HAWKE'S BAY DISTRICT HEALTH BOARD

# 2018/19 Annual Plan incorporating the 2018/19 Statement of Performance Expectations

HAWKE'S BAY
District Health Board
Whakawāteatia

HEALTH
HAWKE'S BAY

E83

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

## 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.

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## OUR VALUES

**TAUWHIRO**

Delivering high quality care to patients and consumers

**RĀRANGA TE TIRA**

Working together in partnership across the community

**HE KAUANUANU**

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

**ĀKINA**

Continuously improving everything we do

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


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# Hon Dr David Clark

MP for Dunedin North

Minister of Health

Associate Minister of Finance


17 DEC 2018

Mr Kevin Atkinson
Chair
Hawke's Bay District Health Board
kevin.atkinson@penkev.co.nz

Dear Kevin

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

This letter is to advise you I have approved and signed Hawke's Bay District Health Board's (DHB's) 2018/19 Annual Plan for one year.

I understand your DHB has planned a deficit for 2018/19 and a track to surplus in 2020/21. This will require a concerted effort and I trust that the DHB will continue to work with the Ministry to evaluate and improve your financial performance.

Production Plan is still to be confirmed, and you will work with the Ministry to resolve this.

I am aware you are planning a number of service reviews in the 2018/19 year. My approval of your Annual Plan does not constitute acceptance of proposals for service changes that have not undergone review and agreement by the Ministry. 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.

I would like to thank you, your staff, and your Board for your valuable contribution and continued commitment to delivering quality health care to your population, and wish you every success with the implementation of your 2018/19 Annual Plan. I look forward to seeing your achievements.

Please ensure that a copy of this letter is attached to all copies of the Annual Plan made available to the public.

Yours sincerely

Hon Dr David Clark
**Minister of Health**

cc: Dr Kevin Snee, Chief Executive, Hawke's Bay District Health Board,
kevin.snee@hawkesbaydhb.govt.nz


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# 1 OVERVIEW OF STRATEGIC PRIORITIES

## 1.1 Strategic Intentions/Priorities

Hawke's Bay District Health Board (HBDHB) is a Crown Entity and is the Government's funder and provider of public health and disability services for the population in our defined district. Our Statement of Intent (SoI) 2016-19 outlines our strategic intentions and shows how local outputs impact on our population and contribute to local, regional and system-level outcomes.

As a sector we have a common vision: "Excellent health services working in partnership to improve the health and well-being 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 its themes as shown in figure 1 below. This year we will be developing a new organisational strategy in line with our Clinical Services Plan (CSP) and our People Strategy and retaining links with the New Zealand Health Strategy.


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

Social and economic forces in combination with biological and environmental factors shape the health of a population over the life course. We see population health approaches and services as essential components of strategies to address the determinants of health and to achieve better health status and equity at a population level. Health starts in our homes, schools, workplaces and communities.

To be healthy, people need:

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

We see multi-sectoral working as crucial to help address these determinants of health, working in partnership with central government agencies, local government, Iwi, Non-Government Organisations (NGOs), business and the community sector. Our Regional Economic Development Strategy (Matariki) and Social Inclusion Strategy are now merged reflecting the inter-relationship. The Social Inclusion actions include addressing barriers to employment, developing a social responsible employment sector, establishing groups to enable a community voice and developing a new sustainable operating system for social services. These innovative steps all support the outcome of greater equity and enabling all whānau in HB to benefit from economic development.

We work collaboratively with our Central Region partners. A Regional Services Plan (RSP) has been developed by the six central region DHBs to provide an overall framework for future planning around optimum arrangements and regionalisation. Working regionally enables us to better address our shared challenges. As a region we are committed to a sustainable health system focussed on keeping people well and providing equitable and timely access to safe, effective, high-quality services, as close to people's home as possible.

Collaboration with our local Primary Health Organisation (PHO), Health Hawke's Bay and other sectors is a strong focus. 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 and ministerial priorities.

HBDHB is committed to the United Nations Convention on the Rights of Persons with Disabilities and the National Healthy Ageing Strategy.

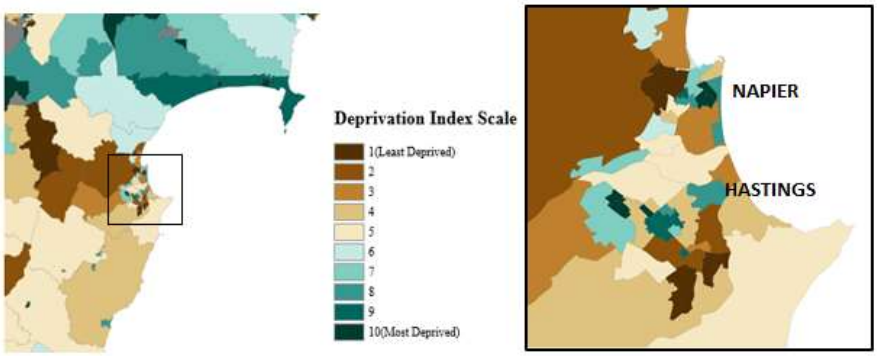


**Figure 2:** Hawke's Bay District relative deprivation NZDep13

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 as well as 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 coordinate 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.

The population of Hawke's Bay (HB) 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%).

- **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 wellbeing 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 Pasifika Health Action Plan 2014-2018 have been developed to align with the above principles and He Korowai Oranga and Ala Mo'ui: Pathways to Pasifika Health and Well-being 2014-2018

Ongoing conversations with our communities have raised specific areas of concern: family violence; youth suicide; addictions to methamphetamine and providing children with the best start. A number of programmes are in development with planned activities included in Section 2.2 Government Planning Priorities.

### 1.1.1 Population Performance

The most significant actions for delivery in the 2018/19 year to address local population challenges for life course grouping are as below:

| Life course group | One significant action which is to be delivered in 2018/19 |
|---|---|
| Pregnancy | Develop a kaupapa Māori maternal health programme to overcome barriers to access to maternal health care, eliminate inequities in maternal and child health, and improve maternal and child health outcomes |
| Early years and childhood | Improve coordination and consolidation of Family Violence and Maternal Well-being and Child Protection by bringing these together under Haumaru Whānau with stakeholders inclusive of Māori Health providers and General Practice |
| Adolescence and young adulthood | Implement the Hawke's Bay Youth Strategy |
| Adulthood | Improve our Oncology Model of Care to bring care closer to home with appropriate and streamlined services and facilities |
| Older people | Establish formal links with community-based groups who work socially with older people, to enable a regular exchange of information and consumer perspectives. |

### *1.1.2 Focus for 2018/19*

In agreeing local priorities with the Ministry of Health (MoH) for 2018/19, five focus areas were signalled. These areas align with national direction and strategic themes identified in our CSP. Actions in support of these local priorities are highlighted through Section 2.2 Government Planning Priorities.

- Equity: A key theme of our CSP and most of the areas below is addressing unmet need and achieving equity. The approach to vulnerable youth and families in 2018/19 will include a community initiative to consolidate: family violence; maternal well-being and child protection initiatives (Haumari Whānau); the development of a kaupapa Māori maternal health programme and the second year of Ngātahi, our initiative designed to bring agencies across health, education and social services to work together to deliver interventions to vulnerable children and their families. Equity focus is to be applied to amenable mortality, mental health and hazardous alcohol use. Strong relationships with local iwi and constructive engagement with Māori continue to be a focus.
- Primary and Community care: The DHB is setting aside funding in 2018/19 for primary care modernisation including Healthcare Home approaches and the development of partnerships to oversee a range of community services including pharmacy, community care and aged residential care.
- Mental Health Services; Improve transition liaison between secondary services, general practice and NGO services toward more treatment in the community via holistic models of care.
- Frail Elderly; Build more formal links with community based advocacy groups. Strategic initiatives to include enhanced Assessment, Treatment and Rehabilitation (AT&R) discharge and re-design of rural services to match client demand.
- Financial sustainability: Meet agreed deficit in 2018/19, working toward a breakeven position in 2019/20 and a return to surplus from 2020/21.

The Ministry and the DHB will undertake joint work to look at consistent rules for counting telehealth events and capturing the work delivered in this space. The Ministry will also work with the DHB over the coming year to ensure traditional contracting, reporting and funding mechanisms do not create artificial barriers or restrict development of the new models of care.

## 1.2 Message from the Chair and Chief Executive

HBDHB has spent much of the past year working with a wide range of consumers and clinicians as it develops its CSP.

The CSP will transform services and where they are provided from. We have engaged widely through public consultation as well as through numerous workshops with clinicians and consumers. Feedback from all who have participated will be incorporated into the final plan which will be delivered to the Board for sign-off in early 2019. This final plan will provide the roadmap for health services in Hawke's Bay for the next 10-15 years.

As part of our desire to improve population health, the DHB is currently refreshing its Health Equity programme. This report will inform the future population health direction to meet equity gaps to address determinants of health and achieve better health equity and well-being.

The Board works closely with Health Hawke's Bay (PHO) and there is a strong willingness from both organisations to work better and more closely to help deliver better health outcomes for the population, with the additional aim of helping to reduce the pressure on emergency services.

Without our workforce we would not be able to achieve the many milestones this DHB has. In recognition of their importance we have invested heavily in workforce development and committed to the Care Capacity Demand Management programme (CCDM) which is now being implemented as business as usual for the organisation. We have increased our nursing and clinical workforce over the past year and there is more investment planned to increase workforce capacity over the coming year.

This year's Annual Plan sets out our direction with detail on how we will deliver Government expectations.

## 1.3 Signature Page

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

Board Member

Hawke's Bay District Health Board

Board Member

Hawke's Bay District Health Board

# 2 DELIVERING ON PRIORITIES

## 2.1 Health Equity

In 2016 we updated the Health Equity in HB report, an analysis and report on health status in HB. The main focus of the report is equity because health inequities are differences in health status that are avoidable or preventable and therefore unfair. The report finds many inequities in health in HB, particularly for Māori, Pasifika and people living in more deprived areas. There are also areas where, with determined and focused effort, we have improved outcomes and reduced inequities. This demonstrates that inequities are not inevitable. We can change them if we have the courage and determination to do so. The Health Equity Report concludes that inequity affects everyone and, for a difference to be made, we must tackle this collectively and take responsibility as a community. An updated Health Equity Report for 2018 is being completed during the 2018-19 year.

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

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

### 2.1.1 Health Equity Tools

HBDHB has developed very good health monitoring and measuring reporting systems. The 'dashboard reports' also measure health equity (by ethnicity) against national and localised health priorities and indicators within its Annual Plan. Māori Health introduced Te Ara Whakawaiora (TAW) programme, an exception based monitoring and improvement programme based on the non-performing indicators within the Annual Plan. TAW is led by 'TAW Champions', members of the Executive Management Team (EMT).

HBDHB also uses the Health Equity Assessment Tool (HEAT) which provides useful scoping and impact information for planning and funding decisions.

## 2.2 Government Planning Priorities

EOA = Equitable Outcomes Activity

| Government Planning Priority | | Focus Expected for the DHB | Link to NZ Health Strategy | DHB Key Response Actions to Deliver Improved Performance | | Measures |
|---|---|---|---|---|---|---|
| | | | | Activity | Milestones | |
| Mental Health (both Māori and Pasifika focussed equity actions are expected | Population Mental Health | Outline actions to improve population Mental Health & Addictions (MH&A), especially for priority populations including vulnerable children, youth, Māori and Pasifika, by increasing uptake of treatment and support earlier in the course of mental illness and addiction, further integrating mental and addiction and physical health care, and coordinating mental health care with wider social services. | One team | Complete a system-wide MH&As redesign inclusive of co-design principles and an equity lens which aligns and integrates the recommendations from the National Mental Health Inquiry and HBDHB's CSP. Phase 1 will consist of a procurement and redesign framework with Phase 2 a redesign of model of care. EOA. | Q1<br>Q4 | PP25<br>PP26<br>PP6<br>Output 1 |
| | | | | See SLM Youth are healthy, safe and supported Implement the HBDHB Alcohol Harm Reduction Strategy (2017-2022). | Q4 | |

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| in this priority area) | | | | See System Level Measure (SLM) Youth are healthy, safe and supported.<br>Continue with resilience training for youth with a focus on 1-3 decile schools. Scope the possibility of an external evaluation. | Q2<br>Q4 | |
| | | | | Research and develop a report to inform decisions regarding an effective DHB response, to the community identified issue of methamphetamines use. | Q1<br>Q4 | |
| | | | | Facilitate evidenced based community suicide prevention workshops and evaluate the effectiveness of those workshops. EOA. | Q2<br>Q4 | |
| | | | | Identified champion to develop a team and structure to ensure 'Supporting Parents Healthy Children" guidelines are visible throughout all mental and addiction services | Q4 | |
| | | Outline how the DHB will ensure your staff and members of your community will be encouraged to participate in the Government Inquiry into MH&A | | HBDHB used a targeted group approach to ensure wide participation in the Government Inquiry into Mental Health and Addiction. Sessions were organised and facilitated around the following groupings-: Māori, suicide; consumer and whānau, Pasifika; plus NGOs and primary care/GP's plus the MH&A provider arm service. EOA.<br>a. Request redacted notes from the Public meeting to assess the need for immediate actions on specific feedback<br>b. Awaiting final report in October to inform redesign | Q2 | |
| | Mental Health and Addictions Improvement Activities | Outline your commitment to the Health Quality & Safety Commission (HQSC) MH&As improvement activities with a focus on minimising restrictive care (including the aspirational goal of eliminating seclusion by 2020), and improving transitions. | One team | Review and monitor all seclusion activity and targets to meet the HBDHB seclusion reduction plan by 2020. | Q2<br>Q4 | PP6: Improving the health status of people with severe mental illness through improved access<br>PP7: Improving mental health services using wellness and transition (discharge) planning |
| | | | | Improve the rate of completed transition plans for clients upon discharge, by improving monitoring visibility. | Q2<br>Q4 | |
| | | | | Integrate quality checks on transition plans within the current quarterly quality audit reviews. | Q1-4 | |
| | | | | Lead the HQSC project/work stream 'DHB Specialist Community Services to Primary care and/or NGO services and/or reverse" in partnership with Health Hawke's Bay. EOA. | Q2<br>Q4 | |
| | Addictions | For those DHBs that are not currently meeting the PP8 addiction related waiting times targets (for total population or all population groups), please identify actions to improve performance. | Value and high performance | Develop and implement an improvement plan with specific actions for DHB Provider services, to ensure that people referred for non-urgent addictions services are seen within three weeks. This plan will have an equity focus with a targeted approach. EOA | Q1-4 | PP8: Shorter waits for non-urgent mental health and addiction |

