BOARD MEETING

Date: Wednesday 26 June 2019

Time: 1:30pm

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

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

Apologies:

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

Minute Taker: Jacqui Sanders-Jones, Board Administrator

Public Agenda

Item	Section 1: Routine	Ref #	Time (pm)
1.	Welcome and Apologies		1:30
2.	Interests Register		
3.	Minutes of Previous Meeting 29 May 2019		
4.	Matters Arising - Review of Actions		
5.	Board Workplan		
6.	Chair's Report (verbal)		
7.	Chief Executive Officer's Report – Kevin Snee	61	

8.	Financial Performance Report – Carriann Hall, ED Financial Services	62	
9.	9.0 Board Health & Safety Champion's Update - Board Safety Champion 9.1 H& S Action Register		
	Section 2: Governance / Committee Reports		
10.	Te Pitau Health Alliance HB Update – Ana Apatu/Hine Flood	63	2:00
11.	Māori Relationship Board report– Chair, Heather Skipworth	64	2:05
12.	HB Health Consumer Council report– Chair, Rachel Ritchie	65	2:15
13.	HB Clinical Council report– Co-Chairs, John Gommans & Julie Arthur	66	2:20
	Section 3: For Decision		
14.	Person & Whanau Centred Care actions - Kate Coley	67	2.25
15.	Moving Equity Forward – Bernard Te Paa	68	2.35
16.	HBDHB Annual Plan – Chris Ash/Kate Rawstron 16.1 Annual Plan Part B	69	2.45
	Section 4: For Information & Discussion		
17.	HB Health Strategy feedback session (round 2)– Chris Ash/Kate Rawstron 17.1 Draft HB Health Strategy 17.2 Equity Framework – Bernard Te paa 17.2.1 Equity Framework Document 17.2.2 Equity Framework Process diagram	70	2.55
18.	He Ngakau Aotea – Bernard Te Paa 18.1 He Ngakau Aotea draft report 18.2 He Ngakau Aotea Priorities & Impacts	71	3.35
19.	2019 HBDHB Elections Update – Ken Foote 19.1 DHB Elections Appendices	72	3.45
	Section 4: For Information		
20.	Mental Health Zero Seclusion– John Burns/Peta Rowden		3.50
21.	**Section 5: Recommendation to Exclude the Public** Under Clause 32, New Zealand Public Health & Disability Act 2000		

Public Excluded Agenda

Item	Section 6: Routine	Ref #	Time (pm)
22.	Minutes of Previous Meeting 29 May 2019 (public excluded)		3.55
23.	Matters Arising (public excluded) – Review of Actions		-
24.	Board Approval of Actions exceeding limits delegated by CEO	73	-
25.	Chair's Update (verbal)		
26.	HB Clinical Council report (public excluded)	74	4.00
27.	Màori Relationship Board report (public excluded)	75	4.05
	Section 7: For Information/Decision		
28.	Finance Risk and Audit Committee – Chair, Dan Druzianic	76	4.15
	Meeting concludes		

The next HBDHB Board Meeting will be held at
1.30pm on Wednesday 31 July 2019

Our shared values and behaviours

HE KAUANUANU RESPECT
ĀKINA IMPROVEMENT
RARANGA TE TIRA PARTNERSHIP
TAUWHIRO CARE

HE KAUANUANU RESPECT

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

	✔	✘
Welcoming	Is polite, welcoming, friendly, smiles, introduce self Acknowledges people, makes eye contact, smiles	Is closed, cold, makes people feel a nuisance Ignore people, doesn't look up, rolls their eyes
Respectful	Values people as individuals; is culturally aware / safe Respects and protects privacy and dignity	Lacks respect or discriminates against people Lacks privacy, gossips, talks behind other people's backs
Kind	Shows kindness, empathy and compassion for others Enhances peoples mana	Is rude, aggressive, shouts, snaps, intimidates, bullies Is abrupt, belittling, or creates stress and anxiety
Helpful	Attentive to people's needs, will go the extra mile Reliable, keeps their promises; advocates for others	Unhelpful, begrudging, lazy, 'not my job' attitude Doesn't keep promises, unresponsive

ĀKINA IMPROVEMENT

*Continuous **improvement** in everything we do*

	✔	✘
Positive	Has a positive attitude, optimistic, happy Encourages and enables others; looks for solutions	Grumpy, moaning, moody, has a negative attitude Complains but doesn't act to change things
Learning	Always learning and developing themselves or others Seeks out training and development; 'growth mindset'	Not interested in learning or development; apathy "Fixed mindset, 'that's just how I am', OK with just OK
Innovating	Always looking for better ways to do things Is curious and courageous, embracing change	Resistant to change, new ideas; 'we've always done it this way'; looks for reasons why things can't be done
Appreciative	Shares and celebrates success and achievements Says 'thank you', recognises people's contributions	Nit picks, criticises, undermines or passes blame Makes people feel undervalued or inadequate

RARANGA TE TIRA PARTNERSHIP

*Working together in **partnership** across the community*

	✔	✘
Listens	Listens to people, hears and values their views Takes time to answer questions and to clarify	'Tells', dictates to others and dismisses their views Judgmental, assumes, ignores people's views
Communicates	Explains clearly in ways people can understand Shares information, is open, honest and transparent	Uses language / jargon people don't understand Leaves people in the dark
Involves	Involves colleagues, partners, patients and whanau Trusts people; helps people play an active part	Excludes people, withholds info, micromanages Makes people feel excluded or isolated
Connects	Pro-actively joins up services, teams, communities Builds understanding and teamwork	Promotes or maintains silo-working 'Us and them' attitude, shows favouritism

TAUWHIRO CARE

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

	✔	✘
Professional	Calm, patient, reassuring, makes people feel safe Has high standards, takes responsibility, is accountable	Rushes, 'too busy', looks / sounds unprofessional Unrealistic expectations, takes on too much
Safe	Consistently follows agreed safe practice Knows the safest care is supporting people to stay well	Inconsistent practice, slow to follow latest evidence Not thinking about health of our whole community
Efficient	Makes best use of resources and time Respects the value of other people's time, prompt	Not interested in effective user of resources Keeps people waiting unnecessarily, often late
Speaks up	Seeks out, welcomes and give feedback to others Speaks up whenever they have a concern	Rejects feedback from others, give a 'telling off' 'Walks past' safety concerns or poor behaviour

Board "Interest Register" - as at 13 March 2019

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

Board Member Name	Current Status	Conflict of Interest	Nature of Conflict	Mitigation / Resolution Actions	Mitigation / Resolution Actions Approved by	Date Conflict Declared
Diana Kirton	Active	Brother, John Fleischl, is a Senior Medical Officer (surgeon) employed by HBDHB.	Perceived Conflict of Interest. Non-Pecuniary interest.	Will not take part in any decisions in relation to surgical services provided by or contracted by HBDHB. All employment matters in relation to John Fleischl are the responsibility of the CEO	The Chair	18.02.09
	Active	Employee of Eastern Institute of Technology (EIT), Practicum Manager, School Health and Sports Science from 3 Feb 2014	Non-pecuniary interest: Organises student practicum placements with some HBDHB funded health providers.	Declare this prior to any discussion in relation to EIT in the area of interest, and an appropirate mitigation action is decided on.	The Chair	16.01.14
	Active	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 coveres 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	Kaumatua - Kaupapa Maori HBDHB	All employment matters are the responsibility of the CEO	The Chair	04.02.14
	Active	Trustee of Te Timatanga Ararau Trust (aligned to Iron Maori Limited)	The Trust has contracts with HBDHB including the Green Prescription Contract; 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 Whararíki Trust (a member of Takitimu Ora Whanau Collective)	A relationship which may be contractural from time to time	Will advise of any perceived or real conflict prior to discussion	PCDP Chair	5.12.16
	Active	Whakaraki Trust "HB Tamariki Health Housing fund"	Formed a relationship and MoU with HBDHB Child Health Team Community Women and Children's Directorate. The Trust created a "HB Tamariki Health Housing fund" to ensure warm dry homes for Hawke's Bay whanau.	Will advise at the outset of any discussions on this topic, and will not take part in any decisions / or financial discussions relating to this arrangement.	The Chair	8.08.18
Hine Flood	Active	Member, Health Hawkes Bay Priority Population Committee	Pecuniary interest - Oversight and advise on service delivery to HBH priority populations.	Will not take part in any conflict of interest that may arise or in relation to any contract or financial arrangement with the PPC and HBDHB	The Chair	14.02.17
	Active	Councillor for the Wairoa District Council	Perceived Conflict - advocate for the Wairoa District population and HBDHB covers the whole of the Hawkes Bay region.	Declare this interest prior to any discussion on the specific provision of services in Wairoa and Chair decides on appropriate mitigation action.	The Chair	14.02.17

MINUTES OF THE BOARD MEETING
HELD ON WEDNESDAY 29 MAY 2019, IN THE TE WAIORA ROOM,
DHB ADMINISTRATION BUILDING, MCLEOD STREET, HASTINGS
AT 1.30PM

PUBLIC

Present:	Kevin Atkinson (Chair) Dan Druzianic Dr Helen Francis (via teleconference) Peter Dunkerley Diana Kirton Barbara Arnott Heather Skipworth Ana Apatu Hine Flood
Apology	Ngahiwi Tomoana (Deputy Chair), Jacoby Poulain
In Attendance:	Kevin Snee (Chief Executive Officer) Members of the Executive Management Team Rachel Ritchie (Chair, HB Health Consumer Council) Members of the public and media Jacqui Sanders-Jones, Board Administrator

APOLOGY

Apologies received from Ngahiwi Tomoana (Deputy Chair) and Jacoby Poulain

2. INTEREST REGISTER

No changes to the interests register were advised

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

3. CONFIRMATION OF PREVIOUS MINUTES

The minutes of the Board meeting held on 24 April 2019, were confirmed as a correct record of the meeting, with small amendment made to Consumer Council report and Health & Safety Champions reference to HDU: ICU bed ratio

Moved: **Barbara Arnott**
Seconded: **Ana Apatu**
Carried

4. MATTERS ARISING FROM PREVIOUS MINUTES

Item 1: **Consumer Experience Facilitators –** for June Workplan incorporated with Person & Whanau Centred Care

Item 2: **Oral Health team project –** included on May agenda item 'Tò Waha'

Item 3: **Person & Whanau Centred Care –** for June Workplan

Item 4: **State Services Commission letter on 'Speaking Up' model of standards –** CEO confirmed that this letter has been circulated to the management team and once feedback collated, a report will return to Board. Remain as action.

Item 5: **Performance Measures –** remove from Workplan

Item 6: **Health & Safety Action Register included onto agenda as regular monthly item –** Complete (remove)

Item 7: **Te Pìtau Alliance query –** Primary care directorate were aware of the review and have been fully engaged by HHB throughout the process. Actions from the review will inform the work of Te Pitau going forward, and the Te Pitau Governance Group have been offered the opportunity by HHB for a high level presentation on the overall findings. Action complete.

Item 8: **MRB Workshop follow up** – recommendations to be further considered by MRB in June. For Board June Workplan 'Moving Equity Forward'.

Item 9: **Three Waters discussion** – Nick Jones provided a written response to the questions posed by Napier City Council Three Waters project team at last month's HBDHB board meeting.

Collaboration between stakeholders is good, however there is a need to review the impact on equity more deliberately. A review of the proposed models has been suggested, highlighting the importance of addressing specific social requirements.

In regards to the key criteria for options assessment, it was proposed to add:

1. Equity in terms of economic, social and health impacts on disadvantaged members within a community as well as impacts on disadvantaged communities as a whole.
2. Contribution to sustainable development and long-term environmental impacts.
3. Ability to deliver on statutory duties (i.e. Local Government Act, Health Act, Resource Management Act etc.).

Discussion followed around criteria for a Council Controlled Organisation (CCO) with particular consideration of communities in Wairoa and CHB communities, feeling that if decision is made purely at a regional level then it will not have enough localised consideration to really benefit rural communities.

RECOMMENDATION

That the HBDHB **Board**:

Note the content of this response.

Adopted.

5. BOARD WORK PLAN

The Board Work Plan was noted, with the following comments made:

- Carriann Hall, Executive Director of Financial Services, informed Board that the Financial Annual Plan will be reviewed this coming month through circular resolution so as to be signed off by HBDHB Board for 21 June.
- Board members then raised concern over the Annual Plan (draft) coming to board today without going through committees first, especially as a lot of management time and energy is spent on this planning.

  The Annual Plan incorporates the expectations from the Minister of Health whilst also being able to fund the resources required to achieve these. Service Level Measures, Service Plans and Executive Challenges for the service directorates of HBDHB have all contributed to its development.

6. CHAIR'S REPORT

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

Name	Role	Service	Years of Service	Retired
Cathy Long	RN	Mental Health Directorate	41	Y

- Chair received a letter from the Minister of Health regarding impairment of National Oracle Solution (NOS), giving direction to include the impairment in June accounts. This will have financial impact on the end of year results.
- Central Region Service Plan signed and approved for 2018/19
- Chair, Helen Francis & Barbara Arnott recently received correspondence from Ken Gilligan, CEO of City Medical in Napier, noting HBDHB's exit from contract with them. CEO reported that he met with City Medical this week to discuss how they can work constructively together. It was felt to be a positive conversation with a trusted partner.
- Board agreed that there could be more positive 'people' stories on social media for HBDHB. E.g. an interview with retiree, Cathy Long shared on Facebook page of HBDHB will have positive impact on staff and public.
  ACTION: Comms team to follow up with Cathy Long and share on HBDHB social media.

7. CHIEF EXECUTIVE OFFICER'S REPORT

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

- The RDA & DHBs in facilitation over further industrial action.
- In regards to the Oranga Tamariki (OT) incident, CEO confirmed that HBDHB are not able to prevent an uplift; our role is to provide care to mother and child. CEO wanted to be clear in the DHB role and noted thanks to our staff in their response to the situation.
- Matching Capacity to Demand; CEO provided past copies of 'In Focus' bulletins to provide information to staff on how blockages to patient flow are being addressed. CEO introduced John Burns as new Executive Director of Provider Services to ensure expedited implementation of these measures and ensure readiness for winter impact.
- Activity and targets; Noted that elective surgeries have been disrupted by strike action and that waiting lists are further affected by this. Immunisation rates for Hawke's Bay are holding up well compared to rest of New Zealand.

RECOMMENDATION

That the Board

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

Adopted.

8. FINANCIAL PERFORMANCE REPORT

Carriann Hall, Executive Director of Financial Services, spoke to the Financial Report for April 2019, which showed a $0.5m unfavourable variance to budget, taking the year to date (YTD) result to $7.7m deficit.

Comments noted in addition to the report included:

- 'Invest to Save' activities are key for 19/20
- Impact of Holidays Act yet to be determined.
- NOS impairment of $2.7m to be applied to end of year results.
- Costs of SMO cover during the strike has significant impact on financials

RECOMMENDATION:

That the HBDHB Board
Note the contents of this report

Adopted.

9. PEOPLE & QUALITY DASHBOARD Q3 (Jan – Mar 19)

Kate Coley, Executive Director of People & Quality presented the People and Quality Q3 report and dashboard during Finance, Risk & Audit Committee. Dashboard provided here for information only.

10. HEALTH & SAFETY BOARD CHAMPION'S UPDATE

- Robin Whyman advised that the adverse event that led to the recommendations regarding airway equipment, recommended immediate purchase of additional blades for the Emergency Department (ED) existing CMAC equipment and he had been advised this occurred quickly after the event review.
  There was also a recommendation to consider standardising airway equipment in ED.
  Upgraded and standard video laryngoscope equipment for ICU and ED was added to the minor capital equipment list for 19/20. Subsequently the current ED system began to experience technical issues in the last 2 weeks and so the capital request was re-visited and approved within the 18/19 year. The ICU equipment will also be purchased at the same time to meet the standardisation recommendation.

- Barbara agreed to extend her Board Health & Safety Champion representation to 31 July 2019. Heather Skipworth to also take on this role from 1 June 2019.

10.1 Action Register

Both Action point remain as outstanding, with Chair highlighting that action is required and these should be addressed ready for update as to progress in June.
Acknowledged that the capital equipment budget of $3.4m is completely allocated. However, it is noted that new stretchers are been trialled with view to replacement of older stock and funding is being worked through.

SECTION 2: GOVERNANCE/COMMITTEE REPORTS

11. TE PĪTAU HEALTH ALLIANCE (HAWKE'S BAY)

Chris Ash, Executive Director of Primary Care, spoke on matters discussed at the Alliance Governance Group meeting on Wednesday 8 May 2019. Two main points of discussion included:

- The resolution on Service Level Measures will take effect in July 2019.

- End of life care redesign continues with good engagement from external stakeholders.

RECOMMENDATION

That the HBDHB Board:

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

Adopted.

11.1 Te Pitau Alliance Governance Group Membership

Ken Foote, Company Secretary spoke to paper requesting approval of realignment of current appointments to be extended to December 2019, so that members have an operating timeline of one year (as technically this has elapsed). All members were approached offline and all agreed.

RESOULTION

That the HBDHB Board:

• **Approve** the extension of the term of the initial appointees to the Te Pìtau Health Alliance Governance Group from June 2019 to December 2019.

• **Agree** that the first 'annual review' of the Governance Group membership be undertaken with effect from December 2019.

Moved: Heather Skipworth

Seconded: Peter Dunkerley

Carried.

12. MĀORI RELATIONSHIP BOARD (MRB)

Heather Skipworth as Chair of MRB spoke on matters discussed at their meeting held Wednesday 8 May 2019.

- George Mackey has resigned.
- Health Strategy draft received and feedback of 'community led and co-design' being recognised as important initial discussions in the process.
- Tò Waha collaborative approach and the move to set up a clinic for those with unmet need within oral care services was well supported by MRB.
- Child Health Kaupapa supported, to track progress of child health activity across the organisation.
- Statements for recommendations on Equity were discussed and following some further refinement, will come back to Board in June.

13. PASIFIKA HEALTH LEADERSHIP GROUP (PHLG)

Bernard Te Paa, Executive Director of Health Improvement & Equity, provided an overview of the meeting held Monday 20 May 2019, supported by Talalelei Taufale.

- ***ALCOHOL SCREENING***

Wi Ormsby, Health Promoter Health Hawke's Bay provided an update on the work being undertaken with general practices on alcohol brief interventions and the new screening tool being rolled out late-May. A

recent survey of doctors and nurses revealed that 70% expressed their concern around patient alcohol levels. PHLG advised that alcohol is a big concern for the Pasifika community; noting ease of accessibility. There are also cultural barriers that need to be addressed.

Health Hawkes Bay will be trialling an amended assessment tool to improve engagement with whanau/ fono/ families.

- ***DRAFT HB STRATEGY***

Members provided feedback to the Draft HB Strategy including some commentary noting:

- Wording to be better identified throughout the document that advocates and influences health across all intersectoral agencies
- Good connection to wider whānau and not just engagement with individuals
- Approach is inclusive of how we engage and work with Pacific communities
- Equity - ensure wording is inclusive to Pasifika across all areas of the Strategy, such as 'double the funding of kaupapa Maori ***and Pasifika services"***
- "Pasifika" needs to be applied and be inclusive across all areas of the Strategy

- ***PHLG WORKPLAN APRIL 2019 – JUNE 2020***

Feedback was sought on the updated Workplan, its four priority areas, goals and key actions, the priority areas being:

- Engaged Pacific communities
- Enhanced DHB and health services understanding of Pacific people
- Promoting the value of the Pacific health workforce
- Targeted initiatives to positively improve Pacific health outcomes

With some additional amendments noted, the PHLG were in agreement and endorsed the PHLG 2019-20 Workplan. Regular progress updates are to be provided quarterly at the PHLG meetings.

14. HAWKE'S BAY HEALTH CONSUMER COUNCIL

Rachel Ritchie, Chair of Consumer Council advised the outcomes of their meeting held on Thursday 9 May 2019.

- Daisy Hill joining next month from Hastings District Youth Council
- Shared the good news story that the DHB's Heart Function Clinic changed its name from Heart Failure Clinic as a positive response to consumer feedback.
- Health Strategy – great input from Consumer Council with several themes highlighted.
- After Hours Care Service was discussed but felt this needed wider discussion with Consumer Council as progress is made with this work.
- Te Ara Whakawaiora redesign of reporting was well supported by committee.

RECOMMENDATION

That the **HBDHB Board:**
Note the content of the report.

Adopted.

15. HAWKE'S BAY CLINICAL COUNCIL

Robin Whyman, Chief Medical & Dental Officer (Hospital) spoke to the report from the Clinical Council's meeting held on Wednesday 9 May 2019, on behalf of Dr Gommans and Julie Arthur who had apologised for non-attendance. Topics of discussion included:

- Health Strategy discussion and feedback highlighting need for better visibility of acute demand and aging in the document.
- Workforce survey from PHO shows challenges for GPs.

RECOMMENDATION

That the **HBDHB Board:**
Note the content of the report.

Adopted.

SECTION 3: FOR INFORMATION & DISCUSSION

16. HB HEALTH STRATEGY FEEDBACK SESSION

Chris Ash, Executive Director of Primary Care, supported by Kate Rawstron, Head of Planning & Strategic Projects & Hayley Turner, Corporate Portfolio Manager, talked of the enriching experience of working this first round of health strategy through the committees, collating great feedback. Every piece of feedback has been taken into consideration and inventory constructed on how it has been worked into the refreshed health strategy document ready for second round through committees.

Discussion followed with the following points noted:

- Simplification – proposal of an A3 one pager being concise, easy to read with appendices as required. Marketing collateral of this strategy needs to be addressing different communities and audiences, and provide information within a 'single picture'.
- Recognised the good planning in this document, but the implementation needs to be the most important document in this process.
- System goals and objectives should be prominent and have less narrative around these.
- Consumer want to know what's useful, what's reflected in the goals; and language used for this is crucial
- Too much jargon- needs to be simpler language. Particularly the Information Technology section. The general public and staff are the two streams to concentrate language approach on.

Health Strategy draft is coming back to committees in June and July and then back to Board in July for final sign off. Implementation plan preparation discussions with stakeholders will be taking place shortly.

17. HBDHB ANNUAL PLAN

Chris Ash, Executive Director of Primary Care alongside Kate Rawstron, Head of Planning & Strategic Projects & Robyn Richardson, Principal Planner, referred to the complete planning pack which was distributed with board papers.

By pulling together actions from several different plans around the organisation, the annual plan was produced and has been checked against our equity obligations, assuring this plan addresses closure of the equity gap.

Discussion followed on the rationale in terms of the Clinical Services Plan in getting services prioritised within the community and risks associated, with the Chief Financial Officer confirming that governance groups will ensure the correct input and prioritisation of services.

RECOMMENDATION

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

Noted

18. HBDHB Non-Financial Framework Dashboard Q3

Provided for information only and noted.

19. HBDHB Performance Framework Exceptions Report Q3

Chris Ash, Executive Director of Primary Care added:

- Working closely with Business Intelligence team to develop improved and concise reporting as this mode of reporting doesn't support assurance.
- Chair noted and thanked contributors towards this report, recognising the work that goes into producing this.

RECOMMENDATION

It is recommended that the HBDHB Board:
Note the contents of this report

Adopted.

20. TE ARA WHAKAWAIORA CHILD HEALTH COMBINED REPORT

Patrick le Geyt, General Manager of Maori Health, explained that following review in 2018, reports have been consolidated into four areas; Child Health, Mental Health, Adult Health and Cultural Responsiveness.

Reaffirmed the four EMT champions and each spoke to their particular indicator:

- **0 – 4 ASH indicators**
  Chris Ash, Executive Director of Primary Care, explained that specific gaps have been identified within respiratory areas of child health. These are being addressed as actions with some included within the Healthy Housing programme. Respiratory project showed there was further follow up in Primary Care required. Some resource is now being allocated to this and every presentation is being followed up.

- **Dental**
  Robin Whyman Chief Medical & Dental Officer (Hospital), addressed the preschool phase and enrolment of service for preventative care. Whilst there was a positive 96% enrolment, the challenges lie in ongoing care and follow up appointments. Performance indicators on preventative care activities are at higher rate for Maori/Pasifika children. Challenges appear at Pasifika >5 year olds due to difficulties in connection with harder to reach families. Year 8 outcomes (permanent teeth) shows equity gaps closing substantially, whoever preschool remains a challenge.

- **Breast Feeding**
  Chris McKenna, Chief Nursing & Midwifery Officer reported a consumer driven change throughout teams (Provider, PHO etc.) with further support in communities recognised as a requirement.

Breast feeding map now online through DHB Facebook page, which shows where mothers can get support across the Bay.

- **Healthy Weights Programme**
  Patrick le Geyt gave an update on the Healthy weights programme, which is included in the 'before school checks'. If a child is found to be outside of normal range, they are guided to an appropriate service.

RECOMMENDATION

It is recommended that the HBDHB Board:
1. **Note** the contents of the report.
2. **Note** the planned improvements and activities over the next 12 months to achieve equitable Health outcomes for tamariki.
3. **Support** the intention to establish a Child Health kaupapa to bring a more cohesive and collaborative approach to track progress and improve effectiveness in child health activities across the organisation.

Adopted.

21. TŌ WAHA – A WHANAU CENTRED COLLABORATIVE APPROACH

Patrick le Geyt, General Manager Maori Health, reported that following the Oral Health initiative with the NZ Defence Force, the team have reviewed the successes, gaps and opportunities which will be now be taken forward, with fundamental acknowledgment that a collaborative approach provides a better outcome with our high need communities. 700+ patients seen as part of the initiative.

This initiative is Hastings based, looking to reach out to CHB, Wairoa and Napier. Resources will be reviewed on how Màori Health can redesign the whànau dental services which are currently contracted out. High needs areas are to be specifically targeted.
Patient files are created for each of those patients seen and on wait list, and will be followed up and handed over to a dental service so as to ensure tracking of patients following treatment. Prevention and use of hygienist will be part of the proposed oral package of care.

Community champions being available to assist with form filling and comfort of patients made a real difference to the attendance of consumers. Great to see such a unity of health provision.

Charitable Tò Waha clinic proposed to be set up to continue this work, with suggestion from Chair to investigate establishment of a Tò Waha Charitable Trust.
ACTION: Patrick to investigate the set up and benefits of establishment of Tò Waha Charitable Trust.

RECOMMENDATION

It is recommended that the **HBDHB Board:**
1. **Note** the key learnings, successes, and unrealised opportunities of the Tō Waha kaupapa
2. **Support** the intention to:
I. Set up a Tō Waha clinic for essential dental care for whānau with unmet need.
II. Develop a long term sustainable Whānau Ora oral health service for adults, with strong links to primary health care and prevention.

Adopted.

SECTION 4: FOR INFORMATION

22. AFTER HOURS CARE SERVICE UPDATE

Provided for information only and noted.

GENERAL BUSINESS

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

SECTION 5: RECOMMENDATION TO EXCLUDE

23. RECOMMENDATION TO EXCLUDE THE PUBLIC

RECOMMENDATION

That the Board

Exclude the public from the following items:

24. Confirmation of Minutes of Board Meeting
25. Matters Arising from the Minutes of Board Meeting 24 April 2019
26. Board Approval of Actions exceeding limits delegated by CEO
27. Chair's Update
28. Finance Risk and Audit Committee Report

Moved: **Peter Dunkerley**
Seconded: **Heather Skipworth**
Carried

The public section of the Board Meeting closed 3.55pm

Signed: _____

Chair

Date: _____

BOARD MEETING - MATTERS ARISING
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	28/11/18	Schedule Consumer Experience Facilitators to attend the May 2019 Board meeting as members would like to hear about their work.	Kate Coley	June 19	Included in FRAC's Clinical Quality & Patient Safety report for June 2019
2	27/03/19	Person & Whanau Centred Care EMT to: Advocate for national changes and consider local changes to current funding models and other disincentives to providing PWCC in primary and community care Ensure PWCC becomes the norm; to do that, present a paper to the June 2019 Board meeting that: Enables the identification and freeing up of appropriate resources to prioritise the development of PWCC across the HB health sector Prioritises the provision of specific education and training to the HB health workforce on implementing PWCC Facilitates raising the levels of PWCC awareness within HB communities and empowering consumers to partner in their own care and contribute to service developments	Kate Coley	June 2019	For inclusion on Workplan – June 19
3	24/04/19	State Services Commission letter on 'Speaking Up – Model of Standards' CEO to obtain feedback from EMT and report to Board	CEO	June 2019	
4	24/40/19	MRB Workshop follow up MRB Recommendations to Board following Workshops	Bernad Te Paa	June 2019	Recommendations to be further considered by MRB in June and brought to June Board mtg

Action	Date Entered	Action to be Taken	By Whom	Month	Status
5	24/04/19	Three Waters discussion As a stakeholder in this project, HBDHB is providing feedback from Nick Jones on the 'preferred option recommendations' once received from the Three Waters project team.	Nick Jones	Tbc	Awaiting final recommendation from Three Waters project team
6	29/05/19	Comms team To make contact with recent retiree Cathy Long (41 years service) and interview for a 'good news story' for sharing via social media.	Anna Kirk	June 2019	
7	29/05/19	Tò Waha Charitable Trust Further investigate the set up and benefits of establishment of Tò Waha as a Charitable Trust	Patrick le Geyt	July 2019	

GOVERNANCE WORKPLAN PAPERS

17-Jun-19

BOARD MEETING 26 JUNE 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Finance Report (May)		Carriann Hall	Chris	18-Jun-19				26-Jun-19	26-Jun-19
He Ngakau Aotea		Bernard Te Paa		4-Jun-19	12-Jun-19				26-Jun-19
Person & Whanau Centered Care actions		Kate Coley		11-Jun-19		12-Jun-19	13-Jun-19	26-Jun-19	26-Jun-19
Moving Equity Forward (MRB Workshop outcomes (**MRB & Board only**))		Bernard T Paa			12-Jun-19				26-Jun-19
HBDHB Annual Plan 19/20		Chris Ash	Kate Rawstron		12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19
HBDHB Elections update		Ken Foote							26-Jun-19
Mental Health - zero seclusion		John Burns	Peta Rowden	4-Jun-19					26-Jun-19
Strategy Feedback round 2 (30mins each committee/45 min MRB, with 20mins added for Equity Frameowrk)		Chris Ash/Bernard Te Paa	Kate Rawstron/Hayley Turner	18-Jun-19	12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19

BOARD MEETING 31 July 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Finance Report (Jun)		Carriann Hall	Chris	16-Jul-19				31-Jul-19	31-Jul-19
Te Ara Whakawaiora -Cultural Responsiveness (inc did not attend, cultural competent workforce)	E	John Burns	Jacqui Mabin	2-Jul-19	10-Jul-19				31-Jul-19
Whole of Board Appraisal (progress against actions Nov 17) - Apr-Aug		Ken Foote							31-Jul-19
VIP/Family Harm report		Bernard Te Paa		25-Jun-19	10-Jul-19	10-Jul-19	11-Jul-19		31-Jul-19
Strategy Feedback round 3 (30mins each committee/45 min MRB, with 20mins added for Equity Frameowrk)					10-Jul-19	10-Jul-19	11-Jul-19		31-Jul-19

BOARD MEETING 28 AUGUST 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Alcohol Harm Reduction Strategy (6 monthly update) Feb **- Aug**		Bernard TePaa	Rachel Eyre	13-Aug-19	14-Aug-19	14-Aug-19	15-Aug-19		28-Aug-19
Annual Plan 2019/20		Chris Ash	Robyn Richardson	6-Aug-19	14-Aug-19	14-Aug-19	15-Aug-19		28-Aug-19
People & Quality Dashboard Q4 (Apr-Jun 19) Feb-May-**Aug**-Nov (formerly HR KPI Rpt)	E	Kate Coley	Jim Scott	13-Aug-19					28-Aug-19
Finance Report(July)		Carriann Hall	Chris	20-Aug-19				28-Aug-19	28-Aug-19
HB Health Strategy - approval		Chris Ash	Kate Rawstron	13-Aug-19	14-Aug-19	14-Aug-19	15-Aug-19		28-Aug-19
NZ Health Partnership - SPE focus		Carriann Hall						28-Aug-19	28-Aug-19
HB Health Awards - preparation for judging **2019**-2020	E	Kevin Snee	Anna Kirk	30-Jul-19		14-Aug-19	15-Aug-19		28-Aug-19
HBDHB Non-Financial Performance Framework Dashboard Q4 - **EMT/Board**	E	Chris Ash	Peter MacKenzie	20-Aug-19					28-Aug-19
HBDHB Performance Framework Exceptions Q4 Feb19 /May/**Aug**/Nov (Just in time for MRB Mtg then to EMT)	E	Chris Ash	Peter McKenzie	13-Aug-19	14-Aug-19				28-Aug-19

BOARD MEETING 25 SEPTEMBER 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Finance Report (Aug)		Carriann Hall	Chris	17-Sep-19				25-Sep-19	25-Sep-19
Matariki HB Regional Development Strategy and Social Inclusion Strategy update (6 mthly) **Sept**-Mar	E	Bernard TePaa	Shari Tidswell	27-Aug-19	11-Sep-19	11-Sep-19	12-Sep-19		25-Sep-19
After Hours Urgent Care Service Update 6mthly (Sept-Mar-Sept) last one in cycle	E	Wayne Woolrich		27-Aug-19	11-Sep-19	11-Sep-19	12-Sep-19		25-Sep-19

BOARD MEETING 30 OCTOBER 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Finance Report (Sept)		Carriann Hall	Chris	15-Oct-19				30-Oct-19	30-Oct-19
Shareholder representatives for Allied Laundry and TAS meetings each year		Ken Foote		15-Oct-19					30-Oct-19
Te Ara Whakawaiora - Access Rates 45 -64 years (local indicators) ADULT HEALTH		Chris Ash	Kate Rawstron	1-Oct-19	10-Oct-19				30-Oct-19

BOARD MEETING 27NOVEMBER 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
People & Quality Dashboard Q1 (Jul-Sep 19) Feb-May-Aug-**Nov**	E	Kate Coley	Jim Scott	12-Nov-19					27-Nov-19
Finance Report (Oct)		Carriann Hall	Chris	19-Nov-19				27-Nov-19	27-Nov-19
HBDHB Non-Financial Performance Framework Dashboard Q1 - **EMT/Board**	E	Chris Ash	Peter MacKenzie	19-Nov-19					27-Nov-19
HBDHB Performance Framework Exceptions Q1 Feb19 /May/Aug/**Nov** (Just in time for MRB Mtg then to EMT)	E	Chris Ash	Peter McKenzie	12-Nov-19	13-Nov-19				27-Nov-19

BOARD MEETING 18 DECEMBER 2019	Emailed	EMT Member	Lead/Author	EMT Meeting Date	MRB Meeting Date	Clinical Council Meeting Date	Consumer Council Meeting Date	F R A C Meeting date	BOARD Meeting date
Finance Report (Nov)		Carriann Hall	Chris	10-Dec-19				18-Dec-19	18-Dec-19

CHAIR'S REPORT

Verbal

HAWKE'S BAY District Health Board Whakawāteatia	**Chief Executive Officer's Report** **61**
	For the attention of: **HBDHB Board**
Document Owner:	Kevin Snee Chief Executive Officer
Reviewed by:	Not applicable
Month as at	21 June 2019
Consideration:	For Information

RECOMMENDATION

That the Board

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

INTRODUCTION

This month I announced my resignation as CEO to take up the role of CEO at Waikato DHB. I am very grateful to the Board for their support for nearly 10 years and I look forward to the progress this organisation will continue to make in the coming years.

The industrial action from the Resident Doctors Association (RDA) in May has had an impact financially on HBDHB as well as on elective and target performance.

We await the recommendations from the Employment Relations Authority facilitation with the RDA, which will be non-binding and will be delivered at the end of month.

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

- Person and whanau centred care
- Moving equity forward
- Hawke's Bay Health Strategy
- He Ngākau Aotea
- Board Elections
- Mental Health Zero Seclusions

PERFORMANCE

Measure / Indicator	Target	Month of May	Qtr to end May	Trend For Qtr
Shorter stays in ED	≥95%	84.6%	84.7%	—
Improved access to Elective Surgery (2018/19YTD)	100%	79.2%	YTD 87.5%	—

Waiting list	*Less than 3 months*	*3-4 months*	*4+ months*
First Specialist Assessments (ESPI-2)	3,046	746	1,307
Patients given commitment to treat, but not yet treated (ESPI-5)	943	104	414

Faster cancer treatment – 62 day indicator* *(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).*	≥90%	100% April	84% 6m to April	▼
Faster cancer treatment - 31 day indicator	≥85%	92.7% April	90% 6m to April	▲
Increased immunisation at 8 months	≥95%	---	92% 3m to May	▲
Better help for smokers to quit – Primary Care	90%		80%	▲
Raising healthy kids (New)	95%		88% 6m to May	▼
Financial – month (in thousands of dollars)	-2,101	-3,857	---	---
Financial – year to date (in thousands of dollars)	-5,754	-11,536	---	---

*****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%	*8/19 = 42%*	*96/114 = 81%*

May and June have been difficult months particularly in the hospital with increasing acute demand impacting on elective activity and ED performance. Faster Cancer treatment improved in the month for both the 31 and 62 day indicators, although the 61 day performance showed a small decrease for the six month figure. Immunisation also improved in May.

Our financial position continues to be challenging and deteriorated further in May. The pattern of increasing acute activity and financial deterioration is fairly constant across DHBs in New Zealand.

PERSON AND WHĀNAU CENTRED CARE ACTIONS

At the March Board meeting, the Chairs of Clinical and Consumer Councils presented a report on a combined workshop held earlier that month, specifically to look at "Person and Whānau Care in Primary Care". Apart from highlighting many constructive ideas on how to advance this concept, the report also noted a number of frustrations and concerns relating to delivering the work, so progress could be made. The consensus was HBDHB needed a greater level of resource to advance Person and Whānau Centred Care (PWCC) across the sector. This needs to be done with consumers, whānau and communities working in partnership with clinicians, managers and providers.

One of the recommendations from this report adopted by the Board was:

1. HBDHB ensures PWCC becomes the norm; to do that, and requests management to present a paper to the June 2019 Board meeting that:
    - Enables the identification and freeing up of appropriate resources to prioritise the development of PWCC across the Hawke's Bay health sector
    - Prioritises the provision of specific education and training to the Hawke's Bay health workforce on implementing PWCC
    - Facilitates raising the levels of PWCC awareness within Hawke's Bay communities and empowering consumers to partner in their own care and contribute to service developments.

HBDHB is committed to person and whānau centred care and there are a number of activities and actions underway. This report will provide an overarching plan to co-ordinate and prioritise the work underway. Research shows that PWCC improves health outcomes and patient experience and best uses available resources. The results of the Big Listen, Korero Mai, Clinical Service Plan and learnings from recent visits to South Central Foundation, demonstrate a need to prioritise and focus on this work. PWCC and Community Led systems are two key strategic objectives within the new health strategy. Enabling PWCC to set the standard will have a significant positive impact on our ability to achieve our strategy and vision for the Hawke's Bay health system.

The paper developed to respond to the Board request has included representatives of Consumer Council, alongside Clinical Council, People and Quality Directorate, Company Secretary and Māori Relationship Board (MRB). It should be noted that the recommendations to appoint a number of fixed term resources to drive and co-ordinate the programme of work has been fully endorsed by both Clinical and Consumer Councils.

MOVING EQUITY FORWARD

Achieving equity is a Government priority and is referenced in the Minister of Health's Letter of Expectations. HBDHB's Board has agreed "equity for Māori as a priority; also, equity for Pasifika and those with unmet need" as its equity objective within the Hawke's Bay Strategic Plan.

