
	What	How	Progress	When
Current activity	<ul style="list-style-type: none"> Work with settings to increase healthy eating including education, schools, workplaces, events, Pasifika churches, marae Support national messaging including sugar reduction i.e. Water Only Advocate for changes in marketing and council planning 	<ul style="list-style-type: none"> Healthy eating policies which reduce sugar intake in 5 ECE centres, key community events increase healthy food choices, 4 Pasifika churches have a healthy eating approaches and guidelines for marae reviewed with Ngāti Kahungunu Iwi Incorporated Communication plan implemented for national and regional messages Supporting the implementation of programmes and plans i.e. i Way, Active Transport, Sport HB and Ngāti Kahungunu Iwi Incorporated plans 	<ul style="list-style-type: none"> School water only policies reviewed by PHNs, all primary schools have policies and two secondary schools. Support is being developed for ECEs with MoH licensing staff. Four churches engaged, two are working toward reducing sugar. Hasting District Council is going sugar sweeten beverage free at their facilities. Water only messaging promoted in schools, under 5 Healthy Food messages DHB rep on Active Transport group, supporting Ngāti Kahungunu Iwi Inc. events to provide health messages and supplying water. 	July 2017
New actions	<ul style="list-style-type: none"> Support education settings to implement healthy eating and food literacy-early childhood, primary schools secondary schools, 	<ul style="list-style-type: none"> 50% increase in schools with “water only” policy annually Decile 9/10 communities have a whānau co-designed programme delivered in primary schools, - trialled 2016, 5 new schools annually 	<ul style="list-style-type: none"> Schools are being engaged via Public Health Nurses and to support this a new resource is being established in the Child Health Team. Best Start Advisory Group has been meeting monthly to support coordination and the development of 	Reported annually to 2020

Activity to deliver objective one				
	<ul style="list-style-type: none"> Establishing a base measure for monitoring Engage cross-sector groups to gain support and influence to increase healthy eating environments Investigate food security for children and their whānau identifying issues 	<ul style="list-style-type: none"> All schools surveyed for status in healthy eating/water only policies Establish a group to influence changes in the environment across Hawke's Bay Partner with Auckland University to establish a baseline for the Hawke's Bay food environment and monitor annually 	<p>resources/programmes/project. Includes: Health HB, Child Health, Oral Health, Maori Health, Population Health, Pasifika Health, Paediatrics, Primary Care Directorate. Current work is looking at delivering an 8 year measurement for weight</p> <ul style="list-style-type: none"> Pre-piloting an 8 year old measure to monitor impact across the lifespan. Food Environment data collection complete and report shared with stakeholders. Working with Boyd Swinburn from Auckland University to look at a HB research project. Presented Healthy Weight Strategy to Hastings and Napier Council. 	

Objective 2: Develop and deliver prevention programmes

Indicator 2a: Rates of breastfeeding at 6 weeks increase

Indicator 2b: Number of healthy weight children at 4 years remain stable or improves

What the data shows

- Child fully or exclusively breastfeeding at 6 weeks rates as 72% for total population, 66% Māori and 82% Pasifika (December 2015 Ministry of Health), these show slight increases
- 67.8% of Hawke's Bay four year olds are healthy weight, 62.7% Māori and 55.7% Pasifika (2016 Before School Check data, Health Hawke's Bay), this is 2016 data. Most recent data is obesity data with 13% of Māori, 26% Pasifika and 5.8% other four year old children in the 98th percentile for weight (June –Dec 2017 B4SC)

Actions and Stakeholders				
	What	How	Progress	When
Current activity	<ul style="list-style-type: none"> • Implementing Maternal Nutrition Programme activities- breastfeeding support, healthy first foods • Supporting settings to implement healthy eating/sugar reduction programmes/policies • Supporting health promoting schools 	<ul style="list-style-type: none"> • Breastfeeding support resources provided via Hauora • All Well Child/Tamariki Ora providers trained in Healthy First Foods • All schools, ECE, Well Child/Tamariki Ora Providers with health eating policies are provided with information resources and advice • Health Promoting Schools health promoters are up-skilled to implement healthy eating approaches 	<ul style="list-style-type: none"> • Complete • Complete • Information and resources shared • Meeting HPS coordinators, attended workshop with other providers. • Training is completed for Tamariki Ora and Plunket staff, LMCs and B4SC nurses. Training plan being delivered for ECEs. • Maternal Nutrition and Physical Activity programme being delivered in Wairoa – great response and across HB 	July 2017
Next actions	<ul style="list-style-type: none"> • Extend the Maternal Nutrition programme developing programmes in ECE and resources to support B4 School Check providers 	<ul style="list-style-type: none"> • Deliver training to LMCs, Well Child providers and B4 School Check nurses to increase skills to promote healthy eating- Healthy Conversation, Healthy First Foods, B4 School Check resources 	<ul style="list-style-type: none"> • Active Families contracts in place and delivered by Iron Māori and Sport HB. Tamariki Ora and Plunket staff trained and delivering Healthy First Foods programmes. Trial programme being delivered via 	Reported annually until 2020

Actions and Stakeholders				
	<ul style="list-style-type: none"> Supporting healthy pregnancies, via education and activity opportunities Support the development of whānau programme (building on existing successful programme) Develop food literacy resources including sugar reduction messages -deliver via programme and settings Support healthy eating programmes and approaches in schools 	<ul style="list-style-type: none"> Contract and support local provider/s to deliver the maternal healthy eating activity programme Contract and support local provider/s to deliver whānau based programmes i.e. Active Families Deliver key messages for whānau with 2–3 year olds Develop food literacy resources for B4 School Check provider, promote Healthy First Food and heart foundation school resources Support the co-designed programme for deprivation 9/10 communities 	<p>Maternity Services to provided increased support for breastfeeding.</p> <ul style="list-style-type: none"> Resource developed with early childhood providers and resources to support healthy weight messages for whānau and children – expert group completed this. Healthy conversation tool implemented and evaluated – this includes BE SMARTER whānau plan, B4 Schools Check nurses Working group developing the survey for all primary schools and tool to support design and delivery of healthy weight schools. Schools programme facilitated via Child Health Team, with additional resource to support this work. 	

Objective 3: Intervention to support children to have healthy weight

Indicator 3a: Increase referrals to programmes which support healthy lifestyles and whānau engagement for 4 year olds with a BMI in the 98th percentile

Indicator 3b: Increase food literacy training to targeted workforce including midwives, Well Child/Tamariki Ora, education workforces, social services and Before School Check practitioners.

What the data shows

- 119 Hawke's Bay children were identified with BMI in the 98th percentile, of these, 90 accepted a referral to a primary care follow, 2 already in care and 27 declined at referral. 98% Māori, 100% other and 100% Pasifika children received a referral to primary care. (Dec 2017 B4 School Check reported Data - MoH)
- 100 participants attended breastfeeding support training, 23 Well Child staff attended First Foods Trainer Workshops, 83 health professionals attended Gestational Diabetes updates (2015 HBDHB Maternal Nutrition Report to MoH) and 45 practice nurses attended CNE session on Raising Healthy Kids Target and whānau conversation tool/plan. 63 early childhood teaching attended an information session

Activities and Stakeholders				
	What	How	Progress	When
Current activity	<ul style="list-style-type: none"> • Screening including gestational diabetes, Well Child/Tamariki Ora and B4 School Checks • Whānau activity based programmes for under 5s • Paediatric dietetic referrals 	<ul style="list-style-type: none"> • Monitor the screening and responding referrals • Fund Active Families under five and monitor implementation. Investigate extending to further providers • Monitor referrals and outcomes 	<ul style="list-style-type: none"> • Monitoring provided via HBDHB Board and MoH. Raising Health Kids target has been met. • Active Families under 5 is funded and DHB has received additional funding from MoH • Majority of referrals are to Active Families which has 80% of children increasing healthy eating and activity. 	July 2017 Māori Health Targets - 6 monthly to the Board
New actions	<ul style="list-style-type: none"> • Support screening in maternal programme, Well Child/Tamariki Ora and B4 School Checks 	<ul style="list-style-type: none"> • Support training for health professionals completing screening - maternal, Well Child/Tamariki Ora and B4 School Checks. 	<ul style="list-style-type: none"> • Completed WellChild/Plunket Health First Foods training, B4 School Check Conversation Tool training 	Annually until 2020

Activities and Stakeholders				
	<ul style="list-style-type: none"> • Provide whānau based programmes to support lifestyle changes which support healthy weight i.e. Active Families • Support referrals to programmes via a range of pathways • Develop a clinical pathway from well child/primary care to secondary services • Support child health workforce, to deliver healthy conversations 	<ul style="list-style-type: none"> • Contract community providers to take referrals for whānau with an overweight child (3-12 years) • Clinical pathway developed with key stakeholders- whānau, parents, children and health professionals • Healthy Conversation training delivered 	<ul style="list-style-type: none"> • Active Families – delivered by Iron Māori and Sport HB. New contracts in place from Oct 2017. • Clinical pathway for B4 School Check complete. Working with diabetes pathway • Training in healthy conversation completed in 2016. Delivered the Healthy Food conversation tool 2017. Complete. • 8 year old measure includes a referral pathway to support whānau with children identified as obese. This includes clinical and family support. 	

Objective 4: Provide leadership in healthy eating

Indicator 4a: Monitor the implementation of the HB DHB Healthy Eating policy


Indicator 4b: Engage support from key partners

What the data shows

Hawke's Bay District Health Board policy has been updated and aligns with MoH guidelines and an implementation plan is in place, endorsed by EMT June 2016. Auckland University review of the policy has HBDHB ranked 3rd most effective policy for DHBs. Healthy Weight Strategy have been presented to the Intersectoral Forum, Napier and Hastings Councils, MoE East Coast, Priority Population Committee (Health HB) and internally across the DHB. Intersector Group has been established

Activities and Stakeholders				
	What	How	Progress	When
Current activity	<ul style="list-style-type: none"> Share information, evidence and best practice and healthy weight data with key community partners Show leadership by establish the HBDHB Healthy Eating Policy and implementing the Healthy @ Work work plan 	<ul style="list-style-type: none"> Regular updates provided via Maternal, Well Child/Tamariki Ora and B4 School Check forums. Regular meetings with community providers Review and monitor the HBDHB Healthy Eating Policy and support the implementation of the Health @ Work work plan 	<ul style="list-style-type: none"> Strategy and Best Start Plan shared with - Sport HB, Mananui, Napier and Hastings Councils, HB Community Fitness Centre Trust, DHB staff and placed on DHB website. Communication Plan developed to increase awareness Policy complete 	July 2017
New actions	<ul style="list-style-type: none"> Lead an equity focus by applying an equity lens to review this plan and delivered activity Lead messaging and delivery to reduce sugar intake Align HBDHB Healthy Eating Policy with national food and beverage guidelines 	<ul style="list-style-type: none"> Equity assessment written and finding used to refine this plan to improve response to equity Cross-sector activity includes a sugar reduction focus Framework/process implemented for cross-sector approach and inter-agency activity reported 	<ul style="list-style-type: none"> All contracts have targets for Māori and Pasifika, resources are tested with Māori and Pasifika whānau and equity lens was applied to funding. Water only and healthy food has been delivered in event planning, Pasifika churches, workplaces and education. Shared Healthy Eating Strategy with Intersectoral Forum – Intersector Group 	Ongoing until 2020

Activities and Stakeholders				
	<ul style="list-style-type: none"> • Develop a process for a cross-sector approach to support healthy eating environments • Influence key service delivery stakeholders to maintain best practise and consistent messaging • Continue engagement with community particularly key influencers for Māori and Pasifika i.e. marae and church leaders 	<ul style="list-style-type: none"> • Hauora, general practice, LMCs, contracted community providers provide national messages consistently to whānau, community and their workplace • Key activities Waitangi Day celebrations - policy/guidance document development Ngāti Kahungunu Iwi Incorporated and engagement with Pasifika church leaders 	<p>establish and setting out leadership activities</p> <ul style="list-style-type: none"> • Messaging is “water is the best drink” and promoting the MoH Nutrition Guidelines • We have worked with the Te Matatini steering group and promoted water and healthy food choices (with a reduction in high fat, sugar and salt foods). The Healthy Events – Food guide material has been reviewed by Ngāti Kahungunu Iwi (events and comms staff), available on DHB website. • Completed submissions and providing feedback on national work including Child Poverty and Child and Youth Wellbeing Strategy. • Partner agencies have delivered policies – HDC has “no fizzy” at the venues, Sport HB is working clubs and code to implement “water is the best drink” and healthy food options. 	

 <p>HAWKE'S BAY District Health Board Whakawāteatia</p>	<p>Te Ara Whakawaiaora (TAW): Access (Ambulatory Sensitive Hospitalisations) (ASH) Rates 0-4 & 45-64 years</p> <p style="text-align: right;">169</p> <p>For the attention of: HBDHB Board</p>
Document Owner	Dr Mark Peterson, Chief Medical Officer - Primary
Document Author(s)	Jill Garrett, Senior Commissioning Manager, Primary Care Directorate Marie Beattie, Planning and Commissioning Manager, Primary Care Directorate
Reviewed by	Patrick Le Geyt, GM Māori - Māori Health; Chris Ash, Executive Director Primary Care and the Executive Management Team; Māori Relationship Board; HB Clinical Council; and HB Health Consumer Council
Month/Year	November 2018
Purpose	Provide a quarterly update on progress against data and activities identified within the System Level Measures (SLM) Improvement plan that relate to ASH rates for 0-4 yrs and 45-64
Previous Consideration Discussions	The TAW access report to have quarterly updates rather than 6 monthly as had been previously
Summary Comments	<p>ASH rates 0-4:</p> <ul style="list-style-type: none"> • Data: No improvement over baseline in headline indicator. No improvement across all ethnicities in the contributory measures • Activities: Activities aligned to this indicator are in their initial stages or are about to begin. Some temporary activities were in place over winter to assess the resource demand and scope feasibility and sustainability. <p>ASH 45-64:</p> <ul style="list-style-type: none"> • Data: Improvement over base line in headline indicator. No shift in contributory measures indicators to date. • Activities: Majority of activities aligned to this indicator are underway. Good progress being made in the area of readmissions, and engAGE extension to the rurals. Too early to be seeing a shift in data in the contributory measures as a result. Teams working closely with business intelligence to ensure uniform and robust data in place for these indicators. <p>Progress on previous recommendations 45-64</p> <ul style="list-style-type: none"> • Completed or on track for completion
Contribution to Goals and Strategic Implications	Focus is on Improving Health and Equity for Māori
Impact on Reducing Inequities/Disparities	Directly aligned to addressing inequity between Māori and Other
Consumer Engagement	(Forms part of each work stream)

Other Consultation /Involvement	Not applicable for this report
Financial/Budget Impact	Not applicable for this report
Timing Issues	Not applicable
Announcements/ Communications	None
RECOMMENDATION: That the HBDHB Board: 1. Note the content of the report and progress against recommendations.	



**Te Ara Whakawaiaora:
Access (Ambulatory Sensitive Hospitalisations
(ASH) Rates 0-4 & 45-64 years)**

Summary: Below is a summary of the current data and activities within the System Level Measure improvement plan relating to ASH 0-4 and 45-64yrs.

ASH 0-4yrs

1. Keeping Children Out of Hospital

Headline Measure 1	ASH 0-4 years				
Milestone	20% reduction in the inequity gap over 5 years will eliminate inequity. This equates to 19 children per year = Maori 6,320				
	Base line	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Māori	6,693	7,490			
Pasifika	10,000	12,535			
Other	4,824	5,498			
Total	6,000	6,843			
Equity Gap - Māori and Other	-1,869	-1,992	0	0	0
Contributory Measure: 1.1	Reduced ASH 0-4 yrs due to Dental				
Aim	20% reduction in the inequity gap over 5 years will eliminate inequity. This equates to 5 children per year = Maori ≤784				
	Base line	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Māori	882	1,096			
Pasifika	556	1,408			
Other	390	461			
Equity Gap - Māori and Other	-492	-635	0	0	0
Contributory Measure: 1.2	Decreased hospitalisations (Māori and Pasifika) due to Respiratory				
Aim	20% reduction in the inequity gap over 5 years will eliminate inequity. This equates to Maori ≤3404				
	Base line	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Māori	3,625	4,243			
Pasifika	4,931	7,605			
Other	2,518	2,749			
Equity Gap - Māori and Other	-1,107	-1,494	0	0	0

Summary Comments:

There has been a deterioration in the equity gap overall for ASH and across all ethnicities. Dental results have increased on baseline which may be an indicator of heightened screening and awareness as the lift the lip initiative is about to begin and awareness has been raised. Respiratory data reflects similar trends.

