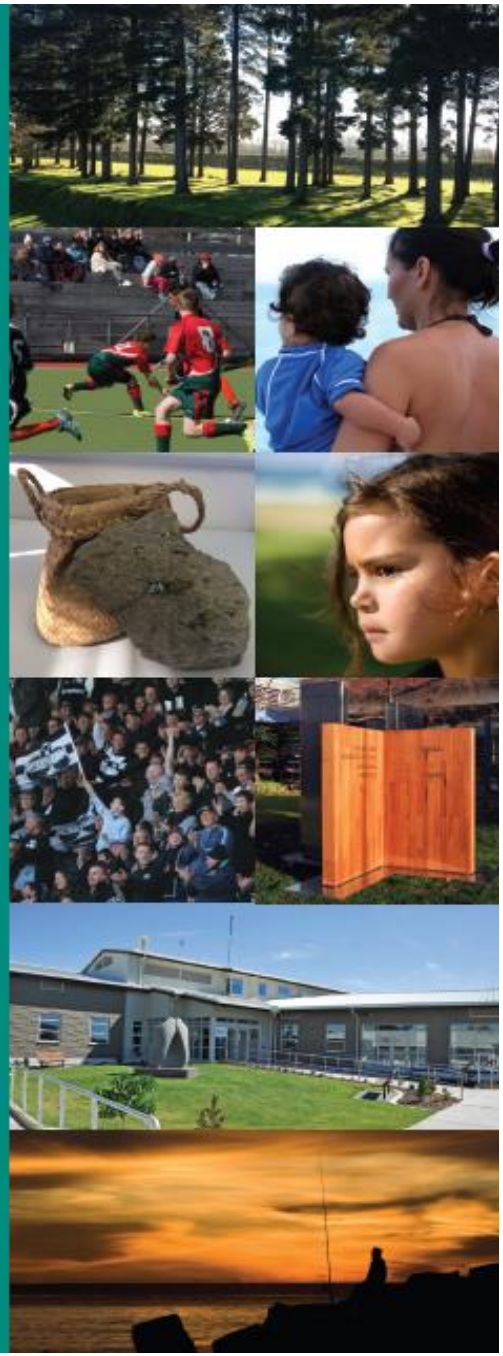
HAWKE'S BAY DISTRICT HEALTH BOARD

ANNUAL PLAN 2016/17

with Statement of Intent
2016 – 2019
and
Statement of Performance Expectations
2016/17

HAWKE'S BAY
District Health Board
Whakawāteatia



OUR VISION

“HEALTHY HAWKE’S BAY”

“TE HAUORA O TE MATAU-A-MAUI”

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

OUR VALUES / BEHAVIOURS

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 2016/17

DHB Contact Information:
Planning, Informatics & Finance
Hawke’s Bay District Health Board
Private Bag 9014
HASTINGS
Ph: 06-878 8109
www.hawkesbay.health.nz

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Office of Hon Dr Jonathan Coleman

Minister of Health
Minister for Sport and Recreation
Member of Parliament for Northcote

- 2 SEP 2016

Mr Kevin Atkinson
Chairperson
Hawke's Bay District Health Board
Private Bag 9014
HASTINGS 4156

kevin.atkinson@penkev.co.nz

Dear Mr Atkinson

Hawke's Bay District Health Board 2016/17 Annual Plan

This letter is to advise you I have approved and signed Hawke's Bay District Health Board's (DHB's) 2016/17 Annual Plan for one year.

I wish to emphasise how important Annual Plans are to ensure appropriate accountability arrangements are in place. I appreciate the significant work that is involved in preparing your Annual Plan and thank you for your effort.

The Government is committed to improving the health of New Zealanders and continues to make significant investments in health services, including for electives initiatives. In Budget 2016 Vote Health received an additional $2.2 billion over four years, demonstrating the Government's on-going commitment to protecting and growing our public health services.

As you are aware, the refresh of the New Zealand Health Strategy is now complete and the Strategy provides DHBs and the wider sector with a clear strategic direction for delivery of health services to New Zealanders. I note that you have committed to the Health Strategy and its themes in your 2016/17 Annual Plan and I look forward to seeing your progress throughout the year. In order to ensure that the Strategy is informing DHB planning, and in order to ensure value and high performance throughout the health sector, I am considering changes to streamline annual plans in the future and you will be engaged in this process.

Living Within our Means

In order to assist the Government to remain in surplus in 2016/17, DHBs are required to budget and operate within allocated funding and to identify specific actions to improve year-on-year financial performance to live within their means. This includes seeking efficiency gains and improvements in purchasing, productivity and quality aspects of DHBs' operation and service delivery. Additionally, improvements through national, regional and sub-regional initiatives must continue to be a key focus for all DHBs.

I am pleased to see that your DHB is planning a surplus for 2016/17 and for the following three years. I expect that you will have contingencies in place, should you need them, to ensure that you achieve your planned net result for 2016/17.

Private Bag 18041, Parliament Buildings, Wellington 6160, New Zealand. Telephone 64 4 817 6818 Facsimile 64 4 817 6518

National Health Targets

Your Annual Plan includes positive actions that will support health target performance for your population. However, as you know, I am concerned about the pace of improvement in relation to the *faster cancer treatment* health target and remind you that this needs to be a particular focus of your service delivery, as does the *improved access to elective surgery* health target given the additional investment made in this area.

I expect delivery of your Annual Plan will improve your performance in relation to the *better help for smokers to quit* and the *faster cancer treatment* health targets, where your most recently published results indicate further work is needed. In addition, I expect that you will also continue to focus on delivery of the *more heart and diabetes checks* target goal.

As you are aware, the *raising healthy kids* health target was launched at the beginning of July 2016 and will see 95 percent of obese children identified in the B4 School Check programme offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions by December 2017. I am pleased to note that your Annual Plan shows a clear plan for achievement of the target and I look forward to hearing of the progress made in your district.

System Integration including Shifting Services

As you are aware, DHBs are expected to continue focussing on integrated healthcare and to shift services closer to home in 2016/17, in line with one of the core Health Strategy themes of providing services and care closer to home. The ability of DHBs to shift services is varied based on local need, context and scalability and can range from co-locating outpatient clinics in the community, through to redesign of services.

I understand that Hawke's Bay DHB has committed to continue its annual community investment reprioritisation review, develop an integrated model of care for Wairoa, explore the possibility of expanding its integrated district nursing service to Wairoa and central Hawke's Bay, and provide sustainable funding for the primary care respiratory management service. I look forward to being advised of your progress with these throughout the year. If these activities trigger the service change protocols you will need to follow the normal service change process.

Cross-government Initiatives and Collaboration

Delivery of Better Public Services continues to be a key focus for the Government. Of the ten whole-of-government key result areas, the health service is leading the following areas:

- increased infant immunisation
- reduced incidence of rheumatic fever
- reduced assaults on children.

In addition to these areas, the health service has a significant role in supporting and contributing to other cross-agency work that will have significant impacts on health outcomes, such as Reducing Unintended Teenage Pregnancy (as a sub-focus of the Better Public Service Result One), Whānau Ora, the Children's Action Plan, Healthy Families New Zealand and Youth Mental Health.

I note that you have included a clear focus and appropriate actions to demonstrate that you are working as one team to deliver on these priorities within your 2016/17 Annual Plan.

Annual Plan Approval

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 of Health. Please ensure that you advise the Ministry as early as possible of any proposals for service change that may require Ministerial approval. Approval of the Plan also does not constitute approval of any capital business cases that have not been approved through the normal process.

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 2016/17 Annual Plan. I look forward to seeing your achievements, in particular in relation to IT programmes, mental health and the New Zealand Health Strategy.

Please ensure that a copy of this letter is attached to the copy of your signed Annual Plan held by the Board and to all copies of the Annual Plan made available to the public.

Yours sincerely

Hon Dr Jonathan Coleman
Minister of Health

cc Dr Kevin Snee
Chief Executive
Hawke's Bay District Health Board
Private Bag 9014
HASTINGS 4156

kevin.snee@hawkesbaydhb.govt.nz

STATEMENT FROM THE CHAIR AND CHIEF EXECUTIVE

Our strategic plan Transform and Sustain is currently being refreshed to ensure we continue to meet the outcomes we set out to achieve. The New Zealand Health Strategy will also inform the Transform and Sustain refresh. The New Zealand Health Strategy is already consistent with this plan.

We continue to build on our excellent relationship with the Primary Healthcare Organisation (PHO): Health Hawke's Bay – Te Oranga Hawke's Bay and other key Organisations to ensure a whole of health system approach. These relationships are key to successfully shifting services into the community and primary care as we have done with District Nursing, Pharmacy Facilitators and Health of Older People Services to name a few examples. This year we will focus on expanding the District nursing and Respiratory programmes in primary care. We will also be increasing primary care capacity to improve access to planned and unplanned care in the community, particularly for vulnerable groups. We will also be celebrating the opening of our new Primary Maternity Unit in July 2016.

Collaboration with other public sector organisations is vital for improving the health of the population. We are working with the intersectoral forum on two key programmes - Economic Development and Social Inclusion.

Heading into the 2016/17 year we are planning to deliver our sixth consecutive surplus. Our baseline funding from the Ministry of Health continues to grow but, in order to fund approved investments along with additional spending needed by our various service directorates, we have a savings plan of $13 million for 2016/17. This is prudent management of resources which allows us to invest in new innovations and services in line with the triple aim that underpins Transform and Sustain.

This annual plan focuses on the 2015/16 year which ends on 30 June 2016. An annual plan is a legal requirement and is the primary accountability document between the Minister of Health and HBDHB.

X_____

Dr Kevin Snee

Chief Executive - Hawke's Bay District Health Board

X_____

Kevin Atkinson

Board Chair – Hawke's Bay District Health Board

X_____

Hon. Dr Jonathan Coleman

Minister of Health

THE PRIMARY HEALTHCARE ORGANISATION

In the 2016 financial year Health Hawke's Bay and Hawke's Bay District Health Board (HBDHB) strengthened our relationship through a number of ways, the secondment of the CEO of Health Hawke's Bay to the role of General Manager Primary Care at HBDHB being one. The purpose of this secondment has been to ensure the focus of both organisations is aligned to the national strategic picture of providing care closer to home.

We take a one team approach toward the achievement of our vision: 'excellent health services working in partnership to improve the health and wellbeing of our people and to eliminate health inequalities within our community'. This 'one team' is not limited to the PHO and the DHB but also includes those from other sectors in our community that influence health outcomes such as social care, education, justice etc.

This plan identifies a number of programmes that will support joint working across the public sector in Hawke's Bay. To enhance the patient journey, uplift our community and support the elimination of inequities we will focus resources on those most in need. By progressing health and social care networks we will be creating people powered community engagement models across Central Hawke's Bay, Te Wairoa, Napier and Hastings

The year ahead, as set out in this plan, will be a tipping point in our development of smarter systems. We will jointly progress the vision of a shared care record and further encourage our population uptake of patient portal.

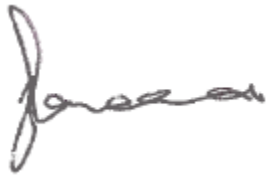
HBDHB and Health Hawke's Bay are jointly committed to supporting general practice and our community providers. Developing systems and processes that enable them to release time and capacity to continue delivering quality services will maximise value, high performance and sustainability.

We are unified with HBDHB through our common vision and values and will continue to progress our one team agenda. Joint planning is prominent throughout this plan and this approach extends to all strategic planning, governance services and management accountabilities to collectively deliver on the requirements of our population.

X_____

Liz Stockley, Chief Executive Health Hawke's Bay – Te Oranga Hawke's Bay

MĀORI RELATIONSHIP BOARD



X_____

Ngahiwi Tomoana, Chair - HBDHB Māori Relationship Board

ALLIANCE LEADERSHIP TEAM

This plan is agreed to by the Alliance Leadership Team

X_____

Bayden Barber, Member – Hawke's Bay Alliance Leadership Team

1 INTRODUCTION & STRATEGIC INTENTIONS

1.1 Executive Summary

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 vision is simple - we want everyone in Hawke's Bay district to be healthy. The funding and provision of services is guided by our statutory obligations and by priorities established at the national, regional and local levels. As an integrated health system, we rely on networks of suppliers across the spectrum of care and across New Zealand. Our organisation is the district's largest single employer making us a significant contributor to the local economy. The population of Hawke's Bay district has some unique characteristics compared to the rest of New Zealand in terms of health status and socio-demographics, and this provides us with some specific challenges.

Locally, we are guided by a health-sector strategic framework and our five year strategic programme - Transform and Sustain, which was launched in December 2013. Our three priority goals for Transform and Sustain are: responding to our population; delivering consistent high-quality care; and being more efficient at what we do. Through the programme we will contribute to the Government's priorities for the health system, which include fiscal discipline, working across government, shifting and integrating services, improving health information technology, achieving the National Health Targets, and tackling the key drivers of morbidity such as obesity. The refreshed New Zealand Health Strategy will drive new initiatives and the five main themes will be embedded into everyday practice. We also work collaboratively for optimal arrangements by aligning our work to a Regional Services Plan developed on behalf of the six Central Region DHBs - Whanganui, Mid-Central, Wairarapa, Hutt Valley, Capital & Coast, and Hawke's Bay. Fiscal responsibility means that we plan for modest annual operating surpluses that enable us to invest in programmes that will deliver the necessary transformational change for ongoing quality improvement.

Our Statement of Intent outlines our strategic intentions for the next four years and shows how local outputs impact on our population and contribute to local, regional and system-level outcomes. The health system outcomes are defined by the Ministry of Health as New Zealanders living longer, healthier and more independent lives, and a cost effective health system supporting a productive economy. Over time, we will measure progress towards our vision by considering patient and whānau experiences of care, resource sustainability and life expectancy gap as headline system outcomes plus a suite of 21 key supporting dimensions that will be evidence of impact.

Targets for service performance standards for the 2016/17 year and are set out in the Statement of Performance Expectations grouped according to four reportable classes of outputs: Prevention Services; Early Detection and Management Services; Intensive Assessment and Treatment Services; and Rehabilitation and Support Services. A set of financial statements for the 2016 to 2020 period are also included. Actual results will be audited against those forecasts by Audit New Zealand after the end of each financial year.

X_____

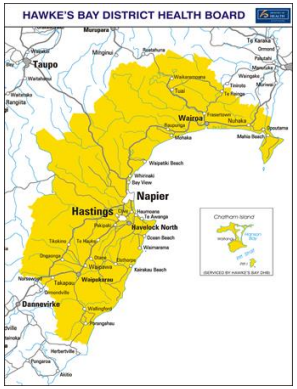
Board Member

X_____

Board Member

1.2 Context

Hawke's Bay District Health Board (HBDHB) is one of 20 District Health Boards (DHBs) that were established by the New Zealand Public Health and Disability Act 2000 (NZPHD Act). HBDHB is the Government's funder and provider of public health services for the 161,300[1] people resident in the Hawke's Bay district. A map of the district, which is defined by the NZPHD Act is shown in Figure 1. In 2016/17, HBDHB's allocation of public health funds will be $504 million, including 3.90%[2] of the total health funding that the Government allocates directly to all DHBs.



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

Figure 1: Hawke's Bay District Health Board District

Funding and Provision of Services

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

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

Other organisations we fund may be community-based private entities, such as residential care providers or individual pharmacists, or may be public entities, such as other DHBs. In 2016/17 we will fund over $231 million worth of services from other providers. 78% (2015/16 76.5%) of those services will be from primary care and private providers mostly based in Hawke's Bay communities and the other 22% will be from other DHBs for more specialised care than is provided locally.

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

Because population numbers are too small to justify a full range of service provision in every district, each DHB is also part of a regional grouping that is coordinated to optimise service delivery. HBDHB is part of the Central Region along with Whanganui, Mid-Central (Manawatu), Capital and Coast (Wellington & Kapiti), Hutt Valley and Wairarapa DHBs. There are approximately 884,000 people living in the Central Region - around 19% of the total New Zealand population.

Despite this larger grouping, a small number of specialised services cannot be efficiently provided even at the regional level and these are, therefore, arranged as national services located at one or two provider hospitals for the whole of New Zealand. Examples are clinical

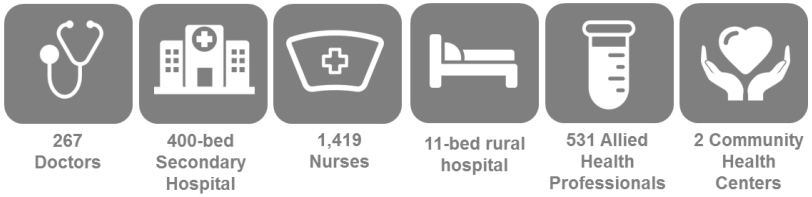
[1] Estimated for 2016 by Statistics New Zealand based on assumptions specified by Ministry of Health
[2] HBDHB share has decreased from 3.96% in 2015/16.
[3] DHB performance objectives are specified in section 22 of the NZPHD Act.

genetics and paediatric cardiology. These services are planned and funded centrally by the National Health Board with all DHBs having access.

Organisational Overview

With over 2,900 employees, HBDHB is the district's largest employer. Our provider arm is known as Health Services and our frontline services are delivered to patients and consumers across the district in a number of settings. For example, we provide public health programmes in schools and community centres, inpatient and outpatient services in leased and owned health facilities, and mobile nursing services in people's homes. The main health facilities include Hawke's Bay Fallen Soldier's Memorial Hospital, Wairoa Hospital and Health Centre, Napier Health Centre and Central Hawke's Bay Health Centre. In addition, we have significant investment in clinical equipment, information technology and other (non-clinical) moveable assets. Corporate and clinical support services are located appropriately to provide effective back-up to our frontline services.

Our organisation is governed by a Board with eleven members, seven of whom are elected every three years (last election in 2013) and four of whom are appointed by the Minister of Health. The Board is advised by four committees that include clinical, community and consumer representation. The Board employs the Chief Executive Officer to lead an executive management team, who oversee the day-to-day operations of the organisation.



Icons made by Freepik from www.flaticon.com

Our population

In 2016/17, the Hawke's Bay district population will grow slightly to just under 162,000 people. Most of our population live in Napier or Hastings, two cities located within 20 kilometres of each other that together account for more than 80% of the total numbers. About 10% of the population live in or close to Wairoa or Waipukurau, which are relatively concentrated rural settlements, and the remaining 10% live in rural and remote locations.

Compared to New Zealand averages, there are some important differences in the makeup of our population – we have a higher proportion of Māori (26% vs 16%), more people aged over 65 years (18% vs 15%) and more people living in areas with relatively high material deprivation (28% vs 20%). The 2013 New Zealand Index of Deprivation (NZDep13)[4] explains how relative deprivation, as one measure of socio-economic status, is an indication of disadvantage in terms of people's opportunity to access and use the health system. Figure 2, shows the pattern across Hawke's Bay DHB according to NZDep2006 – this is not expected to be markedly different to NZDep2013.

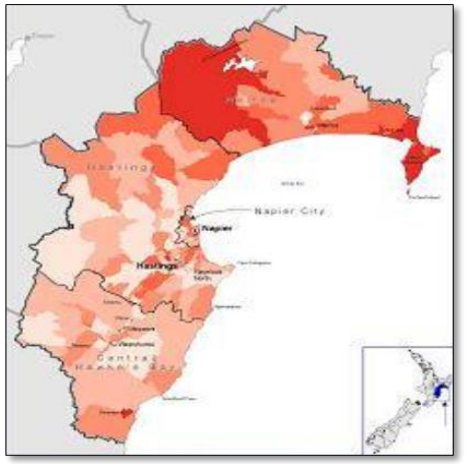


Figure 2: Hawke's Bay District relative deprivation – Darker colour higher deprivation, and lighter colour, lower deprivation

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

Health Status

In 2014 we produced the Health Equity in Hawke's Bay report, an analysis and report on health status in Hawke's Bay. The main focus of the report was on equity because health inequities are differences in health status that are avoidable or preventable and therefore unfair.

The report finds many inequities in health in Hawke's Bay, particularly for Māori, Pasifika and people living in more-deprived areas. There are also areas where, with determined and focused effort, we have improved outcomes and reduced inequities. This demonstrates that inequities are not inevitable. We can change them if we have the courage and determination to do so.

Key findings:

- *More deaths at younger ages:* More Māori, more Pasifika and more people living in the most deprived parts of Hawke's Bay are dying at younger ages
- *Socioeconomic conditions:* Social inequity in Hawke's Bay is widening. The health impacts on children are more immediate and rates of admission to hospital for 0-14 year olds for conditions known to be strongly linked to social conditions are increasing, particularly for Pasifika and Māori children
- *Tobacco use:* The leading cause of avoidable deaths amongst Māori women is now lung cancer. High smoking rates amongst pregnant Māori women is a significant health issue.
- *Obesity:* One in three adults in Hawke's Bay is obese. Hawke's Bay men and women are less active in all age groups than their New Zealand average counterparts
- *Alcohol use:* One in every four adults in Hawke's Bay is likely to be harming their own health or causing harm to others through their alcohol use.
- *Access to primary care:* High self-reported unmet need and higher rates of avoidable hospital admissions, especially amongst 45-64 year olds, show that there continue to be access issues to primary care.

The Health Equity Report concludes that inequity affects everyone and, for a difference to be made, we must tackle this collectively and take responsibility as a community. Since release, the findings of the report have been widely shared. The level of interest has been very positive and has led to the Hawke's Bay Intersectoral Forum[5] taking a role in putting together an action plan, with nominated sector leads, to address priority areas. This multi-agency approach aims to bring a full range of relevant providers together with public, philanthropic and private funders to implement novel opportunities to integrate efforts that will address inequity as a community.

The full Health Equity Report can be accessed from our website. Health status reviews rely on up-to-date population information and HBDHB conducts periodic updates with full reviews following the release of Census data. The next full review is likely to be conducted following the 2018 Census.

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

1.3 Strategic Intentions

Integrating the funding and provision of health and disability services across national, regional and local levels necessitates alignment of strategic direction in the same manner.

National

The driving goals for Government and the State Sector are that New Zealanders have greater opportunities, enjoy greater security, and experience greater prosperity. The health system contributes to these goals by working towards New Zealanders living longer, healthier and more independent lives, and by supporting New Zealand's economic growth.

Government's priorities for the health system are communicated to all DHBs through the Minister of Health's annual "Letter of Expectations"[6]. For 2016/17 the Government's investment of an extra $3 billion in health over the past seven years is highlighted alongside a requirement that DHBs operate within allocated funding and drive efficiency in back-office processes and collaboration at national, regional and sub-regional levels. The Minister also expressed expectations regarding working across government, shifting and integrating services, improving health information technology, achieving the National Health Targets, and tackling the key drivers of morbidity.

The refreshed New Zealand Health strategy sets a clear strategic direction for the sector which DHBs will follow to ensure all New Zealanders live well, stay well and get well. The focus for the sector is based on five themes: People Powered, Closer to Home, Value and High Performance, One Team and Smart System.

There is an ongoing focus on the Better Public Services initiatives and the national health targets with a particular emphasis on reducing the incidence of obesity in New Zealand.

Regional:

A Regional Services Plan (RSP)[7] 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.

Local

In 2013, we published Transform & Sustain[8], our strategic plan for 2014 – 2018. Transform & Sustain provides common understanding of our direction and began with sector-wide agreement on a common vision:

"Excellent health services working in partnership to improve the health and wellbeing of our people and to reduce health inequities within our community."

Underpinning that vision are values, principles, aims, goals and strategies that are summarised in our Strategic Framework in Appendix 1.

The logic that links the impact of our work locally to local, regional and national strategic intentions is shown in Figure 3.

[6] Minister of Health's Letter of Expectations, December 22nd 2015.
[7] Regional Services Plan 2016-2017

[8] Available from our website: http://www.hawkesbay.health.nz/

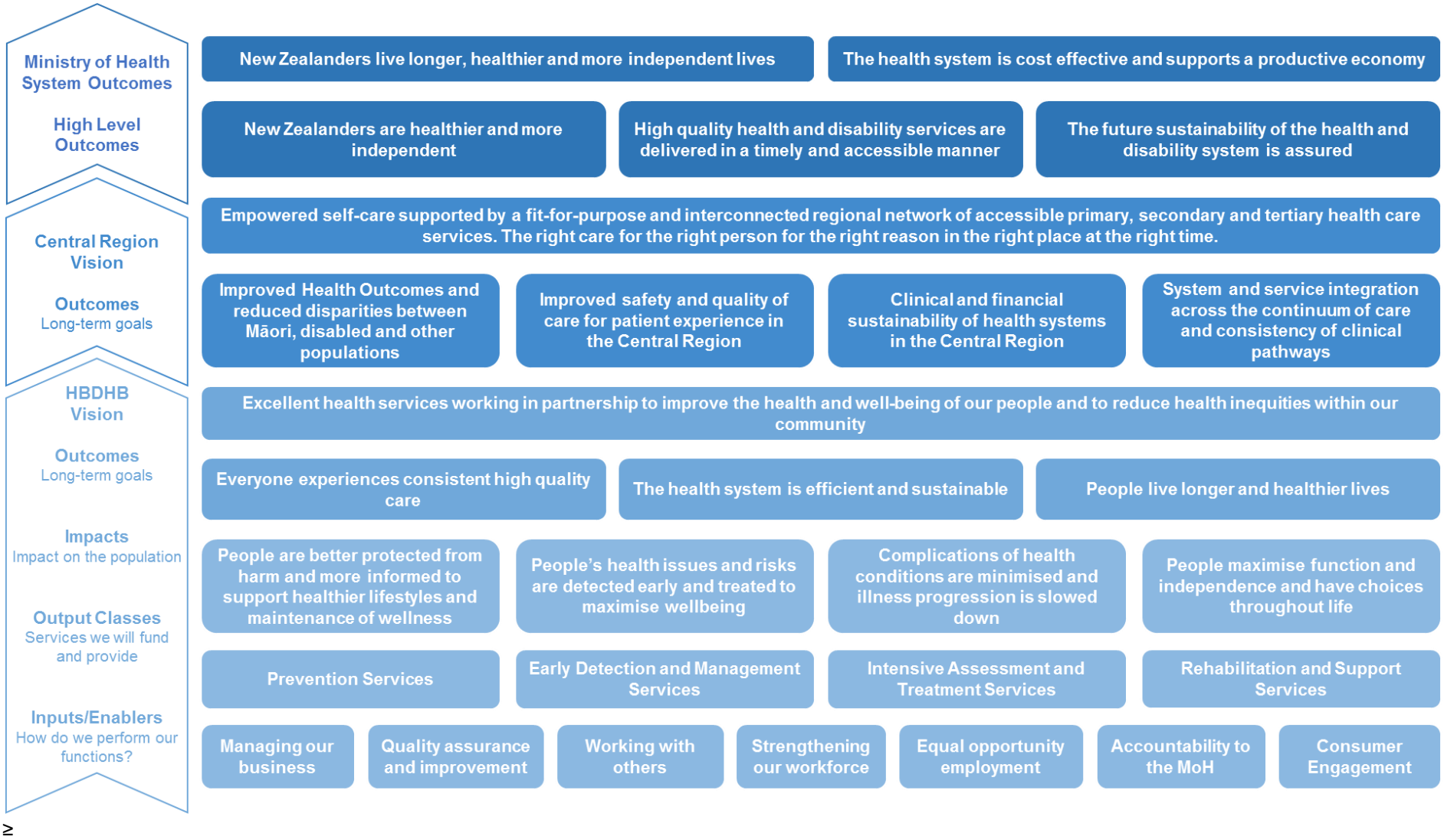


Figure 3: Connecting local activity to local, regional and national objectives

Our Challenges

HBDHB has made significant progress in the recent past. However, we continue to be challenged by ongoing issues, such as the growth in chronic illness, our ageing population and vulnerability in a large proportion of our community. Despite population growth[9] being modest, at about 2.8% in the next 10 years, we will see significant changes in age groups. In our population, the over 65s will grow by 35.6% and the over 85s will increase by 38.6%. The same age group of Māori and Pasifika people will grow even faster at 62% and 69% respectively.

Māori and Pasifika	2016	2026	Growth
0-14	16,220	18,170	12%
15-64	28,480	32,640	15%
65 yrs +	2,900	4,700	62%
85 yrs +	130	220	69%

Total	2016	2026	Growth
0-14	34,350	32,880	-4.3%
15-64	97,680	93,490	-4.3%
65 yrs +	29,270	39,680	35.6%
85 yrs +	3,500	4,850	38.6%

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

These projected population changes emphasise the need for HBDHB to maintain our focus on improving Māori and Pasifika health and to reorient our services to address and manage age-related health issues.

Risk and Opportunity

The health of our population can be described using the diagram in Figure 4, where everyone in the population fits within one of these categories.

Our focus will be to keep people healthy and well to require less hospital care.

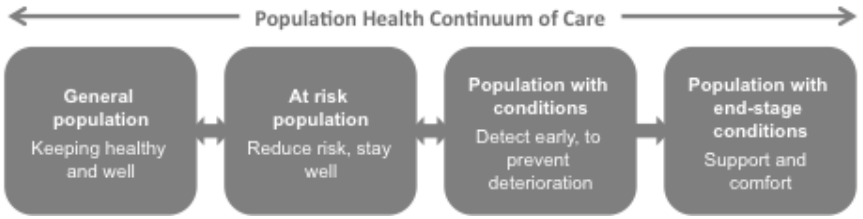


Figure 4: Population Health Continuum of Care

An increasing burden of long-term conditions is a worldwide issue as modern medicine reduces early death. This is particularly so in places with demographics like Hawke's Bay – an ageing population with areas of significant deprivation and vulnerability. New Zealand research shows that, generally, Māori develop ageing conditions about 10 years younger than non-Māori.

[9] Statistics New Zealand, Projections prepared for Ministry of Health, October 2014.

Therefore, due to age-related and other long-term conditions, we need to concentrate on three main themes:

1. Helping people to stay healthy and well and able to live independently in their own home for longer

2. Ensuring that people who have complex long-term illnesses are able to live to their full potential

3. Supporting frail elderly people and their families/whānau.so that they can put in place a better plan for how they want to be cared for as the end of their life approaches (advance care planning).

This needs to be done in an integrated and coordinated way, meaning that all organisations need to work together with a focus on prevention, recognising that good health begins in the places where we live, learn, work and play, long before medical assistance is required. At the same time, by better understanding the changing needs and challenges of our ageing population and their inevitable frailty and dependency towards the end of a long life, we need to put in place better services designed to support the elderly and the changing needs of our population.

In Transform and Sustain, we have summarise these challenges into three priority goals:

Responding to our population

Delivering consistent high-quality health care

Being more efficient at what we do

At the same time it is imperative that we remain financially robust so we are in a position to invest in programmes that will deliver transformational change.

Our Strategic Response

Considering the duties placed on us by the Treaty of Waitangi, the NZPHD Act and the national, regional and local context outlined above, HBDHB will prioritise our funding and provision of health and disability services based on our three priority goals.

Responding to our Population

We have been too focused on the hospital when we could have been taking health services into the community. We have made progress in recent years but it has been slow, and there is still too much focus on meeting demand through secondary (hospital-based) care. We believe patients and whānau should be at the centre of health care, not a hospital or any particular care setting.

Barriers to accessing health care can occur for a number of reasons. For example, a person may be unable to get an appointment soon enough, may not have enough money to pay for an appointment at a medical centre or may not have the transport to get there. Often the services appear to be designed to suit the needs of professionals rather than patients. Our health workforce needs to have a good understanding of the people they serve; we need to have a stronger engagement with consumers. In particular, there are two main areas where we need to focus our attention.

