HAWKE'S BAY
District Health Board
Whakawāteatia

E83

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

2019/22 Statement of Intent

including 2019/20 Statement of Performance Expectations

Hawke's Bay District Health Board

OUR VISION

“HEALTHY HAWKE’S BAY”

“TE HAUORA O TE MATAU-A-MAUI”

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

OUR VALUES

HE KAUANUANU

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

ĀKINA

Continuously improving everything we do

RĀRANGA TE TIRA

Working together in partnership across the community

TAUWHIRO

Delivering high quality care to patients and consumers

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

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STATEMENT FROM THE CHAIR

Transforming Hawke's Bay's health system to better support a growing population and a healthier Hawke's Bay is a key priority for Hawke's Bay District Health Board. The DHB's third Health Equity report, released in December 2018, provided a stark reminder that constant attention, and new ways of working are needed to maintain progress to eliminate inequities in health.

In 2017/2018 the DHB advised one of its refreshed targeted areas of priority was the development of a regional health proposal, the Clinical Services Plan (CSP). This planning aligns with the New Zealand Health Strategy and its five themes – people powered, closer to home, value and high performance, one team and smart system.

From this, a new strategy has since been formed based on 12 months of free and frank discussions with people who live and breathe health care in Hawke's Bay – from health professionals, support groups and regular users. It provides a structured framework for the DHB to measure its progress to deliver and sets out *what* services will be delivered, *how* they will be delivered and *where* they should be delivered.

The DHB's priority is to now to work on the finer details of the strategy and its implementation. This significant piece of work looks at the whole of the health system and the transformation of our health services over the next 10 years. Guiding our integrated planning process, the strategy will provide the mandate for our work with communities and whānau to develop health services, and enable us to prioritise the activities and investment required to achieve equitable health gains in Hawke's Bay.

At the time of this report being published, the DHB's Statement of Performance and Statement of Performance Expectations was being reviewed with the Ministry of Health. Financial statements within this report will be updated once this review is finalised.

Kevin Atkinson

Board Chair – Hawke's Bay District Health Board

Dan Druzianic, Board Member

Hawke's Bay District Health Board

Hawke's Bay District Health Board

Who are we

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

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

Figure 1: Hawke's Bay District Health Board District

Funding and Provision of Services

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

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

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

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

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

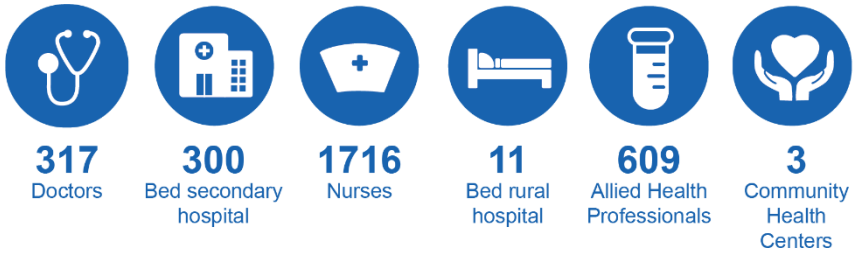
As a provider, we supply health and disability programmes and services for the benefit of our population and on referral for other DHBs' patients. This includes a full range of services from prevention through to end-of-life care that are provided through resources owned or employed directly by us. Where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

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

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

Organisational Overview

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



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

Our population

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

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

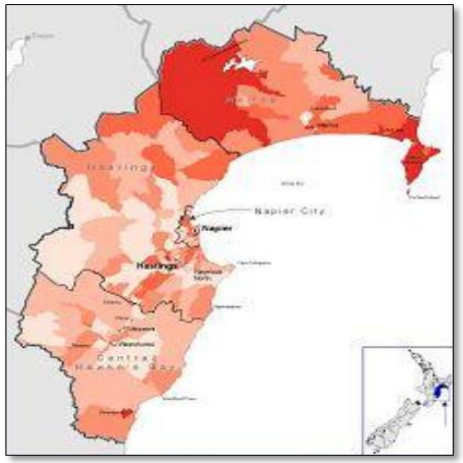


Figure 2: Hawke's Bay District relative deprivation – Darker colour higher deprivation, and lighter colour, lower deprivation update

Health Status

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

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

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

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

Key findings:

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

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

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

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

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

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

Section 1: Strategic Direction (SOI)

1.1 Strategic Outcomes

Why a health strategy?

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

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

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

Where are we at?

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

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

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

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

A focus on people

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

There are two priority population groups that we need to respond to: whānau with children, and older people. We need to support the whole whānau to achieve goals and aspirations and ensure children have the best start in life. At the same time, we recognise our population is ageing and we will step up our response to keep older people well at home and in their communities.

