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HAWKE'S BAY DISTRICT HEALTH BOARD

ANNUAL PLAN 2017/18

Statement of Performance Expectations
2017/18

HAWKE'S BAY
District Health Board
Whakawāteatia

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 2017/18

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Office of Hon Dr David Clark

MP for Dunedin North

Minister of Health | Associate Minister of Finance

Mr Kevin Atkinson
Chair
Hawke's Bay District Health Board
Private Bag 9014
Hastings 4156

21 DEC 2017

Dear Mr Atkinson

Hawke's Bay District Health Board 2017/18 Annual Plan

To formalise ongoing accountability and to provide surety, I have approved and signed your DHB's 2017/18 Annual Plan.

I would like to thank you, your board, and the DHB's staff for their efforts in developing your Annual Plan for 2017/18. I also appreciate your DHB's significant efforts to provide valuable health services to the public in a challenging environment, and I am confident that we can work together to improve outcomes for the population.

I understand your DHB has planned a surplus for 2017/18 and for the following three years, which is commendable. I trust that you have contingencies in place to ensure you achieve this planned result for 2017/18.

As you deliver services for your population, keep in mind that I will shortly be providing a Letter of Expectations to DHBs for the 2018/19 financial year that will provide further clarity on my priorities for DHB planning, such as public provision of health services, improving access to primary care, reducing inequalities and improving mental health services.

Please note that approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry of Health. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

Please ensure that a copy of this letter is attached to any copies of your signed Annual Plan that are made available to the public. Thank you again for your leadership and efforts to deliver high quality and equitable health outcomes for your population.

I look forward to working with you in the future.

Yours sincerely

Dear Kevin
Merry Christmas
Best wishes
David.

Hon Dr David Clark
Minister of Health

cc Dr Kevin Snee, Chief Executive, Hawke's Bay District Health Board

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1 OVERVIEW OF STRATEGIC PRIORITIES

1.1 Strategic Intentions

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 2016-19 outlines our strategic intentions for the next four years 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: "Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community." We face challenges such as the growth in chronic illness, our aging population and vulnerability in a large sector of our community. Our strategy, Transform and Sustain, seeks to overcome these challenges. Our three long term goals are: everyone experiences consistent, high quality care; the health system is efficient and sustainable; and people live longer, healthier lives.

In 2016 Transform and Sustain was refreshed to ensure that we are closely aligned to the New Zealand Health Strategy and it's themes as shown in figure 1 below.

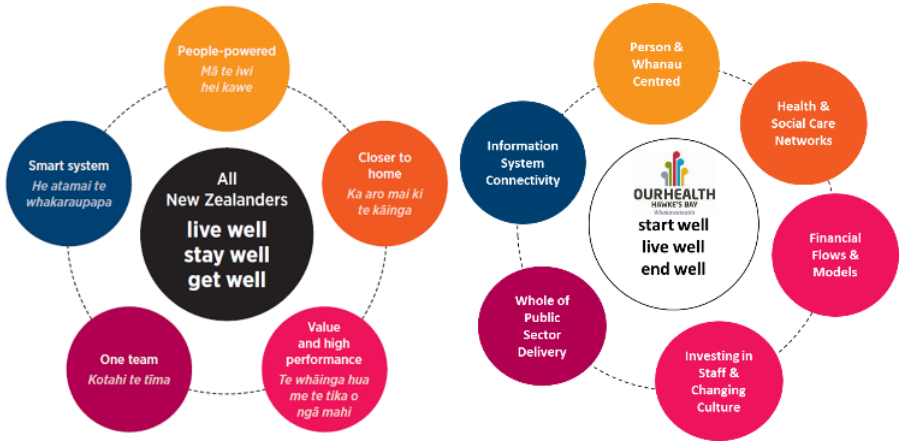


Figure 1: Transform and Sustain linked to the New Zealand Health Strategy themes.

We work collaboratively with our Central Region partners, our local primary health organisation (PHO), Health Hawke's Bay and other sectors for optimal arrangements. Using these relationships we have planned our contribution to the Government's priorities for the health system, which include fiscal discipline, working across government, and achieving the National Health Target.

HBDHB is committed to the UN convention on the Rights of Persons with Disabilities.

1.2 Our Population

The population of Hawke's Bay district has some unique characteristics compared to the rest of New Zealand in terms of health status and socio-demographics, and this provides us with some specific challenges. We have a higher proportion of Māori (26% vs 16%), more people aged over 65 years (19% vs 15%) (Statistics New Zealand, Summary of Resident Total Population Projections, 2018-2043; 2013 base) and more people living in areas with relatively high material deprivation (28% vs 20%)

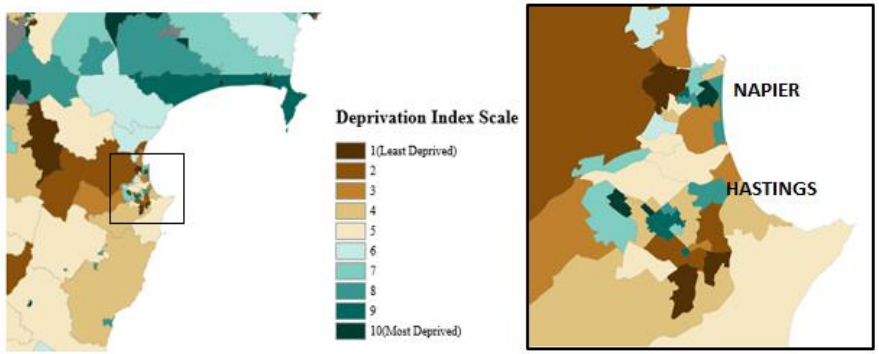


Figure 2: Hawke's Bay District relative deprivation NZDep13

Growth in the population is being driven by a younger age profile in the Māori and Pasifika population, which results in a higher birth rate, plus increased life expectancy across our whole population.

These projected population changes emphasise the need for HBDHB to maintain our focus on improving Māori and Pasifika health and to reorient our services to address and manage age-related health issues as guided by the New Zealand Healthy Ageing Strategy

Te Tiriti o Waitangi guarantees equitable health and social outcomes for everyone, and all Government agencies have a role in making sure that happens. The role and expectations of District Health Boards (DHBs) is emphasised in the New Zealand Public Health and Disability Act, 2000 (NZPHD Act) and HBDHB partners with Health Hawke's Bay to co-ordinate the delivery of publicly funded health care and wellness support services. DHB responsibilities are based on:

- **Partnership** – working together with Iwi, hapū, whānau and Māori communities to develop strategies for improving the health status of Māori.
- **Participation** – involving Māori at all levels of the sector in planning, developing and delivering of health and disability services that are put in place to improve the health status of Māori.
- **Protection** – ensuring Māori well-being is protected and improved, and safeguarding Māori cultural concepts, values and practices. This includes the elimination of Māori health disparities by improving access to services and health outcomes for Māori.

Mai, our Māori Health Strategy 2014-19 and our Pacific Health Action Plan 2014-2018 have been developed to align with the above principles and *Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018.*

In 2016 we updated the *Health Equity in Hawke's Bay* report, an analysis and report on health status in Hawke's Bay. 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 Hawke's Bay, 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. Since release, the findings of the report have been widely shared. The level of interest has been very positive and has led to the Hawke's Bay Intersectoral Forum, LIFT Hawke's Bay,[1] taking a role in developing a Social Inclusion Strategy to address priority areas. This multi-agency approach aims to bring a full range of relevant providers together with public, philanthropic and private funders to implement novel opportunities to integrate efforts that will address inequity as a community.

1.3 Long Term Investment

As a District Health Board, we have worked hard to create financial stability and use our internally generated funds to systematically invest in improved health services for our population. Looking forward, we aim to maintain this stability and continue to make smart investment decisions to meet the changing needs of the population.

Our Long Term Investment Plan (LTIP) outlines Hawke's Bay District Health Board's ten year investment plan based on a simplified outlook to the future from a local, regional and National perspective. In 2017/18 a Clinical Services Plan is being developed to best inform where we will need to prioritise future investment and the LTIP will be updated accordingly.

[1] Includes Mayors, Members of Parliament, Iwi, Local and Regional Councils, Business HB, EIT, Government agencies – Housing NZ; Police, Corrections, Ministry of Social Development, Ministry of Education, Te Puni Kokiri, DHB

Statement from the Chair and Chief Executive

Hawke's Bay District Health Board's Transform and Sustain, vision for the future, programme has been refreshed in 2017 to help the board achieve the outcomes it has prioritised.

The refreshed targeted areas of priority are consistent with the New Zealand Health Strategy and its five themes – people powered, closer to home, value and high performance, one team and smart system. The focus this year will help shape the future of health services in Hawke's Bay through its Clinical Services Plan and its people strategy, The Big Listen.

The Clinical Services Plan will transform services and where they are provided from. The plan is being co-designed with the input of consumers, primary care and secondary services, and will be completed in February 2018. Of greatest value, to this plan, is that it is being built up from primary care first as that is where most care is provided from.

Our people strategy is being informed through The Big Listen. Being well cared for, showing respect and kindness to one another within our organisation, and to our consumers and their families, is fundamental to The Big Listen.

Health targets remain a focus alongside continuing to provide a well-managed financial service through prudent management of resources. We are planning to deliver our eighth consecutive surplus, which enables the Board to reinvest in health services and infrastructure for its community.

Improving the health of our community can only be achieved with the support of many other groups of people and agencies including councils, government and non-government organisations working together. The district health board has worked closely with these groups to develop a Regional Economic Development Strategy (REDS) for Hawke's Bay as well as a pivotal piece of work called Social Inclusion. By working together this will help further reduce disparity and inequities in health and improve the health outcomes for our most vulnerable communities.

Dr Kevin Snee, Chief Executive

Hawke's Bay District Health Board

Kevin Atkinson, Board Chair

Hawke's Bay District Health Board

Hon. Dr David Clark

Minister of Health

2 DELIVERING ON PRIORITIES

This section outlines activity to improve performance against Government priorities, and our contribution to the Central Region's priorities. It provides a sense of our commitment of resources to implementing those priorities, how we coordinate our efforts, and how we will measure success.

Acknowledgement

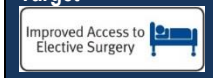
The 2017/18 planning process for this Annual Plan included setting up groups of stakeholders around each priority area. Accountability for collating each section was shared between co-leads from Health Hawke's Bay and HBDHB to ensure that there was PHO participation in the preparation of this plan. The public health unit and frontline clinicians played a vital role in developing the sections over the planning period in 2017.

Leaders from Māori and Pacific Health were consulted with at various stages in the planning process. Māori health priorities are indicated throughout the document and where possible, all measures will be reported on by ethnicity.