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| | | | | | | services for 0-19 year olds |
| Primary Health Care (both Māori and Pasifika focussed equity actions are expected in this priority area) | Access | *As per Budget 2018 announcements, commit to the implementation of new primary care initiatives to reduce the cost of access to primary care services. This includes extending zero fees for under-13s to zero fees for under-14s and reducing fees for community service card holders.*<br>*Describe actions that will ensure at least 95% of eligible children aged under 14 have zero fee access to afterhours care within 60 minutes travel time. This includes general practice services and prescriptions.* | Closer to home | Commit to working with the Ministry of Health to implement new primary care initiatives including extending zero fees for under-13s to zero fees for under-14s and reducing fees for community service card holders. | Q3 | % of eligible children aged under 14 with access to zero fee care and afterhours care within 60 minutes travel time. |
| | | | | Negotiate with urgent care providers to ensure a plan is in place by 1st December (or as confirmed by Ministry of Health) aiming at 95% of eligible children aged under 14 having zero fee access to afterhours care within 60 minutes travel time. Planning will focus on Māori and Pasifika children | | |
| | Integration | *DHBs are expected to continue to work with their district alliances on integration including (but not limited to):*<br>*- Strengthening their alliance (*<br>*- Broadening the membership of their alliance*<br>*- Developing services, based on robust analytics that reconfigure current services.*<br><br>*In addition:*<br>*- Please identify actions you are undertaking in the 2018/19 year to assist in the utilisation of other workforces in primary health care settings.* | Closer to home | Monitor the Strategic Resource Deployment Framework to track the flow of funding across the health system. | Q1-4 | PP22: Delivery of actions to improve system integration including SLMs |
| | | | | Establish the Primary Care Development Partnership (PCDP) governance structure. | Q2 | |
| | | | | Establish stakeholder membership of PCDP inclusive of primary care, secondary care, allied health, local iwi, population health and local NGOs. | Q3 | |
| | | | | Harness learnings from the PCDP shadow year 2018-19 to inform full establishment in 2019-20. | Q4 | |
| | | | | Investigate options for creation of a HB Model of Primary Care inclusive of Kaupapa Māori and NUKA principles and identify lead practices. EOA. | Q2<br>Q4 | |
| | | | | Establish four priority Service Level Alliances (SLA) to enhance co-ordination and delivery of care/support and test the functionality of these initial service alliances to inform future direction of the PCDP. SLA scope to include alternative workforces and consequential workforce development requirements. | Q2<br>Q4 | |
| | | *- Identify actions to demonstrate how you will work proactively with your PHOs and other providers to improve new-born enrolment with General Practice in 2018/19.* | | Continue with Quadruple Enrolment and respond to regular Health Hawke's Bay general practice audits to work with outliers. | Q2<br>Q4 | SI18: Improving new-born enrolment in General Practice |
| | System Level Measures (SLM) | | Value and high perfor | Implement and monitor actions from our SLMs Improvement Plan. .EOA. | Q1-4 | PP22: Delivery of actions to improve system |

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| | | Please reference your-jointly developed and agreed with all appropriate stakeholders SLM Improvement Plan that is attached as an appendix.<br>SLM Guidance is available on the Nationwide Service Framework Library (NSFL). | | Integrate the planning process for SLMs with implementation and monitoring throughout the year. | Q1 | integration including SLMs |
| | Cardiovascular Disease (CVD) and diabetes risk assessment | Commit to maintaining a rate of 90% in undertaking CVD and Diabetes Risk Assessments for their eligible population. Those DHBs whose current performance is below 90% are expected to work closely with their alliance partners to achieve 90%. These DHBs must describe specific actions their alliance will take to reach this target. These actions could be part of the actions committed to in the SLM Improvement Plan (specifically in achieving the Acute Bed Days or Amenable Mortality SLMs), in which case this should be cross-referenced, if that is appropriate. If specific risk assessment activity is not part of the SLM Improvement Plan, actions to improve the level of risk assessments provided must be included in this section along with two quarterly milestones.<br>*In addition, each DHB should identify three priority areas they will be undertaking for quality improvement in diabetes care and services with key actions and milestones. These areas may be informed by their self-assessment against the Quality Standards for Diabetes Care 2014.* | One team | SLM Prevention and early detection:<br>Develop an improvement plan informed by data, analysis and information to increase the provision of Cardiovascular Ris Asessments (CVRA) for Māori in line with national guidelines. This will be inclusive of Māori Women. EOA. | Q1<br>Q3 | PP20: Improved management for long term conditions (CVD, acute heart health, diabetes and stroke) - Focus area 2: Diabetes services |
| | | | | Health HB and Population Health to work in partnership to develop a plan to work with HB businesses with high numbers of Māori and Pacific employees and community and sports clubs. EOA. | Q3 | |
| | | | | See SLM Prevention and Early Detection<br>Map diabetes prevalence in Hawke's Bay and match to services in order to provide a strategic view of delivery of services against population need and health outcomes. EOA. | Q4 | |
| | | | | See SLM prevention and early detection<br>Examine readmission rates in relation to diabetes, targeting those with 1-3 readmissions and work up plan to address.<br>(Quality Standard 14 and 15). | Q4 | |
| | | | | Specialist Diabetes service to plan and provide regular education sessions for ward staff (Quality Standard 13, 14 and 15). | Q2<br>Q4 | |
| | Pharmacy Action Plan | Continue to engage with the agreed national process to develop and implement a new contract to deliver integrated pharmacist services in the community.<br>Continue to support the vision of the Pharmacy Action Plan by working with pharmacists, consumers and the wider health sector (e.g. primary health care) to develop integrated local services that make the best use of the Pharmacist workforce. | One team | Review pharmacy services to determine access to the service by ethnicity. EOA. | Q3<br>Q4 | N/A |
| | | | | Increase understanding of medicine utilisation of medicines listed on the PHARMAC Schedule (Schedule B) from an equity view point – ethnicity, rural, age. EOA. | Q3<br>Q4 | |
| | | | | Support the vision of the Pharmacy Action Plan to work with pharmacists, consumers and the wider health sector to make the best use of the pharmacist workforce by exploring areas were pharmacist services could impact on SLMs. | Q3<br>Q4 | |
| | | | | Support local implementation of national pharmacy contract - Integrated Community Pharmacy Services Agreement. | Q2<br>Q4 | |
| | | | | Health Hawke's Bay (HB) will support general practice smoke free champions. | | |

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| | Support to quit smoking | Please identify activities that continue to support delivery of smoking ABC in primary care | | Health HB will work with the HBDHB Smokefree Team to review and implement systems and processes to support general practice referrals to and engagement with Te Haa Matea for smoking cessation. | | HT % of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months |
| | | | | Health HB will provide smoke free reporting and IT/ Practice Management Systems solutions to assist general practice to identify people who require smoke free messages, brief advice and cessation support. | | |
| | | | | Health HB will engage with high needs population especially Maori through programmes such as Whanau Wellness Resource and Kia Ora Programme with smoke free messaging and support. | | |
| Child Health (both Māori and Pasifika focussed equity actions are expected in this priority area) | Child Well-being | Please identify the most important focus areas to improve child well-being and that realises a measurable improvement in equity for your DHB.<br>Identify key actions that demonstrate how the DHB is building its understanding of population needs, including those of high-needs populations, and making connections with and between local service providers of maternal health, child health and youth focused services. | Value and high performance | Improve coordination and consolidation of Family Violence and Maternal Wellbeing and Child Protection by bringing these together under ' Haumaru Whanau' with stakeholders inclusive of Māori Health providers and general practice. This will encompass review of current structures, implementation of changes and launch. EOA. | Q3 | PP27 |
| | | | | Extend Maternal Well-being Child Protection coverage from 0-6 weeks to up to 2 years. | Q3 | |
| | | | | Develop a community advisory group for Haumaru Whānau to develop a community voice to inform co-design to ensure the needs of our most vulnerable population are met EOA. | Q4 | |
| | | | | Complete a Health Equity Report update for 2018 to inform further planning. EOA. | Q2 | |
| | | | | Roll out Year 2 of the Ngātahi Project - HB Health, education and social services (the "vulnerable children's workforce") working together as one to deliver excellent care and interventions to vulnerable children and their families. EOA. | Q4 | |
| | | | | Implement Year 3 of the Best Start – Healthy Eating and Activity Plan. | Q4 | |
| | | | | See SLM Keeping Children out of Hospital: Provide increased community based respiratory support for tamariki and their whānau during peak winter months. EOA. | Q1<br>Q2 | |
| | | | | Develop a kaupapa Māori maternal health programme to overcome barriers to access to maternal health care, eliminate inequities in maternal and child health, and improve maternal and child health outcomes EOA. | Q4 | |
| | | | | See SLM Youth are healthy, Safe and Supported: Refresh and streamline the HBDHB Youth Strategy and develop implementation plan to engage youth and | Q4 | |

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| | | | | continue to support youth to access youth friendly services. | | |
| | | | | See SLM Youth are Happy, Safe and Supported Health Hawke's Bay to continue with resilience training for youth with a focus on 1-3 decile schools. Scope the possibility of an external evaluation. | Q2<br>Q4 | |
| | Maternal Mental Health Services | Commit to have completed a stock-take by the end of quarter two, of community-based maternal mental health services currently funded by your DHB, both antenatal and postpartum.<br>Please include funding provided to PHOs specifically to address primary mental health needs for pregnant women and women and men following the birth of their baby.<br>Commit to identify, and report in quarter four on the number of women accessing primary maternal mental health services both through PHO contracts that the DHB holds and, through any other DHB funded primary mental health service. | Closer to home | Develop and implement an integrated pathway of care from primary through to secondary care for women who are experiencing maternal mental health needs. | Q1 | N/A |
| | | | | Review and evaluate the above pathway and identify any barriers/gaps for future improvement. EOA. | Q4 | |
| | | | | Develop a directory via Health Point and 'app' explaining services available to support women who are experiencing mental health needs from antenatal through to postnatal. | Q2 | |
| | | | | Complete a stock-take, of community-based maternal mental health services (both through PHO contracts that the DHB holds and, through any other DHB funded primary mental health service).<br>Report numbers of women accessing services | Q2<br>Q4 | |
| | Supporting Health in Schools | Identify actions currently under way to support health in schools by the end of quarter 2. An example can be found on the Frequently asked Questions (FAQ) sheet on the National Service Framework Libriary (NSFL) . In addition to School-Based Health Services (SBHS) – see guidance below). | Closer to home | Develop a list of actions currently under way to support health in schools (in addition to school based services). This will include the name of the initiative, what it is aiming to achieve, the age group it is provided for and coverage (decile). | Q2<br>Q4 | N/A |
| | School-Based Health Services (SBHS) | Commit to have completed a stocktake of health services in public secondary schools in the DHB catchment (MoH to provide list of schools) by the end of quarter 2.<br>Commit to have developed an implementation plan including timeframes for how SBHS would be expanded to all public secondary schools in the DHB catchment (MoH to provide template) by the end of Q4. | Closer to home | Complete a stocktake of health services in public secondary schools in HB. | Q2 | |
| | | | | Develop an implementation plan for expansion of SBHS to all public (including integrated) secondary schools in HB. This will have an equity approach and will include required timeframes, workforce requirements and barriers. EOA. | Q4 | |
| | Immunisation | Work as one team across all immunisation providers within your region, and in collaboration with other child services, to improve immunisation rates and equity for the key milestone ages in early childhood. This includes delivery of the primary series of vaccines under one | One team | Evaluate Kahungunu Executive's progress in supporting the immunisation outreach service in Wairoa targeting high needs / Maori and Pasifika infants. EOA. | Q1 | PP21 |
| | | | | Engage with Te Taiwhenua o Heretaunga (TToH) Whanake Te Kura ante natal programme, designed to engage the HB Population of largely Māori and Pasifika | Q2<br>Q4 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | year of age, and completion of immunisations due at two and five years of age, with a particular focus on increasing immunisation rates for Māori infants. | | births, to increase inclusion of immunisation education within the programme EOA. | | |
| | | | | Investigate augmenting the immunisation contract with Choices to enable them to offer national schedule vaccines across all ages. Choices is a Māori provider offering midwifery services. EOA. | Q3 | |
| | | | | Continue with quarterly Immunisation Steering group meetings including Māori providers, tamariki ora, plunket, maternity representation, school base immunisation provider, pharmacy, General Practice and Health Hawke's Bay. EOA. | Q1-4 | |
| | Responding to childhood obesity | Please identify activities that continue to respond to children identified as obese at their B4 School Check (B4SC). | | Deliver the Best Start Plan: Health Eating and Activity and monitoring progress on activities | Q4 | #referrals by ethnicity |
| | | | | Strengthen relationships with targeted Early Chidlhood In-Home Edu carers to support B4SC Independent Practitioners to screen in these settings EOA | | |
| | | | | Support referrals for 4 year olds to Active Families Under 5 programme | | |
| | | | | Support healthy conversations at the B4SC and other opportunities. | | |
| System Settings (both Māori and Pasifika focussed equity actions are expected in this priority area) | Strengthen Public Delivery of Health Services | Identify any activity planned for delivery in 2018/19 to strengthen access to public health services. | Value and high performance | Completion of our CSP(commenced in 2017/18) will highlight the need to shift the system to focus on people and whānau experiencing poorest outcomes – to be developed in response. EOA. | Q1-4 | SI16: Strengthening Public Delivery of Health Services |
| | | | | Integrate specialist community mental health services with General Practice and NGO providers. EOA. | | |
| | | | | Develop more kaupapa Māori programmes to overcome barriers to access e.g. maternal mental health, youth-friendly primary care. EOA. | | |
| | Shorter stays in emergency department | Please identify activities that continue to improve patient flows through hospital. | | Improve patient flow through AAU by recruiting two additional physicians. | Q2 | HT ED6 |
| | | | | Increase transparency of extended SMO cover to 6 pm Monday to Friday. | Q2 | |
| | | | | Extend medical registrar cover in AAU to 8 pm Monday to Friday. | Q1 | |
| | | | | Extend afternoon shift coordinator in AAU to weekends | Q3 | |
| | | | | Investigate options for establishing a surgical observation area, co-located between ED and surgical specialties. | Q3 | |
| | | | | Extend nurse practitioner cover in fast track area. | Q1 | |
| | | | | Review and implement new orderly service with a direct focus on patient flow right through the hospital. | Q4 | |