As a follow-up from presentation of the Health Equity Report, MRB agreed that an equity workshop was needed to identify 'clear actions and targets for achieving equity'. Workshops held on 10 and 29 April 2019 with MRB have resulted in the following recommendations being submitted to the Board for endorsement to advance equity forward, these being:

1. Re-allocate and commit resources (existing and new) to address equity for Māori as an inherent right under the Treaty of Waitangi.
2. Development and application of equity planning, implementation, and monitoring tools.
3. That workforce measurements for cultural competency of workforce and workforce development be adopted to maintain an equity focus.
4. That there is demonstrated application by HBDHB to address the social determinants of inequity.
5. There is development of whānau focused approaches for gathering, identifying and being accountable to whānau aspirations for health and well-being.
6. That there is a transition to include Hauora Māori models of care.

HAWKE'S BAY HEALTH STRATEGY FEEDBACK SESSION (ROUND 2)

The Hawke's Bay Health Strategy comes back to Board this month in its latest version. Ongoing work has been taking place with our committees and leaders across the system to refine its contents. The strategy will be an important document to hold the health system to account, providing a structured framework for us to measure our progress delivering our vision over the next 10 years. Guiding our integrated planning process, it will provide the mandate for our work with communities and whānau to develop health services, and enable us to prioritise the activities and investment required to achieve equitable health gains in Hawke's Bay. Feedback on the document from June committees signalled we are getting close to a document that reflects the view of all parties, but that there is still more to do – not least in terms of producing a strategy that 'speaks' to the differing needs of a varied readership. We will therefore be undertaking intensive work during July, with a view to returning the document to Board for final sign-off one month later than planned, in August 2019.

HE NGĀKAU AOTEA

In March a paper was received by the Māori Relationship Board (MRB) that outlined Ngāti Kahungunu Iwi Incorporated (NKII) approach to developing a stronger working relationship with the social sector agencies. This high level document aligned Iwi intention with its Treaty of Waitangi obligations as actioned through the principles.

Further work has been carried out which maps Iwi direction towards achieving improved outcomes for whānau Māori, setting out the partnership framework between NKII and HBDHB to commit and operate under over the next five years.

The He Ngākau Aotea strategy is a living document that embodies the core values and points of reference needed to effect real changes in health outcomes for Māori and non-Māori in the role of Te Matau a Maui. This document defines the 'who', understand the 'why' and focuses on the 'what' – what are we going to do that will create a measurable impact? This partnership comes at a time when health outcomes for Māori signal the need to work differently to achieve improved and more sustainable results.

2019 HBDHB ELECTIONS UPDATE

HBDHB elections process continues with key dates established, including two Candidate Information evenings in July.

MENTAL HEALTH ZERO SECLUSION

Zero Seclusion 2020 is a national initiative, endorsed by the Health Quality & Safety Commission, to reduce and look at eliminating the use of seclusion in all mental health inpatient settings by 2020. It was launched in March 2018. In Hawke's Bay, we have opted to narrow our focus with the project aim to "reduce seclusion on admission for Māori by 50 percent". Māori are over represented in the seclusion data and the project team believes that focussing on reducing seclusion for Māori will reduce the use or need for seclusion in other groups.

We have already seen a reduction in seclusion for 2019; attributed to an increased profile of zero seclusion, the training of staff in Safe Practice, Effective Communication (SPEC), and a changing of culture which improves engagement with tangata whaiora on the ward. There is also work occuring with the community mental health teams to plan for alternative interventions rather than the use of restrictive practice.

Engagement with key stakeholders, especially tangata whaiora and their whānau/family, is vital to listen and gain an insight of their experiences with the seclusion process. From there the team will look for common themes and work together in a co-design process to develop a plan including necessary training and education required for all that will improve practice, and experience in inpatient settings, and make Zero Seclusion a sustainable future for tangata whaiora, whānau and staff.

In Christchurch on 8 May 2019 the Hawke's Bay project team received an award, voted for by their peers, for "addressing equity" as part of this initiative.

CONCLUSION

This has been another difficult month with the ongoing impact of strikes causing disruption to our services. Whilst May and June have seen increasing demand and staff sickness, the hospital has coped but has been under significant strain from high patient demand on hospital services, particularly in June, which has impacted on performance. We continue to undertake key strategic work to make progress in improving our mental health service.

HAWKE'S BAY District Health Board Whakawāteatia	**Financial Performance Report May 2019** For the attention of: **HBDHB Board**
Document Owner	Carriann Hall, Executive Director Financial Services
Document Author	Phil Lomax, Financial and Systems Accountant
Reviewed by	Executive Management Team
Month/Year	June, 2019
Purpose	For Information

8

RECOMMENDATION:

That the HBDHB Board:

1. **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 May is $1.8m unfavourable to plan, taking the year-to-date (YTD) result to $5.8m adverse to plan. The forecast has been updated to a $14.6m deficit, which includes the $2.6m impairment of Health Finance, Procurement and Information Management system (FPIM).

An adverse result for May was anticipated given the underlying adverse position and impact of the five day strike. However, demand driving medical and nursing personnel costs, higher than forecast strike cover and further pay settlement costs over our planning assumptions, has resulted in a more adverse result than forecast.

	May				*Year to Date*				*Year End Forecast*	Refer Appendix
$'000	*Actual*	*Budget*	*Variance*		*Actual*	*Budget*	*Variance*			
Income	50,204	48,173	2,031	4.2%	537,511	530,189	7,321	1.4%	586,463	1
Less:										
Providing Health Services	27,304	26,110	(1,193)	-4.6%	271,508	265,701	(5,807)	-2.2%	296,329	2
Funding Other Providers	22,137	20,784	**(1,353)**	**-6.5%**	230,392	224,650	(5,742)	-2.6%	251,337	3
Corporate Services	4,779	4,101	**(678)**	**-16.5%**	47,659	44,996	**(2,663)**	**-5.9%**	51,696	4
Reserves	(158)	(720)	**(563)**	**-78.1%**	(512)	596	**1,108**	**185.9%**	1,693	5
	(3,857)	**(2,101)**	**(1,756)**	**-83.6%**	**(11,536)**	**(5,754)**	**(5,783)**	**-100.5%**	**(14,591)**	

Key Drivers

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

- Income (Appendix 1)

In-Between-Travel (IBT) and pay equity funding from MoH, offset by expenditure in Funding Other Providers (refer appendix 3).

- Providing Health Services (Appendix 2)

  Savings not achieved, pay settlements above planning assumptions, higher than planned use of medical and nursing resources, pharmaceuticals, patient transport costs and blood, were partly offset by medical and allied vacancies and underspending in outsourced elective surgery.

- Funding Other Providers (Appendix 3)

  The cost of pay equity (residential care) and IBT, both offset under income (refer appendix 1), and savings not achieved. Partly offset by Pharmac rebates, and non utilisation of the new investment reserve.

- Corporate Services (Appendix 4)

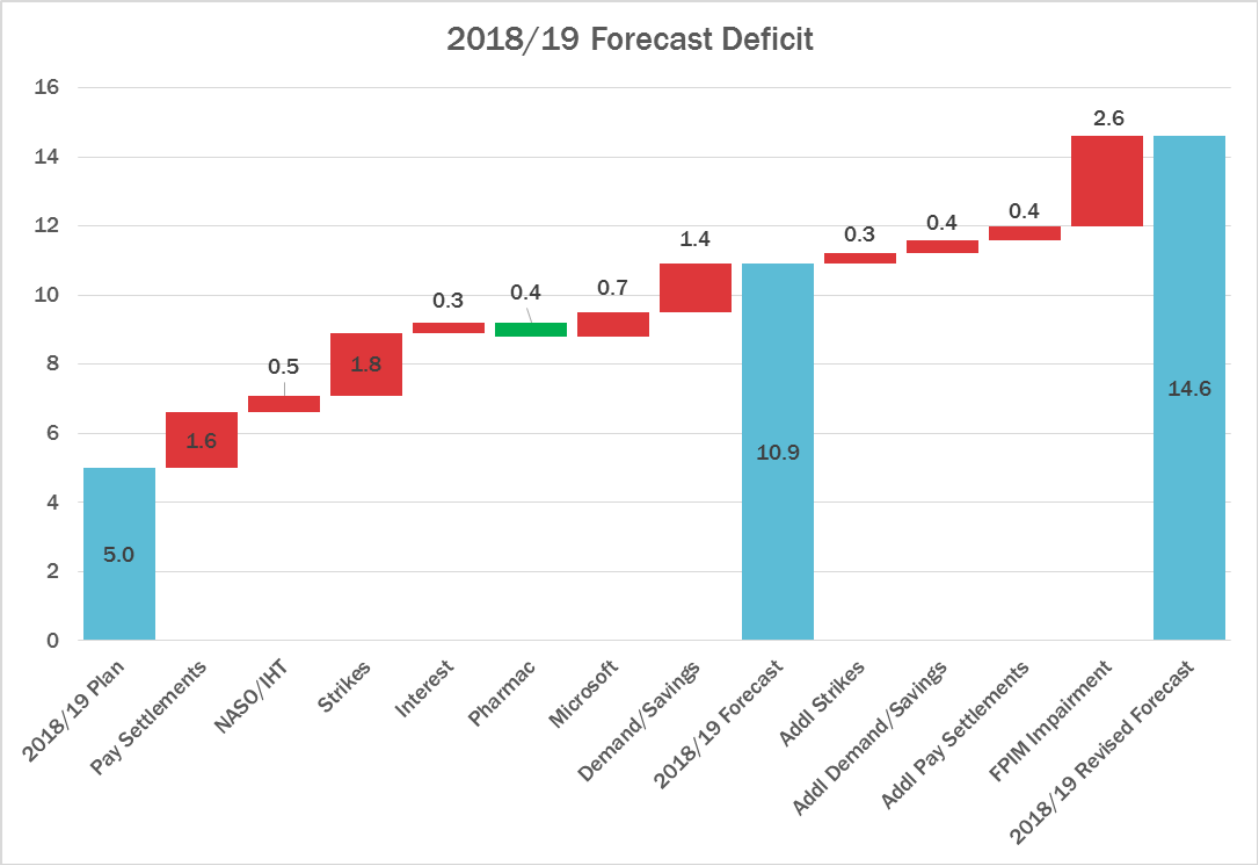
  Strike action, capital charges (offset in income), some unfunded cost increases, and savings not achieved.

- Reserves (Appendix 5)

  Net benefit from prior year provisioning not required and reserves held against deficit

Forecast

The forecast deficit has increased from $10.9m to $14.6m ($11.95m excluding FPIM). The drivers of the forecast deficit are summarised in the chart below.



The forecast excludes provisioning for employee entitlements as a result of Holidays Act issues and other pay related liabilities. It also assumes that the total Combined Pharmaceutical Budget expenditure will be in line with the PHARMAC forecast, and IDF flows will approximate the figures used to estimate the wash-up.

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

Other Performance Measures

	May				Year to Date				Year End Forecast	Refer Appendix
	Actual	Budget	Variance		Actual	Budget	Variance			
	$'000	$'000	$'000	%	$'000	$'000	$'000	%	$'000	
Savings plans	516	1,179	(663)	-56.2%	5,437	12,973	(7,536)	-58.1%	14,152	8
Capital spend	1,966	1,265	701	55.4%	15,057	16,620	(1,563)	-9.4%	17,933	12
	FTE	FTE	FTE	%	FTE	FTE	FTE	%	FTE	
Employees	2,456	2,612	156	6.0%	2,419	2,439	20	0.8%	2,441	2 & 4
	CWD	CWD	CWD	%	CWD	CWD	CWD	%	CWD	
Case weighted discharges	3,018	2,599	419	16.1%	28,223	26,934	1,289	4.8%	29,395	2

- Savings Plans (Appendix 8)

  Delivering our $14.2m saving plan has been a significant issue. On a straight line basis, YTD savings of $13.0m should have been achieved by the end of May, and $5.4m has been made.

- Capital spend (Appendix 12)

  Capital spend is behind budget in the block allocations, and more than offsets the relatively small additional costs relating to strategic projects. Capital spend (excluding the FPIM investment) is expected to be close to plan at year end.

- Cash (Appendices 11 & 13)

  The cash balance immediately before receipt of MOH funding was $8.5m overdrawn on 3 May and $15.2m overdrawn on 31 May. On a prudent basis, we are forecasting to be $18.6m overdrawn by year end, with a low point of $22.6m on 3 July, which is within our current statutory limit of $27m. Interest is expected to come in $0.3m less than planned as a result.

- Employees (Appendices 2 & 4)

  Employee numbers are favourable YTD reflecting challenges filling vacancies in medical and allied health positions. The vacancies are mostly offset by high use of nursing resources.

- Activity (Appendix 2)

  YTD CWD are ahead of plan. However acute demand is limiting the capacity available for elective activity.

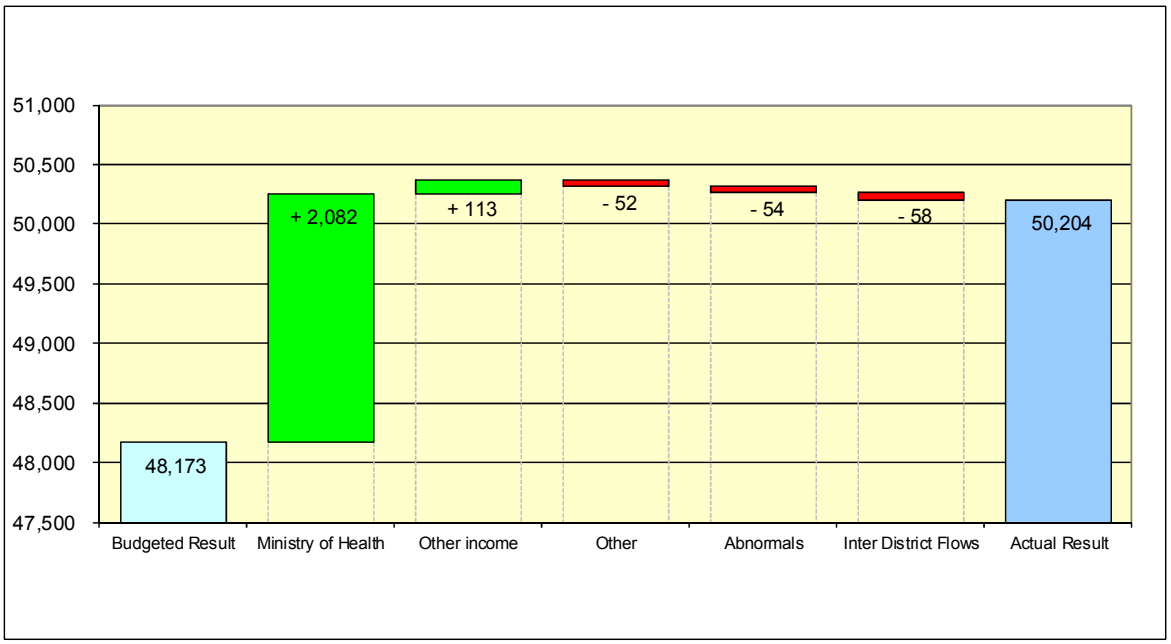
  Elective discharges show a shortfall on achieving the Ministry of Health target.

APPENDICES

1. INCOME

$'000	May Actual	May Budget	May Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Ministry of Health	48,017	45,934	2,082	4.5%	512,501	505,272	7,229	1.4%	559,066
Inter District Flows	704	762	(58)	-7.6%	8,061	8,384	(323)	-3.8%	8,826
Other District Health Boards	345	354	(9)	-2.7%	3,823	3,873	(50)	-1.3%	4,186
Financing	35	55	(21)	-37.4%	308	608	(299)	-49.2%	319
ACC	408	423	(15)	-3.6%	4,789	4,892	(103)	-2.1%	5,255
Other Government	18	43	(25)	-58.3%	470	629	(159)	-25.3%	514
Patient and Consumer Sourced	125	106	19	17.5%	1,162	1,155	7	0.6%	1,258
Other Income	608	495	113	22.7%	5,869	5,360	509	9.5%	6,381
Abnormals	(54)	-	(54)	0.0%	528	17	511	3004.6%	658
	50,204	**48,173**	2,031	4.2%	**537,511**	**530,189**	7,321	1.4%	**586,463**

Month of May



Note the scale does not begin at zero

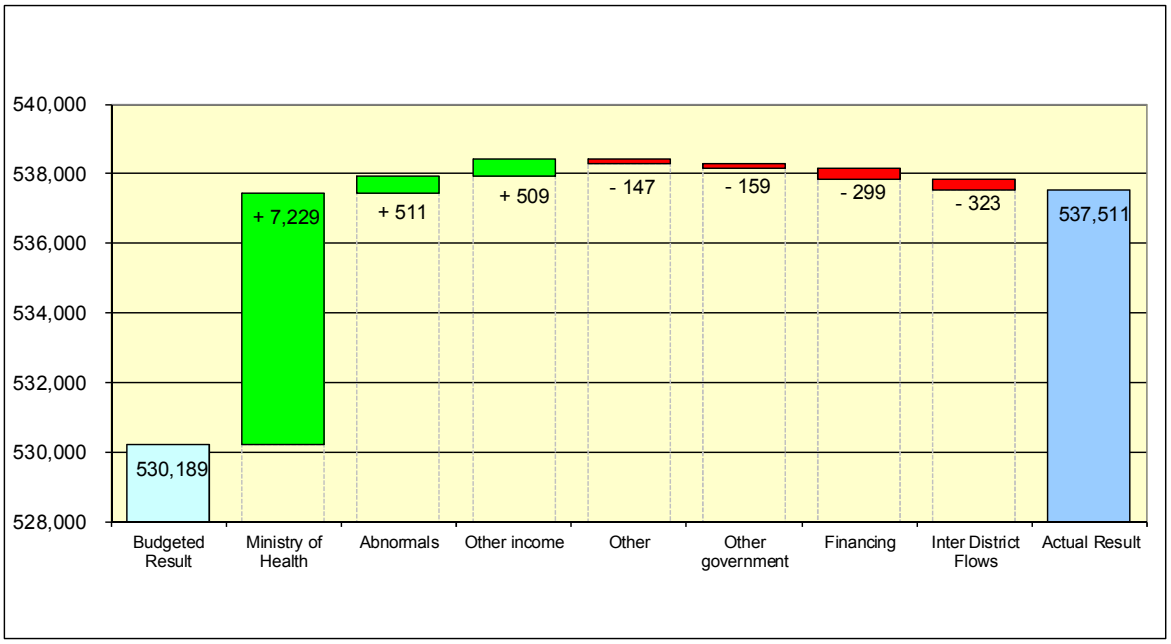
Ministry of Health (favourable)
Mainly In-Between-Travel (home support), and pay equity (residential care) additional income offset in related expenditure (Appendix 4). Also includes capital charge funding relating to the 2017/18 land and buildings revaluations.

Other income (favourable)
Wairoa GP income.

Abnormals (unfavourable)
Claims rejected by ACC, that were invoiced prior to July 2018.

Inter District Flows (unfavourable)
Lower inflows going into winter.

Year to Date



Note the scale does not begin at zero

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

Abnormals (favourable)
Prior year wash-ups and accruals no longer required that were recognised in September, partly offset in May by recognition of ACC rejected claims.

Other income (unfavourable)
Wairoa GP income mostly offset by reduced recoveries from the PHO.

Other government (unfavourable)
Income from the Health Research Council of NZ for the Havelock North Campylobacter Outbreak Study.

Financing (unfavourable)
Reduced interest income relating to lower cash holdings.

Inter District Flows (unfavourable)
Lower than projected visitors to Hawke's Bay, mainly last winter, only partly caught up over the summer months.

2. PROVIDING HEALTH SERVICES

	May				Year to Date				Year End Forecast
	Actual	Budget	Variance		Actual	Budget	Variance		
Expenditure by type $'000									
Medical personnel and locums	6,310	5,879	(431)	-7.3%	63,330	61,988	(1,342)	-2.2%	68,608
Nursing personnel	8,552	8,159	(392)	-4.8%	79,989	77,356	(2,633)	-3.4%	87,390
Allied health personnel	3,442	3,649	206	5.7%	33,777	36,019	2,242	6.2%	36,708
Other personnel	2,113	2,313	201	8.7%	23,400	23,324	(75)	-0.3%	25,447
Outsourced services	1,370	1,004	(365)	-36.4%	9,890	11,089	1,199	10.8%	11,055
Clinical supplies	3,858	3,201	(657)	-20.5%	40,825	35,677	(5,147)	-14.4%	44,790
Infrastructure and non clinical	1,659	1,904	245	12.9%	20,297	20,247	(50)	-0.2%	22,331
	27,304	**26,110**	(1,193)	-4.6%	**271,508**	**265,701**	(5,807)	-2.2%	**296,329**
Expenditure by directorate $'000									
Medical	7,954	7,098	(856)	-12.1%	76,429	71,594	(4,836)	-6.8%	83,302
Surgical	6,599	5,845	(754)	-12.9%	60,047	58,933	(1,114)	-1.9%	65,566
Community, Women and Children	4,306	4,259	(47)	-1.1%	43,116	42,933	(183)	-0.4%	46,933
Mental Health and Addiction	2,039	1,881	(158)	-8.4%	19,732	19,195	(537)	-2.8%	21,541
Older Persons, NASC HB, and Alli	1,402	1,458	56	3.8%	14,499	15,090	591	3.9%	15,827
Operations	3,881	3,678	(203)	-5.5%	39,525	38,002	(1,523)	-4.0%	43,261
Other	1,123	1,892	769	40.6%	18,160	19,956	1,795	9.0%	19,899
	27,304	**26,110**	(1,193)	-4.6%	**271,508**	**265,701**	(5,807)	-2.2%	**296,329**
Full Time Equivalents									
Medical personnel	332.4	375.9	44	11.6%	353	367	13	3.7%	366.6
Nursing personnel	1,051.6	1,095.3	44	4.0%	1,009	979	(30)	-3.1%	980.1
Allied health personnel	473.1	516.5	43	8.4%	466	494	28	5.7%	494.9
Support personnel	152.8	148.6	(4)	-2.8%	145	139	(6)	-4.2%	139.2
Management and administration	277.7	288.5	11	3.8%	273	278	5	1.8%	277.9
	2,287.6	**2,424.8**	137	5.7%	**2,246**	**2,256**	10	0.5%	**2,258.8**
Case Weighted Discharges									
Acute	2,308	1,715	594	34.6%	20,892	18,221	2,671	14.7%	19,957
Elective	565	683	(118)	-17.2%	5,127	6,480	(1,353)	-20.9%	7,006
Maternity	110	164	(54)	-32.7%	1,914	1,839	75	4.1%	2,000
IDF Inflows	34	37	(4)	-9.5%	290	394	(104)	-26.5%	432
	3,018	**2,599**	419	16.1%	**28,223**	**26,934**	1,289	4.8%	**29,395**

Directorates YTD

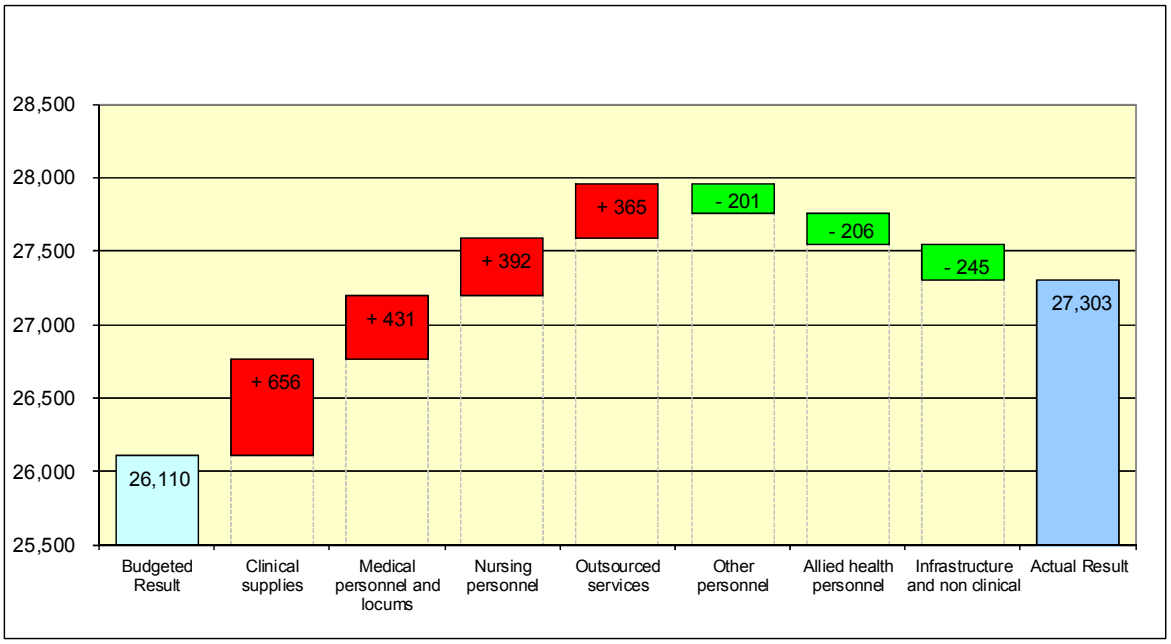
- Medical (May and YTD) – nursing resource use, pharmaceuticals (mainly biologics), medical vacancy cover, and radiology reads (radiologist vacancies);
- Surgical (May) – ramp up of elective capacity, including extra sessions on Saturdays and increased activity with external providers;
- Mental Health and Addiction – cover for psychiatrist vacancies;
- Operations (May) – blood, orderly rosters and savings not achieved;
- Other (May and YTD) – savings and review of costs in facilities and slippage/vacancies in non hospital services

Case Weighted Discharges

The combined Acute and Elective CWDs are favourable in month and YTD. IDF inflows were close to budget in May, but remain well below budget YTD.

For 2019/20 MoH is changing the way measure elective activity, under a new Planned Care approach.

Month of May



Note the scale does not begin at zero

Clinical supplies (unfavourable)
Savings plans, blood, pharmaceuticals (biologics) and instruments and equipment.

Medical personnel and locums (unfavourable)
Vacancy cover and the impact of strike cover on the cost of annual leave payments. Higher than budgeted costs in anaesthetics, psychiatric medical, intensive care, general surgery, and emergency offsetting the favourable variances from vacancies.

Nursing personnel (unfavourable)
Largely driven by higher than budgeted staffing across emergency, surgical inpatients, respiratory and renal, intensive care, general medicine and the mental health inpatient unit. Unachieved annual leave savings also impact in month.

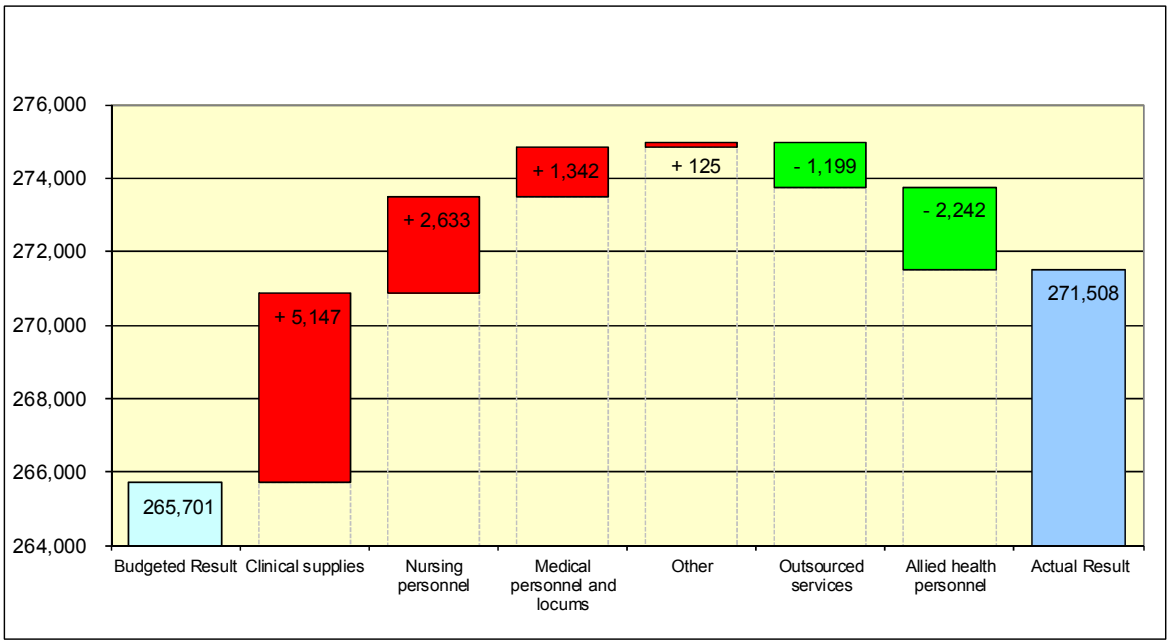
Outsourced services (unfavourable)
Elective surgery and radiology reads (radiologist vacancies).

Other personnel (favourable)
Correction of treatment of a pay provision.

Allied health personnel (favourable)
Vacancies in therapists, social workers, psychologists, therapists, pharmacists and MRTs.

Infrastructure and non clinical
Lower than budgeted feasibility and deferred maintenance costs.

Year to Date



Note the scale does not begin at zero

Clinical supplies (unfavourable)
Planned efficiencies, pharmaceuticals including biologics, and treatment disposables including blood and blood intragam, and patient transport.

Nursing personnel (unfavourable)
Hours worked, both volume and cost, are greater than planned, driven by a number of factors including patient volume and acuity, clinical practice and vacancies.

Medical personnel and locums (unfavourable)
Vacancy cover using locums, exceeding the cost reduction from vacancies.

Outsourced services (favourable)
Elective surgery volumes below plan, partly offset by radiology reads.

Allied health personnel (favourable)
Continuing national issue with recruitment and retention.

Full Time Equivalents (FTE)

FTEs are 10 (0.5%) favourable YTD including:

Medical personnel (13 FTE / 3.7% favourable)

- Vacancies in radiology, Wairoa GPs, psychiatrists, orthopaedics and emergency medicine, marginally offset by additional surgeons and physicians.

Nursing personnel (-30 FTE / -3.1% unfavourable)

- Higher than budgeted staffing in acute areas (ED and ICU), surgical inpatient wards, and respiratory and renal.

Allied health personnel (28 FTE / 5.7% favourable)

- Vacancies in social workers, medical radiation technologists (MRTs), occupational health, psycologists, pharmacists, community support workers, and health promotion workers.

MONTHLY ELECTIVE SURGICAL DISCHARGES REPORT
YTD To May 2019

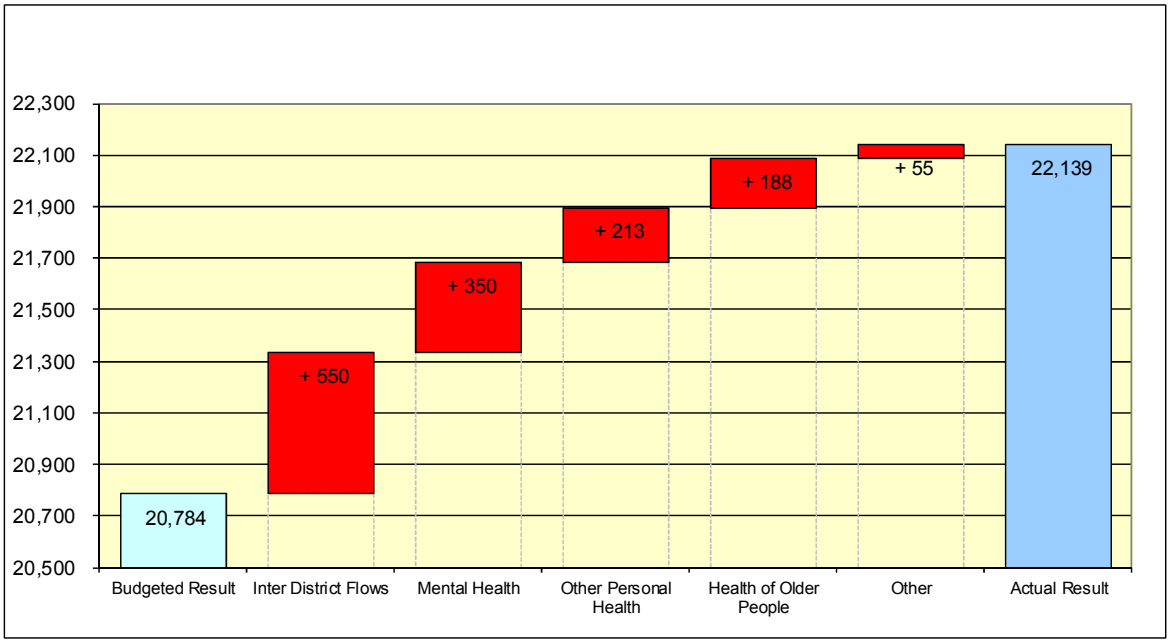
	May 2019				YTD May 2019				Full Year Plan
	Actual	Plan	Variance	%	Actual	Plan	Variance	%	
Anaesthetics	0	0	0	0.0%	**0**	**0**	**0**	**0.0%**	**4**
Cardiothoracic	8	12	-4	0.0%	**94**	**110**	**-16**	**0.0%**	**119**
Avastins	0	21	-21	-100.0%	**184**	**184**	**0**	**0.0%**	**201**
ENT	52	73	-21	-28.8%	**524**	**677**	**-153**	**-22.6%**	**740**
General Surgery	130	133	-3	-2.3%	**1104**	**1213**	**-109**	**-9.0%**	**1324**
Gynaecology	45	71	-26	-36.6%	**544**	**650**	**-106**	**-16.3%**	**708**
Maxillo-Facial	28	50	-22	-44.0%	**312**	**461**	**-149**	**-32.3%**	**507**
Neurosurgery	5	10	-5	0.0%	**76**	**87**	**-11**	**0.0%**	**95**
Ophthalmology	149	133	16	12.0%	**1169**	**1215**	**-46**	**-3.8%**	**1328**
Orthopaedics	107	115	-8	-7.0%	**1052**	**1048**	**4**	**0.4%**	**1145**
Paediatric Surgery	4	8	-4	0.0%	**62**	**76**	**-14**	**0.0%**	**85**
Skin Lesions	26	25	1	4.0%	**203**	**230**	**-27**	**-11.7%**	**254**
Urology	34	63	-29	-46.0%	**444**	**564**	**-120**	**-21.3%**	**618**
Vascular	12	34	-22	-64.7%	**189**	**306**	**-117**	**-38.2%**	**333**
Non Surgical - Arranged	1	14	-13	-92.9%	**107**	**131**	**-24**	**-18.3%**	**144**
Non Surgical - Elective	14	15	-1	-6.7%	**140**	**137**	**3**	**2.2%**	**148**
TOTAL	**615**	**777**	**-162**	**-20.8%**	**6204**	**7089**	**-885**	**-12.5%**	**7753**

Please Note:This report was run on 10 June 2019
The volumes by specialty now include both Elective and Arranged discharges rolled into one.
Data is subject to change.

3. FUNDING OTHER PROVIDERS

$'000	May Actual	May Budget	May Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Payments to Other Providers									
Pharmaceuticals	3,523	3,583	60	1.7%	37,396	39,406	2,010	5.1%	40,961
Primary Health Organisations	3,473	3,360	(113)	-3.4%	36,319	35,985	(334)	-0.9%	39,840
Inter District Flows	5,347	4,797	(550)	-11.5%	53,677	52,767	(910)	-1.7%	58,229
Other Personal Health	2,310	2,097	(213)	-10.1%	21,548	19,984	(1,563)	-7.8%	23,452
Mental Health	1,408	1,058	(350)	-33.1%	12,000	11,636	(363)	-3.1%	13,013
Health of Older People	5,754	5,566	(188)	-3.4%	65,423	61,233	(4,190)	-6.8%	71,456
Other Funding Payments	325	323	(2)	-0.6%	4,031	3,638	(393)	-10.8%	4,380
	22,139	20,784	(1,355)	-6.5%	**230,394**	**224,650**	(5,744)	-2.6%	251,331
Payments by Portfolio									
Strategic Services									
Secondary Care	4,666	4,236	(431)	-10.2%	48,562	46,593	(1,969)	-4.2%	52,660
Primary Care	9,054	8,584	(470)	-5.5%	91,201	90,447	(754)	-0.8%	99,764
Mental Health	1,532	1,343	(189)	-14.0%	14,689	14,778	90	0.6%	16,002
Health of Older People	6,230	5,866	(364)	-6.2%	68,962	64,413	(4,549)	-7.1%	75,287
Other Health Funding	-	133	133	100.0%	-	1,466	1,466	100.0%	-
Maori Health	495	495	0	0.1%	5,494	5,526	32	0.6%	5,994
Population Health	162	126	(36)	-28.3%	1,486	1,426	(60)	-4.2%	1,625
	22,139	20,784	(1,355)	-6.5%	**230,394**	**224,650**	(5,744)	-2.6%	251,331

Month of May



Note the scale does not begin at zero

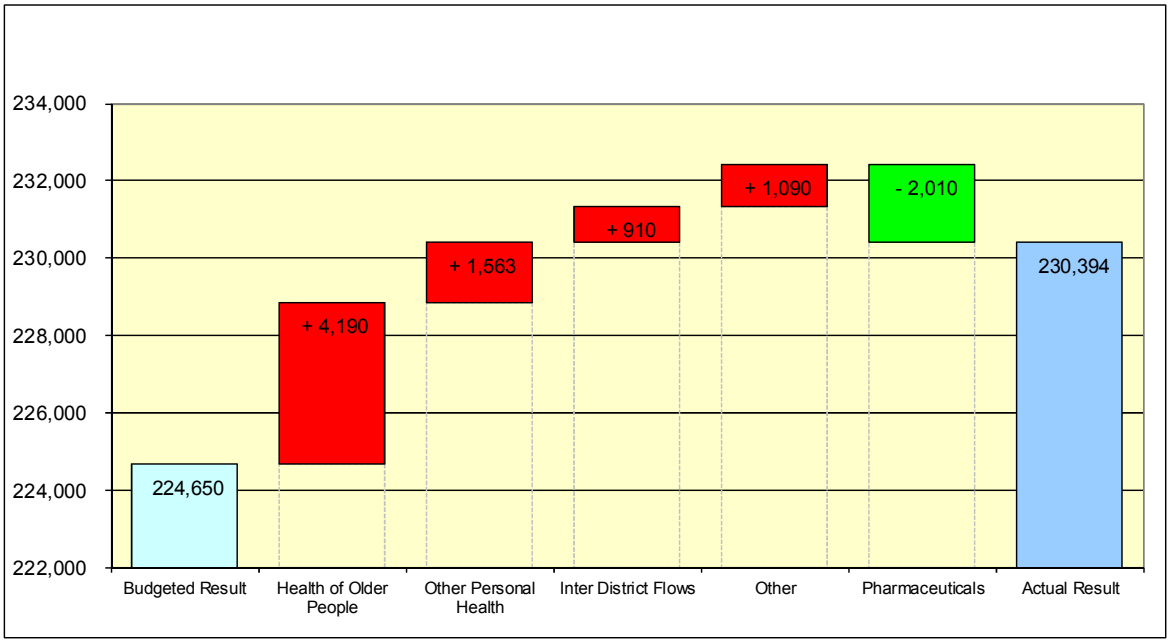
Inter District Flows (unfavourable)
Review of the provision for IDFs base on MoH data. Includes an allowance for late coding by other DHBs.

Mental Health (unfavourable)
High in-month community residential and home based support.

Other Personal Health (unfavourable)
Efficiencies not yet achieved, partly offset by recoveries from providers for unperformed services, and the unutilised new investment reserve.