Firstly, we must take action in regards to how we respond to the changing needs of our ageing population. We will focus on three responses:

Recognising that many older people are well, we will develop opportunities for them to contribute valuable consumer support and advice to the care system

We will provide care for our older people in their community with a clear intent to implement key care pathways and integrate service provision across primary and secondary settings

Aiming to begin earlier conversations about care towards the end of life, we will lead open and honest conversations with people and whānau about decisions that affect them. By doing so, we will get a better understanding of what matters to the person and their whānau during this time and will be able to focus on supportive care that is the most appropriate for them.

Secondly, the growing Māori and Pasifika population and the persistent inequities that we see in terms of their health outcomes, means that we have to find better ways of engaging with whānau. We will:

Improve consumer engagement and put patients and whānau at the centre of care

Create better working relationships that influence Māori and Pasifika health and well-being, acknowledging the formal and informal roles that community-based entities can bring to a partnership. These include iwi, hapū, Treaty settlement entities, Māori providers, individual marae, Pasifika community churches and key Government agencies

Provide good cultural responsiveness training based on advice and support from experts in Māori and Pasifika cultural practices. We will ensure that the health system workforce is well prepared and responsive and that resource allocation and service monitoring are informed through effective engagement, especially with Māori

Work towards having a workforce that is more representative of our community. We have targeted a 10% year-on-year increase in the proportion of Māori staff employed and will focus on culturally appropriate recruitment across the system.

Delivering Consistent High Quality Care

We generally deliver care to a high standard and we have seen some significant improvements in recent years. However, there are still too many examples where patient experience is inadequate and where mistakes that cause harm are made. Delivering high-quality care is about making sure we use all our resources in the best way, with the patients and their family/ whānau at the centre of that care.

The best quality care is appropriate, convenient and precise – the patient gets exactly what they need, delivered as soon as possible and without error or undue waiting.

Every staff member should be aware of their own responsibilities in quality improvement and safety when delivering day-to-day care. Clinicians are not only responsible for the provision of high-quality patient care, their leadership is also important. Clinical participation in the leadership and governance of health services is essential for creating a culture of effective quality and safety.

Being More Efficient at What We Do

The future will not look the same as the present and that future will require different ways of working to deliver more productive services. Reducing waste in health will make us more efficient and will ensure we get the best value from health care resources by delivering the right care to the right people in the right place, the first time. The current systems do not effectively incentivise health providers to be responsive to patient needs or for delivering high-quality care. In addition, health organisations often appear to work around the needs of the organisation rather than the needs of the population.

We know that the whole public sector in New Zealand is facing a reduced growth in funding while, at the same time, the health system must deal with increasing expectations and changing needs. Transformation will rely on better understanding of value, smarter use of resources and frank communication among all stakeholders – this includes a clear responsibility on the population to take care of themselves (where they are able), and on providers to respond to reasonable expectations and true needs.

Achieving Regular Financial Surpluses

The DHB is responsible for most of the Government's spending on health in Hawke's Bay – surpluses are planned and must be delivered according to statutory obligations. This will allow us to invest in our infrastructure and services. Over the past five years, through hard work and good management, we have managed to generate an additional investment in our infrastructure with $77.4 million capital investment planned over the next four years.

Where to Next?

We are stepping up to deliver on our vision through Transform and Sustain. We must continue to recognise and research our population needs, work in partnership for quality health care and become more efficient at what we do. Transformation is happening and remains necessary to move forward in these areas.

The most effective way we can respond to these challenges is by transforming our services by improving quality. Transformation must lead to increased effectiveness – a more efficient system that maximises value for the population and reduces waste.

Financial sustainability is more likely to follow from an effective transformational change programme, where we work with our community so that our services meet their needs. Over time, through that transformation, achieving financial surplus will become business as usual.

How we will Assess Performance

The National Health Board monitors DHB performance on behalf of the Minister of Health. Financial and non-financial performance frameworks are in place as part of wider accountability arrangements providing assurance to the Minister about DHB performance in terms of the legislative requirements and Government priorities. In addition, HBHDB has implemented a performance monitoring process that is closely aligned to the national frameworks and that is used to generate a monthly report so that our Board can assess and query progress against performance objectives set out in our Annual Plan and Statement of Performance Expectations.

Measuring Progress towards Our Vision

The implementation of Transform and Sustain is monitored through a programme of work which is reported monthly. The programme focusses on the 11 key intentions that will support us to address our challenges. These are:

- **Transforming our engagement with Māori**
- **Transforming patient involvement**
- **Transforming health promotion and health literacy**
- **Transforming multi-agency working**
- **Transforming clinical quality through clinical governance**
- **Transforming patient experience through better clinical pathways**
- **Transforming through integration of rural services**
- **Transforming primary health care**
- **Transforming urgent care**
- **Transforming out-of-hours hospital inpatient care**
- **Transforming business models**

Appendix 2 gives a good overview of the implementation of Transform and Sustain. It outlines the programmes that are completed, in progress and planned against each of the intentions. A refresh of the programme is currently underway to ensure we are meeting the outcomes set out in Transform & Sustain and where needed, generate new work to achieve these outcomes.

To measure the impact of Transform and Sustain we have developed the Hawke's Bay Health Sector Performance Framework (figure 5). Our "Vital Signs" represent the outcomes that we expect to see improving over the longer term. We measure the intended outcomes of our work as changes over time and we recognise that the health sector is not solely responsible for achieving them. However, they are all measurable and are aligned to Transform and Sustain objectives as well as NZ Triple Aim dimensions of quality improvement.

Beneath the "Vital Signs" we have a suite of indicators that make up "Supporting Dimensions" – these show the impact of health sector work contributing to the outcomes that we seek.

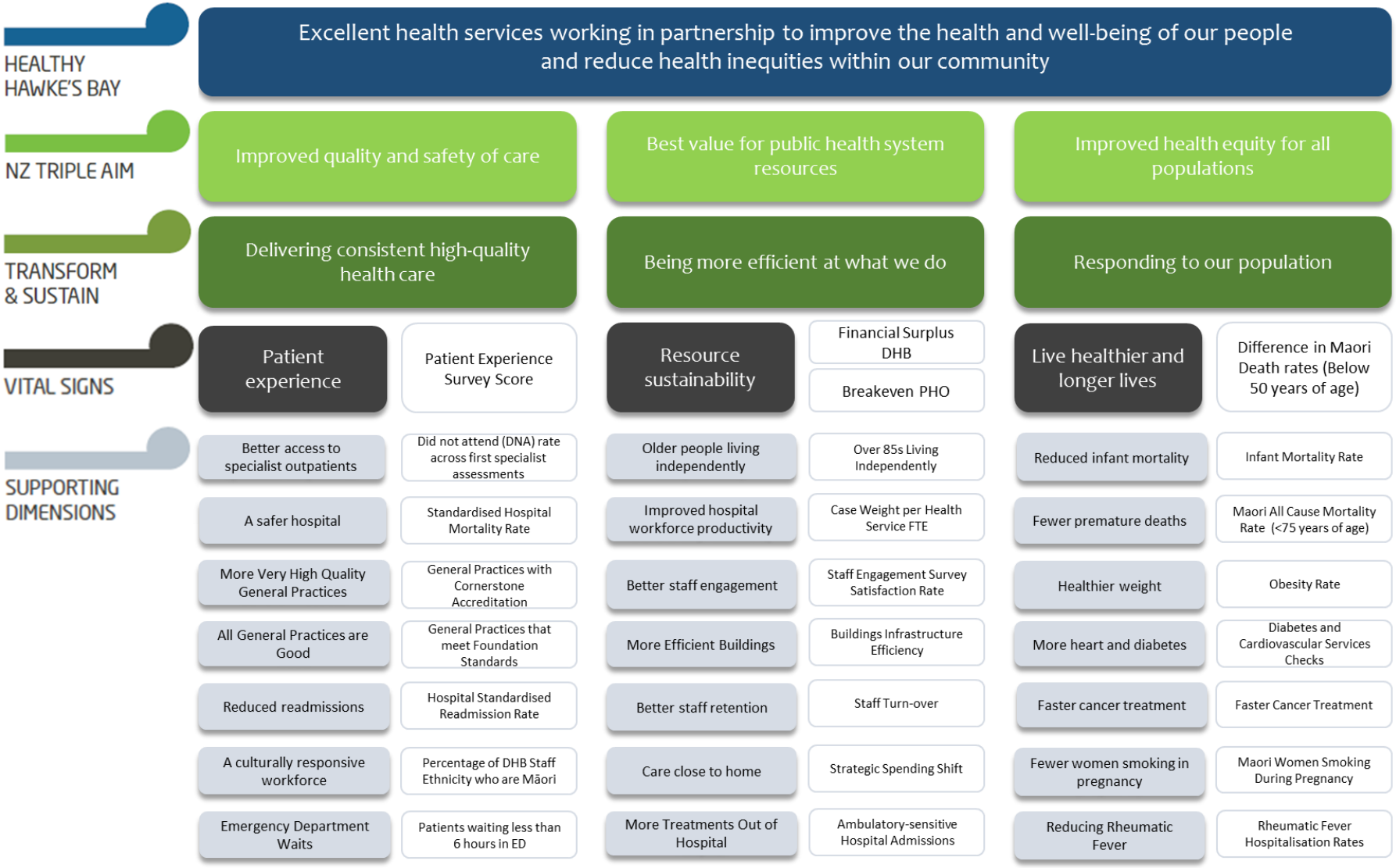


Figure 5: The Hawke's Bay Health Sector Performance Framework

2 MODULE 2

2.1 2A: Implementation of the New Zealand Health Strategy

The Draft New Zealand health strategy sets out a future direction with five key themes: People Powered, Closer to Home, Value and High Performance, One Team, and Smart System. To drive change, the strategy also sets out a roadmap of actions identifying 20 areas of work for the next five years to put the strategy into place. HBDHB is committed to delivering actions in line with the New Zealand Health Strategy Roadmap. Activities to deliver on the strategy are outlined throughout module 2B: Delivering on Priorities and Targets. In this section, some of these activities have been highlighted and reference for further information within the plan is given.

People Powered *Mā te iwi hei kawe*

This theme reflects the Government's priority of delivering 'better public services' and the opportunity to achieve this through more people-centred approaches to health services. A people-powered system will involve people not only as users of health services but also as partners in health care. It will support and equip all New Zealanders to be informed about and **involved** in their own health.

In order to achieve this, people need access to reliable, digestible information and provide feedback regarding health services. The system should be co-designed at every stage from planning to evaluation.

- Developing understanding of users of health services.
- Partnering with them to design services.
- Encouraging and empowering people to be more involved in their health.
- Supporting people's navigation of the health system.

Roadmap Actions	HBDHB Activities	Reference
1. Inform people about public and personal health services so they can be 'health smart' and have greater control over their health and wellbeing.	Continue implementation with Health Hawke's Bay, to enable individuals to have access to their own health information	National Entity Priority Initiative
2. Make the health system more responsive to people.	Improve Māori cultural competency of employees	Māori workforce and Cultural training
3. Engage the consumer voice by reporting progress against measures important to the public, building local responses and increasing participation of priority groups.	Develop a consumer engagement strategy by the end of 2016 and continue to support the consumer council	Improving Quality and Safety
4. Promote people-led service design including for high-need priority populations.	Develop a youth strategy	PMs Youth Mental Health
5. In selected high-need communities, build on, align, clarify and simplify multiple programmes of social investment.	Identify priority areas through the Hawke's Bay Intersectoral Group	Service Configuration

Closer to Home *Ka aro mai ki te kāinga*

Most people, given the choice, would prefer to receive care and support in their home or community. Although there is a need for a hospital, the focus should be on shifting services out of specialist services and into the local communities.

Shifting services closer to home requires true collaboration both within the health sector and intersectoral. We need to work together more effectively to support children, families and whānau, particularly those at risk of poor health or social outcomes. The focus should be on prevention, early intervention, rehabilitation and wellness.

- Providing health services closer to home.
- Integrated health services, including better connection with wider public services.
- An investment early in life.
- A focus on the prevention and management of chronic and long-term conditions.

Roadmap Actions	HBDHB Activities	Reference
6. Ensure the right services are delivered at the right location in an equitable and clinically and financially sustainable way.	Continue to focus on delivering services closer to home and further develop the concept of health and social care	Service Configuration
7. Enable all people working in the health system to add the greatest value by providing the right care at the earliest time, fully utilising their skills and training.	Develop clinical pathways for standardisation of treatment and best utilisation of resources	Long Term Conditions
8. Increase the effort on prevention, early intervention, rehabilitation and wellbeing for long-term conditions. This includes addressing common risk factors.	Develop and implement a kaupapa Māori whānau based nutrition and lifestyle intervention with local providers	Obesity
9. Collaborate across government agencies, using social investment approaches, to improve the health outcomes and the equity of health and social outcomes for children, young people, families and whānau, particularly those at risk.	Continue to promote and participate in cross agency work to develop a Hawke's Bay housing coalition	Rheumatic Fever
	Continue to work with the Hawke's Bay Intersectoral group to develop a model for working collaboratively	Service Configuration
10. Involve health and other social services in developing shared care for older people with high and complex needs in residential care facilities or those needing support at home.	Develop a joint, cross-sector proposal for the local falls and fracture response covering prevention to secondary treatment activity	Health of Older People
12. Review adult palliative care services to ensure all those who would benefit from palliative care at the end of their life are able to access high quality care and have a seamless experience.	Activities to further increase capacity in the sector to deliver high quality palliative care, regardless of where a person lives.	Service Configuration

Value and High Performance *Te whāinga hua me te tika o ngā mahi*

We need to make better use of our funding, better directing it to where the needs and value are greatest. Services need to be configured in a way that is more clinically and financially sustainable and equitable.

Smarter and more transparent use of information is fundamental in making improvements in the performance of the system.

- The transparent use of information.
- An outcome-based approach.
- Strong performance measurement and a culture of improvement.
- An integrated operating model providing clarity of roles.
- The use of investment approaches to address complex health and social issues.

Roadmap Actions	HBDHB Activities	Reference
13. Enable people to be partners in the search for value by developing measures of service user experience and improving public reporting of performance.	Support the implementation of service user experience measures	Improving Quality and Safety
14. Implement a framework focused on health outcomes to better reflect links between people, their needs and outcomes of services.	Continue to monitor the impact of transform and sustain through the Hawke's Bay Health Sector Performance Framework	Measuring progress towards our vision, Strategic intentions
15. Work with the system to develop a performance management approach with reporting that makes the whole system publicly transparent.	Report performance again Module 3 – Statement of Performance Expectations to the Board quarterly	Module 3: Statement of Performance Expectations

Roadmap Actions	HBDHB Activities	Reference
16. Maintain the direction set by the Strategy through monitoring and evaluation, and advice from a Strategy Leadership Group.	Continue to align HBDHB activities to the themes of the NZ Health Strategy	All
17. Align funding across the system to get the best value from health investment.	Identify and work with GP practices to implement zero fees co-payments for 13-17 year olds	Access to Care
18. Continue to develop the application of the social investment approach to health investment with DHBs. Consider using this approach to improve overall outcomes for high-need priority populations, while developing and spreading better practices.	Proposals for new investment to be prioritised by clinical council	Living within our means
19. Continuously improve system quality and safety.	Maintain the hospital Falls Minimisation Committee to co-ordinate HQSC work programmes and monitoring	Health of Older People
	Implementation of training and support to all teams in patient safety QIP methodologies, health literacy and co-design with consumers	Improving Quality and Safety

One Team *Kotahi te tīma*

In order to move in the direction set out in the Refreshed NZ health strategy we need to work as a more integrated and cohesive system. This needs to be led across clinical, managerial and governance domains. The workforce needs to be sustainable to meet the changing population needs and new models of care which may require some up skilling and broadening of scope of practice. The workforce could be supported by developing and drawing on skills in the wider NGO and volunteer communities.

Performance and planning system should support collaboration and the future direction

- Operating as a team in a high-trust system.
- The best and flexible use of our health and disability workforce.
- Organisational Development
- Strengthening the role for people, whānau and communities to support health.
- More collaboration with researchers.

Roadmap Actions	HBDHB Activities	Reference
20. Improve governance and decision-making processes across the system in order to improve overall outcomes, by focusing on capability, innovation and best practice.	Continue to utilise the Alliance leadership team to promote clinical leadership and support clinically led decision-making	Service Configuration
21. Clarify roles and responsibilities and accountabilities across the system as part of the process of putting the Strategy into action.	Continue to promote whole of system collaboration through development of clinical pathways and consider opportunities for collaboration to shift services from secondary to primary care	Service Configuration
22. Create a 'one-team' approach to health in New Zealand through an annual forum for the whole system to share best practice and help build a culture of trust and partnership.		
23. Put in place a system leadership and talent management programme to enhance capacity, capability, diversity and succession planning throughout the sector.	Sustain the HB sector wide transformational leadership programme	Improving Quality and Safety
	Work with local Whānau Ora collectives on the developing their capacity and capability	Whānau Ora
24. Put in place workforce development initiatives to enhance capacity, capability, diversity and succession planning and build workforce flexibility.	Strategic workforce development programmes for HBDHB are coordinated through the Central Region regional training hub.	Workforce Section of Central Region RSP

Smart System *He atamai te whakaraupapa*

Having and sharing good quality information will drive better performance in the health system and support effective work with other government agencies. We need to actively scan, evaluate and develop knowledge and innovative technologies in a New Zealand context, and apply the best of these nationally.

- The increased use of analytics and systems to improve management reporting, planning and service delivery and clinical audit.
- The availability – at the point of care – of reliable and accurate information including on-line electronic health records.
- The health system as a learning system, that continuously monitors and evaluates what it is doing, and shares it.

Roadmap Actions	HBDHB Activities	Reference
25. Increase New Zealand's national data quality and analytical capability to make the whole health system more transparent and provide useful information for designing and delivering effective services.	Work in partnership with the National Health IT Board	National Entity Priority Initiatives
26. Establish a national electronic health record that is accessed through certified systems including patient portals, health provider portals and mobile applications.		
27. Develop capability for effectively identifying, developing, prioritising, regulating and introducing knowledge and technologies.		

2.2 2B: Delivering on Priorities and Targets

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

Performance targets and activity milestones in respect of Government priorities have been set with reference to the National Health Targets[10] and the DHB Performance Measures[11] which are detailed in Module 7. Measurement against regional priorities is discussed in the Regional Services Plan[12] (RSP) and corresponding local activity is cross-referenced in this Module. HBDHB adds to assessment of performance by setting additional targets within our Statement of Performance Expectations (Module 3). The measures contained therein will be audited and used as the basis for our Annual Report for 2016/17 and as a key input to our Quality Accounts 2016.

The Minister of Health's annual "Letter of Expectations"[13] and the National Health Board planning guidelines provide a framework for highlighting Government's priorities in respect of the public health system. The sections below are categorised according to the planning guidelines with appropriate activity shown to illustrate key initiatives that are being implemented to achieve the given measures. An intervention logic approach has been used to illustrate how activity links to achievement of results. In addition, there are details of national and local priorities for Māori health as outlined in the guidance for DHB Māori Health Plans. Our Māori Health Plan 2016/17[14] is fully integrated into this Annual Plan but will be extracted as a stand-alone document only for submission to the MoH in order to comply with the requirements of our Operational Policy Framework.

Acknowledgement

The 2016/17 planning process for this Annual Plan included setting up groups of stakeholders around each priority area. Accountability for collating each section was shared between co-leads from Health Hawke's Bay and HBDHB to ensure that there was PHO participation in the preparation of this plan. The public health unit and frontline clinicians played a vital role in developing the sections over the planning period in 2016.

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

[10] National Health Targets 2016/17
[11] NBHB Non-financial Performance Framework 2016/17
[12] Central Region's Regional Services Plan 2016/17
[13] Minister's Letter of Expectations, 22nd December 2015

[14] Our planning priorities for Māori health in 2016/17 are aligned to the national indicators for Māori health and to our three-year Māori Health Strategy, Mai – available from our website.

2.2.1 Child and Youth Health

A key focus of the Government is vulnerable families. Agencies need to be innovative, responsive and work together in order to provide services that best meet the needs of priority populations. DHBs are expected to continue to support cross-agency work that delivers outcomes for children and young people. A considerable body of evidence links adverse childhood circumstances to poor child health outcomes and future adult ill-health. These adverse health outcomes include low birth weight, infant mortality, poor dental health, poorer mental health and cognitive development and increased hospital admissions from a variety of causes. Maternity services are provided by a range of health professionals to women and families throughout pregnancy, childbirth and for the first six weeks of a baby's life. Child services continue thereafter with a number of primary, community, population-wide and hospital-based programmes aimed at ensuring that all children are regularly assessed against a raft of health and well-being indicators. Our focus in this part of the plan is on pre-pregnancy, maternal and pre-school services.

In this section

Reducing Unintended Teenage Pregnancy

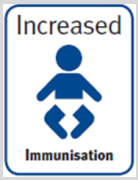
In 2016/17, HBDHB will focus on reducing unintended teenage pregnancy through School Based Health Services (SBHS). SBHS are well established in Hawke's Bay and all SBHS nurses are employed by the DHB therefore are the on MECA contract and receive regular clinical supervision. A Youth Strategy is currently being developed which may influence future activity in this area but we will continue to support this goal through workforce development, access to services and clinical leadership.

Short-term outcome	Activity	Monitoring & Reporting
Support the reduction of unintended teenage pregnancy through School based health service (SBHS) contracts.	SBHS nurses to provide contraception choice eg, discussion, referral, prescriptions or provision and have sufficient access to contraceptive supplies	Q4 confirmation and exception report against the actions identified in the plan
	SBHS nurses to have Emergency Contraceptive Pill (ECP) endorsement and use standing orders	
	SBHS nurses to get appropriate professional support/supervision and remuneration	
	Put plans in place to access SBHS or equivalent during school holidays when contraceptive needs can be high	
	Ensure SBHS nurses are fully integrated into the school community and regularly attend multi-disciplinary meetings.	

Increasing Immunisations

Improved immunisation coverage leads directly to reduced rates of vaccine preventable disease, and consequently better health and independence for people. The HBDHB Immunisation Steering Group provides a forum for a collaborative approach to improving the immunisation rates for Hawke's Bay children and adults. Representation on the Steering Group includes: Midwives, WC/TO, Secondary services, primary care, Māori providers, Health Hawke's Bay, HBDHB Immunisation Team, Public Health, National Immunisation Register (NIR), the Immunisation Advisory Centre (IMAC). New Zealand research has found that established relationships with a primary health care provider is critical in the timely delivery of immunisations and that there is a need for more effective facilitation of early engagement with primary health care providers.

Early enrolment with a General Practice (GP) and Well Child/Tamariki Ora (WC/TO) enables new-born babies to receive timely immunisation and other health checks. If infants are enrolled with a GP before they are six weeks of age then they can be effectively pre-called and vaccinated on time. The NIR is a tool that supports management of both individual and population health, and information from the NIR is used to assist with planning, targeting and monitoring of immunisation services. For those families/whānau not accessing primary care providers, it is important to offer opportunities for receiving childhood scheduled vaccinations in a safe environment. The Immunisation Team will continue to work collaboratively with Māori health providers, WC/TO providers, Before School Check (B4SC) coordinator, PHO, Family Start, and midwifery staff. We continue to provide staff from Māori health providers and Tamariki Ora with resources and training to promote the importance of immunisation with their families/whānau with a strong focus of "on time every time."

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	 **Increase Immunisation coverage in Children**	Continue to facilitate successful Hawke's Bay Immunisation steering group quarterly and use this group to monitor coverage rates, equity and outreach activity.	**Health Target:** 95% of eligible children fully immunised by 8 months **PP21:** 95% of eligible children fully immunised by 2 years **PP21:** 95% of eligible children fully immunised by 5 years by June 2017 Equitable coverage across Māori, Pacific and Other
		Continue to implement strategies in the Immunisation Action *Plan 'Improving Childhood Immunisation On Time Rates in Hawke's Bay'*. - Identify overdue children through access to Dr Info, monthly Karo reports and quarterly benchmarking across practices. - After three recall attempts, refer children to outreach immunisation services - Check immunisation status for all children presenting at paediatric inpatients and outpatients, and offer immunisation where required.	
		Use Datamart reports regularly to measure the coverage rates by ethnicity and deprivation status, identifying increasing numbers of declining or opt-offs or other gaps in service delivery. Tailor the response to data appropriately using the variety of access options available.	
		Health Hawke's Bay to support practices to review, audit and manage their Patient management systems for the systematic and timely review of children.	
		Health Hawke's Bay and HBDHB to work collaboratively on promotion of Immunisation week in Q4 2017	
		Immunisation team to maintain working relationships with age appropriate services such as Tamariki Ora, Plunket, community oral health services and Before School Checks to ensure efficient use of resources for tracking children and appropriate service provision.	

Short-term outcome	Activity	Monitoring & Reporting
Support the cancer strategy goal of reducing the incidence of cancer thorough primary prevention by increasing HPV immunisation rates	Facilitate quarterly HPV stakeholders group, which is a sub group of and reports to The immunisation Steering Group.	**PP21:** 70% of eligible girls fully immunised with HPV vaccine Equitable coverage across Māori, Pacific and Other
	In Q4, provide a list to GPs of those who have declined immunisation through the school based programme for follow up.	
	Provide an education session to Nurse vaccinators, public health nurses and smear takers annualy	
	Ensure all major milestones on the HPV immunisation communication plan are achieved to ensure a systematic process and avoid gaps in service delivery.	

In 2014, Māori had the second highest rate of influenza confirmed hospitalisation, 49.2 per 100,000. The 65 years and over age group also have the highest rates of influenza admissions to ICU. A 75% influenza vaccination rate is required to provide the best protection for this age group and in particular for Māori. In 2015, 68% of Māori aged over 65 years were immunised against influenza (68% total population). For the 2016 Influenza Immunisation Programme NIR reports are being developed by the Ministry of Health to more accurately measure influenza immunisation coverage by ethnicity. There continues to be difficulty to gather accurate coverage data for influenza as not all vaccination events are recorded or captured in the data.

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Increase the rate of seasonal influenza immunisations in over 65 year olds**	Continue to fund immunisation contracts with three NGOs including two Māori providers to ensure a range of access options for flu immunisations.	75% of the eligible population over 65 are immunised against influenza annually Equitable coverage across Māori, Pacific and Other
		Work with Māori providers and other organisations to improve their capability by: - Providing educations sessions - Ensuring there are authorised vaccinators - Providing support with the cold chain - Ensuring consistent health messages	
		Analyse the Winter 2016 influenza immunisation data to show patterns of access and use this to create a strategy for promoting early engagement for winter 2017 by Q4	
		Promote influenza immunisation through Whānau Wellness education session 'Preparing for Winter' in Q4	
		Practice PMS audit systems will be used to identify those eligible for influenza vaccination. The practice will then actively recall these people.	

Supporting Vulnerable Children

HBDHB endeavour to comply with the requirements of the Vulnerable Children's Act 2014. We have signed a Memorandum of Understanding (MoU) between Child, Youth and Family (CYF), Police and DHBs to show our support and commitment to reducing the number of assaults on children. Our strategy in this area is aimed at reducing the health harm to children through early intervention programmes in health services. This includes putting systems in place to actively work with the most vulnerable groups, through support and education. Guidance and intersectoral advice is provided by the Maternal Wellbeing Child Protection multi-agency group (MWCP) who aim to identify at risk families/whānau in need of support. In addition, we will work with stakeholders in established Children's Teams to contribute to and adopt the lessons learned.

Short-term outcome	Activity	Monitoring & Reporting
Improve the quality of Violence Intervention Programmes **PP27 Report**	Complete audits as per Auckland University of Technology (AUT) requirements and random audits. Implement Audit recommendations as the arise	AUT audit completed
	Review the HBDHB child protection policy in line with the new National VIP guidelines	Policy updated
	Continue to provide Ministry accredited training to health professionals to recognise signs of abuse and maltreatment. Refresher and advanced core VIP training programmes provided as required.	10 core VIP training programmes provided
	Maintain and Improve National Child Protection Alert System (NCPAS) policy and standards	
	Continue to enlist and train VIP champions within HBDHB and external providers for more consistent understanding of practices.	All key services have a champion
Ensure there are effective processes in place to make referrals for vulnerable children and families across the continuum **PP27 Report**	Multi-agency maternal wellbeing and child protection group receives referrals from health professionals and provides advice for women with children up to 2 years of age.	# of referrals by ethnicity
	Continue to deliver gateway programme	
	Monitor that safety plans are put in place for all high risk families referred to CYF by 36 weeks gestation	
	Carry out an inter-agency meet and greet to improve staff knowledge of the agencies that are available.	Meet and greet session taken place
	PHO and primary care have effective recognition, reporting and referral guidelines.	Up to date policies in place for all practices
	Family violence training provided for General Practice and independent B4SC providers	Number of sessions
	Working group to investigate implementation of a family violence screening target for HBDHB	

Reducing Rheumatic Fever

HBDHB previously had one of the highest rates of Acute Rheumatic Fever (ARF) in the country. Through combined efforts to reduce first episode Rheumatic Fever hospitalisation HBDHB 2014/15 achieved a rate of 0.6 per 100,000 population. HBDHB will continue to address Rheumatic Fever prevention through five main streams: School based Say Ahh programme in Flaxmere; Primary Care Say Ahh Programme; Child Healthy Housing programme; Communication/health literacy regarding sore throats; and Secondary Rheumatic Fever prevention programme. Our Rheumatic Fever Prevention Plan is reviewed and updated regularly and we are committed to implementing all of the plan. Please see the HBDHB website for a copy of the Refreshed Rheumatic Fever Prevention Plan. At the end of June 2017, the dedicated Ministry of Health led rheumatic fever prevention programme will end and current levels of government funding for rheumatic fever will cease. As HBDHB is a high incidence DHB, the MoH will continue to provide a proportion of the funding for a further five years. HBDHB is committed to providing the remaining funding resulting in a total investment of $458,364 annually.

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Reduced incidence of first episode Rheumatic Fever** **Target Rate <1.5 per 100,000**	Continue Healthy Homes programme targeting 150 annual referrals to prevent Rheumatic Fever	Number of referrals Māori and Pasifika engagement
		Continue to promote and participate in cross agency work to develop a Hawke's Bay housing coalition	
		Regular meetings of the multiagency Rheumatic fever prevention steering group with Health Hawke's Bay, HBDHB & TTOH to provide clear direction and monitoring for Rheumatic Fever Prevention & Management	Meetings held as per schedule & Clear direction and monitoring provided
		Continue delivery of the actions specified in the refreshed Rheumatic Fever Prevention Plan – Development of strategic framework and implementation plan to raise community awareness and health literacy on rheumatic fever	**PP28:** Progress against DHBs Rheumatic fever prevention plan
		Set up a Governance group for Rheumatic Fever by end Q1	CFA reporting on Rapid Response sore throat service
		Continue with Say Ahh programme in targeted schools and in primary care	Governance group established
Effective follow up of Identified Rheumatic Fever Cases		Continue to monitor time between admission and notification of all new cases of rheumatic fever to the Medical Officer of Health.	**PP28:** % of patients notified within 7 days of diagnosis **PP28:** % of patients receiving secondary prophylaxis within 5 days of due date **PP28:** 100% of notified RF cases have case review and actions addressed from lessons learned. **PP28:** Progress report **PP28:** Reports on progress in following-up known risk factors and system failure points in cases of first episode and recurrent acute rheumatic fever
		Continue to monitor patients with a history of Rheumatic Fever are receiving monthly prophylactic antibiotics and carry out an annual audit in Q4 of Rheumatic fever secondary prophylaxis coverage for children aged 0-15 years, youth aged 15-24 years and adults aged 25+ years	
		Undertake case reviews of all Rheumatic fever cases and address identified system failures	
		Follow up on issues identified in the 15/16 audit of recurrent hospitalisations of acute rheumatic fever and unexpected rheumatic disease	

Prime Minister's Youth Mental Health Project

A significant number of young people in New Zealand will experience mental health problems during adolescence. Problems such as depression, anxiety and substance abuse can have life-long consequences. The current system for addressing youth health issues has some significant gaps and there are many barriers to access. Young people are often unable or reluctant to access primary care and mental health services as they are more geared towards adults or people with acute needs. Young people may require a unique mix of social, developmental and health services, and their family GP may not be the most suitable provider for this full range of care needed. The Government has launched the Prime Minister's Youth Mental Health project in order to achieve better mental health and well-being for young people including sub-groups of the population at comparatively higher risk of mental health issues, such as Māori and Pasifika. In early 2016, review was carried out on Primary Mental Health services in Hawke's Bay. From the recommendations, a service redesign project will be carried out to address standardised clinical pathways, Kaupapa Māori services, psychological services, group programmes, nurse credentialing and e-therapies. An action plan will be put in place once the Review report is finalised.