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|---|---|---|---|---|---|---|
| | | | | Consolidate kaitakawaenga presence in ED; daily morning visits supported by co-location each afternoon | Q1 | |
| | Access to Elective Services | Please provide three specific actions that will support your delivery of the agreed number of Elective discharges, in a way that meets timeliness and prioritisation requirements and improves equity of access to services.<br>At least one action to improve equity of access to Elective Services should be included.<br>These actions must be accompanied by a date for implementation of the action, an expected outcome, and a date by which the outcome will be achieved. | Value and high perform | Further surgical expansion as per project plan. | Q3 | SI4: Standardised Intervention Rates (SIRs) PP45 Elective Surgical discharges, OS3 Inpatient Length of Stay, Electives and Ambulatory Initiatives, Elective Services Patient Flow Indicators |
| | | | | Implement permanent Saturday elective operating lists in order to increase in-house surgical capacity. | Q3 | |
| | | | | Free up internal capacity by developing enhanced outsourcing relationships for targeted specialties. | Q4 | |
| | | | | Develop options with general practice, to address improvements in referrals and referral criteria, ensuring equity of access (inclusive of ethnicity) and unmet need, is included as part of discussions. | Q2<br>Q4 | |
| | Cancer Services | Implement improvements in accordance with national strategies and demonstrate initiatives that support the areas outlined below. All initiatives will demonstrate clear strategies for addressing Māori health gain, equitable and timely access to services and the use of data to inform quality improvement across those initiatives.<br>DHBs will describe actions to:<br>- Ensure equity of access to timely diagnosis and treatment for all patients<br>- Implement the prostate cancer decision support tool to improve the referral pathway across primary and secondary services<br>- Provide support to people following their cancer treatment (survivorship). | Value and high performance | Support Living Well beyond Cancer (survivorship) by informing the development of appropriate programmes, services and resources and evaluation of existing programmes, services and resources and to promoting a partnership approach between providers | Q1-4 | PP30: Faster cancer treatment |
| | | | | Explore the opportunities for a "Cancer Navigator" to be established working across primary and secondary care, with Māori and Pacific whānau referred with high suspicion of cancer. EOA. | Q2 | |
| | | | | Develop new Model of Care with MidCentral DHB sign off and review facility options for delivery of service. | Q2<br>Q4 | |
| | | | | Follow on from implementation of the Decision Support Tool (Kupe) and update of the referral priority document; to review e-referral for prostate cancer pathway, given that Map of Medicine is now not live. | Q3 | |
| | | | | Implement the National Bowel Screening Programme (NBSP), inclusive of an equity plan focusing on equity of participation in the programme and quality throughout the screening pathway. EOA. | Q2 | |
| | Healthy Ageing | Deliver on actions identified in the Healthy Ageing Strategy 2016, involving older people in service design, | Closer to home | Advance equity in the district by working proactively with the Wairoa community to drive better linkages with hospital and community-based older persons' services. EOA. | Q1-4 | PP23 |
| | | | | Use the regional infographic to support the co-design of Health of Older Person services in our high Māori community of Wairoa EOA. | Q4 | PP23 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | co-development and review, and other decision-making processes[1], including:<br>- Working with Accident Compensation Corporation (ACC), HQSC and the Ministry of Health(MoH) to promote and increase enrolment in your integrated falls and fracture prevention services as reflected in the associated "Live Stronger for Longer" Outcome Framework and Healthy Ageing Strategy<br>- Contributing to DHB and Ministry-led development of Future Models of Care for home and community support services.<br>In addition, please outline current activity to identify drivers of acute demand for people 75 plus presenting at Emergency Department (ED) or at lower ages for disadvantaged populations). | | Integrate community allied health data related to falls prevention in line with ongoing focus on promoting and increasing enrolment to the ACC/DHB falls and fracture prevention service. | Q4 | PP23 |
| | | | | Introduce Geriatric Evaluation & Monitoring (GEM) beds in AT&R to expedite the acute hospital journey for frail older people. | Q1 | SLM- Acute Hospital Bed days |
| | | | | Improve linkages with HCSS providers to reduce lapses of care provision during periods of transition. | Q1 | PP23 |
| | | | | Work with national and regional groups to contribute to the development of future models of care for home and community support services. | TBC | PP23 |
| | | | | Participate in development and implementation of regionally agreed pathways of care to support early diagnosis and management of young onset dementia. | Q1-4 | RSP SI2 |
| | Disability Support Services | Commit to develop e-learning (or other) training for front line staff and clinicians by the end of quarter 2 2018/19 that provides advice and information on what might be important to consider when interacting with a person with a disability. (Some DHBs have developed tools which could be shared, contact Disability Support Services (DSS).<br><br>Commit to report on what % of staff have completed the training by the end of quarter 4, 2018/19. | One team | Assess Waitemata e-learning module for use at HBDHB. | Q2 | SI14: Disability support services |
| | | | | Launch online e-learning tool for use by front–line staff and clinicians, and monitor % of staff completing this training. | Q4 | |
| | Improving Quality | Identify actions to improve equity in outcomes and patient experience by demonstrating planned actions to:<br>- Work to improve equity in outcomes as measured by the Atlas of Healthcare Variation (DHB to choose one domain from: gout, asthma, or diabetes)<br>- Improve patient experience as measured by your DHB's lowest-scoring question in the Health Quality & Safety Commission's national inpatient experience surveys. | Value and high performance | Refine the diabetes repository to include data from Diabetes Care Improvement Plan, triple risk and external contracts. This will allow an equity lens to be applied to the pre-diabetic and diabetic populations. EOA. | Q2<br>Q4 | SI17 Improving Quality |
| | | | | From SLM: Prevention and early detection<br>Map diabetes prevalence in HB and match to services in order to provide a strategic view of delivery of services against population need and health outcomes. EOA. | Q3 | |
| | | | | Identify the poorest scoring result in Patient Experience Survey. | Q1 | |
| | | | | Develop and implement a quality improvement programme to support improvement in the provision of information on medication side effects to watch for, when the patient goes home. (Average score = 6.3). | Q4 | |

[1] Action 26 of the Healthy Aging Strategy.

| | | | | | | |
|---|---|---|---|---|---|---|
| | Climate Change | Commit to individually and collectively make efforts to reduce carbon emissions and, where appropriate, promote the adoption of Certified Emissions Measurement And Reduction Scheme (CEMARS), or other carbon neutral scheme.<br><br>Commit to undertake a stocktake to be reported in quarter 2 to identify activity/actions being delivered, including procurement, that are expected to positively mitigate or adapt to the effects of climate change. | Value and high performance | Undertake a stocktake to identify activity/actions being delivered, including procurement, that are expected to positively mitigate or adapt to the effects of climate change. | Q2 | N/A |
| | | | | Finalise HBDHB Sustainability Policy and Action Plan. Begin initiating implementation of actions in the key areas – energy and carbon management, water, efficient buildings and site design, transport and travel management, waste. | Q2<br>Q3 | |
| | | | | Facilities Management, Māori Health and Population Health will collaborate to ensure climate change actions are in line with kaitiakitanga. EOA. | Q2<br>Q4 | |
| | Waste Disposal | Provide actions to raise awareness and actively promote the use of your DHB's pharmaceutical waste collection and disposal arrangements.<br><br>Commit to undertake a stocktake to be reported in quarter 2 of 2018/19 to identify activity/actions to support the environmental disposal of hospital and community *(e.g., pharmacy)* waste products (including cytotoxic waste). | Value and high performance | Evaluate awareness of existing programme to reduce inappropriate disposal of pharmaceutical waste in the community by increasing online presence on DHB and Council websites and work with community pharmacies on waste return options. | Q4 | N/A |
| | | | | Perform a stocktake to be reported to identify activity/actions to support the environmental disposal of hospital and community (e.g., pharmacy) waste products (including cytotoxic waste). | Q2 | |
| | | | | Facilities Management, Māori Health and Population Health will collaborate to ensure waste actions are in line with kaitiakitanga. EOA. | Q2<br>Q4 | |
| Fiscal Responsibility | | Commit to deliver best value for money by managing your finances in line with the Minister's expectations. | Value and high performance | Due to the sustained pressure on our resources we have a planned deficit of $5m for 2018-19, with the intent to return to a balanced budget in 2019-20. | Q4 | |
| Delivery of Regional Service Plan | | Identify any significant DHB actions the DHB is undertaking to deliver on the Regional Service Plan. In particular, for Elective Services, identify local actions to support planned Elective activity in the regional service plan across, Workforce, Clinical Leadership, Quality and Pathways. There is a strong focus on regional collaboration in 2018/19 for Orthopaedics, Ophthalmology, Vascular and Breast Reconstruction. | One team | Develop a business case for Percutaneous Coronary Intervention (PCI). | Q4 | SI2: Delivery of Regional Service Plans |
| | | | | Continue to work regionally to formalise care arrangements and consider further development. | Q1-4 | |
| | | | | Engage in regional discussions toward one Cancer Service. | Q1-4 | |
| | | | | Work with regional partners toward improving data quality and use. | Q1-4 | |
| | | | | Actively engage with the Central Region Vascular Network and participate in implementation of Central Region Vascular Services Model of Care | Q3 | |

## 2.3 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* | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
| ***For the year ended 30 June*** | Audited | Forecast | Projected | Projected | Projected | Projected |
| Ministry of Health - devolved funding | 504,865 | 516,592 | 528,221 | 545,660 | 563,328 | 581,012 |
| Ministry of Health - non devolved contracts | 4,599 | 14,702 | 14,181 | 14,478 | 14,797 | 15,122 |
| Other District Health Boards | 12,592 | 12,710 | 13,139 | 13,415 | 13,710 | 14,012 |
| Other Government and Crown Agency sourced | 5,861 | 6,046 | 5,921 | 6,046 | 6,179 | 6,315 |
| Patient and consumer sourced | 1,205 | 1,117 | 1,360 | 1,389 | 1,419 | 1,451 |
| Other | 5,714 | 6,104 | 4,859 | 4,961 | 5,070 | 5,182 |
| **Operating revenue** | 534,835 | 557,271 | 567,681 | 585,949 | 604,503 | 623,093 |
| Employee benefit costs | 195,883 | 209,566 | 224,637 | 231,826 | 239,708 | 248,098 |
| Outsourced services | 18,236 | 19,326 | 17,160 | 17,521 | 17,906 | 18,300 |
| Clinical supplies | 48,028 | 49,696 | 46,794 | 47,024 | 48,231 | 49,498 |
| Infrastructure and non clinical supplies | 46,000 | 50,503 | 50,538 | 54,039 | 55,975 | 56,852 |
| Payments to non-health board providers | 223,121 | 235,028 | 233,552 | 235,539 | 239,683 | 247,346 |
| **Operating expenditure** | 531,268 | 564,119 | 572,681 | 585,949 | 601,503 | 620,093 |
| **Surplus for the period** | **3,567** | (6,848) | (5,000) | - | **3,000** | **3,000** |
| Revaluation of land and buildings | - | 19,312 | - | - | - | - |
| **Other comprehensive revenue and expense** | - | 19,312 | - | - | - | - |
| **Total comprehensive revenue and expense** | **3,567** | **12,464** | (5,000) | - | **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*** | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
| *in millions of New Zealand Dollars* | Audited | Unaudited | Projected | Projected | Projected | Projected |
| **Prevention services** | | | | | | |
| Revenue | 8.9 | 9.1 | 9.0 | 9.4 | 9.7 | 10.1 |
| Expenditure | 8.0 | 8.6 | 9.0 | 9.4 | 9.6 | 9.9 |
| | 0.9 | 0.5 | - | - | 0.1 | 0.1 |
| **Early detection and management** | | | | | | |
| Revenue | 135.4 | 135.2 | 124.4 | 130.6 | 134.2 | 138.6 |
| Expenditure | 133.5 | 126.3 | 125.5 | 130.6 | 133.4 | 137.9 |
| | 1.9 | 8.9 | (1.1) | - | 0.8 | 0.8 |
| **Intensive assessment and treatment** | | | | | | |
| Revenue | 311.5 | 339.8 | 358.9 | 366.9 | 379.8 | 390.8 |
| Expenditure | 312.4 | 354.3 | 362.1 | 366.9 | 378.1 | 389.1 |
| | (0.9) | (14.5) | (3.2) | - | 1.7 | 1.7 |
| **Rehabilitation and support** | | | | | | |
| Revenue | 79.0 | 73.2 | 76.0 | 79.5 | 81.5 | 84.2 |
| Expenditure | 77.3 | 74.9 | 76.7 | 79.5 | 81.1 | 83.8 |
| | 1.7 | (1.7) | (0.7) | - | 0.4 | 0.4 |
| **Net Result** | **3.6** | (6.8) | (5.0) | - | **3.0** | **3.0** |

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

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

# 3 SERVICE CONFIGURATION

## 3.1 Service Coverage

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

## 3.2 Service Change

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

| Change | Description | Benefits of Change | Change for local, regional or national reasons |
|---|---|---|---|
| Urgent Care | Enhancement of Urgent Care Service provision for Hastings and Napier. | Improved access to after-hours care with resulting reduction in presentations and utilisation of ED as a primary care provider of care. | 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.<br>Better links between primary, community and secondary mental health services. | Local |
| | Repatriation of residential A&D services from regional contract to HBDHB. | Services closer to home | Regional / Local |
| Whole of sector mental health services | Commence redesign of MH&A services across the sector | Align with the Government Inquiry into MH&A<br>Align with CSP<br>More accessible and integrated services | Local |
| Adult 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<br>Improved access for Māori and Pasifika populations<br>Enable provision of services under the proposed Substance Addiction (Compulsory Assessment and Treatment) Bill to be implemented in 2017/18. | Regional / Local |
| Community Pharmacy and Pharmacist services | Implement the National Integrated Community Pharmacy Services Agreement and develop local services. | More integration across the primary care team.<br>Improved access to pharmacist services by consumers. | National |

| | | | |
|---|---|---|---|
| | Medicine Use Review (MUR) – review of access to DHB funded blister packing, review of service remuneration.<br>Community Pharmacy Anticoagulation Monitoring Service (CPAMS) – review of service to increase access, potential introduction of co-payment. | Consumer empowerment.<br>Safe supply of medicines to the consumer.<br>Improved support for vulnerable populations.<br>More use of pharmacists as a first point of contact within primary care.<br>Increased geographical coverage. | |
| | Continue to implement the Community Based Pharmacy Services in HB Strategy 2016-2020 | | Local |
| Surgical Expansion Project | HBDHB has received approval from the joint ministers for surgical expansion. The aim is to expand HBDHB surgical in-house capacity to better meet elective health targets and HB population surgical needs. At this stage, 'Go Live' is planned for October 2020, with a new theatre opening at 100% capacity. | HBDHB able to better meet elective health targets and population surgical needs in-house and within in budget. | Local |
| Youth Services | Youth service coordination and enhancement 2017/19. This is based on the HBDHB Youth Health Strategy 2016-19. | Better access for youth to coordinated services.<br>Services provided seek and utilise input from youth and stakeholders. | Local |
| | U18 free access to General Practice Services for high needs youth population i.e. Māori, Pasifika. | Support practices within the programme in the provision of care for 13-17yr olds responding to areas for development identified through the Royal New Zealand College of General Practitioners (RNZGP) Primary Care Youth Friendly Audit. | Local |
| Coordinated Primary Options (CPO) | Provision of care within the primary care team that prevent hospital presentations and admissions | Service review to inform redesign.<br>Expansion of current CPO programmes. | Local / Regional |
| Model of Care (primary) | Funding allocated by PHO/DHB to support the development of new models of care. | Health Care Home Model, Kaupapa Māori models of care et.al used to inform a model of care – fit for purpose for the populations of HB. | Local |
| Long Term Conditions (LTC) Management | HBDHB LTC Framework Implementation. | Socialisation of the LTC framework to inform service planning and improvement in the coordination and transitions of care for patients with LTCs. | Local |
| Older persons services | Responding to acute care needs in different ways may necessitate changes to non-acute services such as rehabilitation, social & diagnostic admissions, convalescent care, etc. Establish an Early Supported Discharge team within secondary services to support people transitioning from hospital to home. | Free up capacity to focus as appropriate on acute care needs and minimising hospital stays for frail elderly.<br>Optimal support for frailty. | Local |

| | | | |
|---|---|---|---|
| Chronic Pain | Change of model from specialist led to person and primary led. The intention is to have a Chronic Pain Service that provides an inter-disciplinary model of care that is driven by the patient allowing them choose from a selection of treatment options in Primary Care/Community settings. This will begin with a pilot programme prior to contract going out for tender | Greater access to a range of options<br>Less use of medicalised models of intervention and inappropriate use of specialist resources. | Local |
| Health and Social Care Localities | Health and Social Care Localities development supported within Wairoa and CHB. | Consumers accessing appropriate services closer to their home. | Local |
| Primary Care Development Partnership (PCDP) | Development of a Primary Care – DHB Alliance for the provision of coordinated services. | Enhancing provision and coordination of services. | Local |
| NBSP | HBDHB planning and establishment of the NBSP 'Go-Live' 9 October 2018. | Reducing mortality rates from bowel cancer provides significant social and economic benefits, improves health outcomes, service delivery and is cost effective healthcare. | Local / National |

**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: 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.

# 4 STEWARDSHIP

Our Transform and Sustain programme has shown good results. We are making significant improvements in delivering services for patients, achieving more equitable health outcomes and improving staff engagement. We have a number of large pieces of work coming together to inform our next organisational strategy i.e. our CSP, The Big Listen (staff engagement) including Kōrero Mai and an update to our Health Equity Report. Initiatives 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 HQCS's' programmes – specifically, Quality and Safety Markers (QSMs) 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

### Organisational Performance Management

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

Strategic

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

Operational

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

General

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

**Funding and Financial Management**

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, HBDHB, as the lead Government agent for the HB public health budget, must continually look for ways to manage in a fiscally prudent manner.