Activities:

1.Keeping Children Out of Hospital		ASH 0-4 years		Activities Plan Progress Green , Amber , Red	
Activities	LEAD	Contributory Measure 1.1	Narrative by Leads		
			Quarter 1		
Develop a pathway for community oral health service referrals to secondary care to ensure the child’s appropriate primary care practitioner is informed of the child’s health status.	Susan Barnes	ASH relating to Dental	A named dental therapist, supported by a dental assistant has been identified to lead a specific workstream as part of the over arching 0-5 year old Dental Equity Project, to develop a care & support package for all children & their families/whanau who have been referred for treatment under general anaesthetic. This package will include notifying the families GP/primary care provider.		
Pilot General Practice ‘Lift the Lip’ at 15-month Immunisation Visit.	Primary Care Innovation Lead		Delayed start as awaiting the arrival of the Clinical Programme and Support Lead in November		
Activities	LEAD	Contributory Measure 1.2	Narrative by Leads		
			Quarter 1		
Develop a respiratory pathway to standardise follow up of tamariki, post admission, by general practice	Charrissa Keenan	ASH relating to Respiratory	Temporary measures were implemented over the winter months this year to ensure follow-up and support to Tamariki 0-4 and their whanau who were admitted to hospital as a result of a respiratory illness. In response, a scoping exercise is being undertaken to ascertain the feasibility and sustainability of these measures within current resourcing. The model, yet to be decided will provide support and education for 0-4 year olds and their whanau to improve understanding of the illnesses and actions to mitigate readmissions and remain well.		
Provide community based respiratory support for targeted tamariki and their whānau during peak winter months	Charrissa Keenan				
Work with the Child Health Team to distribute the skin care resource to early childhood centres, Kohanga Reo and Punanga Reo/language nests, taking a population health approach to promotion and socialisation of the resource.	Liz Read		Te Reo and Samoan translation of the resource completed. Resource will be promoted at Early Childhood Education/Te Kohanga Reo/Te Punavai hauora hui at Pukemokimoki Marae early November		

Summary Comments:

Temporary measures were implemented and as a result of responses to those in regard to respiratory a scoping exercise is being undertaken to ascertain the feasibility and sustainability of these measures. Addressing respiratory wellness from a whanau vs individual perspective across the age bands is forming the thinking around contract reconfiguration and service design modelling. This is underway.

ASH 45-64 yrs

2. Using Health Services Effectively

Headline Measure 2	Acute Hospital Bed Days				
Milestone	20% reduction in the inequity gap over 5 years will eliminate inequity. This equates to 1712 beds p.a. or 33 beds per week (Target = Maori ≤530)				
	Base line	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Māori	570	588			
Pasifika		494			
Other	336	364			
Total	378	407			
Equity Gap - Māori and Other	-234	-224			
Contributory Measure: 2.1	ASH rates 45-64				
Aim	20% reduction in the inequity gap over 5 years will eliminate inequity. This equates to 75 admissions p.a. = Maori ≤7159				
	Base line	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Māori	8,092	8,302			
Pasifika		7,954			
Other	3,404	3,435			
Total	4,370	4,414			
Equity Gap - Māori and Other	-4,688	-4,867	0	0	0
Contributory Measure: 2.2	Acute readmissions to hospital - Diabetes				
Aim	Establishing Baseline indicator with Business intelligence team				
	Base line	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Indicative base line only	12.5%				
Contributory Measure: 2.3	In patient average length of stay				
Aim	To achieve ≤ 2.3				
	Base line	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Quarter 3 2017	2.39	2.4			

Summary Comments:

Small reduction in the equity gap in the headline indicator. Quarter 1 results will show little shift for the contributory measures as activities for aligned to these are only in their early phases of implementation. Focus on the actual reduction number p.a. quantifies for sector leads the size of the task to make an impact on this measure. This make the work that sits under the measure more tangible.

Activities:

	Headline Measure		
2. Using Health Services Effectively	Acute Hosp. Bed Days Per Capita		Activities Plan Progress Green , Amber , Red
Activities	LEAD	Contributory Measure 2.1	Narrative by Leads
			Quarter 1
Identify through the Whānau Wellness Resource Programme, those at risk of respiratory issues / concerns and actively screen through the respiratory programme.	Programme Delivery Lead	ASH 45-64yrs	Work has commenced but will become more evident in this in the October quarter as we have a full complement of staff.
Evaluate the effectiveness of the High needs enrolment programme and work with NGOs, Maori health providers, secondary services, and other stakeholders to increase the understanding, uptake and effectiveness of the high needs enrolment programme.	Clinical Support and Performance Lead		Delays due to waiting new Clinical Performance and Support person to start.
Work with general practice and Hastings Hospital staff to promote and encourage increased use of the Hospital Discharge Programme with a particular emphasis on admissions associated with Diabetes, Respiratory and Cardiac Disease.	Programme delivery Lead		Work has commenced but will become more evident in the October quarter as we have a full complement of staff.
Work with general practice to investigate the feasibility of undertaking different models of patient care with the view of increasing capacity.	Group Manager - Health Services and innovation		Work has commenced but awaiting arrival of Group Manager - Health Services and innovation.
Health Hawke's Bay to review the new urgent care model.	Group Manager - Corporate Services		Met, completed submitted to committees at HHB and UC Governance Group - for further discussion.
Scope extension of the Co-ordinated Primary Care Options (CPO)	Jill Garrett		Proposal to proceed to business case approved by EMT
		Contributory Measure 2.2	Narrative by Leads
			Quarter 1
Examine readmission rates in relation to diabetes, targeting those with 1-3 readmissions and work up a plan to address	Wieske Cloo	Acute Readmission rates	Working group has formed- Tackling Readmissions rates. Multidisciplinary and cross sector. Action plan (3 areas) to be developed end Nov
		Contributory Measure 2.3	Narrative by Leads
			Quarter 1
Increase utilisation of intermediate care beds by reviewing acceptance criteria.	Allison Stevenson	In patient average length of stay for acute admissions	Work is commencing in this area and extending engage to the rural areas has also commenced
Introduce Geriatric Evaluation and Monitoring (GEM) beds in the AT&R to expediate the acute hospital journey for frail and older people	Nikki Ryniker-Doull		AMBER – this work has progressed and patients are being brought directly from ED/AAU under the GEM pathway. The pathway is currently in draft and we are working with the relevant parties to ensure the patients are safely managed under GEM.

Summary comments:

Good progress in the majority of activities aligned to this indicator. Collaboration across the five top medical long term conditions areas to address care coordination and transitions of care well underway. Work in the health of older person, extending engAGE to the Rurals on track.

Status of Recommendations (45-65 yrs)


	Key Recommendation	Implementation lead	Champion(s)	Time Frame	Status
1.	Clinical pathways become part of business as usual supported by a sustainable funding resource.	Strategic Services Manager Primary Care LTC Portfolio Manager	CMO Primary CMO Secondary	Dec 2018	Paper going to EMT and Clinical Council proposing local solution to pathways
3.	In relation to Cardiac/ Respiratory & Renal/ Diabetes Service plans include: <ul style="list-style-type: none"> • Workforce development • Care coordination • Transition of care 	Head of Planning Strategic Services Manager Primary Care LTC Portfolio Manager	Directorate Leads Chief Nursing and Midwifery Officer	Dec 2018	Completed See item 8
4.	Enhance use of CNS/NP in specific LTC, evidenced by the outcomes achieved to date by Diabetes and Respiratory CNS workforce and engagement with primary care	Directorate leads LTC Portfolio Manager	Chief Nursing & Midwifery Officer	On-going	Completed See item 8
5.	Increase the weighting that is applied to health award applications in relation to equity.	Clinical Council	ED Equity and Health Improvement	July 2018	Deferred by coms till 2019 round
6	Retain ASH 45-65 as contributory measure with activities to address within the SLM Improvement Plan	Medical Directorate Leads Portfolio Manager – Integration Innovation and Dev Mgr PHO	Exec. Director Primary Care	Quarterly	In place
7	Present CPO scoping paper to committees and support a focus on addressing equity as the top line priority.	Emergency Department and Medical Directorate Leads Snr. Commissioning Mgr. Innovation and Development Manager - PHO	Exec. Director Primary Care	December 2018	Scoping paper completed. Service redesign and business case to be developed for budget round 2019
8	LTC Framework implementation plan to include formalised use of medical directorate clinical leads to influence activities directly relating to reducing ASH	Medical Directorate Leads Portfolio Manager – Integration Innovation and Dev Mgr PHO	Mark Peterson, CMO Primary	On confirmation into roles (Sept 2018)	LTC cross sector group established. , Action plan stage to address readmission rates top 5 LTC.

RECOMMENDATION:

It is recommended that Māori Relationship Board; HB Clinical Council; HB Consumer Health Council; and the HBDHB Board:

1. **Note** the content of the report

Governance Report Overview

 <p>HAWKE'S BAY District Health Board Whakawāteatia</p>	Te Ara Whakawaiaora - Smokefree 170
	For the attention of: HBDHB Board
Document Owner	Andrew Phillips, Executive Director, Health Improvement and Equity
Document Author(s)	Johanna Wilson, Smokefree Programme Manager
Reviewed by	Shari Tidswell, Intersectoral Development Manager and Executive Management Team, Māori Relationship Board, HB Clinical Council; and HB Health Consumer Council
Month/Year	October 2018
Purpose	To provide an overview of the six months implementation progress on the Smokefree plan for discussion.
Previous Consideration Discussions	Reported six monthly.
Summary	<p>Smokefree</p> <p>95% of all patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking.</p> <ul style="list-style-type: none"> HBDHB achieved 96.7% in Quarter 1. Health practitioners in secondary care continue to achieve the 95% target of all patients who smoke aged 15 years and over, are offered brief advice and offered support to stop smoking. <p>90% of PHO enrolled patients who smoke have been offered help to quit by a health care practitioner in the last 15 months.</p> <ul style="list-style-type: none"> Rates Ethnicity 30/09/2018 Total population 84.7% Asian 84.0% Māori 81.6% Other / Unknown 88.0% Pacific 80.8% Health Hawke's Bay down 5.5% from this time last year. 13 of 25 practices decreased during the month. All ethnicities decreased. Māori and Pacific both decreased by 1.3 % compared to 0.4% for other. <p>90% of pregnant women who identify as smokers upon registration with a Lead Maternity Carer are offered brief advice and support to quit smoking.</p> <ul style="list-style-type: none"> HBDHB achieved 90.5% with Māori achieving 94.4% in Quarter 1. LMCs and DHB midwives have received ABC Smokefree training and education with an emphasis on D – Documentation.

	<p><u>We note data issues for the following:</u></p> <p>90% of young pregnant Māori women were referred to cessation support.</p> <ul style="list-style-type: none"> Data collection was based on all Māori women. Data provided by the DHB employed midwives for the period 1 July–30 September 2018 identified 33 events, with 18 Māori women were smokers. Seventeen (94.4%) received smoking brief advice, fifteen, (88.2%) were offered support to quit smoking and seven (46.7%) were referred to cessation support services. <p>95% of pregnant Māori women who are smokefree at 2 weeks postnatal.</p> <ul style="list-style-type: none"> Data collection is based on women smokefree status at discharge by DHB midwives. There is inadequate data available for pregnant Māori women who are smokefree at two weeks at this time and we will provide data in the next report.
Contribution to Goals and Strategic Implications	<p>Improving health outcomes for pregnant women and their whānau.</p> <p>Health equity – smoking at time of registration and at two weeks postnatal is more common among Māori women.</p> <p>Transform and Sustain – increasing focus on prevention.</p>
Impact on Reducing Inequities/Disparities	<p>Directly aligned to addressing inequity for Māori women and their whānau.</p>
Consumer Engagement	<p>Not applicable.</p>
Other Consultation /Involvement	<p>Not applicable</p>
Financial/Budget Impact	<p>Not applicable</p>
Timing Issues	<p>Not applicable</p>
Announcements/ Communications	<p>Not applicable</p>
<p>RECOMMENDATION:</p> <p>That the HBDHB Board:</p> <p>1. Note the content of the report</p>	



Te Ara Whakawaiaora - Smokefree

Author:	Johanna Wilson
Designation:	Smokefree Programme Manager
Date:	October 2018

OVERVIEW

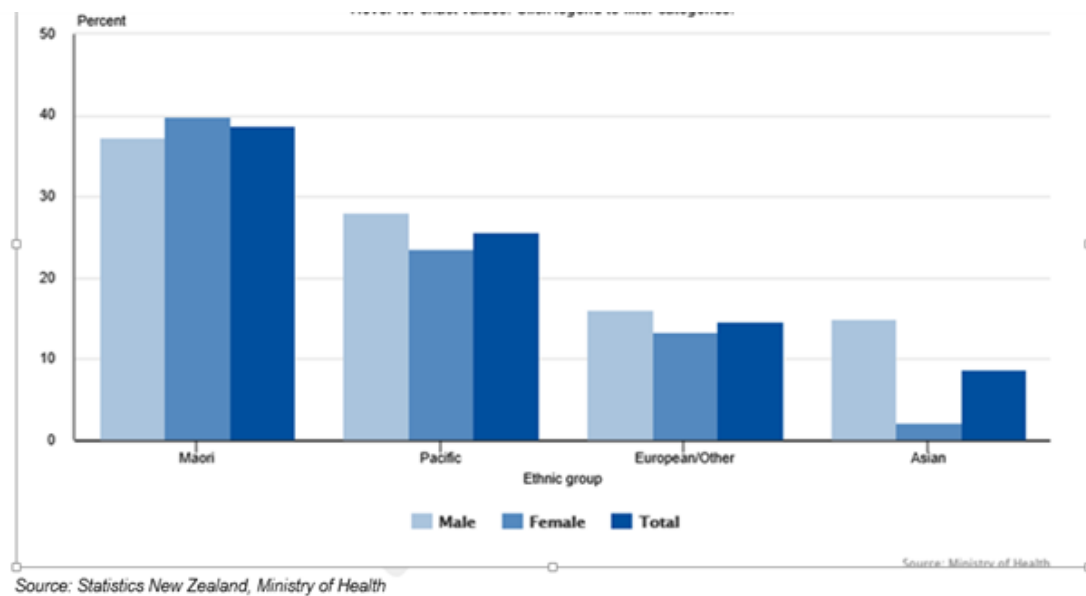
Following concerns from the National Māori General Managers (Tumu Whakarae) about the slow pace of progress on some indicators in reducing health disparities for Māori, the Hawke's Bay DHB Executive Management Team (EMT) decided to establish a championship role in 2013 for each of the indicators to spur faster traction on implementation. The Champions were tasked to provide the Board with six monthly Te Ara Whakawaiaora (TAW) exceptions based report drawn from AMHP quarterly reporting highlighting the implementation progress on these indicators along with recommendations for improvement towards achievement of the annual targets and reducing health disparities. This report is from Kevin Snee, Champion for Smokefree Indicator.

MĀORI HEALTH PLAN INDICATOR: Smokefree

- 95% of all patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking
- 90% of PHO enrolled patients who smoke have been offered help to quit by a health care practitioner in the last 15 months
- 90% of pregnant women who identify as smokers upon registration with a Lead Maternity Carer are offered brief advice and support to quit smoking
- 90% of young pregnant Māori women are referred to cessation support
- 95% of pregnant Māori women who are smokefree at 2 weeks postnatal

WHY ARE THESE INDICATORS IMPORTANT?

80% of smokers want to quit and there are immediate and long-term health benefits for those who do. The risk of premature death from smoking decreases soon after someone quits smoking and continues to do so for at least 10 to 15 years. These are interventions that can be routinely provided in both primary and secondary care.

Figure 1: Proportion of population who currently smoke tobacco

As shown in the National Health Survey (Figure 1), the rates of tobacco smoking are higher among Māori than non-Māori with highest rates of smoking among Māori women (36.5%). This smoking behaviour among women continues even when they are pregnant. While rates of tobacco use have declined over the years, the rates for Māori are not declining fast enough to reach equity levels let alone meeting the national 2025 smokefree target of less than 5%¹.

CHAMPION'S REVIEW OF ACTIVITY THAT WAS PLANNED TO SUPPORT THESE INDICATORS

95% of all patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking

Table 1: Quarter 1 (1 July–30 September 2018) percentage of people who receive smoking brief advice and support

	Events Coded	No. of people who smoke	No. of people given advice /support	Smoking rate	% of people who smoke given advice /support
ALL	8861	1649	1594	18.6%	96.7%
Māori	2212	843	818	38.1%	97.0%
Pacific	307	64	61	20.8%	95.3%

Health professionals in the secondary care settings have continued to achieve the 95% target of all patients who smoke aged 15 years and over, are offered brief advice and help to stop smoking.

The DHB Smokefree Team includes a Smokefree Liaison Nurse whose primary role is to support health professionals and clinicians to offer brief advice and support to quit smoking. This involves smokefree education and training to new staff, regularly meeting with clinical lead managers and liaising with pharmacy and other health services i.e. DHB coding staff for accuracy in smoking brief advice and cessation support documentation.

¹ Regional Tobacco Strategy for Hawke's Bay update, 2015 – 2020 presented at the MRB, HB Clinical and HB Health Consumer Council, November 2016, update.

90% of PHO enrolled patients who smoke have been offered help to quit by a health care practitioner in the last 15 months

		Target	Total	Māori	Pacific	Other
2018/19	Q1	90%	84.7%	81.6%	80.8%	88.0%
	Q2					
	Q3					
	Q4					

As at 30 June 2018 Health Hawke's Bay had a smoking brief advice coverage of 89.1% (Data Source: Karo Management). Twelve practices met the 90% target and nine practices were within 10% of the 90% target.

During the first quarter (1 July–30 September 2018) Health Hawke's Bay have reviewed and restructured its health services to include a new Clinical Performance and Support Lead who commences in November. Through this time of readjustment, the primary care better help for smokers to quit health target has decreased 5.5% from this time last year. All ethnicities have decreased. Māori and Pacific have both decreased by 1.3% and 13 of 25 practices have also decreased.

Health Hawke's Bay will continue to provide a twenty hour a week clinician to contact eligible people for updating records, brief advice and cessation support with a focus on high needs population. This includes after hours and weekend calling to people who cannot be contacted during normal working hours.

90% of pregnant women who identify as smokers upon registration with a Lead Maternity Carer are offered brief advice and support to quit smoking**Whole of DHB**

Number of events (a)	Number of Smokers	Brief advice given	Offered cessation support	Referred to cessation support	Smokers' gestation (weeks) (b)	% offered brief advice	% offered advice and support to quit	% accepted cessation support	Smoking prevalence (c)
46	21	19	16	7	16.6	90.5%	84.2%	43.8%	45.7%

Māori

Number of events	Number of Smokers	Brief advice given	Offered cessation support	Referred to cessation support	Smokers' gestation (weeks)	% offered brief advice	% offered advice and support to quit	% accepted cessation support	Smoking prevalence
33	18	17	15	7	16.6	94.4%	88.2%	46.7%	54.5%

(a) Number of events: number of pregnancies

(b) Smokers gestation: average for all events (pregnancies) included in the table

(c) Smoking prevalence is for the pregnancies that their data is included here

HBDHB continues to provide smokefree training for LMCs and midwives during education and study days, the importance of capturing ABC and D (documentation).