HBDHB work closely with Health Hawke's Bay to improve the health of youth in Hawke's Bay. A Youth Strategy is currently being developed and will be completed by July 2016. The strategy will define the youth population of Hawke's Bay and what a young person needs to be healthy. An outcome of this piece of work will be to form a group to take forward the changes required to meet the needs of youth in Hawke's Bay.

Implement targeted free primary healthcare for 13 to 17 year olds will help to improve access to services for youth. This initiative is included in the Access to Care section of the Annual Plan

Short-term outcome	Activity	Monitoring & Reporting
Improve young person's access to health services through School Based Health Services (SBHS)	Continue provision of School Based Health Services (SBHS) in decile 1-3 secondary schools, teen parent units and alternative education centres.	Number of youth accessing SBHS by ethnicity, gender and age **PP25**: quarterly quantitative reports on the implementation of SBHS.
	All decile 1-3 secondary schools, teen parent units and alternative education centres will have a Plan, Do Study Act (PDSA) cycle completed in the year, based on 'Youth Health Care in Secondary Schools: A Framework for Continuous Quality Improvement'.	**PP25:** quarterly narrative progress reports on actions undertaken to implement Youth Health Care in Secondary Schools
	Deliver a Mental Health 101 training session to broaden knowledge and understanding of mental health for all service providers linked with secondary schools by Q2	No of MH 101 sessions provided Broad range of attendees at 101 sessions
	Deliver presentations in seven schools by Q4 to increase student knowledge of accessing online e-therapy tools.	No of schools presentations
	Complete the Youth Strategy by July 2016 and form a group to implement the strategy	**PP25:** Report to outline actions taken to improve the health of the youth population

Short-term outcome	Activity	Monitoring & Reporting
Improve the responsiveness of primary care to youth	Investigate potential for joint projects with CAFS and Health Hawke's Bay (e.g., whether a joint approach to group-work may be an effective use of Health Hawke's Bay -funding)	Regular meetings with Health Hawke's Bay in Q1 Joint work proposal finalised by Q3
	Begin development of clinical pathways for high prevalence conditions (e.g., depression, anxiety) collaboratively with NGO's, with opportunities for increased efficiency and collaborative working identified.	Working group in progress by Q2, Draft clinical pathway Q3, Completed by Q4
Improve the follow-up care for those discharged from Child and Adolescent Mental Health Services (CAMHS) and Youth Alcohol and Other Drug (AOD) services	Formalise implementation of Transition Planning Checklist as standard practice in Q1; Amend discharge documentation to include standard prompt to primary referrer in Q2; Introduce "error flag" in patient administration system to prompt completion in Q3	**PP7:** 95% of clients discharged with have a transition (discharge) plan + Exception reporting
	Ongoing monthly audit and performance monitoring of compliance with transition plan policy	
Improve access to CAMHS and youth AOD services	Trial an initial phone contact by Choice Clinician and implement as standard practice if successful by Q1	**PP8:** 80% of people referred for non-urgent mental health or addiction services are seen within three weeks and 95% of people are seen within 8 weeks this year + Narrative report
	Liaise with KPI Forum stakeholders and other DHBs regarding "face-to-face" rule for first contact with children and families by Q2	
	DNA's and joint appointments – review policy and impact of current practice by Q3. Redesign if necessary	
	Scoping of potential for alternatives to admission for youth to be developed by Q2, e.g. Home-Based Treatment, and the mechanisms by which this would be sustainable.	
Strengthen Youth Primary Mental Health through: • **Early identification of mental health and/or addiction issues** • **Better access to timely and appropriate treatment and follow up** • **Equitable access for Māori, Pacific and low decile youth**	Use the recommendation from a recent review of Primary Mental Health to formulate a plan to redesign services with a focus on psychological services; group programmes, nurse credentialing, and e-therapies	Plan produced by Q1
	Explore ways to expand Kaupapa Māori services by Q1	
	Develop Clinical Pathways for better collaboration between Primary and secondary care	2 pathways by Q3
	Further activities from the review are under the Rising to the Challenge section	

Breastfeeding

Child health is a national priority. Research shows that children who are exclusively breastfed for around six months are less likely to suffer from childhood illnesses such as respiratory tract infections, gastroenteritis and otitis media. Breastfeeding benefits the health of mother and baby, as well as reducing the risk of sudden unexplained death of Infant and asthma. Breastfeeding is also linked to children maintaining healthy weight across their lifetime and reduced risk of obesity. Our health equity report points out that Māori rates for breastfeeding in Hawke's Bay are persistently lower than that for non-Māori and we are committed to eliminating inequities.

A resource combining breastfeeding, Safe sleep and Smokefree has been developed, in collaboration with Mama Aroha, targeting Māori, but inclusive of all ethnicities. This resource is part of a population health approach to influencing behavioural change around these key issues, and encourages consistent and appropriate messaging.

Lead Maternity Carer (LMC) leadership in the area of breastfeeding is essential to influencing positive change in the early postnatal period. All LMCs are required to undertake annual breastfeeding education and support the Ten Steps of Successful Breastfeeding to maintain knowledge and prevent the giving of conflicting advice. Discussions are taking place with Choices Māori Midwives to examine data collection and improve strategies to increase breastfeeding rates of Māori women.

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Improve breastfeeding rates at 6 weeks**	Hawke's Bay Breastfeeding Governance Group will meet once per quarter to provide strategic direction for breastfeeding activity, to monitor KPIs and drive performance in Māori and non-Māori. This group includes LMC representation	Quarterly Meetings
		Hawke's Bay's Breastfeeding multi-agency clinical group will meet bi-monthly to support breastfeeding workforce in Hawke's Bay. This will ensure all staff working in antenatal and early postnatal services have resources, training and coordination of breastfeeding activities across Hawke's Bay.	Bi-monthly meetings
		Maternity staff will give a take home guide to Breastfeeding, Smokefree and safe sleep to every mother delivering in the DHB maternity unit from Q1.	% of mothers offered take home guide by Maternity ward staff
		The DHB will carry out a review of current Breastfeeding services in Q1 to get a better idea of who is utilising the services and at what age breastfeeding stops. The review will include meeting with targeted consumer groups.	Information gathered by Q1,
		Using the results of the review the DHB will develop a plan to redesign effective breastfeeding interventions for Māori women by Q3	Plan for redesigning services by Q3
		The Women, Children and Youth (WCY) directorate will meet with providers of all antenatal classes in Hawke's bay by Q2 to investigate what breastfeeding information is given and to promote consistent breastfeeding messages.	Meetings with all antenatal class providers taken place by Q2
		The DHB will maintain Baby Friendly Hospital Initiative (BHFI) Accreditation to be achieved by February.	Accreditation achieved

		Lactation consultants will provide access to lactation support in the community through three drop-in Baby Café sessions per week (2 in Hastings and 1 in Napier) throughout the year – excluding public holidays.	Number and profile of attendees
		The WCY directorate will carry out a review in Q2 of babies that received donor milk and the rate that were still breastfed at 6 weeks, 3 months and 6 months	% of infants that received donor breast milk who are receiving breast milk at 6wk, 3 months and 6 months
		The WCY directorate will deliver eight training sessions, which include breastfeeding education for DHB midwives, nurses and LMCs by Q4.	8 sessions delivered by Q4
		The DHB will build a breastfeeding room at the hospital for staff to express in a comfortable and accessible space by Q3.	Build completed Q3
		The Population Health Team will develop a communication plan in Q1 for a Hawke's Bay breastfeeding campaign which promotes local resources, support and services. The plan will target whānau and settings which can support breastfeeding e.g. public spaces, cafes and workplaces.	Communications plans delivered from Q1
		The Population Health Team will localise content of Breastfed NZ app from the Central Region which will be used as an education and support tool. Availability of the app will be promoted through the campaign above.	App available from Q1
Māori Health Priority	**Improve breastfeeding rates at 3 months and 6 months**	The WCY directorate will carry out a 'Plan Do Study Act' (PDSA) cycle on consistent breastfeeding messages amongst Well Child Tamariki Ora (WCTO) providers and LMCs in Hawke's Bay and provide a report on improvements made in Q3.	6 weekly meetings of WCTO QI group Report on PDSA cycle Q3
		Managers of the WCY and Maori Health portfolios will meet fortnightly from Q1 to progress breastfeeding strategy across Hawke's Bay. The goal is to look at current contracts and there utilisation by breastfeeding mothers by ethnicity to ensure we have the best accessible timely support in the right areas of the community.	Fortnightly meetings
		The Executive Management Team Sponsor will present a Te Ara Whakawairora (TAW) report to the various governance committees in Q3 on progress with Breastfeeding rates and agree any new activity that is recommended.	Annual TAW report

Sudden Unexplained Death of Infant (SUDI)

Reducing the rate of SUDI is a national priority. Sudden Unexpected Death in Infancy is the leading cause of preventable post-neonatal death in infancy. Māori infants are 5 times more likely to experience SUDI than non-Māori infants in New Zealand, with around 40 SUDI deaths among Māori per year. Hawkes Bay DHB is committed to reducing the rate of SUDI by decreasing the number of women smoking during pregnancy; encouraging more women to breastfeed; and increasing safe sleep knowledge and access to safe sleep spaced within whānau and the wider community. The Breastfeeding and Tobacco sections contain more detail regarding actions to promote breastfeeding and being Smokefree.

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Reduce the risk of SUDI in Hawke's Bay** ***Target rate <0.4 SUDI deaths per 1000 live births for Māori and non-Māori***	Coordinate quarterly multi-sectoral Safe Sleep Action Group including representatives from Smokefree, Iwi, community providers, Public Health, WCTO, breastfeeding advocates and Women, Children and Youth - to provide strategic guidance for SUDI activities, monitor outcomes and maintain policies. Extend invitation to include PHO & early childhood representatives on safe sleep action group to ensure consistent messaging.	Quarterly Meetings & new representatives included
		Continue to provide training and support the provision of safe sleep education through online resources such as 'baby essentials online' and 'through the tubes' and Safe Sleep Champion Days	
		Complete annual audit of safe sleep messages provided by health services by Q2 and implement recommendations from audit by Q3	
		Improve the provision of antenatal education which is responsive to the needs of Māori and includes advice on safe sleep practices and the benefits of breastfeeding and being Smokefree.	% and number of Māori, Pasifika, teen and those for whom English is a second language attending DHB funded antenatal education
		Socialise pathway for local health professional response when whānau are identified as requiring supported access to a safe sleep space for their infant's first year, or referral for tobacco cessation support.	
		Continue collaboration with Child and Youth mortality Review Committee to provide recommendations on SUDI activities.	
	Caregivers are provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1	Continue to support WCTO Quality Improvement group with a focus on timely provision of core contact 1	Number and % of referrals to WCTO completed by 6 weeks post-birth Number and % of infants receive Core Contact 1 by 6 weeks post-birth
		Implement recommendations from WCTO quality improvement group derived from a review of current practices in other DHBs to improve timeliness of referral to WCTO	

Oral Health

Increasing pre-school enrolments in community oral health services is a national priority. According to our Health Equity Report, dental conditions account for a large number of ambulatory sensitive hospitalisations (ASH) in the 0 – 4 year old population and rates for Māori are 4.3 times those of non-Māori. This reflects a higher prevalence of severe dental caries in this age group, of which some are preventable through better access to oral health services and use of preventable treatment. A project is underway to improve access to community dental services for Māori Tamariki (0-5 years). This project is focussing on patient and whānau centres booking system, reductions in (did not attend) DNA rates and improving community dental utilisation rates. Further reductions in dental caries can be achieved with changes in children's diet, primarily reducing the consumption of sugar sweetened beverages but also supporting healthy first foods for babies. Activity regarding this can be found in the Obesity section.

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Improve the oral health of 5-year olds**	All babies are seen by an oral health clinician at a HBDHB Community Oral Health Clinic by 12 months of age	**PP11**: 67% of 5 year old examined who are carries free. Data for Māori, pacific and other Exception report and resolution plan for non-performance **SI5**: WHĀNAU ORA Key Indicator
		All Māori, Pacific and high risk children have fluoride applications at 6 month intervals	
		Implement initiatives from the Improving Access to Oral Health Services for Māori Tamariki (0-4 years) Project	
		Continue Quadruple New Born Enrolment (National Immunisation Register, GP, Well Child Tamariki Ora, Oral Health) for all babies born in HBDHB Maternity Services.	**PP13**: 95% of pre-school children are enrolled in the COHS Data for Māori, Pacific and other
		Ensure babies not born in HBDHB Maternity Services are enrolled through Well Child Tamariki Ora providers at Core Check 5 (9 months of age)	

Maternity Quality and Safety

Hawke's Bay DHB Maternity services are working toward a two year plan to improve quality and safety. The multidisciplinary Maternity Clinical Governance Group (MCGG) chaired by the Maternity Governance Coordinator (MGC) oversee the implementation of maternity quality and safety activities and ensure consistency and quality across the maternity services. The MCGG reports to the HBDHB Clinical Council which in turn reports to the HBDHB Board. The MGC monitors and drives performance against each of the New Zealand Maternity Clinical Indicators with a specific focus on; increasing registration with an LMC within the first 12 weeks of pregnancy; increasing the normal birth rate and reducing the caesarean section rate; followed by continuing to ensure a preventative focus on reducing our significant perineal tear occurrences.

Short-term outcome	Activity	Monitoring & Reporting
Improve the quality and safety of Maternity Services in line with MOH Maternity Q&S Programme	Continue with Early engagement with LMC Project which involves; A campaign for 5 key things in the first 10 weeks of pregnancy; education of primary care practitioners to support early enrolment; and establishment of another maternity resource centre in Hastings or Central Hawke's Bay.	% of women booked with an LMC by week 12 of their pregnancy Target achieved across ethnicities On track with Project milestones
	Continue with Consumer Engagement Project to establish consumer forums and become more responsive to trends and issues in relation to service delivery and design	Consumers are engaged and involved in our service delivery. On track with Project milestones
	Focus on promoting a culture of normal labour and birth; the opening of our primary maternity facility in July, increasing use of midwifery led labour and birthing techniques, supporting learning and experience in caring for low risk women in a purpose built environment	% of normal births % of use of water for labour and/or birth % of epidurals % of Caesarean sections Positive consumer feedback

2.2.2 Long Term Conditions

Prevention, Identification and Management

Long term conditions are ongoing, long term or recurring conditions. In Hawke's Bay, as around the world, the numbers of people living with LTCs is rising, causing premature mortality and morbidity, which is directly or indirectly linked with the underlying disease. Māori and Pacific people, people living in low socioeconomic circumstances, people with disabilities and people with mental health and addiction issues are disproportionately affected by some long term conditions, with a more significant impact from ill health and earlier mortality.

Better care and support for people with long term conditions is a priority for HBDHB in order to both achieve better health and well-being for our population and to manage the rising demand for services which is a threat to sustainability. Primary care takes the lead role in the management of most LTCs for most people most of the time. Our focus is on creating a more integrated system of care where primary care providers are supported by specialist services to provide high quality care to their patients. Collaborative clinical pathways and shifting resource into the community play a large role in achieving this. Supporting primary care to understand their population's long term conditions profile and to promote health literacy and self-management is also a key focus of activity.

Long term conditions have and will continue to be a focus for HBDHB through the Transform and Sustain Strategy which is currently being refreshed. Early prevention, detection and management of risk areas as identified in the HBDHB in Equity Report-2014 has influenced the use of co design methodologies. This has been a driver for the HBDHB's project work in order to effectuate change in our most vulnerable populations. It has involved cross sector clinical and non-clinical pathways of care and self-management.

The Public Health Unit (PHU) and DHB teams in partnership with Health Hawke's Bay are focusing in particular on prevention, identification and management of obesity, diabetes, cardiovascular disease, tobacco smoking and mental health through collaborative approaches to care inclusive of social care networks. The co-design process employed has ensured engagement with key stakeholders from the community and health sector, providing a far reaching response in addressing long term conditions. This means promotion, prevention, early intervention and management are integrated, via consistent messaging, creating healthy environments and effective leadership.

In this Section:

Obesity

The Health Equity in Hawke's Bay report identified an increase in obesity across the population with disparity in rates with Pasifika (68%) and Māori (51%) compared to total population (34%) - these are all above the national averages. Obesity is recognised as a major public health issue for New Zealand because rates have increased substantially and significantly over the past 15 years and obesity increases a person's risk of dying young, by increasing the risk of cancer, heart disease, diabetes and other related medical conditions. Obesity is second only to tobacco on impact on the health of people in Hawkes Bay.

The leading factor is the obesegenic environment that includes easily accessible calorie-rich, nutrient-poor food and less physical activity. While the causes are identified, the systems we need to change to reduce obesity are complex. They include culture, economics, access, knowledge, family structure, working patterns, government policy and genetics all have a part to play in what we choose to eat and the amount of physical activity we do.

We know that maintaining a healthy weight during the early years of life has a lasting effect with people being more likely to maintain a healthy weight as an adult and have improved health outcomes. The evidence is increasingly showing that getting nutrition and weight right in the first five years is critical, so the HBDHB has been implementing a programme to support whānau to maintain healthy weight by partnering with Well Child providers to deliver Healthy First Foods, supporting early childhood providers to have healthy eating policies, and funding Active Families for children under 5 years. The next steps for HB DHB are to implement the childhood obesity strategy and develop a wider obesity response.

The overall "Hawke's Bay Healthy Weight Strategy" provides a framework to support co-design and collaboration via the lifespan approach used in the framework. The development and implementation of the "Best Start: Healthy Eating and Activity Plan" provides for collaboration with a range of settings (including schools, events and communities), supports a wide range of health sector engagement and ensures community are involved in design and delivery of programmes for children.

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Increase awareness of healthy eating for children**	Support the Big change Starts Small campaign with four local initiatives over the year	# initiatives completed
		Deliver the healthy first food programme via a train the trainer approach which targets Māori and Pasifika families	Six monthly update of progress
		Collaborate with a range of stakeholders for the implementation of 'Best Start: Healthy Eating and Activity Plan' Activities: - Increase healthy eating and activity environments by increasing healthy choices in settings where children engage i.e. marae, schools, events - Develop and deliver prevention programmes for pregnant women, supporting breastfeeding, encouraging healthy first foods, whānau healthy lifestyles and healthy schools. - Support people to have healthy weights via screening, increased food literacy and whānau programmes - Provide leadership in healthy weight to support a cross sector approach to increasing healthy weights for HB	Reporting against Best Start: Healthy Eating and Activity Plan

Short-term outcome	Activity	Monitoring & Reporting
Increased referrals to clinical assessment and family based nutrition, activity and lifestyle interventions	Children recorded as having a BMI ≥98th Percentile in B4 School checks will be referred to services including, clinical support, family based nutrition programme and lifestyle interventions	**HT:** 95 percent of children with BMI ≥98th percentile identified in the Before School Check (B4SC) programme will be referred on for nutrition, activity and lifestyle interventions. # and % of referrals declined by ethnicity **SI5**: WHĀNAU ORA Key Indicator
	Increase skills and resources to support referrers to increase whānau knowledge of healthy weight, eating and activity and awareness of referral options	100% of practises receive resource pack and training support
	Continue to fund Active Families Under 5 programme/s	For individual programmes: # of referrals by ethnicity # and % of referrals declined by ethnicity # and % of referrals completed programme by ethnicity # and % of individuals/whānau completed programme with self-reported lifestyle changes by ethnicity Referral Source
	Develop and implement a kaupapa Māori whānau based nutrition and lifestyle intervention with local providers. Engage consultant to work with healthy lifestyle Māori provider collective and develop programme in Q1, Whānau based nutrition and lifestyle intervention programme developed by Q2, Whānau based nutrition and lifestyle programme implemented by Q3	
	The population health team will work with the PHO to meet the health target	Joint DHB/PHO initiatives
Access to bariatric surgery is equitable	Carry out a review of the number Bariatric surgeries funded for Hawke's Bay residents by Q2	Review completed. Number of surgeries delivered by ethnicity

Living Well with Diabetes

In Hawke's Bay, as around the world, the numbers of people living with diabetes is rising. Our Health Equity Report shows that diabetes is one of the top seven causes of death and one of the five top causes of amenable mortality in Hawke's Bay, and that there are significant equity issues in people's care. Improved access to care and better management of diabetes is cited as one of the factors that will lead to a great reduction in amenable mortality disparities. Better care and support for people with diabetes is a priority for HBDHB in order to both achieve better health and well-being for our population and to manage the rising demand for services which is a threat to sustainability. Primary care takes the lead role in the management of most long-term conditions for most people, most of the time. Our focus for diabetes services is on creating a more integrated system of care where primary care providers are supported by specialist services to provide high quality care to their patients. Health Hawke's Bay and HBDHB are forming an Integrated Diabetes Service Workplan and have based the structure of the workplan on the 20 quality standards of care. Each area of the workplan has clear responsibilities, measure of success / outcomes, and milestones. We are currently consulting with the wider sector to ensure all areas of accountability are allocated to key people to support and assure we achieve an integrated primary, secondary and community quality service. All areas will reflect a priority towards achieving equity of access and outcomes for Māori.

In 2015/16 we have redesigned our podiatry services to improve access to community podiatrists for Māori, Pasifika and people living in areas of higher relative deprivation. We have also developed a Diabetes Clinical Pathway and continue to review existing diabetes services against the National Quality Standards for Diabetes Care. A key focus of activity is around empowering patients to manage their own conditions effectively through improved health literacy and self-management approaches such as the Stanford model.

Short-term outcome	Activity	Monitoring & Reporting
Improve the proportion of patients with good or acceptable glycaemic control	Prioritise support for Māori in proactive management of their diabetes by providing Services to Improve access (SIA) funding for Diabetic Annual Reviews (DAR).	**PP20**: % of patients with HbA1c above 64, 80 and 100 mmol/mol Equity across Māori, Pacific and other.
	Fully implement and socialise the Diabetes Clinical Pathway across the sector by December 2016	
	Continue to support the implementation of the diabetes plan across the sector	
	Continue to promote the utilisation of the Stanford Programme in General Practices	Number of referrals from general practice
	Finalise the joint DHB and Health Hawke's Bay Integrated Diabetes Service workplan, incorporating the 20 quality standards, and establish a governance group and working group to take the plan forward in Q1	Groups established and plan finalised
	All practices to complete a Diabetes Care Improvement Plan (DCIP) for 16/17 year incorporating how the 20 quality standards underpin service delivery and how the practice with provide education on diet, exercise and introduction to self-management strategies	28 DCIPs signed off % of diabetics with a DAR completed
	Subject to MoH support, using the CPI report, consolidated data from PMS will identify current cohort of diabetics in HB for more accurate identification and targeted interventions for service delivery	Establish monthly HbA1c reporting showing proportional changes with outcomes

Cardiovascular Disease

Cardiovascular Disease (CVD) is the leading cause of death in New Zealand. With prevalence rising at a rate that is exceeding population growth, it is a major health burden for New Zealand now and into the foreseeable future. As the population ages, and lifestyles change, CVD is likely to increase significantly without positive intervention. According to our Health Equity Report, ischaemic heart disease is the leading cause of avoidable mortality in Hawke's Bay across all ethnicities. However, the potential years of life lost rates for Māori and Pasifika are four and three times higher respectively than the non-Māori, Non-Pasifika population highlighting a significant equity issue. To reduce the risk of developing CVD, five yearly risk assessments should be carried out on the eligible population. Activity to improving health behaviours in the population and improve equity in these areas is outlined in other sections such as Obesity and Tobacco.

Short-term outcome	Activity	Monitoring & Reporting
Improve the proportion of the eligible population who have received a CVD risk assessment in the last 5 years	Support practices to carry out PMS audits with a particular focus on those who are coming due for Cardiovascular Risk Assessment (CVRA). Including those coming into the cohort, those that are due and those that will require rescreening	**PP20**: 90% of the eligible population will have had their CVD risk assessed in the last five years.
	Provide data to assist Practices to manage the total cohort of their screened population and allow internal benchmarking. Where appropriate, the General Practice facilitation team will work with practices to improve those outliers' performance	
	Specific outreach nursing services will target workplaces where there is a high volume of Māori men in the work place and offer incentives such as prize draws.	

Tobacco

Tobacco is a key contributor to health inequity in Hawkes Bay, as a result the Population Health Service has a focus on reducing smoking rates and are committed to the vision of a smokefree Aotearoa by 2025. The health sector has a role to improve, promote and protect the health and well-being of the Hawke's Bay population. This is delivered via a range of approaches including promoting Smokefree, screening for smoking, regulatory responses, providing cessation support and workforce development. However, the greatest impact occurs with a collaborative approach and to achieve this we work across a wide range of settings including increases in taxation; engaging in Smokefree education retailers, collaboration with Ngati Kahungunu Iwi Incorporated (NKII) and supporting local Councils to develop broader Smokefree Policies.

Hawke's Bay prevalence of tobacco use is higher than the national average and we believe that reducing tobacco consumption remains the best opportunity to improve Māori health and improve equity. In 2016/17 we will continue to focus on achieving the National Health Targets and improving smokefree environments particularly in pregnancy and for neonates, new-borns and infants who are so negatively affected by exposure to first and second-hand tobacco smoke.

Short-term outcome	Activity	Monitoring & Reporting
Better help for smokers to quit 	Implement the co-created Regional Tobacco Strategy 2015 – 2020	Report update of implementation
	Continue to provide brief advice and support to quit smoking to hospital inpatients	**PP31**: 95% of hospitalised patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice & support to quit smoking
	Continue to offer GP Practices and their staff training, support and guidance on Smokefree systems, processes and policy development	**HT**: 90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months Reports Provided to medical director – Primary Care Education provided to GPs in 2016/17
	Provide benchmarking data and audit support for high level leadership and governance structures to manage performance of the 'Better help for smokers to quit' Health Target in primary care. Encouraging the identity and development of Smokefree champions in practices where appropriate.	
	Review the forms used in the primary care Patient Management System to embed mandatory Smokefree fields.	

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Reduce the number of pregnant women who are not Smokefree**	Evaluate recent changes to documentation to ensure accurate data is being captured when being booked into the Maternity Unit.	**HT**: 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
		Scope opportunities to provide smokefree education to LMCs	
		Expand incentivised programme targeting young Māori women and their whānau by implementing recommendations from the recent evaluation of the programme and focussing on improving the proportion of referrals that quit long-term.	90% of young pregnant Māori women are referred to cessation support
		Continue to screen inpatients, offering support to quit for mothers and whānau and monitor Smokefree Rates at discharge from Maternity Unit	% of Women smokefree at discharge from maternity unit
		Continue to monitor the number of Māori Women that are Smokefree at 2 weeks postnatal	95% of pregnant Māori women are smoke free at two weeks postnatal **SI5**: WHĀNAU ORA Key Indicator

Rising to the Challenge

In Hawke's Bay we have undergone significant changes in Mental Health. Ngā Rau Rākau, the new Mental Health Inpatient Unit opened in February 2016. Ngā Rau Rākau means a collection of trees. By standing together, as part of the forest, Ngā Rau Rākau, the trees are protected, they are sheltered, they grow healthier, they grow stronger, and they are supported and safe. And that's what developing our new mental health services has been all about – growing the services, listening and transforming mental health services for Hawke's Bay people.

A successful initiative in Mental Health has been the establishment of the Partnership Advisory Group (PAG) made up of consumers and whānau. The group has been operating for over a year, working in a co-design partnership with the DHB on a number of developments in Mental Health, including some service design and help with the interior design of the new inpatient unit. PAG have made a huge impact on service improvement and were awarded the supreme award at the Hawke's Bay health Awards in 2015. Mental Health services will continue to work collaboratively with PAG to ensure services are consumer focussed.

HBDHB supports the move to commissioning and outcome frameworks underway for mental health and addictions services.

Short-term outcome	Activity	Monitoring & Reporting
Improve access to primary mental health	Use commissioning framework to develop response to recommendations of primary mental health review completed in June 2016 by Q1	**PP26**: Quarterly Update
	Monitor equity of access (ethnic and age) for people suffering from mild and moderate disorders, and adjust targeting where appropriate	
	Improve specialist support for primary care and develop care map/pathways for all levels of mental health & addictions to promote clinical collaboration. Commence in Q1 and complete by Q3	
	Complete assessment by Q2 of existing funding aimed at "equally well" activity and consider opportunities for improving coverage and reach	
Improve outcomes for children	Standardise oversight for allocation of flexible funded packages of care for children and youth with high needs by Q1	**PP26**: Quarterly Update
	Use commissioning framework to develop response to review of Child, Adolescent & Family Services completed in June 2016 by Q1	
	Develop a plan and action implementation of the Supporting Parents, Healthy Children guidelines	
	Provide synchronization of suicide prevention related activities in the region	of promotional events, training and programmes promoted and provided in Hawkes Bay

Implementing expected outcomes within the Hawkes Bay Suicide Prevention and Postvention Plan	Investigate funding streams to support training, coordination and further development in suicide prevention activities in Hawkes Bay	% of successful bids Activities being funded through indirect funding sources (ie: Community Groups)
	Develop an education plan	The education plan shows effective use of available resources and responds to the community needs

Enhanced integration of secondary and primary mental health will provide better opportunities for early intervention with a recovery focus in order to decrease the impact (e.g. unemployment) of severe/treatment resistant illnesses.

Short-term outcome	Activity	Monitoring & Reporting
Improving employment and physical health needs of people with low prevalence conditions. Includes improved inter-agency working relationships with key stakeholders (e.g. NGOs, brokers, WINZ and Workwise); and improved monitoring of physical health for service users.	Audit training needs of Community Mental Health clinicians regarding physical health care by Q4	**PP26**: Quarterly Update
	Audit metabolic monitoring within services from Q1	
	Improve capacity and capability through further development of Consult Liaison service in hospital wards (Q3)	
	Ongoing investment in NGO-based community support workers to support clients with building resilience, development of natural supports and increasing opportunities for employment	% whānau reporting increased opportunities for employment (Kaupapa programme)

Emergency Mental Health Services (EMHS) is currently undergoing several changes to the service and how service delivery is managed. This includes relocation/colocation with the hospital emergency department (ED) to enable better response time to service users presenting to ED for mental health issues. This is also part of the HBDHB AIM 24/7 initiative and working collaboratively with Police to reduce the number of assessments in Police stations. Another key change will be introduction of a single point of entry (SPOE) to include implementation of 24/7 rosters working in an integrated approach with Community Mental Health teams, and enabling EMHS to manage barriers to engagement from service users/family/whānau and other services or agencies.