2.1 Government Planning Priorities

Government Planning Priority	Focus Expected for Hawke's Bay DHB	Link to NZ Health Strategy	Hawke's Bay DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
Prime Minister's Youth Mental Health Project	Commit to continue activity to deliver on the Prime Minister's Youth Mental Health Project.	Value and high performance	1. Complete proposal for group therapies in primary care, led by Child, Adolescent and Family Services (CAFS) clinician, working toward an increase in access to evidence-based intervention 2. Work collaboratively with NGOs to enhance capability and to reduce demand for secondary services 3. School Based Health Services (SBHS) in decile 1-3 secondary schools, teen parent units and alternative education centres, participate with mental health services working toward 'Youth One Stop Shop' 4. Explore ways to expand Kaupapa Māori services as part of the development of new 'Model of Care' for Primary Mental Health services	Q1, Q3 Q2, Q3 Q1-4 Q1	PP25: Prime Minister's Youth Mental Health Project
Reducing Unintended Teenage Pregnancy BPS (contributory activity)	Continue to build on the substantive activities identified in your 2016/17 annual plan to reduce unintended teenage pregnancy.	People powered	1. Train all SBHS nurses to use advanced standing orders for contraception. 2. Extend the SBHS to include a kaiāwhina in decile 1-3 schools 3. All nurses, both SBHS and primary and community, working under standing orders, have an annual update and assessment 4. Develop initiatives within the Sexual Health Governance Group action plan to better engage males in their reproductive health	Q4 100% trained Q3 Q4 100% completion Q4 5% increase in males accessing	PP38: Delivery of response actions agreed in annual plan (section 1)

			5. Monitor difference in access rates and teenage pregnancy rates by ethnicity following implementation of above initiatives.	Q1-4	
Supporting Vulnerable Children BPS Target	DHBs must commit to continue activity to contribute to the reduction in assaults on children.	One team	1. Violence Intervention Programme (VIP) Improvement Group to; establish aggregated quarterly reporting for all health service units; review quarterly report and provide operational support and leadership to services who wish to improve; establish a VIP improvement plan in each area 2. Develop a family violence screening KPI for Health Services to be implemented in 18/19 3. Extend scope of multi-agency Maternal Wellbeing and Child Protection Group to provide support for pregnant women and children up to 2 years(as opposed to 6 weeks as in the past)	Q1-4 Q4 Q1-4	PP27: Supporting Vulnerable Children
Healthy Mums and Babies BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, 90% of pregnant women are registered with a Lead Maternity Carer in the first trimester, with an interim target of 80% by 2019, with equitable rates for all population groups.	One team	1. Roll out consumer resource and public marketing campaign with 'Top 5 for my Baby to Thrive' and measure effectiveness of this. 2. Continue to build relationships with GP practices to facilitate seamless transition of care from Primary Care to Lead Maternity Carer	Q1 Q3 evaluation Q1-4	PP38: Delivery of response actions agreed in annual plan (section 1)
Keeping Kids Healthy BPS Target	Please identify two or three actions and associated milestones you will be undertaking that will support delivery of the target: By 2021, a 25% reduction in hospital admission rates for a selected group of avoidable conditions in children aged 0 - 12 years, with an interim target of 15% by 2019.	One team	1. Increase scope of the Oral Health Project to include a specific focus on reducing ASH rates. The project is generally focused on increasing carried free at 5 years but will now have a workstream designing a collaborative approach to reducing ASH 0-4 through early primary care intervention and investigating the incidence of children experiencing ASH for more than one condition and how they could be better coordinated for risk factors and advice, especially for Māori, Pacific and low decile populations 2. Use learnings from the successful adult respiratory programme, designed to reduce adult hospital admissions due to respiratory conditions, to tailor a paediatric programme and roll out to general practices by Q4.	Q1 Review of initial engagement Q2 Review of project progress Q4 Roll out to general practices	PP38: Delivery of response actions agreed in annual plan (section 1)
Increased Immunisation BPS and Health Target 	Continue current activity, in accordance with national immunisation strategies and service specifications, to maintain high (target) coverage rates for all immunisation milestones.	Value and high performance	1. Survey all child birth educators on their knowledge, confidence and activity around educating people of all cultures on immunisation 2. Meet all major milestones on the HPV immunisation communication plan to ensure a systematic process and avoid gaps in service delivery 3. Work with Māori providers and other organisations to improve their capability by; providing educations sessions; ensuring there are authorised vaccinators; providing support with the cold chain	Q2 Q1-4 Q3, Q4	Immunisation Health Target PP21: Immunisation Services

			4. Develop a 'how to' guide for general practice to enable correct recording of influenza vaccines to ensure these link to the National Immunisation Register (NIR) 5. Work with Kahungunu Executive to explore opportunities to increase capacity and capability for immunisation in Wairoa	Q3 Q4	
Shorter Stays in Emergency Departments Health Target 	Provide a prioritised list of the service improvement activities you will implement in 2017/18 to improve acute patient flow within your hospital(s).	**Value and high performance**	1. Develop project to re-set and implement the FLOW programme developed by the Francis Health Group to improve patient journeys using four key focus areas: a. High performing and supported Emergency Department b. Acute Assessment Unit(s) and ambulatory models of care c. improving our discharge systems d. effective processes in managing patients with frailty 2. Implement Internal Professional Standards (Medical Staff) 3. Implement a Nurse Practitioner led model of care 4. Revise general medical model of care 5. Primary Care ED Co-Operative Programme (PCED) to assist key general practices to develop and implement a new multidisciplinary model of care for high users of ED 6. Develop the functions within the Integrated Operations Centre with a focus on Patient Flow including; resource allocation: bed capacity; primary care communication. Develop Hospital at a glance screen, communication strategy and response for primary care in periods of escalation	Q1 ToR Q2 Q2 Q4 Q1 Review of pilot Q3 Further inform evaluation framework to be completed at pilot end Q4 Complete pilot Q4	ED Health Target
Improved Access to Elective Surgery Health Target 	Deliver agreed service volumes in a way that meets timeliness and prioritisation requirements and improves equity of access to services.	**Value and high performance**	1. Complete business case for surgical expansion project including the building of an 8th theatre, and deliver on agreed milestones for 2017/18 2. Go live with the equity focussed Mobility Action Programme. Monitor participants to ensure that the target population is being reached. If not, alter access criteria. Monitor outcomes through the steering group to inform and service development requirements. 3. Familiarise appropriate staff with the National General Surgery Prioritisation Tool and Implement Use 4. Review outpatient services specialty by specialty with a view to improve ESPI 2 and 5	Q2, Q4 Q2 # clients registered by ethnicity and quintile Q3 Average change in functional scores Q4 Q2	Electives Health Target MOH MAP reporting Elective Services Patient Flow Indicators OS3: Inpatient Length of Stay (Electives)

			5. Deliver 7574 elective discharges plus 35 additionals (17 General Surgery and 18 Orthopaedic Joints) 6. Continue to monitor theatre productivity, volumes and wait times via weekly Theatre Management Committee	Q4 Q1-4	Additional Orthopaedic and General Surgery initiative SI4: Standardised Intervention Rates Major Joint and Cataract procedures Electives and Ambulatory Initiative Bariatric Surgeries
Faster Cancer Treatment Health Target 	Identify the sustainable service improvement activities you will implement to improve access, timeliness and quality of cancer services.	**One team**	1. Review the use of electronic referral system, by GPs, for suspicion of cancer 2. Carry out activity post review; a feasibility study to make e-referral for high suspicion mandatory. This may change dependent on review findings. 3. Establish internal standards for: • Time frames from date of referral to multi-disciplinary meeting (MDM) and from MDM to decision to treat • Timeframes from referral to CT and from CT to CT report 4. Develop a protocol for consistent involvement of Clinical Nurse Co-ordinators in referral prioritisation to support identification of high suspicion cancer 5. Develop and implement an alternative pathway for benign breast, in collaboration with primary care 6. Broaden attendance (medical, surgical, radiology) at MDMs 7. Support or comply with Central Cancer Network (CCN) activities 8. Review options to establish an FCT navigator role in primary care to identify the at risk populations and to develop diagnostic pathways which enable equitable access	Qtr3 Review completed Q4 Post review activity Q2 Q1 Q2 Q2 Q1-4 Q3	Cancer Health Target PP30: Faster Cancer Treatment (31 day indicator) PP29: Improving waiting times for diagnostic services - CT & MRI
Better Help for Smokers to Quit Health Target 	Strengthening the DHB smoking cessation plan with input from primary care and smoking cessation providers.	**Value and high performance**	1. Implement the co-created Regional Tobacco Strategy 2. Review forms used in primary care patient management system to embed mandatory Smokefree fields 3. Provide benchmarking data and audit support for governance reporting to manage performance of the Health Target 4. Support high prevalence populations by providing sufficient training in Wairoa, expanding incentivised programme for young Māori women, monitoring referrals from GPs following the Early Engagement roll out and investigating cessation support tools e.g. 'vaping' 5. Support the establishment of the aligned cessation service, using input from providers and provide project support, development training and communication plans	Q1-4 Q2 Progress Report Q1-4 Draft Report Q2 Q1	Tobacco Health Target PP31: Better Help for Smokers to Quit in Public Hospitals

			6. Continue to screen inpatients in maternity services, offering support to quit for mothers and whānau and monitor Smokefree rates at discharge from Maternity Unit	Q1-4	
Raising Healthy Kids Health Target	Identify activities to sustain efforts and progress towards achieving the Raising Healthy Kids target by December 2017.	Closer to home	1. Close monitoring of progress against the Health Target 2. Monitor implementation of Healthy Conversation tools 3. Support collective action to reduce childhood obesity by implementing the Best Start: healthy eating and activity plan 4. Monitor family-based nutrition and lifestyle interventions including B4 school check, Be Smarter Goal Planning and Active Families under 5 years. Monitor % interventions, % of programme referrals engaged, % of engaged completing programmes. All by ethnicity. 5. Develop responses to equity issues or gaps identified via monitoring; include programme changes, identification of resources and increasing access	Q1 Meet target Māori and Pacific children equitably represented in referral Q2 Q3 Q2, Q4 Q1 # responses developed	Healthy Kids Health Target SI5: Delivery of Whānau Ora
Bowel Screening	Contribute to development activities for the national bowel screening programme, including: - engagement with the Ministry on operational readiness and IT integration - implementation of actions in line with agreed timeframes, incorporating quality, equity and timeliness expectations and IT integration activity - ensuring appropriate access across all endoscopy services.	Value and high performance	1. Commit to provide IT support of the National Bowel Screening Programme (NBSP) and work with the Ministry on IT integration 2. Engage with Hutt Valley DHB as our regional bowel screening centre 3. Establish local whole of sector project group for bowel screening to prepare for roll out of National Bowel Screening Programme (NBSP) in Hawkes Bay in 2018/2019 4. Develop an implementation plan, with the Health Equity Assessment Tool (HEAT) applied, which describes readiness for bowel screening roll out. This will include actions to sustainably meet colonoscopy wait time indicators. 5. Work with the Central Region equity champion for Bowel Screening to determine the best way to promote bowel screening in Māori and Pacific. Take learnings from other screening programmes in Hawke's Bay for engaging with Māori and pacific e.g working with iwi.	Q1-4 TBC Q1 Q4 Q4	PP29: Improving waiting times for diagnostic services – Colonoscopy National Bowel Screening quality, equity and performance indicators
Mental Health	Improve the quality of mental health services, including reducing the rate of Māori under community treatment orders.	One team	1. Monitor Compulsory Treatment Orders (CTOs) by ethnicity and continue with actions which have contributed to a decrease in CTOs for Māori; partnership with police; education of nurses and key workers to support whānau to understand legal issues and the process of CTO courts. 2. Explore written material which is used to explain these processes to whānau in other centres, with a view to using locally, if appropriate.	Q1-4 Q2	PP36: Reduce the rate of Māori on the mental health Act: section 29 community treatment orders relative to other ethnicities.
	Improve population mental health, especially for priority populations including vulnerable children,	Value and high	3. Establish a Pregnancy and Parenting Service: Assertive Outreach to vulnerable whānau experiencing drug and alcohol issues	Q2	PP38: Delivery of response actions agreed