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

Year to Date



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

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

Inter District Flows (unfavourable)
Review of the provision for IDFs base on MoH data.

Pharmaceuticals (favourable)
Pharmaceutical rebates in line with PHARMAC forecasts.

4. CORPORATE SERVICES

$'000	May Actual	May Budget	May Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Operating Expenditure									
Personnel	2,227	1,579	(648)	-41.1%	17,725	16,236	(1,489)	-9.2%	19,047
Outsourced services	99	70	(29)	-40.8%	812	779	(32)	-4.1%	915
Clinical supplies	17	(13)	(30)	-231.5%	111	(133)	(244)	-183.1%	122
Infrastructure and non clinical	732	616	(116)	-18.8%	9,092	8,447	(645)	-7.6%	9,868
	3,076	2,252	(823)	-36.6%	27,740	25,329	(2,410)	-9.5%	29,952
Capital servicing									
Depreciation and amortisation	1,170	1,194	23	2.0%	12,070	12,461	391	3.1%	13,203
Capital charge	533	655	122	18.7%	7,849	7,206	(644)	-8.9%	8,541
	1,703	1,849	146	7.9%	19,920	19,667	(253)	-1.3%	21,744
	4,779	**4,101**	**(678)**	**-16.5%**	**47,659**	**44,996**	**(2,663)**	**-5.9%**	**51,696**
Full Time Equivalents									
Medical personnel	0.4	0.3	(0)	-19.7%	0	0	0	0.5%	0.3
Nursing personnel	15.6	17.2	2	9.0%	13	16	3	17.5%	16.0
Allied health personnel	0.2	0.4	0	56.1%	0	0	0	49.7%	0.4
Support personnel	8.2	8.2	0	0.0%	8	8	(0)	-4.2%	8.0
Management and administration	144.1	160.7	17	10.3%	151	158	7	4.3%	158.0
	168.5	**186.8**	**18**	**9.8%**	**173**	**183**	**10**	**5.2%**	**182.7**

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

5. RESERVES

$'000	May Actual	May Budget	May Variance		Year to Date Actual	Year to Date Budget	Year to Date Variance		Year End Forecast
Expenditure									
Contingency	-	54	54	100.0%	-	636	636	100.0%	-
Other	(158)	(775)	(617)	-79.6%	(512)	(40)	472	1182.5%	2,284
	(158)	**(720)**	(563)	78.1%	**(512)**	**596**	**1,108**	**185.9%**	**1,693**

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 YTD include:

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

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

The “Other” category comprises the net impact of an ongoing review of accruals relating to the prior year. Back-pays relating to a registrar run review and unfunded employment settlements, and the crediting of prior

year claims not accepted by ACC, reduces the favourable variance in May. Any remaining favourable variance at year end will be a one-off benefit.

6. FINANCIAL PERFORMANCE BY MOH CLASSIFICATION

	May			Year to Date			End of Year		
$'000	Actual	Annual Plan	Variance	Actual	Annual Plan	Variance	Forecast	Annual Plan	Variance
Funding									
Income	47,589	45,586	2,003	507,509	500,365	7,144	553,713	537,477	16,236
Less:									
Payments to Internal Providers	27,166	27,089	(77)	285,664	284,821	(842)	311,519	309,025	(2,494)
Payments to Other Providers	21,092	20,162	(930)	221,500	217,812	(3,687)	241,529	233,452	(8,078)
Contribution	**(669)**	**(1,666)**	**996**	**345**	**(2,269)**	**2,614**	**665**	**(5,000)**	**5,665**
Governance and Funding Admin.									
Funding	276	276	-	3,146	3,146	-	3,424	3,383	40
Other Income	3	3	-	28	28	-	30	30	-
Less:									
Expenditure	278	293	15	2,997	3,273	277	3,299	3,413	114
Contribution	**1**	**(15)**	**15**	**177**	**(100)**	**277**	**155**	**-**	**155**
Health Provision									
Funding	26,890	26,814	77	282,518	281,675	842	308,096	305,542	2,554
Other Income	2,357	2,489	(132)	28,759	28,740	19	31,408	30,594	813
Less:									
Expenditure	32,436	29,724	(2,713)	323,335	313,803	(9,533)	354,911	336,136	(18,775)
Contribution	**(3,189)**	**(421)**	**(2,768)**	**(12,059)**	**(3,387)**	**(8,671)**	**(15,408)**	**-**	**(15,408)**
Net Result	**(3,857)**	**(2,102)**	**(1,756)**	**(11,536)**	**(5,756)**	**(5,780)**	**(14,588)**	**(5,000)**	**(9,588)**

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

7. MANAGEMENT BUDGET MOVEMENTS

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

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

$'000	May			Year to Date			End of Year		
	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement	Mgmt Budget	Annual Plan	Movement
Funding									
Income	45,586	44,680	906	500,365	492,517	7,847	546,225	537,477	8,748
Less:									
Payments to Internal Providers	27,089	26,924	(166)	284,821	283,228	(1,593)	310,784	309,025	(1,759)
Payments to Other Providers	20,162	19,612	(550)	217,812	213,878	(3,935)	237,932	233,452	(4,480)
Contribution	**(1,666)**	**(1,856)**	**190**	**(2,269)**	**(4,589)**	**2,320**	**(2,491)**	**(5,000)**	**2,509**
Governance and Funding Admin.									
Funding	276	276	-	3,146	3,106	40	3,424	3,383	40
Other Income	3	3	-	28	28	-	30	30	-
Less:									
Expenditure	293	288	(5)	3,273	3,135	(138)	3,554	3,413	(140)
Contribution	**(15)**	**(10)**	**(5)**	**(100)**	**(2)**	**(98)**	**(100)**	**-**	**(100)**
Health Provision									
Funding	26,814	26,639	174	281,675	280,031	1,644	307,360	305,542	1,819
Other Income	2,489	2,432	56	28,740	28,087	652	31,301	30,594	706
Less:									
Expenditure	29,724	29,308	(415)	313,803	309,284	(4,518)	341,071	336,136	(4,934)
Contribution	**(421)**	**(236)**	**(185)**	**(3,387)**	**(1,166)**	**(2,222)**	**(2,409)**	**-**	**(2,409)**
Net Result	**(2,102)**	**(2,102)**	**(0)**	**(5,756)**	**(5,756)**	**(0)**	**(5,000)**	**(5,000)**	**(0)**

8. QUALITY AND FINANCIAL IMPROVEMENT PROGRAMME

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

The table below shows $11.8m of savings have been identified, and $5.7m of identified savings has been removed from operational budgets. There is no change from February. We are working through the recurrency of savings as a part of 2019/20 budget setting. Savings targets have been budgeted evenly through the year at directorate level.

	Target	Current Year Identification					Savings Delivered / Forecast				Recurrency	
Division	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	Var	2018/19 Forecast	2019/20 Identified Saving $'000	%
Strategic	-	-	- %	-	-	-	-	-	-	-	-	- %
Primary Care	4,673	4,809	103 %	869	3,940	(136)	2,027	4,284	(2,256)	2,105	4,689	100 %
Provider Services												
Medical	1,820	1,866	103 %	1,634	232	(46)	508	1,668	(1,160)	524	554	30 %
Surgical	1,450	807	56 %	766	41	643	224	1,329	(1,105)	250	812	56 %
CWC	1,049	804	77 %	804	-	245	448	962	(514)	487	105	10 %
OPMH	865	1,100	127 %	1,100	-	(235)	804	793	11	896	865	100 %
Operations	893	564	63 %	298	267	329	69	819	(750)	118	192	21 %
Facilities	232	246	106 %	246	-	(14)	162	213	(50)	178	232	100 %
COO	235	(1,170)	(498)%	(1,370)	200	1,405	62	215	(153)	83	200	85 %
Total Provider Services	*6,544*	*4,216*	*64 %*	*3,476*	*740*	*2,328*	*2,277*	*5,999*	*(3,721)*	*2,535*	*2,960*	*45 %*
HI&E	402	435	108 %	435	-	(33)	276	369	(93)	298	184	46 %
People & Quality	105	126	120 %	124	3	(21)	95	96	(1)	107	105	100 %
Information Services	254	272	107 %	18	254	(18)	37	233	(195)	60	254	100 %
Financial Services	1,430	1,238	87 %	158	1,080	192	136	1,311	(1,175)	243	1,116	78 %
Executive	112	28	25 %	28	-	84	9	103	(94)	11	-	- %
Capital Servicing	632	632	100 %	632	-	-	579	579	-	632	632	100 %
Totals	**14,152**	**11,757**	**83 %**	**5,740**	**6,016**	**2,395**	**5,437**	**12,973**	**(7,536)**	**5,991**	**9,940**	**70 %**
Annual Leave Savings Total		*1,499*		*1,499*	-	-	*509*	*1,372*	*(863)*	*583*	-	

NB: these are included in the above Division & Directorate figures.

9. FINANCIAL POSITION

30 June 2018	$'000	May Actual	May Budget	Variance from budget	Movement from 30 June 2018	Annual Budget
	Equity					
164,706	Crown equity and reserves	164,706	175,069	(10,363)	-	174,711
(15,982)	Accumulated deficit	(27,518)	(16,729)	(10,788)	(11,535)	(15,973)
148,723		137,188	158,339	(21,151)	(11,535)	158,738
	Represented by:					
	Current Assets					
7,444	Bank	813	3,148	(2,335)	(6,631)	2,313
1,885	Bank deposits > 90 days	1,881	1,901	(20)	(4)	1,901
25,474	Prepayments and receivables	29,535	25,009	4,527	4,062	25,045
3,907	Inventory	3,823	4,513	(690)	(84)	4,520
2,293	Investment in NZHP	2,638	-	2,638	345	-
-	Non current assets held for sale	-	625	(625)	-	625
41,003		38,690	35,196	3,494	(2,313)	34,404
	Non Current Assets					
175,460	Property, plant and equipment	178,081	184,475	(6,394)	2,621	185,018
1,479	Intangible assets	1,707	4,033	(2,327)	227	4,147
9,280	Investments	10,171	11,798	(1,627)	891	11,798
186,220		189,958	200,306	(10,348)	3,739	200,963
227,223	**Total Assets**	**228,649**	**235,503**	**(6,854)**	**1,426**	**235,368**
	Liabilities					
	Current Liabilities					
-	Bank overdraft	15,160	-	(15,160)	(15,160)	-
35,817	Payables	31,940	36,168	4,228	3,876	36,249
40,064	Employee entitlements	41,741	38,284	(3,457)	(1,677)	37,579
75,881		88,842	74,452	(14,390)	(12,961)	73,828
	Non Current Liabilities					
2,619	Employee entitlements	2,619	2,712	93	-	2,802
2,619		2,619	2,712	93	-	2,802
78,500	**Total Liabilities**	**91,461**	**77,163**	**(14,297)**	**(12,961)**	**76,629**
148,723	**Net Assets**	**137,188**	**158,339**	**(21,151)**	**(11,535)**	**158,738**

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

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

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

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

10. EMPLOYEE ENTITLEMENTS

30 June 2018	$'000	May Actual	May Budget	Variance from budget	Movement from 30 June 2018	Annual Budget
10,004	Salaries & wages accrued	8,400	7,756	(644)	1,604	7,756
1,157	ACC levy provisions	2,024	1,315	(709)	(867)	532
5,945	Continuing medical education	5,817	6,683	866	128	6,456
21,348	Accrued leave	23,545	20,899	(2,646)	(2,197)	21,199
4,230	Long service leave & retirement grat.	4,574	4,343	(232)	(344)	4,438
42,683	**Total Employee Entitlements**	44,360	40,995	(3,365)	(1,677)	40,380

Leave balances (hours) have increased by 1.8% (April was a reduction of 1.0%) across all major staff categories since the beginning of the financial year. However, the value of the liability has increased 10.5% (last month 5.8%) mainly reflecting settlements since the beginning of the year, and the cost of cover relating to strike action over the last few months on the pay-rates used to value leave.

11. TREASURY

Liquidity Management

The surplus cash of all DHBs is managed by 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. May's low point was a $15.2m overdraft incurred on 31 May. The forecast low for the end of the financial year is $12.6m overdraft, which is within our statutory limit of $27m.

Debt Management

The DHB has no interest rate exposure relating to debt.

Foreign Exchange Risk Management

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

12. CAPITAL EXPENDITURE

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

See table on the next page.

2019 Updated Plan (Sep 18)		*Actual $'000*	*Year to Date Budget $'000*	*Variance $'000*
	Source of Funds			
	Operating Sources			
13,652	Depreciation	12,070	12,461	391
(5,000)	Surplus/(Deficit)	(11,535)	(5,756)	5,779
11,688	Working Capital	15,825	10,044	(5,781)
20,340		16,360	16,749	389
	Other Sources			
-	Special Funds and Clinical Trials	67	-	(67)
-	Funded Programmes	4	-	(4)
-		71	-	(71)
20,340	**Total funds sourced**	**16,431**	**16,749**	**319**
	Application of Funds:			
	Block Allocations			
3,347	Facilities	2,348	3,075	727
3,400	Information Services	2,807	3,117	310
3,225	Clinical Plant & Equipment	1,956	2,942	986
9,972		7,111	9,133	2,023
	Local Strategic			
100	Replacement Generators	-	83	83
26	Renal Centralised Development	24	26	2
2,872	Endoscopy Building	3,093	2,867	(226)
350	Travel Plan	338	321	(17)
1,263	Histology and Education Centre Upgrade	1,306	1,263	(43)
150	Radiology Extension	25	100	75
50	Fit out Corporate Building	-	40	40
500	High Voltage Electrical Supply	511	400	(111)
700	Seismic AAU Stage 2 and 3	331	550	219
1,950	Surgical Expansion	2,109	1,837	(273)
7,961		7,738	7,487	(251)
	Other			
-	Special Funds and Clinical Trials	67	-	(67)
-	Funded Programmes	4	-	(4)
-	Other	138	-	(138)
-		209	-	(209)
17,933	***Capital Spend***	***15,057***	***16,620***	***1,563***
	Regional Strategic			
1,945	RHIP (formerly CRISP)	1,029	129	(899)
1,945		1,029	129	(899)
	National Strategic			
462	NOS (Class B shares in NZHPL)	345	-	(345)
462		345	-	(345)
20,340	**Total funds applied**	**16,431**	**16,749**	**319**

13. ROLLING CASH FLOW

	Actual	May Forecast	Variance	Jun Forecast	Jul Forecast	Aug Forecast	Sep Forecast	Oct Forecast	Nov Forecast	Dec Forecast	Jan Forecast	Feb Forecast	Mar Forecast	Apr Forecast	May Forecast
Cash flows from operating activities															
Cash receipts from Crown agencies	45,797	46,959	(1,162)	47,678	49,944	49,276	55,527	49,720	49,825	49,454	49,558	49,362	49,580	49,705	49,362
Cash receipts from donations, bequests and clinical trials	3	-	3	-	-	-	-	-	-	-	-	-	-	-	-
Cash receipts from other sources	1,475	508	967	521	454	454	454	454	454	459	452	454	454	454	454
Cash paid to suppliers	(29,757)	(26,739)	(3,018)	(27,331)	(28,101)	(27,417)	(29,617)	(27,598)	(30,188)	(28,257)	(28,998)	(25,017)	(29,968)	(28,034)	(29,148)
Cash paid to employees	(23,501)	(20,634)	(2,867)	(18,174)	(23,154)	(18,021)	(17,935)	(21,258)	(18,700)	(17,609)	(25,288)	(18,099)	(18,187)	(22,384)	(18,751)
Cash generated from operations	**(5,983)**	**94**	**(6,078)**	**2,694**	**(856)**	**4,293**	**8,429**	**1,317**	**1,391**	**4,049**	**(4,276)**	**6,700**	**1,880**	**(259)**	**1,917**
Interest received	35	12	23	11	7	7	7	7	7	7	7	7	7	7	7
Interest paid	(1)	(84)	83	(84)	(14)	(15)	201	(7)	(69)	(90)	(19)	1	175	(7)	(87)
Capital charge paid	(533)	(0)	(533)	(4,015)	0	0	0	0	0	(4,314)	0	0	0	0	0
Net cash inflow/(outflow) from operating activities	**(6,483)**	**22**	**(6,505)**	**(1,394)**	**(863)**	**4,285**	**8,637**	**1,318**	**1,330**	**(348)**	**(4,287)**	**6,709**	**2,062**	**(258)**	**1,837**
Cash flows from investing activities															
Proceeds from sale of property, plant and equipment	(0)	0	(0)	480	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)	(5)
Acquisition of property, plant and equipment	(1,654)	(1,536)	(118)	(2,212)	(1,899)	(1,899)	(1,899)	(1,899)	(1,899)	(1,899)	(1,899)	(1,899)	(1,899)	(1,899)	(1,899)
Acquisition of intangible assets	(312)	(108)	(204)	(16)	(173)	(173)	(173)	(173)	(173)	(173)	(173)	(173)	(173)	(173)	(173)
Acquisition of investments	(99)	-	(99)	-	-	-	-	-	-	-	-	-	-	-	-
Net cash inflow/(outflow) from investing activities	**(2,066)**	**(1,644)**	**(421)**	**(1,748)**	**(2,078)**	**(2,078)**	**(2,078)**	**(2,078)**	**(2,078)**	**(2,078)**	**(2,078)**	**(2,078)**	**(2,078)**	**(2,078)**	**(2,078)**
Cash flows from financing activities															
Equity repayment to the Crown	-	-	-	(357)	-	-	-	-	-	-	-	-	-	-	-
Net cash inflow/(outflow) from financing activities	**-**	**-**	**-**	**(357)**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Net increase/(decrease) in cash or cash equivalents	(8,548)	(1,622)	(6,927)	(3,500)	(2,941)	2,207	6,559	(760)	(748)	(2,426)	(6,365)	4,631	(15)	(2,336)	(240)
Add:Opening cash	(3,910)	(3,910)	-	(12,459)	(15,958)	(18,899)	(16,692)	(10,132)	(10,892)	(11,640)	(14,066)	(20,431)	(15,800)	(15,816)	(18,151)
Cash and cash equivalents at end of period	**(12,459)**	**(5,532)**	**(6,927)**	**(15,958)**	**(18,899)**	**(16,692)**	**(10,132)**	**(10,892)**	**(11,640)**	**(14,066)**	**(20,431)**	**(15,800)**	**(15,816)**	**(18,151)**	**(18,392)**
Cash and cash equivalents															
Cash	4	4	0	4	4	4	4	4	4	4	4	4	4	4	4
Short term investments (excl. special funds/clinical trials)	(15,162)	(8,226)	(6,936)	(18,642)	(21,594)	(19,386)	(12,827)	(13,587)	(14,335)	(16,761)	(23,126)	(18,495)	(18,511)	(20,846)	(21,087)
Short term investments (special funds/clinical trials)	2,689	2,690	(1)	2,690	2,690	2,690	2,690	2,690	2,690	2,690	2,690	2,690	2,690	2,690	2,690
Bank overdraft	8.41007	-	8	(10)	-	-	-	-	-	-	-	-	-	-	-
	(12,459)	**(5,532)**	**(6,927)**	**(15,958)**	**(18,899)**	**(16,691)**	**(10,132)**	**(10,892)**	**(11,640)**	**(14,066)**	**(20,431)**	**(15,800)**	**(15,816)**	**(18,151)**	**(18,392)**
Cash Low Point (before the 4th of the following month)	(15,162)	(15,162)	-	(22,574)	(22,099)	(19,608)	(16,330)	(13,762)	(14,805)	(16,761)	(23,336)	(20,135)	(27,845)	(20,936)	(20,392)

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

BOARD HEALTH & SAFETY CHAMPION'S UPDATE

Verbal

BOARD HEALTH & SAFETY
ACTION REGISTER
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	24/4/19	ICU report Storage – Investigate provision of appropriate storage for patients/families and ward resources with Facilities	EDPS	June 2019	Ongoing. ICU engaged with Facilities and the Health & Safety Advisor - working through where improvements are possible.

	Te Pītau Health Alliance Governance Group
	For the attention of: **HBDHB and Health Hawke's Bay Ltd Boards**
Document Owner:	Bayden Barber, Chair
Author:	Chris Ash, Executive Director of Primary Care
Month:	June, 2019
Consideration:	For Information

10

Recommendation

That the Boards:

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

The Health Alliance Governance Group met on Wednesday 12 June 2019. Significant issues discussed, including Resolutions, are noted below:

Communication Plan

A Senior Communications Manager appointment made on 7 June will be shared jointly between Health Hawke's Bay, and HBDHB's Primary Care and Health Equity & Improvement Directorates. The new appointment will prioritise a high level Communications Plan outlining the intent of the Te Pītau Health Alliance, and highlight initiatives currently being driven by the Governance Group

Mental Health & Addiction (MH&A) Redesign - to extend scope to consider whole continuum of care

Resolution

Te Pītau Governance Group members:

1. **noted** the contents of the report and letter dated 24/05/19 from MH&A clinicians to Bayden Barber
2. **agreed** that impacts on all services, inclusive of Ngā Rau Rākau (Mental Health inpatient services), be included as part of the scope of work for the model of care continuum for the MH&A redesign
3. **agreed** that review of internal systems and process within Ngā Rau Rākau in the redesign are not included.

MH&A clinicians advised on challenges regarding capacity issues within Ngā Rau Rākau (the Inpatient Unit), partially attributed to limited options available in residential settings, and increased length of stay regarding the provision of care for long-term and high complex patients within Ngā Rau Rākau.

System Level Measures (SLM) Improvement Plan 2019/20 (sign-off)

Resolution

Te Pītau Governance Group members:

1. **noted** the contents of this report and the attached documents
2. **approved** the 2019/2020 SLM Improvement Plan for sign-off.

A transition year for HBDHB was noted.

Information Systems (IS) Strategy

A business-led 'One Health Ecosystem' ws received, which advised on engagement with various internal/external stakeholders. Te Pītau Governance Group members welcomed the approach and identified several priority areas to focus out-of-hospital developments.

Rangatahi Services Redesign

Resolution

Te Pītau Governance Group members:

1. **agreed** to the need to redesign rangatahi service delivery in Hawke's Bay to remove the existing equity gaps
2. **agreed** that any future model should be informed by kaupapa Māori models of service design and delivery, and using the success factors of the Tō Waha initiative and focussing on the obligations under the Treaty of Waitangi
3. **agree**d that regular reporting on progress and monitoring of performance should be through a rangatahi Service Level Alliance to the Te Pītau Governance Group.

Te Pītau Chair advised that his expectation of the Alliance is that redesign will be conducted with appropriate leadership, expertise and discharge of Treaty obligations at every stage.

A new model and contract requires completion prior to 2020.

HAWKE'S BAY District Health Board Whakawāteatia	**Māori Relationship Board (MRB)**
	For the attention of: **HBDHB Board**
Document Owner:	Heather Skipworth (Chair)
Reviewed by:	Not applicable
Month:	June 2019
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board

Review the contents of this report; and

1. **Support** the six equity recommendations developed by MRB for adoption:
    1. Re-allocate and commit resources (existing and new) to address equity for Māori as an inherent right under the Treaty of Waitangi
    2. Development and application of equity planning, implementation, and monitoring tools
    3. Measures for cultural competency of workforce and workforce development (recruitment/retention)
    4. Demonstrated applications by HBDHB to address social determinants of inequity
    5. Development of whānau focused approaches for gathering, identifying, and being accountable to whānau aspirations for health and well-being
    6. Transition to Hauora Māori models of care
2. **Support** appropriate resource (such Health Economist expertise) to be identified and engaged to support the finalisation of the He Ngakau Aotea paper.
3. **Support** Ngāti Kahungunu be engaged and resourced to define what Equity is for Maori

MRB met on 12 June 2019. An overview of issues discussed and recommendations at the meeting are provided below.

The following reports and papers were discussed and considered:

EQUITY AS A PRIORITY

Following a presentation on the Health Equity Report at the 10 October 2018 MRB meeting, MRB agreed that an equity workshop was needed to identify 'clear actions and targets for achieving equity'. Workshops were held on the 10th and 29th of April 2019 with MRB and others to discuss gaps and opportunities for improving equity across HBDHB, and to explore and agree draft recommendations to HBDHB Board to strengthen the organisation's commitment to prioritise equity for Māori at all levels of the health system.

Following an equity presentation and discussion at workshop one and subsequent discussion at workshop two, the following recommendations are presented to MRB for further discussion and agreement. The finalised recommendations will be presented to HBDHB Board for consideration.

1. Re-allocate and commit resources (existing and new) to address equity for Māori as an inherent right under the Treaty of Waitangi
2. Development and application of equity planning, implementation, and monitoring tools
3. Measures for cultural competency of workforce and workforce development (recruitment/retention)
4. Demonstrated applications by HBDHB to address social determinants of inequity
5. Development of whānau focused approaches for gathering, identifying, and being accountable to whānau aspirations for health and well-being
6. Transition to Hauora Māori models of care

HB HEALTH STATEGY DISCUSSION

Chris Ash, Executive Director of Primary Care, opened discussion on the second presentation of the draft HB Health Strategy, providing opportunity for input from MRB.

MRB had previously expressed a desire to be included at the conception phase of strategic planning and the commitment to involvement of Màori at all levels in accordance with the DHB's Treaty obligations. On this occasion MRB queried the exclusion of He Ngakau Aotea and felt it should be a blueprint document for the HB Health Strategy development and implementation.

MRB stated the document is written to talk with the organisation and not written from a whanau perspective with HBDHB serving the community. The objectives and actions were also deemed not explicit enough to address 'equity for Māori as a priority' and the language used needs to be greatly improved if this HB Health Strategy should be considered to be inclusive enough to address Maori health strategic issues. Similarly the use of Te Reo Māori within the document seems academic and not ''feeling" the culture its wants to connect with.

MRB proposed another Hui to further discuss the strategy and collect thoughts for submission to the strategic team, so that by July a final document incorporating all feedback from committees can be agreed.

HE NGAKAU AOTEA

Taasha Romana, project manager for Ngāti Kahungunu Iwi Inc, provided a presentation on the development of the draft plan - 'He Ngakau Aotea'.

He Ngakau Aotea provides a framework on what services and programmes may look like with opportunities on where to reframe and rethink 'what does *well-being* look like for whanau Māori?'

It provides a more active approach to addressing whanau aspiration and achieving through effective engagement.

Key priorities are:
- New Approach to achieve equity
- Invest in social well-being and significant change/transformation
- Màori leadership - talk of collaboration at all levels and enables opportunity for MRB to track progress across sector strategy implementation

MRB recommended that a Health Economist be engaged to support the development of He Ngakau Aotea and estimate what the cost would be to achieve equity for Māori in HBDHB region.

EQUITY FRAMEWORK

Bernard Te Paa presented the draft Equity Framework that his directorate had developed requesting feedback from MRB members on the framework and the document supporting this.

MRB suggested some minor changes but overall saw the logic and look forward to its further development and implementation.

MRB also suggested that equity for Māori needed to be defined from a Ngati Kahungunu perspective and recommended HBDHB fund the development of this.

ANNUAL PLAN 19/20

Chris Ash, Executive Director of Primary Care provided latest draft of HBDHB Annual Plan to provide sight to MRB before the plan is submitted to Ministry of Health at the end of June. Chris, however, noting gaps in template as awaiting clarification on some aspects from the Ministry.

MRB endorsed the Annual Plan but suggested there needed to explicit focus on equity for Maori 'as a priority' and not as currently stated such as the faster cancer treatment equity outcome action referencing the refurbishment of buildings.

	Hawke's Bay Health Consumer Council
	For the attention of: **HBDHB Board**
Document Owner:	Rachel Ritchie (Chair)
Month:	June 2019
Consideration:	For Information

RECOMMENDATION

That the **HBDHB Board:**

1. **Note** the content of the report.
2. **Adopts** the recommendations in the Person & Whanau Centered Care paper

Council met on Thursday 13 June 2019. An overview of matters discussed is provided below:

MEMBERSHIP

Two new members attending their first meeting were welcomed and introduced:

- Tumema Faioso
- Daisy Hill (Hastings District Youth Council representative)

Two long serving members were retiring, having completed the maximum of six years service:

- Jenny Peters
- Olive Tanielu

Both were sincerely thanked for their contributions over these early years of the Consumer Council development and operation.

REPORTS

A number of reports from various consumer representatives were received and discussed as appropriate,:

- Consumer Experience Facilitators
- Consumer experience Committee
- Te Pitau Health Alliance Governance Group
- After Hours Care Service Group

- Professional Standards and Performance Committee
- Integrated Pharmacy Group
- NASC Audit Group

The increasing number of reports coming from consumer representatives, illustrates how consumer engagement is slowly expanding.

HAWKES BAY HEALTH STRATEGY

Council reviewed and discussed the latest draft of the Strategy presented at the meeting, and appreciated the opportunity to once again provide further input, noting the inclusion in this draft of feedback previously provided.

There were three themes to the feedback provided on this draft:

- There was discussion about the Measures of Success - some found them vague; some accepted that in undertaking a 'new approach' and a 'co- design' approach the goals were not known yet. It was however noted that more detail supporting these high levels objectives and measures will be developed and agreed during the implementation planning phase.
- Members, on the whole, were more interested in the implementation phase when the 'direction of travel of the 6 headline goals can be seen in 'action'.
- Members were still concerned about some of the language used throughout the document, e.g.:
    - difficult to see the picture it was painting;
    - technical terms used, particularly in the Digitally Enabled Health System goal were out of touch with a consumer approach which was 'that they wanted their IT health record to work across the system';

Overall there was general support for this draft of Health Strategy, noting that there are still some refinements to be made following this round of discussions and feedback. There was also understanding that the implementation phase is the part of the HB Health Strategy that really counts and importance of co-design highlighted in forming the detail in the implementation.

HBDHB ANNUAL PLAN

The Annual Plan was briefly discussed in the context that this is a compliance document and the Chair explained there was nothing to contribute from a consumer perspective. No issues were raised by members

PERSON & WHANAU CENTRED CARE

Council noted in receiving this paper that:

- PWCC as an initiative arising from a joint workshop between Clinical and Consumer Councils in March
- This report was in direct response to a Board resolution
- Council members Les Cunningham and Deborah Grace had been involved in the development of the report and recommendations

Key points raised during discussion included:

- There has been discussion at Consumer Council for some years about the health outcomes that come from a model focused on the needs of patient and whanau.
- Concern over culture change from clinicians. Importance of getting the right clinical lead to work in partnership with clinical leaders to champion PWCC and create a social movement amongst clinicians.
- Important that the system gives the *time* the patient *needs* not just allocated time.
- Clinical Council had endorsed the paper.
- Noted that the new PWCC appointments will have to communicate effectively with everyone in the system and especially those in community.
- Appropriate information to be included/addressed in the paper :
    - Where the most impact is? (i.e. chronic conditions) and
    - How it improves health outcomes/social change and citing examples,
    - Recognise that the 'system' needs to change;
    - Championing examples of the practical changes already made i.e. heart function clinic, mental health co-design group.

Following discussion, and taking account of changes to be made to the paper as necessary to reflect the feedback provided, Council endorsed the paper and the recommendations, recognising that to make these changes in practice resource needs to be allocated. These recommendations are therefore recommended to the Board for adoption.

1737 MENTAL HEALTH SUPPORT LINE

A general concern was raised by one member about apparent unacceptable response times and general inefficiency of the 1737 Mental Health Support Line. Whilst individuals will continue to raise their concerns directly, Council agreed that HBDHB support would be beneficial.

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

RECOMMENDATION

That the HBDHB Board

1. **Notes** the contents of this report.
2. **Adopts** the recommendations in the Person & Whanau Centred Care paper

HB Clinical Council met on 12 June 2019. A summary of matters discussed is provided below:

COMMITTEES & REPRESENTATIVES REPORTS TO COUNCIL

Reports were received from:

- Consumer Experience Committee
- Patient Safety and Risk management Committee
- Professional Standards and Audit Committee
- Te Pitau Health Alliance Governance Group

HB HEALTH STRATEGY

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

Council congratulated the team on the enhanced clarity achieved from recent changes and taking account of previous Council feedback. There were however some areas that members were particularly concerned about. Additional feedback on these included:

- Section on High Performing and Sustainable System does not reflect the current level of clinical risk (i.e. hospital at capacity, safari rounding, medical patients in surgical beds; impact of acutes on electives; deterioration of ED6; adverse events and the pressure in primary care)
- Indicators do not include key markers of capacity, patient safety and quality care.
- Under "What Does Success Look Like', need simple clear statements on what a safe service and a high quality service looks like.
- Concern around using the words "fit for purpose workforce" can have the connotation around current competence. Do not want to confuse clinical competence with the need for broader skill sets in the workplace.
- Strengthen outcomes framework under the equity section to say we will achieve the health outcomes in the framework

PERSON & WHANAU CENTRED CARE

Council discussed and fully endorsed the proposed approach and recommendations contained in the paper presented. In doing so, a number of points relating to implementation were also noted:

- Need to explore where the resource would best sit
- Multiple stakeholders need to be part of the working group
- Need to be cognisant how the programme aligns with a community driven health system

Council recommends that the Board adopt these recommendations, as implementation of them will go a long way to addressing the concerns raised (and reported) at the combined Councils workshop held back in March 2019.

OTHER ISSUES

Council also discussed and/or noted:

- Progress on Clinical Council Annual Plan
- Latest draft of HBDHB Annual Plan 2019 (no significant issues about the plan were identified but members were encouraged to email comments to planning staff)
- Early Supportive Discharge Model of Care

HAWKE'S BAY District Health Board Whakawāteatia	**Person & Whānau Centred Care** For the attention of: **HBDHB Board**
Document Owner	Kate Coley, Executive Director of People & Quality
Document Author(s)	Kate Coley, Executive Director of People & Quality Ken Foote, Company Secretary, Anne McLeod (Acting) Chief Allied Health Professions Officer, Patrick Le Geyt, Maori Health Services Manager, Caryn Daum & Nancy Barlow, Consumer Experience Facilitators, Les Cunningham & Deborah Grace (Consumer Experience Committee members)
Month/Year	June, 2019
	For Endorsement - Please note that EMT, Clinical and Consumer Council have reviewed, supported and fully endorsed the recommendations.
Purpose	The purpose of this paper is to respond to the specific Board recommendations and requirements as discussed at the March 2019 meeting and seek endorsement of the proposed recommendations.
Summary	At the March Board meeting, the Chairs of Clinical and Consumer Councils presented a report on a combined workshop held earlier that month, specifically to look at 'Person and Whānau Care in Primary Care'. One of the recommendations from this report adopted by the Board was: • **HBDHB Ensures** PWCC becomes the norm; to do that, **requests** management to present a paper to the June 2019 Board meeting that: - **Enables** the identification and freeing up of appropriate resources to prioritise the development of PWCC across the HB health sector - **Prioritises** the provision of specific education and training to the HB health workforce on implementing PWCC - **Facilitates** raising the levels of PWCC awareness within HB communities and empowering consumers to partner in their own care and contribute to service developments This report addresses these issues.
Consumer Engagement	Over the past 12 months both the Clinical & Consumer Councils have been working on the development of the Person & Whānau Centred care concept, and key workshops have informed the context of the Board recommendations and this paper which is in response to those.

	The development of this paper have included representatives of Consumer Council, alongside Clinical Council, People & Quality Directorate, Company Secretary and Māori Relationship Board.
Contribution to Goals and Strategic Implications	Improving safety, wellbeing, and quality of working lives of all HBDHB's staff and patients Improving the safety, quality and experience for patients Value for money Key strategic objective within Clinical Service Plan and Hawke's Bay Health Strategy
Impact on reducing inequities/disparities	Māori and Pacific have lower life expectancy, greater morbidity, higher rates of disability, less access to health and rehabilitation services and poorer experience of health care than non-Māori and non-Pacific. A key driver of transformation in any health system is enabling the voice of the consumer, especially those most in need, to co-design health system and services. Implementation of the proposal will have great potential for improving Māori and Pacific health outcomes and reduce health inequities in the district
Financial/Budget Impact	There are pockets and pieces of work being undertaken and implemented with no budget attached to them and as identified in the full paper there is a lack of coordination and prioritisation of these pieces of activity to really build the momentum that is required for transformational change. It is therefore recommended that an investment and/or resource reprioritisation/secondment be made upfront in a number of key roles for the first two years of the programme of work and that resources for campaigns and collateral are also budgeted. The potential investment required would be c.$340k per annum for a fixed two year period.

RECOMMENDATION:

That HBDHB Board:

- Endorse the need to identify a Clinical Leader who will work with the Executive Director of People & Quality to support this programme
- Endorse the appointment of a fixed term (2 years) Person & Whānau Centred Care Lead to manage the implementation of the programme of work
- Endorse the appointment of a fixed term (2 years) Communications/Campaign Facilitator
- Note the overarching programme structure and potential work streams

HAWKE'S BAY
District Health Board
Whakawāteatia

Person & Whānau Centred Care

Author:	**Kate Coley** Reviewed and supported by Anne McLeod, Patrick Le Geyt, Ken Foote, Deborah Grace, Les Cunningham, Nancy Barlow, Caryn Daum
Designation:	**Executive Director of People & Quality**
Date:	**June 2019**
FAO:	**HBDHB Board**

Purpose

The purpose of this paper is to respond to the Board recommendations and requirements as discussed at the March 2019 meeting and seek endorsement of the proposed recommendations and implementation framework.

Recommendations

That the Board agree the following:

- Endorse the need to identify a Clinical Leader who will work with the Executive Director of People & Quality to support this programme
- Endorse the appointment of a fixed term (2 years) Person & Whānau Centred Care Lead to manage the implementation of the programme of work
- Endorse the appointment of a fixed term (2 years) Communications/Campaign Facilitator
- Note the overarching programme structure and potential work streams

Background

At the March Board meeting, the Chairs of Clinical and Consumer Councils presented a report on a combined workshop held earlier that month, specifically to look at 'Person and Whānau Care in Primary Care'. Apart from noting many of the constructive ideas on how to advance this concept, the report also noted a number of frustrations and concerns about 'who will do all the work and when' to actually get some real progress on this to make a difference. The Māori Relationship Board (MRB) have likewise stressed the importance of consumer voice, especially given that Māori consumers are likely to experience poorer health care experiences. Therefore, the belief was that HBDHB needs a greater level of commitment and needs to do more to advance PWCC across the sector. This needs to be done with consumers, whānau and communities working in partnership with clinicians, managers and providers.

One of the recommendations from this report adopted by the Board was:

- **HBDHB Ensures** PWCC becomes the norm; to do that, **requests** management to present a paper to the June 2019 Board meeting that:

  - **Enables** the identification and freeing up of appropriate resources to prioritise the development of PWCC across the HB health sector

- **Prioritises** the provision of specific education and training to the HB health workforce on implementing PWCC
- **Facilitates** raising the levels of PWCC awareness within HB communities and empowering consumers to partner in their own care and contribute to service developments

This report addresses these issues.

We are committed to person & whānau centred care and there are a number of activities and actions underway. However, to date there has been a lack of an overarching plan to co-ordinate and prioritise the work underway. Research & evidence shows that PWCC improves health outcomes and patient experience and best uses available resources.

The results of the Big Listen, Korero Mai, Clinical Services Plan learnings from recent visits to South Central Foundation, demonstrate a need to prioritise and focus on this work.

Person & Whānau Centred Care and Community Led systems are two key strategic objectives within the new Health Strategy, and enabling PWCC becoming the way we do this around here will have a significant positive impact on our ability to achieve our strategy and vision for the Hawkes Bay health system.

What do we mean by Person & Whānau Centred Care?

Our definition of Person and Whānau Centred Care (PWCC) is informed by the Picker Institute which identified eight dimensions of "patient centred care" as:

- Respect for patients' preferences and values
- Emotional support
- Physical comfort
- Information, communication and education
- Continuity and transition
- Co-ordination of care
- The involvement of family and friends and
- Access to care.