Short-term outcome	Activity	Monitoring & Reporting
Improve crisis response services	Ongoing monitoring of community-based adult crisis respite service to ensure appropriate and equitable access	Up to 155 bed-days available per month **PP26**: Quarterly Update
	Complete co-location of Emergency Mental Health Services (EMHS) team in hospital Emergency Department by Q1	
	Implement single point of entry to EMHS and facilitate patient focused booking by Q2	

	Embed change to community mental health teams so that EMHS staff rotate through CMH to provide crisis response during day shift by Q2	
	Review of rostering and night shift will deliver less disruption of service to key stakeholders including ED, Police and inpatient unit	
	Intensive services holding fortnightly meetings with Police to develop pathways and review procedures	

HBDHB is in the process of a significant change to our model of care for mental health and addictions services. Compulsory Treatment Order (CTO) rates are symptomatic of system-wide and socioeconomic issues. Monitoring rates is important in order to provide data for teams to understand their preparedness for clients under CTO and for them to respond appropriately to need. Responsiveness requires clear understanding of who is impacted and of the socioeconomic issues that increase vulnerability. Better understanding helps to increase collaboration with external agencies including cultural and social agencies so as to provide a more holistic, integrated and comprehensive response.

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Reduce the rate of Compulsory Treatment Orders**	Home-based treatment team increases family involvement with planning and crisis intervention by Q4	Rate of CTO in Māori and non-Māori 100% of intensive service staff trained by Q3 # referrals to specific services **SI5**: WHĀNAU ORA Key Indicator
		Ongoing daily step up step down with Nga Rau Rakau, CMH, HBT, EMHS, Wai-O-Rua and TTOH to improve discharge and admission communication	
		Implement intensive day programme from Q1	
		Staff education around sensory modulation and trauma informed care to help reduce restrictive models of care	
		Increase availability of treatment options across community mental health services	
		Building networks within the community – increased use and referrals to NGOs within the community for follow up; meetings with NGOs and whānau/families to agree on and document plans & outcomes by Q2	

Alcohol and Other Drugs

The HBDHB Māori Relationship Board have identified 'alcohol and other drugs' as a priority for the 2016/17 Annual Māori Health Plan. For both men and women, Māori and non-Māori the rates of hazardous drinking are 1.5 times higher in Hawke's Bay than the New Zealand averages. Men have higher hazardous drinking rates than women (33.6% men, 17% women) and these rates are higher than NZ average for both men (22%) and women (8.9%). Māori have higher hazardous drinking rates than non-Māori (58.9% Māori men, 26.3% non-Māori men, 33.7% Māori females, 11.1% non-Māori females).

Alcohol leads to a range of public health problems and the long term effects of excessive alcohol consumption are a major cause of avoidable hospital admissions. Alcohol related harm also includes a range of social and behavioural effects. The consumption of more than two standard drinks per day increases the risk of health problems in many organ systems, including the central nervous system, gastrointestinal system, and cardiovascular system, as well as affecting fetal development and increasing the risk of several cancers. Alcohol also contributes to death and injury due to vehicle collisions, drowning, suicide, assault and domestic violence.

A more collaborative approach across the sector is required to reduce alcohol-related harm in the community

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Work towards developing a common agenda for reducing alcohol related-harm as a health issue across our DHB and wider community.**	Develop an 'Engagement and Communications Plan' by Q1	Position paper signed off in Q2
		Develop an Issues paper and present to governance committees	
		Develop a Draft Position paper (detailing DHB commitments) for the Board's consideration and sign-off in October.	
		Carry out an investigation to identify current practice of alcohol screening and brief intervention for pregnant women engaged with LMC midwives	
	Implement new regional model for adult AOD services	Complete strategic options analysis of local response to regional model by Q1	
		Finalise preferred option for all components of new service by Q2	
		Implement procurement processes in time for commencement in July 2017	

2.2.3 System Integration

Working Together for Better, Sooner, More Convenient Health Care

We recognise that our vision will not be achieved through the efforts of HBDHB alone because the root causes of poor health often lie outside the health sector and the health system's control. Ensuring that the social and physical environment we live in is one which promotes and protects health requires partnerships with whānau, Hapū and Iwi and working intersectorally across professional and organisational boundaries.

Formal, close working relationships exist with the PHO, General Practice, private hospitals, a variety of Non-Government Organisations (NGOs), local Government, Unions and individual HBDHB employees. Part of our transformational change relies on the strength of these relationships to test new ideas and initiatives, as well as for development of expanded scopes of practice and associated training, and provision of support for aged residential care nursing and carer development in partnership with the PHO. We are working with the PHO to deliver on the national health targets, develop more integrated urgent care services, implement a primary care strategy, realign our respective health promotion services to maximise value for money, and implement broader alliances with organisations in discrete locations who can work together to benefit from efficiency and scale to transform rural care delivery. Our alliance with the PHO continues to be developed locally to drive transformational change.

This section highlights some of the programmes that we are involved in with other entities across the systems, where we are collectively working for system-level quality improvement.

In this section:

Access to Care

A key National priority that has emerged, and is supported by the findings of our Health Equity Report, is improving the access of disadvantaged groups to primary and community care. We want to ensure that all our services are accessible and that everyone who needs care is enabled and empowered to seek that care as early as possible.

With continuing high rates of admission for potentially preventable diseases, and the cost of care being a part of ongoing health inequalities in New Zealand, it is important that financial barriers to primary care be reduced for all children. Therefore HBDHB will be adding to the zero fees for 6-12 year olds primary care consultations by implementing a zero fees co-payment subsidy for 13-17 year olds. The zero fees co-payment subsidy for 13-17 year olds will be targeted towards those population groups where cost is a barrier to accessing primary care and who experience unequal health outcomes. A selection criteria will be applied that provides for a wider geographical coverage and ensures a capture of both high needs communities and the majority of the priority populations.

It is important that Māori have access to General Practice services that are responsive to cultural difference, understand the broader determinants affecting inequitable health outcomes, and provide services to increase the opportunity for Māori to be more self-determining in managing their own health challenges.

For youth, HBDHB aims to improve access to health care by reducing the cost of General Practice services, though the provision of targeted subsidies. Furthermore, by improving access to health care for youth, HBDHB aims to improve health protective factors associated with health literacy and health choices developed in the teenage years and thereby reduce the onset and burden of chronic disease in later years.

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Increase enrolments in the PHO**	Continue focus on new born enrolments	98% of newborns are enrolled with a PHO by 6 weeks of age
		Encourage people to reconnect with primary care providers when attending ED and provide GP enrolment packs for high needs, Māori and Pacific	% of the population enrolled with a PHO
		Work with a number of GP practices to ensure systems adequately identify challenges for enrolment	
		Health HB to audit all Med-Tech General Practices on a quarterly basis to ensure practices are following the right process for newborn enrolment	
		All GP practices to have a designated staff member overseeing newborn enrolments	
		All people who identify as Māori, Pacific or live in quintile 5 who are not enrolled with Health Hawke's Bay will be offered a one-hour nurse consultation and a 15 min GP consultation free of charge to remove the cost barrier to enrolment.	

Short-term outcome	Activity	Monitoring & Reporting
Improve access to primary care for Māori	Engage practices in a formal support quality programme 'He Taura Tieke' to increase the responsiveness to their Māori population	Annual GP utilisation rate by ethnicity 13 practices 2016/17 with He Taura Tieke' self-assessment and annual plan Evaluation of the training and customer service
	Implement Health Literacy programme into General Practice over the next 12 months	
	Continue to implement Health Literacy Campaign with actions to support more understanding in Māori communities of identified health issues	
	Continue to fund Whānau Wellness programme from SIA funding, providing 12 months of GP services free of charge to up to 300 whānau	
Improve access to primary care for Youth	HBDHB to invest up to $520,000 per annum into zero fees co-payment subsidies for 13-17 year olds in Wairoa and Dep 8-10 geographic regions in HB.	
	HBDHB to engage rangatahi Māori and Dep 8-10 youth populations into a co-design of improved access to general practice.	
	Develop a health assessment programme for 0-18 year olds in Hawke's Bay	Assessment Programme developed

Ambulatory Sensitive Hospitalisations (ASH) reflect hospital admissions for conditions which could potentially have been prevented by earlier access to treatment in primary care. While access to primary care is a large factor in reducing ASH rates, there are a number of other factors outside of the health sector which drive the underlying burden of disease (e.g. household income, housing, nutrition, exposure to second hand cigarette smoke). Because of this, there are a number of other sections within the annual plan that outline activities to reduce ASH rates such as Rheumatic Fever (Health Homes Programmes), Obesity, Oral Health, Tobacco, Cardiovascular Disease (CVD) and other Long Term Conditions. In Hawke's Bay there are large inequities evident in ASH rates for both 0-4 and 45-64 year olds. In the last year we have seen a reduction in ASH rates and a narrowing in the equity gap between Māori and Non-Māori however there is a long way to go and we are committed to concentrating efforts on vulnerable populations to improve equity. For children aged 0-4 years the top 5 ASH conditions are Asthma, Dental conditions, Upper respiratory infections and ENT, Lower Respiratory Infections and Cellulitis. For those aged 45-64 the top 3 ASH conditions are Cellulitis, Congestive Heart Failure (CHF) and Respiratory infections (COPD and Pneumonia).

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Reduce Ambulatory Sensitive Hospitalisations for people aged 45-64**	Develop a clinical pathway for Cellulitis to standardise practice by Q1	Pathways developed and implemented
		Implement and socialise the recently developed clinical pathway for Congestive Heart Failure by Q2	
		Secure sustainable funding to continue to provide nurse led respiratory clinics. The clinics are a joint Health Hawke's Bay and HBDHB initiative which has proven to be effective at encouraging self-management resulting in clinical, financial and organisational efficiency. A reduction in hospital admissions resulting from acute exacerbations of chronic respiratory disease has been noted and may be attributable to the respiratory project. This is currently a pilot so sustainable funding will embed the programme into the community.	Funding approved and sustainable service provided
		Develop a reporting structure by Q2 which provide reports to general practices to show their admission rates to hospital and emergency department attendances. This will allow the DHB and PHO to identify practices where admission rates for particular conditions are high and work with the practice to identify causes and solutions.	Reporting structure and link with key practice liaisons established
		Following allocation of funding through new investment prioritisation process, appoint a Congestive Heart Failure nurse practitioner to work in the community alongside primary care with the aim of supporting Heart failure patients to self-manage and avoid hospitalisations	Nurse Practitioner appointed by Q3
		Clinical Nurse Specialist and Breathe HB will provide two Respiratory training sessions in Primary Care by Q4	Number of workshops provided across the health sector

Short-term outcome		Activity	Monitoring & Reporting
	Reduce Ambulatory Sensitive Hospitalisations for children aged 0-4	Implement and socialise the Clinical Pathway 'Wheeze in Preschool children' to primary care, Breathe HB and Central Health by Q2 to standardise care for reducing hospital admissions	Increase the number of 0-4 year olds referred to Breathe HB by GPs Reports from Breathe HB include number of referrals by age and ethnicity **SI5**: WHĀNAU ORA Key Indicator Asthma ASH rates 0-4 years
		Review Breathe Hawkes Bay respiratory contract and ensure health education services is focused on 0-4 year old children and their whānau.	
		Paediatric respiratory clinical nurse specialists to hold an education session on paediatric Respiratory conditions for community Pharmacy and one for Māori Providers by Q3	
		Clinical Nurse Specialist Paediatric Respiratory will receive notification of all paediatric patients that have been admitted to hospital for Asthma and wheeze and follow up by linking them to their general practice and any other relevant actions.	
		Opportunistic flu vaccinations given to children seen in hospital with chronic respiratory conditions and those living with them	Respiratory ASH rates 0-4 years
		Review the criteria for referral to the PHO healthy homes programme through SIA funding by Q2 to ensure the households most in need are receiving the funding	
		Public Health nurse will visit all Kohanga Reo to provide advice and education around all leading ASH conditions by end of Q2. For skin conditions, the public health nurse will use 'Skin Health' talk cards and promotional posters which have been translated to Te Reo for Kohanga Reo and Kura Kaupapa	All Kohanga visited by end Q2 Number of practices displaying and distributing skin resource Additional 1FTE PHN to work on skin programme Cellulitis ASH rates 0-4 years
		Health Hawkes Bay will distribute bilingual skin resources to general practice for wider communication reach	
		Expand the 'Clean It, Cover It, Treat It, Love It' Skin Programme in low decile schools and Kohanga Reo, implementing standing orders for skin infections and infestations as needed and additional health promotion resource	
		Continue to provide consistent messages regarding health initiatives through Hawkes Bay Child Interagency Network Group with representatives from HBDHB child health team, early childhood centres, kindergartens and home-based childcare.	ASH rates 0-4 years

Data quality is a national Māori health priority, particularly in respect of the accuracy of ethnicity reporting in primary care patient management systems. Our commitment to accelerating Māori health and well-being means that we must have good data to gauge progress. The only way to be sure that ethnic disparities are reducing is by measuring indicators across ethnicities. Good ethnic data also enables us to target resources appropriately and to contribute to health research. We have made a commitment to the principle that all our measures should be provided by ethnicity and so we aim to disaggregate our monitoring and reporting increasingly over time. Our Statement of Performance Expectations (Module 3) indicates where ethnicity data is being collected and reported.

Health Hawke's Bay have surveyed primary care using the 'Ethnicity Data Systems Compliance Audit Checklist' in March 2016

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Improve the collection and reporting of Māori ethnic data.**	Provide individual General Practices with monthly reports of patients with an 'unknown'ethnicity to follow up.	% Unknown ethnicity The baseline for unknown ethnicity recorded as at 31 March 2016 is 0.76% (1188)
		Provide practices with enrolment training based on the results of the March 2016 Survey	Training Delivered
		Health Hawke's Bay will provide a training session to general practice administration staff in the 2016/2017 year. The training will include improving data quality with a focus on ethnicity.	

Service Configuration including Shifting Services

Hawke's Bay Intersectoral Group

A group of key organisations based locally mostly representing public organisations have agreed to work together and behave differently to work towards a common goal for the people of Hawkes Bay on issues where collective action across a number of organisations is important. This group of organisations and leaders have come together to commit to the delivery of a common vision: "Hawkes Bay is renowned for its vibrant, cohesive and diverse community, where every household and every whānau is actively engaged in, contributing to, and benefiting from, a thriving Hawke's Bay economy." In order to deliver that vision we recognise that we need to work together and behave differently to deliver this common good for our people on issues where collective action across a number of organisations is important. This year we will continue to work with the group to develop a model for working collaboratively to improve health outcomes.

Alliancing in Hawke's Bay

HBDHB and Health Hawke's Bay entered into an Alliance with effect from December 2013, formalising this with an Alliance Agreement in September 2014.

The Alliance activities include: Promoting clinical leadership and supporting clinically led decision-making; Creating an environment in which Transform and Sustain culture, strategies and actions can be developed and implemented, as appropriate; Determining services to be funded from the Flexible Funding Pool; and Selecting, monitoring and managing district level issues relating to Integrated Performance and Incentive Framework (IPIF) and now, System Level Measures (SLM).

These activities are mainly supported through the Clinical Council. The Alliance Leadership Team (ALT) works closely with Clinical Council to deal with specific issues or barriers to achieving Alliance objectives. This may include appointment and/or coordination of service level advisory groups or working teams to support specific initiatives, particularly ensuring connection to the Clinical Council for decision-making support and to Consumer Council for patient/whānau involvement. All service level advisory groups are linked to cross-sector clinical leadership and to consumer input in this way.

Initiatives to shift services out of the hospital and into the community:

Health and Social Care Networks

In response to the projected growth in the population of frail older people and a further growth in the numbers of people living with complex long term conditions, there is a need for primary care to be better positioned to address acknowledged challenges, to be more connected and collaborative, and to deliver services that are accessible and appropriate for the Hawke's Bay population. Other providers of health and social services in the community need to be more connected and services need to be joined up.

HBDHB and Health Hawke's Bay are working with the health sector and consumers to develop the concept of Health and Social Care Networks. This concept is about the right clinician delivering an appropriate service in the most sensible location supported by a network of providers who understand and respond to the needs of the patient and their whānau, who in turn are empowered to manage their own health and social wellness. In the short term, this will see us delivering more services to work collaboratively with other organisations (across the health and social care spectrum) in specific geographical communities to deliver better care for individuals and whānau.

In 2016/17 we will further develop the concept of Health and Social Care Networks and look at how services work together in Wairoa.

- By Q1: Network model designed, covering primary and secondary care. Social services, when ready to engage, will be included in the model.

- By Q2: Leadership teams are in place for at least 50% of the planned network localities; health profiles and assets maps have been completed for these localities in partnership with each leadership team and the community.
- By Q4: Model of care developed for Central Hawke's Bay and Wairoa localities and an implementation plan is in place to facilitate change.

Pharmacy Facilitators

Hawke's Bay DHB has a Clinical pharmacist facilitation Team. This team works in general practice to support and influence prescribing behaviour as well as address issues of polypharmacy. They also help prescribers manage patients with complex medicine regimens and medicine adherence issues. The team have won awards for Excellence in Provider Collaboration and Integration, and Excellence in Innovation. The team also picked up the HB health awards supreme award in 2014. In 2016 this team has expanded so that the service can be offered more widely in Hawke's Bay. The focus for 2016/17 is:

- Ongoing relationship building with primary colleagues for the newest members of the team to ensure they continue to excel in collaboration and integration.
- Workforce development – developing capability to maximise the facilitator's potential in this role.
- Expanding the service to cover rural communities

At a population level, the DHB and Health Hawke's Bay are working together to develop more targeted and collaborative messaging to practices relating to medicine usage.

Activities:

- Recruit a Pharmacist Facilitator to cover Wairoa and Central Hawkes Bay by Q2
- Provide regular targeted reports on medicine utilisation to practices by Q4

Urgent Care

The Urgent Care Project aims to improve access to the most appropriate urgent care options across Hawke's Bay district. To achieve this, and in partnership with the PHO, we have put in place a service level Urgent Care Alliance (UCA). The goals of the UCA are focused on the consumer.

The people of Hawke's Bay will:

- be well informed about their care choices – choose well
- be supported to enable access to services where financial assistance is needed
- have access 24/7 to telephone or technology based advice - locally delivered, nationally supported and backed
- have formalised continuity of access to primary care services 24/7 – in hours and out of hours
- have a care response which is integrated – right response, right door, right time

To achieve these goals, 11 priority areas were chosen to be developed by the Urgent Care Alliance over 2015/16. Against these priorities we have:

- Set out an Urgent Care Health Service Change Proposal for feedback to consumer groups and all primary and secondary staff associated with Urgent Care
- Published a Registration of Interest for providers to propose a new way of providing Urgent Care Services in Hawke's Bay under an upcoming Request for Proposals process
- Set out options for improved Urgent Care provision for Oral Health, Public Communication, Transport Assistance, Support Pathways and Timely Access to Data
- Entered into Business Case process for Oral Health Urgent Care provision

- Supported a new sustained Public Communication tool 'choose well' (http://www.ourhealthhb.nz/choose-well) to raise awareness of appropriate use and level of existing services

This year we will:

- Finalise the Urgent Care Service proposal with a newly selected primary sector provider for Hawkes Bay by Q1
- Present a business case for new Urgent care Oral Health Service provision by Q1
- Set out options for improved Urgent Care provision for Advanced Practitioner Workforce, Aged Care Residential, Greater Treatment in Pharmacies and Affordable Access b yQ2
- Ensure 'choose well' becomes a sustained key message of the Hawke's Bay Health Alliance by Q2

engAGE

Multidisciplinary teams are working in GP practices in Hastings and Napier to improve coordination of services in the community and reduce hospital admissions. The engAGE orbit team works 7 days in ED to assist older people to return to their own homes as quickly as possible by completing assessments urgently, co-ordinating services, providing equipment and arranging support. The full service will be up and running by the beginning of 2016/17 so the coming year will be about monitoring the impact of engAGE and exploring the possibility of expanding this service to Wairoa and Central Hawke's Bay.

District Nursing

In 2012 a new way of delivering services to our community was established, moving our district nurses who provide care to our population in Hastings, into a number of general practices, so that we provided a better and more integrated way of working to ensure that our consumers received the best possible care. Due to the success in improving relationships between district nurses and general practices, and the positive impact on consumers' care and experience this service is being extended to Napier in 2016. From July we will be measuring the impact of this service in Napier and Hastings and explore the possibility of expanding this service to Wairoa and Central Hawke's Bay.

Musculoskeletal Conditions – Subject to successful application to MoH

HBDHB, with the support of Health Hawke's Bay and NGOs are submitting a proposal for the Mobility Action Programme. The proposal is based on a Whānau Ora, community model to improve access to services for people in high deprivation areas. It aims to offer walk in clinics for early intervention to reduce pain and disability and support people to remain in work and live independently.

Activities

- Completer RFP process by July 7th and implement by end of Q2 if successful

Waioha – Primary Birthing Unit

Waioha is due to open at the beginning of 2016/17 with an aim to: improve normal birthing; decrease intervention; promote physiological labour and birth; improve exclusive breastfeeding rates; increase health promotion conversations; change our birth culture; and develop midwifery leadership

Primary Mental Health

A review was carried out on Primary Mental Health services in Hawke's Bay. From the recommendations, a service redesign project will be carried out in 16/17 to address standardised clinical pathways, Kaupapa Māori services, psychological services, group programmes, nurse credentialing and e-therapies. An action plan will be put in place once the Review report is finalised. Activity regarding Primary Mental Health is located in the Prime Minister's Youth Mental Health Project and Rising to the Challenge sections.

Palliative Care

Hawkes Bay DHB will further increase capacity in the sector to deliver high quality palliative care, regardless of where a person lives.

Implement new innovation funding by:

- Increasing the existing Aged Residential Care Palliative Liaison Nurse resource form 0.6 FTE to 1.2 FTE.
- Establishing 0.9 FTE Nurse Practitioner to support primary care capacity, with an initial focus on rural communities
- Establish a caregiver network facilitator to provide support to whānau/family caring for a person with a life limiting condition by mobilising existing support services and volunteer networks.
- Implementing Te Ara Whakapiri (Last Days of Life) locally
- Agreeing Clinical Pathways for palliative care

Initiatives to shift services out of the hospital and into the community - Subject to Funding:

The following initiatives are subject to funding through a new investment prioritisation process led by Clinical Council.

Primary Care Respiratory Management

A pilot for respiratory management was carried out in 2014/15. It achieved improved health outcomes by providing early diagnostics and enabling early intervention with quality care. The service is responsive to individual patient need and is clinically driven in primary care. The shift to primary care taking the lead in delivering planned care has resulted in greater equity of access and improved quality of life for patients with respiratory issues. The impact has been a dramatic decrease in referrals to secondary care and Breathe HB for spirometry services. By moving the lower risk patients and those requiring spirometry screening to primary care, this enables Secondary Services to focus their management on more complex patients who require specialist assessment and intervention

In the 16/17 year, the service will receive sustainable funding. We will continue to use stratification of the population to identify those patients at risk of COPD and provide timely access to diagnostic screening, prioritising those most at risk. Using best practice, diagnosis is determined, education provided, and treatment instigated, including referral to pulmonary rehabilitation. Timely patient follow up in primary care and collaboration with the general practitioner is essential. Patient education is seen as a priority to ensuring improved self-management to achieve improved patient quality of life.

Collaborative Clinical Pathways

Collaborative Clinical Pathways are designed to provide an up-to-date, localised, evidence-based overview of the standard of care that can be offered following an assessment or diagnosis. The pathways aim to: Promote health services as a single multi-disciplinary system; strengthen primary care with an emphasis on early intervention; Build capability and capacity in primary care;

assist in providing equitable access to quality healthcare by specifying consistent practices across all health settings; and Identify the best location for interventions, both in terms of cost efficiency and to improve the health status of a person.

Clinical pathways are being developed using Map of Medicine. One off funding was used to establish the programme. From 2016/17, sustainable funding will be allocated to ensure ongoing development and maintenance of Collaborative Clinical Pathways and subsequent service changes.

Pharmacy Action Plan

HBDHB is committed to working in collaboration with Health Hawke's Bay and pharmacists both locally and nationally to ensure pharmacists services are cost effective and match supply and demand. We will continue to develop the role of the pharmacist facilitators (see above) and work towards the achievement of the Pharmacy Action Plan.

Medicines Usage Review is being delivered throughout Hawke's Bay at 15 pharmacies with 27 trained pharmacists. This number is due to increase with 40 pharmacists currently in training. HBDHB will continue to support these pharmacists to up skill. Eight pharmacies across Hawke's Bay have contracts for Community Pharmacy Anticoagulation Monitoring Service. The number and locality of contracts will be considered as part of the process to develop a local strategy.

Activities (Dependent on CPSA):

- Develop a local strategy for pharmacist services in the community by Q2 in line with the Pharmacy Action Plan principle aim if making better use of pharmacists, in particular their expertise in the safe and effective use of medicines. This Strategy will cover how pharmacist services will meet demand of the population (number and distribution of services).
- Support the work being done nationally to develop a National Framework for Pharmacist Services in the Community (ongoing) and implement services outlined in the framework as appropriate.
- Participate in a national process to plan the commissioning of pharmacist services in the community that cost effectively matches modern supply of community need
- Support the development and implementation of a sustained solution to the pharmaceutical margin and other supply chain issues
- Review medicines usage locally through monthly meetings
- Local community Pharmacy strategy group to meet monthly

System Level Outcome Measures

The System Level Measures (SLM) Framework has taken over from the Integrated Performance and Incentive Framework (IPIF) and is more focussed value and high performance in the whole system rather than just primary care. The new SLMs are:

- Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0–4 year olds (ie, keeping children out of hospital)
- Acute hospital bed days per capita (ie, using health resources effectively)
- Patient experience of care (ie, person-centred care)
- Amenable mortality rates (ie, prevention and early detection).

HBDHB and Health Hawke's Bay will jointly develop an improvement plan by October 2016 which includes milestones for System Level measures and a set of contributory measures.

Whānau Ora

HBDHB will continue to play a key role in supporting Whānau Ora by focusing on the five priority areas that contribute to Whānau Ora – Mental health, asthma, oral health, obesity and tobacco. We support the Whānau Ora policy and recognise the importance of working with other public sector agencies and local health providers in addressing the health needs of the whānau. Each of the five priority areas are recognised as Māori Health Priorities within the annual plan and specific activities for improving performance in these areas can be located in their respective sections.

The Whānau Ora performance indicators are:

- Mental Health: Reduced rate of Māori committed to compulsory treatment relative to non-Māori.
- Asthma (ASH – Access to care): reduced asthma and wheeze admission rates for Māori children (ASH 0-4 years).
- Oral health: Increase in the number of children who are caries free at age 5.
- Obesity: By December 2017, 95 percent of obese Māori 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.
- Tobacco: 95% of all pregnant Māori women smoke free at two weeks post-natal

Short-term outcome	Activity	Monitoring & Reporting
Contribute to achieving Whānau Ora across the whole of the health system focusing on progress in five key areas - mental health, asthma, oral health, obesity and tobacco – to achieve accelerated progress towards health equity for Māori;	Form working relationships with local Whānau Ora collectives and support them in the developing their capacity and capability 1. Stocktake of their IT systems to assist in the compatibility and connectivity of the wider IS strategy by Q4 2. Liaise with Te Pou Matakana and Pacifika Whānau Ora Commissioning Agencies to gain an understanding of contracted providers' development needs by Q1 3. Align Māori Provider Development Scheme (MPDS) funding allocation to development needs of providers by Q4	**SI5**: Report on progress in the 5 priority areas and impact on whānau, and how we are engaging with Whānau Ora commissioning agencies. KPIs reported in relevant sections
	Define what whānau centric services are to inform a model for working with whānau to influence future service delivery.	
	Focus on achieving health equity in the Whānau Ora key performance indicators through Māori Health Plan reporting. Specific actions to improve performance in each area can be found in the relevant sections of the Plan	

Cancer Services

Cancer services span the continuum from prevention and screening, through treatment and follow-up care. The National Health Target 'Faster Cancer Treatment' (FCT) takes a pathway approach to care, to facilitate improved hospital productivity by ensuring resources are used effectively and efficiently. Cancer treatment is provided by HBDHB through our own provider and in collaboration with a number of other providers. For example, all radiation treatments are provided for Hawke's Bay patients by MidCentral DHB, while some surgical treatments are outsourced from Capital & Coast, Hutt Valley and Auckland DHBs. There is local provision of outpatient-based chemotherapy plus coordination of all Hawke's Bay patients across and through all networked services. This requires a high level of inter-district collaboration to ensure that services are integrated and seamless for patients.

Achieving the Faster Cancer Treatment Health Target is a priority for HBDHB and has been highlighted by the Minister of Health as a key focus area for 2016/17

Short-term outcome	Activity	Monitoring & Reporting
Improve the timeliness and quality of the cancer patient pathway from time of referral through treatment and follow up or palliative care. 	Achieve the Faster Cancer Treatment Health Target	85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks. PP30: 85% of patients receive their first cancer treatment or other management within 31 days from date of decision to treat PP30: All patients ready for treatment wait less than four weeks for Radiotherapy or chemotherapy
	Continue to monitor 31 day indicator which contributes to Faster Cancer Treatment and the Shorter wait for cancer treatment targets	
	Participate in and comply with reviews of current service provision against the tumour standards within the Central Region. Implement any recommended actions from the reviews.	
	Work with the local radiology department to support implementation of regional or local outcomes of their review.	
	Review the Breast cancer referral pathway to reduce time delays within referral management	December 2016
	Work with Central Cancer Network (CCN) to investigate and scope future development of multi-disciplinary meetings and processes. Project report to be prepared June 2016.	CCN project evaluation and recommendations handover to HDBs
	Implement the prostate cancer management and referral guidance by Q4	
	Partner with MidCentral DHB to implement the Supportive Care Framework. Recruitment of Cancer psychological and social worker resource to establish the psychosocial support service for cancer patients.	Psychologist and SW role in place and service established.

Short-term outcome	Activity	Monitoring & Reporting
Improve equity of access to cancer treatment	Localise central region pathways for colorectal and lung cancer by Q1. Work with the central region to develop clinical pathways for bowel and breast cancer and localise by Q4	
	Work with the central region to standardise data interpretation	FCT HT and PP30
	As an outcome of the lung cancer review, audit acute and non-acute episodes of lung cancer to look at the pathway.	Audit report with recommendations by Q3
	Lymphoma audit report and recommendations submitted to Oncology service for review.	Audit report and recommendations by Q2
	Review the opportunities to establish a FCT navigator role in the community to identify the at risk populations and to develop diagnostic PWs that enable equitable access. Focus on the Standard of Service Provision for Lung Cancer as a priority.	Define the at risk group for lung cancer.

Breast and Cervical Screening are national Māori health priorities. Participation in the BreastScreen Aotearoa and National Cervical Screening Programme by Hawke's Bay Māori has been steadily improving, and while the screening sector has employed targeted approaches, a small inequity in screening coverage still persists. Service providers across the sector are singularly committed to improving Māori participation in both screening programmes with strong collaboration and cooperation evident. Hawke's Bay DHB, Health Hawke's Bay, BreastScreen Coast to Coast, Kahunungu Executive, Te Kupenga Hauora Ahuriri, Te Taiwhenua o Heretaunga, Kahungunu Health Services and Central Health continue to implement a joint plan for Hawke's Bay.