The HBDHB Smokefree Service developed a project plan and a three month pilot in Wairoa called CO-free Homes. All midwives (5) in Wairoa have received the Maternity Smokerlyzer and training to complete the following tasks:

- CO readings of all pregnant women (smokers and non-smokers)
- Smokefree conversations with smokers
- Referrals to the Wahine Hapu Increasing Smokefree Pregnancy Programme (ISPP).

This pilot is from 1 September to 30 November. Regular meetings with the midwives during this period to assess progress and iron out any problems prior to an evaluation of the pilot in December. It is our intention to then roll-out a further 10 Maternity Smokerlyzers to LMCs and midwives working in Napier and Hastings with high Māori women case load from February 2019. To date there has been an increase in Wahine Hapu referrals in Wairoa.

90% of young pregnant Māori women are referred to cessation support

The communities where young Māori women live, socialise and belong is also the community in which they learn to smoke, keep smoking and try to quit. The relationships young Māori women have with their whānau and friends influence their smoking. Smoking can be a big part of a young woman's life as many of her whānau, friends, school mates, workplace and social circles smoke. In many instances young Māori women start smoking because their whānau and friends smoke and when socialising, the smoking increases as the two often go together.

In June 2018, HBDHB and Choices Kahungunu Health Services made adjustments to the Wahine Hapu ISPP (the programme) to align with the stop smoking services reporting template to the Ministry of Health and the challenges experienced by the Stop Smoking Practitioners and their clients. The programme includes the following:

- 8 week programme
- Carbon Monoxide testing at the initial assessment then 1, 2, 4, 8 weeks (5 readings documented)
- \$50.00 grocery voucher at weeks 1 and 8. The grocery voucher at week 1 will be banked and given at week 8, making this a total of \$100.00. NB: if the client is not smokefree at week 2 then the grocery voucher will be forfeited
- Nappies will also be provided at 1, 2, 4, 8 weeks
- \$30.00 grocery vouchers at 1, 2, 4, 8 weeks are offered to whānau members who live in the same household or are regular visitors

To date, we have seen an increase in referrals to the programme, with wahine hapu completing the programme.

The following data does not distinguish between young pregnant Māori women and others.

Wahine Hapu ISPP referrals from 1 January to 31 July 2018

Total referrals	185	NZ Māori	NZ European	Pacific	Other
Ante Natal referrals	144	97	41	4	3
Post Natal referrals	15	9	5	1	
Whānau	26	10	12	3	

Wairoa Wahine Hapu ISPP referrals from 1 January to 31 July 2018

Total referrals	26	NZ Māori	NZ European	Pacific	Other
Ante Natal referrals	16	14	2	0	0
Post Natal referrals	3	3	0	0	0
Whānau	7	6	1	0	0

95% of pregnant Māori women who are smokefree at 2 weeks postnatal

There is inadequate data available for pregnant Māori women who are smokefree at two weeks at this time and we will provide data in the next report.

CHAMPION'S REPORT: ACTIVITIES THAT WILL OCCUR TO INCREASE PERFORMANCE OF THIS INDICATOR

Hospital Smokefree Target

1. The DHB Smokefree Team will continue to provide smokefree education sessions for all staff as required.
2. Clinical staff continue to be encouraged to complete the MoH online e-learning tool 'Helping People Stop Smoking' every three years and complete the Nicotine Replacement Therapy Module via Ko Awatea. It is important for all clinical staff to review and receive up-to-date knowledge of smokefree to improve practice and increase confidence with cessation.
3. The Smokefree Team will continue to triage all hospital patients who smoke and want help to quit smoking.

Primary Health Organisation Smokefree Target

1. All clinical staff in GP practices continue to be encouraged to complete the MoH online e-learning tool 'Helping People Stop Smoking' and complete a refresher every three years.
2. The Smokefree Team will continue to provide Wāhine Hapū ISPP and The Top Five to help my baby thrive resources and Te Haa Matea business cards to all GP practices.
3. The Smokefree team will meet with GP Smokefree Champions in the next quarter to evaluate the use of smokefree resources in practices.

Maternity Smokefree Target

1. CO-free Homes pilot in Wairoa will be completed at the end of November. Meetings with the Wairoa Maternity services continue to progress the pilot. An evaluation of the pilot will be completed mid-December for extending out to the rest of Hawke's Bay by February 2019.
2. The Smokefree Team has completed an audit on the unknown categories of the Women Smokefree status at Booking and Discharge by LMC to identify smokefree missed opportunities. The Maternal and Child Health Smokefree Coordinator will make recommendations to address outstanding issues.
3. The Wahine Hapu ISPP has been reviewed and changes made to increase referrals to the programme.
4. The Smokefree Team will develop a programme in schools and alternative education to support young Māori women to stay smokefree.

NEXT STEPS

1. Smokefree Team to evaluate the CO-free Homes project to extend to rest of Hawke's Bay.
2. Link in with the new Whanake te Kuri – Pregnancy and Parenting Education and Information Programme, providing a referral pathway to the Wāhine Hapū Programme.
3. Identify all ante-natal programmes offered in Hawke's Bay to provide a referral pathway to the Wāhine Hapū Programme.

Key Recommendation	Description	Responsible	Timeframe
Ante-natal programmes in Hawke's Bay	<ol style="list-style-type: none"> 1. Link in with the new Whanake Te Kuri – Pregnancy and Parenting Education and Information Programme providing Wāhine Hapū resources and Te Haa Matea business cards and a referral pathway to the Wāhine Hapū programme. 2. Identify all Ante-natal programmes in Hawke's Bay providing Wāhine Hapū resources and Te Haa Matea business cards and a referral pathway to the Wāhine Hapū programme 	Johanna Wilson/ Smokefree Team	October 2018 – On Target
Audit patient files	Select a number of 'Unknown' patient files to determine missed opportunity		


	for Smoking Brief Advice from Quarter 3 data (1 January – 31 March) - Women Smokefree Status at Booking and Discharge by LMC data.	Johanna Wilson/ Smokefree/ Maternity Services/ Medical Records	October 2018 – On Target
Review / evaluate the Wāhine Hapū (Increasing Smokefree Pregnancy Programme)	Conduct an internal review of the Wāhine Hapū programme and action the recommendations.	Johanna Wilson/ Smokefree Team/ Choices Kahungunu Health Services	September 2018 - Completed
Equip LMCs the Maternity Smokerlyzer (Carbon Monoxide Monitor)	<ul style="list-style-type: none"> Meet with Maternity Services Develop Logic Model Identify smoking status of all pregnant women at booking Promote Wāhine Hapū (Increasing Smokefree Pregnancy Programme) to increase referrals to be smokefree 	Johanna Wilson/ Smokefree Team/ Maternity Team	November 2018 – On Target

RECOMMENDATION:

It is recommended that HBDHB Board:

Note the content of the report.

Governance Report Overview

 HAWKE'S BAY District Health Board Whakawāteatia	HBDHB Performance Framework Exceptions Report Quarter 1 2018/19	171
	For the attention of: HBDHB Board	
Document Owner	Chris Ash, Executive Director of Primary Care Directorate	
Document Author(s)	Peter Mackenzie, Business Intelligence Analyst	
Reviewed by	Executive Management Team; Māori Relationship Board and Pasifika Health Leadership Group	
Month/Year	November, 2018	
Purpose	Monitoring	
Previous Consideration Discussions	N/A	
Summary	Areas of Success: HPV Vaccination Areas of Progress: DNA Rates, LMC Booking by Week 12 Areas of Focus: Shorter Stays in ED, Breastfeeding at 3 months	
Contribution to Goals and Strategic Implications	Ensuring the DHB meets/improves performance for our Ministry of Health key performance indicators and local measures outlined in the DHB Annual plan.	
Impact on Reducing Inequities/Disparities	This report highlights areas of inequity, comments are provided in relation to programs of work that are underway/planned in order to positively affect equity gaps.	
Consumer Engagement	N/A	
Other Consultation /Involvement	Comments are supplied from various staff members throughout the DHB including service directors or their delegate, program Leaders and the PHO	
Financial/Budget Impact	NA	
Timing Issues	NA	
Announcements/ Communications	NA	
RECOMMENDATION: That the HBDHB Board: 1. Note the contents of this report		



HBDHB PERFORMANCE FRAMEWORK Quarter 4 2017/18

Author:	Peter Mackenzie
Designation:	Business Intelligence Analyst
Date:	August 2018

OVERVIEW

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

As this report ends 30th September 2018, the results in some instances may vary to those presented in other reports.

BACKGROUND

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

ANNUAL PLAN (AP) 2018/2019

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

STATEMENT OF PERFORMANCE EXPECTATIONS (SPE) 2018/19

The SPE is produced annually within the context of the four-year Statement of Intent (SOI) 2016-19. The SPE informs the House of Representatives of the performance expectations agreed between a Minister and a Crown Entity. Formal agreement is gained annually through the AP process and actual performance is assessed and reported through the audited HBDHB Annual Report.

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

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

The 4 dimensions of DHB performance are:

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

MINISTRY OF HEALTH ASSESSMENT CRITERION

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

Rating	Abbrev	Criterion
Outstanding performer/sector leader	O	1. Applied in the fourth quarter only – this rating indicates that the DHB achieved a level of performance considerably better than the agreed DHB and/or sector expectations.
Achieved	A	<ol style="list-style-type: none"> 1. Deliverable demonstrates targets/expectations have been met in full. 2. In the case of deliverables with multiple requirements, all requirements are met. 3. Data, or a report confirming expectations have been met, has been provided through a mechanism outside the Quarterly Reporting process, and the assessor can confirm.
Partially achieved	P	<ol style="list-style-type: none"> 1. Target/expectation not fully met, but the resolution plan satisfies the assessor that the DHB is on to compliance. 2. A deliverable has been received, but some clarification is required. 3. In the case of deliverables with multi-requirements, where all requirements have not been met at least 50% of the requirements have been achieved.
Not achieved	N	<ol style="list-style-type: none"> 1. The deliverable is not met. 2. There is no resolution plan if deliverable indicates non-compliance. 3. A resolution plan is included, but it is significantly deficient. 4. A report is provided, but it does not answer the criteria of the performance indicator. 5. There are significant gaps in delivery. 6. It cannot be confirmed that data or a report has been provided through channels other than the quarterly process.

KEY FOR DETAILED REPORT

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

Table of Contents

OVERVIEW	2
BACKGROUND	2
ANNUAL PLAN (AP) 2018/2019.....	2
STATEMENT OF PERFORMANCE EXPECTATIONS (SPE) 2018/19.....	2
HAWKE'S BAY DISTRICT HEALTH BOARD (HBDHB) PERFORMANCE FRAMEWORK	2
Ministry of Health assessment criterion	3
KEY FOR DETAILED REPORT	3
PERFORMANCE HIGHLIGHTS – Total Population	4
PERFORMANCE HIGHLIGHTS – Equity	6
Health Targets.....	7
Health Target: Shorter stays in emergency departments	7
Health Target: Faster Cancer Treatment – 62 Day	8
Health Target: Increased immunisation at 8 Months	9
Health Target: Better help for smokers to quit – Primary Care.....	10
Health Target: Better help for smokers to quit – Maternity	11
OUTPUT CLASS 1: Prevention Services	12
Better Help for Smokers to Quit – Smoke-free Households	12
Increase Immunisation – 2 Years	13
Increase Immunisation – 4 Years	14
Increase Immunisation - Influenza	15
Better rates of breastfeeding – 3 months.....	16
OUTPUT CLASS 2: Early Detection and Management Services.....	17
More pregnant women under the care of a Lead Maternity Carer (LMC)	17
CVD Risk Assessments	18
Less waiting for diagnostic services - CT.....	19
Less waiting for diagnostic services - MRI.....	20
OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT SERVICES.....	21
Equitable access to surgery -Standardised intervention rates for surgery per 10,000 population	21
Shorter stays in hospital	23
Quicker access to diagnostics	25
Did not attend (DNA) rate across first specialist assessments	27
Reducing waiting times Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	28
Rate of s29 orders per 100,000 population.....	30
RECOMMENDATION.....	32
ATTACHMENT:.....	32

PERFORMANCE HIGHLIGHTS – TOTAL POPULATION

Achievements

- Health Target – The DHB has remained favourable for the Raising Healthy Kids measure with a Total Rate of 99%, Māori at 100% and Pacific at 100% against a target of 95%.
- HPV Vaccination – The DHB is favourable for eligible girls fully immunised with the HPV vaccine with a Total Rate of 75.7%, Māori at 84.9% and Pacific at 88.3% against a target of 75%.

Areas of Progress

- DNA – Overall the DHB have remained favourable at 6.3% against a target of less than 7.5%. This quarter both Māori at 12.2% and Pacific at 12.2% are unfavourable to the target however they have both improved over the previous quarter (page 27)
- Women book with an LMC by week 12 of pregnancy – The DHB overall result has improved from 57.9% in the previous quarter to 69.9% in the current quarter. There were also improvements for Māori from 50% to 57.9% (page 17).

Areas of Focus

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

- Health Target – Shorter Stays in ED has declined from 91% in the previous quarter to 86% and remains unfavourable to the target of 95% (page 7).
- Breastfeeding at 3 months – The DHB is unfavourable against the target of 70% with Total at 51.7% Māori at 35.6% and Pacific at 34.5%. Both Māori and Pacific have declined from the previous quarter (page 16).

PERFORMANCE HIGHLIGHTS – EQUITY

Achievements

- Immunisation HPV Vaccine – The Māori rate is currently 85% and the Pacific rate is 88%, both are above to the Total rate of 76%.
- Mental Health Wait Times: Māori results for the Mental Health provider arm are 80% within 3 weeks and 94.6% within 8 weeks compared with Other ethnicities at 76% within 3 weeks and 91.8% within 8 weeks (page 28).

Areas of Progress

- Immunisation 4 year olds – Māori have improved this quarter from 89% to 92% compared with the total rate of 92% and the rate for Other ethnicities of 91%, all ethnicities are unfavourable to the target of 95% (page 14).

Areas of Focus

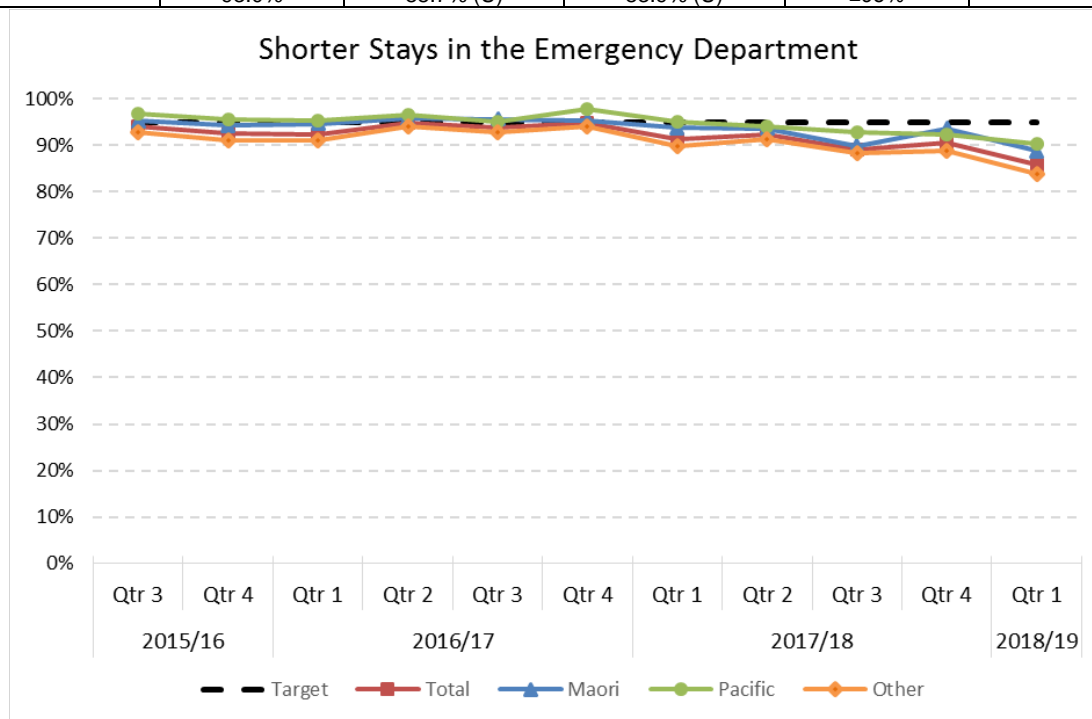
- DNA – The result for Māori 12.2% and Pacific 12.2% are higher than the Other ethnicity at 4.1% (page 27)
- Rate of Section 29 orders per 100,000 population – Māori Rates have improved slightly over the past 12 months from 398 to 385 (per 100,000) against the target of less than 375 however the Māori rates are 3 times higher than the non-Māori Rate 115 per 100,000 (page 30)

HEALTH TARGETS

Health Target: Shorter stays in emergency departments

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

Ethnicity	Baseline ¹	Previous result ²	Actual to Date ³	Target 2018/19	Trend Direction
Total	93.9%	90.5% (U)	85.9% (U)	≥95%	▼
Māori	95.3%	93.6% (U)	88.7% (U)	≥95%	▼
Pacific	96.2%	92.4% (U)	90.3% (U)	≥95%	▼
Other	93.0%	88.7% (U)	83.9% (U)	≥95%	▼