	youth, Māori and Pacifica, by increasing uptake of treatment and support earlier in the course of mental illness, further integrating mental and physical health care, and co-ordinating mental health care with wider social services.		4. Use the recommendation from a recent review of primary mental health to formulate a plan to redesign services with a focus on psychological services; group programmes, nurse credentialing, and e-therapies	Q1	in annual plan (section 2)
			5. Initiate the Work Ready project: Investigate with key partners across the sector, (schools, tertiary education, social services, police and, Work and Income) opportunities to reduce alcohol and drug harm and addiction	Q4	PP26 PP8
			6. Implement, locally, the regional Adult AOD Model of Care pathway	Q1-4	
Healthy Ageing	Deliver on priority actions identified in the Healthy Ageing Strategy 2016, where DHBs are in lead and supporting roles, including: - working with ACC, HQSC and the Ministry of Health to further develop and measure the progress of your integrated falls and fracture prevention services as reflected in the associated Outcome Framework and Healthy Ageing Strategy - working with the Ministry and sector to develop future models of care.	**Closer to home**	1. Further integrate the new 'wrap around' model of care, "engAGE", with other service providers, including primary care and St John and use learnings from kaumātua meetings to improve services for older Māori	Q3	PP23: Improving Wrap Around Services – Health of Older People
			2. Work with ACC to implement a sector wide co-ordination programme to reduce falls and harm caused by falls, ensuring people receive the right care in the right place as per the associated Outcome Framework and Healthy Ageing Strategy	Q1, Q3	
			3. Maintain the hospital Falls Minimisation Committee to co-ordinate HQSC work programmes and monitoring	Q1-4	
			4. Promote the regional infographic on older people and utilise benchmarking information to inform local service planning	Q1-4	
			5. Implement relevant actions to deliver the DHB's Regional Service Plan commitments	Q1-4	
			6. Use Interai data to identify any equity issues	Q1	
			7. Work toward addressing prioritised equity issues	Q2-4	
			8. HBDHB will continue to work with HCSS providers to implement Part B of the In-between Travel settlement.	ongoing	
Living Well with Diabetes	Continue to implement the actions in *Living Well with Diabetes – a plan for people at high risk of or living with diabetes 2015-2020* in line with the Quality Standards r Diabetes Care.	**Closer to home**	1. The Stanford Programme for self-management of chronic disease will be offered by general practice, to people who are diagnosed with pre-diabetes	Q2 4 sessions	PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services
			2. Pre-diabetes patients (meeting inclusion criteria) will be offered participation in the PIPI programme (primary care nurses offering nutrition and lifestyle support)	Q1-4	
			3. Establish audit and reporting processes for both retinal screening and podiatry services for medium to high risk patients	Q2	
			4. All general practices will develop an annual Diabetes Care Improvement Plan (DCIP) with a focus on the delivery of quality care to their respective diabetes population.	Q2 28 practices with plans signed off	
			5. Build capability of our primary care nursing work force by developing outcomes based goals and a role structure for CNS shared care with primary care	Q2	

			6. Analyse diabetes population by monitoring of HbA1c across general practice through provision of trend reports. This will inform the focus to increase services for Māori 7. Review model of care in specialist diabetes services to identify gaps and opportunities specifically relating to sustaining CNS workforce capability and capacity.	Q4 Q2 review completion Q3 actions post review	
Childhood Obesity Plan	Outline the initiatives you are delivering, and where these links with the RCO plan (eg, active families): - how these initiatives will specifically address equity - what milestones are expected by when in 2017/18, and how success will be measured against these.	**Closer to home**	1. Implement the activities identified for 2017/18 from the Best Start; Healthy Eating and Activity Plan (Childhood Obesity Plan for HBDHB) to deliver a coordinated health sector approach to childhood healthy weight. Integrate activity supporting Raising Healthy Kids target and oral health 2. Contract local providers to deliver maternal nutrition and activity programme, Active Families and Green Prescription – with an equitable health outcomes focus 3. Develop with key community partners, a schools programme (5 to 10 year olds) for schools in high deprivation communities and trial in schools with a clear focus on Māori and Pasifika children and their whānau. Programme will include key messages – water only, 60 minutes a day, and healthy eating reflecting national nutrition guidelines 4. Coordinate existing programmes and address gaps - to develop/support healthy eating and activity environments in early childhood education settings (ECEs). Include Oral Health, Hauora Services, Ministry of Education and community providers 5. Promote reductions in sugar for children, via key settings (ECEs, schools, family friendly events, sport clubs) and in messaging (national programmes and locally produced resources). Include: water only, not using sugary food/drink as rewards, healthy lunch boxes. Also include Healthy Heart programme.	Q3 # of planned activities completed Q2 All Contracts include equity targets and monitor behaviour change Q1 development Q2 trial Q1, Q3 Q1, Q2	PP38: Delivery of response actions agreed in annual plan (section 2)
Child Health	Undertake planning and diagnostic work to identify barriers for accessing timely care for young people and their families who are served by Oranga Tamariki. Commit to support national work under way to improve the health outcomes for children, young people and their families serviced by Oranga Tamariki, particularly young people in care.	**Value and high performance**	1. Implement Ngātahi – Vulnerable Children's Workforce Development Project, aligning Education, Health, MSD and other workforces, to identify and address gaps in knowledge and skills of the vulnerable children's workforce in Hawkes Bay in order to work effectively with families and improve outcomes (particularly for tamariki and rangatahi Māori and their whānau) 2. Expand Maternal Wellbeing and Child Protection Multiagency Group to two years postnatal age – see Supporting Vulnerable Children 3. Implement Parenting and Pregnancy (maternal addictions) programme within Mental Health and Addiction Service – see Mental Health	Q2 :Mapping staff skills against core competencies by all agencies working with vulnerable children Q3: Training plan developed post aggregation of data from agencies Q2 Q2	PP38: Delivery of response actions agreed in annual plan (section 2)

Disability Support Services	Identify the mechanisms and processes you currently have in place to support people with a disability when they interact with hospital based services (such as inpatient, outpatient and emergency department attendances).	One team	1. Representatives for physical and sensory disability and also for intellectual and neurological disability are required on Consumer Council 2. Co-location of Mental Health Emergency services with Emergency Department 3. All new reception builds have a lower section to the counter 4. Allied health departments have tools to support communication, movement, and activities of daily living but use is dependent on request from staff for support tools or assessment	N/A	PP38: Delivery of response actions agreed in annual plan (section 2)
Primary Care Integration	DHBs must describe activity to demonstrate how they are working with their district alliances to move care closer to home for people through improved integration with the broad health and disability sector	Closer to home	1. Develop a guideline for transferal of resource to support capability and capacity in primary care 2. Chief Information Officer(CIO) HBDHB, with input from Health Hawkes Bay, to inform future integration platforms for Information Technology 3. Initiate project to investigate ways of incentivising improved primary care outcomes 4. Promote joint sector wide clinical leadership and clinically led decision-making through the HB Clinical Council monthly meetings, on behalf of the Alliance Leadership Team 5. Under the Transform and Sustain programme; further develop a structure for implementing localised prioritised projects: Health and Social Care Localities. a. Two seed localities established b. Alignment with regional economic development strategy and social inclusion strategies c. Priority areas identified by each seed locality d. HB wide Steering group formed e. Review of current governance /advisory structures 6. Investigate further IT tools which will provide increased compatibility and utility with localisation of collaborative pathways 7. Increase scope of the Oral Health Project to include a specific focus on reducing ASH rates 0-4 for Māori children. The project is will now have a workstream designing a collaborative approach to reducing ASH 0-4 through early primary care intervention and investigating the incidence of children experiencing ASH for more than one condition and how they could be better coordinated for risk factors and advice, especially for Māori, Pacific and low decile populations	Q4 Q1 CIO Project plan reflects primary care input Q4 Options and recommendations tabled Q1-4 All service level advisory groups are linked to cross-sector clinical leadership and to consumer input a Q1 b Q2 c Q3 d Q4 e Q4 Q3 Trial and evaluation Q2 Early intervention developed Q3 Early intervention implemented	PP22: Delivery of actions to improve system integration including SLMs

	Please reference your jointly developed and agreed with all appropriate stakeholders System Level Measure Improvement Plan that is attached as an Appendix	Value and high performance	8. Work with our stakeholders toward our jointly developed and agreed System Level Measure Improvement Plan. See Appendix	Q2	PP22: Delivery of actions to improve system integration including SLMs
Pharmacy Action Plan	Commit to implement any decisions made during 2017/18 in relation to the new national pharmacy contracting arrangements	One team	1. Support local implementation of national contracting arrangements once agreed 2. Align 'Community Based Pharmacy Services in Hawke's Bay Strategic Direction 2016 – 2020' with the Ministry of Health's Pharmacy Action Plan (PAP) 3. Work with Health Hawkes Bay to strengthen pharmacy representation at governance and service development level	Q1 85% signed up Q2 Q2 Q4	PP38: Delivery of response actions agreed in annual plan (section 2)
Improving Quality	Demonstrate, including planned actions, how you will improve patient experience as measured by the Health Quality & Safety Commission's national patient experience surveys. You can do this by selecting one of the four categories of the adult inpatient survey to focus on and providing actions to improve patient experience in this area. Commit to either establish (including a date for establishment) or maintain a consumer council (or similar) to advise the DHB.	Value and high performance	1. Maintain front-line ownership of improvement targets by directorate leadership, with oversight provided by Clinical Council representing sector wide clinical leadership 2. Support the ongoing National Patient Experience Survey, supporting the rollout to Primary Care. Focus on "Co-ordination" area relating to discharge planning with the implementation of a number of improvement work streams ensuring patients have sufficient information at discharge. 3. Develop and implement a local patient experience survey, and set of processes to utilise results alongside the National Patient Survey 4. Develop and implement a Consumer Engagement Framework to provide tools to staff and achieve greater consistency across the sector on how and when we engage and partner with consumers 5. Implement and initiate Health Literacy programme of work 6. Maintain and support Consumer Council to advise HBDHB board	Q1-4 Q3 Q3 Q1 Q1 Q1-4	PP38: Delivery of response actions agreed in annual plan (section 2)
Living Within our Means	Commit to manage your finances prudently, and in line with the Minister's expectations, and to ensure all planned financials align with previously agreed results.	Value and high performance	1. HBDHB commits to managing our finances to allow for investment in new and more health initiatives. Our strategic direction, agreed with the MOH, is to provide an average of $3m surplus over six years commencing 2015/16. This surplus is required to enable us to continue to invest in various infrastructure initiatives required to meet the needs of our community and progress Transform and Sustain.	Q1-4	Agreed financial templates.
Delivery of Regional Service Plan	Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan priorities of: - Cardiac Services	NA.	1. Commence development of a staged business case for percutaneous coronary intervention for HBDHB, in conjunction with the central region 2. Contribute to the review and confirmation of the delivery of after hours on call rosters across the region. Achieve 8% or more of eligible patients are thrombolysed.	Q4 Q1-4	NA.