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Achieve the National Cervical Screening Programme (NCSP) National target** **Target: 80% of women having had a cervical smear test in the past three years**	Continue regional coordination of services across the National Cervical Screening Programme - entailing collaborative partnerships, joint planning, coordination of services and activities, effective communication and strengthening supportive networks	Four steering group meetings held per annum 70% of NCSP service providers participate in regional coordination activities.
		Health Hawke's Bay (PHO) will continue to offer promotional $20 voucher to Maori, Pasifika and Asian women when their cervical smear test is completed.	Number of vouchers given to NCSP Māori, Pacific and Asian women.
		Encourage nurses to attend smear-taker training and mentor and/or supervise them to pass their assessments, with specific focus on Māori and Pacific nurses and cultural competency.	Increased number of Māori and Pacific nurses completing smear taker training and passing their assessments.
		Continue recruitment and retention strategies targeting Māori and Pasifika populations using a mix of kanohi ki te kanohi, settings and community development approaches.	Number of Māori and Pasifika women able to be identified as completing screening as a direct result of these strategies.
		Manage a campaign during cervical screening month and provide support to community promotional events where there are a high number of Māori women present and where there is involvement of rural communities.	Number of Māori women able to be identified as completing screening as a direct result of campaign and promotional events.
		Identify unscreened, under screened and priority women on the PHO Cervical Screening Data Match monthly report by Practice. Contact the women through phone, text, letter and/or home visiting to invite them to have a smear test. Arrange appointments and support them to screening.	Number of general practices data matched quarterly Number of unscreened and under-screened priority women who have a cervical smear after being contacted quarterly.
		Identify a range of options to improve screening recall processes for Maori women within General Practice to encourage them to have their smear every three years	80% of Māori women having had a cervical smear test in the past three years.

Short-term outcome		Activity	Monitoring & Reporting
		Continue the quality improvement initiative 'Best Practice in Primary Care' (BPPC) project, focussing on NCSP systems and processes within general practice including improving access, service quality, data quality, patient management systems, compliance with NCSP Policies and Standards and HPV testing.	BPPC established in four new general practices by Q4.
		Continue focus on improving data quality through data matching between NCSP and general practices, and working with smear takers, laboratories and the NCSP register regarding recording ethnicity data.	98% of the Priority group women checked monthly have a correct ethnicity
Māori Health Priority	**Achieve the BreastScreen Aotearoa (BSA) National target** **Target: 70% of eligible women, aged 50 to 69 will have a BSA mammogram every two years.**	Continue regional coordination of services for BreastScreen Aotearoa screening pathways - entailing collaborative partnerships, joint planning, coordination of services and activities, effective communication and strengthening supportive networks. Four Population Screening Steering Group meetings held per annum. Two ISP provider hui held per annum.	One Regional Action Plan jointly developed by BSA service providers. 70% of BSA service providers participate in Steering Group meetings and ISP provider hui. 100% of BSA service providers contribute to the development of the Regional Action Plan.
		Conduct a health promotion campaign to improve participation rates for Māori and Pacific at the breast screening mobile unit located at the Cook Islands Community Centre, Flaxmere, Hastings in September.	Number of additional Māori and Pacific new screens and rescreens by Q2
		Continue focus on improving data quality through data matching between BreastScreen Coast to Coast and general practices. Birthday letters for women turning 45 years and recall letters will be sent to unscreened and under-screened women.	Number of general practices data matched.
		Hold annual Continuing Medical Education and Continuing Nursing Education sessions on BSA for practice nurses and general practitioners	One annual CME/CNE session for BSA
Māori Health Priority	**Improve the timeliness and experience of colposcopy for Māori Women**	Continue to refine the referral process from primary care into colposcopy and work towards reducing DNAs for FSA and follow-up appointment, particularly for Māori women with high grade cytology results (CIN2 and CIN3).	90% of eligible Māori women with a high grade cytology result attend colposcopy FSA and follow-up appointments. Reduction in DNA rates for colposcopy FSA and follow-up appointments for Māori women with a high grade cytology result.

Stroke

HBDHB aim to provide a consistent, organised acute stroke service for our population in a timely manner so that more patients survive stroke events and the likelihood of subsequent stroke events is reduced. A Hyper-acute and acute Stroke Service Redesign project is being led by the Chief Medical Officer (Hospital) and the Lead Stroke Physician. The project is focussed on addressing any issues relating to the thrombolysis service within the context of hyper-acute and acute phases of the stroke care pathway. The project has highlighted a number of barriers to thrombolysis and admission to an ASU/stroke pathway which include: ability to provide stroke thrombolysis 24/7; high rate of late presentation stroke; and contradiction with acute assessment model of care for minor stroke. There are also difficulties getting accurate data regarding stroke admissions. Activities to overcome these barriers are listed below.

Short-term outcome	Activity	Monitoring & Reporting
All stroke patients have equitable access to high quality stroke services, with an interdisciplinary Stroke team, regardless of age, ethnicity or geographic domicile	The stroke service will monitor data quarterly by age and ethnicity	80% of acute stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway. 80% of people with acute stroke who are transferred to in-patient rehabilitation service within 7 days of acute stroke admission
	Ensure patients are admitted to the ASU/stroke pathway by implementing and socialising organised stroke services pathways	
	Continue to have regular Stroke MDT meetings on acute and rehabilitation wards	
	Carry out a stroke education day for all health professionals involved in the treatment of Stroke in Q4	Education day carried out in Q4
	Carry out an annual audit of cases where patients were not admitted to a stroke unit or organised stroke service with demonstrated stroke pathway to identify barriers to achieving the targets and produce recommendations from the findings	Audit report Q4
	Continue to monitor the average length of stay on rehabilitation and identify areas for service improvement using Australian Rehabilitation Outcome Centre (AROC) data	AROC data reports
	Māori and Pasifika people admitted with stroke have access to Māori Health services which meet individual and whānau needs to reduce the burden of care.	Equitable outcomes by ethnicity
	Involve whānau, community providers and primary care in discharge planning	
	Carry out a joint education session with Stroke services and population health targeted at Māori and Pasifika on Wellness and Stroke prevention	One session carried out by Q4
All eligible stroke patients have access to thrombolysis	Promote integrated thrombolysis services with emergency and ambulance services	6% of ischaemic stroke patients thrombolysed
	Complete quarterly thrombolysis audit and review	

Short-term outcome	Activity	Monitoring & Reporting
	Complete and implement a clinical pathway for Primary Care Management of TIA Q1	
	Support the National FAST campaign to promote early recognition of stroke events. Quality improvement advisor to work with Health Hawke's Bay to ensure rapid transfer of patients to hospital.	
	Carry out training for RMOs and physicians to provide stroke thrombolysis to facilitate an improvement in stroke thrombolysis rates	
Actions to support the delivery of the regional service plan	Commence participation in the regional after-hours tele-stroke pilot June 24th which will provide this 24/7 service, with intention to fully investigate ongoing opportunities once the pilot is complete.	RSP Quarterly report
	Attend quarterly Central Region Stroke Network meetings	

Cardiac Services

Across the Central Region there is a commitment to improved and timelier access to cardiac services. HBDHB supports the regional programme outlined in the Regional Services Programme (RSP) and also works locally to improve access to cardiac diagnostics and specialist assessments, reducing waiting times for people requiring cardiac services, improve prioritisation and selection of cardiac surgical patients, increase cardiac surgical discharges and reduce variations in access.

Short-term outcome	Activity	Monitoring & Reporting
Contribute data to the Cardiac ANZACS-QI and Cath/PCI registry to enable reporting measures of Acute Coronary Syndrome (ACS) risk stratification and time to appropriate intervention.	Complete ANZACS QI register for all ACS patients who undergo coronary angiography.	**PP20**: 95% of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days
Patients with suspected ACS receive seamless, coordinated care across the clinical pathway.	Continue to implement agreed protocol for referring to Wellington when local access to angiography is not feasible within 72 hours	**PP20**: 70% of high-risk patients will receive an angiogram within 3 days of admission Target achieved in Māori, Pacific and Other
	Improve local access to coronary angiography by providing additional sessions on a Friday as required and investigate stand-alone cath lab capacity.	
	Complete a review of the accelerated chest pain pathways (ACPPs) in the Emergency Department by Q2	
Access to Cardiac services is equitable	Deliver minimum target intervention rates for Cardiac surgery, Percutaneous revascularisation, and Coronary angiography.	**SI4**: Cardiac surgery: 6.5 per 10,000 Percutaneous revascularisation: 12.5 per 10,000 Coronary angiography: 34.7 per 10,000
	Manage waiting times for cardiac services so that patients wait no longer than four months for first specialist appointment (ESPI2) and or for treatment (ESPI5)	ESPI2 & ESPI5
Actions to Deliver on Regional Service Plan	Continue to work with the regional cardiac clinical network to implement actions to improve outcomes for people	RSP report
	Continue to work with the Regional Cardiac Clinical Network on the development of an integrated regional cardiac service model	
	Support review of Cardiology being completed by TAS by October 2016. Volumes, waiting times, access rates, pathways and processes, analysis of referrals, links and barriers with CCDHB will all be assessed as part of this review.	

Health of Older People

HBDHB continues to increase investment in improving services for older people, with a particular focus on frailty. Designed to boost integration, our engAGE service was launched in 2015 and aspects of the service will continue to be developed in 2016/17. The main benefits of engAGE include: the needs of older people will be met by services that are clinically and financially sustainable; faster access to appropriate care and support; and more effective use of all available expertise and capacity. A benefits management plan is in place to track seventeen measures under 9 key performance indicators. One of the key aims of engAGE is better co-ordination of support for General Practice to manage their enrolled older population. Multi-disciplinary teams now meet regularly in primary care settings to case manage referrals and care delivery.

HBDHB supports the implementation of the In-between Travel (IBT) Settlement Agreement.

Short-term outcome	Activity	Monitoring & Reporting
Better system integration for older people	Our engAGE programme will deliver better co-ordination of support for General Practice to manage their enrolled older population whilst improving the capacity and capability of the "one team". Multi-disciplinary teams will meet regularly in primary care settings to case manage referrals and care delivery and procedures, protocols and access to a range of services will be standardised and developed across the district.	Reduced ED attendances Lower hospital readmission rates Less referrals declined
	Co-ordinate multi-disciplinary team meetings across six community teams	10 quarterly for each team
	Deliver regular cross-service in-service training and up skilling	3 per quarter
	Complete inter-professional assessments for referrals to engAGE service	100% by 2nd community team meeting
	Make current care and support plans available to patients and carers	By Q4
Integrated falls and fracture prevention and rehabilitation	Develop a joint, cross-sector proposal for the local falls and fracture response covering prevention to secondary treatment activity by Q1	PP23: Report
	Redesign and establish fracture liaison service to commence in Q1	
	Maintain the hospital Falls Minimisation Committee to co-ordinate HQSC work programmes and monitoring	
Comprehensive clinical assessment in residential care and in home and community support settings	Work with newly established InterRAI training service to support training of community-based nurses in use of InterRAI. Monitor local InterRAI capability.	All ARC facilities competent or fully competent
	Improve rate of subsequent InterRAI LTCF assessments by monitoring and informing ARC facilities of results – 230 day reassessment rate	>80%

Short-term outcome	Activity	Monitoring & Reporting
	Monitor time from referral to completion of InterRAI and develop responses to improve	Decrease the time
	Monitor equity of service provision through regional InterRAI data collaboration	Quarterly update
Actions to Deliver on Regional Service Plan: Continue development and use of Dementia Care Pathways	Co-ordinate local actions for regional stocktake on dementia education and support programmes by Q2	RSP Quarterly Report
	Monitor use of formal Dementia Care Pathway	% referrals accepted
	Participate in regional development of standardised approach to dementia education and support for implementation in 2017/18	
	Organise and monitor delivery of education sessions to primary care to improve dementia awareness and responsiveness.	2 sessions delivered by Q4
	Support local access to nationally and regionally agreed dementia resources to the person with dementia and their family and whānau	

Shorter Stays in Emergency Departments (ED)

Over the past few years we have seen a steady growth in presentations to our Emergency Department (ED) with a 5.3% increase since last year. This trend is consistent across the country. An investigation into the cause of the increase showed that more people under 65 are self-referring to the ED. There has been a 41% increase over the last 5 years in people who self-refer and are not admitted to hospital. Similar increasing demand is being experienced in primary care (5% in the last year) and a huge growth in the number of under 13s presenting – up 20% in the past year. This is a positive thing as more children are able to access a GP but it has had a significant impact on the demand in primary care.

Improvements to quality of care and patient experience is supported and enhanced by Acute Inpatient Management (AIM) 24/7 project developments and the ED6 plan. For example, the EngAGE Orbit team are now working extended hours and weekends, development of dedicated ED orderly resource and ED front of house standardised triage processes and facility redesign. An Integrated Operations Centre opened at Hawke's Bay Fallen Soldier's Memorial Hospital in March 2016. This operational hub will help to support us to improve patient flow in a more coordinated way and give much better visibility al of the time to how the hospital is functioning. Altogether, these improvements will enable ED better response to increasing demand year on year and surges in patient volumes and increased acuity with a system that is agile and sustainable.

A major contributor to shifting demand from the Emergency Department is the Urgent Care project. Under our Transform and Sustain programme, and in partnership with the PHO, we have put in place a service level Urgent Care Alliance (UCA). This consumer and clinician led team have been tasked with implementing service level changes across the health sector to improve the integration of urgent care in Hawke's Bay. Together with stakeholders we agreed to place the consumer at the heart of the Urgent Care project and address the following issues with the existing service provision:

- Inequity - Urgent Care services that are available to people are different depending on where a person lives and, for many, cost is a barrier to access.
- Confusing, fragmented and unclear – Urgent Care services are not always clear to the consumer
- Lack of integration – A persons experience varies from service to service as some services work well with each other and others less so
- Increasing demand from people for existing Urgent Care services could be managed better within existing resources

Short-term outcome	Activity	Monitoring & Reporting
 **Achieve the national health target for shorter stays in the ED**	Report Health Target performance by ethnicity	Health Target Reporting: 95% patients admitted, discharged or transferred from the ED within six hours. Results reported by ethnicity.
	ED6 Breaches to be reported daily at the operational meeting by Q1 with analysis of reasons for breaches and follow up with specialty teams if further actions are required.	
	Develop more codes to explain reasons for breaches to allow more accurate analysis and follow up by Q3	
	Make ED6 real time data visible in the newly developed Hospital at a Glance screen to be implemented by end Q1	

Short-term outcome	Activity	Monitoring & Reporting
	Complete ED front of House project by end Q1 which includes refurbishing the waiting room and adding clinical space by altering existing treatment rooms.	
	EngAGE rapid response team will continue to support discharges from ED and AAU 7 days per week	
	Complete implementation of the ED Quality framework and ensure processes and systems are in place by end of June to enable monitoring of all mandatory and non-mandatory measures.	
Improve Patient flow through the hospital	Develop and implement a Winter Plan to maintain hospital patient flow during periods of sustained increased demand by Q2	Winter Plan in place by end Q2
	Develop processes to support coordinated patient flow through the operations centre by Q3	Patient flow processes agreed and embedded in Operations Centre by Q3
	Initiate the 'Get Well' project by Q1 which will aim to streamline the patient's hospital journey through the use of integrated patient/whānau centred pathways.	Inpatient Acute ALOS
Reduce the number of inappropriate presentations to the Emergency Department	EngAGE service to provide timely access to coordinated multi-disciplinary services in the community to reduce acute hospitalisations	
	Standardise the management of conditions through collaborative clinical pathways – see long term conditions section.	
	Urgent Care Project activities TBC: - We are currently working with primary sector providers through a registration of interest and subsequent request for proposals process to provide a proposal for changing the current service provision of Urgent Care Services in Hawke's Bay.	
	Health Hawke's Bay, with the support of HBDHB will commence the pilot of ED High Flyers Programme by end Q1	

Improved Access to Diagnostics

Diagnostics are a vital step in the pathway to access appropriate treatment. Improving waiting times for diagnostics can reduce delays to a patient's episode of care and improve patient outcomes in a range of areas

HBDHB is committed to improving access, quality of care and patient flow in diagnostic services. We have completed a Radiology Service Improvement Project aligned to the National Radiology Service Improvement Initiative. The initiatives put in place through this project have maximised efficiency within the service but demand continues to outweigh supply. This year we will continue to implement the service improvement initiatives and reporting from the project to ensure this becomes business as usual once the project is complete. We will also focus on standardising referral criteria to minimise unnecessary testing in the hospital and in the community.

From March 2015, colonoscopy access targets have consistently been exceeded. However, population projections and anticipated increased demand require the physical limitations and capacity constraints of the current facilities to be addressed. A project is underway for the development of new facilities and associated resources to support the sustainable improvement of endoscopy services. The preliminary design of new facilities is due to be completed by September and, pending approval, development will begin.

Short-term outcome	Activity	Monitoring & Reporting
Improve waiting times for CT and MRI	Continue to carry out relevant reporting and implement all service improvement initiatives beyond the end of the project	**PP29**: 95% of accepted referrals for CT scans and 85% of accepted referrals for MRI scans will receive their scan within 6 weeks
	Forecast demand on radiologists and plan for leave cover in advance.	
	Use the learnings from the service improvement initiatives to apply to Ultrasound services	
	Continue to attend regional network for radiology for ongoing collaboration and sharing of learnings.	
	Work with the National Patient Flow (NPF) Project to implement systems and report to NPF as required	
Improve waiting times for colonoscopy	Update monthly reporting against all targets and exception reporting to inform Service manager of any issues requiring mitigation.	**PP29**: Urgent colonoscopy: % of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 2 weeks (14 calendar days, inclusive), 100% within 30 days Non-urgent colonoscopy: % of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days
	Develop audit process to improve the quality of data in the reporting tool Provation to inform service improvements.	
	Complete design and Implementation of Map of Medicine Pathway for Colonoscopy and CT Colonoscopy. The pathway will promote the use of National Referral Criteria for direct access outpatient colonoscopy and standardise the triage process for surgical and medical colonoscopy referrals.	
	Work with the Ministry of Health to re-establish quality improvement systems (NEQIP) for endoscopy including improved regional collaboration	

Short-term outcome	Activity	Monitoring & Reporting
	Continue to investigate regional collaboration for Endoscopic retrograde cholangiopancreatography (ERCP) such as leave arrangements and patient flow	Surveillance colonoscopy: % of people waiting for a surveillance or follow-up colonoscopy will wait no longer than 12 weeks (84 days) beyond the planned date, 100% within 120 days
	Continue progress with project for Improving Endoscopy service by completing the preliminary design phase by September 2016	
	Prepare the workforce for the stand alone endoscopy unit requiring change in practice and additional nurses and consultants.	
Improve access to cardiac diagnostics to facilitate appropriate treatment referrals	Ongoing monitoring of timely access to elective coronary angiography	**PP29**: 95 percent of people will receive elective coronary angiograms within 90 days.
	Ongoing implementation of agreed protocols for faster referral of high-risk patients to improve capacity for elective angiography.	
Actions to Deliver on Regional Service Plan	Continue to attend regional network for radiology for ongoing collaboration and sharing of learnings.	

Improved Access to Elective Surgery

HBDHB supports the national priority of more people receiving access to elective services in order to support New Zealanders to live longer, healthier and more independent lives. Through coordinated and integrated services, patients will have shorter waiting times for elective services meaning they receive faster access to health services, and can regain good health and independence sooner. Local projects/actions to support achievement of the elective surgery health target are focused around our 'Operation Productivity' – a clinically-led programme of work that is systematically identifying and implementing service improvements in our operating theatres and perioperative environment. We are currently in Wave 2 of this programme which includes: increasing theatre capacity; start and finish times of theatre; preadmission, booking and outpatient space; consistency of anaesthetics; and increasing theatre storage. This wave is coming to an end and Wave 3 will be initiated.

Short-term outcome	Activity	Monitoring & Reporting
 **Increase access to elective surgery**	Deliver 7374 elective discharges by end Q4	7374 elective surgical discharges
	Participate in the additional orthopaedic and general surgery initiative	1063 Orthopaedic and 1233 General surgery discharges achieved by Q4
	Continue implementation of initiatives in the Operation Productivity project	
	Carry out Surgical Service reviews for Maxfax, ENT, Urology and Orthopaedics to optimise capacity and efficiency and ensure the people with the greatest need are getting access to surgery.	1 Service review completed per quarter
	Continue progress with outpatient customer focused booking project to achieve a more responsive approach to booking that includes interaction with patients and specialty clinic teams to provide a choice of appointment times and locations, whilst assuring effectiveness, efficiency and safety of patient scheduling.	Reduction in DNA rate
Ensure equitable access to elective surgery	Deliver minimum target intervention rates for Major Joint Replacement and Cataract Procedures	SI4: Major Joint Replacement: 21.0 per 10,000 Cataract Procedures: 27.0 per 10,000
	Manage waiting times for elective services so that patients wait no longer than four months for first specialist appointment (ESPI2) and or for treatment (ESPI5)	ESPI2 & ESPI5
	Developed an end to end system that aligns with the Ministry of Health National Patient Flow specifications to ensure quality data capture, mapping, reporting and analysis to define the patient journey.	National Patient Flow Project Milestones
	Improve the consistency of prioritisation of patients by implementing National Clinical Prioritisation tools as they become available	Available CPAC tools embedded in practice.

Short-term outcome	Activity	Monitoring & Reporting
	Mobility Action Programme: Subject to successful RFP HBDHB and Health Hawke's Bay will develop a community walk in service for people who have experienced joint pain for more than three months based on a whānau ora model.	
	Review clinical pathway for Hip and knee pain to improve self-management and non-surgical intervention in the community and better alignment of primary and secondary care.	
	Initiate the 'Get Well' project by Q1 which will aim to streamline the patient's hospital journey through the use of integrated patient/whānau centred pathways.	Elective ALOS Target 1.55 days
	Subject to funding Prioritisation process by the clinical council we will recruit an orthogeriatrician to contribute to reducing average length of stay	
Actions to support delivery of the Regional Services Plan	Share learnings and successes to date from 'Operation Productivity' with other DHBs in the Region to support Regional work on theatre productivity.	
	Support the development of a Regional Electives Network lead by Central TAS	

2.2.4 Living within Our Means

At HBDHB we are committed to managing our finances to allow for investment in new and more health initiatives. We continue with our strategic direction to provide year-on-year surplus. This surplus is required to enable us to continue to invest in various infrastructure initiatives required to meet the needs of our community and progress Transform and Sustain.

Our strategy of responsible reduction in our cost base includes:

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

More detail on activities to shift resources can be found in the Service Configuration section and on the financials in Module 4: Financial Performance

Activity	Monitoring & Reporting
Focus on shifting more services into the community	See Service Configuration
Improve Theatre Utilisation through the 'Operation Productivity Project'	See Elective Services
Carry out new investment prioritisation process through clinical council	New Investment priorities Determined
TBC: Reduce Inpatient length of stay using Health Round Table Data to initiate initiatives in areas where length of stay is significantly higher than other organisations	**OS3**: Inpatient Length of stay
Monitor readmission rates for over 75 years as a key performance indicator for the engAGE programme	See Service Configuration **OS8**: Readmission rate

Other priorities in this section:

National Entity Priority Initiatives & NZ Health Partnerships Ltd

Workforce

Clinical Governance and Leadership

National Entity Priority Initiatives

HBDHB is committed to working with the national entities in order to drive better economies of scale and to free up resources to move into frontline services. The table below outlines the major programmes of the national entities that we are committed to over the next year. Anticipated costs and benefits for all national programmes, where assessed and agreed, have been factored in to the HBDHB budgets for 2015/16. Given the disestablishment of the National Health Committee, we will work with the Ministry of Health on the work programme of the former National Health Committee once it is confirmed.

Short-term outcome	Activity
National Health IT Board	In 2016/17 HBDHB will: - Work collaboratively with National group to achieve shared Electronic Health Record (HER) by 2020 - Continue to collaborate with the region and make progress on electronic Prescribing and Administration - Implement Regional Clinical Workstation (CWS) and Clinical Data Repository (CDR) and Patient Administration System (PAS) in accordance with the Regional Health Informatics Plan (RHIP) recalibrated timeline which is currently under review. - Continue to Support the National Patient Flow programme - Continue implementation with Te Oranga Hawke's Bay – Health Hawke's Bay (the PHO), to enable individuals to have access to their own health information (patient portals) - Develop implementation plan to enable health professionals to access the health records of the enrolled population - Subject to the successful implementation of Clinical Portals we will implement electronic prescribing in 17/18
Health Quality and Safety Commission (HQSC)	Quality and safety is one of our strategic focus areas and we have a broad programme that is closely aligned to the work of the HQSC. We are committed to complying with the expectations of our Operational Policy Framework and to continuing to develop quality and safety management systems. HQSC programmes that we support include: - Surgical Site Infection Programme - National inpatient patient experience survey and reporting system - Increased capability and leadership - PHO implementation of the primary care patient experience survey and reporting system More details regarding activity within these programmes are included in the Improving Quality section of the Annual Plan

Short-term outcome	Activity
Health Workforce New Zealand (HWNZ)	Strategic workforce development programmes for HBDHB are coordinated through the Central Region regional training hub. The 2016/17 programme of work is outlined in the Workforce section of the RSP and HBDHB is committed to supporting the regional approach to addressing workforce requirements. Strict alignment with HWNZ priorities is maintained.
Health Promotion Agency	We will support the HPA work programme in respect of promoting the national health targets, reducing consumption of alcohol during pregnancy, and increasing alcohol screening in primary settings. More detail is shown in our 2016/17 Public Health Unit Plan

NZ Health Partnerships

Short-term outcome	Activity
NZ Health Partnerships Ltd	HBDHB is committed to working collaboratively with NZ Health Partnerships and the other DHBs to create efficiencies, with savings going back into frontline services, to protect and provide for the future health and wellbeing of New Zealanders. Decisions have been made to decline the National contracts for Food and Laundry services and instead continue with local food services and a regional solution for Laundry.

Workforce

HBDHB is faced with challenges relating to the ageing workforce, skill mix and the ability to retain skills and knowledge. These issues are heightened by increased patient expectations and, with a highly mobile workforce, by the availability of potentially better opportunities outside of New Zealand. From an organisational perspective, there is a need to develop more integrated sector-wide health service pathways making use of expanded scopes of practice in nursing, medical and allied health professional groups. We continue to develop new roles and changed roles as a result of developing and implementing new models of care. Our Transform and Sustain programme will continue to have an impact on the employees and health profession workforce across the district.

Similar challenges exist at the regional level and HBDHB is committed to the regional workforce plans as detailed in the RSP and to the workforce plans outlined within each of the regional priority service plans. We work closely with the Regional Training Director, all other Central Region DHBs, primary and community organisation to advance regional workforce plans.

In early 2016 we implemented all the requirements for a safe and competent workforce in terms of the Vulnerable Children's Act 2014 and its focus on new core workers. In 2016 we will implement all the requirements for existing core workers.

Short-term outcome	Activity	Monitoring & Reporting
Meet Government expectations for pay and employment conditions in the State Sector	All DHB single employer bargaining arrangements and individual employment arrangements that will be put in place in the 2015/16 years will: - Support the delivery of organisation and sector performance improvement, foster continuous improvement, advance our Transform and Sustain strategy and support effective employee engagement to deliver DHB outcomes - Enable the DHB to recruit and retain highly capable staff	
Meet the requirements of the Vulnerable Children's Act	Implement all requirements	All requirements implemented from July 2015

Māori Workforce & Cultural Competence

There is a general intention in Hawke's Bay to increase the Māori workforce across all government agencies. Under the organisational development component of Transform and Sustain, it is a district priority for Health Services to increase Māori staff representation in the health system. At June 2013, the proportion of Māori employed by HBDHB was 9.9% of total staff numbers. This has increased slowly and at the end of June 2015 was 12.3% against a target for the year of 12.97%. This target has increased by 10% to 14.3% by 30 June 2016 and as a stretch target is providing significant challenges to the DHB. It is a challenge we are up for and we are focused on increasing Māori staff representation in Nursing and Allied Health. In addition, we have raised the expectation of cultural competence across the workforce to ensure that services become more responsive to our Māori population in our quest for driving out inequity through our continued rollout of our Engaging Effectively with Māori training which 50% of our staff have completed as at 31 January 2016.

Short-term outcome		Activity	Monitoring & Reporting
Māori Health Priority	**Improved recruitment and retention of Māori employees in areas with high proportion of Māori customers resulting in an increased proportion of Māori employed by HBDHB** **Target: 13.75% by 30 June 2017**	Maintain target focus and promote recruitment of Māori to all hiring managers	All hiring managers engaged in recruitment programme
		Develop Māori staff recruitment plan to incorporate nursing, allied health, management and administration	%r of Māori staff employed and retained increased. Variances are explained
		Connect Māori students with opportunities for health sector careers and career development through Turuki Māori Health Workforce Kia ora Hauora and Incubator programmes	%e of Maori students enrolled in Incubator programme matches the Maori population in Hawke's Bay
Māori Health Priority	**Improve Māori cultural competencies among employees**	Increase online cultural competence training through PHO and NGOs	% of staff completing Cultural training and Treaty of Waitangi online training, by employment group & ethnicity % of employees engaged in health sector is reported six monthly in conjunction with HBDHB reporting
		Promote inter-sectorial partnerships in health related industries	Two providers are engaged in initiative

Clinical Governance and Leadership

HBDHB actively fosters Clinical Governance and Leadership in a number of ways. At the Governance level, our Board is advised by a Clinical Council that is made up of a number of primary care and secondary care clinicians with a balance of doctors, nurses and allied health representation. The Clinical Council meets monthly to consider proposals, reflect on performance and to clarify expectations from a clinical point-of-view. Our service level alliances are given effect through relationships and reference to our Clinical Council. Furthermore, Clinical Council has an important role in resource prioritisation and, for this 2016/17 Annual Plan, the Council initiated a specific process for input and influence over investment and disinvestment decisions within the overarching budgeting function. Other ways that we foster clinical leadership is through participation of clinicians in sector-wide leadership forums, regional and national clinical networks, and at the executive management table. In our provider arm, each directorate is led by a triumvirate that includes a Service Director, a Clinical Director and a Nurse Director. Going forward we will design Allied Health/Health professional leadership roles that will work as part of the Service Directorate teams. As a result, most clinical staff have a professional reporting line for supervision and professional support in addition to their usual managerial reporting line for personnel functions.

We launched in early 2014 our Transformation Leadership Programme for all Service Directorate teams and extended this to our department and speciality leaders. This has run through 2015 with programme refreshers for our Service Directorates held and Primary and Community leaders joining the programme in late 2016. This will continue in 2016/17.

2.2.5 Improving Quality & Safety

Delivering consistent high quality care continues to be one of the key themes and enablers to achieving our Transform and Sustain strategy. Over the past twelve months the Quality Improvement and Patient Safety service has been evolving to support the Hawkes Bay health sectors quality improvement and patient safety framework - Working in Partnership for Quality Healthcare in Hawke's Bay. This framework identified clinical leadership and consumer partnership throughout the health sector as the most important aspect of improving quality health care and patient safety. We use our framework to align our local efforts in support of the national quality improvement work coordinated by the Health Quality and Safety Commission (HQSC). In 2015/16 we have established a new Quality Improvement and Patient Safety (QIPS) team and we appointed the Director of that service to Executive Management Team (EMT) in order to further raise the profile of quality and safety at HBDHB. With a focus on consumer engagement, the QIPS team provide support for integrated quality improvement and performance across the Hawke's Bay health sector and help clinical teams to recognise and define priority areas and to identify actions for implementation. Our focus for the coming year will be on continuing to sustain the improvements made in the past twelve months, continuing to meet the required Health and Disability Standards with our full year Certification Audit and to focus on growing the capability of our teams in regards to co-design and improvement methodologies, and enable a shift in the culture of the DHB to see consumer engagement as the norm and move to becoming far more person and whānau centred.