The concept of PWCC clearly recognises the need to include not only the consumer but also their whānau, friends and carers. For PWCC to be successful, there is also a need to ensure that our workforce has the right values, cultural competency, and capability to enable them to care for others.

One of the simplest and perhaps clearest definitions of person and whānau centred care is:

*'Working **with** consumers and families/whānau, rather than **doing to** or **for** them".*

The Clinical Services Plan (CSP) identified that we need PWCC as the new approach to achieve equity and meet future demand. The CSP contained an illustrative table of what PWCC will look like in the future. A copy of this table is attached as Appendix 1

Components of a PWCC Programme

HBDHB has been influenced by the Nuka System of Care developed by South Central Foundation in Alaska, USA. 'Nuka', globally recognised as a leading health system, emerged from an in-depth and ongoing consumer co-design process that puts the consumer's values and culture at the centre of the health care model, where relationships between the consumer and health provider are seen as the most important mechanism to effect health improvement. Under development are some key principles for PWCC which are detailed in Appendix 2.

'Person and Whānau Centred Care' and 'Relationship Centred Practice' are key parts of the Nuka model of care. PWCC is about acknowledging the consumers as individuals that have whānau and support networks and that taking into account their preferences, cultural perspectives and social environments as vital to achieving shared decision making and better health outcomes. Furthermore, 'Relationship Centred Practice' builds upon PWCC with a recognition that in order to achieve person centred care, and the intended health outcomes, you must build strong, culturally appropriate and collaborative relationships with the consumer and their whānau. The role of the health provider is to work collaboratively in partnership with the consumer and their whānau and support them with the knowledge, skills and confidence to manage their own health.

A person and whānau centred approach is firstly about enabling the workforce to develop partnerships with consumers, whānau, carers, communities and colleagues. This requires working in a different way and not simply developing new skills and knowledge. Changing behaviours and habits is not easy. Practice in the workforce is a complex combination of behaviours, decision and interactions. Behaviour change requires the necessary combination of workforce capability, together with the opportunity and motivation for behaviour change.

He Ngākau Aotea - *a new heart – a new way* – is an active partnership to achieve whānau wellbeing in the Hawkes Bay region between Ngāti Kahungunu Iwi Inc and HBDHB. It stresses the need to put whānau at the centre and signals a need to shift from focussing on individuals. It starts by asking whānau what they want to achieve for themselves, and then responding to those aspirations in order to realise whānau potential. This approach recognises that each whānau has a different set of circumstances, and what works well for one whānau does not work well for other whānau. He Ngākau Aotea will be a key input into the development of PWCC.

A further work stream of the PWCC programme will be around building capability and capacity in the workforce with the introduction of a new orientation programme – Leading with HeART. This aligns to the Core Concepts programme developed in South Central Foundation and focuses on developing behaviours and actions needed to build relationships, including communication tools on how to 'listen and respond to story'. It develops an understanding of your own story, how it may impact relationships, relational styles and the value of compassion and empathy. It also encourages employees to engage fully in their jobs and the people they work with, which also increases positive outcomes across the organization. Induction/Orientation Day into HBDHB is the opportunity to train new staff in the 'way we do things around here'. Similarly, staff already employed in the health system would also be expected to undergo this training.

The sector will need to work in partnership to collaboratively and collectively plan, design and deliver services, systems, care and support that are designed around the needs of consumers and their whānau.

There is also a significant piece of work in regards to raising awareness and empowering our communities, whānau and consumers to become more engaged in the co-design of our health system and to become real partners in decision making about their own care and health. Communities, whānau and consumers can be engaged in various ways, at multiple levels:

- As partners to redesign services through co-design groups
- As committee, advisory and governance group members
- Through workshops, public hui's, working, steering or focus groups
- Through consumer and patient experience surveys and feedback mechanisms
- People plan - Involvement in consumer interviews, patient stories, patient journey mapping
- During consultations with clinicians, receiving services or otherwise engaging with the health system

Further details of what this engagement might include at these various levels is shown in the table at Appendix 3

Most importantly, for this approach and transformational change to 'stick' and become the way we do things around here, it also has to be supported by a system, processes and structure that makes it the easy thing to do, this is not just about behavioural change there will need to be fundamental changes in how the system is structured to enable PWCC.

How will we get commitment to this?

To ensure that we achieve person and whānau centred care across the sector living our values must be embedded in our culture. Therefore, we need a systematic approach to integrating this across the whole sector. This is in effect a significant transformational change programme of work and to successfully transform the sector we will need to consider these key principles (alongside the change envisioned in the People Plan):

- ***Building a shared vision*** – establishing the need for change, the benefits to all stakeholders and building understanding and awareness from the outset.
- ***Committed senior leadership*** – in addition to creating that vision for PWCC, it is pivotal to have governance and executive support and commitment, a designated senior executive with the responsibility for implementing the programme, supported by a lead Clinician, a programme manager and designated champions who model PWCC – sending a clear message about the importance of this approach. Alongside this our leaders' behaviours and values set the tone for the culture as does our ability to communicate openly and engage and listen to feedback from both staff and consumers and their whānau which will require specific communications & campaign expertise.
- ***Engaging consumers and whānau*** – will require partnerships at every level – from governance to individual, service and community – this was identified in the agreed Consumer Engagement strategy
- ***Gathering & utilisation of consumer and whānau experience feedback for improvement*** the need for us to use a range of ways to collect information and to address changes in response to the areas of need identified through this feedback.
- ***Building staff capacity & capability and a supportive environment*** – it is clear from all the evidence that we will need to focus time in our staff to build their capabilities and also create an environment that is kind and caring
- ***Accountability at all levels*** – establish accountability for staff at all levels, which is reinforced through a number of strategies and performance requirements
- ***Creating the right culture*** – one that strongly supports learning, change, improvement and is supportive and committed to the PWCC approach.
- ***One that Champions and celebrates the changes*** – creating visibility and celebrating success and the position impact it has on consumers and clinicians e.g. PAG, and Heart Function Clinic

To get our communities, whānau and consumers committed, we need to reflect the principles of partnership, participation and protection that underpin the involvement of Māori and the wider community. Alongside the shared values and behaviours of our sector, there are a number of other guiding principles that we need to apply to embed effective consumer engagement at all levels.

These are:

1. ***Being open and honest*** **-** Consumer engagement is more successful when all parties involved are mutually respectful, listen actively and have the confidence to participate in full and frank conversations.

2. ***Providing support*** **-** Support for consumer engagement means consumers are welcomed, they are well informed, their expertise is valued, their cultural needs are considered and their viewpoints are acknowledged and taken seriously.

3. ***Being real*** **-** Consumer engagement needs to be genuine; consumers and providers know when we are simply 'going through the motions'. Everyone should know about the purpose of engagement and the real possibilities for change and improvement.

4. ***Person and whānau focus*** **-** All consumer engagement needs to keep the focus on person and whānau centred care. It is important that providers and staff are supported to maintain their focus on patient/consumer/whānau as a core aspect of care.

5. ***Making health easy to understand*** – all engagement needs to meet the needs of whānau and consumers, being easy to understand so they can find their way around the system and contribute as an active partner in their own care.

6. ***Culturally appropriate*****:** - all engagement needs to meet the needs, values and be culturally appropriate to the consumer.

Current Status

There are a number of things happening, with pockets and pieces of work being undertaken that will all contribute in some way to PWCC. These include:

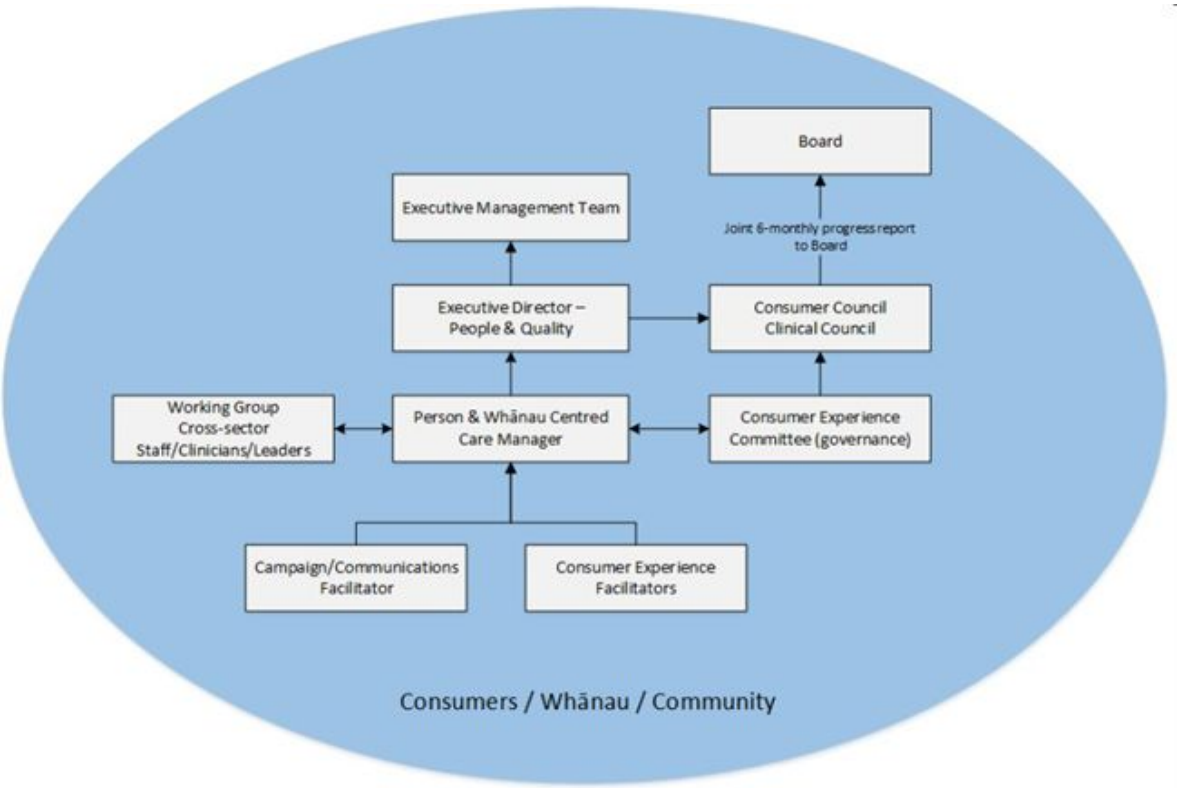
- HB Health Strategy
- People Plan
- Clinical Services Plan
- He Ngākau Aotea
- Patient Journey Workshops Action Plans
- Clinical & Consumer Council workshops
- Wairoa Community partnership Group – co-design
- Te Pitau Health Alliance co-design activities
- Making Health Easy to Understand Framework & Action plans
- Health navigators
- Leading with HeĀRT orientation programme
- Application of appropriate Nuka principles and philosophies
- Core Concepts - Induction
- Clinical Governance – roles and structures
- Relationship Centred Practice training
- PWCC Care Standards development
- Consumer Experience Committee
- Consumer Experience Facilitators
- Consumer Engagement Strategy
- Patient experience surveys and monitoring tools
- Recognising consumer participation policy
- Consumer representatives Guide to Consumer engagement

Whilst each of these pieces of work will all add some value to PWCC, they are not necessarily coordinated, nor do they cover all the issues that need to be addressed. A wider, more coordinated and integrated programme of work is required to maximise the benefits from all this. Much more also needs to be done in raising the general PWCC understanding and skills of the health workforce, and the levels of awareness of communities, whānau and consumers.

Future requirements – prioritising the work

It is recommended that the Executive Director of People & Quality, acts as the Executive Director responsible for the delivery and co-ordination of the programme of work. It will however require a whole of team approach for it to be successfully embedded. The steering group to guide the work and monitor that the work is being completed will be the Consumer Experience Committee, which consists of members from each of the Clinical and Consumer Councils and Māori Relationship Board. A Programme Working Group (made up of a wide cross section of people from across the sector e.g. Primary Care, Māori health Services, population health) will also be established to support the specific recommended operational resources. These will include a Clinical Leader, PWCC Lead, Consumer Experience Facilitators and a Communications/Campaign Facilitator. Six monthly reports will be provided to Board and other governance groups.

The organisational structure supporting PWCC will therefore include:



Investment/resources needed to ensure success

As already identified, there are pockets and pieces of work being undertaken and implemented, however there is a lack of coordination and prioritisation of these pieces of activity to really build the momentum that is required. It is therefore recommended that an investment and/or resource reprioritisation/secondment be made upfront in a number of key roles for the first two years of the programme of work. The below identifies the roles and the rationale for these positions. It should be noted that there will also be a requirement for ongoing budget for collateral and resources to support the programme. These have yet to be considered.

Position	Why do we need it?	Potential Investment (per year)
PWCC Lead	• Development of implementation programme • Co-ordination and priority focus on key activities • Champion for the programme of work • Creation of social movement • Ability to relate to all stakeholders across the sector	$120k
Communications /Campaign Facilitator	• Effective internal and external communications and campaign management • Drive social movement through campaigns • Build awareness of PWCC internally and within the community • Train the trainers • PR, Communications, campaigns • Supporting Making Health Easy for you (MHE4U)	$90-100k
Consumer Experience Facilitators	• Existing resources • Provides for integration and synergy of current activities with wider PWCC culture change • Work alongside services; promote the use of consumer voice in service design and improvement initiatives, build capability in co-design through education and training. • Encourage and provide advice for Healthcare Services to review and improve Health Literacy – to make information easy for our consumers to understand and use. • Attend Consumer Council, Consumer Experience Committee and engage with Consumer Representatives • Use consumer and patient experience survey feedback to identify themes/trends. • Develop a process to share information about consumer driven improvements, i.e. 'you said, we did'	Already budgeted
Clinical Leader	• Cross sector credibility – key to get clinicians on-board • Bring other clinical leaders on-board • Work across and building relationships across the sector	Equivalent of 0.3fte c. $50-70k

Implementation Framework

The first phase of this piece of work will be the development of an overarching implementation framework, which will identify key streams of work, and aims of those work streams. These will be further developed with objectives, activities, measures of success and KPIs. The work streams could include building awareness and socialisation of PWCC, Making Health Easy for You, Consumer Engagement, Using Consumer Experience Feedback for Improvement, Building capacity, Establishing Māori and Pacific Consumer Perspectives and Building Cultural Competency, Community engagement and Co-designing services. This framework will also been aligned to meet the descriptors of what a person & whānau centred care system should look like in the future detailed in the Clinical Services Plan and the principles.

Our approach to implementing the PWCC framework will be important. We will need to consider Māori and Pacific perspectives and ensure culturally competency responsiveness as key foundational inputs. We must balance creating the momentum for change and managing business as usual with

actually delivering and demonstrating the positive change to staff and consumers/whānau. Also, what leadership and relationships are required and how do we build on those relationships to ensure trust and free flow of ideas for transformational change. As this is a longer-term endeavour, with specific targeted pilots and quick wins, the approach should be a balance between a formal structure and one of building a social movement for change.

A social movement is a collective of individuals committed to promoting change through coordinated activity to produce a lasting and self-generating effect and creating as they do, a sense of shared identify. In creating a social movement, see-feel change is more powerful than analysis-think change.

Potential leaders, organisers and members of the movement might have the characteristics:

- Are not satisfied with the current pace, scale and impact of change
- Want to embrace the most effective thinking and practice in breakthrough change
- Believe that traditional thinking has been ineffectual or incomplete
- Recognise that consumers demand cultural competency
- Take personal responsibility for change
- Have a stomach for truth and straight talking
- Are up for the change themselves
- Are prepared to put the effort into change even if it is at a personal cost
- Are optimistic and courageous – want to make a difference and believe they will

In enabling a social movement as part of the developmental phase we will need to consider leadership, relationships and key actions to build the movement, which include the framing of the programme, mobilising the activities and then ensuring that they are being sustained.

Appendix 1 - Extract from Clinical Services Plan

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.
A shortage of safe, warm and dry homes means children experience an unnecessary burden of childhood illness.	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.
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.
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.

Problem with the current state	What a person and whānau centred system looks like in future
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.

Appendix 2 – Draft Strategic Principles

STRATEGIC PRINCIPLES – WHĀNAU ORA HĀPORI ORA

HEALTHY FAMILIES HEALTHY COMMUNITIES

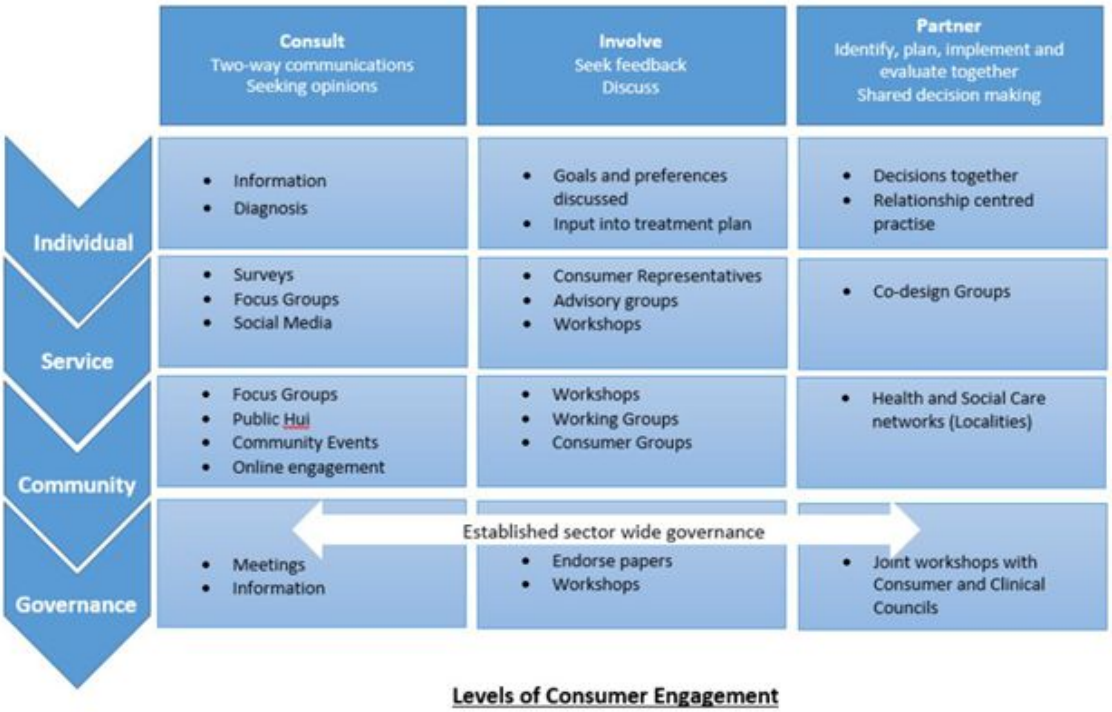
Whānau Participation in their Own Care
Healthy Lifestyles are Encouraged
Āchieving Equity for Maori is a Priority
Nurturing Environments of Trust are Established
Affordable Primary Care is Targetted to Need
Understand Our Populations and their Perspectives

Outstanding Quality of Care is Everywhere
Relationship Centred Practice is where Care Begins
Adopting Safe Practice at All Times

Holistic and Wellbeing Approaches Lead
Āuthentic and Trusting Relationships
Person and Whānau Centred Care
Our Healthcare System is Easy to Navigate
Research and Evidence Based Healthcare
Integrated Health Care Teams

Outcomes Focused
Respectful Relationships Matter
Access to Health Care is Easy

Appendix 3 – Levels of Consumer Engagement



Levels of Consumer Engagement

HAWKE'S BAY District Health Board Whakawāteatia	**Moving Equity Forward**
	For the attention of: **HBDHB Board**
Document Owner	Bernard Te Paa, Executive Director, Te Puni Matawhānui
Document Author(s)	Charrissa Keenan, Programme Manager, Māori Health Patrick Le Geyt, General Manager, Māori Health
Reviewed by	Màori Relationship Board
Month/Year	June 2019
Purpose	The purpose of this report is for MRB to discuss and agree to the proposed equity recommendations contained in this report, and once agreed, to be presented to the HBDHB Board for approval.
Previous Consideration Discussions	MRB equity workshops held on 10th and 29th April 2019.
Summary	A key function of MRB is to provide advice to identify, reduce, and remove health inequity. MRB have identified six key recommendations to achieve these aims, and propose they be presented to HBDHB Board for consideration.
Contribution to Goals and Strategic Implications	HBDHB Board – Equity for Māori is a priority. Health Equity report 2018; Clinical Services Plan - Whānau centred, Kaupapa Māori approaches. Ministry of Health priority – Achieving Equity.
Impact on Reducing Inequities/Disparities	Actions to create a responsive and equitable health system and services for whānau Māori.
Consumer Engagement	Not applicable.
Other Consultation /Involvement	Not applicable.
Financial/Budget Impact	Not applicable.
Timing Issues	Not applicable.
Announcements/ Communications	Not applicable.

RECOMMENDATION:

It is recommended that the **HBDHB Board:**

Agree on the six equity recommendations:

1. Re-allocate and commit resources (existing and new) to address equity for Māori as an inherent right under the Treaty of Waitangi
2. Development and application of equity planning, implementation, and monitoring tools
3. Measures for cultural competency of workforce and workforce development (recruitment/retention)
4. Demonstrated applications by HBDHB to address social determinants of inequity
5. Development of whānau focused approaches for gathering, identifying, and being accountable to whānau aspirations for health and well-being
6. Transition to Hauora Māori models of care

HAWKE'S BAY
District Health Board
Whakawāteatia

Moving Equity Forward

Author:	**Charrissa Keenan**
Designation:	**Programme Manager, Māori Health**
Date:	**May 2019**

OVERVIEW

The World Health Organisation defines equity as the "differences in health outcomes between groups within a population that are systematic, avoidable and unjust". In Aotearoa New Zealand, the Ministry of Health extends that definition further by stating that:

> "people have differences in health that are not only avoidable but unfair and unjust. Equity recognizes different people with different levels of advantage require different approaches and resources to get equitable health outcomes".

For Māori equity is an inherent right under the Treaty of Waitangi. The obligations arising from governance required the Crown to act fairly to both non-Māori and Māori – the interests of non- Māori could not be prioritised to the disadvantage of Māori. Where Māori have been disadvantaged, the principle of equity – in conjunction with the principles of active protection and redress – requires that active measures be taken to restore the balance.

Māori–Crown relations and achieving equity is a government priority set out in the Minister of Health's letter of expectations to HBDHB [letter 2019/20 refers], and HBDHB Board has agreed 'equity for Māori as a priority; also, equity for Pasifika and those with unmet need' [April 2019 HBDHB Board adopted recommendation].

Following a presentation on the Health Equity Report at the 10 October 2018 MRB meeting, MRB agreed that an equity workshop was needed to identify 'clear actions and targets for achieving equity'.

Workshops were held on the 10th and 29th of April 2019 with MRB and others to discuss gaps and opportunities for improving equity across HBDHB, and to explore and agree draft recommendations to HBDHB Board to strengthen the organisation's commitment to prioritise equity for Māori at all levels of the health system.

DISCUSSION

Following an equity presentation and discussion at workshop one and subsequent discussion at workshop two, the following recommendations are presented to MRB for further discussion and agreement. The finalised recommendations will be presented to HBDHB Board for consideration. The draft recommendations are:

1. Re-allocate and commit resources (existing and new) to address equity for Māori as an inherent right under the Treaty of Waitangi
2. Development and application of equity planning, implementation, and monitoring tools
3. Measures for cultural competency of workforce and workforce development (recruitment/retention)
4. Demonstrated applications by HBDHB to address social determinants of inequity
5. Development of whānau focused approaches for gathering, identifying, and being accountable to whānau aspirations for health and well-being
6. Transition to Hauora Māori models of care

In discussion of the above, MRB are asked to consider:

- Do the recommendations provide an explicit focus on achieving equity for Māori?
- Are opportunities for maximising Māori-Crown relations reflected in the recommendations?
- Will the recommendations provide ample opportunity to track and report on progress for achieving equity for Māori?

RECOMMENDATION:

It is recommended that the HBDHB Board:

Agree on the six equity recommendations:

1. Re-allocate and commit resources (existing and new) to address equity for Māori as an inherent right under the Treaty of Waitangi
2. Development and application of equity planning, implementation, and monitoring tools
3. Measures for cultural competency of workforce and workforce development (recruitment/retention)
4. Demonstrated applications by HBDHB to address social determinants of inequity
5. Development of whānau focused approaches for gathering, identifying, and being accountable to whānau aspirations for health and well-being
6. Transition to Hauora Māori models of care

Appendix 1: List of equity workshop attendees

Workshop 1: 10 April 2019	
Name	**Designation**
Tiwana Aranui	Kaumatua HBDHB
Tanira Te Au	Kaumatua HBDHB
Trish Giddens	MRB
Graeme Norton	MRB attendee, previous Chair of Consumer Council
Heather Skipworth	MRB, Chair, HBDHB Board Member
Dr Fiona Cram	MRB, member
Kerri Nuku	MRB, member
Nā Raihania	MRB, member
Peter Dunkerley	HBDHB Board member
Hine Flood	MRB member, HBDHB Board Member
Beverly Te Huia	MRB member
Bernard Te Paa	Executive Director, Health Improvement and Equity Directorate
Chris Ash	Executive Director, Primary Care Directorate
Andrew Phillips	Hospital Commissioner
Patrick Le Geyt	GM Māori, HBDHB
JB Heperi-Smith	Senior Cultural Competency Advisor, HBDHB
Justin Nguma	Senior Population Advisor, HBDHB
Charrissa Keenan	Programme Manager, HBDHB
Rawinia Edwards	Health Gains Advisor, HBDHB
Rebecca Adams	Health Gains Advisor, HBDHB
Workshop 2: 29 April 2019	
Name	**Designation**
Heather Skipworth	MRB, Chair, HBDHB Board member
Ana Apatu	HBDHB Board member
Trish Giddens	MRB member
JB Heperi-Smith	Senior Cultural Competency Advisor, HBDHB
Nā Rahainia	MRB member
Bernard Te Paa	Executive Director, Health Improvement and Equity Directorate
Justin Nguma	Senior Population Advisor, HBDHB
Charrissa Keenan	Programme Manager, HBDHB
Rawinia Edwards	Health Gains Advisor, HBDHB
Rebecca Adams	Health Gains Advisor, HBDHB

	FINAL Draft Hawke's Bay District Health Board Statement of Intent Incorporating the Statement of Performance Expectations – PART B of Annual Plan 2019/20
	For the attention of: **HBDHB Board**
Document Owner	Chris Ash, Executive Director of Primary Care
Document Author(s)	Kate Rawstron, Head of Planning & Strategic Projects Robyn Richardson, Principal Planner
Month/Year	June, 2019
Purpose	For approval
Summary	The first draft of the Hawke's Bay DHB (HBDHB) Annual Plan was shared in May. This final draft has been adapted in response to feedback from the Ministry of Health (MoH).
Contribution to Goals and Strategic Implications	Improving quality, safety and experience of care; improving health and equity for all populations; improving Value from public health system resources are all essential to our Annual Plan.
Impact on Reducing Inequities/Disparities	Note section on Health Status, system goals and target SPEs
Consumer Engagement	Consumer engagement activity is an essential part of activities within this plan.
Other Consultation /Involvement	Planning & Commissioning, Health Hawke's Bay, Population Health, Māori and Pasifika Health, Health Services and Corporate Services have been involved with the development of this plan.
Financial/Budget Impact	Financials have been included in this plan
Timing Issues	DHBs must publish the final signed version of their SOI and SPE (Part B) on their websites (extracted from the annual plan if the annual plan is not approved at this point) on their website by 30th June 2019
Announcements/ Communications	Not applicable

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the changes made to the plan from the May Board
2. **Approve** Part B of the Hawke's Bay District Health Board Annual Plan 2019/20 with **signatures** from the Chair and one other Board member

16

FINAL Draft Hawke's Bay District Health Board Statement of Intent Incorporating the Statement of Performance Expectations – PART B of Annual Plan 2019/20

Author:	**Kate Rawstron, Robyn Richardson**
Designation:	**Head of Planning & Strategic Projects**
Date:	**21st June 2019**

OVERVIEW

All DHB's must place a signed copy of 'Part B' of their Annual plan (extracted from the annual plan if the annual plan is not approved at this point) on their website by 30th June 2019.

The purpose of this paper to secure Board approval of Part B in order to meet this obligation.

Activity to date:

- The first draft of the Hawke's Bay District Health Board (HBDHB) Annual Plan was submitted to the May Board, this contained only a partial draft for Part B:

Part B	Statement of Intent 2019/22 (SOI)	***not included***
	Statement of Performance Expectations (SPE)	***draft SPE***
	Financial Performance	***first cut***

- Content adapted in response to feedback/ further guidance from the Ministry of Health (MoH)
- Amendments following the Strategic Discussion held with the MoH in May

Points to Note:

- The document can be re-publishing to the website after the 30th June – this is sometimes necessary if baseline content requires updating or further guidance is received from the Ministry etc.

ATTACHMENTS

HBDHB Annual Plan Part B 201-20 v3.2 (Cover)

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Note** the changes made to the plan from the May Board
2. **Approve** Part B of the Hawke's Bay District Health Board Annual Plan 2019/20 with **signatures** from the Chair and one other Board member

HAWKE'S BAY
District Health Board
Whakawāteatia

E83

Presented to the House of Representatives pursuant to section 149(L) of the Crown Entities Act 2004

2019/22 Statement of Intent

including 2019/20 Statement of Performance Expectations

Hawke's Bay District Health Board

16.1

OUR VISION

"HEALTHY HAWKE'S BAY"

"TE HAUORA O TE MATAU-A-MAUI"

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

OUR VALUES

HE KAUANUANU

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

ĀKINA

Continuously improving everything we do

RĀRANGA TE TIRA

Working together in partnership across the community

TAUWHIRO

Delivering high quality care to patients and consumers

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

DHB Contact Information:

Planning

Hawke's Bay District Health Board

Private Bag 9014

HASTINGS

Phone: 06-878 8109

www.hawkesbay.health.nz

STATEMENT FROM THE CHAIR AND CHIEF EXECUTIVE

TBC

X_____	X_____	X_____
Dr Kevin Snee	Kevin Atkinson	TBC, Board Member
Chief Executive - Hawke's Bay District Health Board	Board Chair – Hawke's Bay District Health Board	Hawke's Bay District Health Board

Hawke's Bay District Health Board

Who are we

Hawke's Bay District Health Board (HBDHB) is one of 20 District Health Boards (DHBs) that were established by the New Zealand Public Health and Disability Act 2000 (NZPHD Act). HBDHB is the Government's funder and provider of public health services for the 166,400[1] people resident in the Hawke's Bay district. A map of the district, which is defined by the NZPHD Act is shown in Figure 1. In 2019/20, HBDHB's allocation of public health funds will be $524 million, including 3.75%[2] of the total health funding that the Government allocates directly to all DHBs.

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

Figure 1: Hawke's Bay District Health Board District

Funding and Provision of Services

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

As a funder, HBDHB buys health and disability services from various organisations right across New Zealand for the benefit of our population. We fund and work very closely with the Primary Healthcare organisation (PHO) Health Hawke's Bay – Te Oranga Hawke's Bay who coordinate and support primary health care services across the district. Health Hawke's Bay brings together General Practitioners (GPs), Nurses and other health professionals in the community to serve the needs of their enrolled populations.

Other organisations we fund may be community-based private entities, such as residential care providers or individual pharmacists, or may be public entities, such as other DHBs. In 2019/20 we will fund over $258 million worth of services from other providers. 77% (2018/19 76%) of those services will be from primary care and private providers mostly based in Hawke's Bay communities and the other

[1] Estimated for 2018/19 by Statistics New Zealand based on assumptions specified by Ministry of Health
[2] HBDHB share has marginally decreased from the 3.76% received in 2018/19.
[3] DHB performance objectives are specified in section 22 of the NZPHD Act.

23% will be from other DHBs for more specialised care than is provided locally.

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

Because population numbers are too small to justify a full range of service provision in every district, each DHB is also part of a regional grouping that is coordinated to optimise service delivery. HBDHB is part of the Central Region along with Whanganui, Mid-Central (Manawatu), Capital and Coast (Wellington & Kapiti), Hutt Valley and Wairarapa DHBs. There are approximately 928,000 people living in the Central Region - around 19% of the total New Zealand population.

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

Organisational Overview

With just over 3,000 employees, HBDHB is the district's largest employer. Our provider arm is known as Provider Services and our frontline services are delivered to patients and consumers across the district in a number of settings. For example, we provide public health programmes in schools and community centres, inpatient and outpatient services in leased and owned health facilities, and mobile nursing services in people's homes. The main health facilities include Hawke's Bay Fallen Soldier's Memorial Hospital, Wairoa Hospital and Health Centre, Napier Health Centre and Central Hawke's Bay Health Centre. In addition, we have significant investment in clinical equipment, information technology and other (non-clinical) moveable assets. Corporate and clinical support services are located appropriately to provide effective back-up to our frontline services.

Our organisation is governed by a Board with eleven members, seven of whom are elected every three years (next election takes place in 2019) and four of whom are appointed by the Minister of Health. The Board is advised by four committees that include clinical, community and consumer representation. The Board employs the Chief Executive Officer to lead an executive management team, who oversee the day-to-day operations of the organisation.

Our population

In 2019/20, the Hawke's Bay district population is estimated will grow to nearly 168,000 people. Most of our population live in Napier or Hastings, two cities located within 20 kilometres of each other that together account for more than 80% of the total numbers. About 10% of the population live in or close to Wairoa or Waipukurau, which are relatively concentrated rural settlements, and the remaining 10% live in rural and remote locations.

Compared to New Zealand averages, there are some important differences in the makeup of our population – we have a higher proportion of Māori (26% vs 16%), more people aged over 65 years (18% vs 15%) and more people living in areas with relatively high material deprivation (28% vs 20%). The 2013 New Zealand Index of Deprivation (NZDep13)[4] explains how relative deprivation, as one measure of socio-economic status, is an indication of disadvantage in terms of people's opportunity to access and use the health system.

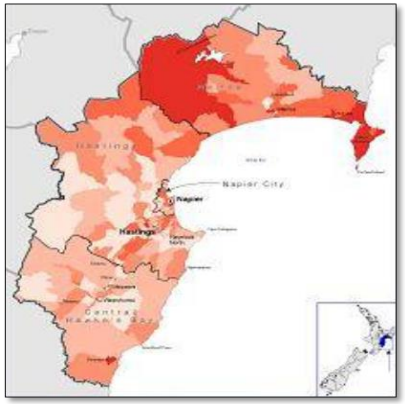


Figure 2: Hawke's Bay District relative deprivation – Darker colour higher deprivation, and lighter colour, lower deprivation update

Health Status

In 2018 we produced our third Health Equity report, an analysis and report on health status in Hawke's Bay. Equity in health means that all groups have fair opportunity to reach their full potential for a healthy life. The main focus of the report is to continue monitoring progress against previously reported equity measures thereby holding ourselves to account, the identification of successful approaches and identifying the greatest opportunities to eliminate health inequities. The report also took a more in-depth analysis into understanding some of the root causes of inequity and some the pathways by which social position contributes to inequity in Hawke's Bay.

The key message from the report is that Māori, Pacific people, and people living in greater socio-economic deprivation are still more likely to die early from avoidable causes.

Whilst a recent study showed that Hawke's Bay DHB was one of the New Zealand's' most successful DHBs in improving life expectancy for Māori for the period 2006 to 2013[5] the findings from the 2018 Equity Report is less positive with most measures of early and avoidable deaths showing no further progress has been made over the last two years of available data (2012-2014). Some of these issues of inequity are clearly linked to deterioration in socioeconomic conditions. For example we know the housing situation for many whanau in Hawke's Bay has deteriorated and we are working across sector with our partners locally and nationally on these issues.

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

Key findings:

- For Māori nearly a quarter of all avoidable deaths can be prevented if we can improve **heart health**
- Another quarter will be prevented when we prevent **lung cancer deaths** through smokefree living (and early detection and more effective treatment) and when we address the underlying causes of **suicide** and **vehicle crashes**
- For Pacific people we also need to focus on preventing and managing **diabetes** and preventing **stroke**
- Pacific pre-schoolers are experiencing higher rates of avoidable hospital stays, particularly for **skin infections**, and have the highest rates of **dental decay** the time they reach school
- Avoidable hospital stays for Māori and Pacific adults aged 45-64 are increasing. This is driven by increases in hospital stays for **heart attacks**, **chronic lung disease** and **skin infection**.

The potential, however, for health services to eliminate health inequity is clearly demonstrated by our continuing progress in immunisation and screening. Successes in delivering these preventative services show what can be achieved when we purposefully set out to understand the needs of our community and delivery our services in a way that meets the needs of whānau.

We need to learn from these successes to address other inequity such as those in sexually transmitted infection. We know from successful programmes both in Hawke's Bay and elsewhere that tackling inequity requires system and culture change, deliberate and sustained focus, realistic resourcing, accountability at all levels, and real community partnership. All critical components baked into our new strategy.

The full Health Equity Report can be accessed from our website. Health status reviews rely on up-to-date population information and HBDHB conducts periodic updates with full reviews following the release of Census data. The next full review is expected to be conducted by 2021.

[5]SandifordP, Consuelo DJJV, Rouse P. How efficient are New Zealand's' District Health Boards at producing life expectancy gains for Māori and Europeans? Australia and New Zealand Journal of Public Health. 41(2)2017

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

Section 1: Strategic Direction (SOI)

1.1 Strategic Outcomes

Why a health strategy?

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

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

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

Where are we at?

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

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

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

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

A focus on people

At its heart, our strategy is about people—as members of communities, whānau, hapū and iwi. We exist because of them and we recognise that people and whānau are the experts in their own lives. We need to focus more on the places people spend their time and take the delivery of healthcare outside traditional clinical venues. We need to plan and deliver health services in the wider context of people's lives, and consider how we include cultural practices (eg, mirimiri and rongoā Māori). This strategy describes our goals to empower and partner with people and whānau, and work across agencies to improve the conditions of life, so that everyone has fair opportunity to achieve good health and wellbeing.

There are two priority population groups that we need to respond to: whānau with children, and older people. We need to support the whole whānau to achieve goals and aspirations and ensure children have the best start in life. 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 turn to our people to find solutions. The District Health Board must act as a careful steward of health resources in Hawke's Bay, which is a challenging task. We need our community to help us so that we invest in the areas that matter most to people and whānau. This strategy prioritises health improvement of populations with the poorest health and social outcomes.

Our commitment to the Treaty of Waitangi

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

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

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

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

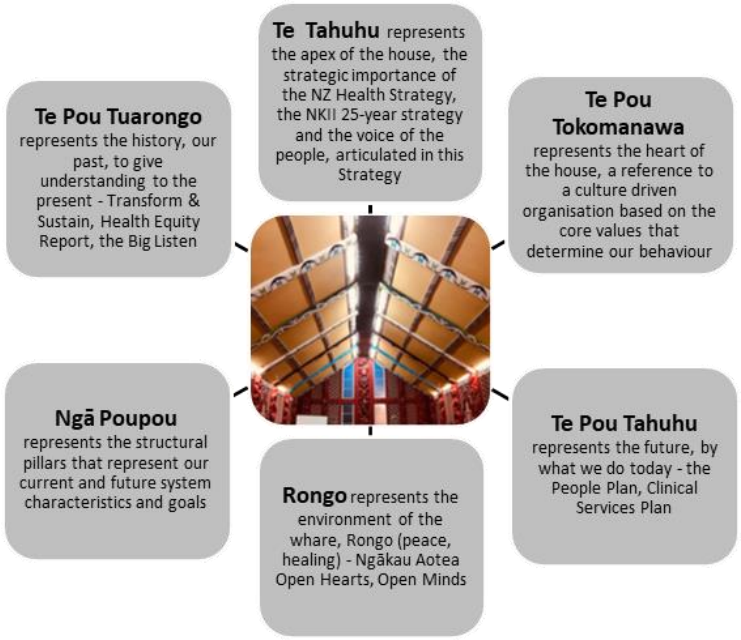
How does the Strategy fit with other plans?