	- Stroke - Major Trauma - Hepatitis C.		3. Continue work on agreed regional clinical guidelines and inter-hospital transfer processes to manage major trauma patients within the region 4. Provide clinical representation on the Central Region Trauma Network to participate in and support the work programme to achieve a contemporary trauma system within the Central Region 5. Work with Central Region community Hepatitis C service to ensure all people living with or at risk of Hepatitis C have access to information, testing, assessment and treatment, as appropriate 6. Support the implementation and use of a clinical healthcare pathway, for identification, assessment and treatment of patients with Hepatitis C	Q2, Q4 Q1-4	

2.2 Financial Performance Summary

(Refer to Appendix A for further detail)

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***	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Ministry of Health - devolved funding	487,400	504,939	515,810	530,598	546,367	562,185
Ministry of Health - non devolved contracts	4,395	4,578	13,930	14,222	14,505	14,810
Other District Health Boards	11,455	11,608	12,291	12,550	12,800	13,069
Other government and Crown agency sourced	5,933	6,163	5,646	5,765	5,880	6,003
Patient and consumer sourced	1,313	1,232	1,321	1,349	1,376	1,405
Other	6,616	5,662	5,245	4,727	5,039	5,529
Operating revenue	517,113	534,182	554,243	569,211	585,967	603,001
Employee benefit costs	187,322	197,475	211,514	217,435	224,177	230,906
Outsourced services	15,116	18,524	14,469	14,773	15,068	15,384
Clinical supplies	44,463	41,113	36,626	34,601	32,391	31,314
Infrastructure and non clinical supplies	45,990	45,977	51,411	53,177	54,966	56,240
Payments to non-health board providers	219,856	227,493	238,724	246,725	256,366	266,157
Operating expenditure	512,747	530,582	552,743	566,711	582,968	600,001
Total comprehensive revenue and expense	**4,366**	**3,600**	**1,500**	**2,500**	**3,000**	**3,000**

Table 1: Projected Statement of Comprehensive Revenue and Expense

Projected Summary of Revenues and Expenses by Output Class ***For the year ended 30 June*** *in millions of New Zealand Dollars*	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Prevention services						
Revenue	10.5	10.6	10.4	9.8	10.2	10.6
Expenditure	10.1	9.5	9.5	9.8	10.2	10.6
	0.4	1.1	0.9	-	-	-
Early detection and management						
Revenue	112.7	119.1	121.7	126.2	131.2	136.6
Expenditure	110.5	117.2	122.2	126.3	131.3	136.5
	2.2	1.9	(0.5)	-	-	-
Intensive assessment and treatment						
Revenue	321.4	331.2	338.4	346.8	354.8	362.8
Expenditure	320.4	331.1	337.6	344.3	351.8	359.8
	1.0	0.1	0.8	2.5	3.0	3.0
Rehabilitation and support						
Revenue	72.5	73.3	83.7	86.3	89.8	93.0
Expenditure	71.7	72.8	83.4	86.3	89.8	93.0
	0.8	0.5	0.3	-	-	-
Net Result	**4.4**	**3.6**	**1.5**	**2.5**	**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 ($10.8m, $14.3m, $17.1m,and $18.9m in 2017,2018,2019,and 2020 respectively) will be reclassified and could affect any line in any output class.

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

2.3 Local and Regional Enablers

Local and Regional Enabler	Focus Expected for Hawke's Bay DHB	Link to NZ Health Strategy	Hawke's Bay DHB Key Response Actions to Deliver Improved Performance		Measures
			Activity	Milestones	
IT	Demonstrate how the DHB is regionally aligned and where it is leveraging digital hospital investments. State when CPOE will be implemented. Complete ePA and nursing documentation implementations.	Smart system	1. Focus on implementation of the Regional Health Informatics Programme (RHIP): Engage with TAS to agree on an implementation plan and timeline for Orion Clinical Portal. Agreed plan and timeline including implementation of clinical forms (including nursing) in first stage 2. Develop a timeline for commencing implementation of ePA (Medchart) 3. Primary Care Clinical Portal: Roll out implementation of the provider portal for district nurses (providing full access), to additional providers and their services 4. Event Reporting System: Select preferred provider and initiate project 5. Telephone Successor System: Initiate planning work for co-design and contract activities	Q2 Q2 Q4 Q2 Q4	Quarterly reports from regional leads.
Workforce	Identify any particular workforce issues that need to be addressed at a local level around capability and capacity (numbers) and include key actions and milestones.	One Team	1. Establish a new 'People Strategy' to enable achievement of the overarching Transform & Sustain strategy in driving culture change across the organisation. Develop a reporting framework and key performance indicators 2. Prioritise the development of a local training hub to ensure effective delivery of training across the sector in order to increase capability 3. Initiate a focus on all Māori staff to ensure effective retention strategies are fully in place 4. Reduce inequity for staff paid below living wage through a variety of initiatives including training and health and wellbeing	Q1 Q2 Q1 Q3	
	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy.		1. Monitor the impact of the settlement agreement including guaranteed hours and workforce training for our kaiāwhina workforce	Q1, Q3	PP23: Improving Wrap Around Services – Health of Older People

Workforce	Identify actions to regularise and improve the training of the kaiāwhina workforce in home and community support services as per Action 9a of the Healthy Ageing Strategy	One Team	2. Monitor the impact of the settlement agreement including guaranteed hours and workforce training for our kaiāwhina workforce	Q1, Q3	PP23: Improving Wrap Around Services – Health of Older People

3 SERVICE CONFIGURATION

3.1 Service Change

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

Change	Description	Expected Benefits	Local, Regional or National
Urgent Care	In partnership with general practices and emergency department implement Urgent Care Service improvements.	More consistent and effective access to appropriate urgent care across the district. Reduce hospital admissions and improve equity.	Local
Primary Mental Health	A redesign of primary mental health services 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
Adults Alcohol and Other Drugs (AOD) model of care implementation	Implementation of change management plan for an Adult AOD Model of Care pathway across six Central Region DHB's. As well as residential options, the model includes: Withdrawal management; Respite/stabilisation; Adult AOD peer support; Whānau Ora approaches to care.	Improved care continuity for AOD service consumers Improved access for Māori and Pacific populations Enable provision of services under the proposed Substance Addiction (Compulsory Assessment and Treatment) Bill to be implemented in 2017/18.	Regional
Community Pharmacy and Pharmacist services	Implement the national pharmacy contracting arrangements and develop local services once agreed	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.	National & local
Laboratory Services	Maintaining safe, accessible laboratory services may lead to a change in the range of laboratory services available 24/7 at all current delivery sites.	Service coverage expectations for clinically-appropriate laboratory tests will be emphasised. Better use of health system resources.	Local
Surgical Expansion Project	Project to expand HBDHB surgical in-house capacity to better meet elective health targets and HB population surgical needs.	HBDHB able to better meet elective health targets and population surgical needs in-house and within in budget.	Local
Ophthalmology – Glaucoma	Utilising community optometrists via a shared care model to conduct glaucoma follow ups.	Increased clinic capacity and reduced clinical risk for glaucoma patients	Local
Youth Services	Youth service redesign process continues from 2016 and is a focus for 2017/19. This is based on the HBDHB youth health strategy 2016-19	Better access for youth. Services designed with input from youth and stakeholders.	Local
	U18 free access to General Practice Services for high needs youth population i.e. Māori, Pasifika.	67% of the 13-17 year population will have access to free primary care (in and out of hours).	Local
	Completion by General Practice of Youth Friendly Primary Care assessment tool.	General practice can be more responsive and receptive to the needs of Youth population.	Local
Model of Care (primary)	Funding allocated by PHO/DHB to support the development of models of care that support patient / relationship centred practice.	Patient care models that demonstrate – consumer input into model of care and priority areas that will lead to heightened self-management and improved health outcomes particularly for Long Term Conditions	Local

		Models will demonstrate utilisation of multidisciplinary and interdisciplinary team approaches and increased utilisation of the nursing workforce as clinical leads in primary care provision	
Long Term Conditions (LTC) Management	LTC Framework developed for implementation to begin May 2017	More consistent and effective approach to manage LTC and support self-management	Regional
Health and Social Care Localities	Providing integrated service models specific to geographical localities based on local identified health needs	Consumers accessing appropriate services closer to their home	Local
Faster Cancer Treatment	From 1/07/2017 HBDHB will be repatriating from MidCentral DHB all Hawke's Bay delivered volumes. This will involve the; Redesigning of our oncology service model and redesign and refurbishing of our buildings.	More streamlined services working toward meeting the FCT target	Regional

Service Integration

In line with Transform and Sustain 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.

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4 STEWARDSHIP

Our transform and sustain programme is showing good results. We are making significant improvements in delivering services for patients, achieving more equitable health outcomes and improving staff engagement. Initiatives such as Acute Inpatient Management 24/7 (AIM 24/7) and others focusing on our after-hours services, theatre productivity, mental health model of care and health of older persons services, are all delivering significant improvement across the sector. These improvements are being achieved within our current funding. In addition, our engagement with and commitment to the Health Quality and Safety Commission's programmes – specifically, Quality and Safety Markers (QSMs), Quality Accounts, and Patient Experience Indicators – provide the public with evidence and transparent links comparing our performance to national benchmarks and declarations about the quality of the services we fund and provide.

4.1 Managing our Business

Processes for Achieving Regular Financial Surpluses

Closing the gap between planned expenditure and expected income is normal business in the health system. As the world economic environment puts even more pressure on all Government spending, Hawke's Bay DHB, as the lead Government agent for the Hawke's Bay public health budget, must continually look for ways to live within an expectation of lower funding growth.

Hawke's Bay DHB continues with its strategic direction to provide a year-on-year surplus. This surplus is required to enable us to continue to invest in various infrastructure initiatives required to meet the needs of our community.

We continue with our strategy of responsible reduction in our cost base by

- Stopping doing things that are clinically ineffective of for which there is insufficient supporting evidence
- Doing things more efficiently by redesigning processes to drive out waste or errors
- Embracing opportunity to enhance quality by providing better care with the available resources

Our focus on reducing our cost base together with opportunities to increase our revenues will produce additional resources for our transformation program.

Financial Management

HBDHB's key financial indicators are budget variance, forecast surplus, sustain savings plan progress, major capital projects, and use of contingency. These are assessed against and reported through HBDHB's performance management process to District Health Board, Finance Risk and Audit Committee and Executive Management Team on a monthly basis.

Shifting Resources

To ensure that our change in focus is also matched by a shift of resources, we have agreed measures to monitor changes in deploying resources over time from specialised hospital services into primary and community services.

