HB Clinical Council Meeting

Date: **Wednesday, 12 June 2019**

Meeting: **3.00 pm to 5:30 pm**

Venue: **Te Waiora Meeting Room (Boardroom), District Health Board Corporate Office, Cnr Omahu Road & McLeod Street, Hastings**

Council Members:

Dr John Gommans (Co-Chair)
Jules Arthur (Co-Chair)
Chris McKenna
Dr Mark Peterson
David Warrington
Dr Robin Whyman
Lee-Ora Lusis
Dr Daniel Bernal
Dr Andy Phillips
Dr Russell Wills
Debs Higgins
Anne McLeod
Dr Peter Culham
Dr Nicholas Jones

Apology:

In Attendance:

Kate Coley, Executive Director - People and Quality (ED P&Q)
Ken Foote, Company Secretary
Tracy Fricker, Council Administrator / EA to ED P&Q
Ana Apatu, Māori Relationship Board Representative

Public

Item	Section 1 – Routine	Time
1.	Welcome and receive apologies	3:00
2.	Interests Register	
3.	Minutes of Previous Meeting	
4.	Matters Arising – Review Actions	
5.	Board Report – May (public) - for information only	
6.	Workplan (monthly)	
7.	Clinical Council Annual Plan – Progress Review	
	Section 2 – Reporting Committees to Council	
8.	Clinical Advisory & Governance Group (verbal) – Chris McKenna	3.15
9.	Consumer Experience Committee – Debs Higgins	3.20
10.	Patient Safety & Risk Management Committee – Russell Wills & Chris McKenna	3.25
11.	Council Representatives update (verbal)	
	Section 3 – Information / Discussion	
12.	HB Health Strategy Round 2 – Chris Ash 12.1 HB Health Strategy draft 12.1 Equity Framework –Bernard Te Paa	3.35
13.	Annual Plan 19/20 – Chris Ash 13.1 Annual Plan Part A 13.2 Annual Plan Part B 13.3 Population Health Annual Plan 13.4 HBDHB SLM Improvement Plan	4.15
14.	Person & Whanau Centered Care actions (late paper)– Kate Coley	4.30
15.	Early Supportive Discharge model of care – John Burns / Allison Stevenson	4.45
16.	**Section 4 – Recommendation to Exclude the Public**	

Public Excluded

Item	Section 5 – Routine	Time
17.	Minutes of Previous Meeting (Public Excluded)	4.55
18.	Matters Arising – Review Actions (Public Excluded)	
19.	Clinical Risk – Kate Coley	5.00
20.	Topics of Interest – Member Issues / Updates	

NEXT MEETING:

Wednesday, 10 July 2019
Te Waiora Meeting Room (Boardroom), HBDHB Corporate Office
Cnr Omahu Road & McLeod Street, Hastings

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

Interests Register
Feb-19

Hawke's Bay Clinical Council

Name **Clinical Council Member**	**Interest** **e.g. Organisation / Close Family Member**	Nature of Interest **e.g. Role / Relationship**	Core Business **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
Chris McKenna (Director of Nursing)	Hawke's Bay DHB - Susan Brown	Sister	Registered Nurse	Yes	Low - Personal - family member
	Hawke's Bay DHB - Lauren McKenna	Daughter	Registered Nurse	Yes	Low - Personal - family member
	Health Hawke's Bay (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
Dr Mark Peterson (Chief Medical Officer - Primary Care)	Taradale Medical Centre	Shareholder and Director	General Practice	Yes	Low
	City Medical Napier	Shareholder	Accident and Medical Clinic	Yes	Contract with HBDHB
	PHO Services Agreement Amendment Protocol (PSAAP)	"Contracted Provider" representative	The PHO services Agreement is the contract between the DHB and PHO. PSAAP is the negotiating group that agrees the contract.	Yes	Representative on the negotiating group
	Health Hawke's Bay Limited (PHO)	Board member	HHB ensures the provision of essential primary health care services, mostly through general practices, to the population of HB.	Yes	Low
	Primary Health Alliance	Executive Member	Primary Care advocacy organisation	Yes	Low
	Council of Medical Colleges	Royal New Zealand College of General Practitioners representative and Council of Medical Colleges Executive	May impact on some discussions around medical training and workforce, at such times interest would be declared.	Yes	Low
	General Practice New Zealand	Executive Member			
	General Practice Leaders Forum	Member			
Dr John Gommans	Stroke Foundation Ltd	Chairman of the Board of Directors	Provides information and support to people with a stroke. Has some contracts to the MOH	Yes	Low
	Internal Medicine Society of Australia and New Zealand (IMSANZ)	Director of IMSANZ	The IMSANZ represents the interests of specialist General Internal Medicine physicians throughout Australia and New Zealand	Yes	Low
Jules Arthur (Midwifery Director)	National Midwifery Leaders Group	Chair	Forum for national midwifery and maternity issues	No	
	Central Region Midwifery Leaders report to TAS	Member	Regional approach to services	No	
	National Maternal Wellbeing and Child Protection group	Co Chair	To strengthen families by facilitating a seamless transition between primary and secondary providers of support and care; working collaboratively to engage support agencies to work with the mother and her whanau in a culturally safe manner.	No	
	NZ College of Midwives	Member	A professional body for the midwifery workforce	No	
	Central Region Quality and Safety Alliance	Member	A network of professionals overseeing clinical governance of the central region for patient quality and safety.	No	
David Warrington (Service Director - Mental Health & Addictions)	The Works Wellness Centre	Wife is Practitioner and owner	Chiropractic care and treatment, primary, preventative and physiotherapy	Yes	Low
	National GM of Mental Health & Addictions	Member		No	Low
Dr Andy Phillips (Chief Allied Health Professions Officer)	Health Systems Performance Insights Programme	Chair	Improving Health System Performance	No	
	The Health Foundation (UK)	Member of College of Assessors	Improving Health System Performance	No	
Dr David Rodgers (GP)	Tamatea Medical Centre	General Practitioner	Private business	Yes	Low. Provides services in primary care
	Tamatea Medical Centre	Wife Beth McElrea, also a GP (we job share)	Private business	Yes	Low. Provides services in primary care
	City Medical	Director and Shareholder	Medical Centre	Yes	Low. Provides services in primary care
	National Advisory Committee of the RNZCGPs	Member and CP Teacher	Health and Wellbeing	No	
	Health Hawke's Bay (PHO)	Medical Advisor - Sector Development	Health and Wellbeing	Yes	Low. Ensure position declared when discussing issues in this area relating to the PHO.
Debs Higgins (Senior Nurse)	The NZ Nurses Society	Member of the Society	Provision of indemnity insurance and professional support.	No	
	Health HB	Employee	Role: Clinical Performance Support Lead	Yes	Low
Anne McLeod (Senior Allied Health Professional)	Aeotearoa NZ Association of Social Workers	Member		Yes	Low
	HB DHB Employee Heather Charteris	Sister-in-law	Registered Nurse Diabetic Educator	Yes	Low
	Directions Coaching	Coach and Trainer	Private Business	Yes	Low: Contracts in the past with HBDHB and Hauora Tairawhiti.
Dr Robin Whyman (Chief Medical Officer - Hospital)	Dental Council of New Zealand	Appointed Member	Oral health professions regulator	No	

5/06/2019

Name **Clinical Council Member**	**Interest** **e.g. Organisation / Close Family Member**	Nature of Interest **e.g. Role / Relationship**	Core Business **Key Activity of Interest**	**Conflict of Interest** **Yes / No**	**If Yes, Nature of Conflict:** **- Real, potential, perceived** **- Pecuniary / Personal** **- Describe relationship of Interest to**
	Royal Australasian College of Dental Surgeons	Fellow	Continuing Professional Development	No	
	NZ Institute of Directors	Member	Professional Network	No	
	NZ Dental Association	Hon Life Member	Professional Network	No	
	Australian NZ Society of Paediatric Dentistry	Member	Professional Network	No	
	Association of Salaried Medical Specialists	Member	Trade union	Yes	Potential pecuniary interest
	NZ Society of Hospital and Community Dentistry	Member	Professional Network	No	
Dr Russell Wills (Community Paediatrition)	HBDHB Community, Women and Children and Quality Improvement & Patient Safety Directorates	Employee	Employee	Yes	Potential, pecuniary
	Wife, Mary Wills employed as General Manager of Presbyterian Support East Coast	Employee	Presbyterian Support East Coast provide services within the HB and are a contractor to HBDHB	Yes	Potential, pecuniary
	Paediatric Society of New Zealand	Member	Professional network	No	
	Association of Salaried Medical Specialists	Member	Trade Union	Yes	Potential, pecuniary
	New Zealand Medical Association	Member	Professional network	No	
	Royal Australasian College of Physicians	Fellow	Continuing Medical Education	No	
	Neurodevelopmental and Behavioural Society of Australia and New Zealand	Member	Professional network	No	
	NZ Institute of Directors	Member	Professional network	No	
Lee-Ora Lusis (Clinical Nurse Manager, Totara Health)	Totara Health and Choices Kahungunu Health Services	Employee	Clinical Nurse Director	Yes	Potential, pecuniary
	Hawke's Bay Primary Health Nurse Practitioner Group	Member / Nurse Practitioner Intern	Professional network	No	
	Hawke's Bay Nurse Leadership Group	Member	Professional network	No	
	College of Nurses Aotearoa (NZ)	Member		No	
	Fusion Group Committee	Representative		No	
	ED High Flyers	Representative		No	
	Totara Health / Youth Contract with Directions	Employee of Totara Health			
	Kidney Health Australia - Caring for Australasians with Renal Impairment	Member		No	Guidelines group - involved with the group "Management of chronic kidney disease among Aboriginal, Torres Strait Islander Peoples and Maori".
Dr Nicholas Jones (Clinical Director - Population Health)	NZ College of Public Health Medicine	Fellow	Professional network	No	
	Association of Salaried Medical Specialists	Member	Professional network	No	
	HBDHB Strategy & Health Improvement Directorate	Employee	Employee	No	
Dr Peter Culham (GP)	Havelock North Properties Limited	Shareholder	Medical Centre owner	Yes	Low, pecuniary, hold leases with healthcare providers
	Te Mata Peak Practice	GP and Director	General Practice	Yes	Low, pecuniary, provides primary care services
	C&G Healthcare	Director	Private business	No	No further exposure beyond mentioned above
	Royal NZ College of General Practitioners	Fellow		No	
Daniel Bernal	New Zealand Hospital Pharmacists Association	Member	Discussion	No	
	Pharmaceutical Society of New Zealand	Member	Access their resources, record my CPD on their website.	No	

MINUTES OF MEETING FOR THE HAWKE'S BAY CLINICAL COUNCIL HELD IN THE TE WAIORA MEETING ROOM, HAWKE'S BAY DISTRICT HEALTH BOARD CORPORATE OFFICE ON WEDNESDAY, 8 MAY 2019 AT 3.00 PM

PUBLIC

Present:	Dr John Gommans (Chair) Dr Peter Culham Dr Mark Peterson Debs Higgins Dr Daniel Bernal Dr Nicholas Jones David Warrington Dr Robin Whyman (from 3.40 pm)
In Attendance:	Ken Foote, Company Secretary Tracy Fricker, Council Administrator and EA to ED P&Q Peter Satterwaite, Health Hawke's Bay Representative
Apologies:	Russell Wills, Le-Ora Lusis, Andy Phillips, Chris McKenna, Anne McLeod and Jules Arthur

SECTION 1: ROUTINE

1. WELCOME AND APOLOGIES

Dr John Gommans (Chair) welcomed everyone to the meeting. Apologies were noted as above and from attendee member Kate Coley.

2. INTEREST REGISTER

No conflicts of interests were noted for today's agenda items.

3. MINUTES OF PREVIOUS MEETING

The minutes of the HB Clinical Council meeting held on 10 April 2019, were confirmed as a correct record of the meeting.

Moved and carried.

4. MATTERS ARISING / REVIEW ACTIONS

Item #1 New Clinical Governance Structure / Terms of Reference

- CAG – no update on whether TOR have been approved. There is still no CAG Representative on Council. Discussion has taken place, awaiting written confirmation.
- TOR for Advisory Groups. All but three have been received although many appear to be out of date. Committee Chairs to review the TOR for Advisory Groups and then send to Ken Foote, Company Secretary to check consistency and standard format.

Action: Advisory Group TOR to be sent to Company Secretary. Will then come to Council for endorsement.

Item #2 Screening for Harms
Work in progress. Update will be provided at the July meeting.

Dan Bernal provided an update on the issue raised by the Trauma Advisory Group. Funding for a fulltime ED Trauma Clinical Nurse Specialist has been approved by the Executive Management Team. It was noted that this was part of a package for matching capacity with demand and that ED, AAU and other areas are receiving additional resources.

5. BOARD REPORT - MARCH (CLINICAL AND CONSUMER COUNCILS' COMBINED)

The report to the Board in April was provided in the meeting papers for information.

The Chair highlighted to Board the Clinical Council's objectives have a high dependence on the People & Quality Directorate for key pieces of work. W&PCC, Risk Management and Workforce Planning and Development.

6. WORKPLAN

The workplan was provided in the meeting papers.

7. CLINICAL COUNCIL ANNUAL PLAN – PROGRESS REVIEW

The Chair advised that progress on the objectives is underway and the table included in the meeting papers has been updated.

The Company Secretary advised that the idea was to have small groups allocated to each objective, with a lead who can update Council at each meeting on progress with that objective. This is where Council can be proactive rather than reactive.

Action: ***Members to advise areas of interest or they will be allocated for them by the Co-Chairs.***

SECTION 2: REPORTING COMMITTEES TO COUNCIL

8. CLINICAL ADVISORY & GOVERNANCE GROUP – VERBAL UPDATE

Dr Mark Peterson provided an update from the last CAG meeting:

- Personnel - Sandra Jessop is to join CAG, Mark Peterson will be Chair with Chris McKenna as Deputy or Co-Chair (to be decided)
- CAG Representative on Clinical Council – verbal agreement, awaiting written confirmation
- GP Representative on Clinical Council – expression of interest process to replace Dr David Rogers is underway.

The Chair noted concern that Clinical Council has limited primary input with the CAG and GP vacancies.

9. COUNCIL COMMITTEE & REPESENTATIVE REPORTS

The Chair asked if members had any updates for Council. Update provided below.

- ***Ti Pitau Health Alliance Governance Group*** - Peter Culham, attended his first meeting today. The group are focusing on three key pieces of work: end of life – ground up consumer driven; after-hours; and they have taken ownership of system level measures.

10. COLLABORATIVE PATHWAYS UPDATE

Dr Mark Peterson provided a verbal update. Some of the existing clinical pathways are being converted to electronic. Health Link have made them cheaper and easier to customise. It is hoped that some of the pathways will be able to be embedded into electronic referrals. This is currently with Information Services.

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

The Chair advised that the Regional Clinical Portal is due to go live in Hawke's Bay in August. Demographic and encounter data has been transferred, two and a half years results data are currently being transferred. Next steps are discharge summaries and clinical letters. Unsure if electronic referrals into the Clinical Portal will be turned on at go live or will be made available at a later date. A Clinical Portal Regional Workshop is being held at Whanganui DHB next week.

SECTION 3: PRESENTATION & DISCUSSION

11. HB HEALTH STRATEGY

The Chair welcomed Chris Ash, Executive Director – Primary Care, Hayley Turner, Corporate Portfolio Manager and Kate Rawstron, Head of Planning & Strategic Projects to the meeting.

Chris advised that the document in the papers is the current draft of the strategy. The source documents for the strategy have been the Clinical Services Plan, People Plan and Health Equity Report. It was agreed at the Health Sector Leadership forum to use those processes which had been extensively consulted and engaged with Whanau to inform the basis of the Health Strategy. The strategy will be a concise high level document covering 10 years. The implementation plan will be co-designed with clinicians and consumers.

- 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

Chris Ash commented that the implementation plan will need to be prioritised and resourced appropriately.

The Chair summarised that there is general agreement for the layout and approach and having smart objectives which reflect what we want to achieve.

Further feedback can be provided to hayley.turner@hbdhb.govt.nz.

12. TE ARA WHAKAWAIORA CHILD HEALTH COMBINED REPORT

The Chair welcomed Patrick Le Geyt, General Manager – Maori Health and Charrissa Keenan, Programme Manager, Maori Health to the meeting.

There has been a review of the Te Ara Whakawaiora programme and a decision has been made to consolidate the indicators under four categories: child health; adult health; cultural responsiveness and mental health. There will be one report each quarter. The aim of the programme was that the executive leadership team are the champions for the indicators:

ASH 0-4 Years – Chris Ash
Child Oral Health – Robin Whyman
Breastfeeding – Chris McKenna
Child Healthy Weight – Bernard Te Paa

Te Ara Whakawaiora is not just an exception report it is about actions. The governance group formed will support the actions which need to occur to improve equity. It was noted that there needs to be further discussion on how child heath governance will be community led.

The Clinical Council **noted** the report and supported the approach of consolidating the report.

Tō Waha – A Whanau-Centred Collaborative Approach

Patrick Le Geyt provided a verbal update of "Tō Waha" the New Zealand Defence Force oral health initiative, working in Flaxmere for 2 weeks with high needs communities in Hawke's Bay. 702 people were treated; 1,297 dental treatments provided (hygiene; fillings and extractions). The success was the cross-collaboration approach between the DHB and community providers. It demonstrated that community led approaches can lead to better health outcomes and collaborative efforts working across the health system can produce better outcomes. More of these initiatives are to be held across Hawke's Bay, Wairoa and Central Hawke' Bay.

Action: ***Letter of thanks from Clinical Council to be sent to the Community Dentists who gave their time for free.***

13. AFTER HOURS SERVICE UPDATE

Peter Satterthwaite, Health Hawke's Bay provided a presentation on the review of the primary care model which needs to be clinically sound, understood by consumers and affordable. Key points included:

- Demographic mappings – where people attending ED are living. Data indicates high decile areas – Hastings high utilisation from Camberley and Flaxmere (similar numbers day and night); Napier - significant numbers from Maraenui travelling to ED

- Options for consideration:
    1. A **dual overnight service** model - **Hastings and Napier**
    2. A **single** overnight service model in **Napier**
    3. A **single** overnight service model in **Hastings**

- Strategic questions:
    - Optimal location – hospital site/TTOH/Hastings Health Centre
    - Provision of specialist nursing staff
    - Medical back-up? None/ED Registrar/On-call GP
    - Who would operate the service

Peter indicated that discussion is to be had with the GP groups and more importantly consumers, on what would change their behaviour from using ED (generally it is due to affordability). This briefing was to keep Council informed on how the PHO is approaching the problem.

The Chair thanked Peter for the briefing and commented that Council would be interested to hear the feedback from the various groups on the proposals outlined.

14. PRIMARY CARE WORKFORCE SURVEY

Rochelle Robertson, Workforce Development provided a presentation on the Hawke's Bay PHO Workforce Analysis "snapshot" conduced September 2018 to March 2019. The presentation included RNZCGP Survey 2018 data; rationale; results; Hawke's Bay PHO workforce analysis; deductions and assumptions and next steps:

- RNZCGP National Survey 2018:
    - Over the next five years, 27% of GPs intend to retire. Over the next 10 years, 47% intend to retire
    - Increasing numbers of GPs say they work in practices that have a GP vacancy (31% percent in urban areas and 39% of rural practices)
    - GP burn-out rates are increasing (26%, compared to 22% in 2016)
- Rationale for local survey:
    - No workforce data for general practices existed (HB PHO)
    - Regular monthly reports received only reflected GPs and nurses; allied health and other roles were not captured
    - Hours of work, ethnic group, and age were not recorded
    - There had been no opportunity for practices to identify roles they might consider in the future
    - Workforce planning needed a start position
- Results – available in the presentation provided to members:
    - 24 out of 26 practices provided workforce data although one large practice was unable to provide a breakdown of their numbers
    - Participation was voluntary
- Hawke's Bay PHO workforce analysis by role (medical; nursing; administration; care & support, allied health and business)– fte numbers; average hours worked; age and ethnicity
- Next Steps:
    - Workforce gap analysis –from now to the next 5 years
    - Model of Care – change support, workforce opportunities - *grow, recruit, sustain*
    - Extended Care teams – stakeholder meetings, driving change
    - Incubator – health career map *grow and recruit*
    - Maori/Pacifica workforce action plan alignment– *grow, recruit and sustain*
    - Nursing development, pathways, education – *recruit, develop and sustain*
    - GP, recruitment MOU DHB – *recruit and sustain*
    - Administration – *grow, train and sustain (Exploring EIT coursing and online or cost effective training for this workforce)*
    - Care support *grow, train, and sustain, Careerforce NZ, EIT, Wananga o Aotearoa*
    - Business education, business mentors *develop and sustain*
    - Allied Health, *inter-professional training opportunities*

General discussion held on the increasing part time GP workforce which has an impact on patient experience and ability to deliver patient and whanau centred care. Healthcare Home is

a model to reform general practice, free up time for GPs, nurses doing work GPs don't need to do; different models for chronic and acute care. Once this work has been done, extended care teams can be introduced.

The Chair thanked Rochelle for the presentation.

15. PHLG NURSE NAVIGATORS

The Chair welcomed Talalelei Taufale, Public Health Development Manager to the meeting. Currently there is a Pacific Navigator team that works in the community and focuses on incoming referrals from the DHB and primary care as well as bowel screening and DNAs.