Short-term outcome	Activity	Monitoring & Reporting
Improve HB Health Sector performance against all National Quality and Safety markers (QSM)	QIPS team to support operational teams by supplying regular performance data from routine monitoring and audits, interpreting data and assisting with the development of improvement opportunities	HQSC quarterly QSM reporting on all targets
	Front-line ownership of improvement targets driven by directorate leadership and oversight provided by Clinical Council representing sector wide clinical leadership.	
	Continue to share consumer stories monthly with all governance bodies and present quarterly quality dashboard.	
Reduce risk of harm from falls	Cross sector integrated approach through the Falls Minimisation Committee. Includes representation from primary, aged residential care and secondary care patients and NGPs Links to activity in hospital (intentional rounding, signalling tools in wards); urgent care (fracture liaison); community (aged residential care); and primary (pharmacy, green prescription).	90% of older patients are given a falls risk assessment 98% of those at risk have an individual care plan completed
	Falls risk assessments and care plans completed for all admissions.	
	Clinical Nurse managers or Nurse Directors to investigate falls events and provide feedback and learnings to Chief Nursing Officer and Falls Minimisation Committee. Focus on reducing falls in older people that result in serious harm.	
	See Health of Older People Section for activity of falls minimisation	

Short-term outcome	Activity	Monitoring & Reporting
Reduce risk of healthcare associated infection	Maintain achievement at or above 80% compliance for hand hygiene	80% compliance with good hand hygiene practice
	Maintain the right number of trained hand hygiene auditors and promote good hand hygiene practices to staff, patients and visitors. Supported by the Chief Nursing Officer's sponsorship	
	Monitor quarterly results and implement related improvements, such as implementing local improvement methodology and front-line ownership through our gold auditors	
	Continue to provide education to all staff and take part in hand hygiene initiatives e.g. National Hand Hygiene Day	
	Improve performance for clinical interventions specified by the surgical site infection improvement programme	95% of hip and knee replacement patients receive cefazolin ≥2g or cefuromine ≥1.5g as surgical prophylaxis 100% of hip and knee replacement patients receive prophylactic antibiotics 0-60 minutes before incision
	Champions on the wards and in DSU to support the process and educate staff	
	Regularly review the results and implement necessary Quality and Safety initiatives to improve performance	
Reduce risk of perioperative harm	Achieve the old QSM threshold of all three parts of the WHO surgical safety checklist (sign in, time out and sign out) being used in a minimum of 90 percent of operations	All three parts (sign in, time out and sign out) of the surgical safety checklist are used in 100 percent of surgical procedures, with levels of team engagement with the checklist at 5 or above, as measured by the 7-point Likert scale, 95 percent of the time.
	Checklist will be used in paperless form, as a teamwork and communication tool rather than an audit tool	
	Work with the Commission to continue to implement briefing and debriefing for each theatre list.	
Reduce the risk of harm from Pressure Injury	Establish a pressure injury review committee by December 2016	
	Support clinicians to complete ACC 45 and ACC 2152 (treatment injury claim) forms for all grades of pressure injury except grade one, to provide a more accurate picture of the incidence of pressure injuries occurring while patients are in our care	
	Report all pressure injuries grade three and above as serious adverse events to HQSC	
	Review all Pressure injury events regularly and implement improvement initiatives as required.	

Short-term outcome	Activity	Monitoring & Reporting
	Improve classification and documentation of pressure injuries by grade in the patient record and ensure they are coded	
	Implement structured risk assessment to support clinical judgment and evidence-based prevention approaches.	
	Provide ongoing education to all staff regarding pressure injuries	
Improve medication safety	Continue to carry out medicines reconciliations and monitor and report these on a quarterly basis with an aim to spread medicines reconciliation through paper-based system	% of medicine reconciliations completed
	Support implementation of electronic medicine reconciliation platform when infrastructure available (dependent on regional programme and implementation of clinical portal) It is anticipated that this will be in 2018.	
Improve Consumer engagement and experience	Continue with initiative to capture correct patient details at 'first point of contact' working closely with the Customer Focused Booking and National Patient Flow Projects	DV4 Quarterly Reporting
	Support implementation of the Patient Experience Survey in Primary Care. Opportunities for improvement will be identified, tracked and implemented	
	Develop a consumer engagement strategy by the end of 2016	
	Support the Hawke's Bay Health Consumer Council	
	Implement a local consumer engagement survey aligned to sector wide values	
	Continue to produce a Quality Dashboard to monitor Safety, Clinical Effectiveness and Patient Experience.	
	Develop and Implement a health literacy framework	
	Co-design Collaborative clinical pathways	
Improve Quality Improvement Capability and clinical leadership	Promote Key messages and themes of Patient Safety Week 2016	Quality accounts demonstrate building of capability for quality improvement and patient safety.
	Sustain the HB sector wide transformational leadership programme	
	Implementation of training and support to all teams in patient safety, QI methodologies, health literacy and co-design.	
	Continue to produce annual Quality accounts and circulate locally to show improvement in key quality and patient safety indicators. Utilise relevant quality data as per HQSC guidance.	

Short-term outcome	Activity	Monitoring & Reporting
Produce Annual Quality Accounts	Implement a quality dashboard by December 2016 and share regularly with Clinical Council; Finance, Risk and Audit Committee; and HBDHB Board.	
Promote Regional Collaboration for Quality and Safety Initiatives	Implement HB sector wide consumer engagement strategy	
	Participate in Central Region's Quality and Safety Alliance and quarterly Quality and Risk meetings to share learnings and build capability for improvement.	

2.2.6 Actions to Support Delivery of Regional Priorities

Our strategic intentions are aligned to those of our regional partners, as depicted in Figure 3 above. Delivery of regional programmes is carried out at regional and sub-regional level based on assessment of the most appropriate approach. Our commitment to regional collaboration is driven through membership of all major governance committees within the regional structure and by participation in clinical networks. DHB personnel are supported to participate in regional forums and regularly contribute to the development of plans and initiatives. We have outlined activity in support of regional priorities within the service actions above and the financial impact of those activities is provided for in operational budgets and within the core funding that HBDHB contributes to the operations of Central TAS as the Central Region's Technical Advisory Service (CR TAS). Regional priorities that are not mentioned above are included below.

Major Trauma

HBDHB is committed to the regional programme in respect of Major Trauma. There is a national objective of improving the survival and post-treatment impacts of major trauma by offering patients a more comprehensive and coordinated response.

Regional activity is outlined in the Regional Service Plan 2016/17 under *Major Trauma* and the local activities to support this are outlined below:

Short-term outcome	Activity	Monitoring & Reporting
Support the delivery of the Regional Service Plan	Collect data for the New Zealand Major Trauma National Minimum Dataset (NZMTNMDS)	RSP Quarterly Report
	Present Trauma data regularly to local Trauma Committee	
	Work with the Central Region Major Trauma Network to adopt regionally consistent clinical guidelines for the management of major trauma patients.	

Spinal Cord Impairment (SCI) Action Plan: The SCI action plan aims to deliver better services in a timely manner across the SCI continuum (acute care through to living in the community) for people of all ages with acquired or congenital SCI that causes significant impairment. The action plan is designed to enable people with a SCI and their families/whānau to achieve better outcomes and support them to remain well and live as independently as possible in their community. Implementation of the SCI action plan is being coordinated by our Trauma Committee, which is led by senior clinicians from ED, Intensive Care Unit and Orthopaedic Surgery.

Hepatitis C

Within the Central Region, we have been developing a single Hepatitis C clinical pathway to ensure consistency of services and care for patients. Central Region pilot sites at Capital & Coast and Hutt Valley DHBs are transitioning to a full regional service.

Regional activity is outlined in the Regional Service Plan 2016/17 under Hepatitis C and the local activities to support this are outlined below:

Short-term outcome	Activity	Monitoring & Reporting
Support the delivery of the Regional Service Plan	Promote and implement the Hepatitis C clinical pathway	RSP Quarterly Report
	Develop and maintain relationship with the service providing fibrous scans	

Information Technology

HBDHB Information Systems (IS) programmes are aligned to the work of the Nation al Health IT board (see National Entity Priority Initiatives section above), the Central Region Information Services plan (CRISP), and to Transform and Sustain. We work closely with Health Hawke's Bay to ensure health data and information is accurate, safe and appropriately available.

Regional activity is outlined in the Regional Service Plan 2016/17 under *Information Communication Technology* and the local activities to support this are outlined below:

Short-term outcome	Activity	Monitoring & Reporting
Support the delivery of the Regional Service Plan	Support the recalibrated CRISP programme of work	RSP Quarterly Report
	Continue Phase 2 implementation of National Patient Flow and progress towards phase 3.	
	Work with the Regional Network to scope and define a Telehealth regional direction in line with the National direction	
	Participate in workshops being held to agree the model for implementation of Shared Electronic Health Records	

3 STATEMENT OF PERFORMANCE EXPECTATIONS

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

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

The SPE describes information in respect of the first financial year of our Statement of Intent and the performance measures are forecast to provide accountability. The outputs and measures presented are a reasonable representation of the full range of services provided by the organisation. Where possible, we have included past performance (baseline data) and the performance target to give the context of what we are trying to achieve and to enable better evaluation of our performance.

Service Performance

Explaining the contribution that our services make towards achieving the population and system level outcomes and impacts outlined in our Statement of Intent above, requires consideration of service performance. For each output class, we will assess performance in terms of the New Zealand Triple Aim (Figure 2). Maintaining a balance of focus across the Triple Aim is at the core of the Health Quality and Safety Commission's drive for quality improvement across the health sector.

The system dimension: Best value for public health system resources

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

The population dimension: Improved health and equity for all populations

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

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

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

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

The HBDHB Statement of Performance Expectations for the 2015/16 year follows:

X_____

Board Member

X_____

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

3.1 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.

System Dimension

The expected revenue and proposed expenses in respect of this output class are shown in Figure 6.

Prevention Services	2015 Actual $'m	2016 Forecast $'m	2017 Budget $'m	2018 Budget $'m	2019 Budget $'m	2020 Budget $'m
Ministry of Health	6.4	10.7	10.2	10.3	10.5	10.7
Other District Health Boards (IDF)	-	-	-	-	-	-
Other sources	0.4	0.2	0.2	0.2	0.2	0.2
Income by Source	**6.8**	**10.9**	**10.4**	**10.5**	**10.7**	**10.9**
Less:						
Personnel	1.5	1.6	1.7	1.7	1.8	1.8
Outsourced services	-	-	-	-	-	-
Clinical supplies	0.1	0.1	0.1	0.1	0.1	0.1
Infrastructure and non clinical supplies	0.4	0.4	0.5	0.5	0.5	0.5
Payments to other District Health Boards	-	-	-	-	-	-
Payments to other providers	8.0	8.7	8.3	8.4	8.5	8.4
Expenditure by type	**10.0**	**10.8**	**10.6**	**10.7**	**10.9**	**10.8**
Net Result	**(3.2)**	**0.1**	**(0.2)**	**(0.2)**	**(0.2)**	**0.0**

Detailed plans for the new investment and efficiency programmes have yet to be defined, and the impact of the programmes on financial performance have been recognised under clinical supplies in the Intensive Assessment and Treatment output class. When the plans are determined, the efficiencies ($10.9m, $12.4m, $13.9m,and $16.5m in 2017,2018,2019,and 2020 respectively) will be reclassified and could affect any line in any output class.

Figure 6 - Funding and Expenditure for Output Class 1: Prevention Services

Population and Individual Dimensions

Short Term Outcome	Indicator	MoH Measure	Baseline					2016/17 Target
			Period	Māori	Pacific	Other	Total	
Better help for smokers to quit	% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking	PP31	Oct 2015 to Dec 2015	99.1%	100%	99%	99.1%	≥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	Jul 2014 to Sep 2015	80.8%	75.7%	75.7%	81.2%	≥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	Oct 2015 to Dec 2015	95.2%	-	-	96.5%	≥90%
	% of pregnant Māori women that are smokefree at 2 weeks postnatal	SI5 / MH	Jul 2014 to Dec 2014	53.0%	81.0%	-	73.0%	≥95%
Increase Immunisation coverage in Children	% of 8 month olds who complete their primary course of Immunisations	HT / MH	Oct 2015 to Dec 2015	92.6%	100%	93.3%	93.3%	≥95%
	% of 2 year olds fully immunised	PP21	Oct 2015 to Dec 2015	95.1%	96.2%	92.9%	93.9%	≥95%
	% of 4 year olds fully immunised by age 5	PP21	Oct 2015 to Dec 2015	94.2%	96.4%	91.1%	92.7%	≥95%
Increase HPV immunisation rates	% of girls that have received HPV dose three	PP21	Jun 2016	87.8%	73.3%	54.9%	68.4%	≥70%
Increase the rate of seasonal influenza immunisations in over 65 year olds	% of high needs 65 years olds and over influenza immunisation rate	MH	Jan 2014 to Dec 2014	68.0%	70.7%	67.6%	67.9%	≥75%
Reduced incidence of first episode Rheumatic Fever	Acute rheumatic fever initial hospitalisation rate per 100,000	PP28/MH	Jul 2014 to Jun 2015	2.48	-	-	0.6	≤1.5
More women are screened for cancer	% of women aged 50-69 years receiving breast screening in the last 2 years	MH	Jan 2014 to Dec 2014	68.4%	66.5%	76.0%	74.7%	≥70%
	% of women aged 25–69 years who have had a cervical screening event in the past 36 months	MH / SI6	Jan 2013 to Dec 2015	74.1%	71.2%	76.5%	75.8%	≥80%

Short Term Outcome	Indicator	MoH Measure	Baseline					2016/17 Target
			Period	Māori	Pacific	Other	Total	
Reduce the rate of Sudden Unexplained Death of Infants (SUDI)	Rate of SUDI deaths per 1,000 live births	MH	2010 - 2014	2.09	-	-	1.16	≤0.4
	% of caregivers of Māori infants are provided with SUDI prevention information at Well Child Tamariki Ora Core Contact 1	MH	2014/15	72.8%	78.6%	-	80.7%	100%
Better rates of breastfeeding	% of infants that are exclusively or fully breastfed at 6 weeks of age	MH	Jul 2014 to Dec 2014	58%	74%	-	68%	75%
	% of infants that are exclusively or fully breastfed at 3 months of age	MH	Jan 2015 to Jun 2015	46%	62%	-	54%	60%
	% of infants that are receiving breast milk at 6 months of age (exclusively, fully or partially breastfed)	MH	Jan 2015 to Jun 2015	46%	57%	-	56%	65%

3.2 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.

How will we assess performance?

System Dimension

The expected revenue and proposed expenses in respect of this output class are shown in Figure 7.

Early Detection and Management	2015 Actual $'m	2016 Forecast $'m	2017 Budget $'m	2018 Budget $'m	2019 Budget $'m	2020 Budget $'m
Ministry of Health	118.1	121.9	120.3	121.5	123.7	125.9
Other District Health Boards (IDF)	1.9	1.8	1.8	1.8	1.9	1.9
Other sources	4.2	2.8	2.7	2.6	2.7	2.7
Income by Source	**124.2**	**126.5**	**124.8**	**125.9**	**128.2**	**130.5**
Less:						
Personnel	24.6	25.8	27.3	27.9	28.7	29.7
Outsourced services	3.8	3.7	3.1	3.2	3.3	3.3
Clinical supplies	2.9	2.5	2.0	1.9	1.8	1.6
Infrastructure and non clinical supplies	7.9	7.9	9.0	9.2	9.4	9.6
Payments to other District Health Boards	2.4	2.5	2.4	2.5	2.5	2.9
Payments to other providers	84.3	91.4	92.1	93.2	94.6	93.0
Expenditure by type	**125.9**	**133.8**	**135.9**	**137.8**	**140.3**	**140.0**
Net Result	**(1.7)**	**(7.3)**	**(11.1)**	**(11.9)**	**(12.1)**	**(9.5)**

Detailed plans for the new investment and efficiency programmes have yet to be defined, and the impact of the programmes on financial performance have been recognised under clinical supplies in the Intensive Assessment and Treatment output class. When the plans are determined, the efficiencies ($10.9m, $12.4m, $13.9m,and $16.5m in 2017,2018,2019,and 2020 respectively) will be reclassified and could affect any line in any output class.

Figure 7 –Funding and Expenditure for Output Class 2: Early Detection and Management Services

Population and Individual Dimensions

Short Term Outcome	Indicator	MoH Measure	Baseline					2016/17 Target
			Period	Māori	Pacific	Other	Total	
Improved access primary care	% of the population enrolled in the PHO	MH	Dec 2015	97.2%	88.7%	96.5%	96.4%	100%
Avoidable hospitalisation is reduced	Ambulatory sensitive hospitalisation rate per 100,000 0-4 years	SI1 / MH / SI5	Oct 2014 to Sep 2015	5,336	-	3,768	4,725	TBC[15]
	Ambulatory sensitive hospitalisation rate per 100,000 45-64 years	SI1 / MH		6,310	-	2,812	3,510	≤3,510
More pregnant women under the care of a Lead Maternity Carer (LMC)	% of women booked with an LMC by week 12 of their pregnancy		Jun 2015 to Sep 2015	50.7%	40.6%	58.5%	54.5%	≥80%
Hospital service users are reconnected with primary care	Rate of high intensive users of hospital ED as a proportion of Total ED visits		Oct 2015 to Dec 2015	6.13%	6.89%	5.27%	5.57%	≤5.4%
Better oral health	% of eligible pre-school enrolments in DHB-funded oral health services	PP13 / MH	2014*	65.3%	71.7%	81.3%	73.9%	≥95%
	% of children who are carries free at 5 years of age	PP11 / SI5	2015*	36.0%	30.5%	70.1%	54.4%	≥67%
	% of enrolled preschool and primary school children not examined according to planned recall	PP13	2014*	5.1%	7.4%	2.9%	4.0%	≤4.8%
	% of adolescents using DHB-funded dental services	PP12	2014*	-	-	-	78.3%	≥85%
	Mean 'decayed, missing or filled teeth (DMFT)' score at Year 8	PP10	2015*	1.43	1.04	0.70	0.96	≤0.92
Improved management of long-term conditions	Proportion of people with diabetes who have good or acceptable glycaemic control	PP20	12 months - Dec 2015	37.8%	45.5%	42.9%	41.4%	≥55%
	% of the eligible population having had a CVD risk assessment in the last 5 years	PP20	5 years to Dec 2015	86.3%	87.0%	91.7%	90.3%	≥90%
Less waiting for diagnostic services	% of accepted referrals for Computed Tomography (CT) who receive their scans within 42 days	PP29	Dec 2015	84%	-	-	84.4%	≥95%
	% of accepted referrals for MRI scans who receive their scans within 6 weeks	PP29	Dec 2015	31%	-	-	31.0%	≥85%
More pre-schoolers receive Before School Checks	% of 4-year olds that receive a B4 School Check		Jan 2015	52%	54%	56%	54%	≥90%

[15] *This target will be set as part of the System Level Measures process*

Short Term Outcome	Indicator	MoH Measure	Baseline					2016/17 Target
			Period	Māori	Pacific	Other	Total	
Increase refferals of obese children to clinical assessment and family based nutrition, activity and lifestyle interventions	% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.	HT / SI5	Sep 2015	30%	-	23%	27%	≥95%

*Calendar Year

3.3 OUTPUT CLASS 3: Intensive Assessment and Treatment Services

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

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

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

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

How will we assess performance?

System Dimension

The expected revenue and proposed expenses in respect of this output class are shown in Figure 8.

Intensive Assessment and Treatment	2015 Actual $'m	2016 Forecast $'m	2017 Budget $'m	2018 Budget $'m	2019 Budget $'m	2020 Budget $'m
Ministry of Health	273.9	286.8	307.9	311.0	316.6	322.3
Other District Health Boards (IDF)	4.0	3.7	3.7	3.8	3.8	3.9
Other sources	14.7	13.7	13.6	13.0	13.4	13.7
Income by Source	**292.6**	**304.2**	**325.2**	**327.8**	**333.9**	**339.9**
Less:						
Personnel	146.6	153.8	162.8	166.5	171.2	177.0
Outsourced services	9.4	9.1	9.1	9.3	9.5	9.7
Clinical supplies	42.2	36.6	32.0	30.1	28.9	25.2
Infrastructure and non clinical supplies	34.3	34.0	38.4	39.2	40.0	40.9
Payments to other District Health Boards	43.2	45.4	44.1	45.7	46.6	53.4
Payments to other providers	9.4	12.2	15.8	16.0	16.2	15.9
Expenditure by type	**285.1**	**291.1**	**302.2**	**306.7**	**312.5**	**322.1**
Net Result	**7.5**	**13.1**	**23.0**	**21.1**	**21.3**	**17.8**

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 ($10.9m, $12.4m, $13.9m,and $16.5m in 2017,2018,2019,and 2020 respectively) will be reclassified and could affect any line in any output class.

Figure 8 –Funding and Expenditure for Output Class 3: Intensive Assessment and Treatment Services

Population and Individual Dimensions

Short Term Outcome	Indicator	MoH Measure	Baseline					2016/17 Target
			Period	Māori	Pacific	Other	Total	
Less waiting for ED treatment	% of patients admitted, discharged or transferred from an ED within 6 hours	HT	Oct 2015 to Dec 2015	94.8%	94.8%	91.6%	94.7%	≥95%
Faster cancer treatment	% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks from Q1 2016/17	HT	6 months to Dec 2015	78.6%		76.7%	77.6%	≥85%
More elective surgery	Number of elective surgery discharges[16]	HT	Jul 14 to Jun 15	NA	NA	NA	6,154	7374
Patients with ACS receive seamless, coordinated care across the clinical pathway	% of high-risk patients will receiving an angiogram within 3 days of admission.	PP20	Oct 2015 to Dec 2015	60.0%	100%	71%	68.7%	≥70%
	% of angiography patients whose data is recorded on national databases	PP20	Oct 2015 to Dec 2015	71.4%	50%	88.5%	84.1%	≥95%
Equitable access to care for stroke patients	% of potentially eligible stroke patients who are thrombolysed	PP20	Oct 2015 to Dec 2015	0%	0%	4.1%	4.1%	≥6%
	% of patients admitted to the demonstrated stroke pathway	PP20	Oct 2015 to Dec 2015	100%	-	78.8%	78.4%	≥80%
	% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission	PP20	Oct 2015 to Dec 2015	80.0%	-	78.2%	77.4%	≥80%
Equitable access to surgery - Standardised intervention rates for surgery per 10,000 population for:	Major joint replacement	SI4	Oct 2015 to Dec 2015	-	-	-	17.6	≥21.0
	Cataract procedures			-	-	-	51.2	≥27.0
	Cardiac surgery			-	-	-	6.3	≥6.5
	Percutaneous revascularisation			-	-	-	12.4	≥12.5
	Coronary angiography			-	-	-	39.5	≥34.7

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

Short Term Outcome	Indicator		MoH Measure	Baseline					2016/17 Target
				Period	Māori	Pacific	Other	Total	
Shorter stays in hospital	Average length of stay Elective (days)		OS3	12 months - Dec 2015	-	-	-	1.66	1.55
	Average length of stay Acute (days)		OS3	12 months - Dec 2015	-	-	-	2.55	2.35
Fewer readmissions	Acute readmissions to hospital		OS8	12 months - Sep 2015				7.7%	TBC
Quicker access to diagnostics	% accepted referrals for elective coronary angiography completed within 90 days		PP29	Oct 2015 to Dec 2015	60.0%	100%	71.0%	68.7%	≥95%
	% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks		PP29	Dec 2015	66.7%	-	85.7%	82.4%	≥85%
	% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within 30 days		PP29	Dec 2015	100%	-	100%	100%	100%
	% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days)		PP29	Dec 2015	82.4%	100%	86.6%	87.1%	≥70%
	% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within 90 days		PP29	Dec 2015	100%	100%	99.2%	99.3%	100%
	70% of people waiting for a surveillance colonoscopy will wait no longer than twelve weeks (84 days) beyond the planned date		PP29	Dec 2015	66.7%	-	80.8%	79.3%	≥70%
	70% of people waiting for a surveillance colonoscopy will wait no longer than 120 days beyond the planned date?		PP29	Dec 2015	66.7%	-	88.5%	86.2%	100%
Fewer missed outpatient appointments	Did not attend (DNA) rate across first specialist assessments			Oct 2015 to Dec 2015	14.9%	18.3%	5.3%	8.1%	≤7.5%
Better mental health services Improving access Better access to mental health and addiction services	Proportion of the) population seen by mental health and addiction services	Child & youth (0-19	PP6	12 months - Sep 2015	4.62%	2.95%	3.70%	4.07%	≥4%
		Adult (20-64)	PP6	12 months - Sep 2015	8.75%	2.95%	3.79%	4.94%	≥5%
		Older adult (65+)	PP6	12 months - Sep 2015	0.96%	0.97%	1.05%	1.04%	≥1.15

Short Term Outcome	Indicator		MoH Measure	Baseline					2016/17 Target
				Period	Māori	Pacific	Other	Total	
Reducing waiting times Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	% of 0-19 year olds seen within 3 weeks of referral	Mental Health Provider Arm	PP8	12 months - Dec 2015	63.2%	75.0%	56.9%	60.1%	≥80%
		Addictions (Provider Arm and NGO)	PP8	12 months - Dec 2015	90.5%	-	61.5%	84.2%	≥80%
	% of 0-19 year olds seen within 8 weeks of referral	Mental Health Provider Arm	PP8	12 months - Dec 2015	86.5%	91.7%	85.3%	81.5%	≥95%
		Addictions (Provider Arm and NGO)	PP8	12 months - Dec 2015	100%	-	92.3%	99.5%	≥95%
Improving mental health services using discharge planning	% children and youth with a transition (discharge) plan		PP7	12 months - Dec 2015	35.9%	37.0	36.3%	36.2%	≥95%
Increasing consumer focus More equitable use of Mental Health Act: Section 29 community treatment orders	Rate of s29 orders per 100,000 population		MH / SI5	Oct 2015 to Dec 2015	196.0	-	93.4	97.0	≤81.5

3.4 OUTPUT CLASS 4: Rehabilitation and Support Services

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

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

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

How will we assess performance?

System Dimension

The expected revenue and proposed expenses in respect of this output class are shown in Figure 9.

Rehabilitation and Support	2015 Actual $'m	2016 Forecast $'m	2017 Budget $'m	2018 Budget $'m	2019 Budget $'m	2020 Budget $'m
Ministry of Health	70.4	68.7	69.6	70.3	71.6	72.8
Other District Health Boards (IDF)	2.1	2.0	2.0	2.1	2.1	2.1
Other sources	0.1	0.3	0.2	0.2	0.2	0.2
Income by Source	**72.6**	**71.0**	**71.8**	**72.5**	**73.8**	**75.2**
Less:						
Personnel	6.5	6.8	7.2	7.4	7.6	7.8
Outsourced services	-	-	-	-	-	-
Clinical supplies	0.8	0.7	0.5	0.5	0.5	0.4
Infrastructure and non clinical supplies	1.8	1.8	2.1	2.1	2.2	2.2
Payments to other District Health Boards	3.6	3.8	3.7	3.8	3.9	4.5
Payments to other providers	59.4	59.8	65.0	65.8	66.8	65.6
Expenditure by type	**72.1**	**72.9**	**78.5**	**79.6**	**80.9**	**80.5**
Net Result	**0.5**	**(1.9)**	**(6.7)**	**(7.0)**	**(7.0)**	**(5.4)**

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 ($10.9m, $12.4m, $13.9m,and $16.5m in 2017,2018,2019,and 2020 respectively) will be reclassified and could affect any line in any output class.

Figure 9 –Funding and Expenditure for Output Class 4: Rehabilitation and Support Services

Population and Individual Dimensions

Short Term Outcome	Indicator		MoH Measure	Baseline					2016/17 Target
				Period	Māori	Pacific	Other	Total	
Better access to acute care for older people	Age specific rate of non-urgent and semi urgent attendances at the Regional Hospital ED (per 1,000 population)	75-79 years		Oct 2015 to Dec 2015	144.4	-	-	136.5	≤139.5
		80-84 years		Oct 2015 to Dec 2015	208	-	-	178.9	≤183.1
		85+ years		Oct 2015 to Dec 2015	153.8	-	-	229.2	≤231.0
Better community support for older people	Acute readmission rate: 75 years +			12 months - Sep 2015	-	-	-	11.1%	<10%
	% of people receiving home support who have a comprehensive clinical assessment and a completed care plan		PP23	Jul 2015 to Sep 2015	100%	100%	100%	100%	≥95%
	Percentage of people in aged residential care by facility and by DHB who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of the previous assessment.		PP23	Oct 2015 to Dec 2015	-	-	-	63%	77%
	The percentage of LTCF clients admitted to an Aged Residential Care (ARC) facility who had been assessed using an interRAI Home Care assessment tool in the six months prior to that first long term care facility (LTCF) assessment.		PP23	Oct 2015 to Dec 2015	-	-	-	-	improve on current performance
Increased capacity and efficiency in needs assessment and service coordination services	Clients with a CHESS score (Change in Health, End-stage disease, signs and symptoms) of 4 or 5 at first assessment			Oct 2015 to Dec 2015	-	-	-	13.8%	<13.8%
Prompt response to palliative care referrals	Time from referral receipt to initial Cranford Hospice contact within 48 hours			Oct 2015 to Dec 2015	-	-	-	91.0%	>80%
More day services	Number of day services			12 months – Jun 2015	-	-	-	21,546	≥21,791
More older patients receive falls risk assessment and care plan	% of older patients given a falls risk assessment % of older patients assessed as at risk of falling receive an individualised care plan			Oct 2015 to Dec 2015	-	-	-	90.5% 78.4%	90% 98%

4 FINANCIAL PERFORMANCE

Planning regulations require the DHB's Annual Plan to contain detailed financial budgets, and information on how the DHB's performance both as a funder and as a provider of services will be demonstrated. This module contains audited financial statements for the 2014/15 financial year, forecast financial statements for 2015/16, and projected financial statements for the 2016/20 period. Separate financial performance statements for the funding of services, providing of services, and governance and funding administration are also included for each of these periods. Performance against the 2016/17 financial year projections will be reported in the 2016/17 Annual Report.

4.1 PROJECTED FINANCIAL STATEMENTS

Introduction

Hawke's Bay District Health Board is planning to deliver a surplus of $5 million this year. This is consistent with the DHB's recent track record, and enables us to fund a proportionate capital programme, including in the plan period the completion of major mental health, maternity, endoscopy and renal facilities associated with service redesign.

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

Projected Financial Statements

Reporting entity

The financial statements of the District Health Board comprise the District Health Board, its 19% interest in Allied Laundry Services Limited, and its 16.7% interest in Central Region's Technical Advisory Services Limited. The District Health Board has no subsidiaries.

Cautionary Note

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

The underlying assumptions were adopted on 25 May 2016.

Accounting Policies

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

The accounting policies applied in the projected financial statements are included as an appendix.