**Comments:**

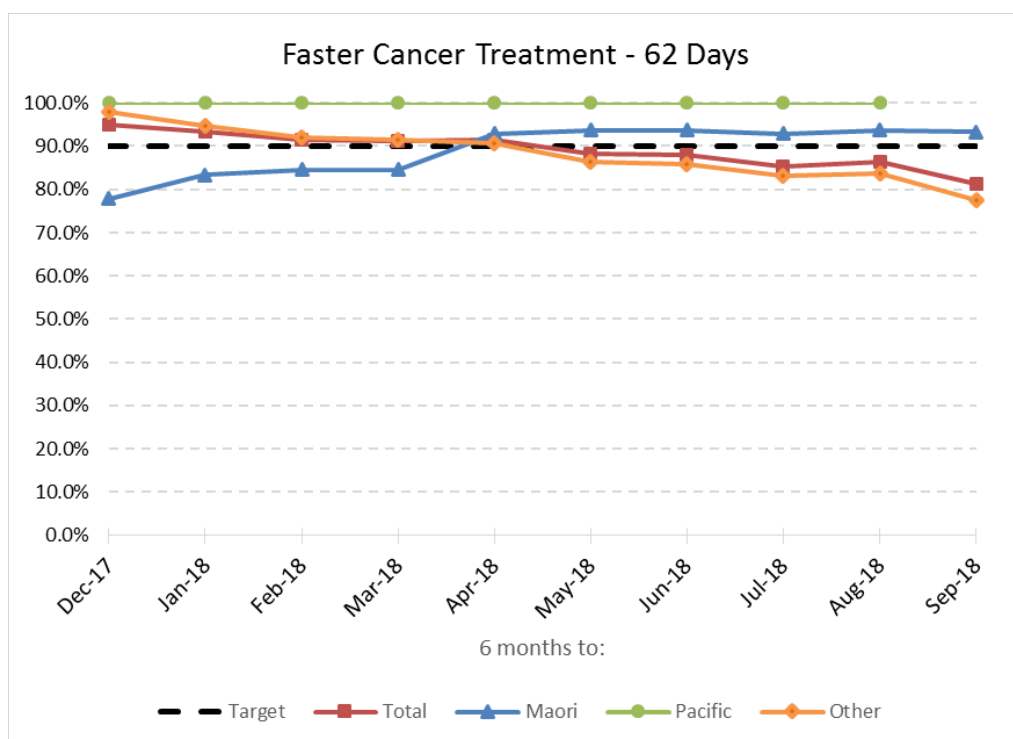
Results for all population groups have been worsening since mid-2017. Poor quarter 1 results are related mainly to inpatient acuity and length of stay along with influenza illness and higher than predicted staff sickness. ED was overcrowded with long delays for patients to be seen, then delays for them to have specialty reviews, including medical, surgical, mental health referrals. There has also been limited resources available to backfill RMO (resident medical officer) sick leave and ICU (intensive care unit) operating at or over capacity, leading to patients remaining in ED until ICU beds are available. Mitigation strategies include putting in place the introduction and reporting of Internal Professional Standards (IPS) and a review of data to identify pressure points either under or outside of ED control. There is ongoing focus by the ED SMO group, Duty Nurse Managers, Senior Nurses and Leadership team on ED length of stay and assessment and referral of patients. HBDHB has extended the hours of the "ORBIT" interdisciplinary team to provide 7 day week patient support and assessment 12 hours each day. Going forward there is the allocation of quality improvement team members to support the department to work through identified work stream to improve patient flow and management. HBDHB will be developing a response requirement for ED and specialty teams, identified by IPS. Over the next month work is being completed on the AAU Model of Care now that physicians have been recruited. We will complete a rapid cycle of change focusing on moving medical patients through more quickly.

¹ October to December 2017² April to June 2018³ July to September 2018

Health Target: Faster Cancer Treatment – 62 Day

patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer

Key Performance Measures	Baseline ⁴	Previous result ⁵	Actual to Date ⁶	Target 2018/19	Trend direction
Total	95.0%	88% (U)	81% (U)	≥90%	▼
Māori	78.0%	94% (F)	93% (F)	≥90%	▼
Pacific	100.0%	100% (F)	-	≥90%	*
Other	98.0%	86% (U)	78% (U)	≥90%	▼

**Comments:**

September was a challenge to meet the cancer target because there were pressures on capacity and there were delays to access Radiation Oncology services in Mid Central. Concerns regarding patient handovers when the consultant is unavailable have been recognised and addressed. Half of the patients identified for the cancer target experienced delays in their journey due to the complex nature of their cancer and existing comorbidities.

⁴ 6 months to December 2016

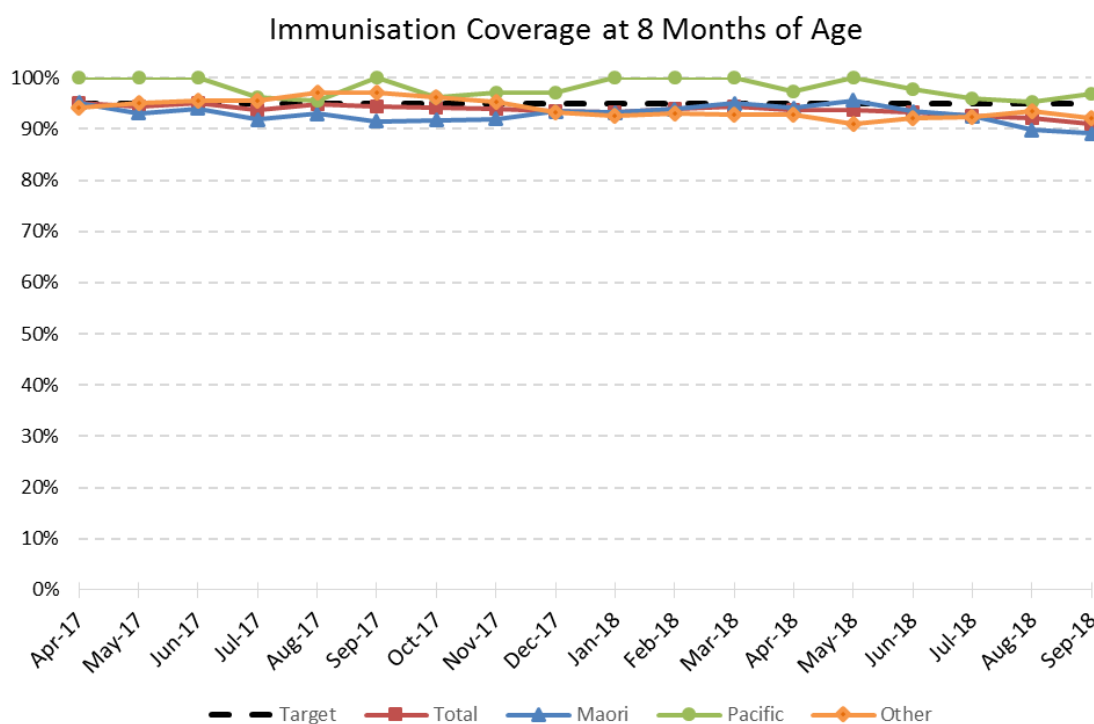
⁵ 6 months to March 2018

⁶ 6 months to June 2018

Health Target: Increased immunisation at 8 Months

% of 8 month olds fully immunised

Ethnicity	Baseline ⁷	Previous result ⁸	Actual to Date ⁹	Target 2018/19	Trend direction
Total	95%	92.2% (U)	91% (U)	≥95%	▼
Māori	93%	89.8% (U)	89.1% (U)	≥95%	▼
Pacific	97%	95.3% (F)	96.8% (F)	≥95%	▲
Other	86%	93.5% (U)	92% (U)	≥95%	▼



Data Source: National Immunisation Register

Comments:

There is a disappointing result with the 8 month overall coverage of 91%. There is a 1.5% increase in the numbers of Pacific babies up to date at this age but a 1.5 % decrease in Other of this age, Māori had the smallest decrease at 0.7 %. In this age group 47 babies were at various stages of their immunisation schedule, 24 of whom had received no immunisations. General Practice has experienced a very busy quarter where appointments have not been readily available. We are working with General Practice and the PHO to see how we can support them to ensure on time immunisations. The drop in our clinic outreach service provider sees a number of children attend and there is opportunity to increase these numbers. We will be working with stakeholders to promote this service as an option for those families who are unable to enrol or secure appointments at general practice. Additionally, the death of 2 infants in Samoa post immunisation events has raised concern among our families who have become hesitant towards their child's immunisations. Often multiple conversations in a variety of forums have been required to allay fears and concerns. Our outreach immunisation team continue to monitor and seek to find those babies who are living in transient families across Hawkes Bay.

⁷ October to December 2017. Source: National Immunisation Register, MOH

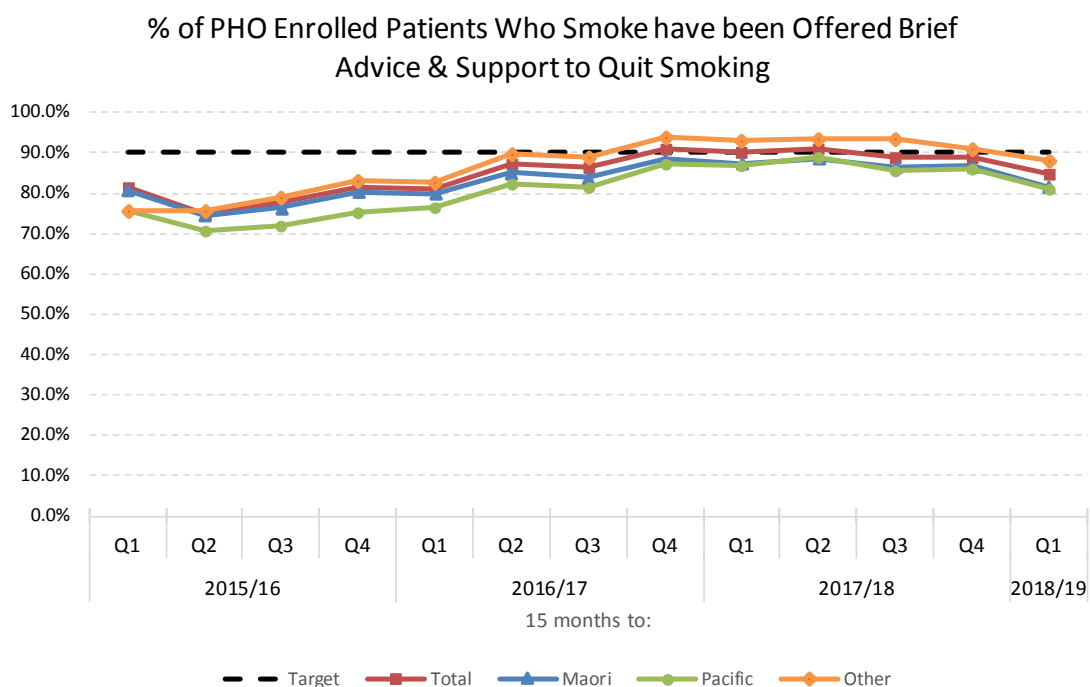
⁸ April to June 2018. Source: National Immunisation Register, MOH

⁹ July to September 2018. Source: National Immunisation Register, MOH

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

% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months

Key Performance Measures	Baseline ¹⁰	Previous result ¹¹	Actual to Date ¹²	Target 2018/19	Trend direction
Total	90%	89% (U)	85% (U)	≥90%	▼
Māori	89%	87% (U)	82% (U)	≥90%	▼
Pacific	89%	86% (U)	81% (U)	≥90%	▼
Other	94%	91% (F)	88% (U)	≥90%	▼

**Comments:**

Staff changes within Health HB has contributed to the results. Mitigation has been put in place including a new Clinical Performance and Support Lead recruited and commences in November. New Health HB structure has a 0.5 clinical support and recruitment will begin once lead has started. We should see an increase in % of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the Quarter 3 data.

¹⁰ 15 months to December 2016. Source: DHB Shared Services

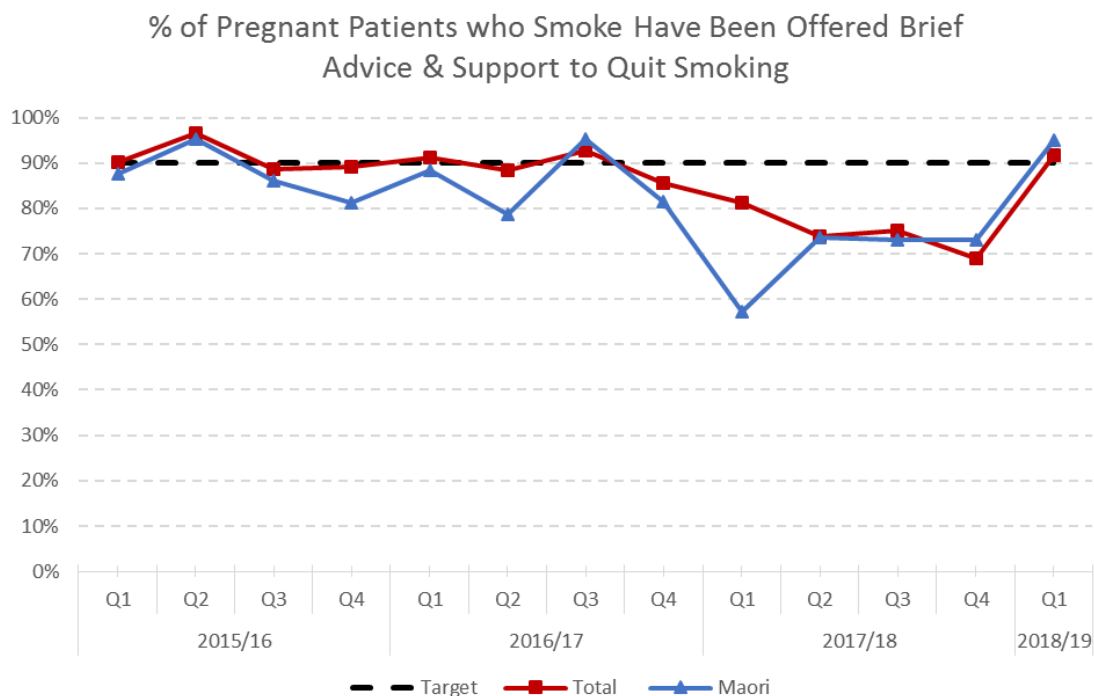
¹¹ 15 months to March 2018. Source: DHB Shared Services

¹² 15 months to June 2018. Source: DHB Shared Services

Health Target: Better help for smokers to quit – Maternity

% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking

Key Performance Measures	Baseline ¹³	Previous result ¹⁴	Actual to Date ¹⁵	Target 2018/19	Trend direction
Total	86.7%	69% (U)	92% (F)	≥90%	▲
Māori	84.0%	73% (U)	95% (F)	≥90%	▲

**Comments:**

Wahine Hapu - Increasing Smoke free Pregnancy Programme was reviewed in July 2018. Changes have been made as a result and this has translated into increased referrals to Te Haa Matea. DHB Smoke free Team attends peer support meetings with Te Haa Matea Stop Smoking Practitioners to discuss case studies and find shared solutions and streamline processes as required. Recommendations from the Maternal Incentives Programme have been implemented. The DHB is trialling using CO monitors for all pregnant women and their whanau. This will capture the impact of smoking and inefficient heating devices (unflued gas heaters, smoky fires). The aim is to start the conversation about Smoke free homes for healthy pēpi (and whanau). Referral to healthy homes can then be processed to address heating. If it works this will roll out to all midwives with high Māori caseloads.

¹³ October to December 2016. Source: DHB Shared Services

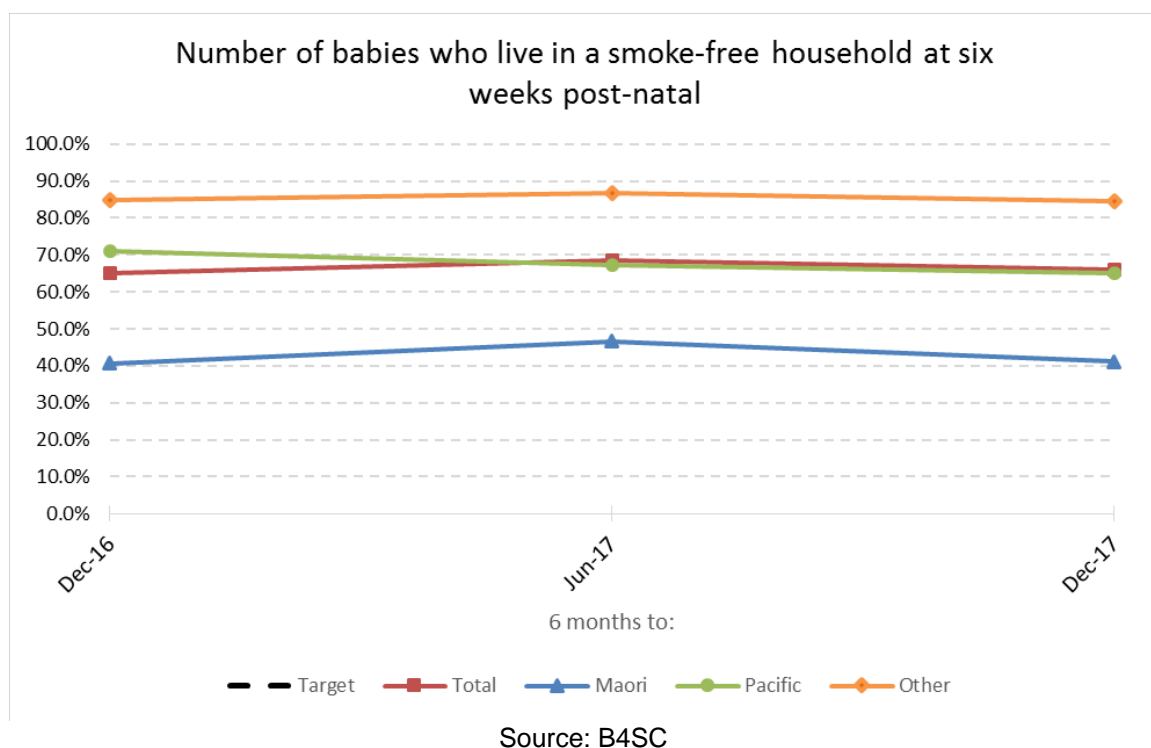
¹⁴ January to March 2018. Source: DHB Shared Services

¹⁵ April to June 2018. Source: DHB Shared Services

OUTPUT CLASS 1: PREVENTION SERVICES**Better Help for Smokers to Quit – Smoke-free Households**

Number of babies who live in a smoke-free household at six weeks post-natal

Key Performance Measures	Baseline ¹⁶	Previous result ¹⁷	Actual to Date ¹⁸	Target 2018/19	Trend direction
Total	66.1%	68.4%	66.1%	TBC	▼
Māori	0.0%	46.6%	41.2%	TBC	▼
Pacific	0.0%	67.3%	65%	TBC	▼
Other	0.0%	86.8%	84.4%	TBC	▼

**Comments:**

For the financial year 2017/18 no target was set as this measure was developmental. The 2018/19 Annual plan contains a target and this will be reflected in the Q2 report.