There are two full time navigators with a social focus and 1.7 fte nursing. The model of work is based on the pacific provider in Waikato and the Counties-Manakau model of care of nurse navigators based at the hospital who work with most complex families in the community which also includes referring on for social issues identified. The Hawke's Bay Pacific Team will be visiting Auckland to see the model in action, to share the learnings and bring back to Hawke's Bay. One of the stepping stones for an integrated Pacific Health Team is to have more clinical skill. There is a need for a nurse navigator.

Talalelei commented that there is a clear disconnect between services and the Pacific Health Team and how they can support services to achieve outcomes. They have a strong relationship with the Nurse Navigator at Totara Health and at Maraenui Health. A key learning from Auckland is that it is important to work with primary care and attend their MDT meetings, link to support families entering the health services.

The Chair commented that the Pacific Health Team is small, but is making a big difference. Council supported the direction Pacific Health Team are taking.

16. SECTION 4: RECOMMENDATION TO EXCLUDE THE PUBLIC

The Chair moved that the public be excluded from the following parts of the meeting:

16. Minutes of Previous Meetings (public excluded)
17. Matters Arising – Review Actions (public excluded)
18. Board Report – April (public excluded)
19. Topics of Interest – Member Issues/Updates

The meeting closed at 5.00 pm.

Confirmed: _____
Chair

Date: _____

4

HB CLINICAL COUNCIL - MATTERS ARISING
(Public)

Action	Date Entered	Action to be Taken	By Whom	Month	Status
1	12/09/18	***New Clinical Governance Structure / Terms of References***			
		• CAG TOR to be provided	C McKenna	TBC	Pending approval
		• Committee Chairs to provide Advisory Group (AG) TOR to Company Secretary for consistency/format review	Committee Co-Chairs	May	Ongoing
		• Committee Chairs to approve TOR for respective AGs	"	June	
		• Clinical Council to endorse AG TOR	All	June	
2	13/03/19	***Screening for Harms*** Small working group to prepare starter for 10 paper for discussion.	Nick Jones, Russell Wills, Andy Phillips and Debs Higgins	July	Ongoing
3	10/04/19	***Clinical Council Annual Plan – Progress Review*** • Members to advise Co-Chairs areas of interest re: six annual plan objectives (if not – they will be allocated).	All members	17~~5~~ May	
4	08/05/19	***Tō Waha*** • Letter of thanks to be sent to community dentists who took part in the initiative.	J Gommans / R Whyman	May	

	Hawke's Bay Clinical Council 35
	For the attention of: **HBDHB Board**
Document Owner:	Dr John Gommans (Co-Chair) Jules Arthur (Co-Chair)
Month:	May 2019
Consideration:	For Information

RECOMMENDATION

That the HBDHB Board

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

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

COMMITTEES & REPRESENTATIVES REPORTS TO COUNCIL

Reports were received from:

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

COLLABORATIVE PATHWAYS UPDATE

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

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

HB HEALTH STRATEGY

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

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

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

TE ARA WHAKAWAIORA CHILD HEALTH COMBINED REPORT

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

TO WAHA – A WHANAU CENTRED COLLABORATIVE APPROACH

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

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

AFTER HOURS SERVICE UPDATE

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

PRIMARY CARE WORKFORCE SURVEY

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

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

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

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

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

PASIFIKA NURSE NAVIGATORS

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

Council supported the direction the Pacific Health Team are taking.

GOVERNANCE WORKPLAN PAPERS

Updated: 31 May 2019

CLINICAL & CONSUMER MEETING 12/13 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
Annual Plan 2019/20		Chris Ash	Robyn Richardson		12-Jun-19	12-Jun-19	13-Jun-19		29-May-19
Clinical Advisory & Governance Group Meeting Update		Chris McKenna				12-Jun-19			
Collaborative Pathways update (Nov - **May**) 6mthly Clinical Council	E	Mark Peterson	Penny Rongotoa	21-May-19		12-Jun-19			
Person & Whanau Centered Care actions (inc Consumer Experience Facilitators)		Kate Coley		11-Jun-19	12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19
Early Supportive Discharge service Model of Care		John Burns	Allison Stevenson			12-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		12-Jun-19	12-Jun-19	13-Jun-19		26-Jun-19

CLINICAL & CONSUMER MEETING 10/ 11 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
Clinical Advisory & Governance Group Meeting Update		Chris McKenna				10-Jul-19			
IS updates/presentations 30 mins - Bi-monthly Feb Apr **Jun** Aug Oct Dec		Anne Speden				10-Jul-19		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

CLINICAL & CONSUMER MEETING 14/15 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
Clinical Advisory & Governance Group Meeting Update		Chris McKenna				14-Aug-19			
Clinical Council Annual Plan 2019/2020 discussion on the year ahead		Jules Arthur / John Gommans				14-Aug-19			
Clinical Council Annual General Meeting						14-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
IS updates/presentations 30 mins - Bi-monthly Feb Apr Jun **Aug** Oct Dec		Anne Speden				14-Aug-19		28-Aug-19	

CLINICAL & CONSUMER MEETING 11/12 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
Clinical Advisory & Governance Group Meeting Update		Chris McKenna				11-Sep-19			
Health Certification Audit Findings (sept19)	E	Kate Coley	Kaye Lafferty	27-Aug-19		11-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
Serious Adverse Events FULL REPORT		Robyn Whyman		3-Sep-19		11-Sep-19		25-Sep-19	

CLINICAL & CONSUMER MEETING 11/12 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
Clinical Advisory & Governance Group Meeting Update		Chris McKenna				9-Oct-19			
IS updates/presentations 30 mins - Bi-monthly Feb Apr Jun Aug **Oct** Dec		Anne Speden				9-Oct-19		30-Oct-19	

HAWKE'S BAY CLINICAL COUNCIL
ANNUAL PLAN 2018/19

ACTION/PROGRESS REPORT

OBJECTIVE	PROGRESS TO Apr 2019
1. Provide a proactive and prioritised clinical perspective on issues and strategies to be addressed in the new 5 Year Strategic Plan for the HB health sector by 30 June 2019	A small sub-group is overseeing the sign-off of the 5 year strategic plan. Robin Whyman has been nominated as the Clinical Council representative by the Co-Chairs. There is a meeting to be held on 2 May.
2. Co-design with Consumer Council and initiate the implementation of a detailed plan for the implementation of PWCC in HB by 30 June 2019	The Person & Whanau Centred Care workshop with Consumer Council has been held and a recommendation has gone to the Board, which was approved. The Executive Director P&Q will bring together a small working group of Clinical and Consumer Council members to prepare the report for the Board in June.
3. Ensure the Clinical Governance Structure is fully implemented and integrated, with appropriate reporting, management and administration processes in place, by 30 June 2019	Still chasing TOR for all Advisory Groups. Council Administrator has been asked to provide the Co-Chairs with the full list of AGs and status of their TOR. It was noted that most groups are functioning, the biggest challenge for these groups is administrative support and a good reporting structure. This is a key area for Council. Effective resourcing is required to support the clinical governance structure.
4. Ensure the development and implemention of a sector wide process for monitoring, managing and reporting clinical risk, by 30 June 2019	Workshop to be held on Risk Management, date to be determined by C0-Chairs with EDP&Q.
5. Facilitate the development of a HB Clinical Workforce Plan to support the new 5 Year Strategic Plan, by 30 June 19	One of the components of the new People Plan is a workforce development plan for the clinical and non-clinical workforce which will help address objective 5 regarding capacity of clinical workforce. Discussion also held around model of care changes influencing future workforce requirements.
6. Promote and support the development and delivery of education and training of all clinicians on the Quadruple Aim and PWCC, and what these mean for clinicians, by 30 June 2019	This is aligned with the Objective 5 but focused on capability of clinical workforce. This has not progressed in terms of action. Given other key work required of the P&Q Directorate including PWCC and Risk Management for Council this aspect of workforce development has a lower priority and won't be addressed within the next 6 months.

@BCL@8401A4D1

CLINICAL ADVISORY & GOVERNANCE GROUP

Verbal update

CONSUMER EXPERIENCE COMMITTEE

Verbal update

HAWKE'S BAY District Health Board	**Patient Safety & Risk Management Committee**
	For the attention of: **HBDHB Clinical Council**
Document Owner:	Dr Russell Wills and Chris Mckenna and (Co-Chairs)
Month:	June 2019
Consideration:	For Information

RECOMMENDATION

That the HB Clinical Council

Note the contents of this report.

The Patient Safety & Risk Management Committee was held on Monday, 27 May 2019.

An overview of matters discussed is provided below:

Advisory Group Reports:

Verbal reports were provided from the Chairs of the Advisory Groups (or their appointed delegate):

Clinical Risk and Event Advisory Group

Positives and progress:
- Workplan completed for reduction of pressure injury as per ACC project funding
- CPR policy updated and signed off
- Improved SAC1&2 count for falls compared to previous year
- Improved falls prevention training statistics for nursing
- MEOWS to be rolled out in Maternity, plan in place.

Risks and issues:
- Dedicated time for clinical leaders to lead clinical projects
- Increasing demand for patient transport for clinical pathways (cardiac and stroke)
- ICNet business case in progress, proven clinical benefits for implementation of this software
- Two SAC2 events for maternity in a month, outcome of reviews to be tabled at CREAG.

Falls Minimisation Advisory Group

Positives and progress:
- Training for staff on Ko Awatea - gradual increase, now 80-90% in B2 and ATR
- Quarterly data 93% of falls risk assessments completed in March
- Acknowledgement for the Nurse Educators who are doing a lot of work to ensure that risk assessments being done. Good progress is being made

- Installation of handrails - there is to be a phased approach for this work due to the high cost and disruption to wards, with high-risk areas being done first. B2 will be the first to have rails installed in July
- There is a lot of work in the community with strength and balance. It is hoped that ACC will continue to fund this initiative.

Risks and issues:
- AG lapsed, difficult without dedicated support (pressure injury – see below). Kerri Cooley has plan to rebuild. Meeting planned for 4 June. Jill Hall, ACC to attend.
- Six serious falls year to date. Falls have been increasing each month, predominately in A1, B2 and ATR
- No quality support on AG with Barbara Ryan changing roles.

Family Violence

Positives and progress:
- Cheryl Newman leading a piece of work on how best to use the limited resource we have to best effect. Work in progress.

Infection Prevention & Control Advisory Group

Positives and progress:
- ICNet Report tabled which provided PSRMC with an overview of the software package, which supports infection prevention and control through automated collection, and analysis of data from ECA, theatres and the laboratory. ICNet enables early notification of infections, outbreak and transmission alerts. PSRMG have asked for a business case including costings.

Maternity Governance Advisory Group

Positives and progress:
- HQSC programmes: new national maternity early warning score system "MEWS"; neonatal programme - neonatal EWS chart to be developed
- Training:
    - GAP (individualised growth chart)
    - GROW new online training and face to face resource from ACC
    - Foetal Surveillance education programme in place
- Sepsis bundle being rolled out - most common readmission reason is sepsis
- 2017 clinical indicators – improvement on all indicators, e.g. intervention rate falling. (See Maternity annual report).

Risks and issues:
- Maternity Quality and Safety Plan – awaiting MOH decision on sustainable funding and governance
- Two SAC2 events this month (necrotising fasciitis, with loss of breast and an unexpected emergency hysterectomy following C-section with massive blood loss). Communication issues, referrals, speaking up, timely review and ability to work across teams, especially at night.
    - Clinical midwifery co-ordinator 24/7 would greatly mitigate these issues.
- Risks around antenatal ultrasound
    - Image storage and retrieval between two systems
    - Cost – new surcharge of $10-20 has increased DNAs to 50%
    - Capacity – difficulty recruiting obstetrics sonographers (long-standing issue, specialist area of radiography expertise), affects access, e.g., Wairoa.

Patient at Risk

Positives and progress:
- CPR Policy has been reviewed and signed off
- MEOWS roll out on 1 January (Kirsten Gaerty is clinical lead)

Risks and issues:
- Wairoa – the need for Acute Care Training (ACT) has been identified. GPs need to do this training for credentialling. Discussion held regarding training being held in Wairoa vs clinicians travelling down to HB Hospital. Increased demand for the transport system (Acute stroke pathway, ACS pathway) reduces access for Wairoa patients to urgent transfers
- Increase in "Code Violet" incidents.
- PAR service remains less than 24/7 cover.

Pressure Injury Advisory Group

Positives and progress:
- Guaranteed 2 years funding from MOH and ACC "Investing in Pressure Injury Prevention & Management in Hawke's Bay" project. CNS Wendy Mildon providing dedicated leadership as project manager. Project transferred to Community, Women 7 Children. Project plan is developed and time lined
- Advisory Group have met
- Reported pressure injuries increased, all low complexity events. ACC reported serious events unchanged. Expected outcomes from improved leadership, training, surveillance and early action. Monthly reporting will include Aged Residential and Hospital-Level community care
- The Pressure Injury policy and procedure has been updated and a staged education programme is to be rolled out
- Progress in this project due to dedicated clinical leadership compared to falls minimisation is striking

Risks and issues:
- Pressure mattress audit demonstrates that we have 49 functional pressure mattresses.

Restraint Advisory Group

Positives and progress:
- Advisory Group is meeting fortnightly, well-attended and has some changes / additions in Membership
- Sub-group (Restraint Review Group, chaired by Nikki Prendeville) is also meeting regularly to review restraints across HBDHB. Restraint events 1 February to 16 May 2019 (Mental Health 57, 54 reviewed; other areas 17, 13 reviewed)
- Enablers – posters are being displayed on all wards, including definition
- Certification audit – information folder on work being done prepared for auditor
- Restraint Policy is being reviewed again by RAG due to the above issues with enablers (CDHB policy helpful, e.g., how to demonstrate consent, I), some changes in restraint holds and noted incorrect information in policy
- Mental Health continues to facilitate SPEC training – for MH only; refreshers commencing. Managing Challenging Behaviour and De-escalation/ Breakaway training is available to all staff via PALS. A paper is being drafted to recommend this is mandatory for all acute clinical areas. Nurse Educators will work together to deliver training – as able due to other training commitments.

Risks and issues:
- Restraint incidents are not being evented appropriately or at all in some areas. Confusion with coding and believed need for multiple event forms for one event indicates training is required

e.g. documentation of “enablers” vs restraints continues to be an issue; inconsistencies across the country
- ED staff want to attend the 2-day training but unable to due to capacity and workload. Despite 8 additional FTE nurses, still 10 FTE short of number required to release staff for training. Asking for 1-2 hour training, but this is not sufficient to manage the behaviours currently being seen.

General Discussion:

- Rapid progress in projects led by dedicated clinical leaders in project management roles (Pressure Injury, Restraint) vs no dedicated time (Falls) or non-clinical project managers.
- Current bed capacity due acute demand can make progress in important patient safety areas very difficult (Restraint, Falls).

Areas of Risk Identified:

- General: freeing up time to enable clinical leadership:
  - Clinical leaders to lead improvement projects
  - Staff to attend training and participate in improvement projects
- Falls: increasing, AG lapsed, QI support ceased
- Maternity: after hours clinical co-ordination, access to antenatal ultrasound and images
- Patient at Risk: ACT training for Wairoa
- Restraint: freeing up staff time to attend training, especially in ED.

11

COUNCIL REPRESENTATIVE UPDATES

Verbal

OURHEALTH HAWKE'S BAY Whakawāteatia	**Hawke's Bay Health Strategy Document** **Draft Document for feedback**
	For the attention of: **HB Clinical Council**
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:	Bernard Te Paa – Executive Director Health Improvement Equity Chris Ash – Executive Director Primary Care Ken Foote – Company Secretary Carriann Hall – Chief Financial Officer
Month:	June 2019
Consideration:	For review and final comment

RECOMMENDATION:

That HB Clinical Council

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 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

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

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?	Accepted	RE view objectives to more qualitative standard. Realign to CSP clarify business and clinical models terminology in document

			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		
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 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	accepted	Update document

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 My big question therefore is – why change from this – should we look to continue with:	Noted	Further discussion at sub EMT

			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

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

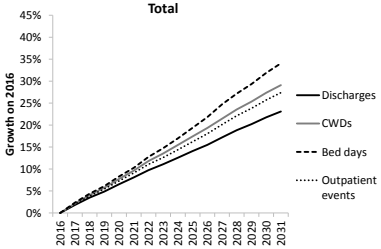
[Consider map of service network and/or key population figures]

Where are we at?

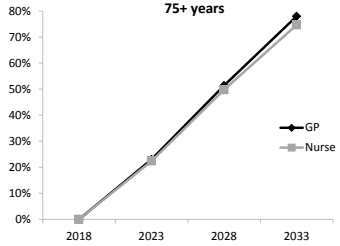
Over the last five years, we have shifted our perspective from DHB services to whole-system management and engagement with iwi and post-settlement governance entities, with our Transform and Sustain strategy. We set up our Consumer Council to work alongside our Clinical Council and Māori Relationship 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?

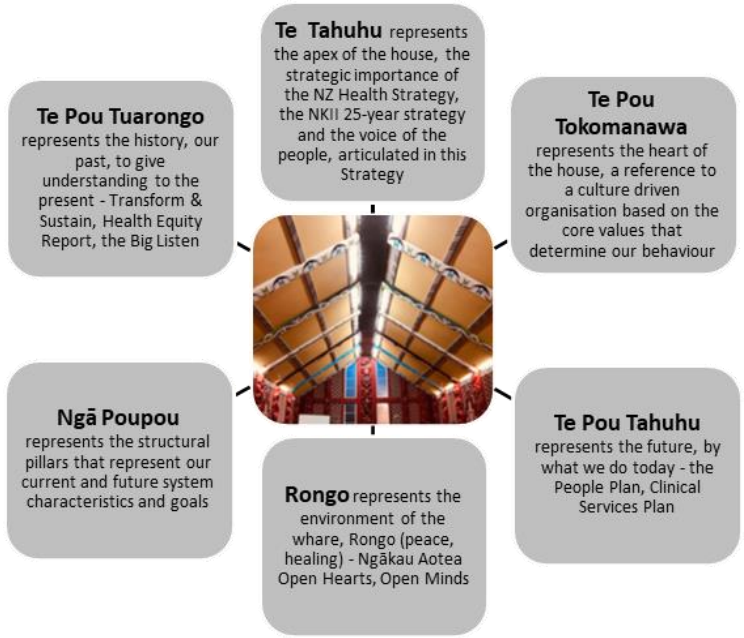
We have done a lot of listening, thinking and planning over the last two years. Our **Clinical Services Plan** sets out the challenges and opportunities the system faces and describes concepts for the future we want. Our **People Plan** describes the culture and values we want and how we will grow our 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

12.1

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

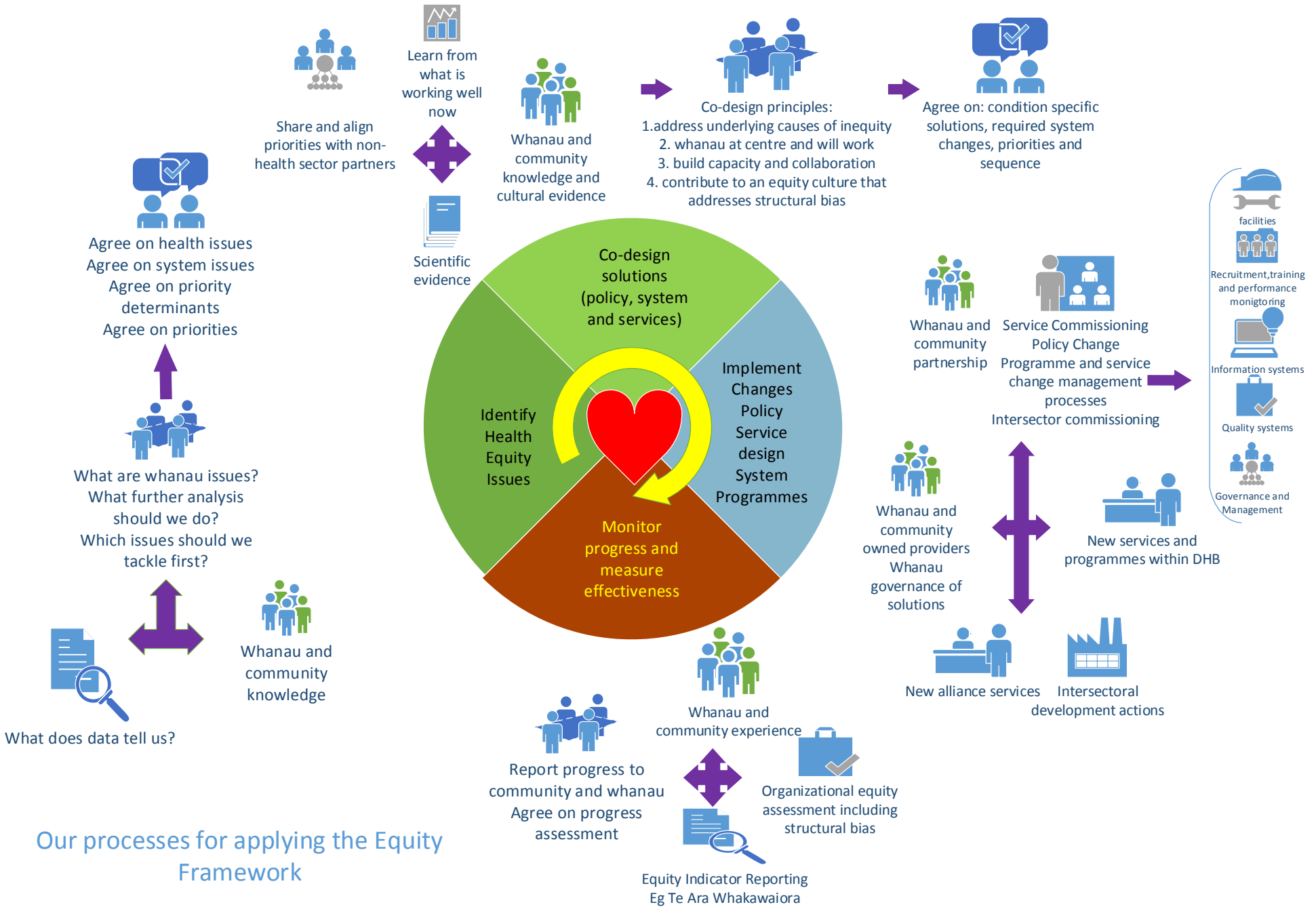
Value driven – prioritisation of investment and dis-investment underpinned by our values, our goal to achieve equity and the concepts of value for money