We have done a lot of listening, thinking and planning over the last two years. Our Clinical Services Plan sets out the challenges and opportunities the system faces and describes concepts for the future we want. Our People Plan describes the culture and values we want and how we will grow our people to deliver on those concepts. The evidence in our Health Equity Report gives weight to the call for a bolder approach to resolving on-going inequities. At the same time we are developing a Digital Health Strategy and Finance Strategy that will enable the implementation of our strategies and plans.
Each of the plans we have produced is an important part of the process and this Strategy is the conclusion of that phase. We have written this Strategy to ground the strategic themes that have emerged as common threads in our more detailed work.

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

Rūia taitea kia tū ko taikaka ānake

(Discard the sapwood to uncover the hardwood)



The wider context

The Government has undertaken or is in the process of important work that will shape the evolution of our health system. That work includes the refreshed New Zealand Health Strategy, the response to the Inquiry into Mental Health and Addiction, the Health and Disability System Review, and the Government's wellbeing budget approach. The Treasury has adopted a Living Standards Framework that aligns stewardship of the public finance system with an inter-generational wellbeing approach.

The kaupapa of this Strategy aligns with the principles and values articulated by central Government and but the 'how' will have a distinctly Hawke's Bay flavour as we co-design responses with our local communities. As a region the Matariki partnership provides a wider context and further enables us to achieve our vision.

Turning strategy into action

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

Population health outcomes

The purpose of the health system is to achieve good health outcomes. This strategy directs us to do things in a different way to how we've done them in the past so we can make better progress in outcomes and equity of outcomes.

Our high-level accountabilities should be focused on outcomes rather than the processes by which they are achieved. We will develop a robust population health outcomes framework to monitor results in the design and delivery of health services. The national System Level Measures are important indicators of system performance.

Improved use of information will help the system as a whole to better target populations with unmet need. We will do this with a cascade of monitoring. For example, if we don't see the changes we are working towards in our outcomes framework, we will look at the performance indicators in the implementation plan for this strategy and see where we need to 'adjust the dials'.

System goals

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

1. Pūnaha Ārahi Hāpori
Community-led system

2. He Paearu Teitei me ōna Toitūtanga
High performing and sustainable system

3. He Rauora Hōhou Tangata, Hōhou Whānau
Embed person and whānau-centred care

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

4. Ngā Kaimahi Āhei Tōtika
Fit-for-purpose workforce

5. Pūnaha Tōrire
Digitally enabled health system

Headline objective

Increase healthy life expectancy for all and halve the life expectancy gap between Māori and non-Māori

This objective is a high-level measure which will help us track achievement of our vision and mission. We also want to reduce the gap for Pasifika and people with unmet need - however it is more difficult to accurately measure life expectancy for these groups.

We know that there are many complex factors that contribute to life expectancy and we don't have control or influence over all of them. We want all groups in our community to enjoy the same length of life, but we know that our health strategy cannot achieve this alone. Closing the life expectancy gap requires collaborative cross-government action to improve general socio-economic, cultural and environmental conditions; and ensure that living and working conditions are equitable.

But we do have a major part to play. The stark message from our Health Equity Report is that Māori, Pasifika and people living in socio-economic deprivation are still more likely to die from avoidable causes. For Māori, nearly a quarter of all avoidable deaths can be prevented if we can improve heart health. Another quarter will be avoided if we prevent lung cancer deaths through smoke-free living, and when we address the underlying causes of suicide and vehicle crashes. For Pasifika we also need to focus on preventing and managing diabetes and preventing stroke.

Pūnaha Ārahi Hāpori Community-led system

Health services will be designed and delivered to meet the needs identified by our communities, whānau and consumers

Why is this important?

We need to find new ways of doing things if we are to achieve equity within our population and meet future demand. We must turn to our communities for the solutions. Our communities are many and varied, including: iwi and hapū, geographical areas (including some small but relatively isolated rural communities), and groups of people with shared identity, experiences or interests. We need to identify and partner with different forms of local leadership to help transform our health system.

Wellness starts at home and in the community. Achieving equitable population health outcomes requires inter-sectoral collaborative action, driven by the wants and needs of communities. Our role is to support community-led planning and action by pooling expertise and resources—supporting communities to address long-standing social determinants of health in Hawke's Bay.

We want to make sure the health services we provide support community goals and reinforce communities to become less dependent on services. This means we need to give up some control.

We need to co-design services with the people that will use them, and follow through to implementation. We bring information and certain expertise to the table, but will support communities to design ground-up service responses to meet their needs. Everyone knows that resources are limited. Communities have local knowledge that can help us to provide cost-effective and sustainable services.

He Paearu Teitei me ōna Toitūtanga High performing and sustainable system

Delivering the best possible quality, safe, effective, efficient and sustainable services to meet the needs of our population within the funding available.

Why is this important?

Our system performs well in many areas but we can and must do better to meet the demand arising from population ageing and social change. We have opportunities to do things differently and need to embrace every opportunity to provide better care within our available resources.

The health system cannot afford to build bigger and bigger hospitals. We need to base services in primary care as much as possible and focus on proactive and preventive care. At the same time we need to implement strategies to reduce the demand for acute hospital admission. That will allow our hospital to focus on specialist assessment, decision making and intensive treatment.

When there is a need for inpatient hospital care we will engage consumers, their whānau and community providers in planning for well supported transitions from hospital.

Through honest and respectful conversations with people and whānau we can stop doing things that are clinically ineffective or offer little value or are not what people want. If we cut out waste in the delivery of services we can then deliver different, better or more extensive services within our available resources.

Technology offers us new ways of interacting with people and we need to modernise our business processes and change our traditional ways of doing things

He Rauora Hōhou Tangata, Hōhou Whānau Person and whānau-centred care

Person and whānau-centred care will become 'the way we do things around here'

Why is this important?

A person and whānau-centred approach has its focus on people, their whānau, friends and carers; understanding their needs and aspirations and what matters to them. Research shows that person and whānau-centred care improves health outcomes and consumer experience, and the use of health resources.

Embedding a person and whānau-centred approach means that our models of care will evolve to meet the specific needs of different groups of consumers, such as older people, families with children, or youth. We need to develop new ways of working alongside people to ensure that they feel ownership both in their own health journey and the system as a whole. Digital technology will enable people to have greater control of their personal health information and plan, access services in different ways and provide feedback.

We need to change our focus to a wellbeing model that supports people to manage their own physical and mental wellbeing. When we make health easy to understand people are able to make better informed and more appropriate health decisions. We also need to develop new types of services, such as behavioural services that help with psychological, emotional, relationship and cultural issues; in a way that is relevant to individuals and whānau, across the life course.

Creating a culture that is person and whānau-centred will require a fundamental shift in behaviours, systems, processes and services for people working across the Hawke's Bay health system.

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

Increase the life expectancy of all, while focussing on reducing the life expectancy gap for Māori, Pasifika and people with unmet need

Why is this important?

Different groups in our community have differences in health that are not only avoidable but unfair. Māori and Pasifika, people with disabilities or who experience mental illness; and those living in socioeconomic deprivation, continue to experience unacceptable inequities in health outcomes.

Achieving equitable health outcomes underpins all of our priorities for the Hawke's Bay health system. A genuine equity focus means that we commit to working with hard to reach groups, for example, people without a home, gang affiliated, or prison populations.

We have an obligation to provide services that are high quality and do not add to the inequities between population groups. We need to work with our inter-sectoral partners to tackle the underlying causes of inequity. Differences in socioeconomic determinants of health (such as housing, education and employment) are often long-term, inter-generational and as a result are ingrained in individuals and families.

We need to support community development, supporting whānau, hapū and iwi to achieve health and wellbeing of their people, which in turn will benefit all in our community.

We have control over the structural problems built into our health services and we can make immediate progress on this. An equitable system recognises that different people with different levels of advantage require different approaches and resources to achieve the same outcome. Resources will be refocused in the areas that will make a real difference to eliminating unmet need and inequities. Whānau will be equal partners in planning and co-design of services that are mana-enhancing and focussed on what matters the most to them.

Ngā Kaimahi Āhei Tōtika Fit-for-purpose workforce

Align the health sector workforce capacity and capability with the future models of care and service delivery

Why is this important?

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

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

Pūnaha Tōrire Digitally-enabled health system

Delivering and sharing information and insights to enable new models of care, better decisions and continuous improvement

Why is this important?

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

We must make information easy to access and share to implement new models of care. Trusted information needs to be available any time, any place and across different channels according to people's preferences and situations. Giving people access to their own digital health record enables them to have greater control of their healthcare journey.

We need to unlock the power of data to deliver insights that help people make better and faster decisions. Better use of data will enable us to measure and improve the quality and effectiveness of health services.

We will develop a continuous service improvement culture to ensure we get best value from our system. This means streamlining workflow and developing more iterative and rapid ways of doing things. We want to make it quicker and easier, and provide the solutions our people and communities need to improve health services and outcomes.

We need to make sure we have the core technology, along with rules for collecting, storing and using data, to enable access and integration.

Section 2: Managing our Business (SOI)

2.1 Managing our business

Organisational Performance Management

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

Strategic

- MoH – DHB Performance Monitoring
- HBDHB Strategic Dashboard.

Operational

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

General

- Chief Executive Report
- Financial Performance
- Human Resources Key Performance Indicators
- Strategic Programme Overview.

Funding and Financial Management

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

Financial Year	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Surplus/ (Deficit)	$3.222m	$3.054m	$4.366m	$3.567m	($8.576m)	($11.950m)*

*For the 2018/19 year the Operational Result is before the provision for Holidays Act remediation of $7m and full impairment of Finance, Procurement and Information Management system (FPIM) of $2.6m. The total deficit including these items will be $21.588m. The Holidays Act remediation estimate is still subject to review and approval by external auditors.

Due to the sustained pressure on our resources we planned a deficit of $5m for 2018-19, with the intent to return to a balanced budget in 2019-20. However increasing cost pressures and difficulties in delivering further sustainable savings in a challenging environment means that achieving a balanced plan for 2019-20 would impact quality of care. Consequently we are setting a deficit plan for 2019-20 of $15m.

The coming year will be a foundation year in our long-term strategy. Alongside strategy implementation, we will be working to deliver sustainable tactical changes which ensure we continue to deliver high quality services, that are clinically appropriate and support achievement of equity goals, in a financially sustainable way and moves HBDHB towards breakeven in 2021-22.

This will require:

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

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

Investment and Asset Management

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

HBDHB also undertakes asset management planning at a local level and has a 10 year long term investment plan which outlines our planned asset expenditure. This will be updated once the strategic implementation plan for delivery of the CSP is developed and reflected in the refresh of our facility master plan.

Approvals at regional and national level are sought depending on the threshold of any proposed investment to help ensure that there is some national consistency in development of the health assets. We will continue to work nationally with the development of the various national initiatives and regionally on the development of a regional solution for our information technology applications.

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

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

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

Risk Management

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

Quality Assurance and Improvement

The HBDHB is committed to improving quality of the services we deliver and apply a quality framework in line with the New Zealand Triple Aim:

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

We use the Ministry of Health approved model for improvement framework designed for developing, testing and implementing changes that lead to sustained improvements. And the national HQSC Quality and Safety markers are used by our governance groups to monitor and report our

patient safety and improvement performance, with our Quality Accounts published annually.

The most recent audit review against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008), was a mid-way Surveillance Audit undertaken in January 2018, a summary of this audit can be found here.

Section 3: Statement of Performance Expectations (SPE)

3.1 Statement of Performance Expectations (SPE)

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

- **Prevention Services**
- **Early Detection and Management Services**
- **Intensive Assessment and Treatment Services**
- **Rehabilitation and Support Services.**

The outputs and measures presented are a reasonable representation of the full range of services provided by the organisation. Where possible, we have included past performance (baseline data) and the performance target to give the context of what we are trying to achieve and to enable better evaluation of our performance.

Service Performance

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

The system dimension: Best value for public health system resources

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

The population dimension: Improved health and equity for all populations

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

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

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

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

The HBDHB SPE for the 2019/20 year follows:

16.1

Board Member Board Member

3.2 Output Classes

Output Class 1: Prevention

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

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

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

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

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

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

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

Short Term Outcome	Indicator	New Nomenclature	MoH Measure	Baseline					2019/20 Target
				Period	Māori	Pasifika	Other	Total	
Better help for smokers to quit	% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	SS06	PP31	Jan-Dec 2018	97%	96%	96%	96%	≥95%
	% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	PH04	HT	Jan-Dec 2018	82%	81%	89%	85%	≥90%
	% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking	CW09	HT	Jan-Dec 2018	88%	N/A	N/A	85%	≥90%
	SLM Number of babies who live in a smoke-free household at 6 weeks post-natal	PH01	SI13	Jan-Jun 2018	45%	45%	64%	45%	≥21.9%
Increase immunisation	% of 8 month olds will have their primary course of immunisation (6 weeks, 3 months and 5 month events) on time	CW08	HT	Jan-Dec 2018	92%	97%	92%	92%	≥95%
	% of 2 year olds fully immunised	CW05	PP21	Jan-Dec 2018	93%	97%	93%	93%	≥95%
	% of 4 year olds fully immunised	CW05	PP21	Jan-Dec 2018	90%	88%	92%	1%	≥95%
	% of boys & girls fully immunised – HPV vaccine	CW05	PP21	Jul 2017-Jun 2018	85%	88%	70%	76%	≥75%
	% of 65+ year olds immunised – flu vaccine	CW05	PP21	Mar-Sep 2018	53%	52%	59%	58%	≥75%
Reduced incidence of first episode of rheumatic fever	Acute rheumatic fever initial hospitalisation rate per 100,000	CW13	PP28	Jul 2016 – Jun 2017	tbc	tbc	tbc	tbc	≤1.5 per 100,000
Improve breast screening rates	% of women aged 50-69 years receiving breast screening in the last 2 years	PV01	SI11	Two Years to Dec 2018	70%	67%	76%	74%	≥70%
Improve cervical screening coverage	% of women aged 25–69 years who have had a cervical screening event in the past 36 months	PV02	SI10	Three Years to Dec 2018	76%	72%	78%	76%	≥80%
Better rates of breastfeeding	% of infants that are exclusively or fully breastfed at 3 months	CW06	PP37	Six months to Dec 2018	43%	58%	N/A	57%	≥60%

Output Class 2: Early Detection and Management Services

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

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

Objective: People's health issues and risks are detected early and treated to maximise wellbeing

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

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

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

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

Short Term Outcome	Indicator	New Nomenclature	MoH Measure	Baseline					2019/20 Target
				Period	Māori	Pasifika	Other	Total	
Improved access primary care	% of the population enrolled in the PHO	PH03	PP33	Jan 2018	99%	92%	97%	98%	≥90%
Reduce the difference between Māori and other rate for ASH Zero-Four - SLM	Ambulatory Sensitive Hospitalisation (ASH) rate per 100,000 zero - 4 years	PH01	SI1 / SI5 / PP22(SLM)	12 months to Dec-18	8,750	18,028	5,891	7,969	Māori ≤8313
Reduce ASH 45-64	ASH rate per 100,000 45-64 years	SS05	SI1		9,328	8,404	3,437	4,613	Māori ≤ 8,710
More pregnant women under the care of a Lead Maternity Carer (LMC)	% of women booked with an LMC by week 12 of their pregnancy			Jul to Sep 2018	55%	44%	72%	64%	80%
Improving new-born enrolment in General Practice	% of new-borns enrolled in general practice by 6 weeks of age	CW07	SI18						≥55%
	% of new-borns enrolled in general practice by 3 months of age	CW07		Dec to Feb2019	93%	91%	88%	90%	≥85%
Better oral health	% of children who are carries free at 5 years of age	CW01	PP11 / SI5	12 months to Dec-18	tbc	tbc	tbc	tbc	≥ 0.62 Yr1 ≥ 0.62 Yr2
	Mean 'DMFT' score at year 8	CW02	PP10		0.94	1.16	0.62	0.76	≤0.69 Yr1 ≤0.69 Yr2
	% of eligible pre-school enrolments in DHB-funded oral health services	CW03	PP13		tbc	tbc	tbc	tbc	≥ 95%Yr1 ≥ 95%Yr2
	% of enrolled preschool and primary school children not examined according to planned recall	CW03	PP13		10%	13%	10%	10%	≤ 10%Yr1 ≤ 10%Yr2
	% of adolescents (school sear 9 up to and including age 17 years) using DHB funded dental services	CW04	PP12	12 months to Dec-16	tbc	tbc	tbc	tbc	≥ 85%Yr1 ≥ 85%Yr2

16.1

Short Term Outcome	Indicator	New Nomenclature	MoH Measure	Baseline					2019/20 Target
				Period	Māori	Pasifika	Other	Total	
Improved management of long-term conditions (CVD, acute heart health, diabetes, and stroke)	Proportion of people with diabetes who have good or acceptable glycaemic control (HbA1C indicator)	SS13	PP20	12m to Dec-18	tbc	tbc	tbc	tbc	tbc
	% of the eligible population will have had a CVD risk assessment in the last five years	SS13	PP20	Five years to Dec-18	84%	80%	87%	86%	≥90%
Less waiting for diagnostic services	% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks)	SS14	PP29	Dec-18	NA	NA	NA	92%	≥95%
	% of accepted referrals for MRI scans who receive their scans within 42 days (6 weeks)	SS14	PP29	Dec-18	NA	NA	NA	90%	≥90%
Increase referrals of obese children to clinical assessment and family based nutrition, activity and lifestyle interventions	% of obese children identified in the B4SC programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	CW10	HT/SI5	6 months to Nov-18	98%	93%	94%	96%	≥95%
Improved youth access to health services - SLM	Total self-harm hospitalisations and short stay ED presentations for <24 year olds per 10,000	PH01	SI12	12 months to Dec -18	79.8	39.6	58	65.6	Māori ≤ 75.0
	% of ED presentations for 10-24 year olds which are alcohol related	PH01		12 months to Dec -18	14.6%	8.5%	12.1%	12.8%	Māori ≤ 14.3%
Amenable mortality - SLM	Relative rate between Māori and Non-Maori Non-Pasifika (NMNP)	PH01	SI9	2015	2.45 relative rate				≤2.5

Output Class 3: Intensive Assessment and Treatment Services

Intensive assessment and treatment services are delivered by a range of secondary, tertiary and quaternary providers to individuals. This output class includes: mental health services, elective and acute services (including outpatients, inpatients, surgical and medical services, maternity services and, AT&R services. These services are usually integrated into facilities that enable co-location of clinical expertise and specialised equipment, such as a 'hospital', and they are generally complex in nature and provided by specialists and other health care professionals who work closely together. There are also important links with community-based services before people come into hospital services and after they are discharged – these links must be well coordinated and work as seamlessly as possible.

Hawke's Bay DHB provides most of this output class through the provider arm, Health Services. However, some more specialised hospital services are funded by HBDHB to be provided by other DHBs, private hospitals, or other providers. Where this happens, other providers are monitored in terms of the operational policy framework or specific contracts, and in accordance with industry standards. On the continuum of care these services are at the complex end of "conditions" and are focussed on individuals with health conditions and prioritised to those identified as most in need.

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

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

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

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

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

Short Term Outcome	Indicator	New Nomenclature	MoH Measure	Baseline					2019/20 Target
				Period	Māori	Pasifika	Other	Total	
Less waiting for ED treatment	% of patients admitted, discharged or transferred from an ED within 6 hours	SS10	HT	Jan to Dec 2018	91%	92%	87%	88%	≥95%
Faster cancer treatment (FCT)	% of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks	SS01	HT	6 months to Dec-18	92%	100%	98%	95%	≥90%
	% of patients who receive their first cancer treatment (or other management) within 31 days from date of decision to treat	SS01	PP30	6 months to Dec-18	NA	NA	NA	85%	≥85%
Patients with ACS receive seamless, coordinated care across the clinical pathway	% of ACS patients undergoing coronary angiogram, door to cath, within 3 days	SS13	PP20	Jan to Dec-18	57%	50%	64%	61%	>70%
	% of ACS patients who undergo coronary angiogram have pre-discharge assessments of LVEF	SS13	PP20	Jan to Dec-18	64%	75%	66%	66%	≥85%
	Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance all ACS patients who undergo coronary angiogram should be prescribed at discharge aspirin, a second anti-platelet agent, statin and an ACE/ARB (four classes) and those with LVEF<40% should also be on a beta blocker (five classes)	SS13	PP20	Jan to Dec-18	67%	80%	51%	55%	>85%
	% of patients presenting with acute coronary syndrome who undergo coronary angiography have completion of ANZACS QI ACS and cath/PCI registry data collection within a) 30 days of discharge and b) within 3 months	SS13	PP20	Sep to Nov 2018	93% 100%	100% 100%	98% 100%	97% 100%	a) >95% b) >99%
Equitable access to care for stroke patients	% of potentially eligible stroke patients who are thrombolysed 24/7	SS13	PP20	Jan to Dec-18	15%	N/A	N/A	9%	10%
	% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	SS13	PP20	Jan to Dec-18	82%	88%	80%	80%	80%
	% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	SS13	PP20	Jan to Dec 18	93%	NA	68%	73%	≥80%

Short Term Outcome	Indicator	New Nomenclature	MoH Measure	Baseline					2019/20 Target
				Period	Māori	Pasifika	Other	Total	
	% of stroke patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge.	SS13	PP20	N/A	tbc	tbc	tbc	tbc	≥60%
Equitable access to surgery - Standardised intervention rates for surgery per 10,000 population for:	Major joint replacement	SS	SI4	12 months to Dec-18	N/A	N/A	N/A	19.7	tbc
	Cataract procedures	SS			N/A	N/A	N/A	46.0	tbc
	Cardiac surgery	SS			N/A	N/A	N/A	4.9	tbc
	Percutaneous revascularisation	SS			N/A	N/A	N/A	12.9	tbc
	Coronary angiography services	SS			N/A	N/A	N/A	40.0	tbc
Shorter stays in hospital	LoS Elective (days)	SS	OS3	12 months to Dec-18	N/A	N/A	N/A	1.59	tbc
	LoS Acute (days)	SS	OS3	12 months to Dec-18	N/A	N/A	N/A	2.31	tbc
Fewer readmissions	Acute readmissions to hospital	SS	OS8	12 months to Dec-18	11.7%	11.9%	12.1%	11.9%	tbc
Quicker access to diagnostics	% accepted referrals for elective coronary angiography completed within 90 days	SS14	PP29	Dec-18	NA	NA	NA	100%	tbc
	% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive),	SS15	PP29	Dec-18	100%	NA	94%	95%	tbc
	% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 days)	SS15	PP29	Dec-18	67%	NA	69%	69%	tbc
	% of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date	SS15	PP29	Dec-18	NA	NA	NA	55%	tbc
	% of participants to have received their colonoscopy within 45 working days of their FIT result being recorded in the NBSP information system	SS15	NA		NA	NA	NA	NA	≥95%
Fewer missed outpatient appointments	Did not attend (DNA) rate across first specialist assessments			Jan to Dec 18	11.3%	13.3%	3.9%	5.9%	≤5% total ≤9% Māori and Pacific

16.1

Short Term Outcome	Indicator		New Nomenclature	MoH Measure	Baseline					2019/20 Target
					Period	Māori	Pasifika	Other	Total	
Better mental health services Improving access Better access to MH&A services	Proportion of the) population seen by MH&A services	Child & youth (zero -19)	MH01	PP6	12 months to Sep-18	4.3%	2.0%	3.8%	5.3%	tbc
		Adult (20-64)	MH01	PP6		9.8%	3.9%	3.9%	5.3%	tbc
		Older adult (65+)	MH01	PP6		1.47%	0.86%	1.01%	1.05%	tbc
Reducing waiting times Shorter waits for non-urgent mental health and addiction services for zero-19 year olds	% of zero-19 year olds seen within 3 weeks of referral	Mental health provider arm	MH03	PP8	12 months to Dec-18	80%	94%	71%	75%	≥ 80%
		Addictions (provider arm and NGO)	MH03	PP8		69%	100%	60%	67%	≥ 80%
	% of zero-19 year olds seen within 8 weeks of referral	Mental health provider arm	MH03	PP8		93%	100%	91%	92%	≥ 95%
		Addictions (provider arm and NGO)	MH03	PP8		93%	100%	93%	89%	≥ 95%
Improving mental health services using discharge planning	Community services transition (discharge) plans		MH02	PP7	Jan-Dec 2018					
	% of clients discharged from community MH&A will have a transition (discharge) plan					N/A	N/A	N/A	78.5%	≥95%
	% of audited files have a transition (discharge) plan of acceptable standard					N/A	N/A	N/A	97.0%	≥95%
	Wellness plans									
	% of clients with an open referral to MH&A services of greater than 12 months have a wellness plan.					N/A	N/A	N/A	99.3%	≥95%
	% of audited files meet accepted good practice – wellness plans					N/A	N/A	N/A	89.0%	≥95%
	Inpatient services transition (discharge) plans									
	% of clients discharged from adult inpatient MH&A services have a transition (discharge) plan					N/A	N/A	N/A	64.3%	≥95%
	% of audited files have a transition (discharge) plan of acceptable standard					N/A	N/A	N/A	-	≥95%
Increasing consumer focus More equitable use of Mental Health Act: Section 29 community treatment orders	Rate of s29 orders per 100,000 population		MH05	PP36 / SI5	12 months to Dec-18	395	119	109		Maori ≤10% reduction

Short Term Outcome	Indicator	New Nomenclature	MoH Measure	Baseline					2019/20 Target
				Period	Māori	Pasifika	Other	Total	
Better patient experience - SLM	Response rate for patient experience surveys - inpatient and general practice tbc	PH01	SI8	tbc	tbc	tbc	tbc	tbc	tbc
Better aligned services - SLM	Total acute hospital bed days per capita (per 1,000 population)	PH01	SI7	Jan-Dec 2018	636	511	354	410	≤ 390 total
More appropriate elective surgery	Number of publicly funded casemix included, elective and arranged discharges for people living within the DHB region	SS	PP45	12 months to Jun-18	NA	NA	NA	7,467	Tbc
Improving the quality of identity data within the national health index (NHI) and data submitted to national collections	New NHI registrations in error	SS9	OS10	3 months to Dec-18	NA	NA	NA	5.1%	≤3%
	Recording of non-specific ethnicity in new NHI registrations	SS09	OS10	3 months to Dec-18	NA	NA	NA	1.3%	≤2%
	Update of specific ethnicity value in existing NHI records with a non-specific value	SS09	OS10	3 months to Dec-18	NA	NA	NA	0.1%	≤2%
	Invalid NHI data updates	SS09	OS10	3 months to Dec-18	NA	NA	NA	NA	tbc
	NPF collection has accurate dates and links to NNPAC, NBRS and NMDS for FSA and planned inpatient procedures	SS09	OS10	3 months to Dec-18	NA	NA	NA	NA	≥90%
	National collections completeness	SS09	OS10	3 months to Dec-18	NA	NA	NA	NA	≥94.5%
	Assessment of data reported to the national minimum set (NMDS)	SS09	OS10	3 months to Dec-18	NA	NA	NA	84.1%	≥75%

16.1

Output Class 4: Rehabilitation and Support Services

This output class includes: needs assessment and service co-ordination, palliative care, rehabilitation, home-based support, aged residential care, respite care and day care for adults. Many of these services are delivered following a 'needs assessment' process and involve coordination of input from a range of providers. Rehabilitation and support services assist people with enduring conditions and disabilities to live independently or to receive the support that they need either temporarily or over the rest of their lives. Hawke's Bay DHB provides NASC services via our provider arm. Other services are provided by our provider arm, general practice and a number of community-based NGOs and private organisations. On the continuum of care these services provide support for individuals who have complex, complicated or end-stage conditions.

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

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

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

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

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

Short Term Outcome	Indicator		New Nomenclature	MoH Measure	Baseline					2019/20
					Period	Māori	Pasifika	Other	Total	Target
Better access to acute care for older people	Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population)	75-79 years		NA	12 months to Dec-18	202.2	83.3	124.7	127.5	≤130
		80-84 years				129.2	250	174.8	169.1	≤170
		85+ years				278.6	166.7	228.8	227.5	≤225
Better community support for older people	Acute readmission rate: 75 years +		SSxx	OS8	12 months to Dec-18	12.8%	10.7%	12.2%	12.3%	≤11%
	Rate of carer stress :informal helper expresses feelings of distress = YES, expressed as a % of all home care assessments		SS04	PP23	Oct-Dec 2017	tbc	tbc	tbc	tbc	≤26%
	% of people having homecare assessments who have indicated loneliness				Oct-Dec 2017	tbc	tbc	tbc	tbc	≤23%
Increased capacity and efficiency in needs assessment and service coordination services	Conversion rate of contact Assessment (CA) to Home Care Assessment where CA scores are four-six for assessment urgency				Oct-Dec 2017	tbc	tbc	tbc	tbc	tbc
	Clients with a Change in Health, End-stage Disease, Signs and Symptoms) (CHESS) score of four or five at first assessment				Oct-Dec 2017	tbc	tbc	tbc	tbc	11%
More older patients receive falls risk assessment and care plan	% of older patients given a falls risk assessment % of older patients assessed as at risk of falling receive an individualised care plan				12 months to Dec-18	N/A	N/A	N/A	93% 90%	≥90% ≥90%

16.1

Section 4: Financial Performance (for SOI and SPE)

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

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

4.1 Projected Financial Statements

Introduction

Hawke's Bay DHB is planning to deliver a $15.0 million deficit result for 2019/20, recognising the increasing demands placed on DHBs, by increased acuity and patient volumes arising from demographic trends and technological advances. The result for 2020/21 is expected to see an improvement to an $8 million deficit, with further improvement to breakeven from 2021/22. To achieve this the DHB will focus on tactical solutions to close the financial gap, whilst the strategy and five-year implementation plan are developed. These include prioritisation of resources and increasing productivity through management of cost drivers.

Reporting entity

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

Cautionary Note

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

The underlying assumptions were adopted on 21 June 2019.

Accounting Policies

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

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

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

Projected Statement of Revenue and Expense						
in thousands of New Zealand Dollars	2018	2019	2020	2021	2022	2023
For the year ended 30 June	Audited	Forecast	Projected	Projected	Projected	Projected
Ministry of Health - devolved funding	516,552	544,682	573,100	593,044	613,446	633,629
Ministry of Health - non devolved contracts	14,369	14,947	14,618	15,127	15,648	16,163
Other District Health Boards	12,710	13,013	12,550	12,997	13,454	13,907
Other Government and Crown Agency sourced	6,046	5,713	5,334	5,533	5,738	5,942
Patient and consumer sourced	1,117	1,258	1,244	1,291	1,339	1,386
Other	6,104	5,539	4,639	4,725	4,899	5,072
Operating revenue	556,898	585,151	611,485	632,717	654,524	676,099
Employee benefit costs	209,611	235,675	243,178	251,690	259,996	269,095
Outsourced services	19,294	20,081	16,023	16,580	17,150	17,715
Clinical supplies	49,696	56,131	57,570	55,002	49,699	50,084
Infrastructure and non clinical supplies	50,773	53,433	51,562	53,311	54,354	56,784
Payments to non-health board providers	236,100	241,419	258,152	264,134	273,325	282,421
Operating expenditure	565,474	606,739	626,485	640,717	654,524	676,099
Surplus/(Deficit) for the period	**(8,576)**	**(21,588)**	**(15,000)**	**(8,000)**	**-**	**-**
Revaluation of land and buildings	15,312	-	-	-	-	-
Other comprehensive revenue and expense	15,312	-	-	-	-	-
Total comprehensive revenue and expense	**6,736**	**(21,588)**	**(15,000)**	**(8,000)**	**-**	**-**

Table 5 – Projected Statement of Comprehensive Revenue and Expense

Projected Statement of Movements in Equity						
in thousands of New Zealand Dollars ***For the year ended 30 June***	2018 Audited	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Equity as at 1 July	**142,345**	**148,724**	**126,778**	**114,871**	**109,695**	**110,766**
Total comprehensive revenue and expense:						
Funding of health and disability services	3,101	665	(15,000)	(8,000)	-	-
Governance and funding administration	568	155	-	-	-	-
Provision of health services	(12,245)	(22,408)	-	-	-	-
	6,736	(21,588)	(15,000)	(8,000)	-	-
Contributions from the Crown (equity injections)	-	-	3,450	3,182	1,428	-
Repayments to the Crown (equity repayments)	(357)	(357)	(357)	(357)	(357)	(357)
Equity as at 30 June	**148,724**	**126,778**	**114,871**	**109,695**	**110,766**	**110,408**

Table 6 - Projected Statement of Movements in Equity

Projected Statement of Financial Position *in thousands of New Zealand Dollars* ***As at 30 June***	2018 Audited	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Equity						
Paid in equity	82,002	81,645	84,738	87,563	88,633	88,276
Asset revaluation reserve	82,704	82,704	82,704	82,704	82,704	82,704
Accumulated deficit	(15,982)	(37,571)	(52,571)	(60,571)	(60,571)	(60,571)
	148,723	**126,778**	**114,871**	**109,695**	**110,766**	**110,408**
Current assets						
Cash	6,488	4	4	4	4	4
Short term investments (special funds/clinical trials)	2,841	2,690	2,690	2,690	2,690	2,690
Receivables and prepayments	25,463	26,060	26,488	27,410	28,353	29,286
Loans (Hawke's Bay Helicopter Rescue Trust)	11	12	-	-	-	-
Inventories	3,907	3,856	3,933	4,070	4,210	4,349
	38,711	32,622	33,116	34,175	35,258	36,330
Non current assets						
Property, plant and equipment	174,500	178,618	176,597	180,836	178,503	176,679
Intangible assets	1,479	2,100	2,661	3,307	4,134	4,546
Investment property	960	610	610	610	610	610
Investment in NZ Health Partnerships Limited	2,293	-	-	-	-	-
Investment in associates	9,266	9,725	10,398	10,398	10,398	10,398
Loans (Hawke's Bay Helicopter Rescue Trust)	15	-	-	-	-	-
	188,512	191,053	190,266	195,151	193,645	192,233
Total assets	**227,223**	**223,675**	**223,381**	**229,326**	**228,903**	**228,563**

16.1

Continued ...

Projected Statement of Financial Position *in thousands of New Zealand Dollars* ***As at 30 June***	2018 Audited	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Less:						
Current liabilities						
Bank overdraft	-	15,011	29,641	35,319	29,649	27,523
Payables and accruals	35,817	32,451	35,952	37,565	39,114	40,420
Employee entitlements	40,065	46,726	39,653	41,040	42,395	43,879
	75,881	94,188	105,246	113,924	111,158	111,822
Non current liabilities						
Employee entitlements	2,619	2,709	2,790	2,888	2,983	3,088
Finance Leases	-	-	475	2,819	3,996	3,245
	2,619	2,709	3,265	5,707	6,979	6,333
Total liabilities	**78,500**	**96,897**	**108,511**	**119,631**	**118,137**	**118,155**
Net assets	**148,723**	**126,778**	**114,871**	**109,695**	**110,766**	**110,408**

Table 7 - Projected Statements of Financial Position

Projected Statement of Cash Flows *in thousands of New Zealand Dollars* ***For the year ended 30 June***	2018 Audited	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Cash flow from operating activities						
Cash receipts from MOH, Crown agencies & patients	554,785	579,423	610,784	632,076	653,858	675,409
Cash paid to suppliers and service providers	(329,707)	(342,661)	(359,081)	(365,428)	(367,679)	(379,735)
Cash paid to employees	(204,561)	(230,214)	(241,246)	(249,689)	(257,929)	(266,957)
Cash generated from operations	20,517	6,548	10,457	16,959	28,250	28,717
Interest received	876	292	84	-	-	-
Interest paid	(235)	(235)	(181)	(487)	(487)	(429)
Capital charge paid	(8,378)	(8,320)	(7,346)	(8,818)	(10,294)	(12,203)
	12,780	(1,715)	3,014	7,654	17,469	16,085
Cash flow from investing activities						
Proceeds from sale of property, plant and equipment	661	9	-	-	-	-
Acquisition of property, plant and equipment	(20,193)	(17,853)	(16,665)	(14,582)	(12,572)	(12,633)
Acquisition of intangible assets	(920)	(1,700)	(1,327)	(1,600)	(1,500)	(1,700)
Acquisition of investments	(1,068)	-	-	-	-	-
	(21,519)	(19,544)	(17,992)	(16,182)	(14,072)	(14,333)
Cash flow from financing activities						
Proceeds from equity injections	-	-	740	3,450	3,182	1,437
Repayment of finance lease liabilities	-	-	(34)	(243)	(552)	(706)
Equity repayment to the Crown	(357)	(357)	(357)	(357)	(357)	(357)
	(357)	(357)	349	2,850	2,273	374

16.1

Continued …

Projected Statement of Cash Flows *in thousands of New Zealand Dollars* ***For the year ended 30 June***	2018 Audited	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Net increase/(decrease) in cash and cash equivalents	(9,097)	(21,616)	(14,629)	(5,678)	5,670	2,126
Cash and cash equivalents at beginning of year	16,541	7,444	(14,172)	(28,801)	(34,479)	(28,809)
Cash and cash equivalents at end of year	7,444	(14,172)	(28,801)	(34,479)	(28,809)	(26,683)
Represented by:						
Cash	6,488	(15,007)	(29,637)	(35,315)	(29,645)	(27,519)
Short term investments	956	835	835	835	835	835
	7,444	(14,172)	(28,801)	(34,479)	(28,809)	(26,683)

Table 8 - Projected Statement of Cash Flows

Projected Funder Arm Operating Results *in thousands of New Zealand Dollars* ***For the year ended 30 June***	2018 Audited	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Revenue						
Ministry of Health - devolved funding	516,552	544,682	573,100	593,044	613,446	633,629
Inter district patient inflows	8,237	8,826	8,494	8,790	9,092	9,391
Other revenue	148	205	239	248	257	266
	524,937	**553,713**	**581,833**	**602,082**	**622,795**	**643,286**
Expenditure						
Governance and funding administration	3,416	3,424	3,532	3,655	3,781	3,905
Own DHB provided services						
Personal health	247,301	273,150	298,767	304,643	306,746	316,736
Mental health	24,435	23,522	24,362	25,211	26,078	26,936
Disability support	9,325	9,370	9,572	9,905	10,245	10,582
Public health	641	1,545	1,830	1,894	1,958	2,022
Maori health	619	619	619	640	662	684
	282,320	308,207	335,150	342,293	345,689	356,960
Other DHB provided services (Inter district outflows)						
Personal health	51,547	54,421	55,317	57,242	59,211	61,159
Mental health	2,375	1,799	2,099	2,172	2,247	2,321
Disability support	3,305	3,136	3,081	3,188	3,298	3,407
	57,228	59,357	60,497	62,602	64,756	66,887

16.1

Continued ...