¹⁶ 6 months to December 2016. Source: B4SC

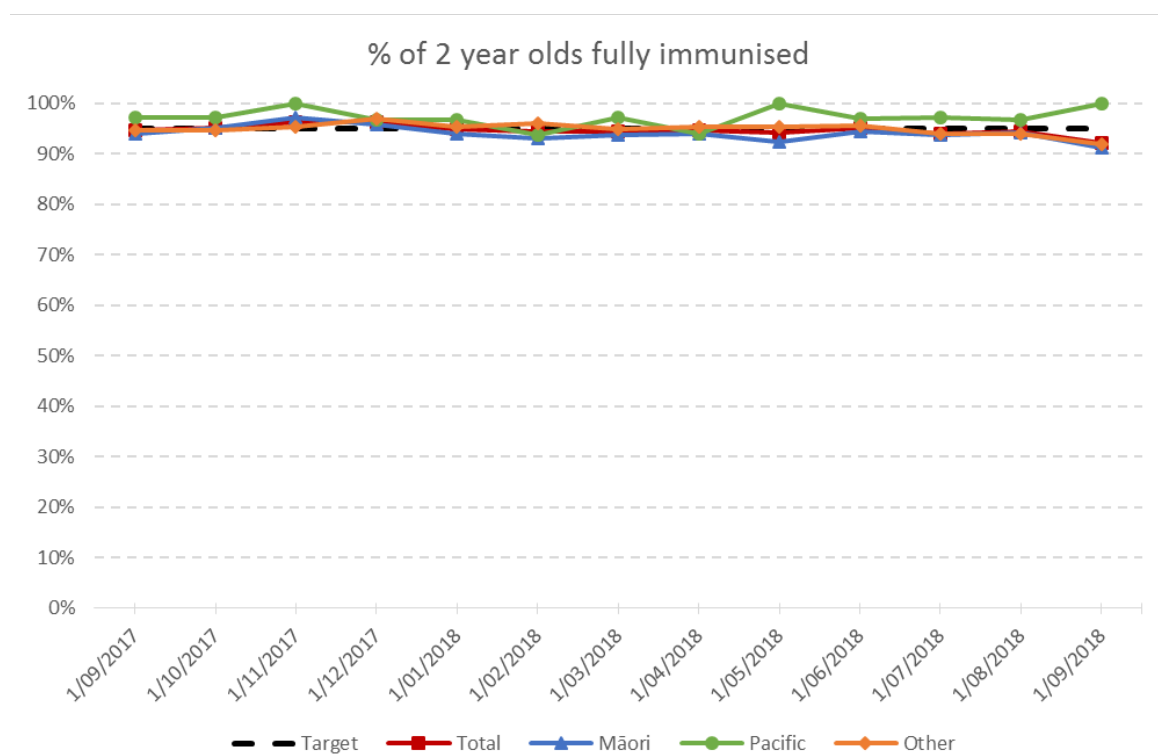
¹⁷ 6 months to June 2017. Source: B4SC

¹⁸ 6 months to December 2017. Source: B4SC

Increase Immunisation – 2 Years

% of 2 year olds fully immunised

Key Performance Measures	Baseline ¹⁹	Previous result ²⁰	Actual to Date ²¹	Target 2018/19	Trend direction
Total	94.0%	95.7% (F)	92.1% (U)	≥95%	▼
Māori	95.0%	94.8% (F)	91.2% (U)	≥95%	▼
Pacific	96.0%	97% (F)	100% (F)	≥95%	▲
Other	86.0%	95.6% (F)	92% (U)	≥95%	▼



Data Source: National Immunisation Register

Comments:

The drop in coverage for 2 year olds is disappointing. However, there has been ongoing challenges with the death of 2 infants at the 15 month old immunisation event in Samoa. Families' are requiring additional support to allay concerns regarding immunisations, in response we have provided additional resources and key messages to across the sector to mitigate the anxiety. Māori rates are continuing to decline and we are unsure of the reasons for this. However, we continue to explore innovative methods to engage with Māori and their whanau to ensure equitable access.

¹⁹ October to December 2017. Source: National Immunisation Register, MOH

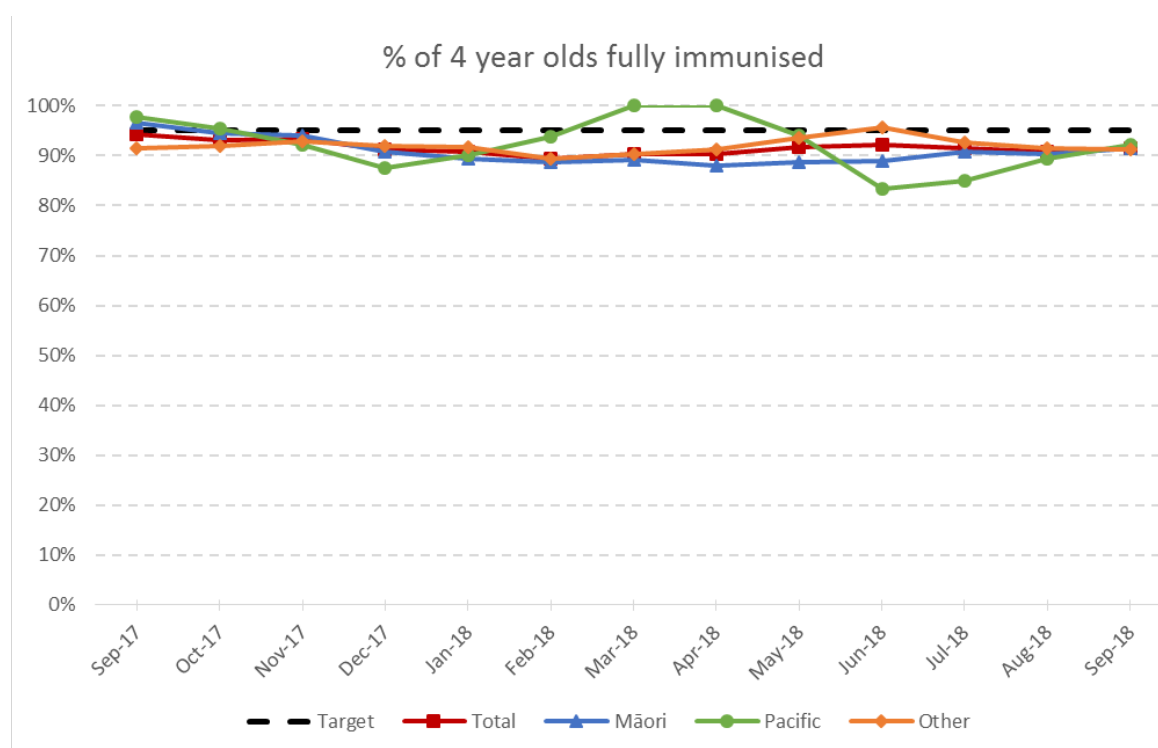
²⁰ April to June 2018. Source: National Immunisation Register, MOH

²¹ July to September 2018. Source: National Immunisation Register, MOH

Increase Immunisation – 4 Years

% of 4 year olds fully immunised

Key Performance Measures	Baseline ²²	Previous result ²³	Actual to Date ²⁴	Target 2018/19	Trend direction
Total	94.0%	92.2% (U)	91.4% (U)	≥95%	▼
Māori	93.0%	89% (U)	91.5% (U)	≥95%	▲
Pacific	96.0%	83.3% (U)	92.1% (U)	≥95%	▲
Other	86.0%	95.7% (F)	91.3% (U)	≥95%	▼

**Comments:**

HBDHB remain pleased with the 4 year old coverage with equity maintained. This cohort is the hardest to make progress with due to all the factors that have affected the younger age bands coverage but more so that we seem to have more children coming in from overseas needing catch up immunisations in this cohort. Although we try, capacity of our team is an issue and the focus remains on the 8 month and 2 year coverage first and foremost. We do have really good collaboration between B4SC and ourselves providing each other with details of children that we were unaware of within our area which helps eliminate children falling through the gaps.

²² October to December 2017. Source: National Immunisation Register, MOH

²³ April to June 2018. Source: National Immunisation Register, MOH

²⁴ July to September 2018. Source: National Immunisation Register, MOH

Increase Immunisation - Influenza					
% of 65+ year olds immunised – flu vaccine					
Key Performance Measures	Baseline ²⁵	Previous result ²⁶	Actual to Date ²⁷	Target 2018/19	Trend direction
Total	59.1%	59.1% (U)	58.1% (U)	≥75%	▼
Māori	56.3%	56.3% (U)	53% (U)	≥75%	▼
Pacific	51.5%	51.5% (U)	51.7% (U)	≥75%	▲
Other	60%	60% (U)	59.4% (U)	≥75%	▼
Data Source: National Immunisation Register					
Comments: Coverage for influenza immunisation has not improved over the previous year according to the coverage report on datamart, although the rate will be higher than this as immunisations given through occupational health providers are not on NIR. We have a large number of pharmacies vaccinating in HB which should be making access easier. We also have 2 Māori providers and 1 rural nurse led health centre with contracts providing influenza immunisation to the eligible population. Health HB have run their Whanau wellness programme again this year and the HBDHB immunisation team presented at these sessions and provided influenza immunization to those who wanted them.					

²⁵ 6 months to September 2017. Source: National Immunisation Register, MOH

²⁶ 6 months to September 2017. Source: National Immunisation Register, MOH

²⁷ 6 months to September 2018. Source: National Immunisation Register, MOH

Better rates of breastfeeding – 3 months					
% of infants that are exclusively or fully breastfed at 3 months					
Key Performance Measures	Baseline ²⁸	Previous result ²⁹	Actual to Date ³⁰	Target 2018/19	Trend direction
Total	51.3%	51.3% (U)	51.7% (U)	≥70%	▲
Māori	41.0%	41% (U)	35.6% (U)	≥70%	▼
Pacific	42.6%	42.6% (U)	34.5% (U)	≥70%	▼
Other	-	-	-	≥70%	*
Data Source: Well Child Tamariki Ora					
Comments: HBDHB is aware of the declining trend in the breastfeeding rate in particular for Māori at 3 months which is reflective of a declining trend of breastfeeding on discharge from hospital and at 2 weeks. Some factors that appear to be related to this trend are higher than average complications i.e. SCBU admissions and also increased staffing/workload pressures for Midwifery services which has reduced the ability of time spent supporting mothers to establish breastfeeding. In response, a one off support PVS from Population Health is being used as a pilot approach to increase community midwifery breastfeeding support in the home of .9FTE for Māori and Pacific mothers on discharge and Te Tai Whenua O Heretaunga have recruited within the last month to a 1 FTE Breastfeeding support position funded via Māori Health for Well Child Tamariki services. A similar contract has also been established up in Wairoa with Kauhungunu Executive. An ongoing concern is a restructure of Plunket services locally to a centralised service which has not yet allowed the local office to appoint their similar Māori health funded contract for a 1 FTE lactation Consultant. Interviews conducted with 50 Māori Mama from last year's birth cohort recently for the Kaupapa Māori Maternal Wellbeing program has identified breastfeeding issues/lack of support as one of the highest priority areas that will need to be addressed and strongly embedded by development of this new program over the next 6 months.					

²⁸ 6 months to December 2017

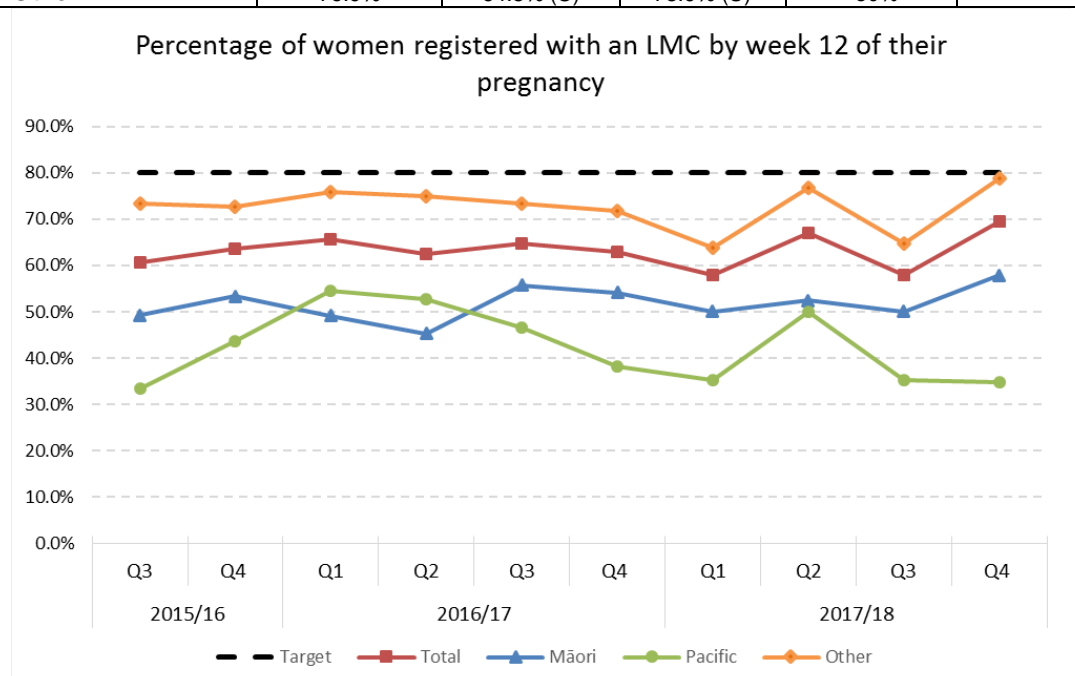
²⁹ 6 months to December 2017

³⁰ 6 months to June 2018.

OUTPUT CLASS 2: EARLY DETECTION AND MANAGEMENT SERVICES**More pregnant women under the care of a Lead Maternity Carer (LMC)**

% of women booked with an LMC by week 12 of their pregnancy

Key Performance Measures	Baseline ³¹	Previous result ³²	Actual to Date ³³	Target 2018/19	Trend direction
Total	67.1%	57.9% (U)	69.6% (U)	≥80%	▲
Māori	52.4%	50% (U)	57.9% (U)	≥80%	▲
Pacific	50.0%	35.3% (U)	34.8% (U)	≥80%	▼
Other	76.9%	64.8% (U)	78.9% (U)	≥80%	▲

**Comments:**

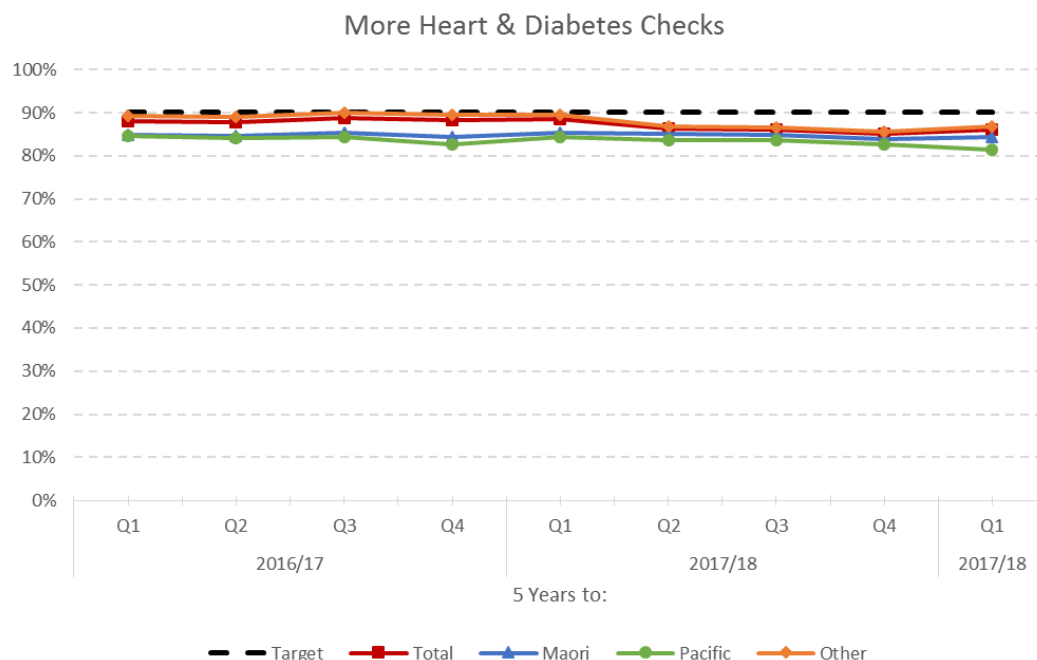
The ongoing fluctuation of bookings by week 12 of pregnancy is evident here with a rise in all ethnicities except Pacific island. As a DHB our top 5 to thrive campaign continues with the intent through the MOH MQS programme to refresh and target both Māori and Pacifica women to support ease of access to a midwife early in pregnancy. Interviews with Māori women who have had a baby in the last 12 months has been completed with good feedback on what would work to support better access. The development of a Hapu Mama maternal programme is coming together with the intent of having this set up by mid next year. Ongoing collaboration with primary care colleagues, LMCs and resource centres across the district supporting visibility and responsiveness to a positive pregnancy tests continues, this is a particular focus and ongoing project within the Maternity quality and safety programme.