The cumulative effect of receiving funding below the real cost pressures faced by the DHB, has turned an unequalled run of surplus years to a financial deficit in 2017-18.

Due to the sustained pressure on our resources we have a planned deficit of $5m for 2018-19, with the intent to return to a balanced budget in 2019-20.

To manage within the planned deficit we continue with responsible reduction in our cost base, by first:

- Stopping doing things that are clinically ineffective or 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 programme.

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 DHB, Finance Risk and Audit Committee (FRAC) and EMT on a monthly basis.

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. In addition, in 2018/19 we will strengthen our commitment to alliancing with our primary care partners with the establishment of four service

level alliances. These SLAs will test collaborative co-design and pave the way for expansion in the years to come.

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 planned asset expenditure whilst we await our CSP and a refresh of our facility master plan.

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

### Shared Service Arrangements and Ownership Interests

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

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

### Risk Management

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

### Quality Assurance and Improvement.

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 HQSC. The Quality Improvement and Patient Safety (QIPS) team provide support for integrated quality improvement and performance across the HB 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 more person and whānau centred.

## 4.2 Building Capability

Over the past five years we have shifted our perspective to integration and the wider health system with our strategy 'Transform and Sustain'. In preparation for our next five year strategy, we commenced development of a CSP and a People Strategy during 2017/18. During 2018/19 we will take those input pieces and develop a new five year strategy that will link the NZ Health Strategy with our response to the key challenges identified. In addition, the national review of the health system and the national mental health inquiry will also inform our response. Broadly, we expect to be focusing on some key areas of capability development, including:

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

### Capital and Infrastructure

Our view of assets must extend across community and primary care and not just be focused on the hospital. In the future we will need fit-for-purpose primary and secondary care facilities. We will need to make best use of all existing spaces and look for opportunities in new models of care that make use of non-specific assets. In response to our clinical services planning, we expect to embark on a facilities master plan in 2018/19 that will, in turn, inform our long-term investment plan right across our capital spend profile.

### Inter-Agency Collaboration

HBDHB is working closely with other agencies to improve outcomes for the population. The HB region Regional Economic Development Strategy (Matariki) is led by an Executive Group of which the DHB is a member. The Executive have merged a Social Inclusion Strategy into Matariki so that there is now a comprehensive regional multi-agency approach based on community direction. The Social Inclusion actions include addressing barriers to employment, developing a social responsible employment sector, establishing groups to enable a community voice and developing a new sustainable operating system for social services. These innovative steps all support the outcome of greater equity and enabling all whānau in HB to benefit from economic development.

*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 SoI. MidCentral DHB will report on Allied Laundry Services Limited in its SoI, on behalf of HB, 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.

## 4.3 Workforce

During 2017/18 HBDHB sponsored The Big Listen and Korero Mai, two initiatives that were explicitly aimed at gathering better understanding of the people challenges faced by the local health system. Along with identifying what makes a good and bad day for people working in health, these exercises identified issues and challenges relating to organisational culture and staff engagement.

The healthcare context is a fast paced, rapidly changing, hugely demanding and rewarding setting in which to work in. Health care professionals are usually intrinsically motivated to do the work they do and are values-driven in their relationship with work. Yet, the constant change, increased levels of demands and complexity, and the constraints around funding, leading to perceived reduction in support and control available to staff, are all significant challenges.

We are developing a People Plan on the foundation of feedback from The Big Listen and Korero Mai, the models and theories around improving engagement, and our desire to bed in our values. We need to ensure that training keeps pace with technology changes and that our workforce reflects our cultural diversity. This will ultimately support and grow our staff to do their best, with a high level of satisfaction and engagement whilst continuing to deliver a high level of patient care which in turn realises the DHB's strategic direction. The People Plan will

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

be finalised early in 2018/19 with the overarching aim being to "Grow our People by Living our Values."

Improving workforce composition is a key priority within all areas of health care and delivery. Growing the Māori nursing workforce is one component of the Māori workforce plan that requires growth within all levels including leadership. An example of one action aimed to increase Māori nursing leadership is to complete a scoping exercise and the development of a Māori nursing database to identify the current baseline of Māori nurses and the current Maori leadership indicators within HBDHB (Timeframe to complete six months – March 2019 )

HBDHB is committed to implementing Care Capacity Demand Management (CCDM) by June 2021 with work continuing to be phased in this year.

### 4.3.1 Healthy Ageing Workforce

With ageing and other changing demographics of our population, and the increasing complexity of need, it is vital that we support and develop skills across of the formal and informal workforce. HBDHB will continue to develop models of care that enable specialist workforces to deliver education and support to non-specialist workforces while also ensuring that our workforce appropriately reflects and caters to a diverse older population. Responding to our CSP will include identifying vulnerable workforces and prioritising allied health, kaiawhina and carer and support worker development.

### 4.3.2 Health Literacy

Health literacy means that health is easy to understand. If people are to remain well at home and in their communities, then it is critical that they know when and how to access services. This is mostly about the way we organise health information and services and it is keenly related to the competencies and behaviours of the health workforce.

HBDHB is committed to:

- Genuine understanding of the status of health literacy in our organisation
- Building capacity for the health workforce to use plain language and proven health literacy practices
- Facilitating staff access to comprehensive programmes of workforce development in good health literacy practice
- Providing training in effective health literacy communication as a core part of professional development.

## 4.4 Information Technology (IT)

There are many areas that require better IT support and we recognise the importance of this. We have developed an information systems strategy and a business intelligence work plan to underpin and complement our strategic direction.

HBDHB is fully engaged nationally and regionally to ensure all work plans are connected and transparent. Full implementation of the Regional Clinical Portal and Primary Clinical Portal ManageMyHealth (MMH) are planned; we are prepared and awaiting full implementation of the national Maternity System and currently providing an interim solution for bowel screening whilst awaiting roll out of the final national solution.

We are connecting with Central Region Chief Information Officers on development and implementation of an aligned plan, e.g. sharing procurement – unified communications and clinical portal.

We are committed to implementing a sustainable fully connected IT programme of work inclusive of telehealth, integrated care and working remotely, under pinned by our own security framework within HBDHB.

| Action | Milestone |
|---|---|
| Unified Communication and Mobilising Our People: Further scheduled work toward a modern telecommunication environment that enables integrated secure communications supporting flexible work practices | Q3 |
| Primary Care Clinical Portal: Implementation of the provider portal for Community Nursing Services and Diabetes Clinical Nurse Specialists providing read/write access supporting a shared care record | Q3 |
| Regional Health Informatics Programme (RHIP) Clinical Portal: Evolve new delivery method which is value driven and clinically led to allow clinicians to on-board whilst data migration runs parallel | Q2 |

# 5 PERFORMANCE MEASURES

## 5.1 2018/19 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 4.3%<br>Age 20-64 5.4%<br>Age 65+ 1.15% | |
| 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 MH&A services for 0-19 year olds | 80% of people seen within 3 weeks.<br>95% of people seen within 8 weeks.<br>Report on activities in the Annual Plan | |
| PP10: Oral Health- Mean Decay-Missing-Filled-Teeth (DMFT) score at Year 8 | Year 1: ≤0.75<br>Year 2: ≤0.75 | |
| PP11: Children caries-free at five years of age | Year 1: ≥59%<br>Year 2: ≥59% | |
| PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years) | Year 1: 85%<br>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%<br>Year 2: 95% |
| | Number of Enrolled Pre-School and Primary School Children Overdue for their Scheduled Examinations | Year 1: ≤10%<br>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**<br>- Report on activities in the Annual Plan.<br>**Focus Area 2: Diabetes Services**<br>- Implement actions from Living Well with Diabetes<br>- Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1C indicator).<br>**Focus Area 3: Cardiovascular Health**<br>- 90% of the eligible population will have had their cardiovascular risk assessed in the last five years.<br>- 90% of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the past five years.<br>**Focus Area 4: Acute Heart Service**<br>>85% ACS patients who undergo coronary angiogram should be prescribed, at discharge, aspirin, a second anti-platelet agent, statin and an ACE/ARB (four classes) and those with LVEF<40% should also be on a beta blocker (five classes)<br>>95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days of discharge and ≥99% within 3 months<br>>70% of ACS patients undergoing coronary angiogram, door to cath, within 3 days<br>≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessments of LVEF<br>**Focus Area 5: Stroke Services**<br>- 10% or more of potentially eligible stroke patients' thrombolysis 24/7.<br>- 80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway.<br>- 80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within seven days of acute admission. |

| Performance measure | Performance expectation |
|---|---|
| | ≥ 60% of stroke patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge. |
| PP21: Immunisation coverage | 95% of two year olds fully immunised<br>95% of four year olds fully immunised<br>75% of girls fully immunised – HPV vaccine<br>75% of 65+ year olds immunised – flu vaccine<br>Report on activities in the Annual Plan |
| 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 | Report on activities in the Annual Plan.<br>Conversion rate of Contact Assessment (CA) to Home Care Assessment where CA scores are 4-6 for assessment urgency. |
| PP25:Youth mental health initiatives | Initiative 1: Report on implementation of 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.<br>Initiative 3: Youth Primary Mental Health. As reported. through PP26 (see below).<br>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 MH&A Service Development Plan | Provide reports as specified for the focus areas of Primary Mental Health, District Suicide Prevention and Post-vention, Improving Crisis Response services, improving outcomes for children, and improving employment and |

| Performance measure | Performance expectation |
|---|---|
| | physical health needs of people with low prevalence conditions. |
| PP27: Supporting Child Well-Being | Report on activities in the Annual Plan. |
| PP28: Reducing Rheumatic fever | Reducing the Incidence of First Episode Rheumatic Fever <1.5 per 100,000 |
| PP29: Improving waiting times for diagnostic services | 95% of accepted referrals for elective coronary angiography will receive their procedure within three months (90 days).<br>95% of accepted referrals for CT scans, and 90% of accepted referrals for MRI scans will receive their scan within six weeks (42 days).<br>90% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days.<br>70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days.<br>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.<br>Report on activities in the Annual Plan. |
| 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). |

| Performance measure | Performance expectation |
|---|---|
| PP33: Improving Māori enrolment in PHOs | Meet and/or maintain the national average enrolment rate of 90%. |
| 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 | 70% of infants are exclusively or fully breastfed at three months. |
| PP39 | Report on activities in the Annual Plan. |
| PP40 | Report on activities in the Annual Plan. |
| PP41 | Report on activities in the Annual Plan. |
| PP42 | Report on activities in the Annual Plan. |
| PP43 | Report on activities in the Annual Plan. |
| PP44 | Report on activities in the Annual Plan. |
| PP45 | 7,753 is the target for number of publicly funded, casemix included, elective and arranged discharges for people living within the DHB region. |
| SI1: Ambulatory sensitive hospitalisations | ASH 0-4: See SLM Improvement Plan.<br>ASH 45-64: See SLM Improvement Plan. |
| 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. |

| Performance measure | Performance expectation |
|---|---|
| | Cataract procedures - a target intervention rate of 27 per 10,000 of population.<br>Cardiac surgery - a target intervention rate of 6.5 per 10,000 of population.<br>Percutaneous revascularization - a target rate of at least 12.5 per 10,000 of population.<br>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. |
| SI12: SLM youth access to and utilisation of youth appropriate health services | See SLM Improvement Plan. |
| SI13: SLM number of babies who live in a smoke-free household at six weeks post-natal | See SLM Improvement Plan. |
| SI14: Disability support services | Report on activities in the Annual Plan. |
| SI15: Addressing local population challenges by life course | Report on activities in the Annual Plan. |

| Performance measure | Performance expectation |
|---|---|
| SI16: Strengthening Public Delivery of Health Services | Report on activities in the Annual Plan. |
| SI17: Improving quality | Report on activities in the Annual Plan. |
| SI18: Improving new-born enrolment in General Practice | 55% of new-borns enrolled in General Practice by six weeks of age.<br>85% of new-borns enrolled in General Practice by three months of age.<br>Report on activities in the Annual Plan. |
| OS3: Inpatient length of stay | Elective Length of Stay (LoS) suggested target is 1.45 days, which represents the 75th centile of national performance.<br>Acute LoS suggested target is 2.3 days, which represents the 75th centile of national performance. |
| OS8: Reducing Acute Readmissions to Hospital | ≤ 11% |
| 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**<br>New NHI registration in error (causing duplication)<br>Group A >2% and <= 4%, Group B >1% and <=3%, Group C >1.5% and <= 6%<br>Recording of non-specific ethnicity in new NHI registrations - >0.5% and <= 2%<br>Update of specific ethnicity value in existing NHI record with non-specific value - >0.5% and <= 2%<br>Validated addresses excluding overseas, unknown and dot (.) in line 1 - >76% and <= 85%<br>Invalid NHI data updates – TBC<br>**Focus Area 2: Improving the quality of data submitted to National Collections** |

| Performance measure | Performance expectation |
|---|---|
| | National Booking Reporting System (NBRS) collection has accurate dates and links to National Non-Admitted Patient Collection (NNAPC) and the National Minimum Data Set (NMDS) - >= 97% and <99.5%<br>National Collections File load Success - >= 98% and <99.5%<br>Assessment of data reported to NMDS - >= 75%<br>Timeliness of NNPAC data - >= 95% and <98%<br>**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 MH&A 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. |

## APPENDIX A: STATEMENT OF PERFORMANCE EXPECTATIONS & FINANCIAL PERFORMANCE

### 1 Statement of Performance Expectations

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

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

The SPE describes information in respect of the third financial year of our SoI 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 SoI, requires consideration of service performance. For each output class, we will assess performance in terms of the New Zealand Triple Aim (Figure 3 in SoI 2016-19). Maintaining a balance of focus across the Triple Aim is at the core of the Health Quality and Safety Commission's drive for quality improvement across the health sector.