Projected Statement of Revenue and Expense

in thousands of New Zealand Dollars

For the year ended 30 June	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Ministry of Health - devolved funding	454,822	484,024	504,227	509,208	518,463	527,744
Ministry of Health - non devolved contracts	14,180	4,039	3,732	3,805	3,886	3,969
Other District Health Boards	11,821	11,598	11,549	11,774	12,024	12,283
Other government and Crown agency sourced	6,421	5,680	6,394	6,519	6,658	6,801
Patient and consumer sourced	1,484	1,211	1,377	1,403	1,433	1,464
Other	7,691	5,964	4,920	4,113	4,201	4,291
Operating revenue	496,420	512,517	532,199	536,822	546,665	556,552
Employee benefit costs	179,099	188,050	199,028	203,507	209,309	216,375
Outsourced services	13,233	12,812	12,248	12,488	12,754	13,029
Clinical supplies	45,967	39,758	34,619	32,523	31,184	27,241
Infrastructure and non clinical supplies	44,937	44,110	50,042	51,016	52,101	53,224
Payments to non-health board providers	210,131	223,798	231,261	235,288	239,317	243,683
Operating expenditure	493,366	508,527	527,199	534,822	544,665	553,552
Surplus for the period	3,054	3,990	5,000	2,000	2,000	3,000
Revaluation of land and buildings	37,444	(1,795)	-	-	-	-
Other comprehensive revenue and expense	37,444	(1,795)	-	-	-	-
Total comprehensive revenue and expense	**40,498**	**2,195**	**5,000**	**2,000**	**2,000**	**3,000**

Table 1 – Projected Statement of Comprehensive Revenue and Expense

Projected Statement of Movements in Equity

in thousands of New Zealand Dollars

For the year ended 30 June	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Equity as at 1 July	**49,140**	**87,626**	**89,465**	**94,108**	**95,750**	**97,393**
Total comprehensive revenue and expense:						
Funding of health and disability services	7,481	5,186	5,000	2,000	2,000	3,000
Governance and funding administration	148	478	0	-	-	-
Provision of health services	(4,575)	(1,675)	(0)	-	-	-
Gain on disposal of assets held for sale	-	-	-	-	-	-
Revaluation of land and buildings	37,444	(1,795)	-	-	-	-
	40,498	2,195	5,000	2,000	2,000	3,000
Contributions from the Crown (equity injections)	-	-	-	-	-	-
Repayments to the Crown (equity repayments)	(357)	(356)	(358)	(357)	(357)	(357)
Transfer of the Chatham Is. to Canterbury DHB	(1,655)	-	-	-	-	-
Equity as at 30 June	**87,626**	**89,465**	**94,107**	**95,750**	**97,393**	**100,036**

Table 2 - Projected Statement of Movements in Equity

Projected Statement of Financial Position

in thousands of New Zealand Dollars

As at 30 June	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Equity						
Paid in equity	35,573	35,216	34,859	34,502	34,145	33,788
Asset revaluation reserve	69,187	67,392	67,392	67,392	67,392	67,392
Asset replacement reserve	15,253	-	-	-	-	-
Trust and special funds (no restricted use)	3,125	3,125	3,125	3,125	3,125	3,125
Accumulated deficit	(35,511)	(16,268)	(11,269)	(9,269)	(7,269)	(4,269)
	87,626	**89,465**	**94,107**	**95,750**	**97,393**	**100,036**
Represented by:						
Current assets						
Cash	9	7	7	7	7	7
Short term investments	13,538	3,146	7,661	2,259	1,926	1,832
Short term investments (special funds/clinical trials)	3,124	3,095	3,095	3,095	3,095	3,095
Receivables and prepayments	17,855	18,225	18,607	18,969	19,371	19,788
Loans (Hawke's Bay Helicopter Rescue Trust)	10	11	11	12	13	13
Inventories	3,881	3,961	4,044	4,123	4,211	4,301
Assets classified as held for sale	1,220	1,220	-	-	-	-
	39,637	29,665	33,425	28,465	28,622	29,036
Non current assets						
Property, plant and equipment	148,303	157,877	166,028	173,575	174,177	176,699
Intangible assets	2,298	1,213	665	58	(620)	(1,325)
Investment property	131	131	131	131	131	131
Investment in NZ Health Partnerships Limited	2,504	2,504	2,504	2,504	2,504	2,504
Investment in associates	4,742	5,804	6,943	8,082	8,481	8,481
Loans (Hawke's Bay Helicopter Rescue Trust)	55	42	29	15	-	-
	158,033	167,572	176,299	184,365	184,673	186,490
Total assets	**197,670**	**197,237**	**209,724**	**212,829**	**213,295**	**215,525**
Less:						
Current liabilities						
Payables and accruals	29,953	30,582	31,194	31,826	29,573	27,511
Employee entitlements	35,248	32,317	34,485	35,260	36,265	37,859
Loans and borrowings	-	-	6,000	11,500	-	10,000
	65,201	62,900	71,679	78,586	65,838	75,370
Non current liabilities						
Employee entitlements	2,342	2,372	2,438	2,493	2,564	2,619
Loans and borrowings	42,500	42,500	41,500	36,000	47,500	37,500
	44,842	44,872	43,938	38,493	50,064	40,119
Total liabilities	**110,044**	**107,772**	**115,617**	**117,079**	**115,902**	**115,489**
Net assets	**87,626**	**89,465**	**94,108**	**95,750**	**97,393**	**100,036**

Table 3 - Projected Statements of Financial Position

Projected Statement of Cash Flows

in thousands of New Zealand Dollars

For the year ended 30 June	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Cash flow from operating activities						
Cash receipts from MOH, Crown agencies & patients	494,548	518,808	531,229	537,058	547,169	557,331
Cash paid to suppliers and service providers	(299,064)	(314,352)	(303,309)	(307,582)	(312,624)	(313,221)
Cash paid to employees	(176,194)	(186,766)	(198,449)	(202,914)	(208,698)	(215,741)
Cash generated from operations	**19,289**	**17,690**	**29,471**	**26,562**	**25,847**	**28,369**
Interest received	1,628	1,360	885	-	-	-
Interest paid	(2,419)	(2,236)	(2,476)	(2,562)	(2,397)	(2,476)
Capital charge paid	(3,740)	(3,971)	(7,186)	(7,326)	(7,482)	(7,642)
Cash flow from investing activities	14,757	12,844	20,694	16,674	15,969	18,251
Proceeds from sale of property, plant and equipment	2,236	1,263	1,220	-	-	-
Acquisition of property, plant and equipment	(15,608)	(23,117)	(22,042)	(21,719)	(15,945)	(17,988)
Acquisition of intangible assets	(921)	(1,094)	-	-	-	-
Acquisition of investments	(1,752)	-	-	-	-	-
Cash flow from financing activities	(16,045)	(22,949)	(20,822)	(21,719)	(15,945)	(17,988)
Proceeds from borrowings	-	-	5,000	-	-	-
Proceeds from equity injections	(1,655)	-	-	-	-	-
Repayment of borrowings	-	-	-	-	-	-
Repayment of finance lease liabilities	(268)	-	-	-	-	-
Equity repayment to the Crown	(357)	(357)	(357)	(357)	(357)	(357)
	(2,280)	(357)	4,643	(357)	(357)	(357)
Net increase/(decrease) in cash and cash equivalents	(3,567)	(10,462)	4,515	(5,402)	(333)	(94)
Cash and cash equivalents at beginning of year	18,536	14,969	4,507	9,022	3,620	3,286
Cash and cash equivalents at end of year	14,969	4,507	9,022	3,620	3,286	3,192
Represented by:						
Cash	9	7	7	7	7	7
Short term investments	14,960	4,500	9,015	3,612	3,279	3,185
	14,969	4,507	9,022	3,619	3,286	3,192

Table 4 - Projected Statement of Cash Flows

Projected Funder Arm Operating Results

in thousands of New Zealand Dollars

For the year ended 30 June	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Revenue						
Ministry of Health - devolved funding	454,822	484,024	504,227	509,208	518,463	527,744
Inter district patient inflows	7,696	7,486	7,545	7,692	7,855	8,024
Other revenue	202	151	30	31	32	33
	462,719	**491,662**	**511,803**	**516,931**	**526,350**	**535,801**
Expenditure						
Governance and funding administration	2,781	3,140	3,220	3,283	3,353	3,425
Own DHB provided services						
Personal health	207,692	214,874	229,142	232,338	236,721	239,766
Mental health	24,366	25,005	24,259	24,732	25,258	25,801
Disability support	9,169	14,701	13,796	14,066	14,367	14,675
Public health	520	4,357	4,523	4,611	4,708	4,811
Maori health	579	601	601	613	626	640
Other DHB provided services (Inter district outflows)	242,326	259,538	272,321	276,360	281,680	285,693
Personal health	45,156	46,843	45,317	46,201	47,183	48,197
Mental health	2,342	2,391	2,410	2,457	2,509	2,563
Disability support	3,210	3,000	3,232	3,295	3,365	3,437
Public health	-	-	-	-	-	-
Maori health	-	-	-	-	-	-
Other provider services	50,709	52,234	50,959	51,953	53,057	54,197
Personal health	87,818	99,483	104,187	105,735	107,014	108,539
Mental health	10,888	11,088	11,164	11,383	11,624	11,874
Disability support	56,101	56,071	59,392	60,549	61,833	63,161
Public health	1,248	1,185	1,578	1,608	1,643	1,677
Maori health	3,368	3,737	3,982	4,060	4,146	4,235
	159,422	171,564	180,302	183,335	186,260	189,486
Total Expenditure	**455,238**	**486,476**	**506,803**	**514,931**	**524,350**	**532,801**
Net Result	**7,481**	**5,186**	**5,000**	**2,000**	**2,000**	**3,000**

Table 5 - Projected Funder Arm Operating Results

Projected Governance and Funding Administration Operating Results

in thousands of New Zealand Dollars

For the year ended 30 June	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Revenue						
Funding	2,781	3,140	3,220	3,283	3,353	3,425
Other government and Crown agency sourced	-	-	-	-	-	-
Other revenue	23	39	30	31	32	33
	2,804	3,179	3,250	3,314	3,385	3,458
Expenditure						
Employee benefit costs	677	729	954	975	1,003	1,038
Outsourced services	414	457	472	481	491	501
Clinical supplies	0	1	1	1	1	1
Infrastructure and non clinical supplies	632	580	878	895	914	933
	1,723	1,767	2,305	2,352	2,409	2,473
Plus: allocated from Provider Arm	933	933	945	962	976	985
Net Result	**148**	**478**	**0**	**-**	**-**	**-**

Table 6 - Projected Governance and Funding Administration Operating Results

Projected Provider Arm Operating Results

in thousands of New Zealand Dollars

For the year ended 30 June	2015 Audited	2016 Forecast	2017 Projected	2018 Projected	2019 Projected	2020 Projected
Revenue						
Funding	242,326	259,538	272,241	276,278	281,596	285,607
Ministry of Health - non devolved contracts	14,180	4,039	3,732	3,805	3,886	3,969
Other District Health Boards	4,126	4,112	4,004	4,082	4,169	4,259
Accident Insurance	5,931	5,291	5,980	6,097	6,227	6,361
Other government and Crown agency sourced	490	389	414	422	431	440
Patient and consumer sourced	1,484	1,211	1,377	1,403	1,433	1,464
Other revenue	7,466	5,774	4,859	4,051	4,137	4,225
	276,004	280,355	292,608	296,138	301,879	306,325
Expenditure						
Employee benefit costs	178,422	187,320	198,075	202,532	208,306	215,337
Outsourced services	12,818	12,355	11,696	11,925	12,179	12,442
Clinical Supplies	45,966	39,757	34,618	32,522	31,183	27,240
Infrastructure and non clinical supplies	44,305	43,530	49,163	50,121	51,187	52,291
	281,512	282,963	293,553	297,100	302,855	307,310
Less: allocated to Governance & Funding Admin.	933	933	945	962	976	985
Surplus for the period	**(4,575)**	**(1,675)**	**(0)**	**-**	**-**	**-**
Revaluation of land and buildings	(37,444)	1,795	-	-	-	-
Net Result	**32,869**	**(3,470)**	**(0)**	**-**	**-**	**-**

Table 7 – Projected Provider Arm Operating Results

4.2 SIGNIFICANT ASSUMPTIONS

General

- Revenue and expenditure has been budgeted on current Government policy settings and known health service initiatives.
- No allowance has been made for any new regulatory or legislative changes which increase compliance costs.
- No allowance has been made for the costs of unusual emergency events e.g. pandemic or earthquake.
- Allowance has been made for the implementation costs of and net savings from regional and national entity initiatives as advised by the Ministry of Health.
- No allowance has been made for any additional capital or operating costs that may be required by the National Oracle Solution (NOS) shared financial platform solution managed by New Zealand Health Partnerships Limited (NZHPL).
- Allowance has been made for net additional costs arising from the Regional Health Information Project (RHIP) of $1.1 million in each of 2016/17 and 2017/18, and $0.4 million in 2018/19.
- The full year impact of ongoing transformation expenditure has required a $10.8 million efficiency programme for the 2016/17 year. Nominal increases in funding (excluding revenue banking), and inflationary increases in expenditure will require further savings of $2.7 million, $2.0 million and $4.6 million in 2017/18, 2018/19, and 2019/20 respectively. No allowance has been made for a new investment programme in the plan, however such programmes are likely and will require increases in the savings targets. Detailed plans for the new investment and efficiency programmes have yet to be defined, 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 1.95%, 2.125% and 2.15% for 2017/18, 2018/19 and 2019/20 respectively based on Treasury forecasts for CPI inflation (30 June Year composite rates based the 31 March rates in the Half Year Economic and Fiscal Update 2015 published 15 December 2015).
-

Revenue

- Crown funding under the national population based funding formula, including adjustments, will be $472.2 million for 2016/17. Funding for the 2017/18, 2018/19 and 2019/20 years will include nominal increases of $8.5 million per annum.
- Crown funding for non-devolved services of $35.8 million is based on agreements already in place with the appropriate Ministry of Health directorates, and assumes receipt of the DHB's full entitlement to elective services funding.
- The remaining $4.2 million of the $5 million of funding left with the Ministry of Health in 2011/12 due to sales proceeds from the Napier Hill site sale, will be drawn down in 2016/17.
- Inter district flows revenue is in accordance with Ministry of Health advice.
- Other income has been budgeted at the District Health Board's best estimates of likely income.

Personnel Costs and Outsourced Services

- Workforce costs for 2016/17 have been budgeted at actual known costs, including step increases where appropriate. Increases to Multi Employer Collective Agreements have been budgeted in accordance with settlements, or where no settlement has occurred, at the District Health Board's best estimate of the likely increase. Personnel cost increases have been allowed for at 2.25%, 2.85% and 3.375% for 2017/18, 2018/19 and 2019/20 respectively based on Treasury forecasts for wage inflation (30 June Year composite rates based the 31 March rates in the Half Year Economic and Fiscal Update 2015 published 15 December 2015).
- Establishment numbers for management and administration staff have been capped by the Minister of Health at 417 FTEs, the same as 2015/16. The District Health Board is managing internally to a cap of 400 FTEs.

Supplies and Infrastructural Costs

- The cost of goods and services has been budgeted the District Health Board's best estimates of likely cost.

- No allowance has been made for cost increases/decreases relating to fluctuations in the value of the New Zealand Dollar.

Services Provided by Other DHB's

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

Other Provider Payments

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

Capital Servicing

- Depreciation has been calculated to write off the cost or fair value of property, plant, and equipment assets, and amortisation has been calculated to write off the cost or fair value of intangible assets (software) less their estimated residual values, over their useful lives. The investment in NZHPL gives the DHB a right to use the systems they provide, so they are considered to have indefinite lives, and consequently no amortisation has been allowed for.
- The drawdown of $5 million of debt funding in June 2016 for the new Mental Health Inpatient Unit (Nga Rau Rakau), as agreed with the Minister of Health as part of the disposal of the Napier Hill site, has an assumed interest rate of 3.42% being 15 points above 10 year government stock rate on 21 January 2016. Interest rates of 4.3%, 4.65% and 4.8% have been applied from the maturity dates of expiring facilities in 2017/18, 2018/19, and 2019/20 respectively based on 15 points above Treasury forecasts for 10 year bonds (30 June Year composite rates based on the 31 March interest rates in the Half Year Economic and Fiscal Update 2015 published 15 December 2015. No maturities or new borrowings are expected in 2016/17.
- The capital charge rate remains at 8%.

Investment

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

Investment	2016/17 $'m	2017/18 $'m	2018/19 $'m	2019/20 $'m
Buildings and Plant	5,710	8,619	4,800	5,500
Clinical Equipment	9,407	6,040	4,500	3,900
Other Equipment	2,800	3,510	3,545	4,588
Information Technology	3,125	2,550	2,100	3,000
Capital Investment	**21,042**	**20,719**	**14,945**	**16,988**
New technologies/Investments	1,000	1,000	1,000	1,000
Investment in RHIP	1,139	1,139	0.399	-
Total Investment	**23,181**	**22,858**	**13,344**	**17,988**

Capital Investment Funding

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

Investment Funding	2016/17 $'m	2017/18 $'m	2018/19 $'m	2019/20 $'m
Total Investment	23,181	22,858	13,344	17,988
Funded by:				
Depreciation and amortisation	14,440	14,779	16,021	16,433
Operating surplus	5,000	2,000	2,000	3,000
Cash holdings	3,741	6,079	(4,677)	(1,445)
Capital Investment Funding	**23,181**	**22,858**	**13,344**	**17,988**

Property, Plant and Equipment

- Hawke's Bay District Health Board is required to revalue land and buildings when the fair value differs materially from the carrying amount, and at least every five years. The last revaluation was at 30 June 2015, and no adjustment has been made for the effect of any other revaluation over the time horizon of the plan.

Debt and Equity

- Debt will be at the levels in the table below. Loans and borrowings are included in the table at face value.

Debt	2015/16 $'m	2016/17 $'m	2017/18 $'m	2018/19 $'m
Borrowing	47.5	47.5	47.5	47.5
Finance leases	-	-	-	-
Total debt	**47.5**	**47.5**	**47.5**	**47.5**
Debt/(Debt+Equity) Ratio	*33.5%*	*33.1%*	*32.8%*	*32.2%*

- No debt funding from the Crown is planned for the four year planning period. There are no banking covenants relating to the debt.

Key Lenders	Facility	Limit $'m	Termination Date
Crown	Term Debt	$47.5 million	31 December 2021

- Equity movements will be in accordance with the table below.

Equity	2016/17 $'m	2017/18 $'m	2018/19 $'m	2019/20 $'m
Opening equity	89.5	94.1	95.8	97.4
Surplus	5.0	2.0	2.0	3.0
Equity repayments (FRS3)	(0.4)	(0.3)	(0.4)	(0.4)
Closing equity	**94.1**	**95.8**	**97.4**	**100.0**

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.

5 STEWARDSHIP & ORGANISATIONAL CAPABILITY

In order to make progress against our strategic outcomes, we have put in place our 'Transform and Sustain' programme, which in time will transform the whole Hawke's Bay health system. Some work is already underway and we are building on those successes and we are using the New Zealand Triple Aim as a guide to ensure we keep change in balance.

Delivering on Transform and Sustain will mean people in Hawke's Bay will experience:

A health system that is responsive to need

Consistent high-quality health care

A more efficient health system

We are also implementing some cultural and structural changes to the system to support transformation and align it with the values that underpin our vision:

TAUWHIRO: delivering high-quality care to patients and consumers

RĀRANGA TE TIRA: working together in partnership across the system

HE KAUANANU: showing respect for each other, our staff, patients and consumers

ĀKINA: continuously improving everything we do.

QUALITY

Transform and Sustain is providing:

- An organisational development programme to support our workforce so they are empowered and valued to make the biggest contribution they can
- A means of reviewing progress in the three aims we have identified
- A model to measure, target and report our expenditure so we move our resources to where we bring about transformational change.

The Sustain programme consolidates the improvements we make in order to support the Transform programme that, together, will significantly improve the value of our services to the people of Hawke's Bay.

Creating Headroom for Change

Over the recent past, individuals across the health system have worked extremely hard to make the improvements that have been necessary. It is important we recognise those efforts and create the right environment and culture for ongoing change that links quality improvement and system integration. While we know we can't make change everywhere at once, we need to identify those services that could lead and support others.

The objectives of the programme cannot be achieved in one year, but readying the whole system for transformation is not something that we could put off. Rather, we have attempted to free-up some systems and processes so those who are ready can make a start. Time and energy continues to be invested in establishing, strengthening and maintaining relationships for better liaison across the system. The transformation agenda has taken time to initiate, but the momentum is gathering as people's expectations change and we respond to patients' needs in different ways.

In the first instance, we attempted to pinpoint opportunities that could easily be implemented in order to release some time and create the space for everyone to come together to design innovative solutions. That included identifying better administrative processes and more flexible budgeting, removing obstacles, facilitating better working partnerships and supporting the generation of new ideas while spending less time on non-essential tasks.

Fundamentally, teams at all levels are being encouraged to make more time to discuss, plan, implement and review improvement opportunities. Managers and team leaders are being supported to make this happen.

5.1 Organisational Development

Workforce

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

Organisational development programmes are focusing on the following:

- Further advancing our Service Directorate structure of Service Director,

  Medical/Surgical Director and Nurse Director
- Clinical leadership and engagement of staff bottom up in our Transform and Sustain priorities
- Talent Management Programme including succession planning
- Transformational management and leadership capability
- Increasing staff engagement, health and well-being
- High performing teams, including re-skilling and up-skilling of staff
- New roles and capabilities to support new models of care and new ways of working
- Building capability, through structured development of current staff and recruitment of high calibre individuals
- Increasing Māori staff representation and increasing effective engagement with Māori
- Maintaining high levels of Union engagement
- Continued development of smart systems and reporting
- Full implementation of the new Health and Safety at Work Act including our new risk management approach to health and safety management.
- Enhanced blended and on-line learning and development programmes for clinicians and staff

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

Communications

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

Health Information

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

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

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

Capital

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. Our asset values were last updated by a Registered Valuer as at the 30 June 2015. Our Asset Management Plan has also been updated in 2014-15 incorporating a ten year plan for expenditure on our assets. 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.

Nga Rau Rākau, the new mental health inpatient unit, opened in February 2016, and Waioha, the primary maternity unit, will open for use in July 2016. The new stand-alone endoscopy unit and the renal centralised development were approved in principle by the DHB Board in July 2015 and September 2015 respectively.

Major Strategic Asset Expenditure 2016-20

	2016-17	2017-18	2018-19	2019-20
	-	-	-	-
Mental Health Inpatient Unit	2,210	-	-	-
Maternity Development	100	-	-	-
New stand-alone endoscopy	3,000	5,000	900	-
Renal centralised development	1,000	389	-	-
Oncology upgrade	-	200	800	-
Upgrade old MHIU	400	2,000	3,000	2,500
Central Region IS Programme	650	7	-	-

Procurement

The Ministry of Business, Innovation and Employment (MBIE) Government Rules of Sourcing (Rules) became mandatory for the public health sector on 1 February 2015. HBDHB intends to comply with the requirements set out in the Rules to the greatest extent that is practicable. Compliance with the Rules is subject to any statutory or similar obligation applying in respect to procurement e.g. pharmaceuticals from the pharmaceutical schedule (PHARMAC), being a requirement of s23(7) of the NZ Public Health and Disability Act; in-scope procurement via Health Alliance (hA), being procurement covered by arrangements consented to by the Minister under s24 of the NZPH&D Act.

5.2 Key Intentions

We have described what our core challenges are:

1. Responding to our population - we believe patients and whānau should be at the centre of health care, not a hospital or any particular care setting, and we need to have a stronger engagement with consumers and their families/whānau
2. Delivering consistent high-quality health care - the best quality care is appropriate, convenient and precise – the patient gets exactly what they need, delivered as soon as possible without error or undue waiting
3. Being more efficient at what we do - reducing waste in health will make us more efficient and ensure we get the best value from health care resources by delivering the right care to the right people in the right place, the first time.

Transform and Sustain includes a number of key intentions that, when implemented, will support us to address our core challenges.

- **Transforming our engagement with Māori**
- **Transforming patient involvement**
- **Transforming health promotion and health literacy**
- **Transforming multi-agency working**
- **Transforming clinical quality through clinical governance**
- **Transforming patient experience through better clinical pathways**
- **Transforming through integration of rural services**
- **Transforming primary health care**
- **Transforming urgent care**
- **Transforming out-of-hours hospital inpatient care**
- **Transforming business models**

Processes for Achieving Regular Financial Surpluses

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

Hawke's Bay DHB continues with its strategic direction to provide a $3m year-on-year surplus. This surplus is required to enable us to continue to invest in various infrastructure initiatives required to meet the needs of our community.

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

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

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

Shifting Resources

To ensure that our change in focus is also matched by a shift of resources, we have agreed measures to monitor changes in deploying resources over time. Figure 3 illustrates a model for measuring and managing a shift of resources. The aim is to measure, monitor and realign expenditure in these categories and to shift resources purposely.

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.

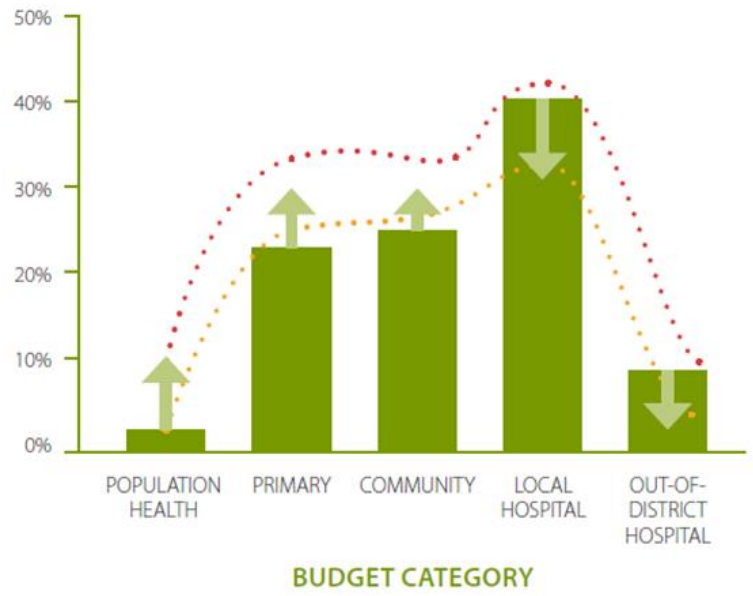


Figure 10: A model for changing resource deployment in a health system

Summary

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

Note A: Subsidiary Companies and Investments

Currently, there are no subsidiary companies in which HBDHB has a controlling interest[17] and HBDHB has no plans to acquire shares or interests in terms of section 100 of the Crown Entities Act 2004. HBDHB has an interest in one multi-parent subsidiary: Allied Laundry Services Limited. Other shareholders are MidCentral DHB, Taranaki DHB, Whanganui DHB, Capital and Coast DHB and Hutt Valley DHB. Allied Laundry Services Limited has an exemption from producing a Statement of Intent (SOI). MidCentral DHB will report on Allied Laundry Services Limited in its SOI, on behalf of Hawke's Bay, Taranaki and Whanganui DHB

Note B: HBDHB 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.

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

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

6 SERVICE CONFIGURATION

6.1 Service Coverage and Service Change

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 (refer Appendix 2), 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.

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

Change	Description	Expected Benefits
Urgent Care	Finalise the outcome of a formal (ROI/RFP) Urgent Care Service Change Proposal process.	More consistent and effective access to appropriate urgent care across the district. Reduce hospital admissions and improve equity.
Allied Health	A review of some allied health services is underway to determine if there are opportunities for more effective service design. This may result in some changes to access for some services.	More effective links to community-based service delivery options Greater equity of access
Primary Mental Health	A redesign of primary mental health services is underway and this will change current delivery.	More targeted access to under-served populations to enable earlier access for mild and moderate mental health concerns. Better linkage between primary, community and secondary mental health services
Adults Alcohol and Other Drugs (AOD) model of care implementation	Implementation of change management plan for an Adult AOD Model of Care pathway across 6 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 our patients Improving access for Māori and Pacific populations Change implementation will support the provision of services under the proposed Substance Addiction (Compulsory Assessment and Treatment) Bill to be implemented in 2016/17.
Community Pharmacy	Consultation is underway for development of Integrated Pharmacist Services in the Community. This process is expected to lead to a change in the current national Community Pharmacy Services Agreement.	Working with others for integrated care Access to pharmacist services by consumers Consumer empowerment Safe supply of medicines to the consumer

		Improves support for vulnerable populations Utilisation of pharmacists as a first point of contact within primary care
Laboratory Services	Maintaining safe, accessible laboratory services may lead to a change in the range of laboratory services available 24/7 at all current delivery sites.	Service coverage expectations for clinically-appropriate laboratory tests will be emphasised Better use of health system resources.
Surgical Services	Each specialty in surgical services is undergoing an internal review which may result in some recommendations for change in service delivery	Better ESPI compliance and demand management. Data capture in line with National Patient Flow requirements. Better Regional collaboration and more standardised clinical prioritisation.
Youth Services	A youth strategy is being developed which may result in changes to services in 16/17	Better access for youth and services which are more responsive to youth

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. More detail on plans to improve integration and shift services is included in Module 2.1, Service Configuration and Shifting Services.