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



Our processes for applying the Equity Framework

12.2

HAWKE'S BAY District Health Board Whakawāteatia	**DRAFT Hawke's Bay District Health Board Annual Plan 2019/20, Statement of Performance Expectations 2019/20, draft SLM Improvement Plan 2019/20, Population Health Annual Plan 2019-20**
	For the attention of: **HB Clinical Council**
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 review and endorsement
Previous Consideration Discussions	Nil
Summary	This draft of the Annual Plan is still in development as Ministry (MoH) feedback on the first draft has only just been received and further guidance is still to come in. We are presenting documents in the current state for review with final drafts being presented at the June board meeting.
Contribution to Goals and Strategic Implications	Improving quality, safety and experience of care; improving health and equity for all populations; improving Value from public health system resources are all essential to our Annual Plan.
Impact on Reducing Inequities/Disparities	Note specific Equitable Outcomes Actions (EOA).
Consumer Engagement	Consumer engagement activity is an essential part of activities within this plan.
Other Consultation /Involvement	Planning & Commissioning, Health Hawke's Bay, Population Health, Māori and Pacifika Health and Health Services have been involved with the development of this plan.
Financial/Budget Impact	Financials have been included in this plan, but will require further adaptation post MOH communication.
Timing Issues	Submission of this final draft document to the MoH is required by 21 June 2019 with final signatures required by 30 June 2019.
Announcements/ Communications	Not applicable

RECOMMENDATION:

It is recommended that the **HB Clinical Council** :

1. **Review** and **endorse** documents
2. **Note** that a final version will be presented at the June Board for sign off

Subject date

DRAFT Hawke's Bay District Health Board Annual Plan 2019/20, Statement of Performance Expectations 2019/20, draft SLM Improvement Plan 2019/20, Population Health Annual Plan 2019-20

Author:	**Kate Rawstron, Robyn Richardson**
Designation:	**Head of Planning & Strategic Projects**
Date:	**4th June 2019**

OVERVIEW

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

This current submission covers the following sections of the package as indicated below. These are included as attachments to this paper:

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

Points to note:

- A SOI is required only three yearly, with the requirement for one this year, with our last being approved in 2016.
- It is important to note that we have only just received feedback on the first submission to the MoH plus are still awaiting final guidance hence a number of areas are not complete and will require adaptations before documents are due to the Ministry on 21st June. We expect that there will be changes to financials as well prior to the final.
- The Annual Plan strategic discussion with the MoH took place on May 14th.
- In order to meet legislative requirements our SOI and SPE require signatures prior to 30th June 2019.

Changes from 2018/19

Subject date

In the Minister's letter of expectations, he identified that achieving equity within the New Zealand health system underpins all his priorities. He described the need for explicit focus on achieving equity for Māori across the life course and unmet need especially for Pacific and other population groups with poorer health outcomes. All of these areas have been addressed in the final draft Annual Plan.

Ministry driven changes:

- New format to outline activity for the year.
- Government planning priorities are clearly identified: Child Wellbeing; Mental Wellbeing; Strong and Equitable Health & Disability System; Environmental Sustainability and Drinking Water Safety and Primary Care and Prevention. Activities are grouped into 39 focus across these priority areas.
- Show line of sight to three of the Government's twelve priority outcomes:

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

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

Internal process changes

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

Reporting

Subject date

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

System Level Measures

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

Current status

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

ATTACHMENTS

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

RECOMMENDATION:

It is recommended that the **HB Clinical Council**:

1. **Review** and **endorse** documents
2. **Note** that a final version will be presented at the June Board for sign off

COVER PAGE

HBDHB ANNUAL PLAN 2019-20

Version 2.5

OUR VISION

"HEALTHY HAWKE'S BAY"

"TE HAUORA O TE MATAU-A-MAUI"

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

OUR VALUES

TAUWHIRO

Delivering high quality care to patients and consumers

RĀRANGA TE TIRA

Working together in partnership across the community

HE KAUANUANU

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

ĀKINA

Continuously improving everything we do

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

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PART A – Annual Plan

SECTION ONE: Overview of Strategic Priorities

1.1 Strategic Intentions/Priorities/Outcomes

Hawke's Bay District Health Board (HBDHB) is a Crown Entity and is the Government's funder and provider of public health and disability services for the population in our defined district. Our Statement of Intent (SoI) 2019-22 outlines our strategic intentions and shows how local outputs impact on our population and contribute to local, regional and system-level outcomes.

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

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

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

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

At its heart, our new strategy is about people: as members of whānau, hapū and iwi; and in their homes communities and workplaces. We exist because of them and we recognise that people and whānau are the experts in their own lives. We need to plan and deliver health services in the wider context of people's lives, and how we include Māori and Pasifika practices. This strategy describes our goals to partner with people and whānau, and work across agencies to improve the conditions of life, so that everyone has fair opportunity to achieve good health and wellbeing

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

In 2019/20, the Hawke's Bay district population will grow to just under 168,000 people. Most of our population live in Napier or Hastings, two cities located within 20 kilometres of each other that together account for 81 % of the total numbers. About 8 % of the population live in or close to Wairoa or Waipukurau, which are relatively concentrated rural settlements, and the remaining 11 % live in rural and remote locations. Compared to New Zealand averages, there are some important differences in the makeup of our population – we have a higher proportion of Māori (26% vs 16%), more people aged over 65 years (19% vs 16%) and more people living in areas with relatively high material deprivation (28% vs 20%). The 2013 New Zealand Index of Deprivation (NZDep13)4 explains how relative deprivation, as one measure of socio-economic status, is an indication of disadvantage in terms of people's opportunity to access and use the health system.

TBC – insert from strategy

1.2 Message from the Chair

TBC

1.3 Message from the Chief Executive

TBC

1.4 Signature Page

X_____

Dr Kevin Snee, Chief Executive

Hawke's Bay District Health Board

X_____

Kevin Atkinson, Board Chair

Hawke's Bay District Health Board

X_____

xxxx, Board Member

Hawke's Bay District Health Board

X_____

Hon. Dr David Clark

Minister of Health

SECTION TWO: Delivering on Priorities

2.1 Health Equity in DHB Annual Plans

In 2018 we updated the Health Equity in HB report, an analysis and report on health status in HB. The main focus of the report is equity because health inequities are differences in health status that are avoidable or preventable and therefore unfair. The report finds many inequities in health in HB, particularly for Māori, Pasifika and people living in more deprived areas. There are also areas where, with determined and focused effort, we have improved outcomes and reduced inequities. This demonstrates that inequities are not inevitable. We can change them if we have the courage and determination to do so. The Health Equity Report concludes that inequity affects everyone and, for a difference to be made, we must tackle this collectively and take responsibility as a community and this is reflected in our plan.

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

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

2.1.1 Health Equity Tools

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

2.2 Māori Health

HBDHB has a treaty partnership relationship with Ngāti Kahungunu Iwi Inc. The Māori Relationship Board (MRB) are the mandated health representatives of Ngāti Kahungunu Iwi Inc and also includes HBDHB Board members. MRB's role is to provide advice and recommendations to the HBDHB Board to ensure equity is achieved for all Maori within Hawkes Bay. HBDHB has committed to include MRB in all of its strategic planning exercises and MRB have identified their set of strategic priorities.

2.4 Government Planning Priorities

2.4.1 Improving Child Wellbeing

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

Immunisation			This is an equitable outcomes action (EOA) focus area	
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
Work with Health Hawke's Bay to standardise new-born enrolment process within general practices	Q4	CW07	**System outcome**	**Government priority outcome**

			We have improved quality of life	Make New Zealand the best place in the world to be a child
Survey two local urgent care providers to investigate provision of opportunistic immunisation to children under five years of age	Q3	CW08 CW05	**System outcome** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
Check immunisation status of all children under five years of age on Health Hawke's Bay Whanau Wellness programme and if not up to date facilitate immunisation through general practice. **EOA Māori and Pacific.**	Q4		**System outcome** We live longer in good health	**Government priority outcome** Make New Zealand the best place in the world to be a child
Explore the potential of a local Māori Health Provider to offer a weekly walk in immunisation clinic. Work with provider to implement. **EOA Māori.**	Q4		**System outcome** We have improved health equity	**Government priority outcome** Make New Zealand the best place in the world to be a child

School-Based Health Services • Commit to providing quantitative reports in quarter two and four on the implementation of school based health services (SBHS) in decile one to four secondary schools, teen parent units and alternative education facilities. • Outline the current activity the DHB will undertake to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS. • Outline the current activity the DHB is taking to improve the responsiveness of primary care to youth. • Commit to providing quarterly narrative reports on the actions of the SLAT to improve health of the DHB's youth population. • Outline the actions the DHB is taking to ensure high performance of the youth service level alliance team (SLAT) (or equivalent).			**This is an equitable outcomes action (EOA) focus area**	
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families	

Midwifery Workforce – Hospital and LMC			**This is an equitable outcomes action (EOA) focus area**	
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
Develop a local midwifery workforce plan, in line with national planning, with a particular focus on matching workforce to community • Building a culturally responsive workforce • Strengthening and supporting Māori midwifery undergraduate pipeline. **EOA Māori and Pacific.**	Q1 plan Q4 phase 1	100% completion rate of Turanga Kaupapa training % of midwifery workforce Māori and Pacific tbc	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Make New Zealand the best place in the world to be a child
Retention: In light of national midwifery shortages, review current workforce models (regulated and non-regulated roles) for maternity, with a view to ensuring safe staffing levels.	Q2		**System outcome** We have improved quality of life	**Government priority outcome** Make New Zealand the best place in the world to be a child
Recruitment: Develop an attractive midwifery package for Hawke's Bay	Q1		**System outcome** We have improved quality of life	**Government priority outcome** Make New Zealand the best place in the world to be a child

First 1000 Days (Conception to Around 2 Years of Age)	**This is an equitable outcomes action (EOA) focus area**

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

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Family Violence and Sexual Violence (FVSV)			This is an equitable outcomes action (EOA) focus area	
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
Undertake a review of the utilisation of family violence and sexual violence services by Pacific families. (Low rates of Pacific community accessing services in HB – actual numbers unknown, but disproportionate rates in NZ Police statistics). • Develop an understanding of family violence/sexual violence from a Pacific perspective. • Develop an understanding of utilisation and barriers of access to services. • Re-shape services to meet the needs identified through the review. • Improve awareness of services in the Pacific community. • Improve service delivery and community follow-up. What are the rates of Pacific families accessing family and/or sexual violence services? What are the barriers to them accessing services for family and/or sexual violence? How do services need to be delivered to support Pacific community engagement? What are the long term pathways for engagement and feedback from the Pacific communities? **EOA Pacific.**	Q3	CW11	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
Improve the responsiveness of family/sexual violence services for whanau Māori. (High prevalence of Māori in acute/crisis level family violence, sexual violence services). • Understand the experience of Māori groups through engagement with stakeholders. • Gather whanau insights into their experiences and barriers to access to care to acute/crisis care and support.	Q4		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities

• Develop clear pathways for whanau Māori whether accessing family violence and sexual violence services. Consider the development of sustainable feedback processes and resources. Make recommendations for family violence and sexual violence service delivery for Māori. **EOA Māori.**				
Utilise community feedback to support the Sexual Assault Service's application of a therapeutic approach for clients accessing their team. Ensure a particular focus on responding to the needs of Pacific and Māori men accessing the service.	Q4		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
Inter-sectoral family harm responses – identify resources to support the on-going development of the Oranga Whānau – Government Agencies Group. Particularly address co-ordination and membership to ensure continued focus on a Family Harm response framework, from prevention through to crisis intervention/post-intervention. (High prevalence of Māori in regional statistics for family harm. Lack of joint up planning and response across Government Agencies).	Q2		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Make New Zealand the best place in the world to be a child

SUDI			This is an equitable outcomes action (EOA) focus area	
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families	
Review the Cot Bank for equity for Māori: Undertake a quality improvement activity to review responsiveness of eligibility criteria, programme referrals and uptake, allocation, ethnicity, deprivation data, and areas for improvement. **EOA Māori.**	Q2	Rate SUDI CW06	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
Analyse and report data collected as part of the māmā Māori interviews undertaken in 2018 • Collate raw data and carry out Kaupapa Māori approach to analyse relevant SUDI, Smoking Cessation, and Breastfeeding responses, complete a thematic analysis, and compile into a brief summary report with recommendations for areas for improvement for whanau Māori. **EOA Māori. See First 1000 days.**	Q1 Q2		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Make New Zealand the best place in the world to be a child
Gather the whānau story of whānau Māori that lost a pēpi to SUDI. • Gather whanau stories about their experience losing pēpi to SUDI. **EOA Māori.**	Q3 Q4		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
Plan the development of appropriate messaging of SUDI for whānau Māori. Based on Actions 1, 2 and 3 above. Include a specific focus on smoking cessation, safe sleep and breastfeeding activities to enhance a SUDI response appropriate for Māori. **EOA Māori. See First 1000 Days.**	Q4		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Make New Zealand the best place in the world to be a child

2.4.2 Improving Mental Wellbeing

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

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

Mental Health and Addictions Improvement Activities			This is an equitable outcomes action (EOA) focus area	
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
Work with GPs to improve the quality of the information and appropriateness of the referrals from GPs to meet secondary care admission criteria as part of connecting care project of HQSC	Q4	MH02 HQSC MH01	**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Scope mechanisms for the transfer of transition to GPs to increase the percentage target	Q4		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Make New Zealand the best place in the world to be a child
Identify where and when to triage in the model of care to de-escalate aggravation, agitation and threatening behaviour, in order to minimise seclusion	Q4		**System outcome** We live longer in good health	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering

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

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

2.4.3 Improving Wellbeing through Prevention

Cross-Sectoral Collaboration			This is an equitable outcomes action (EOA) focus area	
DHB activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
Develop an inter-sector framework to coordinate, prioritise, monitor and measure outcomes for HBDHB activity. **EOA Māori and Pacific**	Q1	n/a	**System outcome** We have health equity for Māori and other groups	**Government priority** Support healthier, safer and more connected communities
Support the access to whānau voices (consumer feedback) collected by partner agencies. Enable its use in designing services, programmes and planning with whānau • Investigate a clearinghouse approach to store and access recorded whanau voice, i.e. research, consumer feedback, meetings and workshop notes, to inform planning, develop and deliver services.	Q4		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
Establish information sharing across Government agencies to ensure quality data is informing decisions and is available to monitor impact • Through information sharing agreements with partner agencies • By having regular meetings between information systems staff beginning with Police, MSD and HBDHB • Through facilitating ways to share whānau voices.	Q4		**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Support inter-sectoral projects by: • Resourcing the work of the family violence interagency group • Contributing to employment programmes including reducing barriers to employment, Rangatahi Ma Kia Eke and pathways to health roles • Improving the quantity and quality of housing via leadership in the Housing Coalition projects • Supporting frontline staff to link clients with mental health and addiction services.	Q4		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities

Climate Change			
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.

Annual carbon emissions footprint and certification process completed through Certified Emissions Management and Reduction Scheme (CEMARS).	Q4 (Ongoing)	n/a	**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Research/explore resources and investment required for HBDHB setting and achieving major emissions reduction target.	Q4		**System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities
Transition HBDHB toward 'dining consumable products' that are more environmentally sustainable	Ongoing		**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Sustainability working group to meet as needed to ensure HBDHB implements a strong response to climate change, in an equitable manner, in line with expectations from the Ministry of Health. Membership to include representation from Māori Health, Pacific Health, Population Health and other departments. **EOA Māori and Pacific.**	Ongoing		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities

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Waste Disposal				
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
Work with medical waste provider and community pharmacies to progress a comprehensive collection process.	Q4	n/a	**System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities
Begin measuring community pharmaceutical waste collected through community pharmacies.	Q4		**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Maintain annual waste reporting of landfill, recycling, green waste and medical waste as part of CEMARS certification process.	Q4 (Ongoing)		**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Apply a Ngāti Kahungunu environmental lens over key activities by partnering with Māori Health Services, Health Gains Advisor, utilising cultural knowledge to support the plan. **EOA Māori.**	Ongoing		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities

Drinking Water	**This is an equitable outcomes action (EOA) focus area**

• Provide actions the DHB will undertake to support their PHU to deliver and report on the drinking water activities in the environmental health exemplar. Activities that DHBs could carry out to support their PHU drinking water work (and other public health regulatory service) can be found on the FAQ page				
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
Undertake the duties and functions of a Drinking Water Assessor and Designated Officer as required by section 69ZL-69ZN of the Health Act 1956. **EOA Māori and Pacific**[1]	Ongoing	See Population Health Plan	**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Continue to build and maintain relationships with relevant stakeholders including the Drinking Water Joint Working Group. Representatives of this group include Iwi, Territorial Authority (TA) Drinking Water suppliers, Regional Council and Medical Officer of Health and Drinking Water Assessors. **EOA Māori.**	Ongoing		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
Continue to provide technical support to supplies which received Capital Assistance Programme (CAP) and to networked supplies which have a population between 25-5000 people. In our area a number of Marae received CAP funding. As part of this programme will be the development of an equity partnership with the Maori Health Leadership team, Health Improvement and Equity Directorate. **EOA Māori.**	Ongoing		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
Advocate for adoption of Source Protection Zones (SPZ) provisions with the TANK plan change and subsequent catchment management plans.	Ongoing		**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities

Healthy Food and Drink			**This is an equitable outcomes action (EOA) focus area**	
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
Continue the implementation of the National Healthy Food and Drink Policy, committed to by HBDHB in August 2016.	ongoing	n/a	**System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities
Identify appropriate nutrition support for health providers from within our DHB.	Q1		We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Develop online tools to support health contract providers e.g. policy templates, checklist etc.	Q1		We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Smokefree 2025			**This is an equitable outcomes action (EOA) focus area**	

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

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

13.1

2.4.4 Better Population Health Outcomes Supported by Strong and Equitable Public Health and Disability System

Engagement and Obligations as a Treaty Partner			This is an equitable outcomes action (EOA) focus area	
DHB activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
Initiate scheduled meetings between HBDHB GM Māori Health and CEO Ngāti Kahungunu Iwi Inc. **EOA Māori.**	Q1	SS12	**System outcome** We have health equity for Māori and other groups	**Government priority** Support healthier, safer and more connected communities
Review memorandum of understanding (MOU) between Ngāti Kahungunu Iwi Inc and HBDHB. **EOA Māori.**	Q2		**System outcome** We have health equity for Māori and other groups	**Government priority** Support healthier, safer and more connected communities
Provide equity training to HBDHB staff. **EOA Māori.**	Q4		**System outcome** We have health equity for Māori and other groups	**Government priority** Support healthier, safer and more connected communities
Provide Māori Cultural Competency Training to HBDHB staff. **EOA Māori.**	Q4		**System outcome**	**Government priority**

			We have health equity for Māori and other groups	Support healthier, safer and more connected communities

Delivery of Whānau Ora DHBs are best placed to demonstrate, and action, system-level changes by delivering whanau-centred approaches to contribute to Māori health advancement and to achieve health equity. Please idendify the significant actions that the DHB will undertake in this planning year to: • Contribute to the strategic change for whanau ora approaches within the DHB systems and services, across the district, and to demonstrate meaningful activity moving towards improved service delivery • Support and to collaborate, including through investment, with the Whānau Ora Initiative and its Commissioning Agencies and partners, and to identify opportunities for alignment. (All Pacific priority DHBs need to also include Pasifika Futures in this activity).			**This is an equitable outcomes action (EOA) focus area** (Equity focus and clear actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs)	
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
			System outcome We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
			System outcome We have health equity for Māori and other groups	**Government priority outcome** Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering

Care Capacity Demand Management (CCDM) • Please detail the actions that you will take towards implementing Care Capacity Demand Management (CCDM) for nursing by June 2021 in your annual plans. • Please outline the most significant actions the DHB will undertake in 2019/20 to progress implementation of CCDM for nursing. Ensure the equitable outcomes actions (EOA) are clearly identified.			**This is an equitable outcomes action (EOA) focus area** (Equity focus and clear actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs)	
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
			System outcome We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
			System outcome We have health equity for Māori and other groups	**Government priority outcome** Make New Zealand the best place in the world to be a child
			System outcome	**Government priority outcome**

			We live longer in good health	Ensure everyone who is able to, is earning, learning, caring or volunteering

Disability			This is an equitable outcomes action (EOA) focus area	
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
Support Health and Wellbeing by establishing practises that ensure the rights of people with disabilities: • Have whanau/support people when engaging with HBDHB services. Review and update policy. • Investigate options to develop a system to record impairments on patient records to enable staff responsiveness and monitoring of health service delivery for people with disabilities. • Develop a monitoring tool for the HBDHB Disability Plan. **EOA Māori and Pacific**	Q4	SI14	**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Improve Accessibility for people with disabilities by: • Establishing feedback mechanisms which enable people with disabilities to provide feedback and receive responses • Identify options of addressing barriers to accessing services **EOA Māori and Pacific**	Q2		**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Improve attitudes toward people with disabilities by: • Developing training opportunities for HBDHB staff, in partnership with the disability community. **EOA Māori and Pacific**	Q4		**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities

Acute Demand			This is an equitable outcomes action (EOA) focus area	
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
Acute Data Capturing. SNOMED coding implementation into ED for NNPAC in 2021. Actions: • Install latest Patient Administration System (ECA) with applicable SNOMED capabilities and configure as required (existing platform, version upgrade only), testing • Super User acceptance testing, training of ED users • Reconfigure NNPAC data capture in Data Warehouse as required, adjust Extract requirements.	Q2 Q4	SS10 Inpatient length of stay	**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Patient Flow. . Investigate digital solutions to managing emergency patient flows to improve health literacy and allow more informed decision regarding treatment options, thereby increasing the number of people appropriately utilising urgent care in primary care rather than ED. **EOA Māori and Pacific**	Q2		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
Patient Flow. Improving wait times for patients requiring mental health and addiction services who have presented to the ED by, in addition to referring to Consult Liaison (in hours) or Emergency Mental Health Service (after hours), referring to Māori Health Service if the person identified as Māori. **EOA Māori**	Q2		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities

Patient Flow. Create hospital capacity to manage acute demand by improving acute hospital flow. • Improved discharge processes by adoption of standardised Criteria Based Discharge (CBD) process across all adult in-patient wards • Reducing acute hospital re-admissions rates by identifying patients at risk of re-admission and focusing on support in the community **EOA Māori**			**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities

Rural Health			**This is an equitable outcomes action (EOA) focus area**	
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
Wairoa Community Partnership Group (CPG); develop shared outcomes and processes (formal and informal) for whanau to input into CPG. **EOA Māori.**	Q4	Whānau feedback Written feedback Strategy completed	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
A clinical governance group is developed and fully functioning for Wairoa health system. **EOA Māori.**	Q2		**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Identify workforce gaps and skills required to implement the future model of care. Develop a strategy for sourcing and developing the Wairoa workforce. **EOA Māori.**	Q2		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
Develop preventative and educational programmes for and with Wairoa community. **EOA Māori.**	Q3		**System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities

Healthy Ageing			**This is an equitable outcomes action (EOA) focus area**	
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
Initiate, develop and monitor the effectiveness of 'Hoki te Kainga' an Early Support Discharge service, to improve patient outcomes and improve hospital flow. Linkages: • Healthy Aging Strategy – enable high quality restorative care for effective rehabilitation, recovery and restoration after acute events • S&B – the rehabilitation service is linked to increasing strength and balance through focused functional rehabilitation goals • Evidence suggests a 25% reduction is six month post discharge all cause readmissions • Clinical Services Plan (CSP)– strong links; moving services from the hospital to the community/patients house	Q1-4	SS04	**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Investigate and develop a formal Health Equity Partnership to inform the ongoing development of health services to improve outcomes for older Māori. **EOA Māori.**	Q2 Q4		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities

Linkages: • CSP – reducing inequalities by working with Māori with an outcome that they own their service delivery • CSP – inclusion in service design to ensure services meet the needs of Māori				
To develop a system and processes for the effective management of frailty within the Medical and HOP Directorates. The objective is to create a hospital wide approach to frailty. The initial focus will be on: • The development and implementation of processes to help prevent admissions for those living with frailty. • The development and implementation of processes to identify frailty on admission that better supports the patient's journey to achieve better outcomes. Linkages: • HAS – "enabling high quality acute care" for elderly that meets their needs • HAS – "value and high performance" (reducing complications and LOS) • CSP – freeing up resources to improve community services	Q1-4		**System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities
Development and implementation of an "End of Life" Service Level Alliance (SLA) with a focus on delivering care closer to home and reducing acute bed days. Linkages: • CSP – Keeping people well in their own homes in their own communities • HAS – Dying well, provide respectful end-of-life care that caters to physical, cultural and spiritual needs	Q4		**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities

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

Develop hospital wide antibiotic usage reports	Q4		**System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities

Cancer Services

This is an equitable outcomes action (EOA) focus area

Cancer is the leading cause of morbidity in New Zealand, accounting for nearly one third of all deaths with 22,000 new cases diagnosed each year. Inequalities between Māori and non-Māori persist. Māori have a higher incidence of many cancers, are diagnosed with more advanced cancers, experience issues that impact on treatment options and are 1.7 times more likely to die from cancer than non-Māori New Zealanders.

Key strategies and plans to help inform DHB Annual Plans are listed below:

New Zealand Cancer Plan

Cancer Health Information Strategy

National Radiation Oncology Plan

DHBs will describe and implement improvements in accordance with national strategies and be able to demonstrate initiatives that support key priority areas as outlined below. All initiatives will demonstrate clear strategies for addressing Māori health gain, equitable and timely access to services and the use of data to inform quality improvement across those initiatives.

DHBs will describe actions to:

- ensure equity of access to timely diagnosis and treatment for all patients on the Faster Cancer Treatment (FCT) pathway (e.g. system/service improvements to minimise breaches of the 62 day FCT target for patient or clinical consideration reasons)

- Each DHB is expected to identify two priority areas for quality improvement identified in the Bowel Cancer Quality Improvement Report 2019 (the Report). DHBs received the draft Report in October 2018. Each DHB is expected to review their results and identify two areas for service improvement that are focused on improving outcomes for people with bowel cancer in their DHB area. DHBs are required to provide evidence that priorities have been identified and will be addressed. These activities could include service improvement initiatives undertaken at a regional or national level; particularly where the DHB relies on the wider region to undertake improvements in the areas it has identified.

- *Commit to working with the Ministry of Health to develop a Cancer Plan. Commit to implement and to deliver on the local actions from within the Cancer Plan.*

DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
Cancer Screening Programmes – BreastScreen Aotearoa. • Continue to target Māori and Pacific unscreened women by conducting data matching between BreastScreen Coast to Coast and general practices patient databases, sending letters offering incentives for women who complete screening. **EOA Māori and Pacific.** • Continue to follow-up Māori and Pacific women who have not responded (DNR) to BSA invitation letters for mobile breast screening unit, and explore extending DNR follow-up for TRG fixed sites at Royston and Greenmeadows. **EOA Māori and Pacific.**	Q1-4	SS07 SS08	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities

National Cervical Screening Programme • Continue to improve general practice screening recall processes including encouraging recall to commence at 32 months to ensure on-time-three yearly screening. Work with general practices to review Karo reports, identify errors and how to resolve. • Continue to target Māori and Pacific unscreened and under-screened women through targeted strategies and kanohi ki te kanohi approaches. **EOA Māori and Pacific.**				
Faster Cancer Treatment – Cancer health target. Comply with Cancer health targets: • >62 days from referral to treatment • >31 days from decision to treat to treatment • Develop monthly report – referral to diagnosis. **EOA.** • Review opportunities to address the gaps currently evident in the National T&A contract. **EOA.** • Review opportunities to address the clinical risks associated with reduced access to cancer medications. **EOA.** • Negotiate with tertiary providers to facilitate access to cancer treatments within the 62 day timeframe. **EOA.**	Q1-4	SS01 SS11	**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Cancer Survivorship Model of Care • Partner with the Cancer Society and Regional stakeholders to implement a model of care for cancer survivors. **EOA.**	Q4		**System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities
tbc				
Continue to work with Central Cancer Network and tertiary providers to facilitate locally based cancer care for HBDHB population. (Radiation Oncology and Standards of Care. **EOA**).			**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities

Bowel Screening New Zealand has one of the highest rates of bowel cancer in the world. Bowel cancer is the second most common cause of cancer death in New Zealand, after lung cancer, with the third highest bowel cancer death rate in the OECD for women and the sixth highest for men. The National Bowel Screening Programme aims to reduce the mortality rate from bowel cancer by diagnosing and treating cancers at an earlier more treatable stage. Early identification and removal of precancerous advanced bowel adenomas aims to reduce bowel cancer incidence over time. Achieving equitable access is a key priority for the bowel screening programme because participation rates for Maori, Pacific and people living in our most deprived areas remain lower than other ethnic groups. A focus on equity is expected throughout the screening pathway. DHBs will describe and implement initiatives that support the National Bowel Screening Programme's priority areas outlined below (depending on their implementation stage). All initiatives will demonstrate clear strategies for increasing health gains for priority groups and improving equitable participation and timely access to services. Depending on implementation stage: ALL DHBs will describe actions to:	**This is an equitable outcomes action (EOA) focus area**

- Ensure colonoscopy wait time indicators are consistently met regardless of implementation stage; this requires active management of demand, capacity and capability.
- Ensure equitable access throughout the screening pathway; this must be supported by visible leadership, effective community engagement, resources and clear accountability for equity at all levels.

All DHBs

The National Bowel Screening Programme has adopted the 2018/19 Elective Funding and Performance Policy to monitor and manage the urgent, non-urgent and surveillance diagnostic colonoscopy wait time indicators. The Policy's escalation process has been adapted to:

- Include an Amber (tolerance period) and
- Enable alignment with DHB non-financial quarterly reporting requirements

DHBS providing the bowel screening programme

To ensure diagnostic colonoscopy wait times are not negatively impacted, the National Bowel Screening Programme indicator 306 will now be reported to measure screening colonoscopy performance in the context of managing total colonoscopy wait times (refer to DHB Non-financial Monitoring Framework and Performance Measures).

DHB Activity	Milestone	Measure	Government Theme: Improving the well-being of New Zealanders and their families.	
Implement Ministry of Health approved National Bowel Screening Programme HBDHB Annual Plan 2019/20, Equity Plan and Communications Plan. **EOA Māori and Pacific.**	Q1-4	SS15	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
Develop, implement and evaluate strategies to achieve at minimum the 62% target in participation for Māori, Pacific, decile 9 and 10, and total National Bowel Screening Programme eligible population through health promotion/health education activities and outreach follow up action. In addition we will set an internal target of 73% participation for Māori consistent with our intent to achieve equity of health outcomes for Māori across the life course. **EOA Māori and Pacific.**	Q1-4		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
Monitor and report on Colonoscopy Wait Time Indicators for urgent, non-urgent & surveillance, including for Māori and Pacific. **EOA Māori and Pacific.**	Q1-4		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
Monitor and report on the NBSP Interim Quality Standards, with specific analysis and relevant improvements for Māori and Pacific. **EOA Māori and Pacific.**	Q1-4		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities

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

Increase Māori and Pacific representation in the workforce via effective recruitment and retention strategies. Ensure alignment to endorsed Māori & Pacific Workforce Development Action plans. **EOA Māori & Pacific.**	Q4	% Māori and Pacific staff % staff trained	**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring and volunteering
Increase HBDHB numbers completing Engaging Effectively with Māori. **EOA Māori.**	Q4		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
Workforce reporting: • Continue to share Human Resource (HR) KPI report • Develop HR dashboards for Directorates • Develop Central Region HR benchmark KPI report.	 Q4 Q2		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
Education Framework: • Prioritise focus on the development of an education framework to support all staff • Implement a Talent Mapping process (Tier 3&4 Managers) for leadership development • Maintain necessary standards for PGY1 and 2 aligned to Medical Council. • Maintain and develop relationships with EIT and tertiary institutions	 Q2 Q1 Q1 Ongoing		We have health equity for Māori and other groups	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
People and Whanau centred Care: • Increase the number of staff completion rates of Relationship Centred Practice.			**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
Health Literacy • Continue to roll out Relationship Centred Practice training • Ensure the Health Literacy Framework is rolled out to departments for them to undertake a self-assessment against the MOH guidelines and for action plans to be in place.			**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering

Data and Digital			**This is an equitable outcomes action (EOA) focus area**	
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
Regional Health Informatics Programme (RHIP) Clinical Portal. Continue programme to evolve new delivery method which is value driven and clinically led to allow clinicians to on-board whilst data migration runs parallel.	Ongoing	n/a	**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
Mobility Programme. Continue our mobility programme to enable access to people, services and information anytime and anywhere.	Ongoing		**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Unified Communications. Continue the rollout and enhancement of our Unified Communications solution to enable a mobile workforce and enhanced communication tools.	Q4		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering

Windows 10 Upgrade. Upgrade of HBDHB end user computing devices to Windows 10.	Q4		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
M365. Plan and commence the implementation of the migration to the Microsoft 365 offering	Multi-year programme		**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Security programme. Continue to improve our security capabilities to improve connectivity while mitigating cyber risk to an acceptable level. In addition to enhancing our security-related incident and event management capabilities we aim to strengthen security controls at the edge of our organisation and increase security awareness of our workforce.	Ongoing		**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Primary Care Integration. Increase the adoption of Manage My Health and improve the referral process between primary and secondary care.	Multi-year programme		**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities

TBA			**This is an equitable outcomes action (EOA) focus area**	
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
			System outcome We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
			System outcome We have health equity for Māori and other groups	**Government priority outcome** Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
Delivery of Regional Service Plan (RSP) priorities and relevant national service plans • Identify any significant actions the DHB is undertaking to deliver on the Regional Service Plan. Please provide actions for the following: Implementation of the New Zealand Framework for Dementia Care			**This is an equitable outcomes action (EOA) focus area** (Equity focus and clear actions to improve Māori health outcomes from all DHBs plus Pacific health outcomes from the Pacific DHBs)	

• Provide input into a regional stocktake of dementia services and related activity, which will be completed and provided to the Ministry by the end of quarter two (via the S12 measure). • Using the stocktake, work with your regional colleagues to identify and develop an approach to progress your DHBs priority areas for implementing the Framework by the end of quarter four. • Report on work to progress the implementation of the New Zealand Framework for Dementia Care in quarters three and four. Hepatitis C • DHBs are asked to identify their role in supporting the delivery of the regional hepatitis C work and objectives. Action include for example how DHBs will: o work in collaboration with other DHBs in the region to implement the hepatitis C clinical pathway o work in an integrated way to increase access to care and promote primary care prescribing of the new pangenotypic hepatitis C treatments.				
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
			System outcome We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
			System outcome We have health equity for Māori and other groups	**Government priority outcome** Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering

13.1

2.4.5 Better Population Health Outcomes Supported by Primary Health Care

Primary Health Care Integration			This is an equitable outcomes action (EOA) focus area	
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
Te Pitāu (Primary Care – DHB Alliance); building the teams to become collective voice. • End of Life model of care development	Q4	# NPs ## RN prescribers	**System outcome**	**Government priority outcome**

		# of contributors	We have improved quality of life	Ensure everyone who is able to, is earning, learning, caring and volunteering
Telemedicine in rural health settings to support the Rural Nurse Specialist model. **EOA Māori.**	Q3		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
Nurse practitioner workforce development: develop and implement pathways for NP development – increase the NP workforce.	Q4		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
Registered Nurse Prescribing workforce development: develop and implement pathways for RN prescribing – increase RN prescribing in primary and community care.	Q3		**System outcome** We have improved quality of life	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
Data sharing – use the development of a diabetes data repository to build data sharing protocols across the sector	Q3		**System outcome** We live longer in good health.	**Government priority outcome** Support healthier, safer and more connected communities

Pharmacy			**This is an equitable outcomes action (EOA) focus area**	
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
Introduce Rongoa Practitioners to Pharmacists in Primary Health Care with the aim of establishing community interventions which may include ensuring Māori and minority stakeholders fully understand their respective illnesses, are familiar with the medicines they are prescribed, may provide education on traditional Māori therapies/rongoa and could involve liaising with regard to the effectiveness and progress of medicines prescribed. **EOA Māori.** • Specify the equity gap that the action is targeting. Māori ASH rates and amenable mortality. • Identify the population group for whom the action will improve equity: Māori. • Specify how success will be measured and monitored – see KPIs.	Q4	n/a	**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Understand the training opportunities in the Pharmacy sector for Rongoa practitioners in order to take their interest in natural medicines and partner with Pharmacists clinical knowledge. **EOA Māori.** • Specify the equity gap that the action is targeting: Māori ASH rates and amenable mortality. • Identify the population group for whom the action will improve equity: Māori. • Specify how success will be measured and monitored – see KPIs.	Q4		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Ensure everyone who is able to, is earning, learning, caring or volunteering
Explore pharmacists providing influenza vaccinations in church settings. **EOA Pacific.** • Specify the equity gap that the action is targeting: immunisation rate for 'flu vaccine in Pacific aged 65 and older population.	Q3-4 (depending on flu		**System outcome** We live longer in good health	**Government priority outcome**

• Identify the population group for whom the action will improve equity: Pacific aged 65 and older population. • Specify how success will be measured and monitored – see KPIs.	vaccination availability)			Support healthier, safer and more connected communities
Educating Pacific community that pharmacy provides free 'flu injections to people over 65 years of age, via Pacific navigators when doing Bowel Screening home visits. **EOA Pacific.** • Specify the equity gap that the action is targeting: immunisation rate for 'flu vaccine in Pacific aged 65 and older population. • Identify the population group for whom the action will improve equity: Pacific aged 65 and older population. • Specify how success will be measured and monitored – see KPIs.	Q1-2		**System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities
Explore the views of general practice and community pharmacy around development of a collaborative pathway which supports increased influenza vaccinations in community pharmacy.	Q4		**System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities

Diabetes and Other Long-Term Conditions			**This is an equitable outcomes action (EOA) focus area**	
DHB Activity	**Milestone**	**Measure**	**Government Theme:** Improving the well-being of New Zealanders and their families.	
Implement and evaluate diabetes repository inclusive of retinal and podiatry services	Q4	SS13	**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Creation of a Long Term Conditions flag within the hospital patient management system identifying those people who have multiple chronic conditions and frequent inpatient services. **EOA Māori and Pacific.**	Q4		**System outcome** We have health equity for Māori and other groups	**Government priority outcome** Support healthier, safer and more connected communities
Implementation of the Long Term Conditions Self Review Matrix. **EOA Māori and Pacific.** Specialties: • Diabetes • Renal • Respiratory • Cardiovascular • Palliative Care Team	Q4		**System outcome** We have improved quality of life	**Government priority outcome** Support healthier, safer and more connected communities
Support the delivery of action priorities within the following key plans acknowledging they contribute to the prevention and reduction in risk of long term conditions: • Tobacco Strategy • Best Start Plan • Child Healthy Homes Plan	Q4		**System outcome** We live longer in good health	**Government priority outcome** Support healthier, safer and more connected communities

2.5 Financial performance summary

Projected Statement of Comprehensive Revenue and Expense

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

Table 1: Projected Statement of Comprehensive Revenue and Expense

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

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

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

SECTION THREE: Service Configuration

3.1 Service Coverage

The Minister explicitly agrees to the level of service coverage for which the MoH and DHBs are held accountable. Service coverage information demonstrates how Government policy is to be translated into the required national minimum range and standards of services to be publicly funded. In the current environment of increasing resource constraints and rising demand, it is likely that the level of services provided in some locations and the standard of some services will be adjusted and that access to some services may have to be modified. Service and care pathway reviews will specifically address the issue of coverage and access as will national, regional and local integrated planning. HBDHB does not expect any exceptions to service coverage. In terms of performance measure SI3, should any unintended gaps in service coverage be identified by the DHB or MoH then the DHB will report progress achieved during the quarter towards resolution of exceptions.

3.2 Service Change

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

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

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

Older Persons Services	Responding to the growing demands of acute and chronic care needs will necessitate providing services in different ways that have more of a rehabilitation and community focus.	Free up capacity and associated resources in order to deliver care more appropriately with the aim of minimising admission to hospital and ARRC settings.	Local
Health and Social Care Localities	Health and Social Care Localities development supported within Wairoa and CHB.	Achieving equity within our rural localities.	Local
Primary Care Development Partnership (PCDP)	Ongoing development and refinement of Te Pitāu (Primary Care – DHB Alliance) for the provision of coordinated services. Building teams to become a collective voice.	Enhancing provision and coordination of services.	Local
Faster Cancer Treatment	Redesigning of our oncology service model and Redesigning and refurbishing our buildings.	More streamlined services working toward meeting the FCT target.	Local/Regional
Bowel Screening	Implement Ministry of Health approved National Bowel Screening Programme HBDHB Annual Plan 2019/20, Equity Plan and Communications Plan.	Reduced mortality from bowel cancer.	Local/National

Service Integration

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

Procurement of Health & Disability Services

HBDHB periodically undertakes competitive processes (Registration of Interest, Request for Proposals etc.), in accordance with the Ministry of Business Innovation and Employments Government Rules of Sourcing. Competitive processes may be undertaken for several reasons including, the time since the last competitive process and changes in service design. Competitive processes ensure cost effective services, increase innovation and can enhance efficient service provision. Competitive processes may result in a change of provider
Note A: HBDHB is permitted and empowered under Section 25 of the New Zealand Public Health and Disability Act 2000 (the Act) to negotiate and enter into any service agreements (and amendments to service agreements) which it considers necessary in fulfilling its objectives and/or performing its functions pursuant to the Act.

SECTION FOUR: Stewardship

TBC

4.1 Managing our Business

Organisational Performance Management

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

Strategic

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

Operational

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

General

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

Funding and Financial Management

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

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

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

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

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

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

Investment and Asset Management

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

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

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

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

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

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

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

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

4.2 Building Capability

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

- Enhancing workforce capability and capacity to deliver new models of care (see 4.3)
- Information technology and communications systems to support a much more mobile workforce and a growing digital strategy (see 4.4)
- Capital and infrastructure development to focus on facilities off the hospital campus, and
- Cooperative developments with a range of stakeholders across the community, including inter-agency collaboration.