*The system dimension: Best value for public health system resources*

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

*The population dimension: Improved health and equity for all populations*

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

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

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

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

The HBDHB SPE for the 2018/19 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<br>*For the year ended 30 June*<br>*in millions of New Zealand Dollars* | 2017<br>Audited | 2018<br>Unaudited | 2019<br>Projected | 2020<br>Projected | 2021<br>Projected | 2022<br>Projected |
|---|---|---|---|---|---|---|
| Ministry of Health | 8.7 | 8.7 | 8.6 | 9.0 | 9.3 | 9.7 |
| Other sources | 0.2 | 0.4 | 0.4 | 0.4 | 0.4 | 0.4 |
| **Income by Source** | **8.9** | **9.1** | **9.0** | **9.4** | **9.7** | **10.1** |
| *Less:* | | | | | | |
| Personnel | 1.6 | 1.4 | 1.5 | 1.5 | 1.6 | 1.7 |
| Clinical supplies | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 |
| Infrastructure and non clinical supplies | 0.4 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 |
| Payments to other providers | 5.9 | 6.8 | 7.1 | 7.4 | 7.6 | 7.8 |
| **Expenditure by type** | **8.0** | **8.6** | **9.0** | **9.4** | **9.6** | **9.9** |
| **Net Result** | **0.9** | **0.5** | **-** | **-** | **0.1** | **0.1** |

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

**Table 1** - Funding and Expenditure for Output Class 1: Prevention Servic

| Short Term Outcome | Indicator | MoH Measure | Baseline | | | | | 2018/19 Target |
|---|---|---|---|---|---|---|---|---|
| | | | Period | Māori | Pasifika | Other | Total | |
| Better help for smokers to quit | % of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking | PP31 | Jan-Dec 2017 | 96.4% | 97.7% | 94.9% | 96.1% | ≥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 2016-Dec 2017 | 88.5% | 88.8% | 93.6% | 90.2% | ≥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 | Jan-Dec 2017 | 84.0% | N/A | N/A | 86.7% | ≥90% |
| | SLM Number of babies who live in a smoke-free household at 6 weeks post-natal | SI13 | Jul-Dec 2017 | 41.2% | 65.0% | 84.4% | 66.1%% | ≥95% |
| Increase Immunisation | % of 8 month olds will have their primary course of immunisation (6 weeks, 3 months and 5 month events) on time | HT | Jan-Dec 2017 | 93% | 97% | 86% | 95% | ≥95% |
| | % of 2 year olds fully immunised | PP21 | Jan-Dec 2017 | 95% | 96% | 86% | 94% | ≥95% |
| | % of 4 year olds fully immunised | PP21 | Jan-Dec 2017 | 93% | 96% | 86% | 94% | ≥95% |
| | % of girls fully immunised – HPV vaccine | PP21 | Jul 2016-Jun 2017 | 76.9% | 72.5% | 61.3% | 70.4% | ≥75% |
| | % of 65+ year olds immunised – flu vaccine | PP21 | Jan-Dec 2017 | 54.2% | 52.4% | 59.5% | 58.5% | ≥75% |
| Reduced incidence of first episode Rheumatic Fever | Acute rheumatic fever initial hospitalisation rate per 100,000 | PP28 | Jul 2016 – Jun 2017 | 7.2 | 16.5 | NA | 1.5 | ≤1.5 per 100,000 |
| Improve breast screening rates | % of women aged 50-69 years receiving breast screening in the last 2 years | SI11 | Two Years to Dec 2017 | 68.0% | 67.5% | 74.8% | 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 | Three Years to Dec 2017 | 74.9% | 77.7% | 78.9% | 77.4% | ≥80% |
| Better rates of breastfeeding | % of infants that are exclusively or fully breastfed at 3 months | PP37 | Six months to Dec 2017 | 41%% | 43% | N/A | 51% | 70% |

## 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*** | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
| *in millions of New Zealand Dollars* | Audited | Unaudited | Projected | Projected | Projected | Projected |
| Ministry of Health | 129.9 | 129.6 | 119.1 | 125.2 | 128.6 | 132.9 |
| Other District Health Boards (IDF) | 2.1 | 2.0 | 2.2 | 2.5 | 2.5 | 2.6 |
| Other sources | 3.4 | 3.6 | 3.1 | 3.0 | 3.0 | 3.1 |
| **Income by Source** | **135.4** | **135.2** | **124.4** | **130.6** | **134.2** | **138.6** |
| *Less:* | | | | | | |
| Personnel | 26.9 | 18.7 | 20.1 | 20.7 | 21.5 | 22.2 |
| Outsourced services | 5.3 | 1.5 | 1.4 | 1.4 | 1.5 | 1.5 |
| Clinical supplies | 3.0 | 0.6 | 0.6 | 0.6 | 0.6 | 0.6 |
| Infrastructure and non clinical supplies | 8.1 | 3.3 | 3.3 | 3.5 | 3.7 | 3.7 |
| Payments to other District Health Boards | 2.6 | 2.7 | 2.8 | 2.5 | 2.5 | 2.6 |
| Payments to other providers | 87.6 | 99.5 | 97.3 | 101.8 | 103.6 | 107.2 |
| **Expenditure by type** | **133.5** | **126.3** | **125.5** | **130.6** | **133.4** | **137.9** |
| **Net Result** | **1.9** | **8.9** | **(1.1)** | **-** | **0.8** | **0.8** |

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

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

| Short Term Outcome | Indicator | MoH Measure | Baseline | | | | | 2018/19 Target |
|---|---|---|---|---|---|---|---|---|
| | | | Period | Māori | Pasifika | Other | Total | |
| Improved access primary care | % of the population enrolled in the PHO | PP33 | Jan 2017 | 96.6% | 89.5% | 98.4% | 97.6% | ≥90% |
| Reduce the difference between Māori and other rate for ASH Zero-Four - SLM | Ambulatory Sensitive Hospitalisation (ASH) rate per 100,000 zero - 4 years | SI1 / SI5 / PP22(SLM) | 12 months to Dec-17 | 6,693 | 10,000 | 4,824 | 6,000 | Māori ≤6,320 |
| Reduce ASH 45-64 | Ambulatory sensitive hospitalisation rate per 100,000 45-64 years | SI1 | | 8,092 | 8,043 | 3,404 | 4,370 | Māori ≤7,159 |
| More pregnant women under the care of a Lead Maternity Carer (LMC) | % of women booked with an LMC by week 12 of their pregnancy | | Oct to Dec 2017 | 52.4% | 50% | 76.9% | 67.1% | 80% |
| Improving new-born enrolment in General Practice | % of new-borns enrolled in General Practice by 6 weeks of age | SI18 | | | | | | ≥55% |
| | % of new-borns enrolled in General Practice by 3 months of age | | Jun to Aug 2018 | 86% | 76% | 86% | 80% | ≥85% |
| Better oral health | % of eligible pre-school enrolments in DHB-funded oral health services | PP13 | 12 months to Dec-17 | 76.1% | 77.1% | 105.2% | 90.5% | ≤10% Yr1<br>≤10% Yr2 |
| | % of children who are carries free at 5 years of age | PP11 / SI5 | | 42.6% | 31.3% | 75.0% | 59.5% | ≥59% Yr1<br>≥59% Yr1 |
| | % of enrolled preschool and primary school children not examined according to planned recall | PP13 | | 6.1% | 5.8% | 9.5% | 8.0% | 95% |
| | % of adolescents(School Year 9 up to and including age 17 years) using DHB-funded dental services | PP12 | 12 months to Dec-16 | NA | NA | NA | 68.8% | 85% |
| | Mean 'DMFT' score at Year 8 | PP10 | 12 months to Dec-17 | 1.0 | 0.9 | 0.53 | 0.72 | ≤0.75 Yr1<br>≤0.75 Yr2 |
| Improved management of long-term conditions(CVD, Acute heart health, Diabetes, and Stroke) | Proportion of people with diabetes who have good or acceptable glycaemic control (HbA1C indicator) | PP20 | 12m to Dec-17 | 35.0% | 33.0% | 50.0% | 43.0% | ≥55% |
| | % of the eligible population will have had a CVD risk assessment in the last five years | PP20 | Five years to Dec-17 | 85.0% | 83.6% | 86.7% | 86.3% | ≥90% |

| Short Term Outcome | Indicator | MoH Measure | Baseline | | | | | 2018/19 Target |
|---|---|---|---|---|---|---|---|---|
| | | | Period | Māori | Pasifika | Other | Total | |
| Less waiting for diagnostic services | % of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days (6 weeks) | PP29 | Dec-17 | NA | NA | NA | 92.5% | ≥95% |
| | % of accepted referrals for MRI scans who receive their scans within 42 days (6 weeks) | PP29 | Dec-17 | NA | NA | NA | 93.8% | ≥90% |
| Increase referrals of obese children to clinical assessment and family based nutrition, activity and lifestyle interventions | % of obese children identified in the B4SC programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions. | HT / SI5 | 6 months to Feb-18 | 97% | 100% | 100% | 98% | ≥95% |
| Improved youth access to health services - SLM | Total self-harm hospitalisations and short stay ED presentations for <24 year olds per 10,000 | SI12 | 12 months to Mar -18 | 55.2 | 33 | 43.1 | 47.3 | ≤ 45.8 |
| | % of ED presentations for 10-24 year olds which are alcohol related | | 12 months to Mar -18 | 11% | 7% | 11% | 10.5% | ≤10.5% |
| Amenable Mortality - SLM | Relative Rate between Māori and Non-Maori Non-Pasifika (NMNP) | S19 | 2015 | 2.45 relative rate | | | | ≤ 2.15 Relative rate |

## OUTPUT CLASS 3: Intensive Assessment and Treatment Services

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

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

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

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

| Intensive Assessment and Treatment | | | | | | |
|---|---|---|---|---|---|---|
| ***For the year ended 30 June*** | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
| *in millions of New Zealand Dollars* | Audited | Unaudited | Projected | Projected | Projected | Projected |
| Ministry of Health | 294.4 | 322.0 | 341.2 | 349.1 | 361.7 | 372.2 |
| Other District Health Boards (IDF) | 4.2 | 4.1 | 4.5 | 5.1 | 5.2 | 5.3 |
| Other sources | 12.9 | 13.7 | 13.2 | 12.7 | 13.0 | 13.3 |
| **Income by Source** | **311.5** | **339.8** | **358.9** | **366.9** | **379.8** | **390.8** |
| *Less:* | | | | | | |
| Personnel | 160.3 | 183.4 | 196.4 | 202.7 | 209.6 | 216.9 |
| Outsourced services | 12.9 | 17.8 | 15.8 | 16.1 | 16.4 | 16.8 |
| Clinical supplies | 44.1 | 48.2 | 45.4 | 45.6 | 46.8 | 48.0 |
| Infrastructure and non clinical supplies | 35.6 | 45.1 | 45.7 | 48.9 | 50.6 | 51.4 |
| Payments to other District Health Boards | 47.6 | 49.2 | 51.1 | 45.6 | 46.4 | 47.4 |
| Payments to other providers | 11.9 | 10.6 | 7.7 | 8.1 | 8.2 | 8.5 |
| **Expenditure by type** | **312.4** | **354.3** | **362.1** | **366.9** | **378.1** | **389.1** |
| **Net Result** | **(0.9)** | **(14.5)** | **(3.2)** | **-** | **1.7** | **1.7** |

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

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

| Short Term Outcome | Indicator | MoH Measure | Baseline | | | | | 2018/19 Target |
|---|---|---|---|---|---|---|---|---|
| | | | Period | Māori | Pasifika | Other | Total | |
| Less waiting for ED treatment | % of patients admitted, discharged or transferred from an ED within 6 hours | HT | 12 months to Jun-17 | 95.3% | 96.2% | 93.0% | 93.9% | ≥95% |
| Faster Cancer Treatment (FCT) | % of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within 2 weeks | HT | 6 months to Dec-17 | 78% | NA | 98% | 95% | ≥90% |
| | % of patients who receive their first cancer treatment (or other management) within 31 days from date of decision to treat | PP30 | 6 months to Dec-17 | 86% | NA | 90% | 89% | ≥85% |
| Patients with ACS receive seamless, coordinated care across the clinical pathway | % of ACS patients undergoing coronary angiogram, door to cath, within 3 days | PP20 | Oct to Dec-17 | 76.5% | 66.7% | 73.0% | 73.5% | >70% |
| | % of ACS patients who undergo coronary angiogram have pre-discharge assessments of LVEF | PP20 | Sep to Nov 2017 | 43% | 50% | 52% | 51% | ≥85% |
| | Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance all ACS patients who undergo coronary angiogram should be prescribed, at discharge, aspirin, a second anti-platelet agent, statin and an ACE/ARB (four classes) and those with LVEF<40% should also be on a beta blocker (five classes) | PP20 | Sep to Nov 2017 | 100% | 100% | 58% | 66% | >85% |
| | % of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within a) 30 days of discharge and b) within 3 months | PP20 | Oct to Dec 2017 | 87% | 100% | 100% | 99% | a) >95%<br>b) ≥99% |
| Equitable access to care for stroke patients | % of potentially eligible stroke patients who are thrombolysed 24/7 | PP20 | Oct to Dec 17 | 5.8% | N/A | N/A | 5.9% | 10% |
| | % of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway | PP20 | Oct to Dec 17 | 90% | NA | 78% | 79% | 80% |

| Short Term Outcome | Indicator | MoH Measure | Baseline | | | | | 2018/19 Target |
|---|---|---|---|---|---|---|---|---|
| | | | Period | Māori | Pasifika | Other | Total | |
| | % of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission | PP20 | Jan to Dec 17 | 100% | NA | 56% | 57% | ≥80% |
| | % of stroke patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team within 7 calendar days of hospital discharge. | PP20 | NA | NA | NA | NA | NA | ≥60% |
| Equitable access to surgery - Standardised intervention rates for surgery per 10,000 population for: | Major joint replacement | SI4 | 12 months to Dec-17 | N/A | N/A | N/A | 22.4 | ≥21 |
| | Cataract procedures | | | N/A | N/A | N/A | 46.6 | ≥27 |
| | Cardiac surgery | | | N/A | N/A | N/A | 4.8 | ≥6.5 |
| | Percutaneous revascularisation | | | N/A | N/A | N/A | 11.9 | ≥12.5 |
| | Coronary angiography services | | | N/A | N/A | N/A | 36.4 | ≥34.7 |
| Shorter stays in hospital | LoS Elective (days) | OS3 | 12 months to Dec-17 | N/A | N/A | N/A | 1.52 | ≤1.45 |
| | LoS Acute (days) | OS3 | 12 months to Dec-17 | N/A | N/A | N/A | 2.39 | ≤2.3 |
| Fewer readmissions | Acute readmissions to hospital | OS8 | Jan – Dec 2017 | 11.6% | 10.7% | 12.9% | 12.5% | <12.5% |
| Quicker access to diagnostics | % accepted referrals for elective coronary angiography completed within 90 days | PP29 | Dec-17 | NA | NA | NA | 87.8% | ≥95% |
| | % of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive), | PP29 | Dec-17 | 100% | 100% | 91.7% | 93.5% | ≥90% |
| | % of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 6 weeks (42 days) | PP29 | Dec-17 | 58% | 75% | 59% | 59% | ≥70% |
| | % of people waiting for a surveillance colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date | PP29 | Dec-17 | NA | NA | NA | 68% | ≥70% |
| Fewer missed outpatient appointments | Did Not Attend (DNA) rate across first specialist assessments | | Oct-Dec 2017 | 9.2% | 10.4% | 3.7% | 5.3% | ≤7.5% |
| Better mental health services | Child & youth (zero -19) | PP6 | | 4.34% | 2.40% | 3.88% | 4.07% | 4.3% |

| Short Term Outcome | Indicator | | MoH Measure | Baseline | | | | | 2018/19 Target |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Period | Māori | Pasifika | Other | Total | |
| Improving access<br>Better access to MH&A services | Proportion of the) population seen by MH&A services | Adult (20-64) | PP6 | Oct 2016 – Sep 2017 | 9.85% | 2.40% | 4.08% | 5.39% | 5.4% |
| | | Older adult (65+) | PP6 | | 1.25% | 0.65% | 1.13% | 1.12% | 1.15% |
| Reducing waiting times Shorter waits for non-urgent mental health and addiction services for Zero-19 year olds | % of zero-19 year olds seen within 3 weeks of referral | Mental Health Provider Arm | PP8 | Jan 2017 – Dec 2017 | 76.4% | 82.6% | 70.2% | 72.5% | ≥ 80% |
| | | Addictions (Provider Arm and NGO) | PP8 | | 61.1% | 100% | 85.7% | 72.1% | ≥ 80% |
| | % of zero-19 year olds seen within 8 weeks of referral | Mental Health Provider Arm | PP8 | | 94.1% | 91.3% | 88.7% | 91.2% | ≥ 95% |
| | | Addictions (Provider Arm and NGO) | PP8 | | 94.1% | 100% | 100% | 95.6% | ≥ 95% |
| Improving mental health services using discharge planning | % of clients discharged will have a quality transition or wellness plan. | | PP7 | Jan-Dec 2017 | | | | | ≥95% |
| Increasing consumer focus<br>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 | 398.2 | 158.7 | | | Maori ≤375 |
| Better patient experience - SLM | Response rate for Patient Experience Surveys - inpatient and general practice | | SI8 | | | | | 15% Inpatient 23% General Practice | 25% Inpatient 25% General Practice |
| Better aligned services - SLM | Total acute hospital bed days per capita (per 1,000 population) | | SI7 | Jan-Dec 2017 | 570 | 441 | 336 | 378 | ≤ 530 |
| More appropriate elective surgery | Number of publicly funded, casemix included, elective and arranged discharges for people living within the DHB region | | PP45 | 12 months to Jun-17 | NA | NA | NA | 7,467 | ≥7,753 |