The shape of the curve will change, with the care models fundamentally transformed to enable more effective deployment of resources. This is not about shifting resources from one provider to another, but rather it is about changing the service model.

Investment and Asset Management

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.

Formal asset management planning is undertaken at HBDHB. We have developed a 10 year long term investment plan which outlines our planed asset expenditure in the absence of a clinical services 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.

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

- Ministry of Health – DHB Performance Monitoring
- HBDHB Transform and Sustain Strategic Dashboard.

Operational

- Exceptions Report on Annual Plan performance
- Exceptions Report on Annual Māori Health Plan
- 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
- Transform & Sustain Projects Progress

Shared Services

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. During 2017/18 HBDHB will be implementing a new integrated risk management system to further enhance and promote the regular identification, monitoring and management of risk.

Quality Assurance and Improvement.

Delivering consistent high quality care continues to be one of the key themes and enablers to achieving our Transform and Sustain strategy. The Working in Partnership for Quality Healthcare in Hawke's Bay framework identified clinical leadership and consumer partnership throughout the health sector as the most important aspect of improving quality health care and patient safety. We use our framework to align our local efforts in support of the national quality improvement work coordinated by the Health Quality and Safety Commission (HQSC). The Quality Improvement and Patient Safety (QIPS) team provide support for integrated quality improvement and performance across the Hawke's Bay health sector and help clinical teams to recognise and define priority areas and to identify actions for implementation. Our focus for the coming year will be on continuing to sustain the improvements made in the past twelve months and implementing our Health Literacy Framework and Consumer Engagement Strategy, enabling a shift in the culture to becoming far more person and whānau centred

4.2 Building Capability

Workforce

The health system needs skilled clinical leaders, team leaders and managers in place to support team performance so that we can achieve transformation. Our teams must continually focus on providing excellent services, improving health and well-being, working in partnership and improving equity, and they must be empowered to try new ways of doing things. This applies to service delivery and support functions. We are working together to support and develop the workforce and the organisations.

Development of a new workforce development framework and strategy focussing on our medical, nursing, allied, support and management and administration workforces.Our Child Protection Policies comply with the requirements of the Vulnerable Children Act, 2014. A copy is available from our website: www.Hawkesbay.health.nz

Communications

The communications team is committed to looking at new and fresh ways to engage successfully with our community and our staff. We challenge our staff to think about effective strategies and how best to communicate them so people can better manage their way through the complexities of the health system. We are always looking to help staff promote new ideas and new initiatives through more effective and compelling communication.

Health Information

In transforming the health system, one of the biggest challenges we face is developing an information system that matches our ambitions for service integration. We are working with our regional partners to deliver a regional health informatics strategy to support improvements in Information Communication Technology (ICT) over the outlook period. The Central Region ICT vision is about the efficient delivery of the right information to the right people at the right time, on an anywhere, anyhow basis to achieve the desired health outcomes and improved organisational performance

Achieving the region's vision for health informatics will contribute to improved consumer experience, better support for clinicians and other health professionals and more integrated care.

There are many areas that require better ICT support and we recognise the importance of rigorous investment to achieve this. We have developed and information systems strategy and a business intelligence work plan to underpin and complement Transform and Sustain.

Inter-Agency Collaboration

Hawke's Bay District Health Board is working closely with other agencies to improve outcomes for the population through 'LIFT Hawke's Bay – Kia Tapatahi'. The group is working towards a common vision: Hawke's Bay is a vibrant, cohesive and diverse community, where every household and every whānau is actively engaged in, contributing to, and benefiting from, a thriving Hawke's Bay". Two strategies being developed and implemented through this forum are the Regional Economic Development Strategy and a Social Inclusion Strategy.

Note A: Subsidiary Companies and Investments

Currently, there are no subsidiary companies in which HBDHB has a controlling interest[2] and HBDHB has no plans to acquire shares or interests in terms of section 100 of the Crown Entities Act 2004. HBDHB has an interest in one multi-parent subsidiary: Allied Laundry Services Limited. Other shareholders are MidCentral DHB, Taranaki DHB, Whanganui DHB, Capital and Coast DHB and Hutt Valley DHB. Allied Laundry Services Limited has an exemption from producing a Statement of Intent (SOI). MidCentral DHB will report on Allied Laundry Services Limited in its SOI, on behalf of Hawke's Bay, Taranaki and Whanganui DHB

Note B: HBDHB has a Health and Safety Policy detailing our commitment to providing a safe and healthy environment for all persons on our sites and business. The policy incorporates the Board-approved Health and Safety Statement which is reviewed every 2 years. The last review was in April 2014.

[2] As defined in section 58 of the Companies Act 1993

5 PERFORMANCE MEASURES

5.1 2017/18 Performance Measures

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:

Code	Dimension
PP	Policy Priorities
SI	System Integration
OP	Outputs
OS	Ownership
DV	Developmental – establishment of baseline (no target/performance expectation is set)
SLM	Inclusion of 'SLM' in the measure title indicates a measure that is part of the 'System Level Measures' identified for 2017/18.

Performance measure	Performance expectation	
HS: Supporting delivery of the New Zealand Health Strategy	Quarterly highlight report against the Strategy themes.	
PP6: Improving the health status of people with severe mental illness through improved access	Age 0-19 Age 20-64 Age 65+	
PP7: 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.	
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	80% of people seen within 3 weeks. 95% of people seen within 8 weeks.	
PP10: Oral Health- Mean DMFT score at Year 8	Year 1: ≤0.96 Year 2: ≤0.96	
PP11: Children caries-free at five years of age	Year 1: ≥64% Year 2: ≥64%	
PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)	Year 1: 85% Year 2: 85%	
PP13: Improving the number of children enrolled in DHB funded dental services	Number of Pre-School Children Enrolled in DHB-funded Oral Health Services	Year 1: 95% Year 2: 95%
	Number of Enrolled Pre-School and Primary School Children Overdue for their Scheduled Examinations	Year 1: 10% Year 2: 10%

Performance measure	Performance expectation
PP20: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)	**Focus Area 1: Long term conditions** - Report on activities in the Annual Plan. **Focus Area 2: Diabetes services** - Implement actions from Living Well with Diabetes - Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1C indicator). **Focus Area 3: Cardiovascular health** - 90% of the eligible population will have had their cardiovascular risk assessed in the last 5 years. - 90% of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the past 5 years. **Focus Area 4: Acute heart service** - 70% of high-risk patients receive an angiogram within 3 days of admission. - Over 95% of patients presenting with ACS who undergo coronary angiography who have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days. - Over 95% of patients undergoing cardiac surgery at the regional cardiac centres will have completion of Cardiac Surgery registry data collection within 30 days of discharge. **Focus Area 5: Stroke services** - 8% or more of potentially eligible stroke patients thrombolysed 24/7. - 80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway. - 80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission.
PP21: Immunisation coverage	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

Performance measure	Performance expectation
PP22: Delivery of actions to improve system integration including SLMs	Report on activities in the Annual Plan.
PP23: Improving Wrap Around Services for Older People	95% of older people who have received long-term home and community support services in the last three months who have had an interRAI Home Care or a Contact assessment and completed care plan
PP25: Prime Minister's youth mental health initiative	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. As reported through PP26 (see below). 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.
PP26: The Mental Health & Addiction Service Development Plan	Provide reports as specified for the focus areas of Primary Mental Health, District Suicide Prevention and Postvention, Improving Crisis Response services, improving outcomes for children, and improving employment and physical health needs of people with low prevalence conditions.
PP27: Supporting vulnerable children	Report on activities in the Annual Plan.
PP28: Reducing Rheumatic fever	Focus Area 1: Reducing the Incidence of First Episode Rheumatic Fever Report progress against BPS target. Provide progress report against rheumatic fever prevention plan.

Performance measure	Performance expectation
	Provide report on lessons learned and actions taken following reviews. Focus Area 2: report progress in following-up known risk factors and system failure points in cases of first episode and recurrent acute rheumatic fever.
PP29: Improving waiting times for diagnostic services	95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days). 95% of accepted referrals for CT scans, and 90% of accepted referrals for MRI scans will receive their scan within 6 weeks (42 days). 90% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days. 70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days. 70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date, 100% within 120 days.
PP30: Faster cancer treatment	85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.
PP31: Better help for smokers to quit in public hospitals	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.
PP32: Improving the accuracy of ethnicity reporting in PHO registers	Report on progress with implementation and maintenance of Ethnicity Data Audit Toolkit (EDAT).
PP33: Improving Māori enrolment in PHOs	Meet and/or maintain the national average enrolment rate of 90%.

Performance measure	Performance expectation
PP34: Improving the percentage of women who are smoke free at two weeks postnatal	
PP36: Reduce the rate of Māori on the mental health Act: section 29 community treatment orders relative to other ethnicities.	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.
PP37: Improving breastfeeding rates	60% of infants are exclusively or fully breastfed at three months.
PP38: Delivery of response actions agreed in annual plan	Report on activities in the Annual Plan.
SI1: Ambulatory sensitive hospitalisations	ASH 0-4: Reduce the difference between Māori and other rate to ≤1,028 per 100,000 ASH 45-64: ≤4,129 per 100,000
SI2: Delivery of Regional Service Plans	Provision of a progress report on behalf of the region agreed by all DHBs within that region.
SI3: Ensuring delivery of Service Coverage	Report progress towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage (as identified by the DHB or by the Ministry).
SI4: Standardised Intervention Rates (SIRs)	Major joint replacement procedures - a target intervention rate of 21 per 10,000 of population. Cataract procedures - a target intervention rate of 27 per 10,000 of population. Cardiac surgery - a target intervention rate of 6.5 per 10,000 of population. Percutaneous revascularization - a target rate of at least 12.5 per 10,000 of population.

Performance measure	Performance expectation
	Coronary angiography services - a target rate of at least 34.7 per 10,000 of population.
SI5: Delivery of Whānau Ora	Provide reports as specified about engagement with Commissioning Agencies and for the focus areas of mental health, asthma, oral health, obesity, and tobacco.
SI7: SLM total acute hospital bed days per capita	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.
SI8: SLM patient experience of care	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.
SI9: SLM amenable mortality	As specified in the jointly agreed (by district alliances) SLM Improvement Plan.
SI10: Improving cervical Screening coverage	80% coverage for all ethnic groups and overall.
SI11: Improving breast screening rates	70% coverage for all ethnic groups and overall.
OS3: Inpatient Length of Stay	Elective LOS suggested target is 1.47 days, which represents the 75th centile of national performance. Acute LOS suggested target is 2.3 days, which represents the 75th centile of national performance.
OS8: Reducing Acute Readmissions to Hospital	TBA – indicator definition currently under review.
OS10: 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** New NHI registration in error (causing duplication) Group A >2% and <= 4%, Group B >1% and <=3%, Group C >1.5% and <= 6% Recording of non-specific ethnicity in new NHI registrations - >0.5% and <= 2% Update of specific ethnicity value in existing NHI record with non-specific value - >0.5% and <= 2%

Performance measure	Performance expectation
	Validated addresses excluding overseas, unknown and dot (.) in line 1 - >76% and <= 85% Invalid NHI data updates – TBA **Focus Area 2: Improving the quality of data submitted to National Collections** NBRS collection has accurate dates and links to National Non-admitted Patient Collection (NNPAC) and the National Minimum Data Set (NMDS) - >= 97% and <99.5% National Collections File load Success - >= 98% and <99.5% Assessment of data reported to NMDS - >= 75% Timeliness of NNPAC data - >= 95% and <98% **Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data** (PRIMHD) Provide reports as specified about data quality audits.
Output 1: Mental health 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.
DV4: Improving patient experience	No performance expectation/target set.
DV6: SLM youth access to and utilisation of youth appropriate health services	No performance expectation/target set.
DV7: SLM number of babies who live in a smoke-free household at six weeks post natal	No performance expectation/target set.