4.3 Workforce

TBC - Cross reference to workforce in Section 2

SECTION FIVE: Performance Measures

5.1 2019/20 Performance Measure

The DHB monitoring framework aims to provide a view of performance using a range of performance markers. Four dimensions are identified reflecting DHB functions as owners, funders and providers of health and disability services. The four identified dimensions of DHB performance cover:

- Achieving Government's priority goals/objectives and targets or 'Policy Priorities'
- Meeting service coverage requirements and supporting sector inter-connectedness or 'System Integration'
- Providing quality services efficiently or 'Ownership'
- Purchasing the right mix and level of services within acceptable financial performance or 'Outputs'.

It is intended that the structure of the framework and associated reports assists stakeholders to 'see at a glance' how well DHBs are performing across the breadth of their activity, including in relation to legislative requirements, but with the balance of measures focused on Government priorities. Each performance measure has a nomenclature to assist with classification as follows:

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

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

Performance measure		Expectation	
CW01	Children caries free at 5 years of age	Year 1	
		Year 2	
CW02	Oral health: Mean DMFT score at school year 8	Year 1	
		Year 2	
CW03	Improving the number of children enrolled and accessing the Community Oral health service		
CW04	Utilisation of DHB funded dental services by adolescents from School Year 9 up to and including 17 years	Children (0-4) enrolled	Year 1
			Year 2
		Children (0-12) examined according to planned recall	Year 1
			Year 2
CW05	Immunisation coverage at 2 years of age and 5 years of age, immunisation coverage for human papilloma virus (HPV) and influenza immunisation at age 65 years and over	95% of two year olds fully immunised.	
		95% of four year olds fully immunised.	
		75% of girls fully immunised – HPV vaccine.	
		75% of 65+ year olds immunised – flu vaccine.	
CW06	Child Health (Breastfeeding)	70% of infants are exclusively or fully breastfed at three months.	
CW07	New-born enrolment with General Practice	55% of new-borns enrolled in General Practice by 6 weeks of age.	
		85% of new-borns enrolled in General Practice by 3 months of age.	
CW08	Increased immunisation (eight-month-olds)	95% of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.	
CW09	Better help for smokers to quit (maternity)	90 percent of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.	
CW10	Raising healthy kids	95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	
CW11	Supporting child wellbeing	Provide report as per measure definition	
CW12	Youth mental health initiatives	Initiative 1: Report on implementation of school based health services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities and actions undertaken to implement *Youth Health Care in Secondary Schools: A framework for continuous quality improvement* in each school (or group of schools) with SBHS.	
		Initiative 3: Youth Primary Mental Health.	
		Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team	

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

SS02		Provide reports as specified		
SS03		Provide reports as specified		
SS04		Provide reports as specified		
SS05				
SS06	Better help for smokers to quit in public hospitals (previous health target)	95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.	Only applies to specified DHBs	
SS07	Improving breast screening coverage and rescreening	70% coverage for all ethnic groups and overall.		
SS08	Improving cervical Screening coverage	80% coverage for all ethnic groups and overall.		
SS09	Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections	Focus Area 1: Improving the quality of data within the NHI	Recording of non-specific ethnicity in new NHI registration	>0.5% and < or equal to 2
			Update of specific ethnicity value in existing NHI record with a non-specific value	>0.5% and < or equal to 2%
			Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and < or equal to 85%
			Invalid NHI data updates	Still to be confirmed
		Focus Area 2: Improving the quality of data submitted to National Collections	NPF collection has accurate dates and links to NNPAC and NMDS for FSA and planned inpatient procedures.	Greater than or equal to 90% and less than95 %

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

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

COVER PAGE

HBDHB Statement of Intent 2019-22

HBDHB Statement of Performance Expectations

Version 2.5

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

Section 1: Strategic Direction (SOI)

TBC

1.1 Strategic Outcomes

TBC

Section 2: Managing our Business (SOI)

2.1 Managing our business

TBC – see 4.1

Section 3: Statement of Performance Expectations (SPE)

3.1 Statement of Performance Expectations (SPE)

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

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

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

Service Performance

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

The system dimension: Best value for public health system resources

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

The population dimension: Improved health and equity for all populations

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

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

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

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

The HBDHB SPE for the 2019/20 year follows:

Board Member Board Member

3.2 Output Classes

Output Class 1: Prevention

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

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

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

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

Prevention Services						
For the year ended 30 June	2018	2019	2020	2021	2022	2023
in millions of New Zealand Dollars	Actual	Forecast	Projected	Projected	Projected	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	SS05	PP31	Jan-Dec 2018	97%	96%	96%	96%	≥95%
	% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	PH04	HT	Jan-Dec 2018	82%	81%	89%	85%	≥90%
	% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking	CW09	HT	Jan-Dec 2018	88%	N/A	N/A	85%	≥90%
	SLM Number of babies who live in a smoke-free household at 6 weeks post-natal	PH01	SI13	Jan-Jun 2018	45%	45%	64%	45%	tbc
Increase Immunisation	% of 8 month olds will have their primary course of immunisation (6 weeks, 3 months and 5 month events) on time	CW08	HT	Jan-Dec 2018	92%	97%	92%	92%	≥95%
	% of 2 year olds fully immunised	CW05	PP21	Jan-Dec 2018	93%	97%	93%	93%	≥95%
	% of 4 year olds fully immunised	CW05	PP21	Jan-Dec 2018	90%	88%	92%	1%	≥95%
	% of boys & girls fully immunised – HPV vaccine	CW05	PP21	Jul 2017-Jun 2018	85%	88%	70%	76%	≥75%
	% of 65+ year olds immunised – flu vaccine	CW05	PP21	Mar-Sep 2018	53%	52%	59%	58%	≥75%
Reduced incidence of first episode Rheumatic Fever	Acute rheumatic fever initial hospitalisation rate per 100,000	CW13	PP28	Jul 2016 – Jun 2017	tbc	tbc	tbc	tbc	≤1.5 per 100,000
Improve breast screening rates	% of women aged 50-69 years receiving breast screening in the last 2 years	SS07	SI11	Two Years to Dec 2018	70%	67%	76%	74%	≥70%
Improve cervical screening coverage	% of women aged 25–69 years who have had a cervical screening event in the past 36 months	SS08	SI10	Three Years to Dec 2018	76%	72%	78%	76%	≥80%
Better rates of breastfeeding	% of infants that are exclusively or fully breastfed at 3 months	CW06	PP37	Six months to Dec 2018	43%	58%	N/A	57%	≥60%

Output Class 2: Early Detection and Management Services

Early Detection and Management services are delivered by a range of health and allied health professionals in various private, not-for-profit and Government service settings to

individuals and small groups of individuals. The Output Class includes primary health care, primary and community care programmes, child and adolescent oral health and dental services, pharmacist services, and community referred tests and diagnostic services. The services are by their nature more generalist, usually accessible from multiple health providers and from a number of different locations within the district.

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

Objective: People's health issues and risks are detected early and treated to maximise well-being

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

Early Detection and Management						
For the year ended 30 June *in millions of New Zealand Dollars*	2018 Actual	2019 Forecast	2020 Projected	2021 Projected	2022 Projected	2023 Projected
Ministry of Health	112.6	126.5	135.0	139.7	144.5	149.3
Other District Health Boards (IDF)	3.0	2.1	2.0	3.1	3.2	3.3
Other sources	2.6	3.4	3.0	2.2	2.3	2.4
Income by Source	**118.2**	**132.0**	**140.0**	**145.0**	**150.0**	**155.0**
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-17	8,750	18,028	5,891	7,969	Māori tbc
Reduce ASH 45-64	Ambulatory sensitive hospitalisation rate per 100,000 45-64 years	PH01	SI1		9,328	8,404	3,437	4,613	Māori tbc
More pregnant women under the care of a Lead Maternity Carer (LMC)	% of women booked with an LMC by week 12 of their pregnancy			Jul to Sep 2018	53%	36%	76%	65%	80%
Improving new-born enrolment in General Practice	% of new-borns enrolled in General Practice by 6 weeks of age	CW07	SI18						≥55%
	% of new-borns enrolled in General Practice by 3 months of age	CW07		Jun to Aug 2018	86%	76%	86%	80%	≥85%
Better oral health	% of eligible pre-school enrolments in DHB-funded oral health services	CW04	PP13	12 months to Dec-18	tbc	tbc	tbc	tbc	≤10% Yr1 tbc Yr2
	% of children who are carries free at 5 years of age	CW02	PP11 / SI5		tbc	tbc	tbc	tbc	≥59% Yr1 tbc Yr1
	% of enrolled preschool and primary school children not examined according to planned recall	CW04	PP13		10%	13%	10%	10%	10%
	% of adolescents(School Year 9 up to and including age 17 years) using DHB-funded dental services	CW03	PP12	12 months to Dec-16	tbc	tbc	tbc	tbc	tbc
	Mean 'DMFT' score at Year 8	CW01	PP10	12 months to Dec-18	0.94	1.16	0.62	0.76	≤0.75 Yr1 tbc Yr2
Improved management of long-term conditions(CVD, Acute heart health, Diabetes, and Stroke)	Proportion of people with diabetes who have good or acceptable glycaemic control (HbA1C indicator)	SS13	PP20	12m to Dec-18	tbc	tbc	tbc	tbc	tbc
	% of the eligible population will have had a CVD risk assessment in the last five years	SS13	PP20	Five years to Dec-18	84%	80%	87%	86%	≥90%

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

Output Class 3: Intensive Assessment and Treatment Services

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

HBDHB provides most of this Output Class through the Provider Arm, Health Services. However, some more specialised hospital services are funded by HBDHB to be provided by other DHBs, private hospitals, or other providers. Where this happens, other providers are monitored in terms of the Operational Policy Framework or specific contracts and in accordance with industry standards. On the continuum of care these services are at the complex end of "conditions" and are focussed on individuals with health conditions and prioritised to those identified as most in need.

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

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

Intensive Assessment and Treatment						
For the year ended 30 June	2018	2019	2020	2021	2022	2023
in millions of New Zealand Dollars	Actual	Forecast	Projected	Projected	Projected	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 Sep-18	N/A	N/A	N/A	19.6	tbc
	Cataract procedures		SS			N/A	N/A	N/A	46.5	tbc
	Cardiac surgery		SS			N/A	N/A	N/A	5.3	tbc
	Percutaneous revascularisation		SS			N/A	N/A	N/A	13.2	tbc
	Coronary angiography services		SS			N/A	N/A	N/A	39.6	tbc
Shorter stays in hospital	LoS Elective (days)		SS	OS3	12 months to Sep-18	N/A	N/A	N/A	1.59	tbc
	LoS Acute (days)		SS	OS3	12 months to Sep-18	N/A	N/A	N/A	2.37	tbc
Fewer readmissions	Acute readmissions to hospital		SS	OS8	12 months to Sep-18	11.3%	11.7%	12.6%	12.2%	tbc
Quicker access to diagnostics	% accepted referrals for elective coronary angiography completed within 90 days		SS14	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
Fewer missed outpatient appointments	Did Not Attend (DNA) rate across first specialist assessments				Jan to Dec 18	11.3%	13.3%	3.9%	5.9%	≤5% total ≤9% Māori and Pacific
Better mental health services Improving access		Child & youth (zero -19)	MH01	PP6	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

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

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

Output Class 4: Rehabilitation and Support Services

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

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

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

Rehabilitation and Support *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 Target
					Period	Māori	Pasifika	Other	Total	
Better access to acute care for older people	Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population)	75-79 years			12 months to Dec-18	202.2	83.3	124.7	127.5	≤130
		80-84 years				129.2	250	174.8	169.1	≤170
		85+ years				278.6	166.7	228.8	227.5	≤225
Better community support for older people	Acute readmission rate: 75 years +		SSxx	OS8	12 months to Sep-18	11.8%	10.7%	12.7%	12.6%	≤11%
	Rate of carer stress :Informal helper expresses feelings of distress = YES, expressed as a % of all Home Care assessments		SS04	PP23	Oct-Dec 2017	tbc	tbc	tbc	tbc	≤26%
	% of people having homecare assessments who have indicated loneliness				Oct-Dec 2017	tbc	tbc	tbc	tbc	≤23%
Increased capacity and efficiency in needs assessment and service coordination services	Conversion rate of Contact Assessment (CA) to Home Care Assessment where CA scores are four-six for assessment urgency					tbc	tbc	tbc		tbc
	Clients with a Change in Health, End-stage Disease, Signs and Symptoms) (CHESS) score of four or five at first assessment				Oct-Dec 2017	tbc	tbc	tbc	tbc	11%
More older patients receive falls risk assessment and care plan	% of older patients given a falls risk assessment % 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%

*baseline to be established' as the target for this measure

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Section 4: Financial Performance (for SOI and SPE)

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

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

4.1 Projected Financial Statements

Introduction

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

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

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

Reporting entity

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

Cautionary Note

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

The underlying assumptions were adopted on 5 April 2019.

Accounting Policies

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

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

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

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

Table 5 – Projected Statement of Comprehensive Revenue and Expense

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**	**139,728**	**149,362**	**173,960**	**205,790**
Total comprehensive revenue and expense:						
Funding of health and disability services	3,101	(539)	-	3,000	3,000	3,000
Governance and funding administration	568	165	-	-	-	-
Provision of health services	(12,245)	(8,264)	-	-	-	-
	6,736	(8,638)	-	3,000	3,000	3,000
Contributions from the Crown (equity injections)	-	-	9,991	21,956	29,187	22,142
Repayments to the Crown (equity repayments)	(357)	(357)	(357)	(357)	(357)	(357)
Equity as at 30 June	**148,723**	**139,728**	**149,362**	**173,960**	**205,790**	**230,575**

Table 6 - Projected Statement of Movements in Equity

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

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	-	11,353	12,535	13,003	10,186	9,414
Payables and accruals	35,817	32,451	37,122	38,414	39,736	41,043
Employee entitlements	40,065	39,727	34,682	35,895	37,080	38,378
	75,881	83,531	84,339	87,312	87,002	88,835
Non current liabilities						
Employee entitlements	2,619	2,709	2,790	2,888	2,983	3,088
	2,619	2,709	2,790	2,888	2,983	3,088
Total liabilities	**78,500**	**86,240**	**87,129**	**90,200**	**89,985**	**91,923**
Net assets	**148,723**	**139,728**	**149,362**	**173,960**	**205,790**	**230,575**

Table 7 - Projected Statements of Financial Position

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

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)	(17,958)	(1,181)	(468)	2,817	772
Cash and cash equivalents at beginning of year	16,541	7,444	(10,514)	(11,695)	(12,163)	(9,346)
Cash and cash equivalents at end of year	7,444	(10,514)	(11,695)	(12,163)	(9,346)	(8,574)
Represented by:						
Cash	6,488	(11,349)	(12,531)	(12,999)	(10,182)	(9,410)
Short term investments	956	835	835	835	835	835
	7,444	(10,514)	(11,695)	(12,163)	(9,346)	(8,574)

Table 8 - Projected Statement of Cash Flows

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

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	92,963	102,543	103,112	106,760	110,371
Mental health	11,725	12,573	13,761	14,238	14,728	15,214
Disability support	66,878	71,015	78,794	81,537	84,343	87,119
Public health	1,237	1,382	2,247	2,325	2,406	2,485
Maori health	2,745	2,965	2,776	2,873	2,972	3,070
	178,873	180,897	200,120	204,085	211,209	218,259
Total Expenditure	**521,836**	**551,269**	**577,517**	**594,615**	**615,174**	**635,513**
Net Result	**3,101**	**(539)**	**-**	**3,000**	**3,000**	**3,000**

Table 9 - Projected Funder Arm Operating Results

Projected Governance and Funding Administration Operating Results						
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	3,614	3,740	3,869	3,996
Other government and Crown agency sourced	7	-	-	-	-	-
Other revenue	67	30	30	31	32	33
	3,490	3,454	3,644	3,771	3,901	4,029
Expenditure						
Employee benefit costs	617	1,182	1,199	1,242	1,283	1,328
Outsourced services	508	512	552	571	590	609
Clinical supplies	-	4	1	1	1	1
Infrastructure and non clinical supplies	852	642	946	978	1,014	1,045
	1,976	2,339	2,699	2,792	2,888	2,983
Plus: allocated from Provider Arm	946	950	946	979	1,013	1,046
Net Result	**568**	**165**	**-**	**-**	**-**	**-**

Table 10 - Projected Governance and Funding Administration Operating Results

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

Table 11 – Projected Provider Arm Operating Results

SIGNIFICANT ASSUMPTIONS

General

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

Revenue

- Crown funding under the national population based funding formula is as determined by MOH. Funding including adjustments has been allowed at $522.1 million for 2019/20. Funding for the years 2020/21, 2021/22 and 2022/23 is based on the standard DHB funding allocation methodology that projects demographic increases of 1.73%, 1.69% and 1.54% respectively, to which a 2% contribution to cost pressures less 0.25% for efficiencies has been added for each year.
- Crown funding for non-devolved services of $14.5 million is based on agreements already in place with the appropriate MOH directorates, and assumes receipt of the DHB's full entitlement to elective services funding.
- Inter district flows revenues is in accordance with MoH advice.
- Other income has been budgeted at the DHB's best estimates of likely income.

Personnel Costs and Outsourced Services

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

Supplies and Infrastructural Costs

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

Services Provided by Other DHB's

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

Other Provider Payments

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

Capital Servicing

- Depreciation has been calculated to write off the cost or fair value of property, plant, and equipment assets, and amortisation has been calculated to write off the cost or fair value of intangible assets (software) less their estimated residual values, over their useful lives. No amortisation has been allowed for the investment in NZHPL as it is a right to use a system, and is considered to have an indefinite life.

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

Investment

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

- The purchase of class B shares in New Zealand Health Partnerships Limited (NZHPL), relating to the Finance, Procurement and Supply Chain shared service, was completed in 2014/15 and took the total investment to $2,504,071. No allowance has been made for any further investment. No allowance has been made for any further impairment of the asset, other than the $0.2 million recognised in 2017/18.
- The DHB's share of the assets in RHIP will be amortised over their useful lives. The cost of amortisation is included in infrastructural costs. No allowance has been made for any impairment of the asset.
- No collaborative regional or sub-regional initiatives have been included other than RHIP.
- No increase in funding for existing associate organisations, Allied Laundry Services Limited and Central Technical Advisory Services have been allowed for.
- Property, plant, equipment, intangible asset expenditure, and investments in other entities are in accordance with the table below :

Capital Investment Funding

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

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

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

Property, Plant and Equipment

- Hawke's Bay DHB is required to revalue land and buildings when the fair value differs materially from the carrying amount, and at least every five years. A revaluation was completed as at 30 June 2018 and is included in the financial statements. The next revaluation is likely to be at 30 June 2021 and the effect is unknown, and no adjustment has been made to asset values as a consequence.

Debt and Equity

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

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

Additional Information and Explanations:

Disposal of Land

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

2019-20

Hawke's Bay District Health Board Population Health Annual Plan

HAWKE'S BAY
District Health Board
Whakawateatia

Contents

13.3

1. The Hawke's Bay Population

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

2. Improving Health and Equity

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

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

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

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

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

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

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

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

The Ministry of Health defines equity as:

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

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

Whānau Voice Informing Our Approach

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

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

National

The Government's priorities are:

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

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

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

Local

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

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

Figure one: Summary of Findings Health Equity Report 2018

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

Population Health Strategy

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

Figure 2: Supporting Healthy Communities objectives

4. Alignment with Other Plans

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

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

5. NZ Triple Aim Quality Framework

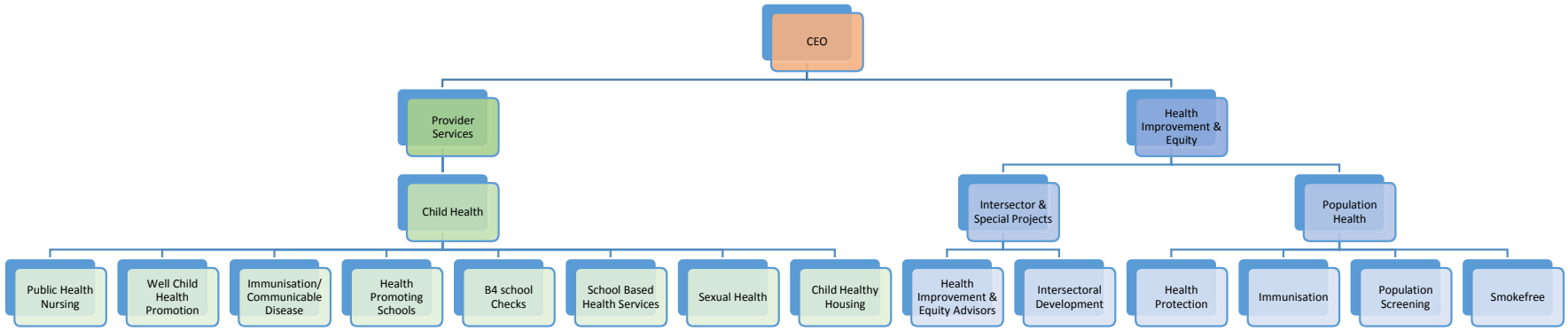
The New Zealand Health Quality and Safety Commission uses the New Zealand Triple Aim goals for quality improvement.