## OUTPUT CLASS 4: Rehabilitation and Support Services

This output class includes: NASC; palliative care; rehabilitation; home-based support; aged residential care; respite care and day care for adults. Many of these services are delivered following a 'needs assessment' process and involve coordination of input from a range of providers. Rehabilitation and Support services assist people with enduring conditions and disabilities to live independently or to receive the support that they need either temporarily or over the rest of their lives. HBDHB provides NASC services 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* | 2017 Audited | 2018 Unaudited | 2019 Projected | 2020 Projected | 2021 Projected | 2022 Projected |
| Ministry of Health | 76.5 | 71.0 | 73.5 | 76.7 | 78.7 | 81.3 |
| Other District Health Boards (IDF) | 2.3 | 2.1 | 2.4 | 2.7 | 2.8 | 2.8 |
| Other sources | 0.2 | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 |
| **Income by Source** | **79.0** | **73.2** | **76.0** | **79.5** | **81.5** | **84.2** |
| *Less:* | | | | | | |
| Personnel | 7.1 | 6.1 | 6.6 | 6.8 | 7.0 | 7.3 |
| Outsourced services | - | - | - | - | - | - |
| Clinical supplies | 0.8 | 0.8 | 0.7 | 0.7 | 0.7 | 0.7 |
| Infrastructure and non clinical supplies | 1.9 | 1.8 | 1.8 | 1.9 | 2.0 | 2.0 |
| Payments to other District Health Boards | 3.9 | 4.2 | 4.3 | 3.8 | 3.9 | 4.0 |
| Payments to other providers | 63.6 | 62.0 | 63.3 | 66.3 | 67.4 | 69.8 |
| **Expenditure by type** | **77.3** | **74.9** | **76.7** | **79.5** | **81.1** | **83.8** |
| **Net Result** | **1.7** | **(1.7)** | **(0.7)** | **-** | **0.4** | **0.4** |

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

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

| Short Term Outcome | Indicator | | MoH Measure | Baseline | | | | | 2018/19 Target |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Period | Māori | Pasifika | Other | Total | |
| Better access to acute care for older people | Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population) | 75-79 years | | Jan – Dec 2017 | 202.1 | 140 | 111.2 | 137.8 | ≤130 |
| | | 80-84 years | | | 152.0 | 133.3 | 173.7 | 170.8 | ≤170 |
| | | 85+ years | | | 235.9 | 116.7 | 400 | 239 | ≤225 |
| Better community support for older people | Acute readmission rate: 75 years + | | OS8 | Jan – Dec 2017 | 11.5% | 5.7% | 13.2% | 13% | ≤11% |
| | Rate of carer stress :Informal helper expresses feelings of distress = YES, expressed as a % of all Home Care assessments | | PP23 | Oct-Dec 2017 | | | | 26% | ≤26% |
| | % of people having homecare assessments who have indicated loneliness | | | Oct-Dec 2017 | | | | 23% | ≤23% |
| Increased capacity and efficiency in needs assessment and service coordination services | Conversion rate of Contact Assessment (CA) to Home Care Assessment where CA scores are four-six for assessment urgency | | | | | | | | TBC* |
| | Clients with a Change in Health, End-stage Disease, Signs and Symptoms) (CHESS) score of four or five at first assessment | | | Oct-Dec 2017 | NA | NA | NA | 7% | 11% |
| Prompt response to palliative care referrals | Time from referral receipt to initial Cranford Hospice contact within 48 hours | | | Oct-Dec 2017 | N/A | N/A | N/A | 97.5% | ≥90% |
| More older patients receive falls risk assessment and care plan | % of older patients given a falls risk assessment<br>% of older patients assessed as at risk of falling receive an individualised care plan | | | Oct-Dec 2017 | N/A | N/A | N/A | 98.3%<br>95.5% | ≥90%<br>≥90% |

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

# 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 2018/19 financial year projections will be reported in the 2018/19 Annual Report.

## 2.1 PROJECTED FINANCIAL STATEMENTS

**Introduction**

HBDHB is planning to deliver a $5 million deficit result this year, recognising the increased demands placed on the DHB by increased acuity and patient volumes. The result for 2019/20 is expected to be break-even, with a return to the $3 million surpluses used to fund capital replacement from 2020/21.

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 DHB comprise the DHB, its 19% interest in Allied Laundry Services Limited, and its 16.7% interest in Central Region's Technical Advisory Services Limited. The DHB has no subsidiaries.

**Cautionary Note**

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

The underlying assumptions were adopted on 25 July 2018.

**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 Generally Accepted Accounting Practice (NZ GAAP). They projected financial statements have been prepared in accordance with tier 1 Public Benefit Entity Standards (PBES) accounting standards.

The accounting policies applied in the projected financial statements are consistent with those used in the 2017/18 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* | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
| ***For the year ended 30 June*** | Audited | Forecast | Projected | Projected | Projected | Projected |
| Ministry of Health - devolved funding | 504,865 | 516,592 | 528,221 | 545,660 | 563,328 | 581,012 |
| Ministry of Health - non devolved contracts | 4,599 | 14,702 | 14,181 | 14,478 | 14,797 | 15,122 |
| Other District Health Boards | 12,592 | 12,710 | 13,139 | 13,415 | 13,710 | 14,012 |
| Other Government and Crown Agency sourced | 5,861 | 6,046 | 5,921 | 6,046 | 6,179 | 6,315 |
| Patient and consumer sourced | 1,205 | 1,117 | 1,360 | 1,389 | 1,419 | 1,451 |
| Other | 5,714 | 6,104 | 4,859 | 4,961 | 5,070 | 5,182 |
| **Operating revenue** | 534,835 | 557,271 | 567,681 | 585,949 | 604,503 | 623,093 |
| | | | | | | |
| Employee benefit costs | 195,883 | 209,566 | 224,637 | 231,826 | 239,708 | 248,098 |
| Outsourced services | 18,236 | 19,326 | 17,160 | 17,521 | 17,906 | 18,300 |
| Clinical supplies | 48,028 | 49,696 | 46,794 | 47,024 | 48,231 | 49,498 |
| Infrastructure and non clinical supplies | 46,000 | 50,503 | 50,538 | 54,039 | 55,975 | 56,852 |
| Payments to non-health board providers | 223,121 | 235,028 | 233,552 | 235,539 | 239,683 | 247,346 |
| **Operating expenditure** | 531,268 | 564,119 | 572,681 | 585,949 | 601,503 | 620,093 |
| | | | | | | |
| **Surplus for the period** | **3,567** | **(6,848)** | **(5,000)** | - | **3,000** | **3,000** |
| Revaluation of land and buildings | - | 19,312 | - | - | - | - |
| **Other comprehensive revenue and expense** | - | 19,312 | - | - | - | - |
| | | | | | | |
| **Total comprehensive revenue and expense** | **3,567** | **12,464** | **(5,000)** | - | **3,000** | **3,000** |

***Table 5 – Projected Statement of Comprehensive Revenue and Expense***

| Projected Statement of Movements in Equity | | | | | | |
|---|---|---|---|---|---|---|
| *in thousands of New Zealand Dollars*<br>***For the year ended 30 June*** | 2017<br>Audited | 2018<br>Forecast | 2019<br>Projected | 2020<br>Projected | 2021<br>Projected | 2022<br>Projected |
| **Equity as at 1 July** | **91,636** | **142,346** | **154,452** | **149,095** | **148,737** | **151,380** |
| Total comprehensive revenue and expense: | | | | | | |
| Funding of health and disability services | 9,607 | 4,091 | (5,000) | - | 3,000 | 3,000 |
| Governance and funding administration | 192 | 568 | - | - | - | - |
| Provision of health services | (6,232) | 7,805 | - | - | - | - |
| | 3,567 | 12,464 | (5,000) | - | 3,000 | 3,000 |
| Contributions from the Crown (equity injections) | 47,500 | - | - | - | - | - |
| Repayments to the Crown (equity repayments) | (357) | (357) | (357) | (357) | (357) | (357) |
| **Equity as at 30 June** | **142,346** | **154,452** | **149,094** | **148,737** | **151,380** | **154,023** |

***Table 6 - Projected Statement of Movements in Equity***

## Projected Statement of Financial Position

*in thousands of New Zealand Dollars*
***As at 30 June***

| | 2017 Audited | 2018 Forecast | 2019 Projected | 2020 Projected | 2021 Projected | 2022 Projected |
|---|---|---|---|---|---|---|
| **Equity** | | | | | | |
| Paid in equity | 82,359 | 82,002 | 81,644 | 81,287 | 80,930 | 80,573 |
| Asset revaluation reserve | 67,392 | 86,704 | 86,704 | 86,704 | 86,704 | 86,704 |
| Trust and special funds (no restricted use) | 2,971 | 3,364 | 3,364 | 3,364 | 3,364 | 3,364 |
| Accumulated deficit | (10,375) | (17,618) | (22,618) | (22,618) | (19,618) | (16,618) |
| | **142,346** | **154,452** | **149,094** | **148,737** | **151,380** | **154,023** |
| **Current assets** | | | | | | |
| Cash | 15,259 | 6,488 | 4 | 4 | 4 | 4 |
| Short term investments (special funds/clinical trials) | 2,971 | 2,841 | 2,877 | 2,876 | 2,876 | 2,876 |
| Receivables and prepayments | 26,725 | 25,572 | 25,033 | 25,570 | 26,132 | 26,707 |
| Loans (Hawke's Bay Helicopter Rescue Trust) | 10 | 11 | 12 | - | - | - |
| Inventories | 4,435 | 3,907 | 4,520 | 4,615 | 4,717 | 4,821 |
| Assets classified as held for sale | 625 | - | - | - | - | - |
| | 50,025 | 38,820 | 32,447 | 33,066 | 33,730 | 34,409 |
| **Non current assets** | | | | | | |
| Property, plant and equipment | 152,280 | 178,500 | 184,887 | 190,892 | 196,385 | 190,199 |
| Intangible assets | 1,820 | 1,479 | 4,147 | 5,103 | 5,918 | 6,611 |
| Investment property | 131 | 960 | 960 | 960 | 960 | 960 |
| Investment in NZ Health Partnerships Limited | 2,504 | 2,293 | 2,293 | 2,293 | 2,293 | 2,293 |
| Investment in associates | 8,168 | 9,197 | 9,294 | 9,428 | 9,428 | 9,428 |
| Loans (Hawke's Bay Helicopter Rescue Trust) | 29 | 15 | - | - | - | - |
| | 164,932 | 192,443 | 201,581 | 208,676 | 214,984 | 209,491 |
| **Total assets** | **214,957** | **231,263** | **234,028** | **241,742** | **248,714** | **243,900** |

***Continued …***

| Projected Statement of Financial Position | | | | | | |
|---|---|---|---|---|---|---|
| *in thousands of New Zealand Dollars* | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
| ***As at 30 June*** | Audited | Forecast | Projected | Projected | Projected | Projected |
| Less: | | | | | | |
| **Current liabilities** | | | | | | |
| Bank overdraft | - | - | 8,311 | 13,704 | 15,802 | 6,003 |
| Payables and accruals | 35,447 | 34,173 | 36,242 | 37,629 | 38,444 | 39,277 |
| Employee entitlements | 34,660 | 40,020 | 37,579 | 38,781 | 40,099 | 41,503 |
| | 70,107 | 74,192 | 82,132 | 90,114 | 94,345 | 86,783 |
| **Non current liabilities** | | | | | | |
| Employee entitlements | 2,504 | 2,619 | 2,802 | 2,891 | 2,989 | 3,094 |
| | 2,504 | 2,619 | 2,802 | 2,891 | 2,989 | 3,094 |
| **Total liabilities** | **72,611** | **76,811** | **84,933** | **93,005** | **97,334** | **89,877** |
| | | | | | | |
| **Net assets** | **142,346** | **154,452** | **149,094** | **148,737** | **151,380** | **154,023** |

***Table 7 - Projected Statements of Financial Position***

## Projected Statement of Cash Flows

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

| | 2017 Audited | 2018 Forecast | 2019 Projected | 2020 Projected | 2021 Projected | 2022 Projected |
|---|---|---|---|---|---|---|
| **Cash flow from operating activities** | | | | | | |
| Cash receipts from MOH, Crown agencies & patients | 531,601 | 554,716 | 567,102 | 585,544 | 603,135 | 620,740 |
| Cash paid to suppliers and service providers | (318,817) | (329,759) | (328,390) | (327,898) | (333,697) | (340,632) |
| Cash paid to employees | (195,465) | (204,561) | (223,429) | (230,578) | (238,418) | (246,763) |
| Cash generated from operations | 17,319 | 20,396 | 15,283 | 27,068 | 31,020 | 33,345 |
| Interest received | 912 | 876 | 765 | - | - | - |
| Interest paid | (1,559) | (235) | (164) | - | - | - |
| Capital charge paid | (5,906) | (8,378) | (8,021) | (9,251) | (9,234) | (9,399) |
| | 10,766 | 12,659 | 7,863 | 17,817 | 21,786 | 23,946 |
| **Cash flow from investing activities** | | | | | | |
| Proceeds from sale of property, plant and equipment | 38 | 661 | - | - | - | - |
| Acquisition of property, plant and equipment | (14,072) | (20,192) | (20,568) | (21,092) | (21,766) | (12,030) |
| Acquisition of intangible assets | (420) | (920) | (1,600) | (1,760) | (1,760) | (1,760) |
| Acquisition of investments | 86 | (999) | (114) | - | - | - |
| | (14,368) | (21,450) | (22,282) | (22,852) | (23,526) | (13,790) |
| **Cash flow from financing activities** | | | | | | |
| Equity repayment to the Crown | 4,643 | (357) | (357) | (357) | (357) | (357) |
| | 4,643 | (357) | (357) | (357) | (357) | (357) |

***Continued …***

| Projected Statement of Cash Flows<br>*in thousands of New Zealand Dollars*<br>***For the year ended 30 June*** | 2017<br>Audited | 2018<br>Forecast | 2019<br>Projected | 2020<br>Projected | 2021<br>Projected | 2022<br>Projected |
|---|---|---|---|---|---|---|
| Net increase/(decrease) in cash and cash equivalents | 1,041 | (9,149) | (14,776) | (5,393) | (2,098) | 9,799 |
| Cash and cash equivalents at beginning of year | 15,552 | 16,593 | 7,444 | (7,331) | (12,724) | (14,822) |
| Cash and cash equivalents at end of year | 16,593 | 7,444 | (7,331) | (12,724) | (14,822) | (5,023) |
| Represented by: | | | | | | |
| Cash | 15,259 | 6,488 | (8,307) | (13,700) | (15,798) | (5,999) |
| Short term investments | 1,333 | 956 | 975 | 975 | 975 | 975 |
| | 16,593 | 7,444 | (7,331) | (12,724) | (14,822) | (5,023) |