³¹ October to December 2017.³² January to March 2018.³³ April to June 2018

CVD Risk Assessments**Improved management of long-term conditions (CVD, Acute heart health, Diabetes, and Stroke)**

% of the eligible population will have had a CVD risk assessment in the last 5 years

Key Performance Measures	Baseline ³⁴	Previous result ³⁵	Actual to Date ³⁶	Target 2018/19	Trend direction
Total	86.3%	85.2% (U)	86.1% (U)	≥90%	▲
Māori	85.0%	83.8% (U)	84.3% (U)	≥90%	▲
Pacific	83.6%	82.7% (U)	81.5% (U)	≥90%	▼
Other	86.7%	85.7% (U)	86.8% (U)	≥90%	▲



Source: Ministry of Health

Contained in the 2018/19 organisation annual plan we have action in place, in particular for Māori men. A new Clinical Performance and Support person is due to start with the organisation in November and this person will have oversight of this program of work. A further clinical 0.5 position has been created and will be filled in the next 3 months. Included in our System Level measures we will develop an improvement plan informed by data, analysis and information to increase the provision of CVRA for Māori in line with national guidelines, this will be inclusive of Māori Women and we will further, engage with general practice and NGO.

³⁴ 5 years to December 2016. Source: Ministry of Health

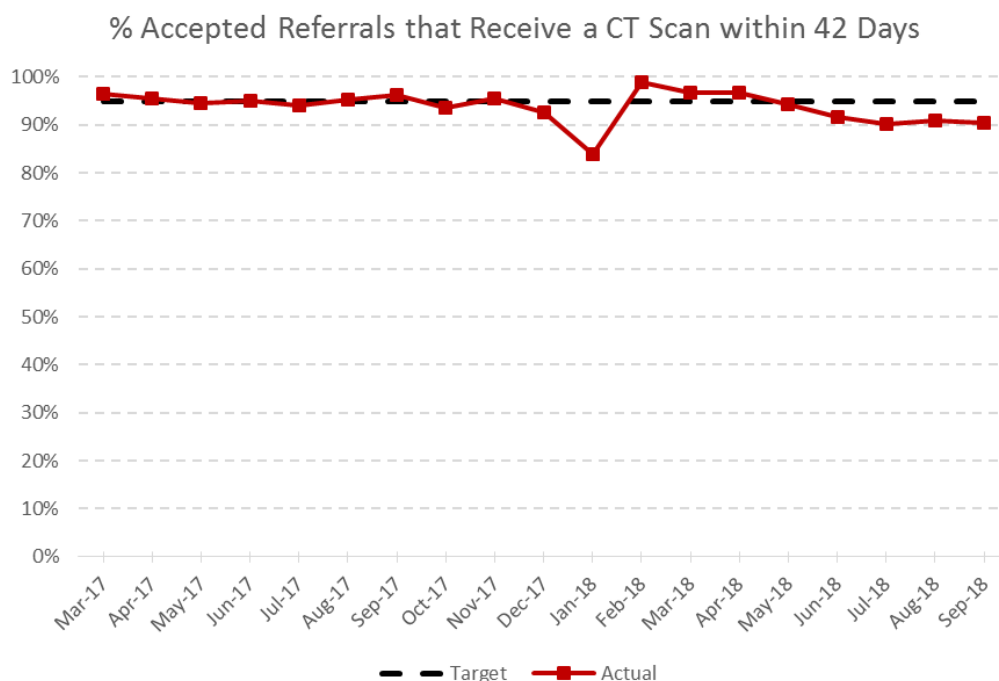
³⁵ 5 years to June 2017. Source: Ministry of Health

³⁶ 5 years to September 2017. Source: Ministry of Health

Less waiting for diagnostic services - CT

% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks)

Key Performance Measures	Baseline ³⁷	Previous result ³⁸	Actual to Date ³⁹	Target 2018/19	Trend direction
Total	92.5%	92% (U)	91% (U)	≥95%	▼
Māori	-	-	-	≥95%	*
Pacific	-	-	-	≥95%	*
Other	-	-	-	≥95%	*

**Comments:**

Quarter 1 saw a reduced compliance in the CT wait time indicator, ranging from 89-91% as anticipated this was due to a high level of acute presentations (Winter pressures) and reduced radiologist resourcing. There continues to be a high volume of acute presentations and demand from both FCT and elective services. HBDHB continues to use the NRSII models and production plans to forecast and plan workload and anticipates that radiologist resourcing and acute demand will continue to be an issue in the next quarters/year and continues to utilise strategies, such as out-sourcing and use of locums, to minimise the effect on compliance.

³⁷ December 2017. Source: Ministry of Health

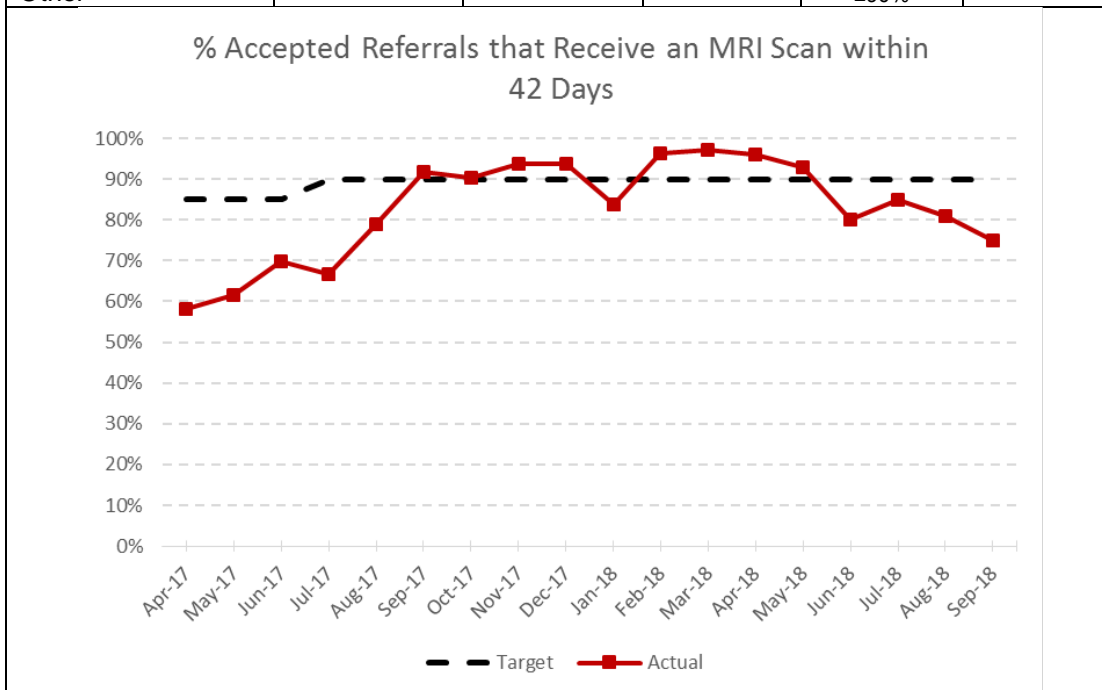
³⁸ June 2018. Source: Ministry of Health

³⁹ September 2018. Source: Ministry of Health

Less waiting for diagnostic services - MRI

% of accepted referrals for MRI scans who receive their scans within 42 days (six weeks)

Key Performance Measures	Baseline ⁴⁰	Previous result ⁴¹	Actual to Date ⁴²	Target 2018/19	Trend direction
Total	93.8%	80% (U)	75% (U)	≥90%	▼
Māori	-	-	-	≥90%	*
Pacific	-	-	-	≥90%	*
Other	-	-	-	≥90%	*

**Comments:**

Quarter 1 has seen the MRI wait time indicator compliance reduce from Q4. Overall there has been a significant improvement in compliance following the commencement of the 7 day - 8 hour - MRI service in July 2017. The failure to meet the indicator has been due to an increase in demand and a high level of acute presentations. There has been a 17.6% increase on scans performed in 2017/18 to 2016/17.

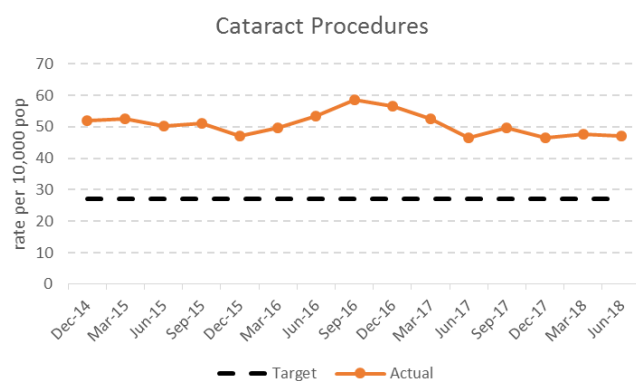
⁴⁰ December 2017. Source: Ministry of Health

⁴¹ June 2018. Source: Ministry of Health

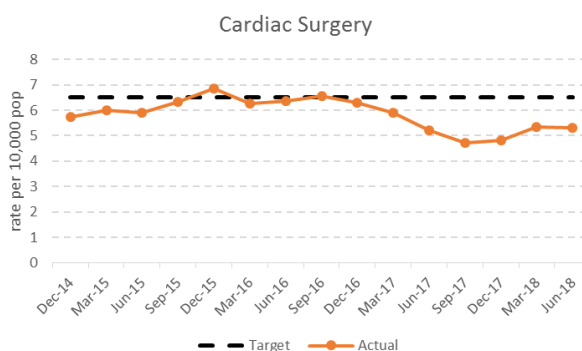
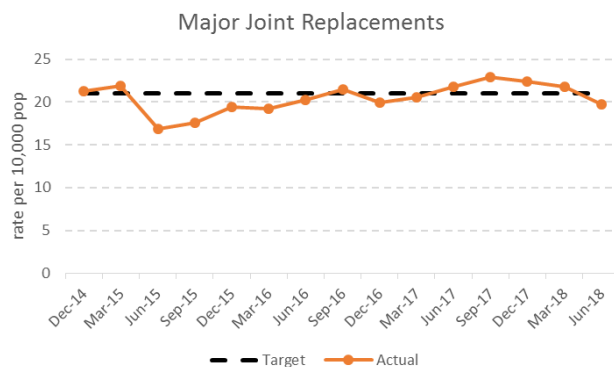
⁴² September 2016. Source: Ministry of Health

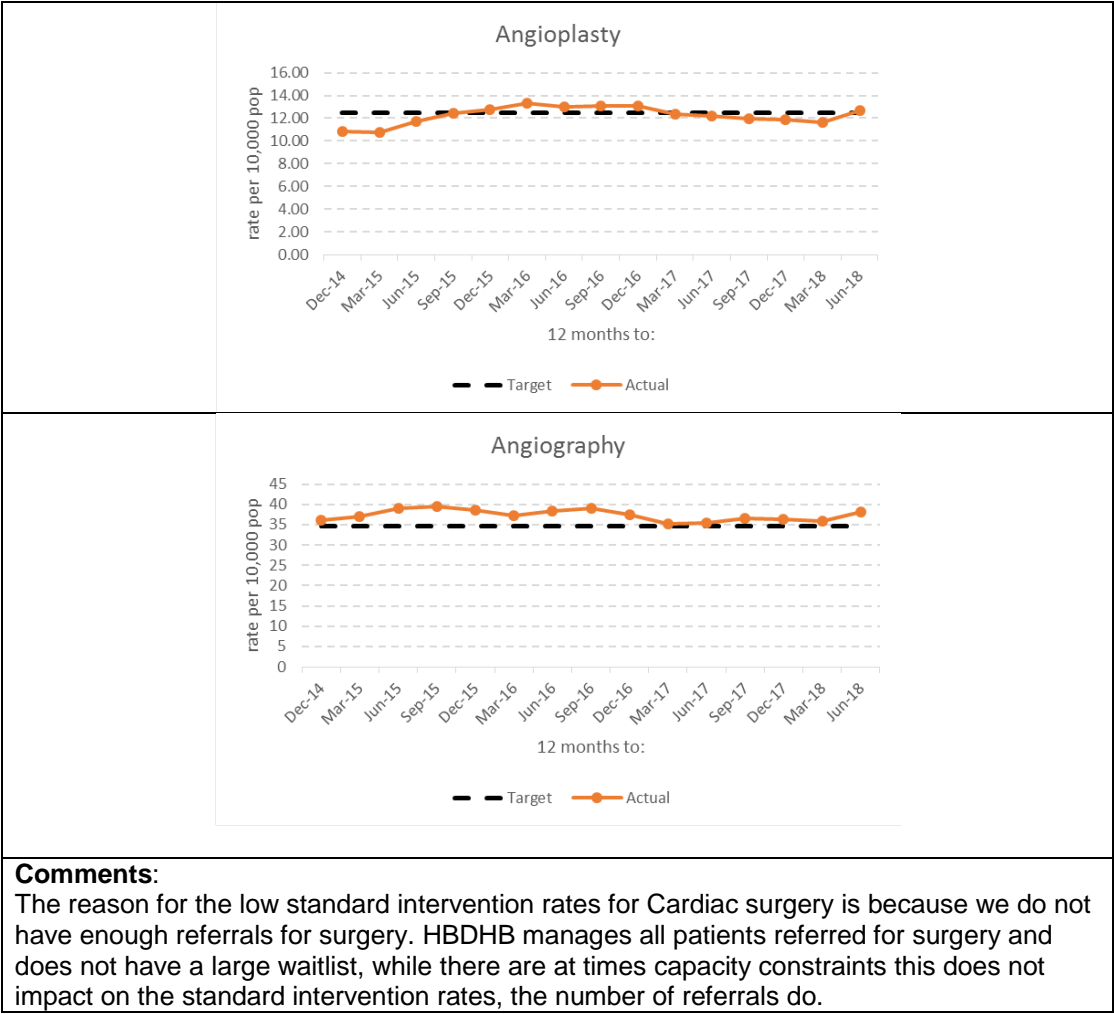
OUTPUT CLASS 3: INTENSIVE ASSESSMENT AND TREATMENT SERVICES***Equitable access to surgery -Standardised intervention rates for surgery per 10,000 population***

Key Performance Measures	Baseline ⁴³	Previous result ⁴⁴	Actual to Date ⁴⁵	Target 2018/19	Trend direction
Major joint replacement	22.4	21.78 (F)	19.77 (U)	≥21	▼
Cataract procedures	46.6	47.54 (F)	47.04 (F)	≥27	▼
Cardiac procedures	4.8	5.36 (U)	5.32 (U)	≥6.5	▼
Percutaneous revascularization	11.9	11.64 (U)	12.67 (F)	≥12.5	▲
Coronary angiography services	36.4	35.91 (F)	38.09 (F)	≥34.7	▲



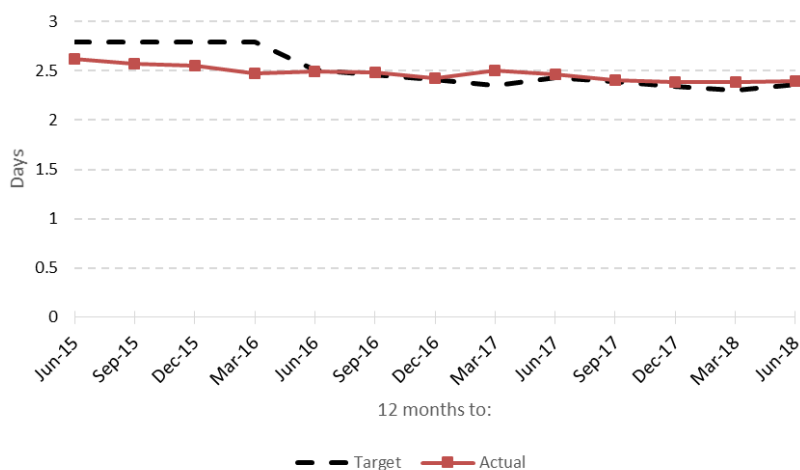
Source: Ministry of Health

⁴³ 12 months ending December 2017. Source MoH⁴⁴ 12 months ending March 2018. Source MoH⁴⁵ 12 months ending June 2018. Source MoH