APPENDIX A: STATEMENT OF PERFORMANCE EXPECTATIONS & FINANCIAL PERFORMANCE

1 Statement of Performance Expectations

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 SPE describes information in respect of the first financial year of our Statement of Intent and the performance measures are forecast to provide accountability. 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 Statement of Intent above, requires consideration of service performance. For each output class, we will assess performance in terms of the New Zealand Triple Aim (Figure 2). 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 Statement of Performance Expectations for the 2016/17 year follows:

Board Member Board Member

Code		Description
MH		Māori Health Plan Targets
HT		Health Targets
MoH Performance Measures - see Appendix 4	**PP**	Policy Priorities
	SI	System Integration
	OP	Outputs
	OS	Ownership
	DV	Developmental
N/A		Data not available

OUTPUT CLASS 1: Prevention Services

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* *in millions of New Zealand Dollars*	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Ministry of Health	10.3	10.4	10.2	9.7	10.1	10.5
Other sources	0.2	0.2	0.2	0.1	0.2	0.2
Income by Source	**10.5**	**10.6**	**10.4**	**9.8**	**10.2**	**10.6**
Less:						
Personnel	1.3	1.3	1.4	1.4	1.5	1.5
Clinical supplies	0.1	-	-	-	-	-
Infrastructure and non clinical supplies	0.3	0.3	0.3	0.3	0.3	0.3
Payments to other providers	8.4	7.9	7.8	8.1	8.4	8.8
Expenditure by type	**10.1**	**9.5**	**9.5**	**9.8**	**10.2**	**10.6**
Net Result	**0.4**	**1.1**	**0.9**	-	-	-

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 ($10.8m, $14.3m, $17.1m,and $18.9m in 2017,2018,2019,and 2020 respectively) will be reclassified and could affect any line in any output class.

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

Short Term Outcome	Indicator	MoH Measure	Baseline					2017/18 Target
			Period	Māori	Pacific	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	PP31	Oct-Dec 2016	99.2%	100%	98.7%	99.0%	≥95%
	% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months	HT	Oct-Dec 2016	85.1%	82.2%	89.8%	87.4%	≥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	HT	Oct-Dec 2016	78.8%	N/A	N/A	88.5%	≥90%
	Number of babies who live in a smoke-free household at six weeks post natal	SLM						N/A
	% of pregnant women who are smokefree at 2 weeks postnatal	SI5	Jul-Dec 2015	65.6%	93.5%	92.1%	80.0%	≥95%
Increase Immunisation	% of 8 month olds will have their primary course of immunisation (six weeks, three months and five month events) on time	HT	Oct-Dec 2016	94.4%	100%	95.9%	95.3%	≥95%
	% of 2 year olds fully immunised	PP21	Oct-Dec 2016	95.4%	100%	93.6%	94.7%	≥95%
	% of 4 year olds fully immunised	PP21	Oct-Dec 2016	95.8%	91.2%	91.8%	93.5%	≥95%
	% of girls fully immunised – HPV vaccine	PP21	Jun 2016	87.8%	73.3%	54.9%	68.4%	≥75%
	% of 65+ year olds immunised – flu vaccine	PP21	Jan-Dec 2016	60%	57%	61%	60.0%	≥75%
Reduced incidence of first episode Rheumatic Fever	Acute rheumatic fever initial hospitalisation rate per 100,000	PP28H	Jul 2016 – Jun 2017	7.23	16.47	-	2.48	≤1.5
Improve breast screening rates	% of women aged 50-69 years receiving breast screening in the last 2 years	SI11	2 Years to Sep 2016	64.7%	65.4%	75.0%	73.6%	≥70%
Improve cervical screening coverage	% of women aged 25–69 years who have had a cervical screening event in the past 36 months	SI10	3 Years to Sep 2016	72.8%	74.8%	78.9%	76.7%	≥80%

Short Term Outcome	Indicator	MoH Measure	Baseline					2017/18 Target
			Period	Māori	Pacific	Other	Total	
Better rates of breastfeeding	% of infants that are exclusively or fully breastfed at 6 weeks		6 months to Dec 2015	66%	82%	N/A	72%	75%
	% of infants that are exclusively or fully breastfed at 3 months	PP37	6 months to Jun 2016	39%	46%	N/A	51%	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*	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Ministry of Health	106.5	113.6	116.5	120.9	125.8	130.9
Other District Health Boards (IDF)	2.8	1.9	3.0	3.0	3.0	3.1
Other sources	3.4	3.6	2.2	2.3	2.4	2.5
Income by Source	**112.7**	**119.1**	**121.7**	**126.2**	**131.2**	**136.6**
Less:						
Personnel	16.7	17.6	18.9	19.4	20.0	20.6
Outsourced services	0.3	1.5	1.2	1.2	1.2	1.3
Clinical supplies	0.5	0.5	0.4	0.4	0.4	0.3
Infrastructure and non clinical supplies	3.0	3.0	3.4	3.5	3.6	3.7
Payments to other District Health Boards	2.5	2.4	2.6	2.7	2.7	2.8
Payments to other providers	87.5	92.2	95.7	99.1	103.3	107.8
Expenditure by type	**110.5**	**117.2**	**122.2**	**126.3**	**131.3**	**136.5**
Net Result	**2.2**	**1.9**	**(0.5)**	-	-	-

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

Short Term Outcome	Indicator	MoH Measure	Baseline					2017/18 Target
			Period	Māori	Pacific	Other	Total	
Improved access primary care	% of the population enrolled in the PHO	PP33	Oct-16	96.8%	89.9%	97.5%	97.1%	90%
Reduce the difference between Māori and other rate for ASH 0-4:	Ambulatory sensitive hospitalisation rate per 100,000 0-4 years	SI1 / SI5 / PP22(SLM)	12m to Sep-16	5,755		4,469	5,272	Gap Māori and other ≤1,028
Reduce ASH 45-64	Ambulatory sensitive hospitalisation rate per 100,000 45-64 years	SI1		7,636	5,872	3,262	4,129	≤4,129
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 2016	49.2%	54.5%	75.9%	65.7%	≥80%
Better oral health	% of eligible pre-school enrolments in DHB-funded oral health services	PP13	12 m to Dec-16	72.7%	69.1%	107.0%	89.2%	≥95%
	% of children who are carries free at 5 years of age	PP11 / SI5		44.0%	31.0%	74.0%	59.0%	≥64%
	% of enrolled preschool and primary school children not examined according to planned recall	PP13		2.2%	2.7%	3.2%	2.8%	≤10%
	% of adolescents(School Year 9 up to and including age 17 years) using DHB-funded dental services	PP12	12m to Dec-15				75.9%	≥85%
	Mean 'decayed, missing or filled teeth (DMFT)' score at Year 8	PP10	12 m to Dec-16	1.1	1.43	0.63	0.81	≤0.96
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)	PP20	12m to Dec-16	46.2%	39.3%	79.2%	65.4%	>65.4%
	% of the eligible population will have had a CVD risk assessment in the last 5 years	PP20	5y to Dec-16	84.5%	84.0%	88.9%	87.8%	≥90%
Less waiting for diagnostic services	% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks)	PP29	Dec-16				95.1%	≥95%
	% of accepted referrals for MRI scans who receive their scans within 42 days (6 weeks)	PP29	Dec-16				48.0%	≥90%
Increase referrals of obese children to clinical assessment and family	% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical	HT / SI5	6m to Nov-16	44%	43%	31%	40%	≥95%

Short Term Outcome	Indicator	MoH Measure	Baseline					2017/18 Target
			Period	Māori	Pacific	Other	Total	
based nutrition, activity and lifestyle interventions	assessment and family based nutrition, activity and lifestyle interventions.							

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, Assessment, Treatment and Rehabilitation (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 *in millions of New Zealand Dollars*	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Ministry of Health	305.7	314.4	322.6	331.4	338.8	346.3
Other District Health Boards (IDF)	5.7	3.8	6.2	6.3	6.4	6.6
Other sources	10.0	13.0	9.6	9.2	9.6	10.0
Income by Source	**321.4**	**331.2**	**338.4**	**346.8**	**354.8**	**362.8**
Less:						
Personnel	163.8	172.7	185.0	190.2	196.1	202.0
Outsourced services	14.7	17.1	13.3	13.6	13.9	14.1
Clinical supplies	43.2	39.8	35.6	33.7	31.4	30.4
Infrastructure and non clinical supplies	41.0	41.1	45.9	47.5	49.1	50.2
Payments to other District Health Boards	45.7	44.7	47.2	48.4	49.4	50.4
Payments to other providers	12.0	15.7	10.6	11.0	11.8	12.6
Expenditure by type	**320.4**	**331.1**	**337.6**	**344.3**	**351.8**	**359.8**
Net Result	**1.0**	**0.1**	**0.8**	**2.5**	**3.0**	**3.0**

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

Short Term Outcome	Indicator	MoH Measure	Baseline					2017/18 Target
			Period	Māori	Pacific	Other	Total	
Less waiting for ED treatment	% of patients admitted, discharged or transferred from an ED within 6 hours	HT	Oct-Dec 2016	94.7%	95.7%	96.5%	94.7%	≥95%
Faster cancer treatment	% 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 two weeks	HT	6m to Dec-16				65.4%	≥90%
More elective surgery	Number of elective surgery discharges[3]	HT	12m to Jun-16				7,469	7574
Patients with ACS receive seamless, coordinated care across the clinical pathway	% of high-risk patients will receiving an angiogram within 3 days of admission.	PP20	Oct to Dec-16	61.1%	100%	75.3%	73.1%	≥70%
	% of patients undergoing cardiac surgery at the regional cardiac centres who have completion of Cardiac Surgery registry data collection within 30 days of discharge	PP20	Oct to Dec-16	95.0%	66.7%	96.8%	95.5%	≥95%
Equitable access to care for stroke patients	% of potentially eligible stroke patients who are thrombolysed 24/7	PP20	Oct to Dec 16				10.2%	≥8%
	% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway	PP20	Oct to Dec 16				88.1%	≥80%
	% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	PP20	Oct to Dec 16				58%	≥80%
Equitable access to surgery - Standardised intervention rates for surgery per 10,000 population for:	Major joint replacement	SI4	12m to Sep-16	N/A	N/A	N/A	21.5	21
	Cataract procedures			N/A	N/A	N/A	58.7	27
	Cardiac surgery			N/A	N/A	N/A	6.6	6.5
	Percutaneous revascularisation			N/A	N/A	N/A	13.1	12.5
	Coronary angiography services			N/A	N/A	N/A	39.0	34.7
Shorter stays in hospital	Length of stay Elective (days)	OS3	12m to Sep-16	N/A	N/A	N/A	1.56	1.47
	Length of stay Acute (days)	OS3	12m to Sep-16	N/A	N/A	N/A	2.48	2.3

3 Health Target Elective Discharges is a number of publicly funded, casemix included, elective and arranged discharges for people living within the DHB district.