Projected Funder Arm Operating Results *in thousands of New Zealand Dollars* ***For the year ended 30 June***	2018 Audited	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Other provider services						
Personal health	96,287	93,213	104,926	105,579	109,312	113,008
Mental health	11,725	13,013	13,000	13,449	13,911	14,371
Disability support	66,878	71,456	75,440	78,065	80,752	83,410
Public health	1,237	1,442	1,327	1,373	1,423	1,470
Maori health	2,745	2,938	2,963	3,066	3,171	3,275
	178,873	182,061	197,655	201,532	208,569	215,534
Total Expenditure	**521,836**	**553,049**	**596,833**	**610,082**	**622,795**	**643,286**
Net Result	**3,101**	**665**	**(15,000)**	**(8,000)**	**-**	**-**

Table 9 - Projected Funder Arm Operating Results

Projected Governance and Funding Administration Operating Results						
in thousands of New Zealand Dollars ***For the year ended 30 June***	2018 Audited	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Revenue						
Funding	3,416	3,424	3,532	3,655	3,781	3,905
Other government and Crown agency sourced	7	-	71	73	76	79
Other revenue	67	30	30	31	32	33
	3,490	3,454	3,633	3,759	3,889	4,017
Expenditure						
Employee benefit costs	617	1,222	1,199	1,242	1,283	1,328
Outsourced services	508	504	552	571	590	609
Clinical supplies	-	3	(8)	(8)	(8)	(8)
Infrastructure and non clinical supplies	852	624	944	975	1,011	1,042
	1,976	2,353	2,687	2,780	2,876	2,971
Plus: allocated from Provider Arm	946	946	946	979	1,013	1,046
Net Result	**568**	**155**	**-**	**-**	**-**	**-**

Table 10 - Projected Governance and Funding Administration Operating Results

16.1

Projected Provider Arm Operating Results *in thousands of New Zealand Dollars* ***For the year ended 30 June***	2018 Audited	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Revenue						
Funding	282,320	308,096	335,150	342,293	345,689	356,960
Ministry of Health - non devolved contracts	14,369	14,947	14,618	15,127	15,648	16,163
Other District Health Boards	4,473	4,186	4,056	4,207	4,362	4,516
Accident insurance	5,423	5,199	4,591	4,762	4,938	5,113
Other Government and Crown Agency sourced	617	514	673	698	724	750
Patient and consumer sourced	1,117	1,258	1,244	1,291	1,339	1,386
Other revenue	5,888	5,304	4,370	4,446	4,610	4,773
	314,207	339,503	364,701	372,824	377,310	389,661
Expenditure						
Employee benefit costs	208,994	234,453	241,979	250,448	258,713	267,767
Outsourced services	18,787	19,467	15,471	16,009	16,560	17,106
Clinical supplies	49,696	56,128	57,578	55,010	49,707	50,092
Infrastructure and non clinical supplies	49,921	52,809	50,619	52,336	53,343	55,742
	327,397	362,857	365,646	373,803	378,323	390,707
Less: allocated to Governance & Funding Admin.	946	946	946	979	1,013	1,046
Surplus/(Deficit) for the period	**(12,245)**	**(22,408)**	**-**	**-**	**-**	**-**
Revaluation of land and buildings	(15,312)	-	-	-	-	-
Net Result	**3,067**	**(22,408)**	**-**	**-**	**-**	**-**

Table 11 – Projected Provider Arm Operating Results

SIGNIFICANT ASSUMPTIONS

General

- Revenue and expenditure have been budgeted on current Government policy settings and known health service initiatives. Where information is not available, assumptions have been made and are included below.
- No allowance has been made for any new regulatory or legislative changes that increase compliance costs.
- No allowance has been made for the costs of unusual emergency events e.g. pandemic or earthquake.
- Allowance has been made for the implementation costs of and net savings from regional and national entity initiatives as advised by the MOH.
- Allowance has been made for the payment of remediation costs relating to compliance with the Holidays Act, which will be provided for in the 2018/19 Annual Report.
- Allowance has been made for expected costs arising from the Regional Health Informatics Programme (RHIP).
- Detailed plans for new investment and efficiency programmes have yet to be finalised. The impact of the two programmes on financial performance have been recognised in clinical supplies.
- Unless otherwise stated, increases in revenue and expenditure due to changes in price levels have been allowed for at 2.0% per annum over the time horizon of the plan, based on Treasury forecasts for CPI inflation in the Half Year Economic and Fiscal Update 2018 published (13 December 2018).

Revenue

- Crown funding under the national population based funding formula is as determined by MOH. Funding including adjustments has been allowed at $524.1 million for 2019/20. Funding for the years 2020/21, 2021/22 and 2022/23 is based on the standard DHB funding allocation methodology that projects demographic increases of 1.73%, 1.69% and 1.54% respectively, to which a 2% contribution to cost pressures less 0.25% for efficiencies has been added for each year.
- Crown funding for non-devolved services of $63.6 million are based on agreements already in place with the appropriate MOH directorates, and assumes receipt of the DHB's full entitlement to elective services funding.
- Inter district flows revenues are in accordance with MoH advice.
- Other income has been budgeted at the DHB's best estimates of likely revenue.

Personnel Costs and Outsourced Services

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

Supplies and Infrastructural Costs

- The cost of goods and services has been budgeted at the DHB's best estimates of likely cost.
- No allowance has been made for cost increases/decreases relating to fluctuations in the value of the New Zealand Dollar.

Services Provided by Other DHB's

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

Other Provider Payments

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

Capital Servicing

- Depreciation has been calculated to write off the cost or fair value of property, plant, and equipment assets, and amortisation has been calculated to write off the cost or fair value of intangible assets (software) less their estimated residual values, over their useful lives
- DHBs do not have authority to borrow long term. The DHB expects to draw on the DHB banking collective's overdraft facility arranged by New Zealand Health Partnerships (NZHP) for working capital requirements, and borrowing costs at 3% per annum have been recognised in the plan.
- The DHB expects to finance a number of capital expenditure projects using equity injections provided by the Crown. The capital charge rate has been allowed for at 6% per annum.

Investment

Investment	2020 Projected *$'000*	2021 Projected *$'000*	2022 Projected *$'000*	2023 Projected *$'000*
Buildings and Plant	12,045	12,534	9,672	7,533
Clinical Equipment	3,500	3,400	3,400	3,400
Information Technology	3,027	3,200	3,000	3,400
Capital Investment	**18,572**	**19,134**	**16,072**	**14,333**

- The investment in the Health Finance Procurement Information Management System (FPIM) managed by New Zealand Health Partnerships Limited (NZHPL), was fully impaired in 2018/19. No allowance has been made for any further investment.
- The DHB's share of the assets in RHIP will be amortised over their useful lives. The cost of amortisation is included in infrastructural costs. No allowance has been made for any impairment of the asset.
- No collaborative regional or sub-regional initiatives have been included other than RHIP.
- No increase in funding for existing associate organisations, Allied Laundry Services Limited and Central Technical Advisory Services have been allowed for.
- Property, plant, equipment, intangible asset expenditure, and investments in other entities are in accordance with the table below :

Capital Investment Funding

- The Ministry of Health is developing a new process for the allocation of capital funding that will impact from 2019/20. While the DHB's capital investment requirements are significant, capital funding is limited, and the DHB is unlikely to have all its needs met within the timeframe it would prefer. Consequently allowance has only been made for strategic projects relating to seismic remediation, for which capital injections have already been approved by MOH. As further strategic projects are funded by MOH, they will have an impact on the DHB's equity, assets and expenditure (depreciation and capital charge), that has not been allowed for in this plan.
- Capital investment will be funded from a number of sources including working capital in accordance with the following table:

Investment Funding	2020 Projected *$'000*	2021 Projected *$'000*	2022 Projected *$'000*	2023 Projected *$'000*
Capital Investment	18,572	19,134	16,072	14,333
Funded by:				
Depreciation and amortisation	14,465	15,752	15,847	17,321
Finance leases	580	2,952	2,000	-
Equity injection	3,450	3,182	1,428	-
Cash holdings/overdraft	77	(2,752)	(3,203)	(2,988)
Capital Investment Funding	**18,572**	**19,134**	**16,072**	**14,333**

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

Property, Plant and Equipment

- Hawke's Bay DHB is required to revalue land and buildings when the fair value differs materially from the carrying amount, and at least every five years. A revaluation was completed as at 30 June 2018 and is included in the financial statements.
- Significant increases in land values and construction costs in Hawke's Bay, indicate the carrying value of the DHB's land and buildings may no longer reflect the fair value of it's properties. A further revaluation as at 30 June 2019 is underway, but the information it provides was not available in time for inclusion in this report.

Debt and Equity

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

Equity	2019/20 *$'000*	2020/21 *$'000*	2021/22 *$'000*	2022/23 *$'000*
Opening equity	126,778	114,871	109,695	110,766
Surplus/(deficit)	(15,000)	(8,000)	-	-
Equiy injections (capital)	3,450	3,182	1,428	-
Equity repayments (FRS3)	(357)	(357)	(357)	(357)
Closing equity	**114,871**	**109,695**	**110,766**	**110,407**

Cash and Overdraft

- The DHB is expected to exceed the overdraft limit, calculated as one-12th of the annual planned revenue paid by the funder arm to the provider arm inclusive of GST, in 2020/21 only. No allowance has been made for any deficit support on the assumption the additional overdraft will be short lived.

Additional Information and Explanations:

Disposal of Land

- Disposal of land is subject to current legislative requirement and protection mechanisms. Hawke's Bay District Health Board is required to notify land declared surplus to previous owners for offer back prior to offering it to the Office of Treaty Settlements, and before any sale on the open market.

OURHEALTH HAWKE'S BAY Whakawāteatia	**Hawke's Bay Health Strategy Document** **Draft Document for feedback**
	For the attention of: **HBDHB Board**
Document Owner:	Kevin Snee - Chief Executive Officer
Document Author:	Hayley Turner –Planning and Strategic Projects Kate Rawstron – Head of Planning and Strategic Projects
Reviewed by:	Clinical Council, Consumer Council & Màori Relationship Board
Month:	June 2019
Consideration:	For review and final comment

RECOMMENDATION:

That HBDHB Board:

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

Purpose of this paper

The purpose of this paper is to provide the context for recording and responding to feedback received during the May round of governance, and to provide a summary of changes made to the final Draft version of the HB Health Strategy.

Attached is the Final Draft of HB Health Strategy (one with comments and one clean) for your review and final comment:

Questions to consider for this review:

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

CONTEXT

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

The Purpose of the HB Health Strategy:

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

**This is not a complete list of inputs*

How is this different from the CSP?

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

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

- It is not an Implementation plan but will drive that activity and output
- This will not include detailed solutions – these will sit within our Implementation Plan that will be developed in the next phase after HB Health Strategy has been signed off.
- It does not replace a Health Outcomes Framework – this will be part of the implementation planning activity which must be aligned to the Strategic objectives set out in this document, and is referenced on pg7.
- Does not include specifics on how we will develop and embed a Person and Whānau Centred culture, this will fall as part of the activity that follows, but lays out the approaches that we will take to get there.
- Does not answer how we will manage the change, bringing our system and people on one journey. This activity is set out in workstream 1 – Kuaka Change Framework – *see appendix 1* and is an enabler for all change including culture. Activity for this kicked off in May.

Response to feedback process

During the month of May, feedback was gathered and collated from all Governance forums. This was then internally reviewed and assessed, and moderated changes have now been incorporated into this third and final draft.

Feedback Responses:

Lots of valuable feedback was received during the first feedback round in May. Some feedback received was not relevant for updating the document itself but referred to process or implementation planning and communication of the strategy. For the purposes of this document, the focus is on the content relevant to the document updates but can be viewed in the excel feedback spreadsheet – appendix 2

A summary of key areas listed below:

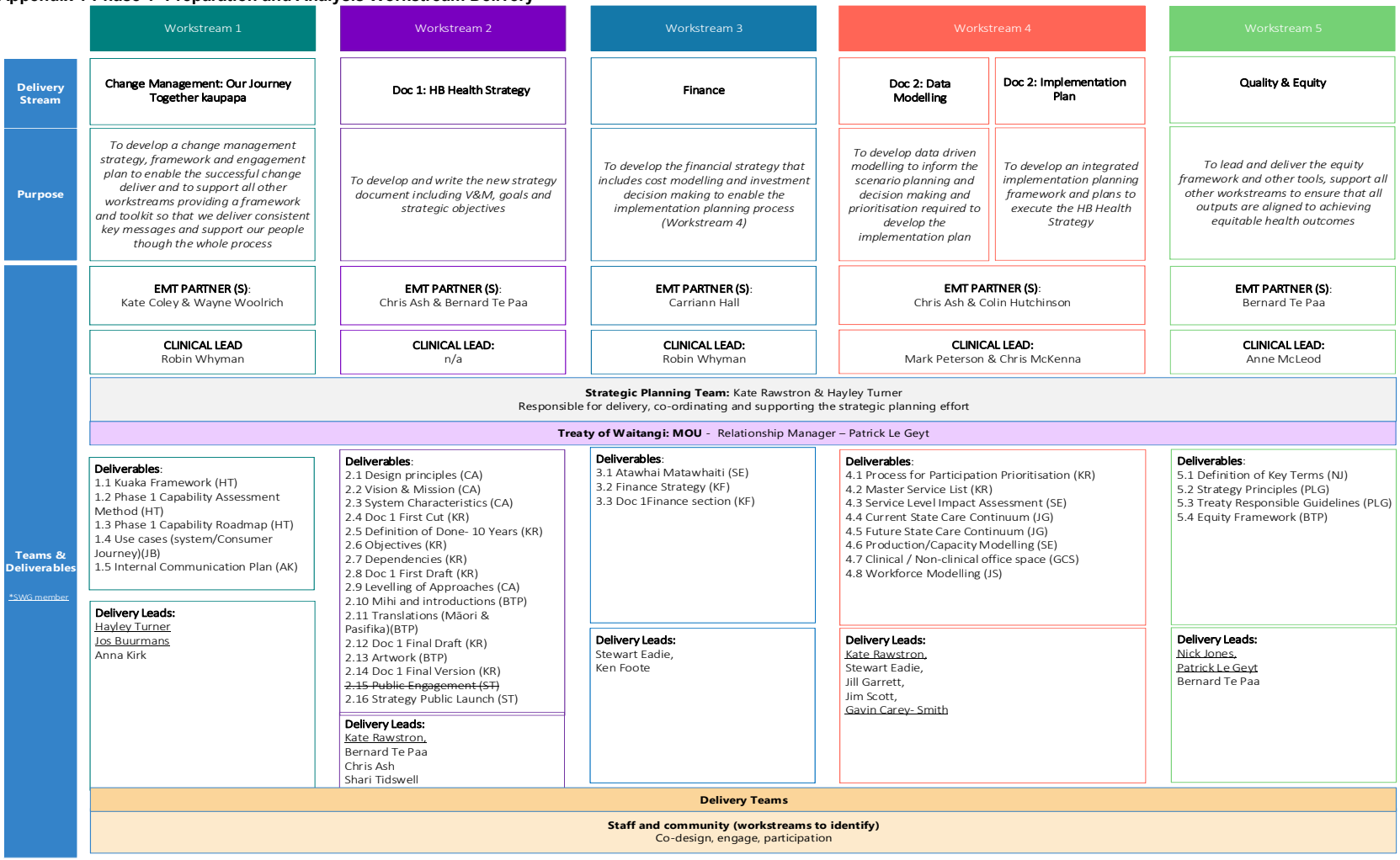
- Support/affirmation of the strategic goals, approaches and dependencies.
- Clarification and definition key of terms – a glossary will accompany the final document
- Support for the document layout and construct, however it was also raised that supplementary shortened versions and one page visuals will be required to connect better with our target audiences.
- Suggested changes for the objectives. This received the majority of feedback and most of it was consistent across the board.
- Language – consensus that the language used within the document will need to be reviewed to make it easier to understand. This activity is planned during June once the document content is more stable and we have a final draft.
- Additional paragraphs/sections and enhanced areas
    - Added te reo Māori inclusions within the document – this has been working progress through the earlier drafts
    - Community led- this underwent further narrative development to emphasise the intention
    - Focus on people section – enhanced to identify the key priority population groups as identified in the CSP.
    - Population health outcomes – added section emphasising working as a whole, identifying linkages with population health outcomes and performance measures
    - Headline Goal – narrative strengthening and including Pasifika and unmet need in alignment with our goal for equity.
    - Person and whānau centred care goal narrative – enhanced with focus on people, consumer experience and health outcome.
    - Digitally enabled – clarity around the meaning of this goal.
    - High performance and sustainability – enhanced to highlight the demand for acute hospital, focus on proactive and preventative care.
    - Further alignment and linkages with the CSP has been weaved through all elements.
    - Change to vision- English version – to Health with Heart

Next steps:

- Final comment on the final draft for MRB, Clinical Council, Consumer Council, Pasifika Health Leadership Group, Board and PHO Leadership Team for a further iteration - **June**
- Review for easy readability and understanding **- June**
- Produce a final version of the document for sign off in **July**
- Print copy and release **– post sign off (date TBC)**

Note:
This document will drive the five year implementation plan which will follow**.**

Appendix 1 Phase 1- Preparation and Analysis Workstream Delivery



The five delivery workstreams currently underway with activity identified in the Strategy Network Diagram

Appendix 2 Collated Feedback and Responses

No	Summary of the changes required
1	Pasifika - needs reviewing to check that it's woven through in a consistent fashion
2	Community led - narrative strengthening - RR has added this, but need reviewing by CA
3	CSP linkages - completed by KF
4	Include in obj/approaches - commission for high performing ….
5	reference acute demand-something like…. appropriate strategies to reduce acute demand on secondary care - HP & S
6	Reference pop health/public health - high level like in CSP Could mention that Pop health strategy needs to be developed as an approach
7	Show linkage to health outcomes and health status so that we have something for the outcomes framework to hang off
8	Models of care - needs to be changed to needs of consumer - ref to term in PWCC and workforce
9	Add access to digital health record
10	Add explanation around digitally enabled in the narrative under goal
11	add ref - Frail and elderly - last 1000 days
12	add recognition of hard to reach communities
13	Highlight that the strategy is different than what we have done before
14	Clarity requested re lines/linkages between primary and secondary - need to check if this a comprehension - we would want the system to look like 1 system
15	pg. 17 "right" clarity was asked what we meant by this - is there alternative wording that would work better
16	add more around meeting needs of young people - CSP link A
17	add reference to a you said , we did - receive, consider and respond to feedback add reference to performance measures in HP & S. Adopting a performance mgt framework that integrates with national measures i.e. SLM
18	add all dealings with community - open hearts and open minds (HNA philosophy)

No	(KF/KR/HT)Agreed parameters:
1	No change to basic layout, sections etc - general agreement that this is good/ liked
2	Intention is for final version to be as succint as possible without unduly abrreviating the content
3	Won't look to shorten but to supplement with an A3 poster etc to meet needs of those that want a 'short' version
4	No change to Equity goal articulation
5	Objectives need to be re-pitched; still measurable quantitative and qualitative but don't need to be SMART
6	Glossary will be required to accompany the document

Date received	category	Source by name (Gov' Grp/Individual)	Feedback Received	Response	Action
9-May-19	General feedback	Consumer Council	Implementation Plan time frame agreed - 2019/20	None	None
9-May-19	General feedback	Consumer Council	Looking pretty good	Noted	None
9-May-19	Language		Kinds of words used from beginning can affect how people connect e.g. • 95% disabilities pg. 14 update to 'who seek services', add ways in which we seek feedback • lovely goal • doesn't speak to multiple identities - diversities. Not enough recognition • pg 17 'right' - what does this mean, who are they? Not specific/clarity needed • responsive + able to work with communities + values	Accepted	Will need to look at language used
9-May-19	Narrative	Consumer Council	Inconsistencies - PASIFIKA. Not mentioned in some parts but needs strengthening	Accepted	Rebecca - please pick up - Need to strengthen this throughout the document.
9-May-19	Narrative	Consumer Council	Equity - some people i.e. Mental Health don't have equity. • CA spoke about equity	Noted	Equity Goal will remain as is.
9-May-19	Narrative	Consumer Council	Like to see this Health Strategy is different! • Not what we have done before • Want to see 'we are going to do things differently'	Accepted	Narrative strengthening. KF added some of the CSP linkages.
9-May-19	Language + Narrative	Consumer Council	• vague on pg. 3 • needs strengthening	Accepted	Narrative strengthening
9-May-19	Narrative	Consumer Council	Recognition of working with communities that are harder to reach i.e. homeless, incarcerated – build on HS's comments at MRB	Noted	Believe this should form part of the collateral that supports the strategy in terms of how we will work to achieve this.
9-May-19	Goal	Consumer Council	Embed PWCC + community led. Great! • Like to see more focus on what embedding PWCC means ~ Didn't know what wellbeing plan was ~ Embed feedback system - closed loop ~ Embed change culture ~ Identify change to partnership and where these are best made ~ 20% resources prioritised. Should reflect where resources are best placed - evidence	Accepted	PWCC is an areas that is listed for further development
9-May-19	Goal	Consumer Council	No real understanding from clinicians what PWCC is. Be part of training.	Noted	Feed into WS 1- Part of change management
13-May-19	Language + Narrative	Consumer Council	• P17 Attracting the 'right people' to work in the health sector – who are the 'right people'? Description would be required. • Sub groups (LTC, Mental Health) could feel excluded with the strategy focus being on Maori and Pasifika. • P14. Weave more 'unmet need' population into the document. • Nothing included in strategy on frail & elderly and last 1000 days/end of life. • Where are the linkages between Primary and Secondary care? Consumers do not 'see' the difference.	Noted	Strengthening ageing and frailty Language review - easy to understand check for linkage to PC and secondary
13-May-19	Goal + Objectives + Narrative	Consumer Council	• Chair added a focus on Person and Whānau Centred Care (PWCC): - Where is the focus on Health Outcomes? - How this gets implemented and embedded into training of our staff? - What does positive progress look like? - Community Led – didn't get feeling this was a community led proposal? Clear baselines for the targeted objectives is required. Require a good rationale • Chris Ash thanks for feedback and recognised that broadening of objectives perhaps required, however felt that those with 'unmet need' are addressed through the strategy, whilst recognising that Elderly specifically need review to inclusion. Chris agreed reviewing wording of 'community led' to recognise those without voice. Equity definition as given by MoH is specific to the design of health strategy. • Bernard Te Paa – we are working at designing a health system which is able to adapt to ensuring equity in line with the present needs of the population.	Noted	Add lineage to health outcomes already accepted

13-May-19	General feedback	MRB	Rewarding bad behaviour - those organisations that are not performing but we are giving $ to	Noted	Commissioning management
13-May-19	General feedback + Narrative	MRB	Difficult to read having not been part of process • not included as source doc/base doc needs to be part of implementation • kaupapa approaches - is it NGO/hospital or both? • Community driven whānau approaches done in the community attract Māori not hospital • tough reading	Accepted	Language review required need to think about how we close the gaps in the questioning
13-May-19	General feedback	MRB	• MRB would want to know who is delivering services • Community led - led by community • Co-design - starts at concept • Double funding - how much $6.3 do we get $12m not much • Is it achievable - % too high. Unrealistic i.e. first 1000 days - some babies taken off mums so they are excluded	Noted	community led section id to be strengthened. The "how" we co-design falls within building/enhancing sectoral capabilities so that we can do this effectively. Acknowledge the question around funding. This is something that yet to be worked through, through the more detailed planning.
13-May-19	Narrative + Language	MRB	Impenetrable management speak • lacked ambition - didn't give me confidence • throw it back • almost in despair	Accepted	Language review to take place after next iteration
13-May-19	General feedback	MRB	can we chop it into bits to think how do we get the most out of this		
13-May-19	General feedback + Narrative + Approaches	MRB	Old fashioned document • missing cycles of co-design • evidence informed practice • expectation of when things will change ~ we are coming to you, we expect things to change - then we are coming back - being community focussed	Noted	Language will be reviewed after next iteration
13-May-19	Language	MRB	changing the language that is used needs strengthening – disabilities	accepted	strengthened in next iteration
13-May-19	General feedback	MRB	Do we need 4, 5 and 6 – aren't they a given?	Rejected	All six are required to describe the system as a whole
9-May-19	Objectives + Narrative + Approaches	MRB	• Strategy achievability needs to be considered on a person level, as initial feeling that this strategy is felt to be quantitative rather than qualitative.. • Essential that He Ngākau Aotea is considered as part of this strategy and its implementation. Aligns with agreement that co-design is vital from the start. • This document needs to be community/consumer focused in its perspective and thus 'future proof'. Agreed that 'Community' term needs clarity on who this is addressing, how we will consult with our communities and who will be carrying this out. • Felt there is assumption that data will make a difference, though this is not necessarily the case. There is a clear difference between health data and data intelligence, which is the understanding of the lives of the people it is referencing		include suggestions in next iteration
7-May-19	Objectives + Narrative + Approaches	Individual- direct feedback	(Own thoughts, not representative of MRB) There is a glaring gap in the strategic objectives ….. these docs assume that only the DHB is capable of delivering quality health care ….. there is no recognition that Maori require a different access and approach model of care – no recognition in terms of strategic objectives for primary care options within the Whānau/Hapu. MRB need to take a position on this point as it is critical to the development in Wairoa, CHB and Heretaunga. Whilst I agree that the whole organisation needs a directional change that must also include serious strategic KPIs for our community wellbeing. To waha is a prime example of why we need to stand firm for our whānau. To Waha happened in the village and it worked!	Accepted	include suggestions in next iteration
8-May-19	Approaches	Clinical Council	Status/roles + models of care (important) • issues around disinvestment (important) • acute demand not mentioned • data	Accepted	Narrative will be strengthened. Investment and prioritisation included within the financial principles. This will be covered in further detail in the Finance Strategy that is currently in progress. The how we invest/disinvest will part of implementation planning

8-May-19	General feedback	Clinical Council	Solid • wanted more time to review • noted collective feedback important	noted	Extra month of feedback added to the schedule.
8-May-19	Approaches + Objectives + Goals + General feedback	Clinical Council	Not clear new approaches + objectives - health gain struggle to see how implementation will be linked to attainment of that goal • short term gains + working with stakeholders, like to see this more clearly • thought it was good • liked lay out • Q - where #1 came from - evidence • liked goals - aspirational • business + clinical models - is it clear which is which? Are easier to do than the other ~ delivery models • like the 6 goals ~ objective missing something i.e. fit for workforce - not identified. What is fit for purpose? ~ some need qualifying - ambiguous ~ and will workforce be children	Noted	Feedback will be taken on board for next iteration
8-May-19	Objectives	Clinical Council	What about national goals i.e. 2025 tobacco goal? • strategy will feed into a reformed planning process	Noted	Strategy should be aligned to National goals
8-May-19	Objectives	Clinical Council	Clear about the model of care in the system and their (staff) role in this • structure of document works • reflects health strategy	noted	
8-May-19	General feedback	Clinical Council	Digitally – access own health record	Accepted	Update wording
8-May-19	General feedback	Clinical Council	Digital System to facilitate PWCC	Accepted	Reflect in wording
8-May-19	Approaches + Objectives + Goals + Dependencies + General feedback	Individual – direct feedback	• I like the overall objectives and goals. I liked the emphasis on equity for Maori and that tikanga is woven through. Health Care Homes have promise and are worth trialling, particularly in high need areas and where there is interest from practice owners. • Mostly the dependencies are about right. However I think there are overall dependencies that could be made clearer. • Head space - Clinical leaders and managers from all areas are time poor and overwhelmed with the day to day running of their directorates and departments. Little progress will be made without freeing up time to lead projects. How will this be achieved? • Deciding what we are going to stop doing - Andy has a framework with reasonable face validity. This needs to be reality-rested against low volume, high cost treatments to test both the methodology and the Board's political will. Otherwise, we will continue to cut services that simply can't fight back - for people with disabilities, frail older people and children. A conversation could be held in each department, asking what the clinicians feel they could do to reduce admissions and procedures of little value, led by medical and surgical directors. • Data - The point is noted in the minutes that it is difficult to plan in the absence of data. The projects in this strategy will massively increase the need for data for improvement, for planning and to assess the differences new investments make. How will this demand for data be accommodated?	Noted	Dependencies to be reviewed for clarity
8-May-19	Approaches + Objectives + Goals + Dependencies + General feedback	Individual – direct feedback	• Acute demand - Is not mentioned at all, yet is the single greatest driver of expense and the biggest barrier to progress. This seems odd, to say the least. Do we really believe health care home will do it? • Skills - More thought needs to go into the skills needed to achieve this strategy. These could include cultural competency, courageous conversations (eg, to challenge unhelpful behaviours, goals of care conversations with whānau), quality improvement, project leadership and management, teaching and mentoring, communication skills. Also, new roles could be considered, eg discharge planning, nurse practitioners. General physicians and surgeons will be in demand, including at the front door, hospitaliist roles, ortho-geriatrics. What's the balance of sub-specialist and generalist in the plan? • New models of care - We have made a tentative start but much more can be done, eg allied health clinics for chronic pain, joint assessment and follow up, optometrist clinics. Community based MDTs for frail older people could be increased. • Community by default - I can see that some services would benefit from this but we should learn from existing models. Eg, in many DHBs, the NASC and Child Development Service are in NGOs in the community, with independent boards and little relationship with their local paediatric service. Children get a poor service in the absence of this leadership. I would fiercely oppose doing this here.	Accepted	Add acute demand. Review approach around "default" in the community

13-May-19	General feedback + Goals + Objectives	Clinical Council Minutes	• Do we have a cohesive strategy for the health system? • Does the strategy reflect feedback provided to date? • Does it need to be enhanced/refined? General discussion held. Key points noted: • Structure of the document is good, brief and comprehensive • Clinical themes not directly mentioned, particularly aging population • Commitment to co-design and community leadership needs strengthening • Need to think about how to quantify smart objectives • What is the role of schools role in the model of care • How we make decisions – what are we going to stop doing • Importance of good data • Acute demand not mentioned and the adverse impact of not addressing this • Not sure how the strategy objectives link to health gain – needs to be more clear • Business and clinical models in primary care? should this be delivery models • High level equity goal – propose specific equity objectives to drive change, need smart objectives across all domains • Like the six objectives, but the key objectives under each need reforming into qualitative statements and outcomes and the implementation plan should have smart objectives and data	Accepted	RE view objectives to more qualitative standard. Realign to CSP clarify business and clinical models terminology in document
2-May-19	General feedback + Narrative	HB Health Sector Leadership Forum Core Leaders Group	Holds together, but as a big picture have we given enough attention to our 'aging community' and highlighted the risk if this was not strengthened within the document. RR was very excited about the goals, in particular seeing Community-led and Person and Whānau Centred Care (PWCC)! At a high level got what we (Consumer) need.	accepted	already identified as areas for strengthening
2-May-19	Objectives + Narrative + General feedback	HB Health Sector Leadership Forum Core Leaders Group	Hs said it had some good stuff in there; what we've (MRB) been harping on about - as long as there's alignment to that and what MRB have been talking about in MRB, to provide that confidence, we are good, but do think there's some good stuff in here. - Not feeling the PWCC statement. Doesn't feel like it has any movement (with it). This led to a brief discussion, where Rachel agreed with Heather's sentiment, and noted that this would be in implementation plan - Want to see 'you said – we did'. - BTP agreed and talked about the tracking of feedback and where it went in the document. - The discussion included reference to the Transform and Sustain strategy in terms of performance monitoring against the intentions around PWCC. - CA highlighted that the Community led Goal in particular need strengthening so that it placed greater emphasis on local setting of priorities. This point has been captured within the draft document that will go out to for feedback.		
2-May-19	Objectives + General feedback	HB Health Sector Leadership Forum Core Leaders Group	BB said he was pleased to see Equity section. He then asked about the link to System Level Measures (SLM's) and wants to ensure they work together. This was confirmed by KR, who advised they do. Baden continued and then raised the question around 'how are we going to afford it all.'		
2-May-19	Goals + Narrative + Objectives	HB Health Sector Leadership Forum Core Leaders Group	STRATEGY SPECIFIC FEEDBACK - Aging Population • Discussion initiated with reference to the current environment and consideration of the Clinical Services Plan (CSP) to pose the question, is there enough in the strategy on our aging population? The general feeling was that it could be managed within the 6 strategic goals and we needed to strengthen this linkage within the document, because we will need to explicitly speak to the community, agree with them what is fair and reasonable levels of care. We have to front foot this with our community. It was suggested that adding a graph showing increase demand and increase complexity, may help to illustrate this within the document. • A further suggestion was made that adding a Strategic Objective around % of 65year olds living in their own home could close the gap. • Conversation held around the need to investment in the young at the same time as managing the aging population. • A question was posed if the CSP was coming through strongly enough; stating that the CSP mentioned three priority groups (Ageing, children and unmet need) and that we needed to strike the balance of showing those in the strategy • It was noted that whatever the statement, GP's in primary care needed to be comfortable with	accepted	Update document

			it/saying it to consumers, plus from a Māori perspective they value both their babies and their elders so it's tricky to do the two in parallel		
2-May-19	Objectives + Narrative	HB Health Sector Leadership Forum Core Leaders Group	STRATEGIC OBJECTIVES - Bulk of Conversation • It was highlighted that there was difficulty with assessing the "realism" of the objectives in the absence of having baseline data. Very hard to then confirm confidence in what has been set. The room agreed that the current drafted objectives look ambitious and so having evidence to support how achievable they were was important. Board would need this to have that level of confidence needed to sigh these off. • The discussion of baseline data was again referenced to the Headline Goal. A question was asked: what other places are doing? (e.g. as actual performance by others/ DHBs), there was talk about spurious goals being no better than objectives that don't have specified targets • An addition was put forward to add % of community surveyed in the relevant objectives. • Need to add assumptions to our strategic objectives and headline objective, need to strike a balance between aspirational and doable within timeframe • There is a need to underpin the strategic objectives with more detail/ logic / evidence / quantification to provide confidence • Should not include inputs, but show outputs which link to outcomes • Objectives must drive health outcomes; not sure how the two come together, but the document must show linkage. • Discussion around whether this document needed the objectives to be SMART written, verses more lofty, but was agreed that it was vital that objectives could be translated to SMART so the thinking had to be done now so that we are able to hold ourselves to account. The concern raised was that if not written SMART within the document, we will have nothing to hang it off in terms of developing the implementation plan.	Accepted	Objectives to be refined
10-May-19	Language + Narrative + Objectives	Individual – direct feedback	Page 2- para under the quote: This is where there needs to be some bold intentions: Something like: HBDHB has a key role to lead...a health system that boldly addresses the health and wellbeing needs of its communities.. linking and co-ordinating its different parts and agencies in new ways to make the transformations necessary to change current inequalities so that the HBDHB take all stakeholders along with it on the journey to living and staying well. Page 5- Why is the Maori framework stuck beside how the Strategy fits with other plans? There is no statement that links these two parts of the page and why they are placed together? Perhaps the last para talking about a "compass" needs to include the Maori framework and the fact that HBDHB is located within Kahungungu and the whare metaphor depicts the foundations of manaakitanga provided by local iwi and within which everyone is included? You would need to run this pass MRG but this explanation is what I remember hearing at one of their hui. Page 10 the Key Objectives need clearer wording e.g. bullet point one- That DHB decision-making regarding health priorities will include community and consumer goals in at least 20% of its overall services and agencies. Not sure why the document is linking to Matariki? If so those goals need to be appended somewhere? I am not sure of the progress and viability of Matariki however and social inclusion was an afterthought? I think it is important to underline that a healthy community contributes to the human capital wealth of a community. See also Treasury Living Standards Framework (2018).		
10-May-19	Goals + Narrative	Individual – direct feedback	Page 14- the HB DHB is following government goals and priorities and are funded to carry out the priorities. (After you left Bernard made a well-judged comment in that going forward we need to have flexibility and the ability to modify priorities as we achieve a measure of equity for the presently identified groupings). The only other feedback was rewording the bullet point 95% of all People with a Disability "who seek access to our services" are satisfied with the care and support they receive. Page 17: Bullet point two: what about collapsing this with point three because "attracting" and recruiting people is close. Instead of "right" people- recruit and retain people who are committed to the values of HBDHB and to implementing the DHB innovative strategies to achieve equity. (or similar).	accepted	
7-May-19	General feedback	Sub EMT Group	• Must be able to hold us to account • Must be able to connect and everyone must see themselves in this document – i.e. man on the moon • Want to see 'you said – we did' • Must show linkage to source data (CSP, PP, HER etc.), also need to be high level (consolidation of all source input) • Needs to be ambitious but let's not reinvent the wheel		

			• Must show linkage to health outcomes, but is not a replacement of outcomes framework. Likewise for performance monitoring. • Must not be ambiguous in language/meaning • Easy to read at all levels • Must provide direction and vision of travel for staff (management levels) to understand where we are going • Must get to hearts and minds of people – rally people together		
7-May-19	Objectives	Sub EMT Group	• Objectives O Need baseline information to be able to have the confidence in the realism of the objectives O Discussion around SMART objectives v's more lofty goals O Where specific calculation – ref how we are calculating to avoid other external interpretations that may damage reputation (media for example may select one they believe that will not be the one we are using and provide different results) O Not be input based in the objective O Be clear on language used – input, output, outcomes etc. They have different meanings O Strike balance between aspirational but doable O Caution not to commit to something we haven't thought through – links to do-ability and having evidence	accepted	Further work on objectives
14-May-19	Vision + Mission	Individual – direct feedback	I realise that this is now late in the process, but I have felt compelled to formally express my concern with the Vision contained in the document. There are a number of reasons why I feel the need to raise this: • Significance of Vision: - I have long held a number of sayings about vision: - 'The most powerful team building activity is the collective development of, and commitment to a shared vision' - 'A vision is never completely defined. This built in ambiguity makes it more valuable than mere goals' - 'Vision is the power, planning is the tool' - 'Without vision, there is insufficient energy to make the plan work' - I just don't feel that the current vision meets most of these • Commitment from staff: - Whilst I agree that the current process is about consolidating the inputs from key documents that have been widely consulted on, we have not consulted on the vision or mission - I am concerned that there will not be a strong favourable response to the vision once the Strategic Plan is taken out for engagement on the implementation plan - From the few staff I have spoken to, none felt any real connection to the vision - Most accept the word 'thrive' as holistic, but see it more within an economic context	Noted	Further discussion at sub EMT
14-May-19	Vision + Mission	Individual – direct feedback	• Potential Overuse/Confusion with 'Thrive" - I understand that the concept of thriving is a key part of the Matariki strategy - I also understand the Wairoa Community Group have developed a vision along the lines of 'Everyone in Wairoa is Thriving' - I have just received an email from the mayor of CHB, where very prominently is displayed the brand 'Bringing Thrive Alive' - For Territorial Local Authorities and Inter-sectoral groups this seems quite appropriate – but is it for us - Health has a big part to play in these 'higher level' general community visions, but it is not all down to us, so should it also be ours when others have as much (if not more) influence on this than we do. • We need a 'Health' vision' - We are the health sector and need a vision that everyone can identify with us – one that we are primarily responsible for influencing and aiming for - We need a vision that everyone in the health sector, our communities and our consumers can directly relate to and 'own' - Given the complexity of our existing vision, we have tended to use the existing tag line 'Healthy Hawkes Bay – Te Hauora o Te Mata a Maui' as our de-facto vision - This is recognisable and generally accepted, and has been in place for some time - It meets most of the positive criteria listed above - It is still very relevant and appropriate	Noted	Further discussion at sub EMT

			My big question therefore is – why change from this – should we look to continue with: HEALTHY HAWKES BAY Te Hauora o Te Mata a Maui Happy to discuss, but also happy to accept that this may be a minority view and therefore accept and support the will of the majority.		