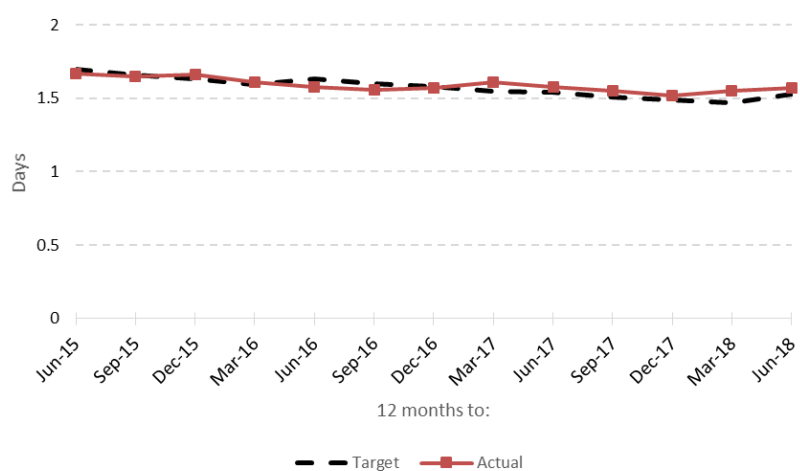


Shorter stays in hospital**Length of stay (days)**

Key Performance Measures	Baseline ⁴⁶	Previous result ⁴⁷	Actual to Date ⁴⁸	Target 2018/19	Trend direction
Acute	2.39	2.39 (U)	2.4 (U)	≤2.3	▼
Elective	1.52	1.55 (U)	1.57 (U)	≤1.45	▼

Average Length of Stay (Acute)

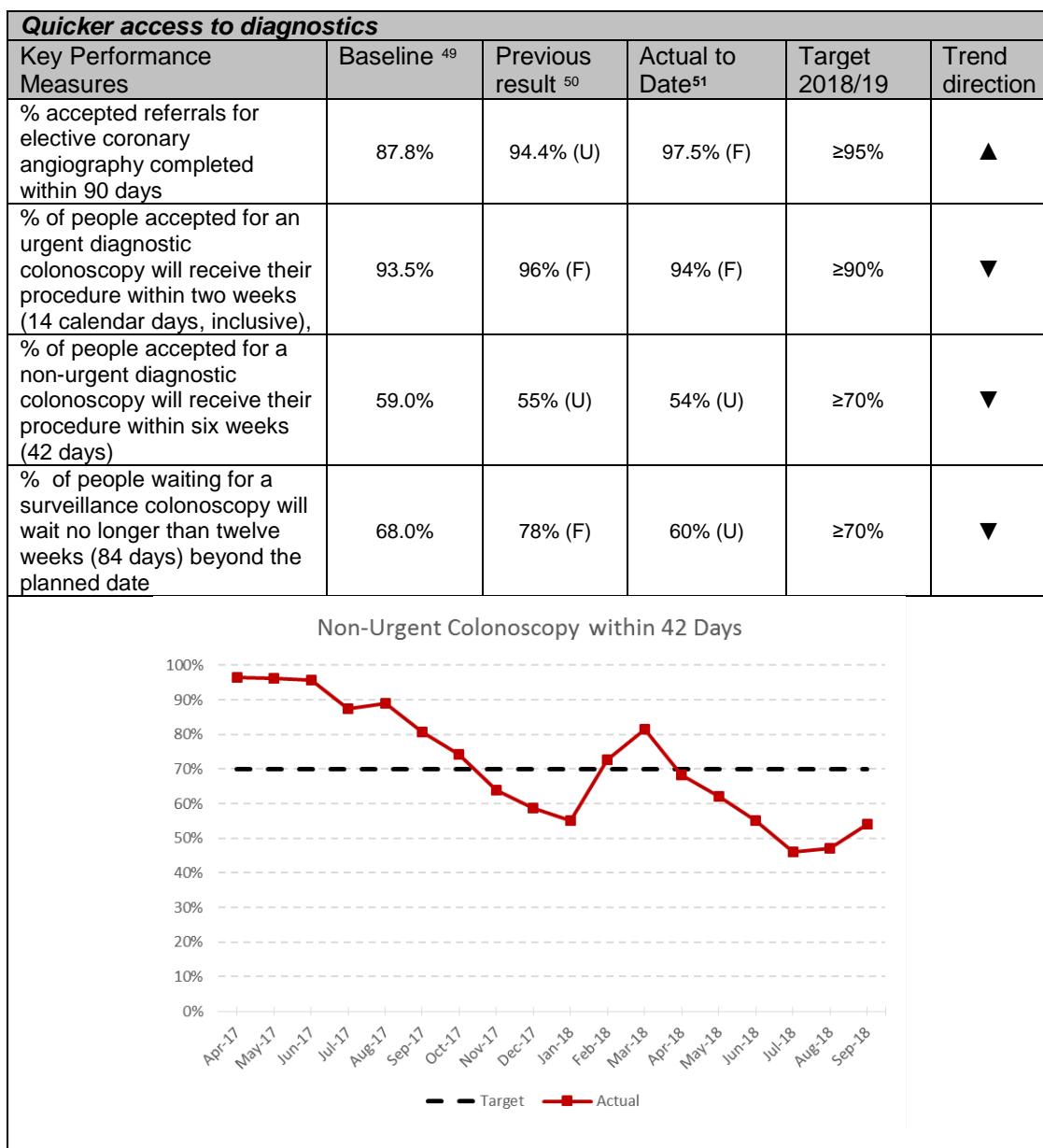
Source: Ministry of Health

Average Length of Stay (Elective)**Comments:**

Acute - The quarter April to June had elevated acute presentations via ED and clinics/GPs with complexity and high acuity. All wards were sitting at over 90% occupancy due to Surgery postponements affected by high electives, with waiting time for acute surgery delayed at times due to high volumes. In order to help, A2 was open to 10 beds and we are recruiting to permanent staff so those beds can be open 7 days per week (In this period only budgeted 5 days a week). Casual and relief nursing pool were increased by 10 FTE to ensure all beds can be resourced. Plans for high care rooms in x2 surgical wards being worked up to ensure these patients coming in increasing numbers are kept under close Senior RN care- this should decrease any rapid responses or post-operative complications that increase LOS.

⁴⁶ 12 months to September 2016. Source: Ministry of Health⁴⁷ 12 months to August 2017. Source: Ministry of Health⁴⁸ 12 months to September 2017 .Source: Ministry of Health

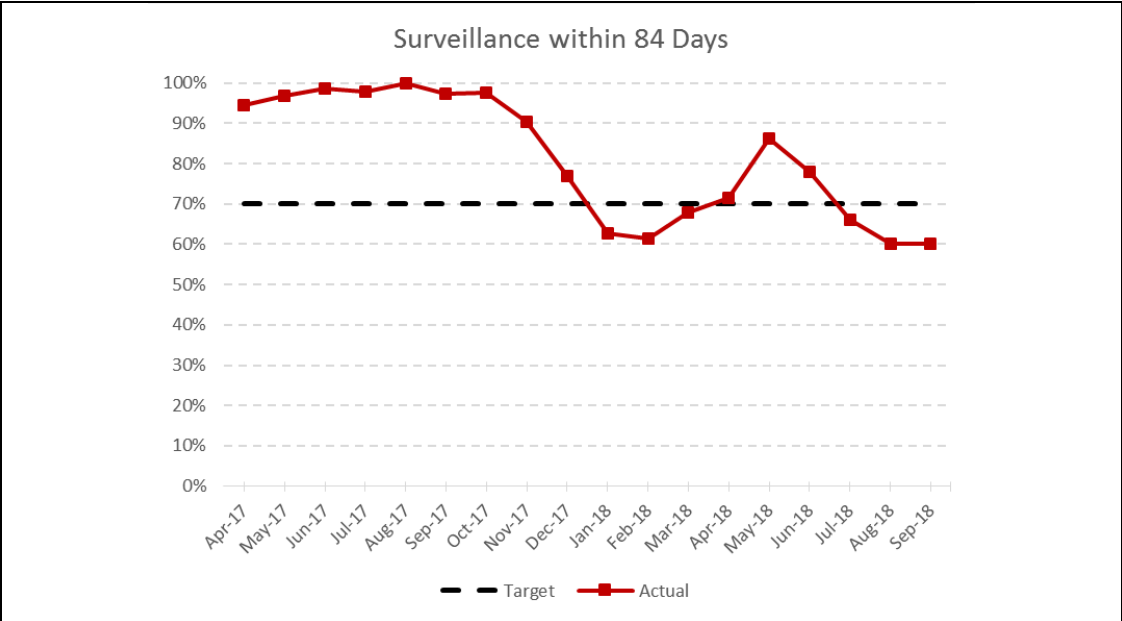
Elective – HBDHB had higher case weights leading to longer stays e.g. increasing bowel cancers requiring complex surgery and often HDU (high dependency unit) stays then to wards and this always lengthens stay. Lighter cases that turn over in 24 hours were not done generally in this period as no theatre or ward capacity was available due to the above. Outsourcing was capped from April and these are smaller case weights but they were all just put into a waiting pool. Going forward HBDHB is looking at making elective We aim to change Lap Cholecystectomy cases to day cases (no overnight stay) were as currently the stay is 24 hours, we will trial with one General Surgeon to being with. HBDHB also have an acute Lap Cholecystectomy pathway developed to ensure these patients are not sitting in an acute beds for 3-4 days waiting for surgery. Instead those that meet the criteria will be sent home with specific instructions and return to a dedicated acute list for this procedure.



49 December 2017.

50 June 2018.

51 September 2018



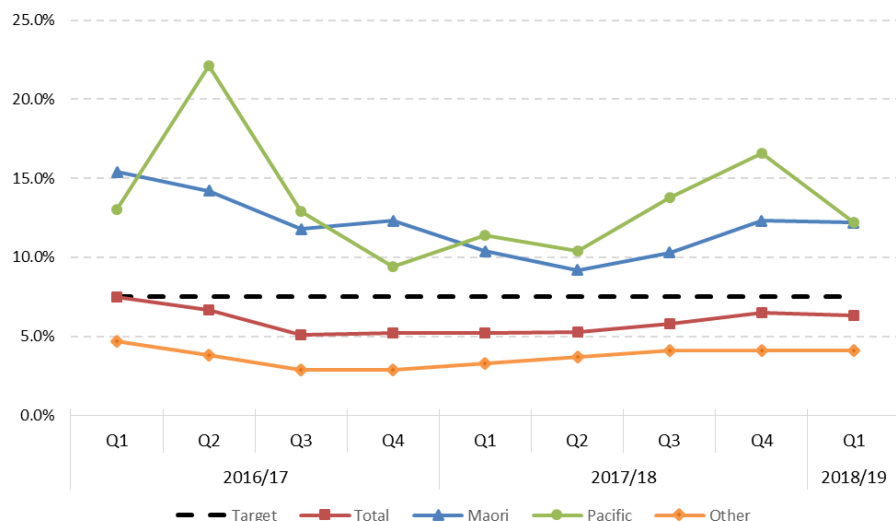
Comments:
HBDHB is currently 13 procedure behind plan when comparing actual referrals received less discharges and other exits to forecast. The Semi urgent and Surveillance MoH targets have been below target for a number of weeks. As agreed with the NBSP team, we plan to utilise the increased capacity of the new unit to improve performance. The current status is the result of increased referrals, more clinical complexity and acute demand. Also we managed the service production to facilitate the smooth transition to the new facility, the transition has experienced technical issues that slowed lists. The clinical complexity of patients requires additional anaesthetic resources that was not foreseen. The access to surgical resources are balanced with the need for surgical services to meet elective targets. The production plan has identified and resourced extra sessions in November (4 x GA lists and 1 x Saturday). The need for further sessions in December is being discussed and the resource requirements quantified. The goal is to be Green by Dec 31 2018 for the three MoH Production Targets.

Fewer missed outpatient appointments

Did not attend (DNA) rate across first specialist assessments

Key Performance Measures	Baseline ⁵²	Previous result ⁵³	Actual to Date ⁵⁴	Target 2018/19	Trend direction
Total	5.3%	6.5% (U)	6.3% (F)	≥7.5%	▼
Māori	9.2%	12.3% (F)	12.2% (U)	≥7.5%	▼
Pacific	10.4%	16.6% (F)	12.2% (U)	≥7.5%	▼
Other	0.037	4.1% (U)	4.1% (F)	≥7.5%	—

Did Not Attend (DNA) Rates Across First Specialists Assessments (ESPI Specialities Only)



Source: HBDHB

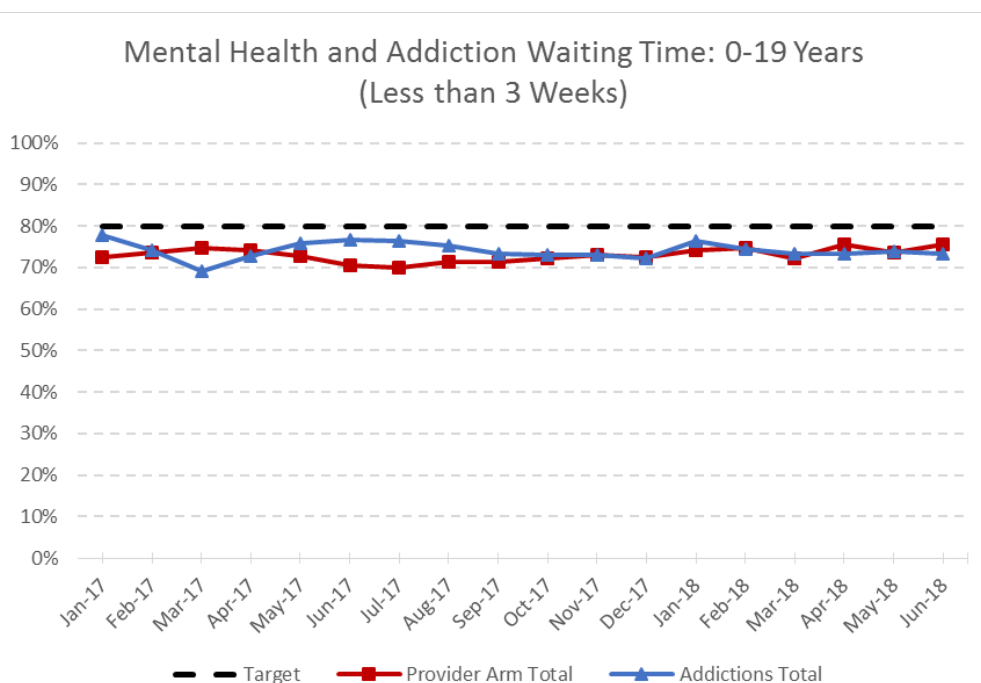
Comments:

The overall total DNA continues to remain below the target rate of 7.5%, however the inequity with Māori and Pacific is still apparent. Māori and Pacific DNA levels sit at three times the level of Other, showing that barriers remain, preventing Māori and Pacific from utilising the HBDHB services in the same way as the rest of our population. The fluctuations in DNA levels over the last 3 months is a reflection of stretched resourcing across Outpatient Booking and Kaitakawaenga, resulting in less resource available to actively chase up those patients that are difficult to reach. The loss of the evening calling by our Switchboard continues to have a negative impact on DNA, and outpatient bookers workloads have been at levels where prioritising the calling of patients to attend appointments has not always been possible. Over the last quarter the Pacific DNA result for September has dropped to 7%, this is the lowest level recorded over the last year. Although Pacific figures vary considerably with low numbers it is worth noting that additional training was recently given to the Pacific Navigator to assist in a more efficient targeted approach to the Pacific population. Hopefully we continue to see this positive impact on the Pacific DNA rate into the next quarter. Focus is going into capturing the 'real story' with plans for Kaitakawaenga to survey people who have DNA'd especially in the worst areas of General Surgery and Dental

⁵² October to December 2016. Source: Ministry of Health⁵³ July to September 2016. Source: Ministry of Health⁵⁴ October to December 2016. Source: Ministry of Health

Reducing waiting times Shorter waits for non-urgent mental health and addiction services for 0-19 year olds

Key Performance Measures	Baseline ⁵⁵	Previous result ⁵⁶	Actual to Date ⁵⁷	Target 2018/19	Trend direction
Mental Health Provider Arm: Age 0-19					
<3 weeks					
Total	72.5%	73.4% (U)	75.7% (U)	≥80%	▲
Māori	76.4%	78.7% (U)	80.2% (F)	≥80%	▲
Pacific	82.6%	91.3% (F)	100% (F)	≥80%	▲
Other	70.2%	68.7% (U)	71.3% (U)	≥80%	▲
<8 weeks					
Total	91.2%	92.7% (U)	93.2% (U)	≥95%	▲
Māori	94.1%	94.4% (U)	94.6% (F)	≥95%	▲
Pacific	91.3%	100% (F)	100% (F)	≥95%	—
Other	88.7%	91% (U)	91.8% (U)	≥95%	▲
Addictions (Provider Arm & NGO): Age 0-19					
<3 weeks					
Total	72.1%	73.8% (U)	73.2% (U)	≥80%	▼
Māori	61.1%	64.9% (U)	66.7% (U)	≥80%	▲
Pacific	100.0%	100% (F)	100% (F)	≥80%	—
Other	85.7%	86.9% (F)	81.8% (F)	≥80%	▼
<8 weeks					
Total	95.6%	93.4% (U)	98.2% (F)	≥95%	▲
Māori	94.1%	94.4% (U)	94.6% (F)	≥95%	▲
Pacific	100.0%	100% (F)	100% (F)	≥95%	—
Other	100.0%	100% (F)	100% (F)	≥95%	—



Source: Ministry of Health

Comments:

In the last quarter we have had a reduction in our workforce that has impacted our ability to