***Table 8 - Projected Statement of Cash Flows***

| Projected Funder Arm Operating Results<br>*in thousands of New Zealand Dollars*<br>***For the year ended 30 June*** | 2017<br>Audited | 2018<br>Forecast | 2019<br>Projected | 2020<br>Projected | 2021<br>Projected | 2022<br>Projected |
|---|---|---|---|---|---|---|
| **Revenue** | | | | | | |
| Ministry of Health - devolved funding | 504,865 | 516,592 | 528,221 | 545,660 | 563,328 | 581,012 |
| Inter district patient inflows | 8,588 | 8,237 | 9,146 | 9,338 | 9,543 | 9,753 |
| Other revenue | 7 | 148 | 264 | 269 | 275 | 281 |
| | **513,461** | **524,977** | **537,631** | **555,267** | **573,146** | **591,046** |
| **Expenditure** | | | | | | |
| Governance and funding administration | 3,197 | 3,416 | 3,383 | 3,467 | 3,558 | 3,652 |
| Own DHB provided services | | | | | | |
| Personal health | 233,389 | 247,301 | 271,070 | 280,908 | 290,773 | 300,122 |
| Mental health | 24,076 | 24,435 | 23,928 | 24,430 | 24,968 | 25,517 |
| Disability support | 13,731 | 9,325 | 9,370 | 9,566 | 9,776 | 9,991 |
| Public health | 5,541 | 763 | 609 | 623 | 637 | 651 |
| Maori health | 800 | 619 | 719 | 734 | 751 | 768 |
| | 277,536 | 282,442 | 305,696 | 316,261 | 326,905 | 337,049 |
| Other DHB provided services (Inter district outflows) | | | | | | |
| Personal health | 49,110 | 51,142 | 53,376 | 54,497 | 55,696 | 56,921 |
| Mental health | 2,366 | 2,375 | 2,114 | 2,159 | 2,206 | 2,255 |
| Disability support | 3,066 | 3,305 | 3,113 | 3,179 | 3,249 | 3,320 |
| | 54,542 | 56,823 | 58,604 | 59,835 | 61,151 | 62,496 |

***Continued …***

| Projected Funder Arm Operating Results<br>*in thousands of New Zealand Dollars*<br>***For the year ended 30 June*** | 2017<br>Audited | 2018<br>Forecast | 2019<br>Projected | 2020<br>Projected | 2021<br>Projected | 2022<br>Projected |
|---|---|---|---|---|---|---|
| Other provider services | | | | | | |
| Personal health | 95,745 | 95,620 | 90,923 | 89,912 | 90,852 | 95,240 |
| Mental health | 11,302 | 11,725 | 12,407 | 12,669 | 12,948 | 13,234 |
| Disability support | 57,855 | 66,878 | 67,451 | 68,869 | 70,385 | 71,934 |
| Public health | 698 | 1,237 | 1,391 | 1,420 | 1,451 | 1,483 |
| Maori health | 2,979 | 2,745 | 2,776 | 2,834 | 2,896 | 2,959 |
| | 168,579 | 178,206 | 174,948 | 175,704 | 178,532 | 184,850 |
| **Total Expenditure** | **503,854** | **520,886** | **542,631** | **555,267** | **570,146** | **588,047** |
| | | | | | | |
| **Net Result** | **9,607** | **4,091** | **(5,000)** | **-** | **3,000** | **3,000** |

***Table 9 - Projected Funder Arm Operating Results***

| Projected Governance and Funding Administration Operating Results | | | | | | |
|---|---|---|---|---|---|---|
| *in thousands of New Zealand Dollars*<br>***For the year ended 30 June*** | 2017<br>Audited | 2018<br>Forecast | 2019<br>Projected | 2020<br>Projected | 2021<br>Projected | 2022<br>Projected |
| **Revenue** | | | | | | |
| Funding | 3,197 | 3,416 | 3,383 | 3,467 | 3,558 | 3,652 |
| Other government and Crown agency sourced | - | 7 | - | - | - | - |
| Other revenue | 30 | 67 | 30 | 31 | 31 | 32 |
| | 3,227 | 3,490 | 3,413 | 3,498 | 3,589 | 3,684 |
| **Expenditure** | | | | | | |
| Employee benefit costs | 828 | 617 | 1,145 | 1,182 | 1,222 | 1,265 |
| Outsourced services | 442 | 507 | 523 | 534 | 546 | 558 |
| Clinical supplies | 1 | - | (12) | (12) | (13) | (13) |
| Infrastructure and non clinical supplies | 819 | 852 | 811 | 828 | 846 | 865 |
| | 2,090 | 1,976 | 2,468 | 2,532 | 2,602 | 2,675 |
| Plus: allocated from Provider Arm | 945 | 946 | 946 | 965 | 987 | 1,008 |
| **Net Result** | **192** | **568** | **-** | **-** | **-** | **-** |

***Table 10 - Projected Governance and Funding Administration Operating Results***

| Projected Provider Arm Operating Results<br>*in thousands of New Zealand Dollars*<br>***For the year ended 30 June*** | 2017<br>Audited | 2018<br>Forecast | 2019<br>Projected | 2020<br>Projected | 2021<br>Projected | 2022<br>Projected |
|---|---|---|---|---|---|---|
| **Revenue** | | | | | | |
| Funding | 277,536 | 282,320 | 305,696 | 316,260 | 326,905 | 337,049 |
| Ministry of Health - non devolved contracts | 4,599 | 14,702 | 14,181 | 14,478 | 14,797 | 15,122 |
| Other District Health Boards | 4,004 | 4,473 | 3,993 | 4,077 | 4,167 | 4,259 |
| Accident insurance | 5,473 | 5,423 | 5,249 | 5,359 | 5,477 | 5,597 |
| Other Government and Crown Agency sourced | 388 | 617 | 673 | 687 | 702 | 717 |
| Patient and consumer sourced | 1,205 | 1,117 | 1,360 | 1,389 | 1,419 | 1,451 |
| Other revenue | 5,676 | 5,888 | 4,565 | 4,661 | 4,764 | 4,868 |
| | 298,880 | 314,540 | 335,716 | 346,912 | 358,231 | 369,064 |
| **Expenditure** | | | | | | |
| Employee benefit costs | 195,055 | 208,949 | 223,492 | 230,644 | 238,486 | 246,833 |
| Outsourced services | 17,794 | 18,697 | 16,637 | 16,986 | 17,360 | 17,742 |
| Clinical supplies | 48,027 | 49,696 | 46,806 | 47,036 | 48,244 | 49,511 |
| Infrastructure and non clinical supplies | 45,182 | 49,651 | 49,727 | 53,211 | 55,129 | 55,987 |
| | 306,058 | 326,993 | 336,662 | 347,877 | 359,218 | 370,073 |
| Less: allocated to Governance & Funding Admin. | 945 | 946 | 946 | 965 | 987 | 1,008 |
| Surplus for the period | **(6,232)** | **(11,507)** | **-** | **-** | **-** | **-** |
| Revaluation of land and buildings | - | 19,312 | - | - | - | - |
| **Net Result** | **(6,232)** | **7,805** | **-** | **-** | **-** | **-** |

***Table 11 – Projected Provider Arm Operating Results***

## 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 that increase compliance costs.
- No allowance has been made for the costs of unusual emergency events, e.g. pandemic or earthquake.
- Allowance has been made for the implementation costs of and net savings from regional and national entity initiatives as advised by the MoH.
- No allowance has been made for any additional capital or operating costs that may be required by the National Oracle Solution (NOS) shared financial platform 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 $129 thousand in 2018/19, and $134 thousand in 2019/20.
- Difficulties achieving the 2017/18 efficiency programme, the full year impact of ongoing transformation expenditure, and an allowance for new investment requires a $14.2 million efficiency programme for the 2018/19 year. Achievement of the efficiencies coupled with nominal increases in funding from 2019/20, is assumed to be sufficient to cope with the cost of demographically driven demand for health services going forward. 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%, 2.2% and 2.2% for 2019/20, 2020/21 and 2021/22 respectively based on Treasury forecasts for CPI inflation in the Half Year Economic and Fiscal Update 2017 published 14 December 2017).

### Revenue

- Crown funding under the national population based funding formula is as determined by MoH. Funding including adjustments has been allowed at $497.2 million for 2018/19. Funding for the years 2019/20, 2020/21 and 2021/22 will include nominal increases of $16.9 million per annum.
- Crown funding for non-devolved services of $32.4 million is based on agreements already in place with the appropriate MOH directorates, and assumes receipt of the DHB's full entitlement to elective services funding.
- Inter district flows revenue is in accordance with MoH advice.
- Other income has been budgeted at the DHB's best estimates of likely income.

### Personnel Costs and Outsourced Services

- Workforce costs for 2018/19 have been budgeted at actual known costs, including step increases where appropriate. Increases to Multi Employer Collective Agreements (MECA) have been budgeted in accordance with settlements, or where no settlement has occurred, at the DHB's best estimate of the likely increase. Personnel cost increases have been allowed for at 3.2%, 3.4% and 3.5% for 2019/20, 2020/21 and 2021/22 respectively based on Treasury forecasts for wage inflation in the Half Year Economic and Fiscal Update 2017 published 14 December 2017).
- Establishment numbers for management and administration staff have been capped by the Minister of Health at 418 FTEs, the same as in 2017/18.

### Supplies and Infrastructural Costs

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

**Services Provided by Other DHBs**

- Inter District Flows (IDFs) expenditure is in accordance with MoH advice.

**Other Provider Payments**

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

**Capital Servicing**

- Depreciation has been calculated to write off the cost or fair value of property, plant, and equipment assets, and amortisation has been calculated to write off the cost or fair value of intangible assets (software) less their estimated residual values, over their useful lives. 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 the MOH to all DHBs converted to equity on 15 February 2017. The DHB is expected to require an overdraft facility from early 2019, and borrowing costs at 6% have been recognised in the plan. No facility is currently in place.
- The capital charge rate has been allowed for at 6%.

**Investment**

- The purchase of class B shares in NZHPL relating to the Finance, Procurement and Supply Chain shared service, was completed in 2014/15 and took the total investment to $2,504,071. No allowance has been made for any further investment. No allowance has been made for any further impairment of the asset, other than the $0.2 million recognised in 2017/18, over the time horizon of the plan.
- The DHB's share of the assets in RHIP will be amortised over their useful lives. The cost of amortisation is included in infrastructural costs. No allowance has been made for any impairment of the asset before 2022/23.
- 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.
- Significant expenditure on the surgical and radiology expansion and a catherisation laboratory is planned over 2018/19 to 2020/21,
- Property, plant, equipment, intangible asset expenditure, and investments in other entities are in accordance with the table below :

| Investment | 2019 Projected | 2020 Projected | 2021 Projected | 2022 Projected |
|---|---|---|---|---|
| Buildings and Plant | 15,568 | 15,602 | 14,974 | 7,190 |
| Clinical Equipment | 3,400 | 4,050 | 5,352 | 3,400 |
| Information Technology | 3,200 | 3,200 | 3,200 | 3,200 |
| **Capital Investment** | **22,168** | **22,852** | **23,526** | **13,790** |
| Investment in RHIP | 129 | 134 | - | - |
| **Total Investment** | **22,297** | **22,986** | **23,526** | **13,790** |

**Capital Investment Funding**

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

| Investment Funding | 2019 Projected | 2020 Projected | 2021 Projected | 2022 Projected |
|---|---|---|---|---|
| Total Investment | 22,297 | 22,986 | 23,526 | 13,790 |
| *Funded by:* | | | | |
| Depreciation and amortisation | 13,648 | 14,633 | 16,332 | 16,992 |
| Operating surplus/(deficit) | (5,000) | - | 3,000 | 3,000 |
| Cash holdings/overdraft | 13,649 | 8,353 | 4,194 | (6,202) |
| **Capital Investment Funding** | **22,297** | **22,986** | **23,526** | **13,790** |

**Property, Plant and Equipment**

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

**Debt and Equity**

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

| Equity | 2018/19 $'m | 2019/20 $'m | 2020/21 $'m | 2021/22 $'m |
|---|---|---|---|---|
| Opening equity | 154.5 | 149.1 | 148.7 | 151.4 |
| Surplus/(deficit) | (5.0) | - | 3.0 | 3.0 |
| Equity repayments (FRS3) | (0.4) | (0.4) | (0.3) | (0.4) |
| **Closing equity** | **149.1** | **148.7** | **151.4** | **154.0** |

***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.

HAWKE'S BAY DISTRICT HEALTH BOARD

# SYSTEM LEVEL MEASURES IMPROVEMENT PLAN 2018/19

HAWKE'S BAY
District Health Board
Whakawāteatia

HEALTH
HAWKE'S BAY
Te Oranga Hawke's Bay

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

***System Level Measures*** are:

- outcomes focused
- set nationally
- require all parts of the health system to work together
- focus on children, youth and vulnerable populations
- connected to local clinically led quality improvement activities and contributory measures.

***Contributory measures*** are:

- chosen locally based on local needs, demographics and service configurations
- used to measure local progress against quality improvement activities

**Current System Level Measures:**

1. Ambulatory Sensitive Hospitalisations (ASH) rates for 0 -4 year olds
2. Total acute hospital bed days per capita
3. Patient experience of care
4. Amenable mortality rates
5. Babies living in smokefree homes
6. Youth access to and utilisation of youth appropriate health services

System Level Measures recognise that good health outcomes require health system partners to work together therefore district alliances are responsible for implementing these. As the Hawke's Bay alliance is currently awaiting transformation into the Primary Care Development Partnership, a local leadership team was formed across the DHB and PHO to manage this piece of work. This year we have widened our planning team to include general practice, pharmacy, Well Child Tamariki Ora providers, school based nurses, youth health providers and population health teams. A joint decision making approach to system integration and service planning is used.

As the year begins, we will be reviewing processes around both planning and implementation of the Improvement Plan to ensure wider participation right through the year and integration with the Primary Care Development Partnership.

***Our goals*** are:

**To harness perspectives from all relevant parts of the health system to identify shared vision and key objectives**
**To apply alliancing principles (way of working)**
**To use SLMs to drive system integration**
**To lead the development of the SLM Improvement Plan**

We continue to present our System Level Measures in 'poster' form as a vehicle to share these with, and engage our teams and community. A more detailed plan stands behind this Improvement Plan outlining responsibilities and leads for each measure and activity.

Although our 2018/19 milestones are around increasing equity for Māori with reference to the Treaty of Waitangi, we are keeping visibility of results for our Pasifika population and are including goals for Pacifika within our contributory measures where equity gaps are large.