Hawke's Bay Health Strategy

2019–2029

Draft v3.3 June 2019

OURHEALTH
HAWKE'S BAY
Whakawāteatia

Mihi

[Placeholder]

He Kupu Whakataki

“Pūnaha ana te hau āwhiōrangi i ngā maunga ihi mārangaranga

Ko te papatātahi o Nukutaurua

Ko te kauanuanu o Moumoukai

Kua Horopāpera ki Whakapūnake

Tātarā-ākina ki Maunga-haruru

Ki te pū o te tonga Ko Kahurānaki

Paearu ake ōna toitūtanga

Hei tāhū ohooho mana taurite

Hei rautaki uru oranga taku haere

Māhere ki te ākau roa a te Mātau-a-Māui

He haumāru nui; He hautapu roa; He hauora e”

Tihei Mauri Ora!!

Message from the CEO / Board

[Placeholder]

Introduction

Why a health strategy?

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

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

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

Our Hawke's Bay health system

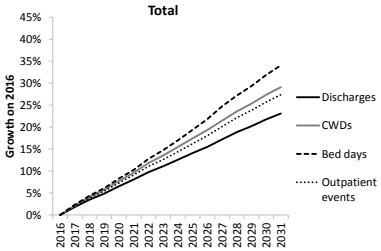
[Consider map of service network and/or key population figures]

Where are we at?

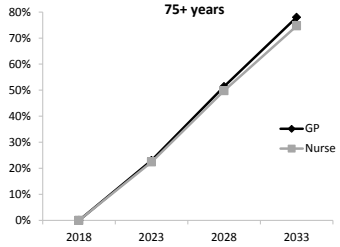
Over the last five years, we have shifted our perspective from DHB services to whole-system management and engagement with iwi and post-settlement governance entities, with our Transform and Sustain strategy. We set up our Consumer Council to work alongside our Clinical Council and Māori Relationship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

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

Hospital demand growth



Primary care demand growth 75+ yrs



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

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

A focus on people

At its heart, this strategy is about people—as members of communities, whānau, hapū and iwi. We exist because of them and we recognise that people and whānau are the experts in their own lives. We need to focus more on the places people spend their time and take the delivery of healthcare outside traditional clinical venues. We need to plan and deliver health services in the wider context of people's lives, and consider how we include cultural practices (eg, mirimiri and rongoā Māori). This strategy describes our goals to empower and partner with people and whānau, and work across agencies to improve the conditions of life, so that everyone has fair opportunity to achieve good health and wellbeing.

There are two priority population groups that we need to respond to: whānau with children and young people, and older people. We need to support the whole whānau to achieve goals and aspirations and ensure children have the best start in life. 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 turn to our people to find solutions. The district health board must act as a careful steward of health resources in the Hawke's Bay, which is a challenging task. We need our community to help us so that we invest in the areas that matter most to people and whānau. This strategy prioritises health improvement of populations with the poorest health and social outcomes.

Our commitment to the Treaty of Waitangi

The New Zealand Public Health and Disability Act holds us accountable for recognising and respecting the principles of Te Tiriti o Waitangi, the Treaty of Waitangi. Our Treaty relationship is premised on our Memorandum of Understanding with Ngāti Kahungunu, and is represented by the Māori Relationship Board which provides governance direction between the two entities. We are committed to

improving health outcomes for Māori, increasing Māori representation in the health workforce, and ensuring a culturally safe and responsive health system.

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

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

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

How does the Strategy fit with other plans?

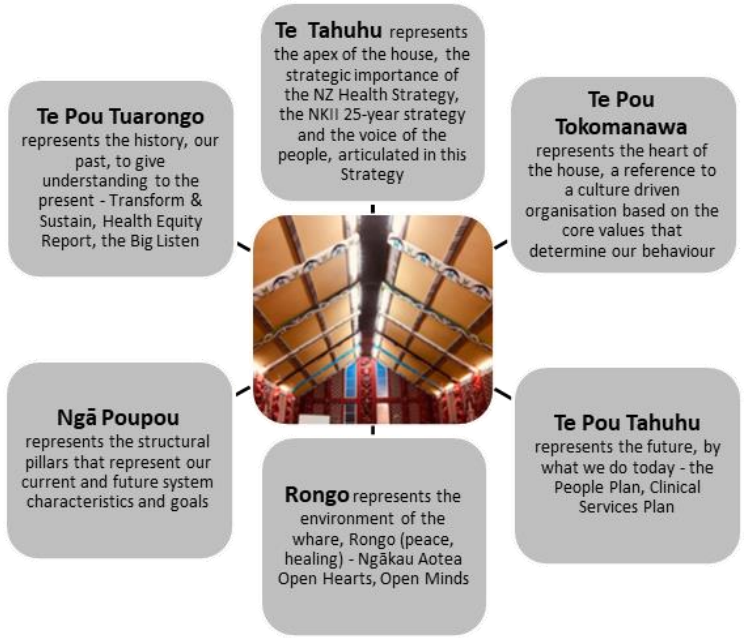
We have done a lot of listening, thinking and planning over the last two years. Our **Clinical Services Plan** sets out the challenges and opportunities the system faces and describes concepts for the future we want. Our **People Plan** describes the culture and values we want and how we will grow our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

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

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

Rūia taitea kia tū ko taikaka ānake

(Discard the sapwood to uncover the hardwood)



The wider context

The Government has undertaken or is in the process of important work that will shape the evolution of our health system. That work includes the refreshed New Zealand Health Strategy, the response to the Inquiry into Mental Health and Addiction, the Health and Disability System Review, and the Government's wellbeing budget approach. The Treasury has adopted a Living Standards Framework that aligns stewardship of the public finance system with an inter-generational wellbeing approach.

The kaupapa of this Strategy aligns with the principles and values articulated by central Government but the 'how' will have a distinctly Hawke's Bay flavour as we co-design responses with our local communities. As a region the Matariki partnership provides a wider context and further enables us to achieve our vision.

Turning strategy into action

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

Our community expects meaningful change and it is important we hold ourselves to account. To do that we need to develop measurable objectives with our system partners and community representatives. We can't measure everything but by setting key objectives—in the areas that matter most—we can demonstrate our progress over time. We will co-design our key objectives using evidence and local expertise as part of our implementation planning.

Population health outcomes

The purpose of the health system is to achieve good health outcomes. This strategy directs us to do things in a different way to how we've done them in the past so we can make better progress in outcomes and equity of outcomes.

Our high-level accountabilities should be focused on outcomes rather than the processes by which they are achieved. We will develop a robust population health outcomes framework to monitor results in the design and delivery of health services. The national System Level Measures are important indicators of system performance.

Improved use of information will help the system as a whole to better target populations with unmet need. We will do this with a cascade of monitoring. For example, if we don't see the changes we are working towards in our outcomes framework, we will look at the performance

indicators in the implementation plan for this strategy and see where we need to 'adjust the dials'.

Vision

Taku wahine purotu, taku tane purotu

Health with Heart

Mission

Insert – te reo - Hawira

Working together to achieve equitable holistic health and wellbeing for the people of Hawke's Bay

[Insert Strategy picture]

Our values

Health with Heart

HE KAUANUANU RESPECT

AKINA IMPROVEMENT

RARANGA TE TIRI PARTNERSHIP

TAUWHIRO CARE

17.1

System goals

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

1. Pūnaha ārahi hāpori
Community-led system

2. Tikanga manaaki tangata mē te whānau
Person and whānau-centred care

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

4. Whaikaha kia aronga ngā kaimahi
Fit-for-purpose workforce

5. [Te Reo to be inserted]
Digitally enabled health system

6. Paearu teitei me te toitūtanga
High performing and sustainable system

In the remainder of this document we set out why each goal is important, our key objectives, strategic approaches and dependencies. Our key objectives describe what our system will look like when we achieve each goal. Our strategic approaches describe our approaches or methods for achieving goals and resolving issues. They don't describe specific activities or projects—that level of detail will be described in our implementation plan(s). Understanding dependencies is important in a system with many activities happening at once. These activities make contributions and interact with each other in planned (and unplanned) ways, and they share expectations and resources.

Headline objective

Increase healthy life expectancy for all and halve the life expectancy gap between Māori and non-Māori

This objective is a high-level measure which will help us track achievement of our vision and mission. We also want to reduce the gap for Pasifika and people with unmet need however it is more difficult to measure life expectancy for these groups.

We know that there are many complex factors that contribute to life expectancy and we don't have control or influence over all of them. We want all groups in our community to enjoy the same length of life, but we know that our health strategy cannot achieve this alone. Closing the life expectancy gap requires collaborative cross-government action to improve general socio-economic, cultural and environmental conditions; and ensure that living and working conditions are equitable.

But we do have a major part to play. The stark message from our Health Equity Report is that Māori, Pasifika and people living in socio-economic deprivation are still more likely to die from avoidable causes. For Māori, nearly a quarter of all avoidable deaths can be prevented if we can improve heart health. Another quarter will be avoided if we prevent lung cancer deaths through smoke-free living, and when we address the underlying causes of suicide and vehicle crashes. For Pasifika we also need to focus on preventing and managing diabetes and preventing stroke.

Pūnaha ārahi hāpori Community-led system

Health services will be designed and delivered to meet the needs identified by our communities, whānau and consumers

Why is this important?

We need to find new ways of doing things if we are to achieve equity within our population and meet future demand. We must turn to our communities for the solutions. Our communities are many and varied, including: iwi and hapū, geographical areas (including some small but relatively isolated rural communities), and groups of people with shared identity, experiences or interests. We need to identify and partner with different forms of local leadership to help transform our health system.

Wellness starts at home and in the community. Achieving equitable population health outcomes requires inter-sectoral collaborative action, driven by the wants and needs of communities. Our role is to support community-led planning and action by pooling expertise and resources—supporting communities to address long-standing social determinants of health in Hawke's Bay.

We want to make sure the health services we provide support community goals and reinforce communities to become less dependent on services. This means we need to give up some control. We need to co-design services with the people that will use them, and follow through to implementation. We bring information and certain expertise to the table, but will support communities to design ground-up service responses to meet their needs. Everyone knows that resources are limited. Communities have local knowledge that can help us to provide cost-effective and sustainable services.

What success will look like

- Health needs assessments and relevant information about services and resourcing, expressed at a local level, is available and easy-to-understand
- Communities report feeling more able to make informed decisions about the services and support whānau need to stay well
- Community level plans promote and build healthy, safe and resilient whānau, with a greater proportion of local health service resources prioritised directly by those communities
- Whānau report feeling influence, ownership and pride of their health services, and confidence that those services will meet their needs
- Local leaders from across public, private and community sector come together on a regular basis to address the health and social issues that whānau tell us matter most to them
- Consumers and whānau have primary healthcare options to meet their needs and wants, with services easily accessed when they require them
- Primary and community services deliver a range of local and integrated support and treatment options for behavioural health needs, reducing the dependence on specialist mental health services and supporting elimination of the associated stigma
- Service developments are always co-designed with local people, and in full partnership with Treaty partners throughout

Our approaches

Support communities with tools and access to expert advice so they can drive 'ground-up' preventative strategies	Co-design services with the communities that will use them and develop 'grass-roots' responses where appropriate
Work actively with our inter-sectoral partners to ensure healthy environments for our communities	Base services in the community as much as possible and support primary health centres to function as people's 'health care home'
Contribute to community-level plans and place-based initiatives that promote and build healthy, safe and resilient whānau	Develop committed alliances with inter-sectoral agencies to improve social and economic conditions for people and whānau
Activate communities with the means, tools and support to take ownership of their local service network	Integrate rural health facilities with local communities and services
Ensure population health strategies and core public health services are a key part of community and/or place-based planning	Support older people to stay well by developing age-friendly communities, with coordination of volunteer services and opportunities to participate in the community

Dependencies

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

- Digital enablement to allow care closer to home
- Alignment and integration of planning across the system

Tikanga manaaki tangata mē te whānau Person and whānau-centred care

Person and whānau-centred care will become 'the way we do things around here'

Why is this important?

A person and whānau-centred approach has its focus on people, their whānau, friends and carers; understanding their needs and aspirations and what matters to them. Research shows that person and whānau-centred care improves health outcomes and consumer experience, and the use of health resources.

Embedding a person and whānau-centred approach means that our models of care will evolve to meet the specific needs of different groups of consumers, such as older people, families with children, or youth. We need to develop new ways of working alongside people to ensure that they feel ownership both in their own health journey and the system as a whole. Digital technology will enable people to have greater control of their personal health information and plan, access services in different ways and provide feedback.

We need to change our focus to a wellbeing model that supports people to manage their own physical and mental wellbeing. When we make health easy to understand people are able to make better informed and more appropriate health decisions. We also need to develop new types of services, such as behavioural services that help with psychological, emotional, relationship and cultural issues; in a way that is relevant to individuals and whānau, across the life course.

Creating a culture that is person and whānau-centred will require a fundamental shift in behaviours, systems, processes and services for people working across the Hawke's Bay health system.

What success will look like

- Patients and whānau consistently report that health services are easy to access, and that communication about their care (both with them and between providers) is effective and timely
- Our primary healthcare system is relationship-based, with patients and whānau experiencing continuity of care from a range of professionals who take the time to understand them
- When something goes wrong in our care, patients and whānau are routinely involved, supported and kept informed throughout the process
- Patients and whānau consistently feel they are supported to make good choices by making health easy to understand and navigate
- Health Care professionals are trained to enable patients and whānau to express clear treatment goals and take a lead in decisions about their care
- People remain well at home with whānau support for as long as that remains their choice
- Youth consistently feel respected and valued when accessing health services, and report that services for them are both welcoming and accessible
- People and whānau consistently have their cultural needs understood, respected and met, no matter which health service they engage with

Our approaches

Ensure people have access to relevant information and enhanced preventative services when they need it, so they can make informed choices and take control of their own health and wellbeing	Identify frailty, developing person-centred plans (including Advance Care Plans) that enable proactive and preventative strategies, and ensure we provide the best and most appropriate care when health events occur
Develop and reconfigure services so people are able to receive quality and timely services in the most convenient way, from the most appropriate provider, in the way they want it	Build wellbeing plans around what's important to people and whānau and everyone delivering care focuses on the person in everything they do
Design services with the input of the people who use them so that they are innovative and effective	Increase home-based and community supports so that older people are kept well at home
Develop real-time feedback opportunities and act upon the feedback provided	Support people to return home safely from hospital as soon as possible
Design integrated health and social services for youth close to where they live, with virtual as well as drop-in options to access them	Plan the majority of care proactively and provide timely access to urgent care when people need it

Dependencies

- Redesign of business models to change the way services are planned and accessed
- Individuals across the system will need to be culturally competent and responsive
- Workforce supply and accessibility to enable people to access the most appropriate provider
- Availability of resources for community investment

- Digital enablement to allow different ways of accessing services and everyone to view and update information
- Health and medical technology availability to support communities to take on full health needs
- Mind-set change to allow increased consumer and whānau ownership and decision making

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

Increase the life expectancy of all, while focussing on reducing the life expectancy gap for Māori, Pasifika and people with unmet need

Why is this important?

Different groups in our community have differences in health that are not only avoidable but unfair. Māori and Pasifika, people with disabilities or who experience mental illness; and those living in socioeconomic deprivation, continue to experience unacceptable inequities in health outcomes.

Achieving equitable health outcomes underpins all of our priorities for the Hawke's Bay health system. A genuine equity focus means that we commit to working with hard to reach groups, for example, people without a home, gang affiliated, or prison populations.

We have an obligation to provide services that are high quality and do not add to the inequities between population groups. We need to work with our inter-sectoral partners to tackle the underlying causes of inequity. Differences in socioeconomic determinants of health (such as housing, education and employment) are often long-term, inter-generational and as a result are ingrained in individuals and families.

We need to support community development, supporting whānau, hapū and iwi to achieve health and wellbeing of their people, which in turn will benefit all in our community.

We have control over the structural problems built into our health services and we can make immediate progress on this. An equitable system recognises that different people with different levels of advantage require different approaches and resources to achieve the same outcome. Resources will be refocused in the areas that will make a real difference to eliminating unmet need and inequities. Whānau will be equal partners in planning and co-design of services that are mana-enhancing and focussed on what matters the most to them.

What it will look like

- Children and their whānau have completed a first 1000 days programme
- Double the funding share for kaupapa Māori services
- Consumers can access traditional cultural practices (such as rongoā Māori) where they are identified in their wellbeing plan
- - People with a Disability report feeling influence, ownership and pride of their health services, and confidence that those services will meet their needs -
- Within 10 years there is no difference between population groups in self-reported health status
- All population groups have equal access to health services and equitable outcomes
- Prioritise and design services to meet the needs of Māori, Pasifika and populations with the poorest health and social outcomes
- Develop our own local model of healthcare that embeds kaupapa Māori practice and builds on the strengths of our iwi led services.

Our approaches

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

Dependencies

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

Whaikaha kia aronga ngā kaimahi Fit-for-purpose workforce

Align the health sector workforce capacity and capability with the future models of care and service delivery

Why is this important?

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

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

What success will look like

- Our workforce reflects, understands and supports the health needs of the population it serves
- Multi-disciplinary teams working at the top of their scope, across the sector, will be focussed on collaborating and sharing skills to meet consumer's needs
- We grow our people by living our values

- A full commitment to providing a safe place, safe people and safe care
- Leadership supports, coaches and inspires our people to be their best
- An embedded learning and innovation culture
- We work collaboratively with education, tertiary providers and unions to ensure that our current and future workforce needs are well supported
- Greater opportunities for local people to train and enter the Hawke's Bay health workforce

Our approaches

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

Dependencies

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

Digitally-enabled health system

Delivering and sharing information and insights to enable new models of care, better decisions and continuous improvement

Why is this important?

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

We must make information easy to access and share to implement new models of care. Trusted information needs to be available any time, any place and across different channels according to people's preferences and situations. Giving people access to their own digital health record enables them to have greater control of their healthcare journey.

We need to unlock the power of data to deliver insights that help people make better and faster decisions. Better use of data will enable us to measure and improve the quality and effectiveness of health services.

We will develop a continuous service improvement culture to ensure we get best value from our system. This means streamlining workflow and developing more iterative and rapid ways of doing things. We want to make it quicker and easier, and provide the solutions our people and communities need to improve health services and outcomes.

We need to make sure we have the core technology, along with rules for collecting, storing and using data, to enable access and integration.

What success will look like

- Consumers and whānau report significant improvements in how easy it is to interact with health services
- Consumers have direct access to personalised health and wellbeing information, supporting them to best manage their own health

- Health Care professionals routinely use digital platforms to plan and record care, and to communicate with each other, leading to directly attributable improvements in workforce motivation and wellbeing
- Digital systems and processes significantly reduce the incidence of patient harm by reducing the impact of human error
- Digital solutions enable significant productivity gains for our workforce, enabling more clinical time focused on building meaningful relationships with our consumers and whānau
- Population health data is widely used to develop preventive care services, reducing the demand burden on urgent and unplanned care services
- Health planners, working with local communities, are able to form increasingly information-based judgements about the performance of services in meeting population needs

Our approaches

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

Dependencies

- Requires investment in digital technologies to keep pace with developments in healthcare and society
- Requires a change from clinical models of 'care' to a comprehensive understanding of holistic person centred health models of wellbeing
- Strong data governance to ensure person and whānau drive the appropriate use of information
- Requires national and regional governance of interoperability standards (so systems 'talk to each other' across boundaries)

Paearu teitei me te toitūtanga High performing and sustainable system

Delivering the best possible quality, safe, effective, efficient and sustainable services to meet the needs of our population within the funding available.

Why is this important?

Our system performs well in many areas but we can and must do better to meet the demand arising from population ageing and social change. We have opportunities to do things differently and need to embrace every opportunity to provide better care within our available resources.

The health system cannot afford to build bigger and bigger hospitals. We need to base services in primary care as much as possible and focus on proactive and preventive care. At the same time we need to implement strategies to reduce the demand for acute hospital admission. That will allow our hospital to focus on specialist assessment, decision making and intensive treatment.

When there is a need for inpatient hospital care we will engage consumers, their whānau and community providers in planning for well supported transitions from hospital.

Through honest and respectful conversations with people and whānau we can stop doing things that are clinically ineffective or offer little value or are not what people want. If we cut out waste in the delivery of services we can then deliver different, better or more extensive services within our available resources.

Technology offers us new ways of interacting with people and we need to modernise our business processes and change our traditional ways of doing things

What success will look like

- Because the health system views patients' time as its most valuable asset, the total amount of time people spend waiting for access to services is radically reduced
- All people working in our system say they understand the health and wellbeing priorities of our population, how their roles relate to the achievement of our strategic goals, and what is expected of them to make that happen
- Consumers and whānau can confidently navigate the health system to achieve quality health outcomes
- All services, provided by and for the DHB and its partners, demonstrate a level of costs effectiveness that matches the leading health systems nationally and internationally
- We support a greater proportion of our population to live, as pain-free as possible, without the need for surgery. When surgery is needed to offset the lifelong impacts and costs of disability, we do so in a timely way
- Health system financial performance sustainably funds a level of capital investment that maintains, replaces and develops the infrastructure needed to deliver safe, modern, person and whānau centred healthcare
- Our health system has achieved significant cuts in emissions of climate-active pollutants for the long term protection of human welfare

Our approaches

Maintain strong local clinical governance and clinical networks to reduce variation in quality, safety and sustainability of services	Adopt a commissioning approach that considers whole-of-system resources and measures outcomes against what matters to people and whānau
Apply lean thinking to primary care business models to deliver more proactive care and better use of the workforce	Deliver services in the least resource intensive setting allowing good access to specialist interventions currently only available in hospital
Develop alternatives to face-to-face contact so people can communicate with a wider range of health providers	Have informed conversations with consumers, whānau and health professionals about interventions that add value to care
Implement acute demand management programmes including primary options for acute care (in and out-of-hours) and rapid response, short term care in the home, to avoid the need for hospitalisation	Make responsible investment decisions that offer best value-for-money and we intervene at the most timely and cost effective time
Build on our 'whole-of-system' approach to older person's care, providing earlier and more responsive input across home, primary and hospital settings; and extend to rural areas	Structure and locate our clinical support services appropriately to provide timely, effective and efficient diagnostics, interventions, treatment and monitoring services
Implement productivity programmes for 24/7 hospital services with timely decision making and minimal wasted time	Base the management of long-term conditions in the community, integrating specialist clinicians with primary care
Ensure facilities are fit-for-purpose and flexible so we can provide contemporary, high quality models of healthcare	Provide leadership and resourcing to ensure our infrastructure is environmentally sustainable

Dependencies

- Redesign of primary care business models enabled by strong relationships and change support that take into account other cultural ways of thinking
- Changes to hospital processes require clinicians to work in different ways, and at different times, than they traditionally have
- Digital enablement to allow virtual and other interactions
- Upgrading current facilities requires capital injection within a constrained funding environment
- An understanding of the emerging risk factors of climate change and seismic risk which are factored in to planning
- Real-time monitoring of system performance
- Focus on lean process design and waste removal
- Robust prioritisation tool and evaluation data
- Learning system culture

Investment principles

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

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

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

Value driven – prioritisation of investment and dis-investment underpinned by our values, our goal to achieve equity and the concepts of value for money

Outcomes-focussed – anticipated health outcomes and key success factors are known and monitored. Stakeholders are held to account for delivery and the systems learns from its successes and challenges

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

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

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

DRAFT VERSION 2 11/06/19

A Health Equity Framework for Hawke's Bay

Introduction

Why do we need a health equity framework?

Our 2018 Health Equity Report found that in Te Matau a Māui/Hawke's Bay, different groups within our population experience differences in health outcomes that are not only avoidable or preventable, but are also unfair and unjust. Social and economic disadvantage is preventing many in our district from enjoying a full and healthy life. Not only do inequities persist but our report found that rates of early and avoidable deaths for Māori and Pacific people have stopped declining while decline has continued for NZ European/Other. The inequity in avoidable deaths is accompanied by similar trends in avoidable hospitalisations and underlying causes. We have made progress over the last decade but it is time to change the way we are doing things if we want to accelerate progress.

What do we mean by framework and what is its purpose?

The term framework can mean many things. Conceptual frameworks provide a way of thinking about something describing a set of core concepts and the relationships between them. Health system frameworks are organisational frameworks that enable an organisation achieve a particular goal. For example organisations may use innovation frameworks to achieve innovation and growth. Frameworks outline the policies, procedures and management changes the organisationm will use to achieve a particular goal. This framework is explicity intended to promote change within the Hawke's Bay health system that will result in achieving health equity.

Definitions of Health Equity

Our 2018 report definitions:

- Equity in health means that all groups have a fair opportunity to reach their full potential for a healthy life.
- Inequities are differences in health that are not only unnecessary and avoidable but, in addition, are unfair and unjust.

The New Zealand Ministry of Health definition:

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

Existing Health Equity Frameworks

The Treaty of Waitangi

The Treaty of Waitangi provides a foundational framework for health equity in Aotearoa/New Zealand. In establishing the principles of partnership, protection and participaton the treaty provides core pillars of a framework. The treaty has also provided for the principle of redress in terms of previous or future breaches.

The NZ Statutory and Policy Framework

Reducing health inequalities has been identified as a key goal of governments internationally and is a priority for NZ government.

The New Zealand Public Health and Disability Services Act 2000 PHD Act includes an explicit purpose to "reduce health disparities by improving the health outcomes of Māori'. Each DHB (in both its funder and provider functions) must aim to reduce health disparities by improving health outcomes for Māori.

The MoH Operational Policy Framework (OPF) is a set of business rules, policy and guideline principles that outline the operating functions of district health boards (DHBs) to, amongst other things, work with Māori. This framework requires DHB to:

- consider and include actions in their annual plans that will help them to reduce health disparities for Māori and achieve health equity for all of their populations
- work with Māori at both governance and operational levels
- enable Māori to contribute to decision-making on and to participate in the delivery of health and disability services
- provide for the needs of Māori as set out in section 4 of the NZPHD Act to ensure there are mechanisms to enable Māori to contribute to decision-making on and to participate in the delivery of health and disability services, as well as responding to the Government's desire to achieve health equity and improve health outcomes for Māori.

Pacific Frameworks

The Organisational Guidelines for Disability Support Services as developed by Pacific NGO Le Va provide a starting point for implementing organisational Pacific cultural responsiveness.

The Organisational guidelines take into account Pacific models of health as well as providing a framework to enable health services at all levels to change the way we traditionally works towards improving Pacific health. The four overarching Pacific guidelines are:

Respecting Pacific Culture:
Individuals and organisations in the health and disability system recognise that Pacific peoples' experience of health can be influenced by cultural beliefs.

Valuing Families:
Workers in the health and disability system are aware that family is the centre of the community and way of life. This is applicable for most families. This outlooks enables Fanau Ola as a way of working with families, as opposed to individuals, towards improving their health.

Quality Health and disability support services:
Addressing quality of care-access, equity, cultural competence, safety, effectiveness, efficiency and person centeredness.

Working together:
We work together in partnership with individuals, families, health services and with sector partners in education, housing and social development.

Within each guideline are three key focus areas that are further broken down into specific actions that are specific Pacific. They provide leaders and staff a useful guide when planning for organisational and systemic change. More importantly they provide an opportunity to deliberately dive deeper into becoming culturally responsive for Pacific. Many western frameworks omit this key aspect and move forward without an appreciation of the need to become culturally in tune with Pacific by integrating and embedding specific Pacific frameworks and models.

The Institute for Healthcare Improvement Equity Guide

The Institute for Healthcare Improvement published "Achieving Health Equity: A guide for healthcare organisations. The guide includes a framework consisting of 5 core ideas along with a self-assessment tool for measuring and monitoring organisational focus on equity (Figure 2).

Figure Two: A framework for healthcare organisations to achieve health equity

The Robert Wood Johnson Foundation and Prevention Institute's Framework of Emerging Systems to Achieve an Equitable Culture of Health

The Robert Wood Johnson Foundation Achieving Heatlh Equity team collaborated with the Prevention Institute to develop and publish "Countering The Production Of Health Inequities A Framework of Emerging Systems to Achieve an Equitable Culture of Health" The extended summary provides a framework for achieving an equitable "Culture of Health" and establishes a vision for a System of Health Equity that accelerates progress towards equitable opportunities for health and wellbeing for all. The report also discusses the connectedness and critical role of 10 Multi-sector Systems in overcoming health inequity. This framework goes beyond health organisations seeking to guide a multisector effort to reduce inequity.

The framework is designed to create a system of ***System of Health Equity*** which is defined as**:**

A way of organizing and structuring relationships, innovation, learning, and advocacy for coherent and interrelated practices – within the foundation, government, private sector, and community – to attain health equity across the population.

The framework is built on the Robert Wood Johnson's Culture of Health action framework. (Figure 3). An analysis of the determinants of inequity is used to identify ten priority multi-sector systems that offer the greatest potential to produce health equity at the community level.

Figure Three: RWJF Culture of Health Framework

17.2

Priority Multi-sector Systems:

1) Community-Driven Solutions for Health Equity in Thriving Communities
2) Health Equity by Design: Healthy Land Use and Planning
3) Active Transportation for Health and Safety
4) Housing Choice to Build Opportunity
5) Sustainable Food System
6) Safe Communities through Preventing Violence
7) Cradle to Community
8) Developing a Workforce for the 21st Century
9) Creating Economic Engines in Service to Community
10) Community-Centered Health System

Across each of the 10 Multi-sector systems four essential elements are described. These form the basis for an integrated equity system framework. In Hawke's Bay the Matariki Development Collaboration provides a potential regional vehicle to implement priority multi-sector programmes.

Figure four: Essential elements for a system of health equity

1. Purpose: Intentionality for Health Equity a) Applies a health equity lens b) Intentionally addresses bias, discrimination, institutional and structural racism, and classism c) Acknowledges the systematic production of inequities by accounting for community trauma d) Fosters connections	***3. Practice: Methodology and Capacity*** a) Tools, approaches, and methodologies b) Training and capacity building
2. People: Leadership and Engagement a) Shared vision and leadership b) Community voice, participation, and leadership c) Multi-sector engagement	***4. Platform: Infrastructure to Support Success*** a) Communications/Make the Case b) Financing and funding equity c) Metrics and measurement

Fair Society Healthy Lives (Marmot Review, 2010)

A similar all of society approach was proposed in the UK in the Marmot Review. The review concluded that reducing health inequalities would require action on six policy objectives:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention.

CHOICE

A framework explicitly focusing on the relationship between community empowerment and health equity was proposed by Susan Rifkin from the London School of Economics. She proposes that six areas that are critical to examining the influence of empowerment and equity on health outcomes.

C Capacity-building
H Human rights
O Organizational sustainability
I Institutional accountability
C Contribution
E Enabling environment

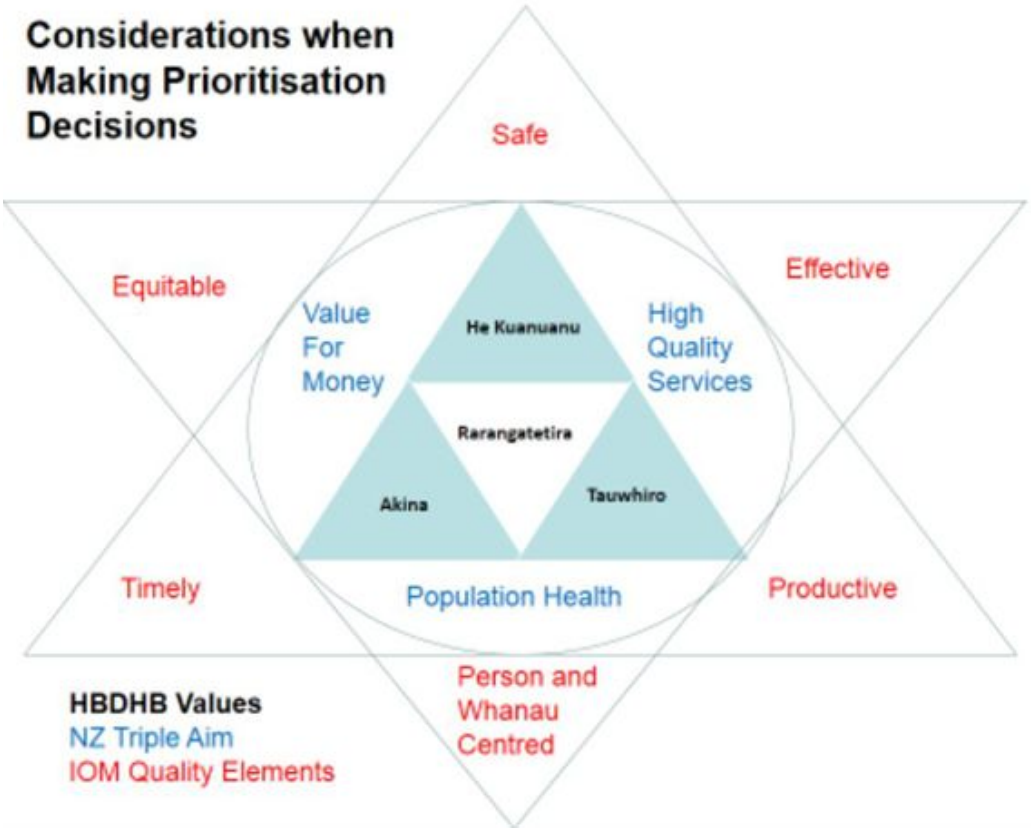
Existing Health Equity Tools

Within an equity framework specific tools are needed to inform decisions .

Atawhai Matawhaiti – The HBDHB prioritisation process

Atawhai Matawhaiti establishes principles and proceses for prioritisation decisions witin the DHB and potentially the wider health sector in Hawke's Bay. The process incorporates both health system values and the triple aim within a program budget marginal anlaysis framework.

It recognises the need to engage with staff, consumers and the community to determine weightings usd for service prioritisation. Atawhai Matawhaiti also provides for a governance panel that includes two members of clinical council, consumer council, MRB and Paskifika leadership group as a representative stakeholder group to make prioritisation recommendations to the Board. Figure five (below) illustrates the integration of HBDHB values, the triple aim and elements of service quality in the prioritisation process.



Whānau Ora Health Impact Assessment

The Whanau Ora HIA is based on the work undertaken by the Public Health Advisory Committee in *A Guide to Health Impact Assessment: A policy tool for New Zealand*, which was released in 2005 (Public Health Advisory Committee 2005). It provides a robust

methodology for policy-makers to predict the potential health impacts of their policies before they implement them. It is also a practical way to apply a sustainable development approach in policy development, based on evidence, focused on outcomes (specifically whanau ora), and with an emphasis on equity.

The aim of this tool is to assess policy level proposals in terms of their likely impact on whanau well being. This tool is therefore likely to be relevant to assessments of policy level solutions. WE note that the tool states

> *Consumer and community participation is an essential part of services. Consumer and community participation results in benefits for everyone involved with the service. It results in improved outcomes through striving for goals that are the same as those of the communities. Services are more accurately directed to what people want and will use. This results in the best use of resources.*

Community engagement and participation enhances community ownership of the activities and or services making individuals more committed and accountable in the implementation and eventual evaluation processes.

Community engagement and participation, particularly for Māori accelerates the reduction of health inequalities between Māori and non-Māori by enabling service provides to focus their interventions on "what matters" to Māori communities".

Health Equity Assessment Tool (HEAT)

The Health Equity Assessment Tool (HEAT) helps users to tackle health inequalities when making health service decisions. HEAT is a flexible tool that can be used in its entirety or, alternatively, selected questions or groups of questions can be asked for specific purposes. For example, questions one to three can promote the consideration of health inequalities and their causes, while question five can assist with assessing a policy, service or programme's responsiveness to Māori.

The HEAT questions can be used to provide a quick overview of potential issues and gaps in policies, services and programmes, such as gaps in information or stakeholder involvement. Alternatively, more in-depth responses to the HEAT questions can assist in developing an evidence base for policy, service and programme development and/or evaluation. This tool will be useful in assessing health system solutions.

Health Equity Impact Assessment

HEIA is a tool used to analyze a new program or policy's potential impact on health disparities and/or on health disadvantaged populations. It is an adaptation of health impact assessment (HIA) with an explicit focus on equity. There are a few variations of HEIA tools (see list below), but they share similar processes with the purpose of prospectively building health equity into the planning of new services, policies, or other initiatives. HEIA has also been used as a way to assess or realign existing programmes. HEIAs may be conducted within an organization to aid decision making, by outside groups to influence decision-making, by potentially affected communities to voice their concerns, or collaboratively by a variety of stakeholders. HEIA tools are easy to use, following five general steps.

Five steps of HEIA

1. **Defining the Issue** —
   Be specific; Have a clear objective for the initiative; Have details available; Articulate the change proposed
   Does the program have the potential to impact health disparities or health disadvantaged groups? If yes, then HEIA is appropriate.
2. **Scoping —**
   Conduct a situational analysis -
   - What populations or groups might be affected by the program?
   - Learn more about health disadvantaged groups.
   - Anticipate trends and issues that may affect the implementation of your programme.

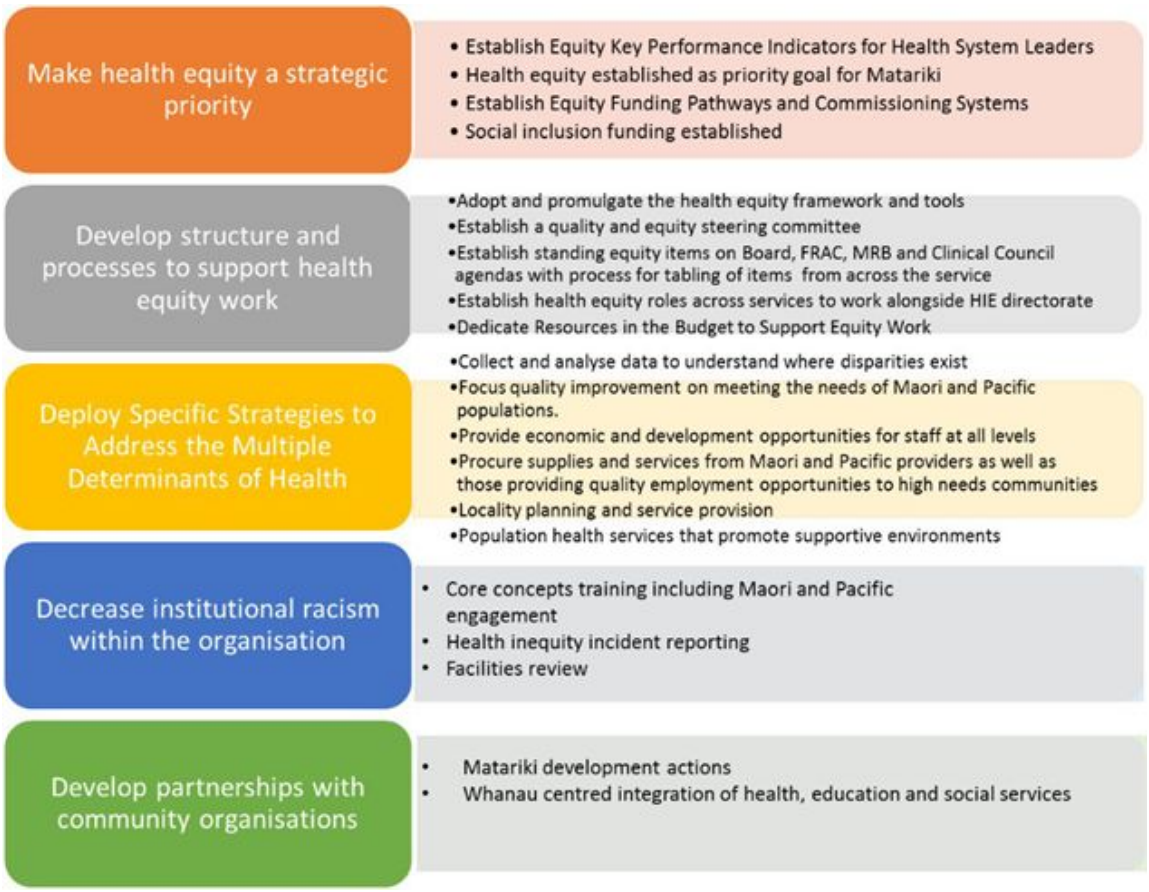
   Gather data related to the issue:
   - Develop a data-gathering plan
   - Organize, synthesize and summarize the data
   - Communicate the information
   - Consider how to proceed with planning

   Identify the determinants of health and inequities
3. **Impact Assessment** —
   Drill down on the impacts of the programme, both positive and negative, for each of the populations affected. What is making the situation better and what is making it worse?
   Consider many types of evidence on how impacts occur, and think about their cumulative effects. What possible solutions, interventions and actions can you take to deal with the situation?
4. **Develop a Strategy** —
   Come up with recommendations on how to mitigate negative effects, and build on positive ones. Involving impacted groups, both in identifying needs and barriers, and in coming up with solutions, is key to HEIA.
   Develop strategies, activities, resources and indicators
5. **Monitoring and Evaluation** —
   Follow up with the programme. Were the recommendations followed? Was the health of identified populations improved? Were disparities reduced? An evaluation built in from the start, with indicators, data collection, and community input helps to figure out what works and why.
   Share the literature reviews, evidence and data, proposed solutions, barriers and evaluation results.