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

Our commitment to the Treaty of Waitangi

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

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

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

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

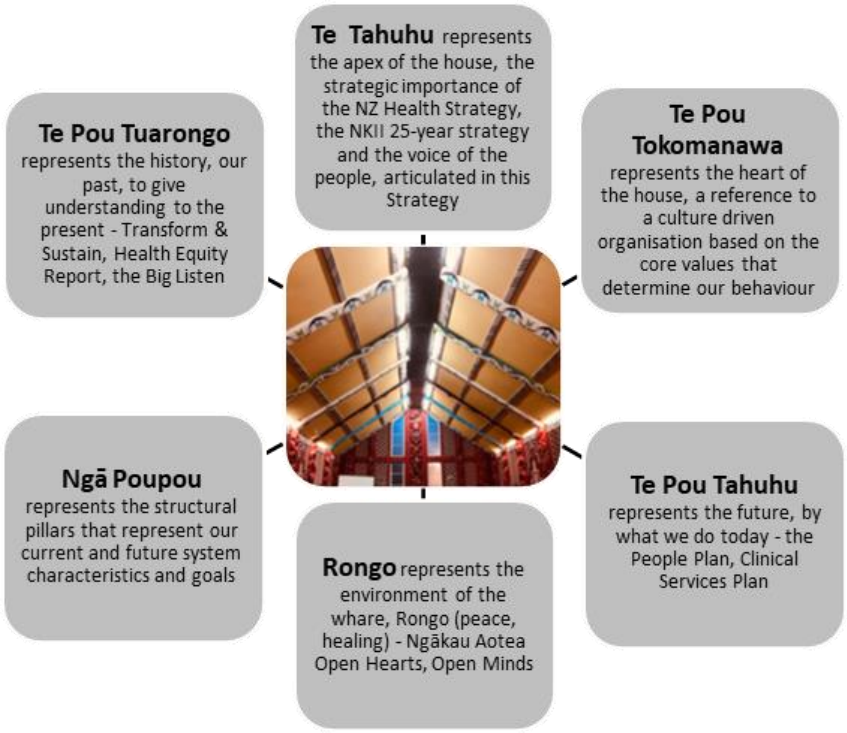
How does the Strategy fit with other plans?

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

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

Rūia taitea kia tū ko taikaka ānake

(Discard the sapwood to uncover the hardwood)



The wider context

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

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

Turning strategy into action

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

Population health outcomes

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

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

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

System goals

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

1. Pūnaha Ārahi Hāpori
Community-led system

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

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

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

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

5. Pūnaha Tōrire
Digitally enabled health system

Headline objective

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

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

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

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

Pūnaha Ārahi Hāpori Community-led system

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

Why is this important?

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

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

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

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

He Paearu Teitei me ōna Toitūtanga High performing and sustainable system

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

Why is this important?

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

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

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

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

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

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

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

Why is this important?

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

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

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

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

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

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

Why is this important?

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

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

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

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

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

Ngā Kaimahi Āhei Tōtika Fit-for-purpose workforce

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

Why is this important?

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

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

Pūnaha Tōrire Digitally-enabled health system

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

Why is this important?

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

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

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

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

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

Section 2: Managing our Business (SOI)

2.1 Managing our business

Organisational Performance Management

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

Strategic

- MoH – DHB Performance Monitoring
- HBDHB Strategic Dashboard.

Operational

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

General

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

Funding and Financial Management

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

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

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

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

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

This will require:

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

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

Investment and Asset Management

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

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

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

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

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

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

Risk Management

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

Quality Assurance and Improvement

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

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

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

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

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

Section 3: Statement of Performance Expectations (SPE)

3.1 Statement of Performance Expectations (SPE)

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

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

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

Service Performance

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

The system dimension: Best value for public health system resources

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

The population dimension: Improved health and equity for all populations

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

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

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

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

The HBDHB SPE for the 2019/20 year follows:

Board Member

Board Member

3.2 Output Classes

Output Class 1: Prevention

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

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

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

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

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

The output class tables have not been included in this statement pending agreement with the Ministry of Health. Refer Section 4 Financial Performance

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

Output Class 2: Early Detection and Management Services

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

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

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

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

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

The output class tables have not been included in this statement pending agreement with the Ministry of Health. Refer Section 4 Financial Performance

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

Short Term Outcome	Indicator	New Nomenclature	MoH Measure	Baseline					2019/20 Target
				Period	Māori	Pasifika	Other	Total	
Improved management of long-term conditions (CVD, acute heart health, diabetes, and stroke)	Proportion of people with diabetes who have good or acceptable glycaemic control (HbA1C indicator)	SS13	PP20	12m to Dec-18	34%	34%	48%	42%	≥60%
	% of the eligible population will have had a CVD risk assessment in the last five years	SS13	PP20	Five years to Dec-18	84%	80%	87%	86%	≥90%
Less waiting for diagnostic services	% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks)	SS14	PP29	Dec-18	NA	NA	NA	92%	≥95%
	% of accepted referrals for MRI scans who receive their scans within 42 days (6 weeks)	SS14	PP29	Dec-18	NA	NA	NA	90%	≥90%
Increase referrals of obese children to clinical assessment and family based nutrition, activity and lifestyle interventions	% of obese children identified in the B4SC programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	CW10	HT/SI5	6 months to Nov-18	98%	93%	94%	96%	≥95%
Improved youth access to health services - SLM	Total self-harm hospitalisations and short stay ED presentations for <24 year olds per 10,000	PH01	SI12	12 months to Dec -18	79.8	39.6	58	65.6	Māori ≤ 75.0
	% of ED presentations for 10-24 year olds which are alcohol related	PH01		12 months to Dec -18	14.6%	8.5%	12.1%	12.8%	Māori ≤ 14.3%
Amenable mortality - SLM	Relative rate between Māori and Non-Maori Non-Pasifika (NMNP)	PH01	SI9	2015	2.45 relative rate				≤2.5

Output Class 3: Intensive Assessment and Treatment Services

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

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

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

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

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

The output class tables have not been included in this statement pending agreement with the Ministry of Health. Refer Section 4 Financial Performance

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

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

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

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

Output Class 4: Rehabilitation and Support Services

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

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

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

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

The output class tables have not been included in this statement pending agreement with the Ministry of Health. Refer Section 4 Financial Performance

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

Section 4: Financial Performance (for SOI and SPE)

Hawke's Bay DHB's Statement of Performance and Statement of Performance Expectations was being reviewed with the Ministry of Health at the time the reports were published in compliance with the Crown Entities Act 2004. The financial statements will be updated once this review is finalised.