Short Term Outcome	Indicator		MoH Measure	Baseline					2017/18 Target
				Period	Māori	Pacific	Other	Total	
Fewer readmissions	Acute readmissions to hospital		OS8	Jan – Dec 2016				7.3	TBC
Quicker access to diagnostics	% accepted referrals for elective coronary angiography completed within 90 days		PP29	Dec-16				97.7%	95%
	% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive),		PP29	Dec-16	100%	N/A	90.9%	91.7%	90%
	% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)		PP29	Dec-16	100%	100%	92.7%	93.9%	70%
	% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date		PP29	Dec-16	100%	-	97.6%	98.1%	70%
Fewer missed outpatient appointments	Did not attend (DNA) rate across first specialist assessments			Oct-Dec 2016	14.2%	22.1%	3.8%	6.7%	≤7.5%
Better mental health services Improving access Better access to mental health and addiction services	Proportion of the) population seen by mental health and addiction services	Child & youth (0-19)	PP6	Oct 2015 – Sep 2016	4.92%	2.14%	3.79%	4.26%	TBC
		Adult (20-64)	PP6		9.26%	2.14%	3.83%	5.11%	TBC
		Older adult (65+)	PP6		1.19%	1.00%	1.11%	1.12%	TBC
Reducing waiting times Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	% of 0-19 year olds seen within 3 weeks of referral	Mental Health Provider Arm	PP8	Oct 2015 – Sep 2016	74.1%	68.4%	71.1%	72.3%	≥80%
		Addictions (Provider Arm and NGO)	PP8		80.5%	-	83.9%	81.1%	≥80%
	% of 0-19 year olds seen within 8 weeks of referral	Mental Health Provider Arm	PP8		93.6%	94.7%	90.0%	91.7%	≥95%
		Addictions (Provider Arm and NGO)	PP8		93.6%	-	96.8%	94.6%	≥95%
Improving mental health services using discharge planning	% of clients discharged will have a quality transition or wellness plan.		PP7	Jan-Dec 2016				92.5%	≥95%
Increasing consumer focus More equitable use of Mental Health Act: Section 29 community treatment orders	Rate of s29 orders per 100,000 population		PP36 / SI5	Oct-Dec 2016	179.9	-	62.1	90.1	≤81.5

OUTPUT CLASS 4: Rehabilitation and Support Services

This output class includes: Needs Assessment and Service Coordination (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 through Options Hawke's Bay - a unit that reports to our General Manager, Integrated Care Services. 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*	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Ministry of Health	69.3	71.1	80.4	82.9	86.2	89.4
Other District Health Boards (IDF)	3.0	2.0	3.1	3.3	3.4	3.4
Other sources	0.2	0.2	0.2	0.1	0.2	0.2
Income by Source	**72.5**	**73.3**	**83.7**	**86.3**	**89.8**	**93.0**
Less:						
Personnel	5.5	5.8	6.2	6.4	6.6	6.8
Outsourced services	0.1	-	-	-	-	-
Clinical supplies	0.7	0.6	0.6	0.6	0.5	0.5
Infrastructure and non clinical supplies	1.6	1.6	1.8	1.9	1.9	2.0
Payments to other District Health Boards	3.9	3.8	4.0	4.1	4.2	4.3
Payments to other providers	59.9	61.0	70.8	73.4	76.6	79.5
Expenditure by type	**71.7**	**72.8**	**83.4**	**86.3**	**89.8**	**93.0**
Net Result	**0.8**	**0.5**	**0.3**	-	-	-

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

OUTPUT CLASS 4

Short Term Outcome	Indicator		MoH Measure	Baseline					2017/18 Target
				Period	Māori	Pacific	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		Jan – Dec 2016	164.3	175.0	111.2	124.0	≤130
		80-84 years			208.3	300.0	167.0	167.8	≤170
		85+ years			136.4	0	237.7	216.6	≤225
Better community support for older people	Acute readmission rate: 75 years +			Jan – Dec 2016				10.2%	<10%
	% of older people who have received long-term home and community support services in the last three months who have had an interRAI Home Care or a Contact assessment and completed care plan		PP23	Oct-Dec 2016				100%	≥95%
Increased capacity and efficiency in needs assessment and service coordination services	Clients with a CHESS score (Change in Health, End-stage disease, signs and symptoms) of 4 or 5 at first assessment			Jul-Sep 2016				14%	<13.8%
Prompt response to palliative care referrals	Time from referral receipt to initial Cranford Hospice contact within 48 hours			Oct-Dec 2016	N/A	N/A	N/A	100%	>80%
More day services	Number of day services								≥21,791
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			Oct-Dec 2016	N/A	N/A	N/A	96.7% 98.0%	90% 98%

2 Financial Performance

In accordance with the Crown Entities Act 2004, this module 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 module 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 module.

Performance against the 2017/18 financial year projections will be reported in the 2017/18 Annual Report.

2.1 PROJECTED FINANCIAL STATEMENTS

Introduction

Hawke's Bay District Health Board is planning to deliver a surplus of $1.5 million this year. This is an average surplus of $3 million per annum over the six years ending 30 June 2021. It enables the DHB to fund a proportionate capital programme, including in the plan period the completion of an endoscopy facility, radiology equipment upgrade and surgical expansion, all associated with service redesign.

The financial numbers are also consistent with the DHB's "Transform and Sustain" strategy. Resource deployment and assumed efficiencies are focussed on our three strategic challenges: responding to our population and patients; systematically ensuring quality in all of our services; and increasing our productivity.

Projected Financial Statements

Reporting entity

The financial statements of the District Health Board comprise the District Health Board, its 19% interest in Allied Laundry Services Limited, and its 16.7% interest in Central Region's Technical Advisory Services Limited. The District Health Board 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 28 June 2017.

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). They projected financial statements have been prepared in accordance with tier 1 Public Benefit Entity Standards (PBE) accounting standards.

The accounting policies applied in the projected financial statements are consistent with those used in the 2015/16 Annual Report. The report is available on the DHB's website at www.hawkesbay.health.nz.

Projected Statement of Revenue and Expense						
in thousands of New Zealand Dollars	2016	2017	2018	2019	2020	2021
For the year ended 30 June	Audited	Forecast	Projected	Projected	Projected	Projected
Ministry of Health - devolved funding	487,400	504,939	515,810	530,598	546,367	562,185
Ministry of Health - non devolved contracts	4,395	4,578	13,930	14,222	14,505	14,810
Other District Health Boards	11,455	11,608	12,291	12,550	12,800	13,069
Other government and Crown agency sourced	5,933	6,163	5,646	5,765	5,880	6,003
Patient and consumer sourced	1,313	1,232	1,321	1,349	1,376	1,405
Other	6,616	5,662	5,245	4,727	5,039	5,529
Operating revenue	517,113	534,182	554,243	569,211	585,967	603,001
Employee benefit costs	187,322	197,475	211,514	217,435	224,177	230,906
Outsourced services	15,116	18,524	14,469	14,773	15,068	15,384
Clinical supplies	44,463	41,113	36,626	34,601	32,391	31,314
Infrastructure and non clinical supplies	45,990	45,977	51,411	53,177	54,966	56,240
Payments to non-health board providers	219,856	227,493	238,724	246,725	256,366	266,157
Operating expenditure	512,747	530,582	552,743	566,711	582,968	600,001
Total comprehensive revenue and expense	**4,366**	**3,600**	**1,500**	**2,500**	**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***	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Equity as at 1 July	**87,627**	**91,635**	**142,378**	**143,521**	**145,663**	**148,306**
Total comprehensive revenue and expense:						
Funding of health and disability services	9,117	4,498	1,500	2,500	3,000	3,000
Governance and funding administration	388	83	-	-	-	-
Provision of health services	(5,139)	(981)	-	-	-	-
	4,366	3,600	1,500	2,500	3,000	3,000
Contributions from the Crown (equity injections)	-	47,500	-	-	-	-
Repayments to the Crown (equity repayments)	(358)	(357)	(357)	(358)	(357)	(357)
Equity as at 30 June	**91,635**	**142,378**	**143,521**	**145,663**	**148,306**	**150,949**

Table 6 - Projected Statement of Movements in Equity

Projected Statement of Financial Position

in thousands of New Zealand Dollars ***As at 30 June***	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Equity						
Paid in equity	35,216	82,359	82,002	81,645	81,288	80,931
Asset revaluation reserve	67,392	67,392	67,392	67,392	67,392	67,392
Accumulated deficit	(10,973)	(7,373)	(5,873)	(3,373)	(374)	2,626
	91,635	**142,378**	**143,521**	**145,663**	**148,306**	**150,949**
Current assets						
Cash	14,263	19,992	17,365	16,365	21,290	28,490
Short term investments	-	-	-	-	-	-
Short term investments (special funds/clinical trials)	3,013	3,026	3,026	3,026	3,026	3,026
Receivables and prepayments	22,423	22,328	22,940	23,421	23,888	24,390
Loans (Hawke's Bay Helicopter Rescue Trust)	10	11	11	12	13	13
Inventories	4,293	4,332	4,419	4,511	4,601	4,698
Assets classified as held for sale	1,220	625	-	-	-	-
	45,222	50,314	47,761	47,336	52,819	60,618
Non current assets						
Property, plant and equipment	151,797	151,550	154,692	158,340	156,130	151,680
Intangible assets	8,239	1,561	2,714	3,468	4,783	6,072
Investment property	131	131	131	131	131	131
Investment in NZ Health Partnerships Limited	2,504	2,504	2,504	2,504	2,504	2,504
Investment in associates	1,045	8,590	9,586	9,586	9,586	9,586
Loans (Hawke's Bay Helicopter Rescue Trust)	42	29	15	-	-	-
	163,758	164,365	169,642	174,029	173,134	169,973
Total assets	**208,980**	**214,679**	**217,402**	**221,364**	**225,952**	**230,590**

Projected Statement of Financial Position *in thousands of New Zealand Dollars* ***As at 30 June***	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Less:						
Current liabilities						
Payables and accruals	38,134	35,002	35,762	36,514	37,245	38,027
Employee entitlements	34,074	34,619	35,381	36,372	37,499	38,625
	72,207	69,621	71,143	72,886	74,744	76,652
Non current liabilities						
Employee entitlements	2,638	2,680	2,739	2,815	2,903	2,990
Loans and borrowings	42,500	-	-	-	-	-
	45,138	2,680	2,739	2,815	2,903	2,990
Total liabilities	**117,345**	**72,301**	**73,882**	**75,701**	**77,647**	**79,642**
Net assets	**91,635**	**142,378**	**143,521**	**145,663**	**148,306**	**150,949**