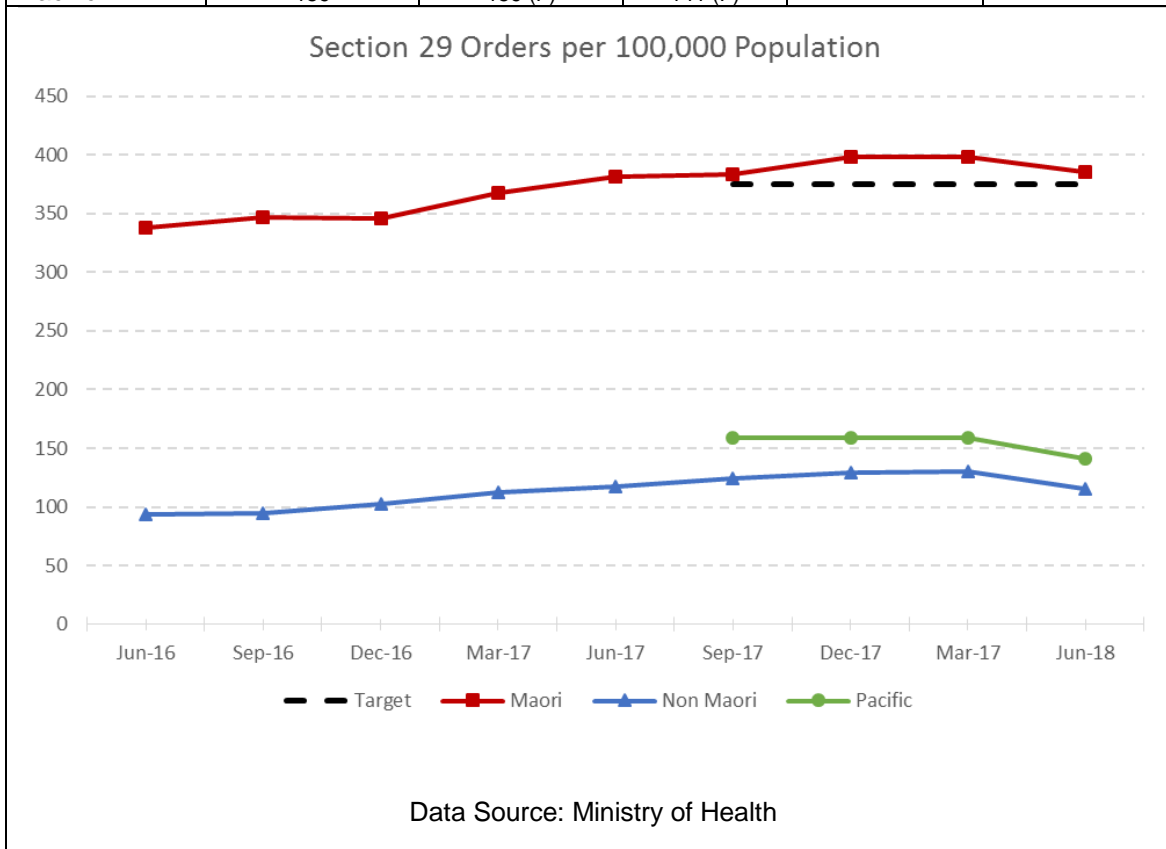
⁵⁵ 12 months to December 2016⁵⁶ 12 months to June 2018⁵⁷ 12 months to September 2018

meet the target. We have put in a number of short term mitigation strategies in place: Firstly the utilisation of the FTE underspend to purchase packages of care from outsourced clinicians, this is currently not reflected in our target data. Secondly the DHB have deployed non clinical capacity to follow up first time appointments to decrease DNAs and ensure the first time appointments are utilised. Lastly the DHB have actively recruited staff with FTE commencing in January 2019.

Increasing consumer focus, More equitable use of Mental Health Act: Section 29 community treatment orders

Rate of s29 orders per 100,000 population

Ethnicity	Baseline ⁵⁸	Previous result ⁵⁹	Actual to Date ⁶⁰	Target 2018/19	Trend direction
Non- Māori	129	130 (F)	115 (F)	-	▲
Māori	398	398 (U)	385 (U)	≤375	▲
Pacific	159	159 (F)	141 (F)	-	▲



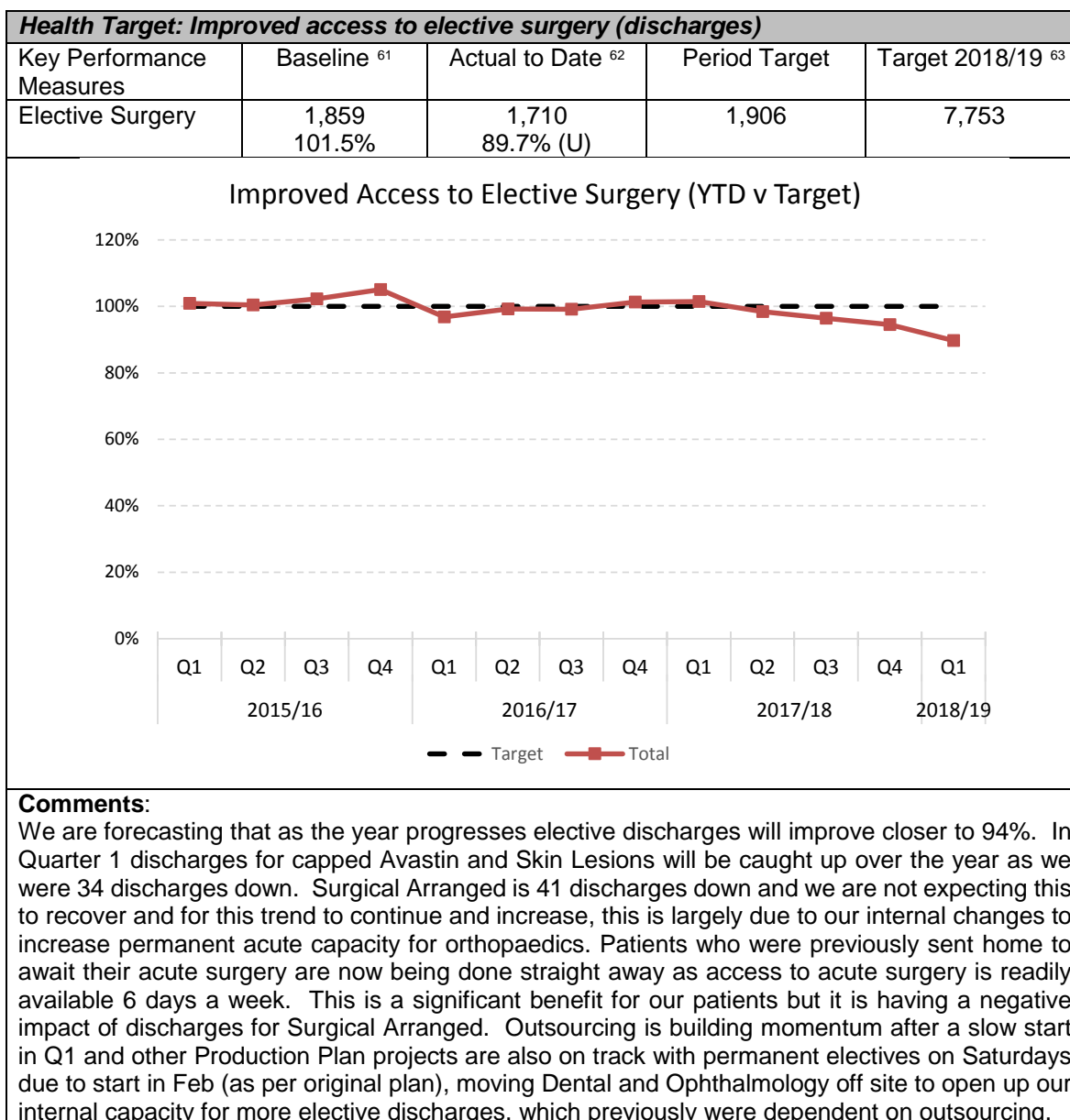
Comments:

We have completed a Mental Health Indicator Review that has provided us with challenging but encouraging information on the status of this mental health indicator. The review recognises that being placed under s29 of the Mental Health Act is compounded by the complexity of social, family and health factors. The differences in the population rates of these underlying factors may be a significant driver of compulsory treatment and is an important component of any strategies to reduce the rate. We are considering the report recommendations.

⁵⁸ 12 months to December 2017

⁵⁹ 12 months to March 2018

⁶⁰ 12 months to June 2018



⁶¹ July to September 2017

⁶² July to September 2018

⁶³ July 2017 to June 2018

RECOMMENDATION:

That the HBDHB Board

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

ATTACHMENT:

- HBDHB Quarterly Performance Monitoring Dashboard Q3



HBDHB PERFORMANCE FRAMEWORK RESULTS – QTR 1, 2018/19

Health Targets:	Target	Baseline	Total	Maori	Pacific	Other
Shorter Stays in ED	≥ 95%	94%	86%	89%	90%	84%
Faster Cancer Treatment	≥ 90%	95%	81%	93%	-	78%
Increased Immunisation	≥ 95%	95%	91%	89%	97%	92%
Better Help for Smoker to Quit (Primary Care)	≥ 90%	87%	85%	82%	81%	88%
Better Help for Smoker to Quit (Pregnant Women)	≥ 90%	89%	92%	95%	-	-
Raising Health Kids	≥ 95%	40%	99%	100%	100%	95%

Output Class 1: Prevention Services	Target	Baseline	Total	Maori	Pacific	Other
Better Help for Smoker to Quit (Hospital)	≥ 95%	96%	97%	97%	95%	96%
SLM Number of babies who live in a smoke-free household at six weeks post natal	≥ 95%	66%	66%	41%	65%	84%
% of 2 year olds fully immunised	≥ 95%	95%	92%	91%	100%	92%
% of 4 year olds fully immunised	≥ 95%	94%	91%	92%	92%	91%
% of girls fully immunised – HPV vaccine	≥ 75%	68%	76%	85%	88%	70%
% of 65+ year olds immunised – flu vaccine	≥ 75%	60%	58%	53%	52%	59%
% of women aged 50-69 years receiving breast screening in the last 2 years	≥ 70%	74%	73%	70%	66%	74%
% of women aged 25–69 years who have had a cervical screening event in the past 36 months	≥ 80%	77%	76%	76%	74%	78%
% of infants that are exclusively or fully breastfed at 3 months	≥ 60%	51%	52%	36%	35%	-

Output Class 2: Early Detection and Management Services	Target	Baseline	Total	Maori	Pacific	Other
% of the population enrolled in the PHO	≥ 90%	98%	97%	98%	91%	97%
Ambulatory sensitive hospitalisation rate per 100,000 0-4 years	≤ 6,320	6,000	6,843	7,490	12,535	5,498
Ambulatory sensitive hospitalisation rate per 100,000 45-64 years	≤ 6,761	4,370	4,414	8,302	7,954	3,435
% of women booked with an LMC by week 12 of their pregnancy	≥ 80%	66%	70%	58%	35%	79%
% of the eligible population will have had a CVD risk assessment in the last 5 years	≥ 90%	88%	86%	84%	82%	87%
% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks)	≥ 95%	93%	91%	No Ethnicity Data		
% of accepted referrals for MRI scans who receive their scans within 42 days (6 weeks)	≥ 90%	48%	75%			
SLM Total self-harm hospitalisations and short stay ED presentations for <24 year olds per 10,000	≤ 45.8	47.3	47.3	55.2	33	43.1
SLM % of ED presentations for 10-24 year olds which are alcohol	≤ 11%	11%	11%	11%	7%	11%
SLM Amenable Mortality Relative Rate between Māori and NMNP	≤ 2.15	2.52	2.45	Not Applicable		

Key:

Within 0.5% or Greater than Target
Within 5% of Target
Greater than 5% from Target

*	Favourable Trend from Previous Quarter
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OUTPUT CLASS 3: Intensive Assessment and Treatment Services	Target	Baseline	Total	Maori	Pacific	Other
% of high-risk patients will receive an angiogram within 3 days of admission.	≥ 70%	74%	63%	70%	-	63%
ACS Left Ventricular Dysfunction (LVEF) assessments >85% of ACS patients who undergo coronary angiogram have pre-discharge assessments of LVEF.	≥ 85%	51%	82%	65%	100%	85%
Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance all ACS patients who undergo coronary angiogram should be prescribed, at discharge, aspirin, a second anti-platelet agent, statin and an ACE/ARB (four classes) and those with LVEF <40% should also be on a beta blocker (five classes)	≥ 85%	66%	55%	33%	67%	58%
% of potentially eligible stroke patients who are thrombolysed 24/8	≥ 10%	6%	20%	11%	-	-
% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	≥ 80%	88%	83%	75%	-	-
% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	≥ 80%	38%	100%	100%	-	-
Major joint replacement	≥ 21	22.4	19.77	No Ethnicity Data		
Cataract procedures	≥ 27	46.6	47.04			
Cardiac surgery	≥ 6.5	4.8	5.32			
Percutaneous revascularisation	≥ 12.5	11.9	12.67			
Coronary angiography services	≥ 34.7	36.4	38.09			
Length of stay Elective (days)	≥ 1.45	1.52	1.57			
Length of stay Acute (days)	≥ 2.3	2.39	2.4			
Acute readmissions to hospital	≤ 12%	7%	12%	11%	11%	13%
% accepted referrals for elective coronary angiography completed within 90 days	≥ 95%	88%	98%	-	-	-
% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive).	≥ 90%	94%	94%	-	-	-
% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)	≥ 70%	59%	54%	-	-	-
% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date	≥ 70%	68%	60.0%	-	-	-
Did not attend (DNA) rate across first specialist assessments	≤ 7.5%	5%	6.3%	12.2%	12.2%	4.1%
% of 0-19 year olds seen within 3 weeks of referral: Mental Health Provider Arm	≥ 80%	73%	76%	80%	100%	71%
% of 0-19 year olds seen within 3 weeks of referral: Addictions (Provider Arm and NGO)	≥ 80%	72%	73%	67%	100%	82%
% of 0-19 year olds seen within 8 weeks of referral: Mental Health Provider Arm	≥ 95%	91%	93%	95%	100%	92%
% of 0-19 year olds seen within 8 weeks of referral: Addictions (Provider Arm and NGO)	≥ 95%	96%	98%	95%	100%	100%
Rate of s29 orders per 100,000 population	≤ 375	398	-	385	141	115
Total acute hospital bed days per capita (per 1,000 population)	≤ 530	378	407	588	494	364
Number of publicly funded, casemix included, elective and arranged discharges for people living within the DHB region	≥ 1,906	1,859	1,710	No Ethnicity Data		

Document Owner: Chris Ash

November 2018
Section 4
1

Board Meeting 28 November 2018 - HBDHB Performance Framework Exceptions Report (Q1 Jul-Sept)

OUTPUT CLASS 4: Rehabilitation and Support Services				Target	Baseline	Total	Maori	Pacific	Other	
Acute readmission rate: 75 years +		TBC	13%	13%	*	11%	*	9%	*	13%
Time from referral receipt to initial Cranford Hospice contact within 48 hours	≥ 80%	98%	100%	*	-	-	-	-	-	-
% of older patients given a falls risk assessment	≥ 90%	98%	90%	No Ethnicity Data						
% of older patients assessed as at risk of falling receive an individualised care plan	≥ 90%	96%	91%							

Not Reported in Q1			
% of new-borns enrolled in General Practice by six weeks of age		Reported in Q2	
% of new-borns enrolled in General Practice by three months of age			
Acute rheumatic fever initial hospitalisation rate per 100,000	≥ 1.5	2.48	
		Reported in Q4	
% of eligible pre-school enrolments in DHB-funded oral health services	≥ 95%	89%	Reported in Q4
% of children who are carries free at 5 years of age	≥ 64%	59%	
% of enrolled preschool and primary school children not examined according to planned recall	≤ 10%	3%	
% of adolescents(School Year 9 up to and including age 17 years) using DHB funded dental services	≥ 85%	76%	
Mean 'decayed, missing or filled teeth (DMFT)' score at Year 9	≤ 96%	81%	
Proportion of people with diabetes who have good or acceptable glycaemic control (HbA1C indicator)	≥ 65%	65%	Reported in Q2
% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.	≥ 60%	0%	Reported in Q2
Proportion of the population seen by mental health and addiction services: Child & Youth (0-19)	≥ 0%	4.3%	Reported in Q2
Proportion of the population seen by mental health and addiction services: Adult (20-64)	≥ 0%	5%	
Proportion of the population seen by mental health and addiction services: Older Adult (65+)	≥ 0%	1%	
% of clients discharged will have a quality transition or wellness plan	≥ 95%	93%	Reported in Q2
Response rate for Patient Experience Surveys - inpatient and general practice		0	Reported in Q4
Number of publicly funded, casemix included, elective and arranged discharges for people living within the DHB region		0	Awaiting Data from MoH
Rate of carer stress :Informal helper expresses feelings of distress = YES, expressed as a % of all Home Care assessments	Reported in Q2		
% of people having homecare assessments who have indicated loneliness			
Conversion rate of Contact Assessment(CA) to Home Care Assessment where CA scores are four-six for assessment urgency			
Clients with a Change in Health, End-stage Disease, Signs and Symptoms) (CHESS) score of four or five at first assessment			



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:

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
27. Chair's Update
28. Radiology Facility Development Business Case Financials
29. Health Equity Report
30. Pasifika Health Leadership Group
31. Māori Relationship Board
32. HB Health Consumer Council
33. HB Clinical Council
34. Finance Risk and Audit Committee

The general subject of the matter to be considered while the public is excluded, the reason for passing this resolution in relation to the matter and the specific grounds under Clause 32(a) of the New Zealand Public Health and Disability Act 2000 for the passing of this resolution are as follows:

- Official Information Act 1982 9(2)(ba) to protect information which is subject to an obligation of confidence.
- Official Information Act 1982 9(g)(i) to maintain the effective conduct of public affairs through the free and frank expression of opinions between the organisation, board and officers of the Minister of the Crown.
- NZPHD Act 2000, schedule 3, clause 32(a), that the public conduct of the whole or relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7 or 9 (except section 9(2)(g)(i) of the Official Information Act 1982).