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

Triple Aim	Quality Improvement Actions
Individual: Improved quality, safety and experience of care	• Client-centred services • Competent, skilled workforce • Ongoing professional development • Scope of practice • Policies & procedures • Performance monitoring & review • Event reporting • Clinical leadership
Population: Improved health and equity for all populations	• Equity focus • Evidence based • Best practice • Evaluation & review • Surveillance
System: Best value for public health system resource	• Stakeholder collaboration • Efficient & effective service delivery • Quality data systems • Quality & risk management

6. Structure of the Population Health Service

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



PART A: PUBLIC HEALTH CORE CONTRACT

1. Environmental and Border Health

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = #/% (quantity and quality of effect)**
1.1	Health Protection	**Drinking Water** Maintain accreditation of Drinking-Water Assessors and Drinking Water Assessment Unit. Identify and investigate incidents, complaints and notifications of adverse drinking water quality (or adequacy) of networked, tankered and temporary drinking water supplies. Undertake all duties and functions required by the Health Act 1956, including: • Register drinking-water suppliers and water carriers as required. • Routinely go through the drinking water register each year and verify or update details of network supplies. • Promote compliance with the drinking-water requirements of the Health Act 1956 and achievement of the *Drinking-Water Standards for New Zealand* to drinking-water suppliers and water carriers, and undertake compliance and enforcement action as required. • Conduct the annual review of drinking-water supplies serving more than 100 people and report to water suppliers as required by Scope 1.	# Drinking Water Assessor FTEs. # investigations related to incidents, complaints and notifications. # water supplies surveyed in the annual review. # of water safety plans assessed.	% Drinking-Water Assessors that maintain accreditation. Numerator: # Drinking-Water Assessors that maintain accreditation; Denominator: # Drinking-Water Assessors. % drinking water register entries (network supplies) verified or updated at least annually. Numerator: # of network registered water supplies verified or updated; Denominator: # of network registered water supplies. % networked water supplies (by class of water supply) receiving at least one compliance inspection per annum with findings confirmed in writing. Numerator: # networked supplies (by class) receiving written findings of visit per annum.	#/% networked water supplies (broken down by class i.e. large, medium, minor, small and rural agricultural) compliant with sections 69V and 69Z of the Health Act 1956 (BC, O). Numerator: # networked water supplies (broken down by class i.e. large, medium, minor, small and rural agricultural) compliant with sections 69V and 69Z of the Health Act 1956; Denominator: # networked water supplies (broken down by class i.e. large, medium, minor, small and rural agricultural). Note: The above measure should be informed by the

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = #/% (quantity and quality of effect)**
		• Assess water suppliers' water safety plans as required and provide a report to the water supplier within 20 working days. Ensure water safety plans include critical control points and promote the use of process control summaries by water supply staff. This will include a visit to the water supplier if the assessor is not familiar with the water supply, treatment plant and water supply staff. • Assess and process applications as required for the use of temporary drinking water supplies. • Ensure water-suppliers have plans and PHU responds in a timely manner to transgressions, water supply contamination or interruptions to the supply, including taking appropriate measures to protect and advise the community. Certify the implementation of water safety plans. At least annually check the water safety plan is being maintained (i.e. is a living document and the water supplier does not wait for the five year review period to update the plan). Authorise organisations for the purposes of ensuring compliance with the Act, drinking water standards, and water safety plans. Report serious drinking water incidents to the Ministry of Health within 24 hours. Report suspected or confirmed waterborne disease outbreaks to the Ministry of Health within 2 hours. Undertake enforcement activities in consultation with, and at the direction of, the Ministry of Health.	# temporary drinking water supplies assessed and approved. # authorisations. # investigations related to enforcement (please specify in narrative).	Denominator: # networked supplies (by class). % water suppliers' water safety plans assessed and reported on within 20 working days. Numerator: # water safety plans assessed and reported on within 20 working days; Denominator: # water safety plans assessed within the reporting period. % networked water supplies (by class of water supply) where timely response was provided by PHU to transgressions, contamination or interruption in accordance with drinking water legislation and standards. Numerator: # networked water supplies (by class) where timely response provided; Denominator: # networked water supplies (by class) which reported transgressions, contamination or interruptions to the PHU.	previous year's Annual Survey % of Hawke's Bay population served by a supplier implementing an approved WSP

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No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = #/% (quantity and quality of effect)**
		Refer issues and concerns with self-supplies to territorial authorities as required. Implement the requirements of the Drinking-Water Standards for New Zealand as required (e.g. P2 assignments, catchment risk assessments, and secure ground water assessments). Ensure activities are integrated with the drinking water technical advice services for networked supplies serving up to 5000 people. Provide technical advice and information on public health aspects of drinking water supplies, including the implications of the Health Act 1956 and the *Drinking Water Standards for New Zealand,* to water suppliers, councils, the public and organisations on issues of public health significance in respect to drinking water supplies. Ensure that the public health effects of drinking water supplies are considered and managed by making timely submissions on: • regional and district plans and policies, including giving effect to the National Environmental Standard for drinking water catchments • territorial authority assessments of drinking water supplies • resource consent applications. Provide advice on the benefits of water fluoridation when the issue becomes a significant issue in the community by:	# assessments related to requirements of the Drinking-Water Standards The TANK collaboration is moving through the plan change process during 2019 and 2020. The plan includes many provisions drafted by the JWG to protect drinking water sources for NCC and HDC. Further submissions and hearing appearances will be required	Note: PHU to assess risk accordingly and determine response within 24 hours on becoming aware of a P1 or P2 transgression, contamination or interruption. % networked water suppliers serving more than 100 people with approved water safety plans. Numerator: # of networked supplies serving more than 100 people with an approved water safety plan; Denominator: # of networked supplies serving more than 100 people. % of network drinking water supplies with an approved WSP that have had an implementation completed in the last 3 years (expected 100%). Numerator: # of network water that have had an implementation completed in the last 3 years; Denominator: # of networked supplies with current approved WSP.	

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = #/% (quantity and quality of effect)**
		• supporting health professionals who are promoting the extension or maintenance of fluoridated water supplies • ensuring appropriate education material is available to institutions, health professionals, territorial authorities, community groups and the public • ensuring that messages on fluoridation and oral health are consistent and current, and keep all health providers well informed • making timely submissions on water fluoridation when appropriate. Form collaborative arrangements with water suppliers, district councils and regional councils to share information about potential risks to drinking-water catchments, drinking-water supplies and other relevant issues. Carry out public health grading of drinking-water supplies at the request of drinking-water suppliers.	As noted above the HB drinking water JWG is acting as an advisory group to the TANK plan change. The JWG is providing oversight of the source water protection zone modelling work. An information sharing protocol is under development	Narrative report: Why it isn't 100% (if it isn't). % of network drinking water supplies with an approved WSP that has been updated and is being actively implemented. Numerator: # of network drinking water supplies with an approved WSP that has been updated and is being actively implemented; Denominator: # of network drinking water supplies with an approved WSP.	#/% networked water supplies serving 1000 or more people that are fluoridated (CC, O). Numerator: # networked water supplies serving 1000 or more people that are fluoridated; Denominator: # networked water supplies serving 1000 or more people.
1.2	Health Protection	**Hazardous Substances**	# public health HSNO enforcement officers.		Narrative reporting:

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

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = #/% (quantity and quality of effect)**
		• attending hazardous substances incidents as requested by Fire and Emergency NZ. • surveillance of hazardous substances injuries and reporting via the HSDIRT system. Work with other HSNO enforcement agencies to support their regulatory roles and manage potential public health risk, for example, through assisting with recalls and public warnings as required. Receive annual reports on methyl bromide fumigations. Maintain effective risk management strategies and response plans for hazmat incidents and emergencies, including deliberate chemical contamination and chemical fires, and including at designated points of entry. Responses are required to be consistent with the Ministry's advice and guidelines as noted in the service delivery expectations. Represent public health interests at meetings of the Area Hazmat Coordination Committee. Promote public knowledge on the risks of environmental and non-occupational exposures to hazardous substances and products, including asbestos in the non-occupational environment by: • providing public health advice and information on hazardous substances and products to the public, health professionals and organisations • advising on the safe management of hazardous substances and products, including their removal and disposal from contaminated areas	# desktop or field audits of non 1080 operations. # VTA complaint investigations received and investigated. # VTA complaints referred to another agency. # hazmat incidents or emergencies attended. # hazmat exercises attended. # response plans reviewed and revised, if necessary, following responses and exercises. # area hazmat coordination committee meetings attended. # investigations/ activities undertaken, by	Numerator: # 1080 operations with permissions audited; Denominator: # 1080 operations with permissions. % debriefs/audits that show responses have been consistent with the Ministry's advice and guidelines, including the *National Hazmat Response Plan*, *Major Response to Fires; guidelines for public health units (Revised 2014), Investigation and Surveillance of Agrichemical Spray drift Incidents:*	Narrative reporting: Outcomes of hazmat meetings and exercises.

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = #/% (quantity and quality of effect)**
		• advising on the safe management of asbestos in the non-occupational environment according to the Ministry of Health's guidelines and direction. • advising on the safe management of products containing lead, including lead-based paint and mercury (including its removal and disposal). Advise, encourage and/or assist territorial authorities and Regional Councils to: • identify potentially contaminated sites in the region and identify contaminants • implement health impact assessment systems to ensure contaminated land is remedied, where appropriate, and to minimise adverse effects on human health • determine appropriate land use controls for contaminated sites to minimise the risk to the public • ensure appropriate advice is provided to manage any public health risk from sites and during any remediation processes.	type (e.g., crayons, face paint, chemical spills).	*guidelines for public health units.* Numerator: # debriefs/audits that show that response was consistent with Plans, Ministry Guidelines, etc.; Denominator: # of responses.	Narrative reporting: Outcomes related to whether Local Authorities have been responding appropriately to public health risks from contaminated land.
1.3	Health Protection	**Mosquito surveillance** Undertake surveillance of mosquitoes at appropriate frequency (weekly over summer and warmer part of spring/autumn and fortnightly over winter and colder part of autumn/spring at international sea and airports or monthly audit of surveillance undertaken by the air or sea port company). Provide mosquito interception response situation reports to the Environmental and Border Health Team using the	# interceptions. # incursions. # responses to other organisms.	% responses initiated within 30 minutes of notification. Numerator: # responses initiated within 30 minutes; Denominator: # responses. Narrative reporting: On mosquito surveillance and whether it is occurring at appropriate frequency (will	#/% exotic mosquitoes that have crossed the border and established in your region (CC, O). Numerator: # incursions; Denominator: # interceptions.

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

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No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = #/% (quantity and quality of effect)**
		Provide sound technical and professional advice on public health issues that are related to border health protection objectives in relation to imported risk goods, disease vector surveillance and control, preparation of contingency plans for emergency response, preparation of submissions as appropriate on proposed pest management strategies. Provide public health training to air and sea port staff, as required, on border health protection risks and their management. Contribute to or lead (when required) the preparation of health impact assessments in relation to border health protection threats and eradication and control activities. Maintain on-call roster to ensure appropriately trained staff are available at all times for any border responses.	# public health training (e.g. advice, update, event) to air and sea port staff.	Numerator: # current staff members involved in ship sanitation inspections who have completed the WHO on-line ship sanitation course; Denominator: # current staff members involved in ship sanitation inspections.	public health response plans (CC, O). Numerator: # international points of entry that have contingency plans to deal with ill travelers and other border health responses that are interoperable with public health response plans; Denominator: # international points of entry located in PHU area of coverage.
1.4		**Emergency Planning and Response** Carry out all emergency management planning, preparedness and responses in collaboration with other relevant agencies and according to Ministry of Health guidelines, plans and advice. Maintain and review Emergency Response Plan(s). There must be plans covering the following minimum areas: - Border Health Response - Communicable Disease – Outbreak/Pandemic	# responses.	% public health unit plans include reduction/readiness/response/recovery/resilience, and identify resources needed to support and carry out public health action (expected 100%). Numerator: # public health unit plans include the four 'Rs'; Denominator: # public health unit plans.	#/% PHU Emergency Planning and Response Plans interoperable with stakeholder plans (i.e. TLAs, DHBs, airport, seaport (CC, O). Numerator: # PHU Emergency Planning and Response Plans interoperable with stakeholder plans (i.e. TLAs, DHBs, airport, seaport;

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = #/% (quantity and quality of effect)**
		- Hazardous Substances (including radiation, hazmat responses, and Chemical and Biological Counter Terrorism Response) - Civil Defence/National Disaster. Take appropriate emergency actions, as the need arises. This includes liaison with and taking directions from other agencies involved, including providing services for, be directed by, and report to civil defence authorities. Maintain, exercise and regularly review plans for responding effectively to a range of public health emergencies, including national, regional and local meetings, exercise and training opportunities. Maintain civil defence and public health emergency planning and response capacity, and ensure there are appropriate numbers of staff trained in emergency management/CIMS. Ensure key health messages are available in educational and promotional materials through collaboration with other agencies/organisations involved in emergency planning and response.	# exercises. Contribution to HBCDEM group plan review in 2019/2020. This will include review of capacity and a new risk assessment. Heat health and climate change related hazards to be included Attendance at CEG meetings	% plans and Standard Operating Procedures updated each year (required 100%). Numerator: # plans and Standard Operating Procedures updated; Denominator: plans and Standard Operating Procedures. Note: As a minimum the annual update should include a check to ensure that relevant contact phone numbers are still correct. % plans tested, including emergency communications (required 100%). Numerator: # plans tested; Denominator: # plans. Note: checking that all emergency phone numbers are still correct as a minimum. % exercises and responses that are followed by a debrief (required 100%) Numerator: # exercises and responses followed by a debrief;	Denominator: # stakeholder plans. Please report in narrative, if plans are not interoperable, on how you are working towards making plans interoperable. Definition of interoperable: *The two Plans operate together seamlessly, are aligned and there is no discontinuity (e.g., if the airport EOC incident controller role is undertaken by the Police, then that is documented in the PHU Plan).* Narrative reporting: Outcomes of exercises. #/% Health Protection Officers and Medical Officers of Health completed CIMS 4 or CIMS (Health) training

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = #/% (quantity and quality of effect)**
				Denominator: # exercises and responses. Note: If the exercise is held by another agency and there is no debrief, the PHU should hold its own debrief. % debrief recommendations that are incorporated into plans and SOPs. Numerator: # debrief recommendations that are incorporated into plans and SOPs; Denominator: # debrief recommendations.	within the last four years (SK, O). Numerator: # Health Protection Officers and Medical Officers of Health completed CIMS 4 or CIMS (Health) training within the last four years and currently employed; Denominator: # Health Protection Officers and Medical Officers of Health employed by the PHU. Narrative reporting: If not 100%, please report on when they would be completing this training. Note: target should be 100% over a four-year period.
1.5	Health Protection	**Stakeholder Planning, Submissions and Resource Management** Encourage and assist Councils to develop and implement policies through processes, such as the review of district plans, including variations or plan changes or Council Long Term Plans that address the wider determinants of health.	# applications/plans/ statements/standards assessed for public health issues. # submissions made.	% submissions completed that include a public health risk assessment to ensure submission is (expected 100%): • evidence based	Narrative reporting: Public Health impact (or expected impact) of submissions and/or proactive/upstream work with stakeholders (i.e., key public health gains).

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = #/% (quantity and quality of effect)**
		Make timely and professional submissions on national (including national policy statements, national environmental standards and or guidelines) and regional plans and policy statements, district long term and annual plans and, where appropriate, resource consent applications to ensure that the public health effects are considered and managed of: • adverse air quality • the disposal of the dead • environmental noise • ionising radiation (in consultation with the Office of Radiation Safety) • non-ionising fields • recreational waters • gaseous, liquid and solid waste • urban design/form • sewage collection, treatment and disposal • drinking water (cross reference with the separate drinking water section) • other environmental health issues. Monitor decisions made under the Resource Management Act 1991 to ensure that the health impacts of environmental hazards have been considered. Follow up with regional councils and territorial authorities where this has not occurred. Make timely and professional submissions on local government assessments of sanitary works to ensure that the public health aspects are considered. Comment, as appropriate, on territorial authority plans for sanitary works infrastructure planning.	# hearings where evidence presented. Narrative reporting: Brief description of proactive/upstream work with stakeholders (who and what).	• proportionate to the public health risk • peer reviewed. Numerator: # submissions completed that include a public health risk assessment; Denominator: # submissions completed. Note: PHU should keep brief documentation to show that above criteria has been considered and implemented.	

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No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = #/% (quantity and quality of effect)**
		Liaise and, where appropriate, undertake joint projects with consent authorities and affected communities to ensure that public health aspects of planning and resource management are considered. Provide technical advice and information to regional councils and territorial authorities. Inform other agencies and the public on the public health aspects of matters relating to sustainable resource management.			
1.6	Health Protection	**Other Regulatory Issues** For the following public health issues: • air quality • the disposal of the dead • environmental noise • ionising radiation • non-ionising fields • recreational waters • gaseous, liquid and solid waste • other environmental health issues undertake the following: • Provide information and advice to other agencies, organisations and the public on their adverse effects • Take appropriate action to minimise risks and to protect the public health from environmental exposures to these issues	# ionising radiation source transports overseen. # requests for advice or information responded to.	% activities and advice related to ionising radiation undertaken in consultation and with approval of the Ministry's Office of Radiation Safety (expected 100%).	

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = #/% (quantity and quality of effect)**
		• Monitor territorial authorities' actions on these issues to ensure health impacts are minimized • Respond to public enquiries and investigate and/or redirect public complaints and queries on these issues. • Support local government implementation of national policy statements and national environmental standards. Ensure applications for approvals are complete, and include the health protection officer's covering report and recommendations before they are forwarded to the Ministry of Health for action, including: • disinterments • burials in special places • medical referee appointments • other burial and cremation approvals. Supervise disinterments as required. Advise and assist applicants to export cadavers, as required, to ensure public health concerns are addressed. (Note that costs may be recovered for this activity.) Conduct six-monthly visits to commercial solaria to encourage compliance with best practice guidelines. Conduct and report on pre-licensing inspections of early childhood centres, including compliance by the licensee of the premises with the Education (Early Childhood Centres) Regulations 1998. Investigate/inspect and report on early childhood centres in response to complaints.	# complaints referred to the appropriate agency for action (where it is outside PHU's responsibility). # complaints investigated (where it is within PHU's responsibility). # sanitary surveys conducted by PHU (if it is within the PHU's responsibility). # commercial solaria visited six-monthly.	Numerator: # activities and advice related to ionising radiation undertaken in consultation with the Ministry's Office of Radiation Safety; Denominator: # activities and advice related to ionising radiation undertaken. % visits to commercial solaria operators six monthly.	#/% of known commercial solaria operators who report

13.3

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

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

2. Alcohol and Other Drugs Harm Prevention

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

[2] There are several scenarios that may be applicable, two examples are as follows:
1. a PHU may have opposed external advertising of alcohol that appeals to young people (RTDs) which the applicant agrees to, and this is subsequently written as a condition of the licence.
2. an applicant may agree to reduce the hours of operation and changes the application accordingly which then doesn't attract an opposition.