A Framework for Hawke's Bay

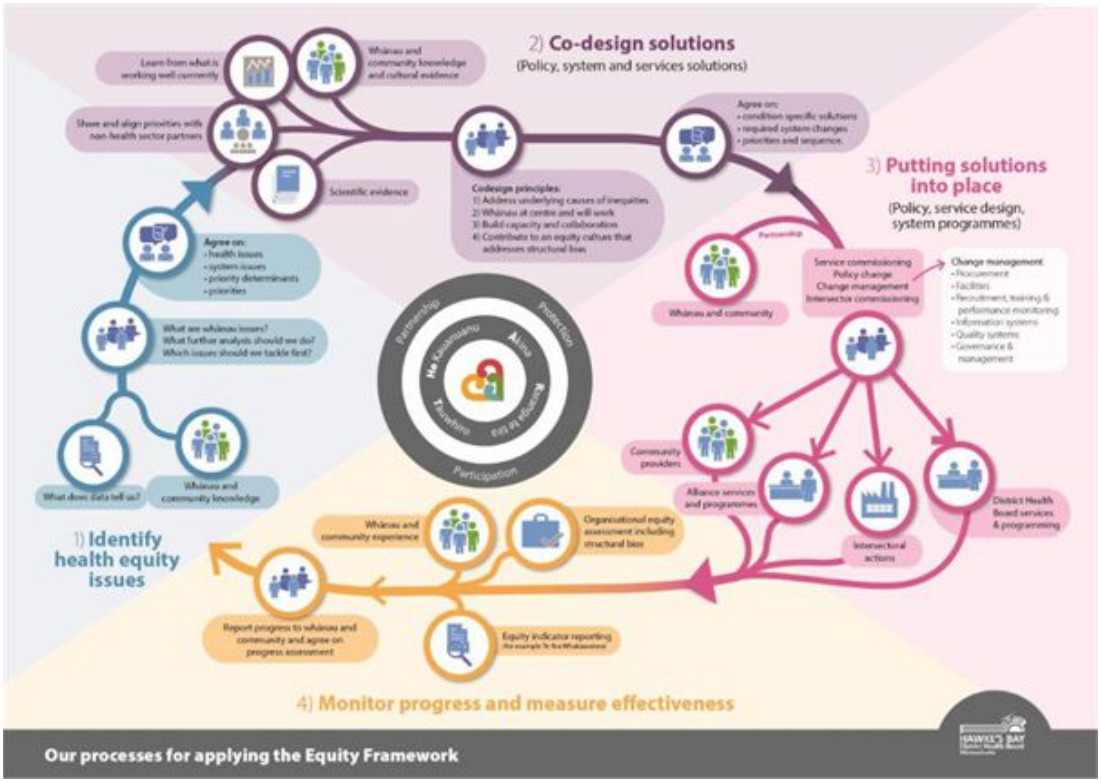
Each of the frameworks above share a number of common themes. Equity must be a shared priority both within the health system and among multisector partners. The role of community and whanau is central and must be embedded within the framework at all stages. Given that Hawke's Bay is in the process of reviewing its Matariki multisector strategy we have chosen to adopt the IHI framework as this is focused on driving change within the health system. We will work with other sectors to ensure that multisectoral efforts support the "system of health equity" approach.

Figure five: A framework for Hawke's Bay Health System to achieve health equity



Embedding the framework

If the framework is going to succeed in reducing inequity in Hawke's Bay it must be embedded within our organisations processes and systems. Appropriate decision support tools will be required for each process and overaching system features such as community driving processes will apply in different ways for each process.



17.2

The process diagram above illustrates how the framework will be embedded into the health system. The application is iterative and cyclical with four overlapping stages completing each cycle. At a high level priority equity issues are identified using a combination of both data analysis and listening to whanau voice. The combined knowledge is then considered by health system leaders in partnership with community leadership to agree on priority issues. These may be priority conditions, system attributes or underlying determinants.

The next stage in the cycle is focused on developing solutions for the priority issues. Learnings from effective existing solutions are combined with knowledge from scientific literature and community knowledge to identify options. Opportunities to collaborate across the health sector and with partners in other sectors are explored working within a co-design framework. Solutions may be service specific eg cardiology or cross health sector eg booking system. At the governance level there is partnership in agreeing on priorities for implementing solutions.

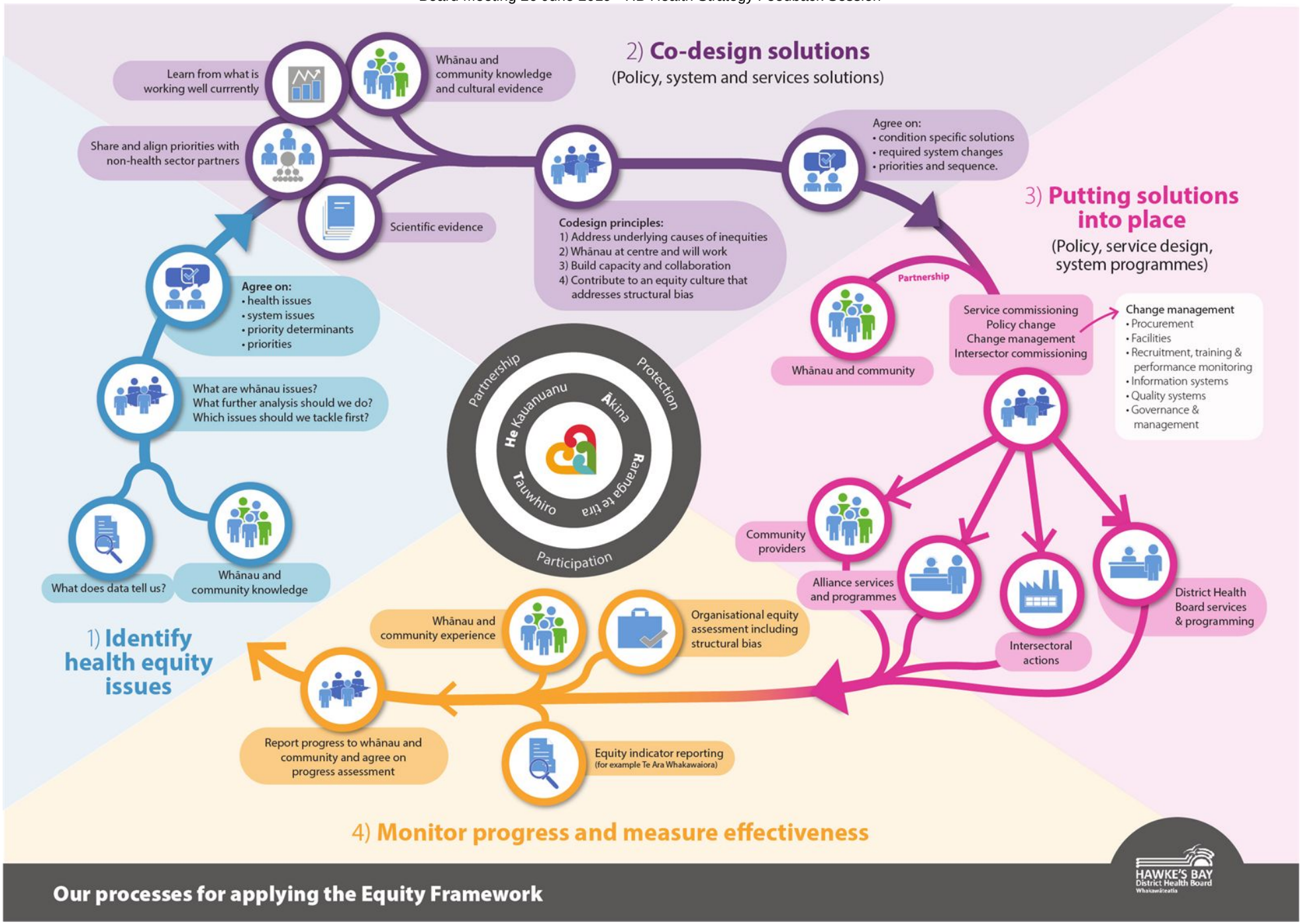
Equity solution co-design is cognisant of four key principles:

1.Solutions address underlying causes of inequity
2. Whanau is at centre and whanau advice on whether the solution will work is critical
3. Solution build capacity and collaboration
4. Solutions contribute to an equity culture that addresses structural bias

The third stage in the equity process cycle is the implementation of solutions. This stage involves the commissioning or contracting of solution providers or the implementation of service changes within DHB provider services. The outcome of the implementation stage is the establishment of solutions in terms of whanau and community provider services, new health alliance programmes and services, multisector system solutions and changes to DHB

services and systems. These are implemented through a dedicated equity change managmenet programme that interfaces with DHB and PHO managmenet and support processes.

The final stage in the cycle is the monitoring and effectivenss assessment stage. As with the other three stages community partnership is embedded with whanau and community contributing to and receiving assessments. A modified version of the IHI organisational equity assessment is repeated to measure progress which is also monitored through a dedicated equity indicators framework.


2) Co-design solutions
(Policy, system and services solutions)
Learn from what is working well currrently
Whānau and community knowledge and cultural evidence
Share and align priorities with non-health sector partners
Scientific evidence
Codesign principles:
1) Address underlying causes of inequities
2) Whānau at centre and will work
3) Build capacity and collaboration
4) Contribute to an equity culture that addresses structural bias
Agree on:
• condition specific solutions
• required system changes
• priorities and sequence.
3) Putting solutions into place
(Policy, service design, system programmes)
Partnership
Whānau and community
Service commissioning
Policy change
Change management
Intersector commissioning
Change management
• Procurement
• Facilities
• Recruitment, training & performance monitoring
• Information systems
• Quality systems
• Governance & management
Agree on:
• health issues
• system issues
• priority determinants
• priorities
What are whānau issues?
What further analysis should we do?
Which issues should we tackle first?
What does data tell us?
Whānau and community knowledge
Partnership
Protection
Participation
Tauwhiro
He Kauanuanu
Ākina
Rangatiratanga
Community providers
Alliance services and programmes
Intersectoral actions
District Health Board services & programming
1) Identify health equity issues
Whānau and community experience
Organisational equity assessment including structural bias
Report progress to whānau and community and agree on progress assessment
Equity indicator reporting
(for example Te Ara Whakawaiora)
4) Monitor progress and measure effectiveness
Our processes for applying the Equity Framework
HAWKE'S BAY
District Health Board

17.2

HAWKE'S BAY District Health Board Whakawāteatia	**He Ngākau Aotea**
	For the attention of: **HBDHB Board**
Document Owner	Bernard Te Paa, Executive Director Health Improvement & Equity
Document Author(s)	Chrissie Hape; Taasha Pomana - Ngāti Kahungunu
Reviewed by	Màori Relationship Board
Month/Year	June 2019
Purpose	For information and discussion.
Previous Consideration Discussions	The Māori Relationship Board received a previous paper on He Ngākau Aotea. This paper provides further detail on that initial high level paper.
Summary	An active partnership with Ngāti Kahungunu to achieve wellbeing for whānau Māori within the Hawke's Bay region.
Contribution to Goals and Strategic Implications	This major piece of work provides a clear Iwi position with regards to its engagement in the health sector, thereby; improving quality, safety and experience of care; improving health outcomes for Māori, Pacific and people with unmet need.
Impact on Reducing Inequities/Disparities	As above.
Consumer Engagement	This paper has been developed by Iwi with significant input from the District Health Board and Te Taiwhenua o Heretaunga.
Other Consultation /Involvement	As determined by Iwi
Financial/Budget Impact	N/A
Timing Issues	This paper will feed directly into our strategic planning processes and will inform future plans and new activities.
Announcements/ Communications	N/A

RECOMMENDATION:

It is recommended that the Māori Relationship Board:

1. **Receive** the He Ngākau Aotea paper for information and discussion.

He Ngākau Aotea

Author:	**Chrissie Hape**
Designation:	**CEO, Ngāti Kahungunu Iwi Incorporated**
Date:	**June 2019**

PURPOSE

This document maps our direction towards achieving improved outcomes for whānau Māori, it sets out the partnership framework between Ngāti Kahungunu (NKII) and Hawke's Bay District Health Board (HBDHB) that we will commit to and operate under over the next 1-5 years.

This strategy is a living document that embodies the core values and points of reference needed to effect real change. Through this, we will clearly define the 'who', understand the 'why' and focus on the 'what' – what are we going to do that will create a measurable impact? This partnership comes at a time when health outcomes for Māori signal the need to work differently to achieve improved and more sustainable results.

RECOMMENDATION:

It is recommended that the HBDHB Board:

1. **Receive** the He Ngākau Aotea paper for information and discussion

ATTACHMENTS:

- He Ngākau Aotea draft report
- He Ngākau Aotea Priorities and Impacts

He Ngakau Aotea

An active partnership to achieve wellbeing for whānau Māori within the Hawkes Bay region

DRAFT REPORT

He Ngakau Aotea

An active partnership to achieve wellbeing for whānau Māori within the Hawkes Bay region

This document maps our direction towards achieving improved outcomes for whānau Māori, it sets out the partnership framework between Ngāti Kahungunu (NKII) and Hawkes Bay District Health Board (HBDHB) that we will commit to and operate under over the next 1-5 years.

To achieve this partnership, we need to:

- *Be bold and courageous* – data tell us what we are currently doing is not working and calls for action
- *Prioritise* – we need to be action focused and ensure that we maximise the time, effort and resources we hold – we must select key priorities to focus on and achieve results
- *Change* – shifting towards Māori models of care that meet whānau wellbeing aspirations
- *Be agile* – responsive and enabling – making sure that where there is need – we create the right conditions to enable fresh and fit for purpose responses

This strategy is a living document that embodies the core values and points of reference needed to effect real change. Through this, we will clearly define the 'who', understand the 'why' and focus on the 'what' – what are we going to do that will create a measurable impact? This partnership comes at a time when health outcomes for Māori signal the need to work differently to achieve improved and more sustainable results.

The partnership framework:

Te Tiriti o Waitangi, provides a framework for accountability and outcomes between Māori and the Crown. Te Tiriti has two fundamental objectives, firstly the survival and development of the Māori people and secondly, the right and duty of the Crown to govern the

country fairly for the benefit of all New Zealanders. The first objective involves the protection and enhancement of rangatiratanga. Rangatiratanga is the right of Māori to live and develop in a Māori way, whatever that may mean over time and in changing circumstances. A key feature of rangatiratanga is self-development where Māori can choose their own path. These represent the breadth of rights and interests that have been previously been characterised as being part of 'Crown-Māori Relationships'.

Tino Rangatiratanga

The second objective involves the rights of Māori to access and receive government services which assist Māori to achieve their full potential and result in Māori achieving the same social and economic outcomes as non-Māori.

Māori Citizenship rights

In this context, these objectives lead to two fundamental outcome questions:

1. Do the HBDHB policies, programmes and services protect and enhance the right of Māori to live and develop in a Māori way?
2. Do the HBDHB policies, programmes and services result in Māori achieving the same social, health and wellbeing outcomes as non-Māori?

Partnership is a relationship in which two or more people, organisations, or countries work together as partners. Synonyms include: cooperation, association, alliance, sharing, union, participation. This is the type of partnership being sought within this strategy.[1]

The Ministry of Health describes the Treaty of Waitangi relationship as embodying the following three principals:

- **Partnership** involves working together with iwi, hapū, whānau

[1] Online Dictionary

and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.

- **Participation** requires Māori to be involved at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services.
- **Protection** involves the Government working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practices.

For our partnership, these translate as:

Partnership –working together across all levels

Participation – decision making, planning, development & delivery

Protection – addressing inequities and safeguarding Māori – incorporating Kahungunu concepts, values and practices

What we choose to do now will have a great impact on our current and future generations. Maui Tikitiki was considered a 'trickster' – somebody who pushed the boundaries, and this is the āhuatanga[2] we want this strategy to possess – we will operate within the following framework:

- Whānau are at the centre – we must adequately address health inequities for whānau Māori;
- create the right conditions to ensure Māori ways, customs and knowledge; and
- be innovative.

Whānau at the centre

Whānau-centred is a shift from focussing on individuals. It starts by **asking whānau** what they want to

[2] Translation = way, aspect, likeness, circumstance, characteristic, property, feature, function, attribute, train, phenomenon

achieve for themselves, and then **responding to those aspirations** in order to realise whānau potential. This approach recognises that **each whānau has a different set of circumstances**, and what works well for one whānau does not work well for other whānau.

Those who attended the NUKA System of Care have been working to identify key aspects of this model that are transferable to this strategy. These aspects:

- Core concepts Training
- Consumer Co-Design
- Integrated Care Teams
- Behaviourists based in the communities;and
- Traditional wellbeing approaches[3]

Health Equity

The 2018 Health Equity Report provides a strong platform to anchor this partnership, it details findings that enable us to prioritise our time, effort and resources. This document does not intend to rehash the report findings, the report's leading message sets out "the starkest message is that Māori, Pacific people and people living in greater socio-economic deprivation are still more likely to die early from avoidable causes"[4]. Within Hawkes Bay, nearly half of all Māori have an annual income of $20,000 or less. At this time, 440 Māori children[5] are living in emergency housing accommodation in Hawkes Bay. The report[6] rightly sets out that the "large disparities in socio-economic conditions that affect Māori people in Hawkes Bay are clearly linked to the inequitable outcomes" and that "we need to act on these findings"[7].

We are focussed on what next – what we choose to act on is the driver of this partnership. What the report determines for us are some opportunities to focus on including:

- Avoidable deaths for Māori
- The management of chronic illnesses
- Rangatahi wellbeing and mental health

[3] Maori Relationships Board paper – He Ngakau Aotea 2018
[4] P6, 2018 Health Equity Report
[5] HB Today April 2019, MSD Data
[6] 2018 Health Equity Report
[7] P8, 2018 Health Equity Report

- Critical success factors, successes need to be replicated and transferable

Alongside this, we know that not one agency or group is able to navigate the breadth and depth of whānau aspiration – we will need to partner widely to incorporate an intersectoral focus to achieve holistic care.

Creating the right conditions

Maui Tikitiki – famous for his exploits and cleverness. Maui was not content – his explorative nature took him on many quests of discovery and learning. He was responsible for many feats – and this is the āhuatanga we want this document to create. The right conditions mean that at all levels from strategic direction through to operations; we are clear on what success looks like.

HBDHB has some bold steps to take. The Māori Relationships Board have been considering alternate solutions and approaches including the NUKA model. This South-Central Foundation model out of Alaska is an indigenous system of whānau (customer) centric health care that has gained international recognition as a viable health model. Successive equity reports have called for 'courageous and determined action,' a shift to 'tackle the problem'. There has been a willingness to partner, but this next phase of development is about ensuring the right conditions to enable the partnership and therefore whānau Māori to thrive. This is not a new approach, He Korowai Oranga: Māori Health Strategy was developed in 2002 as an overarching framework to guide government and the health and disability sector to achieve the best health outcomes for Māori. The Ministry sets out that implementing He Korowai Oranga is the responsibility of the whole of the health and disability sector. It has implications for other sectors as well noting that, *DHBs in particular should consider He Korowai Oranga in their planning, and in meeting*

their statutory objectives and functions for Māori health[8].

Hon Dr David Clark set out clear expectations to "achieving equity within the New Zealand health system underpins all of my priorities. Māori as a population group experience the poorest health outcomes. As you consider equity within your district, there needs to be an explicit focus on achieving equity for Māori across their life course. Māori-Crown relations is a priority for this Government and I expect your DHB to meet your Treaty of Waitangi obligations as specified in the New Zealand Public Health and Disability Act 2000. I am expecting you to report on progress with how you are meeting these obligations as part of your Annual Plan reporting. Unmet need also represents a significant barrier to achieving equity in health outcomes for all population groups across New Zealand. I expect your Annual Plan to contain actions that will enable progress towards achieving equity…"[9]

The elements, directions, key threads and pathways of He Korowai Oranga are the health system's guide to improving Māori health and realising pae ora, healthy futures.

The four pathways of the original He Korowai Oranga framework continue to tell us how to implement the strategy. These pathways are:

- supporting whānau, hapū, iwi and community development
- supporting Māori participation at all levels of the health and disability sector
- ensuring effective health service delivery
- working across sectors.

The right conditions we need to incorporate include:

[8] Ministry of Health Website – He Korowai Oranga

[9] Ministry of Health – DHB Letter of Expectation 2019/20

- Placing whānau at the centre – planning, design, implementation and evaluation
- Authentic shared decision making at all levels – ensuring decisions are referenced towards a treaty-based partnership
- Increasing the Māori workforce – capable (in senior and critical roles) and accessible (across communities)–
- Embedding and protecting tikanga, te reo and Mātauranga Māori – ensuring Māori based approaches are a foundation of practice, processes and pathways.

Defining innovation

There is no single definition of innovation, let alone a definition for healthcare innovation. What is evident from an initial scan of the literature is that innovation is about finding new or improved processes, products and services that result in significant improvements in how we do or deliver our business.

Some of the attributes to think about in terms of defining innovation include:

- Strong leadership on innovation, direction and decisions;
- Integrating innovation into the business mentality of the Hawkes Bay District Health Board– the board and operations;
- Matching innovation to the strategic direction;
- Managing the natural tension between creativity and value capture;
- Identifying and addressing barriers;
- Cultivating an innovation network beyond this strategy (and stakeholders); and
- Creating the tools, methods, incentive, and rewards for innovation within both NKII and HBDHB.

Why does innovation need to be encouraged?

Innovation is rarely easy. It is about changing how things are done and it can have unexpected consequences. There may be resistance to change, sometimes for very good reasons. For

example, some people may already be facing difficult circumstances and introducing an innovative culture may be too much disruption.

Innovation can lead to remarkable achievements and real differences in the quality of life and outcomes for whānau. It can also be deeply rewarding and fulfilling for those doing the innovating.

This approach will aid the focus that "Māori will have a fair opportunity to reach their full potential for a healthy life".[10]

How to achieve this strategy

We need to be bold and prioritise. As partners we have mutual results that we want to achieve and many of these are noted within the Transforming Our Health Services: Clinical Services Plan: the next ten years. What next:

- A partnered approach;
- the creation of new approaches; and
- actions that contribute to the desired impacts.

The current approach has not worked effectively for Māori and significant change is required. The situation is urgent, whānau Māori need to achieve higher overall ora (wellbeing) in our region and in Aotearoa.

Increasing diversity in the Māori population (e.g. different interests across Māori generations, significant variations in demographics and outcomes, and entrenched issues in communities/rohe and in age and gender-specific groups) also creates a demand for more tailored/targeted approaches ('place-based policy') to address specific needs within specific contexts/realities.

This document is to guide the planning approach to give effect to the partnership and strategy with a focused approach. At a priority level we are seeking:

- A new approach to achieve health equity for Māori

[10] P6, Paraphrased from HBDHB Inequities Report 2018

- Investment in social wellbeing and significant change/transformation
- Māori leadership.

Priorities guide the choice of *Outputs* (what is done and who is reached) and associated *Inputs* (what is invested) for each proposed 'intervention' to address a *Situation* (state of affairs, circumstances).

Key priority	Impact
New approach to achieve equity	1. "Take up by decision-makers and of evidence, analysis, and solutions, regarding the impacts of wellbeing policy, services and outcomes for Māori." 2. Contribute to positive Crown-Iwi, hapū and whānau Māori relationships.
Invest in social wellbeing and significant change/ transformation	1. Services are whānau based. 2. Services are 'fit for purpose.' 3. Improved Māori cultural infrastructure. 4. Increased Māori workforce (capable and accessible). 5. Increased access to services that are implemented in 'Māori ways', customs and knowledge. 6. Increased access to place-based services. 7. Increased whānau health literacy.
Māori leadership	1. Māori are more active participants in their communities. 2. Māori are more socially and culturally secure. 3. Whānau Ora is effective for whānau Māori. 4. Increased uptake of Māori based pilots and programmes ('mainstreaming').

18.1

Key priority	What do we mean	Impact	Short term actions
New approach to achieve equity	▪ This is about shifting to where whānau are at the centre, responding to their needs and aspirations. ▪ A model of care that prioritises and embeds Māori knowledge and practices.	1. "Take up by decision-makers and of evidence, analysis, and solutions, regarding the impacts of wellbeing policy, services and outcomes for Māori." 2. Contribute to positive Crown-Iwi, hapū and whānau Māori relationships.	♦ Dedicated budget to design and pilot/deliver places based programmes and Māori targeted programmes. ♦ Expansion of effective Māori services and access to wider services that align with the 'critical success factors'.
Invest in social wellbeing and significant changes/ transformation	▪ From a system and service delivery approach that is top-down to one that recognises and places whānau ora and wellbeing as the primary driver. ▪ Access to Māori designed and responsive services is a fundamental right – not a privilege ▪ Building the Māori capability and capacity of the HBDHB ▪ From an environment where direct and structural racism exists, to one that actively eliminates this behaviour	1. Services are whānau based 2. Services are 'fit for purpose' 3. Improved Māori cultural infrastructure. 4. Increased Māori workforce (capable and accessible) 5. Increased access to services that are implemented in 'Māori ways', customs and knowledge. 6. Increased access to place based services. 7. Increased whānau health literacy	♦ Co-design and implement services that improve health equity for Māori ♦ Higher levels of Māori staffing, particularly at senior levels and in critical roles; ♦ Ensure recruitment for competency in working with and for Māori in key roles or having plans for upskilling where this does not exist ♦ Determining health literacy needs for those managing chronic illness and designing a new approach and programme.
Māori leadership	▪ Collaborative design and leadership of the HBDHB that demonstrates a genuine and strategic treaty partnership ▪ Enable and resource Māori to develop new approaches and evaluation criteria ▪ Appropriate levels of accountability	1. Māori are more active participants in their communities. 2. Māori are more socially and culturally secure. 3. Whānau Ora is effective for whānau Māori. 4. Increased uptake of Māori based pilots and programmes ('mainstreaming')	♦ Agree on the accountability and key metrics to report on underlying the key priorities (ie people measures, decision framework) ♦ Develop a cross-agency working group to develop key metrics on improving whānau Ora.

HAWKE'S BAY District Health Board Whakawāteatia	**DHB Elections 2019 - Update**
	For the attention of: **HBDHB Board**
Document Owner:	Ken Foote, Company Secretary
Month:	June 2019
Consideration:	For Noting

RECOMMENDATION

That the Board:

Notes the contents of this report

PURPOSE

The purpose of this report is to provide an update on progress with issues associated with this year's DHB Elections.

KEY DATES

Key dates relating to the elections include:

17 July	First Public Notice of Election
19 July	Nominations Open / Roll Open for Inspection
16 August	Nominations Close / Electoral Roll Closes
21 August	Public Notice of Candidates
20 September	Delivery of Voting Documents
12 October	Election Day / Voting Closes at Noon
17 October	Official Result Declaration
9 December	New Board comes into office

CANDIDATE HANDBOOKS

This year there will be two Candidate Handbooks:

- District Health Board Elections 2019 – Information for Candidates.
  - Generic handbook prepared by the Ministry of Health
  - Focus on MoH, DHBs and the role of DHB Board members
  - Will be available on line (MoH website) from late June
- 2019 Local Government Elections Candidate Handbook – for HBDHB
  - Based on standard booklet produced by electionz.com
  - Personalised HBDHB cover and content
  - Focus on the election process.
  - Will be available late June

CANDIDATES INFORMATION EVENINGS

With nominations opening on 19 July 2019, arrangements are being made to conduct these as informal sessions to be held between 5.00 and 6.00pm on:

- Wednesday 17 July in Hastings (HBDHB Boardroom)
- Thursday 18 July in Napier (Napier Health Centre Foyer)

Notices for these sessions will be distributed and placed on the website in early July.

BOARD DECISION MAKING DURING THE ELECTION PERIOD

Attached as **Appendix 1**, is a letter from the Office of the Director General of the Ministry of Health dated 10 June 2016. A similar letter relating to the 2019 elections is expected soon. This letter provides guidance on:

- Board Decision making
- Communications by DHB Board Members
- Communications by DHBs
- Communications from DHB staff

It is recommended that Board Members note the contents of this letter. A copy of the 2019 letter will be distributed as soon as it arrives.

ELECTION PROTOCOLS & POLICY

Also attached are:

- HBDHB Election Protocols – 2016 (refer to **Appendix 2)**
- HBDHB Election Protocols Policy – HBDHB Staff (refer to **Appendix 3**

It is important that Board members are aware of the contents and provisions included in these documents.

Election protocols – 2019

Introduction

District health board elections will be held over a three week period leading up to **Saturday 12 October 2019.**

These protocols apply from Wednesday 17 July 2019 to all campaigning activities, whether before, during or after the election.

All candidates (including existing board members) and Hawke's Bay District Health Board staff are expected to follow these protocols.

1 Employees of district health boards may stand for election

District health board employees have a statutory right to be elected as a member of a district health board (Clause 7, Schedule 2, NZ Public Health and Disability Act 2000):

> "A person is not prevented from being elected as a member of a district health board simply because the person is an employee of the district health board."

There is a possibility that a conflict of interest could arise during the campaign period, so employees who offer themselves for election to public office must notify the chief executive immediately they do so, and be familiar with Hawke's Bay District Health Board's policy.

2 District health board staff must be politically neutral

It is important that staff remain politically neutral at all times in their dealings with board members, potential board members and the public in general.

It is not acceptable conduct for staff to obviously align themselves or publicly support any candidate. Any action that exposes staff to an allegation of bias could potentially cause serious problems for the individual employee and to the district health board as an organisation.

Staff should not take part in any activity related to the election campaign of a current or potential elected member (apart from their own, should they choose to stand). This includes:

- Nominating or seconding a candidate's nomination.
- Attendance at private campaign strategy meetings
- Taking part in any activity that could be seen to be a campaign activity (eg canvassing, social media comments, writing speeches, letters or media releases that could be linked to the candidate's campaign)
- Involvement in public meetings (unless they are meetings where all candidates are invited to speak).

3 District health board resources should not be used for campaigning purposes

District health board resources (including time, computers, email, phones, faxes, stationery, photocopiers, stamps, business cards, notice boards, and website or district health board premises) should not be used for campaigning purposes. Campaign photos must not be taken on district health board sites.

Candidates must not link their own Facebook page and social media channels (if they are used for campaigning purposes) to HBDHB Facebook page and social media channels.

Staff must not send or forward emails around the district health board seeking support for a particular candidate or candidates, or use any district health board forum or meeting as a platform for encouraging support (eg district health board public meetings).

4 District health board information

The district health board's website information includes details of current board members and these will be removed during the pre-election period. Following the close of nominations, the candidate profile statements of all candidates will be available through the Hawke's Bay DHB's website.

Care should be taken that district health board publications do not provide an inappropriate high profile for any current board member. This is a matter of judgement, taking into account the spokesperson role of the board chair and the ongoing activities of the district health board.

Where information is supplied by the district health board to a candidate for campaign purposes, it should be supplied to other candidates on request.

Where to go for further help

1 For general information regarding the district health board election processes: **www.health.govt.nz**
and search on "DHB elections".

2 For further detail on communications in a pre-election period, see the website for the Report of the Controller and Auditor-General – *Good Practice for Managing Public Communications by Local Authorities:*
http://www.oag.govt.nz/2004/public-communications/part1.htm

3 If you are unsure whether or not particular requests or activities are in breach of these protocols, please discuss the matter with your manager or Hawke's Bay District Health Board's election contact, Ken Foote, Company Secretary ext. 4527; 06 873 2159; **ken.foote@hbdhb.govt.nz** .

HAWKE'S BAY DISTRICT HEALTH BOARD	**Manual:**	Operational Policy Manual
	Doc No:	HBDHB/OPM/039
Election Protocols Policy - HBDHB Staff	**Issue Date:**	July 2004
	Reviewed Date:	May 2016
	Approved:	Chief Executive Officer
	Signature:	Dr Kevin Snee
	Page:	1 of 4

PURPOSE

The purpose of this policy is three-fold:

- To provide guidance and support to staff who wish to stand for membership of Hawke's Bay District Health Board (HBDHB).
- To provide guidance to staff on the standard of behaviour required of them regarding the election of DHB Boards.
- To ensure HBDHB maintains the confidence of its communities and owners by acting professionally and impartially during the DHB Board election process.

SCOPE

This applies to all employees, include contracted or fixed term employees of HBDHB.

Employees shall be deemed to be representing the organisation when they are writing as a member of staff; are wearing the organisation's uniform and/or identification card; or can be associated with the organisation, e.g. are using a Board vehicle, presenting at meetings or conferences in their capacity as an HBHDB staff member.

OUT OF SCOPE

HBDHB Board, Advisory Committee or any other associated committee or council member. Members of these groups have policies, guidelines, Terms of Reference and codes of conduct and ethics specific to their function.

POLICY

HBDHB supports its population, including staff, to participate in the election of its governing Board as candidates and/or as voters.

People have the right to access HBDHB's services and facilities without harassment. This includes political harassment.

All HBDHB staff are required to remain politically neutral (apolitical) when carrying out their job. This includes interactions with patients/clients and their families, other staff, Board and Committee members.

HBDHB staff must do their job professionally and loyally, without letting their personal interests or views influence their advice or behaviour in the work place.

Employees of HBDHB may stand for DHB Elections:

- District Health Board employees have a statutory right to stand for election as a member of a DHB Board (clause 7, schedule 2, NZ Public Health and Disability Act 2000).

- If elected, Board Members who are also members of staff, will need to:

  - ensure they can do their primary job unhindered and without detriment to the public interest
  - ask for and take approved leave without pay to attend to any board business that occurs in their normal working hours
  - be especially diligent and transparent over potential conflicts of interest
  - are familiar with requirements of Board and committee members as detailed in HBDHB's the e-governance manual available on the DHB's website http://www.hawkesbay.health.nz

- HBDHB upholds the principles of being a good employer. In this context, good and reasonable employer means:

  - making reasonable efforts to enable staff elected as Board members to take leave without pay to attend board business, provided that this does not adversely affect the operation of the organisation
  - make arrangements to cover approved absence where practical

- As governor, HBDHB's Board should:

  - recognise the particular difficulties for DHB employees who are also members of the board
  - pay particular attention to ensuring that conflicts of interest of members who are also DHB employees are handled appropriately
  - avoid as far as possible placing the CEO or board member-employees in situations where any role tensions could develop or be exacerbated
  - not pressure CEOs to grant leave for board members, recognising that the CEO is the employer and that s/he has the responsibility for service provision and employees

- It is important to the reputation and probity of HBDHB that no individual candidates, including staff who are standing for election, are unfairly advantaged through access to DHB resources, including staff time and communication channels.

- HBDHB staff whose regular duties require writing media releases, letters, speeches and carrying out administrative tasks for current elected and appointed members are to exercise extreme care to ensure such activities cannot be linked in any way to a political campaign.

- Staff members involved in an election campaign (either their own or that of any candidate) should ensure that they identify and manage any conflict, or potential conflict of interest with their employment at HBDHB.

- DHB resources should not be used for campaigning purposes:

  - No DHB resources (including staff time, computers, e-mail, cell phones, faxes, stationery, photocopiers, stamps, cards and venues) should be used for campaigning purposes.
  - No DHB-provided forums or meetings (e.g. reference group meetings, DHB forums and public meetings) should be used for campaigning purposes.
  - This provision applies to all staff, board and committee members, including those who are standing, or considering standing, for election to a DHB Board.

- DHB information should be available to all candidates on an equal basis:

  - Where DHB information is supplied to a candidate for campaign purposes, it should be supplied to other candidates as a matter of course.

- HBDHB publications, website, social media and other communication vehicles (eg: DHB-funded radio spots) should not be used for campaign purposes:

  - Where communication platforms are provided by or through HBDHB, all candidates should have equal access to them.
  - Hawke's Bay DHB shall be guided by the Office of the Auditor-General's Guidelines for Advertising and Publicity by Local Authorities (also relevant to DHBs) which states: "*a local authority must not promote, nor be perceived to promote, the re-election prospects of a sitting member. Therefore, the use of Council resources for re-election purposes is unacceptable and possibly unlawful,*" and,

    "When the authority considers that information need not be presented as representing the corporate or collective position, the manner of its presentation should not create the appearance that what is being said represents the personal views of the people to whom the information is being attributed. Special care with presentation is required when attribution is to a spokesperson – commonly the Mayor or authority Chairperson or Chairperson of the associated committee – particularly during the pre-election period".

    The pre-election period is generally regarded as having started when the first public declarations of candidacy have been made.

- Board decision making during the election process:

  - During the election period (opening of nominations to the time the new Board takes office), the Board shall continue to carry out its duties.
  - The Board shall put in place arrangements as appropriate to ensure a smooth transition from the current to the newly elected Board.

RELATED HBDHB DOCUMENTS

House Rules
Media Relations Policy HBDHB/OPM/022
Leave Policy HBDHB/PPM/080

REFERENCES

"Good Practice for Managing Public Communications by Local Authorities", Controller and Auditor-General, April 2004.

FURTHER INFORMATION / ASSISTANCE

If you are unsure whether or not certain requests or activities are a breach of the preceding protocols, please discuss the matter with your manager or contact the Communications Service.

For general information regarding the DHB election processes: www.health.govt.nz

For further detail on communications in a pre-election period, see the website for the Report of the Controller and Auditor-General – Good practice for Managing Public Communications by Local Authorities: http://oag.govt.nz/2004/public-communications/part1.htm

Useful advice sheets from the State Services Commission:
See Understanding the code of conduct - Guidance for State servants: www.ssc.govt.nz/code-guidance-stateservants; and
Political Neutrality Fact Sheet No. 2 Political Views and Participation in Political Activity
www.ssc.govt.nz/political-neutrality-guidance.

KEY WORDS

Board
Elections
Voting

For further information please contact the Company Secretary

MENTAL HEALTH ZERO SECLUSION

Verbal

HAWKE'S BAY
District Health Board
Whakawāteatia

Recommendation to Exclude the Public

Clause 32, New Zealand Public Health and Disability Act 2000

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

22. Confirmation of Minutes of Board Meeting 29 May 2019 - Public Excluded
23. Matters Arising from the Minutes of Board Meeting - Public Excluded
24. Board Approval of Actions exceeding limits delegated by CEO
25. Chair's Update
26. HB Clinical Council Report (public excluded)
27. Màori Relationship Board report (public excluded)
28. 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).