Table 7 - Projected Statements of Financial Position

Projected Statement of Cash Flows

in thousands of New Zealand Dollars
For the year ended 30 June

	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Cash flow from operating activities						
Cash receipts from MOH, Crown agencies & patients	511,732	539,570	552,877	569,415	586,937	604,498
Cash paid to suppliers and service providers	(296,631)	(321,886)	(318,349)	(325,015)	(334,049)	(344,172)
Cash paid to employees	(187,513)	(195,691)	(210,693)	(216,593)	(223,307)	(230,006)
Cash generated from operations	27,588	21,993	23,835	27,807	29,581	30,320
Interest received	1,419	911	885	-	-	-
Interest paid	(1,855)	(1,270)	(164)	-	-	-
Capital charge paid	(6,783)	(6,322)	(8,549)	(8,700)	(8,808)	(8,982)
	20,369	15,312	16,007	19,107	20,773	21,338
Cash flow from investing activities						
Proceeds from sale of property, plant and equipment	123	620	625	-	-	-
Acquisition of property, plant and equipment	(16,733)	(13,322)	(16,320)	(19,749)	(15,491)	(13,781)
Acquisition of intangible assets	(395)	(174)	(1,600)	-	-	-
Acquisition of investments	(2,440)	(1,352)	(982)	-	-	-
	(19,446)	(14,229)	(18,277)	(19,749)	(15,491)	(13,781)
Cash flow from financing activities						
Proceeds from equity injections	(1,655)	-	-	-	-	-
Equity repayment to the Crown	1,298	4,643	(357)	(357)	(357)	(357)
	(357)	4,643	(357)	(357)	(357)	(357)

Continued …

Projected Statement of Cash Flows *in thousands of New Zealand Dollars* ***For the year ended 30 June***	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Net increase/(decrease) in cash and cash equivalents	567	5,726	(2,628)	(999)	4,925	7,200
Cash and cash equivalents at beginning of year	14,970	15,537	21,263	18,636	17,637	22,562
Cash and cash equivalents at end of year	15,537	21,263	18,636	17,637	22,562	29,762
Represented by:						
Cash	14,263	19,992	17,365	16,365	21,290	28,490
Short term investments	1,274	1,271	1,271	1,271	1,271	1,271
	15,537	21,263	18,636	17,637	22,562	29,762

Table 8 - Projected Statement of Cash Flows

Projected Funder Arm Operating Results						
in thousands of New Zealand Dollars ***For the year ended 30 June***	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Revenue						
Ministry of Health - devolved funding	487,400	504,939	515,810	530,598	546,367	562,185
Inter district patient inflows	8,107	7,730	8,314	8,489	8,658	8,840
Other revenue	258	10	-	-	-	-
	495,765	**512,679**	**524,124**	**539,087**	**555,025**	**571,025**
Expenditure						
Governance and funding administration	3,140	3,197	3,294	3,363	3,430	3,502
Own DHB provided services						
Personal health	218,802	233,280	246,542	251,722	256,756	262,150
Mental health	25,005	24,171	23,814	24,314	24,801	25,321
Disability support	14,719	13,731	8,990	9,179	9,362	9,558
Public health	4,463	5,507	641	653	666	679
Maori health	663	802	619	631	644	658
	263,652	277,492	280,606	286,499	292,229	298,366
Other DHB provided services (Inter district outflows)						
Personal health	46,657	45,763	48,259	49,272	50,257	51,312
Mental health	2,386	2,388	2,553	2,607	2,659	2,715
Disability support	3,053	3,113	3,289	3,358	3,425	3,497
Public health	-	-	-	-	-	-
Maori health	-	-	-	-	-	-
	52,097	51,263	54,100	55,237	56,341	57,524

Projected Funder Arm Operating Results						
in thousands of New Zealand Dollars	2016	2017	2018	2019	2020	2021
For the year ended 30 June	Audited	Forecast	Projected	Projected	Projected	Projected
Other provider services						
Personal health	95,025	103,127	99,488	104,562	111,357	118,103
Mental health	10,848	11,210	11,365	11,605	11,838	12,087
Disability support	57,196	57,674	68,652	70,095	71,498	72,999
Public health	1,011	944	1,540	1,573	1,606	1,641
Maori health	3,679	3,275	3,577	3,653	3,726	3,803
	167,760	176,230	184,623	191,488	200,025	208,633
Total Expenditure	**486,648**	**508,182**	**522,624**	**536,587**	**552,025**	**568,025**
Net Result	**9,117**	**4,498**	**1,500**	**2,500**	**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***	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Revenue						
Funding	3,140	3,197	3,294	3,363	3,430	3,502
Other revenue	111	29	30	31	31	32
	3,250	3,226	3,324	3,394	3,461	3,534
Expenditure						
Employee benefit costs	779	826	967	994	1,026	1,058
Outsourced services	506	505	514	525	536	547
Clinical supplies	23	(0)	(3)	-	-	-
Infrastructure and non clinical supplies	620	867	900	910	916	924
	1,929	2,197	2,379	2,429	2,478	2,529
Plus: allocated from Provider Arm	933	945	946	965	984	1,005
Net Result	**388**	**83**	-	-	-	-

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***	2016 Audited	2017 Forecast	2018 Projected	2019 Projected	2020 Projected	2021 Projected
Revenue						
Funding	263,652	277,491	280,606	286,499	292,229	298,366
Ministry of Health - non devolved contracts	4,395	4,578	13,930	14,222	14,505	14,810
Other District Health Boards	3,348	3,878	3,977	4,061	4,142	4,229
Accident Insurance	5,530	5,680	5,233	5,343	5,450	5,564
Other government and Crown agency sourced	403	483	413	422	430	439
Patient and consumer sourced	1,313	1,232	1,321	1,349	1,376	1,405
Other revenue	6,248	5,623	5,215	4,696	5,008	5,497
	284,889	298,965	310,695	316,592	323,140	330,310
Expenditure						
Employee benefit costs	186,543	196,649	210,546	216,441	223,151	229,848
Outsourced services	14,609	18,019	13,955	14,248	14,532	14,837
Clinical Supplies	44,440	41,113	36,629	34,601	32,391	31,314
Infrastructure and non clinical supplies	45,369	45,110	50,511	52,267	54,050	55,316
	290,961	300,891	311,641	317,557	324,124	331,315
Less: allocated to Governance & Funding Admin.	933	945	946	965	984	1,005
Net Result	(5,139)	(981)	-	-	-	-

Table 11 – Projected Provider Arm Operating Results

2.2 SIGNIFICANT ASSUMPTIONS

General

- Revenue and expenditure has been budgeted on current Government policy settings and known health service initiatives.
- No allowance has been made for any new regulatory or legislative changes which 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 Ministry of Health.
- No allowance has been made for any additional capital or operating costs that may be required by the National Oracle Solution (NOS) shared financial platform solution managed by New Zealand Health Partnerships Limited (NZHPL).
- Allowance has been made for net additional costs arising from the Regional Health Information Project (RHIP) of $1.0 million in 2017/18.
- The full year impact of ongoing transformation expenditure, difficulties achieving the 2016/17 efficiency programme, and allowance for new investment (0.3 million) has required a $10.8 million efficiency programme for the 2017/18 year. Nominal increases in funding and inflationary increases in expenditure will require further savings of $3.5 million, $2.8 million and $1.8 million in 2018/19, 2019/20, and 2020/21 respectively. Detailed plans for the new investment and efficiency programmes have yet to be finalised, and 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 2.1%, 2.0% and 2.1% for 2018/19, 2019/20 and 2020/21 respectively based on Treasury forecasts for CPI inflation in the Half Year Economic and Fiscal Update 2016 published 8 December 2016).

Revenue

- Crown funding under the national population based funding formula is as determined by MOH. Funding including adjustments has been allowed at $481.9 million for 2017/18. Funding for the 2018/19, 2019/20 and 2020/21 years will include nominal increases of $15.0 million per annum.
- Crown funding for non-devolved services of $13.9 million is based on agreements already in place with the appropriate Ministry of Health directorates, and assumes receipt of the DHB's full entitlement to elective services funding.
- Inter district flows revenue is in accordance with Ministry of Health advice.
- Other income has been budgeted at the District Health Board's best estimates of likely income.

Personnel Costs and Outsourced Services

- Workforce costs for 2017/18 have been budgeted at actual known costs, including step increases where appropriate. Increases to Multi Employer Collective Agreements have been budgeted in accordance with settlements, or where no settlement has occurred, at the District Health Board's best estimate of the likely increase. Personnel cost increases have been allowed for at 2.8%, 3.1% and 3.0% for 2018/19, 2019/20 and 2020/21 respectively based on Treasury forecasts for wage inflation in the Half Year Economic and Fiscal Update 2016 published 8 December 2016).
- Establishment numbers for management and administration staff have been capped by the Minister of Health at 417 FTEs, the same as 2016/17.

Supplies and Infrastructural Costs

- The cost of goods and services has been budgeted the District Health Board'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 District Health Board'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. The investment in NZHPL gives the DHB a right to use the systems they provide, so they are considered to have indefinite lives, and consequently no amortisation has been allowed for.
- Borrowings from MOH to all DHBs converted to equity on 15 February 2017. No costs related to borrowings have been recognised for Hawke's Bay DHB after 2016/17.
- The capital charge rate has been allowed for at 6% from 2017/18. The decrease in capital charge is offset by a compensating reduction in revenue from the Crown.
- **Investment**
- 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 impairment of the asset over the time horizon of the plan.
- The District Health Board'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 before 2021/22.
- 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 :

Investment	2017/18 $'m	2018/19 $'m	2019/20 $'m	2020/21 $'m
Buildings and Plant	17.3	16.4	10.0	7.1
Clinical Equipment	3.4	3.6	5.8	5.2
Information Technology	3.2	3.2	3.2	3.2
Capital Investment	**23.9**	**23.2**	**19.0**	**15.5**
Investment in RHIP	1.1	0.2	-	-
Total Investment	**25.0**	**23.4**	**19.0**	**15.5**

Capital Investment Funding

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

Investment Funding	2017/18 $'m	2018/19 $'m	2019/20 $'m	2020/21 $'m
Total Investment	25.0	23.4	19.0	15.5
Funded by:				
Depreciation and amortisation	13.6	15.3	16.4	16.9
Operating surplus	1.5	2.5	3.0	3.0
Cash holdings	20.0	17.4	16.4	21.3
Capital Investment Funding	**35.1**	**35.2**	**35.8**	**41.2**

Property, Plant and Equipment

- Hawke's Bay District Health Board is required to revalue land and buildings when the fair value differs materially from the carrying amount, and at least every five years. The last revaluation was at 30 June 2015, and the next is likely at 30 June 2018. The effect of a revaluation 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	2017/18 $'m	2018/19 $'m	2019/20 $'m	2020/21 $'m
Opening equity	142.4	143.5	145.7	148.3
Surplus	1.5	2.5	3.0	3.0
Equity repayments (FRS3)	(0.4)	(0.3)	(0.4)	(0.4)
Closing equity	**143.5**	**145.7**	**148.3**	**150.9**

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.

APPENDIX B: SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

See PDF Version of System Level Measures Improvement Plan Final Draft