No.	Core Functions	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = # % (quantity and quality of effect)**
					discussed with applicants for each licence type (on, off, club, special). #/% reports (for premises where matters in opposition were made by the PHU) submitted to the **DLC,** which resulted in conditions being attached to the licence or a refusal to grant/renew licence, for each licence type[3] (on, off, club, special) (CC, O). Numerator: # reports (for premises where matters in opposition were made by the PHU) submitted to the **DLC,** which resulted in conditions being attached to the licence or a refusal to grant/renew licence, for each licence type (on, off, club, special); Denominator: # reports (for premises where matters in opposition were made by the PHU) for

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

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

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

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

No.	Core Functions	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = # % (quantity and quality of effect)**
2.7					Summarise the remedial actions that are/will be undertaken by the PHU for high risk premises and special licence events identified as not fulfilling their licence conditions/ host responsibility obligations.
2.8		To work with our stakeholders to develop a strategic document which outlines the respective roles, responsibilities, and guides the way we work together to achieve alcohol harm reduction from a regulatory perspective (as per s 295 SASoAA '*Agencies duty to collaborate'*).	Joint liaison /MOU protocol developed (Y/N/Progress)	Joint Liaison Protocol/MOU – evidence of it being applied (Narrative report)	Examples of increased alignment between agencies for example during oppositions to be more effective (Narrative report)
2.9	Health Promotion	Make submissions as needed on national and local policy that supports the outcomes of the HBDHB Alcohol Harm Reduction Strategy. Make submissions to, and proactively support/ influence Territorial Authorities (TA's) to develop and implement policies that will reduce alcohol-related harm, including: • Supporting TAs to develop and maintain their local alcohol policy • Actively participating in LAP reviews.	# of alcohol harm reduction submissions # and names of TAs supported	% submissions are evidence- based & peer reviewed by Medical Officers of Health	#% submissions implement healthy public policy recommendations
2.10		Implement the HBDHB Alcohol Harm Reduction Strategy.	# steering group meetings # reporting to HBDHB Committees and Board	% activities completed	Narrative report

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

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

3. Tobacco

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

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

4. Communicable Disease

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

No.	Core function	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = #/% (quantity and quality of effect)**
4.5		Needle exchange (Onekawa, Napier) is supported by the Medical Officer of Health to maintain their authorisation under the Health (Needle and Syringes) Regulations 1998.	Annual review of Needle Exchange will be undertaken by Medical Officer of Health.		Needle Exchange maintains its authorisation
4.6		Provision of surveillance and communicable disease control advice to cases, health care professionals, local authorities and NGOs, rest-homes, Māori providers and the public. Two publications of 'Public Health Advice' per annum Kotahi Whānau develops a pathway for integrated working 'initiative' involving Māori and Pacific Health Services.	Report any additional specific publications/ communications that target relevant groups, such as GPs.	Narrative report on initiatives taken targeted at primary care. Established pathway developed by Kotahi Whānau. •	Timely reporting by GPs of suspected notifiable diseases is likely to lead to better health outcomes for individuals and communities.
4.7		Support delivery of rheumatic fever prevention programmes and initiatives. Plan for Rheumatic Fever Governance Group to oversee programme/ initiatives to ensure alignment with evidence-based practice.	# of Rheumatic Fever Governance Groups attended. # of clinical and expert advice provided.	As per MoH reporting: • HHI (Child Healthy Homes Programme) • Say Ahh (sore throat management) • Rapid Response Root cause analysis	Narrative

5. Healthy Housing

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = #/% (quantity and quality of effect)**
5.1	Health Assessment and Surveillance	Monitor the impact of housing-related illness as part of the health equity monitoring framework and will be developed further for ongoing Health Equity Reports.	One health equity monitoring framework	External appraisal of effectiveness	Description of impact on housing supply and quality responses within Hawke's Bay
5.2	Health Promotion	Support the Housing Coalition by: • Providing health leadership • Providing secretariat and chairmanship • Support projects	# Coalition meetings		Narrative report of outcomes of meetings
5.3		Support intersectoral housing initiatives including Matariki actions in the Social Inclusion Strategy, Housing First programme and other new developments.			Impact of housing work on key areas i.e. housing supply and housing quality as reported through the Housing Coalition and Matariki Framework
5.4		Complete the assessment of the minor repairs pilot.			Narrative report
5.5	Health Protection	Respond to reported incidences of mouldy or insanitary housing. Implement the insanitary housing toolkit. This work is being completed in collaboration with an external provider (see Habitat for Humanity assessment and minor repairs programme in Part B of this plan).			Description of work including the outcome of the pilot assessment and repair programme

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

6. Immunisation

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = #/% (quantity and quality of effect)**
6.1	Preventative intervention	Infants born to Hepatitis B positive mothers are protected from the disease	# infants per year		All infants born to HepB +Ve mothers receive HBIG and Hep B immunisation post-delivery.
6.2		Promote and support existing networks providing immunisation information, education, support and advice for all vaccinators, non-vaccinators and the general public. Maintain effective collaborative working relationships with all service providers that have an interest in immunisation activity with emphasis on equity and those providers servicing our hard to reach population. Engage with TTOH Whanake Te Kura ante natal programme, designed to engage the HB Population of largely Māori and Pacific births, to increase inclusion of immunisation education within the programme. Meet with Choices, Māori Health Provider, to explore opportunities to increase capacity and capability for immunisation by implementing a weekly walk in immunisation clinic – if contract made available.	12 x Immuwise newsletters created and distributed # of training workshops # of education sessions provided 1 meeting held	% workshop participants report they are satisfied or very satisfied with workshops provided	% of children receiving on-time national schedule immunisation with equity maintained. Evaluation of education sessions by Whanake Te Kura ante natal programme coordinator.

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

7. Child & Youth Wellbeing

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

13.3

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

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = #/% (quantity and quality of effect)**
		In collaboration with the Māori Health Service, analysis and reporting of data collected as part of the māmā Māori interviews undertaken in 2018		appropriate messaging and support for whānau Māori	
7.6		**Breastfeeding** Facilitate Hawke's Bay Breastfeeding interagency forum to promote the benefits of breastfeeding for both mother and baby. Deliver community breastfeeding promotion by implementing a local communication plan that provides consistent breastfeeding messaging, promotes breastfeeding support services and initiatives including: ▪ WHO Breastfeeding week ▪ Mama Aroha resource for mothers ▪ Supporting HBDHB breastfeeding policy ▪ Promotion of local support services Support the Baby Friendly Hospital and Community Initiatives Report any issues concerning compliance of the WHO Code of Marketing of Breastmilk Substitutes.	% of HB Breastfeeding Group stakeholders who report that they are highly satisfied with the leadership & coordination of HB breastfeeding promotion activities. # of meetings% of breaches of the Code followed up and rectified	Narrative summary of engagement with breastfeeding promotions:	100% compliance of the WHO Code of Marketing of Breastmilk Substitutes in HB HB BFHI & accreditation status is maintained
7.7		Healthy conversation tool distributed to all early childhood education settings in Hawkes Bay* Provide training and education to workforce engaged with whānau in early year's settings including healthy conversations, safe sleep.	# of tools distributed to ECE settings # of training/education supports provided # of participants	% of tools in use in ECE settings	% of ECE settings setting that report they have integrated tool in practice % of participants who report that training/education has

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

8. Nutrition, Physical Activity & Healthy Weight

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = #/% (quantity and quality of effect)**
8.1	Health Promotion	Contribute population health evidence and data to inform transport and sustainability initiatives within the HBDHB and other relevant forums with a focus on improving equity in active transport users.	# meetings attended # feedback provided		
8.2		Support the development of a HBDHB sustainability communication plan and education plan to raise staff awareness and initiate further behavior change.	# communication plan # activities delivered	% actions are informed by evidence	
8.3		Deliver actions from Best Start: Healthy Eating and Activity Plan to increase healthy weight environments: • implementing healthy conversation tool – in ECEs* • monitor schools programme* • monitor the National Food and Drink Policy within the HBDHB • Identify nutrition tools to assist HBDHB contract providers with Food & Drink Policy guidance. • Coordinate the delivery of the Maternal and Child nutrition and physical activity program* • Promote breastfeeding* *(*Refer to Child and Youth Wellbeing section)*	# ECEs engaged # schools engaged # agreed activities completed # tools and resources # of programs delivered	% Kohanga, Nests & High Dep ECEs % High deprivation % compliant HBDHB sites % web page content reviews	#/% Children increased fruit and veg #/% of contracted providers with policies
8.4		Deliver actions from to Best Start: Healthy Eating and Activity Plan by providing leadership: • Advocating water only (*links to Oral Health)* • Engaging key partners TLAs, Sport HB, Business organisations	# Events/location promoting water only # partners engaged		

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
		• Linking to regional planning including Matariki, Transport Plan, and TLA Plans.			
8.5		Support the implementation of the National Healthy Food and Drink Policy to which HBDHB committed to in August 2016.			Narrative
8.6		Identify appropriate nutrition support for health providers from within our DHB.			Narrative
8.7		Develop online tools to support health contract providers e.g. policy templates, checklist etc.			Narrative

9. Social Environments, Cross Sector Development

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
9.1	Health Promotion	Support the sharing of data across agencies to support planning, response and measuring outcomes.	# agencies sharing data	% used in planning	
9.2		Utilise cross sector relationships to build capacity and influence key determinants and outcomes of health- • Water • Healthy weight • Tobacco • Drugs • Housing	# of cross sector working groups		See also Healthy Housing section
9.3		Engage with key plans and strategic documents to influence the impact of equity in health outcomes and determinants of health including: • Regional Transport Plan • Regional Economic Development Plan • Regional Social Inclusion Plan • TLA annual and long term plans • Water	# submission made	% of plan with DHB engagement	
9.4		Establish approaches for Population Health to engage the whānau voice across planning, design and deliver.	# approaches	% Māori and Pasifika whānau	#/% whānau voices heard
9.5		Review current cross sector engagement to support: • Effective engagement, people with right information, authority and skill at each engagement • Develop a tool to provide oversight of cross sector engagement and share information	# service manager reviews # tool established	% of tool users	

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

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

10. Mental Health

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

11. Migrant Health

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

12. Sexual Health

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

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

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

13. Health Education

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

13.3

14. Public Health Workforce

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	How well = % (quality of effort)	Is anyone better off = #/% (quantity and quality of effect)
14.1	Public Health Capacity Development	Maintain the MoH target for public health qualifications.		80% of staff hold public health qualifications	#% of staff with public health qualifications
14.2		Managers and Team Leaders support staff to develop and complete their agreed performance development plan.		90% of staff have a current PD plan	#% completing planned training
14.3		Staff are supported to maintain professional competencies. • Professional competencies are articulated to each staff member. • Activities to support professional competency are included in each staff member's development plan. • Competencies are monitored / reviewed with each staff member.		100% of staff with professional competencies are monitored	
14.4		The Population Health Service provides opportunities to share knowledge and skill within and across teams.	# events		#% of staff engaged
14.5		Demonstrate leadership and support workforce development across public health & health promotion.	# forums for sharing projects & work # workforce development opportunities	#of partner organisations # of participants at workforce development	Narrative: workforce development evaluations

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

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

PART B: OTHER CONTRACTS

15. Healthy Housing

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

16. Immunisation – NIR Administration, Coordination, Outreach

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

13.3

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

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

17. Population Screening

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

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = #/% (quantity and quality of effect)**
17.6		**National Cervical Screening Programme** Continue to improve general practice screening recall processes including encouraging recall to commence at 32 months working towards improving on-time three yearly screening. Work with general practices to review Karo reports, identify errors and how to resolve.	# general practices	% general practices	% coverage rate by Māori, Pacific, Asian and total population
17.7		Continue to target Māori and Pacific unscreened and under-screened women through targeted strategies and kanohi ki te kanohi approaches.	# Māori and Pacific women able to be identified as attending screening as a result of these strategies		
17.8		Coordination of screening services • Promote and support existing networks providing cervical screening, education, support and advice for all smear takers, GP's and Practice Nurses and the general public • Deliver lectures at EIT smear taker training • Facilitate the Population Screening Steering group which provides the forum for a collaborative approach to improving screening coverage. • Provide annual training NCSP and BSA information to ISPs.	# of health professionals attending the update 3 meetings One training event per annum	% participants attending the update are satisfied or very satisfied with the update % of stakeholders attending meetings # of stakeholders attending	Evaluation to ensure ongoing benefits for future updates Feedback from the nurses attending training. Annual evaluation of Steering Group by group members shows that this forum is beneficial for its members and the organisations / communities
17.9		Improve ethnicity data quality: o Remind smear takers to enter correct ethnicity on laboratory forms.	# of practice who have updated their 99 & 54 ethnicity codes to the correct code	% of practices identified and amended their PMS	

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = #/% (quantity and quality of effect)**
		○ Identify and follow up Practices on the PHO Cx report using 99 and 54 ethnicity codes ○ General Practice will continue to update the NHI/Ethnicity data as per the National Enrolment Service (NES) workflow			
17.10		Target geographical areas with large pockets of unscreened and under-screened Māori, Pasifika and Asian women using the PHO Cx monthly report and offer the women a smear.	# of Priority women identified and screened	% of Priority women coverage has increased	Equity of cervical screening coverage between different ethnicities.
17.11		Explore the role of GPs in influencing women's cervical screening behaviours ○ GP's encourage positively with women to have a smear when visiting for other health reason ○ All GP letters for a specific period of time are signed by a GP	# of General Practices trial cervical screening letters signed by a GP		% coverage per general practice involved has improved
17.12		Support Primary Care to focus on systems and process within general practice. This quality improvement initiative involves improving participation in NCSP, equity for Māori, improving access, service quality, and data quality. ○ Accurate patient records – ethnicity, contact details, screening status and history ○ Use of patient management systems e.g. clearing inboxes, recalls and checking dashboards ○ Invitation and recall strategies targeting wāhine Māori e.g. personal approach instead of written communication	# General practices supported to and comply with best practice guidelines	# of practices approached participate	Pre and post intervention audits show an increase in Māori and Pasifika coverage rates per practice

No.	Core Function	Activities	Performance Measures		
			How many = # (quantity of effort)	**How well = % (quality of effort)**	**Is anyone better off = #/% (quantity and quality of effect)**
		○ Responsive / available smear taking services and holistic and opportunistic consultations ○ Consumer feedback on the cervical screening experience for women ○ Compliance with NCSP Policies and Standards and HPV			
17.13		Population Screening Kaiawhina and Pasifika Community Support worker working with general practice to increase cervical screening rates for priority women. This includes provision of home screening.	# priority women change in coverage at practices involved.	Feedback from the women screened.	% of Priority women coverage has increased.
17.14		Establish a referral process for general practice to refer all Māori, Pasifika and Asian women who are ≥5 years overdue for cervical screening, to an Independent Service Provider.	# of priority women referred and screened via new process		% of the women referred are contacted and screened.
17.15		Encourage nurses to attend smear-taker training and mentor them to pass their assessments, with specific focus on Māori and Pasifika nurses and cultural competency.	Increased number of Māori and Pasifika nurses completing smear taker training and passing their assessments.	%increase of Māori and Pasifika nurses completing smear taker training and passing assessments.	Smear taker workforce reflects demographic of population.
17.16		Continue to monitor and work towards reducing DNAs for FSA and follow-up appointments, particularly for Māori women with high grade cytology results.	# of Māori & Pacific women referred with a high grade smear who DNA FSA and follow-up appointments for Colposcopy.	90% of eligible Māori women with a high grade cytology result attend colposcopy FSA and follow-up appointments.	HBDHB meet timeliness to treatment guidelines, and cost effective treatments are provided.

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

18. Oral Health

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

19. Tobacco

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

20. Drinking Water Technical Advice Services

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

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

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

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

Cover to come

Final draft SLM 2019-20

Hawke's Bay District Health Board

V1.7

System Level Measures provide a continuous quality improvement and integration across the health system. Equity gaps for Māori and Pasifika populations are evident in all System Level Measures. This framework provides us with a great opportunity to work with health system partners to address equity gaps.

System level measures are:

- Outcomes focused
- Set nationally
- Requiring all parts of the health system to work together
- Focused on children, youth and vulnerable populations
- Connected to local clinically led quality improvement activities and contributory measures

Current System Level Measures:

- Ambulatory Sensitive Hospitalisation(ASH) rates for 0-4 years
- Total acute hospital bed days per capita
- Person experience of care
- Amenable mortality rates
- Youth access to and utilization of youth appropriate health servcices

The Te Pītau Alliance Group is now in place and will provide governance to our System Level Measures. This is a transition year and we are looking forward to establishing service level alliances and working groups to support the System Level Measures and align under the full structure of Te Pitau.

The purpose of Te Pitau is to improve health outcomes for our populations by transforming, developing, evolving and integrating primary and community healthcare services

This year we are choosing fewer but larger initiatives requiring significant integration of working groups

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Bayden Barber, Chair Te Pītau Alliance group

Keeping Children out of Hospital

SYSTEM LEVEL MEASURE

Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0–4 year olds

Ambulatory Sensitive Hospitalisations (ASH) reflect hospital admissions for conditions which could potentially be prevented by early access to treatment in care. In many countries ASH is used as a means to assess the performance of primary care and to identify potential barriers to access.

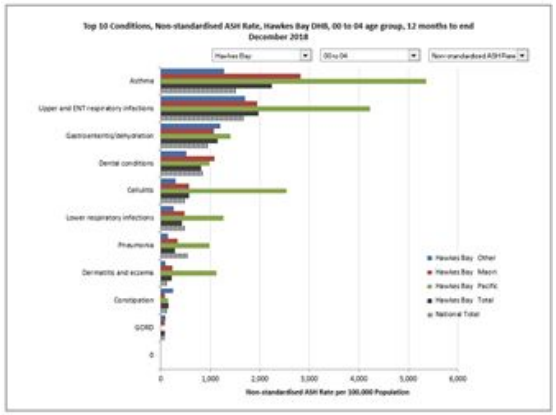
However, while ensuring early access to effective primary care is still likely to be of considerable value in reducing ASH, in countries such as New Zealand, where large socio-economic and ethnic disparities in child health exist, a greater emphasis may need to be placed on addressing those factors, often outside of the health sector, which drive the underlying burden of disease (e.g. household income, housing, nutrition, exposure to second hand cigarette smoke). This is because, even with optimal access, the ability of a general practitioner to prevent a paediatric pneumonia admission after the first crucial hours may be limited, but the opportunities available for a DHB to prevent paediatric respiratory infections via, e.g. healthy housing projects and parental smoking cessation programmes, may be considerable. Note that actions around access to primary care are included under SLMs - Using Health Resources Effectively and Prevention and Early Detection.

There is an inequity in the ASH rates 0-4 for Māori, Pasifika versus other. The largest inequities are observed in asthma, cellulitis and dental

The top ASH conditions for Māori are asthma, upper and ENT, gastroenteritis / dehydration and dental conditions.

	Baseline*	2019/20 Milestone 5% decrease
Total	7,969	Māori 8,313
Māori	8,750	
Pasifika	18,020	
Other	5,891	

*12 months to March 2019



CONTRIBUTORY MEASURES

Measure	Baseline March 2019	Goal 5% decrease
Decreased hospitalisations due to dental conditions for Māori & Pasifika 0-4 (rate per 100,000)	Māori: 1,091 Pasifika: 986 Other: 525	Māori: 1,036 Pasifika: 936
Decreased hospitalisations due to respiratory for Māori and Pasifika 0-4 (rate per 100,000)	Māori: 5,575 Pasifika: 11,831 Other: 3,395	Māori: 5,296 Pasifika: 11,240
Decreased hospitalisations due to cellulitis for Māori and Pasifika 0-4	Māori: 575 Pasifika: 2,535 Other: 300	Māori: 546 Pasifika: 2,408

HOW WILL WE ACHIEVE IT

- Develop whole of sector working group for first 1000 days and beyond; develop first 1000 days outcomes framework for Hawke's Bay, improve maternity workforce, develop paediatric respiratory programme for Hawke's Bay
- Analyse and report data collected as part of the māmā Māori interviews undertaken in 2018
- Interview Pacific families who presented to ED for ASH 0-4 in 18/19 to gain insights into their experience. Develop a plan for the development of appropriate messaging, referral and support for families engaged in this action
- Continue to deliver the activities identified to support healthy weight in the Hawke's Bay Best Start Healthy Eating Plan
- Continue with the Oral Health Under 5 Equity project

Using Health Resources Effectively

SYSTEM LEVEL MEASURE: Acute hospital bed days per capita

Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by effective management in primary care, transition between the community and hospital settings, discharge planning, community support services and good communication between healthcare providers. This includes access to diagnostics services.

Reducing acute hospital bed days continues to be a priority and aligns with our strategic objectives. We continue to focus our efforts on reducing avoidable admissions through more effective care in the community, and reducing length of stay and readmission rates through better hospital processes and collaboration across the sector.

The conditions with the highest impact on acute hospital beds are stroke and other cerebrovascular disorders, respiratory infections and inflammation, cellulitis and hip and femur procedures. The 70+ age groups continue to make the major contribution to acute hospital bed days.

Ambulatory Sensitive hospitalization (ASH) rates for 45-64 years remain a lesser contributing factor to acute hospital bed days but in their own right are a measure of the whole system working effectively. The highest contributing conditions are angina and chest pain, myocardial infarction, cellulitis and COPD. The largest inequity gap for ASH 45-64 between Māori and other is in angina and chest pain then COPD and cellulitis.

2019/20 Milestone: Reduce standardized acute hospital bed days to ≤390 per 1,000

	Estimated Popn	Acute Stays	Acute Bed Days	Standardised Acute Bed Days per 1,000 Popn		
Year	Year to Dec 2018	Year to Dec 2018	Year to Dec 2018	Year to Dec 2016	Year to Dec 2017	Year to Dec 2018
Maori	42,810	7,181	19,782	572	586	636
Pacific	6,350	1,162	2,456	547	441	511
Other	113,740	16,233	54,399	355	359	354
Total	162,900	24,576	76,637	398	400	410

CONTRIBUTORY MEASURES

Measure	Baseline Dec 2018	Goal
Decreased acute readmission rate (28 day)	Total: 12%	Total: ≤ 11.4%
Decreased Inpatient Average Acute Length of Stay (ALOS)	2.31 days	≤ 2.28 days
Decreased Ambulatory Sensitive Hospitalizations (ASH) rates per 100,000 for 45 – 64 year olds Māori	Māori: 9,328 Pasifika: 8,404 Other: 3,437 Total: 4,612	Māori: 8,862

HOW WILL WE ACHIEVE IT?

- Develop a whole of sector working group focused on older and frail people
- Frailty: Develop and implement processes to help prevent admissions for those living with frailty, develop and implement processes to identify frailty on admission which better supports the patient's journey to achieve better outcomes
- Initiate, develop and monitor the effectiveness of 'Hoki Te Kainga' an Early Supported Discharge Service, to improve patient outcomes and improve hospital flow
- Re-design primary care after hours service
- Refresh fit for winter and existing FLOW programme of work

Person Centred Care

SYSTEM LEVEL MEASURE: Patient experience of care

How people experience health care is a key element of system performance that can be influenced by all parts of the system and the people who provide the care. Improved consumer experience of care will reflect better integration of heath care at the service level, better access to information and more timely access to care.

Consumer experience surveys provide scores for four domains which cover key aspects of consumer's experience when interacting with health care services: Communication, partnership, coordination, and physical and emotional needs.

The purpose of these measures is to ensure consumers in New Zealand are receiving quality, effective and integrated health services. Evidence suggests that if consumers experience good care, they are more engaged with the health system and therefore likely to have better health outcomes.

In Hawke's Bay, consumer experience surveys are only one part of much wider pieces of work under "Person and Whanau Centered Care." The four focus areas are: consumer engagement, patient experience, health literacy and consumer participation.

This measu
- Hospital inpatient surveys (undertaken quarterly since 2014)
- Primary care survey (introduced in a phased approach quarterly from Feb 2016).