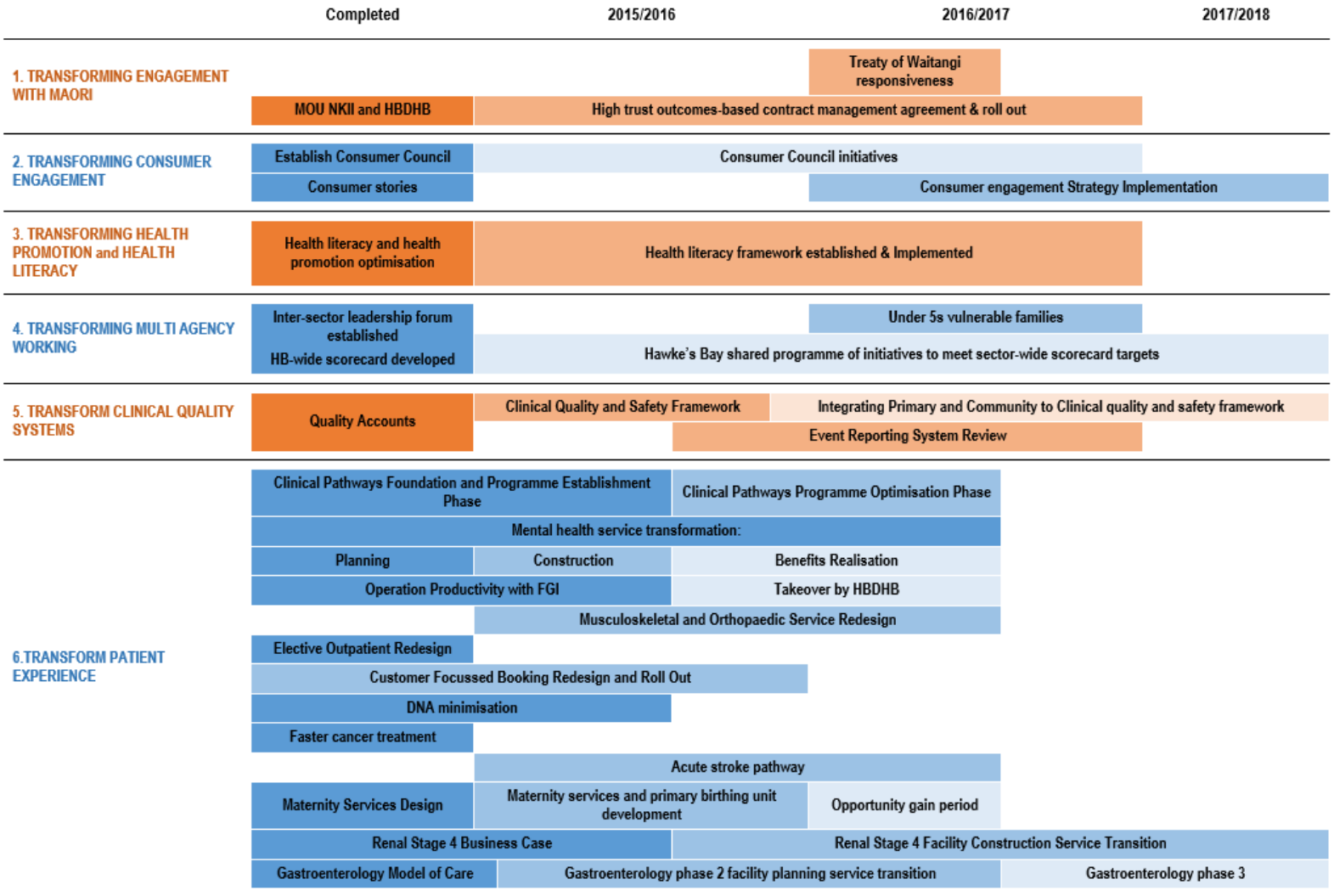
Procurement of Health & Disability Services

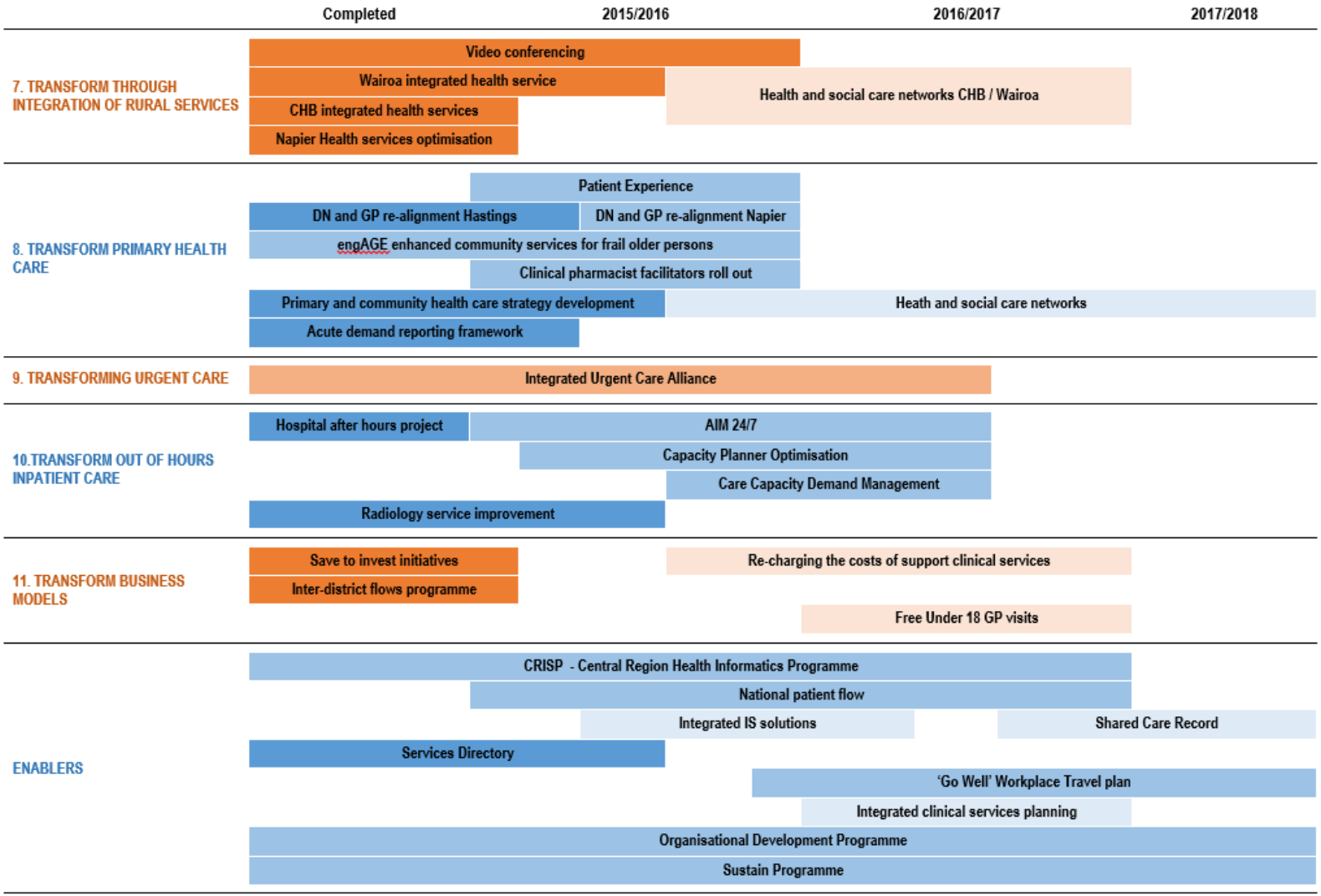
HBDHB periodically undertakes competitive processes (Registration of Interest, Request for Proposals etc.), in accordance with the Ministry of Business Innovation and Employments Government Rules of Sourcing. Competitive processes may be undertaken for several reasons including, the time since the last 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.

7 APPENDICES

7.1 APPENDIX 1 Our Strategic Framework

7.2 APPENDIX 2 Transform and Sustain Programme Overview




Completed
2015/2016
2016/2017
2017/2018
7. TRANSFORM THROUGH INTEGRATION OF RURAL SERVICES
Video conferencing
Wairoa integrated health service
CHB integrated health services
Napier Health services optimisation
Health and social care networks CHB / Wairoa
8. TRANSFORM PRIMARY HEALTH CARE
Patient Experience
DN and GP re-alignment Hastings
DN and GP re-alignment Napier
engAGE enhanced community services for frail older persons
Clinical pharmacist facilitators roll out
Primary and community health care strategy development
Heath and social care networks
Acute demand reporting framework
9. TRANSFORMING URGENT CARE
Integrated Urgent Care Alliance
10.TRANSFORM OUT OF HOURS INPATIENT CARE
Hospital after hours project
AIM 24/7
Capacity Planner Optimisation
Care Capacity Demand Management
Radiology service improvement
11. TRANSFORM BUSINESS MODELS
Save to invest initiatives
Inter-district flows programme
Re-charging the costs of support clinical services
Free Under 18 GP visits
ENABLERS
CRISP - Central Region Health Informatics Programme
National patient flow
Integrated IS solutions
Shared Care Record
Services Directory
'Go Well' Workplace Travel plan
Integrated clinical services planning
Organisational Development Programme
Sustain Programme

7.3 APPENDIX 3 Notes to the Financial Statements

Reporting Entity

Hawke's Bay District Health Board is a District Health Board established by the New Zealand Public Health and Disability Act 2000. The District Health Board is a crown entity as defined by the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. The District Health Board is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

The Hawke's Bay District Health Board's primary objectives are the funding and provision of health, disability and mental health services to the people of Hawke's Bay. Accordingly the District Health Board is a public benefit entity for financial reporting purposes.

The projected financial statements of the Hawke's Bay District Health Board comprise the District Health Board, its 25% interest in Allied Laundry Services Limited, and its 16.7% interest in Central Region's Technical Advisory Services Limited which is jointly controlled by the six district health boards in the central region.

Basis Of Preparation

The financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently to all periods.

Statement of compliance

The financial statements of the district health board have been prepared in accordance with the requirements of the Crown Entities Act 2004, which includes the requirement to comply with generally accepted accounting practice in New Zealand (NZ GAAP). The financial statements have been prepared in accordance with Tier 1 Public Benefit Entity (PBE) accounting standards, and comply with those standards.

Presentation currency and rounding

The financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars unless otherwise specified.

Income and cost allocation

Output classes

Income and expenditure for each output class funded or provided by the Hawke's Bay District Health Board and reported in the statement of service performance, has been derived using the allocation system outlined below.

Direct revenue and costs are allocated directly to output classes. Indirect costs are allocated to output classes using appropriate cost drivers such as volumes provided.

The purchase units that comprise an output class change over time as clinical practice and medical technology develop. Consequently while the figures prepared for each year reported in the annual report will be consistent with the figures for each year reported in its associated annual plan, they are not necessarily consistent with the annual reports and annual plans of other years.

Performance against budget

The budget figures are those approved by the District Health Board in its annual plan. The budget figures are prepared in accordance with NZ GAAP, using accounting policies that are consistent with those adopted by the District Health Board for the preparation of the financial statements.

Patient Care Revenue

Ministry of Health population-based revenue

The Hawke's Bay District Health Board receives annual funding from the Ministry of Health based on Hawke's Bays share of the national population. Revenue is recognised in the year it is received.

Ministry of Health contract revenue

For contracts where the amount of revenue is substantively linked to the provision of quantifiable units of service (exchange contracts), revenue is recognised as services are provided.

For other contracts (non-exchange) the total revenue receivable under the contract is recognised as revenue immediately, unless there are substantive conditions in the contract. If there are substantive conditions, revenue is recognised when the conditions are satisfied. A condition could include the requirement to provide services to the satisfaction of the funder to receive or retain funding. Revenue for future periods is not recognised where the contract contains substantive termination provisions for failure to comply with the service requirements of the contract. Conditions and termination provisions need to be substantive, which is assessed by considering factors such as the past practice of the funder. Judgement is often required in determining the timing of revenue recognition for contracts that span a balance date and multi-year funding arrangements.

Revenue from other district health boards

Inter district patient inflow revenue occurs when a patient treated within the Hawke's Bay District Health Board region is domiciled outside of Hawke's Bay, and is recognised at time of discharge. The Ministry of Health credits Hawke's Bay District Health Board with a monthly amount based on estimated patient treatment for non-Hawke's Bay residents within Hawke's Bay. An annual wash-up occurs at year end to reflect the actual non-Hawke's Bay patients treated at Hawke's Bay District Health Board.

Other Crown entity contracted revenue

Other Crown entity contract revenue is recognised as revenue when services are provided and contract conditions have been met.

Other operating revenue

Revenue is measured at the fair value of consideration received or receivable.

Interest revenue

Interest revenue is recognised using the effective interest rate method.

Rental income

Rental income from investment property is recognised in the surplus or deficit on a straight-line basis over the term of the lease. Lease incentives granted are recognised as an integral part of the total rental income over the lease term.

Sale of goods

Revenue from goods sold is recognised when Hawke's Bay District Health Board has transferred to the buyer the significant risks and rewards of ownership of the goods and the District Health Board does not retain either continuing managerial involvement to the degree usually associated with ownership nor effective control over the goods sold.

Provision of services

Services provided to third parties on commercial terms are exchange transactions. Revenue from these services is recognised in proportion to the stage of completion at balance date.

Vested assets

Where a physical asset is gifted to or acquired by the Hawke's Bay District Health Board for nil or nominal cost, the fair value of the asset received is recognised as income when control over the asset is obtained.

Donated services

The activities of the Hawke's Bay District Health Board are reliant on services provided by volunteers. Volunteers services received are not recognised as revenue or expenditure by the District Health Board.

Other operating expenses

Operating lease payments

An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the term of the lease. Lease incentives received are recognised in the surplus or deficit as a reduction of rental expense over the lease term.

Financing Costs

Borrowing costs are recognised as an expense in the financial year in which they are incurred.

Attributed interest on finance leases are charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

Capital Charge

The capital charge is recognised as an expense in the financial year to which the charge relates.

Cash and cash equivalents

Cash and cash equivalents include cash on hand, deposits held on call with banks, and other short-term highly liquid investments with original maturities of three months or less.

Investments in bank term deposits are initially measured at the amount invested. After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest rate method, less any provision for impairment.

Debtors and other receivables

Receivables and prepayments are recorded at their face value, less any provision for impairment. A receivable is considered impaired when there is evidence that the Hawke's Bay District Health Board will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

Loans

Loans are initially recognised at fair value, then at amortised cost using the effective interest rate method.

Inventories

Inventories held for distribution

Inventories held for distribution, or consumption in the provision of services, that are not issued on a commercial basis are measured at cost on a first in first out basis, adjusted where applicable for any loss of service potential. Where inventories are acquired through non-exchange transactions, cost is the fair value at the date of acquisition.

Inventories held for sale

Inventories held for sale or use in the provision of goods and services on a commercial basis are valued at the lower of cost and net realisable value. The cost of purchased inventory is determined using the weighted average cost method.

The amount of any write-down for the loss of service potential or from cost to net realisable value is recognised in the surplus or deficit in the period of the write-down.

Non-current assets held for sale

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale, are measured at the lower of their carrying amount and fair value less costs to sell.

Any impairment losses for write-downs of non-current assets held for sale are recognised in the surplus or deficit. Any increase in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-current assets held for sale are not depreciated or amortised while they are classified as held for sale.

Property, plant and equipment

Property, plant and equipment consists of the following asset classes: land; buildings; clinical equipment; information technology; motor vehicles; and other equipment.

Land is measured at fair value, and buildings are measured at fair value less accumulated depreciation. All other asset classes are measured at cost, less accumulated depreciation and impairment losses.

Revaluations

Land and buildings are revalued with sufficient regularity to ensure that the carrying amount does not differ materially from fair value, and at least every five years. The carrying value of land and buildings are assessed annually to ensure that they do not differ materially from fair value. If there is evidence supporting a material difference, then the asset class will be revalued. Land and building revaluation movements are accounted for on a class-of-asset basis.

The net revaluation results are credited or debited to other comprehensive revenue and expense and are accumulated to an asset revaluation reserve in equity for that class of asset. Where this would result in a debit balance in the asset revaluation reserve, this balance is not recognised in other comprehensive revenue and expense but is recognised in the surplus or deficit. Any subsequent increase on revaluation that reverses a previous decrease in value recognised in the surplus or deficit will be recognised first in the surplus or deficit up to the amount previously expensed, and then recognised in other comprehensive revenue and expense. Surplus property is carried at the book value on the date the property was declared surplus less impairment losses until it is disposed of.

Additions

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the District Health Board and the cost of the item can be measured reliably. Work in progress is recognised at cost, less impairment, and is not depreciated.

In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

Disposals

Gains and losses on disposals are determined by comparing the proceeds with the carrying value of the asset. Gains and losses on disposals are reported net in the surplus or deficit. When revalued assets are sold, the amounts included in the revaluation reserve are transferred to accumulated surpluses/(deficits).

Subsequent costs

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to Hawke's Bay District Health Board and the cost of the item can be measured reliably. The costs of day-to-day servicing of property, plant and equipment are recognised in the surplus or deficit as they are incurred.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant and equipment other than land, at rates that will write-off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates have been estimated as follows:

Class of Asset	Estimated Life	Depreciation Rate
Buildings	5 to 40 years	2.5% to 20%
Clinical equipment	2 to 32 years	3% to 50%
Information technology	3 to 10 years	10% to 33%
Motor vehicles	3 to 20 years	5% to 33%
Other equipment	3 to 30 years	3.3% to 33%

Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter.

The residual value and useful life of an assets is reviewed, and adjusted if applicable, at each financial year end.

Impairment of property, plant and equipment and intangible assets

Hawke's Bay District Health Board does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Property, plant and equipment held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and the availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss is recognised in the surplus or deficit.

Intangible assets

Software acquisition and development

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software. Costs that are directly associated with the development of software for internal use are recognised as an intangible asset. Direct costs include costs of materials and services, employee costs and and any directly attributable overheads. Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred. Costs of software updates or upgrades are capitalised only when they increase the usefulness or value of the asset.

Rights in shared software developments are considered to have indefinite useful life as the district health board has the ability and intention to review any service level agreement indefinitely. As the rights are considered to have indefinite life, the intangible asset is not amortised and is tested for impairment annually.

Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. Amortisation begins when the assets is available for use and ceases at the date the asset is derecognised. The amortisation charge for each financial year is recognised in the surplus or deficit.

The useful lives and associated amortisation rates of major classes of intangibles assets have been estimated as follows:

Type of Asset	Estimated Life	Amortisation Rate
Acquired computer software	3 to 15 years	6.7% to 33%
Developed computer software	3 to 15 years	6.7% to 33%
NZ Health Partnerships Ltd Class B shares	Indefinite	Nil
Interest in CRISP	Work in progress	Nil

Impairment of intangible assets

Hawke's Bay District Health Board does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Intangible assets held at cost that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using a depreciated replacement cost approach, restoration cost approach, or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and the availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit. The reversal of an impairment loss is recognised in the surplus or deficit.

Intangible assets subsequently measured at cost that have an indefinite useful life, or are not yet available for use, are not subject to amortisation and are tested annually for impairment.

Investment properties

Investment properties are properties which are held either to earn rental income or for capital appreciation or for both. Investment properties are stated at fair value. If there is evidence supporting a material difference in value, an external, independent valuation company, having an appropriate recognised professional qualification and recent experience in the location and category of property being valued, will provide an assessment of the fair values of the properties. The fair values are based on market values, being the estimated amount for which a property could be exchanged on the date of valuation between a willing buyer and a willing seller in an arm's length transaction after proper marketing where the parties had each acted knowledgeably, prudently and without compulsion.

Any gain or loss arising from a change in fair value is recognised in the surplus or deficit. Rental income from investment property is accounted for as described in the accounting policy on rental income (see above).

When an item of property, plant and equipment is transferred to investment property following a change in its use, any differences arising at the date of transfer between the carrying amount of the item immediately prior to transfer and its fair value is recognised directly in equity if it is a gain. Upon disposal of the item the gain is transferred to accumulated surpluses/(deficits). Any loss arising in this manner is recognised immediately in the surplus or deficit.

If an investment property becomes owner-occupied, it is reclassified as property and its fair value at the date of reclassification becomes its cost for accounting purposes of subsequent recording. When Hawke's Bay District Health Board begins to redevelop an existing investment property for continued future use as investment property, the property remains an investment property, which is measured based on the fair value model, and is not reclassified as property, plant and equipment during the redevelopment.

Investments in associates

Investments in associate entities are accounted for using the equity method. An associate is an entity over which the district health board has significant influence, and that is neither a subsidiary nor an interest in a joint venture. The investment is initially recognised at cost and the carrying amount is increased or decreased to recognise the district health board's share of the surplus or deficit of the associate after the date of recognition. Distributions received from an associate reduce the carrying amount of the investment.

If the share of deficits of an associate equals or exceeds the district health board's interest in the associate, further deficits are not recognised. After the district health board's interest is reduced to zero, additional deficits are provided for, and a liability is recognised, only to the extent that the district health board has incurred legal or constructive obligations or made payments on behalf of the associate. If the associate subsequently reports surpluses, the district health board will resume recognising its share of those surpluses only after its share of the surpluses equals the share of deficits not recognised.

Borrowings and finance leases

Borrowings are initially recognised at their fair value plus transaction costs. After initial recognition, all borrowings are measured at amortised cost using the effective interest method. Borrowings are classified as current liabilities unless Hawke's Bay District Health Board has an unconditional right to defer the settlement of the liability for at least 12 months after balance date.

Finance leases transfer to the lessee substantially all the risks and rewards incidental to ownership of an asset, whether or not title is eventually transferred. At the commencement of the lease term, finance leases are recognised as assets and liabilities in the statement of financial position at the lower of the fair value of the leased asset or the present value of the minimum lease payments. The finance component is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability. The amount recognised as an asset is depreciated over its useful life. If there is no certainty as to whether the district health board will obtain ownership at the end of the lease term, the asset is fully depreciated over the shorter of the leased term and its useful life.

Employee entitlements

Short-term employee entitlements

Employee benefits that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave and continuing medical education leave earned, but not yet taken at balance date, retiring and long service leave entitlements expected to be settled within 12 months, and sick leave.

The liability for sick leave is recognised to the extent that absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward on balance date, to the extent that it will be used by staff to cover those future absences.

The liability and an expense are recognised for bonuses where it is a contractual obligation or where there is a past practice that has created a constructive obligation and a reliable estimate of the obligation can be made.

Long-term employee entitlements

Employee entitlements that are due to be settled beyond 12 months after the end of the period in which the employee renders the related service, such as long service leave and retirement gratuities, have been calculated on an actuarial basis. The calculations are based on: likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement and contractual entitlements information; and the present value of the estimated future cash flows.

Superannuation schemes

Defined contribution schemes

Obligations for contributions to Kiwisaver and the Government Superannuation Fund are accounted for as defined contribution superannuation schemes and are recognised as an expense in the surplus or deficit as incurred.

Defined benefit schemes

The Hawke's Bay District Health Board makes employer contributions to the Defined Benefit Plan Contributors Scheme (the scheme), which is managed by the Board of Trustees of the National Provident Fund. The scheme is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine from the terms of the scheme, the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation. The scheme is therefore accounted for as a defined contribution scheme.

Provisions

A provision is recognised for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that an outflow of future economic benefits will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditure expected to be required to settle the obligation using a discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as an interest expense and included in financing costs.

Taxes

Goods and services tax

All items in the financial statements are presented exclusive of goods and services tax (GST), except for receivables and payables that are presented on a GST inclusive basis. Where GST is not recoverable as an input tax, it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) is included as part of receivables or payables in the statement of financial position.

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as a net operating cash flow in the statement of cash flows.

GST relating to revenue from the Crown is recognised when the income is accrued in accordance with section 9(7) of the Goods and Services Tax Act 1985.

Commitments and contingencies are disclosed exclusive of GST.

Income tax

Hawke's Bay District Health Board is a public authority and consequently is exempt from the payment of income tax under section CB3 of the Income Tax Act 2007.

7.4 APPENDIX 4 Dimensions of DHB Performance

Summary Table: 2016/17 Performance Expectations

The DHB monitoring framework aims to provide a rounded 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)

Performance measure	2016/17 Performance expectation/target				
PP6: Improving the health status of people with severe mental illness through improved access. Targets are for Māori and Total population	Age 0-19: ≥4%				
	Age 20-64: ≥5%				
	Age 65+: ≥1.15%				
PP7: Improving mental health services using transition (discharge) planning	Long term clients	Provide a report as specified			
	Child and Youth with a Transition (discharge) plan	At least 95% of clients discharged will have a transition (discharge) plan.			
PP8: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds	Mental Health Provider Arm				
	Age 0-19	<= 3 weeks	80%	<=8 weeks	95%
	Addictions (Provider Arm and NGO)				
	Age 0-19	<= 3 weeks	80%	<=8 weeks	95%
PP10: Oral Health- Mean DMFT score at Year 8	Ratio year 1: ≤0.92				
	Ratio year 2: ≤0.88				
PP11: Children caries-free at five years of age	Ratio year 1: ≥67%				
	Ratio year 2: ≥69%				
PP12: Utilisation of DHB-funded dental services by adolescents (School Year 9 up to and including age 17 years)	% year 1: ≥85%				
	% year 2: ≥87%				
PP13: Improving the number of children enrolled in DHB funded dental services	0-4 years - % year 1: ≥95%				
	0-4 years - % year 2:: ≥95%				
	Children not examined 0-12 years % year 1: ≤4.8				
	Children not examined 0-12 years % year 2: ≤4.7				
PP20: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke) Focus area 1: Long term conditions	Report on delivery of the actions and milestones identified in the Annual Plan.				
Focus area 2: Diabetes services	Reporting on implementation of actions in the Diabetes plan "Living Well with Diabetes"				
	Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1c indicator).				
Focus area 3: Cardiovascular (CVD) health	Indicator 1: 90 percent of the eligible population will have had their cardiovascular risk assessed in the last five years.				
	Indicator 2: 90 percent of 'eligible Māori men in the PHO aged 35-44 years' who have had their cardiovascular risk assessed in the last five years.				
	Report on delivery of the actions and milestones identified in the Annual Plan				

Performance measure	2016/17 Performance expectation/target
Focus area 4: Acute heart service	70 percent of high-risk patients will receive an angiogram within 3 days of admission. ('Day of Admission' being 'Day 0') by ethnicity.
	Over 95 percent of patients presenting with ACS who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days.
	Over 95 percent of patients undergoing cardiac surgery at the five regional cardiac surgery centres will have completion of Cardiac Surgery registry data collection with 30 days of discharge.
	Report on deliverables for acute heart services identified in annual plan and actions and progress in quality improvement initiatives to support the improvement of agreed indicators as reported in ANZACS-QI
Focus area 5: Stroke Services	6 percent of potentially eligible stroke patients thrombolysed
	80 percent of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway
	80 percent of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission
	Report on delivery of the actions and milestones identified in the Annual Plan.
PP21: Immunisation coverage	95% of two year olds fully immunised
	95% of five year olds fully immunised
	70% of eligible girls fully immunised - HPV vaccine
PP22: Improving system integration	Report on delivery of the actions and milestones identified in the Annual Plan. In relation to SLM measures - A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17
PP23: Improving Wrap Around Services – Health of Older People	Report on delivery of the actions and milestones identified in the Annual Plan.
	- The % of older people receiving long-term home support who have a comprehensive clinical assessment and an individual care plan. Target ≥95% - Percentage of people in aged residential care by facility and by DHB who have a subsequent interRAI long term care facility (LTCF) assessment completed within 230 days of the previous assessment. Target ≥77% - The percentage of LTCF clients admitted to an Aged Residential Care (ARC) facility who had been assessed using an interRAI Home Care assessment tool in the six months prior to that first long term care facility (LTCF) assessment. Target: improve on current performance
PP25: Prime Minister's youth mental health project	*Initiative 1*: School Based Health Services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities. Provide quarterly quantitative reports on the implementation of SBHS, as per the template provided. Provide quarterly narrative progress reports on actions undertaken to implement Youth Health Care in Secondary Schools: A framework for continuous quality improvement in each school (or group of schools) with SBHS. *Initiative 3: Youth Primary Mental Health* Provide quarterly narrative progress reports (as part of PP26 Primary Mental Health reporting) with actions undertaken in that quarter to improve and strengthen youth primary mental health (12-19 year olds with mild to moderate mental health and/or addiction issues) to achieve the following outcomes: early identification of mental health and/or addiction issues, better access to timely and appropriate treatment and follow up, equitable access for Māori, Pacific and low decile youth populations. Provide quantitative reports using the template provided under PP26 *Initiative 5*: Improve the responsiveness of primary care to youth. Provide quarterly narrative reports with actions undertaken in that quarter to ensure the high performance of the youth SLAT(s) (or equivalent) in your local alliancing arrangements.

Performance measure	2016/17 Performance expectation/target	
	Provide quarterly narrative reports with actions the youth SLAT has undertaken in that quarter to improve the health of the DHB's youth population (for the 12-19 year age group at a minimum) by addressing identified gaps in responsiveness, access, service provision, clinical and financial sustainability for primary and community services for the young people, as per your SLAT(s) work programme.	
PP26: The Mental Health & Addiction Service Development Plan	Provide reports as specified for each focus area: Primary Mental Health; District Suicide Prevention and Postvention; Improving Crisis response services; Improve outcomes for children; and Improving employment and physical health needs of people with low prevalence conditions	
PP27: Supporting vulnerable children	Report on delivery of the actions and milestones identified in the Annual Plan.	
PP28: Reducing Rheumatic fever	Provide a progress report against DHBs' rheumatic fever prevention plan	
	Hospitalisation rate ≤1.5 (per 100,000 DHB total population) for acute rheumatic fever	
	Reports on progress in following -up known risk factors and system failure points in cases of first episode & recurrent rheumatic fever.	
PP29: Improving waiting times for diagnostic services	Coronary angiography – 95% of accepted referrals for elective coronary angiography will receive their procedure within 3 months (90 days)	
	CT and MRI – 95% of accepted referrals for CT scans, and 85% of accepted referrals for MRI scans will receive their scan within than 6 weeks (42 days)	
	Diagnostic colonoscopy 85% of people accepted for an urgent diagnostic colonoscopy will receive their procedure within two weeks (14 calendar days, inclusive), 100% within 30 days 70% of people accepted for a non-urgent diagnostic colonoscopy will receive their procedure within six weeks (42 days), 100% within 90 days	
	Surveillance colonoscopy 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	Part A: Faster cancer treatment 31 day indicator	85 percent of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat
	Part B: Shorter waits for cancer treatment radiotherapy and chemotherapy	All patients ready-for-treatment receive treatment within four weeks from decision-to-treat.
PP31: Better help for smokers to quit in public hospitals	95 percent 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	
SI1: Ambulatory sensitive (avoidable) hospital admissions	Age group 0 – 4 years. A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22.	
	Age group 45-64 years. Target: Māori rate 138% of national ASH rate, while ensuring there is no increase in Hawkes Bay DHB's total population rate	
SI2: Delivery of Regional Service Plans	Provision of a single progress report on behalf of the region agreed by all DHBs within that region	
SI3: Ensuring delivery of Service Coverage	Report progress achieved during the quarter 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	an intervention rate of 21.0 per 10,000 of population
	cataract procedures	an intervention rate of 27.0 per 10,000
	cardiac surgery	a target intervention rate of 6.5 per 10,000 of population DHBs with rates of 6.5 per 10,000 or above in previous years are required to maintain this rate.
	percutaneous revascularization	a target rate of at least 12.5 per 10,000 of population
	coronary angiography services	a target rate of at least 34.7.5 per 10,000 of population

Performance measure	2016/17 Performance expectation/target	
SI5: Delivery of Whānau Ora	Performance expectations are met across all the measures associated with the five priority areas: Mental health, Asthma, Oral health, Obesity, Tobacco, and narrative reports cover all areas indicated	
SI7: SLM total acute hospital bed days per capita	A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22.	
SI8: SLM patient experience of care	Hospital: Provide a report each quarter as specified in the measure definition. A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22.	
	Primary care: A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22.	
SI9: SLM amenable mortality	A jointly agreed (by district alliances) System Level Measure improvement plan, including improvement milestones, will be provided at the end of quarter one 2016/17 via measure PP22.	
OS3: Inpatient Length of Stay	Elective LOS	1.55 days
	Acute LOS	2.35 days
OS8: Reducing Acute Readmissions	tba - indicator definition under review	
OS10: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections Focus area 1: Improving the quality of identity data	New NHI registration in error A. Greater than 2% and less than or equal to 4% B. Greater than 1% and less than or equal to 3% C. Greater than 1.5% and less than or equal to 6%	
	Recording of non-specific ethnicity Greater than 0.5% and less than or equal to 2%	
	Update of specific ethnicity value in existing NHI record with a non-specific value Greater than 0.5% and less than or equal to 2%	
	Validated addresses unknown Greater than 76% and less than or equal to 85%	
	Invalid NHI data updates (no confirmed target)	
Focus area 2: Improving the quality of data submitted to National Collections	NBRS links to NNPAC and NMDS Greater than or equal to 97% and less than 99.5%	
	National collections file load success Greater than or equal to 98% and less than 99.5%	
	Assessment of data reported to the National Minimum Data Set (NMDS) Greater than or equal to 75%	
	NNPAC timeliness Greater than or equal to 95% and less than 98%	
Output 1: Mental health output Delivery Against Plan	Volume delivery for specialist Mental Health and Addiction services is within: a) five percent variance (+/-) of planned volumes for services measured by FTE, b) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan	
Developmental measure DV6: SLM youth access to and utilisation of youth appropriate health services	No performance target/expectation set	
Developmental measure DV7: SLM number of babies who live in a smoke-free household at six weeks post natal	No performance target/expectation set	