**Signatures:**

Dr Kevin Snee
**Chief Executive Officer**
**Hawke's Bay District Health Board**

Mr Wayne Woolrich
**Chief Executive Officer**
**Health Hawke's Bay**
***Te Oranga Hawke's Bay***

# Keeping Children out of Hospital

## SYSTEM LEVEL MEASURE

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

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

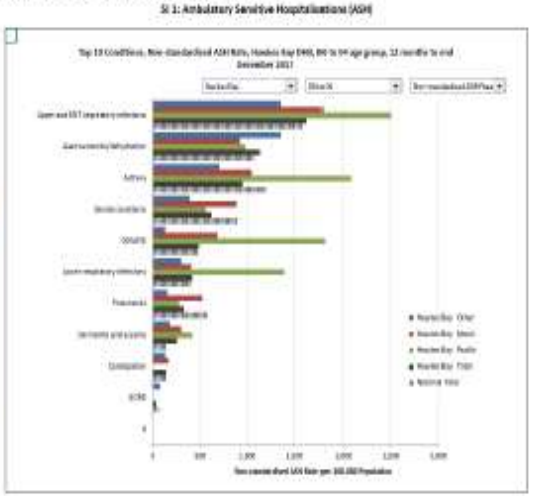
However, while ensuring early access to effective primary care is still likely to be of considerable value in reducing ASH, in countries such as New Zealand, where large socio-economic and ethnic disparities in child health exist, a greater emphasis may need to be placed on addressing those factors,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

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

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

| | Baseline* | 2018/19 Milestone |
|---|---|---|
| Total | 6,000 | Māori 6,320 (20% reduction in gap, 5 year elimination |
| Māori | 6,693 | |
| Pasifika | 10,000 | |
| Other | 4,824 | |

*12 months to December 2017



## CONTRIBUTORY MEASURES

| Measure | Baseline | Goal |
|---|---|---|
| Decreased hospitalisations due to dental conditions for Māori & Pasifika 0-4 (rate per 100,000) | Māori: 882<br>Pasifika: 556<br>Other: 390 | Māori: ≤ 784<br>Pac ≤ 523<br>20% reduction in equity gap) |
| Decreased hospitalisations due to respiratory for Māori and Pasifika 0-4 (rate per 100,000) | Māori 3,625<br>Pasifika 4,931<br>Other 2,518 | Māori ≤ 3,404<br>Pac ≤ 4449<br>(20% reduction in equity gap) |
| Decreased hospitalisations due to cellulitis for Māori and Pasifika 0-4 | Māori 681<br>Pasifika1806<br>Other 130 | Māori ≤ 543<br>Pac ≤ 1472<br>(20% reduction in equity gap) |

## HOW WILL WE ACHIEVE IT?

- Develop a respiratory pathway to standardise follow up of tamariki, post admission, by general practice.
- Provide community based respiratory support for targeted tamariki and their whānau during peak winter months.
- Develop a pathway for community oral health service referrals to secondary care to ensure the child's appropriate primary care practitioner is informed of the child's health status.
- Pilot General Practice 'Lift the Lip' at 15-month immunisation visit.
- Work with the Child Health Team to distribute the skin care resource to early childhood centres, Kohanga Reo and Punanga Reo/language nests, taking a population health approach to promotion and socialisation of the resource.

# Using Health Resources Effectively

## SYSTEM LEVEL MEASURE: Acute hospital bed days per capita

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

Reducing acute hospital bed days aligns with our challenge in Transform and Sustain of being more efficient at what we do. We continue to focus our efforts on reducing avoidable admissions through more effective care in the community, and reducing length of stay and readmission rates through better hospital processes and collaboration across the sector. The conditions with the highest impact on acute hospital beds are stroke and other cerebrovascular disorders, respiratory infections and inflammation and hip and femur procedures. The 70+ age groups make the major contribution to acute hospital bed days – however, the rate is lower than national figures.

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

For further actions around improving access to primary care see SLM - Prevention and Early Detection.

Hawke's Bay DHB of Domicile

| | Estimated Popn | Acute Stays | Acute Bed Days | Standardised Acute Bed Days per 1,000 Popn | | |
|---|---|---|---|---|---|---|
| Year | Year to Dec 2017 | Year to Dec 2017 | Year to Dec 2017 | Year to Dec 2015 | Year to Dec 2016 | Year to Dec 2017 |
| Maori | 42,188 | 8,132 | 17,008 | 601 | 585 | 570 |
| Pacific | 6,100 | 875 | 1,928 | 555 | 542 | 441 |
| Other | 113,900 | 15,416 | 51,534 | 374 | 349 | 336 |
| Total | 162,280 | 22,423 | 70,468 | 414 | 392 | 378 |

**2018/19 Milestone: Reduce standardised acute hospital bed days to ≤530 per 1,000 population for Māori (20% reduction in equity gap)**

## CONTRIBUTORY MEASURES

| Measure | Baseline | Goal |
|---|---|---|
| Decreased Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 45 – 64 year olds Māori | Māori: 8,092<br>Pasifica 8,043<br>Other: 3,404<br>Total: 4,370 | Māori: ≤7,159 (20% reduction in gap Māori and other |
| Decreased acute readmission rate (28 day) | 12.5% | TBC |
| Decreased Inpatient Average Acute Length of Stay (ALOS) | 2.39 | ≤ 2.3 |

## HOW WILL WE ACHIEVE IT?

- Increase utilisation of intermediate care beds by reviewing acceptance criteria.
- Introduce Geriatric Evaluation & Monitoring (GEM) beds in AT&R to expedite the acute hospital journey for frail older people.
- Examine readmission rates in relation to diabetes, targeting those with 1-3 readmissions and work up plan to address.
- Identify through the Whānau Wellness Resource Programme, those at risk of respiratory issues / concerns and actively screen through the respiratory programme.
- Evaluate the effectiveness of the High Needs Enrolment Programme and work with NGOs, Maori health providers, secondary services, and other stakeholders to increase the understanding, uptake and effectiveness of this programme.
- Work with general practice to investigate the feasibility of undertaking different models of patient care with the view of increasing capacity.
- Work with general practice and Hastings Hospital staff to promote and encourage increased use of the Hospital Discharge Programme with a particular emphasis on admissions associated with Diabetes, Respiratory and Cardiac Disease.
- Health Hawke's Bay to review the new urgent care model.
- Scope extension of the Co-ordinated Primary Care Options (CPO).

# Person Centred Care

## SYSTEM LEVEL MEASURE: Patient experience of care

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

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

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

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

This measure captures consumer experience in two settings:

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

| Domains | Inpatient Results Weighted Avg/10 31 May 2018 | Primary Care Results Weighted Avg/10 1 April 2018 |
|---|---|---|
| Communication | 8.4 | 8.4 |
| Partnership | 8.6 | 7.5 |
| Coordination | 8.5 | 8.5 |
| Physical and emotional needs | 8.8 | 7.5 |

**SLM 2018/19 Milestone:**
**Response rate of 25% for General Practice and 25% for Inpatients**
**Baselines: 23% General Practice and 15% Inpatient**

## CONTRIBUTORY MEASURES

| Measure | Baseline | Goal |
|---|---|---|
| HQSC primary care – proportion of Māori invited to complete survey, who respond | 11.5% Māori<br>13% Pasifika | 15%<br>15% |
| HQSC Inpatient survey – proportion of Māori responses | 15% | 20% |
| Proportion of staff having completed online Health Literacy training | DHB: 0% | DHB: 20% |
| Proportion of staff carrying out relationship centred practice training | DHB: 11% | DHB: ≥23% |

## HOW WILL WE ACHIEVE IT?

- Develop a plan to role out relationship centred practice training to the wider DHB and health sector.
- Map experience of care results across primary and secondary care; quarterly results from inpatient survey overlaid with primary care.
- Initiate a project for Consumer Experience that will include the development and implementation of an end to end process for capturing consumer feedback, reporting, analysing, through to the development of an implementation plan that will deliver continuous improvement based on survey results. This is currently in concept stage undergoing scoping activity and will identify any specific actions required to increase Māori response rates.
- Health Literacy Implementation project will deliver a number of resources to make healthcare easier to understand to the consumer through training materials and toolkits for developing new health resources.
- HQSC primary care: Identify and implement ways that Māori and Pasifika Island people can participate in the Patient Experience Survey.
- HQSC primary care: Investigate and consider other ways that could be used to collect the experience of care from Māori and Pasifika people

# Prevention and Early Detection

## SYSTEM LEVEL MEASURE: Amenable mortality rates

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

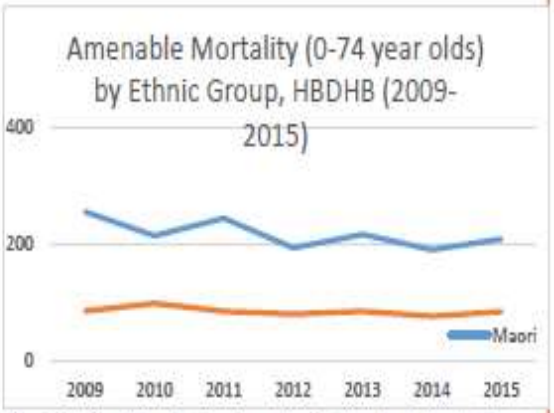
The top five causes of amenable mortality for total populations are: coronary disease, diabetes, suicide, land transport accidents (excluding trains), and female breast cancer with those for Māori being coronary disease, suicide, land accidents (excluding trains), diabetes and COPD.

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

For further actions around improving access to primary care, see SLM – Using Health Resources Effectively.

| Baseline* | 2018/19 Milestone |
|---|---|
| Māori 208.8<br>NMNP 85.1<br>Relative Rate between Māori and NMNP 2.45 | Relative Rate between Māori and NMNP ≤2.15, ≤1.8 by 2023, ≤1 by 2028 |

*Amenable mortality, ages 0-74, 2015




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

## CONTRIBUTORY MEASURES

| Measure | Baseline | Goal |
|---|---|---|
| Increased number of Māori males 35-44 yrs have had a CVD risk assessment in the past 5 years | Māori & Pasifika males 35-44yrs = 66.7% | ≥90% |
| Better help for smokers to quit (PHO) | Māori = 88.2% | ≥90% |
| Decreased ASH rate for angina and chest pain for Māori per 100,000 | Māori 1,593<br>Pacifika 1,417<br>Other 957 | Māori <1,466 |

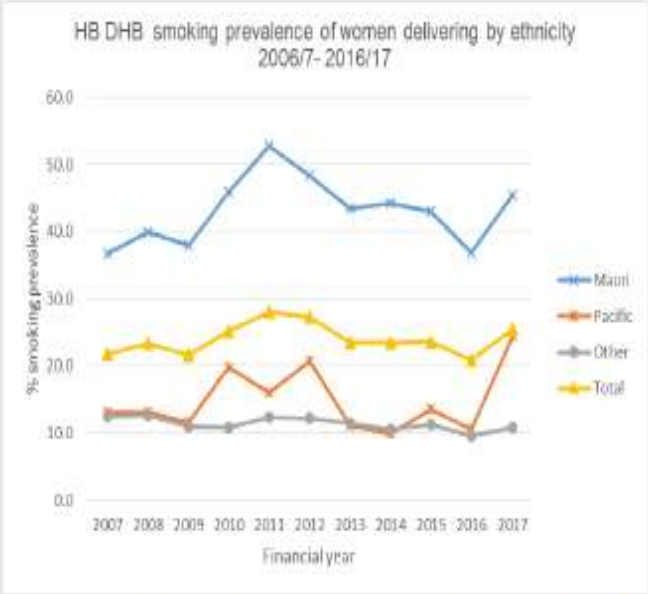
## HOW WILL WE ACHIEVE IT?

- Map diabetes prevalence in Hawke's Bay and match to services in order to provide a strategic view of delivery of services against population need and health outcomes.
- Develop an improvement plan informed by data, analysis and information to increase the provision of CVRA for Māori in line with national guidelines. This will be inclusive of Māori Women.
- Implement the Pre-diabetes Intervention Research Programme to assess reasons for variation in patient response post Pre-diabetes Nutrition Programme.
- Implement the HBDHB Tobacco Strategy 2017-2022.
- Support the Breast Screening Mobile visit to Flaxmere, Wairoa and CHB to reduce the number of Priority women who DNA.
- Health Hawke's Bay to review Services to Improve Access (SIA) inclusive of Care Plus and Health Promotion with a view to 'right care, right time'.

# Healthy Start

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

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




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

SLM Milestone: Reduce the number of 'blank' responses to household smoker question. **Baseline: 16% 'Blank' Target 10% 'Blank'**

## CONTRIBUTORY MEASURES

| Measure | Baseline | Goal |
|---|---|---|
| Increased % of Māori women, booked with an LMC by week 12 of their pregnancy | Māori: 52.4%<br>Pasifika: 50.0%<br>Other: 76.9%<br>Total: 67.1%<br>Dec 2017 | ≥80% Māori |
| % of women who become smokefree over their pregnancy | Māori TBC<br>Other TBC | Improvement on baseline TBC Q1 |

## HOW WILL WE ACHIEVE IT?

- Form a group with representatives from key providers to complete a map of tobacco use in Hawke's Bay, this will inform any updates to the Tobacco Strategy in 2019
- Develop a Kaupapa Māori Maternal Health programme, which includes a specific focus on providing culturally appropriate smoking cessation advice for pregnant Māori women, mothers, and their whanau.
- Review and implement efficient systems and processes to support referrals to and engagement with Te Haa Matea for smoking cessation.
- Work with the Well Child Tamariki Ora Quality Improvement Group to ensure the smoking status of every mother is identified at the six week visit .
- Work with Well Child Tamariki Ora providers and Quality Improvement manager from Central Region TAS to monitor and improve quality of the smokefree data being recorded.
- Implement the HBDHB Tobacco Strategy 2017-2022 and link to population health planning activity.

# Youth are Healthy, Safe and Supported

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

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

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

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

The Hawke's Bay Youth Consumer Council has identified Alcohol and Other Drugs and Mental Health and Well-being as their two top priorities for the System Level Measure. These areas will be developed with a strong focus on youth experience of the health sector.

SLM Milestones:

| Baseline: TBC | 2018/19 Milestone: TBC Due to queries around accuracy of data |
|---|---|

Reduced Alcohol related ED presentations for 10-24 year olds

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

| | Baseline per 10,000 pop'n | 2018/19 Milestone |
|---|---|---|
| Māori | 55.2 | Total 45.8 per 10,000 (3% decrease) |
| Pasifika | 33.0 | |
| Other | 43.1 | |
| Total | 47.3 | |

## CONTRIBUTORY MEASURES

| Measure | Baseline | Goal |
|---|---|---|
| Reduced % of 'unknown' as answer to alcohol related presentation question in ED | 5.4% | ≤5% |
| Increased % of schools with a developed alcohol policy | TBC | 25% of schools |
| Increased utilization rate of general practice by 13-17 year olds | 44% | ≥54% |

## HOW WILL WE ACHIEVE IT?

- Use findings of the Ministry of Health Mental Health Inquiry to identify required activities and measures.
- Refresh and streamline the HBDHB Youth Strategy and develop an implementation plan to engage youth and continue to support youth to access youth friendly services.
- ED data relating to multiple presentations by 13-17 year olds is made available to primary care providers, participating in the 13-17 zero fees programme. This will enable activities to re-engage youth with appropriate services.
- Implement the HBDHB Alcohol Harm Reduction Strategy (2017-2022), work with ED staff to review and improve the quality of ED Alcohol data being collected.
- Health Hawke's Health to continue with resilience training for youth with a focus on 1-3 decile schools. Scope the possibility of an external evaluation.
- Develop a HB Sexual Health Strategy aligned to HBDHB Youth Strategy.
- Fully utilise 50 Youth Mental Health Packages of Care.
- Public Health Nurses to work collaboratively with Population Health team to increase number of schools with an alcohol policy in place.