	Inpatient Results Weighted Avg/10 1 April 2019	Primary Care Results Weighted Avg/10 April 2019
Communication	8.6	8.3
Partnership	8.7	7.5
Coordination	8.5	8.4
Physical and emotional needs	8.8	7.4

SLM 2019/20 Milestone:
Response rate of ≥20% for General Practice and ≥20% % for Inpatients
Baselines: 21% General Practice and 19% Inpatient

CONTRIBUTORY MEASURES

Measure	Baseline March 2019	Goal
HQSC primary care – proportion of Māori invited to complete survey, who respond	Māori 11%	Māori 15%
HQSC Inpatient survey – proportion of Māori responses	Māori 11%	≥10%
Proportion of staff having completed online Health Literacy training	Total 1.2%	tbc
Proportion of staff carrying out relationship centred practice training	Total 0.4%	tbc

HOW WILL WE ACHIEVE IT?

- Improve hospital pharmacist access to patient records in primary care in response to lowest scoring question in the survey
- Develop equity training as a system property, building our organizational capacity and capability
- Develop a consumer engagement framework in general practice
- Develop shared outcomes and processes (formal and informal) for whanau to input into the Wairoa Community Partnership Group
- Explore opportunities for developing local surveys

13.4

Prevention and Early Detection

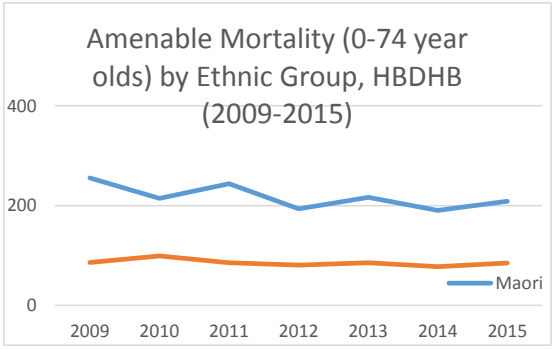
SYSTEM LEVEL MEASURE: Amenable mortality rates

Nearly three-quarters of all deaths before the age of 75 years are avoidable due to either disease prevention or effective treatment and health care. Deaths due to these diseases or conditions can be counted and expressed as a rate. Any difference in these rates by ethnicity or by area of residence can therefore be considered to be a health inequity. We have seen significant reduction in deaths, which could have been minimised by prevention, early treatment programmes or better access to medical care, however this seems to have leveled off since 2012.

The top five causes of amenable mortality for total populations are: coronary disease, diabetes, suicide, land transport accidents (excluding trains), and female breast cancer with those for Māori being coronary disease, suicide, land accidents (excluding trains), diabetes and COPD.

Amenable mortality rates are 2.6 and three times higher for Māori and Pasifika respectively compared to non-Māori, non-Pasifika (NMNP). This highlights a large inequity in prevention and early detection for Māori and Pasifika. Given what we know about our top causes, the system will focus on cardiovascular disease and diabetes, particularly for Māori. Actions on alcohol are not included in this SLM as these are covered within "Youth are Safe and Supported'.

Baseline*	2019/20 Milestone
Māori 208.8 NMNP 85.1 Relative Rate between Māori and NMNP 2.45	Relative Rate between Māori and NMNP ≤2.15, ≤1.8 by 2023, ≤1 by 2029



*Amenable mortality, ages 0-74, 2015

Due to the small number in the Pasifika population, it is difficult to put a target on reducing the standardised rate however, we will be focussing on services to improve equity for Pasifika as well as Māori.

CONTRIBUTORY MEASURES

Measure	Baseline	Goal 5% Change
Increase the number of Māori males 35-44yrs who have had a CVDRA in the past 5 years	Māori: 68.2% Dec 2018	72%
Better help for smokers to quit (PHO)	Māori: 79% Dec 2018	≥90%
Decreased ASH rate for angina and chest pain for Māori per 100,000	Māori: 1,934 Pasifika: tbc Other: 1,048 Total: 1,225 March 2019	Māori 1,837

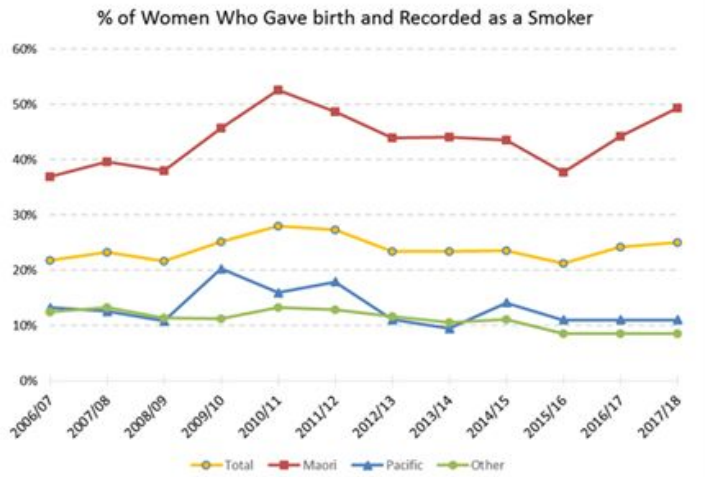
HOW WILL WE ACHIEVE IT?

- Implement the first phase of Health Care Home in General Practice
- Support the delivery of action priorities within the Tobacco Strategy
- Explore horizontal integration of immunization, screening and smoking cessation systems for whānau-centric, outreach services
- See 'Youth' measure regarding alcohol related prevention measures

Healthy Start

SYSTEM LEVEL MEASURE: Proportion of babies who live in a smoke-free household at six weeks postnatal

This measure aims to reduce the rate of infant exposure to cigarette smoke by focusing attention on both maternal smoking and the home and family/whānau environment to encourage an integrated approach between maternity, community and primary care. We know, in Hawke's Bay, that we have an alarmingly high number of women, especially Māori women, who smoke during pregnancy (see graph below).



This year, we will continue to focus on the data collection at multiple points in the maternity journey and the pathway for smokefree services centered around maternal and whānau smokefree support before, during and after pregnancy.

SLM Milestone: Reduce the number of 'blank' responses to household smoker question. Baseline: 5.70 % 'Blank' March 2019 Target ≤ 5%

CONTRIBUTORY MEASURES

Measure	Baseline March 2019	Goal 5% increase
Increased % of Māori women, booked with an LMC by week 12 of their pregnancy	Māori: 55% Pasifika: 44% Other: 72%	Māori: 58% Pasifika: 46%
% of women who become smokefree over their pregnancy	Māori: 64%	Māori: 67%
% of infants exclusively or fully breastfed at 3 months	Māori: 43.0%	Māori: 45%

HOW WILL WE ACHIEVE IT?

- HBDHB Smoke free Service will engage with the Wairoa Whanake Te Kura ante natal programme to encourage and support Wahine Hapu to stop smoking during and after pregnancy. Wahine Hapu will be referred and enrolled on the Wahine Hapu – Increasing Smokefree Pregnancy 8 week programme
- Investigate 'opt-off' option for all Wahine Hapu identified as 'smokers' at booking in HBDHB Maternity services
- Increase Wahine Hapu referrals to the Wahine Hapu – Increasing Smokefree Pregnancy 8 week programme at >12 weeks pregnancy confirmation
- Analyse and report data collected as part of the māmā Māori interviews undertaken in 2018
- Set up CHB maternity resource centre supporting early engagement with midwife and local primary assessment centre

13.4

Youth are Healthy, Safe and Supported

SYSTEM LEVEL MEASURE: Youth access to and utilisation of youth appropriate health services

Youth have their own specific health needs as they transition from childhood to adulthood. Most youth in New Zealand successfully transition to adulthood but some do not, mainly due to a complex interplay of individual, family and community stressors and circumstances, or 'risk factors'. Evidence shows that youth are not in the habit of seeking the services or advice of a registered health practitioner when unwell. Generally they cope with illness with advice from friends and whānau as they see fit. Attending a health clinic is often viewed as a last resort instead of a reasonable first choice.

This measure focuses on youth accessing primary and preventive health care services. Research shows that youth whose healthcare needs are unmet can lead to increased risk for poor health as adults and overall poor life outcomes through disengagement and isolation from society and riskier behaviours in terms of drug and alcohol abuse and criminal activities.

Hawke's Bay has a Youth Strategy which conveys a shared vision for young people by identifying a common set of youth outcomes and indicators that cuts across the work of many organisations/services working with youth. The strategy aligns with the youth development approach, focusing on a balance between services designed to prevent, intervene or treat health problems as well as promoting development through preparation, participation and leadership experiences with youth.

The Hawke's Bay Youth Consumer Council has identified Alcohol and Other Drugs and Mental Health and Well-being as their two top priorities for the System Level Measure.

SLM Milestones:

Reduced Alcohol related ED presentations for 10-24 year olds

Baseline: Dec 2018 Māori 15%	2019/20 Milestone: Māori ≤ 14.3%

Reduced Self harm hospitalisations and short stay ED presentations for <24 year olds

	Baseline per 10,000 pop'n	2019/20 Milestone 5% change
Māori	79.8	Māori 75.0
Pasifika	39.6	
Other	58.0	
Total	65.6	

CONTRIBUTORY MEASURES

Measure	Baseline March 2019	Goal
Increase % of responses given to alcohol related presentation questions in ED	Māori 89% Total 91%	≤95%
% of schools with an alcohol policy	tbc	tbc
Increased utilization rate of youth services by 13-17 year olds	tbc	tbc

HOW WILL WE ACHIEVE IT?

- Rangatahi Service redesign; implement phase 1 of the youth strategy, complete youth workforce SWOT analysis and strategy development, develop new model of care across mental wellbeing continuum from mental distress to recovery
- Wairoa Social Supply Project - Locality project to reduce social supply of Alcohol to under 18 year olds
- Develop DHB responses to support effective employment outcomes for school leavers
- Alcohol free areas and events brand project – joint alcohol strategy with city councils
- Investigate ways to improve the quality of ED data collection

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PERSON & WHANAU CENTERED CARE

Late Paper

14

HAWKE'S BAY District Health Board Whakawāteatia	**Hoki Te Kainga – Early Supported Discharge**
	For the attention of: **HB Clinical Council**
Document Owner	John Burns – Executive Director of Provider Services
Document Author(s)	Allison Stevenson – Service Director Dr. Lucy Fergus – Acting Medical Director
Reviewed by	Alicia Smith – Acting Allied Health Director
Month/Year	June 2019
Purpose	For information only
Previous Consideration Discussions	Hoki te Kainga has been signed off and approved by HSLT and EMT
Summary	To develop a supported discharge team as an extension of AT&R (virtual ward) operating seven days a week, to facilitate a timely and coordinated discharge for people from AT&R and the medical and surgical wards who are medically/surgically stable, and have the real potential to continue to improve through ongoing, time limited support at home. The team will work with clients until their return to independence (up to six weeks), or until stable but requiring continuing input from community services. The key phrase is working with a patient, not doing do. Every activity is designed to increase the patients' independence. For ACC patients, ACC have historically paid the NAR (non-acute rehabilitation) contract on a bed day rate, and have come to realise bed days don't have a direct relationship to outcomes. Based upon the outcomes of the Waikato START programme they are changing the funding formula to drive ESD, with the result DHBs will be financially disadvantaged by keeping patients in hospital.
Contribution to Goals and Strategic Implications	• To provide a service that improves patient flow through the hospital and improves patient outcomes and satisfaction. • Decrease length of stay (LOS) and associated hospital acquired complications by returning home as soon as stable. • To provide a new philosophy of transfer of care (discharge) that integrates with all key community stakeholders. • Develop a service that aligns to the new ACC NAR funding formula. • Reduce readmission and increase time spent in their own home up to three months following discharge. • Drive Advance Care Planning in a high risk population. • Reduce the need for long term home care services.

	• Revitalising an under used workforce. Improve clinical outcomes and patient satisfaction for older people living with frailty.
Impact on Reducing Inequities/Disparities	A key focus be on building processes that formalise greater patient and whanau engagement, and ownership of their journey. Building on existing community services to develop services closer to home, that better meet the needs of Maori and the population as a whole. NZ literature has found Maori and Pacific receive significantly less help.
Consumer Engagement	Consumer engagement was untaken by ACC in their consultation process when changing contracts and by AT&R redesign consumer group. All groups fed into the setup of the new services.
Other Consultation /Involvement	ACC - The team has been working with ACC, Waikato DHB 'START' programme and Professor Matthew Parsons (UOA) to develop the proposed service. ACC contracted Professor Parsons to study and develop the framework and funding schedule for the new NAR (non-acute rehabilitation) contract. Maori Health AT&R Redesign group and work streams HBDHB Commissioning team
Financial/Budget Impact	attachment
Timing Issues	2019
Announcements/ Communications	• Internal • Key Stakeholders • Community Will need normal communications strategy

RECOMMENDATION:

It is recommended that the HBDHB Clinical Council:

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

Hoki te Kainga

Author:	Allison Stevenson – Service Director Dr Lucy Fergus – Acting Medical Director
Designation:	Service Director Acting Medical Director
Date:	**June 2019**

EXECUTIVE SUMMARY

To develop a supported discharge team as an extension of AT&R (virtual ward) operating seven days a week, to facilitate a timely and coordinated discharge for people from AT&R and the medical and surgical wards who are medically stable, and have the real potential to continue to improve through ongoing, time limited support at home.

Proposed Transformational Changes - for the Early Supported Discharge (ESD are:

- To provide a service that improves patient flow through the hospital and improves patient outcomes and satisfaction.
- Decrease length of stay (LOS) and associated hospital acquired complications by returning home as soon as stable.
- To provide a new philosophy of transfer of care (discharge) that integrates with all key community stakeholders.
- Develop a service that aligns to the new ACC NAR (non-acute rehabilitation) funding formula.
- Reduce readmission and increase time spent in their own home up to six weeks following discharge.
- Drive Advance Care Planning in a high risk population.
- Reduce the need for long term home care services.
- Revitalising an under used workforce.

This will be achieved by developing a supported discharge team operating seven days a week, who will provide home based rehabilitation and support for patients from AT&R and the acute services. These patients will be medically stable, able to mobilise to the toilet, and have the real potential to continue to improve through ongoing support in the home. The service will be provided for a maximum of six weeks, and initially up to four times a day.

The service will be provided as an extension of AT&R as a virtual ward.

Three NZ Randomised Controlled Trails and international studies have each demonstrated an average reduction on the length of stay (LOS) of 5.7 days and reduced six month readmissions by an average of 6.4 days per patient.

BACKGROUND

It is widely acknowledged that elderly patients quickly decondition on admission to hospital, resulting in loss of mobility, reduced psychosocial health, and significantly increased risk of developing hospital acquired complications. The literature strongly suggests that once a patient has recovered from their medical emergency and can mobilise from their bed, have better outcomes when discharged home with appropriate support.

The Audit Commission in the United Kingdom (UK) [6] described keeping older people living with frailty in hospital as a 'vicious circle' of spiralling costs, inefficient use of scarce resources and failure to enable older people to live as they prefer – independently in the community. Achieving safe discharge or transfer as soon as possible, while the initiating illness is resolving, is important both to the patient and the acute hospital service. Identifying a means to reduce the time an older person spends in hospital and also to avoid readmission following discharge is of considerable importance to Hawke's Bay DHB.

There are two studied supported discharge initiatives nationally (Waikato and Canterbury) and many internationally. These services target frail older people at risk of losing independence, following discharge from hospital. The participants often have multiple co-morbidities and frailty syndromes impacting on their physical, psychosocial, and cognitive health. These services include a qualified manager, nurse support and specially trained Health Care Assistants (HCA) who undertake up to four visits a day. Activities performed include supporting personal care, increasing activity, strength exercises, and other activities that promote independence, excluding tasks generally requiring a registered nurse. The HCAs are supported by weekly visits by an Registered Nurse to review the client, and other allied health staff as needed to assess and led by Multi-Disciplinary Team who review each patient weekly. The team can withdraw at six weeks of care or earlier if the patient can manage with conventional community services such as home care. Studies have consistently shown that on average clients are seen 28 times. They have found that significantly fewer patients are readmitted to hospital six months following discharge, and significantly higher numbers still at home at one year.

Proposal

A key principle of the service is to respond on the same day. On top of this, other equivalent services nationally have found the need for a clinician to be pulling patients early from the ward into the service (HoPE Registered nurse as per AT&R redesign project), in order to maximise the benefit and achieve the stated outcomes. Experience from other centres strongly suggests that this is a very different model of care, and hospital staff don't readily adapt to the concept a patient doing better at home rather than being cared for in hospital.

The ward staff will liaise with the Hoki te Kainga and arrange for a HCA to meet with the patient and family (where possible) on the ward before discharge. The referral will outline the client's goals that have mutually been set and agreed to by the client and their Key Worker on the ward.

Patients will be transported home in order of preference by (i) Family / friends; (ii) hospital arranged (iii) emergency transport or; lastly if no alternative is identified, the Hoki te Kainga worker will be expected to transport the client home.

In the first visit the Hoki te Kainga HCA will review the goals with the patient. The patient will be seen by a registered practitioner within 24 hours (week days). Direct clinical care responsibility returns to the General Practitioner with MDT support where/if appropriate.

Patients seen by the Hoki te Kainga service's HCA and who deviate from the anticipated pathway outlined in their goal plan, or who have triggered a response through the risk profile, are presented and discussed at the daily ward huddle for re-evaluation.

The team will work with clients until their return to independence (up to six weeks), or until stable but requiring continuing input from community services. Activities for instance could include, facilitating showering, bed making, progressively increasing walking distance, sit to stands, lying in bed to standing, carrying groceries home from shops and putting away in cupboards. The model focuses on maximising independence rather than fostering dependence. The key phrase is working with a patient, not doing do. Every activity is designed to increase the patients' independence.

The experiences from other centres indicate that the average length of care with the team will be four weeks. As with other services, clients will be limited to six weeks maximum attendance. Clients will be supported to develop meaningful distal goals which will be interpreted into a therapy ladder to support development of a care plan utilising functional rehabilitation principles. Hoki te Kainga Assistant will be capable of providing services to clients up to four visits a day, seven days a week with weekly (minimum) reviews by coordinators.

The Hoki te Kainga team will take an integrated approach to care, continuing to coordinating Allied Health support through engAGE, as well as District Nursing for wound care.

ACC partnership for ESD

ACC have historically paid the NAR contract on a bed day rate, and have come to realise bed days don't have a direct relationship to outcomes. Based upon the outcomes of the Waikato START programme they are changing the funding formula to drive ESD, with the result DHBs will be financially disadvantaged by keeping patients in hospital. ACC will fund an ESD programme at $183 per day for each patient, though have given assurance that in the short term we will not be financially disadvantaged as long as the programme is initiated. Furthermore they are keen to form a partnership with HBDHB to evaluate how the funding formula would work for a more rural population.

Way Forward

The next section sets out costs for such a service based upon the Waikato DHB START programme. It is proposed the bulk of the funding will come from ACC NAR funding ($125K, 2019) and the closure of five beds on AT&R ($373K. full year). However there will be a period between having a fully functioning service.

Rationale for closing 5 beds

Changes to date have realised increased productivity and outcomes

- Over 30% decrease in LOS and 25% increase in patient through put
- Combined with the implementation of a supported discharge service would see even greater savings

Financials:

Budget Based on Removing 5 AT&R Beds (Preferred Option)

	FTE	Cost
Rehab Assistant (CA Step 3)	4.0	188,455
CCDM FTE	2.5	Already funded
Nurse (RN Step 5)	1.5	108,443
Co-ordinator (Allied Step 10)	1.0	95,138
Administrator (Admin Step 3)	0.5	23,160
Project Management	0.8	88,000
Total	**10.29**	**503,196**

Budget

	2018/19	Ongoing
Set Up Costs		
12 iPhone 8s	12,903	
5 iPads	7,300	
3 PC	4,800	
1 Data Port	0	
1 Label Printer	600	
Personnel Costs	125,799	503,196
Operating		
3 Fleet Cars	8,550	34,200
Mobile Plan	1,260	420
Mobile Data	15	60
	161,227	**537,876**

Preferred Option

	2018/19	Ongoing
ACC Revenue (estimate)	125,086	500,345
Closing 5 Beds (staff reduced by 5.16 FTE RNs)	93,261	373,043
Reduction in current revenue	-62,715	-250,860
Tower Block bed day savings	0	
Additional AT&R Costs (non ACC ESDs)		
Total	**155,632**	**622,528.43**
	-$5,594.56	$84,652.81

Budget Based on Removing 10 AT&R Beds (Not preferred)

	FTE	Cost
Rehab Assistant (CA Step 3)	4.0	188,455
CCDM FTE	2.5	Already funded
Nurse (RN Step 5)	1.5	108,443
Co-ordinator (Allied Step 10)	1.0	95,138
Administrator (Admin Step 3)	0.5	23,160
Project Management	0.8	88,000
Total	**10.29**	**503,196**

Budget

	2018/19	Ongoing
Set Up Costs		
12 iPhone 8s	12,903	
5 iPads	7,300	
1 PC	4,800	
1 Data Port	0	
1 Label Printer	600	
Personnel Costs	205,149	503,196
Operating		
3 Fleet Cars	8,550	34,200
Mobile Plan	1,260	420
Mobile Data	15	60
	240,577	**537,876**

Preferred Option

	2018/19	Ongoing
ACC Revenue (estimate)	125,086	500,345
Closing 10 Beds (staff reduced by 10.33 FTE RNs) - 2.5 FTE to be utilised above	311,171	746,809
Reduction in current revenue	-104,525	-250,860
Total	**331,732**	**996,294.56**

$91,155.13 $458,418.91

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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:

17. **Minutes of Previous Meeting (Public Excluded)**
18. **Matters Arising – Review of Actions (Public Excluded)**
19. **Clinical Risk discussion**
20. **Topics of Interest / Member Issues**

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).